IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION

NO. 5:06-CT-3018-H

WILLIE BROWN, JR., N.C. DOC #0052205,

Plaintiff,

v.

THEODIS BECK, Secretary, North Carolina Department of Correction, and MARVIN POLK, Warden, Central Prison, Raleigh, North Carolina, and UNKNOWN EXECUTIONERS, Individually, and in their Official Capacities,

Defendants.

REPLY IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Local Civil Rule 7.1(f)(1)

Plaintiff Willie Brown, Jr., N.C. DOC #0052205, (hereinafter "Plaintiff"), through counsel and pursuant to Local Civil Rule 7.1(f), hereby submits this memorandum in reply to Defendants' Opposition to Plaintiff's Motion for Preliminary Injunction.

STATEMENT OF THE CASE

This matter is before the Court on Plaintiff's Amended Complaint filed 8 March 2006. Plaintiff filed this action pursuant to 42 U.S.C. § 1983, challenging the protocol and procedures Defendants intend to employ to carry out Plaintiff's execution by lethal injection. Specifically, Plaintiff alleges that Defendants are determined to use an inadequate protocol for anesthesia as a precursor to carrying out his death sentence, and as a result, Plaintiff faces an unacceptable and unnecessary risk of suffering excruciating pain during the course of his execution in violation of his right to be free from cruel and unusual punishment under the Eighth and Fourteenth

Amendments of the United States Constitution. Plaintiff makes no attack on his conviction or the validity of his sentence to death by lethal injection.

On 28 February 2006, Plaintiff filed in this Court a Motion for Preliminary Injunction and accompanying Memorandum of Law. In this Motion, Plaintiff seeks narrowly drawn equitable relief to prevent Defendants from carrying out his execution using their intended inadequate protocol for inducing and maintaining anesthesia, pending resolution of the merits of his claims under Section 1983. On 20 March 2006, Defendants filed their Memorandum in Opposition to Plaintiff's Motion for Preliminary Injunction.

ARGUMENT

I. PLAINTIFF'S EVIDENCE IN SUPPORT OF PRELIMINARY INJUNCTION DEMONSTRATES A SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS.

In his Motion for Preliminary Injunction and accompanying Memorandum of Law, Plaintiff has presented substantial evidence in support of his request that Defendants be preliminarily enjoined from carrying out his execution using their intended, inadequate protocol for inducing, maintaining, and monitoring anesthesia, to allow fuller development of the record through discovery and trial on the merits of Plaintiff's claim. This evidence includes the affidavits of Plaintiff's expert anesthesiologists, Mark J. S. Heath, M.D. and. Philip G. Boysen, M.D.; Ms. Nancy Bruton-Maree, CRNA; and Kevin Concannon, D.V.M. Plaintiff's experts have explained that Defendants' lethal injection protocol involves the injection of two drugs, pancuronium bromide and potassium chloride, known to cause excruciating pain. As a result, there is a heightened need for anesthesia to be properly induced and monitored by trained and experienced practitioners. Plaintiff's evidence further demonstrates that Defendants' current protocol calls for administration of anesthesia in the absence of medical personnel credentialed,

licensed, and proficient in the practice of anesthesia, without medically appropriate criteria for assessing level of consciousness, and without opportunities for direct monitoring of the inmate. These conditions create a serious risk that anesthesia will not be appropriately administered and that Plaintiff will consciously suffer excruciating pain during the course of his execution in violation of his Eighth Amendment rights.

The evidence offered in support of Plaintiff's Motion for Preliminary Injunction, including that set forth below, demonstrates that Plaintiff will suffer immediate and irreparable harm if Defendants are permitted to proceed with his scheduled execution using their current inadequate protocol for anesthesia. There can be no question that the excruciating pain that Plaintiff will suffer during his execution constitutes irreparable harm. *See Jolly v. Coughlin*, 76 F.3d 468, 482 (2d Cir. 1996). Moreover, because Plaintiff's Amended Complaint alleges a violation of constitutional rights under 42 U.S.C. § 1983, "the showing necessary to meet the irreparable harm requirement for a preliminary injunction should be less strict than in other instances where future monetary remedies are available." *Rum Creek Coal Sales, Inc. v. Caperton*, 926 F.2d 353, 362 (4th Cir. 1991). In contrast, entry of a preliminary injunction will result in only minimal harm to Defendants, because there is no fear of the State's judgment being avoided or denied; in fact, Plaintiff does not seek such relief. On balance, the greater hardship would be suffered by Plaintiff, who will otherwise die on 21 April 2006 without the opportunity to engage in discovery or litigate his constitutional claims, rather than by Defendants, who remain able to execute Plaintiff in an constitutionally permissible fashion.

In their response opposing preliminary injunction, Defendants have relied upon the affidavits of Warden Polk and Dr. Dershwitz to counter Plaintiff's showing of irreparable harm and likelihood of success on the merits. However, much of the evidence offered by Defendants

in these affidavits fails to rebut, or even respond to, the evidence offered by Plaintiff. For instance, Warden Polk claims in his affidavit that "all medical acts" involved in the lethal injection protocol are carried out by individuals with the skills required of emergency medical technicians, registered nurses, or medical doctors. (Polk Aff. ¶ 10.) Neither this statement, nor any other part of his Affidavit addresses whether the personnel responsible for inducing, maintaining, and monitoring anesthesia are appropriately trained and qualified *in the practice of anesthesia.* Warden Polk does not rebut the evidence offered by Plaintiff demonstrating that the administration of anesthesia is complex and risky and requires advanced medical expertise beyond that of a registered nurse, EMT, or non-anesthesiologist physician. (Heath Aff. ¶¶ 32-33; Maree Aff. ¶ 2; Concannon Aff. ¶ 7.)[1]

As another example, Dr. Dershwitz describes in some detail in his Affidavit the expected reaction of a patient upon receiving a 3000 mg dose of sodium pentothal. (Dershwitz Aff. ¶¶ 7-15.) However, Plaintiff has previously acknowledged that 3000 mg is a sufficient dosage to render an inmate unconscious *if this dose is actually administered into circulation.* (Pl.'s Mem. at 10.) Thus, Dr. Dershwitz's testimony fails to respond to the crux of Plaintiff's Amended Complaint, which is that deficiencies in Defendants' anesthesia protocol create an unnecessary and unacceptable risk that the sodium pentothal will not be properly administered, meaning that the full dosage of anesthetic will not reach the inmate prior to administration of the paralyzing pancuronium bromide and painful potassium chloride injections.

To the extent Defendants' evidence in opposition does respond to the showing made by Plaintiff, it is clear that the experts for Plaintiff and Defendant differ on a number of significant points, including the adequacy of the anesthesia protocol used by Defendants, the risks

[1] The Affidavits of Dr. Mark J. S. Heath, Dr. Kevin Concannon, and Nancy Bruton-Maree, are attached as Exhibits F, H, and I, respectively, to Plaintiff's Memorandum in Support of Motion for Preliminary Injunction.

associated with those protocols, the standards of care applicable to administration of anesthesia in advance of a medical procedure known to be agonizing, and the availability of alternative procedures for inducing and monitoring anesthesia. Given the magnitude of the harm that will be suffered by Plaintiff, these disputes of material fact surrounding Defendants' anesthesia protocol "raise[ ] questions going to the merits so serious, substantial, difficult and doubtful, as to make them fair ground for litigation and thus for more deliberate investigation." *Rum Creek Coal Sales, Inc. v. Caperton*, 926 F.2d 353, 359 (4th Cir. 1991); *see also Blackwelder Furn. Co. v. Seileg Mfg. Co.*, 550 F.2d 189, 194-95 (4th Cir. 1977) ("[W]here serious issues are before the court, it is a sound idea to maintain the status quo ante litem.")

Based on the evidence offered by Plaintiff in support of preliminary injunction, without the benefit of full fact discovery or any expert discovery, a trier of fact could resolve each of the disputed questions listed above in Plaintiff's favor and ultimately conclude that Defendants' protocol for anesthesia creates an unacceptable and unnecessary risk of conscious suffering in violation of Plaintiff's Eighth Amendment rights. Plaintiff has therefore met the less onerous burden of demonstrating likelihood of success on the merits so as to warrant a preliminary injunction pending the resolution of this litigation.

In further reply to Defendants' Opposition to Plaintiff's Motion for Preliminary Injunction, Plaintiff offers the following response to specific points raised in the affidavits of Warden Polk and Dr. Dershwitz:

A. Defendants' Protocol Fails to Ensure that the Personnel Responsible for Anesthesia are Appropriately Trained and Qualified.

In his Affidavit, Warden Polk describes the current North Carolina lethal injection process, including the personnel responsible for performing various functions in connection with the execution. He states that the persons injecting the chemicals are under observation of

"qualified, licensed medical professionals."[2] (Polk Aff. ¶ 10.) However, Warden Polk does not represent that *any* of the personnel participating in executions are credentialed, licensed, and proficient in the field of anesthesiology. The record before this Court demonstrates that the individuals responsible for administering the injections, including the sodium pentothal used to induce anesthesia, possess no medical expertise whatsoever. (Polk Dep. at 103, Exhibit A to Errata Sheet at 3.) Moreover, the Warden's statement that persons performing "medical acts" are trained as registered nurses or EMTs only confirms the information contained in licensing documents submitted by Plaintiff in support of his Motion for Preliminary Injunction. (Pl.'s Mem., Exhibit E.) Defendants' own evidence confirms that there is no requirement that the individuals who are responsible for the provision of general anesthesia possess any training in the field of anesthesiology. Warden Polk also acknowledges that the "NCDOC conducts no specialized, technical training for the medical professional members of the execution team." (Polk Aff. ¶ 10.)

Plaintiff's expert evidence demonstrates that the individuals employed by Defendants lack the advanced training necessary to properly administer anesthesia and monitor consciousness. Dr. Heath has identified numerous foreseeable issues that may arising during the administration of anesthesia and has testified that anesthesia "can only be safely performed by individuals who have completed the extensive requisite training to permit them to provide anesthesia services." (Heath Aff. ¶¶ 30, 32.) Moreover, only persons trained in anesthesia are able to properly assess whether the inmate has attained the degree of unconsciousness necessary to render him insensitive to pain. (*Id.* ¶¶ 33-35.) For this reason, in North Carolina and

[2] Warden Polk's Affidavit also explains that "appropriately qualified personnel" are responsible for preparing the syringes containing each of the chemicals used during the execution and inserting intravenous catheters into the inmate's veins. (Polk Aff. ¶¶ 6(b), (c).) However, labeling these individuals as "appropriately qualified" provides no information regarding their medical training or experience in the field of anesthesia, which is the issue raised by Plaintiff's Amended Complaint.

elsewhere, physicians and nurses who have not completed the requisite training to become anesthesiologists or CRNAs are not permitted to provide general anesthesia. (*Id.* ¶ 33.)

Additionally, Warden Polk states that the personnel injecting the chemicals "are under observation of qualified, licensed medical professionals." (Polk Aff. ¶ 10.) To the extent that this statement refers to the registered nurses and EMTs discussed above, oversight by persons lacking training and expertise in anesthesiology does not suffice to bring Defendants' protocol into compliance with accepted medical standards. To the extent that the Warden is referring to the physician located in the small observation room directly adjacent to the death chamber, (Polk Dep. at 113-14), Plaintiff's evidence demonstrates that such observation is not possible. According to Ms. Bruton-Maree, who toured the execution facilities, an individual located in the observation room "can see at best only the head of the inmate and cannot see the inmate's right arm or the lines and other equipment administering the IV fluids." (Maree Aff. ¶ 10.) A curtain separating the inmate from the executioners within the execution chamber prevents anyone outside the chamber from observing the personnel administering injections. (*See* Polk Dep. at 81-82; Beck Dep. at 19-20; Diagram[3] (attached hereto as Exhibit A).)

In his Affidavit, Dr. Dershwitz takes the position that qualified personnel with training in anesthesiology "are not required to participate in a judicial execution because the 3000-mg dose of thiopental sodium reliably produces unconsciousness for a period far in excess of that required to complete the administration of pancuronium and potassium chloride." (Dershwitz Aff. ¶ 29.) He also opines that, "[s]ince such a large overdose of thiopental sodium is used in a judicial execution in North Carolina, there is no need to have an expert clinician monitoring the depth of anesthesia." (*Id.* ¶ 19.) These conclusions are apparently based upon Dr. Dershwitz's

[3] This diagram of the execution area, which is not to scale, was marked as Exhibit 7 to the depositions of Warden Polk and Secretary Beck in *Page v. Beck*, No. 5:04-CT-4-BO.

"pharmacokinetic analysis," which predicts the effect administration of 3000 mg of sodium pentothal would have on an average man. (Dershwitz Aff. ¶¶ 8-15.) However, such predictions depend entirely upon Dr. Dershwitz's assumption that the dosage of sodium pentothal will be successfully administered into the inmate's circulation. According to Dr. Heath, "Dr. Dershwitz misses the point, which is not that the specified quantity of thiopental is inadequate, but rather that there has been a failure to take all reasonable and easily taken steps to reasonably ensure that the full intended dose of thiopental will in fact be delivered into the prisoner's circulation." (Second Heath Aff. ¶ 5.)

Dr. Dershwitz's assumption that an adequate dose of anesthetic will be administered fails to respond to Plaintiff's evidence that deficiencies in the Defendants' anesthesia protocol — including the absence of personnel with appropriate training in anesthesia, the lack of medically appropriate standards for administering anesthesia or assessing consciousness, and barriers to direct monitoring of the inmate — create an unnecessary and unacceptable danger that the full dosage will not be delivered into circulation, and therefore, the inmate will not be rendered fully unconscious prior to administration of the painful lethal chemicals. Indeed, while Dr. Dershwitz asserts that the participation of qualified personnel is unnecessary because such a large dose is administered, the absence of personnel credentialed, licensed, and proficient in the practice of anesthesia significantly increases the likelihood that the full dosage will not be properly administered. As Dr. Heath explains, "Dr. Dershwitz's Affidavit does not address the probability of error in the administration of thiopental sodium during the execution process, nor does he address the reality that such errors are more likely to occur in the hands of personnel who are not credentialed, licensed, and proficient in the underlying knowledge, skills, and

procedures upon which establishment of an appropriate plane of anesthesia throughout the lethal injection process is founded." (Second Heath Aff. ¶ 7.)

Though the intended outcome of a judicial execution is the death of the inmate, this does not diminish the importance of ensuring that the inmate is fully unconscious and unable to experience pain during the execution process. According to Dr. Concannon, in a veterinary setting, "[t]he fact that a euthanized animal will not ultimately emerge from anesthesia does not lessen the importance of minimizing physical pain and mental distress to the patient. This remains my primary objective when euthanizing an animal." (Second Concannon Aff. ¶ 10.) Indeed, the Defendants' stated reason for administering sodium pentothal is to "quickly render[ ] the inmate unconscious." (Dershwitz Aff. ¶ 5(a)(ii); *see also* Polk Aff. ¶ 6(a)(ii).) Plaintiff's evidence demonstrates that the failure to require that anesthesia be administered and monitored by medical personnel who are credentialed, licensed, and proficient in the practice of anesthesia creates an unacceptable and wholly unnecessary risk that the inmate will not be adequately anesthetized. As Dr. Heath has explained, a surgeon would not begin a medical procedure without first confirming with the anesthesiologist that an adequate plane of anesthesia has been established. (Second Heath Aff. ¶ 9.) "Likewise, before proceeding with the introduction of pancuronium bromide and potassium chloride in the lethal injection process, it is essential that properly credentialed and licensed personnel and proficient in anesthesia induce and assess an appropriate plane of anesthesia in the prisoner." (*Id.*)

Furthermore, Dr. Dershwitz's "pharmacokinetic analysis" and the conclusions he draws from these calculations are potentially inconsistent with toxicology data obtained from the Office of the Chief Medical Examiner ("OCME") for the four most recent executions conducted in North Carolina. Records indicate that blood samples were drawn at the prison before the

inmates' bodies were transported to the OCME, and that further samples were subsequently drawn hours later at the OCME. It appears that the blood samples were then delivered to an outside laboratory for toxicology testing to identify the amount of thiopental sodium in the samples. For instance, one of the blood samples for Mr. Perrie Dyon Simpson, who was executed on 20 January 2006, indicates that it was drawn eight minutes post-mortem. (*See* Simpson Toxicology Report (attached hereto as Exhibit E).) Records further indicate that samples were drawn from various locations on the body, including left and right side and subclavian and femoral vessels.

In the graphs attached to Dr. Dershwitz's affidavit, he predicts that, for a man of average size, the expected concentration of sodium pentothal in the blood after ten minutes would be approximately forty mcg/mL. (Dershwitz Aff., Exhibits B, C.) After twenty minutes, the expected concentration would be approximately thirty-three mcg/mL. The toxicology analysis for the four most recent North Carolina executions revealed the following data:

Inmate Name	**Execution Date**	**Source of Blood Sample**	**Thiopental Level**
Steven Van McHone	11 Nov. 2005	Left Femoral Vessel (drawn at Central Prison)	21 mg/L
		Left Femoral Vessel (drawn at OCME)	1.5 mg/L
Elias Syriani	18 Nov. 2005	Right Femoral Vessel (drawn at Central Prison)	12 mg/L
		Left Femoral Vessel (believed to have been drawn at OCME)	4.4 mg/L
		Left Subclavian Vessel (believed to have been drawn at OCME)	11 mg/L
Kenneth Boyd	2 Dec. 2005	Femoral Vessel (drawn at Central Prison)	29 mg/L
		Subclavian Vessel (believed to have been drawn at OCME)	11 mg/L
Perrie Dyon Simpson	20 Jan. 2006	Unknown (drawn at Central Prison)	42 mg/L

Right Subclavian Vessel (believed to have been drawn at OCME)	12 mg/L
Left Subclavian Vessel (believed to have been drawn at OCME)	8.7 mg/L

(McHone Toxicology Report (attached hereto as Exhibit B); Syriani Toxicology Report (attached hereto as Exhibit C); Boyd Toxicology Report (attached hereto as Exhibit D); Simpson Toxicology Report (attached hereto as Exhibit E).)

At this stage in the proceedings, without the opportunity to conduct factual discovery regarding the circumstances under which these blood samples were drawn, Plaintiff cannot definitively represent to this Court what conclusions, if any, can be drawn from these results regarding the quantity of sodium pentothal actually administered to these inmates and their level of consciousness at the time of execution. However, the wide variation among the results raises legitimate question as to whether the sodium pentothal is being properly administered under Defendants' protocol so that an adequate dosage reaches the inmate prior to execution. Moreover, it is troubling that only one of the four toxicology results from the samples drawn at Central Prison approaches Dr. Dershwitz's the level Dr. Dershwitz would expect after ten minutes, and only two approach the expected value after twenty minutes. (Dershwitz Aff., Exhibits B, C.) These results raise serious questions going to the merits of Plaintiff's claims and warrant further discovery and development during the course of this litigation.

B. Defendants' Protocol Lacks Adequate Standards for Administering Injections and Monitoring Consciousness.

Defendants have presented conflicting information regarding the criteria applied by execution personnel to assess consciousness prior to administering pancuronium bromide and potassium chloride injections, raising serious questions as to what, if any, standards are being used to ensure that an inmate is adequately anesthetized and unable to feel pain. Indeed, Warden

Polk has offered a number of different explanations as to how he knows that an inmate is sufficiently anesthetized following injection of sodium pentothal so that pancuronium bromide may be administered.

During his deposition in *Page v. Beck*, No. 5:04-CT-4-BO, on 31 August 2005, Warden Polk specifically stated that the fact that an inmate begins to snore satisfies him that an adequate plane of anesthesia has been achieved:

> Q: Now how is it that you ensure or that you know the inmate is at that level of unconsciousness at the time you administer the Pavulon?
>
> A: At the time that we administer Pavulon, the inmate is snoring deeply. It is obvious that he's asleep and unaware.
>
> Q: So is that how you tell in every case that he has arrived at the proper level of unconsciousness?
>
> A: In 24 executions I have never seen one that did not snore.

(Polk Dep. at 39.) This testimony would seem to indicate that snoring continues for sufficient period of time to be characterized as "deep" and, during the course of this snoring, executioners proceed with the injection of the paralytic agent, pancuronium bromide. In fact, when he reviewed and signed his deposition on 24 October 2004, Warden Polk corrected the transcript to reflect that, when an inmate "ceased being able to count and *started* snoring, that was certain evidence that he was unconscious and unaware." (*Compare* Polk Dep., p. 40 *with* Errata Sheet, Exhibit A at p. 1.)

Yet, in his affidavit dated 20 March 2006, Warden Polk states that "each succeeding chemical solution [is] introduced within a few seconds after the injection of the immediately preceding chemical is completed." (Polk Aff. ¶ 6(d).) This description of the execution procedure suggests that the injections are given one immediately after the other, without any period of delay between injections and without any attempt by members of the execution team to

assess the inmate's plane of anesthesia to ensure unconsciousness before the paralyzing pancuronium bromide and painful potassium chloride injections are administered.

Finally, in response to statements by Plaintiff's experts regarding the inappropriateness of snoring as in indicator of consciousness, Warden Polk has offered a third explanation. He now insists that the snoring begins and ends within the short time it takes to administer the injection of sodium pentothal. (*Id.* ¶ 9.) This statement differs significantly from the Warden's prior deposition testimony and suggests that the cessation of snoring indicates to the Warden that the inmate is sufficiently unconscious to permit the executioners to proceed with the injections of pancuronium bromide and potassium chloride.

The variation in the Warden's testimony raises significant questions as to whether the Defendants' protocol includes *any* criteria for assessing consciousness after administration of anesthesia. Moreover, even if some efforts are made to monitor consciousness before administration of painful chemicals, Plaintiff's evidence suggests that the criteria relied upon are medically inappropriate.

The Warden's statement that no period of delay is observed under Defendants' protocol is particularly troubling in light of Dr. Dershwitz's assertion "that the dose of thiopental sodium used by North Carolina would render most people unconscious *within 60 seconds* from the time of the start of administration." (Dershwitz Aff. ¶ 10) (emphasis added). There is no indication that Defendants' protocol allows even one minute for the anesthetic to fully circulate through the body and take full effect before proceeding with the next injection. Defendants have offered no explanation for their failure to include in their protocol any period of delay to permit assessment of the inmate's the level of anesthesia and to ensure that the inmate is, in fact, unconscious.

In the event that snoring is used as a criterion for assessing consciousness, as Warden Polk asserts, this reflects some recognition that monitoring the level of anesthesia is a necessary component of a humane execution. Nevertheless, Defendants have made no efforts to ensure that this monitoring is performed by appropriately qualified personnel and pursuant to medically appropriate criteria. Although Dr. Dershwitz asserts in his affidavit that "[p]atients frequently snore following loss of consciousness," Dr. Heath has stated that "administration of a large anesthetic dose of thiopental would be associated with at most a couple of cycles of respiratory activity, such as a hiccup, cough, gasp, snore, snort, yawn, or sigh. Persistent snoring is utterly incompatible with the successful delivery of many grams of thiopental into the circulation." (Second Heath Aff. ¶ 16.) Ms. Maree agrees that, "when a dose of 3000 mg of thiopental sodium is administered a patient should progress rapidly from loss of consciousness to apnea (stopped breathing). Persistent snoring is not consistent with this progression." (Second Maree Aff. ¶ 9.) A finder of fact could thus conclude that Defendants' protocol either lacks standards for assessing consciousness and ensuring an appropriate plane of anesthesia or relies upon wholly inappropriate criteria in making this assessment.

Among the numerous deficiencies raised in the Motion for Preliminary Injunction and accompanying Memorandum, Plaintiff has offered evidence that the "site of insertion of the intravenous catheter is not under direct vision" and "the intravenous line connecting the syringe and drug source to the prisoner is longer than what would be used in clinical medicine." (Boysen Aff. ¶ 5.)[4] Defendants have argued that, "[while] this is generally a true statement," in some instances the use of longer intravenous lines would be appropriate in a clinical setting, as when general anesthetic is administered to patients undergoing MRI testing. (Dershwitz Aff. ¶ 30.)

[4] The affidavit of Dr. Philip G. Boysen is attached as Exhibit G to Plaintiff's Memorandum in Support of Motion for Preliminary Injunction.

However, Dr. Heath explains that Dr. Dershwitz's invocation of the MRI environment is "misleading and inapplicable" for two reasons:

> First, the situation of the MRI is an exigent circumstance in which the strength of the magnet often requires the anesthesiologist to monitor the patient from an adjacent room. However, one would never gratuitously provide anesthesia from a removed location; the steps required by the MRI are only taken because there is no alternative. Second, as Dr. Dershwitz is aware, one virtually never induces anesthesia from the observation room in an MRI suite. Instead, anesthesiologists induce anesthesia while standing directly next to the patient using a short IV line, and only withdraw to the observation area once the desired level of anesthetic depth is demonstrably obtained.

(Second Heath Aff. ¶ 15.) Similarly, Ms. Maree has explained that, "[w]hen anesthesia is induced in a conscious MRI patient, it is standard medical practice for the anesthesia provider to induce anesthesia at the patient's side prior to beginning the MRI." (Second Maree Aff. ¶ 4.)

Defendants' failure to ensure proper administration of anesthesia in accordance with medically accepted standards of practice is particularly alarming given their insistence on including potassium chloride in their lethal injection protocol to effectuate death by "interrupt[ing] nerve impulses to the heart causing the heart to stop beating." (Polk Aff. ¶ 6(a)(v).) There is no statutory requirement that potassium chloride be administered, N.C. Gen. Stat. §§ 15-187, 15-188, and the stated objective behind the addition of this chemical is "to make the execution by lethal injection more humane for the condemned death row inmate." (State's Emergency Petition for Writs of Certiorari and Prohibition and Motion to Vacate Stay of Execution, *State v. Hunt*, No. 5A86-10, at 7.)[5] Defendants do not dispute that administration of potassium chloride in the absence of adequate anesthesia would be horrifically painful, as this

[5] A copy of the State's Petition in *State v. Hunt*, No. 5A86-10, is attached as Exhibit B to Plaintiff's Memorandum in Support of Motion for Preliminary Injunction.

chemical activates sensory nerve fibers in the veins that are highly sensitive to potassium ions. (Heath Aff. ¶ 15.)

Plaintiff has offered the expert opinion of Dr. Heath that "Defendants' selection of potassium chloride to cause cardiac arrest needlessly increases the risk that an inmate will experience excruciating pain prior to execution. There exist, however, alternative chemicals that do not activate the nerves in the vessel walls of the veins in the way that potassium chloride does." (*Id.*) In response, Dr. Dershwitz has argued that "no available medication will stop electrical activity in the heart as rapidly as does potassium chloride." (Dershwitz Aff. ¶ 20.) This statement suggests that Defendants believe it is appropriate to sacrifice humaneness for speed in developing an anesthesia protocol. However, the Eighth Amendment prohibits the unnecessary infliction of pain and does not permit Defendants to disregard a conscious risk of suffering in order that the execution may proceed more quickly. *See Gregg v. Georgia*, 428 U.S. 153, 173 (1976). Furthermore, according to Dr. Heath, "there are multiple medications and substances that, when successfully administered in sufficient dose, will stop the heart extremely rapidly. Even if it were true that these medications would take longer to stop electrical activity than potassium chloride, the difference would not be material." (Second Heath Aff. ¶ 10.)

C. Defendants Fail to Make Adequate Efforts to Identify and Address Foreseeable Problems During Execution.

Notwithstanding Dr. Dershwitz's contention that anesthesia may be blindly administered and assumed to be effective, Defendants' Memorandum includes a discussion of "steps taken to reduce the possibility of mishap during the execution." (Defs.' Resp. at 16.) However, the only specific action mentioned by Defendants is the stationing of an officer in the witness room to observe the inmate. (Polk Aff. ¶ 18.) According to the Warden, this officer observes the inmate

from the other side of the viewing window during the execution, "paying particular attention to the sheet covering the condemned prisoner's body and noting the development, if any, of any areas of discoloration or wetness" that would indicate displacement or leaking of the intravenous line. (*Id.*)

According to Plaintiff's experts, watching for wetness on the sheet is not a medically acceptable way to determine whether there has been a failure of the intravenous lines that so as to prevent the full dosage of sodium pentothal not reaching the inmate's body. Based on her inspection of the witness room outside the death chamber, Ms. Maree states that "it is not clear that the senior correctional officer would have a full view of the prisoner's left arm. In any event Warden Polk admits that the senior correctional officer cannot see the IV sites on the prisoner because a sheet covers them." (Second Maree Aff. ¶ 6.) Defendants' attempt to identify problems in drug administration by observing the sheet is also misguided and inappropriate because infiltration of solution would not necessarily produce any visible change in the appearance of the sheet. According to Ms. Maree:

> Infiltration of solution into tissue is not a dramatic eruption. In my experience, infiltrated IVs rarely leak out of the skin. More often, all that is present with infiltration is swelling of the tissue. Even if the IV did leak above the skin, the IV solution may run down toward the gurney and may not make the sheet covering the prisoner wet.

(Second Maree Aff. ¶ 6.)

Furthermore, there is no indication that the person charged with monitoring the intravenous lines has any medical training or expertise of any kind. Rather, Warden Polk describes this person as "a senior correctional officer." Dr. Heath has previously explained that "[a]ccepted medical practice . . . would dictate that *trained* personnel monitor the IV lines and the flow of anesthesia into the veins through visual and tactile observation and

examination." (Heath Aff. ¶ 38 (emphasis added).) Only an anesthesiologist or CRNA possesses the advanced training skills, experience, and credentials to perform this or any other aspect of the provision of anesthesia. (*Id.* ¶¶ 32-35.)

Dr. Dershwitz opines in his Affidavit that any problems in administration of sodium pentothal would be readily apparent because the inmate would be expected to cry out and complain about the pain being experienced. (Dershwitz Aff. ¶¶ 27, 40.) This opinion is directly contradicted by Plaintiff's evidence. According to Dr. Heath, "Dr. Dershwitz neglects the accepted reality that the administration of pancuronium bromide greatly hinders the assessment of anesthetic depth and confers a risk factor for intraoperative awareness." (Second Heath Aff. ¶ 12.) Dr. Dershwitz's opinion that an inmate who is capable of speaking out can be expected to do so if not properly anesthetized "neglects the real possibility that [the inmate] will be unable to do so if weakened by pancuronium bromide." (Second Heath Aff. ¶ 13.)

Disregarding the fact that pancuronium bromide would mask all physical indications of the excruciating pain being experienced by a conscious inmate, Dr. Dershwitz attempts to justify the use of this chemical because it serves to "prevent or decrease the intensity of . . . involuntary muscle movements" because such movements "could be misperceived by lay witnesses." (Dershwitz Aff. ¶ 22). Dr. Dershwitz's argument creates a situation in which concerns regarding the appearance of the execution are elevated over the humaneness of the protocol. (Second Heath Aff. ¶ 13.) This position is directly at odds with the position of the Ethics Committee of the American Society of Critical Care Physicians regarding the use of paralytic agents to prevent witnesses from seeing movement at the time of death. (*Id.*)

By placing an officer at the window to observe the intravenous lines, Defendants acknowledge that it is foreseeable that problems may arise during the administration of

anesthesia. However, they have offered no evidence to indicate how a problem, even assuming it is identified, would be addressed under Defendants' protocol. Warden Polk states that the officer would be able to communicate any problems by means of a direct telephone. (Polk Aff. ¶ 18.) Even if such communication could take place within sufficient time to prevent the experience of excruciating pain by the inmate, there is no evidence that any individual with the requisite training and expertise in anesthesiology is located within the execution facility and in a position to respond in to immediately respond to an emergency. In sum, "[t]he senior correctional officer's observation of the sheet covering the prisoner is not in keeping with the standard of care for intravenously inducing anesthesia." (Second Maree Aff. ¶ 6.)

D. Defendants' Observations Regarding Prior Executions and Protocols Utilized in Other States Do Not Diminish the Likelihood that Plaintiff Will Needless Suffer Excruciating Pain Under Defendants' Intended Protocol.

Warden Polk insists that, in the twenty-nine executions in which he has been involved, he has never observed or been informed that an inmate has cried out, complained, or otherwise indicated that he was suffering pain during the course of his execution. (Polk Aff. ¶ 17; *see also* Dershwitz Aff. ¶¶ 27, 28.) This is not at all surprising in light of the fact that Defendants' protocol calls for the injection of 40 mg of pancuronium bromide, a paralytic agent. Plaintiff's have specifically alleged and presented expert evidence demonstrating that the administration of pancuronium bromide would mask any signs of physical suffering being experienced by the inmate. (Boysen Aff. ¶ 9; Heath Aff. ¶ 21.) Indeed, it appears that the sole purpose for administrating this drug is to ensure that the execution appears peaceful and serene to observers. (*See* Heath Aff. ¶ 12 ("Pancuronium bromide is not an anesthetic or sedative drug, and it does not affect consciousness."); *see also* Boysen Aff. ¶ 9 ("There is no medical reason to infuse this drug").)

Dr. Heath has specifically explained that the fact that an inmate does not cry out or otherwise demonstrate physical signs of pain cannot be relied upon by observers as evidence of a peaceful and painless execution.

> [I]n a recent article the Robeson County, North Carolina, prosecutor was quoted noting that there was nothing to indicate any pain, specifically no grimacing, jerking or convulsing, during the execution of Henry Lee Hunt in 2003. However, this prosecutor would have observed very similar if not identical circumstances if Mr. Hunt had been administered only pancuronium bromide and potassium chloride without any sodium pentothal and had consciously suffered the agony of suffocation and the excruciating pain that follows injection of potassium chloride.

(Heath Aff. ¶ 21 (citing Paul Woolverton, *Execution Objections on Rise*, Fayetteville Observer, Feb. 26, 2006, *available at* http://www.fayettevillenc.com/article?id=227272).)

The Warden also maintains that he "is aware of no credible evidence that would cause [him] to believe that execution by lethal injection, as done in North Carolina, would cause the condemned prisoner to suffer pain during the execution." (Polk Aff. ¶ 22.) This statement completely ignores the affidavits submitted by Plaintiff describing horrifying displays of suffering during past executions. These affidavits, submitted by officers of the court who observed the executions of their clients, include reports of inmates "convulsing," "twitching and moving about," "relentlessly convuls[ing] and contort[ing]," and "gagg[ing] and chok[ing]." (Adcock Aff. ¶¶ 10, 14, 19; Wells Aff. ¶ 11; Stevens Aff. ¶ 5.)[6]

Although it is possible that the Warden has a different interpretation of the events described by these attorneys, these affidavits plainly constitute some "credible information" to suggest that inmates have suffered pain during their executions. Dr. Dershwitz has opined that any "writhing and convulsing" observed during prior executions can be explained away as

[6] The affidavits of Cynthia F. Adcock, Heather Wells, and Kim Stevens are attached as Exhibits J, K, and L, respectively, to Plaintiff's Memorandum in Support of Motion for Preliminary Injunction.

"involuntary muscle contractions." (Dershwitz Aff. ¶ 27.) However, according to Dr. Heath, "another very possible interpretation is that the prisoners were in distress or agony." (Second Heath Aff. ¶ 13); *see also Morales v. Hickman*, 2006 WL 335427, at *6 (N.D. Cal. Feb. 14, 2006)[7] (evaluating a similar explanation offered by Dr. Dershwitz and concluding that "[w]hile Dr. Dershwitz's explanation may be correct, evidence from eyewitnesses tending to show that many inmates continue to breathe long after they should have ceased to do so cannot simply be disregarded on its face."). At the very least, the affidavits offered by Plaintiff demonstrate that, contrary to what has been suggested in Warden Polk's Affidavit, the twenty-nine executions he has observed have not all been peaceful and serene events in which the condemned prisoner has quickly and quietly fallen asleep. (Polk Aff. ¶¶ 9, 22.)

Warden Polk and Dr. Dershwitz also base their conclusions regarding the effectiveness of Defendants' anesthesia protocol on the fact that the North Carolina execution protocol is "similar" to that used in approximately thirty-six other states, the federal government, and the United States Armed Forces. (Polk Aff. ¶¶ 6, 22; Dershwitz ¶¶ 5, 17.) While it may be the case that all of these jurisdictions use a combination of the same three chemicals (sodium pentothal, pancuronium bromide, and potassium chloride), Defendants have offered no information regarding the procedures for inducing, maintaining, and monitoring anesthesia to support their comparison. The gravamen of Plaintiff's Amended Complaint is that the protocols and procedures used by Defendants, including the qualifications of the personnel responsible for administering anesthesia, the criteria relied upon to assess the inmate's level of consciousness, and the ability of personnel to directly monitor the inmate, create an unacceptable risk that Plaintiff will needlessly suffer excruciating pain during his execution. The properties of the

[7] Pursuant to Local Civil Rule 7.2(d), a copy of this decision was attached as Exhibit D to Plaintiff's Memorandum in Support of Motion for Preliminary Injunction.

specific chemicals used by Defendants to effectuate death are relevant only insofar as they create an increased risk of conscious suffering necessitating a heightened degree of care in inducing and monitoring anesthesia. (Heath Aff. ¶ 35; Concannon Aff. ¶ 12.)

The Warden testified during his deposition that he does not know the procedures used by United States Government to carry out executions by lethal injection:

> Q: Do you know how the United States government provides with lethal injection execution?
>
> A: I understand that their protocol for the drugs is the one that we currently modified to. Now, how exactly they administer that, no, I don't.

(Polk Dep. at 38.) There is no information in Defendants' affidavits, depositions, or memoranda before this Court to suggest that North Carolina's protocol bears any similarity to that in other jurisdictions beyond the use of the tri-chemical combination. If fact, records indicate that protocols for administration and monitoring may vary dramatically. For example, in Tennessee, a camera is mounted immediately over the gurney allowed the executioner to "zoom in" and see catheters during the execution process. *Abdur'Rahman v. Bredesen*, 181 S.W.3d 292, 301 (Tenn. 2005). In California, all personnel are located outside the execution chamber and remotely inject the sequence of chemicals. *Morales v. Hickman*, No. 5:06-CV-00219-JF, (N.D. Cal. Feb. 21, 2006) (explaining that, according to defendants "having a person in the execution chamber is contrary to departmental policy"). Obviously, each of these arrangements would necessitate equipment and protocols different from those currently used by Defendants.

Moreover, in California, detailed logs are maintained during each execution documenting, *inter alia*, the time of administration of each chemical, the time the inmate ceases breathing, and the time of death. *See Morales v. Hickman*, 2006 WL 335427, at *5-6 (N.D. Cal. Feb. 14, 2006) (summarizing data contained in execution logs from recent executions). Warden

Polk has previously testified at deposition that no such records are kept for executions in North Carolina:

> Q: Now, going back to we've asked you about records and logs that are kept of executions, and I want to revisit that for just a minute. Do I understand you to say that so far as you know, no records are kept of what happens during an execution?
>
> A: What happens during an execution, no.
>
> Q: No records?
>
> A: No.

(Polk Dep. at 114.) Defendants' failure to comply with accepted medical practices by maintaining records regarding the administration of anesthesia or other phases of the execution is not the common practice in all jurisdictions. Because Defendants have offered no information regarding procedures used in other states so as to permit comparison by this Court, their claims of uniformity are not supported by record and do not rebut Plaintiff's evidence regarding the unacceptable likelihood of conscious suffering posed by Defendants' anesthesia protocol.

E. Defendants' Protocol Would Not Be Acceptable for Euthanizing Household Animals.

Unlike physicians, veterinarians have had the opportunity to develop a significant body of knowledge and expertise regarding humane methods of performing euthanasia. Veterinary guidelines demonstrate the existence of significant dangers inherent in Defendants' protocol. The American Veterinary Medical Association (AVMA) has previously indicated that the use of pancuronium is not acceptable for use in veterinary euthanasia. *See* 2000 Report of AVMA Panel on Euthanasia, *available at* http://www.avma.org/resources/euthanasia.pdf. According to Plaintiff's veterinary expert, Dr. Concannon, "using thiopental sodium in combination with pancuronium bromide increases concerns that a veterinary patient

could awaken during the euthanasia process but be unable to display the physical symptoms relied upon by trained veterinary personnel to identify the need for further anesthesia." (Concannon Aff. ¶ 15.)

In their Response, Defendants make much of the fact that an introductory statement has been added to the AVMA guidelines and, remarkably, suggest that Dr. Concannon's opinions should be disregarded because of this statement. (Defs.' Mem. at 26-27 n.6.) However, the addition of this introductory statement does not alter Dr. Concannon's opinions regarding the appropriateness neuromuscular agents, such as pancuronium bromide, in euthanasia protocols. (Second Concannon Aff. ¶ 4.) Specifically, the AVMA Report "does not list any neuromuscular blocking agent used any drug protocol deemed acceptable or conditionally acceptable" and Dr. Concannon is "unaware of any veterinarian or veterinary group that advocates the use of neuromuscular blocking agents during the euthanasia procedure." (*Id.* at 5.)

The AVMA disclaimer statement does not in any way amend or clarify the Report's cautions regarding the need for adequate anesthesia prior to administration of potassium chloride. According to the Report, "[i]t is of utmost importance that personnel performing this technique are trained and knowledgeable in anesthetic techniques, and are competent for assessing anesthetic depth appropriate for administration of potassium chloride intravenously." AVMA Panel Report, *available at* http://www.avma.org/resources/euthanasia.pdf; (*see also* Second Concannon Aff. ¶ 7.) Dr. Dershwitz's suggestion that the anesthesia need not be administered or monitored by medical professionals credentialed, licensed, and proficient in the practice of anesthesia (Dershwitz Aff. ¶¶ 19, 29) is completely contrary to standards of veterinary practice. As Dr. Heath explains:

> Dr. Dershwitz's statements directly contradict basic veterinary practice, which requires that when intravenous potassium is used to

> euthanize animals the practitioner be experienced in the assessment of anesthetic depth and take steps to ensure that a surgical plane of anesthesia is established prior to the administration of potassium chloride. Indeed, animal research policies in Dr. Dershwitz's own institution follow the AVMA guidelines for euthanasia. In essence, Dr. Dershwitz is opining here that prisoners in North Carolina should not receive the same protections afforded to experimental animals in Massachusetts.

(Second Heath Aff. ¶ 8.)

Most importantly, the new introductory statement to the AVMA has no bearing whatsoever on Dr. Concannon's opinion that humane euthanasia requires the participation of appropriately qualified and experienced personnel who are able to engage in direct monitoring of the patient. (Second Concannon Aff. ¶¶ 7-10.) Dr. Concannon continues to believe "to a reasonable degree of medical certainty that the execution protocol currently used in North Carolina would not be an acceptable method for euthanasia of animals." (*Id.* at 12.)

II. BASED ON THE EVIDENCE BEFORE THE COURT, PLAINTIFF HAS PRESENTED A MERITORIOUS CLAIM FOR DELIBERATE INDIFFERENCE TO A SERIOUS MEDICAL NEED.

Plaintiff has presented evidence from which a trier of fact could reasonably find that Defendants intend to employ an inadequate anesthesia protocol that will subject Plaintiff to an objectively serious risk of suffering excruciating pain, and that they are acting with deliberate indifference to the inadequacies of the anesthesia protocol and resulting risk of harm to Plaintiff. Because Plaintiff has raised serious questions going to the merits of both the objective and subjective prongs of the deliberate indifference analysis, entry of preliminary injunctive relief is appropriate in this case.

A. The Evidence Establishes that Defendants' Protocol Fails to Ensure that Anesthesia be Properly Administered, Creating an Objectively Serious Risk of Suffering.

All of the evidence outlined in Plaintiff's memoranda and affidavits demonstrates the existence of critical deficiencies in Defendants' anesthesia protocol such that this protocol cannot be relied upon to induce and maintain an adequate plane of anesthesia, thereby rendering execution under this protocol unconstitutionally cruel. In particular, Plaintiff has offered evidence, wholly unrebutted, tending to show that the nature of the chemicals used by Defendants to effectuate death creates a heightened need for proper anesthesia. Plaintiff has further shown that Defendants' anesthesia protocol is insufficient to meet this need because: (1) Defendants have failed to require personnel credentialed, licensed, and proficient in the practice of anesthesia to ensure proper administration and to monitor depth of anesthesia; (2) their protocol includes no criteria or, at best, inappropriate criteria for monitoring consciousness; (3) their protocol involves unnecessary barriers to direct monitoring of anesthesia; and (4) Defendants fail to appropriately account for foreseeable issues that may arise during the course of the execution.

In their Memorandum, Defendants submit that, notwithstanding the evidence summarized above, Plaintiff cannot establish the objective component of his Eighth Amendment claim because lethal injection is the predominant method of execution in the United States. (Defs.' Mem. at 37-40.) This argument fails to appreciate that understanding and application of the Eighth Amendment must be informed by "evolving standards of decency that mark the progress of a maturing society." *Trop v. Dulles*, 356 U.S. 86, 101 (1958); *see also Stanford v. Kentucky*, 492 U.S. 361, 369 (1975) (explaining that the Supreme Court has interpreted the Eighth Amendment "in a flexible and dynamic manner.").

Significantly, the Defendants cite two cases in support of the proposition that lethal injection is generally agreed to be a humane and acceptable method of execution. (Defs.' Mem. at 39.) These cases, *Hill v. Lockhart*, 791 F. Supp. 1388 (E.D. Ark. 1992), and *People v. Stewart*, 520 N.E.2d 348 (Ill. 1988), were decided fourteen and eighteen years prior to the filing of Plaintiff's Amended Complaint. During this time, a compelling body of medical, scientific, and legal evidence has been developed that raises serious questions about the humaneness of lethal injection as it is currently performed — in the absence of appropriately trained and qualified personnel and without adherence to medically accepted standards of care. *See, e.g.*, *Beardslee v. Woodford*, 395 F.3d 1064, 1075 (9th Cir. 2005) (finding accounts of recent California executions to be "extremely troubling" because they indicate "that there were problems associated with the administration of the chemicals that may have resulted in the prisoners being conscious during portions of the executions"); Atul Gawande, *When Law and Ethics Collide – Why Physician Participate in Executions*, 354 New Eng. J. Med.1221, 1228-29 (Mar. 23, 2006), *available at* http://content.nejm.org/cgi/reprint/354/12/1221.pdf ("There can be little doubt that lethal injection can be painless and peaceful, but as courts have recognized, this requires significant medical assistance and judgment – for placement of intravenous catheters, monitoring of consciousness, and adjustments in medication timing and dosage.").

These developments make clear that Defendants' anesthesia protocol cannot be deemed constitutional simply because lethal injection has been widely adopted or in use for a number of years. Indeed, North Carolina used electrocution as the means of execution from 1910 to 1938. North Carolina Department of Correction "History of Capital Punishment," *available at* http://www.doc.state.nc.us/dop/deathpenalty/DPhistory.htm. The State then switched to lethal gas for a period of nearly sixty years before adopting lethal injection as the sole method of

execution in 1998. *Id.*; *see also* N.C. Gen. Stat. §§ 15-187, 15-188. Thus, despite prior general acceptance of both electrocution and lethal gas, each of these methods was ultimately determined to be inhumane, as reflected by legislative trends in North Carolina and elsewhere.

Based on the evidence currently available to Defendants and to the Court, serious questions have been raised regarding the objectively serious risk of harm to Plaintiff posed by Defendants current inadequate anesthesia protocol. Defendants' reliance upon the prior general acceptance of lethal injection as a humane method of execution cannot defeat the showing made by Plaintiff regarding unacceptable and unnecessary risk that he will not be properly anesthetized and will consciously suffer excruciating pain during the course of his execution.

B. The Evidence Establishes That Defendants Are Acting With Deliberate Indifference to the Inadequacies of the Anesthesia Protocol and the Resulting Risk that Plaintiff Will Suffer Excruciating Pain.

With respect to the subjective prong of the deliberate indifference, Plaintiff has also demonstrated a sufficient likelihood of success on the merits to justify entry of a preliminary injunction. Specifically, the record includes evidence from which a trier of fact could conclude that Defendants have disregarded obvious deficiencies in their anesthesia protocol and the resulting, foreseeable risk that Plaintiff will remain conscious and suffer excruciating pain before his death.

The fact that Defendants' protocol calls for the administration of sodium pentothal for the stated purpose of "quickly put[ting] the inmate to sleep," (Polk Aff. ¶ 6(a)(ii)), shows that Defendants recognize that anesthesia is a necessary element of a humane execution protocol. Despite this awareness, Defendants have failed to adopt an anesthesia protocol that ensures that anesthesia will be properly administered, deviating significantly from accepted medical practices for inducing, maintaining, and monitoring anesthesia. Similarly, the testimony of Warden Polk makes clear that Defendants understand the need to monitor anesthesia in order to determine

whether an inmate is fully anesthetized prior to the administration of pancuronium bromide, which masks indicia of consciousness, or potassium chloride, which is excruciatingly painful upon injection. The Warden has stated that he relies on the fact that an inmate either begins to snore or ceases snoring following administration of sodium pentothal to indicate that an appropriate plane of anesthesia has been achieved. (Polk Dep. at 38-41; Polk Aff. ¶ 9.) Again, despite this recognition of the need for monitoring to ensure unconsciousness, Defendants have failed to establish appropriate criteria by which to assess consciousness, employ appropriately credentialed, licensed and proficient personnel, or to address significant barriers to direct monitoring of the inmate created by the current protocol.

In addition, Defendants have failed to conduct any independent investigation in the appropriate medical standards of practice for administering and monitoring anesthesia. In an effort to justify this failure, Defendants maintain that they are not required to accept the opinions offered by Plaintiff's experts instead of those of Dr. Dershwitz. (Defs.' Mem. at 40.) However, before deciding that they will adhere only to the opinions offered by Dr. Dershwitz, Defendants should be expected to ensure that the opinions of Dr. Dershwitz are consistent with accepted medical standards. There is no evidence that Defendants have ever undertaken to investigate Plaintiff's concerns that existing anesthesia protocols fail to ensure that the inmate receives the full dosage of sodium pentothal and is properly anesthetized prior to administration of pancuronium bromide and potassium chloride. In contrast, the warden in Tennessee convened a committee to develop that state's protocol, gathered information from a number of other states, and met with officials from the United States Bureau of Prisons and prisons in Texas and Indiana. *Abu-Ali Abdur'Rahman v. Bredesen*, 181 S.W.3d 292, 300 (Tenn. 2005).

Defendants also consciously disregard the objective risk of harm to Plaintiff by relying on the supposed uniformity of their lethal injection protocol with the protocols used by other states, the federal government, and the United States Armed Forces. (Polk Aff. ¶¶ 6, 22; Dershwitz ¶¶ 5, 17.) Such reliance is misplaced because Defendants have not demonstrated any familiarity with the specific procedures used to administer and monitor anesthesia in other jurisdictions. Moreover, Defendants have failed to adopt safeguards enacted in other jurisdictions to address foreseeable problems, such as those raised in Plaintiff's Amended Complaint. *See, e.g.,* Conn. Gen. Stat. § 54-100; Idaho Code § 19-2716; Kan. Crim. Pro. Code Ann. § 22-4001.

Perhaps most tellingly, the fact that the Warden insists that he has seen "no credible information that would cause [him] to believe that execution by lethal injection, as done in North Carolina, would cause a condemned prisoner to suffer pain during the execution" implies precisely the type of willful ignorance that gives rise to a finding of deliberate indifference. In the face of attorney affidavits, expert medical opinion, standards of practice for veterinary euthanasia, recent rulings in other jurisdictions, and grievances filed by a number of North Carolina inmates, Defendants plainly have before them credible evidence that should prompt them to investigate and ensure that their protocol for the administration of anesthesia can be depended upon to reliably induce an adequate plane of anesthesia such that the inmate will be executed with a minimum of pain and suffering. Defendants cannot simply choose to ignore this evidence when it presents a significant risk of harm to Plaintiff. *Odom v. South Carolina Dept. of Corr.,* 349 F.3d 765, 771 (4th Cir. 2003); *LaFaut v. Smith*, 834 F.2d 389, 394 (4th Cir. 1987).

III. DEFENDANTS' RELIANCE ON DECISIONS FROM OTHER JURISDICTIONS IS MISPLACED AND DOES NOT DEFEAT PLAINTIFF'S SHOWING OF LIKELIHOOD OF SUCCESS ON THE MERITS.

Plaintiff has developed and offered to this Court a substantial evidentiary record, particularly given the pre-discovery stage of this litigation, which includes expert opinion, deposition testimony, licensing records, toxicology data, and other materials, in support of his Motion for Preliminary Injunction. In responding to Plaintiff's showing of likelihood of success on the merits of his constitutional claim, Defendants rely heavily on decisions in other jurisdictions, which they claim demonstrate "virtual unanimity in rejecting challenges to the chemical combination." (Defs.' Mem. at 24.)

As an initial matter, a review of Plaintiff's Amended Complaint reveals that it is not a challenge to the composition of the chemical cocktail used by Defendants' to effectuate death. Rather, Plaintiff has alleged and offered evidence that Defendants' procedures and protocols do not require the participation of personnel credentialed, licensed, and proficient in the practice of anesthesia or adherence to medically appropriate standards for inducing and maintaining anesthesia, thereby creating an unacceptable risk that Plaintiff will consciously suffer during his execution. Thus, while Defendants spend many pages discussing the case of *Reid v. Johnson*, 333 F. Supp. 2d 543 (E.D. Va. 2004), this case is entirely inapposite because the Court limited the scope of discovery and the introduction of evidence "only to those issues pertaining to the particular chemical combination to be used in this case and their probable affect (sic) on Reid." *Id.* at 548.

Upon review of the plethora of cases cited by Defendants, Plaintiff has found no case in which a court considered a fully developed challenge addressing whether an anesthesia protocol was adequately designed to ensure that an appropriate plane of anesthesia is induced and maintained. Other cases were in a different procedural posture, where the court was not

reviewing a full evidentiary record; involved challenges solely to the use of the chemical cocktail; involved factually distinct procedures and protocols; or challenged the constitutionality of lethal injection itself as a means of execution.[8]

Finally, Defendants suggest that the only opinions granting relief have been "district court decisions overturned on appeal and an occasional dissent or concurrence in the appellate courts." (Defs.' Mem. at 24 n.4.) This statement ignores the recent decision in *Morales v. Hickman*, 2006 WL 335427 (N.D. Cal. Feb. 14, 2006), in which the court determined that a California inmate presented sufficient evidence regarding the risk of conscious suffering during his execution to warrant modification of the state's lethal injection protocol before allowing the scheduled execution to go forward. While *Morales* involved a challenge to the particular

[8] *See, e.g., Abdur'Rahman v. Bredesen*, 181 S.W.3d 292, 301 (Tenn. 2005) (rejecting the plaintiff's claim after reviewing evidence that the executioner could see the inmate through an adjacent window; that a camera immediately over the gurney allowed the executioner to "zoom in" and see the catheters; and that the execution team practiced monthly); *State v. Webb*, 750 A.2d 448, 456 (Conn. 2000) (rejecting the plaintiff's claim after determining that "[t]he person selected as the executioner shall be trained to the satisfaction of a licensed physician to ensure that he/she is qualified to establish the intravenous line and administer the drugs in a professional manner" and "receiving testimony from a physician that executioners could be adequately trained"); *Hill v. Lockhart*, 791 F. Supp. 1388 (E.D. Ark. 1992) (court did not review evidence relating to composition of chemical cocktail and heightened need for reliable induction of anesthesia); *Illinois v. Stewart*, 520 N.E.2d 348, 358 (Ill. 1988) (defendant submitted *no* evidence to support his contention that lethal injection results in protracted death or unnecessary pain); *Beardslee v. Woodford*, 395 F.3d 1064 (9th Cir. 2005) (defendant denied eve-of-execution injunctive relief where record failed to reflect any evidence that administration of sodium pentothal would be improper); *Poland v. Stewart*, 117 F.3d 1094, 1105 (9th Cir. 1997) (habeas petition including lethal injection challenge properly denied where sole evidence put forward by petitioner was affidavit regarding "botched" executions in states other than Arizona, where defendant was to be executed); *LaGrand v. Stewart*, 133 F.2d 1253, 1264-65 (9th Cir. 1998) (limited evidence included report from one physician filled with speculation); *Hinchey v. Arizona*, 890 P.2d 602, 610 (Ariz. 1995) (broad challenge to lethal injection as method of execution raised on direct appeal; no apparent evidence proffered to trial court in support of challenge); *Dawson v. Delaware*, 673 A.2d 1186, 1196 (Del. 1996) (merits of claim not addressed because Defendant failed to address claim on direct appeal and court held it to be defaulted); *United States v. Chandler,* 450 F. Supp. 1545 (N.D. Ala. 1996) (failure to show that DOJ regulations prescribe unconstitutionally cruel method of injection; no discussion that any evidence proffered in support of that contention); *Russell v. State,* 849 So.2d 95 (Miss. 2003) (defendant cited no authority and presented no evidence in support of challenge to method of execution); *State v. Moen*, 786 P.2d 111, 143 (Ore. 1990) (court declined to find that lethal injection is, on its face, unconstitutional; no narrower challenge to protocol or evidence adduced in support); *Hopkinson v. State*, 798 P.2d 1186 (Wyo. 1990) (facial challenge to constitutionality of death by lethal injection rejected, no development of evidence of flawed protocol).

procedures and protocols used in California, the court's analysis involved a weighing of considerations similar to that presented in the instant case. Specifically, the court emphasized the importance of the state's "strong interest in proceeding with its judgment" and that "under the doctrines of comity and separation of powers, the particulars of California's lethal-injection protocol are and should remain the province of the State's executive branch." *Id.* at *7. Nevertheless, the evidence before the court raised sufficiently serious questions regarding the risk of conscious suffering that the court refused permit plaintiff's execution to proceed using the intended procedures and personnel. The court concluded that the plaintiff's evidence:

> raises at least some doubt as to whether the protocol actually is functioning as intended, and because of the paralytic effect of pancuronium bromide, evidence that an inmate was conscious at some point after that drug was injected would be imperceptible to anyone other than a person with training and experience in anesthesia . . . Other evidence in the present record raises additional concerns as to the manner in which the drugs used in the lethal-injection protocol are administered

Id. at *6.

CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests that the Court grant his Motion for Preliminary Injunction and enjoin Defendants from using their inadequate protocol for inducing and maintaining anesthesia during the course of his execution

Respectfully submitted this the 3rd day of April 2006.

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CERTIFICATE OF SERVICE

This is to certify that on this date, I electronically filed the foregoing **REPLY IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION** with the Clerk of Court using the CM/ECF system, which will send notification of such filing to counsel of record, and also served a copy of the same by hand-delivering a copy to the following the address:

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This the 3rd day of April, 2006.

/s/ Laura M. Loyek
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