IN THE COURT OF CRIMINAL APPEALS OF THE STATE OF OKLAHOMA

RICHARD EUGENE GLOSSIP,	)	
JOHN MARION GRANT,	)	
CHARLES WARNER,	)	
	)	
Appellants,	)	**Case Nos. D-2000-653 (Grant)**
	)	**D-2003-829 (Warner)**
v.	)	**D-2005-310 (Glossip)**
	)	
STATE OF OKLAHOMA,	)	
	)	
Appellee.	)	

STATE'S NOTICE REGARDING SCHEDULED EXECUTION DATES

COMES NOW E. Scott Pruitt, Attorney General of Oklahoma, by and through Seth S. Branham, Assistant Attorney General, and provides the Court the following notice regarding scheduled execution dates in the above-styled and numbered cases.

I. Introduction.

The following execution dates are currently scheduled: November 13, 2014 — execution of Charles Warner; November 20, 2014 — execution of Richard Eugene Glossip; December 4, 2014 — execution of John Marion Grant. These execution dates were scheduled by this Court to allow for the completion of Oklahoma Department of Public Safety Commissioner Michael C. Thompson's investigation into the execution of Clayton Lockett. The State was directed to keep the Court advised as to the status of Commissioner Thompson's investigation together with any proposed adjustments to ODOC's execution protocol. *See* Exhibit 1 at 1 (order setting Warner's execution date); Exhibit 2 at

2 (order setting Glossip's execution date); Exhibit 3 at 2 (order setting Grant's execution date) (all attached).

Commissioner Thompson's investigation was concluded on September 4, 2014, with release of a written report addressing the execution of Clayton Lockett. *See* Exhibit 4 (attached). The report concludes, *inter alia*, that "the viability of the IV access point was the single greatest factor that contributed to the difficulty in administering the execution drugs." Exhibit 4 at 14. Toxicology tests conducted during Lockett's autopsy

> indicated elevated concentrations of midazolam in the tissue near the insertion site in the right groin area, which was indicative of the drugs not being administered into the vein as intended. **Thus, the IV access was not viable as early as the administration of the midazolam.**

Exhibit 4 at 19 (emphasis added).

Commissioner Thompson's report contains recommendations to improve ODOC's execution protocol, including recommendations for the training of execution personnel. Exhibit 4 at 26-29. On September 30, 2014, ODOC released a revised execution protocol which incorporates Commissioner Thompson's recommendations. *See* Exhibit 5. This includes the requirement of a full set of backup drugs in the event the initial administration is unsuccessful, Exhibit 6 at 1 (Attachment D to Sept. 30, 2014 protocol), and additional training requirements for execution personnel, discussed below. Exhibit 5 at 9-10. It should also be noted that, at the direction of ODOC Director Robert Patton, the execution chamber has been reconfigured.

II. The State's Request for Additional Time.

ODOC is preparing for the executions of Charles Warner, Richard Glossip and John Marion Grant as currently scheduled for November 13th, November 20th and December 4th. The State requests that all three execution dates be rescheduled, with Charles Warner's execution being reset for no earlier than January 15, 2015, and Glossip's and Grant's executions being scheduled thereafter. The Attorney General has made inquiry of ODOC and its preparedness for implementation of the new execution protocol. This inquiry reflects an effort of the Attorney General to more properly inform this Court of whether the State would in fact be ready to proceed with the execution scheduled for November 13th. The State has been advised as follows:

> 1. ODOC is diligently attempting to secure all necessary drugs to carry out these executions. However, the required drugs are not currently in possession of ODOC's pharmacist;
>
> 2. ODOC is in the process of obtaining the necessary medical personnel. However, ODOC has not secured commitments from the required medical personnel at this time;
>
> 3. ODOC has begun the necessary training. However, to have the training completed by November 13th will require multiple training sessions to be held each week. The training will involve multiple training scenarios for all execution team members and will include contingency plans for execution equipment and supplies, offender IV access, inmate consciousness, unanticipated medical or other issues concerning the offender or execution team, and security issues at the penitentiary during an execution. Exhibit 5 at 10. The training too will involve implementing into the execution process new equipment obtained by ODOC,

including an EKG monitor and an ultrasound machine to assist in obtaining venous access.

The State does not want to rush implementation of this new training program, especially so soon after revision of the execution protocol. The additional requested time for all three executions will allow ODOC sufficient time in which to obtain the necessary drugs and medical personnel and to fully and thoroughly train each member of the new execution team. The additional time will allow ODOC to address any unanticipated contingencies that arise which could impact training such as scheduling issues for the new execution team members. Simply stated, steps remain and continued work is necessary to ensure the State is ready and adequately trained to incorporate all recommendations as contained in the report of Commissioner Thompson.

Finally, in its conversations with this Office, ODOC has suggested that if an extension of time is requested, that the execution dates be reset as follows: January 15, 2015 – execution of Charles Warner; January 29, 2015 – execution of Richard Eugene Glossip; and February 19, 2015 – execution of John Marion Grant.

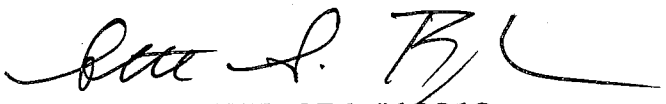
III. Conclusion.

Based on the totality of the circumstances, the State requests that this Court reschedule the executions of Charles Warner, Richard Eugene Glossip and John Marion Grant. Accordingly, Warner's execution date should be reset to Thursday, January 15, 2015. Glossip's execution should be reset to

Thursday, January 29, 2015. Grant's execution should be reset to Thursday, February 19, 2015.

Respectfully submitted,

E. SCOTT PRUITT
ATTORNEY GENERAL OF OKLAHOMA



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ASSISTANT ATTORNEY GENERAL

313 N.E. 21st Street
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(405) 521-3921 (Voice)
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COUNSEL FOR THE STATE

CERTIFICATE OF MAILING

On this 10th day of October, 2014, a true and correct copy of the foregoing was mailed, with full first-class postage pre-paid, to:

Susanna M. Gattoni
Seth A. Day
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Chase Tower
100 North Broadway, Suite 2900
Oklahoma City, OK 73102-8865

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Denver, CO 80203

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Oklahoma City, OK 73102

SETH S. BRANHAM

IN THE COURT OF CRIMINAL APPEALS OF THE STATE OF OKLAHOMA

CHARLES FREDERICK WARNER,	)	
	)	
Appellant,	)	
	)	
v.	)	No. D-2003-829
	)	
STATE OF OKLAHOMA,	)	
	)	
Appellee.	)	

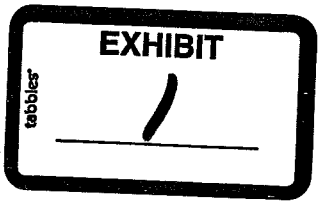
ORDER GRANTING STAY OF EXECUTION

On May 5, 2014, Appellant filed with this Court *Charles Warner's Objection to the Execution Date and Emergency Application for an Indefinite Stay.* Appellant objects to the execution date of May 13, 2014 set by Governor Fallin and asks this Court to issue a stay of execution for at least six months pending the full and final review of the execution of Clayton Lockett on April 29, 2014. This Court ordered the State to respond to the allegations raised in Appellant's motion. In its timely filed response, the State does not object to the requested stay. The State is directed to keep this Court advised as to the status of the independent investigation together with any proposed adjustments to the protocol.

FOR GOOD CAUSE SHOWN, we find the execution set for May 13, 2014 is hereby VACATED and the execution is rescheduled for November 13, 2014.

IT IS SO ORDERED.

WITNESS OUR HANDS AND THE SEAL OF THIS COURT this 8th day of May, 2014.



DAVID B. LEWIS, Presiding Judge

Special Concur

CLANCY SMITH, Vice Presiding Judge

GARY L. LUMPKIN, Judge

Special Concur

CHARLES A. JOHNSON, Judge

ARLENE JOHNSON, Judge

ATTEST:

Clerk

C. JOHNSON, JUDGE, SPECIALLY CONCURRING:

This Court has appropriately granted Warner's request for a stay of execution in this case. The fact that the Director of the Oklahoma Department of Corrections has expressed that this stay is necessary to allow sufficient time for a complete review/revision of the execution protocols in order to conform to best practices and ensure that Oklahoma protocol adopts proven standards compels this decision as does the fact that the Oklahoma Attorney General has no objection to the request for stay of execution. Indeed, if the State is allowed to enforce the ultimate penalty of death, it is incumbent upon this Court to allow the State the time necessary to ensure that the penalty is carried out in a constitutionally sound manner.

I am authorized to state that Vice Presiding Judge Clancy Smith joins in this separate opinion.

IN THE COURT OF CRIMINAL APPEALS OF THE STATE OF OKLAHOMA

RICHARD EUGENE GLOSSIP,	)	
	)	
Appellant,	)	NOT FOR PUBLICATION
	)	
v.	)	Case No. D-2005-310
	)	
THE STATE OF OKLAHOMA,	)	
	)	
Appellee.	)	

ORDER SETTING EXECUTION DATE

Richard Eugene Glossip is incarcerated at the Oklahoma State Penitentiary pursuant to a conviction and sentence of death for the crime of first degree murder in Oklahoma County District Court case number CF-1997-244. *See Glossip v. State*, 2007 OK CR 12, 157 P.3d 143. The State of Oklahoma has informed this Court that Glossip has now exhausted all State and Federal appeals of his first degree murder conviction and death sentence. The State notes that his last appeal was denied by the United States Supreme Court on May 5, 2014. *See Glossip v. Trammell*, 2014 WL 859612 (U.S. May 5, 2014). The State, pursuant to 22 O.S.2011, § 1001.1, requests an execution date and suggests the appropriateness of setting the date.

The State notes that recent developments occurring during the execution of Clayton Lockett necessitated that the scheduled execution of Charles Warner be stayed for fourteen days. The lethal injection process mandated by the legislature, and the lethal injection protocol adopted by the State in order to carry out the mandate, will undoubtedly be under scrutiny. With that understanding,

this Court vacated Warner's execution date and reset his execution for November 13, 2014, in order that investigation of the execution protocol could be completed. Glossip has filed an objection to the setting of an execution date prior to Warner's scheduled execution.

Under traditional circumstances, this Court would be required to set a date "sixty (60) days after the dissolution of the stay of execution" (the stay, in this case, being dissolved on May 5, 2014). In this case, however, we note the State's obvious commitment that no executions be facilitated until a complete investigation into Lockett's execution is completed. As we ordered in Warner's case, the State shall keep this Court informed about the status of the investigation and any adjustments to the execution protocol.

Therefore, we hereby order the execution of the judgment and sentence of death be carried out. The execution of Richard Eugene Glossip shall be set for November 20, 2014.

IT IS SO ORDERED.

WITNESS OUR HANDS AND THE SEAL OF THIS COURT this 28 day of May, 2014.

DAVID B. LEWIS, Presiding Judge

CLANCY SMITH, Vice Presiding Judge

GARY L. LUMPKIN, Judge

CHARLES A. JOHNSON, Judge

ARLENE JOHNSON, Judge

ATTEST:

Clerk

ORIGINAL

IN THE COURT OF CRIMINAL APPEALS OF THE STATE OF OKLAHOMA

JOHN MARION GRANT,	)	
	)	
Appellant,	)	NOT FOR PUBLICATION
	)	
v.	)	Case No. D-2000-653
	)	
THE STATE OF OKLAHOMA,	)	
	)	
Appellee.	)	

FILED
IN COURT OF CRIMINAL APPEALS
STATE OF OKLAHOMA
JUL - 9 2014
MICHAEL S. RICHIE
CLERK

ORDER SETTING EXECUTION DATE

John Marion Grant is incarcerated at the Oklahoma State Penitentiary pursuant to a conviction and sentence of death for the crime of first degree murder in Osage County District Court case number CF-1999-28. *See Grant v. State*, 2002 OK CR 36, 58 P.3d 783. The State of Oklahoma has informed this Court that Grant has now exhausted all State and Federal appeals of his first degree murder conviction and death sentence. The State notes that his last appeal was denied by the United States Supreme Court on June 9, 2014. *See Grant v. Trammell*, 2014 WL 1355962 (U.S. June 9, 2014). The State, pursuant to 22 O.S.2011, § 1001.1, requests an execution date and suggests the appropriateness of setting the date.

The State notes that recent developments occurring during the execution of Clayton Lockett necessitated that the scheduled execution of Charles Warner be stayed for fourteen days. The lethal injection process mandated by the legislature, and the lethal injection protocol adopted by the State in order to carry out the mandate, will undoubtedly be under scrutiny. With that understanding,

EXHIBIT
tabbies
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this Court vacated Warner's execution date and reset his execution for November 13, 2014, in order that investigation of the execution protocol could be completed. Grant has filed an objection to the setting of an execution date. Alternatively, Grant requests that, should a date be set, it should neither be prior to Warner's scheduled execution nor prior to another execution scheduled for November 20, 2014.

Under traditional circumstances, this Court would be required to set a date "sixty (60) days after the dissolution of the stay of execution" (the stay, in this case, being dissolved on May 5, 2014). In this case, however, we note the State's obvious commitment that no executions be facilitated until a complete investigation into Lockett's execution is completed. As we ordered in Warner's case, the State shall keep this Court informed about the status of the investigation and any adjustments to the execution protocol.

Therefore, we hereby order the execution of the judgment and sentence of death be carried out. The execution of John Marion Grant shall be set for Thursday, December 4, 2014.

IT IS SO ORDERED.

WITNESS OUR HANDS AND THE SEAL OF THIS COURT this 9th day of July, 2014.

DAVID B. LEWIS, Presiding Judge

CLANCY SMITH, Vice Presiding Judge

GARY L. LUMPKIN, Judge

CHARLES A. JOHNSON, Judge

ARLENE JOHNSON, Judge

ATTEST:

Clerk

OKLAHOMA DEPARTMENT OF PUBLIC SAFETY

The Execution of Clayton D. Lockett

Case Number 14-0189SI

Executive Summary

Table of Contents

I. BACKGROUND

The State of Oklahoma, through the Office of the Attorney General (OAG), filed an *Application for Execution Date* for Clayton Derrell Lockett on January 13, 2014. Lockett had been convicted of first degree murder for a 1999 case in Noble County and sentenced to death. On January 22, the Oklahoma Court of Criminal Appeals ordered the execution to be set for March 20. Motions were later filed on behalf of Lockett and another offender sentenced to death, Charles Warner, that challenged Oklahoma's execution-secrecy law and execution protocol. On March 18, the Court of Criminal Appeals vacated Lockett's execution date and it was reset for April 22. This order also rescheduled Warner's execution from March 27 to April 29.

On April 9, the Court of Criminal Appeals denied an application for stay made by both offenders. On April 21, the Oklahoma Supreme Court issued a stay of execution for Lockett and Warner. In response, Governor Mary Fallin issued Executive Order 2014-08, which granted a stay of Lockett's execution and rescheduled it for April 29, based on the Supreme Court not having constitutional authority to issue a stay. On April 23, the Supreme Court dissolved their stay. Between April 23 and April 29, an application for extraordinary relief was denied by the courts, as was another request for a stay.

On the morning of April 29, Oklahoma Department of Corrections (DOC) personnel began procedures to prepare for Lockett's and Warner's executions at the Oklahoma State Penitentiary (OSP) in McAlester, Oklahoma. Lockett's execution was scheduled to begin at 6:00 p.m. Lockett was removed from his cell that morning and taken to the Institutional Health Care Center (IHCC), located on prison grounds, for self-inflicted lacerations to the inside of his arms and his pre-execution medical examination. Lockett remained at IHCC until later that afternoon, when he was returned to H-Unit to await his execution.

Lockett was taken to the execution chamber, placed onto the table, and after failed attempts in other locations, an intravenous (IV) line was started in Lockett's right groin area. On the order of Warden Anita Trammell, the administration of execution drugs began. Several minutes into the process, it was determined there was a problem with the IV patency. The execution was stopped and Lockett later died in the execution chamber.

On April 30, Governor Fallin issued Executive Order 2014-11, which appointed Secretary of Safety and Security and Department of Public Safety (DPS) Commissioner Michael Thompson to conduct an independent review of the events leading up to and during Lockett's execution. This order stated the review should include:

1. An inquiry into the cause of death by a forensic pathologist;
2. An inquiry into whether DOC correctly followed their current protocol for executions;
3. Recommendations to improve the execution protocol used by DOC. The order further directed that the Office of the Chief Medical Examiner (OCME) authorize the Southwestern Institute of Forensics Science (SWIFS) in Dallas, Texas to perform the autopsy, additional examination, and all other related testing of Lockett's remains.

In order to effectuate the examination, OCME was directed to transport Lockett's remains to and from SWIFS. OCME was also ordered to appropriately maintain Lockett's remains until they were released to his family. Commissioner Thompson assembled a team of DPS investigators to conduct this investigation and report its findings. This executive summary, along with its attachments and supporting documentation, are the result of the investigation conducted by this team.

II. INVESTIGATION

This investigation was conducted by a team of six investigators assigned full-time to the case. Nine investigators and a criminal intelligence analyst were also utilized part-time to assist with the case. All investigators were sworn, law enforcement members of the Oklahoma Highway Patrol (OHP) Division of DPS. A medical expert was also consulted during the investigation to assist the investigators in understanding the various technical aspects related to the medical procedures that were performed during the execution. The expert was a current, American Board of Surgery certified physician with more than 35 years of experience in the medical field. The remainder of this section outlines the methodology utilized by the team to complete this investigation.

A. Autopsy of Clayton D. Lockett

On April 29, at 7:50 p.m., DOC released Lockett's body to the OCME designated transport contractor, Ray Francisco's Embalming Service, who transported the body to OCME in Tulsa, Oklahoma. On the morning of April 30, OCME pathologists began an external examination of the body. A portion of the superficial veins of the right and left arms were explored, photographed and removed. Personnel also obtained a blood sample from the left femoral artery/vein. Around 11:30 a.m., pathologists were notified to stop the examination pursuant to the aforementioned Executive Order. They had not started a posterior body inspection or internal examination. OCME staff sealed the body and evidence in a body bag and placed it in storage. Later that day, Lockett's body and evidence were transported by Ray Francisco's Embalming Service to SWIFS and the transport was monitored by a member of the investigation team.

On May 1, the autopsy of Lockett's body was conducted by Dr. Joni McClain and other SWIFS staff. A member of the investigation team observed the autopsy and evidence processing procedures. Dr. McClain completed the external and internal examinations of the body utilizing SWIFS' normal procedures and protocols. After the autopsy was complete, Lockett's body was released to Ray Francisco's Embalming Service and transported back to OCME in Tulsa.

During this investigation, the investigation team met with the SWIFS pathologists and staff to gain a better understanding of their autopsy process and its findings. The results of the autopsy and the toxicology tests that were completed are summarized in the *Findings* section of this report.

B. Tour of the Oklahoma State Penitentiary

On May 5, the investigation team met with Warden Trammell and several OSP staff members to prepare for a tour of H-Unit and IHCC. The team was escorted through H-Unit, where they viewed the holding cells, shower, execution chamber, executioners' room and medical room. The team also collected evidence during the tour. The team was then escorted to IHCC and viewed the area where Lockett was treated for his self-inflicted wounds and the cell where he was held, until being returned to H-Unit. After the tour, the team met with Warden Trammell and her staff to collect additional evidence and

retrieve documents requested for the investigation. Several measurements and photographs were taken during the tour to document the execution facilities, which were later used to construct Diagram II.1.

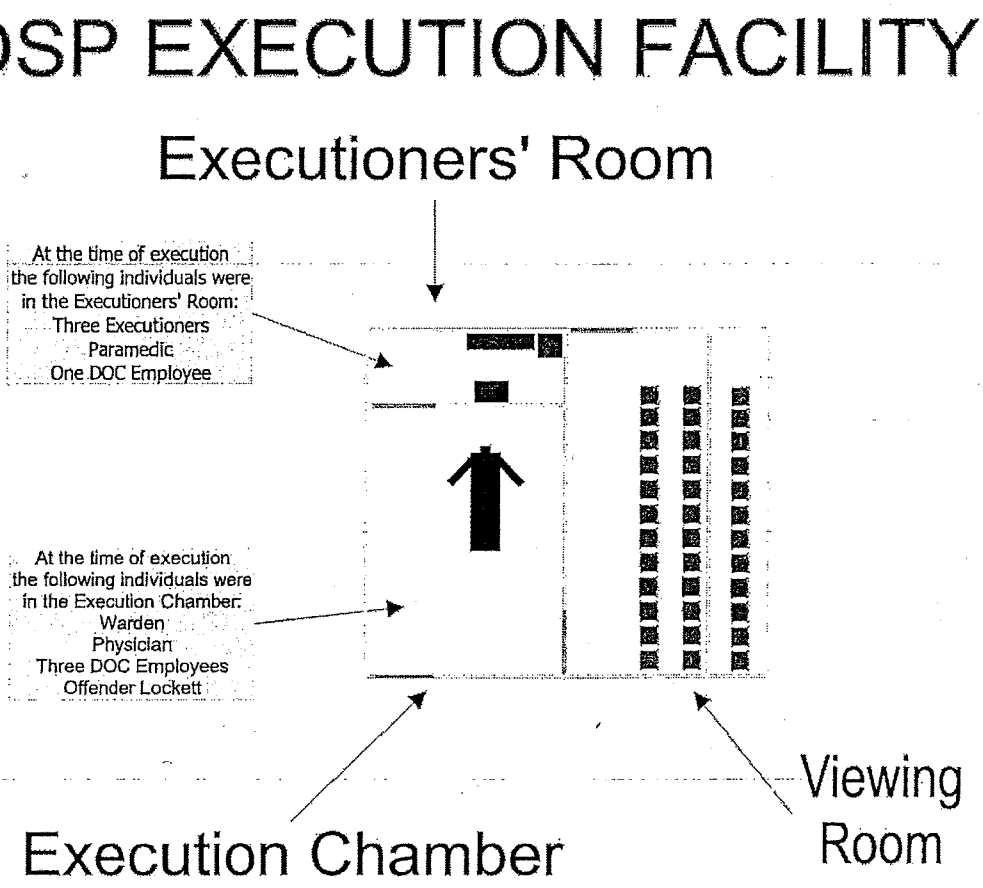

Diagram II.1

On June 30, members of the investigation team returned to OSP to gather additional information from the execution chamber. A team member was strapped to the execution table by two OSP strap-down team members who had strapped Lockett to the table. OSP staff observed the process to ensure that every strap was utilized in the same manner it was on the day of Lockett's execution. The team measured the ability for a person to move and their range of motion, once secured to the table, and took photographs from the viewing room to show the different perspectives from the various seating locations.

C. Collection of Evidence

Numerous items of evidence were collected and preserved during this investigation. This evidence included digital photographs, audio recordings, video recordings, documents and other items of physical evidence. The remainder of this section is a summary of the evidence collected.

During their examination, OCME staff collected a blood sample from Lockett's left femoral artery/vein. An aliquot of that sample was submitted by OCME to NMS Labs in Willow Grove, Pennsylvania, to test for the presence and concentration of midazolam and vecuronium bromide. On June 12, the investigation team obtained another aliquot of that sample and submitted it to ExperTox Laboratory in Deer Park, Texas, to test for the presence and concentration of potassium. In accordance with their normal procedure, OCME had not requested NMS Labs to test for the presence and concentration of potassium. The results of these examinations are included in the *Findings* section of this summary. The remainder of the sample is being stored by OCME.

On May 1, evidentiary items related to the administration of execution drugs to Lockett were released by SWIFS to the investigation team. These items were delivered by a team member to ExperTox. Evidence items that were inside Lockett's body bag and body are being maintained at SWIFS, the Oklahoma State Bureau of Investigation Laboratory or the OHP evidence storage facility. The team also collected the execution drugs and containers that were prescribed to offender Charles Warner. Custody was transferred from OSP personnel to a team member, who hand-delivered them to ExperTox for testing.

On May 5, approximately 200 items of evidence were collected at OSP, during the facility tour. They consisted of items from Lockett's cell, the execution chamber, the executioners' room and video footage from inside the facility prior to the execution. Executions are not recorded; therefore, there was no video footage of the actual execution. These items are being maintained at the OHP evidence storage facility.

D. Review of Surveillance and Camcorder Video

Thirty-two compact disks containing surveillance and camcorder video footage were collected and viewed. Following is a summary of this video provided by DOC:

1. Video surveillance footage from OSP for April 29, from 5:15 a.m. to 5:22 p.m., that recorded Lockett's movements in H-Unit and IHCC;
2. Camcorder video footage for the planned use of force that showed the extraction of Lockett from his cell on the morning of April 29. The footage contained statements explaining the force, restraints to be used and each extraction team member's duties. The footage also captured his treatment at H-Unit medical, his transport to IHCC, his treatment at IHCC and his X-ray;
3. Camcorder video footage of Lockett refusing a meal on April 29. The footage captured Lockett refusing a meal and had a statement from DOC personnel that Lockett had refused all three meals that day.

E. Documentation Provided by Oklahoma Department of Corrections

Throughout this investigation, several hundred pages of documents were requested and obtained from DOC. This team requested any documentation related to Lockett and his execution, including but not limited to logs, incident reports, timelines and historical medical records. Following is a non-inclusive summary of those documents obtained from DOC.

1. Memorandums from Warden Trammel to OSP personnel;
2. Legal documentation related to Lockett's court proceedings;
3. Use-of-force documentation from April 29, including TASER training records;
4. Property inventory and log of items sent to Lockett's family;
5. Sequence of events, execution logs and execution timeline;
6. Lockett's historical medical records, mental health check information and case manager reports;
7. Execution drugs chain-of-custody forms;
8. Execution duties listed by department and training/practice logs;
9. Lockett's 30-day notification packets;
10. DOC execution procedures;
11. Various incident reports;
12. Affidavit of Warden Anita Trammell related to the execution drugs;
13. Diagram of the execution chamber;
14. Death warrant for Clayton Lockett;

15. Execution debrief personnel log;
16. Execution chamber key log;
17. Interoffice memorandums, emails and training documents related to the execution duties of DOC personnel.

F. Interviews

During this investigation, 113 people were identified to interview. Of those, 108 were interviewed, four media witnesses who viewed the execution declined to interview and one OCME employee was on extended leave and not available to interview. Follow-up interviews of select witnesses were also conducted. Each interview, with the exception of four, was audio recorded and reduced to a typed report by a transcription service. The four interviews that were not recorded included the three executioners and the pharmacist. Below is a summary of those that were interviewed:

1. The physician, Warden Trammell and three additional DOC personnel that were in the execution chamber at the time of the execution;
2. The paramedic, one DOC employee and the three executioners that were in the executioners' room at the time of the execution;
3. Persons that viewed the execution from the viewing room or overflow area, including personnel from DOC, Office of the Attorney General, media outlets, Lockett's attorneys, members of the Neiman family, the Noble County District Attorney and Sheriff's offices, the Perry Police Department and the Secretary of Safety and Security;
4. Governor Fallin and eight members of her staff;
5. Members of DOC's administrative staff including the Director, Associate Director, District Manager, current and former members of DOC's General Counsel staff;
6. OSP corrections officers involved in different aspects of the execution, including staff who interacted with Lockett several days leading up to the execution;
7. DOC medical and mental health staff members;
8. OCME staff involved in the examination and chain-of-custody of Lockett's body and evidence;

9. Employees of Ray Francisco's Embalming Service responsible for the transport of Lockett's body;
10. The pharmacist that filled the prescription of execution drugs.

III. FINDINGS

After reviewing and considering all interviews, documentation and evidence gathered during this investigation, this team has reached several conclusions regarding Lockett's execution. Some factors ultimately contributed to the issues that arose during the process, while others directly affected how those issues were handled by the personnel in the execution chamber. Each of this team's findings is listed below, along with a detailed timeline of events.

A. Timeline

The following is a timeline of events that occurred in regards to Lockett's execution. The approximate times associated with each event have been compiled utilizing witness accounts and documentation obtained during this investigation.

April 29, 2014

12:00-4:30 a.m. DOC personnel conducted a unit check and count in H-Unit every 30 minutes. At 12:30 a.m., personnel conducted a welfare check of Lockett and no problems were noted or discovered.

4:30-5:05 a.m. The Correctional Emergency Response Team (CERT) arrived at H-Unit and began preparations to remove Lockett from cell SW-3-JJ to escort him to IHCC for x-rays.

5:06 a.m. CERT arrived at cell SW-3-JJ and Lockett refused to comply with orders. He was covered by a blanket and moving, but would not uncover or approach the cell door to be restrained.

5:09-5:50 a.m. CERT exited the area of cell SW-3-JJ to prepare for cell entry and extraction. Blood was observed by DOC personnel inside cell SW-3-JJ. A use of force plan was established and approval was given by DOC administration to utilize a TASER.

5:30 a.m.	DOC personnel performed another check and Lockett failed to comply with the order to approach the cell door and uncover himself.
5:50 a.m.	CERT arrived at cell SW-3-JJ for extraction and determined Lockett had attempted to jam the door. The door was forced open, Lockett refused to comply with verbal commands and a TASER was deployed. CERT members observed self-inflicted lacerations on Lockett's arms.
5:53 a.m.	Lockett was secured by CERT, removed from the cell, placed on a gurney and transported to H-Unit medical. A razor blade from an issued, disposable shaving razor was located inside the cell and confiscated.
5:53-6:45 a.m.	Lockett was medically evaluated at H-Unit medical.
6:35 a.m.	Lockett was transported from H-Unit medical to IHCC. He was placed in IHCC holding cell S2 and remained in handcuffs and leg irons.
6:45 a.m.	DOC personnel entered cell S2 and medical staff evaluated Lockett's lacerations.
7:00-8:15 a.m.	DOC personnel entered cell S2 every 15 minutes to check Lockett.
8:15 a.m.	Lockett was removed from cell S2 and taken to the IHCC emergency room to be examined by DOC medical staff.
8:40 a.m.	Lockett was returned to cell S2.
8:50-9:35 a.m.	DOC personnel entered cell S2 every 10-15 minutes to check Lockett.
9:15 a.m.	Lockett refused visits from his attorneys.
9:42 a.m.	Lockett refused a food tray.
9:55 a.m.	DOC personnel entered cell S2 to check Lockett.
10:15-10:30 a.m.	DOC personnel entered cell S2 to check Lockett every 15 minutes.
10:25 a.m.	Lockett confirmed his refusal to visit with his attorneys.
10:45 a.m.	DOC personnel entered cell S2 to check Lockett and adjust restraints.
11:11 a.m.	Lockett refused a food tray.

11:20 a.m.	DOC personnel entered cell S2 to check Lockett and adjusted restraints.
11:35a.m.-3:55p.m.	DOC personnel entered cell S2 to check Lockett every 15-20 minutes.
3:35 p.m.	DOC personnel retrieved the execution drugs from refrigerated storage at OSP for transport to the execution chamber.
4:10 p.m.	DOC personnel entered cell S2 to adjust restraints, redress and prepare Lockett for transport from IHCC to H-Unit.
4:15 p.m.	DOC personnel placed the execution drugs in the executioners' room.
4:31 p.m.	The three executioners and paramedic entered the executioners' room and began preparation.
4:40 p.m.	Lockett was transported to H-Unit and placed into shower SW-4.
4:55-5:10 p.m.	Lockett visited with a DOC mental health staff member.
5:19 p.m.	The five strap-down team members and Warden Trammell entered the cell area to remove Lockett from shower SW-4.
5:21 p.m.	Lockett was removed from shower SW-4 and escorted to the execution chamber.
5:22 p.m.	Lockett was placed onto the execution table and strapped down.
5:26 p.m.	The strap-down team exited the execution chamber.
5:27-6:18 p.m.	The paramedic and physician attempted IV placement access in multiple locations and were unsuccessful. The physician believed he started an IV in Lockett's right groin area.
5:45-5:57 p.m.	Victim's witnesses, media personnel, and Lockett's attorneys were summoned to the viewing room and seated.
6:18 p.m.	The paramedic and physician determined the IV line was viable.
6:20 p.m.	The paramedic re-entered the executioners' room.
6:22 p.m.	DOC Director Robert Patton and selected officials were summoned and seated in the viewing room.

6:23 p.m. Director Patton received approval from the Governor's Office to proceed with the execution. He then approved Warden Trammell to proceed. The blinds between the viewing room and execution chamber were raised and Lockett was asked if he wished to make a statement. He refused and Warden Trammell announced that the execution was to begin.

The full dose of midazolam and an appropriate saline flush were administered. A DOC employee began to keep time on a stopwatch.

6:30 p.m. The signal was given that five minutes had elapsed and the physician determined Lockett was conscious. DOC personnel began to keep additional time on a stopwatch.

6:33 p.m. The signal was given that two minutes had elapsed and the physician determined Lockett was unconscious. Warden Trammel signaled for the execution to continue. The full dose of vecuronium bromide, an appropriate saline flush and a majority of the potassium chloride were administered.

6:33-6:42 p.m. Lockett began to move and make sounds on the execution table. It should be noted that the interview statements of the witnesses regarding Lockett's movements and sounds were inconsistent.

The physician inspected the IV insertion site and determined there was an issue, which was relayed to Warden Trammell.

6:42 p.m. At the direction of Warden Trammell, the blinds were lowered. The executioner stopped administering the potassium chloride.

6:42-7:06 p.m. It should be noted that the interview statements of the individuals in the execution chamber were inconsistent. However, it was determined the following events did occur inside the execution chamber during this time period.

- The paramedic re-entered the execution chamber to assist the physician.
- The physician attempted IV access into Lockett's left, femoral vein. However, no access was completed.

- When questioned by Warden Trammell, the physician initially believed that Lockett may not have received enough of the execution drugs to induce death. He also believed there were not enough execution drugs left to continue the execution.
- The physician and paramedic continued to monitor Lockett's heart rate utilizing an EKG machine. While attempting to gain the IV access, it was observed that Lockett's heart rate continued to decrease.
- The physician made the observation that the drugs appeared to be absorbing into Lockett's tissue.
- The physician and paramedic concluded that Lockett's heart rate had entered a state of bradycardia and eventually slowed to an observed six beats per minute.
- There were three different recollections of Lockett's movements during this period. Four reported that Lockett did not move, one reported he moved slightly and the last recalled a more aggressive movement.

The following events occurred outside the viewing room door in the H-Unit hallway.

- Director Patton, OAG representatives Tom Bates and John Hadden and Secretary Thompson removed themselves from the viewing room and discussed with the Governor's Office about how to proceed.

6:56 p.m.	Director Patton halted/stopped the execution, which was relayed to the execution chamber.
6:57-7:06 p.m.	Witnesses were escorted out of the viewing room.
7:06 p.m.	The physician pronounced Lockett deceased.
7:50 p.m.	After being unstrapped from the execution table, Lockett's body was removed from OSP and transferred to the Office of the Chief Medical Examiner transport.

B. Autopsy Results for Clayton D. Lockett

Based on the autopsy, Lockett's cause of death was listed as *Judicial Execution by Lethal Injection*. The manner of death was listed as *Judicially Ordered Execution*. SWIFS pathologists concluded that Lockett died as the result of judicial execution by lethal injection. Following is a summary of the findings made by SWIFS personnel during their examination of Lockett's body and additional information obtained by the investigation team from SWIFS or through the investigation:

1. Judicial execution with:
    a. Execution protocol medications used: midazolam, vecuronium and potassium chloride.
    b. History of difficulty finding intravenous access sites resulting in numerous attempts to start an IV.
    c. Attempts in both antecubital fossa, both inguinal regions, left subclavian region, right foot and right jugular region.
2. Superficial incised wounds of the upper extremities consistent with history of self-inflicted incised wounds with a safety razor.
3. Contusions and abrasions of extremities.
4. Cardiac hypertrophy (480 grams)
5. Mild coronary artery atherosclerosis.
6. Hydroxyzine detected.
    a. Lockett was prescribed hydroxyzine, but the prescription had ended March 3. There were emails from DOC personnel alleging Lockett had been hoarding medication. SWIFS personnel stated there were higher than therapeutic levels of hydroxyzine present in Lockett's system and hydroxyzine should not have interfered with the execution drugs administered. They also could not determine when or how much of the hydroxyzine was taken.
7. No evidence of dehydration.
8. No Taser marks on the body.
9. Toxicology indicated elevated concentrations of midazolam in the tissue near the insertion site in the right groin area, which is indicative of it not being administered into the vein as prescribed in execution protocols. The presence of midazolam in the psoas muscle indicates midazolam was distributed

throughout Lockett's body during the execution. According to SWIFS pathologists, the concentration of midazolam located in Lockett's blood was greater than the therapeutic level necessary to render an average person unconscious.

10. Vecuronium bromide was found in the femoral blood sample taken from Lockett's body. The presence of vecuronium bromide in the psoas muscle indicates vecuronium bromide was distributed throughout Lockett's body during the execution.
11. Potassium was found in the femoral blood sample taken from Lockett's body.

C. DOC Execution Protocols

Regarding whether DOC correctly followed their current execution protocols, it was determined there were minor deviations from specific requirements outlined in the protocol in effect on April 29. Despite those deviations, it was determined the protocol was substantially and correctly complied with throughout the entire process. None of the identified deviations contributed to the complications encountered during this execution.

D. IV Insertion, Viability and Administration of Execution Drugs

The physician and paramedic made several attempts to start a viable IV access point. They both believed the IV access was the major issue with this execution. This investigation concluded the viability of the IV access point was the single greatest factor that contributed to the difficulty in administering the execution drugs.

While exploring this issue, several DOC personnel made statements referencing Lockett purposefully dehydrating himself. Lockett made statements to the paramedic that he had been dehydrating himself for three days. However, SWIFS pathologists found no indication that Lockett was dehydrated at the time of his execution. SWIFS also concluded Lockett's blood loss from the self-inflicted wounds to his arms should not have caused issues with the IV access.

Interviews and documentation indicated several vein checks had been performed by DOC medical personnel leading up to and on the day of the execution. Each check indicated that Lockett's veins were "good". At least three interviews of DOC medical personnel indicated they viewed Lockett's veins on the morning of the execution. Their observations concluded his veins were "good" and acceptable for IV access.

The IV insertion process was started by an emergency medical technician licensed as a paramedic. The paramedic had been licensed in emergency medical services for more than 40 years and as a paramedic for over 20 years. This person had also instructed at the intermediate level. The licenses possessed at the time of the execution were valid until 2015 and were from the Oklahoma State Department of Health and the National Registry of Emergency Medical Technicians. The paramedic provided the prison a copy of the above licenses in January or February 2014. The paramedic estimated he/she had been involved in every lethal injection execution in Oklahoma, except for two. His/her specific assignments were to start an IV, ensure a proper infusion of saline, attach a cardiac monitor to Lockett and during the execution, make sure the executioners did their part of the procedure aseptically, at the correct time and the correct speed.

The IV access was completed by a physician licensed as a medical doctor. The physician graduated medical school over 15 years ago, currently worked in emergency medicine and was certified in family medicine. His license expires July 1 of each year and was current at the time of the execution. He had not provided a current copy of his license to DOC prior to April 29, but days later was called and asked for a copy. This was his second execution with the first being four to five years earlier. The physician understood his duties were to assess Lockett to determine if he was unconscious and ultimately to pronounce his death. He was contacted two days prior to the execution date and asked to fill in for another physician that had a scheduling conflict.

Before Lockett was moved into the chamber, the paramedic prepared the IV lines and available execution tools. He/she also verified the drugs were properly labeled and were for Lockett. After Lockett was brought to the chamber and secured to the execution table, the paramedic began to assess his veins. The paramedic first attempted access in the left arm and found a vein with an 18-gauge needle/catheter and observed flashback, a condition sought during IV placement. The paramedic did not have adhesive tape on

his/her person to secure the catheter. Before the tape was retrieved, the vein became unviable. The paramedic then attempted two additional IV insertions into the left arm using the same type needles/catheters, but never observed flashback.

After these attempts, the physician became involved and attempted IV access into Lockett's left, external jugular vein utilizing a 1¼ inch, 14-gauge needle/catheter. During his interview, the physician stated he penetrated this vein and obtained flashback. Seconds later, it became unviable and he was unable to continue with that vein. As the physician was attempting this access, the paramedic was attempting IV access into Lockett's right arm. After three attempts, the paramedic was unable to start a viable IV access point in this arm.

Next, the physician attempted to locate the subclavian vein on Lockett's left side utilizing a central venous catheritization kit. During the attempt, the physician observed a very small amount of flashback, but he was unable to repeat it. The physician believed the needle was penetrating through the vein. He noted during his interview he did not have access to an ultrasound machine, which is a commonly used tool to locate and penetrate veins.

As the physician attempted subclavian access, the paramedic attempted IV access in two separate locations on Lockett's right foot with 20 gauge needles/catheters. The paramedic said the veins rolled and disappeared during those attempts. The paramedic believed the needle penetrated the veins, but flashback was never observed. The paramedic did not attempt access into any other veins because the physician made the decision to attempt access into a femoral vein.

The physician requested a longer needle/catheter for the femoral access. The paramedic attempted to locate a 2 or 2½-inch, 14-gauge needle/catheter, but none were readily available. The physician also asked for an intraosseous infusion needle, but was told the prison did not have those either. Both agreed their preferred needle/catheter length would have been 1¾ to 2½ inches. The physician had never attempted femoral vein access with a 1¼ inch needle/catheter; however, it was the longest DOC had readily available. An additional central venous catheterization kit was available, but the physician did not think about utilizing one for femoral access.

Lockett's scrub pants and underwear were cut in order to expose the femoral area. The physician located the femoral vein and believed the vein was penetrated because he observed good flashback. The paramedic taped the catheter to Lockett's body, and stated during his/her interview it became positional. The physician believed it was bending because of its length. He and the paramedic positioned the catheter where they were able to observe slow infusion of saline and secured it with adhesive tape. The autopsy did not conclude the femoral vein was punctured. However, SWIFS personnel indicated they only examined the portion of the femoral vein that had been dissected by OCME and not the entire vein.

The physician was asked about starting a second IV line. He stated he was not going to make another attempt. The physician and paramedic were comfortable with the IV placement and the infusion of saline through the line. This was not the first execution in Oklahoma where only one IV access point had been obtained and protocol allowed for only one access point.

Warden Trammell decided to cover Lockett's body with a sheet, including the IV insertion area, which, according to her, was normal in all executions. Another reason for her decision was to maintain Lockett's dignity and keep his genital area covered. From that time, no one had visual observation of the IV insertion point until it was determined there was an issue and the physician raised the sheet. Warden Trammell acknowledged it would be her normal duty to observe an IV insertion point for problems. She believed if the IV insertion point had been viewed, the issue would have been detected earlier. The physician added that an IV would normally be monitored by watching the flow of the IV line and the area around the insertion point for any signs of infiltration. This investigation found that neither of these observations occurred, which led to the issue being discovered several minutes after the execution began.

After the IV insertion was complete, the paramedic went into the executioners' room and the physician remained in the execution chamber. Once Warden Trammell announced it was time to begin the execution, the paramedic began the procedure to administer the drugs. The paramedic first used a hemostat to clamp the IV line above the access port, to stop the flow of execution drugs from going up the line. The IV drip was never reestablished after that point. The midazolam and the appropriate flushes were

administered into the single access port by the executioners in the order they were presented by the paramedic. The paramedic and executioners were certain the drugs were pushed steady and in the proper manner because of their past experiences in performing the same roles. The DOC employee in the executioners' room then began to keep time using a stopwatch.

According to execution protocol, the vecuronium bromide shall not be administered until at least five minutes after the administration of midazolam. Prior to the execution, DOC administration determined if Lockett was not unconscious after five minutes, he would be checked every two minutes, until he was declared unconscious. Five minutes after the administration of midazolam, the physician determined Lockett was conscious. After an additional two minutes, the physician determined that Lockett was unconscious.

Warden Trammell signaled for the execution process to continue. The executioners, with assistance from the paramedic, began administering the vecuronium bromide, the potassium chloride and the appropriate saline flushes. Both syringes of the vecuronium bromide, appropriate saline flushes, the first full syringe of potassium chloride and a portion of the second syringe of potassium chloride were administered. At some point during the administration of these two drugs, Lockett began to move and the physician recognized there was a problem.

The physician approached Lockett and indicated to Warden Trammell that something was wrong. He looked under the sheet and recognized the IV had infiltrated. At this same time, Warden Trammell viewed what appeared to be a clear liquid and blood on Lockett's skin in the groin area. The physician observed an area of swelling underneath the skin and described it as smaller than a tennis ball, but larger than a golf ball. The physician believed the swelling would have been noticeable if the access point had been viewed during the process.

The execution process was stopped as one of the executioners was administering the second syringe of potassium chloride. The executioner immediately stopped pushing the syringe with approximately 10 milliliters of potassium chloride remaining. The remainder of the drug was later wasted into a bio-hazard bin by the paramedic.

The blinds to the execution chamber were lowered and the paramedic exited the executioners' room to assist the physician. The physician told the paramedic the catheter dislodged. The paramedic observed the catheter was tilted to one side and believed it was no longer penetrating the vein. The physician decided to attempt IV insertion into the left-side femoral vein. The physician first penetrated Lockett's femoral artery and another access point into the vein was never completed because the physician believed the drugs were being absorbed into his tissue.

The physician and paramedic were unsure when the catheter became dislodged and how much of each drug had made it into Lockett's vein. The autopsy indicated elevated concentrations of midazolam in the tissue near the insertion site in the right groin area, which was indicative of the drugs not being administered into the vein as intended. Thus, the IV access was not viable as early as the administration of the midazolam.

E. Toxicology Results of Femoral Blood Sample: Clayton D. Lockett

On May 14 and May 19, OCME documented the toxicology results they received from NMS Labs on an aliquot of the femoral blood sample they obtained from Lockett's body on April 30. The results indicated a midazolam concentration of 0.57 mcg/mL and a vecuronium concentration of 320 ng/mL. On June 26, ExperTox completed toxicology testing of an aliquot of the same femoral blood sample. The results of this test indicated a potassium concentration of 0.74 mole/L. It should be noted that testing for the concentration of potassium after death can be problematic due to the body's natural processes, which cause an increase in the concentrations of potassium in the blood over time.

F. Toxicology Results of Execution Supplies: Clayton D. Lockett

On May 5, ExperTox completed testing of the execution supplies utilized during Lockett's execution. They analyzed the contents by liquid chromatography/triple quad mass spectrometry (LC/MSMS) and inductively coupled argon plasma-mass spectrometry (ICP-MS) for the detection and quantitation of midazolam, vecuronium bromide and potassium chloride. ExperTox reported the following:

1. The two syringes labeled midazolam contained residues consistent with the listed label content of 5 mg/mL.
2. The two syringes labeled vecuronium bromide contained residues consistent with the listed label content of 1 mg/mL.
3. The two syringes labeled potassium chloride contained residues consistent with the listed label content of 2 meq/mL.
4. The IV Tubing connected to two 0.9% NaCl one liter IV bags contained sodium chloride, blood, residues of vecuronium bromide at the final concentration of 0.013 g/mL and residues of potassium chloride at the final concentration of 1.3 meq/mL.

G. Toxicology Results of Execution Drugs: Charles Warner

On May 5, ExperTox completed testing of the drugs intended for use during the execution of Charles Warner. They analyzed the contents by LC/MSMS and ICP-MS for the detection and quantitation of midazolam, vecuronium bromide and potassium chloride. These tests were also utilized to determine drug agent potency. ExperTox reported the following:

1. The two 0.9% NaCl injection USP 1 liter IV bags tested consistent with the listed contents.
2. The seven 0.9% NaCl 50 mL bags tested consistent with the listed contents.
3. The two syringes labeled midazolam tested consistent with the listed label content of 5 mg/mL.
4. The two syringes labeled vecuronium bromide tested consistent with the listed label content of 1 mg/mL.
5. The two syringes labeled potassium chloride tested consistent with the listed label content of 2 meq/mL.

H. Execution Protocol Training of Execution Team

This investigation determined that DOC personnel did conduct training sessions as required by the protocol in effect on April 29. The sessions were conducted during the weeks and days leading up to the execution and consisted of planning meetings, on-the-job training for each of the respective positions in the execution chamber and

executioners' room and walk-through training sessions for all involved staff members. The paramedic, physician and the three executioners were not included in this training prior to the day of the execution. The final training session included DOC administrative staff reviewing the sequence of events with all parties in the execution chamber just prior to the execution.

Field Memorandum OSP-040301-01, *Procedure for the Execution of Offenders Sentenced to Death*, outlines the training requirements that should occur prior to an execution. The following is a summary of the training procedures that were conducted prior to Lockett's execution.

1. A deputy warden or designee was required to review the sequence of events inside the executioners' room with the executioners and paramedic prior to each execution. Documentation and interviews substantiated this requirement was completed on April 29 at 5:06 p.m.
2. The paramedic was required to give the following instructions to the executioners, "Administer the drugs at a steady flow without pulling back on the plunger of the syringe." The paramedic did not give this statement prior to this execution. However, the three involved executioners had been involved in multiple executions prior to Lockett's and each acknowledged their roles and duties. The paramedic also acknowledged his/her role to ensure the executioners did their job aseptically, at the correct time, speed and dosage.
3. The warden was required to review the sequence of events with the physician and other DOC personnel in the execution chamber prior to beginning the execution. Interviews and documentation indicated this occurred on April 29 at 5:15 p.m.
4. DOC protocol required the strap-down team to conduct a walk-through of the strap-down procedures no later than two weeks prior to the execution. There were multiple walk-through training sessions conducted prior to Lockett's execution. The last session was conducted within two weeks of Lockett's execution, as required by protocol.

This investigation revealed areas of training that need to be addressed. It was noted there was no formal training process involving the paramedic, the physician or the executioners and their specific roles. They were not involved in any pre-execution training or exercises to ensure they understood the overall process. For those individuals, the current protocol had very minimal training requirements. The executioners only receive formal training from the paramedic on the day of the execution and informal training from previous executioners during actual executions.

Warden Trammell and Director Patton both acknowledged the training DOC personnel received prior to the execution was inadequate. Warden Trammell stated the only training she received was on-the-job training and that DOC had no formalized training procedures or processes concerning the duties of each specific position's responsibility. The warden and director both indicated DOC had no training protocols or contingency plans on how to proceed with an execution if complications occur during the process.

I. Contingency Planning for Executions

The DOC execution protocol in effect on April 29 had limited provisions for contingencies once the execution process began. One contingency allowed the physician to assist with initial IV access and the other concerned life-saving measures if a stay was granted. After it was determined that problems were present during Lockett's execution, personnel involved with the execution were unaware of how to proceed due to the lack of policies and/or protocols in place at that time. It was determined that no contingency actions were taken inside the chamber other than the physician attempting to locate the femoral vein on Lockett's left side, which was never completed prior to his death.

J. Cessation of Execution Protocols

When an issue with the administration of execution drugs was discovered, the blinds between the chamber and viewing room were lowered. Several conversations took place inside and outside the chamber regarding how to proceed. The conversation outside the chamber included whether to continue or how to stop the execution. The conversations inside the chamber included whether to provide life-saving measures.

Outside the execution chamber, there were several conversations between Director Patton, Secretary Thompson, OAG representatives at the execution and General Counsel Steve Mullins with the Governor's Office. It was determined between Director Patton and General Counsel Mullins, who had conversed with the Governor, that the execution would be stopped. Director Patton then relayed to the witnesses and the personnel in the chamber that the execution was being stopped. In an additional conversation, General Counsel Mullins further told Director Patton that they would begin preparing a stay at the direction of the Governor. Lockett died prior to the order for a stay being relayed to the personnel inside the execution chamber. There was conversation inside the chamber about administering life-saving measures to Lockett, including transporting him to the emergency room, but no order was given.

K. Two Executions Scheduled on the Same Day

It was apparent the stress level at OSP was raised because two executions had been scheduled on the same day. This was the first time since 2000 two offenders were scheduled to be executed the same day. Four days prior to the execution, the protocol was revised to accommodate the logistics for two offenders.

Several comments were made about the feeling of extra stress. Warden Trammell believed this caused extra stress for all staff. The paramedic stated he/she felt stress and a sense of urgency in the air. This was based on him/her having been involved in numerous executions.

L. Maintenance of Daily Logs

In accordance with protocol, OSP staff maintained a daily log of events and occurrences related to Lockett. Protocol stated, "Seven days prior to the execution of an offender sentenced to death, a daily log will be kept regarding every aspect of the proceedings except names." This investigation determined the information recorded on the logs was incomplete.

M. Use of Midazolam, Vecuronium Bromide and Potassium Chloride

The new three drug protocol utilized in this execution included the administration of midazolam, vecuronium bromide and potassium chloride. It was determined vecuronium bromide and potassium chloride had both been used in previous executions as the second and third drugs to be administered. This was the first Oklahoma execution where midazolam was used.

On April 14, midazolam was the newest drug added to the protocol after it was determined pentobarbital was not available. Pursuant to the death warrant, a dosage of 100 mg was ordered and administered to Lockett. According to protocol, vecuronium bromide was to be administered at a total quantity of 40 mg and the potassium chloride at a total quantity of 200 meq. These dosages were equivalent to the quantities used in other Oklahoma three-drug methods dating back to at least 2011.

This investigation could not make a determination as to the effectiveness of the drugs at the specified concentration and volume. They were independently tested and found to be the appropriate potency as prescribed. The IV failure complicated the ability to determine the effectiveness of the drugs.

On the day of the execution, OAG representatives presented an affidavit to Warden Trammell related to the execution drugs. The warden signed the affidavit and attested that the drugs had been obtained legally from a licensed pharmacy and had been handled appropriately since their acquisition. Interviews of DOC and OAG staff revealed this type of affidavit had been signed in the past, but never on the day of an execution. According to OAG representatives, the affidavit was executed on the day of the execution, due to ongoing litigation concerns regarding the drugs.

N. Historical Incident Reports and Medical Records

The investigation team obtained historical incident reports, emails and medical records from OSP regarding Lockett. The incident reports included approximately 42 instances where Lockett was disciplined for behavioral issues and for contraband located or suspected by DOC personnel. Examples include:

1. A cellular telephone was discovered in Lockett's cell several months prior to the execution;

2. DOC personnel suspected Lockett had been hoarding Vistaril (hydroxyzine) from a prescription that ended March 3;
3. A homemade rope was discovered on the floor of Lockett's cell during his extraction on the day of the execution;
4. A razor blade from an issued, disposable shaving razor was discovered in Lockett's cell on the day of the execution.

The review of Lockett's medical records by a medical professional indicated that he had no past medical conditions or factors that would be considered problematic for IV insertion or drug administration.

O. Lockett's Movements and Sounds after Drug Administration

The description of Lockett's movements and sounds varied among the witnesses. The movement descriptions ranged from quivering to thrashing, but most agreed Lockett's head did rise off the table. There were differing recollections regarding whether Lockett's eyes opened after he was deemed unconscious. The sound descriptions varied from mumbling to Lockett making statements. The recollections varied greatly; therefore it was difficult to determine what was said, if anything.

Several conclusions were made pursuant to the execution table assessment. While strapped to the table, the team member made attempts to move all parts of his body. He was able to rotate his feet inward and outward, move his shoulders slightly and his head had a full range of motion. He was not able to bend or move his knees and had minimal movement in his hips as he attempted to move from side to side. He could not move his hips up and down. The hands had no movement and the arms had minimal movement due to the elbow having limited motion. Based on what was observed, witnesses would have a different perspective of the amount of movement depending on where they were seated. Due to the restrictiveness of the straps, the movements were minimal to non-existent with the exception of the head and feet.

IV. RECOMMENDATIONS

Based on the findings, the following recommendations are made for future lethal injection executions in Oklahoma. DOC, the Office of the Attorney General and any other entity or individual responsible for execution protocols in this state are urged to thoroughly research, review and deliberate these recommendations prior to their implementation. Further, DOC should review and consider policies and protocols from other states responsible for executions. Any changes to the current policies and protocols should comply with Oklahoma and federal law.

A. Observation of IV Insertion Point(s) and Infusion

1. The IV catheter insertion point(s) should remain visible during all phases of the execution and continuously observed by a person with proper medical training in assessing the ongoing viability of an IV. This person should remain inside the execution chamber during the entire process.
2. Once the appropriate saline infusion has started, it should not be stopped, except for the times that execution drugs are being administered. It should be continuously monitored to assist in ensuring IV viability in accordance with current medical practices and standards;
3. After one hour of unsuccessful IV attempts, DOC should contact the Governor to advise the status and potentially request a postponement of the execution.

B. Training and Maintenance of Execution Log for Condemned Offenders

1. Conduct formal, specific training related to information documented on all execution logs.
2. The information to be recorded on execution logs should include, but not be limited to:
    a. all statements or behaviors that could be detrimental to completing an execution;
    b. all meals provided to an offender and what portions of the meals the offender consumed or refused;

c. all medication provided to an offender and the observations made by personnel as to whether the offender ingested the medication as prescribed;
d. all liquids consumed by the offender.

C. Additional Execution Supplies

DOC should maintain and provide their own equipment and supplies ensuring their operability prior to each execution.

1. DOC should obtain from the selected pharmacist, one complete, additional set of each execution drug being utilized for an execution to be used in the event an issue arises with the primary set.
2. DOC should consult with appropriate medical personnel to determine any and all supplies or equipment necessary including, but not limited to the following:
   a. Heart monitoring equipment;
   b. Venous ultrasound equipment;
   c. Appropriate needle/catheters to coincide with the IV access options listed in protocol.

D. Contingency Plans in Protocols/Policy

DOC should evaluate and establish protocols and training for possible contingencies if an issue arises during the execution procedure. DOC should consider planning for contingencies including, but not limited to:

1. Issues with execution equipment or supplies;
2. Issues with offender IV access, including obtaining alternate IV access site(s);
3. The offender is not rendered unconscious after execution drug administration;
4. A combative offender;
5. Unanticipated medical or other issues concerning the offender or an execution team member;
6. Issues regarding order, security or facilities at OSP.

E. Formal and Continuing Training Program for Execution Personnel

DOC should establish formal and continual training programs for all personnel involved in the execution process. They should explore successful training procedures used by other correctional institutions and implement accordingly.

F. Formal After-Action Review of the Execution Processes

At the conclusion of each execution, all personnel with assigned execution duties should attend an after-action review. The review should be completed within five business days and conducted by the director or his designee. The events that occurred during the execution should be discussed in detail and each involved person should discuss their responsibilities and observations. The review should serve as an opportunity for all involved personnel to voice their opinions, concerns and/or recommendations in order for continuous improvement to the process. The review should be formally documented and retained for future reference.

G. Defined Execution Terminology

It was apparent during this investigation that specific terminology should be clearly defined so they are understood by all personnel involved in the execution process. This will allow DOC, OAG and Governor's Office personnel to have a common understanding of how each term affects the execution process and the actions that should take place, if such terms are used. Defined terms should include, but are not limited to "stop," "stay," and "halt".

H. Completion of One Execution per Seven Calendar Days

Due to manpower and facility concerns, executions should not be scheduled within seven calendar days of each other.

I. Updated Methods of Communication

The current communication methods used during the execution process are antiquated and require unnecessary multi-tasking from key personnel in the execution chamber. DOC should explore options on how to update the following:

1. Communication between the execution chamber and executioners' room.
    a. DOC should research and implement modern methods that allow personnel in these two areas to communicate clearly.
    b. The current processes, including the use of color pencils and hand signals, could be used as a contingency if other modern methods fail.
2. Communication between DOC and the Governor's Office.
    a. DOC should research and implement methods to modernize the communication link that would allow direct, constant contact between the personnel in the execution chamber and the Governor's Office.

J. Disposition of Executed Offender's Property

DOC should explore maintaining an executed offender's personal property and any items removed from his/her cell until the autopsy report is completed. This would allow DOC administrative personnel time to determine if such property should be maintained for an additional period of time, if appropriate circumstances exist. In any event, no property should be released until it has been properly searched and inventoried.

K. Execution Witness Briefing

As a result of the changing execution protocols and procedures, DOC should conduct a prepared pre-execution briefing with all attending witnesses. This briefing should include, but not be limited to the following:

1. An overview of the events the witnesses will view during the execution process, including an explanation that witnesses will not be allowed to view all aspects of the execution;
2. Requirements regarding the conduct of witnesses throughout the process.

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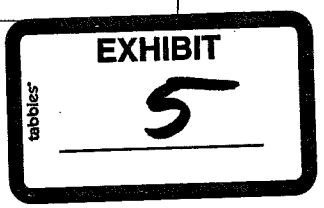
Execution Procedures	**ACA Standards: 2-CO-1A-27-1**		

Robert Patton, Director **Signature on File**
Oklahoma Department of Corrections

Execution of Offenders Sentenced to Death



The Oklahoma Department of Corrections (ODOC) establishes procedures for planning and carrying out the execution of a person convicted of a capital offense and sentenced to death. These procedures shall be followed as written unless deviation or adjustment is required, as determined by the director of Corrections or their designee (in the event of an absence). This procedure outlines the internal procedures and does not create any legally enforceable rights or obligations.

I. Definitions

A. Stay or Stop An Execution

1. Stay

An order by the governor or court of competent jurisdiction to reprieve or suspend the execution of the judgment of death.

2. Stop

Upon order by the director, all acts congruent to an execution shall immediately cease until the director orders the execution to continue or a stay is ordered by the governor or court of competent jurisdiction.

II. Responsibility

The ODOC ensures the execution of a person sentenced to death under state law by a court of competent authority and jurisdiction is carried out in keeping with statute, case law and professional practices.

A. The ODOC shall make every effort in the planning and preparation of an execution to ensure the execution process:

1. Faithfully adheres to constitutional mandates against cruel and unusual punishment, in accordance with Article II, Section 9 of the Oklahoma Constitution and the Eighth Amendment to the United States Constitution;

2. Is handled in a manner that minimizes its impact on the safety, security and operational integrity of the facility and the community in which it occurs;

3. Accommodates the public's right to obtain certain information concerning the execution;

4. Reasonably addresses the privacy interests as provided by law;

5. Provides contingency planning to identify and address unforeseen problems;

6. Allows for stays of execution, commutations and other exigencies;

7. Provides opportunity for citizens to exercise their First Amendment Rights to demonstrate for or against capital punishment in a lawful manner; and

8. Ensures there is an appropriate response to unlawful civil disobedience, trespass and other violations of the law by any person attempting to impact the execution or the operation of the facility.

B. The ODOC shall detain, seek the arrest and encourage prosecution of persons who:

1. Violate prohibitions against filming, taping, broadcasting or otherwise electronically documenting the execution of the offender;

2. Trespass and otherwise enter upon ODOC property without authorization;

3. Participate in unlawful demonstrations or unlawfully attempt to disrupt, prevent and otherwise interfere with the execution; and

4. Unlawfully threaten, intimidate and otherwise attempt to influence authorized persons involved in the execution process.

These prohibitions apply to the offender population, ODOC personnel and members of the general public engaging or attempting to engage in disruptive and other prohibited behaviors.

III. Conduct and Selection of Staff for Execution Teams

A. Conduct of Staff

1. Participating staff shall adhere to OP-110215 entitled "Rules Concerning the Individual Conduct of Employees" and guided principles evidenced by:

a. Appropriate levels of professionalism, restraint and courtesy when interacting with witnesses, demonstrators, attorneys, news media, state and local law enforcement and any other member of the public directly or indirectly involved with the imposition of the sentence of death;

b. All assigned duties are performed proficiently and professionally;

c. Their ability to exercise the option to withdraw from the process by the prescribed means at any time;

d. Conduct that appropriately reflects the solemnity of the activities in which they elect to engage and the duties they choose to perform;

e. Reserving public comment on any and all facets of the execution; and

f. Maintaining confidentiality of identifying information regarding any person who participates in or performs any function of an execution. As defined in Oklahoma State Statute Title 22, Section 1015, "The identity of all persons who participate in or administer the execution process and persons who supply the drugs, medical supplies or medical equipment for the execution shall be confidential and shall not be subject to discovery in any civil or criminal proceedings. The purchase of drugs, medical supplies or medical equipment necessary to carry out the execution shall not be subject to the provision of the Oklahoma Central Purchasing Act."

2. All team members serve on a strictly voluntary basis. At any point before, during, or after an execution any team member may decline to participate or participate further without additional notice and explanation or repercussion.

3. The associate director of Field Operations shall ensure all team members understand and comply with the provisions contained herein.

B. Selection of Staff for Execution Teams

1. The associate director of Field Operations coordinates the activities of the division managers of East and West Institutions and the wardens of Oklahoma State Penitentiary (OSP) and Mabel Bassett Correctional Center (MBCC) in activating the Execution Teams.

2. The OSP and MBCC wardens shall review the current teams' rosters and recommend retention and replacement of staff and alternates to the division manager of West Institutions.

3. The division manager of West Institutions shall evaluate the teams' composition and the wardens' recommendations to the director.

4. In the selection and retention of any staff for the teams, the division manager for West Institutions shall consider:

   a. Employees suspended or demoted in the past 12 months or currently under investigation shall not be selected;

   b. Special consideration may be given to staff with pertinent specialized training and qualifications;

   c. Staff shall only be assigned to one team in the overall execution process;

   d. Staff serving on any team shall not be related to the offender by blood or marriage or have any other legal relationship with the offender, the offender's family or the crime victims(s); and

   e. Staff participation in the execution process is strictly voluntary. ODOC staff is not required to attend or participate in an execution.

5. Any staff volunteers may withdraw from performing their assigned duties specific to the execution at any time by advising their team leader, advising a team member or advising their immediate chain of command.

IV. Execution Teams

A. Command Team

1. Provides overall coordination of execution procedures.

2. Consists of a minimum of three team members:

   a. Commander (division manager of East Institutions);

   b. Recorder;

   c. Telephone operator; and

d. Others as necessary.

3. The commander is selected by the director.

4. All other team members are selected by the division manager of East Institutions with the documented approval of the director.

B. H Unit Section Teams

1. The H Unit Section chief shall coordinate the activities of the H Unit Section Teams to ensure compliance with conditions of confinement and application of approved procedures.

2. The director shall select the H Unit Section chief.

3. The H Unit Section Teams shall be comprised of the Restraint Team and the Special Operations Team.

a. Restraint Team

(1) Provides continuous observation of the offender on the day of the execution and applies appropriate restraint procedures and offender management prior to, during, and after the execution.

(2) Consists of one team leader and six team members divided into two teams.

(3) The division manager of West Institutions shall select the team leader with the documented approval of the director.

(4) Team members are selected by the warden of OSP with the documented approval of the director.

b. Special Operations Team

(1) Implements the protocols associated with the administration of the chemicals for the execution (Attachment D, attached).

(2) Consists of a minimum of five team members:

(a) Team leader;

(b) Recorder; and

(c) Three additional team members.

(3) The team members and team leader are selected by the division manager of West Institutions with the documented approval of the director.

(4) The team leader shall designate functions of the team members.

C. Intravenous (IV) Team

1. The IV Team shall consist of a team leader and member(s) of any one or more of the following:

a. Physician(s).

b. Physician assistant(s).

c. Nurse(s).

d. Emergency medical technician(s) (EMT).

e. Paramedic(s).

f. Military corpsman or other certified or licensed personnel including those trained in the United States military.

2. The team leader and member(s) shall be currently certified or licensed within the United States.

3. The team leader and member(s) shall be selected by the director.

a. Selection of any team member shall include a review of the proposed team member's qualifications, training, experience, and/or any professional license(s) and certification(s) they may hold.

b. Licensing and criminal history reviews shall be conducted by the inspector general's office prior to assigning or retaining any team member and upon the issuance of an Order Setting Execution Date.

4. The division manager of West Institutions shall ensure the team leader and member(s) thoroughly understand all provisions contained herein as written and by practice.

5. Team members shall be required to participate in the training sessions scheduled 24 hours prior to the actual execution.

6. Documentation of team members' qualifications, including training of the team members, shall be maintained by the director or his designee.

7. All information pertaining to the selection and review of the IV Team members shall remain confidential in accordance with O.S. 22 Section 1015 of Oklahoma State Statute.

D. Maintenance Response Team

1. Tests all H Unit equipment utilized to impose the sentence of death and ensures electrical, plumbing, heating and air conditioning units are in working order.

2. Consists of one team leader and three team members.

3. The team leader and members are selected by the warden of OSP.

4. Reports to the Command Team.

E. Critical Incident Management Team (CIMT)

1. Educates affected staff at all levels in the ODOC prior to, during, and after the execution regarding possible psychological responses and effective coping mechanisms as well as provides ongoing follow-up contact to staff.

2. Consists of one team leader and three team members.

   a. The team leader is the Employee Assistance Program coordinator or designee.

   b. Team members are CIMT responders and are selected by the Employee Assistance Program coordinator.

3. Reports to the Command Team.

F. Traffic Control Team

1. Supervises the movement of people and vehicles into and out of the facility before, during, and after the execution.

2. Consists of one team leader and eight team members.

3. Team members and the team leader are selected by the warden of OSP.

4. Reports to the Command Team.

G. Witness Escort Teams

1. Coordinates the movement of all pre-approved witnesses on and off facility grounds and within its perimeter.

   a. One (1) Witness Escort Team is assigned to escort and assist each group of pre-approved officials, victims, news media and offender family witnesses.

   b. Witness Escort Team members shall always remain with witnesses within established areas.

2. Consists of one team leader and eight team members divided into four teams.

3. Team members and the team leader are selected by the warden of OSP.

4. Reports to the Command Team.

H. Victim Services Team

1. Ensures victims of the crime that resulted in the imposition of death are informed of the execution date and their opportunity to witness the execution.

   a. The team explains the execution process.

   b. If the victim is interested in attending, the team submits the victim's name(s) for consideration to the director.

2. Consists of one team leader and one team member.

3. The team leader is the victim services coordinator.

4. The team member is selected by the victim services coordinator.

5. Reports to the Witness Escort Team leader.

V. Training

The agency will establish protocols and training to enable staff to function in a safe, effective and professional manner before, during and after an execution.

A. The division manager of West Institutions shall establish a training schedule and identify dates for periodic on-site practice by the H Unit

Section Teams, to include ten training scenarios within the 12 months preceding the scheduled execution. Multiple training scenarios can be accomplished on the same date, including but not limited to contingency plans for:

1. Issues with execution equipment or supplies;
2. Issues with offender IV access, including obtaining alternate IV access site(s);
3. Issues if offender is not rendered unconscious after administration of execution chemicals;
4. Unanticipated medical or other issues concerning the offender or an execution team member; and
5. Issues regarding order, security or facilities at OSP.

B. The H Unit Section Team shall initiate training sessions no less than once per week until the scheduled date of execution beginning 35 days prior to the execution date.

C. The H Unit Section Team shall conduct a minimum of two training sessions with multiple scenarios within two days prior to the scheduled execution.

D. The IV Team members shall participate in at least one training session with multiple scenarios, within one day prior to the scheduled execution.

E. The Command Team leader shall conduct training of the following team members seven days prior to the execution date.

1. Witness Escort Team
2. Maintenance Response Team
3. Critical Incident Management Team
4. Traffic Control Team
5. Victim Services Team

VI. Selection of Execution Witnesses

A. ODOC Staff Witnesses

The following staff shall be present at the execution:

1. Director or designee.
2. H Unit Section chief.
3. Other necessary correctional officials.

B. Law Enforcement Witnesses

The following persons may be present at the execution:

1. State Attorney General or designee.
2. Cabinet Secretary of Public Safety or designee.
3. Judge who presided during the trial.
4. Chief of police of the municipality in which the crime occurred.
5. District attorney or designee of the county of conviction.
6. Sheriff of the county of conviction.
7. Lead law enforcement officials from agencies that investigated the crime or testified in court or clemency proceedings related to the crime.
8. In the event the defendant has been sentenced to death in one or more criminal proceedings in this state, or has been sentenced to death in this state and by one or more courts of competent jurisdiction in another state (or pursuant to federal authority), or any combination thereof, and this state has priority to execute the defendant, the general counsel must invite the district attorney, the judge and the chief law enforcement official from each jurisdiction where any death sentence has been issued. The above mentioned officials shall be allowed to witness the execution or view the execution by closed circuit television as determined by the director.
9. The law enforcement witnesses authorized to be present at the execution shall receive a two-week prior written notice of the scheduled execution per Attachment A entitled "Notification Letter to Dignitaries/Law Enforcement (sample)" (attached).

C. Victim and Offender Witnesses

1. Victim and Offender witnesses may be subject to a criminal records check which will be conducted using the "Oklahoma Department of Corrections Request for Record" (DOC 090211B).

2. The division manager of West Institutions shall prioritize persons to view the execution, including: surviving victims; offender's immediate family members; individuals who served a close supporting role or professional role to the offender including, but not limited to, a minister or licensed counselor. The warden of OSP may set a limit on the number of viewers within occupancy limits.

3. The victim and offender witnesses authorized to be present at the execution shall receive a two-week prior written notice of the scheduled execution per Attachment B entitled "Notification Letter to Offender Witnesses (sample)" (attached).

   a. Victim Witnesses

      (1) Any surviving victim of the offender who is 18 years of age or older may view the execution if approved by the general counsel and the warden of OSP.

      (2) As used in this section, 'surviving victim' means any immediate family member of the deceased victim who, as a direct result of the crime, suffered serious harm or injury due to the criminal acts of the offender of which the offender has been convicted in a court of competent jurisdiction.

      (3) Immediate family is defined as the spouse, child by birth or adoption, stepchild, parent by birth or adoption, stepparent, grandparent, grandchild, sibling or stepsibling of each deceased victim or the spouse of any immediate family member specified in this section.

      (4) Any surviving victim approved to view the execution of the offender may request to have an accompanying support person who serves a close supporting role or professional role to the deceased victim or an immediate family member, including, but not limited to, a minister or licensed counselor. The warden of OSP and the director shall approve or disapprove such requests.

(5) A representative from the Attorney General's Victim Services Unit and the ODOC Victim Services team coordinator or designee shall be allowed to attend the execution.

b. Offender Witnesses

(1) Witnesses may include five persons, relatives or friends, and two qualified ministers who are 18 years of age or older, as selected by the offender and approved by the general counsel and the warden of OSP. If the offender is female, approval shall be received by the warden of MBCC in conjunction with the warden of OSP.

4. All witnesses shall be provided a summary detailing the execution process which shall include what to expect and rules of conduct throughout the execution.

D. News Media Witnesses

1. News media witness selection is contingent upon adherence to the provisions stipulated in the "News Media Statement After an Execution" (Attachment E, attached).

2. No more than five members of the news media may be selected to witness the execution. First preference will be given to a local media representative in the market where the crime was committed and to the associated press.

3. News media witnesses shall be held to the same standards for conduct as are all other official witnesses.

4. All witnesses shall be provided a written summary detailing the execution process which shall include what to expect and rules of conduct throughout the execution.

5. The Command Team may exclude any news media witness at any time if the media witness fails to abide by the provisions of this procedure.

a. News media witnesses are not permitted to bring unauthorized items into H Unit. Examples of unauthorized items include:

(1) Any electronic or mechanical recording device;

(2) Still, moving picture, or video tape camera;

(3) Tape recorders or similar devices; and

(4) Radio/television broadcasting devices.

b. Each news media witness shall be provided a tablet of paper and a pencil for taking notes once they have completed security screening.

c. News media not selected to witness the execution shall remain in the designated Media Room during the execution.

E. Persons Excluded from the Execution Process

1. The correctional officers, case manager and medical staff who attended to the offender while in isolation shall not participate in the execution process.

2. Minors shall not be permitted to witness an execution.

3. The director shall retain full discretion as to the selection of, and any change in, the witnesses selected for each scheduled execution.

VII. Timeline of Events for Executions

A. Receipt of Order Setting Execution Date

Upon receipt of the Order Setting Execution Date, the following staff shall initiate the protocols below.

1. General Counsel's Office

a. Notify the director and associate director of Field Operations.

b. Notify the division manager of West Institutions, the warden of OSP and, if a female offender, the warden of MBCC.

c. Forward the original Order Setting Execution Date to the warden of OSP or MBCC.

d. Notify the coordinator of the Victim Services Team who shall contact the victim(s) and inform them of the court's issuance of the Order Setting Execution Date.

e. Notify the appropriate government officials and law enforcement officials.

2. Director of Corrections

a. Select the time of the execution and provide notice to the Oklahoma Court of Criminal Appeals.

b. Under exigent circumstances, the director shall have the authority to change the timeframes established in this procedure.

3. Warden of OSP or MBCC

a. Coordinate the monitoring and evaluation of offender activity at their facilities for any activity related to the execution or its impact on the facility operation.

b. Direct the offender to complete the "35-Day Notification Packet" (Attachments F-1 thru F-5, attached (links in the reference section) and return it to the warden no later than 30 days prior to the scheduled execution date.

c. Notify the offender that minors are prohibited from witnessing the execution pursuant to Oklahoma State Statute Title 22, Section 1015.

d. Notify the offender's family members as indicated by the offender.

e. Notify the offender that requests for ODOC or contract staff to attend the execution shall be denied.

f. Notify the offender that requests for other offenders to attend the execution shall be denied.

g. Notify the offender to review and update as necessary DOC 030120B entitled "Designation for Disposition of Property." The warden shall direct the offender to provide any changes no later than 14 days prior to the execution. If the offender does not provide instruction, the property and accounts shall be disposed of in accordance with OP-030120 entitled "Offender Property."

h. Advise the offender that his/her body shall not be used for organ donation.

i. Summarize the options available with the offender for release and disposition of his/her body.

1. The warden shall direct the offender to review the previously completed "Release of Remains and Burial Arrangements" form (Attachment C, attached) and update as necessary no later than 14 days prior to the execution.

2. If the offender provides no instruction or the information is insufficient or incorrect, the deceased shall be disposed of in accordance with OP-140111 entitled "Offender Death, Injury and Illness Notification and Procedures."

j. Summarize the options available to the offender for the release of medical information in accordance with HIPAA regulations.

k. Advise the offender he/she may request a last meal by completing the "Last Meal Request" (Attachment F-5, attached). Reasonable effort shall be made to accommodate the request which shall not exceed $25.00.

B. Thirty-Five (35) Days Prior to the Day of Execution

1. Facility

a. The warden or designee shall confirm in writing to the associate director of Field Operations that the following steps have been completed:

(1) Warrant has been read to the offender.

(2) An outline was provided to the offender how conditions of confinement shall be modified over the next 35 days with a brief description of the relevant aspects of the execution process. (Attachments F-1 thru F-5)

(3) The offender's medical condition shall be assessed in order to identify any necessary accommodations or contingencies that may arise from the offender's medical condition or history.

(a) Any medical condition or history that may affect the performance of the execution shall be communicated as soon as possible through the chain of command to the director, who shall confer with others as necessary to plan such accommodations or contingencies.

(b) The facts of the assessment and any conclusions shall be documented in the offender's healthcare record.

(4) Any concerns for establishing or maintaining IV lines and any concerns or plans for medical accommodations or contingencies shall be communicated to the Special Operations Team in order that they may be discussed and addressed in execution trainings or rehearsals.

(5) An appropriate member of the mental health staff shall evaluate the offender approximately thirty-five (35) days prior to the execution to evaluate his or her stability and mental health in light of the scheduled execution.

(a) Any concerns or contingencies affecting the execution process shall be communicated through the chain of command to the director as soon as possible and documented in the offender's healthcare record.

(b) The director shall order the warden to notify the appropriate district attorney and the attorney general of any concerns or contingencies.

(6) Transfer the offender to the appropriate cell on Death Row at OSP (or MBCC when the offender is female). Before transferring the offender into the cell, the offender shall be strip searched, x-rayed, screened on the calibrated BOSS Chair and then issued a new set of clothes and shoes to wear.

(7) The assigned cell shall be thoroughly searched prior to placing the offender in the cell.

(8) Place the offender on 24-hour continuous observation and post staff to the offender's cell to maintain visual contact with the offender.

(9) Establish an observation log to chronicle staff's observations of the offender's activities and behavior until the sentence of death is imposed or a stay of execution is issued.

(10) The shift commander shall be responsible for ensuring the information recorded in the observation logs includes, but is not limited to:

(a) All statements or behaviors that could be detrimental to completing an execution;

(b) All meals provided to the offender and what portions of the meals the offender consumed or refused;

(c) All medications provided to the offender and the observations made by staff as to whether the offender ingested the medication as prescribed; and

(d) All liquids consumed by the offender.

(11) The warden shall be responsible for reviewing observation logs once every twenty-four hour period, excluding weekends and holidays.

(12) In the instance where the offender is female, the 35 day protocols shall be implemented with the offender housed at MBCC.

b. Conditions of Confinement

(1) The warden shall:

(a) Ensure none of the offender's personal property is transferred with the offender, except as provided in this section;

(b) Have the offender's personal property inventoried in his/her presence before the

transfer of cells occurs and then have it boxed, sealed and removed from the cell;

(c) Store the offender's property pending receipt of written instruction by the offender regarding disposition of property, or otherwise dispose of the property as outlined in OP-030120 entitled "Offender Property;"

(d) Allow the offender to keep in the cell one (1) cubic foot each of legal and religious materials, a safety ink pen, paper and a book or periodical;

(e) Issue the offender a new mattress, pillow and bedding;

(f) Provide the offender limited hygiene supplies, including a towel and washcloth and exchange these items on a daily basis;

(g) Ensure all offender medications are unit-dosed and issued in liquid form, when available. None of the offender's medication, including over-the-counter medications, shall be dispensed or maintained by the offender as keep-on-person (KOP);

(h) Ensure the offender has access to a ODOC television set that is secured inside the cell and does not have access to any other appliances; and

(i) Continue to provide outdoor exercise and showers, non-contact visits and phone calls per the current schedule for other death row offenders.

c. State and Local Law Enforcement Briefing

(1) The warden of OSP shall ensure state and local law enforcement is periodically briefed and adequately prepared for the execution.

d. Site Checks

(1) All of the equipment necessary to the administration of the execution shall be available on site and in good working order including:

(a) Transportation vehicles;

(b) Communication devices with inter-operability capability and restricted frequencies;

(c) Climate control;

(d) Tool control;

(e) Safety equipment;

(f) Audio/Visual equipment;

(g) Utility infrastructure;

(h) Key control/locking devices; and

(i) Medical emergency response capability

2. Division Manager of West Institutions

a. Identifies and assigns team leaders and members, with documented approval by the director, and upon approval shall activate the teams.

b. Ensures preventative maintenance in H Unit occurs and that an equipment inventory is completed. If deficiencies are noted, ensures appropriate and timely action is taken to correct the deficiency.

c. Directs the initiation of the continuous observation log commencing 35 days prior to the day of the execution. The log shall be maintained until the execution occurs or a stay of execution is issued.

d. Activates the training schedule ensuring staff participating in the execution receives adequate training, written instruction and practice, all of which is documented.

3. Division Manager of Correctional Health Services

a. Directs Health Services staff to conduct a medical records file review to identify any prescribed medication(s) and

dosages the offender is currently or was recently taking. Health Services staff provider shall modify prescribed medication as may be necessary.

b. Directs Health Services staff to dispense all offender medications in unit doses and in liquid form, when available. No medication, including over-the-counter medication, shall be provided or maintained by the offender as KOP.

c. Ensures Health Services staff continuously monitors offender for significant changes in his/her medical and/or mental health. Reports findings immediately to the division manager of West Institutions and the general counsel.

4. Victim Services Office

a. Identifies and advises victims of the crime for which the offender has been sentenced to death of the issuance of the Order Setting Execution Date and the scheduled date and time of the execution.

C. Fourteen Days (14) Prior to the Day of Execution

1. Inspector General or Designee

a. Finalizes arrangements with the State Medical Examiner for the disposition of the body, security for the medical examiner's vehicle and the custodial transfer of the body.

b. Obtains a body bag and tag from the Medical Examiner's office.

2. General Counsel

a. Finalizes a list and documented approval of all witnesses for the director's review including official offender and victim witnesses through coordination with the offices of Victim Services.

b. Upon documented approval, the director or designee shall prepare a written invitation to each chosen witness.

c. Sends the completed list of approved witnesses to the warden of OSP.

D. Two Days (2) Prior to the Day of Execution

1. Division Manager of West Institutions

   a. Schedules and conducts on-site scenario training sessions, modifying practices as warranted.

   b. Confirms adequate staffing and vehicles are in place for regular operations and the execution.

2. Warden of OSP

   a. Confirms staff assigned to the Maintenance Response Team (MRT) are scheduled and shall be on-site eight (8) hours prior to the time scheduled for imposition of sentence.

   b. Restricts access to H Unit to those with expressly assigned duties.

   c. Verifies execution inventory and equipment checks are completed and open issues resolved in accordance with established protocols.

E. Twenty-Four (24) Hours Prior to the Day of Execution

1. Final preparation of the execution area is completed. Each room receives final evaluation specific to its functions including security, climate control, lighting, sound, sanitation, and ensures that separation screens and appropriate restraints are ready.

2. Detailed staff briefings detailing operational changes, security and intelligence information as well as protocol and checklist requirements are provided to facility staff through shift briefings, staff meetings, etc.

3. The offender's telephone privileges shall be terminated at 2100 hours the day prior to the execution, excluding calls from the offender's attorney of record and others as approved by the division manager of West Institutions.

4. The offender's visitation privileges shall be terminated at 2100 hours the day prior to the execution. The offender shall be permitted two hours of in-person visitation with no more than two attorneys of record, concluding two hours prior to the scheduled execution or earlier if necessary to begin preparing the offender for the execution.

5. The warden of OSP shall ensure the offender receives the last meal as requested in accordance with procedures. Every reasonable effort to accommodate the last meal request shall be made. All eating utensils and remaining food and beverage shall be removed upon completion of the meal.

6. The Traffic Control Team shall confer with state and local law enforcement agencies, establish check points and parameters for traffic control, and formulate inter-agency emergency response strategies. The team shall also coordinate the ingress/egress for ODOC and contract staff and other persons whose attendance is necessary. This process shall continue through the conclusion of the execution process.

F. Twelve Hours (12) Prior To and Through the Execution

1. Restricting Access to Institution Property

a. During the final 12 hours prior to the execution, access to the Oklahoma State Penitentiary is limited to:

1. On-duty personnel;

2. On-duty contract workers;

3. Volunteers deemed necessary by the warden;

4. Law enforcement personnel on business-related matters; and

5. Approved witnesses.

b. Restriction to the facility shall remain in effect until normal operations are resumed after the execution or stay of execution is issued.

c. Any non-execution related visitation sessions or special visits shall be cancelled.

d. Approved witnesses are gathered and separated into pre-determined staging areas.

(1) One Witness Escort Team is assigned to escort and assist pre-approved officials, victims, news media witnesses and offender's witnesses.

(2) Witness Escort Teams shall remain with the assigned witnesses within established areas.

(3) The Victim Services Team coordinator shall meet with the victim(s) in the staging area and shall remain available to them throughout the process. The team shall provide support and advocacy as appropriate.

2. News Media Access

a. Reasonable efforts shall be made to accommodate the representatives of the news media before, during, and after a scheduled execution; however, the ODOC reserves the right to regulate media access to ensure the orderly and safe operations of its facility.

b. The Communications Office shall coordinate the release of information to news media outlets. All ODOC and contract staff is expressly prohibited from providing information not readily available in the public domain.

c. News media witnesses to the execution shall be limited to five representatives.

(1) One seat will be given to a local media representative in the market where the crime was committed.

(2) One seat will be given to the associated press.

(3) Three seats will be chosen from the remaining media representatives with preference given to Oklahoma-based media.

d. If more than one media representative meets criteria for the available seats, a lottery or lotteries shall be held.

e. The public information officer shall provide general information regarding the execution and the offender.

f. News media witnesses shall return to the Media Room after the execution to answer questions of all other media representatives concerning their observations during the execution, prior to filing or reporting their story.

3. Offender Preparation and Observation Log

a. The offender shall be escorted to medical to receive a full body x-ray.

b. All property in the assigned cell shall be removed and the cell thoroughly searched prior to the return of the offender from medical.

c. The offender shall be strip-searched and screened on the calibrated BOSS Chair before placement in the cell.

d. The offender shall be issued one pair each of pants, shirt, underwear and socks on the morning of the execution.

e. The cell shall be furnished with a mattress, pillow and pillowcase, one each top and bottom sheet, blanket, wash cloth, towel, and toilet paper.

f. The offender may have a safety ink pen and paper, religious items, a book or periodical and indigent-sized hygiene supplies (liquid soap, toothpaste) and a toothbrush and comb. These items may be made available only for the duration of the use and shall be removed immediately thereafter. Any other requested property shall require approval by the warden and shall be documented.

g. The Restraint Team shall take custody of the offender and the observation log. The Restraint Team members shall assume maintenance of the log until the execution is completed or a stay of execution is issued.

h. The offender shall remain on continuous watch. The Restraint Team members shall record observations and make entries every 15 minutes, or as incidents occur, in the observation log during the final four hours.

i. The warden will ensure the assigned cell is preserved and secured immediately after the offender is moved to the execution chamber. Entry will be limited to preservation of mission only and will be released by the inspector general once the execution is completed or a stay of execution is issued.

j. The offender may be offered a mild sedative.

k. No later than four hours prior to the execution the offender may be offered an additional mild sedative.

l. These time frames may be adjusted as necessary in the event of a stay of execution or other exigencies.

4. Notification to Proceed With Execution

a. Prior to moving the offender from the holding cell to the execution table, the director shall confer with the attorney general or designee and the governor or designee to confirm there is no legal impediment to proceeding with the lawful execution.

b. The H Unit Section chief shall direct the Restraint Team to prepare and escort the offender into the execution chamber.

c. The Restraint Team shall secure the offender on the execution table.

5. IV Site(s) Preparation and Establishment

a. The IV Team shall enter the Execution Room to prepare and insert a primary IV catheter and a backup IV catheter. The arm veins near the joint between the upper and lower arm shall be utilized as the preferred site for the IV injection.

b. The director, acting upon the advice of the IV Team leader, shall determine the catheter sites.

c. In the event that the IV Team is unable to establish an IV at a preferred site, the member(s) may establish an IV at an alternative site(s), including a central femoral venous line, for use by the Special Operations Team when administering execution drugs.

d. The IV Team may utilize a non-invasive device to assist in locating a vein.

e. The IV Team shall be allowed as much time as is necessary to establish a viable IV site(s).

f. If the IV Team is unable to establish viable IV sites(s) the member(s) shall consult with the director.

g. The director shall consult with others as necessary for the purpose of determining whether or how long to continue efforts to establish viable IV sites(s).

h. After one hour of unsuccessful IV attempts, the director shall contact the governor or designee to advise of the status and potentially request a postponement of the execution.

i. A central femoral venous line shall not be used unless the person placing the line is currently certified or licensed within the United States to place a central femoral line.

6. Confirming and Recording Establishment of IV Sites(s)

a. An IV Team member shall test the viability of the IV site with a low-pressure saline drip through IV tubing. If necessary, a heparin lock may be attached to the IV needle as an alternative to the saline drip.

b. The H Unit Section chief and IV Team leader shall both confirm the visibility of the IV sites.

c. The H Unit Section Team Recorder shall document in the execution timeline the number of attempts to establish an IV site.

7. Using Alternative IV Sites

a. The H Unit Section Team chief shall observe the offender during the injection process to look for signs of swelling or infiltration at the IV site, blood in the catheter, and leakage from the lines and other unusual signs or symptoms.

b. The H Unit Section Team chief shall determine whether it is necessary to use an alternate IV site.

c. Whenever it is necessary to use alternate IV sites, the Special Operation Team shall administer a full dosage of the execution drugs through the alternate site, using additional syringes as necessary, prepared in accordance with the terms of this procedure.

d. In the event the H Unit Section Team chief changes to another IV site, the Special Operation Team recorder shall capture that information on the execution timeline.

8. Proceeding with the Execution

   a. When the offender is secured on the execution table by the Restraint Team and readied by the IV Team, the H Unit Section Team chief shall advise the director and order the witnesses to their respective seating.

   b. The director shall reconfirm with the attorney general or designee and the governor or designee that there is no legal impediment to proceeding. Upon oral confirmation that there are no legal impediments to proceeding with the execution, the director shall order the H Unit Section chief to proceed with the execution.

      (1) If there is a legal impediment the director shall instruct the H Unit Section chief to stop the execution and to notify the offender witnesses that the execution has been stayed or delayed. The H Unit Section chief shall also notify the Command Team to notify the agency's public information officer in the Media Room.

   c. The H Unit Section chief shall read aloud a summary of the Warrant of Execution.

   d. The H Unit Section chief shall ask the offender if he wishes to make a last statement that is reasonable in length and does not contain vulgar language or intentionally offensive statements directed at the witnesses. The microphone shall remain on during the last statement, after which time it shall be turned off. The microphone may be turned off earlier in the event the offender uses vulgarity or makes intentionally offensive statements.

   e. The director shall instruct the disbursement of chemicals to begin by the prescribed means.

G. Pronouncement and Documentation of Death

1. The director or designee shall announce death has occurred.

2. The H Unit Section chief shall complete and sign the return of the Death Warrant. The H Unit Section chief is also responsible for coordinating with the general counsel's office for the filing of the

document with the sentencing court and the Oklahoma Court of Criminal Appeals within 48 hours.

3. The State Medical Examiner's Office shall be given custody of the body in order to issue a Certificate of Death.

H. Stay of Execution

1. Upon receipt of notification that the court and/or governor has issued a Stay of Execution, the director shall advise the Command Team.

2. Upon receipt of the notification, the H Unit Section chief shall:

   a. Instruct the Special Operations Team to stand down.

   b. Direct the Restraint Team to remove the offender from the chamber and return to the assigned cell if the stay of execution is less than 35 days.

      (1) Prior to moving the offender back to the assigned cell, the inspector general shall release the cell.

      (2) The assigned cell shall be thoroughly searched prior to placing the offender in the cell.

   c. Advise the witnesses a Stay of Execution has been issued.

   d. The Command Team shall inform the following teams of the Stay of Execution:

      (1) Traffic Control Team Leader.

      (2) Critical Incident Management Team Leader.

      (3) Communications Director.

      (4) Victim Services Coordinator.

      (5) Escort Team Leader.

   e. The Traffic Control Team leader shall notify any protestors of the issuance of the Stay of Execution.

I. Post Execution/Stay of Execution

1. The Witness Escort Teams shall commence escorting witness groups from H Unit in the prescribed order from the facility.

2. Each group of witnesses shall continue to be kept separated from the other groups at all times.

3. News media witnesses shall return to the Media Room to participate in the media briefing.

4. Victim witnesses speaking with the media shall be escorted to the Media Room.

5. Media may remain on site in a designated location outside the secure perimeter for a limited time to complete live broadcasts.

6. The Victim Services team leader ensures the victim(s) receives follow up phone calls and support.

J. Site Clean Up and Recording of Execution Drugs

1. In accordance with OP-040109 entitled "Control of Contraband and Physical Evidence," the Special Operations Team leader shall properly dispose of any execution drugs that have not been utilized. The drugs will be inventoried on the form entitled "Oklahoma State Bureau of Investigation Inventory of Drugs Submitted for Destruction" (www.ok.gov/osbi/documents/LABdestructForm.pdf) and forwarded to the Oklahoma State Bureau of Investigation.

2. The warden of OSP shall witness the disposal of the unused execution drugs and document the disposal in accordance with procedure.

3. The Special Operations Team leader shall document the name, description, expiration date, and lot number of all execution drugs used.

4. The Special Operations Team Leader shall save any packaging of the used execution drugs or take photographs of such packaging of items.

5. Under supervision of a person designated by the warden, the execution room shall be cleaned and secured. Institutional staff trained in infectious diseases preventive practices shall utilize appropriate precautions.

K. Normal Operations

1. The Command Team shall determine when the prison shall resume normal operations.

2. ODOC staff shall be deactivated at the direction of the Command Team.

L. Execution Documentation

1. The division manager of West Institutions shall gather all documents pertaining to the executions and forward to the general counsel for archiving.

2. The division manager of West Institutions shall attach a copy of the death warrant and forward it to the general counsel, who shall then forward it to the court from which it was rendered, indicating the time and mode and manner of which it was accomplished. Copies of the report and log shall be sent to closed records department for filing. MBCC shall receive a copy for females that are executed.

M. After-Action Review

1. Immediately following an execution, all of the Execution Teams and the on-site administrators directly involved in the execution process shall meet to review the process of the execution.

2. Any unique or unusual events shall be discussed, as well as opportunities for improvement and successful procedures.

3. Actions and documentation of the events shall be reviewed to identify any discrepancies.

4. The review should serve as an opportunity for all involved personnel to voice their opinions, concerns, and/or recommendations.

5. The review shall be formally documented and retained for future reference.

N. Critical Incident Debriefing

1. The Command Team shall ensure that critical incident debriefings are available for the Execution Teams and staff participants immediately following the execution.

2. The Critical Incident Management Team shall conduct interviews in accordance with Critical Incident Program guidelines.

VIII. Quality Assurance Review

The director shall designate the division manager for Field Support to evaluate the performance of the execution process and report findings to the director.

a. The division manager shall review documentation, training, and professional qualifications, to ensure compliance with the written procedure directive.

b. The division manager may utilize assistance as necessary to compile or assess the information, and may consult with others consistent with the confidentiality of the process.

c. Whenever appropriate, the division manager shall consult with a properly trained medical person when reviewing the medical aspects of the execution procedures.

d. The division manager shall provide consultation and advice concerning modifications in the written directive.

e. The division manager shall prepare a report to the director following each execution, with appropriate suggestions or recommendations as needed.

IX. References

Policy Statement No. P-040100 entitled "Security Standards for the Oklahoma Department of Corrections"

OP-030120 entitled "Offender Property"

OP-040109 entitled "Control of Contraband and Physical Evidence"

OP-110215 entitled "Rules Concerning the Individual Conduct of Employees"

OP-140111 entitled "Offender Deaths, Injury and Illness Notification and Procedures"

Robinson v. Maynard, 857 P.2d 817 (Okla. App. 1992)

21 O.S. § 142A-14
22 O.S. §1014 and 1015

X. Action

The wardens of Oklahoma State Penitentiary and Mabel Bassett Correctional Center are responsible for compliance with this procedure.

The associate director of Field Operations is responsible for the annual review and revisions.

Any exception to this procedure will require prior written approval from the director.

This procedure is effective as indicated.

Replaced: Operations Memorandum No. OP-040301 entitled "Procedures of the Execution of Offenders Sentenced to Death" dated July 3, 2013

Distribution: Policy and Operations Manual
Agency Website

Attachments	Title	Location
Attachment A	"Notification Letter to Dignitaries/Law Enforcement (sample)"	Attached
Attachment B	"Notification Letter to Offender Witnesses (sample)"	Attached
Attachment C	"Release of Remains and Burial Arrangements"	Attached
Attachment D	"Preparation and Administration of Chemicals"	Attached
Attachment E	"News Media Statement After an Execution"	Attached
Attachment F-1	"35 Day Information Packet"	Attached
Attachment F-2	"Summary of Rules and Procedures"	Attached
Attachment F-3	"Witnesses"	Attached
Attachment F-4	"Visitors"	Attached
Attachment F-5	"Last Meal"	Attached

Referenced Forms	Title	Location
DOC 030120B	"Designation for Disposition of Property"	OP-030120
DOC 090211B	"Oklahoma Department of Corrections Request for Record"	OP-090211
OSBI Form	"OSBI Inventory of Drugs Submitted for Destruction and/or Other Items in OSBI Custody for Destruction" http://www.ok.gov/osbi/documents/LABdestructForm.pdf	Website Link

PREPARATION AND ADMINISTRATION OF CHEMICALS

A. Obtaining Chemicals and Equipment

1. Upon receipt of the Order Setting Execution Date, the H Unit Section Chief shall:

   a. Confirm and ensure all equipment necessary to properly conduct the procedure is on site, immediately available for use and functioning properly.

   b. Ensure all medical equipment, including a backup electrocardiograph, is on site, immediately available for use and functioning properly.

   c. Ensure the chemicals are ordered, arrive as scheduled and are properly stored. The chemicals shall be under the direct control of the H Unit Section Chief and stored in a secured, locked area and monitored to ensure compliance with manufacturer specifications.

B. Preparation of Chemicals

1. At the appropriate time, the H Unit Section Chief shall transfer custody of the chemicals to the Special Operations Team to begin the chemical(s) and syringe preparation in the chemical room, under the direct supervision by the Intravenous (IV) Team leader.

2. The Special Operations Team leader shall assign a team member(s) to assist preparing each chemical and the corresponding syringe under the supervision of the IV Team leader. The IV Team leader, with the assistance of the Special Operations Team members, shall prepare the designated chemical and syringes for a total of one (1) complete set of chemicals. One (1) full set of syringes is used in the implementation of the death sentence and an additional complete set of the necessary chemicals shall be obtained and kept available in the chemical room.

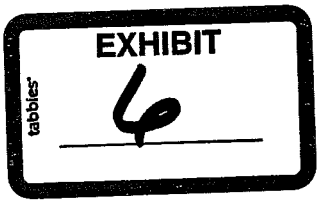
3. The IV Team leader, with the assistance of a Special Operations Team member, shall be responsible for preparing and labeling the assigned sterile syringes in a distinctive manner. The specific chemical contained in each syringe will be identified with the following information as set forth in the chemical charts:

   a. Assigned number

   b. Chemical name

   c. Chemical amount

   d. Designated color



This information shall be pre-printed on a label, with one label affixed to each syringe to ensure the label remains visible.

C. Chemical Charts

1. CHART A: One (1) Drug Protocol with Pentobarbital

CHEMICAL CHART	
Syringe No.	**Label**
1A	2.5 gm pentobarbital GREEN
2A	2.5 gm pentobarbital GREEN
3A	60 ml heparin/saline, **BLACK**

a. Syringes 1A and 2A shall each have a dose of 2.5 grams of pentobarbital for a total of 5 grams. Each syringe containing pentobarbital shall have a **GREEN** label which contains the name of the chemical, chemical amount and the designated syringe number.

b. Syringe 3A shall contain 60 milliliter of heparin/saline solution at a concentration of 10 units of heparin per milliliter. The syringe shall have a **BLACK** label which contains the name of the chemical, chemical amount and the designated syringe number.

2. CHART B: One (1) Drug Protocol with Sodium Pentothal

CHEMICAL CHART	
Syringe No.	**Label**
1A	1.25 gm sodium pentothal, GREEN
2A	1.25 gm sodium pentothal, GREEN
3A	1.25 gm sodium pentothal, GREEN
4A	1.25 gm sodium pentothal, GREEN
5A	60 ml heparin/saline, **BLACK**

a. Syringes 1A, 2A, 3A, and 4A shall each contain 1.25 grams/50 milliliter of sodium pentothal in 50 milliliter of sterile water in four (4) syringes for a total dose of 5 grams of sodium pentothal. Each syringe containing sodium pentothal shall have a **GREEN** label which contains the name of the chemical, the chemical amount and the designated syringe number.

b. Syringe 5A shall contain 60 milliliter of heparin/saline solution at a concentration of 10 units of heparin per milliliter. The syringe shall have a **BLACK** label which contains the name of the chemical, chemical amount and the designated syringe number.

3. CHART C: Two (2) Drug Protocol with Midazolam and Hydromophone

CHEMICAL CHART	
Syringe No.	**Label**
1A	250 mg midazolam, GREEN
2A	250 mg midazolam, GREEN
3A	60 ml heparin/saline, **BLACK**
4A	500 mg hydromorphone, YELLOW
5A	60 ml heparin/saline, **BLACK**

a. Syringes 1A and 2A shall each have a dose of 250 milligrams of midazolam for a total dose of 500 milligrams. Each syringe containing midazolam shall have a GREEN label which contains the name of each chemical, the chemical amounts and the designated syringe number.

b. Syringe 4A shall have a dose of 500 milligrams hydromorphone. The syringe containing hydromorphone shall have a YELLOW label which contains the name of each chemical, the chemical amounts and the designated syringe number.

c. Syringes 3A and 5A shall each contain 60 milliliter of heparin/saline solution at a concentration of 10 units of heparin per milliliter. Each syringe shall have a **BLACK** label which contains the name of the chemical, chemical amount and the designated syringe number.

4. CHART D: Three (3) Drug Protocol with Midazolam, Vecuronium Bromide and Potassium Chloride

CHEMICAL CHART	
Syringe No.	**Label**
1A	250 mg midazolam, GREEN
2A	250 mg midazolam, GREEN
3A	60 ml heparin/saline, **BLACK**
4A	50 mg vecuronium bromide, YELLOW
5A	50 mg vecuronium bromide, YELLOW
6A	60 ml heparin/saline, **BLACK**
7A	120 mEq potassium chloride, **RED**
8A	120 mEq potassium chloride, **RED**
9A	60 ml heparin/saline, **BLACK**

a. Syringes 1A and 2A shall each have a dose of 250 milligrams midazolam for a total dose of 500 milligrams. Each syringe containing midazolam shall have a GREEN label which contains the name of each chemical, the chemical amounts and the designated syringe number.

b. Syringes 4A and 5A shall each have a dose of 50 milligrams vecuronium bromide or 50 milligrams pancuronium bromide or 50

milligrams rocuronium bromide, for a total dose of 100 milligrams. Each syringe containing the selected bromide shall have a YELLOW label which contains the name of each chemical, the chemical amounts and the designated syringe number.

c. Syringes 7A and 8A shall each contain 120 milliequivalents potassium chloride for a total dose of 240 milliequivalents. Each syringe containing potassium chloride shall have a **RED** label which contains the name of each chemical, the chemical amounts and the designated syringe number.

d. Syringes 3A, 6A, and 9A shall each contain 60 milliliter of heparin/saline solution at a concentration of 10 units of heparin per milliliter. Each syringe shall have a **BLACK** label which contains the name of the chemical, chemical amount and the designated syringe number.

D. Choice of Chemicals

1. The director shall have the sole discretion as to which chemicals shall be used for the scheduled execution. This decision shall be provided to the offender in writing ten (10) calendar days prior to the scheduled execution date.

2. Any compounded drug used shall be obtained from a certified or licensed compounding pharmacist or compounding pharmacy in good standing with their licensing board. Licensing certification and criminal history reviews shall be conducted by the Inspector General's office prior to obtaining the compounded drug. A qualitative analysis of the compounded drug to be used in the execution shall be performed no more than thirty (30) calendar days prior to the execution date. The decision to use compounded drugs shall be provided to the offender in writing no less than ten (10) calendar days prior to the scheduled execution.

3. After the IV Team prepares all required syringes with the proper chemicals and labels as provided in the Chemical Chart, the IV Team leader shall attach one complete set of the prepared and labeled syringes to a 3-Gang, 2-Way Manifold in the order in which the chemicals are to be administered. The syringes shall be attached to the 3-Gang, 2-Way Manifold in a manner to ensure there is no crowding, with each syringe resting in its corresponding place in the shadow board which is labeled with the name of the chemical, color, chemical amount and the designated syringe number.

4. The syringes shall be affixed in such a manner to ensure the syringe labels are clearly visible. Prior to attaching the syringes to the 3-Gang, 2-Way Manifold, the flow of each gauge on the manifold shall be checked by

the IV Team leader running the Heparin/Saline solution through the line to confirm there is no obstruction.

5. After all syringes are prepared and affixed to the 3-Gang, 2-Way Manifold in proper order, the Special Operations Team leader shall confirm that all syringes are properly labeled and attached to the manifold in the order in which the chemicals are to be administered as designated by the Chemical Chart. Each chemical shall be administered in the predetermined order in which the syringes are affixed to the manifold.

6. The quantities and types of chemicals prepared and administered may not be changed in any manner without prior documented approval of the director.

7. All prepared chemicals shall be utilized or properly disposed of in a timely manner after the time designated for the execution to occur.

8. The chemical amounts as set forth in the Chemical Chart are designated for the execution of persons weighing 500 pound or less. The chemical amounts shall be reviewed and may be revised as necessary for an offender exceeding this body weight.

9. The Special Operations Team Recorder is responsible for completing the Special Operations Team Log. The Recorder shall document on the form the amount of each chemical administered and confirm that it was administered in the order set forth in the Chemical Chart. Any deviation from the written procedure shall be noted and explained on the form.

E. Movement and Monitoring of Offender

1. Prior to moving the offender from the holding cell to the execution table, the director shall confer with the attorney general or designee and the governor or designee to confirm there is no legal impediment to proceeding with the lawful execution.

2. The offender may be offered a mild sedative based on the offender's need. The sedative shall be provided to the offender no later than four (4) hours prior to the execution, unless it is determined medically necessary.

3. At the designated time, the offender shall be brought into the execution room and secured on the table by the prescribed means with the offender's arms positioned at an angle away from the offender's side.

4. The offender shall be positioned to enable the IV Team or the Special Operations Team leader and the H Unit Section Chief to directly observe the offender and/or to monitor the offender with the aid of a high resolution color camera and a high resolution color monitor.

5. After the offender has been secured to the execution table, the Restraint Team leader shall personally check the restraints which secure the offender to the table to ensure they are not so restrictive as to impede the offender's circulation, yet sufficient to prevent the offender from manipulating the catheter and IV lines.

6. A microphone shall be affixed to the offender's shirt to enable the IV Team, or the Special Operations Team leader, to hear any utterances or noises made by the offender throughout the procedure. The Special Operations Team leader shall confirm the microphone is functioning properly, and that the offender can be heard in the chemical room.

7. The Restraint Team members shall attach the leads from the electrocardiograph to the offender's chest once the offender is secured. The IV Team leader shall confirm that the electrocardiograph is functioning properly. A backup electrocardiograph shall be on site and readily available if necessary. Prior to and on the day of the execution both electrocardiograph instruments shall be checked to confirm they are functioning properly.

8. An IV Team member shall be assigned to monitor the electrocardiograph at the commencement and completion of the administration of the chemicals.

9. Throughout the procedure, the IV Team leader shall monitor the offender's level of consciousness and electrocardiograph readings utilizing direct observation, audio equipment, camera and monitor as well as any other medically approved method(s) deemed necessary by the IV Team leader. The IV Team leader shall be responsible for monitoring the offender's level of consciousness.

F. Intravenous Lines

1. The director, acting upon the advice of the IV Team leader, shall determine the catheter sites. A femoral central line shall only be used if the person inserting the line is currently certified or licensed within the United States to insert a femoral central line. The IV Team members shall insert a primary IV catheter and a backup IV catheter.

2. After one hour of unsuccessful IV attempts, the director shall contact the governor or designee to advise of the status and potentially request a postponement of the execution.

3. The IV Team leader shall ensure the catheters are properly secured and properly connected to the IV lines and out of reach of the offender's hands. A flow of heparin/saline shall be started in each line and administered at a slow rate to keep the lines open.

4. The primary IV catheter shall be used to administer the chemicals and the backup catheter shall be reserved in the event of the failure of the first line. Any failure of a venous access line shall be immediately reported to the director.

5. The IV catheter in use shall remain visible to the H Unit Section Chief throughout the procedures.

6. The H Unit Section Chief shall physically remain in the room with the offender throughout the administration of the chemicals in a position sufficient to clearly observe the offender and the primary and backup IV sites for any potential problems and shall immediately notify the IV Team leader and director should any issue occur. Upon receipt of such notification, the director may stop the proceedings and take all steps necessary in consultation with the IV Team leader prior to proceeding further with the execution.

7. Should the use of the backup IV catheter be determined to be necessary, a set of backup chemicals should be administered in the backup IV site.

G. Administration of Chemicals – Charts A, B, and C

1. At the time the execution is to commence and prior to administering the chemicals, the director shall reconfirm with the attorney general or designee and the governor or designee that there is no legal impediment to proceeding with the execution. Upon receipt of oral confirmation that there is no legal impediment, the director shall order the administration of the chemicals to begin.

2. Upon receipt of the director's order and under observation of the IV Team leader, the Special Operations Team leader shall instruct the assigned Special Operations Team member(s) to begin dispensing the chemicals in the order they appear in the corresponding chart.

3. Upon direction from the Special Operations Team Leader, the assigned Special Operations Team member shall visually and orally confirm the chemical name on the syringe and then administer the full dose of the chemicals immediately followed by the heparin/saline flush.

4. When five (5) minutes has elapsed since commencing the administration of the chemicals, the IV Team leader, dressed in a manner to preserve their anonymity, shall enter into the room where the section chief and offender are located to physically confirm the offender is unconscious by using all necessary and medically-appropriate methods. The IV Team leader shall also confirm that the IV line remains affixed and functioning properly.

5. If, after five (5) minutes the offender remains conscious, the IV Team shall communicate this information to the director, along with all IV Team input. The director shall determine how to proceed or, if necessary, to start the procedure over at a later time or stop. The director may order the curtains to the witness viewing room be closed, and if necessary, for witnesses to be removed from the facility.

6. If deemed appropriate, the director may instruct the Special Operations Team to administer additional doses of the chemical(s) followed by the heparin/saline flush.

7. Upon administering the chemical(s) and heparin/saline from a backup set, the IV Team shall confirm the offender is unconscious by sight and sound, utilizing the audio equipment, camera and monitor. The IV Team leader shall again physically confirm the offender is unconscious using proper medical procedures and verbally advise the director of the same.

8. When all electrical activity of the heart has ceased as shown by the electrocardiograph, the IV Team leader shall confirm the offender is deceased and the offender's death shall be announced by the director.

9. The Special Operations Team Recorder shall document on the Special Operations Team log the start and the ending times of the administration of the chemical(s).

10. Throughout the entire procedure, the IV Team members, the Special Operations Team members and the H Unit Section Chief shall continually monitor the offender using all available means to ensure that the offender remains unconscious and that there are no complications.

H. Administration of Chemicals – Chart D

1. At the time the execution is to commence and prior to administering the chemicals, the director shall reconfirm with the attorney general or designee and the governor or designee that there is no legal impediment to proceeding with the execution. Upon receipt of oral confirmation that there is no legal impediment, the director shall order the administration of the chemicals to begin.

2. Upon receipt of the director's order and under observation of the IV Team leader, the Special Operations Team leader shall instruct the assigned Special Operations Team member(s) to begin dispensing the chemicals in syringe numbers 1A, 2A, and 3A.

3. Upon direction from the Special Operations Team Leader, the assigned Special Operations Team member shall visually and orally confirm the chemical name on the syringe and then administer the full dose of the chemicals in syringe numbers 1A, 2A, and 3A.

4. When five (5) minutes has elapsed since commencing the administration of the first chemical, the IV Team leader, dressed in a manner to preserve their anonymity, shall enter into the room where the section chief and offender are located to physically confirm the offender is unconscious by using all necessary and medically-appropriate methods. The IV Team leader shall also confirm that the IV line remains affixed and functioning properly.

5. If confirmed the offender is unconscious, an announcement will be made and the director will order the remaining chemicals be dispensed in the order they appear in the chart.

6. Upon direction from the Special Operations Team Leader, the assigned Special Operations Team member shall visually and orally confirm the chemical name on the syringe and then administer the full dose of the remaining chemicals in the order they appear in the chart.

7. If the offender remains conscious after five (5) minutes, the IV Team shall communicate this information to the director, along with all IV Team input. The director shall determine how to proceed or, if necessary, to start the procedure over at a later time or stop the execution. The director may order the curtains to the witness viewing room be closed, and if necessary, for witnesses to be removed from the facility.

8. If deemed appropriate, the director may instruct the Special Operations Team to administer additional doses of the chemical(s) followed by the heparin/saline flush.

9. Upon administering the chemical(s) and heparin/saline from a backup set, the IV Team shall confirm the offender is unconscious by sight and sound, utilizing the audio equipment, camera and monitor. The IV Team leader shall again physically confirm the offender is unconscious using proper medical procedures and verbally advise the director of the same.

10. When all electrical activity of the heart has ceased as shown by the electrocardiograph, the IV Team leader shall confirm the offender is deceased and the offender's death shall be announced by the director.

11. The Special Operations Team Recorder shall document on the Special Operations Team log the start and the ending times of the administration of the chemical(s).

12. Throughout the entire procedure, the IV Team members, the Special Operations Team members and the H Unit Section Chief shall continually monitor the offender using all available means to ensure that the offender remains unconscious and that there are no complications.

I. Post Execution Procedures

1. Upon the pronouncement of death, the director shall notify the governor or designee and the attorney general or designee via telephone that the sentence has been carried out and the time that death occurred.

2. An IV Team member shall clamp and cut the IV lines leaving them connected to the offender for examination by a medical examiner.

3. An investigator with the Inspector General's office and a medical examiner shall take photos of the offender's body:

   a. While in restraints prior to being placed in the body bag;

   b. Without restraints prior to being placed in the body bag;

   c. Sealed in the body bag; and

   d. A photo of the seal in place on the bag.

4. The offender's body shall be placed on a medical examiner's gurney and released into the custody of a medical examiner's office.

5. Once the offender's body is placed in a medical examiner's transport vehicle, it shall be escorted off the premises. The examiner's office shall take the offender's body to the medical examiner's office designated by the county.

J. Documentation of Stay Prior to Execution

1. In the event that a pending stay results in more than a two (2) hour delay, the catheters shall be removed, if applicable, and the offender shall be returned to the holding cell until further notice.

2. The Special Operations Team Log and the list of identifiers shall be submitted to the general counsel for review and storage.

K. Contingency Procedure

1. An Automated External Defibrillator (AED) shall be readily available on site in the event that the offender goes into cardiac arrest at any time prior to dispensing the chemicals. Trained medical staff shall make every effort to revive the offender should this occur.

2. Trained medical personnel and emergency transportation, neither of which is involved in the execution process, shall be available in proximity to respond should any medical emergency arise.

3. If at any point any team member determines that any part of the execution process is not going according to procedure, they shall advise the IV Team leader who shall immediately notify the director. The director

may consult with persons deemed appropriate and shall determine to go forward with the procedure, start the procedure over at a later time within the twenty-four (24) hour day, or stop the execution.

4. There shall be no deviation from the procedures as set forth herein, without prior consent from the director.

L. Debrief and Policy Review

1. The IV and Special Operations Teams shall participate in an informal debriefing immediately upon completion of the event.

2. Upon an assignment to a team, team members shall review OP-040301 entitled "Execution of Offenders Sentenced to Death."

3. Periodically, and in the discretion of the director, a review of OP-040301 entitled "Execution of Offenders Sentenced to Death," along with this attachment may be reviewed to confirm it remains consistent with the law. The general counsel shall advise the director immediately upon any change that may impact these procedures.