8. Report of Janine S. Arvizu, June 18, 2008

June 18, 2008

Peter Cannon
Capital Collateral Regional Counsel
3801 Corporex Park Drive, Suite 210
Tampa, FL 33619

Subject: Comparative Review of Kentucky and Florida Lethal Injection Protocols, and Review of Recently Received Training Records

Dear Mr. Cannon,

As requested, I have conducted a comparative review of the current lethal injection protocols issued by the states of Kentucky and Florida and provided by your office. The most current revision to the Kentucky protocol (dated 12/14/2004) was provided as Volume IV (Redacted for Public Record). The most current revision of the Florida protocol (approved and effective as of August 1, 2007) was provided in 2007; I previously provided a detailed quality assessment of the Florida protocol in a letter to your attention dated 8/14/2007.

Also as requested, I conducted a quality assessment of recently received training records that were provided by your office. These records document the required Department of Corrections training sessions that occurred between September 2007 and May 2008.

This letter provides my conclusions regarding the quality issues relevant to the two state protocols and a quality assessment of the training records.

Comparison of State Protocols

The records that document the lethal injection protocol used by the state of Kentucky consist of 14 pages; there is a one page pre-execution visiting schedule for death row inmates, a four page checklist of pre-execution medical actions, and a nine page checklist of execution events in sequence. In contrast, the protocol used in Florida is documented in a ten page procedure that describes personnel qualifications, responsibilities, and actions from receipt of a warrant through post-execution activities.

From a facial review of the two protocols, it is apparent that the scope and content of the Florida protocol more closely reflects expectations for quality documents that are intended to control the outcome of a process and ensure that quality objectives are satisfied. The Florida protocol provides significantly more detail than the Kentucky protocol, it is approved and issued under the signature of the Secretary of the Department of Corrections, and it addresses each of the issues that merit control to ensure acceptable outcomes. In contrast, the Kentucky protocol does not explicitly address individual responsibilities, many of the discrete and important activities attendant to an execution are not addressed, and essential activities are identified, but their requirements are not described in explicit detail.

Despite the fact that the Florida procedure has the potential to function as a better means of controlling and ensuring the acceptability of an execution, its potential is unrealized. It suffers from a number of serious deficiencies and inconsistencies (as identified in my letter to your attention, dated August 14, 2007) that render it ineffective in achieving its goal of controlling the execution process to achieve an acceptable result.

In contrast, despite the fact that the Kentucky protocol provides relatively little detail, it addresses issues that have the potential to cause critical failure of the execution process, but that are not addressed in the Florida procedure. For example:

> The Kentucky protocol provides for comprehensive medical and psychiatric assessment and monitoring of the inmate in the weeks prior to the execution, with provision for immediate notification of changes in condition. In contrast, the Florida procedure provides for only a limited physical examination of the inmate, with no provision for psychiatric assessment or monitoring for changes in condition.
>
> The Kentucky protocol provides for 10 training exercises a year, and each member of an execution team must participate in at least two training exercises before participating in an execution. Most importantly, the Kentucky protocol requires that each practice exercise include actual siting of two IV lines in a volunteer. In contrast, the Florida procedure calls for quarterly training exercises, with one exercise the week before an execution, and actual siting of an IV line is not required. A newly hired Florida employee could participate in an execution after participating in only one training exercise, and that exercise need not have included the actual siting of an IV line.
>
> The Kentucky protocol addresses requirements for a stabalization (sic) procedure in the event that a stay is issued after an execution has begun. Although Florida's procedure has provisions for an open phone line to receive a last minute stay, it does not address requirements to ensure that an efficacious medical response is possible.
>
> The Kentucky protocol and the Florida procedure call for different amounts of lethal chemicals during the injection sequence. Sodium thiopental (Kentucky 3 grams; Florida 500mg), pancuronium bromide (Kentucky 50 mg; Florida 50 mg), and potassium chloride (Kentucky 240 meq; Florida 120 meq).
>
> The Kentucky protocol provides direction to the IV team to help ensure that a needle is properly inserted into a vein. Given historical problems with appropriate needle siting during execution processes, this is particularly important.
>
> In recognition of historic problems with siting an IV, the Kentucky protocol provides for the Commissioner to request that an execution be rescheduled in the

event that an acceptable site is not obtained within a reasonable period of time. No such provision exists in the Florida procedure.

In the event that an inmate is not unconscious within a minute of administration of a dose of sodium thiopental, the Kentucky protocol calls for administration of a second dose of sodium thiopental through a secondary IV line. This approach implicitly addresses a number of issues that would result in restricted delivery through the primary IV line, without requiring that a blocked line be identified.

If a heart monitor does not indicate a flat line within ten minutes of completing the administration of lethal chemicals, the Kentucky protocol requires that the Warden order another set of lethal chemicals to be administered. The Florida procedure does not address the situation in which a flat line is not obtained after administration of the chemicals. This has been an issue in Florida, given the large degree of variability in the duration of executions.

From a quality assurance perspective, written protocols can only realize their quality benefits if they are prepared in careful consideration of the process that is subject to control. Unless and until a process' critical failure points and mechanisms have been identified, the control measures for those failures cannot be incorporated into a protocol. Although the Florida procedure has considerable procedural structure and scope, it does not address and control each of the potential failure points that have been addressed in the Kentucky protocol.

Quality Assessment of Training Records

The purpose of my review of the recently received training records was to determine whether the Department of Corrections' current lethal injection training program is sufficient to ensure its readiness to conduct future executions in accordance with department objectives, and to determine whether training deficiencies identified during earlier reviews have been satisfactorily addressed and resolved.

This letter describes the results of my review of training records that document execution training sessions that were conducted on ten separate days in 2007 and 2008. It is noted that the individuals participating in these mock execution training exercises were expected to perform, and to keep records, as if these scenarios were real executions. A summary of the training session documentation reviewed is provided in the following table.

Date	Hours	Number Practices	Execution Checklist	Executioners Room Checklist	Attendance Report(s)	Other
9/26/07	7	3	1, 2, 3	1, 2, 3	MP, FDLE, STM	none
10/10/07	6	4	1, 2, 4	1, 2, 3, 4	MP, STM	
10/24/07	6	3	1, 2, 3	1, 2, 3	MP, STM	EX2
11/7/07	8	2	1,2	1, 2, chemical checklist for #1	MP, FDLE, STM	EX1, EX2

Date	Hours	Number Practices	Execution Checklist	Executioners Room Checklist	Attendance Report(s)	Other
11/14/07	8	3	1, 2,3	1, 2,3	MP, STM	EX1, EX2
1/17/08	6	3	1, 2, 3	1, 2, 3	MP, STM	
2/20/08	8	4	1, 2, 3, 4	1, 2, 3, 4	MP, STM	EX1, EX2
3/13/08	6	2	1, 2	1, 2	MP, STM	
4/23/08	6	3	1,2, 3	1, 2, 3	MP, STM	
5/20/08	6	3	1, 2,3	1, 2, 3	MP, STM	EX1, EX2 2 LI Logs

Findings and observations regarding these records follow. Continued findings that were previously identified during reviews of earlier training records are identified as such.

Continued Finding: An Execution Checklist and an Executioners Room Checklist were provided for most, but not all, practice sessions. Execution by Lethal Injection Procedures (section (5)) requires that upon completion of each step in the process, compliance be documented on the checklist by a team member. This requirement was not consistently met during the subject training exercises.

Continued Finding: As documented on the checklists, the scope of the subject training exercises did not address essential steps that are integral to the execution process. The first page of the Execution Checklist and the first page of the Executioners Room Checklist were blank for most of the training exercises. This indicates that the following important steps were not consistently performed:

Public Address System check
Radio check/Radio accountability
Visual Monitor/Video Equipment Check
Checked Phase Light System
Medical Equipment Check (wireless telemetry monitors, UPS for wireless telemetry monitors, cardiac monitors, and cardiac monitor leads)
Preparation, filling, and labeling of 8 syringes in Stand A
Preparation, filling and labeling of 8 syringes in Stand B
IV infusion sets clearly marked #1 and #2

Continued Finding: As documented on the checklists, a required debriefing session was not performed after any of the training exercises. (section 13(f)) In addition to the fact that this is not procedurally compliant, it represents a missed training opportunity.

Continued Finding: The checklists that were used by DOC in the training exercises do not identify and require documentation of each critical step, as required by procedure (section (5)). Essential steps that are not addressed on the checklist were identified in my earlier report.

Continued Finding: The checklists completed by DOC personnel do not meet standards for quality records. Checklist entries documenting required actions are consistently incomplete, and some entries have been written over. Entries to quality records should be

in ink, and entries should not be obliterated. Errors should be lined out and initialed without obscuring the original entry.

Continued Finding: As documented on the training records, FDLE was only present for three of ten training sessions (on 9/26/07, 11/7/07, and 5/20/07). Under DOC procedure (section (7)), two FDLE monitors are responsible for overseeing and maintaining a detailed log of all actions during an execution. A copy of the required FDLE log was provided for one practice session on May 20, 2008, but was not provided for any of the other sessions.

Continued Finding: Although a secondary executioner is required to be present during administration of lethal chemicals (section 12(c)), the checklists do not document that either the primary or a secondary executioner was present.

Continued Finding: In a number of instances, individuals who were listed as present on the Training Record for a given date were not documented as having performed in any capacity on any of the training exercises on that day. Similarly, individuals identified on an execution training checklist as having been responsible for particular tasks on a given date were not identified on the training record for that same date.

Continued Finding: The training records for the period from September 2007 through May 2008 document the fact that a total of 30 individual practice executions were staged over ten days of training. During 17 of these practice executions, the team members practiced the sequence of steps in the procedure without experiencing or addressing a condition that would be considered a substantive contingency. During 13 of the practice executions, the team members experienced or addressed a situation that would be considered a substantive contingency, where the inmate or system response was not as expected. Based on the team members' actions and responses to these contingencies, nine of the thirteen contingency exercises should be considered failed exercises. When the exercise reports a response that is inconsistent with the expected effects of a particular chemical (e.g., flat line after a sodium pentothal or pancuronium bromide syringe) it may be an indication that the wrong chemical or wrong amount was administered (e.g., a syringe was mislabeled or filled with the wrong chemical), or they don't understand the physical effects of the lethal chemicals (as required in FL procedure page 4, paragraph (4) Training of the Execution Team and Executioners) and is indicative of a failed exercise. A summary of responsibilities and substantive contingencies for each individual practice session and identification of the failed exercises are provided on the attached table.

The problems identified through review of Florida's training records are more readily apparent in comparison to the relevant provisions of the Kentucky protocol. Florida's training records document the nature and scope of the contingencies that have been addressed during training. The substantive contingencies that have been addressed during training are largely limited to blocked lines. During practice exercises, Florida has not addressed some of the contingencies that have been experienced in past Florida

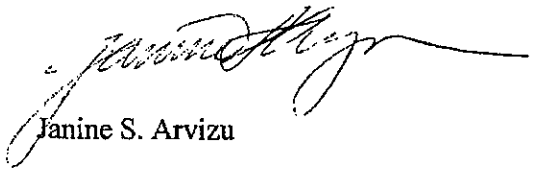
executions or that have the potential to compromise the execution process (e.g., execution duration of >12 minutes, or an inability to site the IV lines within more than an hour); requirements for addressing these serious contingencies are explicitly addressed in the Kentucky protocols.

Based on the recently received training records, Florida has not provided training to address an inmate's known medical problems. In contrast, the Kentucky protocol is designed to ensure that the inmate's recent, and potentially changing medical and psychiatric condition is well documented in advance of the execution.

Based on my previous reviews of the DOC procedure and earlier training records, I concluded that the department did not have the systems and controls necessary to ensure that they can predictably and reliably perform executions by lethal injection in accordance with their own objectives. Based on my review of these additional, more recent records, my conclusion has not been altered. It is particularly troubling that progress has not been made toward resolution of continuing deficiencies in the training program.

Should you have questions or wish to discuss any of my conclusions, please do not hesitate to contact me at your convenience.

Sincerely,



Janine S. Arvizu

Attachment: as stated

ATTACHMENT

Summary Table of Training Exercises

September 2007 – May 2008

	9/26/07	9/26/07	9/26/07	10/10/07	10/10/07	10/10/07	10/10/07	10/24/07
	#1	#2	#3	#1	#2	#3	#4	#1
Preparation prior to receiving inmate	Recorded	Blank	Blank	Recorded	Blank	Blank	Blank	Recorded
Open phone line with Governor's office	19	19	19	19	19	not provided	19	19
Read warrant;	12	12, 19	12	12	14	not provided	12	12
Restraints applied	6	6	6, 3, 2, 8	6	6	not provided	7	6
Security team	6,2, 3, 4	6, 4, 2, 3, 21	6, 3, 2, 8	6, 2, 4, 3	6,2, 21, 4, 7	not provided	3, 6, 7, 4	6, 2, 3, 4
Technical Team process	MP1, MP2	MP1, MP2	MP1, MP2	MP1, MP2	MP1, MP2	not provided	MP1, MP2	MP1, MP2
Official Media Witnesses	20	20	20	20	20	not provided	20	20
Curtain and PA tasks	12, 16, 6	12, 6	12, 2	6, 12	6, 14	not provided	6, 12	6
Communication with Governor's office	12	12	12	12	14	not provided	12	12
Execution phase begins; initiate phases	12	12	12	12	14	not provided	12	12
Executioners Room	14	14	14	14	16, 12	14	14	14
Contingencies (**failed exercises in bold**)	none			none			none	none
Trained to apply camera for a cutdown, trained STM2								
Activate backup PA system								
Line 1 kinked, conscious after syringe 3; switched to IV line 2, began phase I syringe 1 from stand B.		x						
Poor clarity on monitor, heart monitor switched. Flat lined after syringe 5. Syringes 6-8 not used.			X					
Inmate not unconscious after syringe 3; administered syringes 1-3 from stand B; Flat lined after syringe 4. Syringes 5-8 not used.					X			
Flat lined after syringe 5. Syringes 6-8 not used.						X		

	10/24/07	10/24/07	11/7/07	11/7/07	11/14/07	11/14/07	11/14/07	1/17/08
	#2	#3	#1	#2	#1	#2	#3	#1
Preparation prior to receiving inmate	Blank	Blank	recorded	Blank	Recorded	Blank	Blank	Recorded
Open phone line with Governor's office	19	19	19	19	19	19	19	Blank
Read warrant;	12	12	12	12	12	12	12	12
Restraints applied	6	6	6, 3, 4, 2	2	6, 2, 3, 4	6, 2, 3, 4	6	6
Security team	6, 8, 3, 2	3, 4, 6, 2, 21	6, 3, 4, 2	6, 2, 3, 4	6, 2, 3, 4	6, 2, 3, 4	6, 3, 4, 2	4, 2, 3, 6
Technical Team process	MP1, MP2	MP1, MP2	MP1, MP2	MP1, MP2	MP1, MP~~3~~7	MP1, MP ~~37~~	MP1, MP ~~37~~	MP1, MP7
Official Media Witnesses	20	20	20	20	20	20	20	20
Curtain and PA tasks	6	6	12, 6	12, 6	12, 6	12, 6	12, 6	12, 6
Communication with Governor's office	12	12	12	12	12	12	12	12
Execution phase begins; initiate phases	12	12	12	12	12	12	12	12
Executioners Room	14	14	14	14	14	14	14	14
Contingencies (**failed exercises in bold**)	none		none		none		none	none
Blocked line syringe 1, switched to line 2. No syringes administered after syringe 2. Flat lined.		X						
Blocked line syringe 2, phase I began on line 2.				x				
Blocked line syringe 1, switch to line 2, syringe 1. No syringes administered after syringe 4. Flat lined.						X		

	1/17/08	1/17/08	2/20/08	2/20/08	2/20/08	2/20/08	3/13/08	3/13/08
	#2	#3	#1	#2	#3	#4	#1	#2
Preparation prior to receiving inmate	Blank	Blank	Recorded	Blank	Blank	Blank	Recorded	Blank
Open phone line with Governor's office	19	19	19	19	19	19	Blank	19
Read warrant;	12	12	Blank	12	Blank	Blank	12	12
Restraints applied	6	2	6	6	6	6	6	6
Security team	2, 3, 4, 6	2, 7, 8, 3	2, 4, 6, 3	2, 3, 4, 6	2, 3, 4, 6	2, 3, 4, 6	2, 3, 4, 6	7, 8, 6, 2
Technical Team process	MP1, MP7	MP1, MP7	MP1, MP2	MP1, MP2	MP1, MP2	MP2, MP7	MP1, MP2	MP1, MP2
Official Media Witnesses	20	4	20	20	20	20	20	20
Curtain and PA tasks	12, 6	12, 2	6, 12	6, 12	6, 12	6, 12	12, 6	12, 2
Communication with Governor's office	12	12	12	12	12	12	12	12
Execution phase begins; initiate phases	12	12	12	12	12	12	12	12
Executioners Room	14	14	14	14	14	14	14	14
Contingencies (**failed exercises in bold**)		None	None		None			None
Blocked line syringe 1. Proceeded with line 2	X							
"Syringe 1 and 2 was chemical" No documentation of chemical preparation				**X**				
Blocked line on syringe 2. Switched to line 2, administered syringes 1 and 2, then flat line. No syringes after syringe 2.						**X**		
Blocked line syringe 4. Began phase I with line 2.							X	

	4/23/08	4/23/08	4/23/08	5/20/08	5/20/08	5/20/08	5/20/08	
	#1	#2	#3	#A	#1	#2	#3	
Preparation prior to receiving inmate	Recorded	Blank	Blank	Recorded	Recorded	Blank	Blank	
Open phone line with Governor's office	19	19	19	Blank	19	19	19	
Read warrant;	12	12	12	12	12	12	12	
Restraints applied	6	6	6	6	6	6	6	
Security team	2, 3, 4, 6	2, 3, 4, 6	2, 3, 4, 6	6, 4, 21, 2	6, 2, 21, 4	6, 2, 4, 21	6, 2, 4, 21	
Technical Team process	MP1, MP2	MP1, MP2	MP1, MP2		MP1, MP2	MP1, MP2	MP2, MP7	
Official Media Witnesses	20	20	20		20	20	20	
Curtain and PA tasks	12, 6	12,6	12, 6		6, 12	12, 6	6, 12	
Communication with Governor's office	12	12	12		12	12	12	
Execution phase begins; initiate phases	12	12	12		12	12	12	
Executioners Room	14	14	14		14	14	14	
Contingencies (**failed exercises in bold**)	None	None			None	None		
Blocked line syringe 3. Used line 2 syringes 1-3, then flat lined. Syringes 4-8 not used.			X					
"Just a strap down." Exercise stopped when restraint process completed.				x				
Note: Chemical prep checklist partially completed					x			
Blocked line on syringe 2. switched to line 1 and administered syringes 1 and 2. Flat lined. Syringes 3-8 not administered.							X	