# OHIO DEPARTMENT OF

# REHABILITATION AND CORRECTION

## LORAIN COUNTY
## COURT OF COMMON PLEAS

*State v. Rivera, Case Number 04CR065940*
*State v. McCloud, Case Number 05CR068067*

**Materials prepared by Director Terry Collins**
**Department of Rehabilitation and Correction**
**Pursuant to Order of the Court**
**November 1, 2007**

**LORAIN COUNTY COURT OF COMMON PLEAS**
**Ohio Department of Rehabilitation and Correction**

State of Ohio vs. Ruben Rivera, Case No. 04CR065940
State of Ohio vs. Ronald McCloud Case No. 05CR068067

## RESPONSE OF TERRY J. COLLINS, DIR. OF DEPARTMENT OF REHABILITATION & CORRECTION TO ORDER OF 11/01/07

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From Opinion and Journal Entry of July 24, 2007, at page 6, attached to above order:

1. An exhaustive and detailed list of all equipment and supplies used in the lethal injection process;

   * See Tab 4, Medical Equipment and Supplies; Tab 5, Timelines; Tab 6, Survey with Additional Information; and Tab 7, Policies – A.

2. Specifications and maintenance procedures for all equipment and supplies identified in #1 above;

   * See Tab 4, Medical Equipment and Supplies; Tab 5, Timelines; Tab 6, Survey with Additional Information; Tab 7, Policies – A; and Tab 8, Policies – B.

3. Specifications on the set-up of the intravenous bag of fluids, drip chamber(s), flow regulator(s), IV tubing, stopcock(s), injection port(s), and/or means of injection;

   * See Tab 1, Guidelines; Tab 4, Medical Equipment and Supplies; Tab 6, Survey with Additional Information; and Tab 7, Policies – A.

4. Specifications, plans and procedures to be implemented when intravenous access cannot be obtained through an arm or a leg;

   * See Tab 1, Guidelines; Tab 3, Training; and Tab 6, Survey with Additional Information.

5. The physical design, layout and dimensions (including any blueprints or diagrams) of the execution chamber and surrounding areas used in the lethal injection process;

   * See Tab 6, Survey with Additional Information; and Tab 7, Policies – A.

6. Specifications and maintenance procedures for how the drugs used in the lethal injection process are acquired, stored, maintained, examination of their shelf life and expiration dates, and how they are prepared for administration; and,

   * See Tab 1, Guidelines; Tab 4, Medical Equipment and Supplies; Tab 6, Survey with Additional Information; Tab 7, Policies – A ; and Tab 8, Policies – B.

7. A list of job qualifications, certifications, training and experience required of persons who participate in any way in the preparation and carrying out of the lethal injection process.

   * See Tab 1, Guidelines; Tab 2, Medical Certifications; Tab 3, Training; Tab 6, Survey with Additional Information; Tab 7, Policies – A; and Tab 11, Summary of Qualifications, Certifications and Experience.

# GUIDELINES

## Protocol for the SOCF Execution Team

Pursuant to DRC policy 01-COM-11, the Execution Team consists of no less than twelve (12) members, designated by the Warden of the Southern Ohio Correctional Facility (SOCF) and the Religious Services Administrator. Their duties include preparation and testing of equipment, carrying out pre and post execution activities; and monitoring the offender's behavior/attitude. The role of the Religious Services Administrator is to serve as a liaison between the inmate, his/her family members, and his/her spiritual advisor; or to serve as the spiritual advisor upon request.

The following protocol/policy language is submitted to document the manner in which team members are recruited, screened, selected, trained and reviewed:

Recruitment of Execution Team Members

When a vacancy occurs among the general team members (non-medical), a posting is placed by the SOCF employee time clock for viewing by all incoming and outgoing staff members. Interested staff members are directed to express their desire to join the execution team, a brief biography of their correctional experience, and the reasons why would like to join the team; all of which is to be forwarded to the Execution Team Leader by the posted deadline.

When a vacancy occurs among the medical team members a similar notice is posted. In addition, the Bureau of Medical Services is notified to assist in department wide recruitment for qualified individuals.

Selection Criteria for New Team Members

The criteria and selection process for general team members are as follows:

- Written applications are turned in to the Execution Team Leader.
- Applications are screened for discipline and attendance issues, additional specialized training, and overall employment record.
- Applications are reviewed and subject to approval by the Warden, Deputy Warden of Operations, Chief of Security and the Execution Team Leader.
- Approved applicants are then reviewed with the Execution Team and a team vote is held. Confidentiality and trust are essential elements for the operation of the team.

The criteria and selection process for medical team members are as follows:

- Applicant must be qualified under Ohio law to prepare and administer intravenous drugs; and/or to start an intravenous injection (depending on the medical team vacancy).
- Applicants are reviewed for any discipline or attendance issues, as well as their overall employment record.

- If selected for the team, the applicant is afforded the opportunity to attend the next scheduled execution rehearsal in order to meet the team, observe the process and finalize their membership on the team.

The Execution Team Leader and Assistant Team Leader are jointly approved between the Warden and the team members. The criteria and selection of Leadership decisions are based upon the individual's leadership skills, knowledge of the execution process, and experience on the team.

Criteria for Removal from the Team

Current team members must maintain a good employment record, as determined by the Warden, including but not limited to an annual review of the employee's attendance record, disciplinary record, leave usage, and overall job performance.

For medical team members, any failure to maintain current certifications and/or continuing education requirements will result in an immediate dismissal from the team.

On-going Team Training

General and medical team members will participate in on-going training, no less than four times per year. NOTE: this is training that goes above and beyond the execution routine that is rehearsed pursuant to DRC policy 01-COM-11.

Medical team members are required to participate in all necessary continuing education requirements for their respective licensure/certification.

**Process Improvement/Quality Assurance Issues**
**ODRC Execution Process**

Facilitated by Edwin C. Voorhies, Jr., Warden
Southern Ohio Correctional Facility

Pursuant to direction from Director Collins, the following issues are being reviewed in an effort to refine and/or improve elements of the execution process for the Ohio Department of Rehabilitation and Correction. Each issue will be individually identified and accompanied by recommendations for change/improvement. Wherever necessary, issues or procedures that require policy changes are properly identified.

**Issue # 1** **Adherence to Incident Command System protocol during Execution process.**

Recommendations:

- Special meal requests will be reviewed by the Execution Team Leader and posted on the timeline.
- Incident Commander & Warden will evaluate request and render approval and/or any modifications to request.
- Once approved, the special meal request will be forwarded to the PIO and DRC PIO for media release.
- All parties (staff or visitors) must receive clearance from the Command Post prior to proceeding to the Death House.
- Condemned inmate has the right to refuse any/all visitors. Execution Team Leader will serve as liaison between inmate and Incident Commander.
- All SOCF staff requiring access to the Death House will enter through the back of J-1. Timing for cell front access to be determined by the Team Leader.
- Notification of OSP re: completion of execution.

**Issue # 2** **Execution Protocols.**

Recommendations:

- Develop "checklist" for preparatory and execution protocols.
- Formalize vein inspection process; previously done during medical exam without the inmate's knowledge. Propose briefing inmate and formally assessing viability of veins at primary injection sites.
- Prepare a second complete set of syringes for contingencies.
- Eliminate "self imposed" time pressures/constraints re: establishing injection sites.
- Utilize medical cart (laid out and labeled for medical team supplies).
- Make provisions for the comfort of medical team members during insertion process (stools w/wheels and adjustable seats).

**Issue # 2 Execution Protocols (continued).**

Recommendations:

- Formally develop contingency plans re: delays (short & long term). Briefing for witnesses, breaks, etc.
- Maintain existing bed position (for improved visibility by equipment room).
- Restraint team will roll up the inmate's sleeves during restraint process to improve injection site visibility.
- "Low pressure" saline flow would begin as soon as lines are connected and would continue throughout last statement (further verifying continuity of the vein). Equipment room will signal (solid light for good flow & flickering light for no flow). Oversight provided by equipment room checklist.
- Utilize "double signal" system. First signal begins Thiopental Sodium followed by "low pressure" saline flush **(requires policy change)**. Equipment room signals back once Thiopental Sodium and saline flush is taking place (approx. 10 second flush). Visual exam for infiltration of the vein coupled with medical team verifying flow. Once complete, second signal begins remainder of injections. (Discuss potential changes for high vs. low pressure flush between Pancuronium Bromide and Potassium Chloride; does the same logic apply, or is this the point of no return? **"low pressure" would require policy change**).
- Revise contingency plan for delayed process (before second signal is given). 2) medical team members and 2) restraint team members will enter the chamber. Only one medical team member will attempt to establish new injection site(s).
- Improve labeling & anchoring of the IV lines in the equipment room (verified by checklist prior to start).

**Issue # 3 Utilization of a Monitor**

Recommendations:

- Maintain current policy/practice unless mandated otherwise.
- If monitor is mandated, medical team and/or HCA could be trained to monitor

# Ohio Department of Rehabilitation and Correction

1050 Freeway Drive North
Columbus, Ohio 43229

Bob Taft, Governor | www.drc.state.oh.us | Terry J. Collins, Director

June 27, 2006

TO: Governor Bob Taft

FROM: Director Terry J. Collins

RE: Joseph Clark Execution

As you requested, a review of the May 2, 2006 execution of Joseph Clark has been completed. Inmate Clark's execution took an unprecedented amount of time in comparison to the previous twenty (20) executions. The fact that the team had difficulty in establishing the IV's, and then lost use of the only IV site, accounted for the delay.

On May 15, 2006 a meeting was held with counsel from the Attorney General's office, members of DRC legal staff, Southern Ohio Correctional Facility (SOCF) Warden Ed Voorhies, Assistant Director Mike Randle, and myself. This meeting was to determine if refinements to the existing process should or could be made. After much discussion consensus was reached that the review should address the issue that created the delay, that being the insertion of the IV's. A follow up meeting was held on June 12, 2006 to conclude the process review and finalize the recommendations which were submitted to my office (a copy is attached).

The group made five (5) recommendations and I have accepted all recommended actions. The recommendations and process changes are defined below:

1. Time Pressures: Our current practice has created an artificial self-imposed time barrier resulting in enormous pressure on the execution team members. Allowing this expectation has caused staff to believe they must act quickly, contributing to the difficulty of the task. PROCESS CHANGE: Removal of the barrier by advising staff that we have no requirement to act within the self-imposed narrow time frame. In addition, we should advise all persons witnessing and the media that the process may take longer, which does not mean there are issues. Our goal is to always complete the process in a professional and dignified manner for all parties.
2. Prior Evaluation: The current practice has been to review the medical file and make a visual observation of the inmate upon arrival at SOCF the day before the execution. PROCESS CHANGE: Upon arrival the medical file will be reviewed and to the extent possible, a hands-on evaluation will be completed. Later that evening, at a time determined by the SOCF Warden, another hands-on evaluation, to the extent possible, will be conducted. Finally, the morning of the

execution a hands-on evaluation, to the extent possible, will be conducted no later than 9:00 a.m. All evaluations will be used to determine if potential problems exist and if so what alternatives may be employed to reduce the problem.

3. IV Sites: Our practice has been to have two (2) IV sites, one in each arm. In the case of Joseph Clark the team was unsuccessful in obtaining a second site. A decision was made to proceed with one established site, which became compromised and caused the interruption. PROCESS CHANGE: In the future every effort will be made to obtain two (2) sites prior to proceeding from the holding cell to the chamber.

4. Low Pressure Drip: The current process to check the viability of the IV line has been by the use of saline injection via syringe which is termed "high pressure" injection. An alternative method is to establish a "low pressure" drip of saline to keep the line open and confirm its ongoing viability. PROCESS CHANGE: We will use the "low pressure" process in all future cases, and will amend our policy directive accordingly.

5. Effective Delivery of Drugs: The current process has involved staff observation of the viability of the IV line, and that process should continue.

I believe that the recommendations and implementation of process changes will lessen the probabilities of the reoccurrence of such an issue in future executions. This review was focused strictly and solely on the cause of the problem in the Joseph Clark execution. Our objective was to determine refinements, and our goal is to implement those refinements, thereby reducing probabilities of future occurrences.

Please let me know if you would like any additional information or clarification. I plan to implement the recommendations immediately so they can be in place before the next scheduled execution which is set for July 12, 2006.

## Execution Procedures

## Process Review

### Introduction and Charge

Following the execution of Joseph Lewis Clark #183-984, Governor Taft asked Director Terry Collins to review the execution procedures due to the unprecedented length of time necessary for the execution process. During the previous 20 executions, the process was carried out and concluded within one half hour of commencement. Clark's was not concluded until approximately ninety minutes after it was begun. During the process of carrying out Clark's execution, staff found it difficult to start and maintain the intravenous lines that would carry the lethal drugs, and those difficulties accounted for the delay in concluding the execution. Director Collins requested a meeting with counsel from the office of the Attorney General, the Warden of SOCF and two members of DRC's in-house legal staff to discuss the design of the process and the manner of carrying out the procedures.

The first meeting was convened on May 15, 2006 and the purpose of the meeting was described and agreed as a process review, an effort to identify ways that the process and procedures could be improved. It was the consensus of the group that inserting and maintaining the intravenous lines was the single procedure that presented the staff with difficulty. No other issue or procedure was identified as a source of operational concern.

### Clark's Execution

Clark was received at the Southern Ohio Correctional Facility the day before his execution, as would normally be the case. His medical file was reviewed and he was visually examined by a nurse on the day of arrival to assess his health and to detect any potential difficulties with the intravenous insertion. The persons who insert the needles are trained medical professionals who are legally qualified to start intravenous lines in patients. No physician participates in the insertion of the needles, the delivery of the medication, or in any way other than the pronouncement of death.

On the morning of the execution, the process commences when the needles are inserted in the prisoner's arms. This is done while the inmate is in the holding cell, prior to his entrance into the execution chamber. Attached to the needles are small vials containing heparin, an anti-coagulant to prevent the blood from clotting at the intravenous site. Typically, two "heparin locks" are inserted, one into each arm, prior to the inmate's entry into the chamber. The drugs are always delivered to just one needle

site, but previous executions had always started two, with one to function as a back-up location in the event of some difficulty.

In Clark's case, one needle site was established, checked and found to be viable by flushing saline through the needle into the vein. The other site proved more difficult; the team members did not find and establish a second site within a number of minutes, and at some point, the decision was made to proceed with what appeared to be a single, viable site. The establishment of intravenous lines is more difficult for some individuals than others, as occurs in delivering medical care in the community.

The process of delivering the chemicals was initiated, but it soon became apparent to the team that the intravenous insertion was compromised, and the process was interrupted. The team members searched for another viable intravenous site. Finding and establishing an effective intravenous site proved to be difficult and time-consuming, but eventually it was accomplished. Once a new intravenous site was established, the process was re-commenced and concluded without further delay or interruption.

**Recommendations**

DRC officials and counsel agreed that the procedures for inserting and maintaining the intravenous lines should be the proper focus of the discussion. A number of suggestions for improvement were made and agreed upon. This report was prepared as a result of the meeting, listing each issue and the suggested, corresponding improvement.

Time Pressures Those persons involved in performing the execution are acutely aware of the profound significance of their roles and the attention focused upon them. There is a natural desire on the part of everyone involved to want the process to move smoothly toward the mandated conclusion, and this can be translated into a desire that it be performed quickly. The pressure to insert the needles quickly can contribute to the difficulty of that particular task.

Therefore, it is recommended that the administration relieve the staff of this pressure. The administration should recognize that the condemned prisoner may not always enter the death chamber at precisely 10:00 am. If the insertion of the needles requires more time that should not be considered cause for concern. If those responsible need to pause in their duty to discuss alternatives, this may well be an appropriate response. There should be no effort to hurry this stage of the process.

Prior Evaluation Whether or not Clark's difficult veins could have been "diagnosed" in advance is a matter of speculation. The establishment of an intravenous line is more difficult with some persons than others, and it is believed that such occurrences happen normally in the delivery of health care in the community.

Nevertheless, every possible step should be taken to anticipate and plan for foreseeable difficulties. The condemned prisoner should be thoroughly evaluated on the day of arrival at the institution, which should include a hands-on evaluation to the extent possible, and a review of the medical file as has occurred previously. Potential problems and alternatives should be discussed.

Two Intravenous Sites Clark's execution was begun with a single intravenous site established. However, it became necessary to interrupt the process to search for a second intravenous site. The fact of this interruption caused concern for the witnesses and the administration, and it almost certainly increased the level of difficulty for those persons responsible for finding a new vein.

In future executions, every effort should be made to establish intravenous lines in two sites. If the search for a second intravenous site causes delay in commencing the process, this should be viewed as a necessary consequence in order to avoid a start-and-stop scenario.

Low Pressure Flow The viability of the intravenous line was checked with a high-pressure injection of saline prior to entering the chamber. This is not the only alternative, however, as Maryland's procedure calls for the establishment of a low-pressure saline drip to keep the line open and confirm its ongoing viability.

It is recommended that future executions utilize a low-pressure drip to keep the line open and verify viability. The drip can be started in the holding cell and continued in the chamber. The lethal medications will be injected by syringe into the line at high pressure, and the low-pressure drip will continue between syringes. This will assist staff in monitoring the effectiveness of the delivery of the drugs into the blood stream.

The utilization of a low-pressure saline drip will eliminate the necessity of a saline syringe between chemicals. The policy should be changed to eliminate the use of and reference to three syringes of saline solution in a high-pressure flush between chemical doses.

Effective Delivery of Drugs The warden and other team members will observe the inmate's arms and check for signs of IV incontinence during the entire time that the drugs are being administered to the inmate.

CONTINGENCY PLANNING MEETING HELD JULY 19, 2006
REGARDING FERGUSON EXECUTION SCHEDULED
FOR TUESDAY, AUGUST 8, 2006

- Notification Issues Regarding Media
  - PIT Team member assignments and Media Packets must be submitted to the Incident Commander PRIOR to the day of the scheduled execution.
  - Any media-related issues (i.e., unauthorized media requesting entrance into the institution, media without credentials) must go through the PIO, not the Incident Commander.
  - PIT Team members are to be in place in A-Building by 6:00 a.m. in order to process media, etc.
  - Andrea and Larry should have something prepared for the media in case the inmate recants.

- Inspection of Veins
  - Assessment of the inmate's veins by medical staff must be documented on the timeline the night before and the day of the scheduled execution to show they have taken place.

- "Morning Of" Issues
  - The assigned maintenance staff member (generally [redacted] conducting communication checks must enter the death house via J1 to avoid traffic during visitation.
  - Escorts for inmate's witnesses need to be in place in A-Building so they can be processed and into the institution by 6:30 a.m. Upon arrival, they need to check-in with the Command Center, obtain their radios, and be in A-Building by 6:00 a.m. in order to begin visitation on time.
  - [redacted] is to enter the death house in the back of J1 and shall remain out of sight of the inmate. He will be there for the team only.
  - In the future, the spiritual advisor needs to have a cut off time on visiting with the inmate (8:45).

- "Night Before" Issues
  - If given the opportunity, team members should assess the inmate's arms in the event the inmate is uncooperative the "morning of." Try to push liquids (water or caffeine free soda)

- **Medical Team Entering Cell**
  - Disposal boxes and safety needles will be used.
  - A spit sock will be available
  - Restraints – chain cuffs to be used and the inmate will be cuffed to the side of the bed. Legirons will also be used. (Note: Practice at future training sessions)
  - There is concern with the inmate attempting to get syringes and sticking team members. (Note: Practice at future training sessions)

- Inmate Resistance
  - If the inmate resists he may be restrained in the cell and IV's inserted there.
  - Is he changing his mind since he's a volunteer?
  - If force is used to insert heparin locks and he refuses to be escorted to the chamber, we need to ask if he wants to continue.

- If Inmate Recants Once Drugs are Being Administered
  - If the inmate recants, the witnesses (both inmate and victims) and the media need to be briefed.
  - The curtain needs to be closed immediately.
  - Medical needs to assess inmate. Once the light is on it becomes a medical issue.
  - The Warden needs to know how we can accurately determine how much thiopental sodium is in his system. This will be assessed during the next practice.
  - If we send him out, two team members will go in the squad with the inmate and two team members will be in a chase vehicle.

- "Worse Case Scenario"
  - 45 seconds after signal is given and the inmate recants just before he is unconscious it could be a lethal dose ([redacted] will research). 80cc's once the flush is started (before 2nd syringe).
  - [redacted] is first responder
  - Coroner – legally and morally has to respond?
  - Nurse and physician on standby in Infirmary
  - [redacted] are obligated to respond
  - Have crash bag in death house

- **If Inmate Recants Immediately Following Last Statement**
    - Curtains will be closed
    - Witnesses will be escorted out of death house
    - IV's and heparin locks will be removed
    - Release team will enter chamber
    - Inmate will be placed back in the cell
    - We have an obligation until the death warrant expires (at midnight) just in case he would change his mind. The AG's office may possibly have the death warrant rescinded, but the execution team and those involved will stay until a decision is reached.

- **Additional Issues**
    - If the inmate recants at any given time, Andrea will go to the Director for a statement and the Warden will brief the witnesses and the media.
    - Funeral Director: after the process is complete, [redacted] is to remain at CC1 and [redacted] will escort the funeral director from the premises.
    - If the inmate changes his mind before getting to the chamber, he will be turned around and escorted back to the cell, the curtain will be pulled and the Warden will brief witnesses.
    - If the heparin locks are in and the inmate is escorted into the chamber, but he doesn't recant and pulls out the heparin locks, he is to be asked if he's stopping the process. If not, he is to be strapped on the bed and restrained.

- **Future Training**
    - Wednesday, July 26th and Wednesday, August 2nd

# MEMORANDUM

DATE: February 18, 1998

TO: Warden Steven Huffman

FROM:

RE: LETHAL INJECTION GUIDELINES

1. Pharmacist will pick up needed medication from designated source and store in locked box in the safe (PAVULON must be kept **refigerated** in a locked box) in the pharmacy two weeks prior to execution date.
2. On the day of execution, the locked box will be delivered in person to the warden by the pharmacist at the designated time. The warden will have control of the medication until the time of the execution.
3. Following UNIVERSAL PRECAUTIONS the designated individual will start one IV in each arm of 500 cc NORMAL SALINE with large bore needle to run at TKO.
4. The inmate will be prepared on the gurney by the appropriate team member prior to initiating the lethal injection process.
5. **Drugs shall be administered in the following sequence:**

   A. **SODIUM PENTATHOL - 2GM** in normal saline **concentration 25mg/cc (total 80cc)**

   B. **FLUSH WITH 20CC NORMAL SALINE.**

   C. **PAVULON 100MG TOTAL** in normal saline **concentration 1mg/cc (total** 100cc). **HOLD** another 50MG as **STANDBY.**

   D. **FLUSH WITH 20CC NORMAL SALINE.**

   E. **POTASSIUM CHLORIDE 100MEQ TOTAL** in normal saline **concentration 2meq/cc (total 50cc). HOLD** another 50MEQ as **STANDBY.**

   F. **FLUSH WITH 20CC NORMAL SALINE.**