

9. Report of Janine Arvizu, dated April 1, 2008.

April 1, 2008

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

Subject: Lethal Execution Protocol Training Records Review and Quality Assessment,  
Richard Anderson

Dear Mr. Cannon,

As requested, I have conducted an independent quality assessment of the records and documents provided by your office in the above referenced case, including the letter report (dated 3/31/08) by G. Douglas Lunsford, MA providing statistical analysis of lethal injection data. Although all the documents that were requested for an independent assessment of the subject case have not been received at this time, this letter provides a summary of the quality issues that have been identified based on review of the available records. In particular, this review focuses on thirty pages of training records generated during training exercises conducted on 8/1/08, 8/15/08 and 8/22/08.

As referenced in the Department of Corrections Secretary's letter to the Governor certifying the Department's readiness for administration of an execution (dated July 31, 2007), the determination of readiness was based on having the necessary procedures, equipment, facilities, and personnel in place, as described in the revised lethal injection procedure (the version identified as in effect for executions after August 1, 2007). I previously reported the deficiencies and inconsistencies in the department's procedure (Lethal Execution Protocol Review and Quality Assessment, Mark Schwab; letter to Peter Cannon, 8/14/2007); these deficiencies still exist.

This letter describes the results of my review of training records that document the conduct of five separate mock executions on two different days (8/15/07 and 8/22/07). Specific findings and observations follow. 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.

Findings and observations regarding these records follow.

The records document three execution exercises conducted on August 15, 2007, and two execution exercises on August 22, 2007. An Execution Checklist and an Executioners Room Checklist were provided for each exercise. 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 training exercises. In addition, although the Team Warden

was required to sign each of the forms, attesting to the proper performance of all steps, only two of the ten forms were signed. Note: Copies of twenty forms were provided; it was assumed that the originals were double sided forms.

As documented on the checklists, the scope of the 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 every training exercise. This indicates that the following important steps were never 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

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.

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 include the following:

- o Verification that chemicals have not reached their expiration dates.
- o Verification that all chemicals used are correct and current; preparation, filling, and labeling of 8 syringes in Stand A and 8 syringes in Stand B.
- o Preparation of two IV infusion sets, labeled 1 and 2.
- o Verification that the leads to two heart monitors are attached.
- o Verification that the heart monitors are operational both before AND after the chest restraints are secured.
- o Verification that a freely flowing IV has been established in each arm, and that each line is properly identified.
- o Verification of viability of IV lines after transfer of saline bags to the executioners room, and prior to initiation of phases.

The omission of these steps from the checklists presents a quality problem for several reasons. First, a failure in any one of these important areas has the potential to compromise the process. Second, historical practice has demonstrated that these are process areas that are subject to failure. Given their importance on the reliability of the process, and their recognized failure potential, these steps merit quality control checks.

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 scratched out. 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.

As documented on the training records, FDLE was only present for two training scenarios (exercise 1 on 8/1/08 and exercise 1 on 8/22/08). 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 not provided with the training records.

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

The scope, contingencies, and learning objectives associated with each training scenario should have been documented in advance in training plans. No such records were provided, and it isn't known whether they exist. In the absence of records that document the learning objectives for each exercise, it wasn't possible to determine whether unplanned problems were encountered during the exercises, or whether the participants were experiencing planned scenarios.

8/1/08; exercise 1: Two Training Attendance Reports were provided for this exercise. As indicated by the records, each of the individuals identified on the attendance report did not participate in the training scenario (STM-20, STM-3, STM-21, and STM-19 were listed on the attendance log, but not on the exercise records), and some of the individuals who participated in the exercise were not listed on the attendance record (STM-16 and STM-12).

8/1/08; exercise 2: During administration of syringe 4, resistance and an infiltrated IV line was noted. In response to this contingency, the lines were swapped to #2, and the execution phase was initiated with syringe 1 from line 2, as prescribed by procedure.

8/15/08; exercise 1: After administration of syringe 4, the Executioners Room Log reports a flat line. This represents a response that is inconsistent with the expected effects of pancuronium bromide, and might have been an indication that the wrong chemical was administered (e.g., a syringe was mislabeled or filled with the wrong chemical). There was no documentation that the heart monitors were operating properly prior to or during this exercise, or that a debriefing to address the cause of the failure was held. This is indicative of a failed exercise.

8/15/08; exercise 2: The recordkeeping was a problem for this exercise. The first entry on the Execution Checklist indicates that four members of the security team opened the phone line with the Governor's Office. This appears to be an error; in every other exercise, this task was the responsibility of another individual who was not a member of the security team. Documentation of the contingencies for this exercise is difficult to read; the writing is nearly illegible. Three contingencies were documented for this exercise. First, the inmate struggled, and the right arm was secured by members of the security team. On the Executioners Room Checklist, documentation of the subject's struggle was entered, but the record was not made

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contemporaneously (an 11:15 entry regarding the struggle (which occurred at 10:58) was made after an 11:17 entry regarding a blocked line). The second contingency that was recorded was a blocked line (Line 1); in response to this, Line 2 was utilized (the entry on the Execution Checklist was illegible). Finally, immediately after switching to Line 2, telemetry data were lost from one heart monitor. The Team Warden directed phase one to be restarted with a single telemetry unit. There was no documentation that the operational status of the heart monitors was verified prior to phase one, and a debriefing to address the multiple contingencies was not held.

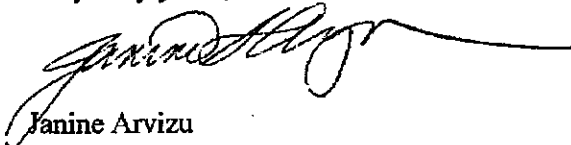
8/15/08; exercise 3: During administration of syringe 5, a notation was made that the subject "flat lined". Once again, this represents a response that is inconsistent with the expected effects of pancuronium bromide, and might have been an indication that the wrong chemical was administered (e.g., a syringe was mislabeled or filled with the wrong chemical). There was no documentation that the heart monitors were operating properly prior to or during this exercise, or that a debriefing to address the cause of the failure was held. This is indicative of a failed exercise.

8/22/08; exercise 1: The Execution Checklist includes a notation "FDLE Present - Training", but copies of the detailed logs that are required to be produced by FDLE were not provided. The number of FDLE representatives who participated in the exercise could not be determined from the records since an attendance log was not provided. The only contingency documented for this exercise was "Sound Contingency - Power in to PA System." From the available records, it could not be determined whether the team members neglected to check the PA power prior to receiving the inmate (the first page of the checklist was not completed) or whether the PA power was lost during the exercise.

8/22/08; exercise 2: During administration of syringe 2, a blocked line was noted. On the advice of the medical team, IV line 2 became the primary, and phase 1 was initiated with syringe 1 from stand B (on the Executioners Room Checklist, it was recorded as "stand 2"; an alphabetical designation was used in an attempt to prevent mix-ups of numbers and letters).

Based on my earlier review of the DOC procedure and available 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 records, my conclusion has not been altered. If I am able to obtain and review copies of additional requested materials about the department's training program, I will provide additional or revised comments and conclusions, as appropriate.

Very truly yours,



Janine Arvizu

Attachment: Summary of training records reviewed

Training Activities and Participants	8/1/07 #1	8/1/07 #2	8/15/07 #1	8/15/07 #2	8/15/07 #3	8/22/07 #1	8/22/07 #2
Open phone line with Governor's office	Not entered	Not entered	6,4,3,2*	19	19	19	19
Read warrant; communicate with Governor's office	Not entered	Not entered	12	12	12	12	12
Restraints applied	6	Not entered	6	6	6	6,4,3,2	6,4,3,2
Security team	6,4,3,2	6,4,3,2	6,4,3,2	6,4,3,2	6,4,3,2	6,4,3,2	6,4,3,2
Technical Team process	MP1, MP2	MP1, MP2	MP1, MP2	MP1, MP2	MP1, MP2	MP1, MP2**	MP2
Official Media Witnesses	Not entered	Not entered	20	20	20	20	20
Curtain and PA tasks	Not entered	Not entered	6	6	6	2	2
Communication with Governor's office	Not entered	Not entered	12	12	12	12	12
Execution phase begins; initiate phases	Not entered	Not entered	12	12	12	12	12
Executioner	16, 12	16, 12	16	16	16	14	14
Observers	"FDLE"	"FDLE"				"FDLE"	
<b>Contingencies</b>							
"IV line infiltrated. Resistance Felt. Lines swapped		X					
#2. Medical line cleared."			X				
"Flat line after syringe #4. Team Leader advised.							
Summoned physician."							
"??? Struggled with team with right arm & right arm secured by STM 6&3"				X			
"Infiltration in line 1" "Blocked line -- infiltrated line"				X			
"Subject struggled; heart leads still have capture" "Line 2 will be utilized. Lost one heart monitor - continue"							
"Flat lined"					X		
"Sound contingency - Power on to PA system"						X	
"Infiltration/blocked ???" "Team leader advises to temporarily suspend. Medical team enters. Medical team departs. Medical advises to access 2 <sup>nd</sup> line. Curtain raised. Team Leader - begin phase 1 from Tray ?"							X
"Block in the line while pushing syringe (2) Medical checked the lines. IV line 2 became the primary, began phase 1 with syringe 1 from stand (2).							

\* This entry appears to be an error  
 \*\* Although MP2 was present, only MP1 was documented as responsible for tasks during this exercise