Record No. 07-18

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

CHRISTOPHER SCOTT EMMETT
Plaintiff/Appellant

v.

GENE M. JOHNSON, et al.
Respondents/Appellees.

On Appeal from the United States District Court
for the Eastern District of Virginia,
Richmond Division

SUPPLEMENTAL BRIEF OF PLAINTIFF-APPELLANT

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INTRODUCTION

The Supreme Court's decision in *Baze v. Rees*, 128 S. Ct. 1520 (2008), confirms that the district court erred in granting summary judgment to the State. *Baze* establishes that the constitutionality of a lethal injection protocol depends on the facts: the procedures that are used, the evidence of what has happened at executions, and the competency of the team members. Emmett has developed a compelling record showing that in Virginia there is a substantial risk that he will be inadequately anesthetized during his execution. Among other risks, Virginia frequently administers the pancuronium and potassium before the anesthetic thiopental has taken full effect. And equally inexplicably, Virginia's response when inmates exhibit signs of inadequate anesthesia is to give *more* pancuronium and potassium without giving additional thiopental, a dangerous practice that appears to have no parallel anywhere in the country. This evidence, coupled with the litany of botches, miscommunications, and errors by the execution team is more than sufficient to preclude summary judgment.

The State will no doubt argue that by approving Kentucky's protocol, *Baze* has pre-approved Virginia's as well. That is not the case. All *Baze* held, and indeed all *Baze* could have held, is that like protocols should be treated alike. But Virginia's procedures are not like Kentucky's: not only are there critical differences in both its protocol and its actual practices, but Virginia's 70-execution

history reveals evidence of maladministration that the *Baze* Court, considering Kentucky and its single lethal injection execution, did not have before it. Put simply, risk is shown by the record, and Virginia's record shows substantial risk. Because Emmett has demonstrated -- at minimum -- a material dispute about that risk, reversal and remand to the district court is required.

ARGUMENT

I. *BAZE*'S LEGAL FRAMEWORK MUST BE APPLIED TO VIRGINIA'S FACTS.

In *Baze*, a three-Justice Plurality held that in order to prevail on a claim that a state's method of execution violates rights protected by the Eighth Amendment, an inmate must demonstrate that the challenged protocol would subject the inmate to a "substantial risk of serious harm."[1] *Baze*, 128 S. Ct. at 1532. The Plurality recognized that such a risk exists where an inadequately anesthetized inmate is given pancuronium and potassium. *Id.* at 1533 (holding that in the absence of "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."). The Plurality further held that a method of execution is

[1] No opinion in *Baze* garnered the votes of more than three Justices. The Plurality opinion, authored by the Chief Justice, is the controlling opinion as it represents the narrowest reasoning necessary to support the judgment. Unless otherwise noted, all citations to *Baze* are to the Plurality opinion.

unconstitutional where it imposes a substantial risk of serious harm, and there is a feasible and readily available alternative to the State that significantly reduces the risk. *Id.* at 1532.

Taken together, these principles conclusively establish that risk -- assessed objectively -- is the touchstone of the Eighth Amendment inquiry. But while *Baze*'s objective risk framework governs this case, *Baze*'s *application* of that standard to Kentucky's protocol is not determinative here.[2] Assessment of objective risk is inherently a factual inquiry because different facts may reveal different risks. *Baze* makes clear that a reviewing court must examine all aspects of a State's procedures to determine if a plaintiff has shown a substantial risk of "maladministration." *Id.* at 1537-38. Indeed, the Plurality's repeated acknowledgement that the maladministration of the written protocol could lead to a "substantial and unconstitutional risk" of pain, *id.* at 1533-34, presupposes that some plaintiffs will be able to demonstrate just such a danger. While the *Baze* Court found that those plaintiffs had not marshaled facts sufficient to demonstrate that risk, its conclusion was based on a record that was severely truncated in numerous ways.

[2] Because Emmett's case is on direct review, this Court is bound to apply *Baze* as the law currently in effect. *See West v. Anne Arundel County*, 137 F.3d 752, 762 (4th Cir. 1998); *Smith v. Hampton Training School for Nurses*, 360 F.2d 577, 580-81 (4th Cir. 1966).

First, and most obviously, there was little evidence in *Baze* as to whether Kentucky's procedures actually worked as intended because there had been "[o]nly one Kentucky prisoner … executed since the Commonwealth adopted lethal injection" and there were "no reported problems" at that execution. *Id.* at 1528. Virginia, in contrast, has carried out 70 executions by lethal injection and Emmett has presented compelling evidence, discussed below, that many executions have proceeded in a way that is inconsistent with the successful administration of thiopental. Such evidence, which was entirely absent in *Baze*, demonstrates objective risk.

Second, *Baze* necessarily could pass upon only the particular execution procedures that were before it. To the extent that another state's procedures differ Kentucky's, *Baze* does not (and could not) address whether they pose a substantial risk. Kentucky's procedures differ importantly from Virginia's. Virginia inexplicably, for example, routinely gives additional doses of pancuronium and potassium -- but not thiopental -- when an execution takes longer than expected, which is precisely the situation in which there is reason to think that there has been a drug administration problem. That practice not only differs from Kentucky's, but from every other state that Emmett is aware of.

Third, because the Supreme Court does not find facts in the first instance, but merely reviews trial court fact-findings for clear error, the Supreme Court was

limited to considering the testimony -- both opinion and expert -- actually presented in *Baze* about the risks associated with Kentucky's procedures. Thus, for example, although the Plurality found that there was no reason to think that Kentucky's personnel would not be able to carry out their tasks properly, it did so on a record in which depositions of those personnel were not allowed. Reply Brief of Petitioner at 16, *Baze v. Rees*, 128 S. Ct. 1520 (2008) (No. 05-7439), *available at* http://www.law.berkeley.edu/clinics/dpclinic/LethalInjection/LI/ briefs.html. Had the record in *Baze* revealed confusion and inconsistent practice by execution personnel -- as is the case here -- it would have been considered in determining whether Kentucky's procedures created a substantial risk.

Fourth, the *Baze* record lacked any evidence on the efficacy of alternative methods of carrying out lethal injection. The Plurality noted that Baze's primary proposed alternative -- administration of a single massive dose of thiopental -- "was not proposed to the state courts below," and thus could not be passed upon by the Supreme Court. 128 S. Ct. at 1534. Consequently, *Baze* did not conclusively pass upon the viability of any particular alternative to Kentucky's procedures, let alone Virginia's.

These factual shortcomings of the *Baze* record should put to rest any contention by the State that *Baze* unilaterally pre-approved all three-drug protocols, or Virginia's practices in particular. As the remainder of this brief discusses, the

facts in Virginia show that the State's practices and record are not substantially similar to Kentucky's. Instead, the evidence that Emmett has presented demonstrates that Virginia's practices create substantial and remediable risks of serious harm that Kentucky's did not.

II. *BAZE* REQUIRES THAT THE DISTRICT COURT BE REVERSED.

Under the principles articulated in *Baze*, it was error for the district court to award summary judgment to Virginia. This section proceeds in three parts. Part A explains that after *Baze* deliberate indifference has no place in a method of execution challenge. Part B discusses three critical areas in which the evidence in Virginia demonstrates a substantial risk of harm that was not present in *Baze*. *First*, Virginia frequently administers pancuronium and potassium before the thiopental has taken full effect, creating a substantial risk that the inmate will be cognizant of suffocation and pain from those chemicals, but unable to express it. *Second*, regardless of how quickly Virginia administers the chemicals, there is substantial evidence in Virginia that inmates are not receiving a full dose of thiopental, and even more alarmingly, that Virginia's response is to give more pancuronium and potassium, but not additional thiopental. *Third*, even with respect to the aspects of Virginia's protocol that are facially similar to Kentucky's, there is copious evidence of errors and maladministration by Virginia's personnel that demonstrate that the protocol has not served to eliminate substantial risks of

injury. Finally, Part C demonstrates that there are entirely feasible alternative solutions that would greatly reduce the risks in Virginia's procedures.

A. *Baze* Makes Clear That The Intent Of The Executioners Is Not Material In A Method Of Execution Challenge.

Baze unequivocally refutes Virginia's argument -- made at length in its primary brief to this Court, and accepted by the district court -- that an Eighth Amendment challenge to a state's method of execution requires the plaintiff to show that the executioners were deliberately indifferent to the risks they created. *See* St. Brief at 18-26. The Supreme Court rejected this argument after the United States made it in *Baze*. Brief of the United States at 22-24, *Baze v. Rees*, 128 S. Ct. 1520 (2008) (No. 07-5439), *available at* http://www.law.berkeley.edu/clinics/dpclinic/LethalInjection/LI/briefs.html. The Plurality held instead that an "execution method can be viewed as 'cruel and unusual' under the Eighth Amendment" where the plaintiff can demonstrate a "substantial risk of serious harm" and a "feasible, readily implemented" alternative that will "significantly reduce" that risk. 128 S. Ct. at 1532. *See also id*. at 1538 (Alito, J., concurring) (same).

This test sets forth an objective inquiry and does not look to the subjective state of mind of the defendants. Indeed, Justice Thomas and Justice Scalia were the only Justices who would have held that subjective intent was relevant to an Eighth Amendment challenge to a method of execution. *See id.* at 1556 (Thomas,

J., concurring in the judgment) (adopting an intent requirement and disagreeing with the Plurality's reasoning because it holds that a "method of execution violates the Eighth Amendment if it poses a substantial risk of severe pain that could be significantly reduced by adopting readily available alternative procedures").

In light of *Baze*, it was error for the district court to hold that the Eighth Amendment "requires the inmate to demonstrate deliberate indifference," J.A. 361 n.11, and that portion of the lower court's opinion must necessarily be reversed. For the same reason, this Court must reject the defendants' argument that even if their protocol creates a substantial risk of harm (which it does), they may persist in their dangerous practices unless they are also shown to be deliberately indifferent to those risks. It is enough for Emmett to demonstrate -- as he has -- that such risks exist and that there are ready alternatives available.[3]

[3] *Baze* also refutes the State's audacious argument that the Eighth Amendment permits it to administer pancuronium and potassium without any thiopental because there is no requirement a "condemned inmate must be anesthetized" prior to being executed. St. Br. at 29. The Plurality held that absent anesthetization there is an "unacceptable" risk that the inmate will suffer excruciating pain from the other chemicals. 128 S. Ct. at 1533.

B. The Record Demonstrates Substantial Risks That Were Not Present In *Baze*.

1. Unlike Kentucky, Virginia's Practice Of Administering Pancuronium And Potassium Before The Thiopental Takes Full Effect Creates A Substantial Risk Of Serious Harm.

An obvious and substantial risk of harm unique to Virginia's procedures is that it frequently administers the pancuronium and the potassium within a minute of the thiopental. *E.g.*, J.A. 2047, 2049, 2042, 2010-13, 2016-18, 2021, 2022. Emmett submitted expert pharmacokinetics testimony presented in federal court in the Western District of Missouri showing that thiopental takes more than a minute to cause the inmate to be sufficiently unconscious -- a state known as "burst suppression" -- to ensure that he will be unable to feel the pain caused by the second two chemicals.

The expert, Dr. Thomas Henthorn, is the chairman of the Department of Anesthesiology at the University of Colorado, and specializes in modeling the time course of thiopental -- in other words, how long it takes thiopental to produce different effects on humans. J.A. 285-92, 299. Dr. Henthorn testified that based on the modeling he conducted, it was "unlikely," and in fact there was "*less than a one percent chance*," that an inmate would achieve burst suppression within one and a half minutes after receiving two grams of thiopental. J.A. 313-314 (emphasis added). Consistent with the expert testimony of Dr. Lowson, J.A. 100, Dr. Henthorn opined that a prisoner might well appear fully unconscious to

observers upon the initial administration of the thiopental, but still would be able to feel pain from the administration of the second two chemicals.[4]

Baze considered only the inmates' claim of risk that the chemicals would not be administered in their intended doses, and thus had no occasion to discuss the risks that are created by injecting the intended doses in too quick a sequence. But what little evidence there is in *Baze* on this point suggests that Kentucky pauses after administering the thiopental to allow for a consciousness check. 128 S. Ct. at 1534. While Emmett disputes that such a check -- performed by inexperienced laypeople -- would be sufficient to determine anesthetic depth, it would have the salutary effect of delaying the introduction of the second two chemicals. Thus Virginia's practices in this regard are different from and more dangerous than the protocol the Supreme Court approved in *Baze*. Further evidence that Virginia's practice is idiosyncratically dangerous is that subsequent to Dr. Henthorn's testimony in *Taylor v. Crawford*, Missouri amended its protocol to require a three-minute pause after administering the thiopental. *Taylor v. Crawford*, 487 F.3d 1072, 1083 (8th Cir. 2007).

[4] For this reason, the district court's primary critique of Dr. Henthorn's testimony -- that "he fail[ed] to quantify the likelihood of [not reaching burst suppression prior to receiving pancuronium]" -- is plainly erroneous. J.A. 363.

2. Unlike Kentucky, Inmates In Virginia Routinely Die In A Manner That Suggests Inadequate Anesthetization, And Virginia Compounds This Problem With Its Unique Practice Of Giving Additional Pancuronium And Potassium *Without* Giving Additional Thiopental.

In stark contrast to the record in Kentucky, in which only a single, problem-free execution had taken place, the record in this case demonstrates a substantial risk that inmates routinely receive only a partial dose of thiopental. Even worse, Virginia engages in an unique and inexplicable practice of giving inmates additional doses of pancuronium and potassium -- but *not* thiopental -- when an execution takes longer than expected, which is the precisely the situation in which there is reason to think there has been a problem with drug administration. This evidence easily demonstrates a material dispute as to whether Virginia's practices create a substantial risk of inadequate anesthesia within the meaning of *Baze*.

Evidence of Inadequate Anesthesia. Inmates in Virginia routinely take longer to die from the potassium than the State's expert predicted should be the case, suggesting that they have not received all of the potassium, which in turn suggests that they have not received all of the thiopental. Virginia determines death by waiting for the cessation of the heart's electrical activity (a "flatline") on an electrocardiograph. J.A. 355. The State's expert, Dr. Mark Dershwitz, opined that potassium should typically cause a flatline within a "minute or less," if it is properly administered. J.A. 1150. Dr. Dershwitz then added that the presence of

thiopental (which slows circulation) might make "the time a little longer" but still "very, very rapid," such that the inmate should flatline within "one to two minutes," J.A. 1150, which he claimed was consistent with Virginia's experience. And indeed, Virginia's execution records show that many inmates do die within two minutes of receiving the potassium.

But many others do not: three inmates have taken five or more minutes to flat-line after receiving the potassium (J.A. 2019, 2046, 2052); six inmates have taken four minutes (J.A. 2014, 2015, 2034, 2038, 2051);[5] and six inmates have taken three minutes (J.A. 2020, 2021, 2041, 2043, 2050, 2055). Even if one conservatively assumes that every three-minute delay was exaggerated by rounding (Virginia marks times only to the nearest minute) or delay in pronouncing the time of death, that still leaves 9 inmates out of 70 executions (or nearly 13%) who have taken an inexplicably long time to die. Disturbingly, the greatest delay came in Virginia's most recent execution, in which the inmate, John Yancey Schmitt, did not die until *ten* minutes after the potassium was first injected,[6] and thirteen minutes after receiving the thiopental.[7] J.A. 2046.

[5] Execution records for the sixth inmate, Herman Barnes, were not included in the joint appendix.

[6] After stating unequivocally in his 2006 deposition that an inmate should flatline within two minutes after the administration of potassium, J.A. 1150, Dr. Dershwitz changed his analysis upon learning that it took ten minutes for Schmitt to die after first receiving potassium. J.A. 108-109. Based on his review of Schmitt's EKG readout, Dr. Dershwitz's self-described "possible, and certainly plausible"

Equally disturbing is the deposition testimony of execution team members that "most" inmates begin snoring a minute after receiving the thiopental, and *continue to do so* for another minute beyond that. J.A. 522, 560, 614. Indeed, Secret Witness #2 stated in his deposition that the sound of snoring signaled to him that the thiopental had taken effect. J.A. 522. Yet Dr. Dershwitz testified unequivocally that an inmate who receives two grams of thiopental should stop breathing altogether *within* a minute. J.A. 1103. An inmate who is snoring, however, plainly must still be breathing, suggesting that he has not received the

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explanation was that only a "fraction" of the potassium reached the heart, which impaired its function, and prevented the rest of the potassium from reaching it. J.A. 109. Not only is Dr. Dershwitz's "fractional" explanation equally consistent with only a fraction of the potassium actually being administered due to error, it does not address the numerous other instances in which the potassium took longer than expected to kill, or why there is such a wide disparity among the times of death of Virginia inmates.

[7] The fact that the execution personnel stated that they noticed no signs of IV problems during Schmitt's execution does not establish, as the State suggests, that the drugs must have been successfully injected in their full doses. IV problems such as leaks and infiltration can elude visual observation -- particularly by laypeople such as Witness #2 -- even if they are severe enough to prevent all but a fraction of each drug from entering the circulation. Indeed, after the 2006 execution of Angel Diaz, the medically trained supervisor of the execution team testified that he had observed no infiltration, even though both IVs infiltrated badly enough to cause the execution to take 35 minutes and leave foot-long chemical burns in each arm. *See Proceedings Before the Governor's Comm'n on Lethal Injection*, Tr. at 92-95 (Feb. 19, 2007), *available at* http://www.law.berkeley.edu/clinics/dpclinic/LethalInjection/LI/documents/commission/fl/VolumeIV/02192007.pdf.

full dose of thiopental.[8] *See Morales v. Hickman*, 415 F. Supp. 2d 1037, 1044 (N.D. Cal. 2006) (according to Dershwitz testimony, indications that inmates continued to breathe for over a minute after injection of thiopental was evidence that "thiopental has not had its intended effect").

Virginia likely will contend that these indications of inadequate anesthesia are unpersuasive because, as in Kentucky's sole execution, "there were no reported problems" in its executions, in the sense that no obvious signs of pain or consciousness were reported by witnesses. *See Baze*, 128 S. Ct. at 1528. But executions can be, and often are, botched in a manner that does not result in obvious indications that would be discernible to witnesses or executioners. *See, e.g.*, *Morales v. Tilton*, 465 F. Supp. 2d 972, 980 (N.D. Cal. 2006) (6 out of 11 inmates displayed signs of inadequate anesthesia that were not observed by witnesses and were detected only upon expert review of vital sign records). The paralytic effect of pancuronium will obscure any evidence of consciousness or pain upon its administration. And, as Dr. Henthorn explained, even without pancuronium, a partially conscious inmate who has received an inadequate dose of thiopental may be able to feel pain but unable to indicate that to observers. J.A.

[8] The district court held that snoring was "consistent with the proper administration of the sodium thiopental." J.A. 368. It did not cite any evidence for this proposition nor did it address Dr. Dershwitz's deposition testimony that breathing should cease within a minute of the administration of thiopental.

314-15. Thus, the appearance of Virginia's executions is a false assurance, and the State's confidence is unfounded.

Virginia's Dangerous Second Dose Practice. Against the backdrop of this evidence suggesting inadequate anesthetization, Virginia engages in a uniquely dangerous practice of giving additional pancuronium and potassium -- but not thiopental -- when an execution takes longer than expected. The protocol in fact prohibits giving additional thiopental as part of the second dose. DOP 426 at 107 ("Pavulon and Potassium Chloride only"). In eight of the nine executions mentioned above in which the inmate ultimately took at least four minutes to die upon receiving the potassium, Virginia gave a second partial dose of the painful drugs, but no additional anesthesia.[9] Giving additional doses of pancuronium and potassium is particularly risky under those circumstances because there is reason to think there has been a drug administration problem if the execution has taken longer than expected. To give more of just the painful drugs when the inmate may have been insufficiently anesthetized is indefensible.

This problem is further compounded by the fact that Virginia's protocol requires that the second partial set of drugs be given through a second IV line, J.A.

[9] As discussed in Emmett's opening brief, there is enormous confusion in Virginia about how the second dose is administered, which has led some inmates to receive only a second dose of pancuronium, and others only a second dose of potassium. Emmett Opening Br. at 51-53. There is no record of any inmate ever receiving a second dose of thiopental.

355, which may not have the problem that led to inadequate anesthetization in the first IV line. In other words, when there is reason to think that a problem with the first IV line prevented the full dose of the chemicals from being administered, Virginia administers more of *just the painful chemicals* through a new line.[10]

Virginia's record of risk goes far beyond anything that was presented in *Baze*. Because Kentucky had conducted but a single execution and no problems were reported at it, *Baze*, 128 S. Ct. at 1532, the Supreme Court did not have occasion to consider evidence of the type presented here. Moreover, Virginia's use of a partial second set of drugs is notably different from Kentucky's practice. In finding Kentucky's methods adequate, the Supreme Court praised the fact that Kentucky used a back-up line to "ensure that if an insufficient dose of sodium thiopental is initially administered through the primary line, *an additional dose* can be given through the backup line *before* the last two drugs are injected." *Id.* at 1534 (emphases added). Virginia's response to a possibly insufficient dose of thiopental is to give additional doses of the other two drugs. That practice is far more dangerous than Kentucky's procedures.

[10] The record shows that contrary to its protocol, Virginia has not always used the backup line for delivering the second doses of pancuronium and potassium. Giving the second doses without giving additional thiopental creates a substantial risk of serious harm regardless of which line is used, and Virginia's failure to adhere to its protocol is an additional source of concern.

Counsel is unaware of any other jurisdiction that excludes thiopental from a back-up dose as part of its protocol, and some jurisdictions have added the back-up dose in response to concerns that omitting it increases the danger of inhumane executions. For instance, Florida agreed to alter its protocol to ensure that in the event of problems, "the entire lethal chemical administration process is re-initiated from the beginning (syringe # 1{sodium pentothal})," after a state-appointed commission found that failure to do so contributed to the botched execution of Angel Diaz. *See DOC Response to the Governor's Comm'n on Administration of Lethal Injection's Final Report with Findings and Recommendations*, at 9 (May 9, 2007), *available at* http://www.law.berkeley.edu/clinics/dpclinic/LethalInjection /LI/ documents/commission/fl/DOC/2007.05.09%20DOC%20Report.pdf. Virginia has never explained why it prohibits an additional dose of thiopental in this context.

The problem of inadequate anesthetization is especially pertinent in Virginia, because Virginia, to the best of counsel's knowledge, has chosen to use the smallest dose of thiopental of any jurisdiction in the United States. Notably, Kentucky increased its dosage from two grams to three grams in response to the petitioner's litigation in *Baze*. 128 S. Ct. at 1528. Two grams thus leaves Virginia with relatively little margin for error. Virginia itself recognizes this risk, as its

protocol provides that the two-gram dose should be increased for large inmates. DOP 426 at 89.

In light of this evidence of risk, *Baze* demonstrates that the district court erred in granting summary judgment to Virginia. The evidence showed that executions were not proceeding as predicted, yet the district court largely relied on the irrelevant truism that there would be no pain *if* the chemicals were properly administered. J.A. 361, 365. Failing that, it dismissed the evidence as mere "speculat[ion]," which ignored the systematic regularity with which the evidence of inadequate anesthetization arose. Ignoring record evidence of risk of that sort is error both under *Baze*'s substantial risk framework and basic rules of summary judgment.

3. Under *Baze*, Virginia's Failure to Employ Competent Execution Personnel and Its Haphazard Drug Administration Procedures Create a Substantial Likelihood of Maladministration and Inhumane Executions.

Virginia will likely argue that none of this evidence of unsuccessful drug administration is relevant because Virginia's protocol is "substantially similar" to Kentucky's. *Baze*, 128 S. Ct. at 1537. That is not so. *Baze* was concerned primarily with Kentucky's written protocol because there was no suggestion that the State, in its one lethal injection execution, was unable to implement its protocol reliably and consistently. Here, in contrast, the evidence of Virginia's implementation of its protocol reveals a pervasive pattern of incompetence and

maladministration. Whatever the facial similarities between Virginia's and Kentucky's written protocols, Virginia's use of incompetent personnel and its actual practices in executions create substantial risks of harm that were not present in *Baze*. *See id*. at 1533-34. Moreover, Virginia's written protocol omits several important safeguards highlighted by the Court in approving Kentucky's protocol, and therefore provides no assurance that errors in administration will be detected.[11]

Executioner Incompetence. As noted above, the *Baze* Plurality was careful to note that Kentucky's execution personnel were "trained and experienced," and that it had found no evidence that they were not competent to perform their execution responsibilities. *Id*. at 1537. In Virginia, in contrast, there is ample evidence that Virginia's execution team members, whatever their on-paper qualifications, *have* performed incompetently in previous executions. These failures have created a foreseeable likelihood that the inmates in question would be inadequately anesthetized -- and they demonstrate that such incompetence is a foreseeable characteristic of the conduct of future executions.

Examples of the personnel's track record of deficient performance in previous executions abound. In the execution of Dwayne Wright, the primary IV line failed during the injection of thiopental. When the execution team, including

[11] The district court's summary resolution of factual questions regarding these failings was error before *Baze*. It is certainly error now that it is clear that Virginia lacks or has failed to achieve many of the attributes that the Supreme Court found material in *Baze*.

Secret Witness #4, realized that the thiopental was not being successfully injected, they switched to the second IV line and gave the remaining thiopental -- at most, one gram -- and then full doses of the painful chemicals. However, they did not administer any additional thiopental to compensate for the probability that as much as half of the intended dose of thiopental had not reached the inmate's circulation. J.A. 728. It was precisely this course of conduct that led to the botched execution of Florida inmate Angel Diaz, and that a state-appointed commission later found demonstrated the personnel's "inadequate training." *See* The Governor's Comm'n on Administration of Lethal Injection, *Final Report with Findings and Recommendations*, at 9 (Mar. 1, 2007), *available at* http://www.law.berkeley.edu/clinics/dpclinic/LethalInjection/LI/documents/commission/fl/lethalinjectionfinalreport.pdf.

In addition, execution personnel and DOC officials have demonstrated a complete lack of understanding of thiopental and pancuronium, and their respective functions within the execution procedure. Virginia's protocol recognizes that the customary two-gram dose of thiopental may be insufficient for obese or large inmates; therefore DOP 426 requires a physician to calculate a higher dose for such inmates. DOP 426 at 89. But when the attending physician and execution team encountered Lem Tuggle, an obese inmate weighing 400 pounds, they failed to increase the dose of thiopental, and instead *increased the*

dose of pancuronium. J.A. 761-62. Not only would increasing the pancuronium not ensure adequate anesthesia -- given its lack of anesthetic properties -- but it may have simply served to mask the inadequacy of the two-gram dose of thiopental for someone of Tuggle's size.

This serious failure was apparently the result of ignorance; Secret Witness #4 testified that "the physician and [DOC officials] … decided because of Mr. Tuggle's weight" that it was necessary to increase the pancuronium "to make it so that [Tuggle] would have a painless exit to the world." J.A. 761-762. In other words, the physician in charge incorrectly believed that pancuronium had anesthetic, instead of agonizing, properties, as did Secret Witness #4, J.A. 681.[12] As a result, these individuals do not understand the need to ensure that the inmate is deeply anesthetized before the pancuronium is administered, which is a particularly alarming deficiency given Virginia's practice of giving pancuronium with a minute of the thiopental, and giving additional pancuronium where an execution is taking too long.

In sum, in Virginia far more is known about the execution team's actual performance than was the case in *Baze*. The personnel's deficiencies create a

[12] The current physician is hardly more knowledgeable; he testified that he did not have the expertise in anesthesia to determine a proper dose of thiopental for an obese inmate. Emmett Opening Br. at 50-51.

substantial and unnecessary risk that executions will be improperly performed.[13] *See, e.g.*, *Harbison v. Little*, 511 F. Supp. 2d 872, 891(M.D. Tenn. 2007) ("failure to utilize adequately trained executioners" contributed to substantial risk of excruciating pain).

Drug Administration Problems. The lack of competence described above makes drug delivery failures and inadequate anesthesia more likely. Crucial to ensuring successful administration is the execution team's ability to insert and maintain reliable IVs.[14] In *Baze*, the Plurality noted that there was no evidence of any IV problem in Kentucky's single execution, 128 S. Ct. at 1528, and therefore there was no showing of a substantial risk that such problems would occur in the future, *id*. at 1537-38. In Virginia, in contrast, a number of foreseeable IV problems have occurred in previous Virginia executions.

For instance, the primary IV failed during the Wright execution, either because the IV was never properly set or the catheter migrated after the injection

[13] In considering the execution personnel's training, the district court stated that the "inconsistencies" in the evidence "are disturbing" -- yet it improperly resolved these questions in the State's favor, concluding that the record did not demonstrate that the personnel were incompetent to perform their tasks. *Baze* clarifies that this was error. The Plurality emphasized the importance of evidence that a State's execution "procedures will *not* be properly followed," and recognized that an unconstitutional risk can be created by a record of problematic performance. *Baze*, 128 S. Ct. at 1530. This establishes the relevance of detailed evidence as to the execution team's abilities and performance record.

[14] Infiltration, catheter migration, and other IV problems can result in the delivery of insufficient thiopental to fully anesthetize, but sufficient pancuronium and potassium to paralyze and cause pain and death. J.A. 97.

began. Either way, Secret Witness #4 and others did not detect the problem until *after* the execution had begun, despite Secret Witness #4's insistence that he would be able to detect any IV problem immediately upon inserting the catheter. J.A. 744.

In addition, some inmates have veins that are difficult to cannulate, leading to unreliable IV placement. J.A. 99. During the execution of Joseph Savino, the IV Team was unable to place a second IV; unsuccessfully attempted to place a catheter in the jugular vein; and ended up placing an IV in the thumb. J.A. 714-15, 737. The execution went forward even though the team was apparently aware that the thumb IV did not work, J.A. 714-15, a deviation from the protocol and a dangerous practice given the potential need for a backup IV. *See Morales*, 465 F. Supp. 2d at 979. These significant difficulties inserting catheters render inadequate anesthesia a foreseeable likelihood.[15]

Deficient Administration Procedures and Lack of Safeguards. These problems are particularly concerning because Virginia's procedures lack several of

[15] The district court apparently discounted IV problems, stating that there was no evidence that any IV failure had ever resulted in an inhumane execution. Under *Baze*, however, that is clearly the wrong analysis. *Baze* establishes that "subjecting individuals to a risk of future harm -- not simply actually inflicting pain -- can qualify as cruel and unusual punishment." 128 S. Ct. at 1530. There is no suggestion that Emmett, in demonstrating the risk as applied to him, need show that the danger was actually realized in previous executions. Rather, evidence of difficulties in previous executions indicates a likelihood that the personnel will have trouble "properly follow[ing]" the procedures, and administering the drugs correctly, in Emmett's execution. *See id*. at 1533-34.

the "important safeguards" employed in Kentucky's procedures. *Baze*, 128 S. Ct. at 1533. The *Baze* Plurality relied on the presence of these safeguards to conclude that any administration errors would be detected. The same cannot be said here.

First, unlike in Kentucky, Virginia's execution personnel have little to no ability to observe the inmate during the execution.[16] Compare J.A. 707-08, with *Baze*, 128 S. Ct. at 1534 (officials in execution chamber tasked with observing inmate). Only the team leader has any view of the inmate,[17] and he cannot observe any signs of consciousness from his vantage point behind the top of the inmate's head. J.A. 293. As the *Baze* Plurality recognized, effective observation is crucial in detecting IV failures and signs of consciousness. 128 S. Ct. at 1534; J.A. 119, 293.

Second, while Kentucky's protocol requires personnel to check the inmate for signs of consciousness before the second two drugs are administered, Virginia's protocol contains no such check, or even any pause before the pancuronium is injected. *Baze*, 128 S. Ct. at 1534; *see also supra*. This both renders the procedure more dangerous than Kentucky's and provides more

[16] Although one prison official stands in the execution chamber with the inmate, he is not responsible for observing the inmate or any part of the drug administration process; instead, he remains on the phone with the Governor's office for the duration of the execution. J.A. 1813, 1828-29.

[17] Indeed, the team leader's view of the inmate is limited to the sight line from two small IV portholes in the dividing curtain, and some team leaders have chosen not to observe the inmate at all.

evidence of the DOC's failure to understand the importance of ensuring adequate anesthesia.

Third, Virginia's execution team, unlike Kentucky's, does not prepare or plan to administer additional thiopental in the event that an IV failure occurs. DOP 426 at 107; J.A. 850; *but cf. Baze*, 128 S. Ct. at 1534 (approvingly discussing Kentucky's plan to administer "an additional dose" of thiopental if at first an "insufficient dose" is delivered).

Finally, while Kentucky's protocol explicitly provides for communication between the personnel observing the inmate and the personnel injecting the drugs, Baze, Brief of Respondents at 21, *Baze v. Rees*, 128 S. Ct. 1520 (No. 07-5439), *available at* http://www.law.berkeley.edu/clinics/dpclinic/LethalInjection/LI/briefs.html. Virginia's practice is to forbid all spoken communication. J.A. 826, 834. Virginia's personnel adhere to this rule *even when problems arise*, including the need to give a second dose of potassium. This sows confusion among the team regarding the nature of the problem, and would prevent them from responding quickly and effectively. See J.A. 1950 (Physician #2 did not know why second dose given to Schmitt because only communication was "strange looks and maybe some hand waving"); J.A. 744. It is thus not surprising that each team member has a different impression of the rules governing, and authority for, the administration of a second dose of pancuronium and potassium. See Emmett Opening Br. at 52.

In short, Virginia's procedures are hardly "substantially similar" to the procedures approved in *Baze*. Rather, the system is unique in its deficiencies, and the assurances on which the *Baze* Plurality relied are entirely absent here.

C. There Are Readily Available Alternatives That Would Substantially Reduce These Risks.

There are "feasible [and] readily implemented" alternative procedures available to Virginia that will "significantly reduce the risk[s]" described above. The district court discounted the importance of available alternatives, and chose instead merely to encourage the Department of Corrections to make improvements in light of the "disturbing … inconsistencies" in the record. J.A. 364 n.7. *Baze* makes clear, however, that it is appropriate for a court to order relief where a plaintiff has shown a substantial risk, and there is a ready alternative available to the state.

In this case, the alternatives available to Virginia are not just feasible, they are obvious. At a minimum, Virginia should not inject the pancuronium and potassium until at least three minutes have elapsed since the injection of the thiopental. And Virginia should not give supplemental doses of pancuronium and potassium without first giving a supplemental dose of thiopental. The record reveals no impediment to these reforms -- not only has Virginia never articulated a justification for either aspect of its current practice, but other States have

implemented precisely these changes -- and they would represent a substantial improvement in Virginia's practices.

But while such overdue reforms would be welcome, they are not sufficient to remedy entirely the substantial risks in Virginia's practices. Virginia's record of unexplained delays in inmates' deaths and prolonged inmate breathing shows a substantial risk of inadequate anesthetization. As Emmett has explained in his earlier brief to this Court, the best and most feasible alternative procedure to eliminate this risk is to move to a protocol that uses only a single, massive dose of thiopental, pentobarbital, or some other barbiturate to cause death. Emmett Opening Br. at 20.

The feasibility of a so-called "anesthetic-only" protocol was not definitively addressed in *Baze* because that "alternative was not proposed to the state courts below." *Baze*, 128 S. Ct. at 1534. Having no findings to review on the efficacy of that reform, the Supreme Court could not have concluded in the first instance whether it was feasible or readily implementable. On remand, the district court should hear and consider evidence concerning the efficacy of such a protocol. Given that there is no dispute among the parties that a sufficiently large dose of thiopental or some other barbiturate will be lethal and painless, the only remaining question is whether some legitimate, countervailing consideration makes the use of a single drug infeasible. Emmett notes, however, that it became a matter of public

record after the district court entered judgment in this case, that the State's expert, Dr. Dershwitz, advised Tennessee in April 2007 to switch from its three-drug protocol to "a one-drug protocol which provided for the administration of 5 grams of sodium thiopental, ... and a waiting period of five minutes before the physician came in and confirmed death." *Harbison*, 511 F. Supp. 2d at 876. In any case, given the factual nature of the question, its resolution is a proper task for the district court on remand in the first instance.[18]

[18] Remand for further factual development is particularly appropriate here because *Baze* changed the legal rule regarding the presentation of alternative methods. In *Hill v. McDonough*, 547 U.S. 573, 582 (2006), the Supreme Court held that a method of execution challenge need not allege specific alternatives to the challenged practice. In *Baze*, the Plurality changed course and held that a plaintiff must show that a feasible alternative is available. It is appropriate then on remand to allow Emmett (and the State) to present additional evidence regarding the feasibility of an anesthetic-only alternative. *Patterson v. American Tobacco Co.*, 586 F.2d 300, 304 (4th Cir. 1978) ("Since the effect of *Teamsters* [an intervening Supreme Court decision] raised new and difficult issues, we think that we are justified in . . . remanding the issue to the district court for further findings. On remand, the district court may reopen the record and receive additional proof with regard to the [affected issue] since that issue emerged after the original record was made."); *In re Chattanooga Wholesale Antiques, Inc.*, 930 F.2d 458, 464 (6th Cir. 1991) ("A change in legal standards is a proper ground for reopening proof.").

CONCLUSION

For the foregoing reasons, the Supreme Court's decision in *Baze* confirms that this Court should reverse the district court's grant of summary judgment and remand.

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1. This brief has been prepared using Microsoft Word 2003. The typeface is Times New Roman fourteen point, which is a proportionally spaced, serif typeface.

2. Exclusive of the table of contents, table of citations, and certificates of counsel, the brief contains 6,907 words.

I understand that a material misrepresentation can result in the Court's striking the brief and imposing sanctions. If the Court so requests, I will provide an electronic version of the brief.

Date: May 2, 2008

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Matthew S. Hellman

CERTIFICATE OF SERVICE

I hereby certify that on May 2, 2008, I caused the foregoing Supplemental Brief of Plaintiff-Appellant to be served by next business-day mail on Richard Vorhis, Office of the Attorney General, 900 East Main Street, Richmond, VA 23219.

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