NO. 11-35940

IN THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PAUL EZRA RHOADES,
Petitioner-Appellant,

vs.

BRENT REINKE, *et al*.,
Respondent-Appellees.

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

PETITIONER-APPELLANT'S EXCERPTS OF RECORD

VOLUME V OF VI

CAPITAL HABEAS UNIT
Federal Defender Services of Idaho
Oliver W. Loewy, IL #6197093
Teresa A. Hampton, ID #4364
702 W. Idaho Street, Suite 900
Boise ID 83702
Telephone: 208-331-5530
Facsimile: 208-331-5559
Oliver_Loewy@fd.org
Teresa_Hampton@fd.org

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Teresa A. Hampton, ID #4364
Federal Defender Services of Idaho
702 W. Idaho, Suite 900
Boise, Idaho 83702
Telephone: (208) 331-5530
Facsimile: (208) 331-5559
ECF: Oliver_Loewy@fd.org
Teresa_Hampton@fd.org

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAUL EZRA RHOADES, Mr. Rhoades, v. **BRENT REINKE,** in his official capacity as Director, Idaho Department Of Correction; **RANDY BLADES**, in his official capacity as Warden, Idaho Maximum Security Institution; **DOES 1-50, UNKNOWN EXECUTIONERS,** in their official capacities as Employees and/or Agents of the Idaho Department of Correction.	Civil Action No. 11-445 **COMPLAINT**

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NATURE OF ACTION

1. This Complaint seeks relief pursuant to 42 U.S.C. §1983, 18 U.S.C. §3599, and 28 U.S.C. §2201.

2. Mr. Rhoades seeks relief pursuant to 42 U.S.C. §1983, 18 U.S.C. §3599, and the United States Constitution for violations and threatened violations of his rights to be free from cruel and unusual punishment as prohibited by the Eighth and Fourteenth Amendments to the United States Constitution; the deliberate indifference of the Defendants toward Mr. Rhoades's health and safety in violation of the Eighth and Fourteenth Amendments to the United States Constitution; the infringement of his fundamental right against cruel and unusual punishment in violation of the Due Process Clause of the Fourteenth Amendment; and the infringement on his statutory right to counsel at his execution as well as his counsel's First Amendment right to witness his execution.

3. Mr. Rhoades seeks declaratory judgments pursuant to 28 U.S.C. §2201 clarifying that the safeguards contained in the Controlled Substances Act ("CSA") (21 U.S.C. §801 *et seq.*) and the Food, Drug and Cosmetic Act ("FDCA") (21 U.S.C. §301 *et seq.*) apply to his lethal injection in Idaho; that Defendants are now violating or, if they act in compliance with Idaho Department of Correction policy, will violate these statutes because the means the policy prescribes for Defendants to obtain and administer the lethal injection chemicals violate the aforementioned federal statutes.

4. All statements of fact in this Complaint are based upon sworn testimony, declarations or affidavits, or upon well-founded information or belief.

5. All statements of fact and allegations made anywhere in this Complaint are incorporated by reference into each legal claim as if fully rewritten therein.

JURISIDICTION AND VENUE

6. The Court has jurisdiction pursuant to 28 U.S.C. §§1331, 1343, 2201, and 2202.

7. The Court has personal jurisdiction over each Defendant in this matter because events giving rise to this claim have already occurred or will occur in Boise, Idaho.

8. Venue in the Court is proper under 28 U.S.C. §1391 because events giving rise to this action have occurred or will occur in this District.

PARTIES

9. Mr. Rhoades is a United States citizen residing at the Idaho Maximum Security Institution in Boise, Idaho, and is under the control and supervision of the Idaho Department of Correction. The State of Idaho has not set a date for Mr. Rhoades's execution. Mr. Rhoades now has pending before the United States Supreme Court, in each of his two capital cases, an application seeking certiorari review of the Ninth Circuit Court of Appeals' decision denying relief. Should the Supreme Court deny review in either case, Mr. Rhoades anticipates that the State of Idaho will seek a state court order to execute him on a date certain.

10. Defendant Brent Reinke is the Director of the Idaho Department of Correction ("IDOC"). As Director, Reinke is responsible for the daily supervision of operations of the Idaho Department of Correction. He has a duty to ensure that executions are carried out in compliance with the Eighth and Fourteenth Amendments to the United States Constitution, Idaho law, and departmental procedure. Defendant Reinke is sued in his official capacity as Director of the IDOC. Defendant Reinke is a citizen of the United States and a resident of the State of Idaho.

11. Defendant Randy Blades is the Warden of the IDOC's Idaho Maximum Security Institution ("IMSI"), where any execution will occur. As Warden, Defendant Blades is responsible for the day-to-day operations of IMSI. He also has a duty to ensure that executions are carried out in compliance with the Eighth and Fourteenth Amendments to the United States Constitution, Idaho law, and departmental procedure. Defendant Blades is sued in his official capacity as Warden of IMSI. Defendant Blades is a citizen of the United States and a resident of the State of Idaho.

12. Defendants Unknown Employees and/or Agents of the IDOC are involved in the implementation of the IDOC's execution procedures, including procedures governing the preparation and administration of chemicals designed to execute people. Mr. Rhoades is not yet able to further identify these individuals. However, the other Defendants can easily identify them because each is within the set of individuals whom the named Defendants consider qualified to participate in

executions and because the Defendants are responsible for the selection of execution team members.

13. Upon information and belief all unnamed Defendants are United States citizens and residents of the State of Idaho. Each is sued in his or her official capacity.

JUSTICIABLE CASE OR CONTROVERSY

14. There is a real and justiciable case or controversy between the parties.

15. This lawsuit does not challenge the fact of Mr. Rhoades's convictions and death sentences or the constitutionality of Idaho's statute requiring execution by lethal injection. Challenges to Mr. Rhoades's convictions and death sentences are pending before the United States Supreme Court.

16. Upon information and belief, the IDOC either has very recently or is about to adopt a lethal injection protocol with which Defendants will have to comply if executing Mr. Rhoades later this or early next year. Mr. Rhoades has obtained a copy of a draft protocol ("Draft Protocol") which IDOC counsel has stated "substantially reflects the Department's practices." Exhibits 1 (Draft Protocol) & 2 (IDOC counsel letter). The IDOC continues to publish on its website an earlier protocol ("2006 Protocol"), but that protocol is materially different from the Draft Protocol. Exhibit 3.

17. Mr. Rhoades challenges the constitutionality of his execution, whether done in accordance with the Draft Protocol or the 2006 Protocol, or in the absence of a controlling protocol. Each of these challenges is brought pursuant to 42 U.S.C. §1983.

18. Mr. Rhoades seeks a declaratory judgment that the safeguards contained in the CSA and FDCA apply to his lethal injection in Idaho and that each Defendant is now violating or, if each acts in accordance with either IDOC policy, will violate these statutes by obtaining and administering (or supervising the obtaining and administering of) the lethal injection chemicals in accordance with either IDOC policy. Mr. Rhoades seeks these declaratory judgments pursuant to 28 U.S.C. §2201.

19. Absent judicial intervention, Mr. Rhoades's execution will be pursuant to Defendants' arbitrary and capricious lethal injection protocol or pursuant to no mandated protocol at all. Either way, Mr. Rhoades's execution will violate his right against cruel and unusual punishment. There is a justiciable case or controversy regarding the constitutionality and other illegality of the IDOC lethal injection protocols, and the constitutionality of an execution carried out in the absence of any protocol.

FACTS COMMON TO ALL CLAIMS

20. Mr. Rhoades was twice sentenced to death in 1988, once in the District Court of Bonneville County, Idaho, and once in the District Court of Bingham County, Idaho.

A. Multiple Botched Lethal Injection Executions Are a Contemporary Reality.

21. Lethal injection was developed at least partly in response to the visually revolting and apparently unnecessarily painful nature of botched executions by electrocution and gas. *See Baze v. Kentucky*, 553 U.S. 35, 43 n.1 (2008).

22. Regardless of the intent, however, a lethal injection protocol that removes the visually troubling aspects of electric chair and gas chamber executions may still preserve the unnecessary pain associated with those methods. *Baze*, 553 U.S. at 53.

23. At least thirty-one botched lethal injection executions occurred between 1982 and 2001. Deborah W. Denno, *When Legislatures Delegate Death: The Troubling Paradox Behind State Uses of Electrocution And Lethal Injection And What It Says About Us*, 63 Ohio St. L.J. 63, 139-41 (2002) (listing by inmate name the botched lethal injection executions, and describing evidence of error).

24. While some cases are included in Denno's list because it took an extended period of time to initiate the intravenous catheter ("IV"), others are included because the inmate needlessly suffered after the chemicals started to flow.

25. Witnesses reported that during his 1992 Oklahoma execution, Robyn Lee Parks "violently gagged and bucked in his chair after the drugs were administered." *Id.* at 140.

26. Justin Lee May, executed by the State of Texas in 1992, "gasped and reared against his restraints during his nine-minute death." *Id.* at 140.

27. After the chemicals started to flow into Luis M. Mata during his 1996 Arizona execution, his "head jerked, his face contorted, and his chest and stomach sharply heaved." *Id.*

28. Scott Dawn Carpenter, executed by the State of Oklahoma in 1997, "gasped and shook for three minutes following the injection." *Id.*

29. Bert Leroy Hunter, executed by the State of Missouri in 2000, "lost consciousness and his body convulsed against its restraints during what one witness called 'a violent and agonizing death.'"*Id.*

30. In each of these five executions, the protocol used called for administering a series of three chemicals, starting with sodium thiopental, an anesthetic, followed by a paralytic and, then, a cardiac-arrest inducing chemical.

31. This year has seen three botched lethal injection executions, in each of which the protocol called for using pentobarbital as the anesthetic.

32. On June 16, 2011, the State of Alabama executed Eddie Powell under the Alabama protocol which called for using pentobarbital instead of sodium thiopental as the first of three lethal-injection chemicals. *Powell v. Thomas*, 2011 WL 243748 (11th Cir. June 15, 2011).

33. The Executive Director of the Middle District of Alabama Federal Defender Program, described Mr. Powell's execution:

> Shortly after the chaplain stopped praying, Mr. Powell violently jerked his head up off of the gurney. His eyes were wide open and looked glazed and confused. He seemed to be looking and he turned his head from side to side. His jaw muscles seemed to clench. He appeared to be in pain. He lay his head back down, but

> his eyes still appeared to be slightly open. Because we were seated in an observation room on Mr. Powell's side, it was difficult to tell how long this lasted, but his eyes appeared to remain open in this position for quite a while. The entire process lasted about 25 minutes and his eyes remained open in this fashion until towards the end.

Exhibit 4, p. 3, para. 12 (Affidavit of Christine Freeman, *DeYoung v. Owens et al*., No. 11-CV-2324-SCJ (N.D. Ga.), Complaint Exhibit #16).

34. The *Birmingham News* reported:

> A chaplain, present in the execution chamber, prayed with Powell, taking him by the hand. Powell closed his eyes.
>
> After a moment his eyes opened again and he raised his head and neck off the gurney. Seemingly confused and startled, he jerked his head to one side and began breathing heavily, his chest rose and contracted. The execution cocktail drugs had begun to be administered. After a few seconds his breathing slowed again and he closed his eyes. When the chaplain let go of his hand, it was limp in the gurney's straps and Powell's head lay back down.

Exhibit 5, p. 1 (*Birmingham News* article, 6-16-2011).

35. On June 23, 2011, the State of Georgia executed Roy Blankenship by lethal injection.

36. In executing Mr. Blankenship, the State of Georgia used pentobarbital as the first chemical in its three-chemical protocol.

37. An Associated Press reporter who witnessed Mr. Blankenship's execution wrote that:

> He was laughing and chatting with a prison chaplain in the moments before his execution, at one point trying to converse with the observers sitting behind a glass window.

> As the injection began, he jerked his head toward his left arm and made a startled face while blinking rapidly. He soon lurched to his right arm, lunging with his mouth agape twice. He then held his head up, and his chin smacked as he mouthed words that were inaudible to observers.
>
> Within three minutes, his movements slowed. About six minutes after the injection began a nurse checked his vital signs to ensure he was unconscious before the execution could continue. He was pronounced dead nine minutes later. His eyes never closed.

Exhibit 6, p. 4 (Affidavit and attached newspaper article of Associated Press reporter Greg Bluestein, *DeYoung v. Owens*, No. 11-cv-2324-SCJ (N.D. Ga.)).

38. On May 6, 2011, South Carolina executed Jeffrey Motts.

39. In executing Mr. Motts, the State of South Carolina used the same three chemicals used to kill Mr. Blankenship. Exhibit 7, p. 1 (Associated Press reporter Jeffrey Collins's newspaper article noting that the first chemical—the anesthetic—was pentobarbital).

40. During the execution process, Mr. Motts reportedly "took several heavy breaths, blinked and his head jerked slightly for about a minute before his breaths became shallow and eventually stopped about 90 seconds later." *Id.* at 1.

B. A Potential Cause of Botched Executions: Problems Relating to the Initiation, Maintenance and Administration of Chemicals through IVs.

41. Initiating and maintaining an functioning, open and unblocked IV, and delivering chemicals through an IV are complex skills which require training, experience, and competence.

42. Absent proper training and practice, there is a high risk that the IV will not serve as a reliable mechanism for delivering chemicals into the bloodstream.

43. In the lethal injection context, this means that there is a high risk that an insufficient amount of anesthetic will reach the prisoner, leaving the prisoner to experience the pain caused by a paralytic chemical and a cardiac-arrest inducing chemical which do reach him.

44. The necessary training and experience needed to avoid this high risk is reserved for advanced healthcare professionals.

45. Infiltration is one problem commonly encountered with initiating and maintaining an IV and administering chemicals through an IV.

46. David Waisel, M.D., an anesthesiologist with one of Harvard University's teaching hospitals, Childrens Hospital of Boston, has recently testified in federal court regarding potential difficulties with initiating and maintaining an IV and with administering chemicals through an IV.

47. After an IV is initiated with the fluid flowing into the blood vessel, the IV can shift so that the fluid flow is redirected from the blood vessel into the surrounding soft tissue (and, sometimes, flowing outside of the body). Exhibit 8, p. 53 (Testimony of David Waisel, M.D., *Blankenship v. Owens et al.*, No. 11-CV-202236 (Super.Ct, Fulton County Ga.)).

48. Under these conditions, the IV is said to be infiltrated. *Id*.

49. Infiltration stretches the tissue, including the skin, which can be excruciatingly painful. *Id*.

50. Some medications cause extraordinary pain when they infiltrate into soft tissue. *Id.*

51. If the IV infiltrates or is initiated improperly such that the fluid never reaches a blood vessel, any anesthetic administered through that IV will not have its intended effect.

52. If an anesthesia-inducing chemical does not have its intended effect on a prisoner being executed, the prisoner will not be anesthetized against the pain and suffering caused by any other chemicals subsequently administered through a functioning, open, and unblocked back-up IV.

53. IV infiltration is not all-or-nothing: an insufficient amount of anesthesia-inducing chemical could reach the prisoner while a sufficient amount of the paralytic and cardiac arrest inducing chemicals to cause extreme pain could reach him.

54. To assess whether an IV is infiltrated, a properly trained and experienced individual inspects the site, visually and tactilely. Exhibit 8, p. 52.

55. Dr. Waisel explained what a properly trained and experienced person does in inspecting an IV site to assess whether an IV is infiltrated:

> I'm looking for a swelling in that area *which can be very subtle*. I am feeling for coolness in that area which may indicate distribution of the I.V. fluid right at that site. I am assessing to see[,] *if I pinched the vein—obstructed the vein[,] pinch the vein is not the proper term*—higher up[,] [d]oes that stop the I.V. flow[,] which it should if the I.V. is in the vein. And . . . it's not [stopped] if it's infiltrated and I think most anesthesiologists . . . have a very low threshold for replacing the I.V. because [an] infiltrated I.V.—in addition to not working—can cause a great deal of pain.

Id. at 52 (emphasis added).

56. Another potential problem is that the chemicals never reach the prisoner, or reach him in only a fraction of the intended dose, because of leaks in the IV tubing.

57. Typically, several sections of IV tubing are connected end-to-end to reach from the point of administration to the prisoner.

58. With this setup, there is a risk that the IV line will leak at a connection point, particularly if one tube is improperly connected to the next.

59. It is also possible for a poorly set IV to leak at the IV site, i.e.- at the connection between the IV tubing and the needle.

60. Either scenario - leaking at IV tubing connection points or leaking at the IV site - can lead to inadequate anesthesia reaching the prisoner.

61. Either scenario can, therefore, result in the prisoner experiencing conscious paralysis, in which he perceives the paralysis and suffocation caused by the pancuronium bromide (or other paralytic) and the excruciating pain caused by the potassium chloride. *Id.* at 57.

C. Idaho Statutes

62. Idaho legislative mandates regarding executions have long been contained in Idaho Code §19-2716.

63. The legislature last amended Idaho Code §19-2716 in 2009.

64. Idaho Code §19-2716 is set out in full in Exhibit 9.

65. Idaho Code §19-2716 provides that the "substance or substances" to be used in an execution must be "approved by the [IDOC] director[.]"

66. Idaho Code §19-2716 provides that the IDOC director must "determine the procedures to be used in any execution."

D. The IDOC Published Lethal Injection Rules

67. The IDOC electronically publishes its rules governing a variety of matters, including lethal injection. http://www.idoc.idaho.gov.

68. According to the IDOC website:

> Through providing on this website access to policies, standard operating procedures, and related manuals, forms, administrative rules, and statutes, the department is making every attempt to be a transparent agency and be fully compliant with Idaho public records law. However, Idaho public records law does allow the department to limit access or exempt from disclosure any policy-related document that, if released, may be a detriment to the safety and/or security of our correctional facilities, staff, or offenders. Where we have determined that such risks exist, those policy-related documents are easily identifiable.

http://www.idoc.idaho.gov/content/about_us/policies_and_forms (last visited 9/13/2011).

69. Since at least 2006, the IDOC has continuously published without change three rules relating to lethal injection: Control No. 135.02.01.001, Policy No. 135, and Directive No. 401.06.03.069.

70. Each of these three rules is set out in full in Exhibit 3 (Control No. 135.02.01.001 is set out in full in Exhibit 3. Policy No. 135 is set out in full in Exhibit 10, and Directive No. 401.06.03.069 is set out in full in Exhibit 11.

71. Of the three rules, Control No. 135.02.01.001 is the most detailed. Hereinafter, Control No. 135.02.01.001 is referred to as Idaho's "2006 Protocol."

72. Insofar as the procedures to be used in executing a prisoner are concerned, everything contained in Policy No. 135 is also contained in the 2006 Protocol.

73. Directive No. 401.06.03.069 excludes certain individuals from participating in executions.

74. Directive No. 401.06.03.069 does not provide for any step to be taken in preparation for an execution.

75. The 2006 Protocol states that it was approved on January 1, 1994, reviewed on March 23, 2006, and was to be next reviewed on March 23, 2008. Exhibit 3, p. 1.

76. Nothing in the 2006 Protocol indicates that it actually was reviewed in March, 2008, or at any later time.

77. The 2006 Protocol sets out the chemicals to be used:

- Two (2) syringes, each containing 5.0g sodium pentothal [i.e.-thiopental], as a normal anesthetic
- Three (3) syringes, each containing 50 ml of 1 mgm/ml pavulon, a curare preparation, to stop muscle spasms as the anesthetic takes effect; and
- Two (2) syringes each containing 50 ml of 2 mEq/ml potassium chloride, the lethal agent to stop the heart.

Exhibit 3, pp. 6-7.

78. Beyond stating that the above-listed chemicals will be (presumably) drawn into syringes, the 2006 Protocol does not describe or otherwise provide instruction for how the chemicals are to be administered to the condemned prisoner.

79. Unlike lethal injection protocols from other states, the 2006 Protocol does not provide for initiating one or more IVs into peripheral veins to be used to administer the lethal chemicals.

80. Nor does the 2006 Protocol imply IV administration by, for example, providing for saline to prevent clogging between injections. Cf. infra at ¶ 98 (noting that the Draft Protocol provides for saline to prevent clogging between injections).

81. The 2006 Protocol directs that "[t]he warden of the Idaho Maximum Security Institution . . . will establish a field memorandum to identify authority and guidelines to carry out the execution of the condemned offender." Exhibit 3, p. 1.

82. Assuming the field memorandum exists, the IDOC did not disclose it to undersigned counsel or a third party in response to their separate Idaho Public Records Act requests for the IDOC's lethal injection protocol and related documents.

83. No such field memorandum is published on the IDOC website.

84. The 2006 Protocol does not provide for a consciousness check of any kind at any time during the execution procedure.

85. The 2006 Protocol does not include any minimum qualifications for execution team members or anyone else who may participate in an execution.

E. The IDOC Draft Lethal Injection Protocol

86. On or about March 11, 2011, pursuant to the Idaho Public Records Act, undersigned counsel requested that the IDOC provide its current execution protocol and related information. Exhibit 12.

87. Through counsel, the IDOC denied undersigned counsel's request. Exhibit 13.

88. In May, 2011, undersigned counsel learned that the IDOC granted in part and denied in part a public records request for its execution protocol and related information made by the University of California, Berkeley, School of Law ("the Berkeley request").

89. The IDOC granted the Berkeley request to the extent that it provided a document in the form of a Standard Operating Procedure ("SOP") entitled "Execution Procedures" and assigned Control No. 135.02.01.001. Exhibits 14 (Berkeley request), 2 (IDOC counsel letter), & 1 (SOP).

90. That SOP's control number is the same control number assigned to the Standard Operating Procedure published on the IDOC website.

91. The SOP is referred to throughout this Complaint as the Draft Protocol.

92. In its cover letter in response to the Berkeley request, IDOC counsel cautioned "that the SOP is a draft and while it substantially reflects the Department's practices, it is subject to further revision." Exhibit 2.

93. "CONFIDENTIAL DRAFT" appears in large capital letters at a diagonal attitude across the face of each page of the Draft Protocol.

94. The Draft Protocol calls for the use of three chemicals.

95. The first, sodium thiopental ("thiopental"), is a barbiturate and widely referred to as Sodium Pentothal and thiopental.

96. The second, pancuronium bromide, is a paralytic and widely referred to by its brand name, Pavulon.

97. The third chemical, potassium chloride, interferes with the electricity of the heart, causing it to stop beating.

98. In addition to listing the chemicals to be used, the Draft Protocol specifies some steps to be taken in administering them. Exhibit 1 at paras. 5 & 10. Paragraph 5 of the Draft Protocol states:

> The Director has approved the following lethal injection substances and methods:
>
> - Two (2) syringes, each containing 5.0 g sodium pentothal [aka thiopental], as a normal anesthetic
> - Three (3) syringes, each containing 50 mg of pavulon [aka pancuronium bromide], a curare preparation, to stop muscle spasms as the anesthetic takes effect; and
> - Two (2) syringes each containing 240 mill equivalents of potassium chloride, the lethal agent to stop the heart.
> - Four (4) syringes each containing 25 mg of saline to prevent clogging between injections.

Exhibit 1, p. 6.

99. The Draft Protocol contemplates that additional steps will be prescribed in a field memorandum, which the Draft Protocol instructs "will [be] establish[ed]" by the Idaho Maximum Security Institution warden. Exhibit 1, p. 1.

100. Assuming the field memorandum exists, the IDOC did not disclose it in response to the Berkeley Request or undersigned counsel's request for the lethal injection protocol and associated information.

101. No such field memorandum is published on the IDOC website.

102. The Draft Protocol addresses the national shortage of thiopental (aka sodium pentothal).

> In the event of an unavailability of a sufficient quantity of sodium pentothal from available resources, a sufficient quantity of pentobarbital will be acquired and administered as follows:
>
> - Five (5) grams of pentobarbital (100 ml of a 50 mg/ml solution) shall be withdrawn and divided into two (2) syringes to be administered, one immediately after the other.
>
> - A low pressure saline drip shall be allowed to flush saline through the line(s) following completion of the IV medication administration.

Exhibit 1, p. 6.

103. The Draft Protocol does not clarify whether in the event pentobarbital must be used, it is a substitute for thiopental only or a substitute for all three chemicals.

104. The Draft Protocol specifies that the particular steps to be taken to administer the chemicals are to be determined as late as three days in advance of an execution and that it may be changed even thereafter.

> At least three (3) days before the scheduled execution date the warden of IMSI will obtain technical assistance for the purpose of reviewing the lethal substances, the amounts, the methods of delivery and injection, and the offender's physical and historical characteristics to evaluate compliance with this [Draft Protocol] and the appropriate institutional Field Memos. The individual(s) conducting the technical review and the warden of IMSI will meet

> with the Director to review their findings. The Director will make the final determination regarding compliance with this [Draft Protocol] and the appropriate institutional field memorandum.

Exhibit 1, p. 6.

105. The Draft Protocol provides for intravenous access and the administration of the first syringe, a consciousness check limited to visual inspection, and a step to be taken in the event the offender appears visually conscious.

> 10. Execution Preparations
>
> IV set-up and drug preparation will be completed before the inmate is brought to the chamber.
>
> After the inmate has been secured to the injection table, the execution team shall initiate the IV. A primary and backup IV line shall be established. If the IV team cannot secure one (1) or more sites within one (1) hour, there will be no further attempts, and the warden will immediately suspend the execution of sentence. The warden will notify the prosecuting attorney of the county with jurisdiction and the governor's office, and will contact the sentencing judge to request that the execution be scheduled for a later date.
>
> Following the injection of the first syringe (Sodium Pentothal), the warden shall make visual inspection of the offender. If it appears that the offender is not unconscious within 60 seconds of the injection, then the warden shall stop the flow of Sodium Pentothal and order that the backup IV be used with a new flow of Sodium Pentothal.

Id. at p. 9, para. 10.

106. The Draft Protocol provides that "[a]ll members of the execution team must have at least one year of medical experience as a certified medical assistant, Phlebotomist, EMT, paramedic, or military corpsman." *Id.* at p. 6.

107. The Draft Protocol does not require that any member of the execution team have any experience or training in starting IVs.

108. The Draft Protocol does not require that any member of the execution team be currently certified or licensed by any local, state, federal, or private agency, company, board, or association to perform in any of the specified health care provider roles.

109. The Draft Protocol does not provide that the required year of medical experience have been acquired within any particular period of time in advance of an execution.

110. So long as the kind and duration of experience requirements are met, the Draft Protocol's one year experience requirement is satisfied no matter how far in the distant past the experience was acquired, even where the candidate has had no such experience in the interim.

111. The Draft Protocol does not require that the execution team members currently work as a certified medical assistant, Phlebotomist, EMT, paramedic, or military corpsman.

F. The IDOC 2006 and Draft Protocols' Chemicals and Their Known Effects

112. The chemicals which are to be presumptively[1] used in accordance with the Draft Protocol are the same chemicals which the 2006 Protocol provides for using: thiopental, pancuronium bromide, and potassium chloride.

[1] If an insufficient quantity of thiopental is available, pentobarbital is to be used.

1. Thiopental

113. Thiopental is an ultra-short acting barbiturate.

114. As an ultra-short-acting barbiturate, thiopental has a rapid onset/offset of action.

115. When received in sub-anesthetic doses, barbiturates may increase the reaction to painful stimuli and have little analgesic effect.

116. Once in the bloodstream, thiopental rapidly enters the brain and is then rapidly redistributed into other tissues.

117. At the therapeutic dose to produce an anesthetic state, thiopental's rapid redistribution accounts for its very short duration of action.

118. When combined with pancuronium bromide, thiopental forms a solid substance which can clog the IV line.

119. Thiopental was, by the early to mid-1950s, the standard chemical used for inducing anesthesia. Exhibit 15, p. 20 (Dr. Waisel testimony, *DeYoung v. Owens*, No. 11-cv-2324-SCJ (N.D. Ga. July 19, 2011)).

120. From the mid-1950s until the early-1990s, thiopental was used in approximately 90 percent of patients requiring anesthesia. *Id.*

121. Thiopental is no longer produced in the United States.

122. Domestically produced thiopental is no longer commercially available in the United States.

123. Some state departments of correction have obtained and distributed thiopental between themselves in apparent violation of federal law. Exhibit 16 (Sidley Austin LLP and Equal Justice Initiative letters to United States Attorney General

Holder outlining illegal importation and DEA seizure of thiopental in several states).

2. Pancuronium Bromide

124. Pancuronium bromide is a neuromuscular blocking chemical that paralyzes the skeletal muscles, including the intercostal muscles of the rib cage and diaphragm which are necessary for breathing.

125. Pancuronium bromide does not affect consciousness.

126. Pancuronium bromide does not negate the perception of pain.

127. When an appropriate dose of pancuronium bromide is administered intravenously to a human being, motor weakness progresses to a total muscular paralysis.

128. When an appropriate dose of pancuronium bromide is administered intravenously to a human being, the consequent paralytic effect starts first in the small muscles (eyes, jaw, etc.).

129. The paralytic effect then progresses to the limbs.

130. The paralytic effect progresses, finally, to the intercostal and diaphragmatic muscles, which results in a cessation of breathing.

131. Pancuronium bromide precludes an accurate assessment of consciousness by visual and auditory observations.

132. An accurate assessment of consciousness by visual and auditory observations is precluded because pancuronium bromide paralyzes all muscles that would otherwise move when an individual is in excruciating pain. Exhibit 17 at paras. 5,

17 (Sworn declaration of David Lubarsky, M.D., *Arthur v. Thomas, et al*., No. 11-CV-438-MEF-TFM, Amended Complaint Exhibit A).

133. An individual who receives a therapeutic or greater dose of pancuronium bromide following a sub-anesthetic dose of a barbiturate or other anesthetic chemical would experience suffocation and be unable to move or otherwise respond.

3. Potassium Chloride

134. Potassium chloride is critical to maintaining normal cellular function and the electrical activity of muscles, including the heart, and nerves.

135. At a sufficient dose, potassium chloride disrupts the normal electrical activity of the heart, inducing cardiac arrest.

136. Potassium chloride does not affect consciousness.

137. Potassium chloride does not negate the perception of pain.

138. As it travels in the bloodstream from the site of the injection towards the heart, potassium chloride activates all of the nerve fibers inside the blood vessel.

139. This activation causes an extraordinarily painful burning sensation absent anesthesia. *Id.* at para. 5.

4. Pentobarbital

140. The Draft Protocol provides for the use of pentobarbital in the event that an insufficient amount of thiopental is available. Exhibit 1, p. 6.

141. Pentobarbital is a fast-acting barbiturate.

142. Unlike thiopental, pentobarbital is not an ultra-short acting barbiturate which takes effect within seconds.

143. Pentobarbital is less lipid soluble and crosses the blood-brain barrier much more slowly, taking 15 to 60 minutes to take full effect, according to the FDA-approved package insert for pentobarbital. *Id.* at para. 8.

144. The FDA-approved package insert classifies pentobarbital as a short-acting barbiturate.

145. The FDA-approved package insert does not classify pentobarbital as an ultra-short-acting barbiturate.

146. There is "no body of clinical knowledge regarding the behavior of pentobarbital and its effects on human beings when rapidly administered in high dosages to a conscious person." Exhibit 18 at para. 2(d) (Mark Heath, M.D., sworn declaration, *Arthur v. Thomas, et al*., No. 11-CV-438-MEF-TFM, Amended Complaint Exhibit B).

147. There is no scientific literature establishing what dose of pentobarbital will induce anesthesia. Exhibit 19 (Dr. Waisel report on Arizona protocol, *West v. Brewer*, No. 2:11-cv-01409-NVW, Complaint Exhibit D); Exhibit 17 at para. 7.

148. This absence of scientific literature makes it more difficult to determine how much pentobarbital would constitute a sufficient overdose. Exhibit 19, p. 3; Exhibit 17 at para. 7.

149. Pentobarbital is not approved by the FDA as an anesthesia induction chemical.

150. Instead, pentobarbital is FDA-approved as a sedative-hypnotic and as an anticonvulsant for patients suffering a particular type of epilepsy.

151. While there is an off-label use of pentobarbital for induction of anesthetic coma in severe brain injury patients, this use involves the slow administration of pentobarbital over several hours.

152. The pentobarbital which Defendants would use in executing Mr. Rhoades was manufactured by Lundbeck, Inc.

153. In correspondence to Defendant Reinke, Lundbeck, Inc., has warned that pentobarbital is not safe for use in judicial lethal injections. Exhibit 20.

154. Preparing pentobarbital for administration by IV is much more complicated than preparing thiopental for the same use.

155. Reconstitution is required for preparing either thiopental or pentobarbital.

156. The procedure for reconsituting pentobarbital requires many more steps than is required for reconstituting thiopental.

157. The increased number of steps necessary to reconstitute pentobarbital as compared to thiopental increases the risk of error in the reconstitution process.

158. Neither the 2006 Protocol nor the Draft Protocol addresses how to reconstitute either thiopental or pentobarbital.

G. None of the Draft Protocol's Mandated Healthcare Credentials for Execution Team Members Require Any Training or Experience in Starting, Maintaining, or Injecting Chemicals Via an IV or in Consciousness Checks.

159. The Draft Protocol provides that "[a]ll members of the execution team must have at least one year of medical experience as a certified medical assistant, Phlebotomist, EMT, paramedic, or military corpsman." Exhibit 1, p. 6.

160. The State of Idaho does not license, certify, or regulate the training or scope of practice of Certified Medical Assistants. Exhibit 21 (Timothy P. Hodges, DO, FAAFP, Medical Director – Medical Assistant Program/College of Western Idaho, 8/22/11 letter).

161. Medical Assistant programs in Idaho do not include training on initiating IVs. *Id.*

162. Medical Assistant programs in Idaho do not include training on medication administration. *Id.*

163. Medical Assistant programs in Idaho do not include training on hydration via IV. *Id.*

164. The two largest local hospital systems in Boise, Idaho, are St. Alphonsus Regional Medical Center and St. Lukes's Health System and their associated hospitals.

165. Each of these two hospital systems prohibits Medical Assistants from initiating IVs. *Id.*

166. Each of these two hospital systems prohibits Medical Assistants from maintaining IVs. *Id.*

167. Each of these two hospital systems prohibits Medical Assistants from managing IV medications. *Id.*

168. Each of these two hospital systems prohibits Medical Assistants from managing IV fluids. *Id.*

169. The State of Idaho does not license, certify, or regulate the training or scope of practice of Phlebotomists. See Exhibit 22 (Nicole Walton, Pbt, Phlebotomy Instructor, College of Western Idaho, 8/25/11).

170. Phlebotomists do not initiate, maintain, or administer any substance via IVs. *Id.*

171. Phlebotomists are not trained to initiate, maintain, or administer any substance via IVs. *Id.*

172. The State of Idaho licenses and regulates the training and scope of practice of Emergency Medical Technicians ("EMTs") and Paramedics.

173. The Idaho legislature has invested the Idaho Emergency Medical Services Physician Commission ["EMS Physician Commission"] with the authority and obligation to "adopt appropriate rules defining the allowable scope of practice and acts and duties which can be performed by persons licensed by the EMS bureau[.]" I.C. §56-1023(1).

174. The EMS Physician Commission Standards Manual ("Standards Manual") fulfills this legislative mandate. Exhibit 23 (EMS Physician Commission Standards Manual).

175. The Standards Manual distinguishes between EMTs and Advanced EMTs ("AEMTs") for training and scope of practice purposes. *Id.* at 16-18, 21-24.

176. The Standards Manual allows only Advanced EMTs and Paramedics to initiate an IV and administer non-medicinal substances via IV infusion. *Id.* at 22-23.

177. The Standards Manual allows only Paramedics to administer medicinal substances via IV infusion or to administer any substance via IV push. *Id.* at 23.

178. Of the healthcare professionals which the Draft Protocol permits to be on an execution team (certified medical assistant; phlebotomist; EMT, paramedic, or military corpsman), none is required for credentialing purposes to have any

training and/or experience in conducting consciousness checks of individuals who have had anesthesia administered to them.

179. There are different kinds of military corpsmen. Not all kinds have training and/or experience in initiating, maintaining or administering substances through an IV.

180. The Draft Protocol does not require that the Warden of IMSI have any training and/or experience in initiating, maintaining or administering substances through an IV.

181. The Draft Protocol does not require that the Warden of IMSI have any training and/or experience in conducting consciousness checks of individuals to whom an anesthetic has been administered.

H. The National Shortage of Thiopental and the Illegal Acquisition of Thiopental Produced Without Quality Assurance

182. The Attorney General for the State of Idaho, Lawrence Wasden, was one of several signatories to a January 25, 2011, letter to United States Attorney General Eric Holder seeking his "assistance in either identifying an appropriate source for sodium thiopental or making supplies held by the Federal Government available to the States." Exhibit 24 (letter to U.S. Attorney General Holder).

183. As Idaho Attorney General Wasden explained:

> The protocol used by most of the jurisdictions employing lethal injection includes the drug sodium thiopental, an ultra-short-acting barbiturate. Sodium thiopental is in very short supply worldwide and, for various reasons, essentially unavailable on the open market. For those jurisdictions that have the drug available, their supplies are very small—measured in a handful of doses. The result is that many jurisdictions shortly will be unable to perform

> executions in cases where appeals have been exhausted and Governors have signed death warrants.

Id. at 1.

184. United States Attorney General Eric Holder responded that:

> At the present time, the Federal Government does not have any reserves of sodium thiopental for lethal injections and is therefore facing the same dilemma as many States. . . . I appreciate and share your concerns about this matter, but I am optimistic that workable alternatives are available that will allow us to carry out our duties.

Exhibit 25.

185. Upon information and belief, any thiopental which Defendants may use in executing Mr. Rhoades was illegally obtained. Cf. Exhibit 16 (Sidley Austin LLP and Equal Justice Initiative letters to United States Attorney General Holder outlining illegal importation and DEA seizure of thiopental in several states).

186. Upon information and belief, any thiopental which Defendants may use in executing Mr. Rhoades was manufactured without adequate safeguards to ensure its identity as thiopental.

187. Upon information and belief, any thiopental which Defendants may use in executing Mr. Rhoades was manufactured without adequate safeguards to ensure its quality.

188. Upon information and belief, any thiopental which Defendants may use in executing Mr. Rhoades has deteriorated to an extent that it cannot be reliably used to induce anesthesia, due to improper storage or age.

I. The 2006 and Draft Protocols' Exclusive List of Individuals Who May Witness An Execution.

189. The 2006 Protocol provides a list of "individuals [who] are approved as witnesses to the execution[.]" Exhibit 3, p. 7. The prisoner's attorney is not among the approved witnesses.

190. The Draft Protocol includes a list of "individuals [who] are approved as witnesses to the execution[.]" Exhibit 1, p. 7. The prisoner's attorney is not among the approved witnesses.

J. The Controlled Substances Act and The Food, Drug And Cosmetic Act

191. The Controlled Substances Act ("CSA"), 21 U.S.C. §§801 *et. seq.*, creates five schedules of controlled substances. *Id.* at §812.

192. Because sodium thiopental contains a derivative or salt of barbituric acid, it is a Schedule III controlled substance. 21 C.F.R. §1308 (c)(3) (including in Schedule III "any substance which contains any quantity of a derivative of barbituric acid or any salt thereof").

193. Pentobarbital is a Schedule II controlled substance. 21 C.F.R. §1308.12 (e)(3).

194. 21 U.S.C. §829 provides that, unless dispensed directly by a practitioner other than a pharmacist, Schedule II and III controlled substances may be dispensed only upon prescription by a practitioner licensed by law to administer such a substance.

195. This provision means that either a doctor or other person licensed to administer pentobarbital or thiopental must administer the sodium thiopental to Mr. Rhoades, obtain the thiopental, or issue a prescription for the use of thiopental. Cf. 21

U.S.C. §802 (2, 8, 10, 21) (defining 'administer,' 'deliver,' 'dispense,' and 'practitioner').

196. Rules governing the issuing, filling and filing of prescriptions under the CSA are set out at 21 C.F.R. 1306.01, *et seq.*

197. "A prescription for a controlled substance [such as pentobarbital or sodium thiopental] must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. 1306.04.

198. The Federal Food, Drug & Cosmetic Act provides that only a licensed medical practitioner may obtain and use prescription substances. 21 U.S.C. §353 (b).

199. Pancuronium bromide and potassium chloride are regulated substances requiring a prescription. 21 U.S.C. §353(b) (defining prescription drug); 21 U.S.C. §321(g)(1) (defining 'drug' as including any article included in the official United States Pharmocopoeia ("USP")); http://www.pharmacopeia.cn/v29240/usp29nf24s0_alpha-18-1190.html (official USP listing pancuronium bromide) (last visited 9/19/2011); http://www.pharmacopeia.cn/v29240/usp29nf24s0_m67340.html (official USP listing potassium chloride) (last visited 9/19/2011).

CLAIMS

A. Claims Pursuant To 42 U.S.C. §1983

200. As articulated in each of the following specific 42 U.S.C. §1983 claims, Defendants are acting under color of Idaho law and with deliberate indifference to

the wanton and unnecessary infliction of prolonged, intense pain their conduct will cause Mr. Rhoades Paul Rhoades during his execution. *Baze*, 553 U.S. at 54.

1. Executing Mr. Rhoades Without Any Lethal Injection Protocol in Place Would Violate His Right Against Cruel and Unusual Punishment.

201. While the IDOC purports that the rules published on its website are currently in effect, its response to the Berkeley Law School's public records request states that its materially different Draft Protocol "substantially reflects the Department's practices[.]" Exhibit 2.

202. The IDOC's response to the Berkeley Law School's public records request clarifies that the 2006 Protocol is no longer in effect or, at a minimum, that the IDOC is no longer requiring that Defendants act in accordance with it. Either way, the response makes clear that there is no IDOC protocol in place mandating procedures Defendants must act in accordance with in carrying out an execution. The Draft Protocol is, as it states on its face and as IDOC counsel cautions in his cover letter, only a draft.

203. Executing Mr. Rhoades with no protocol in place would violate *Baze v. Kentucky*, 553 U.S. 35 (2008), because there would be no safeguards whatsoever against Mr. Rhoades suffering pain to a degree unacceptable under the Eighth and Fourteenth Amendments.

2. Executing Mr. Rhoades Pursuant to an Execution Protocol Which He Has Not Been Afforded a Reasonable Opportunity to Review and Be Heard on Would Violate His Right to Due Process.

204. Executing Mr. Rhoades without first according him a fair opportunity to review the lethal injection protocol and register any legal objections to it in a court of law would violate his right to due process. U.S. Const. Amend. XIV. *Dickens v. Brewer*, 2009 WL 1904294 (D.Ariz. 2009) ("Fundamental fairness, if not due process, requires that the execution protocol that will regulate an [sic] prisoner's death be forwarded to him in prompt and timely fashion.") (quoting *Oken v. Sizer*, 321 F.Supp.2d 658, 664 (D.Md. 2004).

205. If the IDOC has an execution protocol in place, Mr. Rhoades asks that the Court order Defendants to immediately disclose that protocol in its entirety. That is, Mr. Rhoades asks that the Court order Defendants to immediately disclose any and all documents describing any step(s) to be taken by any IDOC employee or agent in preparation for and/or during an execution.

206. The 2006 Protocol and the Draft Protocol each provide that the protocol applied at any particular execution may be changed in any way at any time up to three days before the execution and, arguably, at any time thereafter. Allowing Defendants to change as late as three days or later before Mr. Rhoades's execution the protocol actually applied at his execution denies him a fair opportunity to review the lethal injection protocol and register any legal objections to it in a court of law, in violation of his right to due process. U.S. Const. Amend. XIV.

207. The 2006 Protocol and the Draft Protocol each mandate the creation of a Field Memorandum relating to lethal injection executions. No such documents is published on the IDOC website. Nor has any such document been provided in response to undersigned counsel's Idaho Public Records Request or the Berkeley Request.

208. The Draft Protocol does not specify whether pentobarbital is a substitute for all three chemicals or only for thiopental.

209. The Draft Protocol makes no provision for steps to be taken in the event the prisoner does not become unconscious after the administration of pentobarbital.

3. Because the *Draft Protocol* Lacks the Procedural Safeguards *Baze* Requires, Executing Mr. Rhoades In Accordance With It Would Violate His Eighth Amendment Right Against Cruel and Unusual Punishment.

210. The Draft Protocol provides for administering the anesthetic thiopental before the paralytic and heart arresting chemicals (pancuronium bromide and potassium chloride) are administered. "The proper administration of [thiopental] ensures that the prisoner does not experience any pain associated with the paralysis and cardiac arrest caused by the second and third drugs." *Baze*, 553 U.S. at 44.

211. In approving the Kentucky lethal injection protocol, the United States Supreme Court held that:

> A stay of execution may not be granted on grounds such as those asserted here unless the condemned prisoner establishes that the State's lethal injection protocol creates a demonstrated risk of severe pain. He must show that the risk is substantial when compared to the known and available alternatives. A State with a

> lethal injection protocol substantially similar to the protocol we uphold today would not create a risk that meets this standard.

Baze, 553 U.S. at 61. The Draft Protocol is materially different from that approved in *Baze*.

212. The *Baze* petitioners conceded that "the proper administration of the particular protocol adopted by Kentucky . . . would be 'humane and constitutional.'" *Id.* at 49. The *Baze* petitioners claimed that there existed an unconstitutionally significant risk that the procedures would "*not* be properly followed-in particular, that the sodium thiopental [would] not be properly administered to achieve its intended effect-resulting in severe pain when the other chemicals [were] administered." *Id.* Further, the State of Kentucky did not contest "that, failing a proper dose of sodium thiopental that would render the prisoner unconscious, there is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride." *Id.* at 53-54.

213. The *Baze* petitioners proffered several grounds in support of their claim that there was an unconstitutionally significant risk that the sodium thiopental would not be properly administered, including that "the protocol fails to establish a rate of injection, which could lead to a failure of the IV;" that "it is possible that the IV catheters will infiltrate into surrounding tissue, causing an inadequate dose to be delivered to the vein;" and that there existed "inadequate facilities and training[.]" *Id.* at 54. The Supreme Court rejected the petitioners' position, holding that the

problems "related to the IV lines do not establish a sufficiently substantial risk of harm to meet the requirements of the Eighth Amendment." *Id.* at 55.

214. The Supreme Court approved the Kentucky lethal injection protocol but only because it included "several important safeguards to ensure that an adequate dose of sodium thiopental is delivered to the condemned prisoner." *Id.* at 55. These safeguards were relevant training, contemporary and continuing experience, redundancy, and a meaningful consciousness check.

i. The First Safeguard: Relevant Training

215. The first "most significant" safeguard was that "members of the IV team must have at least one year of professional experience as a certified medical assistant, phlebotomist, EMT, paramedic, or military corpsman" and that they have daily experience establishing IV catheters for inmates in Kentucky's prison population. *Id.* Although it contains some similar language, Idaho's Draft Protocol stands in stark contrast.

216. The Draft Protocol does not contemplate the existence of an IV team. Instead, it requires that "[a]ll members of the execution team must have at least one year of medical experience as a certified medical assistant, Phlebotomist, EMT, paramedic, or military corpsman." Exhibit 1, p. 6.

217. Certified medical assistants, Basic EMTs and some military corpsmen are neither trained nor experienced in initiating, maintaining, or administering any kind of substance via IVs. Because the Draft Protocol does not preclude an execution team from consisting exclusively of certified medical assistants, Basic EMTs

and/or military corpsmen without the necessary training of experience, there is no reason to believe that any member of an IDOC execution team knows how to initiate, maintain, or administer any substance via an IV.

ii. The Second Safeguard: Contemporary and Continuing Experience

218. Idaho's Draft Protocol also contrasts with the Kentucky protocol with regard to the experience required by those establishing the IVs. The Draft Protocol allows for an execution team consisting exclusively of individuals without any training or experience, let alone the "daily experience" required by the Kentucky protocol, in establishing IV catheters.

219. The training and experience safeguard which the Supreme Court found the "most significant" in *Baze* is absent from Idaho's Draft Protocol.

220. Another of the Kentucky protocol's important safeguards on which the Supreme Court relied was the requirement that "IV team members, along with the rest of the execution team, participate in at least 10 practice sessions per year." *Baze*, 553 U.S. at 55. Idaho's Draft Protocol does not contain this important safeguard. Instead, it requires only two practice sessions, which may occur at any time rather than within the same year as the execution in which the team member would participate.

iii. The Third Safeguard: Redundancy

221. The Kentucky protocol includes another safeguard, that the IV team prepare two sets of lethal injection chemicals before the execution commences as well as a

primary and secondary IV line. The Supreme Court held, "These redundant measures ensure that if an insufficient dose of sodium thiopental is initially administered through the primary line, an additional dose can be given through the backup line before the last two drugs are injected." *Baze*, 553 U.S. at 55. These redundancies constitute a safeguard in Kentucky because that state's protocol requires that the chemical preparation and placement of the lines be accomplished by trained and experienced personnel.

222. Idaho's Draft Protocol requires a backup IV as well. However, it does not require that the individuals initiating, maintaining, or delivering chemicals through the IV have any relevant training and experience in doing so. Where no such training and experience requirements exist, such as in Idaho, the redundancies do not become a safeguard. Having that same untrained and inexperienced person do the task twice does not materially improve the chances of it being done correctly.

iv. The Fourth Safeguard: Consciousness Check

223. The Kentucky "protocol specifically requires the warden to redirect the flow of chemicals to the backup IV site if the prisoner does not lose consciousness within 60 seconds." *Baze* 553 U.S. at 57.

224. The Draft Protocol does not provide for any waiting period between the administration of thiopental and pancuronium bromide.

225. The Draft Protocol does provide that if the prisoner is not unconscious "within 60 seconds of the injection, then the Warden shall stop the flow of [thiopental] and order that the backup IV be used with a new flow of [thiopental]." Ex. 1, p. 9.

226. The Draft Protocol does not provide that the thiopental be administered at any particular rate.

227. The thiopental could be administered in less than 60 seconds, and the pancuronium bromide could immediately be administered. The prisoner would be consciously suffocating.

228. If the pancuronium bromide was administered quickly enough and the potassium chloride immediately administered thereafter, the prisoner would be consciously suffocating and experience the pain of suffering of burning throughout his blood vessels.

229. The Draft Protocol makes no provision for step to be taken in the event that pentobarbital rather than thiopental is administered.

a) The Draft Protocol's Providing For The Administration of Pancuronium Bromide "To Stop Muscle Spasms As The Anesthetic Takes Effect" Negates The Subsequent Consciousness Check's Effectiveness, Thereby Creating A Substantial Risk of Serious Harm.

230. The Draft Protocol provides that

- Three (3) syringes, each containing 50 mg of pavulon [aka pancuronium bromide], a curare preparation, to stop muscle spasms as the anesthetic takes effect;

Exhibit 1, p. 6. This provision is factually wrong. Properly administered, anesthetics do not cause muscle spasms. Cf. *Baze* at 57 (trial court specifically found that pancuronium bromide serves two purposes: it "prevents involuntary physical movements during unconsciousness that may accompany the injection of potassium chloride[,]" and it "stops respiration, hastening death.")

231. To stop muscle spasms purportedly created by the anesthetic, the paralytic (i.e.- pancuronium bromide) would have to be given before the anesthetic takes full effect. This would negate the consciousness check safeguard relied on by *Baze* because it would mean that the prisoner is paralyzed *before* the consciousness check is performed. The prisoner would be aware he was suffocating, then feel the extreme burning throughout his blood vessels as the potassium chloride is administered, and finally consciously suffer a massive heart attack.

b) The Draft Protocol's Visual Consciousness Check Is Inadequate To Ensure That The Prisoner Is Anesthetized Against The Severe Pain Associated With Pancuronium Bromide And Potassium Chloride, Creating A Substantial Risk of Serious Harm.

232. Idaho's Draft Protocol provides for a consciousness check, but the check is limited to a visual inspection. "If it appears that the offender is not unconscious within 60 seconds of the injection, then the warden shall stop the flow of Sodium Pentothal and order that the backup IV be used with a new flow of Sodium Pentothal." Exhibit 1, p. 9. A visual consciousness check is inadequate to determine whether the offender is sufficiently unconscious that he will not perceive the excruciating pain associated with the injection of the remaining two chemicals.

233. David Waisel, M.D., a board certified anesthesiologist at Children's Hospital, a pediatric teaching hospital of Harvard Medical School, has recently testified that a light stimulus around the eyes, such as touching the eyelashes, is an inadequate means for an anesthetist to detect whether an individual is sufficiently anesthetized to not perceive a more painful stimulus, such as potassium chloride. Exhibit 15,

pp. 40, 74 (Dr. Waisel testimony in *DeYoung v. Owens*, No. 1:11-cv-2324-SCJ (N.D. Ga. July 19, 2011)). It follows that Idaho's exclusively visual assessment by the Warden, untrained in assessing consciousness, is an even less adequate means to assess whether one is sufficiently anesthetized against the excruciating pain otherwise created by the injection of potassium chloride.

234. Requiring an appropriate consciousness check by an individual experienced in conducting and certified or adequately trained to conduct consciousness checks is an alternative which would significantly reduce the risk of needless excruciating pain inherent in administering the remaining two chemicals. That consciousness check would include the use of a bispectral index monitor, a device used by many anesthesiologists in their daily practice. Bispectral index monitors determine, through analysis of an anesthetized individual's electroencephalogram, the anesthetic depth that the individual has reached. A person experienced and either certified or adequately trained in conducting consciousness checks is necessary because discerning levels of consciousness is a nuanced skill.

> The sophistication necessary comes not only from theoretical knowledge, but from training under supervision and feedback and experience. Patients respond differently, and the educated eye needs to be able to give an increasing level of stimulation and needs to be looking for subtle signs, such as, . . . fluttering of the eyes, wincing, finger movement, toe movement, any of those, and it takes a practiced eye to do that.

Exhibit 15, pp. 74-5 (Dr. Waisel testimony, DeYoung v. Owens, et al., No. 11-CV-2324-SCJ (N.D. Ga.)). A person needs training in order to adequately assess

an individual's consciousness following the administration of anesthesia. *Id*. at 75.

c) The Absence of Any Waiting Period After Administering Pentobarbital To Ensure That it Has Had the Necessary Anesthetic Effect Before Administering the Remaining Two Chemicals Creates a Substantial Risk of Serious Harm.

235. The Kentucky protocol approved in *Baze* required a 60 second delay between the administration of thiopental and the remaining two chemicals. It was undisputed that if the thiopental were properly administered, it would have the desired anesthetic effect. *Baze*, 553 U.S. at 41, 44, 49. It was also undisputed that the 60 second delay was sufficient for the properly administered thiopental to anesthetize against the excruciating pain caused by the subsequently administered chemicals.

236. It is unknown how long it takes for five grams of injected pentobarbital to anesthetize against the extreme pain caused by the remaining two chemicals. The inadequate consciousness check is not a safeguard against 60 seconds being too brief a time for the pentobarbital to have the desired anesthetic effect.

237. An alternative method to ensure sufficient anesthesia is described supra at ¶234.

d) The Use of Pentobarbital as an Anesthetic in an Untested Manner Creates a Substantial Risk of Serious Harm.

238. In the event that a sufficient quantity of sodium thiopental is unavailable, the Draft Protocol requires that pentobarbital be used. There are no studies addressing the efficacy of pentobarbital as the primary and/or initial anesthetic chemical or in the quantities contemplated by the Draft Protocol. Assuming the pentobarbital is to be followed by pancuronium bromide and potassium chloride, the effect of

pentobarbital is unknown. Its use in this manner would create a substantial risk of serious harm to Mr. Rhoades.

239. There are several reported cases of pentobarbital executions where substantial safeguards against maladministration of the anesthetic were in place but where the prisoners suffered obvious and prolonged pain.

4. Using the 2006 Protocol to Execute Mr. Rhoades Would Violate His Eighth Amendment Right Against Cruel and Unusual Punishment.

240. Neither Policy Number 135 nor Control Number 135 incorporate *any* identical or substantially similar safeguards present in the Kentucky protocol. Pursuant to Policy Number 135 and Control Number 135:

- Idaho does not require that those who initiate the IV be licensed or certified as any kind of medical care professional. Even if Idaho uses licensed or certified medical care professionals, there is no requirement that they have any experience as a licensed or certified medical care professional. The IDOC has refused to disclose whether any other IDOC rule mandates any such or similar requirements.

- The IDOC has refused to disclose whether the individual who will establish the IV catheter has any recent experience establishing IV catheters.

- Idaho does not require that those who will establish the IV catheter have first participated, together with the remaining members of the execution team, in 10 (or any) practice sessions per year.

- Idaho does not require establishing both primary and backup IV lines and to prepare two sets of the lethal injection chemical(s) before the execution commences. Thus, Idaho has no redundant measures to "ensure that if an insufficient dose of sodium thiopental is initially administered through the primary line, an

additional dose can be given through the backup line before the last two drugs are injected." *Baze*, 553 U.S. at 55.

- Idaho does not require that the warden and/or deputy warden be in the execution chamber during the execution. Thus, there is no requirement "allow[ing] them to watch for signs of IV problems, including infiltration." *Id.* at 56.

- Idaho does not require "the warden to redirect the flow of chemicals to the backup IV site if the prisoner does not lose consciousness within 60 seconds." *Id.*

241. IDOC Policy Number 135 and Control Number 135 do not contain any safeguards identical or substantially similar to those relied on by the *Baze* court in upholding the Kentucky protocol. Nor do they contain any other requirements which safeguard to a substantially similar degree against the risk that the sodium thiopental will be improperly administered such that Mr. Rhoades will suffer an excruciatingly painful death by horrifically painful suffocation while experiencing a torturously severe burning sensation throughout his blood vessels. For these reasons, there exists a sufficiently substantial risk that Mr. Rhoades's execution by Defendants will violate his Eighth and Fourteenth Amendment right against cruel and unusual punishment.

5. Executing Mr. Rhoades in Accordance with Either the 2006 Protocol *or* the Draft Protocol Would Infringe Mr. Rhoades's Fundamental Right Against Cruel And Unusual Punishment.

242. Fourteenth Amendment fundamental due process jurisprudence governs this claim. The *Baze* standard, derived from Eighth Amendment jurisprudence, is inapplicable in this arena. Instead, "the Fourteenth Amendment 'forbids the government to infringe . . . fundamental liberty interests *at all*, no matter what

process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.'" *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997) (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)).

243. The prohibition against the unnecessary infliction of cruelty is a fundamental right protected by the Due Process Clause of the Fourteenth Amendment. The Eighth Amendment's prohibition against cruel and unusual punishment encompasses this fundamental right. The prohibition is a direct descendant of the "[p]rohibition against the wanton infliction of *pain* [extant in] the [English] Bill of Rights of 1688." *State of La. ex rel. Francis v. Resweber*, 329 U.S. 459 at 463 (1947) (emphasis added). The *Resweber* Court acknowledged that, "The Fourteenth [Amendment] would prohibit by its due process clause execution by a state in a cruel manner." *Id.*

244. Distinguishing between "cruelty inherent in the method of punishment" and "the necessary suffering involved in *any* method employed to extinguish life humanely[,]" the *Resweber* Court held that the cruelty which the Eighth Amendment prohibits is the former and not the latter. *Resweber*, 329 U.S. at 464 (emphasis added). Only that cruelty exceeding the cruelty in all methods of execution violates the cruel and unusual clause prohibition.

245. In *Wilkerson v. Utah*, 99 U.S. 130 (1878), the Supreme Court provided guidance on how to determine whether a particular method of execution violates the prohibition against cruel and unusual punishment. First, it noted Blackstone's statement that while the sentence of death was generally executed by hanging,

"circumstances of terror, pain, or disgrace were sometimes superadded." *Id.* at 135. It then observed that Blackstone provided several examples of superadded circumstances, concluding that "it is safe to affirm that punishments of torture, such as those mentioned [by Blackstone], and all others in the same line of unnecessary cruelty, are forbidden by that emendment [sic] to the Constitution." *Id.* at 136. Blackstone's examples were these: a "prisoner was drawn or dragged to the place of execution . . .; he was [dis]emboweled alive, beheaded, and quartered . . .; [he was subjected to] public dissection [or] burning alive[.]" *Id.* at 135.

246. Lethal injection pursuant to either the 2006 Protocol or the Draft Protocol is as likely to cause extreme pain. *Baze* relied on safeguards being present to ensure that the anesthetic reaches the prisoner and takes effect before the extremely painful pancuronium bromide and potassium chloride are administered. None of those safeguards are present in Idaho's 2006 Protocol or its Draft Protocol. To use the *Wilkerson* terminology, the pain associated with lethal injection is superadded to the sentence.

247. There is no compelling state interest served by the superadded pain inherent in lethal injection pursuant to the 2006 Protocol or the Draft Protocol. Even if there was a compelling state interest, neither protocol is narrowly tailored. Executing Mr. Rhoades pursuant to either protocol would, therefore, violate his fundamental right against cruel and unusual punishment in violation of his Fourteenth Amendment right to due process.

6. Excluding Mr. Rhoades's Counsel as a Witness Violates Mr. Rhoades's Statutory Right to Counsel and His Eighth and Fourteenth Amendment Rights Against Cruel and Unusual Punishment, As Well as His Lawyer's Due Process to Witness His Execution.

248. The 2006 Protocol and the Draft Protocol each include an exclusive list of who may witness an execution.

249. The 2006 Protocol contains the following list of approved witnesses:

- Coroner from the county in which the execution is located
- Sheriff from the county of conviction
- Prosecuting attorney from the county of conviction
- A spiritual advisor of the offender's choosing
- Sentencing judge
- Representative from the Governor's office
- Attorney General
- Representative from the Board of Correction
- A member of the victim's family
- A friend or member of the offender's family
- Four news media representatives

Exhibit 3, p. 7.

250. The Draft Protocol contains the same list, except that it allows for either the Attorney General or his representative. Exhibit 1, p. 7.

251. Counsel for the prisoner is not among the potential witnesses allowed under either protocol. Consequently, under either protocol, the prisoner's counsel is excluded from witnessing the execution.

252. Since the mid-1990s, the Capital Habeas Unit of the Federal Defenders of Idaho (and that Federal Defender Office's predecessor office, the Federal Defenders of Eastern Washington and Idaho) has represented Mr. Rhoades before multiple state and federal courts.

253. Mr. Rhoades has a material interest in his counsel's presence at his execution. In particular, he is entitled to the Defendants acting in substantial compliance with the IDOC protocol in place at the time of his execution. Bound to a gurney, Mr. Rhoades will have no recourse should the Defendants fail in this regard. Non-compliance with a state execution protocol has recent precedent. *Cf. Cooey v. Kasich*, 2011 WL 2681193 at *21 (S.D. Ohio July 8, 2011) (enjoining execution where Mr. Rhoades demonstrates substantial likelihood of succeeding on Equal Protection claim premised on "substantive departures from some of the most fundamental tenets of Ohio's execution policy"); *West v. Brewer*, 2011 WL 2912699 at *2 (D.Ariz. July 20, 2011) (denying motion to dismiss count alleging that Arizona Department of Correction "has substantially deviated from its lethal injection protocol[,]" thus creating "a substantial risk that the anesthetic drug will not be properly administered, causing serious harm"). Should the execution process used to kill Mr. Rhoades differ materially from an otherwise constitutionally adequate process, Mr. Rhoades is entitled to have counsel seek to

stop the proceeding through appeals to courts or by taking other appropriate action.

254. Assuming Defendants comply with IDOC protocol in place at the time of Mr. Rhoades's execution, unforeseen difficulties may arise which cause or threaten to cause constitutionally unacceptable pain. Strapped to a gurney, Mr. Rhoades will be unable to communicate about any such difficulties and, thus, will be precluded from being heard in a court of law. Should this occur, Mr. Rhoades is entitled to have counsel seek to stop the proceeding through appeals to court or by taking other appropriate action.

255. In appointing counsel to represent Mr. Rhoades in federal proceedings, this Court ruled that he is entitled to counsel pursuant to 18 U.S.C. §3599.

256. As a member of the public, counsel "enjoys a First Amendment right to view executions from the moment the condemned is escorted into the execution chamber, including those 'initial procedures' that are inextricably intertwined with the process of putting the condemned inmate to death." *California First Amendment Coalition v. Woodford*, 299 F.3d 868, 877 (9th Cir. 2002). The holding in *California First Amendment Coalition* is grounded in the First Amendment right of access to governmental proceedings. An infringement on this fundamental right is constitutionally improper if it is "an exaggerated response" to "legitimate penological objectives." *Id.* at 879 (quoting *Turner v. Safley*, 482 U.S. 78, 87 (1987).

257. Barring the prisoner's counsel from witnessing his execution serves no legitimate penological objective. Alternatively, it is an exaggerated response to a legitimate penological objective.

258. Undersigned counsel's ability to advance his own First Amendment interest in attending Mr. Rhoades's execution is compromised by the need to devote time to litigating this application and to prepare for clemency proceedings.

259. Mr. Rhoades has third party standing to sue on his lawyers' behalf as members of the public.

260. Mr. Rhoades is entitled to have his counsel witness his execution under 18 U.S.C. §3599.

B. Request for Declaratory Judgment Pursuant to 28 U.S.C. 1331.

261. The 2006 Protocol and Draft Protocol conflict with the CSA and FDCA.

262. In violation of the CSA, no appropriately licensed medical practitioner has or will obtain and/or administer the sodium thiopental and/or pentobarbital which Defendants would use in executing Mr. Rhoades.

263. In violation of the FDCA, no appropriately licensed medical practitioner has or will obtain and/or administer the sodium thiopental, pentobarbital, pancuronium bromide and/or potassium chloride which Defendants would use in executing Mr. Rhoades.

264. The Supremacy Clause of the United States Constitution requires that the Defendants obey the CSA and FDCA.

265. Courts entertain federal preemption claims seeking declaratory and injunctive relief even where the statutes at issue do not grant a private right of action. *See Planned Parenthood of Houston & Southeast Texas v. Sanchez*, 403 F.3d 324, 331-34 (5th Cir. 2005). A statutory grant of a cause of action is unnecessary. *Id.*

266. Courts may entertain preemption claims even where the statute does not expressly confer jurisdiction. *Pharm. Research & Mfrs. Of America v. Walsh*, 538 U.S. 644, 661-69 (2003) (indicating that a Supremacy Clause preemption claim exists by considering a claim that alleged a conflict between a state statute and the Medicaid Spending clause statute; the lower court had observed that the Mr. Rhoades was not asserting an action to enforce the Medicaid statute, but was asserting a preemption-based challenge under the Supremacy Clause); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006) (finding that the lack of a federally created "right" required for a §1983 claim was inconsequential to analysis of a Supremacy Clause preemption challenge to a Missouri statute which allegedly conflicted with the Medicaid statute; "Preemption concerns the federal structure of the Nation rather than the securing of rights, privileges and immunities to individuals.") (quoting *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 117 (1989)); *Qwest Corp. v. City of Santa Fe*, 380 F.3d 1258, 1266 (10th Cir. 2004) ("A federal statutory right or right of action is not required where a party seeks to enjoin the enforcement of a regulation on the grounds that the local ordinance is preempted by federal law.").

267. Mr. Rhoades seeks equitable relief in the form of a declaratory judgment clarifying that the safeguards contained in the CSA and FDCA apply to his lethal injection.

268. Mr. Rhoades seeks a declaratory judgment that if Defendants act in compliance with either of the Idaho Department of Correction protocols discussed above, they will violate the CSA and FDCA because the means those protocols prescribe for Defendants to obtain and administer the lethal injection chemicals violate those statutes.

PRAYER FOR RELIEF

For all of these reasons, considered separately and together, Mr. Rhoades Paul Rhoades respectfully asks that the Court:

1. Order Defendants to immediately disclose to Mr. Rhoades any Idaho Department of Correction protocol now in place for execution by lethal injection, i.e.- any documents describing and/or mandating any steps to be taken in preparation for and/or during an execution by lethal injection, regardless of who created the document(s), when the document(s) was created, and the kind of document (e.g.- policy, directive, field memorandum);

2. In the event that the Defendants indicate that there is no protocol now in place for execution by lethal injection, order Defendants to immediately disclose this fact to Mr. Rhoades, and order that Defendants disclose any such protocol to Mr. Rhoades

sufficiently in advance of any intended execution of Mr. Rhoades to allow him sufficient time to fully and fairly review it and seek to be heard regarding it in a court of law;

3. In the event that the Idaho Department of Correction has no lethal injection protocol in place or has in place the 2006 Protocol or the Draft Protocol, permanently enjoin the Defendants from executing or allowing others within their control to execute Mr. Rhoades pursuant to no protocol or pursuant to the 2006 Protocol or Draft Protocol;

4. Permanently enjoin Defendants from executing Mr. Rhoades pursuant to any protocol which does not expressly allow counsel to witness his execution or which allows it only in the absence of a family member or friend of Mr. Rhoades as a witness;

5. Permanently enjoin Defendants from executing Mr. Rhoades unless he has access to his counsel before and throughout the execution process, including the administration of any execution protocol, such that counsel can immediately access the courts or otherwise seek necessary relief, in exercise of Mr. Rhoades's rights under the Eighth and Fourteenth Amendments;

6. Enter a declaratory judgment that the CSA and FDCA apply to his lethal injection and that Defendants' executing Mr. Rhoades in accordance with either of the Idaho Department of Correction lethal injection protocols discussed above would violate the CSA and FDCA because the means those protocols prescribe for Defendants to obtain and administer thiopental, pentobarbital, pancuronium bromide and/or potassium chloride violate those statutes;

7. Permit Mr. Rhoades reasonable and expedited discovery to further develop facts supporting his claims for relief; and

8. Grant such further relief as it deems just and proper.

Dated this 22nd day of September, 2011.

Respectfully submitted,

_____/s/_____

Oliver W. Loewy
Capital Habeas Unit
Federal Defenders Services of Idaho, Inc.
702 West Idaho Street, Suite 900
Boise, Idaho 83702
208-331-5530

JS 44 (Rev. 12/07)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

I. (a) PLAINTIFFS

Paul Ezra Rhoades

(b) County of Residence of First Listed Plaintiff Ada County
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorney's (Firm Name, Address, and Telephone Number)

Federal Defender Services of Idaho, Oliver Loewy,Teresa Hampton
702 W. Idaho, Suite 900, Boise, Idaho 83702, 208-331-5530

DEFENDANTS

IDOC, Brent Reinke, Director; IMSI, IDOC, Randy Blades, Warden; and IDOC Does 1-50,Unknown Executioners

County of Residence of First Listed Defendant Ada County
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	☒ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excl. Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury

PERSONAL INJURY
- ☐ 362 Personal Injury - Med. Malpractice
- ☐ 365 Personal Injury - Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 444 Welfare
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 440 Other Civil Rights

PRISONER PETITIONS
- ☐ 510 Motions to Vacate Sentence

Habeas Corpus:
- ☐ 530 General
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition

FORFEITURE/PENALTY
- ☐ 610 Agriculture
- ☐ 620 Other Food & Drug
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 630 Liquor Laws
- ☐ 640 R.R. & Truck
- ☐ 650 Airline Regs.
- ☐ 660 Occupational Safety/Health
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
- ☐ 730 Labor/Mgmt.Reporting & Disclosure Act
- ☐ 740 Railway Labor Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Empl. Ret. Inc. Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 463 Habeas Corpus - Alien Detainee
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 810 Selective Service
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 875 Customer Challenge 12 USC 3410
- ☒ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 892 Economic Stabilization Act
- ☐ 893 Environmental Matters
- ☐ 894 Energy Allocation Act
- ☐ 895 Freedom of Information Act
- ☐ 900Appeal of Fee Determination Under Equal Access to Justice
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN (Place an "X" in One Box Only)

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from another district (specify) ☐ 6 Multidistrict Litigation ☐ 7 Appeal to District Judge from Magistrate Judgment

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (**Do not cite jurisdictional statutes unless diversity**):
42 U.S.C. Section 1983; 28 U.S.C. Section 2201

Brief description of cause:
Idaho's particular means of administering lethal injection

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☐ No

VIII. RELATED CASE(S) IF ANY (See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
09/22/2011

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

AO 440 (Rev. 12/09) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Idaho

Paul Ezra Rhoades

Plaintiff

v.

Brent Reinke, Director,IDOC; Randy Blades,Warden, IMSI; and IDOC Does 1-50, Unknown Exectioners

Defendant

Civil Action No. 11-445

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Randy Blades, Warden
Idaho Maximum Security Institution
13400 S. Pleasant Valley Rd
Kuna ID 83634

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Federal Defender Services of Idaho
Capital Habeas Unit
Oliver Loewy
Teresa A. Hampton
702 W. Idaho, Suite 900
Boise, ID 83702

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 11-445

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

.

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

AO 440 (Rev. 12/09) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

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Oliver Loewy
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❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

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I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

EXHIBIT LIST

EXHIBIT #	EXHIBIT DESCRIPTION
1	Idaho Department of Correction Draft Protocol
2	Idaho Department of Correction Counsel's Letter to University of California, Berkeley, School of Law
3	Idaho Department of Correction 2006 Protocol
4	Affidavit of Christine Freeman, *DeYoung v. Owens et al.*, No. 11-CV-2324-SCJ (N.D. Ga.) (July 14, 2011).
5	*Birmingham News* article regarding Eddie Powell execution (June 16, 2011).
6	Affidavit of Associated Press reporter Greg Bluestein's affidavit (& attached, as appendix, June 23, 2011 newspaper article) (July 18, 2011).
7	Associated Press reporter Jeffrey Collins' article regarding South Carolina execution of Jeffrey Motts (May 6, 2011).
8	David Waisel, M.D., testimony, Blankenship v. Owens et al., No. 11-CV-202236 (Super.Ct, Fulton County Ga.) (June 21, 2011).
9	Idaho Code Section 19-2716.
10	Idaho Department of Correction Policy Number 135.
11	Idaho Department of Correction Directive Number 401.06.03.069.

12	Oliver W. Loewy Idaho Public Records request letter to Idaho Department of Corrections (March 11, 2011).
13	Idaho Department of Correction counsel's letter denying Oliver W. Loewy's Idaho Public Records Request (March 30, 2011).
14	University of California, Berkeley, School of Law's Idaho Public Records request letter to Department of Corrections (April 27, 2011).
15	Testimony of David B. Waisel, M.D., *DeYoung v. Owens*, No. 1:11-CV-2324-SCJ (N.D. Ga. July 19, 2011).
16	Sidley, Austin LLP & Federal Public Defender for the District of Arizona letter to United States Attorney General Eric H. Holder, Jr. (February 16, 2011). Equal Justice Initiative letter to United States Attorney General Honorable Eric H. Holder, Jr. (April 22, 2011).
17	Sworn Declaration of David Lubarsky, M.D. (July 22, 2011), *Arthur v. Thomas, et al.*, No. 11-CV-438-MEF-TFM, Amended Complaint Exhibit A)
18	Sworn Declaration of Mark J.S. Heath, M.D. (July 22, 2011), *Arthur v. Thomas, et al.*, No. 11-CV-438-MEF-TFM, Amended Complaint Exhibit B).
19	David Waisel, M.D.'s Expert Report re Arizona Protocol (July 16, 2011), *West v. Brewer*, No. 2:11-cv-01409-NVW, Complaint Exhibit D)
20	Staffan Shuberg, President, Lundbeck Inc., letter to Brent Reinke, Director, Idaho Department of Correction (August 18, 2011).

21	Timothy P. Hodges, DO, FAAFP, Medical Director-Medical Assistant Program/College of Western Idaho letter to Greg Worthen, Federal Defender Services of Idaho. (August 22, 2011).
22	Nicole Walton, Phlebotomist instructor letter. (August 25, 2011).
23	State of Idaho EMS Physician Commission Standards Manual. Edition 2011-1.
24	Idaho Attorney General Lawrence Wasden, et al. letter to United States Attorney General Eric Holder (January 25, 2011).
25	United States Attorney General Eric Holder letter responding to January 25, 2011 letter from Idaho Attorney General Lawrence Wasden, et al. (March 4, 2011).

EXHIBIT 1

EXHIBIT 1

Idaho Department of Correction	Standard Operating Procedure Division of Operations General Administrative	**Control Number:** 135.02.01.001	**Version:** 2.0	**Page Number:** 1 of 10 **Adopted:** 00-00-0000 **Reviewed:** 03-25-2011 **Next Review:** 00-00-0000
		Title: Execution Procedures		

This document was approved by Kevin Kempf, chief of the Division of Operations, on TBD (signature on file).

BOARD OF CORRECTION IDAPA RULE NUMBER 135

Executions

Policy Statement Number 135

Execution Procedures

POLICY DOCUMENT NUMBER 135

Execution Procedures

DEFINITIONS

Standardized Definitions List

PURPOSE

The purpose of this Standard Operating Procedure is to establish specific procedures for administration of capital punishment in accordance with Idaho statutes and the Constitutions of the United States of America and the State of Idaho

SCOPE

This Standard Operating Procedure (SOP) applies to all Idaho Department of Correction (IDOC) employees involved in the administration of capital punishment and to offenders who are under death warrant and the execution of which has not been stayed.

RESPONSIBILITY

The Director will exercise overall control of the administrative policy, standard operating procedure, field memoranda, and of the execution process itself.

The chief of the Division of Operations has control authority and responsibilities for the following institutions and has identified the following responsibilities:

The warden of the Idaho Maximum Security Institution (IMSI) will establish a field memorandum to identify authority and guidelines to carry out the execution of the condemned offender. The chief of the Division of Operations must approve this field memorandum.

The warden of the Idaho State Correctional Institution (ISCI) will establish a field memorandum to identify authority and guidelines to coordinate media activity and provide logistic and communication support at the IDOC South Boise Complex. The chief of the Division of Operations must approve this field memorandum.

The warden of the South Idaho Correctional Institution (SICI) will establish a field memorandum to identify authority and guidelines to coordinate and implement external security measures, including guidelines of other law enforcement and support agencies operating on the IDOC South Boise Complex. The chief of the Division of Operations must approve this field memorandum.

Table of Content

GENERAL REQUIREMENTS

1. Introduction

Execution of an offender under sentence of death is one of the most serious responsibilities of the agency and a high regard for the dignity of all involved must be maintained.

An execution generates public debate and attention. Staff members must be aware of the pressures an execution places on themselves, offenders, and other staff members. Extra security precautions are necessary and employees must be prepared and able to meet the situations that might arise.

No IDOC employee, except as identified by state statute, will be forced to participate in an execution.

2. Death Warrant

When the IDOC receives a death warrant, the steps in Table 2.1 will followed:

Table 2.1

Functional Roles and Responsibilities	Steps	Tasks
Sentencing judge	1	Sign and file a death warrant with an execution date not more than thirty (30) days after the date the warrant was issued.
Sentencing judge	2	Deliver the death warrant to the Director of the IDOC.
Director	3	Immediately notify the facility head of the facility in which the offender is housed. (If the warrant is delivered to a facility head instead of the director, the facility head will implement step 5, and will notify the director and the chief of operations within 24 hours.)
Director	4	Notify the Board of Corrections and the Governor's Office.
Warden	5	Serve the death warrant on the offender and completes a return of service.
Warden	6	Immediately segregate the offender from the general offender population.
Warden	7	Appoint a staff member to serve as liaison between the condemned offender and himself.
Warden's liaison	8	Meet with the condemned offender at least once each working day and forwards all of the offender's questions and concerns directly to the warden.
Warden	9	Instruct the security staff to conduct 30-minute random visual checks on the offender.
Security staff	10	Make a random 30-minute check on the offender.

Security staff	11	Document each 30-minute check on a daily log.
Security staff	12	At the end of the day, forward each log to the warden.
Warden	13	Forward the death warrant along with the return of service to the sentencing court, files a copy of the death warrant in the offender's central file, and forwards a copy of the death warrant to the lead deputy attorney general assigned to the IDOC.
Warden	14	Keep the offender segregated from the general offender population until the execution, or there is a stay of execution.
Warden	15	If there is a stay of execution, the facility head will determine housing in accordance with 319.02.01.001 Restrictive Housing.

Twenty-four (24) hours before the execution, the steps in Table 2.2 will be followed.

Table 2.2

Functional Roles and Responsibilities	Steps	Tasks
Warden	1	Ensure that during the last twenty-four (24) hours before an execution date, that a primary contact telephone at the facility is staffed by approved IDOC employees.
Warden	2	Establish and maintain contact with the telephone contact center by telephone, radio, or other means to ensure that communication is constantly available between the telephone contact employee and the warden.
Warden	3	Arrange a last meal of the offender's choice, to be selected from the current available IDOC cycle menu.
Warden	4	If the execution is completed, signal the coroner to examine the offender.
Coroner	5	Examine the offender, pronounce the offender's death, and signal the warden that the execution has been completed.
Warden	6	Signal staff to escort the witnesses to the approved area.
Warden	7	Make a return of service upon the death warrant, showing the time, mode, and manner in which it was executed.
Warden	8	Forward the death warrant to the sentencing judge.

3. Death Warrants and Pregnant Females

If there is reason to believe that a female under death warrant is pregnant, the warden will require the offender to be examined by three (3) physicians. If the offender is found to be

pregnant, the warden will immediately notify the prosecuting attorney of the county with jurisdiction, the governor's office, and the sentencing judge. The warden will suspend the execution of the sentence, until the offender is no longer pregnant and the sentencing court has appointed a day for execution

All execution procedures, for both male and female offenders, will be conducted at IMSI.

4. **Conditions of Confinement under Warrant of Death**

In addition to the conditions of confinement described in 319.02.01.001 Restrictive Housing, the following conditions apply to offenders under death warrant. If any visitor's conduct poses a risk to the secure, orderly operation of the facility, the IMSI warden, in conjunction with the Director, may restrict the visitor's visitation privileges.

Access and visitation will be limited to the following:

- Law enforcement personnel investigating matters within the scope of their duties
- The offender's attorneys of record
- Agents of the offender's attorneys of record
- Attending physicians
- Spiritual adviser of the offender's choosing
- Members of the offender's immediate family, specifically the offender's:
  - Mother or father, including step parent
  - Brothers or sisters of whole or half (½) blood, by adoption or stepbrothers or stepsisters
  - Lawful spouse verified by marriage license or other operation of law
  - Natural child, adopted child, or stepchild
  - Grandparents of blood relation
  - Grandchildren of blood relation

Seven Days before the Execution Date

During the seven (7) days immediately preceding the scheduled execution, the condemned person may have contact visits with the following:

- Attorneys of record
- Agents of their attorneys of record
- Spiritual adviser of their choosing
- Members of their immediate family.

Seventy-two to Twenty-four Hours before the Execution

Not to exceed seventy-two (72) hours, but at least twenty-four (24) hours before a scheduled execution, the condemned person will be housed in a cell isolated from other offenders. Staff will be assigned to observe the offender at all times and a separate log will be kept of that watch.

If a death warrant is stayed, the offender's housing status will be reviewed in accordance with 319.02.01.002 Offenders Under Sentence of Death.

5. Lethal Substance Approved by the Director (Idaho Code Section 19-2716)

The warden of IMSI is responsible to do the following:

- Purchase the lethal substances in accordance with Idaho Code §19-2716 and fiscal procedures
- Lock the substances in a secure location with access limited to staff the warden designates
- Documents a chain of custody of all substances
- Maintains control of the substances until they are given to the execution team the day of the execution
- Disposes of any remaining substances in accordance with proper handling procedures.

The Director has approved the following lethal injection substances and methods:

- Two (2) syringes, each containing 5.0g sodium pentothal, as a normal anesthetic
- Three (3) syringes, each containing 50 mg of pavulon, a curare preparation, to stop muscle spasms as the anesthetic takes effect; and
- Two (2) syringes each containing 240 mill equivalents of potassium chloride, the lethal agent to stop the heart.
- Four (4) syringes each containing 25 mg of saline to prevent clogging between injections.

In the event of an unavailability of a sufficient quantity of sodium pentothal from available resources, a sufficient quantity of pentobarbital will be acquired and administered as follows:

- Five (5) grams of pentobarbital (100 ml of a 50 mg/ml solution) shall be withdrawn and divided into two (2) syringes to be administered, one immediately after the other.
- A low pressure saline drip shall be allowed to flush saline through the line(s) following completion of the IV medication administration.

At least three (3) days before the scheduled execution date the warden of IMSI will obtain technical assistance for the purpose of reviewing the lethal substances, the amounts, the methods of delivery and injection, and the offender's physical and historical characteristics to evaluate compliance with this SOP and the appropriate institutional Field Memos. The individual(s) conducting the technical review and the warden of IMSI will meet with the Director to review their findings. The Director will make the final determination regarding compliance with this SOP and the appropriate institutional field memorandum

6. Execution Team

The warden of IMSI will select an escort team and an execution team. The identity of the members of the execution team will be confidential and the disclosure of the names of the team will be limited to the IDOC Director and the chief of the Division of Operations.

All members of the execution team must have at least one year of medical experience as a certified medical assistant, Phlebotomist, EMT, paramedic, or military corpsman.

The warden of IMSI shall be responsible for execution team member training and practice sessions. Such sessions must include practice IV setting on volunteers, and a complete

rehearsal of execution protocol. Only individuals who have taken part in at least two (2) of these practice sessions shall be eligible to serve on an actual execution team.

7. Witnesses

The following individuals are approved as witnesses to the execution:

- Coroner from the county in which the execution is located
- Sheriff from the county of conviction
- Prosecuting attorney from the county of conviction
- A spiritual advisor of the offender's choosing
- Sentencing judge
- Representative from the Governor's office
- Attorney General, or his representative
- Representative from the Board of Correction
- A member of the victim's family
- A friend or member of the offender's family
- Four news media representatives (see Section 8)
- No minor child shall be permitted to witness an execution.

Seventy-two hours before the scheduled execution, the chief of the Division of Operations or designee will extend a written invitation to the designated witnesses to witness the execution. Witnesses must confirm their plan to witness the execution. They will be provided a scheduled time to arrive at the institution.

The invitations will include the following information:

- The time that the witnesses are to arrive at the facility
- The location, directions, and instructions for entering the site
- A warning that the following items are not allowed in the facility: tobacco, cameras, video cameras, or recording devices
- Disclosure that all witnesses are subject to a records check and search (metal detector and random pat search) prior to entering the facility.

The witnesses will gather in a designated area and will remain under constant staff supervision. At the warden's command, staff will escort the witnesses to the viewing room in the execution chamber.

After the coroner has pronounced the offender's death and the warden has declared that the execution has been completed, the witnesses will be escorted in a group from the execution viewing area and returned to the designated administrative area.

8. News Media

Seventy-two hours before the execution, the IDOC public information officer will extend a written invitation to local media (media that provides local news to Idaho residents) representatives. The invitation will include directions to the media center, a schedule, and further instructions. Media representatives must confirm their plan to attend the execution in accordance with the written instructions provided in the written invitation. Only the media

representatives that have confirmed their plan to be present will be permitted access to the IDOC South Boise Complex.

The news media notification will include the following information:

- The time that the media representatives are to arrive at the facility
- The location, directions, and instructions for entering the site
- A warning that the following items are not allowed within the facility: tobacco, cameras, video cameras, or recording devices
- Disclosure that media representatives are subject to a records check and search (metal detector and random pat search).

A random drawing to select four representatives of the local news media will occur not more than five (5) hours before the scheduled execution. The local news media representatives that will be allowed to witness the execution will include the following:

- One selected by the Associated Press
- One from a local daily newspaper
- One from a local radio station
- One from a local television station.

Representatives from the news media, selected as witnesses, will be escorted from the media center to the main lobby at IMSI. The news media witnesses will join the other designated witnesses to be escorted as described above.

When the execution is declared completed by the warden of IMSI, the news media witnesses will be escorted to the main lobby of IMSI. The news media witnesses will then be transported to the media center.

Idaho State Correctional Institution Media Center:

- ISCI has been identified as the media center. Media representatives who have confirmed their plans to attend the execution will meet in the visiting center at the designated time.
- Media representatives will sign in as ISCI. They will be processed at the visiting sally port and escorted to the visiting center.
- ISCI will provide two (2) escort officers and a transport van to transport the representatives from the news media who have been selected as witnesses from ISCI to the lobby of IMSI.
- The transport officers will remain in a pre-assigned area at IMSI until the execution is declared completed by the warden. The escort officers will then transport the media representatives back to ISCI.

9. Execution Chamber

The following are approved to be in the execution chamber during the execution procedure:

- The injection team: (up to 4 members as identified by the warden of IMSI)
- A licensed physician: The physician will not be a part of the execution team, and will not participate in the execution in any way, but will assist in any necessary resuscitation effort. The physician will have access to an on-site medical crash cart

and defibrillator. The physician must be licensed under the provisions of chapter 18, title 54, Idaho Code, in accordance with accepted medical standards.

- A coroner or deputy coroner.
- The Director, the chief of the Division of Operations, and the warden of IMSI.
- Witnesses (no more than ten (10).
- News media representatives (at least four (4), no more than seven (7). The final number is predicated upon how many other official witnesses are in attendance.

No more than twenty-two (22) individuals, in addition to the offender, will be allowed in the execution chamber at one time.

10. Execution Preparations

IV set-up and drug preparation will be completed before the inmate is brought to the chamber.

After the inmate has been secured to the injection table, the execution team shall initiate the IV. A primary and backup IV line shall be established. If the IV team cannot secure one (1) or more sites within one (1) hour, there will be no further attempts, and the warden will immediately suspend the execution of sentence. The warden will notify the prosecuting attorney of the county with jurisdiction and the governor's office, and will contact the sentencing judge to request that the execution be scheduled for a later date.

Following the injection of the first syringe (Sodium Pentothal), the warden shall make visual inspection of the offender. If it appears that the offender is not unconscious within 60 seconds of the injection, then the warden shall stop the flow of Sodium Pentothal and order that the backup IV be used with a new flow of Sodium Pentothal.

11. Licensed Physician

A licensed physician will be on site staged near the execution chamber. The physician will have access to an on-site medical crash cart and defibrillator. The physician must be licensed under the provisions of chapter 18, title 54, Idaho Code, in accordance with accepted medical standards. The physician will not be a part of the execution team, and will not participate in the execution in any way.

The physician will provide the following services:

- First Aid: Provide emergency care if needed to any person in the immediate area.
- Resuscitation: Will assist in any necessary resuscitation effort of the offender in case of a stay of execution.

12. Pronouncement of Death

Idaho Code § 19-2716 requires that the death of a condemned offender be pronounced by a coroner or deputy coroner.

The Ada County Coroner will be in the execution chamber during the execution process and after the execution procedure the coroner will determine death.

13. External Security

Before the execution the SICI warden will request that the Federal Aviation Administration (FAA) place a temporary flight restriction (TFR) surrounding the South Boise Complex consisting of the following:

- **Radius:** Three (3) nautical miles
- **Altitude:** Five hundred (500) feet from the surface.

At the designated time, the warden of SICI will control access to the IDOC complex south of Boise to include IMSI, ISCI, SICI, and South Boise Women's Correctional Center (SBWCC). The warden of SICI is responsible for establishing posts at strategic access and checkpoints in the area surrounding the institutions.

The IDOC property south of Boise known as IMSI, ISCI SICI, and SBWCC will be broken down into four (4) security areas:

- **Inner perimeter zone:** the respective institutional fences
- **Controlled perimeter zone**: an extended perimeter around the four (4) institutions
- **Restricted zones:** areas designated for the media
- **Extended zones:** areas designated for observers/demonstrators.

14. Disposition of the Deceased Offender's Body

The body of the deceased offender will be turned over to the coroner. If the family of the offender wishes to claim the body, the warden or designee will assist the family in contacting the coroner to make those arrangements. If no family member claims the body, the body will be handled in accordance with Standard Operating Procedure 312.02.01.001 Death of an Inmate.

REFERENCES

Idaho Code Sections 19-2705, 19-2716

Department Policy 135, Execution Procedures

-- End of Document --

EXHIBIT 2

EXHIBIT 2

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL
LAWRENCE G. WASDEN

May 11, 2011

University of California, Berkeley
School of Law
Death Penalty Clinic
392 Simon Hall
Berkeley, CA 94720-7200

RE: *Your May 4, 2011 letter*

Dear Ms. Moreno,

Your above-dated letter regarding execution issues was referred to me for response. In response to request No. 1, enclosed please find a substantially finalized version of the IDOC's SOP on Execution Procedures. Be advised that the SOP is a draft and while it substantially reflects the Department's practices, it is subject to further revision. The remainder of your requests is denied pursuant to the attached Notice of Action form. Thank you for your attention to this matter.

Sincerely,

William M. Loomis
Deputy Attorney General

cc: Jeff Zmuda

Criminal Law Division, Department of Correction
1299 North Orchard, Suite 110, P.O. Box 83720, Boise, Idaho 83720-0018
Telephone: (208) 658-2097, FAX: (208) 327-7485

EXHIBIT 3

EXHIBIT 3

Idaho Department of Correction	Standard Operating Procedures Operations General Administrative	CONTROL NUMBER: 135.02.01.001	PAGE NUMBER: 1 of 10
		TITLE: Execution Procedures	Approved: 01-01-1994 Reviewed: 03-23-2006 Next Review: 03-23-2008

This document was approved by Pam Sonnen, Administrator of Operations, on 03/23/06 (signature on file).

BOARD OF CORRECTION IDAPA RULE NUMBER 135.

Executions

POLICY STATEMENT NUMBER 135.

Execution Procedures

POLICY DOCUMENT NUMBER 135.

Execution Procedures

DEFINITIONS

Standardized Definitions List

PURPOSE

The purpose of this Standard Operating Procedure is to establish specific procedures for administration of capital punishment in accordance with Idaho statues.

SCOPE

This Standard Operating Procedure applies to all Idaho Department of Correction employees involved in the administration of capital punishment and to offenders who are under death warrant and the execution of which has not been stayed.

RESPONSIBILITY

The Director will exercise overall control of the administrative policy, standard operating procedure, field memoranda, and of the execution process itself.

The Administrator of Operations has control authority and responsibilities for the following institutions and has identified the following responsibilities:

The warden of the Idaho Maximum Security Institution (IMSI) will establish a field memorandum to identify authority and guidelines to carry out the execution of the condemned offender. The Administrator of Operations must approve this field memorandum.

The warden of the Idaho State Correctional Institution (ISCI) will establish a field memorandum to identify authority and guidelines to coordinate media activity and provide logistic and communication support at the IDOC South Boise Complex. The Administrator of Operations must approve this field memorandum.

The warden of the South Idaho Correctional Institution (SICI) will establish a field memorandum to identify authority and guidelines to coordinate and implement external security measures, including guidelines of other law enforcement and support agencies operating on the IDOC South Boise Complex. The Administrator of Operations must approve this field memorandum.

GENERAL REQUIREMENTS

Table of Contents

1. Introduction

Execution of an offender under sentence of death is one of the most serious responsibilities of the agency and a high regard for the dignity of all involved must be maintained.

An execution generates public debate and attention. Staff members must be aware of the pressures an execution places on themselves, offenders, and other staff members. Extra

security precautions are necessary and employees must be prepared and able to meet the situations that might arise.

No IDOC employee, except as identified by state statute, will be forced to participate in an execution.

2. Death Warrant

The following procedure will be followed when a sentencing judge issues a death warrant:

Functional Roles and Responsibilities	Steps	Tasks
Sentencing judge	**1**	Signs and files a death warrant with an execution date not more than thirty (30) days after the date the warrant was issued.
Sentencing judge	**2**	Delivers the death warrant to the Director of the IDOC.
Director	**3**	Immediately notifies the facility head of the facility in which the offender is housed. (If the warrant is delivered to a facility head instead of the director, the facility head will implement step 5, and will notify the director and administrator of operations within 24 hours.)
Director	**4**	Notifies the Board of Corrections and the Governor's Office.
Warden	**5**	Serves the death warrant on the offender and completes a return of service.
Warden	**6**	Immediately has the offender segregated from the general offender population.
Warden	**7**	Appoints a staff member to serve as liaison between the condemned offender and himself.
Warden's liaison	**8**	Meets with the condemned offender at least once each working day and forwards all of the offender's questions and concerns directly to the warden.
Warden	**9**	Instructs the security staff to conduct hourly random visual checks on the offender.
Security staff	**10**	Makes a random hourly check on the offender.
Security staff	**11**	Documents each hourly check on a daily log.
Security staff	**12**	At the end of the day forwards each log to the warden.

Warden	**13**	Forwards the death warrant along with the return of service to the sentencing court, files a copy of the death warrant in the offender's central file, and forwards a copy of the death warrant to the lead deputy attorney general assigned to the IDOC.
Warden	**14**	Keeps the offender segregated from the general offender population until the execution, or there is a stay of execution.
Warden	**15**	If there is a stay of execution, the facility head will determine housing in accordance with 319.02.01.001 Restrictive Housing.

Twenty-four (24) hours before the execution

Functional Roles and Responsibilities	Steps	Tasks
Warden	**1**	Ensures that during the last twenty-four (24) hours before an execution date, that a primary contact telephone at the facility is staffed by approved IDOC employees.
Warden	**2**	Establishes and maintains contact with the telephone contact center by telephone, radio, or other means to ensure that communication is constantly available between the telephone contact employee and the warden.
Warden	**3**	Arranges a last meal of the offender's choice, not to exceed a cost of $50.00 for the food items.
Warden	**4**	If the execution is completed, signals the medical authority to examine the offender.
Medical Authority (licensed physician)	**5**	Examines the offender, pronounces the offender's death, and signals the warden that the execution has been completed.
Warden	**6**	Signals staff to escort the witnesses to the approved area.
Warden	**7**	Makes a return of service upon the death warrant, showing the time, mode, and manner in which it was executed.
Warden	**8**	Forwards the death warrant to the sentencing judge.

3. Death Warrants and Pregnant Females

If there is reason to believe that a female under death warrant is pregnant, the warden will require the offender to be examined by three (3) physicians. If the offender is found to be pregnant, the warden will immediately notify the prosecuting attorney of the county with jurisdiction and the sentencing judge. The warden will suspend the execution of the sentence, until the offender is no longer pregnant and the sentencing court has appointed a day for execution.

All execution procedures, for both male and female offenders, will be conducted at IMSI.

4. Conditions of Confinement Under Warrant of Death

In addition to the conditions of confinement described in Standard Operating Procedure 319.02.01.001 Restrictive Housing, the following conditions apply to offenders under death warrant. If any visitor's conduct poses a risk to the secure, orderly operation of the facility, the IMSI warden, in conjunction with the Director, may restrict the visitor's visitation privileges.

Access and visitation will be limited to the following:

- Law enforcement personnel investigating matters within the scope of their duties
- The offender's attorneys of record
- Agents of the offender's attorneys of record
- Attending physicians
- Spiritual advisers of the offender's choosing
- Members of the offender's immediate family, specifically the offender's:
  - Mother or father, including step parent
  - Brothers or sisters of whole or half (½) blood, by adoption or stepbrothers or stepsisters
  - Lawful spouse verified by marriage license or other operation of law
  - Natural child, adopted child, or stepchild
  - Grandparents of blood relation

Grandchildren of blood relation. Not to exceed seventy-two (72) hours, but at least twenty-four (24) hours before a scheduled execution, the condemned person will be housed in a cell isolated from other offenders. Staff will be assigned to observe the offender at all times and a separate log will be kept of that watch.

- If a death warrant is stayed, the offender's housing status will be reviewed in accordance with Standard Operating Procedure 319.02.01.002 Offenders Under Sentence of Death

Seven Days before the Execution Date

During the seven (7) days immediately preceding the scheduled execution, the condemned person may have contact visits with the following:

- Attorneys of record
- Agents of their attorneys of record
- Spiritual advisers of their choosing
- Members of their immediate family.

Seventy-two to Twenty-four Hours before the Execution

Not to exceed seventy-two (72) hours, but at least twenty-four (24) hours before a scheduled execution, the condemned person will be housed in a cell isolated from other offenders. Staff will be assigned to observe the offender at all times and a separate log will be kept of that watch.

If a death warrant is stayed, the offender's housing status will be reviewed in accordance with Standard Operating Procedure 319.02.01.002 Offenders Under Sentence of Death.

5. Lethal Substance Approved by the Director (Idaho Code Section 19-2716)

The warden of IMSI is responsible to do the following:

- Purchase the lethal substances in accordance with Idaho Code §19-2716 and fiscal procedures
- Lock the substance in a secure location with access limited to staff the warden designates
- Documents a chain of custody of all substances
- Maintains control of the substances until they are given to the execution team the day of the execution
- Disposes of any remaining substances in accordance with proper handling procedures.

The Director has approved the following lethal injection substances and methods:

- Two (2) syringes, each containing 5.0g sodium pentothal, as a normal anesthetic
- Three (3) syringes, each containing 50 ml of 1 mgm/ml pavulon, a curare preparation, to stop muscle spasms as the anesthetic takes effect; and

- Two (2) syringes each containing 50 ml of 2 mEq/ml potassium chloride, the lethal agent to stop the heart.

At least three (3) days before the scheduled execution date the warden of IMSI will obtain technical assistance for the purpose of reviewing the lethal substances, the amounts, the methods of delivery and injection, and the offender's physical and historical characteristics to evaluate the above lethal substances and delivery protocol. The individual(s) conducting the technical review and the warden of IMSI will meet with the Director to review their findings. The Director will make the final determination regarding the lethal substances and the delivery methods.

6. Execution Team

The warden of IMSI will select an escort team and an execution team. The identity of the members of the execution team will be confidential and the disclosure of the names of the team will be limited to the IDOC Director and the Administrator of Operations.

7. Witnesses

The following individuals are approved as witnesses to the execution:

- Coroner from the county in which the execution is located
- Sheriff from the county of conviction
- Prosecuting attorney from the county of conviction
- A spiritual advisor of the offender's choosing
- Sentencing judge
- Representative from the Governor's office
- Attorney General
- Representative from the Board of Correction
- A member of the victim's family
- A friend or member of the offender's family
- Four news media representatives (see section 7).

Seventy-two hours before the scheduled execution, the Administrator of Operations or designee will extend a written invitation to the designated witnesses to witness the execution. Witnesses must confirm their plan to witness the execution. They will be provided a scheduled time to arrive at the institution.

The invitations will include the following information:

- The time that the witnesses are to arrive at the facility
- The location, directions, and instructions for entering the site
- A warning that the following items are not allowed in the facility: tobacco, cameras, video cameras, or recording devices
- Disclosure that all witnesses are subject to search (metal detector and random pat search).

The witnesses will gather in a designated area and will remain under constant staff supervision. At the warden's command, staff will escort the witnesses to the viewing room in the execution trailer.

After the medical authority has pronounced the offender's death and the warden has declared that the execution has been completed, the witnesses will be escorted in a group from the execution viewing area and returned to the designated administrative area.

8. News Media

Seventy-two hours before the execution, the IDOC public information officer will extend a written invitation to local media (media that provides local news to Idaho residents) representatives. The invitation will include directions to the media center, a schedule, and further instructions. Media representatives must confirm their plan to attend the execution in accordance with the written instructions provided in the written invitation. Only the media representatives that have confirmed their plan to be present will be permitted access to the IDOC South Boise Complex.

The news media notification will include the following information:

- The time that the media representatives are to arrive at the facility
- The location, directions, and instructions for entering the site
- A warning that the following items are not allowed within the facility: tobacco, cameras, video cameras, or recording devices
- Disclosure that media representatives are subject to search (metal detector and random pat search).

A random drawing to select four representatives of the local news media will occur not more than five (5) hours before the scheduled execution. The local news media representatives that will be allowed to witness the execution will include the following:

- One selected by the Associated Press
- One from a local daily newspaper
- One from a local radio station

- One from a local television.

Representatives from the news media, selected as witnesses, will be escorted from the media center to the main lobby at IMSI. The news media witnesses will join the other designated witnesses to be escorted as described above.

When the execution is declared completed by the warden of IMSI, the news media witnesses will be escorted to the main lobby of IMSI. The news media witnesses will then be transported to the media center.

9. Execution Trailer

The following are approved to be in the execution trailer during the execution procedure:

- The injection team as identified by the warden of IMSI
- The Director, Administrator of Operations, and the warden of IMSI
- Witnesses (no more than eleven)

No more than twenty-one (21) individuals will be allowed in the execution trailer at one time.

10. External Security

Before the execution the IMSI warden will request that the Federal Aviation Administration (FAA) place a temporary flight restriction (TFR) surrounding the South Boise Complex consisting of the following:

Radius: Three (3) nautical miles

Altitude: Five hundred (500) feet from the surface.

At the designated time, the warden of SICI will control access to the IDOC complex south of Boise to include IMSI, ISCI, SICI, and South Boise Women's Correctional Center (SBWCC). The warden of SICI is responsible for establishing posts at strategic access and checkpoints in the area surrounding the institutions.

The IDOC property south of Boise known as IMSI, ISCI SICI, and SBWCC will be broken down into four (4) security areas:

Inner perimeter zone: the respective institutional fences

Controlled perimeter zone: an extended perimeter around the four (4) institutions

Restricted zones: areas designated for the media

Extended zones: areas designated for observers/demonstrators.

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11. Disposition of the Deceased Offender's Body

The body of the deceased offender will be turned over to the coroner. If the family of the offender wishes to claim the body, the warden or designee will assist the family in contacting the coroner to make those arrangements. If no family member claims the body, the body will be handled in accordance with Standard Operating Procedure 312.02.01.001 Death of an Inmate.

REFERENCES

Idaho Code Sections 19-2705, 19-2716

Department Policy 135, Execution Procedures

-- End of Document --

EXHIBIT 4

EXHIBIT 4

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

ANDREW DEYOUNG,

Plaintiff,

v.

BRIAN OWENS, Commissioner,
Georgia Department of Corrections,

CARL HUMPHREY, Warden,
Georgia Diagnostic and
Classification Prison,

OTHER UNKNOWN EMPLOYEES
AND AGENTS,
Georgia Department of Corrections,

Defendants.

Civil Action No. 1 11-CV-2324 SCJ

Execution scheduled July 20, 2011, 7:00 p.m.

APPENDIX

AFFIDAVIT OF CHRISTINE FREEMAN

STATE OF ALABAMA)
)
COUNTY OF MONTGOMERY)

Christine A. Freeman, being duly sworn, states the following:

1. I am employed by the Middle District of Alabama Federal Defender Program, Inc., as attorney and Executive Director. My office is located in Montgomery, Alabama.

2. I witnessed the State of Alabama's execution of Eddie Duval Powell, which occurred on June 16, 2011 at Holman Prison in Atmore, Alabama. The following describes my observations of that event.

3. I arrived at Holman on the afternoon of June 16, and visited in the visiting room with Mr. Powell, his family members, his spiritual advisor, and Matt Schulz, another attorney from my office who has represented Mr. Powell.

4. Around 4:00 p.m., Mr. Powell's family and his spiritual advisor left. Matt Schulz and I parted from Mr. Powell around 4:30 p.m. When we left him, Mr. Powell said that he would see us "on the other side." Mr. Powell appeared to be well and not under the influence of any drug. He mentioned that he planned to try to call his children before being taken to the execution room.

5. Shortly before 5:30 p.m., Mr. Schulz and I returned to the parking lot at Holman and got into a car driven by a male correctional officer. A second, female officer rode as a passenger in the front seat of the car. The car drove us toward the back of Holman, and stopped before an electric gate. I went with the female officer into a guard house next to the gate and she patted me down. Then Mr. Schulz and I returned to the car, which went through the gate and backed into a driveway next to the execution building.

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6. Our car was accompanied by two white vans. It appeared that one van had news media representatives and I assume the other van contained family members related to the murder victim of Mr. Powell's case. Each vehicle's occupants were led separately into the execution area.

7. Mr. Schulz and I, and at least three media representatives, were seated in an observation room. There was a large window at the front of the room, through which we could see into the execution room.

8. When we were seated, a corrections officer opened a curtain in the execution room. We could see that the execution room had at least three windows looking into it. The other two windows were on our left of our window. We could not see into these other observation rooms behind those windows.

9. We could see that Mr. Powell was already in the room, lying on and tied down to a gurney. His feet were towards the windows, about five or six feet from and perpendicular to the central window. His feet and lower body up to his armpits were swathed in a white sheet, with belts or fasteners of some kind holding his body to the gurney. The gurney was slightly slanted, so that his head was raised higher than his feet. His arms were stretched out straight, at right angles to his body, with his arms apparently tied onto trays attached to the gurney. The intravenous tubes were already inserted in his arms.

10. The warden came into the execution room shortly after 6:00 p.m. and read the execution order aloud. He held a microphone to Mr. Powell's head and asked if he wanted to say anything. Mr. Powell apologized to his family and the victim's family and the people of the state of Alabama. A chaplain came to Mr. Powell's left side, placed his hands on Mr.

Powell's left hand, and knelt and prayed. I could hear the pencil writing of the reporters in the observation room with me.

11. Mr. Powell turned his head and looked at our window. Mr. Schulz had told Mr. Powell that we would be behind the window on Mr. Powell's left. After looking towards us, Mr. Powell lay his head down again.

12. Shortly after the chaplain stopped praying, Mr. Powell violently jerked his head up off of the gurney. His eyes were wide open and looked glazed and confused. He seemed to be looking and he turned his head from side to side. His jaw muscles seemed to clench. He appeared to be in pain. He lay his head back down, but his eyes still appeared to be slightly open. Because we were seated in an observation room on Mr. Powell's side, it was difficult to tell how long this lasted, but his eyes appeared to remain open in this position for quite a while. The entire process lasted about 25 minutes and his eyes remained open in this fashion until towards the end.

13. After Mr. Powell had laid his head back down, the corrections officer in the execution room stepped to Mr. Powell's side and called his first name, "Eddie, Eddie" and touched Mr. Powell's face. Then the officer stepped back against the wall of the room. The officer remained in the execution room, the windows' curtains remained open, and we all remained seated, for quite a while longer.

14. Around 6:25 p.m., someone in the execution room stepped over and shut the curtains on our window. We continued to remain in our observation room, and we could hear other doors opening and footsteps walking on the hall out to the parking lot. Eventually, we were led out, back to the car in which we had arrived, and we were driven back to the

Holman parking lot in front of the prison.

15. I witnessed a prior execution in Alabama, in August 2010, in which, it is my understanding, the drug sodium thiopental was used. During that execution, our client, Jeff Land, closed his eyes and lay his head down, and did not move his head or open his eyes again. The execution of Mr. Powell was quite different.

I hereby declare, pursuant to 28 U.S.C. 1746, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge and belief.

Christine A. Freeman

July 14, 2011
DATE

EXHIBIT 5

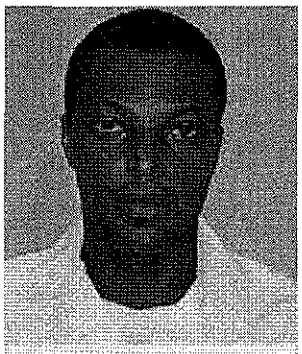
EXHIBIT 5

Everything Alabama

Powell says he's sorry before death by lethal injection at Alabama's Holman Prison

Published: Thursday, June 16, 2011, 8:12 PM Updated: Thursday, June 16, 2011, 8:12 PM

By **Matthew Busch -- The Birmingham News**



Eddie Duval Powell was executed tonight for the 1995 slaying of 70-year-old Mattie Wesson in Tuscaloosa County. (AP Photo/Alabama Department of Corrections)

ATMORE, Alabama -- Eddie Duval Powell was executed by lethal injection tonight at Holman Prison in Alabama. He died at 6:30 p.m.

It was Alabama's fourth execution this year, the third under Gov. Robert Bentley.

Powell was convicted of the 1995 murder, rape and sodomy of 70-year-old Mattie Wesson during the burglary of her home in Holt in Tuscaloosa County.

Powell addressed the witnesses with his final words as he lay strapped to the prison gurney.

"I would like to say I'm sorry for all the pain I've caused to my family and the victim's family," Powell said. "I've made peace with myself and God and hope everyone can move on from this situation."

A chaplain, present in the execution chamber, prayed with Powell, taking him by the hand. Powell closed his eyes.

After a moment his eyes opened again and he raised his head and neck off the gurney. Seemingly confused and startled, he jerked his head to one side and began breathing heavily, his chest rose and contracted. The execution cocktail drugs had begun to be administered. After a few seconds his breathing slowed again and he closed his eyes. When the chaplain let go of his hand, it was limp in the gurney's straps and Powell's head lay back down.

About 20 minutes later, after the entire execution cocktail had been administered, Powell lay dead.

The family of the victim issued a statement after Powell's execution.

"While nothing can ever replace our Mother, Mother-in-law, Grandmother or Aunt, or replace the times we've missed, we take comfort in knowing that justice has been served in this case," they said. "We would like to

offer our condolences to the family of Mr. Powell. We truly understand the grief they are experiencing. It is our prayer that Mr. Powell has found forgiveness from our Lord Jesus and that he will spend eternity in Heaven."

Mattie Wesson's sons Jerold Wesson, Curtis Wesson, William Wesson and their families signed the statement.

Powell visited with family members Thursday **before his execution.** His mother, brother, sister, uncle and friend visited him.

Officers said Powell wrote letters Thursday morning. They described him as talkative and calm.

Powell refused breakfast but had two meatball subs, one chicken sandwich, three grape sodas, and two bags of corn chips from vending machines, said Brian Corbett, a spokesman for the Department of Corrections. He did not request a last meal.

Powell left the majority of his belongings to fellow inmates, including a black and white TV, a Bible, radio, shoes and a thesaurus. He left his mother, Alice Neal, his photographs.

Powell appealed twice to the U.S. Supreme Court before his death. His motions were denied. In one, Powell stated that he was mentally challenged. The other stated that Alabama's use of a new drug in its execution cocktail, pentobarbital, could cause him pain and suffering.

Alabama recently began using pentobarbital in its execution cocktail. The switch from the previously used sodium thiopental is due to a national shortage of the drug. It's only U.S. manufacturer halted production of the drug in 2009.

Powell's family said that they would receive his body.

EXHIBIT 6

EXHIBIT 6

STATE OF GEORGIA

COUNTY OF FULTON

AFFIDAVIT OF GREG BLUESTEIN

1. My name is Greg Bluestein. I am over the age of eighteen and competent to testify as to the matters set forth in this affidavit.

2. I currently work in Atlanta, Georgia, as a reporter covering legal affairs and breaking news for the Associated Press (AP). In that capacity, I attended and witnessed the execution of Roy Willard Blankenship at the Georgia Diagnostic and Classification Prison in Jackson, Georgia, on June 23, 2011.

3. After the execution, I wrote an account of the execution for the AP news wire which ran in several newspapers on June 23, 2011. This article is available here: http://www.timesunion.com/news/article/Ga-executes-inmate-convicted-of-Savannah-slaying-1438037.php AP stories are routinely posted online through AP and its members in the regular course of business of reporting the news.

4. A true and accurate printout of the online version of my story is attached to this affidavit as "Exhibit A." I have initialed the pages of that printout.

5. My story is a true and accurate account of what I witnessed during the execution of Roy Willard Blankenship on June 23, 2011, as timed by a clock reflected in a mirror in the chamber.

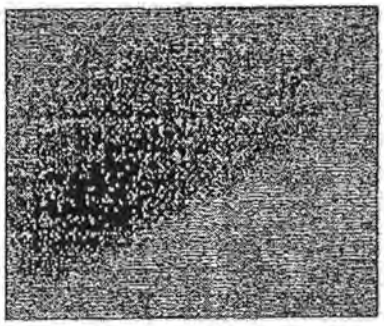
Declared under penalty of perjury this 18th day of July, 2011:

Greg Bluestein

Ga. executes inmate convicted of Savannah slaying

GREG BLUESTEIN, Associated Press
Updated 10:06 p.m. Thursday, June 23, 2011

FILE -In this undated file photo released by the Georgia Department of Corrections, death row inmate Roy Willard Blankenship is shown. Blankenship, convicted of killing a 78-year-old Savannah woman is set to become the first person in Georgia executed using a new lethal injection drug, Thursday, June 23, 2011. (Georgia Department Of Corrections / AP)



JACKSON, Ga. (AP) — A prisoner who was executed Thursday for killing an elderly Savannah woman more than three decades ago appeared to grimace and jerk as he became the first person put to death in Georgia with a drug that the state had not used before.

Roy Willard Blankenship jerked his head several times throughout the procedure and muttered after the pentobarbital was injected into his veins. The 55-year-old's breathing and movements slowed within minutes, and he was pronounced dead at 8:37 p.m.

He was executed for the 1978 murder of Sarah Mims Bowen, who died of heart failure after she was sexually assaulted in her Savannah apartment. Before the procedure began, Blankenship stammered and then told the warden "I hope to see you again."

Blankenship's attorneys claimed in court filings that pentobarbital was unsafe and unreliable, and his attorney Brian Kammer warned that

GB

using the drug as the first part of a three-drug combination would risk needless pain and suffering for the condemned man.

State attorneys countered that the claims were unfounded, and said the drug had been used in more than a dozen executions by other states that switched from sodium thiopental amid a nationwide supply shortage. The Georgia Supreme Court and U.S. Supreme Court agreed Thursday, rejecting Blankenship's last-ditch appeals.

Blankenship's supporters also asked the state medical board to revoke the license of Dr. Carlo Musso, who participated in the execution Thursday. The complaint claimed Musso ran afoul of the law by importing sodium thiopental from overseas manufacturers without first registering with state regulators and that he later sold the drugs to officials in Tennessee and Kentucky.

Musso said in a statement released to The Associated Press late Thursday that he is being singled out for "political purposes" and urged critics of the death penalty not to specifically target him. The statement did not directly address the allegations.

"When they fail to make progress with policymakers, groups opposed to capital punishment continue to attack physician licensure as a method to end lethal injection as form of execution," he said.

Blankenship's execution was under close scrutiny by state attorneys, death penalty defense lawyers and other observers. He was laughing and chatting with a prison chaplain in the moments before his execution, at one point trying to converse with the observers sitting behind a glass window.

As the injection began, he jerked his head toward his left arm and made a startled face while blinking rapidly. He soon lurched to his right arm, lunging with his mouth agape twice. He then held his head up, and his chin smacked as he mouthed words that were inaudible to observers.

Within three minutes, his movements slowed. About six minutes after the injection began, a nurse checked his vital signs to ensure he was unconscious before the execution could continue. He was pronounced dead nine minutes later. His eyes never closed.

Death penalty critics said Blankenship's movements were proof that Georgia shouldn't have used pentobarbital to sedate him before injecting pancuronium bromide to paralyze him and then potassium chloride to stop his heart.

"It is unconscionable that Georgia would experiment with untested and potentially harmful drugs on a human being," said Kathryn Hamoudah of Georgians For Alternatives to the Death Penalty, which opposes capital punishment.

Prosecutors had sought Blankenship's execution for more than 30 years. He was sentenced to death three times in Bowen's killing.

Her bloody, nude body was discovered by friends and neighbors after the attack, and police were able to trace footsteps to the area where Blankenship lived across the street. They also matched blood scrapings and seminal fluid to Bowen.

At his 1980 trial, Blankenship told jurors that he broke into Bowen's house and tried to rape her but then bolted when she appeared to wake. He said she was still clothed when he left, and she hadn't been beaten up.

The jury didn't buy his account and he was sentenced to die, but the Georgia Supreme Court reversed the sentence a year later. He was re-sentenced to death in 1982, but that sentence was also reversed when the court ruled that Blankenship's attorneys were restricted from presenting key evidence.

He was again sentenced to die in 1986, but this time state and federal courts upheld the capital sentence.

After his execution was scheduled earlier this year, the Georgia pardons board granted him a temporary reprieve in February to allow for more DNA testing. But it rejected his appeal in June after the tests returned inconclusive.

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Troy police seek man in assault of disabled woman 06:08 p.m.

Judge agrees to hearing for welfare cheat who wants plea back 03:47 p.m.

Movie star at Schenectady City Hall 02:23 p.m.

Mazzone lands GlobalFoundries dining contract 01:05 p.m.

FROM OUR HOMEPAGE

SEEN: Women's World Cup at Wolff's Biergarten

Recalling victims of Salem blast

Historical photos: Saratoga Springs through the years

Georgia joins a growing number of states that have begun using pentobarbital in executions. Many of the nation's 34 death penalty states switched to pentobarbital or began considering a switch after Hospira Inc., the sole manufacturer of sodium thiopental in the U.S., said in January it would no longer make the drug.

But Georgia has been under particular scrutiny after Drug Enforcement Administration regulators seized the state's stockpile of sodium thiopental amid questions about how it had obtained the supply. Court records show the state bought the drug from Dream Pharma, a London company. Inmates' attorneys have called it a fly-by-night supplier that operates from the back of a driving school.

Bluestein can be reached at http://www.twitter.com/bluestein

GB

EXHIBIT 7

EXHIBIT 7

Inmate Jeffrey Motts first to die in SC with new combo of drugs

BY JEFFREY COLLINS
Associated Press
Friday, May 6, 2011

COLUMBIA — South Carolina inmate Jeffrey Motts wished a happy Mother's Day to his mother and grandmother, warned children to stay off drugs and apologized to his own family and the families of his victims before he was executed Friday for strangling his cellmate.

Motts, who turned 36 the day before he died, was the first inmate in South Carolina to be killed using a new combination of lethal drugs. It appeared to take him longer to die, but otherwise the execution was similar to several other lethal injections the state has carried out.

The state had to switch the sedative used as the first drug in the three drug combination from sodium thiopental to pentobarbital because federal agents seized the state's supply as part of a nationwide investigation into whether prisons obtained the drugs legally from England. The remaining two drugs remained the same.

Motts was sentenced to death for killing his cellmate at a state prison in Greenville County in 2005. He was already serving a life sentence for killing two elderly people during a Spartanburg County robbery in 1995.

Motts, strapped to a gurney in a green jumpsuit, never looked at the witnesses and stared at the ceiling as his lawyer read his final statement: "To my mom and grandma, happy Mother's Day. I know this is a sad one but let us remember the good times. I am finally free and at peace in heaven."

After his lawyer left the room, the IV tubes twitched as it appeared the lethal drugs began to flow. He took several heavy breaths, blinked and his head jerked slightly for about a minute before his breaths became shallow and eventually stopped about 90 seconds later.

Clemson
Carolina
Battery
Family Circle Cup
Riverdogs
Stingrays
National Sports
Sports Columnists
Life in the Minors

Business

Local Business
Business Review
Real Estate
Automotive
Columnists

Multimedia

Video
Audio
Photo Galleries
Evening Post Books
eBooks
iPhone App
Android App New!
Man On The Street
In The News
Share Photos

Entertainment

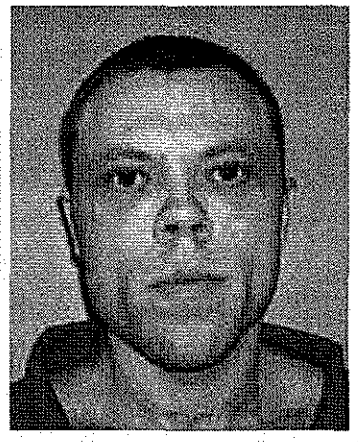
CharlestonScene
Events
Restaurants
Movies
TV Listings
Music
Columnists
Games
Comics

Features

Savvy Shopper New!
Moxie
Your Health
Family Life
Arts/Travel
Home/Garden
Food
People
Faith/Values
Your Faith
Asking Around
Columnists

Supplements

Spoleto Today New!
Wine + Food
SEWE
North Charleston
Magazine
My Charleston
Lowcountry Parent
Tideline Magazine
Lowcountry Paws
Attorney Directory
Real Estate Guide



South Carolina Department of Corrections/AP

Jeffrey Motts

His eyes slowly closed, never to open again, but it would be 14 more minutes before a doctor officially declared him dead with a nod toward the warden at 6:17 p.m.

Motts abandoned all his appeals and volunteered for the death chamber

He confessed to strangling Charles "Chuck" Martin just hours after telling guards at Perry Correctional Institution in Greenville County where to find his body in a prison common area. During that confession, he also asked investigators to tell prosecutors he was serving two life sentences and a third wasn't going to make a difference.

He told his attorneys he wanted to die, saying he only went to trial so his parents wouldn't think he was giving up. His push to enter the death chamber wavered briefly when his lawyers suggested he might be able to donate a kidney to his ailing sister, but he reaffirmed his wish to die after the two turned out not to be a match.

Motts and Martin had ended up in the same cell together in November 2005 despite asking to be kept apart because of a dispute over a stolen radio and a shank found in another inmate's cell.

After an early morning argument on Dec. 5, Motts said he went into a rage, knocked his cellmate unconscious and tied him up. When Martin came to, begging for his life, Motts said he choked him for five minutes. When the cell doors opened for breakfast, Motts smoked a cigarette, ate, then came back to his cell, dragged Martin's body to a common area and kicked him in the head, saying "this is what snitches get."

Motts was already serving a life sentence for a 1995 double murder in Spartanburg County in the northwest part of the state. He tied up 79-year-old Clyde Camby and shot him at close range in the cheek at a home in Pacolet, then shot his 73-year-old great-aunt Etta Osteen in the back as she tried to get away, investigators said.

Camby was found with his pockets turned inside out. Authorities said Motts killed the pair to get money to buy crack.

He mentioned his drug addiction in his last statement.

"I want to warn kids of the dangers of drugs. I was the child everyone wanted their children around until I got on drugs. Drugs will destroy your life."

Motts ate a final meal of pizza, fried fish, popcorn shrimp, french fries, sweet tea and cherry cheesecake.

EXHIBIT 8

EXHIBIT 8

IN THE SUPERIOR COURT OF FULTON COUNTY

STATE OF GEORGIA

ROY WILLARD BLANKENSHIP,

PLAINTIFF,

BRIAN OWENS, IN HIS CAPACITY AS COMMISSIONER OF THE GEORGIA DEPARTMENT OF CORRECTIONS; CARL HUMPHREY, IN HIS CAPACITY AS WARDEN OF THE GEORGIA DIAGNOSTIC PRISON; DOES 1-50, UNKNOWN EXECUTIONERS. IN THEIR CAPACITIES AS EMPLOYEES AND/OR AGENTS OF THE GEORGIA DEPT. OF CORRECTIONS.

DEFENDANTS.

CIVIL ACTION FILE
NO: 2011CV202236

VOL. 1
*****

TRANSCRIPT OF PROCEEDINGS IN THE ABOVE-ENTITLED AND NUMBERED CAUSE, HEARD BEFORE THE HONORABLE WENDY L. SHOOB, FULTON COUNTY, GEORGIA, ON JUNE 21, 2011.

*****

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

ON BEHALF OF THE PLAINTIFF:
BRIAN KAMMER,
ATTORNEY AT LAW

LYNN PEARSON,
ATTORNEY AT LAW

ON BEHALF OF THE DEFENDANTS:
JOSEPH DROLET,
ATTORNEY AT LAW

BETH A BURTON,
ATTORNEY AT LAW

CHRISZANIER D. REID, CCR NO. B-1092
OFFICIAL COURT REPORTER
ATLANTA, FULTON COUNTY, GEORGIA

DR. DAVID WAISEL.

THE SHERIFF: COULD YOU RAISE YOUR RIGHT HAND PLEASE?

THE WITNESS: (COMPLIES WITH REQUEST).

THE SHERIFF: DO YOU SWEAR OR AFFIRM THE TESTIMONY YOU ARE ABOUT TO GIVE TODAY IN COURT IS THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH SO HELP YOU GOD?

THE WITNESS: I AFFIRM.

THE SHERIFF: PLEASE HAVE A SEAT AND STATE YOUR NAME AND SPELLING IT FOR THE RECORD.

THE WITNESS: MY NAME IS DAVID WAISEL. W-A-I-S-E-L.

MR. KAMMER: MAY I APPROACH THE PODIUM, YOUR HONOR?

THE COURT: YES, SIR.

DR. DAVID WAISEL,

HAVING BEEN DULY SWORN, WAS EXAMINED AND TESTIFIED AS FOLLOWS:

DIRECT EXAMINATION

BY MR. KAMMER:

Q. GOOD MORNING.

A. GOOD MORNING.

Q. DR. WAISEL, CAN YOU TELL US WHERE YOU ARE COMING FROM TODAY PLEASE?

ANESTHESIOLOGY. AT TIMES THERE ARE CERTIFIED REGISTERED NURSE ANESTHETISTS, WITH TRAINING AND PRACTICE IN THESE AREAS, WHO ARE RIGHT IN THE FRONT LINE WITH THE PHYSICIAN BEING AVAILABLE FOR CONSULTATION AND FOR COMPLEX MATTERS. HOW TO RESPOND TO THE CASES. OTHER TIMES IT'S A PHYSICIAN. OTHER TIMES IT'S A TRAINEE WHO IS A PHYSICIAN WHO IS LEARNING OF THE SPECIAL EVENTS THAT'S GOING ON.

Q. AND IN THE OPERATING ROOM WHERE ARE THOSE PEOPLE PHYSICALLY IN RELATION TO THE PATIENT?

A. ONE OF US IS ALWAYS A FOOT OR TWO AWAY FROM THE PATIENT. OFTENTIMES BOTH PEOPLE.

Q. DO YOU EVER TOUCH THE PATIENT?

A. FREQUENTLY.

Q. AND WHY DO YOU DO THAT?

A. ASSESSMENT. I MIGHT BE ASSESSING THE PATIENT'S TEMPERATURE. I MIGHT BE ASSESSING A CONCERN WITH THE I.V. AS INFILTRATED. PALPATING THE SITE IS ONE OF THE BEST MECHANISMS WE HAVE FOR HELPING MAKE THAT ASSESSMENT.

Q. WHAT DOES THAT MEAN, PALPATING THE SITE?

A. TOUCHING. EXAMINING BOTH VISUALLY AND WITH MY HANDS.

Q. HOW WOULD YOU DO THAT WITH YOUR HANDS?

A. I'M LOOKING FOR SEVERAL THINGS. WELL, LET

ME STEP BACK FOR A MOMENT. WHAT HAPPENS WHEN AN I.V. INFILTRATES IS THE FLUID GOES INTO THE SOFT TISSUE UNDER THE SKIN. DEPENDING ON YOUR SIZE A GREAT DEAL OF FLUID CAN ACCUMULATE IN THERE BEFORE YOU HAVE SIGNIFICANT RESISTANCE. OR BEFORE YOU BURN. SO WHEN I PALPATE I'M LOOKING FOR SEVERAL THINGS. I'M LOOKING FOR A SWELLING IN THAT AREA WHICH CAN BE VERY SUBTLE. I AM FEELING FOR COOLNESS IN THAT AREA WHICH MAY INDICATE DISTRIBUTION OF THE I.V. FLUID RIGHT AT THAT SITE. I AM ASSESSING TO SEE IF I PINCHED THE VEIN -- OBSTRUCTED THE VEIN. PINCH IS NOT THE PROPER TERM -- HIGHER UP. DOES THAT STOP THE I.V. FLOW. WHICH IT SHOULD IF THE I.V. IS IN THE VEIN. AND IF IT'S NOT IF IT'S INFILTRATED AND I THINK MOST ANESTHESIOLOGISTS -- I KNOW MYSELF -- HAVE A VERY LOW THRESHOLD FOR REPLACING THE I.V. BECAUSE INFILTRATED I.V. -- IN ADDITION TO NOT WORKING -- CAN CAUSE A GREAT DEAL OF PAIN.

Q. I WANT TO ASK YOU ABOUT THAT. BUT JUMPING BACK YOU SAID YOU HAVE A VERY LOW THRESHOLD FOR REPLACING THE I.V., CAN YOU EXPLAIN THAT A LITTLE BIT MORE? WHAT DO YOU MEAN BY THAT?

A. EVEN AMONG EXPERIENCED HANDS IT'S SOMETIMES HARD TO TELL. ESPECIALLY IN LARGER PEOPLE. BECAUSE WE KNOW WE CAN'T TELL AND BECAUSE WE KNOW IT IS HARMFUL TO THE PATIENT, WE WOULD RATHER ERR ON THE SIDE OF SAFETY

AND REPLACE IT AND OBTAIN INTRAVENOUS LINE THAT WE ARE MORE CONFIDENT IN.

Q. AND YOU SAID THAT INFILTRATION IS PAINFUL, WHY IS THAT?

A. FOR A NUMBER OF REASONS. THE STRETCHING OF THE TISSUE. WHICH SKIN HAS AN INCREDIBLY AMOUNT OF NERVE ORGANS AND IF YOU STRETCH IT EXCRUCIATING PAINFUL. IN ADDITION SOME MEDICATIONS, WHEN YOU GO IN THE SOFT TISSUE, BURN EXTREMELY AND RATHER EXCESSIVELY. PATIENTS REPORT EXTRAORDINARY PAIN.

Q. AFTER YOU SET THE I.V. IS IT POSSIBLE FOR AN I.V. TO SHIFT AND INJECT CHEMICAL INTO THE ISSUE?

A. YES.

Q. AND IS THAT WHAT YOU'RE LOOKING FOR?

A. YES.

Q. DO YOU KEEP A CONSTANT FLOW OF ANESTHESIA DURING THE SURGERY?

A. YES.

Q. AND WHY IS THAT?

A. WHEN WE EXPLAIN TO PATIENTS HOW THE ANESTHESIA WORKS WE LIKEN IT TO DRIVING A CAR. YOU PUSH ON THE GAS AND THEN WHEN YOU ARE DONE TAKE YOUR FOOT OFF THE GAS AND IT COMES TO A STOP. MANY OF THE AGENTS WE USE, ONE, WORK FOR A SHORT PERIOD OF TIME. SO WE DON'T WANT THE PATIENT TO WAKE UP DURING THE CASE; AND, TWO,

WE ARE ABLE TO ADJUST BASED ON FEEDBACK. SO WE KNOW WHAT, FOR EXAMPLE -- JUST TO PICK AN EXAMPLE. THERE'S AN ANESTHETIC GAS CALLED ISOCHLORIDE AND WE KNOW WHAT'S IN THE CONCENTRATION. THERE'S MOST LIKELY -- WITH HIGHLY CONFIDENCE ABOUT -- AMNESIA. ONE OF THE WORSE THINGS A PATIENT COULD EXPERIENCE IS AWARENESS DURING ANESTHETIC.

Q. WHEN YOU SAY...YOU WERE TALKING ABOUT INJECTING THE DRUG OR PUSHING THE DRUG INTO THE PATIENT. WHAT EXACTLY DOES THAT ENTAIL PHYSICALLY?

A. YOU HAVE A SYRINGE IN YOUR HAND AND YOU HOOK IT UP TO THE I.V. LINE EITHER THROUGH A BLUNT NEEDLE AND A PLASTIC TUBE -- OR WHAT WE CALL A THREE-WAY STOPCOCK YOU HOOK IT IN -- AND YOU PUSH DOWN ON THE SYRINGE AND PUSH THE MEDICATION THROUGH THE I.V. TUBING INTO THE PATIENT.

Q. WHAT IS THE TYPICAL LENGTH OF THE I.V. TUBING THAT YOU USE?

A. WELL, WE TRY TO INJECT IT AS CLOSE AS POSSIBLE TO THE PATIENT. IN GENERAL MOST INJECTIONS OCCUR WITHIN TWO FEET.

Q. AND WHY DO YOU TRY TO BE AS CLOSE TO THE PATIENT AS POSSIBLE?

A. TWO REASONS. SPEED. IT GETS THERE MORE QUICKLY AND IT WORKS MORE QUICKLY AND GREATER

SENSITIVITY IF THE I.V. IS NOT WORKING. IF THE I.V. IS INFILTRATED. THE CLOSER I AM TO THE SITE THE BETTER ABLE I AM TO TELL CHANGE IN THE AMOUNT OF PRESSURE I HAVE TO USE.

Q. WHAT IS THE BENEFIT, IF ANY, OF PHYSICALLY PUSHING IN AND APPLYING YOUR OWN SYRINGE BY HAND? WHY CAN'T YOU GET A MACHINE TO DO THAT?

A. IN CLINICAL PRACTICE MANY OF THE DRUGS WE GIVE NEEDS TO BE GIVEN ONCE OR TWICE. IT IS CUMBERSOME TO SET UP A PUMP -- AS WE CALL IT -- TO DO IT. FOR INFUSION -- THAT IS THINGS OVER TIME OR FOR DRUGS WE ARE LESS FAMILIAR -- THAT WE DON'T USE REGULARLY -- IT IS ALMOST DERIVATIVE TO USE A PUMP BECAUSE THAT PROVIDES A MARGIN OF SAFETY.

Q. WHAT ARE THE BENEFITS, IF ANY, IN USING YOUR HAND?

A. ASSESSMENT OF THE PATENCY OF THE I.V. IN THAT IF THE I.V. HAS BECOME INFILTRATED IN SOFT ISSUE AT A CERTAIN POINT THERE WILL BE INCREASED PRESSURE AND I WILL FEEL THAT AND SO I WOULD TURN MY CONCERN NOW WITH EXAMINING TO SEE HOW THAT FEELS.

Q. IS YOUR HAND ON A PLUNGER FOR A PERIOD OF TIME DURING THE SURGERY PROCESS?

A. YES.

Q. HOW LONG DO YOU HAVE YOUR HAND PHYSICALLY

HOLDING SYRINGE?

A. EPISODICALLY. SO DEPENDING ON THE TYPE OF SURGERY. I WOULD GIVE VERY DIFFERENT MEDICATIONS FOR EACH ONE I GIVE. SO TEN SECONDS.

Q. AND SO IS THAT GRAB THAT SYRINGE MULTIPLE TIMES DURING SURGERY? ANY GIVEN SURGERY?

A. YES.

Q. I THINK YOU MENTIONED RESISTANCE. WHAT IS RESISTANCE IN THE CONTEXT OF INJECTING ANESTHESIA?

A. IN THE I.V. LINE TUBING AND THE I.V. CATHETER SHOULD BE PATENT -- IT SHOULD BE HOLD ALL THE WAY THROUGH -- AND DEPENDING ON THE SIZE OF THE I.V. AND THE PATIENT THERE IS A CERTAIN AMOUNT OF RESISTANCE FROM THE VEIN. IN OTHER WORDS, IF IT'S A SMALL CHILD YOU CANNOT PUSH FULLY QUICKLY AS YOU CAN AN ADULT BECAUSE THE VEINS ARE OF A DIFFERENT SIZE. OR A DIFFERENT CALIBER. SO THE RESISTANCE WHICH COMES FROM THE TUBING AND SIZE OF THE I.V. AND THE VEIN IS GENERATED BY HOW SMALL OR LARGE THOSE TUBES ARE AND HOW THE FLUID AND HOW QUICKLY IF I'M TRYING TO PUSH IT THROUGH.

Q. AND IS IT IMPORTANT TO MONITOR RESISTANCE DURING SURGERY?

A. YES, BECAUSE IT GIVES ME AN INDICATION OF WHETHER, AGAIN, I'M HAVING I.V. INFILTRATION.

Q. IN TURNING BACK TO THE LETHAL INJECTION

PROTOCOL, WHAT ARE THE TYPICAL RISKS THAT ARE OF CONCERN IN TERMS OF THE SEQUENCE OF THE DRUGS? RISKS OF PAIN AND SUFFERING. HOW WOULD PAIN AND SUFFERING OCCUR POTENTIALLY IN THAT KIND OF A PROCEDURE?

A. I WOULD SUGGEST TO YOU THE FOLLOWING RISKS AND I WOULD SUGGEST THAT IT MAY HAVE BEEN SEEN. ONE IS INAPPROPRIATE MIXING OR INAPPROPRIATE DRAWING UP OF DRUGS. TWO -- AND I WILL LUMP THEM TOGETHER AND CATEGORIZE THEM -- TWO IS JUST WHAT WE CALL DRUG SWAP. OR CONFUSING WHICH DRUG IS IN WHICH SYRINGE. BOTH OF THESE CAN LEAD TO INADEQUATE ANESTHETIC REACHING THE INMATE. INCREASING THE LIKELIHOOD OF AWARENESS. THE I.V. TUBING MAY NOT BE APPROPRIATELY CONNECTED. MOST OFTEN I.V. TUBING IS VERY LONG IN THIS CASE. THE I.V. MAY BECOME INFILTRATED, SUCH AS IN DIAZ, WHERE ARE REPORTS THE GENTLEMAN ENDED UP WITH BURNS ON BOTH SIDES OF HIS ARM AND HIS LEGS BECAUSE SODIUM PENTOTHAL INFILTRATED. THERE IS NO ASSESSMENT -- OR LET ME QUALIFY THAT. THERE'S NO ASSESSMENT OF CONSCIOUSNESS BY PEOPLE TRAINED. CERTIFIED TO ASSESS UNCONSCIOUSNESS.

Q. I WANT TO COME BACK TO THAT IN A LITTLE BIT. BUT LET ME JUST ASK SOME VERY BASIC THINGS. IF THE PRISONER IS NOT ADEQUATELY SEDATED WHAT IS THEN THE CONCERN ABOUT PAIN AND SUFFERING?

A. AWARENESS, NUMBER ONE, WHICH IS HORRIFIC.

WHEN YOU ARE PARALYZED IN THE WAY YOU CAN BE SUFFOCATING. TWO, THE FEELING OF POTASSIUM CHLORIDE WHICH -- BY REPORTS -- BURNS INCREDIBLY.

Q. LET ME TURN TO GEORGIA'S NEW PROTOCOL WHICH INCORPORATES PENTOBARBITAL. WE TALKED A LITTLE BIT ABOUT THE MANUFACTURER OF PENTOBARBITAL. LUNDBECK. DID YOU REVIEW THE CORRESPONDENCE AGAIN BETWEEN LUNDBECK AND THE DEPARTMENT OF CORRECTIONS?

A. YES.

Q. DOES IT SURPRISE YOU THAT LUNDBECK WOULD ISSUE SUCH A WARNING ABOUT THIS DRUG?

A. IN MY EXPERIENCE IT'S UNPRECEDENTED THAT A COMPANY WOULD ISSUE SUCH A WARNING -- EVEN FOR OFF LABEL USE -- WITHOUT THE F.D.A. INSTITUTING A CONCERN.

Q. AND WHY DOES THAT SHOCK YOU?

A. I HAVE NO KNOWLEDGE OF THE INNERWORKINGS OF LUNDBECK, BUT I ASSUME THEY ARE VERY CONCERNED ABOUT THE SAFETY OF PENTOBARBITAL IN THESE SITUATIONS.

Q. YOU HAD TALKED EARLIER ABOUT THE INTENSIVE USE OF SODIUM THIOPENTAL IN SURGICAL SETTINGS. WHAT DO WE KNOW ABOUT THE USE AND EFFICACY OF PENTOBARBITAL ON HUMAN SUBJECTS?

A. THE USE OF PENTOBARBITAL IN SURGICAL SETTINGS IN NORMAL HEALTHY PEOPLE IS RARE. SO WE HAVE VERY LITTLE CLINICAL KNOWLEDGE AND THERE IS VERY LITTLE

EXHIBIT 9

EXHIBIT 9

C
West's Idaho Code Annotated Currentness
Title 19. Criminal Procedure
Chapter 27. Execution

§ 19-2716. Infliction of death penalty

The punishment of death shall be inflicted by continuous, intravenous administration of a lethal quantity of a substance or substances approved by the director of the Idaho department of correction until death is pronounced by a coroner or a deputy coroner. The director of the Idaho department of correction shall determine the procedures to be used in any execution. This act shall apply to all executions carried out on and after the effective date of this enactment, irrespective of the date sentence was imposed.

CREDIT(S)

S.L. 1978, ch. 70, § 1; S.L. 1982, ch. 257, § 1; S.L. 2009, ch. 81, § 1, eff. July 1, 2009.

Codifications: Cr. Prac. 1864, § 467; R.S. 1887, R.C. 1909, and C.L. 1919, § 8020; C.S. 1919, § 9063; I.C.A. § 19-2616.

HISTORICAL AND STATUTORY NOTES

2009 Legislation

S.L. 2009, ch. 81, § 1, rewrote the section, which prior thereto read:

"The punishment of death shall be inflicted by continuous, intravenous administration of a lethal quantity of an ultra-short-acting barbituate in combination with a chemical paralytic agent until death is pronounced by a physician licensed under the provisions of chapter 18, title 54, Idaho Code, in accordance with accepted medical standards. The director of the department of correction shall determine the substance or substances to be used and the procedures to be used in any execution; provided, however, that, in any case where the director finds it to be impractical to carry out the punishment of death by administration of the required lethal substance or substances for the reason that it is not reasonably possible to obtain expert technical assistance, should such be necessary to assure that infliction of death by administration of such substance or substances can be carried out in a manner which causes death without unnecessary suffering, the sentence of death may be carried out by firing squad, the number of members of which shall be determined by the director; and provided further, that any infliction of the punishment of death by administration of the required lethal substance or substances in the manner required by this section shall not be construed to be the practice of medicine and any pharmacist or pharmaceutical supplier is authorized to dispense drugs to the director or his designee, without prescription, for carrying out the provisions of this section, notwithstanding any other provision of law. This act shall apply to all executions carried out on and after the effective date of this enactment, irrespective of the date sentence was im-

posed."

I.C. § **19-2716**, ID ST § **19-2716**

Current through (2011) Chs. 1-335 that are effective on or before July 1, 2011

END OF DOCUMENT

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EXHIBIT 10

EXHIBIT 10

DEPARTMENT OF CORRECTION	POLICY MANUAL	POLICY NUMBER: 135	PAGE NUMBER: 1 of 4
		SUBJECT: Execution Procedures	Adopted: 01-94 Revised: 05-98 Reformatted: 01-2001

01.00.00. POLICY OF THE DEPARTMENT

It is the policy of the Board of Correction that the Department of Correction carry out scheduled executions of the death penalty in a manner consistent with professional correctional standards. Execution of an inmate under sentence of death is one of the most serious responsibilities of the agency and must be approached with a high regard for the dignity of all involved. Legitimate missions of the public will be accommodated to the degree possible within reasonable standards of security and budget restrictions.

02.00.00. TABLE OF CONTENTS

03.00.00. REFERENCES

Idaho Code Section 19-2705

04.00.00. DEFINITIONS

IDOC: The Idaho Department of Correction.

IMSI: The Idaho Maximum Security Institution. This institution houses death row inmates and is the location of the execution trailer.

ISCI: The Idaho State Correctional Institution, which is located just east of IMSI.

SICI: The South Idaho Correctional Institution, which is located east of ISCI.

Institutional compound: The area west of Pleasant Valley Road where the three institutions are located.

05.00.00. PROCEDURE

05.01.00. Execution Resources

Execution of a sentence of death requires the use of a variety of IDOC resources.

The warden of the IMSI will inform the administrator of the division of prisons and the director of the IDOC when an order of execution is received.

IMSI personnel will inform, in writing, potential official execution witnesses within the criminal justice system.

IMSI personnel will carry out the execution warrant.

By statute, the warden of IMSI shall be the official executioner.

Execution of the sentence of death shall be by lethal injection.

The lethal injection series shall consist of:

Sodium pentothal, as a normal anesthetic;

Pavulon, a curare preparation, to stop muscle spasming as the anesthetic takes effect; and

Potassium chloride, the lethal agent to stop the heart.

Injection shall be through intravenous catheter.

ISCI personnel will coordinate media activity and provide logistics/communications support.

A media center shall be established;

The pre-execution briefing will be delivered in the media center;

The lottery selection of media witnesses will occur in the media center;

The post-execution briefing will occur in the media center.

The director will designate a public information officer to deal with execution-related media requests and releases of information.

SICI personnel will coordinate and implement external security measures.

Assistance may be requested of the Idaho State Police (ISP), the national guard and the Ada county sheriff's office.

Assistance may be requested of community medical resources.

The warden of the SICI will direct the activities of supporting agencies involved in external security.

05.02.00. Public and Media Parking

Areas for public and media parking will be provided and maintained in a secure manner.

05.03.00. Public Gathering and Demonstration Parking

Areas for public gathering and demonstration of support or opposition to the death penalty will be provided and maintained in a secure manner.

05.04.00. Official and Media Witnesses

An area will be provided for the gathering of official witnesses and media witnesses immediately prior to the scheduled execution.

05.05.00. Stay of Execution

Communication of a stay of execution will be accepted only from the office of the solicitor general.

A deputy attorney general assigned to the Department of Correction will be at the IMSI with an open line of communication to the solicitor general beginning two hours prior to a scheduled execution.

POLICY NUMBER: 135	SUBJECT: Execution Procedures	PAGE NUMBER: 4 of 4

The deputy attorney general will have an open line of communication to the director of the IDOC beginning one hour prior to a scheduled execution.

The director of the IDOC shall convey any stay of execution to the administrator of the division of prisons and the warden of the IMSI.

05.06.00. Absence of Stay of Execution

In the absence of a legitimate stay of execution, the execution will be carried out as ordered.

The coroner will make the official pronouncement of death.

The warden of the IMSI will make the official pronouncement of completion of the execution after the coroner pronounces the death.

05.07.00. Witness Execution Area

Witnesses to the execution will exit the execution witness area under escort.

Media witnesses will be transported to the media center.

Media witnesses will deliver a post-execution briefing to remaining media representatives.

05.08.00. Post Execution Procedures

Post execution procedures determined by field memoranda will be followed by IDOC personnel.

Director, Department of Correction **Date**

EXHIBIT 11

EXHIBIT 11

DEPARTMENT OF CORRECTION INSTITUTIONAL SERVICES DIVISION	**DIRECTIVE NUMBER:** 401.06.03.069	**PAGE NUMBER:** 1 of 2
	SUBJECT: Participation – Executions	Adopted: 06-01-95 Revised: 05-03-99 Reformatted: 02-2001

01.00.00. POLICY OF THE DEPARTMENT

It is the policy of the Idaho Board of Correction that the Department of Correction ensure proper medical, dental, psychiatric and psychological services and treatment be provided to inmates incarcerated under its jurisdiction, including those state-sentenced offenders held in non-IDOC facilities.

02.00.00. TABLE OF CONTENTS

03.00.00. REFERENCES

Standards for Health Services in Prisons, P-69.

04.00.00. DEFINITIONS

Facility Health Authority: The on-site Health Authority or senior health staff assigned.

Medical Authority: Idaho Department of Correction Health Services Chief.

Medical Director: A physician (M.D.) either employed by the Idaho Department of Correction or the physician in charge if medical services are privatized.

Mid-Level Provider: Physician Assistant or Nurse Practitioner.

Qualified Health Professional: Physician, physician assistant, nurse practitioner, nurse, dentist, mental health professional and others who by virtue of their education, credentials, and experience are permitted by law within the scope of their professional practice are to evaluate and care for patients.

DIRECTIVE NUMBER: 401.06.03.069	SUBJECT: Participation – Executions	PAGE NUMBER: 2 of 2

Regional Health Manager: The individual assigned as the primary manager who is administratively responsible for the delivery of medical services if health services are privatized.

05.00.00. PROCEDURE

It shall be considered unethical for physicians, physician assistants, nurse practitioners or other health care professionals, regardless of their personal views on capital punishment, to participate in legally authorized executions.

Where state law and regulation require that such acts be performed by health professionals, the services of outside health professionals shall be obtained.

Executions are not medical procedures and should not occur in the medical unit.

Administrator, Institutional Services Division Date

EXHIBIT 12

EXHIBIT 12

FEDERAL DEFENDER SERVICES OF IDAHO

SAMUEL RICHARD RUBIN
EXECUTIVE DIRECTOR

TERESA A. HAMPTON
SUPERVISING ATTORNEY

CAPITAL HABEAS UNIT
702 W. IDAHO ST., STE. 900
BOISE, IDAHO 83702
(208) 331-5530
FAX (208) 331-5559

BRUCE D. LIVINGSTON
OLIVER W. LOEWY
COLLEEN BRADY WARD
KIRILL ERSHOV

March 11, 2011

Idaho Department of Corrections
ATTN: Records Custodian
1299 N. Orchard St., Suite 110
Boise, ID 83706

Re: Public Records Request for documents re lethal injection and its administration

Dear Records Custodian:

Kindly disregard the Public Records Request for documents re lethal injection and its administration which this office sent yesterday, March 10, 2011. Instead, please reply to this letter. Though the letters are similar, this letter corrects some mistakes in the letter sent yesterday.

This requests, pursuant to the Public Records Act (I.C. §9-337 *et seq.*), copies of all documents (as defined below) in the possession of the Idaho Department of Corrections relating to lethal injection and its administration. This request includes, but is not limited to any and all documents:

1. Setting out the protocol for administering lethal injection pursuant to Idaho Code Section 19-2716, including but not limited to any documents which set out:

    a. the specific substance or substances to be administered and in what quantities and concentrations (per substance);

    b. the process for achieving intravenous access, including but not limited to (i) the procedures for determining whether intravenous access is to be obtained, (ii) the procedures for determining whether intravenous is to be obtained in a peripheral or central blood vessel, (iii) the procedures for determining whether intravenous access will be obtained by a percutaneous technique, a cutdown technique, or some other method, and (iii) the procedures for obtaining intravenous access;

    c. the sequence and/or timing of injection or injections;

d. the use of a flush solution or solutions, if any, the identification of that solution or solutions, and the flow rates of the solution or solutions;

e. the topology of the execution chamber(s), including but not limited to the number of rooms used, their dimensions, and the access between them;

f. any action which may or will be taken to allow, prevent, or alter the view of spectators at any time during the execution, including but not limited to whether a curtain or other opaque material may or will be used to prevent witnesses from observing the prisoner at any time during the execution;

g. the description or identification of any and all equipment used in preparation for and during an execution;

h. who may witness any part or all of an execution;

i. who may be present in the rooms used during the administration of the lethal injection protocol while the prisoner is present in those rooms;

j. how many individuals are involved in administering the lethal injection protocol;

k. the role of each individual involved in administering the lethal injection protocol;

l. identifying which of the individuals involved in administering the lethal injection protocol is in charge of that administration, and describing the minimum qualifications—formal education, experience, and training—such individuals must have, if any;

m. identifying which individual(s) involved in administering the lethal injection protocol is (are) responsible for any preparation of the substances administered to the prisoner, describing the preparation for which they are responsible, and/or describing the minimum

qualifications—formal education, experience, and training—such individuals must have, if any;

n. identifying which individual(s) involved in administering the lethal injection protocol is (are) responsible for establishing the intravenous and/or arterial line, and describing the minimum qualifications—formal education, experience, and training—such individuals must have, if any;

o. identifying which individual(s) involved in administering the lethal injection protocol is (are) for depressing the syringe plunger (s) of any syringe which contains substances which are or may be administered to the prisoner; describing the minimum qualifications—formal education, experience, and training—such individuals must have, if any; and, if individuals have been selected for administering the lethal injection protocol for any anticipated execution, describing the actual qualifications—formal education, experience, and training—of the person who made the selection(s).

p. identifying who selects the individuals involved in administering the lethal injection protocol; describing the minimum qualifications—formal education, experience, and training—such individual must have, if any; and, if individuals have been selected for administering the lethal injection protocol for any anticipated execution, describing the actual qualifications—formal education, experience, and training—of the person who made the selection(s).

2. Documents identifying the author(s) of the IDOC protocol(s) for administering lethal injection; describing the minimum qualification—formal education, experience, and training—such individual(s) must have, if any; and describing the actual qualifications—formal education, experience, and training—of the author(s).

3. Documents describing the complete provenance of any particular substance(s) now in the possession of the IDOC which may be administered to a prisoner in

administering the lethal injection protocol, i.e.- which company or person manufactured the substances, where the substances were manufactured, when the substances were manufactured, and who has possessed the substances before the IDOC came into their possession.

4. Documents describing the complete provenance of any particular substance(s) which the IDOC anticipates obtaining for use in the administration of a lethal injection protocol, i.e.- which company or person manufactures the substance(s), where the substances are manufactured, when the substances will be manufactured, and who will possess the substances before the IDOC comes into possession of the substances.

5. Documents describing the IDOC's quality control requirements in manufacture, storage, and transport of the particular substances (to be administered during the lethal injection procedures) which must be met before the IDOC will purchase or otherwise obtain those substances.

6. Documents describing the IDOC's manner of storing the particular substances prior to administering them during lethal injection procedures.

7. Documents describing the expiration dates of the particular substances to be administered.

8. Documents describing the minimum qualifications—formal education experience, and training--for each person involved in administering the lethal injection protocol; and, if individuals have been selected for administering the lethal injection protocol for any anticipated execution, describing the actual qualifications—formal education, experience, and training—of those individuals.

9. Documents describing any required "practice" or "dry run" mock executions in which each person involved in an actual execution must engage prior to the actual execution, including but not limited to the number of such "practices" or "dry runs" and the lethal injection protocols to be used in the "practices" or "dry runs."

10. Documents describing the manner in which the IDOC Director is now supposed to and/or was at any time in the past supposed to "determine the substance or substances" to be used and "the procedures to be used" in any execution, *see* I.C. §19-2716; and, if such a decision has been made at any time in the past,

documents describing or reflecting the actual manner in which the IDOC Director has made that determination.

11. Documents describing or reflecting any changes to the lethal injection protocol at any time, including but not limited to any changes in factors used by the IDOC to take into consideration the weight, age, and/or physical condition of the inmate in administering any substances during the administration of the lethal injection protocol, and any changes in factors used by the IDOC to take into consideration the relation between the timing of that process and the time and quantity of food last ingested by the prisoner.

12. Documents describing or reflecting the manner in which the IDOC Director is to determine whether a competent lethal injection team can be assembled. *See* IDAPA 06.01.01, Section 135.01(p. 14); IDOC Standard Operating Procedure Control Number 135.02.01.001 at 7 ("Execution Team").

13. Documents describing or reflecting the actual preparation for and execution by lethal injection of any Idaho prisoner, including but not limited to those identifying in any way:

    a. The role or physical location of any official witness identified in Idaho Administrative Code Section 135 ("Executions");

    b. The injection team;

    c. The Director, Administrator of the Division of Prisons, and the head of the facility in which prisoner was housed;

    d. The coroner;

    e. The sheriff from the county of conviction;

    f. The prosecuting attorney from the county of conviction;

    g. The sentencing judge;

    h. Any representative from the Governor's Office;

FEDERAL DEFENDER SERVICES OF IDAHO

CAPITAL HABEAS UNIT

i. The Attorney General or his representative;

j. Any representative from the Board of Correction;

k. Any member of the news media;

For purposes of this request, the term **'document' is defined as** "includ[ing], but . . . not limited to, handwriting, typewriting, printing, photostating, photographing and every means of recording, including letters, words, pictures, sounds or symbols or combination thereof, and all papers, maps, magnetic or paper tapes, photographic films and prints, magnetic or punched cards, discs, drums or other documents." I.C. §9-337(15). Consistent with this statutory definition, other examples of documents include but are not limited to memoranda (including internal memoranda), purchase orders, schedules, books, indices, notes, printed forms, publications, press releases, notices, minutes, summaries, abstracts, reports, files, transcripts, computer tapes, computer files, printouts, drawings, photographs, recordings (including videotape, audiotape, CD, CD-ROM, or any other form of electronic recordation), telegrams, telex messages, as well as any reproductions thereof that differ in any way from another reproduction, such as copies containing marginal notations.

We ask that document copies be provided without charge or at minimum cost. When determining whether my office should be exempt from incurring fees, please consider that its mandate, as part of the federally funded Federal Defender Services of Idaho, Inc., is to represent only indigent petitioners. If you determine that my office is subject to fees, please call me [208-331-5530] in advance of producing copies so that I may seek funding approval in advance.

Thank you in advance for your assistance.

Sincerely,

Oliver W. Loewy
Assistant Federal Defender
Capital Habeas Unit

EXHIBIT 13

EXHIBIT 13

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL
LAWRENCE G. WASDEN

March 30, 2011

Federal Public Defender Services
Capital Habeas Unit
Attn: Oliver Loewy
702 W. Idaho St., Suite 900
Boise, Id 83702

RE: *Public Records Request – your letter of 3/11/11*

Dear Mr. Loewy,

This letter is in response to your above-dated public records request seeking documents regarding "lethal injection and its administration." I regret we cannot assist you. This office has been informed that all capital offenders in Idaho are currently represented by counsel. Hence, we view your request as an effort to supplement or substitute discovery procedures prohibited by I.C. § 9-343(3). Thank you for your attention to this matter.

Sincerely,

William M. Loomis
Deputy Attorney General

Criminal Law Division, Department of Correction
1299 North Orchard, Suite 110, P.O. Box 83720, Boise, Idaho 83720-0018
Telephone: (208) 658-2097, FAX: (208) 327-7485

NOTICE OF ACTION ON PUBLIC RECORDS REQUEST

IDAHO DEPARTMENT OF CORRECTION
1299 N. Orchard, Suite 110
Boise, Idaho 83706

Name of Requestor: Oliver Loewy Date: 3/30/11

Address of Requestor: 702 W. Idaho St., Suite 900, Boise, ID

Dear Mr. Loewy:

The Idaho Department of Correction received your public records request on 3/14/11 (Date)

I. Request Granted

☐ The requested record is enclosed.

☐ You may inspect and photocopy the requested records during regular office hours by contacting

Name	Title	Telephone Number

II. Request Granted in Part and Denied in Part or Denied in its Entirety

Your request has been processed. However, your request has been

☐ Granted in part and denied in part

☑ Denied in its entirety

Pursuant to:

___ Idaho Code 9-340A(1)	___ Idaho Code 9-340B(4)(a)	___ Idaho Code 9-340C(13)
___ Idaho Code 9-340A(2)	___ Idaho Code 9-340B(4)(b)	___ Idaho Code 9-340C(17)
___ Idaho Code 9-340B(1)	___ Idaho Code 9-340B(4)(c)	___ Idaho Code 9-340E(5)
___ Rule 32 of the Idaho Rules of Criminal Procedure		___ Idaho Code 9-342(3)(e)
___ No Record Found	___ IDAPA 06.01.01.108	
___ 9-343(3)		

The statutory exemptions provided herein shall not constitute a waiver of any and all other legal bases or privileges which may also be applicable.

☑ If your request was denied in part or entirely, the reason for denial was reviewed by the deputy attorneys general who represent the Idaho Department of Correction.

☑ If your request was denied in part or entirely, you have the right to appeal the denial of your request by filing a petition in conformance with the provisions of the Idaho Public Records Law, Title 9, Chapter 3, Idaho Code. Your petition must be filed in the 4th Judicial District Court of the State of Idaho within One Hundred Eighty (180) calendar days of the of the date of mailing of this notice.

III. Additional Comments:

Sincerely, William

Custodian/Designated Custodian

Date: 3/30/11

cc: Central Records (offender records denied in its entirety or in part)

EXHIBIT 14

EXHIBIT 14

BerkeleyLaw
UNIVERSITY OF CALIFORNIA
Death Penalty Clinic

University of California, Berkeley
School of Law
392 Simon Hall
Berkeley, CA 94720-7200
Tel 510.289.1600
Jmoreno@law.berkeley.edu
www.deathpenaltyclinic.org

April 27, 2011

Transmitted by email to:

Idaho Department of Corrections
1299 N. Orchard St., Suite 110
Boise, ID 83706
inquire@idoc.idaho.gov

Re: Request for Records Pursuant to State Open Records Law

Dear Public Records Officer:

I am writing on behalf of the Berkeley Law Death Penalty Clinic to request records from the Idaho Department of Corrections (IDOC) pursuant to the state open records law, Idaho Code Ann. Secs. 9-337 to 9-350. I seek copies of all records in the agency's possession, regardless of who wrote them, regarding the following:

1. Any and all written protocols, regulations, guidelines, checklists, or other documents that instruct or direct the carrying out of an execution.
2. Any and all drugs intended or considered for use in executions.
3. The expiration date of any and all drugs intended or considered for use in executions.
4. Any and all activity by IDOC from January 1, 2009 to the present to purchase or acquire any drugs for use in executions.
5. Any correspondence between IDOC and any party from January 1, 2009 to the present regarding drugs for use in executions.

If your agency does not maintain these public records, please let me know who does and include the proper custodian's name and address. I agree to pay any reasonable copying and postage fees of not more than $25. If the cost would be greater than this amount, please notify me. Please provide a receipt indicating the charges for each document.

As provided by the open records law, I will expect your response within three (3) business days. *See* Idaho Code Ann. Sec. 9-339(1).

If you choose to deny this request, please provide a written explanation for the denial including a reference to the specific statutory exemption(s) upon which you rely. Also, please provide all segregable portions of otherwise exempt material.

Thank you for your assistance.

Sincerely,

Jennifer M. Moreno
Staff Attorney
Death Penalty Clinic
510-289-1600
jmoreno@law.berkeley.edu

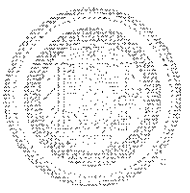

EXHIBIT 15

EXHIBIT 15

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

ANDREW DEYOUNG,	)	DOCKET NO.
	)	1:11-CV-2324-SCJ
PLAINTIFF,	)	
	)	
V.	)	
	)	
BRIAN OWENS AND WARDEN CARL HUMPHREY, ET AL.,	)	ATLANTA, GEORGIA
	)	JULY 19, 2011
DEFENDANTS.	)	

TRANSCRIPT OF TRO HEARING
BEFORE THE HONORABLE STEVE C. JONES
UNITED STATES DISTRICT JUDGE

APPEARANCES:

FOR THE PLAINTIFF: MARK EVAN OLIVE
JEFFREY LYN ERTEL
BRIAN S. KAMMER
ATTORNEYS AT LAW

FOR THE DEFENDANTS: SABRINA B. GRAHAM
BETH ATTAWAY BURTON
THERESA MARIE SCHIEFER
JOSEPH J. DROLET
ATTORNEYS AT LAW

LOIS D. PHILLIPS, RMR, CRR
OFFICIAL COURT REPORTER
UNITED STATES DISTRICT COURT
U.S. DISTRICT COURT
ATLANTA, GEORGIA 30303-3361
(404) 215-1317
LOIS_PHILLIPS@GAND.USCOURTS.GOV

YES, GIVE IT TO MS. WRIGHT.

OKAY. CALL YOUR FIRST WITNESS.

THE COURT: WHEN HE GETS UP TO THE STAND DR. WAISEL, MS. WRIGHT WILL ADMINISTER THE OATH TO YOU.

09:39 **DAVID B. WAISEL, PLAINTIFF'S WITNESS,**

UPON BEING FIRST DULY SWORN, WAS EXAMINED AND TESTIFIED AS FOLLOWS:

THE COURT: YOU MAY BE SEATED.

DIRECT EXAMINATION

09:39 BY MR. OLIVE:

Q. GOOD MORNING, WOULD YOU STATE YOUR NAME, PLEASE, SIR?

A. DAVID B. WAISEL.

Q. SPELL YOUR LAST NAME?

A. W-A-I-S-E-L.

09:39 Q. AND WHAT IS YOUR PROFESSION, SIR?

A. I AM AN ANESTHESIOLOGIST.

Q. YOU SAID ANESTHESIOLOGIST?

A. YES, SIR.

Q. WHERE ARE YOU EMPLOYED?

09:40 A. CHILDREN'S HOSPITAL, BOSTON HARBOR MEDICAL SCHOOL.

Q. WHAT ARE YOUR DUTIES THERE?

A. TO PROVIDE PERI-OPERATIVE CARE FOR CHILDREN OF ALL AGES WHO HAVE DISEASES, SURGICAL, OF ALL AGES. I ALSO DO MEDICAL ETHICS THERE, AND I ALSO WORK INPATIENT SAFETY.

09:40 Q. AND I ASSUME THAT YOU PERFORM ANESTHESIA, ADMINISTER

A. YES, I AM.
Q. ARE YOU FAMILIAR WITH THE TWO DIFFERENT PROTOCOLS THAT GEORGIA PROMULGATED, ONE WITH THIOPENTAL AND THE MORE RECENT ONE WITH PENTOBARBITAL?
10:03 A. YES, I AM.
Q. HAVE YOU REVIEWED THEM BOTH?
A. YES, I HAVE.
Q. CAN YOU TELL US THE RELATIVE DEGREE OF STUDY AND RESEARCH INTO THOSE TWO DRUGS?
10:04 A. OF COURSE. WHILE BOTH DRUGS WERE DEVELOPED IN THE LATE TWENTIES, EARLY THIRTIES, BY THE EARLY TO MID-FIFTIES THIOPENTAL BECAME THE STANDARD DRUG FOR ANESTHESIA, FOR INDUCING ANESTHESIA. SO IF YOU WERE TO HAVE AN OPERATION IN 1980, YOU WOULD HAVE RECEIVED IT. I WOULD SAY THAT 90 PERCENT OF PATIENTS FROM THE
10:04 MID-FIFTIES TO EARLY NINETIES RECEIVED THIOPENTAL, WHICH IS AN ASTRONOMICAL NUMBER OF PATIENTS, BEYOND MY ABILITY TO CALCULATE.
BECAUSE IT BECAME THE STANDARD, WE, MEDICINE STUDIED IT VERY MUCH BECAUSE WE WANTED TO KNOW EVERYTHING ABOUT IT. SO BETWEEN THE TWO, BETWEEN THE EXTENSIVE STUDYING AND BETWEEN THE
10:04 EXTENSIVE USE, WHICH OFTEN EXPOSES ISSUES ABOUT A DRUG THAT AREN'T FOUND OTHERWISE, WE KNOW EVERYTHING ABOUT THIOPENTAL.
PENTOBARBITAL, ON THE OTHER HAND, WAS NOT ADOPTED AS A DRUG TO INDUCE GENERAL ANESTHESIA AND DEVELOPED FOR MORE OF A NICHE AREA IN TREATING PATIENTS WITH BRAIN DISEASE, SPECIFICALLY,
10:05 SEIZURES THAT WOULD NOT ABATE THROUGH OTHER MEASURES AND THE

TRAINED PERSON WITH EXPERIENCE WOULD.
Q. AND DO YOU HAVE ANY EVIDENCE THAT THAT CONSCIOUSNESS CHECK THAT WAS PERFORMED ON MR. BLANKENSHIP WAS NOT A PROPER CONSCIOUSNESS CHECK?
10:41 A. MAY I LOOK AT THE NOTES?
Q. ABSOLUTELY.
THE COURT: I THINK HE'S READY.
BY MS. SCHIEFER:
Q. OH, I APOLOGIZE?
10:42 A. I WOULD HAVE SIGNIFICANT CONCERNS THAT IT WAS NOT A PROPER CONSCIOUSNESS CHECK FOR TWO REASONS: ALTHOUGH I DO NOT KNOW THE HISTORY OF THE NURSE DOING THIS, VERY, VERY FEW NURSES -- AND IT'S CERTAINLY NOT REQUIRED BY THEIR CERTIFICATION -- HAVE KNOWLEDGE OR EXPERIENCE IN ASSESSING ANESTHETIC DEATH. NUMBER TWO, ALTHOUGH I
10:42 ONLY HAVE REPORTS ABOUT WHAT THEY DID, IT SEEMED TO ME IT WAS A VERY LIGHT STIMULUS, LIGHT STIMULUS AROUND THE EYES, AND SO AS I ALLUDED TO EARLIER, A PERSON CAN BE -- NOT RESPOND TO A MILD STIMULUS, BUT THEN RESPOND TO A MORE PAINFUL STIMULUS, SUCH AS POTASSIUM CHLORIDE.
10:43 Q. AND AGAIN, WE WON'T GET INTO THIS TOO MUCH AT THIS POINT, BUT YOU WERE NOT ACTUALLY PRESENT AT THE EXECUTION, CORRECT?
A. I WAS NOT PRESENT AT THE EXECUTION.
Q. AND THE INFORMATION THAT YOU RECEIVED INITIALLY IN PUTTING TOGETHER YOUR AFFIDAVIT WAS SOLELY AFTER A THIRTY-MINUTE
10:43 CONVERSATION WITH AN AP REPORTER WITNESS, CORRECT?

A. ON TOP OF A SERIOUS BRAIN DISEASE.
Q. SO THAT'S TWO ON-TOP-OF'S?
A. YES.
Q. YOU WERE ASKED ABOUT A CONSCIOUSNESS CHECK BY THE NURSE. TO
12:06 YOUR KNOWLEDGE THIS WAS THE FIRST TIME A PROTOCOL REQUIRED A
CONSCIOUSNESS CHECK IN GEORGIA? IS THAT CORRECT? OR DO YOU NOT
KNOW?
A. I DO NOT RECALL. I CAN CHECK THE OLDER ONE, IF YOU WISH ME
TO.
12:06 Q. THAT'S ALL RIGHT.
IF YOU WILL CHECK THE RESPONDENTS' OR DEFENDANTS'
APPENDIX M, IT'S THE BLUE COVER, AND GO TO PARAGRAPH 8. IT READS,
I SAW THE NURSE TOUCH HIS RIGHT SHOULDER, SPEAK TO
MR. BLANKENSHIP, TOUCH HIS EYELASHES, AND RECEIVE NO RESPONSE TO
12:06 ANY OF THIS. IS TOUCHING EYELASHES AN EFFECTIVE CONSCIOUSNESS
CHECK?
A. NOT AS A WHOLE CHECK, NO. IT IS OFTEN USED AS AN INITIAL
CHECK ON A PRELUDE TO OTHER CHECKS.
Q. CAN YOU TALK TO US IN A LITTLE MORE DETAIL ABOUT THE
12:07 SOPHISTICATION NECESSARY FOR TRUE CONSCIOUSNESS CHECKS?
A. THE SOPHISTICATION NECESSARY COMES NOT ONLY FROM THEORETICAL
KNOWLEDGE, BUT FROM TRAINING UNDER SUPERVISION AND FEEDBACK AND
EXPERIENCE. PATIENTS RESPOND DIFFERENTLY, AND THE EDUCATED EYE
NEEDS TO BE ABLE TO GIVE AN INCREASING LEVEL OF STIMULATION AND
12:07 NEEDS TO BE LOOKING FOR SUBTLE SIGNS, SUCH AS, YOU KNOW,

FLUTTERING OF THE EYES, WINCING, FINGER MOVEMENT, TOE MOVEMENT, ANY OF THOSE, AND IT TAKES A PRACTICED EYE TO DO THAT.

Q. OKAY. SO A NURSE HYPOTHETICALLY WHO HAD BEEN THROUGH EVERY EXECUTION IN GEORGIA THAT DID NOT REQUIRE BY PROTOCOL A CONSCIOUSNESS CHECK -- ACCEPT THIS AS HYPOTHETICAL AS TRUE, IT MAY PROVE FALSE -- AND THIS IS THE FIRST TIME A CONSCIOUSNESS CHECK IS REQUIRED, WOULD YOU EXPECT THAT PERSON TO REQUIRE TRAINING?

A. OF COURSE.

Q. YOU WERE ASKED ABOUT WHETHER YOUR TESTIMONY HERE WAS SIMILAR TO THE TESTIMONY IN THE BLANKENSHIP HEARING WHERE YOU EXPRESSED OTHER CONCERNS ABOUT THE LETHAL INJECTION PROTOCOL? DO YOU REMEMBER THAT QUESTION?

A. YES, I DO.

Q. DO YOU STILL HAVE THE CONCERNS THAT YOU TESTIFIED TO EARLIER IN THE BLANKENSHIP TRANSCRIPT?

A. YES.

Q. AND DO YOU REAFFIRM THAT TESTIMONY?

A. YES.

Q. SO YOU STILL MAINTAIN THE PROBLEMS EXIST THAT YOU FORECAST IN BLANKENSHIP?

A. YES.

Q. AT THAT HEARING COUNSEL FOR THE STATE ASSURED THE COURT -- AND IT'S OUR APPENDIX 8 AT 16 -- THAT PENTOBARBITAL WORKS AS FAST AS SODIUM PENTOTHAL, AND THAT A PERSON WILL BE UNCONSCIOUS WITHIN, QUOTE, THIRTY TO SIXTY SECONDS, CLOSED QUOTE, AFTER RECEIVING AN

INJECTION OF PENTOBARBITAL. DO YOU THINK THAT HAPPENED IN THIS CASE?

A. I DO NOT THINK THAT HAPPENED IN THIS CASE.

Q. THE ISSUE OF THE EYES BEING OPEN: I COULD HAVE MY EYES WIDE OPEN, I COULD HAVE THEM HALF OPEN, I COULD HAVE THEM AN EIGHTH OPEN. WHEN YOU SAY, EYES WIDE OR EYES OPEN, WHAT ARE YOU REFERRING TO WHEN YOU SAY THAT?

A. IT IS NOT UNREASONABLE THAT WHEN SOMEONE CLOSES THEIR EYES UNDER ANESTHESIA THERE IS A SMALL BIT, 80 PERCENT CLOSED, 90 PERCENT CLOSED, THAT KIND OF THING. BUT THERE IS A VAST DIFFERENCE BETWEEN THAT MERELY ALMOST CLOSED AND ANYTHING, YOU KNOW, HALF OPEN OR MORE THAN THAT. AS I LOOK AT YOU NOW, SIR.

Q. AS YOU BELIEVE WHAT?

A. AS I LOOK AT YOU NOW. THERE IS A VAST DIFFERENCE BETWEEN, YOU KNOW, 10, MAYBE 20 PERCENT OPEN AND OPEN TO THE POINT WHERE I CAN SEE THEY ARE OPEN FROM A DISTANCE.

Q. SO IF A PERSON SAYS, I'VE SEEN A LOT OF EXECUTIONS AND IN THOSE EXECUTIONS IT'S NOT INFREQUENT THAT THE INMATES EYES ARE OPEN AT DEATH, YOU NEED TO KNOW HOW OPEN, I TAKE IT?

A. CORRECT.

Q. WIDE OPEN WOULD INDICATE WHAT?

A. WIDE OPEN WOULD BE A VERY STRONG INDICATOR THAT THEY WEREN'T ADEQUATELY ANESTHETIZED.

Q. AND IS THERE A WORD FOR ONE-THIRD OPEN?

A. NO.

EXHIBIT 16

EXHIBIT 16

SIDLEY AUSTIN LLP
SIDLEY

SIDLEY AUSTIN LLP
1501 K STREET, N.W.
WASHINGTON, D.C. 20005
(202) 736 8000
(202) 736 8711 FAX

cklasmeier@sidley.com
(202) 736 8132

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FOUNDED 1866

February 16, 2011

By Facsimile (without enclosure) and Courier

The Honorable Eric H. Holder, Jr.
Attorney General of the United States
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Re: Sodium Thiopental

Dear General Holder:

We write in response to a letter dated January 25, 2011, in which thirteen state attorneys general requested information and other assistance from your office that would facilitate the states' procuring sodium thiopental for use in lethal injection. That letter failed to note that litigation is currently pending alleging that the process by which three states (including Tennessee, a signatory to the letter) were permitted to obtain sodium thiopental violated federal law. We write to apprise you of that litigation and its relevance to the request made by the states, and to suggest that your role as Attorney General may require a course of action opposite from the one urged upon you by the states.

We represent death-row prisoners in California, Arizona, and Tennessee in litigation currently pending in the United States District Court for the District of Columbia against the Food and Drug Administration (FDA) and related defendants. The lawsuit seeks declaratory and injunctive relief, primarily on the ground that FDA violated 21 U.S.C. § 381(a) in allowing sodium thiopental into United States commerce for use in lethal injection. *See Beaty v. FDA*, No. 1:11-cv-00289 (D.D.C. filed Feb. 2, 2011). A copy of our complaint is enclosed.

At the core of our claims is the fact, also unaddressed in the January 25 letter from the states, that sodium thiopental is an illegal product in the United States. It has never been reviewed or approved for use by the FDA. This means that, in statutory terms, it is an unapproved new drug within the meaning of the Federal Food, Drug, and Cosmetic Act (FDCA), 21 U.S.C. §§ 321(p), 355(a). It is also a misbranded and

adulterated drug, the distribution of which constitutes a distinct legal violation. At issue in the litigation is not whether sodium thiopental is legal—we believe that FDA agrees it is not—but rather FDA's decision to permit sodium thiopental to enter the United States despite a clear statutory prohibition against such admission.

We believe that FDA was statutorily required to deny admission into the United States of unapproved sodium thiopental, whether for use in lethal injection or otherwise under 21 U.S.C. § 381(a)(3). The language of that statutory provision is unequivocal on this point. There is no exception for lethal injection or for uses which the FDA believes fall outside its public health mandate. Moreover, despite FDA's claim that lethal injection somehow falls entirely outside its public health mission, it is important to understand that the purpose of sodium thiopental in lethal injections is precisely the same as in all other medical uses: anesthesia.

FDA's decision to permit entry of the unapproved sodium thiopental into the United States notwithstanding the statutory prohibition is, we believe, a clear violation of federal law. For the same reason, the states' letter gives us serious concern. The FDCA includes broad remedial provisions that forbid both a direct violation and the causing of a prohibited act. *See* 21 U.S.C. § 331. These prohibitions are supported by criminal sanctions. Acceding to the attorneys general request would fall within the ambit of, and therefore is prohibited by, these same provisions. To put it bluntly, we believe the attorneys general are urging you to commit an illegal act.

In our view, fulfilling the duties of your office requires precisely the opposite course: ensuring that FDA abides by the clear congressional command of 21 U.S.C. § 381(a). We appreciate, of course, that your department will defend the *Beaty* lawsuit. But we hope you will agree that the prudent and responsible course for you, as the nation's chief law enforcement officer, is to deny the request of the attorneys general for assistance in procuring additional quantities of illegal sodium thiopental and indeed to ensure that no further importation of unapproved sodium thiopental occurs while the matter is under review by the courts. The federal interest in securing our Nation's borders against unapproved medical products easily outweighs the interest of certain states in importing illegal drugs to accelerate lethal injections, particularly given the ready availability of lawful substitutes.[1]

[1] Ohio recently announced that, rather than violate federal law by importing illegal sodium thiopental, it would switch to an FDA-approved, domestically available alternative. *See, e.g.*, Andrew Welsh-Huggins, *Ohio to Use Assisted-Suicide Drug In Executions*, AOL News (AP), Jan. 25, 2011, www.aolnews.com/2011/01/25/ohio-to-use-surgical-drug-pentobarbital-in-lethal-injections/ (last visited

SIDLEY AUSTIN LLP
SIDLEY

We therefore respectfully request that you deny the request of the attorneys general in the January 25 letter. If you elect to give the attorneys general the opportunity to discuss the sodium thiopental issue with you or your staff, we further request the opportunity to participate in that discussion or, at a minimum, to receive equal time to explain our views and respond to any questions the Department may have.

Sincerely yours,

Bradford A. Berenson
Coleen Klasmeier
Sidley Austin LLP

DALE A. BAICH /bab

Dale A. Baich
Office of the Federal Public Defender
for the District of Arizona

Enclosure

cc: Gerald C. Kell (without enclosure)
Ralph S. Tyler (without enclosure)
Eric M. Blumberg (without enclosure)

Feb. 15, 2011). Ohio's action belies the claim of the thirteen attorneys general that they will be "unable to perform executions" without sodium thiopental.

Equal Justice Initiative
122 Commerce Street
Montgomery, Alabama 36104

April 22, 2011

The Honorable Eric H. Holder, Jr.
Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

Dear Mr. Attorney General:

We are writing on behalf of Jason Oric Williams and other condemned inmates on Alabama's death row. Mr. Williams is scheduled to be executed on May 19, 2011, and another execution is set for June 16, 2011. As explained in more detail below, it recently came to our attention that the Alabama Department of Corrections appears to have violated the federal Controlled Substances Act by obtaining sodium thiopental from the State of Tennessee, whose supply has been seized by the Drug Enforcement Administration due to concerns that it was illegally obtained from overseas.

Alabama, like most states that administer lethal injection as a form of execution, has to date employed a three drug cocktail with the lethal dose being a specified amount of sodium thiopental. This protocol was used as recently as March 31, 2011, during the execution of William Glen Boyd. As your office is aware, last year, many states experienced a shortage of the drug after Hospira Inc., the sole U.S. supplier of sodium thiopental, experienced problems with its raw material providers. Many states desperately sought to acquire unexpired doses.

Mindful of this shortage, prior to the scheduled execution date of November 4, 2010, counsel for Phillip Hallford, an Alabama death row inmate, sent a letter to the Alabama Department of Corrections inquiring as to the source and expiration date of its supply of sodium thiopental. Mr. Hallford's attorneys were informed by counsel for the Alabama Department of Corrections that it was in possession of a supply of sodium thiopental from

Phone 334.269.1803 • Fax 334.269.1806

Hospira, Inc., which was not due to expire until three weeks ago, on April 1, 2011.[1]

In January 2011, a time that Hospira, Inc. previously indicated it would have renewed supplies of sodium thiopental, the company issued a release, explaining that it was discontinuing its production of sodium thiopental. Because overseas importation of sodium thiopental is highly restricted under federal law and there were no domestic suppliers of the drug, on January 25, 2011, thirteen states, including Alabama, sent a letter to your office requesting assistance with the procurement of sodium thiopental, explaining that their supplies were low and would soon be exhausted.[2] Having been informed that the federal government was experiencing the same problem as the states, several state Departments of Corrections sought to obtain the drug in violation of federal law by either importing it directly from foreign countries or purchasing it from United States pharmacies who had done so.

Federal law imposes a comprehensive set of restrictions on the importation of non-narcotic controlled substances, such as sodium thiopental. In particular, these regulations prohibit persons or entities from importing such substances unless the individual or the entity is registered with the DEA as an importer and provides a declaration pertaining to any such importation. See 21 U.S.C. § 954(2) ("A controlled substance in schedule II, III, or IV may be so imported, transferred, or transshipped if and only if advance notice is given to the Attorney General in accordance with regulations of the Attorney General."); 21 U.S.C. § 822 (a)-(b) (it is unlawful to "possess, manufacture, distribute, or dispense" controlled substances absent a properly issued registration by the DEA); 21 C.F.R. § 1312.11(b) ("[n]o person shall import or cause to be imported any non-narcotic controlled substance listed in Schedule III . . . unless and until such person is properly registered under the Act (or exempt from registration) and has filed an import declaration to do so with the Administrator."). The goal of these regulations is to ensure the integrity of imported substances and safeguard against the use of adulterated or counterfeit ones.

Concerned with the illegal importation of sodium thiopental, the Drug Enforcement Administration recently seized several states' supplies. Among them was Tennessee.[3]

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[1] Appendix A, Letter from Kim Thomas to Andrew Kantra (with attached copy of vial bearing April 1, 2011, expiration date).

[2] Appendix B, Letter from Thirteen States to Attorney General Eric Holder (dated January 25, 2011).

[3] Appendix C, Public Record obtained from Tennessee Department of Corrections (U.S. Department of Justice, DEA Receipt detailing the seizure of 44 vials of thiopental

Undersigned counsel just recently received documentation from the State of Tennessee which indicated that Alabama's most recent, and only known to be unexpired, batch of sodium thiopental was obtained from Tennessee's Department of Corrections on March 15, 2011.[4] Because it was not until March 22, 2011, that the DEA seized Tennessee's supply of sodium thiopental, Alabama's supply seemingly derives from the same batch. The unlawful acquisition of such unregulated narcotics increases the likelihood that they are adulterated, counterfeit, or otherwise ineffective.

Given Mr. Williams' imminent execution date, we request that your office and the Drug Enforcement Administration investigate this matter expeditiously and thoroughly. As occurred in Tennessee, we ask that all necessary steps be taken to prevent the State from utilizing or possessing what appear to be unlawfully obtained drugs.

We appreciate your time and attention to this matter. If you or a member of your staff have any questions or are otherwise in need of assistance in handling this matter, please do not hesitate to contact our office.

Sincerely,

Bryan Stevenson
Executive Director, Equal Justice Initiative

Angela Setzer
Senior Attorney, Equal Justice Initiative

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injection).

[4] Appendix C, Public Record obtained from Tennessee Department of Corrections (invoice detailing that 8 grams of thiopental injection were received by the Alabama Department of Corrections on March 15, 2011).

cc: Michele Leonhart
Administrator
Drug Enforcement Administration

Jimmy S. Fox III
Special Agent in Charge, New Orleans Division
Drug Enforcement Administration

Rodney Benson
Special Agent in Charge, Atlanta Division
Drug Enforcement Administration

EXHIBIT 17

EXHIBIT 17

DECLARATION OF DAVID LUBARSKY

1. My name is David Lubarsky, M.D. I am a practicing anesthesiologist and the Emanuel M. Papper Professor and Chair of the Department of Anesthesiology at the University of Miami, as well as Senior Associate Dean for Safety and Quality. I have been asked by counsel representing Mr. Thomas Arthur to provide opinions regarding the lethal injection procedures employed by the Alabama Department of Corrections.

2. My professional qualifications are fully expressed in the attached curriculum vitae. Brief highlights include the following: I oversee one of the largest anesthesia training programs in the world in a department providing more than 80,000 anesthetics per year (as of 2010) in 8 different facilities. I serve as Chief of the Clinical Service at one of the largest hospitals in America, Jackson Memorial Hospital. I have published more than 75 peer reviewed articles, and authored more than 200 overall publications in a variety of venues. Those publications include three peer reviewed articles on the conduct of the death penalty in the United States, and for more than a decade, multiple editions of the chapter on intravenous anesthetic induction agents in our specialty's definitive textbook, Miller's *Anesthesia*.

3. In connection with this declaration, I was given the following documents:

   a) Report of Dr. Mark Dershwitz, May 2, 2011 in *Powell* v. *Thomas* (Alabama).

   b) Testimony of Dr. Mark Dershwitz in *Pavatt* v. *Jones* (Oklahoma).

   c) Affidavit of Christine Freeman, regarding the execution in Alabama of Mr. Eddie Powell.

   d) Affidavit of Matt Schulz, regarding the execution in Alabama of Mr. Eddie Powell.

   e) State's Motion to Dismiss/Motion for Summary Judgment, *Arthur* v. *Thomas* (June 30, 2011).

   f) Report of Dr. David Waisel, Oct. 29, 2010 in *Pavatt* v. *Jones* (Oklahoma).

   g) Affidavit of Dr. David Waisel, regarding the execution in Georgia of Mr. Roy Willard Blankenship.

   h) District court opinion, *Powell* v. *Thomas*, May 16, 2011, Middle District of Alabama.

   i) Court of appeals opinion, *Powell* v. *Thomas*, May 19, 2011, Eleventh Circuit.

   j) District court opinion, *Powell* v. *Thomas*, June 9, 2011, Middle District of Alabama.

   k) Court of appeals opinion, *Powell* v. *Thomas*, June 15, 2011, Eleventh Circuit.

   l) Deposition of Dr. Mark Dershwitz, Dec. 9, 2008 in *Dickens* v. *Napolitano* (Arizona).

   m) Complaint in *Arthur* v. *Thomas* (June 7, 2011).

4. Because the State of Alabama has not released its lethal injection protocol, I have relied on the description of that protocol in the report of Dr. Mark Dershwitz in the case of *Powell* v. *Thomas*. Dr. Dershwitz states that an inmate is injected with three drugs in sequence: 2,500 mg of pentobarbital, 50 mg of pancuronium bromide, and 120 mEq of potassium chloride.

5. Alabama, like most states with the death penalty, administers lethal injections using a three-drug protocol. The first drug, which historically has been sodium thiopental and more recently was changed to pentobarbital, is intended to anesthetize the inmate completely to prevent the inevitable pain that would be caused by the administration of the second and third drug absent proper anesthesia. The second drug, pancuronium bromide paralyzes voluntary muscles, including the diaphragm. Even when administered effectively, pancuronium bromide does not affect consciousness or the perception of pain, nor does it prevent the inmate from suffering a slow and excruciatingly painful death by asphyxiation. Awareness after pancuronium injection has been described as being buried alive. The third drug, potassium chloride, is used to stop the heart. An inmate who is conscious during the administration of potassium chloride will feel excruciating pain. If the first drug, now pentobarbital, fails to establish and maintain loss of consciousness and loss of sensation, the pancuronium bromide will mask the inmate's pain and suffering from observers. For this reason, such cocktails are forbidden in animal euthanasia. Animal euthanasia typically employs up to 100mg of pentobarbital per kilogram of body weight in a variety of species, a dose far in excess of that described for Alabama inmates. To achieve a comparable dose, an inmate who weighs 75 kilograms (about 165 pounds) would require 7,500mg of pentobarbital, or three times the amount the protocol calls for.

6. Sodium thiopental has been routinely used as an ultra-fast-acting anesthetic, whose use is designed to produce unconsciousness quickly. Pentobarbital, on the other hand, is designed to produce sedation, not anesthesia. As described below, the switch from sodium thiopental to pentobarbital is very significant because pentobarbital confers a substantial risk of inflicting severe and needless pain.

7. Pentobarbital is not approved by the FDA as an anesthesia induction agent, and there is no scientific literature establishing the anesthetic dose of pentobarbital. Pentobarbital has been approved by the FDA and is indicated as a sedative-hypnotic and as an anticonvulsant for patients with refractory status epilepticus. There is also an off-label use of pentobarbital for induction of barbiturate coma in severe brain injury patients, although this use involves slow administration of the drug over several hours.

8. Pentobarbital acts much more slowly as a sedative than sodium thiopental works as an anesthetic. Sodium thiopental can achieve its maximum effect within sixty seconds. The comparable figure for pentobarbital is fifteen to sixty minutes, though as noted above, pentobarbital is not generally used as an anesthetic. The FDA-approved package insert for pentobarbital notes that patients in convulsive states should be given pentobarbital "slowly with due regard to the time required for the drug to penetrate the blood-brain barrier." There is no data at all about the onset time of large boluses (doses of a drug given intravenously) of pentobarbital in humans.

9. Pentobarbital has been tested in humans only at doses much lower than the one specified in Alabama's lethal injection protocol, and administered slowly. Among other potential problems with the use of pentobarbital is the possibility of acute tolerance, in which an inmate's body is quickly desensitized to the drug, which diminishes the effect of the drug. The possibility of acute tolerance further increases the risk that an inmate will regain consciousness and feel pain during the administration of pancuronium bromide and potassium chloride. There is no data in humans at all about the impact of large doses and acute tolerance.

10. The dosage of pentobarbital provided for in Alabama's lethal injection protocol is insufficient to assure that an inmate is unconscious when given pancuronium bromide and potassium chloride. The package insert for pentobarbital states, "There is no average intravenous dose of [pentobarbital] that can be relied on to produce similar effects in different patients."

11. Moreover, it is reasonable to assume that just before execution, an inmate experiences adrenergic overdrive, a state in which the inmate's sympathetic nervous system releases large amounts of epinephrine or related substances, in this case due to anxiety or fear. Adrenergic overdrive counteracts the effects of sedatives such as pentobarbital. This effect further increases the risk that pentobarbital will not have rendered an inmate fully unconscious when the pancuronium bromide and potassium chloride are administered.

12. Pinching an inmate's arm after the administration of pentobarbital, especially by someone who is not extensively trained, is not an acceptable way to determine consciousness. Anesthesiologists are trained to determine consciousness on thousands of cases over a period of years.

13. Anesthetic depth cannot be reliably determined during an execution after the administration of pancuronium bromide. Pancuronium bromide precludes an accurate assessment by observers, paralyzing all of the muscles which would otherwise move when a prisoner is in excruciating pain. Because no one can reliably assess anesthetic depth using this process (and make appropriate adjustments), the procedures Defendants use can result in conscious paralysis (and therefore suffocation) masked from observers by the use of pancuronium bromide.

14. I have reviewed the affidavits of Matt Schulz and Christine Freeman regarding the execution of Eddie Powell, in which pentobarbital was used as the first drug in a three-drug execution protocol. According to these affidavits, Mr. Powell abruptly or violently raised or jerked his head off the gurney. He had a confused look on his face, and his teeth/jaw muscles were clenched. This was estimated to have lasted for a minute. His eyes either opened during the execution or were open throughout the execution.

15. The accounts of Mr. Powell's execution, including the fact that his eyes were open, are inconsistent with the statement of Dr. Dershwitz that Alabama's lethal injection protocol "will render an inmate unconscious quickly and cause the inmate's rapid and painless death." They are also inconsistent with Dr. Dershwitz's statement that "there is an exceedingly small risk that a condemned inmate to whom 2,500 mg of pentobarbital is

properly administered pursuant to the lethal injection protocol of the State of Alabama would experience any pain and suffering associated with the administration of lethal doses of pancuronium bromide and potassium chloride."

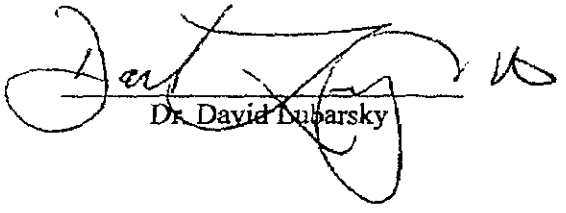
16. Therefore, based upon my current understanding, I believe that the use of pentobarbital as part of Alabama's lethal injection protocol would very likely cause serious harm or needless suffering.

17. I hold these opinions to a high degree of medical and scientific certainty, and reserve the right to amend them upon provision of additional information that so warrants.

18. I am being compensated at the rate of $650 per hour.

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

Dated: July 22, 2011
Miami, Florida



Dr. David Lubarsky

EXHIBIT 18

EXHIBIT 18

Declaration of Mark J. S. Heath, M.D.

1) My name is Mark Heath, M.D. I am an Assistant Professor of Clinical Anesthesiology at Columbia University in New York, New York.

2) I have been asked by counsel representing Mr. Thomas Arthur to provide opinions regarding the lethal injection procedures employed by the Alabama Department of Corrections (ADOC).

Summary of Opinions

a) The ADOC has declined to disclose its operative lethal injection protocol. By withholding the operative lethal injection protocol the ADOC hinders the identification of potential problems with their procedures. This in turn hinders implementation of corrective measures.

b) The ADOC appears to have made a substantial change in its lethal injection procedures in that it now intends to use pentobarbital rather than thiopental.

c) The chemical properties of pentobarbital strongly suggest that it would produce a more gradual and prolonged transition from consciousness to unconsciousness than would thiopental.

d) I am unaware of a single instance of the use of pentobarbital in the clinical setting to induce anesthesia or unconsciousness in a conscious person. There is therefore no body of clinical knowledge regarding the behavior of pentobarbital and its effects on human beings when rapidly administered in high dosages to a conscious person. In contrast, thiopental has been used many millions of times to induce anesthesia and unconsciousness in conscious persons, and its behavior and clinical effects are therefore well-characterized and well-understood.

e) The use by the ADOC of pentobarbital as part of a triple drug protocol using pancuronium bromide and potassium chloride presents a substantial risk of a torturous execution. It is undisputed that pancuronium bromide and potassium chloride necessarily cause excruciating agony when administered without adequate anesthesia. The switch to pentobarbital, for which there is no clinical knowledge regarding its effects on human

beings when rapidly administered in high dosages to a conscious person, combined with the use of pancuronium bromide and potassium chloride, confers a substantial risk of an excruciating and agonizing death process.

f) The recent switch to pentobarbital (from thiopental) in some states has been accompanied by unexpected, unusual, and concerning behavior in which prisoners display prolonged periods of movement, activation, and animated facial expressions.

g) Cognizant of the risks created by using pancuronium bromide and potassium chloride in lethal injection procedures, other states have abandoned the use of these drugs and are carrying out lethal injection procedures using either thiopental or pentobarbital as the sole execution drug.

h) It appears that the ADOC may not be adhering to one of the key aspects of its own protocol, namely the application of a painful stimulus (pinching the arm) prior to the administration of pancuronium bromide. If this is in fact the case, it demonstrates an unacceptable sloppiness or lack of diligence on the part of the ADOC, and means that the ADOC cannot be relied upon to administer lethal injection in a humane fashion.

i) I hold these opinions to a high degree of medical and scientific certainty, and reserve the right to amend them upon provision by the ADOC of additional information that so warrants.

3) **Background and Qualifications**

a) I am an Assistant Professor of Clinical Anesthesiology at Columbia University in New York, New York. My professional practice involves, on a daily basis, the use of anesthetic and paralytic drugs in the care of human patients. My clinical practice is currently focused primarily on patients undergoing cardiac and thoracic surgical procedures. Approximately half of my patients receive potassium chloride in order to produce cardiac arrest.

b) I received an M.D. from the University of North Carolina at Chapel Hill, completed an Internship in Internal Medicine at George Washington University, and completed Medical Residency and Fellowship Training at Columbia University Medical Center. I am licensed to practice medicine in New York State, and I am board certified in Anesthesiology and Advanced Perioperative Transesophageal Echocardiography.

c) Like all anesthesiologists who practiced when it was frequently used, I am experienced in the use of thiopental for inducing general anesthesia. I have used high-dose pentobarbital

to induce barbiturate coma, but have never used it to induce general anesthesia in a conscious patient (and I do not believe that any anesthesiologist has ever done so).

d) I am experienced in animal research and am familiar with the legal and regulatory requirements for the humane treatment of animals, including acceptable practices of animal euthanasia.

e) Over the past decade I have gathered and studied information regarding the practice of lethal injection as a method of execution. As a result of my interest in the practice of lethal injection, I have been invited to deliver lectures at multiple scholarly institutions, including giving Grand Rounds at the National Institutes of Health. I have also testified by invitation before legislative bodies and/or regulatory committees in Pennsylvania, Maryland, Nebraska, South Dakota, and Florida. I have also testified by invitation about lethal injection before a Joint Parliamentary Committee in the House of Lords in London, U.K.

f) I have served as an expert witness regarding lethal injection in State and Federal proceeding in the following jurisdictions: Alabama, Arizona, Arkansas, California, Connecticut, Delaware, Florida, District of Columbia (regarding Federal executions), Georgia, Indiana, Kentucky, Louisiana, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Washington.

g) As a result of serving as an expert witness in litigation in the above jurisdictions I have reviewed multiple iterations of multiple lethal injection protocols. I have also reviewed lethal injection protocols from a small number of jurisdictions in which I have not, so far, provided testimony.

h) As a result of serving as an expert witness in litigation in the above jurisdictions, I have attended tours and inspections of the lethal injection facilities and equipment in multiple states, including Alabama, Arizona, California, Connecticut, Delaware, the Federal lethal injection facility in Terre Haute, Indiana, Maryland, Texas, and North Carolina.

i) As a result of serving as an expert witness in litigation in the above jurisdictions I have spoken with, interviewed, and heard and/or read the testimony of a large number of participants in lethal injection procedures throughout the United States. The participants include physicians, nurses, physician assistants, emergency medical technicians, military medics, lay prison staff, wardens, and Directors of Departments of Corrections.

j) I have presented peer-reviewed scholarly abstracts regarding lethal injection at multiple scientific/scholarly meetings, and have published regarding lethal injection in the Mayo Clinic Proceedings.

k) As noted above, I have served as an expert in prior litigation regarding the Alabama lethal injection procedures.

4) **Documentation and information reviewed**

a) I have reviewed the following material provided by counsel for Mr. Arthur:

i) Report of Dr. Mark Dershwitz, May 2, 2011 in *Powell* v. *Thomas* (Alabama).
ii) Testimony of Dr. Mark Dershwitz in *Pavatt* v. *Jones* (Oklahoma).
iii) Affidavit of Christine Freeman, regarding the execution in Alabama of Mr. Eddie Powell.
iv) Affidavit of Matt Schulz, regarding the execution in Alabama of Mr. Eddie Powell.
v) State's Motion to Dismiss/Motion for Summary Judgment, *Arthur* v. *Thomas* (June 30, 2011).
vi) Report of Dr. David Waisel, Oct. 29, 2010 in *Pavatt* v. *Jones* (Oklahoma).
vii) Affidavit of Dr. David Waisel, regarding the execution in Georgia of Mr. Roy Willard Blankenship.
viii) District court opinion, *Powell* v. *Thomas*, May 16, 2011, Middle District of Alabama.
ix) Court of appeals opinion, *Powell* v. *Thomas*, May 19, 2011, Eleventh Circuit.
x) District court opinion, *Powell* v. *Thomas*, June 9, 2011, Middle District of Alabama.
xi) Court of appeals opinion, *Powell* v. *Thomas*, June 15, 2011, Eleventh Circuit.
xii) Deposition of Dr. Mark Dershwitz, Dec. 9, 2008 in *Dickens* v. *Napolitano* (Arizona).
xiii) Complaint in *Arthur* v. *Thomas* (June 7, 2011).

b) I have spoken with Greg Bluestein, an Associated Press reporter who witnessed prolonged movement and breathing after pentobarbital was administered as the first part of a three-drug protocol in the execution of Roy Blankenship in Georgia. I have also read newspaper articles by Mr. Bluestein in which he describes the prolonged movements that he witnessed during the execution.

c) As noted previously, I have served as an expert witness in prior litigation in Alabama. As a result of this, I have toured the lethal injection facility in the Holman Correctional Facility. I believe it is likely that I have also reviewed documentation in prior litigation in Alabama that may not have been produced during the present litigation.

d) Of note, I have not been provided with a copy of the current and active ADOC lethal injection protocol. Mr. Arthur's attorneys told me that they do not have a copy of the current ADOC protocol to provide me with. I am relying on the description given by Dr. Mark Dershwitz in his expert report.

5) **Discussion**

a) In his expert report Dr. Mark Dershwitz discusses his research and expertise regarding the pharmacokinetics and pharmacodynamics of drugs. I note that Dr. Dershwitz does not provide a quantitative pharmacokinetic or pharmacodynamics analysis regarding pentobarbital. This contrasts with numerous prior expert reports regarding thiopental, in which he provides detailed quantitative analysis, including graphs and predictions of the effects of various doses of thiopental at various times after administration.

b) High-dose intravenous pentobarbital is, to my belief, never used to induce general anesthesia in a conscious person. Dr. Dershwitz does not cite any literature regarding the effects of administering high-dose intravenous pentobarbital to conscious persons (probably because in clinical practice high-dose intravenous pentobarbital is only administered to unconscious patients and there is therefore no such literature to cite). I am also not aware of any published research that Dr. Dershwitz has performed regarding the pharmacokinetics or pharmacodynamics of pentobarbital.

c) In the clinical setting the principal use of high-dose intravenous pentobarbital is to induce barbiturate coma. This is typically practiced by neurologists, neurosurgeons, neurointensivists, and neuroanesthesiologists (anesthesiologists who sub-specialize in the care of neurosurgical patients).

d) It is important to understand that all proficient and practicing anesthesiologists possess both extensive knowledge and extensive practical hands-on experience with the pharmacokinetics and pharmacodynamics of the drugs that we use on our patients. The disciplines of pharmacokinetics and pharmacodynamics of anesthetic and anesthesia-related drugs is an essential and substantial part of our training. Our ability to safely anesthetize and care for our patients is founded in part on our years of education, training, and daily clinical use of pharmacokinetic and pharmacodynamic data and theory. While Dr. Dershwitz possesses particular expertise in computational modeling of the behavior and effects of drugs, and while he has used this expertise to predict the effects of high-dose thiopental, he has not to my knowledge used it to predict the effects of high-dose pentobarbital. Put another way, it appears that in opining on the use of pentobarbital in executions, Dr. Dershwitz is relying upon the same set of information and training that would be in the possession of or readily available to any proficient practicing anesthesiologist.

e) Dr. Dershwitz has made important errors in prior testimony regarding pharmacology as it pertains to lethal injection. For example, he has testified that when thiopental and pancuronium bromide mix within an intravenous line, the pancuronium bromide will precipitate out of solution. In fact, it is widely known and there is undisputed literature demonstrating that it is thiopental, and not pancuronium bromide, that precipitates when these two drugs are inadvertently mixed during injection.

f) In his report Dr. Dershwitz notes that pentobarbital is classified as an intermediate-acting barbiturate. By contrast, thiopental is classified as an ultrashort-acting and/or ultrafast-acting barbiturate. Dr. Dershwitz fails to mention that, by dint of its being in a different class of barbiturates, pentobarbital would be slower in producing sedation and unconsciousness than would thiopental. In other words, the time it takes to transit from consciousness to unconsciousness would be longer with pentobarbital than with an equivalent dose of thiopental.

g) According to the report of Dr. Dershwitz, the current ADOC protocol begins with 2.5 grams of pentobarbital followed by a saline flush. A team member then attempts to assess the level of consciousness of the prisoner. After the warden confirms that the inmate is unconscious, he injects 50 mg of pancuronium bromide, then a saline flush, then 120 mEq of potassium chloride, followed by a saline flush. If the prisoner displays a response to the stimuli used in the consciousness check, then additional pentobarbital is administered.

h) In paragraph 5, Dr. Dershwitz writes that "while the protocols and the jurisdictions differ in terms of the doses of the three medications used, each of these protocols, when implemented as written, will render an inmate unconscious quickly and cause the inmate's rapid and painless death" (underline mine). Dr. Dershwitz fails to mention the numerous instances in which lethal injection protocols have not been implemented as written, and in which executions were clearly botched. Further, Dr. Dershwitz fails to mention the lethal injection protocols that he has reviewed and in which he identified serious flaws that he has pointed out to his clients and that have consequently been changed.

i) Subsequent to Dr. Dershwitz providing this expert report, pentobarbital was used as the anesthetic drug in the execution of Mr. Roy Blankenship in Georgia. Based on a discussion with a Greg Bluestein, a reporter and witness to the execution, the pentobarbital did not produce the rapid and smooth transition from consciousness to unconsciousness that Dr. Dershwitz evidently expects of pentobarbital. The apparent botching of this execution has led to videotaping of executions in Georgia.

j) Also subsequent to Dr. Dershwitz providing this expert report, pentobarbital was used as the anesthetic drug in the execution of Mr. Eddie Powell in Alabama. In their affidavits, Matt Schulz and Christine Freeman describe that Mr. Powell abruptly/violently raised or jerked his head off the gurney. He had a confused look on his face, and his teeth/jaw muscles were clenched. This was estimated to have lasted for a minute. His eyes were open for most or all of the execution. As with the execution of Mr. Blankenship in Georgia, in the execution of Mr. Powell in Alabama the pentobarbital did not produce the rapid and smooth transition from consciousness to unconsciousness that Dr. Dershwitz evidently expects of pentobarbital.

k) Medicine is a complex and incompletely understood discipline, and it is important to be open to the unexpected. In many situations, drugs do not act in the ways that we predict or expect. In many instances, a drug that works as expected on some patients will not work as expected on other patients. We need to be particularly careful and considerate of the unexpected if we ever use a drug in a way that it has never been clinically used before. The administration of high-dose intravenous pentobarbital to conscious persons is clinically unprecedented. Indeed, the only experience of using high-dose intravenous pentobarbital on conscious persons that I am aware of is in the lethal injection context. While it is appears that some executions using pentobarbital proceed smoothly, it is clear that this is frequently not the case. At present, in the absence of discovery regarding executions using pentobarbital, I am not able to identify the cause of the unexpected effects of pentobarbital in the Georgia and Alabama executions.

l) In his report, Dr. Dershwitz does not focus on the effects of high-dose intravenous pentobarbital as it accomplishes the transition from consciousness to unconsciousness. Instead, his discussion centers on the depth of anesthesia that will be produced once the high dose of pentobarbital has fully established its effects. It is my understanding, based on extensive experience in lethal injection litigation, that it is the intent of the staff to produce a rapid and suffering-free transition from consciousness to unconsciousness. Unfortunately, it appears that, at least in the hands of Georgia and ADOC personnel, pentobarbital does not reliably produce such a transition.

m) There appears to be a discrepancy between the ADOC protocol described by Dr. Dershwitz and the witness descriptions of the July 16, 2011 Powell execution carried out by the ADOC. Specifically, Dr. Dershwitz describes that the consciousness check involves the application of graded stimuli (saying the prisoner's name, then stroking the eyelashes, then pinching the prisoner's arm). I have been provided with two witness reports from the Powell execution. Both reports confirm that the prisoner's name was spoken and that his eyelashes were stroked. However, neither witness reports that the arm was pinched. If in fact the arm was not pinched, and if in fact Dr. Dershwitz is correct that pinching the arm is part of the written ADOC protocol, this would represent a substantial and significant departure from the protocol. Voicing a prisoner's name and stroking the eyelashes are not painful levels of stimulation, whereas pinching the arm represents a painful stimulation. The presumed intent of applying a painful stimulation is to determine whether the prisoner is adequately anesthetized to not be aroused from unconsciousness by the application of pain. The apparent failure to carry out this step of the protocol (if indeed this is actually part of the protocol) would mean that no step was taken to ensure that the prisoner had in fact received sufficient pentobarbital to produce a sustained unconsciousness that would persist throughout the otherwise agonizing effects of pancuronium bromide and potassium chloride. Once pancuronium bromide has taken effect, the prisoner would be unable to move or otherwise call attention to his state of awareness and the agonizing effects of pancuronium bromide and potassium chloride.

n) In paragraph 12 of his report, Dr. Dershwitz states that "even in the absence of the administration of pancuronium bromide and potassium chloride, the administration of 2,500 mg of pentobarbital by itself would cause death to almost everyone". While he does not state, in this report, his exact meaning of "almost everyone," in prior litigation he has made it clear that the use of high-dose barbiturate would be highly reliable and effective for producing death. In particular, he has not to my knowledge raised any concern that the use of barbiturate-only protocols would fail to reliably produce death. Given the opinion of their expert on this matter, it is difficult to understand why the ADOC includes pancuronium bromide and potassium chloride in their execution protocol. Given that, as their own expert holds, pancuronium bromide and potassium chloride are unnecessary to produce death, and given that, as their own expert has conceded, pancuronium bromide and potassium chloride present a risk of producing suffering and agony, and given that, as their own expert concedes, pancuronium bromide obscures any suffering that may be present, there would appear to be no justifiable or legitimate reason for the use of pancuronium bromide or potassium chloride in the ADOC execution process.

o) It is notable that in his expert report Dr. Dershwitz supplies no justification or explanation for the use of pancuronium bromide and/or potassium chloride in the ADOC protocol. I believe it is important that the ADOC asks its expert to provide such explanation or justification, and that if he is unable to provide a robust defense of their use, the ADOC should re-examine its procedures. This is particularly important given the unanticipated effects of pentobarbital in its recent use by the ADOC.

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p) I hold these opinions to a high degree of medical and scientific certainty, and reserve the right to amend them upon provision by the ADOC of additional information that so warrants.

q) I am being compensated at the rate of $400 per hour.

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

Mark J. S. Heath, M.D.

July 22, 2011

New York City

EXHIBIT 19

EXHIBIT 19

EXPERT REPORT OF DAVID B. WAISEL, MD

RE: Evaluation of Arizona's Execution Practices and Procedures and Planned Novel Use of Pentobarbital

July 16, 2011

I, David B Waisel, MD, declare under penalty of perjury the following to be true to the best of my information and belief:

I. INTRODUCTION

1. I have been asked to provide an opinion about Arizona's protocol, practices and processes for execution by lethal injection. I am not being compensated for this opinion.

2. In forming my opinion I have reviewed the following materials presented in this case:

    a. Arizona Department of Corrections, Department Order 710: Execution Procedures (09/15/09)

    b. Affidavit of Matt Schulz (July 14, 2011)

    c. Affidavit of Christine Freeman (July 14, 2011)

    d. Email to Charles Flanagan; Subject: Update; Date: 9/28/2010 2:50 pm

II. SUMMARY OF EXPERT QUALIFICATIONS

1. The complete curriculum vitae is provided in the appendix.

2. I received my M.D. from the Medical College of Pennsylvania in 1989. I performed my anesthesiology residency at Wilford Hall Medical Center, Lackland Air Force Base. As part of my residency, I spent my 3rd year of anesthesia residency at Children's Hospital Boston, doing what was then considered a fellowship in pediatric anesthesiology. Following a second year at Children's Hospital Boston in which I performed research and received training in medical ethics, I returned to Wilford Hall Medical Center for five years. In 1999, I returned to Children's Hospital Boston. I am an anesthesiologist, the program director of the pediatric anesthesiology fellowship, the committee chair responsible for hospital-wide physician education about patient safety and quality clinical care, and a clinical ethicist. I have written over 60 articles and chapters, most of which relate to medical ethics. I am currently an Associate Professor of Anaesthesia, Harvard Medical School. I have been qualified as an expert in anesthesiology and as an expert in medical ethics.

III. SUMMARY OF EXPERT OPINION

3. Arizona Department of Corrections, Department Order 710: Execution Procedures (09/15/09) is in my opinion insufficient to protect inmates against a substantial risk of serious and undue pain and suffering, particularly from awareness while being paralyzed and receiving potassium chloride. A primary focus of this report is the replacement of thiopental with pentobarbital as the anesthetic agent (first drug) of a three drug protocol. Lundbeck, the manufacturer of pentobarbital, has recently announced that this drug is untested and unsafe for use in judicial lethal injections. The use of pentobarbital as an agent to induce anesthesia is not FDA approved, has no relevant clinical history and has no relevant clinical reference doses on which to determine what dose would cause a clinically adequate depth of anesthesia, much less an adequate lethal injection dose. The non-standard use of a novel drug for lethal injection increases the importance of safeguards in preventing undue harm to the inmate, but Arizona's safeguards are inadequate. Especially given the increased risks posed by pentobarbital, the provisions for achieving and monitoring intravenous access and checking the prisoner's consciousness are inadequate. **The combination of significant unknowns from a lack of clinical history related to using pentobarbital to induce anesthesia, inadequate implementation of procedural safeguards and a history of either a cavalier attitude toward lethal injection or a slipshod assessment of problems puts the inmate at risk for serious undue pain and suffering.**

IV. DISCUSSION

4. Lethal injection is the predominant form of execution in the United States. The lethal injection procedures used in many states include a large dose of the anesthetic sodium thiopental (up to 10 times a normal induction dose used for inducing anesthesia), a similarly large dose of the muscle relaxant pancuronium bromide, and potassium chloride (which burns upon injection) to stop the heart. Arizona's procedures follow this general model; the current procedure is a three-drug technique that includes the use of pentobarbital as the drug used to induce anesthesia.

5. Anecdotal literature and legal cases describe numerous problems with the above processes. The primary problem is inadequate anesthesia most commonly from inadequate physical and technical ability of the execution team members to assess anesthetic depth prior to injecting pancuronium bromide and potassium chloride.

6. The June 16, 2011 execution of Eddie Duval Powell in Alabama highlights the additional risks of using pentobarbital in lethal injection. I have reviewed the affidavit of Matt D. Schulz. Schulz was Powell's attorney and was present at the execution. According to Schulz, the timing of the injection of the drugs is hidden from the viewers. Approximately one minute or so after Powell "laid his head back, took a deep breath and closed his eyes," Powell "raised his head abruptly. He appeared to be attempting to sit up, and was pressing against the restraints." "He appeared to be clenching his teeth..." "After about a minute, Mr. Powell's jaw and neck muscles flexed a few last times, before his eyes closed and his head again laid back down." Powell was clearly in distress. The one-minute time course of the extensive and perhaps purposeful agitation should not have happened if the "massive" overdose of pentobarbital worked as claimed. I have seen many anesthetic inductions using thiopental at the much smaller clinically appropriate dose and I have never seen nor seen reported such extensive agitation lasting for such a long time as at least one minute. Therefore, the pentobarbital either was not successfully delivered to Powell or it did not work the same as thiopental works.

7. The June 23, 2011 execution of Roy Willard Blankenship in Georgia further highlights the additional risks of using pentobarbital. Following the execution, I interviewed Greg Bluestein, an AP reporter present at the execution. According to Bluestein, as the lethal injection commenced, Blankenship jerked his head toward his left arm and made a startled face while blinking rapidly. He had a "tight" look on his face and leaned backward. Shortly thereafter, Blankenship grimaced, gasped and lunged twice toward his right arm. During the next minute, Blankenship lifted his head, shuddered and appeared to be mouthing words. Three minutes after the injection, Blankenship had his eyes open and was making swallowing motions. Four minutes after injection, Blankenship became motionless. About 13 minutes after the presumed injection, Blankenship was declared dead. Critically, Blankenship's eyes were still open and never closed during the entirety of the lethal injection process.

   Based on the lunging toward his arms and the lifting of his head and the mouthing of

words, I can say with near certainty that Blankenship was inadequately anesthetized and was sentient for approximately the first three minutes of the execution and that he suffered greatly. Blankenship should not have been sentient or exhibiting these movements, nor should his eyes have been open, after the injection of pentobarbital.

Likely reasons for these events include that the pentobarbital did not work as the state claimed it would work or that the pentobarbital was not successfully delivered to Blankenship's circulatory system.

8. It is my understanding that to date, pentobarbital has been used in sixteen reported executions utilizing the three-drug sequence. The fact that executions of 16 inmates have generated two reports of botched executions underscores the fact that we do not have sufficient data for the safety, efficacy or reliability of pentobarbital as used to induce anesthesia. Only when a drug has been tested systematically can we begin to reliably assess how a new drug will affect human subjects. We do not have that data as to pentobarbital, and therefore do not know in any given case how this dose of pentobarbital will affect a human patient. Further, in medicine, a procedure that had an untoward event in 2 of 16 thoroughly assessed attempts would be considered substantially harmful and would only be implemented in the most desperate circumstances.

9. Sodium thiopental has a long history of being used for clinical induction of anesthesia in healthcare and for induction of anesthesia for lethal injection. It has recently been used in a single drug technique for lethal injection. Pentobarbital has rarely been used in the operating room. Because of the significant unknowns and a lack of clinical history related to using pentobarbital to induce anesthesia, using pentobarbital puts the inmate at risk of needless pain and suffering. The FDA package insert classifies sodium thiopental as an ultra-short acting barbiturate. The FDA package insert classifies pentobarbital as a short-acting barbiturate, not an ultra-short acting barbiturate. Developed in 1928, pentobarbital has never been considered as an agent to induce anesthesia, in large part because of the extended length of action. There are therefore no standard clinical doses of pentobarbital to induce anesthesia, making it much harder to determine how much pentobarbital would constitute a sufficient overdose.

    a. The FDA package inserts[1] for sodium thiopental and for pentobarbital reflect these differences. The package insert for PENTOBARBITAL declares that

[1] The United States Food and Drug Administration (FDA) is the scientific, regulatory, and public health agency that regulates many products, including food products, drugs, medical devices, radiation emitting devices, and cosmetics for the federal government of the United States. The FDA's mission is to assure that consumer products made and sold in the United States are safe, effective, and pure. The purpose of the package insert (also known as prescription drug product insert or

b. pentobarbital may be used in the parenteral form for sedatives, hypnotics for short-term treatment of insomnia, preanesthetics (essentially sedatives) and anticonvulsants. Contrast the pentobarbital FDA package insert with the SODIUM THIOPENTAL package insert which explicitly states that sodium thiopental is approved for use as a sole anesthetic or to induce anesthesia.

c. The pentobarbital package insert also states "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."

d. The pentobarbital package inserts states for sedation that a commonly used initial dose for the 70 kg adult is 100 mg. To be clear, the state of sedation is different than the state of anesthesia. Sedated individuals are often aware and often perceive pain. The insert also states "the drug may be given up to a total of from 200 to 500 mg for normal adults." The package insert does not say the intended effects of these dosage recommendations. But since pentobarbital is not approved for induction of anesthesia, it is reasonable to assume that these doses are either for sedation or for control of an acute seizure.

10. The procedures for achieving and monitoring peripheral venous access are inadequate to safeguard against the risks posed by the use of pentobarbital in a three-drug sequence. Infiltration (extravascular injection) of pentobarbital creates risk of pain and suffering in two regards: injection of pentobarbital into the tissue instead of the vein is excruciatingly painful; also, it will result in insufficient quantities of drug being injected, risking inadequate anesthesia. The pentobarbital package insert states, "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.**" Phlebotomists and certified medical assistants, although certified to draw blood, do not have the training or experience necessary in achieving and monitoring IV access to guard against these risks.

11. I have serious concerns about other aspects of Arizona's procedures as well:

a. **Consciousness check.** Given the lack of clinical data about the effects of pentobarbital as an anesthetic, the provisions for a consciousness check are inadequate. There are gradations of consciousness and anesthesia; these are analog rather than binary processes. In other words, an inmate may appear unconscious but may be able to perceive pain or may have some awareness.

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professional labeling) is to provide detailed drug information compiled and distributed by the drug manufacturer, after FDA review and approval.

Unqualified individuals are very likely to miss the subtle signs of inadequate anesthesia that highly qualified, certified individuals will recognize. The protocol states "The Medical Team leader, dressed in a manner to preserve their anonymity, will enter into the room where the warden and inmate are located to physically confirm the inmate is unconscious by using all necessary medically appropriate methods." The protocol does not specify as to the training, skills and certification of the Medical Team leader. The risks to the inmate of the Medical Team leaders having various levels of experience in assessing consciousness is greatly exacerbated by the protocol not specifying what interventions will be used to assess consciousness. This lack of precision presents the possibility of an insufficiently stimulating consciousness check which would put the inmate at a substantial risk of harm.

b. **Lack of Assessment of Errors.** The protocol provides "[I]n the unlikely event that the inmate is conscious, the Medical Team shall assess the situation to determine why the inmate is conscious." This vague requirement to assess and the lack of specificity as to what should be assessed may miss many causes as to why injection did not have the intended effects. These errors could presumably be left uncorrected, to the severe detriment of the prisoner and the prolonging of a painful death.

c. **Inadequate Practice Procedures.** I understand that Arizona uses saline instead of pancuronium bromide. This may defeat one of the most important aspects of the practice. We know that basic sodium thiopental precipitates when combined with acidic pancuronium bromide because of the combination of an acid and a base. It is my medical opinion that the basic pentobarbital will precipitate when combined with the acidic pancuronium bromide. Using these two drugs in practice would help identify faulty techniques in the injections of the drugs. For example, if during practice these the pentobarbital and pancuronium form a precipitate, then the medical team can look for errors in technique, such as faulty flushing with saline. However, if saline is used instead of the drugs, faulty techniques will not only remain unidentified and uncorrected but also will likely be reinforced by their repetition. Using saline prevents identification of substandard technique and substantially increases the risk of harm to the inmate.

12. In sum, adding an untested and likely problematic drug whose own manufacturer has warned about its unreliability for use in lethal injections into an already dysfunctional and dangerous system increases in an unpredictable and dramatic fashion the already substantial risk of needless pain and suffering for inmates.

EXHIBIT 20

EXHIBIT 20

Lundbeck Inc.
Four Parkway North
Deerfield, IL 60015
USA

Tel 847-282-1000
Fax 847-282-1001
www.lundbeckinc.com

August 18, 2011

Mr. Brent D. Reinke
Idaho Department of Corrections
1299 N. Orchard St., Suite 110
Boise, ID 83706

Dear Mr. Reinke,

Lundbeck understands that the state of Idaho has decided to use or is considering using our product Nembutal® (pentobarbital sodium injection, USP) for the purpose of capital punishment. We are adamantly opposed to the use of Nembutal to execute prisoners because it contradicts everything we are in business to do – provide therapies that improve people's lives.

The use of pentobarbital outside of the approved labeling has not been established. As such, Lundbeck cannot assure the associated safety and efficacy profiles in such instances. For this reason, we are concerned about its use in prison executions.

On Friday, July 1, Lundbeck announced that it has overhauled the distribution of Nembutal in order to restrict its application as part of lethal injection in the U.S. Going forward, Nembutal will be supplied exclusively through a specialty pharmacy drop ship program that will deny distribution of the product to prisons in U.S. states currently active in carrying out the death penalty by lethal injection. A press release is attached with further detail on this new distribution process.

Please respect our company's position as well as this new distribution process and no longer use – or consider using – Nembutal as part of lethal injection in the state of Idaho.

This letter was also sent to Governor C. L. Otter.

Sincerely,

Staffan Schüberg
President
Lundbeck Inc.

EXHIBIT 21

EXHIBIT 21

SALTZER
MEDICAL GROUP
3277 E. Louise Dr., Suite 200 • Meridian, Idaho 83642 • (208) 884-2920

22 August 2011

Greg Worthen

Investigator, Federal Defense Services, Capital Habeas Section

Fax: 208-331-5559

Dear Mr Worthen:

As per our conversation earlier today by telephone, I am writing to confirm that to the best of my knowledge, Medical Assistant programs at present do not include IV medication administration, Intravenous catheter insertion nor IV fluid hydration training. At present, this is out of the scope of their practice and certification.

I checked with our course instructor, and she was aware of an independent course which had existed in the Nampa area which did offer IV certification, but this is no longer available. She also stated that at one time the College of Southern Idaho, which offers a 2 year Associate Degree Medical Assistant program, did offer IV certification inclusive in their course. She was not aware if they still offer this.

In the local hospitals (St Lukes or St Alphonsus systems) Medical Assistants are not allowed to administer, initiate, or manage intravenous medications or fluids. To the best of my knowledge only Registered Nurses or Licensed Practical Nurses with additional training are allowed to manage IV medications.

The problem with MA training is that in independent physician offices, an MA may assist the physician with many procedures which the physician feels comfortable assigning his Medical Assistant. In Idaho, there is no separate Board under which a Medical Assistant is licensed, even though they may be certified nationally by taking the RMA or CMA board exams. The Medical Assistant operates under the supervision and licensure of their physician.

In my opinion I cannot think of an incident in which it would be appropriate for a Medical Assistant to start or manage IV fluids, or administer intravenous medications. I hope that this letter clarifies the situation. If you have further questions or concerns, please feel free to contact me.

Timothy P. Hodges, DO, FAAFP, Medical Director – MA Program/CWI

EXHIBIT 22

EXHIBIT 22

College of Western Idaho

August 25, 2011

To Whom It May Concern,

I am the Phlebotomy instructor with College of Western Idaho. I am also nationally certified as a Phlebotomist by the American Society for Clinical Pathology with over 12 years' experience in the field.

The state of Idaho does not regulate what training or experience a phlebotomist must have to work in Idaho. Anyone can start working in Idaho as a phlebotomist with no previous training or experience needed. In fact many Phlebotomists get on the job training only.

We do however have voluntary guidelines which the course at CWI is modeled after. These national guidelines are set out by the Clinical Laboratory Standards Institute (CLSI). According to CLSI, phlebotomists are not allowed to start IV's or use implanted devices. This rule has proved true in my 12 years' experience, as I have never been allowed to access devices (including but not limited to starting IV's and administering medications). This is something I teach my students as out of their "scope of practice".

Phlebotomists are also not trained in assessing patient's consciousness or in basic patient care, such as vital sign assessments.

Sincerely,

Nicole Walton

Nicole Walton Pbt
nicolewalton@cwidaho.cc

EXHIBIT 23

EXHIBIT 23

STATE OF IDAHO

EMS PHYSICIAN COMMISSION

STANDARDS MANUAL

Authority:
Idaho Code § 56-1013A, § 56-1016, and § 56-1017(1)

Rules for EMS Physician Commission Idaho Administrative Procedures Act 16.02.02

Edition 2011-1

IDAHO DEPARTMENT OF HEALTH & WELFARE

Idaho EMS Physician Commission Standards Manual
Edition 2011-1
Effective April 8, 2011

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I. DEFINITIONS.

As promulgated by and in addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services," the following terms are used in this manual as defined below:

Advanced Emergency Medical Technician (AEMT). A person who holds a current active license issued by the EMS Bureau at the Advanced Emergency Medical Technician or Advanced Emergency Medical Technician-Ambulance level and is in good standing with no restriction upon, or actions taken against, his license.

Affiliation. The recognition of an individual as a member or employee.

Contemporaneous. Originating, existing, or occurring during the same period of time.

Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician.

Credentialing. The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice.

Critical Care Paramedic. A person who holds a current active license issued by the EMS Bureau at the Paramedic or Emergency Medical Technician-Paramedic level and has successfully completed training objectives as set forth in the Critical Care Transport Curriculum Guide of the EMS Bureau and who possesses a current active credential to provide Critical Care.

Critical Care Transport. The transportation of a patient with continuous care, monitoring, medication, or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer.

Designated Clinician. A licensed Physician Assistant (PA) or Nurse Practitioner designated by the EMS medical director, hospital supervising physician, or medical clinic supervising physician who is responsible for direct (on-line) medical supervision of licensed EMS personnel in the temporary absence of the EMS medical director.

Direct (On-Line) Supervision. Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to licensed EMS personnel who are providing medical care.

Emergency Medical Services (EMS). The services utilized in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

Emergency Medical Services Bureau. The Emergency Medical Services Bureau of the Idaho Department of Health and Welfare.

Emergency Medical Services Physician Commission. The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as "the Commission."

Emergency Medical Responder (EMR). A person who holds a current active license issued by the EMS Bureau at the First Responder or Emergency Medical Responder level and is in good standing with no restriction upon, or actions taken against, his license.

Emergency Medical Technician (EMT). A person who holds a current active license issued by the EMS Bureau at the Emergency Medical Technician or Emergency Medical Technician-Basic level and is in good standing with no restriction upon, or actions taken against, his license.

EMS Agency. An organization licensed by the EMS Bureau to provide emergency medical services in Idaho.

EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency.

Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code.

Hospital Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a hospital.

Indirect (Off-Line) Supervision. The medical oversight provided by a physician to licensed EMS personnel who are providing medical care. The components of medical supervision include EMS system design, education, quality management, patient care guidelines, medical policies, and compliance.

License. A license issued by the EMS Bureau to an individual for a specified period of time indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met.

Licensed EMS Personnel. Individuals who possess a valid license issued by the EMS Bureau.

Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or injury.

Medical Clinic Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a medical clinic.

Medical Supervision. The advice and direction provided by a physician, or under the direction of a physician, to licensed EMS personnel who are providing medical care, including direct and indirect supervision.

Medical Supervision Plan (MSP). The written document describing the provisions for medical supervision of licensed EMS personnel.

Nurse Practitioner. An Advanced Practice Professional Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing."

Out-of-hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of emergency medical services may take place.

Paramedic. A person who holds a current active license issued by the EMS Bureau at the Paramedic or Emergency Medical Technician-Paramedic level and is in good standing with no restriction upon, or actions taken against, his license.

Physician. A person who holds a current active license issued by the Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restriction upon, or actions taken against, his license.

Physician Assistant. A person who meets all the applicable requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants."

II. EMS Physician Commission Standards Manual Authority

Idaho Code 56-1013A(1) empowers the EMS Physician Commission with statutory authority to establish standards for scope of practice and medical supervision for licensed personnel, air medical, ambulance, and non-transport agencies licensed by the EMS Bureau. Idaho Code 56-1017(1) specifically authorizes and directs the Commission to adopt appropriate rules defining the allowable scope of practice and acts and duties which can be performed by persons licensed by the department and the required level of supervision by a licensed physician.

IDAPA 16.02.02, "Rules of the EMS Physician Commission," Section 004 incorporate this EMS Physician Commission Standards Manual by reference. The purposes of this EMS Physician Commission Standards Manual are to establish the scope of practice of licensed EMS personnel and to specify the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS licensure.

III. EMS Personnel Authority to Act

To provide emergency medical services, EMS licensed personnel must comply with Idaho Code and IDAPA 16.02.02, "Rules of the EMS Physician Commission." The policies of the EMS Physician Commission are documented in this Standards Manual.

Licensed EMS personnel who are representing an Idaho EMS agency and who possess a valid credential issued by that agency's EMS medical director may act and provide services in the out-of-hospital setting under the following conditions:

1. When participating in a planned deployment of personnel resources approved by the EMS medical director; or
2. When administering first aid or emergency medical attention as a "Good Samaritan" and without expectation of remuneration in accordance with Idaho Code 5-330 or 5-331 in a manner approved by the EMS medical director; or
3. When participating in a training program approved by the EMS Bureau or the EMS medical director.
4. When on duty, visibly display at all times identification specifying name and level of EMS licensure.

In addition, licensed EMS personnel may only provide out-of-hospital care when:

1. The patient care does not exceed the scope of practice as defined by this Standards Manual; and
2. Licensed EMS personnel have been trained, based on curricula or specialized training approved according to IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services;" and
3. The patient care does not exceed the scope of practice approved by their EMS medical director and does not include assessments or interventions that have been specifically prohibited by their EMS medical director.

Licensed EMS personnel who are representing a hospital or medical clinic and who possess a valid credential issued by the hospital or medical clinic supervising physician may act and provide services in the hospital and medical clinic setting under the following conditions:

1. When participating in a planned deployment of personnel resources approved by the hospital or medical clinic supervising physician; or
2. When administering first aid or emergency medical attention as a "Good Samaritan" and without expectation of remuneration in accordance with Idaho Code 5-330 or 5-331 in a manner approved by the hospital or medical clinic supervising physician; or
3. When participating in a training program approved by the EMS Bureau or the hospital or medical clinic supervising physician.

In addition, licensed EMS personnel may only provide hospital and medical clinic care when:

1. Licensed EMS personnel have been trained, based on curricula or specialized training approved according to IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services," or additional training approved by the hospital or medical clinic supervising physician and
2. The patient care does not exceed the scope of practice approved by their hospital or medical clinic supervising physician and does not include assessments or interventions that have been specifically prohibited by their hospital or medical clinic supervising physician.

IV. OUT-OF-HOSPITAL SUPERVISION

All Idaho-licensed EMS agencies, including hospital-based EMS agencies, must comply with the requirements described in this section. Hospital-based EMS agencies must comply with both the requirements described in this section and with the hospital and clinic supervision requirements described later in this Standards Manual when their licensed EMS personnel also have patient care duties in the hospital or clinic setting.

EMS Medical Director Qualifications, Authority and Responsibility.

In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director.

1. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency.
2. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director.

The EMS medical director will have a written agreement with the EMS agency(s) that includes the following elements:

1. Identification of the EMS agency(s) for which he provides medical supervision.

2. Acknowledgement of the authority of the EMS medical director as established in Idaho statute and IDAPA 16.02.02, "Rules of the EMS Physician Commission."
3. An effective date.
4. An expiration date or a provision for automatic renewal upon mutual agreement.
5. Assurance of EMS medical director access to relevant agency, hospital, or medical clinic records as permitted or required by statute to ensure responsible medical supervision of licensed EMS personnel.

The EMS medical director will provide the EMS Bureau with documentation of the written agreement annually or upon request.

The EMS medical director must:

1. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel.
2. Obtain and maintain knowledge of the contemporary design and operation of EMS systems.
3. Obtain and maintain knowledge of Idaho EMS laws, regulations and standards manuals.
4. The EMS medical director shall demonstrate appropriate training and/or expertise in adult and pediatric emergency medical services.

The EMS medical director is authorized to:

1. Provide explicit approval for licensed EMS personnel under his supervision to provide medical care. Licensed EMS personnel may not provide medical care without the explicit approval of an EMS medical director.
2. Credential licensed EMS personnel under his supervision with a scope of practice. This scope of practice may be limited relative to the scope of practice authorized by the Commission and may not exceed the scope of practice established by the Commission.
3. Restrict the scope of practice of licensed EMS personnel under his supervision and withdraw approval of licensed EMS personnel to provide services when such personnel fail to meet or maintain proficiencies established by the EMS medical director or the Idaho EMS Bureau.
    - Such restriction or withdrawal of approval must be reported in writing within fifteen (15) days of the action to the EMS Bureau in accordance with Section 39-1393, Idaho Code.

The EMS medical director is responsible for:

1. Approving the planned deployment of personnel resources.
2. Approving the manner in which licensed EMS personnel administer first aid or emergency medical attention as a "Good Samaritan" in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration.

3. Documenting the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual.
4. Documenting that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment.
5. Developing and implementing a program for continuous assessment and improvement of services by licensed EMS personnel under their supervision.
6. Reviewing and updating protocols, policies, and procedures at least every two (2) years.
7. Developing, implementing and overseeing a Medical Supervision Plan, as defined in this Standards Manual.
8. Collaborating with other EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians to ensure EMS agencies and licensed EMS personnel have protocols, standards of care, and procedures that are consistent and compatible with one another.
9. Designating other physicians to supervise licensed EMS personnel in the temporary absence of the EMS medical director.
10. Designating Physician Assistants and Nurse Practitioners to serve as designated clinicians, as defined in this Standards Manual.

Direct Medical Supervision by Physician Assistants and Nurse Practitioners.

The EMS medical director can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct (on-line) medical supervision of licensed EMS personnel. Such designated clinicians may only provide direct medical supervision when a designated physician is not present in the anticipated receiving health care facility. The following conditions must also be satisfied:

1. A written agreement between the designated Nurse Practitioner and the EMS medical director which describes the role and responsibilities of the designated Nurse Practitioner is required.
2. A written agreement between the designated PA and the EMS medical director which describes the role and responsibilities of the designated PA related to supervision of EMS personnel is required.
3. Designated clinicians must possess and be familiar with the Medical Supervision Plan, as defined in this Standards Manual, protocols, standing orders, and standard operating procedures authorized by the EMS medical director.
4. The physician supervising the PA, as defined in IDAPA 22.01.03, Idaho Department of Health and Welfare, "Rules for the Licensure of Physician Assistants," must authorize the designated PA to provide direct (on-line) supervision.

Provisions for direct medical supervision by designated clinicians must be documented in the Medical Supervision Plan.

Medical Supervision Plan for the Out-Of-Hospital Setting.

The medical supervision of licensed EMS personnel must be provided in accordance with a documented Medical Supervision Plan (MSP) that includes direct, indirect, on-scene, educational, and proficiency standards components. The EMS medical director is responsible for developing, implementing, and overseeing the MSP. However, non-physicians can assist the EMS medical director with the indirect medical supervision of licensed EMS personnel. The EMS medical director will submit the Medical Supervision Plan to the EMS Bureau by November 1, 2008 and thereafter annually or upon request. The EMS Bureau must be notified upon any changes in the Medical Supervision Plan, including changes in designated clinicians, within thirty (30) days of the change(s).

At a minimum, the MSP must consist of the following elements:

A. Credentialing of licensed EMS personnel.

Credentialing is an EMS agency process by which licensed EMS personnel are authorized by the EMS medical director to provide medical care in accordance with a scope of practice that is established by the EMS medical director. The process for credentialing licensed EMS personnel is an extension of the "affiliating" of personnel and is consistent with contemporary EMS system design.

The process for credentialing will include the following:

1. Verification of EMS Bureau licensure;
2. Affiliation to the EMS agency;
3. Review of the qualifications and proficiencies of the EMS provider, and all other EMS agency, hospital, and medical clinic affiliations.
4. Completion of an EMS agency orientation, as prescribed by the EMS agency, that includes:
    a. EMS agency policies;
    b. EMS agency procedures;
    c. Medical treatment protocols;
    d. Radio communications procedures;
    e. Hospital/facility destination policies;
    f. Other unique system features.

Upon successful completion of the credentialing process, the EMS medical director may issue the EMS provider with a card, certificate, or other document which indicates explicit approval to provide patient care and specifically authorizes a scope of practice for the EMS provider.

- This credential should include a specific expiration date which may be the same date of expiration as the EMS Bureau license.
- This credential will be sufficient evidence of "affiliation" for his or her license or renewal by the EMS Bureau, if the dates are inclusive of the

licensure period and the credential has not been withdrawn by the EMS medical director.

B. Indirect (off-line) medical supervision.

Indirect (off-line) supervision will include all of the following:

1. Written standing orders and treatment protocols for both adult and pediatric patients including direct (on-line) supervision criteria;
2. Description of authorized optional psychomotor skills and patient care interventions, as defined by the Commission;
3. Initial and continuing education in addition to those required by the EMS Bureau;
4. Methods of assessment and improvement;
5. Periodic assessment of psychomotor skill proficiency;
6. Provisions for medical supervision of and defining the patient care provided by licensed EMS personnel who are present for a multiple or mass casualty incident, disaster response, or other significant event involving response of licensed EMS personnel;
7. Defining the response when licensed EMS personnel discover a need for EMS while not on duty;
8. The credentialing of licensed EMS personnel for emergency response;
9. The appropriate level of emergency response based upon dispatch information provided by the designated Public Safety Answering Point(s);
10. Triage, treatment, and transport guidelines;
11. Scene management for multiple EMS agencies anticipated to be on scene concurrently;
12. Criteria for determination of patient destination;
13. Criteria for utilization of air medical services in accordance with IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services," Section 415;
14. Policies and protocols for patient refusal, "treat and release", advanced directives by patients and physicians, determination of death, termination of resuscitation and other predictable patient non-transport scenarios;
15. Criteria for cancellation or modification of EMS response;
16. Equipment authorized for patient care;
17. Medical communications guidelines; and
18. Methods and elements of documentation of services provided by licensed EMS personnel.
19. Policies and protocols for the identification, treatment and transport of patients with ST-elevation myocardial infarction to ensure timely re-perfusion therapy.

20. Policy for recognition and utilization of bystander providers that are not credentialed by the local EMS system.

C. Direct (on-line) medical supervision.

Direct supervision may be accomplished by concurrent communication with the EMS medical director, other physicians designated by the EMS medical director, or designated clinicians, who must be available twenty-four (24) hours a day seven (7) days a week. Provisions for direct supervision, including on-scene supervision, will be documented in the MSP which shall identify designated clinicians.

The EMS medical director will develop and implement procedures in the event of on-scene supervision by:

1. The EMS medical director or other physician(s) designated by the EMS medical director;
2. A physician with a pre-existing relationship with the patient; and
3. A physician with no pre-existing relationship with the patient who is present for the duration of treatment on scene or transportation.

Direct supervision of licensed EMS personnel by other persons is prohibited except in the manner described in the MSP.

Designated on-line physicians and clinicians shall have appropriate training and/or expertise in adult and pediatric emergency care.

D. Standards of supervision and training for students of state-approved training programs.

The EMS medical director, in collaboration with the course medical director or course coordinator, will define standards of supervision and training for students of state-approved training programs, who have been placed for clinical practice and training. These standards will be defined, identified, and documented in the MSP.

V. HOSPITAL AND MEDICAL CLINIC SUPERVISION

Licensed EMS Personnel Responsibilities.

The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must:

1. When on duty, visibly display at all times identification specifying their level of EMS licensure.
2. Report such employment or utilization to the EMS Bureau within thirty (30) days of engaging in such activity.

Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician or designated clinicians, as defined in this Standards Manual.

Hospital Supervising Physician and Medical Clinic Supervising Physician Qualifications, Authority and Responsibility.

In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician.

1. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic.
2. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician.
3. Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician or designated clinicians, who are defined in this Standards Manual.

The hospital supervising physician and medical clinic supervising physician must:

1. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel.
2. Obtain and maintain knowledge of the contemporary design and operation of EMS systems.
3. Obtain and maintain knowledge of Idaho EMS laws, regulations and standards manuals.

The hospital supervising physician and medical clinic supervising physician are authorized to:

1. Provide explicit approval for licensed EMS personnel under his supervision to provide medical care. Licensed EMS personnel may not provide medical care without the explicit approval of a hospital supervising physician or medical clinic supervising physician.
2. Credential licensed EMS personnel under his supervision with a scope of practice. This scope of practice may be limited relative to the scope of practice authorized by the Commission. If the authorized scope of practice exceeds the out-of-hospital scope of practice established by the Commission, the hospital supervising physician and/or medical clinic supervising physician must approve additional training to ensure competency in the expanded scope of practice. The Commission recognizes that hospital and medical clinic policies, state rules and the local community standard of care will influence the specific elements of any expanded scope of practice and the development of additional local oversight requirements.
3. Restrict the scope of practice of licensed EMS personnel under his supervision and to withdraw approval of licensed EMS personnel to provide services when such personnel fail to meet or maintain proficiencies established by the hospital supervising physician or

medical clinic supervising physician or the Idaho EMS Bureau.

- Such restriction or withdrawal of approval must be reported in writing within fifteen (15) days of the action to the EMS Bureau in accordance with Section 39-1393, Idaho Code.

The hospital supervising physician and medical clinic supervising physician are responsible for:

1. Approving the planned deployment of personnel resources.
2. Approving the manner in which licensed EMS personnel administer first aid or emergency medical attention as a "Good Samaritan" in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration.
3. Approving additional training when the local scope of practice exceeds the out-of-hospital scope of practice established by the Commission.
4. Documenting the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual.
5. Documenting that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment.
6. Developing, implementing and overseeing a Medical Supervision Plan, as defined in this Standards Manual.
7. Collaborating with other EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians to ensure EMS agencies and licensed EMS personnel have protocols, standards of care and procedures that are consistent and compatible with one another.
8. Designating other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician.
9. Designating Physician Assistants and Nurse Practitioners to serve as designated clinicians, as defined in this Standards Manual.

Direct Medical Supervision by Physician Assistants and Nurse Practitioners.

The hospital supervising physician or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct (on-line) medical supervision of licensed EMS personnel under the following conditions:

1. A written agreement between the designated Nurse Practitioner and the hospital supervising physician or medical clinic supervising physician which describes the role and responsibilities of the designated Nurse Practitioner is required,
2. A written agreement between the designated PA and the hospital supervising physician or medical clinic supervising physician which describes the role and responsibilities of the designated PA related to supervision of EMS personnel is required,
3. Designated clinicians must possess and be familiar with the Medical Supervision Plan, as defined in this Standards Manual, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or medical clinic supervising physician.

4. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," must authorize the designated PA to provide direct (on-line) supervision.

Provisions for direct medical supervision by designated clinicians must be documented in the Medical Supervision Plan.

Medical Supervision Plan for the Hospital and Medical Clinic Settings.

The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan (MSP). The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the MSP.

The MSP will include:

1. A credentialing process for licensed EMS personnel as defined by the hospital or medical clinic.
2. A current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel.
3. The hospital or medical clinic will submit such descriptions upon request of the Commission or the EMS Bureau.
4. Provisions for direct medical supervision by designated clinicians and the identification of designated clinicians.

VI. EMS BUREAU RESPONSIBILITIES.

The EMS Bureau will provide:

1. Technical assistance to medical directors, hospital supervising physicians, medical clinic supervising physicians, and their administrators to develop appropriate Medical Supervision Plans.
2. The Commission with EMS agency Medical Supervision Plans annually and upon request.
3. The Commission with the identification of EMS medical directors and their designated clinicians annually and upon request.

VII. EMS PHYSICIAN COMMISSION RESPONSIBILTIES.

The Commission will provide interpretation of the Rules of the Commission.

VIII. IDAHO AUTHORIZED SCOPE OF PRACTICE.

The Commission has approved the Scope of Practice for licensed EMS personnel, which is articulated in Appendix A. Appendix A lists specific psychomotor skills and patient care interventions and indicates the level of EMS licensure that may perform each skill or intervention. The EMS Medical Director, Hospital Supervising Physician, or Medical Clinic Supervising Physician must oversee a process to verify competency in all credentialed skills and interventions. The effective date of this Scope of Practice will be sine die of the 2011 legislative session.

It must be noted that not everyone is currently operating at the levels indicated by Xs in Appendix A and that it is only upon completion of required education, competency assessment, and endorsement or permission by their medical director that a provider can perform the procedures.

EMS personnel will transition to the 2011-1 scope of practice no later than September 30, 2014.

Appendix A implicitly defines both a "floor" and "ceiling" for each level of EMS licensure. Licensed EMS personnel must receive training and demonstrate competency in each skill and intervention that lies within their "floor." Training for skills and interventions within the "floor" is based on curricula or specialized training approved according to IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services." Training and competency in skills and interventions within the "floor" are verified by examination and state EMS license according to IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services." Skills and interventions designated by an "X" in Appendix A are included in the "floor" for the specified level of EMS licensure.

Skills and interventions designated by "OM" in Appendix A may be authorized by the EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician and are considered optional. These skills and interventions lie between the "floor" and "ceiling" of the specified level of EMS licensure. The EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician must ensure that licensed EMS personnel receive appropriate initial and continuing training for optional skills and interventions. In addition, the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician must take an active role in verifying competency in optional skills and interventions since state EMS licensing will not address optional skills or interventions.

When an EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician desires to incorporate an OM, they must:

1. Report patient care response data to the Idaho Prehospital Electronic Record Collection System (PERCS) directly or by way of an Idaho validated export from a National EMS Information System (NEMSIS) compliant software application.

2. Submit an addendum to their medical supervision plan to the EMS Bureau that indicates which OM(s) they want to adopt.

3. Submit verification of credentialing to the EMS Bureau prior to utilization of OM skills or interventions.

Psychomotor skills and patient care interventions that are not designated by either an "X" or "OM" in Appendix A fall outside the Commission's established Scope of Practice for the specified level of EMS licensure and may not be performed by licensed EMS personnel at that level in the out-of-hospital setting. As such, Appendix A defines the "ceiling' for the specified level of EMS licensure.

Appendix A includes a CC Skills (Critical Care Skills) column that designates optional psychomotor skills and patient care interventions that may be performed by a Paramedic who receives additional training in critical care transport and who is appropriately credentialed by the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician. This formal training program must meet or exceed the applicable objectives of the curriculum approved according to IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services." Completion of the entire curriculum is not required. Curriculum objectives are currently listed in the "Idaho EMS Critical Care Transport Curriculum Guide." The EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician must ensure that licensed EMS personnel receive appropriate initial and continuing training for optional skills and interventions. In addition, the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician must take an active role in verifying competency in optional skills and interventions since state EMS licensing will not address optional skills and interventions.

The Commission has created additional requirements for certain psychomotor skills and patient care interventions that, if done improperly, represent a significant hazard to the patient. Additional standards may include but are not limited to on-line medical direction prior to performance of the skill or intervention, completion of specified training prior to credentialing, required elements for Patient Care Report documentation, required elements for performance assessment and improvement and/or compliance with a state-wide protocol or guideline. See Appendices B through D. Skills and interventions with additional requirements are designated in Appendix A by a 1, 2, 3, 4, 5, etc. alongside the "X" or "OM".

Emergency Medical Responder (EMR)

The primary focus of the Emergency Medical Responder, which prior to July 1, 2009 was known as a certified First Responder, is to initiate immediate lifesaving care to critical patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. Emergency Medical Responders function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Responders perform basic interventions with minimal equipment.

Description of the Profession

The Emergency Medical Responder's scope of practice includes simple skills focused on lifesaving interventions for critical patients. Typically, the Emergency Medical Responder renders on-scene emergency care while awaiting additional EMS response and may serve as part

of the transporting crew, but not as the primary care giver.

In many communities, Emergency Medical Responders provide a mechanism to increase the likelihood that trained personnel and lifesaving equipment can be rapidly deployed to serious emergencies. In all cases, Emergency Medical Responders are part of a tiered response system. Emergency Medical Responders work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Emergency Medical Responder's scope of practice includes simple, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, the Emergency Medical Responder provides care designed to minimize secondary injury and comfort the patient and family while awaiting additional EMS resources.

A major difference between the lay person and the Emergency Medical Responder is the "duty to act" as part of an organized EMS response.

In some systems, Emergency Medical Responders serve as a part of the crew on transporting EMS units; however, the Emergency Medical Responder is not intended to be the highest level caregiver in such situations. They must function with an EMT or higher level personnel during the transportation of emergency patients. The scope of practice model of an Emergency Medical Responder is limited to simple skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.

After initiating care, the Emergency Medical Responder transfers care to higher level personnel. The Emergency Medical Responder serves as part of an EMS response system that ensures a progressive increase in the level of assessment and care.

Emergency Medical Technician (EMT)

The primary focus of the Emergency Medical Technician is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Technicians perform interventions with the basic equipment typically found on an ambulance. The Emergency Medical Technician is a link from the scene to the emergency health care system.

Description of the Profession

The Emergency Medical Technician's scope of practice includes basic skills focused on the acute management and transportation of critical and emergent patients. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

In many communities Emergency Medical Technicians provide a large portion of the prehospital care. In some jurisdictions, especially rural areas, Emergency Medical Technicians provide the highest level of prehospital care. Emergency Medical Technicians work alongside other EMS

and health care professionals as an integral part of the emergency care team.

Emergency Medical Technicians' scope of practice includes basic, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, Emergency Medical Technicians provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.

An Emergency Medical Technician's knowledge, skills, and abilities are acquired through formal education and training. The Emergency Medical Technician has the knowledge of, and is expected to be competent in, all of the skills of the Emergency Medical Responder. A major difference between the Emergency Medical Responder and the Emergency Medical Technician is the knowledge and skills necessary to provide medical transportation of emergency patients.

The Emergency Medical Technician level is the minimum licensure level for personnel transporting patients in ambulances. The scope of practice is limited to basic skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight and limited training.

The Emergency Medical Technician transports all emergency patients to an appropriate medical facility. The Emergency Medical Technician is not prepared to make decisions independently regarding the appropriate disposition of patients. The Emergency Medical Technician serves as part of an EMS response system, assuring a progressive increase in the level of assessment and care. The Emergency Medical Technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Emergency Medical Technicians often perform medical transport services of patients requiring care within their scope of practice.

Advanced Emergency Medical Technician (AEMT)

The primary focus of the Advanced Emergency Medical Technician is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Advanced Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Advanced Emergency Medical Technicians perform interventions with the basic and advanced equipment typically found on an ambulance. The Advanced Emergency Medical Technician is a link from the scene to the emergency health care system.

Description of the Profession

The Advanced Emergency Medical Technician's scope of practice includes basic and limited advanced skills focused on the acute management and transportation of critical and emergent patients. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

For many communities, Advanced Emergency Medical Technicians provide an option to provide high benefit, lower risk advanced skills for systems that cannot support or justify Paramedic level care. This is frequently the case in rural and volunteer systems. In some jurisdictions, Advanced Emergency Medical Technicians are the highest level of prehospital care. In communities which utilize emergency medical dispatch systems, Advanced Emergency Medical Technicians may function as part of a tiered response system. In all cases, Advanced Emergency Medical Technicians work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Advanced Emergency Medical Technician's scope of practice includes basic and limited advanced interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, Advanced Emergency Medical Technicians provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.

The Advanced Emergency Medical Technician's knowledge, skills, and abilities are acquired through formal education and training. The Advanced Emergency Medical Technician has the knowledge associated with, and is expected to be competent in, all of the skills of the Emergency Medical Responder and Emergency Medical Technician. The major difference between the Advanced Emergency Medical Technician and the Emergency Medical Technician is the ability to perform limited advanced skills for emergency patients.

The Advanced Emergency Medical Technician is the minimum licensure level for patients requiring limited advanced care at the scene or during transportation. The scope of practice is limited to lower risk, high benefit advanced skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight and limited training.

The Advanced Emergency Medical Technician transports all emergency patients to an appropriate medical facility. The Advanced Emergency Medical Technician is not prepared to independently make decisions regarding the disposition of patients. The Advanced Emergency Medical Technician serves as part of an EMS response system assuring a progressive increase in the level of assessment and care. The Advanced Emergency Medical Technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Advanced Emergency Medical Technicians often perform medical transport services of patients requiring care within their scope of practice.

Paramedic

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care

system.

Description of the Profession

The Paramedic's scope of practice includes basic and advanced skills focused on the acute management and transportation of the broad range of patients who access the emergency medical system. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

In some communities, Paramedics provide a large portion of the prehospital care and represent the highest level of prehospital care. In communities that utilize emergency medical dispatch systems, Paramedics may be part of a tiered response system. In all cases, Paramedics work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Paramedic's scope of practice includes invasive and pharmacological interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on an advanced assessment and the formulation of a field impression. The Paramedic provides care designed to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an appropriate health care facility.

The Paramedic has knowledge, skills, and abilities developed by appropriate formal education and training. The Paramedic has the knowledge associated with, and is expected to be competent in, all of the skills of the Emergency Medical Responder, Emergency Medical Technician, and Advanced Emergency Medical Technician. The major difference between the Paramedic and the Advanced Emergency Medical Technician is the ability to perform a broader range of advanced skills. These skills carry a greater risk for the patient if improperly or inappropriately performed, are more difficult to attain and maintain competency in, and require significant background knowledge in basic and applied sciences.

The Paramedic is the minimum licensure level for patients requiring the full range of advanced out-of-hospital care. The scope of practice is limited to advanced skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.

The Paramedic transports all emergency patients to an appropriate medical facility. The Paramedic serves as part of an EMS response system, ensuring a progressive increase in the level of assessment and care. The Paramedic may make treat and release decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Paramedics often perform medical transport services of patients requiring care within their scope of practice.

IX. EMS Proficiency and Performance Assessment Requirement.

Additional performance assessment requirements exist for advanced airway management including all intubation attempts and placements by any personnel affiliated with the EMS agency. The responsibility of the EMS medical director includes implementation of these requirements and EMS personnel compliance pursuant to IDAPA 16.02.02.300.05 and .06. The required data elements to be supplied by every EMS provider who attempts advanced airway management will be defined by the EMS Physician Commission. EMS providers will electronically submit the required data elements directly to the EMS Physician Commission starting January 1, 2010 in a manner established by the EMS Physician Commission. EMS providers will submit the required data elements contemporaneously with the completion of their patient care documentation. In the interest of evaluating aggregate performance, the EMS Physician Commission will compile and supply the EMS medical director with submitted data elements.

X. Idaho EMS Physician Commission Contact Information

EMSPhysiciancomm@dhw.idaho.gov

www.emspc.dhw.idaho.gov

Call Toll Free: 1-877-554-3367

Idaho EMS Physician Commission
650 W. State Street, B-17
PO Box 83720
Boise, Idaho 83720-0036
(208) 334-4000
Fax (208) 334-4015

XI. Idaho EMS Bureau Contact Information

IdahoEMS@dhw.idaho.gov

www.idahoems.org

Call Toll Free: 1-877-554-3367

650 W. State Street, B-17
PO Box 83720
Boise, ID 83720-0036
(208) 334-4000
Fax (208) 334-4015

	EMSPC Scope of Practice - All Levels 2011-1 - Standards Manual					
		EMSPC 2011-1				
	AIRWAY / VENTILATION / OXYGENATION					
	Skill	EMR	EMT	AEMT	Paramedic	CC Skills
1	Airway devices not intended to be inserted into trachea			X	X	
2	Airway – Nasal	X	X	X	X	
3	Airway – Oral	X	X	X	X	
4	Airway – Obstruction - removal of foreign body by direct laryngoscopy				X	
5	Bag-Valve-Mask (BVM)	X	X	X	X	
6	BiPAP					2,OM
7	Chest Decompression – Needle				X	
8	Chest Tube Placement					2,OM
9	Chest Tube – Monitoring & Management				X	
10	CPAP			2,OM	OM	
11	Cricoid Pressure (Sellick)	X	X	X	X	
12	Cricothyrotomy – Needle/Percutaneous				X	
13	Cricothyrotomy - Surgical				X****	
14	Demand Valve – Manually triggered ventilation		X	X	X	
15	End Tidal CO_2 Monitoring/Capnometry			2,OM	X	
16	Gastric Decompression – NG Tube				X	
17	Gastric Decompression – OG Tube				X	
18	Head-tilt/chin-lift	X	X	X	X	
19	Intubation – Digital				X	
20	Intubation – Medication Assisted (non-paralytic)				X	
21	Intubation – Medication Assisted (paralytics) (RSI)				2,3,OM	
22	Intubation - Nasotracheal				X	
23	Intubation - Orotracheal			2,3,OM	X	
24	Intubation – Retrograde					
25	Jaw-thrust	X	X	X	X	
26	Jaw-thrust - Modified (trauma)	X	X	X	X	
27	Mouth-to-Barrier	X	X	X	X	
28	Mouth-to-Mask	X	X	X	X	
29	Mouth-to-Mouth	X	X	X	X	
30	Mouth-to-Nose	X	X	X	X	
31	Mouth-to-Stoma	X	X	X	X	
32	Obstruction – Direct Laryngoscopy				X	
33	Obstruction – Manual	X	X	X	X	
34	Oxygen Therapy – Humidifiers	X	X	X	X	
35	Oxygen Therapy – Nasal Cannula	X	X	X	X	
36	Oxygen Therapy – Non-rebreather Mask	X	X	X	X	
37	Oxygen Therapy – Partial Rebreather Mask	X	X	X	X	
38	Oxygen Therapy – Simple Face Mask	X	X	X	X	
39	Oxygen Therapy – Venturi Mask	X	X	X	X	
40	PEEP – Therapeutic (>6cm H_2O pressure)					2,OM
41	Pulse Oximetry			2,OM	X	
42	CO Oximetry		2,4,OM	2,4,OM	OM	
43	Suctioning – Tracheobronchial via advanced airway			X	X	
44	Suctioning – Upper Airway	X	X	X	X	
45	Ventilators – Automated Transport (ATV) for non-intubated patients				X	
46	Ventilators – Automated Transport (ATV)				X	
47	Ventilators, Automated – Enhanced Assessment & Management					2,OM

		EMSPC 2011-1				
	CARDIOVASCULAR / CIRCULATION					
	Skill	**EMR**	**EMT**	**AEMT**	**Paramedic**	**CCS**
48	EKG - 12-lead data acquisition		2,OM	2,OM	X	
49	EKG - 12-lead interpretation				X	
50	EKG - 3-lead rhythm interpretation				X	
51	Cardiopulmonary Resuscitation (CPR)	X	X	X	X	
52	Cardioversion – Electrical				X	
53	Carotid Massage				X	
54	Defibrillation – Automated / Semi-Automated	X	X	X	X	
55	Defibrillation – Manual				X	
56	Hemorrhage Control – Direct Pressure	X	X	X	X	
57	Hemorrhage Control - Pressure Point	X	X	X	X	
58	Hemorrhage Control – Tourniquet		X	X	X	
59	Impedance Threshold Device (ITD)		OM	OM	OM	
60	IABP monitoring & management					2,OM
61	Pacing - Transvenous & Epicardial – monitoring & management					2,OM
62	Invasive Hemodynamic Monitoring					2,OM
63	Mechanical CPR Device		X	X	X	
64	Pericardiocentesis					2,OM
65	Pacing - Transcutaneous				X	
66	Pacing - Permanent/ICD				X****	

		EMSPC 2011-1				
	IMMOBILIZATION					
	Skill	**EMR**	**EMT**	**AEMT**	**Paramedic**	**CCS**
67	Cervical stabilization – Cervical Collar	2,OM	X	X	X	
68	Spinal Immobilization – Long Board	2,OM	X	X	X	
69	Cervical stabilization – Manual	X	X	X	X	
70	Spinal Immobilization – Seated Patient (KED, etc.)	2,OM	X	X	X	
71	Extremity stabilization - Manual	X	X	X	X	
72	Extremity splinting	2,OM	X	X	X	
73	Extremity splinting – Traction		X	X	X	
74	MAST/PASG for pelvic immobilization only		X	X	X	
75	Pelvic immobilization devices		OM	OM	OM	

		EMSPC 2011-1				
	VASCULAR ACCESS / FLUIDS					
	Skill	**EMR**	**EMT**	**AEMT**	**Paramedic**	**CCS**
76	Arterial Line – Monitoring & Access Only					2,OM
77	Central Line – Placement				X****	
78	Central Line – Monitor & Maintain Only				X	
79	Intraosseous – Pediatric			X	X	
80	Intraosseous – Adult			OM	X	
81	Peripheral – Initiation			X	X	
82	Umbilical - Initiation				X****	
83	IV Fluid Infusion - Non-medicated			X	X	

	EMSPC 2011-1				
	TECHNIQUE OF MEDICATION ADMINISTRATION				
	Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.				
	Skill	**EMR**	**EMT**	**AEMT**	**Paramedic**	**CCS**
84	Aerosolized (MDI)				X	
85	Auto-Injector	X	X	X	X	
86	Buccal		X	X	X	
87	Endotracheal Tube (ET)				X	
88	Intramuscular (IM)		2,OM	2,OM	X	
89	Intranasal				X	
90	Intraosseous, pediatric			X	X	
91	Intraosseous, adult				X	
92	IV infusion				X	
93	IV Programmable volume infusion device					2,OM
94	IV push				X	
95	IV Push-D50/concentrated dextrose solutions only				X	
96	Accessing implanted central IV port				X	
97	Nasogastric				X	
98	Nebulized (SVN)				X	
99	Oral		X	X	X	
100	Rectal				X	
101	Subcutaneous		2,OM	2,OM	X	
102	Sub-lingual				X	
103	Topical				X	

	EMSPC 2011-1				
	MISCELLANEOUS				
	Skill	**EMR**	**EMT**	**AEMT**	**Paramedic**	**CCS**
104	Arterial Blood Sampling, Radial Site - Obtaining					
105	Assist with prescribed meds		X	X	X	
106	Over-the-Counter Medications (OTC)				X	
107	Assisted childbirth delivery - normal	X	X	X	X	
108	Assisted childbirth delivery- complicated		X	X	X	
109	Blood Chemistry Analysis					2,OM
110	Blood Glucose Monitoring - automated		2,4,OM	X	X	
111	Blood Pressure – Manual	X	X	X	X	
112	Blood Pressure – Automated		X	X	X	
113	Eye Irrigation		X	X	X	
114	Eye Irrigation – Morgan Lens				X	
115	Extrication awareness/patient access	X	X	X	X	
116	Emergency Moves for Endangered Patients	X	X	X	X	
117	Mechanical patient restraints		X	X	X	
118	Rapid extrication		X	X	X	
119	ICP Monitoring					2,OM
120	Taser Barb Removal	OM	OM	OM	OM	
121	Urinary Catheterization				X****	
122	Venous Blood Sampling – Obtaining			X	X	

	EMSPC 2011-1				
	MEDICATION FORMULARY				
	Formulary	EMR	EMT	AEMT	Paramedic	CCS
123	Acetylsalicylic acid (Aspirin)				X	
124	Acetylsalicylic acid (Aspirin) for suspected cardiac chest pain		OM	OM		
125	Activated Charcoal			X	X	
126	Antihistamines				X	
127	Blood products administration					2,OM
128	Dextrose 50%				X	
129	Dextrose, concentrated solutions				X	
130	Epinephrine (Adrenalin)				X	
131	Epinephrine Auto Injector	2,4,OM	2,4,OM	2,4,OM	X	
132	Glucagon		2,4,OM	2,4,OM	X	
133	Glucose (Oral)		X	X	X	
134	Inhaled beta agonist		X**	X**	X	
135	Maintenance of blood administration					2,OM
136	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer				X	
137	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote)				X	
138	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	5X	5X	5X	X	
139	Medical director approved medications				X	
140	Naloxone (Narcan)				X	
141	Nitroglycerin - sublingual		X**	X**	X	
142	Nitrous Oxide (Nitronox)				X	
143	Oxygen	X	X	X	X	
144	Plasma volume expander administration					2,OM
145	Thrombolytic therapy administration				X	

OM=Optional Module

X in a white square = Existing Idaho SOP, will be removed from future standard manual editions.

Change from previous version 2010-1

Levels of Medical Supervision	
Requires online medical direction before performing	1
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires additional standards as defined by the EMSPC	3
Requires EMSPC protocol	4
Just In Time Training	5

*for chest pain of suspected ischemic origin
**may carry and administer only if already prescribed
*** may assist with patients own medication only
****will be included in Critical Care Curriculum in future Standards Manual

Advanced EMT Statewide Intubation Standards

Topic	Requirements	Available Options
Patient Selection		
Adult / Peds over 12 only	Unconscious w/ineffective respiration	
	Cardiac arrest	
	Apnea or agonal respirations	
Equipment		
Laryngoscope blades	adult	Macintosh
	at least 3 sizes of 2 different blade types	Miller
		other blade types permissable
Continuous Pulse Oximetry	before, during & after intubation	
Rescue device	must have at least one available	LMA
		Combitube
		King LT
		bougie/flexguide
Tube placement	must have at least one available	ETCO2, qualitative
		esophageal detector device (EDD)
Selection of tube size	based on patient age or size of 5th finger	
Suction device	per minimum EMS Bureau equipment list	
Bag Valve Mask	per minimum EMS Bureau equipment list	
Oxygen	per minimum EMS Bureau equipment list	
Intubation Attempts		
Preoxygenation	100% by BVM prior to any attempts	
Provider limited to 3 attempts	duration: each attempt should be no more than 30 seconds. If unsuccessful should oxygenate before subsequent attempts.	
Patient limited to 5 attempts	multiple attempts should not delay transport	
NAEMSP definition of attempt: insertion of laryngoscope blade into mouth		
Confirmation of Tube Placement		
Confirmation of Tube Placement	Utilize multiple methods	Breath sounds
		Epigastric sounds
		ETCO2
		EDD
		chest rise
		tube misting
		Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		

Required Elements for Performance Assessment and Improvement		
Monitoring		
100% chart review		
Intubation success rate		
	agency	
	provider	
1st attempt success rate		
	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)		
	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

Paramedic Non-RSI Statewide Intubation Standards		
Topic	**Requirements**	**Available Options**
Patient Selection		
Adult / Peds	Unconscious w/ineffective respiration	
	Cardiac arrest	
	Apnea or agonal respirations	
	Conscious with ineffective respirations (Nasal intubations only)	
Equipment		
Laryngoscope blades	adult & ped blade sizes	Macintosh
	2 different blade types	Miller
		other blade types permissable
Continuous Pulse Oximetry	before, during & after intubation	
Rescue device	must have at least one available	LMA
		Combitube
		King LT
		bougie/flexguide
Tube placement	must have at least one available	ETCO2, qualitative
		esophageal detector device (EDD)
Selection of tube size	based on patient age or size of 5th finger	
Suction device	per minimum EMS Bureau equipment list	
Bag Valve Mask	per minimum EMS Bureau equipment list	
Oxygen	per minimum EMS Bureau equipment list	
Intubation Attempts		
Preoxygenation	100% oxygen prior to any attempts	Bag Valve Mask
		Non-Rebreatther Mask
Provider limited to 3 attempts	duration: each attempt should be no more than 30 seconds. If unsuccessful should oxygenate before subsequent attempts.	
Patient limited to 5 attempts	multiple attempts should not delay transport	
NAEMSP definition of attempt: insertion of laryngoscope blade into mouth or insertion of tube through nares		
Confirmation of Tube Placement		
Confirmation of Tube Placement	Utilize multiple methods	Breath sounds
		Epigastric sounds
		ETCO2
		EDD
		chest rise
		tube misting
		Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		

Required Elements for Performance Assessment and Improvement		
Monitoring		
100% chart review		
Intubation success rate		
	agency	
	provider	
1st attempt success rate		
	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)		
	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

EMSPC RSI Statewide Standards

Topic	Requirements	Available Options
Patient Selection		
Adult /Peds	Patient requires intubation; AND is not flaccid, or has intact protective airway reflexes. Not a difficult airway	
Equipment		
Laryngoscope blades	adult & ped blade sizes	Macintosh
	2 different blade types	Miller
		other blade types permissable
Medications	As per local EMS Medical Director	
Continuous Pulse Oximetry	before during and after intubation	
Rescue device	must have at least one available	LMA
		Combitube
		King LT
		other
Tube placement	must have at least one available	ETCO2, qualitative
		esophageal detector device (EDD)
Selection of tube size	based on patient age or size of 5th finger	
Suction device	per minimum EMS Bureau equipment list	
Bag Valve Mask	per minimum EMS Bureau equipment list	
Oxygen	per minimum EMS Bureau equipment list	
Intubation Attempts		
Preoxygenation	100% oxygen prior to any attempts	Bag Valve Mask
		Non-Rebreatther Mask
Provider limited to 3 attempts	duration: each attempt should be no more than 30 seconds. If unsuccessful should oxygenate before subsequent attempts.	
Patient limited to 5 attempts	multiple attempts should not delay transport	
NAEMSP definition of attempt: insertion of laryngoscope blade into mouth		
Confirmation of Tube Placement		
Confirmation of Tube Placement	Utilize multiple methods	Breath sounds
		Epigastric sounds
		ETCO2
		EDD
		chest rise
		tube misting
		Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		

Required Elements for Performance Assessment and Improvement		
Monitoring		
100% chart review		
Intubation success rate		
	agency	
	provider	
1st attempt success rate		
	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)		
	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

EXHIBIT 24

EXHIBIT 24

A Communication From The Chief Legal Officers Of The Following States
Alabama * Colorado * Delaware * Florida * Idaho * Mississippi * Missouri * Nevada * Oregon * Tennessee * Utah * Washington * Wyoming

January 25, 2011

Attorney General Eric Holder
Department of Justice
950 Pennsylvania Ave., NW
Washington, DC 20530

Dear Attorney General Holder:

The majority of jurisdictions in the United States that include the death penalty as an authorized punishment in certain cases, including the Federal Government, provide for lethal injection as the prescribed method of execution. In a majority of those capital-crime jurisdictions, again including the Federal Government, it is the only prescribed method of execution. We, the Attorneys General of the States listed below, seek your assistance in resolving an issue concerning the procurement of one of the prescribed medications used in lethal injection protocols.

The protocol used by most of the jurisdictions employing lethal injection includes the drug sodium thiopental, an ultra-short-acting barbiturate. Sodium thiopental is in very short supply worldwide and, for various reasons, essentially unavailable on the open market. For those jurisdictions that have the drug available, their supplies are very small – measured in a handful of doses. The result is that many jurisdictions shortly will be unable to perform executions in cases where appeals have been exhausted and Governors have signed death warrants.

Therefore, we solicit your assistance in either identifying an appropriate source for sodium thiopental or making supplies held by the Federal Government available to the States. We also request an opportunity to discuss this important matter with you.

We look forward to hearing from you.

Sincerely,

John Kroger
Oregon Attorney General

Luther Strange
Alabama Attorney General

John Suthers
Colorado Attorney General

Pam Bondi
Florida Attorney General

Jim Hood
Mississippi Attorney General

Catherine Cortez Masto
Nevada Attorney General

Mark Shurtleff
Utah Attorney General

Bruce Salzburg
Wyoming Attorney General

Joseph Biden III
Delaware Attorney General

Lawrence Wasden
Idaho Attorney General

Chris Koster
Missouri Attorney General

Robert Cooper
Tennessee Attorney General

Rob McKenna
Washington Attorney General

EXHIBIT 25

EXHIBIT 25

Office of the Attorney General

Washington, D.C. 20530

March 4, 2011

Mr. James McPherson
Executive Director
National Association of Attorneys General
2030 M Street, NW
Washington, DC 20036

Dear Mr. McPherson:

This letter responds to the January 25, 2011 letter from various State Attorneys General concerning the difficulties related to procurement of sodium thiopental for use in lethal injections.[1] The lack of availability of sodium thiopental is a serious concern that the Federal Government is currently analyzing.

At the present time, the Federal Government does not have any reserves of sodium thiopental for lethal injections and is therefore facing the same dilemma as many States. The relevant Federal officials tasked with implementing the Federal death penalty have undertaken a review of this matter. They are looking at all applicable options to determine the best course of action for effectively discharging our legal responsibilities, as well as any necessary changes to current Federal death penalty procedures. Bureau of Prisons General Counsel Kathleen Kenney is coordinating our efforts to resolve this issue and is available to discuss it with you; she can be reached at 202-307-3062.

I appreciate and share your concerns about this matter, but I am optimistic that workable alternatives are available that will allow us to carry out our duties.

Sincerely,

Eric H. Holder, Jr.
Attorney General

[1] The January 25 letter was sent by the Attorneys General of Alabama, Colorado, Delaware, Florida, Idaho, Mississippi, Missouri, Nevada, Oregon, Tennessee, Utah, Washington, and Wyoming.