COMMONWEALTH OF KENTUCKY
FRANKLIN CIRCUIT COURT
DIV. I

RALPH BAZE and, THOMAS C. BOWLING, Plaintiffs, v. JONATHAN D. REES, Commissioner, KentuckyDepartment of Corrections, Frankfort, Kentucky GLENN HAEBERLIN, Warden, Kentucky State Penitentiary, Eddyville Kentucky, and, HON. ERNIE FLETCHER, Governor of Kentucky Defendants.	CIV. ACTION # 04-CI-1094 **PLAINTIFFS' POST-TRIAL BRIEF**

"Absolute fires of hell." "Agony." "Tremendous amount of pain." "I wanted to die from the pain." "Bleed to death." During almost twenty hours of testimony, witnesses used these phrases to describe the pain and suffering potentially caused by the chemicals and procedures used in Kentucky lethal injections - - pain and suffering that is not necessary and could be easily avoided by using readily available alternatives.

Each of the chemicals used in Kentucky poses an unnecessary risk of pain and suffering in violation of the Eighth Amendment ban on cruel and unusual punishment. The killing agent - - potassium chloride - - causes extreme burning and involuntary muscle reactions resembling convulsions - - so unpleasant to the viewer that Defendants inject a chemical for the sole purpose of preventing people from seeing them. That chemical, pancuronium bromide, unnecessary to cause death, paralyzes all voluntary muscle causing the agony of suffocation and making it extremely difficult to determine if an inmate is conscious during an execution.

Defendants do nothing to ensure that an inmate is unconscious prior to injecting pancuronium bromide and potassium. They continue to use an ultra-shorting acting anesthetic when more reliable anesthetics are available. They had no idea what anesthesia awareness was. After being told about it, they have done nothing to alleviate the risk of it or to monitor for it. Instead, they hastily applied a hodge podge of "band-aid" quasi-solutions, including sticking a needle in a location that could cause a person to bleed to death or a location that would require a two-inch incision, allowing the condemned inmate to be stuck with a needle for 60 minutes, and adding a crash cart in case a last minute stay is granted, and assigning the revival responsibilities to a psychiatrist. These are not the acts of individuals concerned with ensuring that an execution is carried out constitutionally, with as little pain and suffering as possible. These are the acts of Defendants who were made aware that the chemicals and procedures they use for lethal injection create an unnecessary risk of pain and suffering, and who have decided to act deliberately indifferent towards that risk.

FACTS

Almost 30 years ago, lethal injection first became a method of execution. Tape 1; 4/18/05; 10:05:04 (Testimony of Prof. Deborah Denno). After conducting no scientific or medical studies, Oklahoma adopted the two-drug cocktail of sodium thiopental and a paralytic agent, which it believed potassium chloride to be. *Id*. Potassium chloride is not a paralytic agent. *See* Tape 3; 4/19/05; 11:30:30 (Testimony of Dr. Hiland); Tape 2; 4/18/05; 16:36:07 (Testimony of Defendant Haeberlin). Yet, this erroneous language in Oklahoma's protocol became the model for every other state's lethal injection protocol. States saw the words "paralytic agent," "potassium chloride," and "thiopental," and thought all three were needed. Numerous states blindly copied Oklahoma, thinking they meant three chemicals. Tape 1; 4/18/05; 10:07:36 (Testimony of Prof. Deborah Denno). No state, including Kentucky, ever conducted scientific or medical research on whether any of these chemicals caused pain when used in combination, or whether alternative chemicals that pose less risk of conscious pain and suffering exist. *Id*. at 10:09:40.

Kentucky is one of the states that blindly adopted the tri-chemical cocktail of sodium thiopental, pancuronium bromide, and potassium chloride. Tom Campbell, who was involved in adopting Kentucky's lethal injection protocol testified that Kentucky did not conduct any scientific or medical studies on how to implement lethal injection and that no doctors or scientific literature were consulted prior to adopting the Kentucky lethal injection protocol. Tape 1; 4/1/8/05; 10:43:45. Bill Henderson stated the same thing and added that Defendants just looked at other state protocols in adopting the lethal injection chemicals. Tape 1; 4/18/05; 10:55:10. Phil Parker, the Warden, who actually wrote the protocol and decided on what chemicals to use for lethal injection, testified that he never consulted an anesthesiologist or any

other medical personnel when deciding what chemicals to use for lethal injection. Tape 2; 4/18/05; 2:07:50. Instead, he just looked at the other states, believed (mistakenly) they all used the same three drugs, and adopted sodium thiopental, pancuronium bromide, and potassium chloride, because that is what he believed all other states were using. *Id*. Again, no scientific or medical studies were consulted on the effects of these chemicals when used in combination or whether alternative chemicals that pose less risk of pain existed. *Id.*

If Defendants had consulted medical professionals about these chemicals or conducted any scientific or medical research into the effects of the chemicals, they would have learned:

1) that none of the chemicals used in Kentucky lethal injections relieve pain (*see, e.g.*, Tape 4; 4/20/05; 1:26:51 (Testimony of Dr. Heath));
2) that sodium thiopental is an ultra short acting barbiturate that usually wears off in 5 minutes or less (*Id*. at 1:28:30; Tape 3; 4/19/05; 12:32:34 (Testimony of Dr. Haas));
3) that thiopental may have been a state of the art anesthetic when lethal injection was adopted in this country, but it has been supplanted by a safer drug that does not have to be mixed (*Compare* Tape 3; 4/19/05; 11:50:00, 11:55:50 (Testimony of Dr. Hiland); *with*, Tape 4; 4/20/05; 1:49:40 (Testimony of Dr. Heath));
4) that potassium chloride, the third chemical administered, is the chemical that causes death (*See, e.g.*, Tape 4; 4/20/05; 2:03:24 (Testimony of Dr. Heath));
5) that potassium chloride is extremely painful in a conscious person, and that less painful drugs exist that quickly stop the heart from beating (Tape 4; 4/20/05; 1:46:40 (Testimony of Dr. Heath); *accord*, Tape 6; 5/2/05; 11:15:10; (Testimony Dr. Dershwitz));

6) that the second chemical, pancuronium bromide otherwise known as pavulon, neither renders a person unconscious nor causes death as long a potassium chloride is used, and therefore serves no purpose during a lethal injection other than the illegitimate purpose of preventing people from seeing the body convulse from the reaction of potassium chloride (*See, e.g*, Tape 4; 4/20/05; 2:03:24));

7) that pancuronium paralyzes the body, creating a situation where the person is unable to move whether conscious or not, thus greatly increasing the risk of unnecessary pain and suffering (*See, e.g.*, Tape 4; 4/20/05; 1:31:35 (Testimony of Dr. Heath); Tape 6; 5/2/05; 10:07:10 (Testimony of Dr. Dershwitz);

8) that it is odd to use a short acting barbiturate followed by a long acting paralytic agent because that could result in a person regaining consciousness but being unable to express it because of paralysis, a phenomenon known as anesthesia awareness, which as Carol Weihrer told us, is so painful that one wants to die (Tape 4; 5/20/05 1:46:40) (Testimony of Dr. Heath); Tape 4; 5/20/05; 10:16:18 (Testimony of Carol Weihrer));

9) that pancuronium prevents people from determining whether a person is conscious but paralyzed, a risk that is substantially increased in Kentucky lethal injections as compared to surgical settings, because Kentucky lethal injections inject a long acting paralytic agent after injecting an ultra short acting barbiturate (*Id*.);

10) that not all states use the same chemicals as Kentucky ---New Jersey, for instance, does not use a paralytic agent (Tape 1; 4/18/05; 10:10:39 (Testimony of Prof. Deborah Denno); and,

11) that an alternative chemical or combination of chemicals that pose less risk of unnecessary pain and suffering during an execution exist.

Defendants could have learned all of this and taken steps to avoid these problems if they had conducted any medical or scientific studies or consulted with any medical personnel. Defendants could have done this prior to adopting their tri-chemical cocktail for lethal injection, as shown by testimony of numerous doctors during this trial. Instead of inquiring whether any problems exist with the chemicals used in lethal injections, Defendants blindly followed what other states had done and used the tri-chemical cocktail to execute Eddie Harper. Tape 2; 4/18/05; 2:07:50 (Testimony of Phil Parker).

As one would expect from using a chemical combination that was blindly adopted because other states used those chemicals in the past, Harper's execution was problematic. The witnesses, however, were unaware of the problems because of the use of a paralytic agent. Witnesses testified that Harper appeared to go to sleep within a minute of the injection of thiopental and remained asleep for the entire execution. *See, e.g.*, Tape 2; 4/18/05; 11:21:50 (Testimony of Bill Henderson). Yet, their observations are unreliable. The paralytic agent would make anyone seem asleep, even when they are paralyzed but consciously suffering the agony of pancuronium bromide, and the pain of potassium chloride. The EKG readout shows that Harper was alive after the thiopental was injected, and also alive when the pancuronium bromide was injected. Tape 4; 4/20/05; 2:10:08 (Testimony of Dr. Heath). It was not until a minute after the injection of potassium chloride, which was five minutes after the lethal injection began, that Harper died. *Id*. Thus, the potassium chloride killed Harper. *Id*.

Post mortem thiopental levels from Harper show that the risk of consciously suffering pain is not just a theoretical event, but a reality that likely occurred to him –or at the least – that there was an unnecessary risk that he was consciously experiencing excruciating pain and suffering during his execution - - a risk that could be alleviated if not avoided altogether.

During Harper's autopsy, Dr. Tracey Corey (Kentucky's Chief Medical Examiner, and a board certified Forensic Pathologist) drew blood from the most reliable location for determining post mortem concentrations of blood - - peripheral blood. Tape 2; 4/18/05; 2:21:30 (Testimony of Dr. Corey). Specifically, she drew blood from the vena cava and the axilliary vein because thiopental levels found in those locations would show that the thiopental cycled through the entire body and therefore the levels in the vena cave and the axilliary vein would reflect the level of thiopental in the brain - - the location that effects consciousness. *Id*. at 2:22:20. The heart, on the other hand, is disproportionately high because of redistribution of the chemicals. Tape 2; 4/18/05; 2:56:30 (Testimony of Michael Ward). Michael Ward, who has over 29 years of experience as a toxicologist, confirmed that peripheral blood is the most reliable indicator of thiopental levels in the body at the time of death. *Id*. at 2:52:00; *accord*, Tape 5; 4/21/05; 10:20:20 (Testimony of Dr. Watson). Ward testified that Harper's blood was properly preserved and correctly tested for the concentration of thiopental at the time of Harper's death. *Id*. at 2:57:30.

Ward found 3 mg/L of thiopental in Harper's vena cava - - a level that was validated by the finding of 3 mg/L of thiopental in Harper's axilliary vein (locations that would have been zero if the thiopental did not cycle through the body) - - and 6.5 mg/L of thiopental in Harper's heart. *Id*. at 2:56:15. The higher level in Harper's heart is consistent with the redistribution that is seen in thiopental after death. *Id*. at 2:56:30. As each medical witness testified (except for Dr. Dershwitz who only talked about situations where thiopental is used in combination with other drugs), at least 35 mg/L of thiopental in the blood is necessary to ensure that a person will not wake up from painful stimuli during a surgical procedure. Tape 2; 4/18/05; 2:54:50 (Testimony of Michael Ward); Tape 5; 4/21/05; 10:17:30 (Testimony of Dr. Watson). Even Defendants'

medical expert admitted that the 6.5 mg/L in Harper's heart was troubling and that more than 50% of the population would be able to feel pain at that level. Tape 6; 5/02/05; 10:21:48, 11:34:55 (Testimony of Dr. Dershwitz). In fact, he has also stated that after 5 minutes, with 3 grams of thiopental, a person would not be at the level of general anesthesia. *Id*. at 11:40:00. Thus, when Harper died, although he appeared unconscious - - he was able to feel painful stimuli.

In light of this information proving that problems existed with Harper's execution and that chemicals that pose less risk of conscious pain and suffering exist, Defendants had the opportunity to undertake precautions to alleviate or lessen the risk of pain and suffering, but failed to do so. Instead, they made the bare minimum of changes solely is an attempt to end this lawsuit.

After the litigation began, Defendant Haeberlin, Defendant Rees, and General Counsel for Defendants made changes to the lethal injection protocol. Yet, they failed to consult any medical books. They failed to speak with an anesthesiologist or any other medical personnel knowledgeable in the effects of the chemicals when used in combination. They failed to consult any medical books or medical personnel about what other chemicals exist. They failed to learn what monitoring is necessary to determine whether a person is suffering from anesthesia awareness. Tape 2; 4/18/05; 3:11:55 (Testimony of Defendant Rees); Tape 3; 4/19/05; 10:02:20 (Testimony of Defendant Haberlin) (no medical personnel consulted on 2004 revisions). Instead, individuals with no medical knowledge made medical changes to Kentucky's lethal injection protocol.

Defendant Rees testified that he, Defendant Haeberlin, and their General Counsel decided to increase the amount of thiopental from 2 –3 grams. Tape 2; 4/18/05; 3:10:55 (Testimony of

Defendant Rees). In doing so, they never consulted anyone in the medical field, a fact that Warden Haeberlin confirmed. Tape 3; 4/19/05; 10:02:20 (Testimony of Defendant Haeberlin). And, possibly as a result, they failed to recognize that unless they fixed the problem with getting the 2 grams in, 3 grams also would not work. Tape 5; 4/21/05; 11:44:42 (Testimony of Dr. Watson).

So, why is 2 or 3 grams of thiopental not ensuring that an inmate is conscious when executed? Many possible reasons exist. The I.V. may not be properly inserted in the vein. Defendants are not properly monitoring for this. Tape 4; 4/20/05; 2:36:00 (Testimony of Dr. Heath). The I.V. could be leaking at the I.V. team location. No one is monitoring for this. Or, what about the issue of concentration of thiopental that Dr. Heath discussed in detail, and Defendants did not understand? Defendants kept confusing cc with concentration/volume. Tape 4; 4/20/05; 3:57:38 (Testimony of Dr. Heath). As Dr. Heath explained, cc and concentration/volume are not the same thing. A dose of 3 grams of thiopental, ten grams, or even a 100 grams, is meaningless unless one knows what concentration of thiopental is being administered. *Id*. at 2:46:00. If thiopental is too diluted, the amount of thiopental getting into the body is not as potent - - lasts a shorter amount of time – just is not as strong - - and takes longer to reach full effect. *Id*. at 2:47:00. Is this what happened with Harper? Possibly. So, what are Defendants doing about it? Nothing. Kentucky's lethal injection protocol, unlike the more than 30 execution protocols that Dr. Heath has reviewed, does not specify the concentration of thiopental being administered. *Id*. at 2:46:00. Thus, we don't know if they are injecting a high enough concentration of thiopental to ensure that Plaintiffs will not suffer unnecessary pain and suffering during their execution. Harper's post mortem thiopental levels, however, suggest

strongly that Defendants are giving too low a concentration of thiopental. Thus, the increase from 2 to 3 grams clearly does not solve this problem. *Id*. at 2:47:24.

So, what other problems did DOC try to cover up with a band aid without fixing? They never looked at the chemicals KY uses for lethal injections, and whether alternative chemical combinations exist. Tape 1; 4/18/05; 3:13:30 (Testimony of Defendant Rees); Tape 3; 4/19/05; 10:35:40 (Testimony of Defendant Haeberlin). Defendant Rees testified that he viewed other states' protocols as did Warden Haeberlin, but they were unaware - - in fact Rees was shocked to learn - - that some states do not use the same chemicals as Kentucky uses for lethal injection. *Id*.; Tape 3; 4/19/05; 10:35:40 (Testimony of Defendant Haeberlin). For instance, New Jersey does not use pancuronium bromide, and thus they are able to determine if a person is awake or not. Tape 1; 4/18/05; 10:10:39 (Testimony of Prof. Deborah Denno). Defendants also did not look at what chemicals are available to stop the heart from beating. Tape 1; 4/18/05; 3:13:30 (Testimony of Defendant Rees); Tape 3; 4/19/05; 10:35:40 (Testimony of Defendant Haeberlin). As Dr. Heath testified, chemicals less painful than potassium chloride would do the job. Tape 4; 4/20/05; 1:46:40 (Testimony of Dr. Heath). They also did not look at the continued viability of thiopental. Tape 1; 4/18/05; 3:13:30 (Testimony of Defendant Rees); Tape 3; 4/19/05; 10:35:40 (Testimony of Defendant Haeberlin). If they did, they would have learned that it has been supplanted by other anesthetics that pose less risk of pain and suffering. Tape 4; 4/20/05; 1:49:56 (Testimony of Dr. Heath).

One would think that having been made aware of anesthesia awareness through this litigation, Defendants would have taken steps to ensure that Plaintiffs are unconscious during their execution. Yet, they have done nothing of the sort. They do not ensure unconsciousness prior to injecting the paralytic agent. They do not have an EKG in the execution room to

monitor for consciousness - - instead only using the EKG to determine death. They do not use blood pressure cuffs to monitor for consciousness. All equipment that easily could be used and regularly are used in surgical procedures. Instead, Defendants remain willfully blind to the concept of anesthesia awareness. Defendant Haeberlin and Deputy Warden Pershing – the only people in the execution chamber with the condemned during an execution - - claimed to have no knowledge of anesthesia awareness. Tape 3; 4/19/05; 10:13:00 (Testimony of Defendant Haeberlin); Tape 3; 4/19/05; 11:22:20 (Testimony of Richard Pershing). Of course, as they conceded this means that they don't know what to look for to determine whether a person is consciously paralyzed. *Id*. Yet, they could have learned this merely by asking their medical staff and then taking the appropriate steps to have the proper equipment present and to have people on site trained in using the equipment.

Instead of reducing the risk of unnecessary pain, Defendants have made executions in Kentucky more painful. First, Defendant Rees, who has no medical knowledge suggested that the I.V. team must attempt to insert a needle for up to one hour. Tape 2; 4/19/05; 3:12:00. General Counsel and Defendant Haeberlin agreed to this without consulting any medical personnel. *Id*. at 3:12:44. Attempting to insert an I.V. for up to an hour is not only unnecessarily painful, but also contrary to current medical knowledge. Dr. Heath testified that he would never do such a thing and that it would not only be quite painful but also gratuitous. After about 20 minutes, the I.V. team will have exhausted all potential I.V. sites. Tape 4; 4/20/05; 2:48:18 (Testimony of Dr. Heath). Thus, the additional 40 minutes inflicts unnecessary pain as the I.V. team continues to attempt to insert a needle into locations they already know will be unsuccessful. *Id*.

Second, the current protocol allows the I.V. team to insert a needle in the neck. Numerous DOC officials including Defendant Haeberlin stated that the I.V. would be inserted into the carotid artery. Tape 3; 4/19/05; 10:15:17. Yet, Defendants' own medical director, the doctor at the prison where executions are carried out, and another one of their doctors, stated that they would never insert an I.V. into the carotid artery. Tape 3; 4/19/05; 11:47:08 (Testimony of Dr. Hiland); Tape 3; 4/19/05; 12:14:50 (Testimony of Dr. Haas); Tape 4; 4/20/05; 10:05:53 (Testimony of Nurse Wood); Tape 5; 4/21/05; 1:48:28 (Testimony of Dr. Rafi). They stated that inserting an I.V. into the carotid artery would be extremely painful, could cause the condemned to suffocate, and could even kill the inmate. *Id*. Dr. Rafi stated that an I.V. could be inserted into the jugular vein in the neck. Tape 5; 4/21/05; 1:58:46. But, how this could be done in Kentucky lethal injections remains to be seen. Inserting an I.V. into the jugular vein would require a two-inch incision into the neck, which is not in the execution protocol. Tape 6; 4/21/05; 11:17:50 (Testimony of Dr. Dershwitz). And, even beyond that, Defendants have stated that they are not prepared or trained to make such an incision, which is similar to inserting a "central line."

Finally, they have added a crash cart in case a stay of execution occurs at the last minute. A possibility that is so strong that a New Jersey court stopped all executions until a properly trained crash cart team with the proper equipment is readily available to intervene if a last minute stay of execution is granted. *In the Matter of Readoption with Amendments of Death Penalty Regulations*, 842 A.2d 207 (N.J.Super. 2004). A possibility that is so strong that Defendants amended their protocol during this litigation to add a crash cart. Yet, as Dr. Heath explained and Dr. Dershwitz confirmed, the equipment and sections of the protocol dealing with the crash cart are woefully inadequate to explain how to revive a person after the first two chemicals have been

administered. Tape 4; 4/20/05; 2:16:00 (Testimony of Dr. Heath); Tape 6; 5/2/05; 11:18:45 (Testimony of Dr. Dershwitz). If properly trained medical personnel - - and a doctor of general medicine or an EMT do not have this training - - has the proper equipment, a condemned inmate could be revived at the execution chamber, even after minutes have gone by since the injection began. Tape 4; 4/20/05; 2:16:00 (Testimony of Dr. Heath). Yet, Defendants leave the responsibility of reviving condemned inmates to a psychiatrist who testified that he has not treated patients in a long time, because his current position is administrative. Tape 3; 4/19/05; 10:21:30 (Testimony of Defendant Haeberlin).

STANDARD OF REVIEW

This lawsuit was brought as a civil action seeking declaratory judgment under Kentucky Rules of Civil Procedure. Thus, Plaintiffs must establish a constitutional violation by a preponderance of the evidence.

ARGUMENT

I. THE CHEMICALS AND PROCEDURES DEFENDANTS USE FOR CARRYING OUT LETHAL INJECTIONS CREATE AN UNNECESSARY RISK OF PAIN AND SUFFERING DURING AN EXECUTION IN VIOLATION OF SECTION 17 OF THE KENTUCKY CONSTITUTION AND THE EIGHTH AMENDMENT TO THE UNITED STATES CONSTITUTION.

Numerous aspects of Defendants' lethal injection procedure do not pass constitutional muster. Here, Plaintiffs first discuss the applicable legal standard. Then, Plaintiffs apply the legal standard to the following issues: 1) the use of pancuronium bromide during an execution; 2) the use of potassium chloride during an execution; 3) the failure to administer an analgesic during an execution by lethal injection; 4) the use of sodium thiopental during an execution; 5) the insertion of a needle in the neck; 6) sticking a condemned inmate with a needle for up to

sixty minutes in an attempt to insert an I.V.; and, 7) the lack of monitoring to determine consciousness prior to the injection of pancuronium bromide and potassium chloride.

A. The cruel and unusual punishment standard under section 17 of the Kentucky Constitution and the Eighth Amendment to the United States Constitution

A particular aspect of an execution procedure violates section 17 of the Kentucky Constitution and the Eighth Amendment to the United States Constitution if one of three criteria have been satisfied:[1]

1) the physical pain inflicted during the particular means for carrying out a lethal injection is excessive;
2) the risk of pain caused by the means for carrying out a lethal injection is more than the Constitution tolerates; or,
3) the risk of pain and suffering is unnecessary in light of available alternatives.

1. excessive pain.

A punishment causes excessive pain in violation of the cruel and unusual punishment clause when it involves "something more than the mere extinguishment of life," such as "torture or a lingering death." *In re Kemmler*, 136 U.S. 436, 447 (1890). The degree of suffering not the amount of time a person suffers is the important inquiry. Extreme or torturous pain during moments of consciousness would render an aspect of an execution procedure unnecessarily cruel. *See Fierro v. Gomez*, 865 F.Supp. 1387, 1410 (N.D. Cal. 1994), *remanded on other grounds by, Gomez v. Fierro*, 519 U.S. 918 (1996). Suffering for as little as forty seconds has been considered excessive. *See Palmer v. Clarke*, 293 F.Supp.2d 1011, 1064-66 (D. Neb. 2003) (twenty seconds of suffering constitutes cruel and unusual punishment); *see also*, *Fierro* (stating

that *Campbell v. Wood*, 18 F.3d 662, 687 (9th Cir. 1994), suggests that one and a half minutes of suffering constitutes cruel and unusual punishment).

Although excessive pain is often thought of in terms of the level of a pain a person suffers, it is much more than that. It also includes punishments that are "nothing more than the purposeless and needless imposition of pain and suffering," *Louisiana ex rel. Francis v. Resweber*, 329 U.S. 459, 463 (1947), and those that are "totally without penological justifications." *Rhodes v. Chapman*, 452 U.S. 337, 346 (1981) (*quoting Gregg v. Georgia*, 428 U.S. 153,183 (1976)); *Workman v. Commonwealth*, 429 S.W.2d 374, 378 (Ky. App. 1968) (holding that a punishment is cruel and unusual when "it exceeds any legitimate penal aim").

2. risk of pain that is more than the Constitution tolerates.

In capital cases, as in other cases, the teaching of the Supreme Court's cases is that Eighth Amendment adjudication cannot proceed just by correcting ugly but isolated instances of deviation from generally acceptable standards of procedure. Rather, it must be concerned with assuring that procedures are adequately designed and maintained to avoid undue risks of inflicting inhumane punishments. *Farmer v. Brennan*, 511 U.S. 825, 846 (1994) (acknowledging that the focus of the inquiry is whether there exists an "objectively intolerable risk of harm"); *Helling v. McKinney*, 509 U.S. 25, 33 (1993) (holding that the "Eighth Amendment analysis "requires a court to assess whether society considers the risk that the prisoner complains of" to be more than the Constitution tolerates); *Campbell v. Wood*, 18 F.3d 662, 687 (9th Cir. 1994) (holding that an Eighth Amendment challenge to a method of execution must be considered in terms of the risk of pain). An aspect of an execution procedure that poses too great a risk of pain is unconstitutional whether or not alternatives exist.

[1] A punishment can also violate the cruel and unusual punishment clause if it violates the evolving standards of

3. unnecessary risk of pain and suffering.

The Eighth Amendment to the United States Constitution also "forbids the infliction of unnecessary pain in the execution of the death sentence." *Louisiana ex rel. Francis v. Resweber*, 329 U.S. 459, 463 (1947); *accord Gregg v. Georgia*, 428 U.S. 153, 173 (1976) (holding that the Eighth Amendment prohibits punishments that "involve the unnecessary and wanton infliction of pain. In determining whether a punishment constitutes unnecessary pain or creates an unnecessary risk of pain and suffering, a court must judge the cruelty of the method of execution in light of currently available alternatives. *Workman*, 429 S.W.2d at 378 (a cruel and unusual punishment approach "should always be made in light of developing concepts of elemental decency."). In essence, any risk of pain is unnecessary if a viable alternative that poses less risk of pain and suffering exists.

B. Defendants use of pancuronium bromide as one of the lethal injection chemicals violates the cruel and unusual punishment clause because it creates an unnecessary risk of pain and suffering and makes it extraordinarily difficult to monitor for conscious paralysis.

The second chemical administered during the lethal injection process, pancuronium bromide, has no effect on pain. *See, e.g.,* Tape 4; 1:55:57; (Testimony of Dr. Heath). Instead, pancuronium bromide is a neuromuscular blocking agent that paralyzes the body and collapses the organs, making it extremely difficult to detect if a person can feel pain. If a person is at a level of consciousness where the person can respond to painful stimuli, the pancuronium bromide masks the extreme pain caused by the potassium chloride and the agony of suffocation resulting from the pancuronium bromide. *Id*.; Tape 5; 11:13:00 (Testimony of Dr. Dershwitz); Tape 3; 10:14:00 (Testimony of Carol Weihrer, describing the conscious paralysis as the "absolute fires of hell").

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decency or if the punishment causes mutilation of the human body.

The agony of suffocation and risk of pain and suffering caused by pancuronium bromide is unnecessary, because potassium chloride will cause death with or without the addition of other chemicals. Tape 4; 4/20/05; 2:03:00 (Testimony of Dr. Heath); Tape 6; 5/2/05; 9:40:28 (Testimony of Dr. Dershwitz). Defendants' argued that pancuronium served the "legitimate" purpose of preventing witnesses from seeing the unpleasant sight of the condemned inmate suffering convulsions caused by the potassium chloride. Tape 6; 10:23:44 (Testimony of Dr. Dershwitz). But there is nothing legitimate about perpetrating a fraud on the public by creating a false impression that an inmate peacefully "goes to sleep" and never wakes up, when in reality, the potassium chloride is causing convulsions.

Preventing the public from viewing the reactions to the chemicals - - including convulsions and potentially conscious pain and suffering - - is a purpose not recognized or allowed by the Kentucky Constitution or the Eighth Amendment. *See California First Amendment Coalition v. Woodford*, 2000 WL 33173913 (N.D. Cal. July 26, 2000) (recognizing that the public's perception of the amount of suffering endured by the condemned and the duration of the execution is necessary in determining whether a particular execution protocol is acceptable under the cruel and unusual punishment clause).

Using pancuronium bromide also creates an unnecessary risk of conscious pain and suffering because the convulsions could be alleviated by using a different chemical to stop the heart, which also would negate any basis for using pancuronium.

In sum, Defendants' use of pancuronium bromide creates an unnecessary risk of pain and suffering in violation of the cruel and unusual punishment clause for five reasons.

1) pancuronium bromide does not relieve pain;

2) pancuronium bromide causes agony in a person capable of feeling pain (i.e. not in a surgical plane of anesthesia);

3) pancuronium bromide makes it more difficult to monitor for consciousness, and therefore increases the risk that a condemned inmate's consciousness will go undetected;

4) pancuronium bromide is not necessary to cause death, therefore inherently increasing the risk that it causes unnecessary pain and suffering because it could be completely avoided without preventing the execution from being completed; and,

5) preventing convulsions could be accomplished by using a chemical to stop the heart that poses less risk of pain and suffering than potassium chloride.

C. **Defendants use of potassium chloride as one of the lethal injection chemicals violates the cruel and unusual punishment clause because it creates an unnecessary risk of pain and suffering in light of readily available alternatives.**

Defendants' use of potassium chloride as one of the lethal injection chemicals constitutes cruel and unusual punishment. Potassium chloride, the third and final chemical used in Kentucky lethal injections causes excessive pain in violation of the cruel and unusual punishment clause because it causes an extremely painful burning sensation as the chemical ravages the nervous system and stops the heart from beating. Tape 3; 4/19/05; 11:30:50 (Testimony of Dr. Hiland); Tape 4; 4/20/05; 2:01:29 (Testimony of Dr. Heath); Tape 6; 11:13:55 (Testimony of Dr. Dershwitz). Defendants, however, may argue that the fact that potassium chloride causes pain is

irrelevant because the inmate is unconscious before the potassium of chloride enters the inmate's bloodstream. As discussed in the next section, the evidence presented before this Court shows the exact opposite - - that an intolerable risk exists that an inmate will be conscious or regain conscious during the execution. Nonetheless, establishing that an inmate likely will be conscious when the potassium chloride is injected is not necessary to prevail on this claim, because there is a viable alternative to potassium chloride.

The Eighth Amendment deals with unnecessary risks of pain and suffering in light of available alternatives. Because "many non painful ways of stopping the heart" exist, Tape 4; 4/19/05; 1:46:40 (Testimony of Dr. Heath); *accord*, Tape 6; 11:15:10; (Testimony Dr. Dershwitz), Defendants' use of potassium chloride during a lethal injection constitutes an unnecessary risk of pain and suffering in violation of the cruel and unusual punishment clause regardless of whether or not the inmate is conscious.

D. The failure to administer an analgesic as one of the lethal injection chemicals violates the Eighth Amendment because it creates an unnecessary risk of pain and suffering.

Defendants inject three chemicals into a condemned inmate during a lethal injection:

1) sodium thiopental to render an inmate unconscious purportedly so the inmate does not feel pain;

2) pancuronium bromide to paralyze all voluntary muscles so convulsions are not visible to witnesses; and,

3) potassium chloride to stop the hear from beating.

Analgesics - - which include opiates - - are drugs that relieve pain. During surgery, analgesics are used in conjunction with barbiturates to ensure that the patient does not suffer pain. Tape 6; 5/2/05; 11:24:26 (Testimony of Dr. Dershwitz) (one type of medication used to put someone to sleep during surgery and another chemical used to relieve pain). None of the

chemicals used in lethal injections (including thiopental) are analgesics. Thus, Defendants are not giving condemned inmates a pain reliever during their execution. *See* Tape 4; 1:26:50 (Testimony of Dr. Heath, whose major area of research is the mechanisms of pain). The failure to administer a pain reliever during an execution creates an unnecessary risk of pain and suffering, because injecting an analgesic would easily decrease the likelihood that a condemned inmate will feel pain during an execution. *See* Tape 5; 12:25:50 (Testimony of Dr. Watson) (adding analgesic would increase the likelihood that potassium chloride would not be painful).

E. Defendants' use of an ultrashort acting barbiturate that could wear off during an execution and their failure to ensure that they are actually delivering an adequate concentration of thiopental to place a condemned inmate under general anesthesia for the entire execution creates an unnecessary risk of pain and suffering

Instead of injecting a long acting barbiturate to render the condemned inmate unconscious, Defendants inject an ultra-short acting barbiturate (thiopental) that begins to wear off immediately. Because of thiopental's short acting nature, anesthesiologists primarily use thiopental as an introductory anesthetic that is followed up with a longer acting anesthetic that keeps the patient asleep for an entire surgical procedure. Tape 4; 4/20/05; 1:28:16 (Testimony of Dr. Heath). When administered in combination with another anesthetic, approximately 10-12 mg/L of thiopental in the body is necessary to ensure that a person is unable to respond to verbal stimuli. Tape 6; 5/2/05; 11:27:14 (Testimony of Dr. Dershwitz) (saying that 10-12 mg/L level is based on using thiopental in combination with another anesthetic); 10:16:08 (claiming that the accepted definition of consciousness is the ability of a person to respond to a simple command such as raise a leg). However, that number increases both when thiopental is used as the only anesthetic and when attempting to ensure that an unconscious person will not wake up from painful stimuli - - two areas where Defendants' expert, Dr. Dershwitz has little experience. *Id*. at

11:26:00 (admitting that his numbers on thiopental are lower than the 39 mg/L of thiopental specified in Baselt's Disposition of Toxic Drugs and Chemicals in Man because Baselt's study is based on using thiopental as the only anesthetic while his testimony is based on using thiopental in conjunction with other anesthetics); *accord* Tape 4; 4/20/05; 1:26:30 (Testimony of Dr. Heath); Tape 7; 5/10/05; 9:10:56 (Testimony of Dr. Watson).

Dr. Dershwitz testified that all his calculations concerning consciousness only deal with the amount of thiopental necessary to ensure a lack of response to verbal stimuli, and are based on administering thiopental in conjunction with another anesthetic. Tape 6; 5/2/05; 10:16:08, 11:27:14 (Testimony of Dr. Dershwitz). This is because Dr. Dershwitz rarely relies upon thiopental as the sole medication for surgical procedures, and has not reviewed literature on injecting thiopental as the sole anesthetic. *Id*. at 11:28:58. Surprisingly, he is unfamiliar with the standard text for determining the amount of thiopental necessary to ensure that a person will not respond to painful stimuli, Disposition of Toxic Drugs and Chemicals in Man by Randall Baselt. *Id*. at 11:25:07.

According to Baselt, at least 39 mg/L of thiopental are necessary to induce general anesthesia (level of consciousness necessary to ensure that a person will not respond to painful stimuli). *Id*. at 11:25:57. Michael Ward and Dr. Watson confirmed Baselt when they testified that approximately 35 or 40 mg/L of thiopental are necessary to achieve general anesthesia. Tape 2; 4/18/05; 2:54:50 (Testimony of Michael Ward); Tape 5; 4/21/05; 10:17:30 (Testimony of Dr. Watson).

3 grams of thiopental (the dose Kentucky injects) is not likely to produce 35-40 mg/L of thiopental in the body for the five minutes that it took Edward Harper to die (some executions last longer). As exhibit 32 shows, Dr. Dershwitz created a graph determining the level of

thiopental in the body after 5 minutes. His graph stated that 30.15 mg/L will be in the body after 5 minutes. Tape 6; 5/2/05; 11:40:02. This amount is much lower than the amount necessary to ensure that a person does not feel pain. When confronted with his Maryland data, Dr. Dershwitz claimed that Maryland injected a lower amount of thiopental than Kentucky. *Id*. Yet, that is not the case. Dr. Dershwitz's Maryland affidavit, which is part of exhibit 32, states that Maryland also injects 3 grams of thiopental. *Id*. at 11:41:16. Thus, Defendants' own expert's data shows that, for at least part of the execution, an inmate injected with 3 grams of thiopental likely will be able to feel the excruciating pain and suffering caused by pancuronium bromide and potassium chloride. This pain is intolerable under the cruel and unusual punishment clause. *See Fierro v. Gomez*, 865 F.Supp. 1387, 1410 (N.D. Cal. 1994). Suffering for as little as forty seconds is been considered excessive. *See Palmer v. Clarke*, 293 F.Supp.2d 1011, 1064-66 (D. Neb. 2003) (twenty seconds of suffering constitutes cruel and unusual punishment); *see also*, *Fierro* (stating that *Campbell v. Wood*, 18 F.3d 662, 687 (9th Cir. 1994), suggests that one and a half minutes of suffering constitutes cruel and unusual punishment). Further, the risk that the amount of thiopental injected will not prevent an inmate from feeling painful stimuli is more than the cruel and unusual punishment clause tolerates, particularly since other barbiturates that will last a longer period of time could be used instead of thiopental.

However, even if 3 grams of thiopental could prevent an inmate from feeling painful stimuli, Plaintiffs should prevail on this claim. The evidence from the execution of Edward Harper and condemned inmates in North Carolina and South Carolina proves that there is an unacceptable risk that even 3 grams of thiopental will not reach the condemned inmate's bloodstream. For example, Edward Harper's toxicology results showed 3 mg/L of thiopental in the vena cava and the axilliary vein and 6.5 mg/L of thiopental in the heart, Tape 2; 4/18/05;

2:56:15 (Testimony of Michael Ward) - - levels that troubled Defendants' expert, Dr. Dershwitz. Tape 6; 5/2/05; 11:34:55.

It was reasonable for Dr. Dershwitz to be troubled by the 6.5 mg/L of thiopental found in Harper's heart. Repeatedly, he has submitted affidavits saying that 50% of the population will be conscious when they have 7 mg/L of thiopental in their body, and that the heart blood level is the most reliable indicator of the level of thiopental. *Id*. at 10:21:48; 11:31:13. Yet, Dershwitz testified that Harper was unconscious for the entire duration of his execution. *Id*. at 9:50:23. To explain this inconsistency, Dershwitz claimed, for the first time anywhere, that thiopental levels are only reliable if drawn from the left side of the heart, and said that he never told anyone that before because it was obvious and no one asked. *Id*. at 11:31:32. In saying this, Dr. Dershwitz is inaccurate and testifying beyond the scope of his area of expertise.

Dr. Dershwitz deals with living people not dead people like Michael Ward, Dr. Corey and Dr. Watson do. Although obvious from Dershwitz's field of practice - - anesthesiology - - this is even more clear after analyzing his testimony, which was based on tests he conducted using chemicals that react differently in the body because of different physiological properties. *Compare* Tape 6; 5/2/05; 12:01:00 (Testimony of Dr. Dershwitz); *with*, Tape 7; 5/10/05; 9:12:10 (Testimony of Dr. Watson). Dershwitz claimed that the heart is the most reliable indicator of the level of thiopental in the body because of the mixing within the body necessary to achieve equilibrium. Tape 6; 5/2/05; 11:35:50. He also claimed that post mortem redistribution does not exist with thiopental. *Id*. Even more remarkable, Dr. Dershwitz claimed that necrokinetics, the scientific term for the movement and concentration of drugs in dead people over time, does not exist. *Id*. at 10:03:53. All of this evidence was discredited by doctors who specialize in analyzing blood concentrations of chemicals in dead people.

Dr. Corey and Dr. Watson - - who, unlike Dershwitz, has published an abstract on post mortem redistribution of thiopental, Tape 7; 5/10/05; 9:17:00 - - testified that post mortem redistribution occurs with thiopental - - a fact that Dershwitz would have known if he was familiar with the standard reference for determining the movement of chemicals in the human body. Tape 2; 4/18/05; 2:23:33 (Testimony of Dr. Corey); Tape 5; 4/21/05; 10:20:20 (Testimony of Dr. Watson). According to both Dr. Corey and Dr. Watson, post mortem redistribution causes levels of thiopental in the heart to be higher than the concentration at death. *Id*. It is for that reason that both of them testified that venous blood is the most reliable indicator of thiopental in the body. *Id*. Further, Dr. Watson, the only witness who has studied the movement of thiopental after death, explained that after 14 hours, the level of thiopental in venous blood is about the same as it was at death. Tape 5; 4/21/05; 10:34:50. Thus, according to Dr. Corey, Michael Ward, and Dr. Watson, the level of thiopental found in Edward Harper's venous blood after death is a reliable indicator of the level of thiopental in his body at the time of death. Tape 2; 4/18/05; 2:41:08 (Testimony of Dr. Corey); Tape 2; 4/18/05; 2:57:32 (Testimony of Michael Ward); Tape 5; 4/21/05; 10:47:14 (Testimony of Dr. Watson).

Although allegedly injected with 2 grams of thiopental, Harper only had 3 mg/L of thiopental in his venous blood at the time of the autopsy, fourteen hours after death. Tape 2; 4/18/05; 2:56:15 (Testimony of Michael Ward). As both Michael Ward and Dr. Watson testified, a person with 3 mg/L of thiopental can feel painful stimuli. *Id*. at 2:56:00; Tape 5; 4/21/05; 10:17:30 (Testimony of Dr. Watson). Thus, Harper was able to feel the excruciating pain of pancuronium bromide and potassium chloride ravaging his system.

Defendants, however, have increased the amount of thiopental from 2 to 3 grams. According to Dr. Watson, this change is negligible, because the thiopental concentrations in

Harper show that a one gram increase of thiopental will not fix whatever is currently wrong with Kentucky's lethal injection protocol. Tape 5; 4/21/05; 11:44:42. In fact, unless other major changes to the protocol occur, Dr. Watson predicts that the level of thiopental in a person injected with 3 grams of thiopental will be only a small amount more than would be found in a person injected with two grams. *Id*. Thus, if Defendants use the current protocol to inject 3 grams of thiopental, Plaintiffs will still not receive enough thiopental in their body to achieve general anesthesia, and thus will be able to feel pain.

The likelihood of this is increased by Defendants' failure to specify the concentration of thiopental being administered. If too low a concentration of thiopental is injected, it will take longer to get the three grams of thiopental into the body. Tape 4; 4/20/05; 2:47:00 (Testimony of Dr. Heath). Because of the increase in time, more of the thiopental will have worn off before the pancuronium bromide and potassium chloride is injected. Perhaps this is why Harper did not receive enough thiopental. But, Plaintiffs do not have the burden of explaining why condemned inmates are not receiving enough thiopental to prevent them from feeling painful stimuli. Plaintiffs only have to establish, by a preponderance of the evidence, that the chemicals Defendants' use during lethal injections pose an unnecessary risk of pain and suffering. The concentration of thiopental found in Harper's blood after death along with the similar data collected in North Carolina and South Carolina demonstrate this. It shows that Defendants have not and are not addressing and eliminating the risk that condemned inmates are feeling pain during their execution. The risk that this will occur during Plaintiffs' execution is more than the Eighth Amendment tolerates, particularly since the risk could be lessened by the use of a different chemical combination.

F. Inserting a needle into a condemned inmate's neck could cause an inmate to bleed to death, thereby creating a risk of pain and suffering that is more than the Eighth Amendment tolerates.

The cruel and unusual punishment clause bars anything that is "more than the mere extinguishment of life, such as "torture" or a "lingering death," *In re Kemmler*, 136 U.S. 436, 447 (1890), and any aspect of a punishment that creates an "objectively intolerable risk of harm." *Helling v. McKinney*, 509 U.S. 25, 33 (1993). Inserting an I.V. into Plaintiffs' neck will cause torture, a lingering death, or an objectively intolerable risk of pain.

Inserting a needle into the neck is a dangerous procedure that should only be done in emergencies. Tape 5; 4/21/05; 1:58:30 (Testimony of Department of Corrections' Dr. Rizalino Rafi). Dr. Rafi would never insert an I..V. in the neck, partly because it could result in complications that would make it difficult to breath, *Id*. at 1:49:00, causing extreme pain and suffering. Yet, Defendants may insert an I.V. into Ralph Baze or Thomas Bowling's neck during their execution.

The trial testimony showed that Defendants have no idea what they are doing when it comes to inserting an I.V. into the neck. Some witnesses testified that if an I.V. is going to be inserted into the neck, it would be inserted into the carotid artery while others testified that the I.V. would be inserted into the jugular vein. *Compare* Tape 2; 4/18/05; 10:15:17 (Testimony of Defendant Haeberlin on inserting I.V. into carotid artery); *with*; Tape 5; 4/21/05; 1:58:45 (Testimony of Department of Corrections' Dr. Rizalino Rafi).

Placing a needle in the carotid artery or the jugular vein is constitutionally intolerable. An I.V. in the carotid artery would cause excessive bleeding, possibly causing a person to bleed to death. Because of this risk, Dr. Hiland, Dr. Haas, Nurse Wood, and Dr. Rafi, would never insert an I.V. into the carotid artery. Tape 3; 4/19/05; 11:47:08, 12:14:50; Tape 4; 4/20/05;

10:05:53, Tape 5; 4/21/05; 1:48:00. Neither should defendants. The objectionably unreasonable risk of pain or a lingering death from excessive bleeding caused by inserting an I.V. in the carotid artery violates the cruel and unusual punishment clause of the Eigth Amendment.

Putting a needle in the jugular vein is not any better. The insertion process is similar to starting a central line, which this Court has already prohibited. A central line involves an incision into the body and threading a catheter to the heart. With the jugular vein, a two inch incision must be placed into a conscious individual. Tape 6; 5/2/05; 11:17:11 (Testimony of Dr. Dershwitz). Cutting two inches into the body of a conscious person able to feel pain constitutes the unnecessary infliction of pain, in violation of the cruel and unusual punishment clause.

G. Spending up to 60 minutes attempting to insert an I.V. violates the cruel and unusual punishment clause because it is nothing more than the needless imposition of pain and suffering.

When this Court prohibited the use of a cut-down procedure, Defendant Rees, who has no medical training, unilaterally ordered that the execution team must spend sixty minutes attempting to insert an I.V. before the team can make the decision that an I.V. cannot be started without additional medical intervention. Tape 2; 4/18/05; 3:12:00 (Testimony of Defendant Rees). Defendant Rees' order was adopted without any consultation with any medical professionals. *Id.*

The only testimony on attempting to insert an I.V. for up to 60 minutes came from Dr. Heath, who testified that 60 minutes of sticking a person with a needle is useless and extremely painful. He said that it should only take two to three minutes to insert an I.V. Tape 4; 4/20/05; 2:48:18 (Testimony of Dr. Heath). After ten minutes, someone else should try to insert the I.V. *Id*.; *see also*, Tape 3; 4/19/05; 11:58:03 (Testimony of Department of Corrections' Nurse Chanin Hiland) (after making three attempts to insert an I.V. into a vein, she would ask someone else to

try). After 20 minutes of attempting to insert an I.V., the execution team will have exhausted all available locations to insert a needle. Tape 4; 4/20/05; 2:48:18 (Testimony of Dr. Heath). Thus, attempting to insert a needle for more than twenty minutes is useless as there is little to no chance that the execution team will be able to insert an I.V. after that point. Further, for up to forty minutes, the execution team is needlessly inflicting pain in violation of the cruel and unusual punishment clause. *See Resweber*, 329 U.S. at 463.

Yet, the cruel and unusual punishment clause is violated even before the execution team spends twenty minutes attempting to insert an I.V. It should only take two to three minutes to insert an I.V. Tape 4; 4/20/05; 2:48:18 (Testimony of Dr. Heath). Well before the twenty minutes has elapsed, the condemned inmate will be in "a lot of pain and discomfort." *Id*. at 2:48:28. Thus, the portion of Defendants' execution protocol requiring the execution team to spend 60 minutes attempting to insert an I.V. constitutes torture in violation of the cruel and unusual punishment clause. *See Kemmler*, 136 U.S. at 447; *Palmer*, 293 F.Supp.2d at 1064-66 (twenty seconds of pain and suffering constitutes cruel and unusual punishment).

H. The lack of monitoring to ensure that a condemned inmate is unconscious from the time period just prior to injecting pancuronium until death creates an unnecessary risk of pain and suffering in violation of the cruel and unusual punishment clause.

An individual injected with sodium thiopental is capable of feeling pain if the level of thiopental in the body is below the amount necessary to maintain general anesthesia. Normally, this would be easy to detect since people react to pain by moving or crying out. But, as previously discussed, the second chemical administered during lethal injections, pancuronium bromide paralyzes all voluntary muscles. Nonetheless, there are ways to monitor for consciousness during an execution.

The easiest and most obvious way to ensure that a condemned inmate is unconscious during an execution is to check for consciousness prior to injecting pancuronium bromide. This can be accomplished by checking the corneal reflexes, or pinching a person to see if the person responds. None of these tests work once a person has been injected with a paralytic agent, such as pancuronium bromide.

Yet, monitoring for consciousness still could be done through the use of proper equipment. The following equipment would aid in monitoring consciousness after pancuronium bromide has been injected: a BIS monitor; blood pressure monitoring; EKG machine (if located in the execution chamber and being read throughout the execution not just to determine death); and an EEG monitor. Tape 4; 4/20/05; 1:39:00 (Testimony of Dr. Heath). Defendants use none of this equipment to monitor for consciousness.

Instead, they claim that monitoring for consciousness is not necessary because the inmate "goes to sleep" once the first chemical injected. However, the injection of pancuronium bromide prevents anyone from knowing if that is really the case. Defendants also fail to recognize that an unconscious person could regain consciousness before the execution is over. Thus, it is essential to monitor for consciousness before and after the injection of pancuronium bromide. Defendants' failure to monitor for consciousness creates a risk of pain and suffering that is completely unnecessary, because it could be alleviated by proper monitoring by adequately trained personnel.

II. IF A STAY OF EXECUTION OCCURS AFTER THE FIRST CHEMICAL IS ADMINISTERED, DEFENDANTS HAVE AN AFFIRMATIVE DUTY TO RENDER ADEQUATE MEDICAL CARE TO REVERSE THE EFFECTS OF THE CHEMICALS. DECLARATORY JUDGMENT SHOULD ISSUE UNTIL DEFENDANTS OBTAIN THE NECESSARY EQUIPMENT TO MAINTAIN LIFE AFTER THE FIRST TWO CHEMICALS HAVE BEEN ADMINISTERED, AND UNTIL DEFENDANTS DESIGNATE A DOCTOR TRAINED IN USING THIS EQUIPMENT TO PERFORM LIFE SAVING MEASURES IF NECESSARY.

Once a stay of execution is granted, the execution is no longer sanctioned. This is true even if the stay is granted after the first chemical is administered. *See In the Matter of Readoption with Amendments of Death Penalty Regulations*, 842 A.2d 207, 211 (N.J.Super. 2004). Thus, the stay creates an affirmative obligation under contemporary standards of decency and morality to take measures to give the inmate a chance to continue living. *See In the Matter of Readoption with Amendments of Death Penalty Regulations*, 842 A.2d at 211.

If the proper equipment is on hand, medical personnel certified in cardiac life support - - not EMT's, phlebotomists, pyschiatrists, or doctors of general medicine - - would have relatively little difficulty maintaining life after the first two chemicals have been injected. Tape 4: 4/20/05; 2:16:40 (Testimony of Dr. Heath). Because the effects of sodium thiopental and pancuronium bromide are reversible, Tape 2; 4/18/05; 12:16:44 (Testimony of Dr. Haas); Tape 4; 4/20/05; 2:15:18 (Testimony of Dr. Heath), Defendants' failure to have the necessary equipment and adequately trained personnel to reverse the effects of these chemicals violates due process and fundamental fairness. *Id*.

After litigation began, Defendants took some steps to prepare for the need to reverse the effects of the lethal injection chemicals. They added a crash cart. That step, however, is wholly inadequate to maintain the life of the condemned inmate after the first two chemicals have been administered. A crash cart is only as good as the equipment on the crash cart and the medical training of the people operating that equipment.

As Dr. Heath and Dr. Dershwitz testified, the document prepared by Defendants' does not come close to being comprehensive enough for someone to use in maintaining life after the first two chemicals have been injected. Tape 4; 4/20/05; 2:24:10 (Testimony of Dr. Heath); Tape 6; 5/02/05; 11:19:24 (Testimony of Dr. Dershwitz). After questioning about a crash cart began, Defendants produced an inventory of the items on the crash cart, which Defendants' own expert, Dr. Dershwitz, admitted would be insufficient to maintain life after the first two chemicals were injected. According to Dr. Dershwitz, the following medications would be essential: medications to increase blood pressure and contract the heart; insulin; neostigmine; and artificial ventilation. Tape 6; 11:19:24 (Testimony of Dr. Dershwitz). None of these medications are part of Defendants' crash cart. *Id*.

Defendants seem to see their obligation of maintaining life if a stay is entered prior to the injection of potassium chloride as a joke, stating that it is as likely as a plane crashing into the Kentucky State Penitentiary. Instead of having a medical professional trained in cardiac life support ready to render emergency first aid, they have delegated the life saving duties to a psychiatrist who has not treated patients in a relatively long time. Tape 2; 4/18/05; 10:21:30 (Testimony of Defendant Haeberlin); Tape 2: 4/18/05; 12:13:30 (Testimony of Dr. Haas).

Even worse, Defendants do not think addressing this issue is worth their time. Defendants objected to the entire line of questioning about whether they had adequate equipment or personnel on hand to render life saving treatment if a stay was obtained after the lethal injection began. Defendants' reasoning was that the likelihood of this occurring was so remote that it is as likely as a plane crashing into the Kentucky State Penitentiary during an execution. Tape 2; 4/18/05; 2:20:50 (Objection by defense counsel).

Although, "the grant of a stay of execution communicated to prison authorities after the lethal injection has been administered is not a likely event, it can happen," *In the Matter of Readoption with Amendments of Death Penalty Regulations*, 842 A.2d at 211, and has happened. Dr. Heath testified about two cases that he is aware of where this happened. Tape 4; 4/18/05; 4:02:36 (Testimony of Dr. Heath). Thus, as Defendants' recognized by adding a crash cart to its lethal injection protocol, "it is a foreseeable occurrence. And should it occur, there can be no justification for depriving that inmate a chance at life." *Id*. A matter of minutes may separate the state of being sedated, close to dead, and dead. Prompt medical attention is necessary to maintain life. Defendants not only are currently unwilling to allow a properly trained physician to perform life saving measures, but they also do not have the necessary equipment nearby for a physician to use in attempting to save a life.

Although Defendants have referred to Ralph Baze and Thomas Bowling as "animals" during this litigation, they remain human beings. If a stay is granted after the lethal injection process begins - - the condemned inmate has a constitutionally protected right to maintain life. Defendants' failure (and seeming refusal) to take reasonable steps to preserve a condemned inmate's life if stay is granted after the lethal injection process violates due process, fundamental fairness, and the basic respect for human dignity underlying the Eigth Amendment to the United States Constitution.

III. DEFENDANTS' DELIBERATE INDIFFERENCE TO THE RISK OF PAIN AND SUFFERING DURING AN EXECUTION, PARTICULARLY IN LIGHT OF AVAILABLE ALTERNATIVES AND PRECAUTIONS THAT LESSEN THE RISK OF PAIN AND SUFFERING, VIOLATES THE EIGHT AMENDMENT PROHIBITION OF CRUEL AND UNUSUAL PUNISHMENT.

"[D]eliberate indifference to serious medical needs of prisoners [also] constitutes the unnecessary and wanton infliction of pain, proscribed by the Eighth Amendment." *Gamble*, 429 U.S. 97, 104 (1976). "Deliberate indifference" means "the official was subjectively aware of the risk." *Farmer v. Brennan*, 511 U.S. 825, 828-29 (1994). Therefore, "[i]n order to state a cognizable claim, a [plaintiff] must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs," *Gamble*, 429 U.S. at 106, by establishing that "the official knows of and disregards an excessive risk to inmate health or safety." *Farmer*, 511 U.S. at 837. Defendants have been made aware of the unnecessary risk of pain and suffering caused by their execution protocols and the chemicals they use. Instead of dealing with the issue, Defendants chose to remain willfully blind - - making haphazard changes to the protocol that were based on attempts to avoid liability, rather than medical consultations. Tape 6; 5/2/05; 12:08:00 (Testimony of Defendant Rees).

As Commissioner of the Department of Corrections, Defendant Rees has oversight authority over how lethal injections are carried out in Kentucky. Defendant Rees also was involved in adopting the first lethal injection protocol in the country. Tape 2; 4/18/05; 3:08:40 (Testimony of Defendant Rees). No medical or scientific tests were conducted on the effects of these chemicals used individually or in combination. Tape 1; 4/18/05; 10:06:28 (Testimony of Prof. Deborah Denno). Defendant Rees was involved in drafting a chemical cocktail that was flawed – it referred to potassium chloride as a paralytic agent. Tape 2; 4/18/05; 3:07:40 (Testimony of Defendant Rees). Other states looked at the Oklahoma protocol, noticed that it

mentioned sodium thiopental, a paralytic agent, and potassium chloride, and blindly decided that they needed to use those three chemicals for lethal injections. Tape 1; 4/18/05; 10:10:49 (Testimony of Prof. Deborah Denno). Kentucky was no different.

In 1998, Warden Parker decided what chemicals to use for Kentucky lethal injections and what amount to administer. Tape 2; 4/18/05; 2:07:50 (Testimony of Phil Parker). He based his decision on what other states used, and believed that all other states used the same chemicals. *Id.* He never consulted an anesthesiologist or any other medical personnel to determine whether the chemicals he chose would serve its intended purpose, whether alternative chemicals existed, or even to find out if other chemicals existed that would pose less risk of pain and suffering. *Id.* Instead, he blindly chose sodium thiopental, pancuronium bromide, and potassium chloride, solely because Oklahoma did something like that twenty years earlier and other states did the same.

More than nine months ago, Defendants were put on notice that

- the chemicals they use in lethal injections are problematic;
- that other states use different chemicals;
- that a person could be paralyzed but consciously feeling the pain of the lethal injection chemicals;
- that life can be maintained after the first two chemicals have been administered;
- and that there are ways to monitor for conscious paralysis and to lessen the risk that conscious paralysis would occur.

See Complaint and Memorandum of Law on Lethal Injection. Defendants could have looked into these issues, conducted research, and taken steps to lessen the risk of pain and suffering

caused by their execution procedures and chemicals. Instead, they chose to be deliberately indifferent to the risk and to remain willfully blind of any information unfavorable to their cause.

As discussed earlier, Defendants Rees and Haeberlin made changes to Kentucky's lethal injection procedure during the litigation without consulting any medical personnel familiar with the effects of the lethal injection chemicals or inserting I.V.'s. Tape 2; 4/18/05; 3:11:55 (Testimony of Defendant Rees); Tape 3; 4/19/05; 10:02:20 (Testimony of Defendant Haeberlin). Yet, the changes never addressed the concerns mentioned above. Further, since 27 other states use the same chemicals during lethal injections, Defendants saw no reason to learn why sodium, thiopental, pancuronium bromide, and potassium chloride, are used in lethal injections. Tape 2; 4/18/05; 3:13:30 (Testimony of Defendant Rees); Tape 2; 4/18/05; 10:35:40 (Testimony of Defendant Haeberlin). This was despite Defendants being informed during this lawsuit that New Jersey does not use a paralytic agent. *See Motion for Temporary Injunction*. Defendants chose not to look at New Jersey's lethal injection protocol, and then testified at trial that they were not aware that New Jersey does not use a paralytic agent. *Id*. Defendants' failure to consider using other chemicals after being informed that alternative chemical combinations that pose less risk of pain and suffering may exist constitutes deliberate indifference in violation of the Eighth Amendment.

The failure to consider alternative chemicals is not the only instance of Defendants' deliberate indifference to the issues raised in this lawsuit. Defendants' gave a psychiatrist the duty to perform life saving medical treatment if a last minute stay of execution is granted. Having a psychiatrist perform that function - - rather than a medical professional trained in cardiac life support and the use of a crash cart - - constitutes deliberate indifference towards the medical needs of the condemned inmate, and a lack of concern for the gravity of the situation.

Finally, through this lawsuit, Defendants were made aware of the possibility of conscious paralysis during an execution. Their own expert testified that conscious paralysis is a "real problem." Tape 6; 5/02/05; 10:10:45 (Testimony of Dr. Dershwitz). Yet, neither of the two people in the execution chamber with the condemned inmate during an execution know how to monitor for conscious paralysis. Deputy Warden Richard Pershing testified that he has "no knowledge of anesthesia awareness." Tape 3; 4/19/05; 11:22:20. Defendant Haeberlin testified that he "doesn't know what to look for to see if person is consciously paralyzed." Tape 3; 4/19/05; 10:13:00. Defendant Haeberlin's failure to find out how to monitor for conscious paralysis and to attempt to implement techniques and/or equipment for monitoring evinces Defendants' deliberate indifference towards the risk of pain and suffering during an execution.

IV. THE FAILURE TO PROVIDE A CONTINUOUS ADMINISTRATION OF THE LETHAL INJECTION CHEMICALS VIOLATES K.R.S. 431.220.

As alleged in Paragraphs 5 and 12 of Plaintiffs' Complaint for Declaratory Judgment, Defendants' current lethal injection procedure violates KRS § 431.220 because Kentucky's execution protocol does not conform with 431.220's requirement of a "continuous administration" of all the chemicals, particularly including the chemical intended to function as an anesthetic. Under § 431.220, "every death sentence shall be executed by continuous intravenous injection of a substance or combination of substances sufficient to cause death." Under this language, a lethal injection must consist either of a continuous injection of a single drug, or a continuous injection of a combination of chemicals sufficient to cause death, presumably in a manner also consistent with the state and federal Constitutions.

Kentucky's protocol complies with neither of the two acceptable statutory alternatives. Therefore, Plaintiffs are entitled to an order declaring that Kentucky's current protocol for lethal

injection violates KRS § 431.220, because sodium thiopental –along with the other chemicals—is not administered "continuously."

Proof at the hearing before this court has established that sodium thiopental is not administered continuously, but rather is administered in a single dose at the outset of the lethal injection process. This is plain from the protocol itself, and was confirmed by virtually every witness who spoke on the subject. After the sodium thiopental is injected, there are separate injections of saline solution, then pancuronium bromide, then saline solution, then potassium chloride, and, finally, saline solution (added to the protocol after the hearing by amendment in May 2005). The protocol does not direct the IV team to administer the chemicals "continuously." Instead, the protocol directs that the drugs be administered one at a time.

According to the proof at the hearing, sodium thiopental is an ultra-short acting anesthetic that starts wearing off immediately, creating an unacceptable risk that the condemned prisoner will awaken prior to death, to experience the agony of conscious paralysis and the searing pain of potassium chloride. Thus in addition to constituting a statutory violation of KRS 431.200's "continuous" requirement, the failure to administer the chemicals - - particularly sodium thiopental-- continuously also constitutes cruel and unusual punishment in violation of § 17 of the Kentucky Constitution and the 8th Amendment of the United States Constitution.

CONCLUSION AND REQUEST FOR RELIEF

The chemicals and procedures Defendants use for carrying out executions in Kentucky violate the prohibition of cruel and unusual punishment under section 17 of the Kentucky Constitution and the Eighth Amendment to the United States Constitution for any one of three reasons:

1) the chemicals and procedures cause a level of pain that is more than the Constitution tolerates;

2) the chemicals and procedures cause a risk of pain that is more than the Constitution tolerates; and,

3) the risk of pain and suffering caused by the chemicals and procedures is unnecessary because readily available alternatives exist that pose less risk of pain and suffering.

Thus, Plaintiffs respectfully request that this Court hold that the chemicals Defendants use in Kentucky lethal injections and the procedures (or lack thereof) violate the cruel and unusual punishment clause. Specifically, Plaintiffs request that this Court issue a declaratory judgment that Defendants' lethal injection procedures violate the cruel and unusual punishment because they:

1) use pancuronium bromide during an execution;

2) use potassium chloride during an execution;

3) fail to administer an analgesic;

4) use an ultrashort acting barbiturate;

5) fail to ensure that they are delivering an adequate concentration of thiopental to the condemned inmate;

6) fail to specify the concentration of thiopental being administered;

7) may insert a needle into a condemned inmate's neck;

8) will spend up to 60 minutes attempting to insert an I.V.;

9) fail to monitor for anesthesia awareness before the pancuronium bromide is administered;

10) fail to monitor for anesthesia awareness after pancuronium bromide is administered;

11) do not have on hand the proper equipment for monitoring for anesthesia awareness;

12) do not have the proper equipment to maintain life if a stay of execution is granted after the first or second chemical has been administered; and,

13) leave the responsibility for maintaining life after a stay of execution is granted to a psychiatrist.

Plaintiffs also request a declaratory judgment because Defendants are violating K.R.S. 431.220 by not providing a continuous administration of the lethal injection chemicals, and because Defendants are deliberately indifferent to the risk of pain and suffering during a lethal injection.

RESPECTFULLY SUBMITTED,

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DAVID M. BARRON
Assistant Public Advocate
Department of Public Advocacy
100 Fair Oaks Lane, Suite 301
Frankfort, Kentucky 40601
502-564-3948 (office)
502-564-3949 (fax)

_____

SUSAN J. BALLIET
Assistant Public Advocate
Department of Public Advocacy
100 Fair Oaks Lane, Suite 301
Frankfort, Kentucky 40601
502-564-3948 (office)
502-564-3949 (fax)

_____

THEODORE S. SHOUSE
Assistant Public Advocate
Department of Public Advocacy
207 Parker Drive, Suite 1
LaGrange, Kentucky 40031
502-222-6682

May 20, 2005.

CERTIFICATE OF SERVICE

I hereby certify that on this date, I caused the original of *PLAINTIFFS' POST-TRIAL BRIEF* to be hand delivered to Franklin Circuit Court Clerk this 20th day of May, 2005. I caused a true and correct copy of the foregoing *PLAINTIFFS' POST-TRIAL BRIEF*, to be served VIA FIRST CLASS MAIL, POSTAGE PREPAID, on the following individuals:

Hon. Jeff Middendorf
General Counsel
Department of Corrections
2439 Lawrenceburg Road
P. O. Box 2400
Frankfort, Kentucky 40602

Hon. Brian Judy
Hon. David Smith
Assistant Attorney Generals
1024 Capital Center Drive
Frankfort, Kentucky 40601

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COUNSEL FOR PLAINTIFFS

May 20, 2005.