IN THE CHANCERY COURT OF DAVIDSON COUNTY, TENNESSEE

STEPHEN MICHAEL WEST,	)	
	)	
Plaintiff,	)	
	)	**No. 10-1675-I**
	)	**DEATH PENALTY CASE**
v.	)	
	)	
GAYLE RAY, in her official capacity as Tennessee's Commissioner of Correction, et al	)	
	)	
Defendants.	)	

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MEMORANDUM IN SUPPORT OF PLAINTIFF'S OPPOSITION TO DEFENDANTS' MOTION TO AMEND FINDINGS OF FACT AND TO ALTER OR AMEND JUDGMENT

I. Introduction

On November 22, 2010, this Court "found that Tennessee's lethal injection protocol was unconstitutional because it 'allows ... death by suffocation while the prisoner is conscious.'" *State v. West*, No. M1987-000130-SC-DPE-DD, order p.2 (Tenn. Nov. 29, 2010); *West v. Ray*, No. 10-1675-I, Court's ruling, p.10 (Chancery Ct. Davidson Co. Nov. 22, 2010). This Court also determined "that there are feasible and readily available alternative procedures which could be supplied at execution to insure unconsciousness and negate any objectively intolerable risk of severe suffering or pain." *State v. West*, *supra*, order p.2; *West v. Ray*, *supra*, Court's ruling, p.37.

According to Defendants, "[o]n November 24, 2010, in response to, and heeding, this Court's ruling, the State added an explicit check for consciousness to Tennessee's lethal injection protocol." Defendants' Memorandum p.1-2. They allege that Tennessee took "the step th[is]

Court deemed necessary to ensure that the plaintiffs' sentences are carried out in a constitutional manner." *Id.*

The Tennessee Supreme Court's November 29, 2010, order belies Defendants' contention that this Court has already determined the "check for consciousness" eliminates the unconstitutionality of the protocol. Defendants' Memorandum at *id.* and p.5-6. The Tennessee Supreme Court remanded the case to give this Court "the opportunity to consider in the first instance whether the revised protocol eliminates the constitutional deficiencies [already] identified in the prior protocol and whether the revised protocol is constitutional." *State v. West*, No. M1987-000130-SC-DPE-DD, order p.3 (Tenn. Nov. 29, 2010).[1]

The remand order directs "Mr. West to prove that the revised protocol creates an 'objectively intolerable risk of harm that qualifies as cruel and unusual.'" *Id.* p.3, quoting *Baze v. Rees*, 553 U.S. 35, 52 (2008). The first step to carrying this burden is to "demonstrate that the revised protocol imposes a substantial risk of serious harm." *State v. West*, *supra*, order p.3. The second step is to demonstrate the existence of "an alternative method of execution that is feasible, readily implemented, and which significantly reduces the substantial risk of severe pain ... or demonstrate that no lethal injection protocol can significantly reduce the substantial risk of

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[1]The remand order also disposes of Defendants' repeated suggestion that Mr. West's initial allegations of deliberate indifference, based in part on Tennessee officials' knowledge that other states had rejected the idea that the use of thiopental alone will insure unconsciousness, were a concession that any "check for consciousness" would render Tennessee's protocol constitutional. *See* Defendants' Memorandum p.2, 3, 4, 6 (discussing "Plaintiff's criticism" of the failure to include in the protocol a check for consciousness). The Tennessee Supreme Court "fully reviewed" the transcript of the October 2010, evidentiary hearing. *State v. West*, No. M1987-000130-SC-DPE-DD, order p.2. It would not have stayed four pending executions and remanded the case for a second hearing on the constitutionality of the protocol, *id.* p.3, if it believed there was such a concession.

severe pain." *State v. West*, *supra*, order p.3, (Tenn. Nov. 29, 2010).

II. Tennessee's three-drug lethal injection protocol, as revised, creates an objectively intolerable risk of harm that qualifies as cruel and unusual punishment.

The examination into whether the new provisions to Tennessee's protocol eliminate the substantial risk that condemned inmates will be unconscious as they are paralyzed, suffocated, and injected with potassium chloride does not begin on a clean slate. This Court has found:

> In this case, the plaintiff has carried his burden to show that the first injection of 5 grams of sodium thiopental followed by rapid injection of the second drug will result in the inmate's consciousness during suffocation.
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> * * *
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> And as for the medical proof, the plaintiff carried his burden to show that the Tennessee protocol does not insure that the prisoner is unconscious before the paralyzing drug; that is, the second becomes active – is injected and becomes active in the body.
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> * * *
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> This Court finds that the current amount and concentration of sodium thiopental are insufficient to insure unconsciousness because the body's ability to and the body's actual use of this drug depends on so many variables, and both medical experts agree that that was the case.
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> * * *
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> And so although this Court listened very closely to the experts' opinions about this particular issue, this Court is unable to find what level of sodium thiopental is sufficient to insure unconsciousness because I don't think there is one, given the medical proof that the Court is relying on; given the medical proof in the case.

West v. Ray, No. 10-1675-I, Court's ruling, p. 13, 14, 35, 36.

Defendants have proffered no proof to undermine the existing factual record or this Court's previous findings.

This Court and the Tennessee Supreme Court have also already determined that the

examination does not include consideration of the determinations of other courts involving different legal issues and/or different facts. Such material is excluded from consideration because a "[d]ecision[] involving such profoundly important and sensitive issues such as the ones involved in this case are best decided on evidence that has been presented, tested, and weighed in an adversarial hearing ... ." *West v. Ray*, No. M2010-02275-SC-R11-CV, order p.2 (Tenn. Nov. 6, 2010). Indeed, "[t]he principles of constitutional adjudication and procedural fairness require that decisions regarding constitutional challenges ... be considered in light of a fully developed record addressing the specific merits of the challenge." *State v. West*, *supra*, order p.3 and p.2 (distinguishing holding in *Abdur'Rahman v. State*, 181 S.W.3d 292 (Tenn. 2005)). *See also West v. Ray*, No. 10-1675-I, Court's ruling, p.18-19 (facts about the one-drug protocol in Ohio are not dispositive of how Tennessee's three-drug protocol works), p.31-32, 34 (distinguishing holdings from other courts). Defendants' arguments based on other cases fly in the face of these principles. *See* Defendants' Memorandum p.3, 5, 7-9, and Appendix. Mr. West's case must be decided upon the facts and findings established only in his case.

Defendants have neither appealed nor challenged the established facts and findings in this case, instead, they claim to have "heeded" and submitted to them. *See* Defendants' Memorandum p.1-2. To this end, Defendants revised the lethal injection protocol to include a "check for consciousness" after the administration of five grams of sodium thiopental with a contingency plan for a second-dose of thiopental:

> At this time, the Warden shall assess the consciousness of the condemned inmate by brushing the back of his hand over the condemned inmate's eyelashes, calling the condemned inmate's name, and gently shaking the condemned inmate. Observation shall be documented. If the condemned inmate is unresponsive, it will demonstrate that the inmate is unconscious, and the Warden shall direct the

> Executioner to resume with the administration of the second and third chemicals. If the condemned inmate is responsive, the Warden shall direct the Executioner to switch to the secondary IV line[] ... and being administration of the second set of chemicals.

Defendants' motion, Exhibit A, p.65 & 67.[2]

Aside from setting forth the protocol revisions and citing to lethal injection practices in other states, Defendants have not presented evidence to show that the alleged "check for consciousness" (or for that matter, any of the practices followed in other states) will insure that the protocol does not "allow[] ... death by suffocation while the prisoner is conscious." *State v. West*, No. M1987-000130-SC-DPE-DD, order p.2. *See also id.* at p.3 (the question is "whether the revised protocol eliminates the constitutional deficiencies [this] court identified in the prior protocol and whether the revised protocol is constitutional). In addition, three fallacies underlie the asserted efficacy of the new provisions to the protocol: (1) the implication that the inmate will remain unconscious after administration of the second and third drugs which arises from the assertion that "[i]f the condemned inmate is unresponsive, it will demonstrate that the inmate is unconscious;" (2) the implication that the untrained Warden can accurately "assess the consciousness of the condemned inmate," and (3) the implication that the contingency plan to

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[2] State officials and the Tennessee protocol committee previously had rejected this type of "check for consciousness," specifically, "checking for an eyelash response by brushing a finger across them ... lifting up the person's arm ... [and] a pin prick or pinching the nipples." One reason for rejecting it was that "there was a concern about the types of things they [doctors] had suggested ...-like plucking an eyebrow comes to mind. Things that didn't seem to add a lot of medical specificity to the process." Other suggestions to "do a pinprick or move something on the inmate's foot, pinch them" had been rejected as inappropriate. *Harbison v. Little*, 511 F.Supp. 872, 886 (M.D. Tenn. 2007), *injunction vacated and remanded*, *Harbison v. Little*, 571 F.3d 531 (6th Cir. 2009).

administer a second five gram dose of thiopental if an inmate responds to the "check for consciousness" will sufficiently anesthetize the condemned inmate. A careful review of the record evidence in this case demonstrates the baselessness of Defendants' arguments. Defendants have thus failed to demonstrate any grounds for relief from this Court's November 22, 2010, order declaring that Tennessee's protocol violates the Eighth Amendment of the United States Constitution and Article 1, § 14 of the Tennessee Constitution.

A. The revised protocol imposes a substantial risk of serious harm.

The record now, and at the time Defendants implemented revisions to the protocol, establishes: (1) that administration of pancuronium bromide and/or potassium chloride to conscious inmates constitutes cruel and inhuman punishment;[3] (2) that Tennessee's three-drug protocol allows death by suffocation of conscious inmates;[4] (3) that fifty percent of condemned inmates subjected to Tennessee's protocol are likely respond to the "check for consciousness" and fifty percent of condemned inmates are not likely to respond to the "check for consciousness;"[5] (4) the "check for consciousness," consisting of the application of mild stimuli,

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[3] "It is uncontested that, failing a proper dose of sodium thiopental that would render the prisoner unconscious, there is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride." *Baze v. Rees*, 553 U.S. 35, 53 (2008). Thus, "[p]roper administration of an adequate amount of sodium thiopental is essential to the constitutionality of Tennessee's three-drug protocol." *State v. West*, No. M1987-000130-SC-DPE-DD, order p.2 (Tenn. Nov. 29, 2010).

[4] This Court "found that Tennessee's lethal injection protocol was unconstitutional because it 'allows ... death by suffocation while the prisoner is conscious.'" *State v. West*, No. M1987-000130-SC-DPE-DD, order p.2 (Tenn. Nov. 29, 2010); *West v. Ray*, No. 10-1675-I, Court's ruling, p.10 (Chancery Ct. Davidson Co. Nov. 22, 2010). *See also, id.*, Court's ruling p.13, 14, 35.

[5]T.T. pp.92, 104, 142-144, 204-205(testimony of Dr. Lubarsky); *West v. Ray*, *id.*, Court's ruling p.15 (finding Dr. Lubarsky's testimony accurate). Affidavit of Dr. David A. Lubarsky,

will do nothing to determine whether the inmate is, or will be, conscious during the painful stimuli of pancuronium bromide and potassium chloride;[6] (5) that administration of pancuronium bromide induces paralysis and prevents outward signs that an inmate is conscious, or has become conscious, of painful stimuli;[7] and, (6) the plan to administer another five gram dose of thiopental in the event consciousness is detected will not eliminate the substantial risk of consciousness after the painful effects which follow the injection of pancuronium bromide and potassium chloride because bolus doses of thiopental do not produce the expected results and there is no one level sufficient to insure unconsciousness.[8]

Given these established and uncontested facts, it is clear that the revised protocol does not eliminate the constitutional deficiencies in the prior protocol. The uncontested facts establish "an 'objectively intolerable risk of harm' that officials may not ignore." *Baze*, 553 U.S. at 50, quoting, *Farmer v. Brennan*, 511 U.S. 825, 846, and n.9 (1994).

Jan. 17, 2011, p.3 ¶8 (Attachment A).

[6]Affidavit of Dr. David A. Lubarsky, Jan. 17, 2011, p.2 ¶6, p.3 ¶7 (Attachment A); *see also* Plaintiff's Exhibit 9; T.T. pp.93-94, 100, 105 (testimony of Dr. Lubarsky).

[7] *West v. Ray*, No. 10-1675-I, Court's ruling p.11-12, 15; T.T. pp.97, 98, 131(testimony of Dr. Lubarsky).

[8] "[T]he current amount and concentration of sodium thiopental are insufficient to insure unconsciousness because the body's ability to and the body's actual use of this drug depends on so many variables, and both medical experts agree that [] was the case. ... And ... this Court is unable to find what level of sodium thiopental is sufficient to insure unconsciousness because I don't think there is one, given the medical proof that the Court is relying on; given the medical proof in the case." *West v. Ray*, *supra*, Court's ruling, p.35, 36; *see also* p.14-15, 17. Affidavit of Dr. David A. Lubarsky, Jan. 17, 2011, p.5-6, ¶14-15 (Attachment A).

1. The "check for consciousness" is ineffective against the pain which follows the injection of pancuronium bromide and potassium chloride.

Though the effectiveness of any given method of checking for consciousness has not been litigated, the record contains established, uncontested evidence that the new protocol provisions will do nothing to prevent an inmate from being suffocated while conscious. The established evidence before the Court shows that the new "check for consciousness" will prove only whether the inmate is conscious of the stimuli applied, in this case brushing the inmate's eyelashes, calling the inmate's name, and gently shaking the inmate.

As Dr. Lubarsky explained, a person who was sufficiently unconscious to remain in that state during the application of such mild stimuli would not remain unconscious when subjected to the radically more painful effects of the second and third drugs in Tennessee's three-drug protocol. Plaintiff's Exhibit 9, Orlando R. Hung, M.D., John R. Varvel, M.D.,Steven M. Shafer, M.D., and Donald R. Stanski, M.D., *Thiopental Pharmacodynamics*, 77 ANESTHESIOLOGY (1992)); T.T. p.93-94 (testimony of Dr. Lubarsky); *see also* Affidavit of Dr. David A. Lubarsky, Jan. 17, 2011, p.2 ¶6, p.3 ¶7 (Attachment A). The problem, of course, is that the administration of pancuronium bromide will mask all signs of an inmate's awareness. *West v. Ray*, No. 10-1675-I, Court's ruling p.11-12, 15. Dr. Lubarsky testified about a well-accepted medical study widely relied upon by anesthesiologists that measured what level of thiopental was required to establish unconsciousness to differing levels of painful stimuli.

> Q. Okay. And the same would be true for the next article which is authored by – says Hung O-R and a number of other authors entitled Thiopental Pharmacodynamics II. Do you see that?
> A. Yes. Uh-huh, I do.
> Q. Okay. And is – I see that that was published in the – apparently, Anesthesia. Is that the Journal of Anesthesia? Why does that –

A. Yes. Anesthesiology is the highest regarded journal in the – in our subspecialty. The most – one of the greatest impact factors, which means that it – it is quoted and accessed the most of all the various journals.
Q. Is there reason for that? Is – are they – is it a – is it considered to be that carefully reviewed, that reliable?
A. Yeah. I mean, different journals have different levels of expectations in terms of the meaningfulness and of a particular study, you know, et cetera. And in – in our field, anesthesiology probably is the most rigorous, and this article is considered a classic.

T. 88-89.

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Q. Looking at the article, Thiopental Pharmacodynamics, could you – do you recall the nature of the study that was performed that led to the publication of this article?
A. Yes. They basically were determining what the serum levels were that correlated with different responses to graded stimuli, meaning minor stimuli to major painful stimuli and when people would respond at given levels of thiopental in their blood.
Q. Okay. And is this a study that's regularly relied upon by anesthesiologists when trying to make this determination about what thiopental levels need to be achieved to establish a certain level of consciousness?
A. Yes, it is.

T. 90-91.

Dr. Lubarsky explained that the "Hung Study," (Plaintiff's Exhibit 9, "Thiopental Pharmacodynamics II"), measured thiopental levels required to render fifty-percent of the subjects unconscious to differing levels of painful stimuli.

Q. In the first column of Table 1, it says, Cp50 plus or minus – is that an SE?
A. Standard error.
Q. Okay.
A. It's a measure of the distribution of data around the central theme.
Q. Okay. It – it defines Cp50 right underneath the table, but I'm not sure I completely understand it. Could you explain to the Court what Cp50 means?
A. Sure. It's the concentration in the plasma that – at which 50 percent of people will not respond. On the other hand, it's also the concentration in which 50 percent of people will respond. So if you're concerned about making sure that no one will respond, these are ex – these are not appropriate numbers. This is the

– this is 50 percent of the people respond; 50 percent of the people don't respond. That's a traditional way that we measure drug potencies and drug effects. Very common use in anesthesia. And it's a way – allows us to kind of get an idea of what we're shooting for if we're shooting for a lot higher than the numbers in this particular table.

Q. Because if half the people aren't sufficiently unconscious –

A. Yeah, then it –

Q. – that's – that's not a – that's not a good result, is it?

A. No, it would not be a good result.

Q. Okay. That – that isn't a kind of outcome that could really be – that's a tolerable outcome. It – it's not in – in your –

A. That's correct. I mean, the – even with all of our knowledge and all of our overdosing relative to these, you know, we still have incidences of awareness that are 1 to 2000 that occur per, you know, 1 to 2 in 1,000 surgeries. Not necessarily painful awarenesses, I might add; but it still does happen. You know, there's marked individual variation in the response to any particular drug dose.

Q. Now, Doctor, do – we – I think we think about anesthesia – and at least I – I do – in kind of a very common way, which is we put them in, it goes – as soon as they go to sleep, they never feel anything else. On the other hand, these numbers appear to change in regard to the painfulness of the stimuli that's – that's applied. Do you have to have a higher level of unconsciousness in order to be anesthetized against a more severe degree of pain?

A. Yes, you do. And matching the depth of anesthesia to stimulus intensity is part of what takes years of training for an anesthesiologist to know.

Q. When we look at these numbers, could you describe for the Court like what a trapezius squeeze is?

A. Sure. If you've got some – you ever played sports, high school sports, people come up behind you, squeeze the trapezius muscle right there in the back of your neck, it's painful, and you -- I don't know if maybe your guy -- your jocks don't fool around the way they did when I was in high school. You know, they're something that, you know, makes people flinch. It's pretty painful -- pretty painful, but it's not like being punched in the face or anything. It's kind of in between that.

Q. Okay. It's – would you say mildly, moderately painful?

A. Moderately painful, yes.

Q. Okay. Then we have a laryngoscopy. What – what does that entail?

A. That's sticking a giant tongue depressor down your throat. You know, and – and we do that on a lighted handle so that we can see the vocal cords. So that's what we do before we put a breathing tube in which would be the next thing, which is intubation, which is when we place a plastic breathing tube inside of your air pipe, your trachea. And that is very, very stimulating.

T.T. p.92-95.

Plaintiff's Exhibit 9 (the Hung Study), illustrates the serum thiopental levels required to produce a 50/50 chance that a person will have the corresponding state of unconsciousness:

15.6 mg/L ± 1.1: Loss of purposeful movement in response to verbal stimulation

30.3 mg/L ± 3.8: Loss of purposeful movement in response to tetanic nerve stimulation

39.8 mg/L ± 3.3: Loss of purposeful movement in response to trapezius muscle squeeze

50.7 mg/L ± 2.9: Loss of movement in response to laryngoscopyangoscopy

78.8 mg/L ± 7.4: Loss of movement in response to intubation

(Plaintiff's Exhibit 9, at p.4, Table 1).

Dr. Lubarsky compared the stimuli used in the Hung Study to the stimuli produced by Tennessee's three-drug lethal injection protocol.

> Q. Okay. How would you describe that experience [suffocation while paralyzed] when it's happening as a painful experience?
> A. Painful and extremely disturbing to the patient. The inability to get one's air is among the most intense experiences that you can possibly have. I mean, it is – you know, it's what life is all about is – is getting a breath of air; and if you talk to people with near drowning experiences, et cetera, you know, they can explain to you how desperately their lungs burn, their body felt on fire as they – you know, they would – they were – they were driving up to the surface, you know, if possible to – to get a breath of air because your body is finely tuned and, you know, from ions of evolution, finely – finely pushed to – to get air. I mean, that's what – that's, you know – and it's a – it's a primary survival mechanism –
> Q. More painful than a squeeze of the muscle there by your shoulder?
> A. No comparison.
> Q. Not even close?
> A. Not even close.
> Q. How about the larng –
> A. Laryngoscopy?
> Q. Laryngoscopy, yes.
> A. Again, not even close.

T.T. p.99-100.

Dr. Lubarsky compared the thiopental levels required for unconsciousness of differing levels of painful stimuli to the thiopental levels present in Tennessee's executed inmates. Robert Coe, Philip Workman, and Sedley Alley had thiopental levels of 10.2 mg/l, 18.9 mg/l, and 8.31 mg/l, respectively. *West v. Ray*, No. 10-1675-I, Court's ruling p.17. There is a fifty-fifty chance that a person with a thiopental level of 10.2 or 8.31 mg/l would respond to minor stimuli, such as a verbal command, brushing the eyelashes or gentle shaking. T.T. p.142-144 (testimony of Dr. Lubarsky). It was conclusively proven at the prior evidentiary hearing, and remains uncontested, that Tennessee inmates are not adequately anesthetized by the administration of five grams of thiopental.

> Q. And yet the – the numbers we're looking at in this study for a laryngoscopy – got it that time – are 50.7 – and I – it's - I believe this is micrograms per milliliter, but it's the equivalent of 50.7 milligrams per liter of sodium thiopental?
> A. That is correct. And that's for 50 percent of people to respond. Not a hundred percent of people – that's not an adequate level for that procedure. That is the – a – the Cp50 is – is basically half respond; half don't respond.
> Q. So let me see if I understand this correctly. At 50.7 milligrams per liter, half of the people – half of the people who are subjected to a stimulus much less painful than what goes on during the lethal injection, half of those people respond?
> A. Correct.
> Q. Now, something else happens in a – in a lethal injection or is supposed to happen in a lethal injection besides this suffocation you've just described, and – and that is a drug called the potassium chloride is – is administered. How painful is that in relation to our trapezius squeeze and these kind of things?
> A. Again, no comparison. There are many instances where the patients have gotten some IV – small little amounts of IV potassium chloride, and it burns like the dickens. And you inject a whole lot of IV potassium chloride and you'll have – you know, you have people jumping off the table and hitting the roof. I mean, it is extremely caustic. It's extremely caustic. And you – you just wouldn't do that.
> Q. So – and I – would it be fair to say that, at the same time they're experiencing this same caustic kind of thing, they're still experiencing these other opinions as you've described before? It's just heaped on top of it?
> A. That is correct.
> Q. So what we're looking at is just a phenomenally painful experience that

these last two drugs produce?
A. Correct.
Q. And one which is going to require a higher than – a higher level than what we're seeing in these clinical studies with clinical kinds of stimuli?
A. Right.

T.T. p.104 -106.

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Q. Now, Dr. Lubarsky, if the pathologist who conducted this – conducted this examination [of Robert Coe] did their job, looked carefully, and determined that the catheters were still in place, there was no sign of infiltration or misplacement of the catheters, would you consider this 10.2 level to be problematic?
A. I would.
Q. And why is that?
A. Well, the key is that it's nowhere near the level that's required in the blood on – remember, I talked about up and down – on the upside, going to sleep, okay, it's nowhere near the level required just simply not to sit up and shake your hand when you asked someone to in terms of they're not even – they're not even really sedated if they're responding to verbal commands at that level.

And there would be a high likelihood that they would respond to command, and -- which is why, again, you know, it's very – it's always very important to, you know, look at the – the data that you have. You know, it's – and, again, this is half to a third probably of what someone who's experiencing acute tolerance to a large bolus of thiopental would require in terms of being asleep in response to a mere verbal request to perform an activity.

Totally different from being, you know, fighting for your life, needing to take a breath, feeling the excruciating pain of potassium chloride being injected. That's on top of all that. But just this level alone, just like you talking to me, and I would be responding to you.
Q. And that's the kind of level that – that was produced here, a level that would respond to a verbal command.

T.T. p.142-144.

It was conclusively proven at the prior evidentiary hearing, and remains uncontested, that persons who are unconscious during the application of mild stimuli can still respond to more painful stimuli. This is not just a function of matching the depth of anesthesia to stimulus intensity. It is also a function of pharmacodynamics and pharmacokinetics that a person will

regain consciousness at a higher serum thiopental level than that which initially induced unconsciousness. Thus, a deeper level of unconsciousness is required to remain anesthetized against a more severe degree of pain.

Defendants, however, appear to argue the "check for consciousness" is effective because condemned inmates will receive thiopental levels comparable to those of Tennessee's executed inmates, such as 10.2 mg/l. Defendants' Memorandum p.7. At those levels, fifty percent of Tennessee's condemned inmates are likely to respond to the "check for consciousness." *Id.*; Affidavit of Dr. David A. Lubarsky p.3 ¶8 (Attachment A). Then, as set forth on page 67 of the protocol, the executioner will switch to the secondary IV line and administer the second set of chemicals. Defendants' Memorandum p.7. Yet, Defendants ignore the fact that fifty percent of Tennessee's condemned inmates will likely *not* respond to the "check for consciousness." Affidavit of Dr. David A. Lubarsky p.3 ¶8 (Attachment A). Those unresponsive inmates will not receive a second five gram dose of thiopental and will indisputably be conscious and suffering from the painful effects of the administration of pancuronium bromide and potassium chloride. Affidavit of Dr. David A. Lubarsky p.3-4 ¶8-9 (Attachment A). Defendants' belief regarding the "check for consciousness" allows at least a fifty percent torture rate, which is constitutionally unacceptable.

Defendants further fail to acknowledge that the administration of thiopental under Tennessee's three-drug protocol does not have the intended or expected effect, therefore, even those inmates receiving a second dose are likely to become aware of the pain produced by the protocol. There is no proof that the revised protocol will eliminate even fifty percent of unconstitutional executions, as Defendants allege. The record facts demonstrate, instead, that

even those inmates who do receive an additional dose of sodium thiopental are not assured of continuous unconsciousness. Affidavit of Dr. David A. Lubarsky p.5-6 ¶14-15 (Attachment A). The medical proof shows that there is no one level of sodium thiopental sufficient to insure unconsciousness during an execution under Tennessee's three-drug protocol. *West v. Ray*, No. 10-1675-I, Court's ruling p.36. Five grams of thiopental administered under Tennessee's three-drug protocol does not have the intended effect.

> [T]he problem is that we don't really understand the acute tolerance, the rapid redistribution, the effect of acid-base changes, and hyperdynamic circulation on the drop in thiopental levels or the change in receptor sensitivity to thiopental after the fact. We don't understand that at all.
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> But it turns out that it's not having the intended effect, which suggests that we've got it wrong, and that our assumptions that simply 5 grams is 10 times better than 500 milligrams is an erroneous assumption. It's not a linear relationship.

T.T. p.196-197 (testimony of Dr. Lubarsky).

Even under a layman's linear assumption that a second dose would produce an additional 10.2 milligrams of thiopental per liter, the total thiopental level of 20.4 mg/l would still be insufficient. A thiopental level of 50.7 mg/l is required to maintain unconsciousness in fifty percent of people during a laryngoscopy.[9] Plaintiff's Exhibit 9; T.T. p.104-106 (testimony of Dr. Lubarsky). There is "no comparison" between the pain of a laryngoscopy and the phenomenally painful experience resulting from the injection of pancuronium bromide and potassium chloride.

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[9]Dr. Lubarsky explained that the thiopental levels in the Hung Study represent "the concentration in which 50 percent of people will respond. So if you're concerned about making sure that no one will respond, these are ex – these are not appropriate numbers. ... we're [anesthesiologists are] shooting for a lot higher than the numbers in this particular table." T.T. p.92-95 (testimony of Dr. Lubarsky).

T.T. p.104-106 (testimony of Dr. Lubarsky). It's "not even close." T.T. p.99-100 (testimony of Dr. Lubarsky). Thus, giving a second five gram dose of thiopental to an inmate upon whom the first dose did not render unconscious does not eliminate the substantial risk that the inmate will die from conscious suffocation. *See* T.T. p.196-198 (testimony of Dr. Lubarsky). Affidavit of Dr. David A. Lubarsky, Jan. 17, 2011, p.5-6 ¶14-15 (Attachment A). At bottom, all condemned inmates are likely to become aware of the pain produced by Tennessee's three-drug protocol. Affidavit of Dr. David A. Lubarsky, Jan. 17, 2011, p.3 ¶8 (Attachment A).

An additional problem with the new protocol provisions is that they require no further check for consciousness following administration of the second dose of sodium thiopental, not even the ineffective check already required after the first dose. The revised protocol simply assumes that a second dose will render the inmate unconscious, just as the unconstitutional prior protocol assumed that the first dose would render inmates unconscious. Accordingly, Defendants' argument that the changes in Tennessee's protocol would assure the unconsciousness of half of the inmates who responded to Tennessee's "check for consciousness" is directly contrary to the evidence and this Court's prior ruling. In any event, a fifty percent torture rate is constitutionally unacceptable.

> In order to be effective, any test that consists of applying noxious stimuli to determine consciousness must apply stimuli equivalent to that which the person will be subjected to.[10]

Affidavit of Dr. David A. Lubarsky, Jan. 17, 2011, p.3 ¶7 (Attachment A); *see also* Plaintiff's

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[10]It is questionable whether any test for consciousness can be both effective and constitutional. The application of any stimuli which would be painful enough to determine whether a condemned inmate would remain conscious during the pain and horror created by the protocol's second and third drugs would itself inflict unnecessary and severe pain.

Exhibit 9; T.T. p.93-94 (testimony of Dr. Lubarsky). Thus, Defendants' proposed "check for consciousness" is only effective if the pain produced by the three-drug protocol is equal to that produced by brushing the eyelashes or a gentle shake. It is not. The three-drug protocol produces pain that is substantially greater than what is produced by a layrngoscopy. T.T. p.99-100, 104-106 (testimony of Dr. Lubarsky). At a level 50.7 milligrams of thiopental per liter, fifty percent of people will respond to the stimulus from a laryngoscopyangoscopy which is much less painful than the pain produced during Tennessee's lethal injection procedure where the condemned have received 40 mg/l *less* thiopental. T.T. p.104-106 (testimony of Dr. Lubarsky); *West v. Ray*, No. 10-1675-I, Court's ruling p.17-18.[11] Thus, the "check for consciousness" does not eliminate the substantial risk that Tennessee inmates will remain conscious when subjected to the pain and horror of the second and third drugs used in the protocol. Defendants ignore this indisputable fact, proven during the prior hearing before this Court.

2. An untrained Warden cannot accurately assess the consciousness level of a condemned inmate.

Under Tennessee's revised protocol, it is the responsibility of the untrained warden to look for signs of consciousness. The protocol does not include any training for the warden to be able to ascertain consciousness and the current warden, Ricky Bell, doesn't have any education, training or experience in assessing depth of anesthesia. Warden Bell's only execution training has consisted of viewing executions in Texas years ago, visiting an execution site in Indiana, and

---

[11]In fact, Dr. Lubarsky testified that the effect of the administration of pancuronium bromide and potassium chloride would be more painful than even the most painful stimuli used in the Hung study (Plaintiff's Exhibit 9). T.T. p.105-106 (testimony of Dr. Lubarsky). A serum thiopental level of 78.8 mg/l ± 7.4mg/l was required to prevent a response to the most painful stimuli in one-half of the subjects of the Hung study.

talking with some other states about the process. Plaintiff's Collective Exhibit 1 at p.97-100 (Attachment B)(testimony of Ricky Bell).[12]

Dr. Lubarsky testified that medical expertise is required to detect signs of consciousness following the administration of noxious stimuli.

> Q. Now, Doctor, do – we – I think we think about anesthesia – and at least I – I do – in kind of a very common way, which is we put them in, it goes – as soon as they go to sleep, they never feel anything else. On the other hand, these numbers appear to change in regard to the painfulness of the stimuli that's – that's applied. Do you have to have a higher level of unconsciousness in order to be anesthetized against a more severe degree of pain?
> A. Yes, you do. And matching the depth of anesthesia to stimulus intensity is part of what takes years of training for an anesthesiologist to know.

T.T. p.94. An untrained warden cannot accurately assess the consciousness of a condemned inmate. Affidavit of Dr. David A. Lubarsky, Jan. 17, 2011, p.4-5 ¶13 (Attachment A).

Tennessee's "check for consciousness," even if carried out by medical professionals, would not determine whether an inmate would remain conscious when experiencing the effects of pancuronium bromide and potassium chloride. Affidavit of Dr. David A. Lubarsky, Jan. 17, 2011, p.2 ¶6 (Attachment A). Furthermore, once the inmate is injected with pancuronium bromide any outward signs of consciousness will be masked by paralysis. *West v. Ray*, No. 10-1675-I, Court's ruling p.11-12, 15. The fact that a prison warden lacks the expertise to carry out that check merely adds to the inescapable conclusion that the check fails to cure the unconstitutionality of Tennessee's three-drug protocol.

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[12]Plaintiff's collective exhibits are not Bates stamped. For ease of reference, Plaintiff has attached copies of those pages of the collective exhibits to which he cites in his memorandum.

B. Tennessee officials have determined that a one-drug protocol eliminates the substantial risk of severe pain caused by the three-drug protocol and that it is a feasible, readily implemented alternative method of execution.

Defendants have never claimed that methods of execution which significantly reduce the substantial risk of pain and suffering do not exist.[13] The record evidence demonstrates that almost four years ago Tennessee officials proposed what they deemed an alternative, feasible, readily implemented method of execution that significantly reduces the substantial risk of severe pain. Plaintiff's Collective Exhibit 1, at p.25-26 (testimony of George Little), and at 96 (testimony of Gayle Ray)(Attachment C). That method was a one-drug protocol. Because the proposed one-drug protocol called only for the injection of sodium thiopental, Tennessee's protocol committee determined that it removes the substantial risk of severe pain resulting from the injection of pancuronium bromide and potassium chloride.

In 2007, after two months of research, consultation and deliberation, Tennessee's protocol committee recommended that the state implement a one-drug lethal injection protocol. The committee identified the advantages of the one-drug protocol: it is easier to defend in court; it is a simpler procedure than the three-drug protocol; it is peaceful to witnesses; it is similar to animal euthanasia; all physicians who consulted with the committee agreed on it; it contains less

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[13]Mr. West notes that methods of rendering a person sufficiently unconscious to withstand painful procedures have obviously been employed in a clinical setting for decades. In the past, courts have been reluctant to deem such methods as feasible alternatives because they require the participation of an anaesthesiologist. *See Baze v. Rees*, 553 U.S. at 64 (Alito, J. concurring) ("Prominent among the practical constraints that must be taken into account in considering the feasibility and availability of any suggested modification of a lethal injection protocol are the ethical restrictions applicable to medical professionals."). The evidence in this case, however, indicates that at least one prominent anaesthesiologist, Dr. Mark Dershwitz, is unconstrained by such ethical restrictions and has actively assisted other states in the area of lethal injection. T.T. p.223-225 (testimony of Edwin Voorhies).

chance of error than the three-drug protocol; it eliminates the pain producing drugs, pancuronium bromide and potassium chloride; and, there is no downside to a vein issue if there was a need to switch sites. Plaintiff's Collective Exhibit 3 at p.134, 157 (Attachment D).

Dr. Dershwitz informed the committee that "there was no possibility that 5 grams of sodium pentothal would not cause death." Plaintiff's Collective Exhibit 1 at p.69 (testimony of Gayle Ray)(Attachment E). He also told them that if one dose did not work, another dose of sodium thiopental could be given as "a very plausible back-up." Plaintiff's Collective Exhibit 1 at p.70 (testimony of Gayle Ray)(Attachment F). Physician A, who pronounces death at Tennessee's executions, preferred one dose of sodium thiopental, a wait of five minutes, and then a second dose of sodium thiopental and then check for death. Plaintiff's Collective Exhibit 1 at p.79 (testimony of Gayle Ray)(Attachment G). The committee thus created and recommended a one-drug lethal injection protocol.

> Under the protocol recommended by the Committee, one dose of five grams of sodium thiopental would be administered to the inmate. (TR 595) Subsequently, a physician would assess whether or not the inmate was dead. (*Id.*) If he was not dead, another five grams of the drug would be administered. (*Id.*) In a draft of its recommendation, the Committee discussed the benefits of this method, stating:
>
> The primary advantage of the one-drug protocol is that it is much simpler to administer and provides an even lower risk of error in its administration. As compared to the two- and three-drug protocols, it has the advantage of eliminating both of the drugs which, if injected into a conscious person, would cause pain. It is similar to the humane process used in animal euthanasia. Using one drug that does not require refrigeration greatly simplifies the process of maintaining and accounting for the lethal injection drugs. Most importantly, all of the medical experts consulted by the State were very supportive of the one-drug protocol, and the 5 gram dose.
>
> (Plaintiff's Ex. 36 at 6) In fact, if the Department of Corrections had adopted the Committee's recommendation, it would have greatly mitigated the plaintiff's risk of pain. As the Committee stated in its draft, the one-drug protocol would have

eliminated the use of the second two drugs-pancuronium bromide and sodium thiopental-which, without proper anaesthesia, would cause pain. Even if the sodium thiopental were improperly administered, the only result would be that the plaintiff would be given more sodium thiopental. Committee minutes, notes, and "pro" and "con" lists all, alluding to this intrinsic advantage, were introduced into evidence at the hearing. (See Plaintiff's Ex. 7 at 1; Plaintiff's Ex. 26 at 1; Plaintiff's Ex. 31 at 24; TR 541; TR 544; TR 546-47) As Debbie Inglis testified, the Committee found that the only risk to the inmate under the one-drug protocol "is that the person might regain consciousness," after which more anaesthesia would be given. (TR 577)

This advantage was highlighted by the medical experts consulted by the Committee. Dr. Payne highlighted the potential dangers of the three-drug protocol when he informed the Committee that the second drug "prevents the ability to tell if a person is waking up" and that, if the first drug is insufficient, "a person could wake and not be able to breathe." (Plaintiff's Ex. 20 at 2) Gayle Ray, the Deputy Commissioner of Corrections, testified that Dr. Dershwitz later "encouraged the Committee to write a protocol that states if five grams are used, then wait five minutes, then check for circulation, heart beat. If death does not occur, wait another five minutes and check again. If death does not occur, administer five more grams." (TR 544) That is the one-drug protocol the Committee ultimately recommended.

Harbison v. Little, *supra* at 895-896.

The protocol committee only identified three disadvantages of a one-drug protocol and none apply today: no other state does it; it would change the old procedures; and, states that use an EKG/ECG might not want to do this because of potential longer time to pronounce death but there was no issue when using a stethoscope. Plaintiff's Collective Exhibit 3 at p.157 (Attachment H). This last disadvantage did not really apply as a con because Tennessee uses the stethoscope to confirm death and, therefore "the length of time isn't an issue with the one-drug protocol when a stethoscope is used to declare death." Plaintiff's Collective Exhibit 1, at p.83-84 (testimony of Gayle Ray)(Attachment I). Regarding the first disadvantage, subsequent to 2007, two states, Ohio and Washington, have adopted one-drug lethal injection protocols using sodium

thiopental. Jennifer Sullivan, "*Washington state says new execution method was carried out 'humanely,'*" THE SEATTLE TIMES (Sept. 10, 2010) *available at:* http://seattletimes.nwsource.com/html/localnews/2012866400_execution11m.html. Washington has carried out one execution using its one-drug protocol. *Id.* Ohio has carried out nine executions using its one-drug protocol. T.T. p.213 (testimony of Edwin Voorhies). The remaining disadvantage, regarding having to change the procedures, appears to no longer be an issue since Defendants decided on their own to recently revise Tennessee's protocol.

Although in 2007, the committee's one-drug protocol was rejected by the Commissioner of the Department of Corrections,[14] he determined that if the three-drug protocol were held unconstitutional, Tennessee "could always fall back on the one-drug protocol." Plaintiff's Collective Exhibit 1 at p.25-26)(Attachment J)(testimony of George Little). Tennessee's three-drug protocol has twice been declared unconstitutional. *Harbison v. Little*, *supra*; *West v. Ray*, *supra*. Tennessee officials, however, have failed and/or refused to adopt the one-drug protocol they deemed feasible and easy to implement.

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[14] The Commissioner rejected the one-drug protocol because he did not want "Tennessee to be at the forefront of making the change from the three-drug protocol to the one-drug protocol," and he thought adoption of the one-drug protocol could lead to "political ramifications." (Plaintiff's Collective Exhibit 1 at p. 25-26 (Attachment J)(testimony of George Little). Even if these reasons were legitimate, they have been alleviated by the change in circumstances since that time.

III. Conclusion

The evidence before this Court demonstrates that the revisions to Tennessee's three-drug protocol do not eliminate the constitutional deficiencies identified by this Court because they do not reduce the substantial risk that a condemned inmate will suffer death by conscious suffocation. The evidence establishing this objectively intolerable risk of harm stands uncontested. Defendants have not even attempted to provide evidentiary support for the efficacy of the protocol revisions nor have they attempted to demonstrate that this Court's November 22, 2010, decision was incorrect. There is no dispute of material fact requiring this Court's resolution. Based on the evidence now before the Court, Mr. West is entitled to judgment in his favor.

Accordingly, this Court should deny Defendants' motion and declare (1) that Tennessee's revisions to the protocol do not eliminate the constitutional deficiencies this Court previously identified, (2) that the protocol remains unconstitutional, and (3) that Tennessee officials determined almost four years ago that a one-drug lethal injection protocol is a feasible and readily available method of execution that will reduce the substantial risk of serious and unnecessary pain.

If the Court in its discretion determines that Defendants should be given an additional opportunity to present expert testimony to support the bare allegation that Tennessee's "check for consciousness" cures the unconstitutional protocol, this matter should be set down for an evidentiary hearing.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, Stephen M. Kissinger, hereby certify that a true and correct copy of the foregoing document was delivered by email and Fed Ex overnight to:

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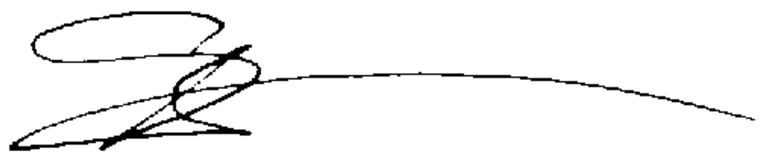
this the18th day of January, 2011.



Stephen M. Kissinger

ATTACHMENT

"A"

IN THE CHANCERY COURT OF DAVIDSON COUNTY, TENNESSEE

STEPHEN MICHAEL WEST,	)	
	)	
Plaintiff,	)	
	)	No. 10-1675-I
v.	)	**DEATH PENALTY CASE**
	)	
GAYLE RAY, in her official capacity as Tennessee's Commissioner of Correction, *et al.*,	)	
	)	
Defendants.	)	

AFFIDAVIT OF DR. DAVID A. LUBARSKY

Comes now the affiant, David A. Lubarsky, M.D., M.B.A., and declares under the penalty of perjury as follows:

1. My name is David A. Lubarsky.

2. I have previously testified in this matter as an expert in anesthesiology.

3. I have reviewed the changes made to the protocol for execution of a death sentence in Tennessee as set out in the attachments to the November 24, 2010, Memorandum from Gayle Ray to Warden Ricky Bell attached as Exhibit A to the Motion to Amend Findings of Fact and to Alter or Amend Judgment filed by the Defendants in this case.

4. I have also reviewed the protocol for execution of a death sentence in Tennessee which this Court declared unconstitutional on November 22, 2010, to which these changes were made.

5. It is my opinion, within a reasonable degree of medical certainty, that the addition of the step described at Paragraph 6 on Page 65 of the execution protocol does not in any way assure that Tennessee inmates will remain unconscious as they experience the effects of pancuronium bromide and potassium chloride, nor does it reduce the risk that an inmate will remain conscious as they experience the effects of pancuronium bromide and potassium chloride.

6. The claim that "[i]f an inmate is unresponsive [to the application of a mild stimuli described in Paragraph 6 on Page 65 of the execution protocol], it will demonstrate that the inmate is unconscious" and by implication that he will remain unconscious after the administration of the second and third drugs, is incorrect. Whether an inmate responds after the application of a mild stimuli such as those described in Paragraph 6 on Page 65 of the execution protocol cannot determine whether an inmate will respond after the administration of pancuronium bromide and potassium chloride. As I stated during my prior testimony, an inmate who will not respond to the mild stimuli described in Paragraph 6 on Page 65 of the execution protocol can still respond following the far more noxious and/or painful experience which would follow the administration of pancuronium bromide and potassium chloride.

7. The administration of pancuronium bromide in the manner required by Tennessee's protocol for carrying out death sentences prevents an inmate from responding to the application of noxious stimuli. Therefore, any check to assess whether an inmate will respond after experiencing the effects of the injection of pancuronium bromide and potassium chloride involving the application of noxious stimuli must both: (a) take place prior to the administration of pancuronium bromide; and (b) involve the application of stimuli as noxious and/or painful as the experience the inmate will suffer after the administration of pancuronium bromide and potassium chloride.

8. The serum sodium thiopental levels obtained following Tennessee executions fall in a range where, according the "Thiopental Pharmacodynamics II" study introduced as Plaintiff's Exhibit 9, one-half of inmates subjected to the mild stimuli described in Paragraph 6 on Page 65 of the execution protocol, would respond; one-half would not, but all inmates will experience the effects which would follow the injection of the pancuronium bromide and potassium chloride.

9. Given the serum sodium thiopental levels obtained following Tennessee executions, under the procedure described in Paragraph 6 on Page 65 of the execution protocol, even though all inmates would be conscious after being administered pancuronium bromide and potassium chloride, in the best

scenario only half of these inmates would be provided with a second 5 gram dose of sodium thiopental.

10. As demonstrated by the "Thiopental Pharmacodynamics II" study, as serum thiopental levels increase above 15.6 mg/l, subjects are less likely to respond to a mild stimuli, however, it is not until serum thiopental levels reach 78.8 mg/l ± 7.4mg/l that even one-half of those subjects would not respond after receiving a stimuli (intubation) less noxious than the effects of the administration of pancuronium bromide and potassium chloride.

11. Serum thiopental levels from samples obtained in other states immediately after the inmate has been pronounced dead have never been above 42 mg/l and there is only one reported level above 30 mg/l.

12. Inmates with a serum thiopental level higher than those obtained following Tennessee executions, yet equal to, or lower than, the highest serum thiopental levels ever reported following an execution by lethal injection would be less likely to respond to the procedure described in Paragraph 6 on Page 65 of the execution protocol, yet still not sufficiently anaesthetized.

13. The procedure described in Paragraph 6 on Page 65 of the execution protocol requires the Warden to make a determination whether an inmate has responded after being subjected to the mild stimuli described in that provision. The protocol contains no requirement that the Warden be trained, in any manner, as to what constitutes a response to a given stimuli,

or how to detect such a response. As I previously testified in this proceeding, matching the depth of anesthesia to stimulus intensity is part of what takes years of training for an anesthesiologist to know. An untrained Warden cannot accurately "assess the consciousness of a condemned inmate."

14. Finally, even in the event that an inmate were to respond to the procedure described in Paragraph 6 on Page 65 of the execution protocol, there are no assurances that, following the remedial procedure of administering another 5 grams of sodium thiopental, the inmate will remain unconscious following the administration of pancuronium bromide and potassium chloride.

15. There have been no studies regarding the levels of unconsciousness obtained through the administration of either 5 or 10 grams of sodium thiopental in the manner required under the Tennessee execution protocol. The serum thiopental levels obtained following Tennessee executions indicate that the administration of 5 grams of sodium thiopental produces serum thiopental levels which are only a fraction of those sufficient to assure unconsciousness following the administration of pancuronium bromide and potassium chloride. A repetition of that ineffective procedure cannot assure a sufficient level of unconsciousness.

16. All opinions which I have expressed in this affidavit are held to a reasonable degree of medical certainty.

FURTHER AFFIANT SAITH NAUGHT.

I declare under penalty of perjury that the foregoing is true and correct.

DAVID A LUBARSKY, M.D. M.B.A.
Emanuel M. Papper Professor and Chair
Department of Anesthesiology
Perioperative Medicine and Pain Management
University of Miami Miller School of Medicine
and
Professor
Department of Management
University of Miami School of Business

STATE OF FLORIDA)

COUNTY OF MIAMI-DADE)

Sworn to and subscribed before me by David A. Lubarsky, who provided personal identification or is personally known to me, this 17th day of January, 2011.

Notary Public

My Commission Expires:

November 16, 2012

SHARRON LADSON
MY COMMISSION # DD 836218
EXPIRES: November 16, 2012
Bonded Thru Notary Public Underwriters

ATTACHMENT

"B"

master's in business. I started out my career as an English teacher. I've been a college administrator, a Metro council member, a sheriff, and now deputy commissioner.

Q. You were the sheriff of Davidson County at one time, were you not?

A. Yes, I was.

Q. For how long?

A. Eight years.

Q. And how long have you been Deputy Commissioner of the Department of Correction?

A. Three years, three months.

Q. And as we've heard a lot of testimony from you this morning, you were on the committee to review the lethal injection protocol, as instructed by the commissioner. Is that correct?

A. Yes.

Q. Do you recall the purpose of that committee?

A. The purpose of the committee was to carry out the executive order of the Governor and to come up with our recommendation of execution protocols for Tennessee.

Q. Was it a goal to find the most humane and professional protocol?

A. Very much so.

Q. And, obviously, we've heard testimony this morning that the committee met numerous times.

A. Yes.
Q. You consulted with physician experts.
A. Yes, we did.
Q. You took a trip to Virginia.
A. Yes.
Q. And did you also take a trip to Indiana?
A. Yes, we did.
Q. What did y'all do during the Indiana trip? What was that for?
A. That was the Federal Bureau of Prisons. We went up to observe a periodic training that they go through for lethal injection.
Q. Do you know what sort of protocol --
Do they use a three-drug protocol?
A. Yes.
Q. Now, I wanted to ask you --
MS. CAMPBELL: If this witness could be handed Plaintiff's Exhibit 26.
THE COURT: This is two pages from Exhibit 28 to the Julian Davis deposition.
MS. CAMPBELL: Yes, ma'am.
THE COURT: Which is also the end of her notes.
MS. CAMPBELL: Yes, ma'am. That's what I'm going to try to clear up on the record.
Q. (By Ms. Campbell) You have not looked at Plaintiff's

Exhibit 26 before, Ms. Ray, but I would ask you to look at it right now.

A. Yes.

Q. Does that appear to be the portion of your notes that's contained at the very end or the last two pages of Plaintiff's Exhibit 31, which you've testified about today?

A. Yes.

Q. So that is the same document?

A. It is.

Q. What is this document that is the end of 31 and all of 26? What is that document?

A. This document is a result of a request by the committee for Warden Bell to go back to the institution and sit down with members of the execution team and to the best of their ability to come -- to write down precisely, step by step, the procedures that they were currently using.

Q. Do you know who created this document, to the best of your knowledge? The typed portion.

A. I'm not sure who the person was, if it was Warden Bell or one of his associates.

Q. But your understanding is this reflects their practice prior to the committee meetings?

A. Correct.

Q. And there's been questions about and you've been questioned about the fact that at the very bottom of Page 1

of that exhibit there is a sentence crossed out. The sentence is, The drugs were inspected every 15 to 20 minutes to insure that the first syringe of pentothal does not become cloudy, form any particles, and remains completely clear.

A. Correct.

Q. That is marked out.

A. Yes, it is.

Q. Who marked that out?

A. I did.

Q. Why did you mark that out?

A. I marked it out because of -- I believe it was either Dr. Payne or Dr. Dershwitz explaining to us that once pentothal is mixed appropriately, that it is dissolved, suspended. Everything is good to go for several days.

So we were trying to also simplify the process as much as we could and felt that that was an unnecessary step.

Q. Now, we've heard a lot of testimony during the trial about what has been referred to as minutes of the committee meetings that were prepared by --

Is it Ms. Dana Duke? Is that her name?

A. Yes.

Q. And you have referred to -- you would prefer to refer to it as notes, I believe your testimony was.

A. Yes.

Q. Do you know what the purpose of these minutes were --

ATTACHMENT

"C"

MR. KISSINGER: On the one-drug protocol.

THE COURT: On the one-drug protocol.

MR. KISSINGER: That is correct.

A. My recollection of the conversation was that either way, I was very much involved in the process. In effect, my fingers were, if you will, all over the processes.

Q. (By Mr. Kissinger) And, Commissioner Little, I understand your impression of whether your fingers were on the process or not. What I'm asking you is during this conversation was the comment made that your fingers were not on the one-drug protocol?

A. I do not remember making that statement specifically.

Q. Do you recall Mr. Elkins making that statement?

A. No, sir.

Q. Commissioner Little, did you tell Mr. Elkins that one of the reasons that you rejected the committee's recommendation for the one-drug protocol is because you didn't want Tennessee to be out at the forefront of making the change from the three-drug protocol to the one-drug protocol?

A. I did make that statement.

Q. And did you tell Mr. Elkins that you felt that if you discarded the three-drug protocol and adopted the one-drug protocol there could be political ramifications from that decision?

A. I did make that statement.

Q. Did you also tell Mr. Elkins that you were going with the three-drug protocol because if you went with the three-drug protocol and this court or any other court declared the three-drug protocol unconstitutional, you could always fall back on the one-drug protocol?
A. I did express that that was one of the contingencies.
Q. That's the reason we're here today, isn't it?
A. I'm not sure that that's the reason.
MR. KISSINGER: I don't have any further questions, Your Honor.
THE COURT: Cross.

CROSS EXAMINATION

BY MR. HUDSON:
Q. Commissioner Little, just to get a little background information.
How long have you been the Commissioner of the Department of Correction?
A. Well, I was actually -- I guess the announcement was made just about two years ago Thursday. I've actually been in the position since October of 2005.
Q. And what was your prior employment history?
A. Prior to assuming this position, I was Director of Corrections for -- of the Division of Corrections for Shelby County, Tennessee. Prior to that I was an executive

was made by Commissioner Little.

MR. KISSINGER: Let me rephrase that question then.

Q. (By Mr. Kissinger) Is this why the committee ultimately provided Commissioner Little with a report and recommendation which recommended the three-drug protocol? Because you could go fight it out in court.

A. No.

THE COURT: Well, it's not clear to me. I haven't heard that the committee recommended the three-drug protocol to Commissioner Little. Did they?

THE WITNESS: No.

THE COURT: What did they recommend to Commissioner Little?

THE WITNESS: The one-drug protocol.

MR. KISSINGER: I believe I have no further questions, Your Honor.

THE COURT: Cross.

MS. CAMPBELL: One moment, Your Honor.

(Discussion held off the record.)

CROSS EXAMINATION

BY MS. CAMPBELL:

Q. Ms. Ray, quickly give me your educational background and work history, please, ma'am.

A. I have a bachelor's and master's in English and a

ATTACHMENT

"D"

- Deputy Commissioner Ray questioned the exact moment of death. The physician told her there is no problem pronouncing death with a stethoscope if you are not using an EKG.

- Ms. Inglis asked if there is a problem pronouncing death based on a physical (no heartbeat). The physician told her there is no problem with it because this is the way it is done traditionally.

- Deputy Commissioner Ray asked the physician if he has a problem with the EMT checking for death before the physician. He stated he does not.

-

- Mr. Davis stated the total time is roughly seven to eight minutes. He asked the physician if there are side effects from the first and second drug. The physician stated there is not because the first drug will make a patient unconscious very quickly.

- Ms. Inglis asked the physician the cause of death with one drug. He stated that a person stops breathing with that amount of Pentothal. It suppresses the brain; oxygen does not get to the brain. It is a barbiturate overdose.

(At the end of conference call, the physician was thanked for his time and expertise).

<u>PROS AND CONS ONE DRUG</u>

- Pros: Drug procurement and tracking; no downside if there is a vein issue; simplicity; avoid having to ascertain level of consciousness; peaceful to witnesses; similar to animal anesthesia; all physicians consulted have agreed with the protocol; less risk of error; easier to defend; eliminates Pavulon; less waste of drugs; addresses the psychological impact on the staff.

- Cons: No one else does it; changes the current procedure. (States that use the EKG might not want to do this because of potential of longer time to pronounce death. There is no issue with a stethoscope).

<u>PROS AND CONS TWO DRUGS</u>

- Pros: Eliminates Pavulon (paralytic, eight syringes, contested in court); approximately three minutes less time overall; less waste of drugs.

Drug Protocol Options

1 Drug Procedure (5 syringes)

5 gram Sodium Pentothal
Saline
If needed, 5 grams Sodium Pentothal
Saline

Pros

- Easier to defend by AG Office
- Simplicity
- Peaceful to witnesses
- Similar to animal euthanasia
- All physicians have agreed
- Less chance of error
- Eliminates Pavulon & Potassium Chloride
- No other state does it
- Changes procedures
- Drug procurement tracking
- No downside to vein issue if needed to switch sites

Cons

- No other state does it
- Changes procedures
- States that use an EKG/ECG might not want to do this because of potential longer time to pronounce death. No issue with stethoscope

2 Drug Procedure (8 syringes)

5 grams Sodium Pentothal
Saline
100 mg/mL Potassium Chloride
Saline

Pros

- Eliminates Pavulon (paralytic contested in court)
- Approximately 3 minutes less time overall
- Less waste of drugs

Cons

- Involuntary movement (some people may interpret as seizure, consciousness, etc)
- Not as clearly free of pain
- No one else does it

ATTACHMENT

“E”

A. Yes. You're correct. That's correct.
Q. He states that it makes no sense. Is that correct?
A. Correct.
Q. And if you turn to the second page, at the very top of the page, Dr. Dershwitz tells the committee that there is no likelihood that 5 grams of sodium pentothal would not cause death.
Do you see where --
A. I asked that question and he said no.
Q. So Dr. Dershwitz told the committee and the committee recognized that there was no possibility that 5 grams of sodium pentothal would not cause death.
A. Correct.
Q. And that was his opinion; is that correct?
A. Yes.
Q. He's an expert anesthesiologist; is that correct?
A. Yes.
Q. And he was consulted as part of your effort to come up with the best protocol; is that correct?
A. Yes.
Q. And he was relied upon by the committee because you didn't have any expertise on your own; is that correct?
A. That's correct.
Q. Okay.
A. One of the things we relied on.

ATTACHMENT

"F"

Q. Do you see just below that -- again, staying with Plaintiff's Exhibit 3 -- where Dr. Dershwitz goes on to say, A statement can be added to the protocol that says that after a certain amount of time if the inmate is not deceased, another dose can be given. That is a very plausible back-up.

Do you see that?

A. Yes.

Q. Are these notes accurate when they say that?

A. They're accurate. They're not -- I don't think they're complete.

That's what I mean when I say minutes. You know, because there's other conversation going on. You know, these were not the only words said in the meeting. I mean as I recall, you know --

Understandably, I think the committee was particularly concerned that there be no possibility of anything going wrong. And even though --

It was more of just a guarantee for the committee, you know, about these back-up things. It wasn't necessarily --

We were asking is there any additional thing we could do or -- you know, it wasn't something that was just offered out of hand, is what I'm saying.

Q. Tell me what conversations are omitted from these notes, to the best of your recollection.

Here in this section where Dr. Dershwitz says that there

ATTACHMENT

"G"

Q. Now, if we look at -- returning again to your notes, Plaintiff's Exhibit 31. Looking at Bates 28.

Do you see right below what appears to be your doodle, do you see Dr. Dershwitz's name and the date 4/12?

A. Yes.

Q. And Dr. Dershwitz describes, in your notes, the use of 10 grams as arbitrary.

Do you see that?

A. Yes.

Q. And do you see just a little lower -- and I want to quote your notes exactly, where they say "this would work".

This is something that Dr. Dershwitz told you about; is that correct?

A. I'm not sure if he told us about it or we asked him -- gave him the protocol and asked him if it would work. But one or the other.

Q. Did someone on the committee have the kind of expertise to come up with a protocol that they thought would work and they wanted to run by Dr. Dershwitz?

A. We did come up with a variety of possibilities, based on information that we had gotten from doctors, that may not have been exactly what was discussed with them. And if we did do that, then we certainly wanted to ask the physician if that was anywhere in the realm of plausibility.

Q. So your testimony is that these notes do not reflect

ATTACHMENT

"H"

Drug Protocol Options

1 Drug Procedure (5 syringes)

5 gram Sodium Pentothal
Saline
If needed, 5 grams Sodium Pentothal
Saline

Pros

- Easier to defend by AG Office
- Simplicity
- Peaceful to witnesses
- Similar to animal euthanasia
- All physicians have agreed
- Less chance of error
- Eliminates Pavulon & Potassium Chloride
- No other state does it
- Changes procedures
- Drug procurement tracking
- No downside to vein issue if needed to switch sites

Cons

- No other state does it
- Changes procedures
- States that use an EKG/ECG might not want to do this because of potential longer time to pronounce death. No issue with stethoscope

2 Drug Procedure (8 syringes)

5 grams Sodium Pentothal
Saline
100 mg/mL Potassium Chloride
Saline

Pros

- Eliminates Pavulon (paralytic contested in court)
- Approximately 3 minutes less time overall
- Less waste of drugs

Cons

- Involuntary movement (some people may interpret as seizure, consciousness, etc)
- Not as clearly free of pain
- No one else does it

ATTACHMENT

"I"

is that correct?

A. That's correct.

Q. And the only cons we see are that no one else does it and that it changes the current procedure. And following that it says, States that use an EKG might not want to do this because of the potential longer time to pronounce death, but that there's no issue with a stethoscope.

Do you see that that's the only cons listed here in these minutes?

A. Yes.

Q. And those are the conclusions that the committee reached; is that correct?

A. Yes. These were the pros and cons that we came up with.

Q. Okay. And if I understand Tennessee's protocol correctly, Tennessee doesn't use an EKG or anything like that, do they, to determine death?

A. No.

Q. They use a stethoscope; isn't that right?

A. Right.

Q. So at least according to the pros and cons that we see here, the length of time that it takes to declare death isn't even listed as a con with the one-drug protocol, is it? Because it's something you don't need to worry about when a stethoscope is used, like they do in Tennessee.

MS. CAMPBELL: Your Honor, he's asked her a

question and then asked her to presume the reason for it.

THE COURT: Overruled. I think it's a proper question.

Do you understand the question?

THE WITNESS: Would you repeat it, please. I understood it, but I forgot what it was. Yeah, about the length of time to pronounce death.

Q. (By Mr. Kissinger) Right. The length of time -- at least according to these minutes, the length of time isn't an issue with the one-drug protocol when a stethoscope is used to declare death.

A. Right.

Q. Okay.

A. According to these.

THE COURT: So Tennessee has always used a stethoscope as opposed to an EKG?

THE WITNESS: To my knowledge, yes.

Q. (By Mr. Kissinger) Ms. Ray, could you turn to Page 3 of the same minutes. There's a section entitled *Notes*.

A. Yes.

Q. And if you could go down to the fourth bullet point. Can you read for the Court what it says there.

A. Deputy Commissioner Ray suggested that the committee reach a consensus of the one-drug protocol. 10 grams of pentothal, saline, the EMT checks for signs of life, the

ATTACHMENT

"J"

MR. KISSINGER: On the one-drug protocol.

THE COURT: On the one-drug protocol.

MR. KISSINGER: That is correct.

A. My recollection of the conversation was that either way, I was very much involved in the process. In effect, my fingers were, if you will, all over the processes.

Q. (By Mr. Kissinger) And, Commissioner Little, I understand your impression of whether your fingers were on the process or not. What I'm asking you is during this conversation was the comment made that your fingers were not on the one-drug protocol?

A. I do not remember making that statement specifically.

Q. Do you recall Mr. Elkins making that statement?

A. No, sir.

Q. Commissioner Little, did you tell Mr. Elkins that one of the reasons that you rejected the committee's recommendation for the one-drug protocol is because you didn't want Tennessee to be out at the forefront of making the change from the three-drug protocol to the one-drug protocol?

A. I did make that statement.

Q. And did you tell Mr. Elkins that you felt that if you discarded the three-drug protocol and adopted the one-drug protocol there could be political ramifications from that decision?

A. I did make that statement.

Q. Did you also tell Mr. Elkins that you were going with the three-drug protocol because if you went with the three-drug protocol and this court or any other court declared the three-drug protocol unconstitutional, you could always fall back on the one-drug protocol?

A. I did express that that was one of the contingencies.

Q. That's the reason we're here today, isn't it?

A. I'm not sure that that's the reason.

MR. KISSINGER: I don't have any further questions, Your Honor.

THE COURT: Cross.

CROSS EXAMINATION

BY MR. HUDSON:

Q. Commissioner Little, just to get a little background information.

How long have you been the Commissioner of the Department of Correction?

A. Well, I was actually -- I guess the announcement was made just about two years ago Thursday. I've actually been in the position since October of 2005.

Q. And what was your prior employment history?

A. Prior to assuming this position, I was Director of Corrections for -- of the Division of Corrections for Shelby County, Tennessee. Prior to that I was an executive