IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

PHILIP WORKMAN,	)	
	)	
Plaintiff,	)	
	)	**No. 07- CV- 0490**
v	)	**Death Penalty Case**
	)	**Execution Date May 9, 2007, 1:00 a.m.**
GOVERNOR PHIL BREDESEN, in his official capacity as Governor of the State of Tennesseee;	)	
	)	
GEORGE LITTLE, in his official capacity as Tennessee's Commissioner of Corrections;	)	
	)	
RICKY BELL, in his official capacity as Warden, Riverbend Maximum Security Institution;	)	
	)	
GAYLE RAY, in her official capacity as Assistant Commisioner of Corrections;	)	
	)	
ROLAND COLSON, in his official capacity as Assistant Commissioner of Corrections;	)	
	)	
JULIAN DAVIS, in his official capacity as Executive Assistant to the Commissioner;	)	
	)	
DEBBIE INGLIS, in her official capacity as General Counsel to the Department of Corrections;	)	
	)	
JOHN DOE PHYSICIANS 1-100;	)	
	)	
JOHN DOE PHARMACISTS 1-100;	)	
	)	
JOHN DOE MEDICAL PERSONNEL 1-100;	)	
	)	
JOHN DOE EXECUTIONERS 1-100;	)	

JOHN DOES 1-100;	)
	)
Defendants.	)

C O M P L A I N T

I. Introduction[1]

1. On May 9, 2007 at 1:00 a.m., the State of Tennessee intends to kill Plaintiff Philip Workman by lethal injection under a "new" lethal injection protocol first made known to Philip Workman on just eight days prior on April 30, 2007. On April 30, 2007, the State released its new protocol after a 90-day reprieve of all executions, wherein the Governor had ordered that the current execution protocols, "whether written or otherwise, used by the Department of Correction and related to the administration of death sentences in Tennessee, both by lethal injection and electrocution, [we]re ... revoked." See Governor's Executive Order No. 43, Exhibit 1.[2] Along with the reprieve, the Governor directed the Department of Corrections (TDOC) to undertake a "comprehensive review of the manner in which death sentences are administered in Tennessee" including "to utilize all relevant and appropriate resources, including but not limited to scientific and medical experts, legal experts, and Correction professionals, both from within and outside the state of Tennessee." Id. Having concluded its "comprehensive" review, on April 30, 2007,

[1]This Complaint was prepared under extreme time constraints. Plaintiff would intend to amend the Complaint after sufficient time. Plaintiff incorporates, as if set forth fully herein, all of the factual allegations in his Motion and Memorandum In Support of Motion for Temporary Restraining Order and Exhibits, as well as all arguments made at the May 4, 2007, 1:30 p.m. oral argument on these motions. See Docket Entry Nos. 1, 2, and 5.

[2]All Exhibits are identified as those attached to the Memorandum in Support of Motion for Temporary Restraining Order.

the TDOC released a protocol that is only slightly different than the prior protocol, which was described by the Governor as having "deficiencies in the written procedures," "sloppy," and "not adequate to preclude mistakes." Moreover, this "new" protocol is essentially identical to the protocols used in other states, including in Florida, California, Missouri, North Carolina, Ohio, and Arkansas, where federal or state courts have refused to allow executions by lethal injection to proceed because of grave concerns about the constitutionality of the protocol.

2. To kill Mr. Workman, the State intends to use a protocol whereby he would be injected with a dose of sodium thiopental, then with a dose of pancuronium bromide (Pavulon), and third with a dose of potassium chloride. The use of this protocol is unconstitutional. The sodium thiopental does not sufficiently anesthetize any individual. The use of pancuronium bromide is arbitrary, serves no legitimate interest, unreasonably risks the infliction of torture, and, at bottom, offends the dignity of humanity: Indeed, it cannot be used in Tennessee to kill a dog. Its use violates equal protection. The potassium chloride does not stop the heart. The use of this mixture of chemicals causes an unnecessarily painful and prolonged death experienced without total unconsciousness.

3. This Court should also declare the New April 30, 2007 Protocol unconstitutional and enjoin its use as it is unconstitutional under the Eighth and Fourteenth Amendments. See New April 30, 2007 Protocol, Exhibit 2.

II. Nature of Action

4. This action is brought pursuant to 42 U.S.C. §1983[3] for violations and threatened

[3]The United States Supreme Court decisions in Hill v. McDonough, 547 U.S. ___, 126 S.Ct. 2096 (2006) and Nelson v. Campbell, 541 U.S. 647, 124 S.Ct. 2117 (2004) confirm that a civil rights action pursuant to 42 U.S.C. §1983 is an appropriate vehicle for a claim alleging that the procedures

violations of the right of Plaintiff under the Eighth, Ninth, and Fourteenth Amendments, including the right to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments to the United States Constitution. Plaintiff seeks equitable and injunctive relief.

III. Plaintiff

5. Plaintiff Philip Workman is a United States Citizen and a resident of the State of Tennessee. He is currently a death-sentenced inmate in the custody of Defendants and under the control and supervision of the Tennessee Department of Corrections. He is held in the Riverbend Maximum Security Prison, 7475 Cockrill Bend Industrial Drive, Nashville, Davidson County, Tennessee; telephone (615) 350-3400.

IV. Defendants

6. Defendant Governor Phil Bredesen is the Governor of the State of Tennessee. Plaintiff sues Governor Bredesen in his official capacity. Defendant is a state actor acting under color of state law, and his actions in directing and approving the development of a new execution protocol, and then seeking to execute or executing Plaintiff with that new protocol, as described *infra,* violate Plaintiff's constitutional rights, as described *infra*.

7. Defendant George Little is the Commissioner of the Tennessee Department of Corrections. Plaintiff sues Commissioner Little in his official capacity. Defendant is a state actor acting under color of state law, and his actions in directing and developing a new execution protocol, and then seeking to execute or executing Plaintiff with that new execution protocol, as described *infra,* violate Plaintiff's constitutional rights, as described *infra*.

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used to carry out a death sentence violate the Eighth Amendment.

8. Defendant Ricky Bell is the Warden of Riverbend Maximum Security Institution. Bell is directly in charge of executing Plaintiff. Plaintiff sues Warden Bell in his official capacity. Defendant is a state actor acting under color of state law, and his actions in helping to develop a new execution protocol, and then seeking to execute or executing Plaintiff with that new execution protocol, as described *infra,* violate Plaintiff's constitutional rights, as described *infra*.

9. Defendant Gayle Ray is an Assistant Commissioner for the Tennessee Department of Corrections. Plaintiff sues Assistant Commissioner Ray in her official capacity. Defendant is a state actor acting under color of state law, and her actions in helping to develop a new execution protocol, and then seeking to execute or executing Plaintiff with that new execution protocol, as described *infra,* violate Plaintiff's constitutional rights, as described *infra*.

10. Defendant Roland Colson is an Assistant Commissioner for the Tennessee Department of Corrections. Plaintiff sues Assistant Commissioner Colson in his official capacity. Defendant is a state actor acting under color of state law, and his actions in helping to develop a new execution protocol, and then seeking to execute or executing Plaintiff with that new execution protocol, as described *infra,* violate Plaintiff's constitutional rights, as described *infra*.

11. Defendant Julian Davis is the Executive Assistant to the Commissioner for the Tennessee Department of Corrections. Plaintiff sues Executive Assistant Davis in his official capacity. Defendant is a state actor acting under color of state law, and his actions in helping to develop a new execution protocol, and then seeking to execute or executing Plaintiff with that new execution protocol, as described *infra*, violate Plaintiff's constitutional rights, as described *infra*.

12. Defendant Debbie Inglis is the General Counsel to the Tennessee Department of Corrections. Plaintiff sues Counsel Inglis in her official capacity. Defendant is a state actor acting under color of state law, and her actions in helping to develop a new execution protocol, and then seeking to execute or executing Plaintiff with that new execution protocol, as described *infra*, violate Plaintiff's constitutional rights, as described *infra*.

13. Defendants John Doe Physicians 1-100 are any and all medical doctors involved in the prescription, procurement and/or administration of sodium thiopental, pancuronium bromide, and/or potassium chloride for use upon Plaintiff without the purpose to heal, but to cause Plaintiff's death. Such Defendants are state actors acting under color of state law, and their actions in seeking to execute or executing Plaintiff as described *infra* violate Plaintiff's constitutional rights, as described *infra*.

14. Defendants John Doe Pharmacists 1-100 are any and all persons involved in procuring, prescribing, dispensing, and/or administering sodium thiopental, pancuronium bromide, and/or potassium chloride for use upon Plaintiff without the purpose to heal, but to cause Plaintiff's death. Such Defendants are state actors acting under color of state law, and their actions in seeking to execute or executing Plaintiff as described *infra* violate Plaintiff's constitutional rights, as described *infra*.

15. Defendants John Doe Medical Personnel 1-100 are any and all persons involved in using, preparing, or otherwise handling Plaintiff or sodium thiopental, pancuronium bromide, and/or potassium chloride in any attempt to administer or inject sodium thiopental, pancuronium bromide, and/or potassium chloride upon Plaintiff without the purpose to heal, but to cause Plaintiff's death. Such Defendants are state actors acting under color of state law, and their

actions in seeking to execute or executing Plaintiff as described *infra* violate Plaintiff's constitutional rights, as described *infra*.

16. Defendants John Doe Executioners 1-100 are any and all persons involved in using, preparing, or otherwise handling Plaintiff or sodium thiopental, pancuronium bromide, and/or potassium chloride in any attempt to administer or inject sodium thiopental, pancuronium bromide, and/or potassium chloride upon Plaintiff to cause Plaintiff's death. Such Defendants are state actors acting under color of state law, and their actions in seeking to execute or executing Plaintiff as described *infra* violate Plaintiff's constitutional rights, as described *infra*.

17. Defendants John Does 1-100 are any and all other persons who are, or would be, involved in the prescription, procurement, dispensing and/or administration of sodium thiopental, pancuronium bromide, and/or potassium chloride for use upon Plaintiff without the purpose to heal, but to cause Plaintiff's death; or otherwise involved in the actual execution of Philip Workman through the use of sodium thiopental, pancuronium bromide, and/or potassium chloride. Such Defendants are state actors acting under color of state law, and their actions in seeking to execute or executing Plaintiff as described *infra* violate Plaintiff's constitutional rights, as described *infra*.

V. JURISDICTION/VENUE

18. In this action, Plaintiff invokes 28 U.S.C. §§1331 (federal question), 1343 (civil rights violations), 2201 (declaratory relief), and 2202 (further relief). This action arises under the Eighth and Fourteenth Amendments to the United States Constitution and under 42 U.S.C.§1983.

19. As to exhaustion of administrative remedies, on May 2, 2007, less then forty-eight hours after the New April 30, 2007 Protocol for executions in Tennessee was released, Plaintiff

filed a Emergency Grievance with the TDOC, pursuant to TDOC Policy 501.01 and Tenn. Code Ann. §§ 4-3-603, 4-3-606, and 41-24-110. See Emergency Grievance of Philip Workman, Exhibit 3. Plaintiff's Emergency Grievance was apparently denied by Commissioner Little on May 3, 2007. Plaintiff and Plaintiff's counsel were not informed of the denial until May 4, 2007 at 10:00 a.m. Defendants admit that Plaintiff has now exhausted administrative remedies.

20. Venue is proper in this district under 28 U.S.C. §1391 and this Court has personal jurisdiction over the Defendants in this matter because the events giving rise to these claims will occur in Nashville, Tennessee, which is within the Middle District of Tennessee.

VI. FACTS

21. Plaintiff Philip Workman has been on death row since 1982.

22. Plaintiff Workman was a heavy intravenous drug user prior to his incarceration in 1982.

23. On January 17, 2007, the Tennessee Supreme Court set Mr. Workman's execution for May 9, 2007.

24. On February 1, 2007, Defendant, Tennessee's Governor Phil Bredesen, issued an Executive Order directing the Department of Corrections to "complete a comprehensive review of the manner in which the death penalty is administered in Tennessee" by May 2, 2007. See Governor's Executive Order No. 43, Exhibit 1.

a. The Order directs that by May 2, 2007 the Commissioner of Corrections should "establish and provide to me new protocols and related written procedures for administering death sentences in Tennessee, both by lethal injection and electrocution." See Exhibit 1.

b. To that end, the Governor issued a Reprieve to four individuals who had death sentences "scheduled to be carried out within the next ninety (90) days" and ordered that the Reprieve remain in place until May 2, 2007. See Exhibit 1.

c. Plaintiff's execution date was not included in the Reprieve, although it was scheduled for just one week (7 days) and four (4) business days after the May 2, 2007 deadline.

d. On March 15, 2007, Mr. Workman filed a Motion to Vacate his May 9, 2007 execution date in the Tennessee Supreme Court because it was apparent that Mr. Workman would not have sufficient time to review and litigate any possible claims that he may have under any newly enacted protocol. See Philip Workman's Motion to Vacate Execution Date, Exhibit 4. The State of Tennessee opposed Mr. Workman's motion (See State's Response to Motion to Vacate Execution Date, Exhibit 5), and the Tennessee Supreme Court refused Mr. Workman's request. See Tennessee Supreme Court Order, March 27, 2007, Exhibit 6.

e. The Governor's execution review team conducted their work in complete secrecy.

f. The contents of the New April 30, 2007 Protocol were only made known to Mr. Workman for the first time at 4:10 p.m. on April 30, 2007.

g. The review team's Report on Administration of Death Sentences In Tennessee was delivered the following day. See Tennessee Report on Administration of Death Sentences in Tennessee. Even so, Mr. Workman has outstanding requests for public records sent to the Governor, the Commissioner of the Department of Corrections, and each member of the review team, relating to the development, promulgation, evaluation, and implementation of those

protocols. See Philip Workman's April 25, 2007 Records Requests. Some documents have been disclosed, other documents have not.

h. The few documents from the execution review team that have been disclosed demonstrate that the State of Tennessee was deliberately indifferent in its development of the New April 30, 2007 Protocol.

i. The execution review team contained no members with medical or pharmacological expertise. Emails provided by the State of Tennessee, reveal that the "lead" member of the Lethal Injection Review Team is the Commissioner's Executive Assistant. See Email from Julian Davis to Dr. Mark Dershwitz.

25. In a report to the Governor, the Commissioner told the Governor that the Board had consulted with the Bureau Of Prisons in Terre Haute and went on a site visit to participate in their lethal injection training. See Tennessee Report on Administration of Death Sentences in Tennessee, Exhibit 7, p. 5.

26. The Commissioner's Report fails to reveal that the lethal injection protocol at the federal facility in Terre Haute has been suspended **by the agreement of the United States Attorney General** while concerns about the constitutionality of the lethal injection protocol are being examined. See Roane v. Gonzales, No. 05-2337 (D.C. Dist.), February 16, 2007 Order and Unopposed Motion for Preliminary Injunction, Exhibit 10.

27. Pursuant to the Governor's direction, Defendant Little assembled a committee to develop a new execution protocol. That committee allegedly included: Commissioner Little himself, Warden Ricky Bell, Assistant Commissioner Gayle Ray, Assistant Commissioner Roland Colson, General Counsel Debbie Inglis, and Executive Assistant Julian Davis.

28. On April 30, 2007, the Commission of Corrections provided new protocols and related written procedures for carrying out executions in Tennessee ("New April 30, 2007 Protocol") to the Governor (See Exhibit 2), and a Report on Administration of Death Sentences In Tennessee ("TDOC Report"). See TDOC Report, Exhibit 4.

29. Immediately thereafter on April 30, 2007 , the Governor approved the New April 30, 2007 Protocol.

30. On May 2, 2007, Plaintiff filed an Emergency Grievance pursuant to TDOC Policy 501.01C.1, grieving the New April 30, 2007 Protocol provided by Commissioner and his committee and approved by the Governor for use in Plaintiff's execution because it is unconstitutional under the Eighth, Ninth, and Fourteenth Amendments. See Exhibit 3.

31. On May 3, 2007, Commissioner Little denied Plaintiff's grievance; Plaintiff was not informed of this denial until the morning of May 4, 2007.

LETHAL INJECTION

32. According to the New April 30, 2007 Protocol devised and promulgated by Defendants, at Plaintiff's proposed May 9, 2007 execution, Defendants intend to inject the following drugs into Plaintiff in order to kill him:

a. 5 grams of Sodium Thiopental

b. 100 mg/100 mL of Pancuronium bromide

c. 100 mg/mL of a 2 mEq/mL concentrate of Potassium Chloride

33. The Defendants' New April 30, 2007 Protocol, including the combination of chemicals (sodium thiopental, pancuronium bromide, and potassium chloride); the lack of proper training, qualifications, screening and review of the persons involved in the process; the absence

of standardized procedures for administration of the chemicals; the absence of a sufficient anesthetic and any monitoring of anesthetic depth; and the absence of a back-up plan should problems arise during the protocol, creates a grave and substantial risk that Plaintiff will be conscious throughout the execution process and, as a result, will experience an excruciatingly painful and protracted death. In addition, the New April 30, 2007 Protocol, devised and promulgated by Defendants, demonstrates a deliberate indifference on the part of Defendants to the excruciatingly painful and horrifying death that will result from its use.

LETHAL INJECTION CHEMICALS

Sodium Thiopental

34. Anesthesia is the process of blocking the perception of pain and other sensations, creating insensibility to pain.

35. Sodium Thiopental is an ultra-short acting barbiturate.

36. In the New April 30, 2007 Protocol, the alleged purpose of sodium thiopental is to "depress[] the central nervous system, causing sedation or sleep, depending on the dose. It reduces oxygen flow to the brain and causes respiratory depression." See Exhibit 1, p. 35.

37. Induction of anesthesia using thiopental occurs quickly, but its effect wears off in a matter of minutes. Sodium thiopental is used as an anesthetic in surgery because it enables an anesthesiologist to quickly awaken a patient should complications arise. It is usually used only during the preliminary phase of anesthesia administration.

38. There are differing levels of anesthesia, and thus consciousness.

39. The human body reacts to various stimuli differs depending upon the level of anesthesia.

40. The New April 30, 2007 Protocol also fails to address the individual prisoner's medical condition and history as related to the effectiveness of sodium thiopental; instead each inmate will be given a 5 gram dose. See Exhibit 1, p. 35. Several regularly prescribed drugs at Riverbend Maximum Security Institution interfere with the ability of sodium thiopental to act properly as an anesthetic.

41. Despite the grave risk that sodium thiopental will not work effectively to induce surgical anesthesia for the inmates, as demonstrated by medical studies and the experiences in other states, the New April 30, 2007 Protocol fails to provide for proper monitoring of anesthetic depth as is necessary when using sodium thiopental. See Exhibit 1, p. 43.

42. As is clear from medical studies and the experiences of other states and from the Declaration of Dr. Mark Heath, sodium thiopental, as used in the New April 30, 2007 Protocol, does not adequately anesthetize a person prior to the introduction of pancuronium bromide and potassium chloride resulting in an excruciatingly painful and horrifying death as a result of the conscious asphyxiation by pancuronium bromide followed by the painful intense burn and cardiac arrest of potassium chloride.

Pancuronium Bromide (Pavulon)

43. As used in Tennessee's New April 30, 2007 Protocol, pancuronium bromide is supposed to "assist in the suppression of breathing and ensure death." See Exhibit 1, p. 35.

44. Pancuronium bromide, marketed under the name Pavulon, is a neuromuscular blocking agent which causes paralysis of the skeletal muscles of an individual.

45. Pancuronium bromide does not affect the brain or nervous system, nor does it block the actual reception of nerve impulses in the brain or the passage of such impulses within

the brain.

46. Pancuronium bromide does not affect consciousness or the sensation of pain or suffering.

47. An individual under the influence of pancuronium bromide, though paralyzed, still has the ability to think, to be oriented to where he is, to experience fear or terror, to feel pain, and to hear.

48. While pancuronium bromide paralyzes the diaphragm to prevent breathing, it does not affect the heart muscle.

49. Pancuronium bromide, administered by itself as a "lethal dose," would not result in a quick death; instead, it would ultimately cause someone to asphyxiate or suffocate to death while still conscious.

50. If an individual is not properly anesthetized when injected with pancuronium bromide, he will consciously experience extreme pain while being completely paralyzed.

51. Thus, an individual will undergo the terrorizing and excruciating experience of suffocation without the ability to move or to express the pain and suffering which he is experiencing as he is being suffocated.

52. Because pancuronium bromide paralyzes all skeletal muscles including facial muscles and those used to speak or communicate through noises, an observer cannot detect, from outward appearance, any expression of pain, horror, or suffering experienced because of the use of pancuronium bromide.

53. Moreover, the paralyzing effect of pancuronium bromide also prevents any expression of the pain, horror, or suffering from any other source, such as potassium chloride

which will activate the nerves of the venous system causing an extreme burning pain. The use of pancuronium bromide under the New April 30, 2007 Protocol to paralyze Plaintiff greatly increases the risk that a conscious prisoner will be subjected to a painful and protracted death.

54. Death caused by the use of pancuronium bromide is gruesome, horrible, and painful. Pancuronium bromide could not lawfully be used alone as the fatal agent because causing death by suffocation violates the Eighth Amendment's prohibition against cruel and unusual punishment. It serves no legitimate penological purpose.

55. The use of pancuronium bromide is arbitrary, unreasonable, degrading to human dignity, and serves no legitimate interest.

56. Because pancuronium bromide causes paralysis, suffocation, and the suffering attendant to such paralysis and suffocation, in 2001, Tennessee declared in the "Nonlivestock Humane Death Act" (Tenn. Code Ann. 44-17-301 *et seq*.) that pancuronium bromide cannot be used to euthanize animals, because its use is not humane.

57. Where the use of pancuronium bromide is not "humane" to use on non-humans, it is arbitrary to claim that its use is "humane" on humans, and its use on humans to cause death violates basic precepts of human dignity.

a. The use of pancuronium bromide in execution is unnecessary and arbitrary.

b. The use of pancuronium bromide in execution is unreasonable and irrational.

c. The use of pancuronium bromide in execution serves no legitimate state interest and is not narrowly tailored to any compelling state interest.

d. As Chancellor Ellen Hobbs Lyle has explained elsewhere:

> [T]he use of Pavulon is . . . unnecessary. . . [T]he State [has] failed to demonstrate any reason for its use. The record is devoid of proof that the Pavulon is needed. Thus, the Court concludes that . . . the State's use of Pavulon is . . . in legal terms 'arbitrary.'

Abdur'Rahman v. Sundquist, No. 02-2236-III, In The Chancery Court For The State Of Tennessee, Twentieth Judicial District, p. 13 (June 2, 2003).

Potassium Chloride

58. As used in Tennessee's New April 30, 2007 Protocol, potassium chloride is supposed to cause "cardiac arrest and rapid death." See Exhibit __, p. 35.

59. The administration of potassium chloride is extremely painful, because it activates all the nerve fibers inside the venous system. Because veins are replete with nerve fibers, the administration of potassium chloride into the veins creates extreme pain.

60. In the absence of adequate anesthesia, the introduction of potassium chloride, like the introduction of pancuronium bromide, creates extreme and excruciating pain.

61. Under Tennessee's New April 30, 2007 Protocol, 100 mg/mL or a 2 mEq/mL concentrate of potassium chloride are introduced into the body through a vein. See Exhibit 1, p. 35.

62. This method of administering this amount of potassium chloride is inadequate to stop the heart.

63. This is confirmed by the autopsy of Robert Coe, which demonstrates that his vitreous potassium was 9 mEq/l (9mmol/l). It actually takes a serum concentration of more than 16 mEq/l (16mmol/l) of potassium to arrest the heart.

64. Moreover, a study published just last week confirms that potassium chloride is not the lethal agent in lethal injection. See Leonardis Koniaris et al, *Lethal Injection For Execution: Chemical Asphyxiation?*, PLOS Medicine, Vol. 4, Issue 4, April 2007.

65. A person being lethally injected under Tennessee's New April 30, 2007 Protocol thus actually dies from the suffocation caused by the pancuronium bromide and the resulting anoxic state, and not from cardiac arrest due to the administration of potassium chloride.

NEW APRIL 30, 2007 LETHAL INJECTION PROTOCOL

66. The New April 30, 2007 Lethal Injection Protocol is set forth in the Tennessee Department of Corrections' "Execution Procedures for Lethal Injection." See Exhibit 1, p. 1.

67. The New April 30, 2007 Protocol was adopted by the Governor upon a recommendation from the TDOC on April 30, 2007 without any medical research or review to determine that a prisoner would not suffer pain beyond that attendant to the extinguishment of life.

68. Under the New April 30, 2007 Protocol, an execution by lethal injection requires the participation of the Commissioner, the Warden, the Deputy Warden, the Administrative Assistant, the Death Watch Supervisor and assigned officers, a Chaplain, a Medical Doctor and associate, an "Execution Team," an "IV Team," and an "Extraction Team."

69. The New April 30, 2007 Protocol contains no description of the "IV Team" or the "Extraction Team."

70. Thus, the New April 30, 2007 Protocol fails to indicate how the members of the IV Team or Extraction Team are qualified to participate, or what screening, if any, has been done to insure that these members do not have a criminal background, mental health issues, personnel

and disciplinary issues, drug or alcohol issues.

71. As to each member participating in the lethal injection, including the Execution Team, the IV Team, and the Extraction Team, as well as the Warden, the Deputy Warden, the Administrative Assistant, the Death Watch Supervisor and assigned officers, a Chaplain, a Medical Doctor and associate, the New April 30, 2007 Protocol fails to indicate what training, if any, each person has had to equip them for their duties, and what screening, if any, has been done to insure that each person is competent to perform their duties, and what practices the teams have had to prepare for the execution.

72. The New April 30, 2007 Protocol fails to indicate what training, education, or licensing the IV Team and any medical doctor or associate has accomplished, if any.

73. The use of the three-drug cocktail ("Lethal Injection Chemicals") as outlined in the New April 30, 2007 Protocol is unconstitutional. See Exhibit 1, p. 35.

a. The New April 30, 2007 Protocol instructs that an inmate will be injected with 5 grams of sodium thiopental, 100 cc of pancuronium bromide (Pavulon), and 100 mg/mL of 2 mEq/mL concentrate of potassium chloride. See Exhibit 1, p. 35.

b. The use of this New April 30, 2007 Protocol is unconstitutional as it is cruel and unusual punishment.

c. The sodium thiopental does not sufficiently anesthetize any individual and is contraindicated for use on individuals such as Mr. Workman.

d. The use of pancuronium bromide is arbitrary, serves no legitimate interest, unreasonably risks the infliction of torture, and, at bottom, offends the dignity of humanity: Indeed, it cannot be used in Tennessee to kill a dog. Its use violates equal protection.

e. The potassium chloride, as used, does not stop the heart.

f. The use of this mixture of chemicals causes an unnecessarily painful and prolonged death experienced without total unconsciousness.

74. The use of 5 grams of sodium thiopental in the New April 30, 2007 Protocol for the purpose of "general anesthesia" is false and misleading. See Exhibit 1, p. 35. Sodium thiopental is an ultra-short acting barbiturate wherein the induction of anesthesia occurs quickly, but its effect wears off in a matter of minutes.

a. The New April 30, 2007 fails to educate its readers (the execution team) that thiopental not only has a rapid onset, but also has a rapid withdrawal and that is may cause pain if the drug is infiltrated. See Exhibit 1, p. 35.

75. Mr. Workman objects to the use of sodium thiopental in the New April 30, 2007 Protocol for the following reasons:

a. Sodium thiopental reacts differently based on a person's weight. The New April 30, 2007 Protocol fails to address an individual prisoner's weight as related to the dosage of sodium thiopental necessary to effectively anesthetize him, but instead just indicates that a 5 gram dose will be given. See Exhibit 1, p. 35. In a study published just last week, Leonardis Koniaris found that body weight must be taken into account when using sodium thiopental as the sodium thiopental reacts differently in the body depending on weight. See Leonardis Koniaris et al, *Lethal Injection For Execution: Chemical Asphyxiation?*, PLOS Medicine, Vol. 4, Issue 4, April 2007.

b. The New April 30, 2007 Protocol also fails to address the individual prisoner's medical condition and history as related to the effectiveness of sodium thiopental. See

Exhibit 1, p. 35. Several regularly prescribed drugs at Riverbend Maximum Security Institution interfere with the ability of sodium thiopental to act properly as an anesthetic.

c. The New April 30, 2007 Protocol uses sodium thiopental despite the fact that findings made as a result of the autopsy of Robert Coe, who was executed in Tennessee in 2000, show that his serum thiopental levels were 10 mg/l, which as recent research establishes, is inadequate to establish unconsciousness. See Leonidas Koniaris et al, *Inadequate Anaesthesia In Lethal Injection For Execution*, 365 Lancet 1412-1414 (2005) (Attached as Exhibit 3). The New April 30, 2007 Protocol ignores this medical evidence and instead calls for the same dosage of sodium thiopental (5 grams) that was purportedly given to Robert Coe in 2000. See Exhibit 1, p. 35.

d. The New April 30, 2007 Protocol fails to take into account a new study by Leonard Koniaris examining toxicology reports from prisoners executed by California and North Carolina, along with reports from witnesses to executions in other states, that confirms that some prisoners remained conscious during the administration of lethal drugs due to the ineffectiveness of sodium thiopental. See Leonardis Koniaris et al, *Lethal Injection For Execution: Chemical Asphyxiation?*, PLOS Medicine, Vol. 4, Issue 4, April 2007 (Attached as Exhibit 2).

e. The New April 30, 2007 Protocol fails to provide for any monitoring of anesthetic depth as is necessary when using sodium thiopental. See Exhibit 1, p.43. The only monitoring provided for by the New April 30, 2007 Protocol is monitoring of the IV site via close-circuit camera, which is inadequate. See Exhibit 1, p. 43. There is no monitoring of the inmate for anesthetic depth or of the IV lines and tubing during the administration of the drugs. This lack of monitoring coupled with the ineffectiveness of sodium thiopental has caused

numerous botched executions in the United States.

i. The two most well-known botched executions in the United States related to the failure of sodium thiopental. In Florida in December 2006, Mr. Angel Diaz did not get an effective amount of sodium thiopental because the IV lines were improperly seated in his veins with through and through punctures. As a result, none of the materials injected went to the right place. Instead, the drugs entered his bloodstream first through his flesh and muscle tissue. This process caused foot-long chemical burns on both arms from the sodium thiopental. During execution, observers reported that Mr. Diaz moved and tried to mouth words. It took 34 minutes and 14 syringes of chemicals for Mr. Diaz to die, during which he was clearly in pain, struggling for breath and grimacing. Following the Diaz execution, Governor Bush ordered that all executions be stayed while a committee undertook a review of the Diaz execution and of lethal injection protocols in Florida in general, which were exactly the same as the New April 30, 2007 Protocol here. Executions remain stayed in Florida under the Governor's order. See Florida Commission Report (Attached as Exhibit 4).

ii. During the May 2006 lethal injection of Joseph Lewis Clark, execution team members took over twenty minutes to insert one IV catheter into Mr. Clark's arm. According to protocol two catheters were necessary, but the team proceeded with only one. After the single IV was inserted and the chemicals began to flow, Mr. Clark remained breathing, legs moving, arms strapped down. After minutes, he sat up several times and told executioners, "It's not working, it's not working." Minutes later, Mr. Clark raised up again and said, "can't you just give me something by mouth to end this?" At that point, the team closed the curtain, and witnesses heard groans and moans from Mr. Clark as if he was in agony. Witnesses reported

that the cries of pain lasted for about five or ten minutes and were followed by snores from Mr. Clark. Obviously if the sodium thiopental had worked properly then Mr. Clark would not have been able to cry out in pain, feel pain, or sit up during the execution. Ohio uses a lethal injection protocol that is similar to the New April 30, 2007 Protocol here.

f. As is clear from both medical studies and from experiences of other states, sodium thiopental, as used in the New April 30, 2007 Protocol (without the assistance of an anesthesiologist or certified nurse anesthetist and at such a low dosage that fails to take into account either body weight or drug interaction), does not adequately anesthetize a person prior to the introduction of pancuronium bromide and potassium chloride, resulting in an excruciatingly painful and horrifying death as a result of the conscious asphyxiation by pancuronium bromide followed by the painful intense burn and cardiac arrest of potassium chloride.

76. The use of pancuronium bromide in the New April 30, 2007 Protocol as a "muscle paralytic" that will "assist in the suppression of breathing and ensure death" is unconstitutional. See Exhibit 1, p. 35.

77. Pancuronium Bromide, marketed under the name Pavulon, is a neuromuscular blocking agent which causes paralysis of the skeletal muscles but does not affect the brain or nervous system. Thus, Pancuronium Bromide does not affect consciousness or the sensation of pain or suffering.

78. An individual under the influence of pancuronium bromide, though paralyzed, still has the ability to think, to be oriented to where he is, to experience fear or terror, to feel pain, and to hear. While pancuronium bromide paralyzes the diaphragm to prevent breathing, it does not affect the heart muscle. Thus pancuronium bromide would ultimately cause someone to

asphyxiate or suffocate to death while still conscious. And if an individual is not properly anesthetized when injected with pancuronium bromide, he will consciously experience extreme pain of suffocation while being completely paralyzed and unable to cry out.

79. Thus, the paralyzing effect of pancuronium bromide also prevents any expression of the pain, horror, or suffering from any other source, such as potassium chloride which will activate the nerves of the venous system causing an extreme burning pain.

80. The New April 30, 2007 Protocol fails to educate it readers (the execution team) regarding the true nature of pancuronium – that its paralytic nature blocks the ability to determine if someone is in pain. See Exhibit 1, p. 35.

81. There is no legitimate penological purpose articulated in the New April 30, 2007 Protocol for the use of pancuronium bromide. See Exhibit 1, p. 35.

82. The use of pancuronium bromide is arbitrary, unreasonable, degrading to human dignity, and serves no legitimate interest. Because pancuronium bromide causes paralysis, suffocation, and the suffering attendant to such paralysis and suffocation, in 2001, Tennessee declared in the "Nonlivestock Humane Death Act" (Tenn. Code Ann. 44-17-301 *et seq*.) that pancuronium bromide cannot be used to euthanize animals, because its use is not humane. Where the use of pancuronium bromide is not "humane" to use on non-humans, it is arbitrary to claim that its use is "humane" on humans, and its use on humans to cause death violates basic precepts of human dignity.

83. The use of pancuronium bromide serves no legitimate state interest and is not narrowly tailored to any compelling state interest. As Chancellor Ellen Hobbs Lyle has explained:

> [T]he use of Pavulon is . . . unnecessary. . . [T]he State [has] failed to demonstrate any reason for its use. The record is devoid of proof that the Pavulon is needed. Thus, the Court concludes that . . . the State's use of Pavulon is . . . in legal terms 'arbitrary.'

Abdur'Rahman v. Sundquist, No. 02-2236-III, In The Chancery Court For The State Of Tennessee, Twentieth Judicial District, p. 13 (June 2, 2003).

84. The use of potassium chloride in the New Protocol as the means for "cardiac arrest and rapid death" is unconstitutional and is false. See Exhibit 1, p.35. See Leonardis Koniaris et al, *Lethal Injection For Execution: Chemical Asphyxiation?*, PLOS Medicine, Vol. 4, Issue 4, April 2007 (Exhibit 2). Moreover, the New April 30, 2007 Protocol fails to educate its reader (the execution team) about the true nature of potassium chloride – that it would cause extreme pain in someone who is not properly anesthetized. See Exhibit 1, p. 35.

85. The New April 30, 2007 Protocol fails to indicate how persons on the Execution Team are qualified to participate in an execution, or what screening, if any, has been done to insure that these persons do not have a criminal background, mental health issues, personnel and disciplinary issues, drug or alcohol issues. See Exhibit 1, p.32.

86. The New April 30, 2007 Protocol fails to indicate how specialized members of the execution team identified as "two (2) EMTs - Paramedic - Certified Emergency Medical Technician"are qualified to participate, how they were chosen to participate, by whom they were chosen, or what screening, if any, has been done to insure that these members do not have a criminal background, mental health issues, personnel and disciplinary issues, drug or alcohol issues. See Exhibit 1, p.32. Moreover, the New April 30, 2007 Protocol fails to indicate what role these EMTs - Paramedic - Certified Emergency Medical Technician" play on the execution

team. See Exhibit 1, p. 32.

87. The New April 30, 2007 Protocol fails to indicate how the "three correctional officers" who "received IV training through the Tennessee Correction Academy by qualified medical professionals" are qualified to participate as part of the IV team, how they were chosen to participate on the IV team, by whom were they chosen to participate, what screening, if any has been done to insure that these specific members do not have a criminal background, mental health issues, personnel and disciplinary issues, drug or alcohol issues, and what screening has been done, if any, to insure that they can competently perform their duties as part of the IV team. See Exhibit 1, p.32. Moreover, the New April 30, 2007 Protocol fails to specifically indicate that these "three correctional officers" actually make up the IV team. See Exhibit 1, p. 21, 32. In addition, the New April 30, 2007 Protocol fails to explain or elaborate on the alleged "IV training through the Tennessee Correction Academy by qualified medical professionals." See Exhibit 1, p. 32.

88. The New April 30, 2007 Protocol fails to indicate what training is required for members of the execution team. See Exhibit 1, p. 33. The New April 30, 2007 Protocol only indicates that execution team members are required to read the manual and that "the Warden or his designee holds a class during which the manual is reviewed and clearly understood by all participants." See Exhibit 1, p. 33. The New April 30, 2007 Protocol does not explain how the Warden insures that the manual is clearly understood by all participants nor does it explain who teaches the science and medical technique to be utilized in the manual. See Exhibit 1, p. 33.

89. The New April 30, 2007 Protocol fails to indicate what instruction the Executioner receives, by whom that instruction is given, and what qualifications, education,

training, and licensing that individual has to provide any such instruction. The New April 30, 2007 Protocol only says that "The Executioner receives initial and periodic instruction from a qualified medical professional." See New Protocol, p. 33. Moreover the New April 30, 2007 Protocol fails to define the role of Executioner, fails to identify the Executioner, how he or she is chosen, by whom he or she is chosen, what qualifications or training he or she has, or what screening, if any, has been done to insure that the Executioner does not have a criminal background, mental health issues, personnel and disciplinary issues, drug or alcohol issues.

90. The New April 30, 2007 Protocol fails to indicate what training, education, or licensing the IV Team and the medical doctor has, if any, and if any training, education, or licensing is required for their selection for those positions. See Exhibit 1, pp.20, 21, 32. Moreover, the New April 30, 2007 Protocol fails to indicate how the medical doctor is qualified to participate, how he or she is chosen, by whom he or she is chosen, or what screening, if any, has been done to insure that the medical doctor does not have a criminal background, mental health issues, personnel and disciplinary issues, drug or alcohol issues.

91. The New April 30, 2007 Protocol fails to indicate how "the Warden or his designee" chooses one member from the execution team who has access to the Lethal Injection Chemicals during their procurement and storage. See Exhibit 1, p. 36. The protocol indicates that "the Warden or his designee" (the designee is not identified) instructs one member of the execution team to "check[] the supply of chemicals and expiration dates," to order additional chemicals, to pick up the additional chemicals and deliver them to RMSI, and to "inventory" the chemicals prior to an execution date. See Exhibit 1, p. 36. The New April 30, 2007 Protocol fails to indicate what qualifications, training, and screening is done to insure that the execution

team member who is given this access to the lethal injection chemicals does not have a criminal background, mental health issues, personnel and disciplinary issues, or drug or alcohol issues.

92. The New April 30, 2007 Protocol fails to indicate who prepares and mixes the "Lethal Injection Chemicals" (other than "one member of the execution team") and what training, education, or licensing any member of the execution team has in the preparation and mixing of chemicals. See Exhibit 1, p. 38. Based on the vague descriptions of the execution team, there is no one who has pharmaceutical training or knowledge of drug compounding to mix the drugs.

93. Moreover, the New April 30, 2007 Protocol provides only that "another member of the execution team observes and verifies that the procedure has been carried out correctly." See Exhibit 1, p. 38. Again, the New April 30, 2007 Protocol fails to indicate what training, education, or licensing, or any other qualifications any execution team member has for observing the mixing of the "Lethal Injection Chemicals" to make sure it is done correctly. There is no quality control to assure that the chemicals have actually been mixed correctly and at the proper dosage.

94. The New April 30, 2007 Protocol fails to include the proper instructions for mixing sodium thiopental by failing to identify what the sodium thiopental should be mixed in, whether it is to be mixed all together (10 boxes in one mixing container) or one box at a time, what instrument is to be used to actually mix the solution, how many syringes should be filled per box of powder, or what precautions are taken to avoid settling or contamination of the sodium thiopental. See Exhibit 1, p. 38.

95. Under the New April 30, 2007 Protocol, for Philip Workman, who was an IV drug

user prior to his incarceration, there is a greater risk that the veins in his arms will be inaccessible and that surgical measures, like the cutdown proposed by the New April 30, 2007 Protocol, will be necessary to insert the IV catheters. See Exhibit 1, pp. 41, 67.

a. The New Protocol indicates that a cut-down may be used but does not indicate at what point in the procedure the IV technicians would resort to this option or who would make the determination that a cutdown is necessary.

b. The New April 30, 2007 Protocol is silent as to the physician's qualifications to perform a cutdown. Only 15% of physicians in the United States are qualified to perform a cutdown.

c. Any cutdown procedure is a dangerous and antiquated medical procedure that is rarely performed in the practice of medicine.

d. A cutdown procedure involves making a series of sharp incisions through the skin and through several layers of connective tissue, fat, and muscle - all with only local anesthetic – to expose a suitable vein for IV catheterization.

e. A cutdown is a complicated medical procedure requiring equipment and skill that has a very high probability of not proceeding properly in the absence of adequately trained and experienced personnel, and without the necessary equipment. If done improperly, the cut-down process can result in very serious complications including severe hemorrhage (bleeding), pneumothorax (collapse of a lung which may cause suffocation), and severe pain.

f. Thus, cutdowns are out-dated and are only used in clinical situations that are not pertinent to executions by lethal injection, including emergency scenarios where there has been extensive blood loss, and in situations involving very small pediatric patients and premature

infants.

g. Cutdowns have been replaced by the percutaneous technique which is less invasive, less painful, less mutilating, faster, safer, and less expensive than the cut-down technique.

h. The use of a cutdown as a back-up before trying to find percutaneous access is a profound departure from standard medical methods and from the standard of care used in executions in other jurisdictions.

i. To use a cut-down as the backup method of achieving IV access would defy contemporary medical standards and would be a violation of any modern standard of decency.

j. The New April 30, 2007 Protocol is completely silent on the procedures that will be followed by the physician should a cutdown become necessary. See Exhibit 1, pp. 41, 67.

96. The New April 30, 2007 Protocol fails to indicate whose responsibility it is to watch the IV lines for leaks in the tubing, junctions, and valves during the administration of the Lethal Injection Chemicals and what any member of the execution team would do should a leak be found. See Exhibit 1, p. 43. A leak in the tubing, junctions, or valves can result in the failure to properly administer a full dosage of anesthetic to the inmate, resulting in an excruciatingly painful and horrifying death.

97. The only monitoring prescribed by the New April 30, 2007 Protocol during the administration of the Lethal Injection Chemicals is "by watching the monitor in his room which displays the exact location of the catheter(s) by means of a pan-tilt zoom camera" and allows for

the "monitoring the catheter sites for swelling or discoloration." See Exhibit 1, p. 43.

98. Thus, there is no monitoring of the IV tubing or the drip chamber during the administration of Lethal Injection Chemicals. Moreover, the monitoring of an IV site from a remote camera is not medically proper – in order to insure that an IV does not migrate, infiltrate, move, and is working properly, the IV site must be monitored from the bedside. The New April 30, 2007 Protocol does not provide for anyone to monitor the IV site from the bedside, nor is there any qualified medical personnel in the room to do any personal, medical monitoring of the process. See Exhibit 1, p. 43.

99. The New April 30, 2007 Protocol fails to indicate what Defendants will do if the inmate has small veins or general venous incompetence and which member of the execution team will make a decision surrounding those issues. Small veins or venous incompetence can result in an inability to properly administer a full dosage of anesthetic to the inmate, resulting in an excruciatingly painful and horrifying death. See Exhibit 1, p. 41. Moreover, the New April 30, 2007 Protocol fails to identify any execution team member who has medical training in general venous incompetence.

100. The New April 30, 2007 Protocol fails to indicate what any member of the execution team will do if the catheter migrates during the lethal injection. See Exhibit 1, p. 67. The migration of an IV catheter can result in an inability to properly administer a full dosage of anesthetic to the inmate, resulting in an excruciatingly painful and horrifying death.

101. The New April 30, 2007 Protocol fails to indicate what any member of the execution team will do if the inmate has a collapsed vein, perforation or leakage of the vein, or a blown vein from the pressure of the syringe plunger. See Exhibit 1, pp. 41-42, 67. A collapsed,

torn, or blown vein can result in an inability to properly administer a full dosage of anesthetic to the inmate, resulting in an excruciatingly painful and horrifying death.

102. The New Protocol fails to indicate which member of the execution team, if any, is responsible for loosening the tourniquets or restraining straps. See Exhibit 1, pp. 41-42. The failure to properly loosen the tourniquets or restraining straps on an inmate can result in an inability to properly administer a full dosage of anesthetic to the inmate, resulting in an excruciatingly painful and horrifying death.

103. The New April 30, 2007 Protocol fails to indicate the length of time between the administration of each drug. See Exhibit 1, pp. 43-44. This is important to ensure that an inmate is adequately anesthetized by the sodium thiopental prior to the introduction of the pancuronium bromide and potassium chloride. .

104. The New April 30, 2007 Protocol fails to indicate who, if anyone, is monitoring the inmate during the administration of the drugs to assure that the sodium thiopental (anesthesia) is working. See Exhibit 1, pp. 43-44.

105. The New April 30, 2007 Protocol fails to indicate the presence of an anesthesiologist or a certified nurse anesthetist who could properly monitor consciousness. See Exhibit 1, pp. 43-44. Indeed, there is no one present on the execution team who is qualified to monitor the anesthetic depth of the inmate. Moreover, the New April 30, 2007 Protocol fails to indicate the presence of any medical technology that might be used to monitor consciousness. See Exhibit 1, pp. 43-44.

106. The New April 30, 2007 Protocol does not indicate what plan is in place if the execution must be stopped because the Governor or the courts have entered a stay or reprieve.

See Exhibit 1, p. 67. The New April 30, 2007 Protocol does not indicate if anyone on the execution team is qualified to resuscitate the inmate or if any of the necessary equipment is present for resuscitation.

107. The New April 30, 2007 Protocol was prepared by the Governor and TDOC despite their awareness of the risks inherent in the New April 30, 2007 Protocol, based on prior lethal injection litigation in this state and ongoing lethal injection litigation in 14 other states (all of which have almost identical protocols to the New Protocol), but persisted with deliberate indifference in promulgating a protocol that has been declared unconstitutional by other federal courts and unusable by Governors of other states, and that will cause an excruciatingly painful and horrifying death from the use of these three drugs by untrained personnel. See Report on Administration of Death Sentences in Tennessee.

108. The New April 30, 2007 Protocol was prepared without consultation with and the requesting of documents from correctional officials, state officials, or medical experts with experience in lethal injection and lethal injection litigation from any of the listed states or jurisdictions as a part of its review and development of the New April 30, 2007 Protocol despite their knowledge of the ongoing lethal injection litigation in multiple states and jurisdictions.

109. The New April 30, 2007 Protocol that was promulgated by TDOC and approved by the Governor, is one-sided, unscientific and fails to take into account the serious known and demonstrated risks of the use of the chemicals and procedures selected for the New April 30, 2007 Protocol.

110. TDOC's failure to properly consult, review, and research in promulgating its New

April 30, 2007 Protocol (a failure which was approved by the Governor), despite the ready availability of experienced state officials and medical experts, demonstrates a deliberate indifference to the excruciatingly painful and horrifying death that will result from the use of these three drugs by untrained personnel under the new execution protocol. See Exhibit 5.

111. The New April 30, 2007 Protocol, including the combination of chemicals (sodium thiopental, pancuronium bromide, and potassium chloride); the lack of proper training, qualifications, screening and review of the persons involved in the process; the absence of standardized procedures for administration of the chemicals; the absence of a sufficient anesthetic and any monitoring of anesthetic depth; and the absence of a back-up plan should problems arise during the protocol, creates a grave and substantial risk that Mr. Workman will be conscious throughout the execution process and, as a result, will experience an excruciatingly painful and protracted death in violation of his constitutional rights and substantive due process under the Eighth, Ninth, and Fourteenth Amendments.

112. In addition, the New April 30, 2007 Protocol, devised and promulgated by the TDOC and approved by the Governor violates evolving standards of decency. See Trop v. Dulles, 356 U.S. 86 (1958).

113. Finally, the New April 30, 2007 Protocol, devised and promulgated by TDOC and approved by the Governor, demonstrates a deliberate indifference to the excruciatingly painful and horrifying death that will result from its use in violation of the Fourteenth Amendment.

114. The New April 30, 2007 Protocol fails to indicate how long the IV tubing is, what connections and junctures are used in the tubing, what kind of stopcock is used, or the size of the IV catheter.

115. The New April 30, 2007 Protocol fails to indicate what Defendants will do if a retrograde injection occurs because the stopcock is turned the wrong way nor does it indicate whose job it is to turn the stopcock. A retrograde injection can result in the failure to properly administer a full dosage of anesthetic to the inmate, resulting in an excruciatingly painful and horrifying death.

116. The New April 30, 2007 Protocol fails to indicate what Defendants will do if the inmate has a collapsed vein, perforation or leakage of the vein, or a blown vein from the pressure of the syringe plunger. A collapsed, torn, or blown vein can result in an inability to properly administer a full dosage of anesthetic to the inmate, resulting in an excruciatingly painful and horrifying death.

117. The New April 30, 2007 Protocol fails to indicate which member of the Execution, IV, or Extraction team is responsible for loosening the tourniquets or restraining straps. The failure to properly loosen the tourniquets or restraining straps on an inmate can result in an inability to properly administer a full dosage of anesthetic to the inmate, resulting in an excruciatingly painful and horrifying death.

118. The New April 30, 2007 Protocol fails to indicate the length of time between the administration of each drug.

119. The New April 30, 2007 Protocol fails to indicate whose responsibility it is to monitor the IV catheter during the administration of the drugs.

120. The New April 30, 2007 Protocol fails to indicate who or what, if anyone, on the Execution Team is monitoring anesthetic depth or what physical symptoms they would monitor if they were attempting to monitor anesthetic depth.

121. The New April 30, 2007 Protocol does not indicate whose responsibility it is to determine whether the injection of the drugs should be repeated if the Plaintiff is not dead.

122. The New April 30, 2007 Protocol does not indicate what plan is in place if the execution must be stopped because the Governor or the courts have entered a stay or reprieve. The New April 30, 2007 Protocol does not indicate if anyone on the Execution Team is qualified to resuscitate the inmate or if any of the necessary equipment is present for resuscitation.

123. According to the Governor and the TDOC, the TDOC will follow this New April 30, 2007 Protocol to perform Plaintiff's execution.

124. Dr. Mark Heath, Assistant Professor of Clinical Anesthesiology at Columbia University who has reviewed and/or testified about lethal injection procedures in twenty-seven jurisdictions, has reviewed the New April 30, 2007 Protocol and reached the following conclusion:

> Based on my research into methods of lethal injection used by various states and the federal government, and based on my training and experience as a medical doctor specializing in anesthesiology, it is my opinion stated to a reasonable degree of medical certainty that, given the apparent absence of a central role for a properly trained professional in TDOC's execution procedure, the characteristics of the drugs or chemicals used, the failure to understand how the drugs in question act in the body, the failure to properly account for foreseeable risks, the design of a drug delivery system that exacerbates rather than ameliorates the risk, the TDOC has created an revised execution protocol that does little to nothing to assure they will reliably achieve humane executions by lethal injection.

See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 69.

125. A growing body of evidence, including medical evidence, eyewitness observations, and veterinary studies, persuasively demonstrates that Tennessee's New April 30,

2007 Protocol creates a significant risk Mr. Workman will fail to receive adequate anesthesia and will be conscious for the duration of his execution.

126. Indeed, Tennessee's New April 30, 2007 Protocol has been described by Dr. Mark Heath as a "revised execution protocol that does little to nothing to assure [the TDOC] will reliably achieve humane executions by lethal injection.." See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 69.

127. The New April 30, 2007 Lethal Injection Protocol Creates a Tremendous Risk of Unnecessary Pain During Executions by Imposing Conditions Conducive to Botched Executions and Failing to Compensate for these Conditions.

128. The New April 30, 2007 Protocol instructs that executions shall be carried out by means of an IV line inserted into a vein and monitored and controlled remotely, from a separate room. See New April 30, 2007 Protocol, Exhibit 1, pp. 40-44. This line is inserted into a "usable" vein by an EMT, with unspecified training and credentials. Id. at pp. 32,41. Once a flow of saline solution has been started and the inmates hands are taped in place, "the members of the IV team leave the Execution Chamber." Id. at p. 43. Dr. Mark Heath discusses the risks associated with this procedure:

> The intravenous ("IV") catheters are to be inserted by a team of persons whom the TDOC represents as having, at some time, training or background as emergency medical technicians. The TDOC has not presented any information which shows that these persons are currently licensed or credentialed as an emergency medical technicians or whether placement of IV lines is currently part of any team members' regular occupation or duties. The protocol does not require that the injection team members be qualified in any particular way. The absence of currency with IV access procedures would render the IV team unqualified to perform IV access in an execution context.

See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 18.

129. If the EMT cannot gain access to an inmate's vein, the New April 30, 2007 Protocol instructs that a doctor will do a cutdown. See New April 30, 2007 Protocol, Exhibit 1, pp 41, 67. There are serious dangers associated with a cutdown procedure:

> When peripheral IV access is not possible, the TDOC will use a cut down to achieve venous access. A "cut-down" is a complex medical procedure requiring equipment and skill that are not accounted for in Tennessee's protocol on cut down procedures. It has a very high probability of not proceeding properly in the absence of adequately trained and experienced personnel, and without the necessary equipment. If done improperly, the "cut-down" process can result in very serious complications including severe hemorrhage (bleeding), pneumothorax (collapse of a lung which may cause suffocation), nerve injury, and severe pain. It is well documented that lethal injection procedures in other states require the use of central intravenous lines. As is widely recognized in the medical community, administration of intravenous medications and the management of intravenous systems are complex endeavors with significant risks and complications.
>
> Cut-down procedures are an outdated method of achieving venous access for the administration of anesthetic drugs. The cut-down procedure has been virtually completely supplanted by the "percutaneous" technique for achieving central venous access. The percutaneous technique is less invasive, less painful, less mutilating, faster, safer, and less expensive than the cut-down technique. I have personally never used the cut-down technique to achieve intravenous access for drug delivery to a patient. The cut-down technique is still used in clinical situations that are not pertinent to executions by lethal injection, including emergency scenarios where there has been extensive blood loss, and in situations involving very small pediatric patients and premature infants. These are the only situations in which I have seen colleagues perform cut-down procedures for the administration of drugs. That Tennessee intends to use a cut down procedure on Mr. Workman if it can not successfully place peripheral IVs after 4 attempts is unconscionable. To use a cut-down as the backup method of achieving IV access would defy contemporary medical

> standards and would be a violation of any modern standard of decency. The ready availability of a superior alternative technique for achieving central IV access, should it be necessary, means that the TDOC's adherence to the outdated cut-down method would represent the gratuitous infliction of pain and mutilation to the condemned prisoner. Most other states have abandoned the use of the cutdown procedure as a means of obtaining IV access during executions.

See Declaration of Dr. Mark Heath, Exhibit 2, pp. 21-23, ¶¶64-66.

130. After veinous access or access to a vein through a cutdown is achiever, the Executioner, who is never identified in the protocol in any way whatsoever, selects "either the right or left solution set." See New April 30, 2007 Protocol, Exhibit 1, p. 43.

131. Upon the Warden's signal, the "Executioner receives the first syringe from the member of the IV team and inserts and twists it into the extension line." Id.

132. The Executioner then proceeds to inject a total of eleven separate syringes containing the three drug cocktail – 4 doses of sodium thiopental, followed by a saline flush, followed by 2 doses of pancuronium bromide, followed by a saline flush, followed by 2 dose of potassium chloride, and finally a saline flush. Id. at p. 44. After the 11 syringes have been "pushed" into the extension line (which is at least seven feet and one inch in length), the "Executioner signals the Warden that all of the LIC's and saline have been administered." Id. at p. 43.

133. Administering the lethal drugs in the manner dictated by the New April 30, 2007 Protocol creates the risk that the sodium thiopental will not be administered properly and the inmate will not be rendered fully unconscious by the time that the other two drugs are administered. As Dr. Heath explains:

> Of note, there is no description whatsoever of the actual mechanics of the administration of the drugs (page 65). Instead, the protocol elides the necessary step-by-step instructions, moving from "The Warden gives the signal to proceed and the Executioner begins to administer the first chemical…." to "Following the completion of the lethal injection process…" This is non-sensical, and it is also a departure from the written protocols of many other states, which describe in detail the intended mechanical steps to be taken during the sequence of injections. While Tennessee's omission might in theory be acceptable if the drugs were to be administered by an individual possessing the requisite demonstrated professional experience to undertake this activity, it is in fact not acceptable if it is the case that it is being done by personnel who lack such experience and qualifications. I know this from, among other things, my experience teaching medical students and junior anesthesiology residents in the operating room. Despite a significant degree of immersion in the clinical setting, medical students and junior anesthesiology residents often initiate or make critical errors in their handling and use of intravenous tubing, injection sites, and syringes. Part of my job, as a practitioner in a teaching hospital, it to intercept such errors on the part of junior personnel, to apprise them of their errors, and to instruct them on how to avoid, detect, and correct such errors. It is not acceptable, under any standard, to permit personnel who have not undergone such elbow-to-elbow training to perform lethal injection, particularly in view of the inclusion of pancuronium and potassium in the currently proposed procedure.

Declaration of Dr. Mark Heath, Exhibit 2, pp 5-6, ¶ 9.

134. The risk that inmates will be conscious during their executions is in part inherent in the use of sodium thiopental itself; TDOC has chosen to use an ultrashort-acting anesthetic that is extremely sensitive to errors in administration.

135. In medical situations, sodium thiopental is used only for specific, expeditious tasks, and only by personnel who have considerable expertise in anesthesia. See Id., pp. 14-15, ¶¶ 50-53.

136. Monitoring the effects of sodium thiopental, like those of other ultrashort-acting

anesthetics, requires considerable expertise in anesthesia. Id.

137. Moreover, because sodium thiopental is extremely unstable, it must be carefully and properly mixed so that it does not crystallize, a technical task that requires significant training in pharmaceutical calculations. Id. at ¶ 54.

138. Thus, sodium thiopental's instability makes it more likely to be administered incorrectly, and its fast-acting properties heighten the risk that improper administration will result in ineffective anesthesia and consciousness. Again, Dr. Heath writes:

> Thiopental is an ultrashort-acting barbiturate that is intended to be delivered intravenously to induce anesthesia. In typical clinical doses, the drug has both a quick onset **and short duration**, although its duration of action as an anesthetic is dose dependant.
>
> When anesthesiologists use thiopental, we do so for the purposes of temporarily anesthetizing patients for sufficient time to intubate the trachea and institute mechanical support of ventilation and respiration. Once this has been achieved, additional drugs are administered to maintain a "surgical depth" or "surgical plane" of anesthesia (i.e., a level of anesthesia deep enough to ensure that a surgical patient feels no pain and is unconscious). The medical utility of thiopental derives from its ultrashort-acting properties: if unanticipated obstacles hinder or prevent successful intubation, patients will likely quickly regain consciousness and resume ventilation and respiration on their own.
>
> The benefits of thiopental in the operating room engender serious risks in the execution chamber. The duration of unconcsiousness provided by thiopental is dose-dependent. However, if the intended amount of thiopental fails to reaches the condemned inmate's brain (as can occur as a result of an infiltration, leakage, mixing error, or other causes), and the condemned inmate receives a near surgical dose of thiopental, the duration of narcosis will be brief and the inmate could reawaken during the execution process. Then, a condemned inmate in Tennessee would suffer the same fate that apparently befell Mr. Angel Diaz in Florida who was intended to receive a 5 gram dose of thiopental just as Mr. Workman is intended to receive, but who did not, and then

> apparently experienced a conscious or semi-conscious response to the execution process.
>
> Many foreseeable situations exist in which human or technical errors could result in the failure to successfully administer the intended dose. The TDOC's procedure both fosters these potential problems and fails to provide adequate mechanism for recognizing these problems, and it does these things needlessly and without legitimate reason.

Id. at pp. 14-15, ¶¶50-53.

139. The danger of improper administration of sodium thiopental is exacerbated by the fact that the New April 30, 2007 Protocol does not require medically trained personnel to supervise or assist in any way in the medical tasks necessary to prepare for the execution or during the execution. See New April 30, 2007 Protocol, Exhibit 1, p. 32 (stating only that the person who inserts the IV shall have either some unspecified training, or be "authorized by law" to initiate the procedure). These critical, medical tasks include: mixing the sodium thiopental solution; setting up the IV line and associated equipment in order to ensure that fluids do not leak and are not misdirected; finding a usable vein and properly inserting the IV line in the proper direction into the vein; and, verifying that the drugs are flowing into the inmate's vein rather than into surrounding tissue.

140. All of these critical, medical tasks require a high degree of specialized training which the New April 30, 2007 fails to acknowledge or account for in any way:

> It is my opinion that, to reasonably minimize the risk of severe and unnecessary suffering during the TDOC's execution by lethal injection, there must be: proper procedures that are clear and consistent; qualified personnel to ensure that anesthesia has been achieved prior to the administration of pancuronium bromide and potassium chloride; qualified personnel to select chemicals and dosages, set up and load the syringes, administer "pre-injections,"

> insert the IV catheter, and perform the other tasks required by such procedures; and adequate inspection and testing of the equipment and apparatus by qualified personnel. The TDOC's procedures for implementing lethal injection, to the extent that they have been made available, provide for none of the above.

Id. at ¶ 67.

141. There are very serious and foreseeable problems with the New April 30, 2007 Protocol's failure to provide for any medically trained and qualified personnel to administer sodium thiopental:

> Because of these foreseeable problems in administering anesthesia, in Tennessee and elsewhere in the United States, the provision of anesthetic care is performed only by personnel with advanced training in the medical subspecialty of Anesthesiology. The establishment of a surgical plane of anesthesia is a complex task which can only reliably be performed by individuals who have completed the extensive requisite training to permit them to provide anesthesia services. *See Practice Advisory for Intraoperative Awareness and Brain Function Monitoring*, 104 Anesthesiology 847, 859 Appendix 1 (Apr. 2006) (recommending the use of "multiple modalities to monitor depth of anesthesia'). If the individual providing anesthesia care is inadequately trained or experienced, the risk of these complications is enormously increased. The President of the American Society of Anesthesiologists, writing about lethal injection, recently stated that "the only way to assure [a surgical plane of anesthesia] would be to have an anesthesiologist prepare and administer the drugs, carefully observe the inmate and all pertinent monitors, and finally to integrate all this information." Orin F. Guidry, M.D., *Message from the President: Observations Regarding Lethal Injection* (June 30, 2006).
>
> In Tennessee and elsewhere in the United States, general anesthesia is administered by physicians who have completed residency training in the specialty of Anesthesiology, and by nurses who have undergone the requisite training to become Certified Registered Nurse Anesthetists (CRNAs). Physicians and nurses who have not completed the requisite training to become anesthesiologists or CRNAs are not permitted to provide general

anesthesia.

In my opinion, individuals providing general anesthesia in the Tennessee prison should not be held to a different or lower standard than is set forth for individuals providing general anesthesia in any other setting in Tennessee. Specifically, the individuals providing general anesthesia within Tennessee's prisons, including during execution procedures, should possess the experience and proficiency of anesthesiologists and/or CRNAs. Conversely, a physician who is not an anesthesiologist or a nurse who is not a CRNA or any person who lacks the requisite training and credentials should not be permitted to provide general anesthesia within Tennessee's prisons (or anywhere else in Tennessee or the United States).

There is no evidence, at this time, that any person on the TDOC's injection team has any training in administering anesthesia, or, if personnel are given training, what that training might be. The absence of any details as to the training, certification, or qualifications of injection personnel raises critical questions about the degree to which condemned inmates risk suffering excruciating pain during the lethal injection procedure. The great majority of nurses are not trained in the use of ultrashort-acting barbiturates; indeed, this class of drugs is essentially only used by a very select group of nurses who have obtained significant experience in intensive care units and as nurse anesthetists. Very few paramedics are trained or experienced in the use of ultrashort-acting barbiturates and/or pancuronium. Based on my medical training and experience, and based upon my research of lethal injection procedures and practices, inadequacies in these areas elevate the risk that the lethal injection procedure will cause the condemned to suffer excruciating pain during the execution process. Failure to require that the injection team have training equivalent to that of an anesthesiologist or a CRNA compounds the risk that inmates will suffer excruciating pain during their executions.

In addition to apparently lacking the training necessary to perform a lethal injection, the TDOC's protocol imposes conditions that exacerbate the foreseeable risks of improper anesthesia administration described above, and fails to provide any procedures for dealing with these risks. Perhaps most disturbingly, the protocol makes no mention of the need for effective monitoring of the inmate's condition or whether he is anesthetized and unconscious. After IV lines are inserted and the execution begins,

it appears that the injection team will be in a different room from the prisoner, and thus will not have the ability to monitor the IV deliver system and catheter sites as they would if they were at "the bedside". Accepted medical practice, however, dictates that trained personnel are physically situated so that they can monitor the IV lines and the flow of anesthesia into the veins through visual and tactile observation and examination. The apparent lack of any qualified personnel present in the chamber during the execution thwarts the execution personnel from taking the standard and necessary measures to reasonably ensure that the thiopental is properly flowing into the inmate and that he is properly anesthetized prior to the administration of the pancuronium bromide and potassium. Other states have taken steps to place personnel with medical backgrounds actually within the execution chamber for the purpose of monitoring the IV delivery system during the injection process.

In my opinion, having a properly equipped, trained, and credentialed individual examine the inmate after the administration of the thiopental (but prior to, during, and after the administration of pancuronium, until the prisoner is pronounced dead) to verify that the inmate is completely unconscious would substantially mitigate the danger that the inmate will suffer excruciating pain during his execution. This is the standard of care, and in many states the law, set forth for dogs and cats and other household pets when they subjected to euthanasia by potassium injection. Yet the TDOC protocol does not apparently provide for such verification.

Indeed, it appears that departments of correction around the country are now agreeing that some assessment of anesthetic depth is required to insure a humane execution. As a result of my participation in lethal injection litigations around the country I have become aware that the State of Indiana and the State of Florida now concede that some attempt at measuring or assessing anesthetic depth should be performed. Additionally, in Missouri, a federal district judge has ordered that an appropriately qualified person assess anesthetic depth. While Judge Fogel in California has not, to my understanding, issued a final decision regarding the evidence presented to him, it is clear from his discussion of the case that he recognizes that the use of drugs that cause great pain or suffering (such as pancuronium and potassium) places a heightened burden on the execution team and the state to properly monitor and maintain adequate anesthetic depth.

Declaration of Dr. Mark Heath, Exhibit 2, ¶¶57-63.

142. In addition, the New April 30, 2007 Protocol makes several of the above tasks even more prone to mistakes by deviating from established medical practice.

143. Further, because the drugs are administered from another room, IV line extensions must be used, (see New April 30, 2007 Protocol, Exhibit 1, p. 40), which increases the risk that a flaw or kink in the IV line will disrupt the flow of drugs. A reasonable medical standard of care would not permit these unnecessary line extensions.

> If the drugs are not at the bedside, which they are not in Tennessee, but are instead in a different room then it will be impossible to maintain visual surveillance of the full extent of IV tubing so that such leaks may be detected. The configuration of the death chamber and the relative positions of the executioners and the inmate in Tennessee will hinder or preclude such surveillance, thereby causing a failure to detect a leak. Leaking IV lines have been noted in executions in other states. The induction of general anesthesia in the medical context, and I believe in the veterinary context, is always a "bedside procedure"; it is never conducted by the administration of drugs in tubing in one room that then is intended to travel into the body of a person in another room.

Id. at ¶¶ 54 (e).

144. The risk of inadequate anesthesia is compounded by the fact that the New April 30, 2007 Protocol requires that only the Warden, who is not a qualified medical professional, be present in the execution chamber when *any* of the drugs are administered. The protocol thus prevents qualified personnel from obtaining any sort of visual or other verification that the drugs are actually being administered to the inmate, or that the sodium thiopental anesthetic has taken effect. Proper monitoring of the flow of fluids into the vein requires a clear view of the IV site, and also tactile examination of the skin surrounding the IV site to verify skin firmness and

temperature. See Declaration of Dr. Mark Heath, Exhibit 2, pp. 15-18, ¶¶ 54 (a)-(l).

145. Proper monitoring of the inmate would also necessitate that a person trained specifically in assessing anesthetic depth closely observe the inmate at all times after the sodium thiopental is administered. Only persons trained in anesthesia are able to assess properly whether the inmate has attained the degree of unconsciousness necessary to render him insensitive to pain. Id. at ¶¶ 21-23. For this reason, the American Veterinary Medical Association (AVMA) requires that persons euthanizing animals be "competent in assessing depth [of anesthesia] appropriate for administration of potassium chloride." See 2000 Report of the AVMA Panel on Euthanasia, 218 J. Am. Veterinary Med. Ass'n 669, 681 (2001). Similarly, Tennessee requires extensive training in the use of anesthesia for all technicians authorized to euthanize animals.

146. Thus, the New April 30, 2007 Protocol, by requiring that non-medical personnel remotely inject an unstable drug into inmates without proper monitoring, creates conditions that are highly conducive to serious errors that could cause the sodium thiopental to be administered improperly.

147. In the face of this danger, the protocol fails to take even the most rudimentary steps towards minimizing the obvious potential problems. Indeed, the protocol is stunning in its complete failure to acknowledge any risk or potential problem other than tampering with the lethal drugs in the days leading up to the execution. See New April 30, 2007 Protocol, Exhibit 1, pp. 36-37.

148. Examples of the New April 30, 2007 Protocol's failure to account for the very risks that it creates are numerous. Those risks include: Errors in Drug Preparation; Errors in Labeling of Syringes, Error in Selecting the Correct Syringe, Error in Correctly Injecting the

Drug into the Intravenous Lin, The IV tubing may leak, Incorrect Insertion of the Catheter, Migration of the Catheter, Perforation or Rupture ore Leakage of the Vein, Excessive Pressure on the Syringe Plunger, Errors in Securing the Catheter, Failure to Properly Loosen or Remove the Tourniquet, Impaired Delivery Due to Restraining Straps. See Declaration of Dr. Mark Heat, Exhibit 2, pp. 15-18 ¶¶ 54(a)-(l). Dr. Heath concludes:

> These types of drug administration problems are not uncommon in the practice of medicine. A number of medical publications detail exactly these types of administration issues. For example, the National Academy of Sciences Institute on Medicine has just published the report of the Committee on Identifying and Preventing Medication Errors, which details the rates of drug preparation and administration errors in hospital setting and concludes "[e]rrors in the administration of IV medications appear to be particularly prevalent." PREVENTING MEDICATION ERRORS: QUALITY CHASM SERIES 325-60 (Philip Aspden, Julie Wolcott, J. Lyle Bootman, Linda R. Cronenwett, Eds. 2006); *id*. at 351. Likewise a recent study shows that "drug-related errors occur in one out of five doses given to patients in hospitals." *See* Bowdle, T. A., *Drug Administration Errors from the ASA [Am. Soc. Anesthesiologists] Closed Claims Project*, 67(6) ASA NEWSLETTER, 11-13 (2003). This study recognizes that neuromuscular blockers have been administered to awake patients and to those who have had inadequate doses of general anesthetic. *Id*.

Exhibit 2, p. 18, ¶ 55.

149. Despite the New April 30, 2007 Protocol's insistence on removing all personnel from the execution chamber before any drugs are administered, the protocol does not anticipate and provide for the problems that could arise as a result of this policy.

150. There is no procedure for testing or verifying the efficacy of the extended IV tubing.

151. Nor is there a procedure for entering the chamber during the execution should any

of the equipment malfunction or the inmate somehow indicate that something has gone awry.

152. Finally, and most disturbingly, the protocol apparently does not require execution personnel to verify in *any* manner, even through the windows of the execution chamber, that the inmate has been rendered unconscious by the sodium thiopental.

> Because of the potential for an excruciating death created by the use of potassium chloride and the risk of conscious asphyxiation created by the use of the pancuronium bromide, it is necessary to induce and maintain a deep plane of anesthesia. The circumstances and environment under which anesthesia is to be induced and maintained in a Tennessee execution create, needlessly, a significant risk that inmates will suffer. It is my opinion, stated to a reasonable degree of medical certainty, that the lethal injection procedures selected by the TDOC subject condemned inmates to an increased and unnecessary risk of experiencing excruciating pain in the course of execution.
>
> Presumably, because of the TDOC's awareness of the potential for excruciating pain evoked by potassium, the protocol plans for the provision of general anesthesia by the inclusion of thiopental. When successfully delivered into the circulation in sufficient quantities, thiopental causes sufficient depression of the nervous system to permit excruciatingly painful procedures to be performed without causing discomfort or distress. Failure to successfully deliver into the circulation a sufficient dose of thiopental would result in a failure to achieve adequate anesthetic depth and thus failure to block the excruciating pain.
>
> The TDOC's procedures do not comply with the medical standard of care for inducing and maintaining anesthesia prior to and during a painful procedure. Likewise, the TDOC's procedures are not compliant with the guidelines set forth by the American Veterinary Medical Association for the euthanasia of animals.

Declaration of Dr. Mark Heath, Exhibit 2, p. 14, ¶¶ 47-49.

153. Thus, despite the foreseeable risks created by the protocol and described above, the New April 30, 2007 Protocol simply does not acknowledge, much less provide for, the possibility that the five-gram dose of sodium thiopental will fail to render the inmate

unconscious.

154. The New April 30, 2007 Protocol thus both creates an unacceptable quantum of risk that the inmate will not be anesthetized and therefore will suffer excruciating pain during his execution, and also fails utterly to account for these obvious contingencies and instruct personnel on how to react to or prevent them.

155. In light of the fact that sodium thiopental is an ultra-short acting anesthetic, and the New April 30, 2007 Protocol creates the grave risk that the sodium thiopental will not be properly administered, it is critical that an inmate be able to alert execution personnel should he regain – or never lose – consciousness and that execution personnel have the ability to ascertain whether an inmate is properly anesthetized.

156. Yet the use of pancuronium bromide in combination with sodium thiopental effectively prevents an inmate from alerting anyone in any way to the fact that he is conscious and experiencing excruciating pain and prevents anyone, even a trained anesthesiologist, from ascertaining whether the inmate is properly anesthetized. It is for this very reason that the use of pancuronium bromide is prohibited for use on animals. Despite the grave dangers and illegality of its use, the New April 30, 2007 Protocol incorporates pancuronium bromide even though it serves no legitimate purpose within its lethal injection process. See New April 30, 2007 Protocol, Exhibit 1, p. 35.

157. Pancuronium is a neuromuscular blocking agent that blocks nerve cells from interacting with muscle tissue, therefore paralyzing the inmate's muscles, including those of the chest and diaphragm. A patient given pancuronium bromide alone would slowly suffocate to death; thus, the unanesthetized experience of the effects of pancuronium bromide would in itself

involve extraordinary suffering, as the inmate struggled to breathe. The drug does not affect the brain or nerves themselves, however, so an unanesthetized patient would remain completely conscious, but due to the paralysis would be completely unable to communicate either verbally or by movement the fact that he is conscious. See Declaration of Dr. Mark Heath, Exhibit 2, ¶¶ 37-39.

158. Pancuronium bromide also prevents observers from determining whether an inmate is conscious. According to Dr. Mark Heath, the drug's paralytic effect is so complete that it would be difficult for even an anesthesiologist to assess consciousness. See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 38.

159. Thus, even if the New April 30, 2007 Protocol provided some mechanism by which personnel could monitor the inmate's consciousness (which it does not), the use of pancuronium bromide all but ensures that it would be impossible to determine visually whether the inmate is still able to feel pain. Should an inmate retain or regain consciousness after the sodium thiopental is administered, the inmate would suffer slow suffocation as well as the excruciating pain of the potassium chloride, all while being completely paralyzed and unable to communicate. Id. at ¶ 42.

160. It is precisely this risk of the combination of ineffective sodium thiopental and paralyzed consciousness from pancuronium bromide that has led at least nineteen (19) states to prohibit the use of a sedative in conjunction with a neuromuscular blocking agent like pancuronium bromide to euthanize animals. See Beardslee, 395 F.3d at 1073 & n.9 (listing the relevant state laws and noting that this evidence is "somewhat significant").

161. In 2001, the state of Tennessee declared as inhumane – and illegal – the use of

pancuronium bromide or any other neuromuscular blocking agent on non-livestock animals. See Tenn. Code Ann. §44-17-303(c); 44-17-303(j)(criminal sanctions for violation of Humane Death Act: any substance which "acts as a neuromuscular blocking agent . . . may not be used on any nonlivestock aniumal for the purpose of euthanasia."). The AVMA, moreover, has promulgated guidelines that prohibit the use of a sedative with a drug like pancuronium bromide. See *2000 Report of the AVMA Panel on Euthanasia*, 218 J. Am. Veterinary Med. Ass'n 669 (2001), Exhibit 16, p. 681. AVMA also prohibits the use of neuromuscular blocking agents alone, stating that because the drugs cause "respiratory arrest before loss of consciousness, . . . the animal may perceive pain and distress after it is immobilized." Id. at p. 696, App. 4.

162. The fact that so many states and the nation's leading veterinary association have condemned as inhumane the use of anesthetics and neuromuscular blocking agents in tandem is persuasive evidence that this combination of drugs is not consistent with evolving standards of decency.

163. As a result, given that the Eighth Amendment prohibits the same infliction of unnecessary pain that cannot be imposed on household pets and other animals, the veterinary avoidance of this method of euthanasia is compelling.

164. Despite the evidence that employing pancuronium bromide is not consistent with basic standards of care for animals, and the fact that the use of pancuronium bromide increases the risk that an inmate will suffer unnecessary pain, the New April 30, 2007 Protocol incorporates pancuronium bromide, alleging that it "assists in the suppression of breathing and ensure[s] death." See New April 30, 2007 Protocol, Exhibit 1, p. 35.

165. However in the Defendants' Report, it is clear that pancuronium bromide is used

simply "because it speeds the death process, prevents involuntary muscular movement that may interfere with the functioning of the IV equipment, and contributes to the dignity of the death process." See Tennessee Report on Administration of Death Sentences, Exhibit 7, p. 7.

166. What Defendants do not say either in their Report or in the New April 30, 2007 Protocol is that a state court judge has already determined that the use of pancuronium bromide (pavulon) in Tennessee's lethal injection protocol is arbitrary:

> [T]he use of Pavulon is . . . unnecessary. . . [T]he State [has] failed to demonstrate any reason for its use. The record is devoid of proof that the Pavulon is needed. Thus, the Court concludes that . . . the State's use of Pavulon is . . . in legal terms 'arbitrary.'

Abdur'Rahman v. Sundquist, No. 02-2236-III, In The Chancery Court For The State Of Tennessee, Twentieth Judicial District, p. 13 (June 2, 2003), Exhibit 17.

167. The paucity of the record accords with Dr. Heath's opinion that pancuronium bromide serves no legitimate purpose in the execution procedure while greatly increasing the risk of an inmate's suffering and undetected agony. See Declaration of Dr. Mark Heath, Exhibit 2, ¶ 43.

168. The Defendants' use of pancuronium bromide to kill Mr. Workman violates the Eighth Amendment. Again, Mr. Workman has shown entitlement to relief on the merits.

169. Potassium Chloride, As Contemplated In The New April 30, 2007 Protocol, Is Wholly Ineffective To Cause Cardiac Arrest

170. According to Dr. James Ramsey, a licensed clinical perfusionist at the Department of Cardiac and Thoracic Surgery at Vanderbilt University Medical Center in Nashville, Tennessee, the potassium component of the New April 30, 2007 Protocol (100 mg/mL of a

2mEq/ml concentrate)[4](See New April 30, 2007 Protocol, Exhibit 1, p.35), "is wholly ineffective in causing electrical arrest of the human heart." See Affidavit of Dr. James Ramsey, Exhibit 18, p. 1.

171. Dr. Ramsey opines that "it is a pathophysiological impossibility, based upon well-established and accepted mathematical equations, for the heart to succumb to electrical arrest due to the potassium component of the lethal injection protocol." Instead, any cardiac arrest that may occur during an execution by lethal injection under the New April 30, 2007 Protocol, "is entirely due to suffocation and lack of oxygen delivery, and not electrical arrest due to potassium injection." Id. at p. 3. The suffocation and lack of oxygen delivery is caused by the paralysis induced by the use of pancuronium bromide.

172. The ineffectiveness of the potassium chloride is the result of two false assumptions on the part of Defendants.

173. First, the manner in which the potassium is delivered to the inmate in the New April 30, 2007 Protocol – IV injection – assumes, inaccurately, that "potassium solution in high concentrations would reach the coronary arteries and effect an arrest." Id. at p.8. However, as Dr. Ramsey opines, "the solution would necessarily have to pass through the lungs (which have the surface area of approximately that of a tennis court), during which potassium concentrations would fall dramatically." Id.

174. Second, Defendants have assumed that the dosage of potassium chloride to be injected according to the New April 30, 2007 Protocol will result in death. However, as Dr.

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[4]The New April 30, 2007 Protocol's expression of the potassium chloride dosage is not consistent with scientific or pharmacological principles. See Affidavit of Dr. James Ramsey, Exhibit 18, p. 2.

Ramsey has concluded, the amount and concentration of potassium delivered "cannot result in the minimum potassium concentration of 16.4 mEq/L being achieved that is required to arrest the electromechanical function of the heart." See Affidavit of Dr. James Ramsey, Exhibit __, pp. 8-9.

175. In support of Dr. Ramsey's conclusion, the resultant potassium concentrations post-mortem for Robert Glen Coe, who was killed under the prior Tennessee lethal injection protocol which utilized a similar dosage of potassium chloride, "indicates an extracellular potassium concentration of 9 mEq/L, far short of the required minimum concentration of 16.4 mEq/L to cause electromechanical arrest of the heart." Id. at p. 9.

176. As a result, where the potassium chloride is not sufficient in either the manner of delivery or dosage to cause cardiac arrest, it is clear that under the New April 30, 2007 Protocol an inmate will die an excruciating painful and horrifying death by asphyxiation because of the paralysis caused by pancuronium bromide, while suffering the severely painful effects of the potassium chloride. Thus, the Defendants' improper and unscientific use of potassium chloride in their attempts to kill Mr. Workman violates the Eighth Amendment. Mr. Workman has shown entitlement to relief on the merits.

177. The Risk Created By The New April 30, 2007 Protocol Has Been Realized In Executions In Numerous Other States.

178. While the New April 30, 2007 Protocol has obviously not been used in Tennessee since it was promulgated just three days ago, the New April 30, 2007 Protocol is essentially identical to the lethal injection protocols used in other states and jurisdictions, the use of which

has resulted in numerous botched executions.

179. As a result, there is ample evidence that the New April 30, 2007 Protocol will cause an inmate to experience unnecessary pain during his or her execution. Both execution records and witnesses' accounts of these executions provide evidence that is consistent with consciousness following the administration of the sodium thiopental and during the administration of the pancuronium bromide and potassium chloride.

a. Florida. Just four months ago in Florida, on December 13, 2006, using a protocol essentially identical to Tennessee's New April 30, 2007 Protocol, Mr. Angel Diaz did not get an effective amount of sodium thiopental because the IV lines were improperly seated in his veins with through and through punctures. As a result, none of the materials injected went to the right place. Instead, the drugs entered his bloodstream first through his flesh and muscle tissue. This process caused foot-long chemical burns on both arms from the sodium thiopental. During the execution, observers reported that Mr. Diaz moved and tried to mouth words. It took 34 minutes and 14 syringes of chemicals for Mr. Diaz to die, during which he was clearly in pain, struggling for breath and grimacing. See Chris Tisch, *Executed Man Takes 34 Minutes To Die*, www.Tampabay.com, December 13, 2006; Chris Tisch, *Second Dose Needed To Kill Inmate*, www.Tampabay.com, December 14, 2006; Florida Commission Report, pp.8-9

Following the Diaz execution, Governor Bush ordered that all executions be stayed while a committee undertook a review of the Diaz execution and of lethal injection protocols in Florida in general. Executions remain stayed in Florida under that order. See Florida Commission Report, Exhibit 21, p. 2. Tennessee's New April 30, 2007 Protocol does not differ in any material respect from that use in the botched Diaz execution.

b. California.[5] Witness accounts of the 2002 execution of Stephen Wayne Anderson in California suggest that Mr. Anderson was not properly anesthetized when he died. The execution took over 30 minutes, and during that time Mr. Anderson's chest and stomach "heaved more than 30 times." See Declaration of Margo Rocconi, Exhibit 22, ¶ 6. According to Dr. Mark Heath, the typical reaction to sodium thiopental is yawning, drawing one or two deep breaths, or visibly exhaling so that the cheeks puff out. See Declaration of Dr. Mark Heath (California), Exhibit 23, ¶ 45. Irregular heaving of the chest is not consistent with the depression of the central nervous system caused by sodium thiopental. Id. Rather, chest heaving is indicative of labored respiratory activity, which in turn strongly suggests that Mr. Anderson was conscious, and indeed may have been laboring against the paralyzing effect of the pancuronium bromide. Id.

The execution log of Manuel Babbit's 1999 execution also indicates that something went wrong during the process. A minute after the pancuronium bromide was administered, Mr. Babbit had shallow respirations and brief spasms in his upper abdomen – again suggesting an attempt to fight against the effects of the pancuronium bromide. See id.at ¶ 47; Execution Log of Manuel Babbit, Exhibit 24. In addition, Mr. Babbit's heart rate remained constant until the potassium chloride was administered; had the full five grams of sodium thiopental reached Babbit, his heart rate would have changed significantly. See Declaration of Dr. Mark Heath (California), Exhibit 23, ¶ 47.

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[5]The United States District Court for the Northern District of California has stayed executions in California. See Morales v. Hickman, No. 06-00219 (N.D.Cal.). California is purportedly releasing new execution protocols on May 15, 2007.

The execution logs of William Bonin's 1996 execution also reflect irregularities that may have caused Bonin to die in excruciating pain. Mr. Bonin was given a second dose of pancuronium bromide for reasons that remain unclear, even though the initial dose would paralyze an inmate for several hours. See Execution Log of William Bonin, Exhibit 25; Declaration of Dr. Mark Heath (California), Exhibit 23, ¶ 46. The redundant dose raises questions about whether Bonin received the initial doses of sodium pentothal and pancuronium bromide; whether the injection team believed that he was still conscious; and, more broadly, whether such an irregularity is indicative of the lack of training or judgment of injection personnel. Id.

Tennessee's New April 30, 2007 Protocol does not differ in any material respect from that used in the California executions, including 5 grams of thiopental.

c. North Carolina.[6] In Brown v. Beck, No. 06-3018, the District Court of the Eastern District of North Carolina, Western Division, had before it toxicology data following four executions in North Carolina showing low post-mortem levels of sodium thiopental. North Carolina's protocol calls for a 3 gram dosage of the drug, to be followed by pancuronium bromide and potassium chloride. The toxicology data contradicted the opinion of the State's experts as to the expected concentration that would be present in a man of average size after

[6]Executions in North Carolina have also been stayed by North Carolina state courts until physicians are permitted to participate in executions by lethal injection. See Robinson and Thomas v. Beck, No. 07-CVS-001109 (Wake County, NC)(Ordering that no executions will proceed in North Carolina until physicians agree to participate or a protocol is developed that is satisfactory and does not require doctor participation); North Carolina DOC v. North Carolina Medical Board, 07-CVS-003574 (Wake County, NC) (DOC suing medical board for position statement that "physician participation in capital punishment is a departure from the ethics of the medical profession"and "which adopt[ed] and endorse[d] the provisions of the American Medical Association Code of Medical Ethics Opinion No. 2.06.").

having been given a dose of 3000 mg of sodium thiopental. See Brown v. Beck, 2006 U.S. Dist. LEXIS 60084 (E.D.N.C. April 7, 2006)(denying preliminary injunction, but conditioning future executions on presence of an anesthesiologist), Exhibit 26.

Also in Brown, the District Court had before it affidavits from attorneys present at recent executions who had witnessed the condemned inmates writhing, convulsing, and gagging when executed. Again, such witness accounts were inconsistent with a sufficient dose of sodium thiopental having been successfully delivered to the brain such that the condemned inmate would not feel pain. For instance:

During the lethal injection of Willie Fisher, "Mr. Fisher appeared to lose consciousness around 9:00 p.m. but subsequently began convulsing . . . he looked as though he was trying to catch his breath but could not and his eyes were open as his chest heaved repeatedly." He was not pronounced dead until 9:21 p.m. See Brown, *supra* at *17.

During the lethal injection of Timmy Keel, Mr. Keel's body was "twitching and moving about for approximately ten minutes" after the injection of the chemical cocktail. Id.

During the lethal injection of John Daniels, Mr. Daniels convulsed violently after the administration of the chemical cocktail. "He sat up and gagged." Witnesses "could hear him through the glass." "A short time later, [Mr. Daniels] sat up and gagged and choked again, and struggled with his arms under the sheet. He appeared to [witnesses] to be in pain. He finally lay back down and was still." Id.

During the lethal injection of Eddie Ernest Hartman, Mr. Hartman appeared to suffer for at least five minutes after the lethal injection. "Eddie's throat began thrusting outward and collapsing inward. His neck pulsed, protruded, and shook repeatedly. Eddie's chest at first

pulsated frequently, then intermittently, and at least twice I saw Eddie's chest heave violently . . . Throughout the execution, Eddie's eyes were partly open while his body relentlessly convulsed and contorted." See Brown, *supra* at *16.

As the District Court there found, "evidence of the problems associated with these executions while, perhaps, not clearly indicative of the protocol, does raise some concerns about the effect of North Carolina's protocol." See Brown, *supra* at *18 (concluding "it would be inappropriate to allow Defendants to proceed with Mr. Brown's execution under the current protocol considering the substantial questions raised").

d. Ohio.[7] During the May 2006 lethal injection of Joseph Lewis Clark, execution team members took over twenty minutes to insert one IV catheter into Mr. Clark's arm. According to protocol two catheters were necessary, but the team proceeded with only one. After the single IV was inserted and the chemicals began to flow, Mr. Clark remained breathing, legs moving, arms strapped down. After minutes, he sat up several times and told executioners, "It's not working, it's not working." Minutes later, Mr. Clark raised up again and said, "can't you just give me something by mouth to end this?" At that point, the team closed the curtain, and witnesses heard groans and moans from Mr. Clark as if he was in agony. Witnesses reported that the cries of pain lasted for about five or ten minutes and were followed by snores from Mr. Clark. See Adam Liptak, *Trouble Finding Inmate's Vein Slows Lethal Injection in Ohio*, New York Times, May 3, 2006, Exhibit 27.

The botched execution of Mr. Clark demonstrates graphically and horrifically how an

[7]Plaintiffs involved in the lethal injection litigation in Ohio are currently litigating a statute of limitations issue in the Sixth Circuit Court of Appeals which has resulted in a stay of execution there for many Plaintiffs. See Cooey v. Strickland, No. 05-4057 (6th Cir. March 2, 2007).

execution that appeared completely normal and routine at the outset can rapidly go horribly wrong. Ohio's protocol calls for 2 grams of sodium thiopental, following by pancuronium bromide and potassium chloride. The federal District Court for the Southern District of Ohio found that "evidence raises grave concerns about whether a condemned inmate would be sufficiently anesthetized under Ohio's lethal injection protocol prior to and while being executed." See Cooey v. Taft, 430 F.Supp. 2d 702, 707 (S.D. Ohio April 28, 2006)(granting preliminary injunction), Exhibit 28.

e. Arkansas.[8] The Arkansas lethal injection protocol calls for a 2 gram dose of thiopental, followed by pancuronium bromide and potassium chloride. Using this protocol, the Department of Corrections there has presided over several executions where "inmates remained conscious and suffered pain during their executions." See Nooner v. Norris, No. 06-00110 (E.D.Ark.), June 26, 2006 Order (granting a preliminary injunction), p. 4, Exhibit 29.

Ronald Gene Simmons was executed in Arkansas by lethal injection on June 25, 1990. The administration of the lethal chemicals began at 9:02 p.m. Between 9:02 and 9:04 p.m., according to an eyewitness, Mr. Simmons appeared to nod off into unconsciousness. However, "at 9:05 p.m. he called out 'Oh! Oh!' and began to cough sporadically as though he might be having difficulty breathing. During the next two minutes, he coughed slightly, approximately 20 times, each cough heaving his stomach slightly and causing the gurney to shake a little." See Bill Simmons, *Stoic Murderer Meets His Fate By Quiet Means*, Arkansas Democrat Gazette, June 26, 1990 at 9A, Exhibit 30. Mr. Simmons became still at 9:07 p.m. after which his face and arm

[8]The United States District Court for the Eastern District of Arkansas, stayed executions to allow further investigation into the constitutionality of the lethal injection protocol. See Nooner, et al., v. Norris, No. 06-00110 (E.D.Ark.).

turned first blue and then purple. An ADC employee twice appeared to adjust the IV tube in Mr. Simmons' arm, and not until 9:19 p.m. was Mr. Simmons pronounced dead by the coroner. Id. As Dr. Mark Heath has indicated, the chest heaving is indicative of labored respiratory activity, which in turn strongly suggests that Mr. Simmons was conscious, and indeed may have been laboring against the paralyzing effect of the pancuronium bromide. See Affidavit of Dr. Mark Heath (Arkansas), Exhibit 31, ¶ 44. Two years later, the execution of Ricky Ray Rector in Arkansas in January of 1992 took 1 hour and 9 minutes. Mr. Rector's hands and arms were punctured no less than 10 separate times searching for a suitable vein. Ultimately, someone on the execution team did a cut-down into his arm. Witnesses could hear his moans as they looked for a vein. See Sonja Clinesmith, *Moans Pierced Silence During Wait*, Arkansas Democrat Gazette, January 26, 1992, at 1B, Exhibit 32; Ron Fournier, *13 Outsiders View Death Of Rector, Witnesses Listen, Wait Beyond Curtain*, Arkansas Democrat Gazette, January 26, 1992, at 4B, Exhibit 33. Rector talked after 2 minutes and then after 5 minutes his lips were still moving rapidly - as if he was trying to draw shallow breaths. He was not pronounced dead until 10:09 p.m. See Joe Farmer, *Rector, 40, Executed for Officer's Slaying*, Arkansas Democrat Gazette, January 25, 1992, at 9A, Exhibit 34; Fournier, Exhibit 33.

On May 7, 1992, Steven Douglas Hill was executed in Arkansas. His execution began at 9:02 p.m. His eyes closed one minute later, but shortly afterwards he had what witnesses described as "a 'seizure' arching his back with his cheeks popping." See Andy Gotlieb and Linda Satter, *Hill Dies By Injection for '84 Police Killing*, Arkansas Democrat Gazette, May 8, 1992, at 17A, Exhibit 35. He was visibily gasping for air, and even though he was strapped down to the gurney his chest was heaving against the wide belt that covered his chest. The

seizure ended at 9:04 p.m. and Mr. Hill was pronounced dead at 9:10 p.m.

180. The accounts of these numerous botched executions across the United States are "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 their executions." Beardslee v. Woodford, 395 F.3d 1064, 1075 (9th Cir. 2005).

181. "This Court would be remiss if it did not take note of the evidence [from other states] . . . . [that] raises grave concerns about whether a condemned inmate would be sufficiently anesthetized under [Tennessee's April 30, 2007 Protocol] prior to and while being executed." See Cooey, 430 F.Supp. 2d at 707, Exhibit 28.

182. The Deficiencies In The New April 30, 2007 Protocol Are The Result of Defendants' Deliberate Indifference To The Known Risks Inherent In Such A Protocol.

183. Because the Governor and the TDOC is aware of the risks inherent in Tennessee's New April 30, 2007 Protocol based on prior lethal injection litigation in this state and ongoing lethal injection litigation in at least fourteen (14) other states – all of which have protocols that are almost identical to Tennessee's New April 30, 2007 Protocol, the New April 30, 2007 Protocol was developed and promulgated and will be used with deliberate indifference to the excruciatingly painful and horrifying death that will result from the use of sodium thiopental, pancuronium bromide, and potassium chloride by untrained, uneducated and unqualified personnel.

184. Defendants are certainly aware of executions in other states where correctional employees have encountered significant problems during lethal injection procedures and orders from state and federal courts and from governors staying executions by lethal injection, including

in Arkansas, California, Delaware, Florida, Maryland, Missouri, New Jersey, North Carolina, Ohio, South Dakota, and any federal executions. Defendants are also certainly aware that the lethal injection protocols in each of these states is virtually identical to the New April 30, 2007 Protocol that Defendants intend to use to execute Philip Workman.

185. Arkansas. On June 26, 2006, the United States District Court for the Eastern District of Arkansas, granted a stay of execution for Don Davis and a preliminary injunction to allow further investigation into the constitutionality of the lethal injection protocol. See Nooner, et al., v. Norris, No. 06-00110 (E.D.Ark.)(June 26, 2006 Order granting a preliminary injunction), Exhibit 29. The lethal injection protocol used in Arkansas is almost identical to the new protocol in Tennessee, using the same three drug cocktail and failing to require the participation of trained medical personnel. In its Order granting a preliminary injunction, the Nooner court found that "Davis has shown that he is personally under a threat of irreparable harm. If Davis remains or becomes conscious during the execution, he will suffer intense pain that will never be rectified. The Court further finds the balance of potential harms favors Davis. If a stay is granted and Davis's allegations prove true, he and others will be spared subjection to an unconstitutional execution procedure, and the State's interest in enforcing death penalties in compliance with constitutional standards will be served." Id. at p. 5. The Court went on to note that "Davis has raised serious questions that call for deliberate investigation." Id.

186. California. On February 14, 2006, the United States District Court for the Northern District of California in the case of Morales v. Hickman, No. 06-00219 (N.D.Cal.), denied Michael Morales a preliminary injunction conditioned on certain requirements for the manner in which his execution would be carried out. See Morales v. Hickman, 415 F.Supp.2d

1037 (N.D.Cal. 2006), aff'd, 438 F.3d 926 (9th Cir. 2006), cert. denied 126 S.Ct. 1314 (2006), Exhibit 13. The protocol used in California was almost identical to the New April 30, 2007 Protocol, using the same three drug cocktail and failing to require the participation of trained medical personnel. The District Court's conditions dramatically changed California's protocol, including requiring that only sodium thiopental be used in the lethal injection or that someone with training in the field of anesthesiology had to assist in determining whether the inmate was properly sedated before the administration of the pancuronium bromide or the potassium chloride. Id. at 1047-1048. Defendants agreed to comply with the second alternative and enlisted two anesthesiologists, who promptly quit when they realized they were being asked to assist in an execution. See Morales v. Tilton, 465 F. Supp. 2d 972, 976 (N.D.Cal. Dec. 15, 2006), Exhibit 36. As a result, all executions in California are currently stayed while the Governor and correctional officials develop a new lethal injection protocol. California has indicated that it will issue a new protocol on May 15, 2007.

187. Delaware. The United States District Court for the District of Delaware on May 9, 2006, granted a preliminary injunction which has stayed all executions since that time. See Jackson v. Taylor, et al., 2006 U.S. Dist. LEXIS 27658 (D. Del. May 9, 2006), Exhibit 37. While the stay was for the purpose of awaiting the United States Supreme Court decision in Hill v. McDonough, *supra*, the parties in Delaware are now engaging in discovery for the purpose of a future evidentiary hearing on the issue of the constitutionality of the Delaware lethal injection protocol. The three-drug cocktail used in the Delaware protocol is the same as that used in Tennessee, although the specifics of the Delaware protocol are secretive. On February 23, 2007, the Jackson court certified a state-wide class consisting of all current and future prisoners who

are and will be sentenced to death in Delaware. See Jackson v. Danberg, 2007 U.S. Dist. LEXIS 12376 (D. Del. 2007), Exhibit 38.

188. Florida. In Florida, the December 2006 execution of Mr. Angel Diaz exposed the Florida lethal injection protocol as a deep failure. The autopsy of Mr. Diaz showed that the veins in each of his arms had through and through punctures revealing that the IV lines were improperly seated in his veins. As a result, Mr. Diaz did not get an effective amount of the drug in a vein in either arm – none of the materials injected went to the right place. Instead, the drugs entered his bloodstream first through his flesh and muscle tissue. This process caused foot-long chemical burns on both arms from the sodium thiopental. During execution, observers reported that Mr. Diaz moved and tried to mouth words. It took 34 minutes and 14 syringes of chemicals for Mr. Diaz to die, during which he was clearly in pain, struggling for breath and grimacing.

Following the Diaz execution, Governor Bush ordered that all executions be stayed while a committee undertook a review of the Diaz execution and of lethal injection protocols in Florida in general.

After three months, eight hearings, consultations with multiple medical experts and others, the Florida Commission on Administration of Lethal Injection published a Report that contained findings and recommendations for extensive modifications of the lethal injection protocol in Florida. See Florida Report, Exhibit 21. The prior protocol used in Florida for the execution of Angel Diaz used the same three drug cocktail and failed to require the participation of trained medical personnel just like the new protocol in Tennessee. Lethal injection executions

in Florida remain stayed by order of the Governor.[9]

189. Maryland. On December 16, 2006, the Maryland Court of Appeals ruled in Evans v. State, 396 Md. 256 (Md. App. Ct. 2006), that the state had not complied with the administrative procedures act in adopting its lethal injection procedures. All executions in Maryland are on hold until those procedures for reviewing such changes to the law have been followed. Maryland's prior protocol used the same three drug cocktail and did not provide for the assistance of medical personnel just like the new protocol in Tennessee.

190. Missouri. The United States District Court for the Western District of Missouri has stayed executions in Missouri finding its lethal injection protocol to be unconstitutional, and requiring corrections officials to revise their lethal injection protocol, which was identical to the New April 30, 2007 Protocol – using the same three drug cocktail and also failing to require the assistance of trained medical personnel. See Taylor v. Crawford, 2006 U.S. Dist. LEXIS 74896 (W.D.Mo. October 16, 2006)(finding Missouri's revised protocol inadequate and denying the motion to lift the preliminary injunction), Exhibit 39; Taylor v. Crawford, 2006 U.S. Dist. LEXIS 51008 (W.D.Mo. July 25, 2006)(same), Exhibit 40. In the District Court's July 25, 2006 Order, the Court, having reviewed one of the several revised protocols submitted by Missouri corrections officials said, "Missouri's revised protocol is an improvement over the current procedure. However, there continue to be inadequacies with the personnel required to monitor and oversee the use of the anesthetic thiopental. While the use of a board certified anesthesiologist may not be possible, the alternative proposed by the State falls short of ensuring

[9]Although the Commissioner acknowledged reviewing the Florida Report, the protocols adopted by the Commissioner fail to address any of the concerns raised by the Florida Commission.

the protection required**. If the proposed three drug protocol is to be used, it is crucial that someone with the appropriate training and experience in monitoring anesthetic depth must be present to ensure that Missouri's executions of its condemned inmates are carried out humanely.**"[10] See Taylor, 2006 U.S. Dist. LEXIS 51008, *2-3 (emphasis added), Exhibit 40. Executions in Missouri remain stayed.

191. New Jersey. On February 20, 2004, in In The Matter of Readoption With Amendments of Death Penalty Regulations, 842 A.2d 207 (New Jersey 2004), an appellate court in New Jersey stayed all executions until the state could justify its lethal injection procedures. New Jersey used both sodium thiopental and pancuronium bromide in its lethal injection procedures, just as Tennessee's New April 30, 2007 Protocol does.

192. North Carolina. Executions in North Carolina have also been stayed by North Carolina state courts until physicians are permitted to participate in executions by lethal injection. See Robinson and Thomas v. Beck, No. 07-CVS-001109 (Wake County, NC)(Ordering that no executions will proceed in North Carolina until physicians agree to participate or a protocol is developed that is satisfactory and does not require doctor participation), Exhibit 41;[11] State v. Holman, No. 97-49226 (March 6, 2007)(order cancelling execution date), Exhibit 42. The lethal injection protocol in North Carolina used the same three drug cocktail and did not require the use of trained medical personnel just like the new protocol

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[10]Tennessee's New April 30, 2007 Protocol makes no provision for the monitoring of anesthetic depth.

[11]The North Carolina Department of Corrections is currently suing the North Carolina Medical Board for its position statement that "physician participation in capital punishment is a departure from the ethics of the medical profession"and "which adopt[ed] and endorse[d] the provisions of the American Medical Association Code of Medical Ethics Opinion No. 2.06" in North Carolina DOC v. North Carolina Medical Board, 07-CVS-003574 (Wake County, NC).

in Tennessee.

193. Ohio. In 2006, the United States District Court of the Southern District of Ohio found that there was "mounting evidence calling Ohio's lethal injection protocol, and the same or similar protocols employed by other states, increasingly into question." See Cooey, 430 F.Supp. 2d at 706 (granting preliminary injunction), Exhibit 28. Ohio's lethal injection protocol uses the same three drug cocktail and does not provide for the assistance of medical personnel just like the new protocol in Tennessee. Plaintiffs involved in the lethal injection litigation in Ohio are currently litigating a statute of limitations issue in the Sixth Circuit Court of Appeals. See Cooey v. Strickland, No. 05-4057 (6th Cir. March 2, 2007).

194. South Dakota. The Governor of South Dakota stayed the execution of Elijah Page because of concerns about the state's lethal injection process. South Dakota's lethal injection protocol uses the same three drug cocktail and does not provide for the assistance of medical personnel just like the new protocol in Tennessee. Executions appear to be on hold until July 1, 2007.

195. Federal District Courts. The Attorney General of the United States has agreed to a preliminary injunction for federal capital plaintiffs challenging the federal lethal injection protocols as unconstitutional. See Roane v. Gonzales, No. 05-2337 (D.C. Dist.), February 16, 2007 Order and Unopposed Motion for Preliminary Injunction, Exhibit 10.[12] In federal executions, the method is determined by the state in which the sentencing took place. Apparently, the federal protocol calls for the same three-drug combination that is called for in the

[12]The federal facility in Terre Haute is the facility where the Commissioner and his review committee performed their site visit.

New April 30, 2007 Protocol.

196. The New April 30, 2007 Protocol is virtually identical to the protocols which these states are currently forbidden to use, and violates constitutional and statutory provisions enacted to prevent cruelty, pain, and torture and to provide all citizens of the United States with due process and equal protection of law.

197. Despite knowledge of the ongoing lethal injection litigation in multiple states and jurisdictions, Defendants failed to consult correctional officials, state officials, or medical experts with experience in lethal injection and lethal injection litigation from any of the listed states or jurisdictions, with the exception of the Federal Prison in Terre Haute, as a part of its review and development of the New April 30, 2007 Protocol. See Tennessee Report on Administration of Death Sentences, p.5.

198. Despite knowledge of the ongoing lethal injection litigation in multiple states and jurisdiction, Defendants failed to request documents and information from any correctional officials, state officials, or medical experts with experience in lethal injection and lethal injection litigation from any of the listed states or jurisdictions, with the exception of the Terre Haute facility,[13] as part of its review and development of the New April 30, 2007 Protocol. See Id.

199. Defendants' analysis was one-sided, unscientific and failed to take into account the serious known and demonstrated risks of the use of the chemicals and procedures selected for the New April 30, 2007 Protocol.

200. Defendants' failure to properly consult, review, and research in promulgating its

[13]BOP refuses to disclose their protocols to any party and apparently did not provide their documents to the Commissioner, but, did allow a site visit. The Commissioner does not acknowledge that the BOP is currently enjoined from using their lethal injection protocols.

New April 30, 2007 Protocol, despite the ready availability of experienced state officials and medical experts, demonstrates a deliberate indifference to the excruciatingly painful and horrifying death that will result from the use of these three drugs by untrained personnel under the new execution protocol.

201. Defendant's analysis of any alternatives for lethal injection methods further demonstrates their deliberate indifference. Defendant's defend their use of the three drug cocktail by simply saying that 29 other jurisdictions use it. See Tennessee Report on Administration of Death Sentences, Exhibit 7, p. 2. This, "everybody else does it" defense fails to acknowledge the number of jurisdictions who are now under judicial and/or executive order not to do it because of concerns that the protocol is unconstitutional.

202. Further, Defendant's discussion of the other methods makes clear the Commissioner and the review committee were concerned with making the lethal injection experience more palatable and acceptable to the witnesses with utter disregard for the risk of pain and suffering to the condemned. See Id. at pp. 6-8.

203. The Commissioner told the Governor that the review committee rejected a protocol that eliminates the use of pancuronium bromide because "the administration of potassium chloride without a preceding dose of pancuronium bromide would typically result in involuntary movement which might be misinterpreted as a seizure or **an indication of consciousness**." Id. at p.8. Nowhere does the report recognize or express a concern that movement might actually indicate consciousness, which would mean that the sodium thiopental did not work and that the inmate is actually feeling the searing pain of the potassium chloride.

204. In discussing the use of a single drug protocol, the Commissioner acknowledges

that a single drug protocol would be simpler, would decrease the risk of error, and would eliminate the drugs which cause pain. See Tennessee Report on Administration of Death Sentences, Exhibit 7, p. 8. The Commissioner then rejects this protocol because, he (falsely) claims, the two and three drug protocols will produce a faster death, that the effect and required dosage of the sodium thiopental is less predictable, and nobody else does it that way. Id.

205. Thus, the Commissioner and the review team have admitted that they are fully aware of the unpredictability of sodium thiopental and the fact that pancuronium bromide will mask the failure of the sodium thiopental to work properly. They have further admitted that they could eliminate the risk of pain to the condemned completely, but refuse not to for the sole purposes of making the killing go faster and making it more palatable for the witnesses. This evidences the complete and utter disregard on the part of all of the Defendants to the great risk, and likelihood, of pain and suffering that will be caused by the use of the New April 30, 2007 Protocol by poorly trained, misinformed, and unqualified members of the execution team, while the only medical doctor on the premises waits in the garage.

206. The opinions of the United States District Judge Gregory L. Frost in the class-action case of Cooey v. Taft are instructive in analyzing Mr. Workman's likelihood of success on the merits of his deliberate indifference claim.[14] In granting a preliminary injunction in that case, Judge Frost took "judicial notice that multiple states have recently placed executions on hold due

[14]The District Court's Order in *Cooey* was later vacated by a panel of the Sixth Circuit on statute of limitations grounds not relevant to this litigation regarding the newly promulgated protocol. See Cooey v. Strickland, 479 F.3d 412 (6th Cir. March 2, 2007). Nonetheless, the *Cooey* panel decision is being considered *en banc* and one Ohio inmate has received a stay of execution pending the outcome of the *en banc* court's decision. See Cooey v. Strickland, 474 F.3d 268 (6th Cir. Jan. 16, 2006).

to serious concerns over their lethal injection protocols." Cooey v. Taft, 2006 U.S. Dist. LEXIS 92521, n.5 (S.D. Ohio Dec. 21, 2006), Exhibit 43. This Court should do the same.

207. In conducting his analysis of the factors that weighed in favor of granting a preliminary injunction, Judge Frost wrote:

> Given the evidence that Jeffrey Hill and Jerome Henderson first produced, as well as anecdotal evidence that Spirko included demonstrating problems that occurred during Ohio's execution of inmate Joseph Clark on May 2, 2006, Spirko has demonstrated a *stronger* likelihood of success on the merits than some of the plaintiffs that preceded him, in view of the growing body of evidence calling Ohio's lethal injection protocol increasingly into question. This Court stated unequivocally in its order granting Hill's request for a preliminary injunction that it can not and will not turn a blind eye to the evidence presented in the cases of *Brown v. Beck* in North Carolina and *Morales v. Hickman* in California appearing to contradict the opinion of Dr. Mark Dershwitz[15] that virtually all persons given the dose of sodium thiopental prescribed under Ohio's lethal injection protocol would be rendered unconscious and would stop breathing within one minute. The evidence that has begun to emerge calling this and other conclusions of Dr. Dershwitz into question also persuades this Court that there is an unacceptable and unnecessary risk that Spirko will be irreparably harmed absent the injunction, *i.e* that Spirko could suffer unnecessary and excruciating pain while being executed in violation of his Eighth Amendment right not to be subjected to cruel and unusual punishment.

Cooey v. Taft, 2006 U.S. Dist. LEXIS 85234, *20-21 (S.D. Ohio Nov. 22, 2006), Exhibit 44.

208. In addressing the Ohio Warden's complaint about "the Court's reliance on evidence produced in other cases around the country and anecdotal evidence regarding problems that have occurred during recent executions in Ohio and other states," Judge Frost observed that

[15]Defendants consulted with and relied on information provided to them by Dr. Mark Dershwitz in creating the New April 30, 2007 Protocol. See Email from Julian Davis to Dr. Mark Dershwitz, Exhibit 9.

while the evidence wasn't "ideal, it is nonetheless persuasive regarding the first factor in *McPherson* and is arguably the best evidence that the plaintiffs could produce, given the fact that this case was stayed before any discovery of other fact-finding could commence." Cooey, 2006 U.S. Dist. LEXIS 92521, *14, Exhibit 43.

209. The body of evidence which demonstrates the unreasonable and unacceptable risk of pain and suffering under Tennessee's New April 30, 2007 lethal injection protocol continues to grow.

210. Just last week, a scientific study of executions in California and North Carolina revealed botched executions in those states. See Leonardis Koniaris et al, *Lethal Injection For Execution: Chemical Asphyxiation?*, PLOS Medicine, Vol. 4, Issue 4, April 2007, Exhibit 45.

211. Two days ago, Professor Deborah Denno published a working draft of her most recent research about the state of lethal injections in this country and the risks involved. See Deborah Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled The Death Penalty*, Fordham University School of Law, May 2, 2007, Exhibit 46.

VII. CLAIMS FOR RELIEF

A. Violation of Fourteenth Amendment: Due Process And Equal Protection of Law (Sodium Pentothal)

212. Plaintiff incorporates the preceding paragraphs in their entirety by reference.

213. Plaintiff has fundamental life and liberty interests protected by the Fourteenth Amendment to the United States Constitution.

214. Plaintiff's right to equal protection under law is protected by the Fourteenth Amendment to the United States Constitution. Plaintiff has right to a lethal injection procedure

which is as humane, or even more humane, as the procedure for euthanizing animals in this country and in Tennessee.

215. The use of sodium pentothal violates Plaintiff's right to due process and equal protection of the law under the Fourteenth Amendment.

216. The use of sodium pentothal, as opposed to a longer-lasting anesthetic, is arbitrary, unreasonable, irrational, and serves no legitimate or compelling state interest. As administered under Tennessee's New April 30, 2007 Protocol, and especially as administered by untrained personnel, the use of sodium pentothal shocks the conscience and is inhumane.

217. Inducing unconsciousness by correctly administering sodium pentothal is indispensable to preventing the wanton infliction of pain.

218. Use of sodium pentothal as administered under Tennessee's New April 30, 2007 Protocol does not cause sufficient anesthesia for the duration of the lethal injection process.

219. The absence of trained personnel to administer sodium pentothal and insure a prisoner is properly anesthetized before the other chemicals are introduced greatly increases the risk that a prisoner would not receive the necessary amount of anesthetic prior to being paralyzed by the pancuronium bromide and internally burned by the potassium chloride.

220. Sodium pentothal, as administered under the New April 30, 2007 Protocol, does not adequately anesthetize the prisoner from the pain and horror of asphyxiation or suffocation caused by the pancuronium bromide.

221. Sodium pentothal, as administered under the New April 30, 2007 Protocol, does not adequately anesthetize the prisoner from the extreme pain caused by potassium chloride.

222. The AVMA uses a longer-lasting barbiturate when euthanizing animals. It also

requires personnel be trained and knowledgeable in anesthetic techniques, and competent in assessing anesthetic depth appropriate for the subsequent administration of potassium chloride. Tennessee's New April 30, 2007 Protocol contains no comparable requirements for the personnel who use the same drug in executing prisoners.

B. Violation Of Eighth And Fourteenth Amendments: Cruel and Unusual Punishment (Sodium Pentothal)

223. Plaintiff incorporates preceding paragraphs in their entirety by reference.

224. The use of Sodium Pentothal, as administered under Tennessee's New April 30, 2007 Protocol, violates Plaintiff's right to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments.

225. Specifically, Plaintiff has a right to be free from arbitrary methods of punishment; from suffering pain beyond that inherent in the course of death; from suffering extreme horror and pain; and from a prolonged death.

226. Although it is possible to conduct executions in a constitutionally compliant manner, the TDOC has chosen not to do so. The TDOC could choose to use different chemicals that pose a low risk of administration error yet do not cause extraordinarily grave consequences to a condemned inmate if not properly administered. Instead, it has knowingly and recklessly and deliberately chosen to use chemicals that pose a high risk of administration error, like sodium pentothal. Moreover, it has not taken precautions to ensure that the personnel who administer the lethal injection chemicals possess the training, experience, and expertise needed to administer those chemicals properly.

C. Violation Of Fourteenth Amendment: Due Process Of Law (Pancuronium Bromide)

227. Plaintiff incorporates preceding paragraphs in their entirety by reference.

228. Plaintiff has a fundamental life interest protected by the Fourteenth Amendment to the United States Constitution.

229. The use of pancuronium bromide is arbitrary, unreasonable, and serves no legitimate or compelling state interest. The use of pancuronium bromide shocks the conscience and is inhumane.

230. The use of pancuronium bromide violates Plaintiff's right to due process of law under the Fourteenth Amendment.

231. It is well-settled under the due process clause of the Fourteenth Amendment that a state cannot act in a way which fails to serve a legitimate state interest. City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 105 S.Ct. 3249 (1985). Likewise, when fundamental interests are involved (such as life) the state must act in a way that is necessary to promote a compelling state interest. Troxel v. Granville, 530 U.S. 57, 120 S.Ct. 2054 (2000).

232. Without question, there is no legitimate interest in the use of pancuronium bromide upon Plaintiff or any other human being. As Chancellor Ellen Hobbs Lyle has held:

> [T]he use of Pavulon is . . . unnecessary. . . [T]he State [has] failed to demonstrate any reason for its use. The record is devoid of proof that the Pavulon is needed. Thus, the Court concludes that . . . the State's use of Pavulon is . . . in legal terms 'arbitrary.'

Abdur'Rahman v. Sundquist, No. 02-2236-III, In The Chancery Court For The State Of Tennessee, Twentieth Judicial District, p. 13 (June 2, 2003).

233. Further, use of pancuronium bromide violates substantive due process for the separate reason that its use shocks the conscience. See Rochin v. California, 342 U.S. 165

(1952). Without question, under Tennessee's "Nonlivestock Animal Humane Death Act," pancuronium bromide cannot be used to euthanize a non-livestock animal in Tennessee. Tenn.Code Ann. §44-17-301 *et seq*, including §44-17-303(c)(any substance which "acts as a neuromuscular blocking agent . . . may not be used on any nonlivestock animal for the purpose of euthanasia."). If pancuronium bromide can't be used to kill a dog or a cat because it is not "humane," it shocks the conscience to think that it can be used in an attempt to kill a human being.

234. The use of pancuronium bromide is arbitrary, unreasonable, irrational, and serve no legitimate or compelling state interest. Because Tennessee's New April 30, 2007 Protocol calls for the potassium chloride to be administered in a lethal dose, the use of pancuronium bromide serve no purpose in the execution process. Pancuronium bromide unnecessary increases the risk that a conscious prisoner will be conscious and paralyzed, yet unable to inform personnel of his condition. The use of pancuronium bromide shocks the conscience and is inhumane.

D. Violation Of Eighth And Fourteenth Amendments: Cruel and Unusual Punishment (Pancuronium Bromide)

235. Plaintiff incorporates preceding paragraphs in their entirety by reference.

236. The use of pancuronium bromide is inhumane, violates the dignity of the human person, and is contrary to the evolving standards of decency.

237. The use of pancuronium bromide in the New April 30, 2007 Protocol violates Plaintiff's right to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments. Specifically, Plaintiff has a right to be free from arbitrary methods of punishment; from suffering pain beyond that inherent in the course of death; from suffering extreme horror

and pain; and, from a prolonged death.

238. The Eighth and Fourteenth Amendments prohibit punishments which do not comport with the evolving standards of decency that mark the progress of a maturing society. Trop v. Dulles, 356 U.S. 86 (1959).

239. In 2001, the State of Tennessee declared as inhumane – and illegal – the use of pancuronium bromide or any other neuromuscular blocking agent on nonlivestock animals. Tenn. Code Ann. §44-17-303(c); 44-17-303(j)(criminal sanctions for violation of Humane Death Act). *A fortiori*, the legislative judgment of Tennessee establishes the fundamental baseline concerning the evolving standards of decency applicable to human beings. Especially where the Tennessee Legislature passed the Nonlivestock Humane Death Act in 2001 – before Defendants' established the New April 30, 2007 protocol – the very existence of the Act establishes an Eighth Amendment violation of the evolving standards of decency.

240. Further, where Tennessee has already determined that use of pancuronium bromide to kill animals is not "humane," using such a substance to kill a human being is not humane either. It is likewise degrading to humanity itself to allow the Defendants to do what they would intend to do. It sends a message that the State can treat human being with the type of contempt and cruelty that is not befitting an animal.

250. Moreover, pancuronium bromide could not lawfully be used alone as the fatal agent. It would not result in a quick death; instead, it would ultimately cause someone to suffocate or asphyxiate to death. Causing death by suffocation or asphyxiation violates the Eighth Amendment's prohibition against cruel and unusual punishment.

E. Violation Of Fourteenth Amendment: Equal Protection (Pancuronium Bromide)

251. Plaintiff incorporates preceding paragraphs in their entirety by reference.

252. The use of pancuronium bromide upon Plaintiff while its use is legally prohibited for use on animals because it is not "humane," is inhumane, arbitrary, unreasonable, and serves no legitimate interest, nor is it narrowly tailored to serve a compelling state interest. The use of pancuronium bromide violates Plaintiff's right to the equal protection of the laws under the Fourteenth Amendment.

253. By procuring and using pancuronium bromide upon Plaintiff, Defendants would invidiously discriminate against Plaintiff: Under Tenn. Code Ann. §44-17-303(h) & §39-14-201(3), the State of Tennessee has protected the following animals against the use of pancuronium bromide: any "pet normally maintained in or near the household or households of its owner or owners, other domesticated animal, previously captured wildlife, an exotic animal, or any other pet, including but not limited to, pet rabbits, a pet chick, duck, or pot bellied pig that is not classified as "livestock" pursuant to this part." Tenn.Code Ann.§44-17-201(3). There is no legitimate basis – let alone a compelling state reason – for Tennessee to provide dogs, cats, chicks, ducks, and pot-bellied pigs more protection from cruelty than it would Plaintiff, who is a human being who retains a fundamental right to life. This classification is arbitrary, unreasonable, and serves no legitimate interest, let alone a compelling state interest. Defendants' procurement and use of pancuronium bromide is therefore unconstitutional.

F. Violation Of Eighth, Ninth, and Fourteenth Amendments: Cruel And Unusual Punishment

254. Plaintiff incorporates preceding paragraphs in their entirety by reference and by

reference his Memorandum In Support Of TRO.

255. Defendants' use of sodium thiopental, pancuronium bromide, and potassium chloride as dictated by the New April 30, 2007 Protocol causes unreasonable and unnecessary pain and suffering and does not conform with evolving standards of decency and occurs with deliberate indifference and/or reckless disregard of the substantial or significant known risk of pain and suffering, given all the deficiencies identified in this complaint related to the selection, preparation, and manner of administration of such chemicals by persons who are inadequately trained and inexperienced and where there is not adequate monitoring of anesthetic depth and/or the proper administration of such chemicals, individually and cumulatively, and where the process suffers from the various deficiencies identified in the complaint and as yet unknown and/or disclosed to Plaintiff.

256. Defendants' use of the protocol violates the dignity of the human person and Plaintiff's right to be free from cruel and unusual punishment under the Eighth, Ninth, and Fourteenth Amendments.

VIII. PRAYER FOR RELIEF

WHEREFORE, based on the foregoing complaint, incorporated herein by reference, this Court should do the following:

1. Enter an order granting a declaratory judgment to Plaintiff declaring unconstitutional the New April 30, 2007 Protocol for all the reasons stated in this complaint and Motion & Memorandum For TRO, because, *inter alia*, it utilizes inadequate anesthesia through the use of sodium thiopental, and grant an injunction against the use upon Plaintiff of the New April 30, 2007 Protocol.

2. Enter an order granting a declaratory judgment to Plaintiff declaring unconstitutional the use of pancuronium bromide by Defendants under the circumstances, and prohibiting Defendants from using, seeking to obtain, ordering, writing a prescription, writing a physician's order, prescribing, dispensing, or in any other manner transferring to Defendants Bell or any other Defendants involved in the execution process pancuronium bromide in any form whatsoever.

3. Enter an order granting a declaratory judgment to Plaintiff declaring unconstitutional the use of pancuronium bromide by Defendants under the circumstances, and enjoin Defendants from seeking to execute, or executing, Plaintiff using the above-described protocol which employs pancuronium bromide.

4. Enter an order granting a declaratory judgment to Plaintiff declaring unconstitutional the New April 30, 2007 Protocol and enjoining the administration of the lethal injection procedure by personnel who lack sufficient training, credentials, certification, experience, or proficiency to conduct the lethal injection procedure.

5. Enter an order granting a declaratory judgment to Plaintiff declaring unconstitutional the New April 30, 2007 Protocol, and grant an injunction against the use of the protocol upon Plaintiff.

6. Grant further relief that this Court finds necessary and just.

Respectfully submitted,

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Gretchen L. Swift

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By: /s/ *Kelley J. Henry*

CERTIFICATE OF SERVICE

I certify that a copy of this notice was served via electronic filing upon counsel for the Defendants, Mark Hudson, Asst. Attorney General, Office of the Attorney General, 425 Fifth Avenue North, Nashville, Tennessee 37243 this 4th day of May, 2007.

Kelley J. Henry
Counsel for Philip Workman