[This is my working rough draft. Material set forth in italics within brackets is rougher still but provided to give you an idea of where I am presently headed. Even though the deadline is twoand one-half months away, a key component of the review remains undone: interviews of the key medical personnel who have been retained for the next execution and the opportunity I have long requested to observe a complete rehearsal of the legal injection protocol. These interviews and observation of the rehearsal could affect my present conclusion that lethal injection while theoretically achievable is, in actual practice, fundamentally unreliable, unworkable and unacceptably prone to errors.

The footnotes are for my own drafting purposes and will not, with limited exceptions, be included in the Final Report.]

In Executive Order 5, Governor Katie Hobbs declared that Arizona's history and manner of conducting executions raised serious questions about the Arizona Department of Corrections, Rehabilitation & Reentry 's ("ADCR&R") execution protocols and lack of transparency. The Executive Order recognized that while ADCR&R will be making improvements in its policies and practices under new leadership, this new leadership would be operating from a history that demonstrated a need for better oversight, accountability, and transparency. To address these issues, Executive Order 5 authorized the appointment of an Independent Review Commissioner ("IRC") "to review and provide transparency into the ADCRR's lethal injection drug and gas chamber chemical procurement process, execution protocols, and staffing, including training and experience." The Governor determined that Arizona must conduct "a comprehensive and

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independent review" to ensure that problems with past executions "are not repeated in future executions." Executive Order 5 requires the IRC "to issue a final report to the Governor and Attorney General that includes recommendations on improving the transparency, accountability, and safety of the execution process." This is the IRC's Final Report. Arizona stayed executions pending the completion of the IRC Final Report to assure the opportunity to realize the benefit of the Final Report's findings.

This Final Report is presented in four sections. Section 1 provides a history of the application of capital punishment in Arizona from the reauthorization of capital punishment in 1973 until Arizona's most recent execution in November 2022. Section 2 describes the method and manner of the preparation of this Final Report and describes the background and qualifications of the IRC. Section 3 identifies the root causes of the failures of the previous executions. Finally, Section 4 identifies how Arizona may best accomplish executions that pose the least possibility of producing executions that are deemed as "botched.".

As a further preamble, it is important to state what this Final Report does not address. The Executive Order did not provide for an omnibus examination of capital punishment. Rather, its analysis limited: to "review and provide transparency into ADCRR's lethal injection drug and gas chamber chemical procurement process, execution protocols, and staffing considerations including training and experience." Thus, within the appropriate scope of the Independent Review, the reader will not find answers to questions often posed when considering capital punishment as a matter of public policy. No answer will be provided regarding the wisdom of spending millions of dollars to execute capital defendants rather than committing them to prison for the remainder of their natural lives without possibility of parole at a fraction of the cost. No

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answer is contained herein as to whether it is defensible to allow for the utilization of an irrevocable punishment when it is known that mistakes in prosecution are made such that it is a fact that the innocent have been executed and that the executed cannot be exonerated. Moreover, this Report does not address whether it is humane to subject the victims of capital crimes, often surviving family members, to a decades-long process that deprives the surviving victims of the healing that can occur when legal proceedings are finally concluded [Consider inserting Justice Breye's quote that one cannot have a death penalty that is both quick and fair.] Finally, there is presented here no answer whether it is wise public policy to employ the death penalty in reliance on a supposed deterrent effect when that supposed effect is unsupported by evidence. These are important questions worth considering, but that does not suggest that a more limited inquiry is ill-advised or without utility. While other states have placed the entire issue of capital punishment on the table and assigned such broader questions to blue ribbon commissions composed of all stakeholders, other states have adopted Arizona's approach and undertaken a more limited inquiry. Arizona, through its citizens or elected leaders, may choose to pursue a broader inquiry, but again that is not the subject matter or task assigned to the IRC.

Section 1

Following <u>Furman v. Georgia</u>, 408 U.S. 238 (1972), the Arizona legislature enacted A.R.S. § 13-454 in 1973, which set forth a new procedure for death penalty cases.¹ Today, the statute provides that "[t]he penalty of death shall be inflicted by an intravenous injection of a substance or substances in a lethal quantity sufficient to cause death, under the supervision of the

¹ <u>https://corrections.az.gov/death-row/arizona-death-penalty-history;</u> <u>https://www.azag.gov/sites/default/files/publications/2018-06/Capital_Case_Commission-</u> <u>Final_Report.pdf</u>

state department of corrections." Id. § 13-757(A). [Insert at the appropriate place that this Report directs comparatively little attention to lethal gas because asphyxiation by poison gas cannot be remade into anything that is not grossly inhumane, and because so few inmate are eligible to make this election even if the Executive were willing to conduct such an execution. In addition, the use of a decades-old, rarely used gas chamber poses risks to the operators and the general public. Indeed, the Pinal County coroner had to purchase a special container to contain the cyanide infused out-gassing lungs after they take possession of the executed cadaver.]

Arizona changed its method of execution from lethal gas to lethal injection in 1992.² The state legislature clarified that lethal injection would be the default method of imposing the penalty of death, but that a defendant sentenced to death for an offense committed before November 23, 1992, may choose either lethal injection or lethal gas. <u>Id.</u> § 13-757(B).

In 2000, Arizona Attorney General Janet Napolitano created the Capital Case Commission to study the death penalty in Arizona, to identify key issues and make recommendations to ensure that the death penalty in Arizona is "just, timely, and fair to defendants and victims."³ The Commission was not charged with and did not consider whether a mortarium or abolition of the death penalty was warranted.⁴ Some of the Commission's recommendations, including making defendants with intellectual disabilities ineligible for the death penalty, were already enacted by the United States Supreme Court by the time the

² https://corrections.az.gov/death-row/arizona-death-penalty-

history#:~:text=In%20November%201992%2C%20Arizona%20voters.lethal%20gas%20or%20lethal%20injection.

³ <u>https://www.azag.gov/sites/default/files/publications/2018-06/Capital_Case_Commission-</u> Final Report.pdf

⁴ Id.

recommendations were published.⁵ Subsequently, in 2002, the United States Supreme Court determined that the Arizona death penalty sentencing scheme was unconstitutional in <u>Ring v.</u> <u>Arizona</u>, 536 U.S. 584 (2002).⁶ Following <u>Ring</u>, Arizona revised its death penalty statute.⁷

In 2011, the United States Department of Justice informed Arizona that its supply of sodium thiopental was imported illegally.⁸ Arizona then switched to pentobarbital and continued executions.⁹

In 2014, Arizona executed Joseph Wood using a two-drug cocktail of midazolam and hydromorphone. It took Wood almost two hours to die and required 15 injections of the experimental drug that previously had failed in Ohio.¹⁰ Governor Jan Brewer directed the Department of Corrections to conduct a full review of the process.¹¹ The Department concluded that "the execution of inmate Wood was handled in accordance with all department procedures," and "was done appropriately and with the utmost professionalism."¹² The Department of Corrections nevertheless adopted a new drug protocol to implement the death penalty.¹³ Instead of using midazolam and hydromorphone, the Department would instead try to obtain sodium

⁵ <u>https://www.nytimes.com/2003/02/20/us/national-briefing-southwest-arizona-plan-to-change-death-penalty-system.html</u>

⁶ <u>https://corrections.az.gov/death-row/arizona-death-penalty-history;</u> <u>https://az.fd.org/fpd/capital-habeas-</u>unit/death-penalty.

⁷ https://www.azleg.gov/Briefs/Senate/CAPITAL%20PUNISHMENT%202022.PDF

⁸ https://www.theguardian.com/business/2010/oct/27/british-firm-denies-exporting-drug.

⁹ https://deathpenaltyinfo.org/state-and-federal-info/state-by-state/arizona;

https://www.azcentral.com/story/news/arizona/death-row/2014/03/26/arizona-switches-drug-executionsdeath-row/6914575/.

¹⁰ <u>https://www.cbsnews.com/news/execution-of-joseph-wood-60-minutes-2/; https://eji.org/news/arizona-execution-joseph-wood-botched/; https://www.bbc.com/news/world-us-canada-28444667;</u>

https://azmirror.com/2023/04/27/poorly-executed-the-experiment-failed-halting-executions-in-arizona/ https://www.nytimes.com/2014/07/24/us/arizona-takes-nearly-2-hours-to-execute-inmate.html;

https://www.nytimes.com/2014/07/25/us/a-prolonged-execution-in-arizona-leads-to-a-temporaryhalt.html

¹² https://apnews.com/small-business-general-news-0d6f86a5b37644e6a50c63e31ac8caab

¹³ <u>https://tucson.com/news/state-and-regional/arizona-will-change-drugs-used-in-</u>

executions/article d6411b96-8a1b-11e4-b648-0383e72048cb.html

pentothal and sodium pentobarbital. If the state could not obtain those drugs, it would use a three-drug combination that includes midazolam and potassium chloride.¹⁴

In 2015, Arizona again attempted to import illegal lethal injection drugs (sodium thiopental) – this time from India – but the drugs were confiscated at the Phoenix airport by FDA officials.¹⁵

In 2021, the Arizona Department of Corrections refurbished the state's gas chamber at a cost of approximately \$10,000,¹⁶ and spent more than \$2000 procuring cyanide gas ingredients in preparation to kill death row inmates using hydrogen cyanide. The resulting lethal gas is the same as that deployed by the Nazi regime during the Holocaust.¹⁷

On May 11, 2022, the State of Arizona executed Clarence Dixon. His was the first execution in nearly eight years, following the execution of Joseph Wood.¹⁸ The execution team took approximately 40 minutes to complete the IV insertion process.¹⁹ The execution team was

¹⁴ <u>https://www.usatoday.com/story/news/local/arizona/2014/12/22/arizona-execution-drug-change/20774877/;</u> See Arizona Department of Corrections, Consulting Services for Assessments and Review of Execution Protocols, December 15, 2014.

¹⁵ <u>https://www.reuters.com/article/world/u-s-regulators-block-texas-arizona-over-import-of-indian-execution-drug-idUSL1N1HT01W/; https://www.theguardian.com/us-news/2015/oct/23/arizona-illegally-import-lethal-injection-drug;</u>

https://www.azcentral.com/story/news/arizona/investigations/2015/10/22/arizona-corrections-import-thiopental-illegal-execution-drug/74406580/.

¹⁶ Visit to the Florence Prison, 9-26-24.

¹⁷ <u>https://www.pbs.org/newshour/nation/arizona-refurbishes-gas-chamber-in-push-to-resume-executions;</u> https://deathpenaltyinfo.org/state-and-federal-info/state-by-state/arizona;

¹⁸ https://corrections.az.gov/news/scheduled-execution-inmate-clarence-dixon-completed;

https://www.azcentral.com/story/news/local/arizona/2022/05/11/execution-death-row-inmate-clarencedixon-arizona-updates-protests/9710466002/

¹⁹ <u>https://www.azcentral.com/story/news/local/arizona/2022/05/18/after-acquiring-lethal-injection-drugs-az-struggles-administer-them/9817921002/</u>.

unable to set two functioning peripheral IVs and resorted to cutting into Dixon's groin area to set a femoral line, which resulted in "a fair amount of blood"²⁰ and signs he was exhibiting pain.²¹

On June 8, 2022, Arizona executed Frank Atwood and the execution team had similar problems inserting two functioning IV lines. After several attempts, the executioners set one peripheral line in Atwood's left arm, and then began preparing to set a femoral line on the right side.²² The execution team ultimately put the needle in Atwood's right hand – rather than his right arm – at Atwood's suggestion.²³

The most recent execution was completed on November 16, 2022.²⁴ Murray Hooper was executed by lethal injection and again, the execution team struggled to insert the intravenous needles.²⁵ Witnesses reported seeing execution team members attempt and fail to insert IVs into both of Hooper's arms. The execution team ultimately inserted a catheter into Hooper's femoral vein near his groin. Witnesses reported that it took between 10-12 minutes for Hooper to die.²⁶

There are currently 111 inmates on Arizona's death row,²⁷ at least 21 of whom have exhausted the appeals process.²⁸

²⁰ <u>https://www.ncja.org/crimeandjusticenews/several-states-under-scrutiny-after-recent-lethal-injection-</u> failures

²¹ <u>https://www.azcentral.com/story/news/local/arizona/2022/05/11/execution-death-row-inmate-clarence-dixon-arizona-updates-protests/9710466002/</u>

²² https://www.cbsnews.com/news/frank-atwood-execution-arizona-murder-vicki-hoskinson/

²³ https://www.azcentral.com/story/news/local/arizona/2022/06/08/frank-atwood-execution-arizona-vickilynne-hoskinson-murder/7547656001/

²⁴ https://corrections.az.gov/news/scheduled-execution-inmate-murray-hooper-completed

²⁵ https://www.azcentral.com/story/news/local/arizona/2022/11/16/murray-hooper-execution-day-1980-phoenix-murder-convictions/10666614002/

²⁶ https://apnews.com/article/arizona-executions-f999919f50df1158b8dc2f4c03915842;

https://www.azcentral.com/story/news/local/arizona/2022/11/16/murray-hooper-execution-day-1980-phoenix-murder-convictions/10666614002/

²⁷ https://corrections.az.gov/death-row

²⁸ https://www.azleg.gov/Briefs/Senate/CAPITAL%20PUNISHMENT%202022.PDF

[This Section will also detail and provide examples of the difficulty other jurisdictions have encountered in seeking to employ lethal injection as a means of execution.]

[Insert here **The Cost of Capital Punishment.** This Subsection shall include all available costs of chemicals and specially retained medical personnel as well as the cost of the chemicals presently on hand and the anticipated cost of the medical personnel and chemicals needed for all individuals on death row. I have asked the Department to assemble that data.]

Section 2

[This Section describes the manner and methods of the investigation. The first task of the IRC was to determine the appropriate timeline for such an investigation. As mentioned above, other states have employed various methods to review capital punishment. It appeared that the average length of such investigations was approximately two years. The IRC then reviewed all of the legal papers filed in every Arizona capital case from 1973 until the present, including state and federal courts. Next the IRC reviewed every document pertaining to modern era executions maintained by the ADCR&R in its files and archives. These documents numbered in the tens of thousands and were contained in more than 20 bankers' boxes. The IRC also interviewed dozens of individuals including those appointed to lead examinations of lethal injection practices in other jurisdictions, current and former ADCR&R employees, lawyers for the state and capital defendants, family members of victims who witnessed executions, lawyers for victims, physicians and other medical personnel, veterinarians, and law school professors who have distinguished themselves in their study of lethal injections. I will enumerate the individuals interviewed by category, i.e., 14 prosecutors, 12 capital defense lawyers, etc. This Section will conclude with a brief description of the IRC's background and qualifications (including my participation in a

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multi-day critical analysis program at the Los Alamos National Laboratory designed to improve judges' ability to study problems and develop solutions based on sound evidence.]

Section 3

[Section 3 will open with a discussion of the fundamental challenge to lethal injection and the root cause of the difficulties which have been encountered. Indeed, Executive Order 5 presciently recognizes this root cause. It is the absence of transparency, which is endemic in the application of the death penalty. This impenetrable shroud of secrecy that cloaks the execution process is a by product of the desire and legislative command to protect the identity of the executioner. Unfortunately the black hood that covered the head of the person carrying out the execution has grown to a cement silo that shields nearly all aspects of execution procedures. It is this siloed environment that breeds the errors and flawed practices that hobble lethal injections. Such secrecy in government is not desirable or normal. The "administrative state" conducts most of the business of government. The country long ago outgrew the ability of our elected leaders to make every decision of state governance As the country grew government became more and more the activity of what is done by government agencies instead of elected leaders who define policies but not details. This model works and indeed can work well when certain prerequisites for success are maintained. The most vital requirement is that such agency decisions be made in the open. Best practices can only emerge if information is shared. Optimal results are only possible if "lessons learned" are observed and shared THIS DOES NOT HAPPEN ANYWHERE IN THE REALM OF CAPITAL PUNISHMENT IN THE UNITED STATES. Mistakes are made and they are repeated. Best practices never emerge because no one is learning from what others have tried. The Supreme Court in its seminal public trial ruling

in Waller v. Georgia, 467 U.S. 39, 40-41 (1984), said it well: people function more effectively when others are watching and their performance is the subject of public scrutiny.

[The IRC's investigation found chilling examples of the failures that can occur when others are not watching --- from corrections officials seeking to learn on the eve of an execution what doses of lethal drugs to administer from Wikipedia, to shipments of state procured lethal drugs delivered to a private home in Phoenix with no apparent or verifiable chain of custody, to the storage of lethal drugs in unmarked jars with no labeling whatsoever.]

[This secrecy, a functioning and literal cone of silence, is the fundamental flaw that dooms lethal injection. Beyond this fundamental challenge, two issues in particular hobble lethal injection and assure suboptimal results: The unavailability of the appropriate and best drugs for the task and the unavailability of the best and most suited medical personal are practical limiting realities that cannot be overcome. This section will detail how the best drugs are unavailable, and the danger posed when governments seek to circumvent those limitations by non-standard measures (including a secondary threat to public safety in general). Included in this section will be the difficulties posed by compounding This section will also examine the need for the most skilled and appropriate medical personnel, anesthesiologists, their unavailability, and the dangers posed by employing non-equivalent practitioners. In summation, this Section is expected, unless contradicted by the yet-to-be-completed dry run observation and interviews mentioned above, this Section will make the case that while certainly possible in theory, lethal injection is not a viable method of execution in actual practice.]

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Section 4

[Section 4 identifies how Arizona may best accomplish executions that pose the least possibility of producing executions that are deemed as "botched." It will also address steps Arizona can take to preserve the critical transparency this Report advocates. Given that lethal injections cannot fulfill its promised function, other states have turned to other methods, some old and others new. Alabama recently has conducted executions with nitrogen gas, but its experience is not transparent and thus there is little to no public knowledge about its efficacy and safety.]

[There is a method of execution which appears to overcome the limitations discussed above, execution by firing squad. It is important to state that the firing squad as a method of execution is subject to the fundamental flaw endemic to everything associated with executions. The knowledge, experience, and opportunity to benefit from "lessons learned" is so limited by the cloak of secrecy that conceals everything about executions, that one can honestly know very little for certain. The firing squad method does overcome the impediments to lethal injections from unavailability of material and skilled personnel. Presumably skilled marksmen and markswomen are among the employees of the ADCR&R and the material, rifles and ammunition, are readily available and subject to no limitations on their use. While visibly violent (the ending of a life and overcoming that person's will and biological command to live is by nature a violent act in every case — even lethal injection), execution by firing squad produces unconsciousness almost immediately and final death is achieved very soon thereafter. A dozen shooters targeting a silhouette of the heart placed immediately above the actual organ would result in an obliteration of that organ and an immediate cessation of its pumping function thus depriving all cells in the body of the oxygen required to function.]

[Transparency can be maintained by maintaining the role of an Independent Review Commissioner as an external monitor to assure that activities associated with executions, not required to be restricted because of the statutory command or legitimate public safety concerns, are fully transparent.]



Arizona Department of Corrections Rehabilitation & Reentry

> 701 E. Jefferson St. PHOENIX, ARIZONA 85034 (602) 542-5497 corrections.az.gov



RYAN THORNELL DIRECTOR

November 22, 2024

VIA EMAIL ONLY

Ben Henderson, Director of Operations Office of Governor Katie Hobbs 1700 West Washington Street Phoenix, Arizona 85004

RE: Independent Death Penalty Review Commissioner

Director Henderson,

Over the past 16 months, the Arizona Department of Corrections, Rehabilitation & Reentry (ADCRR) has remained committed and steadfast in its efforts to facilitate a thorough, comprehensive, and transparent review by Retired Judge David Duncan as the Governor's Independent Review Commissioner. Having served as ADCRR's General Counsel from July 2023 through October 2024, and appointed as Deputy Director in October 2024, I was personally responsible for ensuring and overseeing Judge Duncan's access during the course of his review.

Below, I have briefly detailed the steps I took to facilitate Judge Duncan's review. Following this brief overview, you will find in *Section 1*, substantive concerns and inaccuracies with Judge Duncan's draft report and in *Section 2*, specific concerns regarding Judge Duncan's process, documentation, and handling of this review, overall.

Beginning in July 2023, I compiled thousands of documents obtained from various divisions of the ADCRR. These documents included individual execution files, hand-written notes from past administrations, logs of activities from the moment a warrant of execution was issued, receipts, protocols, among other records. Ultimately, these documents were sorted and made available to Judge Duncan to review in my office. Judge Duncan's review of those records began in September 2023 and culminated over the course of a year.

I was also responsible for providing Judge Duncan with access to individuals involved in executions, past and present, and scheduling those interviews. And, I coordinated a tour for Judge Duncan of ASPC-Florence on September 26, 2024 with two senior staff members. That tour included an opportunity to view the Department's current supply of raw pentobarbital, lethal injection room, gas chamber, and chemical room.

Over the course of the past 16 months, I have made every effort to ensure Judge Duncan has open and transparent access, including diligence in facilitating his review, and responsiveness

KATIE HOBBS GOVERNOR to each of his requests. After reviewing the draft report Judge Duncan issued on October 25, 2024, I feel it's necessary to express my concerns. As I've outlined below in *Section* 1, there are numerous inaccuracies and misrepresentations of facts that seriously call into question the validity of the draft report.

Section 1

1. Silos and secrecy in execution procedures

Judge Duncan characterizes the silos and secrecy in execution procedures as, "... a by product of the desire and legislative command to protect the identity of the executioner." He goes on to state, "Optimal results are only possible if "lessons learned" are observed and shared THIS DOES NOT HAPPEN ANYWHERE IN THE REALM OF CAPITAL PUNISHMENT IN THE UNITED STATES."¹

The Department does not dispute that silos and secrecy in execution procedures have existed for quite some time. And, on a number of occasions during Judge Duncan's review he expressed this concern. However, the Department has informed Judge Duncan, on many occasions, of its recent efforts to break down these silos. This includes conversations with multiple other states and the Department's actions in traveling to other states to learn, observe, and collaborate. Judge Duncan failed to include this information in his draft report painting an inaccurate picture that the current ADCRR is not making sizable changes to improve transparency.

2. Sources of information re: Dixon, Atwood, and Hooper executions

Judge Duncan cites to media reports from the last three executions, however, for at least two, he fails to reconcile this information with other media sources and with what is contained in the official execution files provided by the Department to Judge Duncan for review.

For example, in the execution of Frank Atwood on June 8, 2022, Judge Duncan's draft report provides, "On June 8, 2022, Arizona executed Frank Atwood and the execution team had similar problems inserting two functioning IV lines. After several attempts, the executioners set one peripheral line in Atwood's left arm, and then began preparing to set a femoral line on the right side. The execution team ultimately put the needle in Atwood's right hand – rather than his right arm – at Atwood's suggestion."² However, CBS News, cited by Duncan, provides the following, "Bud Foster, a journalist for CBS affiliate KOLD-TV who has witnessed multiple executions, including Wednesday's, said the process of setting up IVs into Atwood for the lethal injection went smoothly and that "it was probably the most peaceful of any of the executions that I witnessed in the past."³ And the official execution file documents that

¹ Hon. David K. Duncan (Ret.), DRAFT FINAL REPORT (Oct. 25, 2024), p. 9.

² Hon. David K. Duncan (Ret.), DRAFT FINAL REPORT (Oct. 25, 2024), p. 7.

³ Frank Atwood executed in Arizona for 1984 murder of 8-year-old girl, CBS NEWS (June 8, 2022, 5:50 p.m.), https://www.cbsnews.com/news/frank-atwood-execution-arizona-murder-vicki-hoskinson/.

the IV procedure took approximately 15 minutes with the primary catheter placed in Atwood's left elbow and the backup IV catheter placed in Atwood's right wrist.

In the execution of Murray Hooper on November 16, 2022, Judge Duncan's draft report provides, "Witnesses also reported seeing execution team members attempt and fail to insert IVs into both of Hooper's arms before finally resorting to inserting a catheter into Hooper's femoral vein near his groin."⁴ However, the official execution file documents that the IV catheters were placed in the right femoral vein (primary) and the right forearm (backup).

Although Judge Duncan provides at the outset of his draft report, "*The footnotes are for my own drafting purposes and will not, with limited exceptions, be included in the Final Report*,"⁵ these discrepancies raise questions regarding the accuracy of reporting and the information relied upon for the draft report.

3. The cost of capital punishment

Judge Duncan indicates in his draft report that he asked the Department to assemble the relevant data related to the cost of the medical personnel and chemicals for executions. This information was provided to Judge Duncan by way of his file review, and subsequently reviewed by him some seven to eight months prior to the issuing of his draft report. Nonetheless, the Department reassembled the relevant information, providing it to Judge Duncan again on October 24, 2024, and allowing him in-person access to the files, again, on November 7, 2024.

4. Unmarked jars and labeling

Judge Duncan reports "*chilling examples of the failures that can occur when others are not watching*" such as "... *the storage of lethal drugs in unmarked jars with no labeling whatsoever*."⁶ The Department has spoken to the supplier of its current stock of raw material pentobarbital regarding the drug's shelf life, expiration dates, and proper testing protocols. These discussions also inquired as to the reason for the material to have been sent to the Department in unlabeled and unmarked jars. We learned from those conversations that this was done at the request of the previous administration to maintain confidentiality, and documentation confirms this. We have done our due diligence in verifying the purchase made by the prior administration and efficacy testing. The Department has also procured a sterile storage container for the raw material and ensured pertinent labeling including chemical, packaging, and receipt information, so as to not alter the state of the original packaging with which the previous administration received the pentobarbital, but to address the overarching concern regarding labeling. To imply the current ADCRR administration is

⁴ Jimmy Jenkins, Miguel Torres, Angela Cordoba Perez, *In Murray Hooper execution, Arizona struggles with lethal injection for 3rd time*, ARIZONA REPUBLIC (Nov. 16, 2022, 6 a.m., Updated 5:24 p.m.), <u>https://www.azcentral.com/story/news/local/arizona/2022/11/16/murray-hooper-execution-day-1980-phoenix-murder-convictions/10666614002/</u>.

⁵ Hon. David K. Duncan (Ret.), DRAFT FINAL REPORT (Oct. 25, 2024), p. 1.

⁶ *Id*. at p. 10.

perpetuating practices of the past is dangerous, especially when Judge Duncan was provided with facts to the contrary.

5. Chain of custody

Another example Judge Duncan provides of the "chilling examples of the failures that can occur when others are not watching" is "shipments of state procured lethal injection drugs delivered to a private home in Phoenix with no apparent or verifiable chain of custody. . .".⁷ Judge Duncan's statement, which appears to attribute the shipment of the Department's current supply of pentobarbital to a "private home in Phoenix" is factually inaccurate. The Department has provided Judge Duncan with documentation which includes the invoice for the pentobarbital sodium salt. That invoice identifies the address as "To be determined" and identifies that these were packaged unlabeled and shipped in unmarked jars and boxes. If the Department were offered a chance to respond to the draft report, the Department would have been able to share that the shipment was received at an official ADCRR location.

6. Gas chamber and Pinal County Medical Examiner

Judge Duncan also provides that the "rarely used gas chamber poses risk to the operators and the general public" and proffers that the Pinal County Medical Examiner had to "purchase a special container to contain the cyanide infused out-gassing lungs after the take possession of the executed cadaver."⁸ To my knowledge, Judge Duncan never inquired about the gas chamber nor did he speak to the Pinal County Medical Examiner to support this statement, despite multiple offers made by the Department to arrange a meeting.

7. Judge Duncan's recommendation for firing squad

Judge Duncan proposes that execution by firing squad appears to overcome the limitations with lethal injection. Judge Duncan further provides "What can be said with certainty is the firing squad method does overcome the impediments to lethal injection from unavailability of material and skilled personnel."⁹

To provide additional background and context, there have been three executions by firing squad in the United States since the Supreme Court reinstated capital punishment in 1976.¹⁰ The most recent execution by firing squad occurred in 2010, after a 14-year hiatus.¹¹ Prior to 1976, there were two known "botched" executions in the United States by firing squad, both in Utah in 1951 and 1879, respectively.¹²

⁷ *Id*. at p. 10.

⁸ *Id*. at p. 4.

⁹ *Id*. at p. 11.

¹⁰ Methods of Execution, DEATHPENALTYINFORMATIONCENTER.COM,

https://deathpenaltyinfo.org/executions/methods-of-execution (last accessed November 19, 2024).

¹¹ Ed Pilkington, Utah firing squad executes death row inmate, The Guardian (June 18, 2010, 02:46 EDT) <u>https://www.theguardian.com/world/2010/jun/18/firing-squad-executes-death-row-inmate</u>.

¹² Botched Executions in American History, DEATHPENALTYINFORMATIONCENTER.COM, <u>https://deathpenaltyinfo.org/stories/botched-executions-in-american-history</u> (last accessed November 19, 2024).

Currently, five states allow execution by firing squad - Idaho, Mississippi, Oklahoma, South Carolina, and Utah.¹³

However, with the last execution by firing squad occurring 14 years ago, little recent data and information exists as to how this would be practically carried out today. Idaho, as the most recent state to adopt execution by firing squad, has publicly estimated it will cost approximately \$1 million to retrofit the execution chamber to be utilized for purposes of a firing squad.¹⁴

Turning to Judge Duncan's review, the Department is unaware of any analysis he conducted regarding the safety, operational, or logistical challenges in recommending execution by firing squad in Arizona. Putting aside, for a moment, that this recommendation does not appear to be supported with sufficient information, the proposal fails to consider the potential for error, overlooks the operational and logistical challenges in retrofitting a proper space, and assumes that "*six to a dozen*" individuals are "*readily available*" to assist.¹⁵ None of this is known nor is it discussed in the draft report. What we do know is that only three executions by firing squad have been carried out in the last 48 years, and two "botched" firing squad executions occurred prior.

Section 2

Notwithstanding the substantive concerns and inaccuracies in Judge Duncan's draft report, I further write to candidly share troubling observations and instances regarding Judge Duncan's process, documentation, and handling of this review, overall.

1. Failure to take minimal confidentiality precautions

On a number of occasions, Judge Duncan failed to take minimal confidentiality precautions. For example, in emails on October 29, 2024 and November 12, 2024, Judge Duncan referred to the past medical/IV team doctor by name and failed to note in the subject line, or elsewhere, that the information was confidential or otherwise protected.¹⁶

ADCRR's concerns over Judge Duncan's failure to take minimal confidentiality precautions extend to his in-person review and access to ADCRR records. On October 26, 2024, more than a year into his review, the Department learned that Judge Duncan

¹³ Methods of Execution, DEATHPENALTYINFORMATIONCENTER.COM,

https://deathpenaltyinfo.org/executions/methods-of-execution (last accessed November 19, 2024).

¹⁴ Kevin Fixler, *Firing squad chamber priced at \$1M as Idaho preps for next execution by lethal injection*, Idaho Statesman (Oct. 20, 2024, 4 a.m.),

https://www.idahostatesman.com/news/northwest/idaho/article294177959.html.

¹⁵ Hon. David K. Duncan (Ret.), DRAFT FINAL REPORT (Oct. 25, 2024), p. 11.

¹⁶ The Non-Disclosure Agreement (NDA) signed by Judge Duncan provided in relevant part, that Judge Duncan "agrees not to directly or indirectly disseminate to any third party person or entity any observations made or information obtained, both written and oral, either before, during or after the review or when issuing any reports, that is confidential and not subject to disclosure by A.R.S. § 13-757(C) or is otherwise proscribed by *First Amendment Coalition v. Ryan*, 938 F.3d 1069 (9th Cir. 2019)."

had previously taken photographs of key documents from execution-related folders, files, and boxes. This was never discussed with, or agreed to, by the Department. Had the Department known that Judge Duncan intended to duplicate confidential documents on his personal I-Pad, it would have been prohibited from the outset. To my knowledge, the only documents provided to Judge Duncan with explicit permission for him to take included blank recorder logs and an inventory log. When asked for copies of the photos to ensure fulfillment of the Department's obligations to keep these documents confidential, Judge Duncan refused to provide them and questioned why it was necessary. Judge Duncan provided the following response,

"With respect to your request regarding the photos, be assured that only I have access to them and I will destroy them when the project is complete. I would not allow you to stand at my shoulder while I reviewed the Department's documents and took notes. Similarly, I can perceive of no valid reason to provide the photos, especially in light of EO 5's command for transparency and that "[t]he Commissioner shall have access to ADCRR records."

Lastly, during Judge Duncan's most recent review of the Department's documentation on November 7, 2024, he haphazardly placed documents back in the box, mixing up their order and folder origin, increasing the risk of exposing confidential information to unauthorized individuals and making it harder to both track and control access.

2. Communication challenges

I also experienced a number of troubling communication challenges during the course of Judge Duncan's review ranging from cancellations, periods of silence, and failure to follow through with commitments. At the outset, these challenges are perhaps best illustrated by way of a timeline. Following the timeline, I have provided a summary of the significance of these events.

December 14, 2023	Judge Duncan emailed me, asking for additional files and notifying me that he would not be able to conduct further review until January 13, 2024. In that email, Judge Duncan asked that I draft letters on his behalf for current and former employees and provided, "I will submit my interview requests when the document phase is complete."
December 15, 2023	I responded to Judge Duncan's December 14 th email one day later, asking for additional context on the remaining files he was looking for and letting him know that I would draft letters on his behalf for current and former employees.

January 16, 2024 I sent an email following up with Judge Duncan. In that email, I asked Judge Duncan (1) when he planned to finish his record review, (2) for a list of individuals he'd like to interview, and (3) notified him that the draft letters for

	former and current employees were prepared. On the same day, Judge Duncan asked for my indulgence to focus on some personal matters at home.
January 25, 2024	Judge Duncan emailed me to let me know he would "be on the back burner for a bit longer" due to some personal matters and that he would check in the following week.
February 1, 2024	Judge Duncan asked to start his interviews by talking first with "the senior person currently responsible for executions."
February 5, 2024	I asked Judge Duncan for his availability to schedule interviews with the "senior team" currently responsible for executions. ¹⁷
February 26, 2024	I was copied on an email in which Judge Duncan reached out to a former high ranking Department employee without providing that information to the Department ahead of time, as we had agreed upon. On the same date, I followed up with Judge Duncan again, in response to his query from December 14, 2023, to ask if he had assembled his list of current/former employees he'd like to interview and reminded him that the draft letters were prepared. Judge Duncan responded, letting me know that he was working on the list of current/former employees to interview and indicating that he jumped ahead with that employee "because I [knew] him from his time at my court."
May 10, 2024	After the March 1, 2024 meeting with ADCRR's senior team, the Department did not hear from Judge Duncan until May 10, 2024. In the May 10, 2024 correspondence, Judge Duncan updated the Department on a personal issue that was causing a delay longer than anticipated. Judge Duncan also requested time to review the last box of files and schedule interviews at that time, but neglected to include a list of individuals he wanted to interview.
May 13, 2024	On May 13, 2024, I provided Judge Duncan with the date of May 17, 2024 to review any subsequent documents in my office. I also suggested that Judge Duncan start by interviewing a former high-ranking Department employee to learn about past executions. ¹⁸ Also in the May 13, 2024 correspondence, I offered for Judge Duncan to meet with two

 ¹⁷ The meeting with the "senior team" was scheduled and completed on March 1, 2024.
 ¹⁸ Judge Duncan later indicated he did not believe this would be fruitful and declined the recommendation.

	current senior ADCRR staff members on May 21, 2024 to learn more about current readiness and future executions. ¹⁹
May 28, 2024	I sent Judge Duncan a draft of our Department Order governing executions (DO 710), which contained substantial revisions, and invited his review and feedback.
August 28, 2024	I attended a meeting with Judge Duncan and members of the Governor's Office. During that meeting, Judge Duncan again stated he would provide a list of employees to interview and agreed he would send comments to DO 710 by the end of the following week.
August 30, 2024	I followed up with Judge Duncan, in writing, regarding his feedback to DO 710 and again inquiring about a list of former employees he wished to speak to.
September 3, 2024	Judge Duncan emailed and provided, "I will send interviewee names and protocol comments after I return to Phoenix tomorrow." Neither were sent.
September 4, 2024	I emailed Judge Duncan proposing interview times on September 20, 2024 and September 24, 2024 to interview three members of the current execution team.
September 6, 2024	Judge Duncan confirmed the September 20, 2024 and September 24, 2024 interview times would work.
September 9, 2024	Judge Duncan emailed "Dear Ashley: Did not finish on the deliverables owed to you today, but hope to tomorrow." Tomorrow came. The deliverables did not.
September 13, 2024	Judge Duncan emailed and said he would send over the draft protocol with his thoughts. Judge Duncan never sent his feedback.
September 20, 2024	Judge Duncan called me at 9:18 a.m. and emailed me at 9:26 a.m. to cancel two interviews scheduled to begin at 10:00 a.m. that morning.
September 22, 2024	Judge Duncan emailed me scanned copies of his paper calendar to review and find time for re-scheduling the two September 20, 2024 interviews. In reviewing Judge Duncan's paper calendar, I noticed the previously scheduled September 24, 2024 interview was not documented. On September 23, 2024, I pointed this discrepancy out to Judge

¹⁹ The meeting with two current senior ADCRR staff members was scheduled and completed on May 21, 2024.

Duncan and confirmed he intended to complete the interview. That interview did occur.

October 4, 2024 I emailed Judge Duncan offering, again, for him to take another look at the boxes of materials to help formulate his list of employees (current/former) who participated in the last three executions. I never received a response.

As demonstrated above, there were significant periods over the past 16 months in which ADCRR did not hear from Judge Duncan. Specifically, during a five-month period, from March 1, 2024 to May 10, 2024 and from May 28, 2024 to August 2024, Judge Duncan was only responsive during a two-week window. During that five-month time period, ADCRR was expecting Judge Duncan to provide a list of individuals to interview and to provide feedback to DO 710. Despite having access to Department files, records, and staff for over a year, Judge Duncan never provided a list of individuals to interview as part of the process and never provided feedback to DO 710.

During the course of Judge Duncan's file review, a number of other cancellations occurred. Judge Duncan was scheduled to review documents at the Department's Central Office on Monday November 13, 2023, Thursday November 16, 2023, and Friday November 17, 2023. On November 9, 2023, Judge Duncan canceled the Monday November 13, 2023 review and on November 15, 2023, Judge Duncan canceled the remaining days of the week.

3. Failed utilization of resources

The Department fully participated in Judge Duncan's review, offering to connect him with any and all resources intended to assist the process. And despite its limitations, the Department managed to propose alternative solutions that would address operational and confidentiality concerns. Unfortunately, Judge Duncan didn't take advantage of many of the resources made available to him. A few key examples highlight this issue.

- *Pinal County Medical Examiner* | The Department met with the Pinal County Medical Examiner to discuss its role in the execution process. This meeting was very informative, providing key historical information, protocols following an execution, and recommendations based on insight gained. Following that conversation, the Department offered for Judge Duncan to meet with the Pinal County Medical Examiner on multiple occasions. Judge Duncan declined each offer.
- *Refusal to communicate with medical/IV team in writing* | The Department has a statutory obligation to ensure the confidentiality of "the identity of executioners and other persons who participate or perform ancillary functions in an execution and any information contained in records that would identify those persons..." A.R.S. § 13-757(C).

In light of that statutory obligation, the Department suggested that Judge Duncan make recommendations regarding the qualifications of the medical/IV team and propose questions the Department should consider asking as part of the vetting process (as the specific individual members of the team may change over time), which could be included in his final report. However, he disagreed and remained adamant that he could only draw conclusions about the overall process by interviewing this specific medical/IV team in-person.

When Judge Duncan initially requested to interview the Department's new medical/IV team face-to-face, the Department instead offered to facilitate written questions being submitted to the team for their response, ensuring Judge Duncan received necessary information while maintaining the team's confidentiality. Judge Duncan refused to accept this offer of communication, demanding to interview the team in-person, allowing him "to look them in the eye" while gathering information. The Department did not support this demand, nor did the medical/IV team agree to a face-to-face interview, due to confidentiality concerns.

• *Refusal to observe an execution practice/walk-through simulation* | The Department offered to walk Judge Duncan through a "mock" training. And, as discussed above, two senior staff members met Judge Duncan at ASPC-Florence on September 26, 2024 with the intention of performing a walk-through. However, Judge Duncan remained adamant that observing a training would only be fruitful for his review if the medical/IV team were there in person and he could observe a training from the IV and lethal injection room. Judge Duncan refused to take advantage of any attempts to observe the walk through on September 26, 2024. Following that date, the Department once again made an offer to put together a "mock" training with ADCRR staff acting in place of the teams. Judge Duncan also denied this request and remained fixated on needing to see the medical/IV team in-person.

4. Failure to document interviews and conversations

On a number of occasions, Judge Duncan failed to document interviews and conversations which led to duplication of efforts later on. For example, on May 21, 2024, Judge Duncan interviewed two current ADCRR senior staff members. That conversation centered around best practices, confidentiality and transparency, the medical/IV team, procurement of pentobarbital, lab testing, and chain of custody. During that conversation, the qualifications of the new medical/IV team were explained to Judge Duncan, in detail. During that same meeting, Judge Duncan mentioned that he spoke to a past doctor who participated in executions.

However, on September 26, 2024, during the ASPC-Florence tour, Judge Duncan had no recollection of that prior conversation regarding the qualifications of the new medical/IV team and denied speaking to a doctor who has ever participated in an execution.

5. Difficulties in remembering meeting and document content

During the course of Judge Duncan's review, I have grown increasingly troubled by the challenges Judge Duncan has exhibited in reference to his ability to recall meeting and document content. A few specific examples illustrate this concern.

During an August 28, 2024 meeting between myself, Judge Duncan, and members of the Governor's team, it was agreed upon that the Department would allow Judge Duncan to visit ASPC-Florence for a walk through of a "mock" training. On August 30, 2024, I emailed Judge Duncan with the date and time to meet (September 26, 2024 at 12:00 p.m.) letting him know that two current senior ADCRR staff members would meet him at ASPC-Florence. And on September 26, 2024, two current senior ADCRR staff members met Judge Duncan at ASPC-Florence and provided him with an opportunity to view the lethal injection chemicals, execution room, chemical room, and walk through a "mock" training.

However, despite the previous conversation on August 28, 2024 and email correspondence on August 30, during the visit on September 26, 2024 Judge Duncan indicated that until the week prior, he thought he was coming to watch a "live training" with the medical/IV team.

Also during the September 26, 2024 meeting at ASPC-Florence, Judge Duncan asked about the cost of the chemicals, which was previously provided to him by way of his file review, and reviewed by him in early 2024. Nonetheless, I reassembled the relevant information, providing it to Judge Duncan on October 24, 2024, and allowing him in-person access to the files, again, on November 7, 2024.

During the September 26, 2024 meeting at ASPC-Florence, Judge Duncan observed the Department's supply of pentobarbital. It was explained to Judge Duncan, at that time, that the material in those jars consists of the raw material to be compounded. It was also confirmed this is the raw material that would be compounded for future executions. In relation to the previously compounded supply, since expired, Judge Duncan was informed that it was properly disposed of. When Judge Duncan raised concerns with the unmarked, unlabeled jars, the Department openly discussed the chain of custody, supported by documentation, and the Drug Enforcement Administration (DEA) oversight. One month later, on October 26, 2024, Judge Duncan emailed the Department, asking the same questions which had previously been answered. Specifically, his email provided:

"With respect to the seven pentobarbital jars . . . that I saw, is this the base to be compounded or is it the compounded base that has been prepared for use? If the latter, where is the 30 ml amber vial that the compounder prepared? If it has been destroyed, when was that, how was it disposed of, and is there a log or record of that? Also, is it the Department's intention to use for any future executions the pentobarbital that is presently in . . . ?" A response was provided on October 29, 2024 with the following, repeating information that had been provided to him on multiple numerous other occasions:

"The seven pentobarbital jars ... include the base to be compounded. Prior compounded pentobarbital (which expired) was properly disposed of through the use of a hazardous waste disposal company earlier this year.

Yes, it is the Department's intention to use the pentobarbital that is presently ... (and which corresponds to Attachment 2 in my previous email) for future executions."

I take my role in carrying out a warrant of execution with the utmost responsibility. And I have treated my role in facilitating Judge Duncan's review with that same responsibility and respect – with diligence every step of the way and a dedicated effort to ensure full transparency. While I believe Judge Duncan entered into his Commissioner role in good faith, the factual inaccuracies contained in his October 25, 2024 draft report, coupled with my concerns over his process and handling of the review overall, seriously call into question the validity of the draft report.

Respectfully,

Deputy Director

November 26, 2024

The Honorable David K. Duncan 3033 N. Central Avenue, Suite 500 Phoenix, Arizona 85012

Judge Duncan,

In March 2023, you were retained pursuant to Executive Order 2023-05 to produce recommendations for improving the execution process at the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR). You were primarily charged with reviewing the State's procurement of execution drugs, as well as the policies and protocols in place for carrying out an execution under existing law.

Your review has, unfortunately, faced repeated challenges, and I no longer have confidence that I will receive a report from you that will accomplish the purpose and goals of the Executive Order that I issued nearly two years ago. The early drafts of your work have called into question your understanding of the Executive Order and the actual scope of work you were hired to perform. For example, you recommend that ADCRR conduct executions by firing squad (a method not currently authorized by Arizona law), despite the Executive Order's direction to focus on procurement, protocols, and procedures related to carrying out an execution under existing law. I therefore write today to inform you that your continued service to the State is no longer necessary.

Under Director Thornell's leadership, ADCRR has undertaken a comprehensive review of prior executions and has made significant revisions to its policies and procedures. The Department has also doubled the size of its medical team with required regular training, implemented extensive documentation requirements for all aspects of the process, and mandated a post-execution review to inform any necessary changes to policy and procedure.

With these extensive changes in place, ADCRR is prepared to conduct an execution that complies with legal requirements if an execution warrant is issued.

I thank you for your service to the State and wish you the best in the future.

Sincerely,

Katie Hobbs Governor

From: David Duncan <	>		
Sent: Wednesday, November	r 27, 2024 7:58 PM		
To: Ashley Oddo <	; Bo Dul <	>; Kori Lorick <	>
Subject: David Duncan's resp	oonse to Ashlev Oddo's 11-2	2-24 letter to Ben Henders	on

Dear Ashley and Ben:

I write to respond to Ashley's November 22, 2024 letter, in which Ashley writes "[a]fter reviewing the draft report Judge Duncan issued on October 25, 2024, I feel it's necessary to express my concerns [about] numerous inaccuracies and misrepresentations of facts that seriously call into question the validity of the draft report."

My fundamental reaction to your letter is that I never "issued" a draft report. On October 24, 2024, I provided Director Thornell a draft outline I had prepared and previously provided to the Governor's counsels' office at their request. It was by no means a "draft report" as you describe it. The document makes that plain. On each page in bolded capital letters appeared the following banner: "**CONFIDENTIAL WORKING ROUGH DRAFT /NOT FOR DISTRIBUTION**". The first sentence of the first paragraph – an introductory preamble -- reads in italicized letters "*This is my working rough draft. Material set forth in italics within brackets is rougher still but is provided to give you an idea of where I am presently headed.*" The last sentence of the preamble reads, also in italics, "*The footnotes are for my own drafting purposes and will not, with limited exceptions, be included in the Final Report.*"

This document which was issued to the press was a "working" inchoate document designed to inform the Governor's office of my progress and serve as a tool to facilitate further preparation of the Final Report, which was by everyone's agreement to be issued before the close of this year.

Frankly, I was shocked that a high state official would think it permissible or honorable to publicly distribute a document knowing full well that it was a rough working draft that was not yet intended for distribution. Moreover, it is odd that you complain about your inability to respond to the draft when you made no effort to do so directly to me. Instead, you launched an inaccurate screed which includes its own errors and omissions. For the accuracy of the record, I address the most egregious inaccuracies below.

Paragraph 3 of your letter's first page states that the documents you provided for my review "were sorted" which suggests an organizational state that did not exist. Often it was impossible to ascertain the source of the document and there were frequent examples where it appeared that documents had been jumbled and haphazardly placed in no obvious organizational order.

Section 1

1 "Silos and secrecy in execution procedure"

Here you wrote that I failed to report that the Department was collaborating with other departments across the country. I repeatedly asked you and Director Thornell, including in March and October of this year, whether there was any such activity. When I asked Director Thornell whether there was information exchanged with other directors; whether there was a list serve, for

example. The answer was always no and there never was no effort to expand that answer, for example by saying, "but we are doing this..." I was never told about and never saw a document evidencing that your administration ever traveled to another facility.

2. "Sources of Information re: Dixon, Atwood and Hooper executions"

You criticize my citation to those witnesses who were critical of the last three executions. Different people had different impressions, but it is true that questions arose after each execution about whether things had gone well. Bud Foster standing on the other side of the glass may have thought Atwood's execution was not "botched", but your own senior officer told both of us in his interview that as the Atwood process took longer and longer tensions rose in the execution room.

3. "The cost of capital punishment".

You criticize my request to you that you assist me in the computation of the total cost of capital punishment. I asked for your help beyond providing documents because I found the documents you provided did not provide the all-inclusive answer I believed the Governor was seeking. One would expect a state agency to maintain a centralized budget line-item document identifying the costs associated with capital punishment. The documents you provided did inform me about some particular costs, but I could not reconcile those documents in a recognized accounting method. I was hopeful you could do that.

4. "Unmarked jars and labeling"

When you showed me the unmarked jars with no labeling whatsoever containing a Schedule 2 Controlled Substance, I was indeed shocked and justifiably so. No handler of such a dangerous chemical would consider this practice acceptable. Here you criticize my failure to include relevant information in the draft outline, but this was information you never provided to me (I only learned of the new container and labeling in your letter to Ben – which you never provided to me. I received it from a member of the media.) Finally, in response to your assertion that I lay responsibility for actions of previous administrations at your doorstep, it is your administration which maintained unmarked jars of a Controlled Substance in your refrigerator at the prison.

5. "Chain of Custody"

You say without any evidence that my statement describes the shipment of the Department's current supply of pentobarbital to a "private home". I did not know and do not know what purchase was associated with this private home but there were records of a substantial amount paid to a company with an address of a private home. These records were included in the Department's execution records. The records I reviewed did reveal past efforts of the Department to procure lethal drugs by way of subterfuge including concealing their true use or destination.

6. "Gas Chamber and Penal County Medical Examiner"

You say my comment regarding the Pinal County Medical Examiner's concerns about the gas chamber could not be true because I did not speak to the Pinal County Medical Examiner. Those comments were made by your Department's Inspector General to me as we walked from the gas chamber and I believed him (and I also believe you were present for that conversation).

7. "Judge Duncan's recommendation for "Firing Squad"

Your criticism of this procedure, with the lowest botch rate (0%) of all procedures (disregarding the two incidents you cite where it is said that the riffle team and the inmate were drunk at the time of the execution and the other where it is said that the team purposefully missed so as to inflict pain and suffering upon the prisoner whom they wished to bleed to death), is far preferable to the widely reported 7% botch rate for lethal injection.

Section 2

1. 1. "Failure to take minimal confidentiality precautions"

At all times, I scrupulously maintained the confidentiality of all protected information. As a retired federal judge, I am well-schooled, well-trained and well-practiced in assiduously protecting confidential information. All of the emails you criticize were directed to you. I am permitted to communicate otherwise confidential information to you and the Governor. You also complain about documents I scanned which was never prohibited by the Governor's order which specified to the contrary that I would have access to all department records. As a person with low vision, the scanned documents were much easier for me to read with my assistive device. As I promised you, I have destroyed the images now that my work is over. During the time they were in my assistive devise they were protected by a security system and two-factor identification security procedures. Last, you claim that I "haphazardly placed documents in the box." The box I suspect you refer to was packed in a way where there was not always an obvious order that could be observed. All of the documents were returned to you in that very box and thus I cannot see how the security of those documents could plausibly have been threatened.

2. 2. "Communication challenges"

This section mainly described times during the period of March through September 2024 where you knew that I faced a number of severe medical challenges, including a gym accident to my eye that required emergency surgery and a serious debilitating bout of Long Covid for which I traveled to the nation's leading Covid Center at Yale Medical School twice for diagnoses and treatment. Through the spring and summer, I missed appointments and sometimes was too sick to keep you as informed as I would have wished, but it was from no dereliction of duty. It was the most severe medical condition I have ever encountered. Nevertheless, I was focused on and

accomplished the tasks I thought most critical to the mission at hand. Interviewing former participants in executions was less relevant to me than interviews with those slated to participate in executions going forward. Indeed, when we arranged for some of those interviews you made the activity far less productive by producing people who had no responsibility going forward for the medical aspects of the execution process.

3. 3. "Failed utilization of resources"

It is not a valid criticism to suggest I erred by not following your suggestion of how best to conduct my independent investigation. The Governor sought and appointed an Independent Reviewer and thus it was my call what resources I thought would be most valuable. From the start I made it very clear that the medical aspects of the execution process would be the center of my focus because this is where the mistakes occur. Thus, speaking with the team directly and observing the medical team in a dry run was critical to applying the substantial knowledge I acquired about the perils and pitfalls of lethal execution. I am not a doctor but I have intensively studied the medical aspects of lethal injection. The medical team I wished to interview and observe in practice has never undertaken the tasks now expected of them. Any issue about my expectations or timing of my opportunity to observe a dry run is the fault of shifting sands at the Department and does not represent my inability to comprehend different proposals. I sensed the shift in the sands but was hoping to prevail in my request to observe the dry run that I was told would happen in September, and otherwise occurs four times a year.

4. 4. "Failure to document interviews and conversations"

Here I find your statements difficult to fathom. At the time you say I told you I I had spoken to a doctor who participated in an execution, I told you I had never spoken to any such doctor. Notwithstanding that I have previously addressed this claim with you, you repeat it here. One of us is lying or mistaken. It is not I.

5. 5. "Difficulties in remembering meeting[s] and document content"

This accusation, which I also have previously addressed with you, was not the product of an impaired or addled judge but part of my efforts to make certain I had the facts right in the face of many irreconcilable and incomplete records. Your statement that I sought confirmation of facts previously provided is correct in certain instances because I heard different things from you. Ashley, please recall, that when I recently asked you whether the pentobarbital base had an expiration date, you said it did not. When I asked how you knew that, you said the manufacturer told you so. When I pointed out that I had seen no documents reflecting this conversation in the files provided to me, which were to be all files relative to lethal injection and the modern execution process maintained by the Department (including active files of current employees), you said you had notes but that you then destroyed them. I then and now find it difficult to comprehend how someone as careful as you would fail to document the evidentiary foundation for such an important fact.

In conclusion, if I failed to respond to any particular point and either of you wish further elucidation, I will gladly provide it. The draft outline was in part designed for such productive interchange which your precipitous actions precluded. I note that I am limited here by the deadline to prepare a response to documents criticizing me that you prepared several days ago, and did not provide to me but somehow were provided to the press yesterday. I received these letters last night from the press and was chagrined to learn about them in this manner.

Sincerely yours,

David K. Duncan

United States Magistrate Judge (retired)



Arizona Department of Corrections Rehabilitation & Reentry

701 E. Jefferson St. PHOENIX, ARIZONA 85034 (602) 542-5497 <u>corrections.az.gov</u>



RYAN THORNELL DIRECTOR

KATIE HOBBS GOVERNOR

November 22, 2024

The Honorable Katie Hobbs Governor, State of Arizona 1700 West Washington Phoenix, AZ 85007

RE: ADCRR's Execution Preparedness

Dear Governor Hobbs,

One of the most significant responsibilities I have as the Director of the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) is to properly and responsibly carry out a warrant of execution. I take this responsibility very seriously. Upon being named as Director, I knew that a full review and understanding of this process would be necessary in order to confidently proceed with an execution.

Below I have detailed the review that I, along with my senior staff, conducted to ensure we are fully prepared to properly and responsibly fulfill this role on behalf of the State. Additionally, you will find important information about the improvements we have made to the execution process overall.

Beginning in March 2023, I initiated a thorough review of past execution procedures and the current level of preparedness of ADCRR to carry out an execution, if necessary. This review involved inspecting execution files, touring execution areas and understanding past practices, meeting with staff and stakeholders, and observing other states' procedures, among other activities. Ultimately, this review culminated in the revision of the Department Order governing executions (DO 710)¹ and the implementation of many procedural changes to strengthen the process.

The initial stage of this effort involved a substantial review of ADCRR policy related to the execution process and individual execution files, including records of actions and transactions associated with the death penalty. The Department maintains an official execution file for every execution, with some past files more detailed and complete than others. This file review oriented

¹ ARIZ. DEPT. OF CORRECTIONS, REHABILITATION & REENTRY, DEPT. ORDER 701, EXECUTION PROCEDURES (Oct. 23, 2024).

us with decisions of the past, including the names of key staff members, action steps, and logs explaining what had occurred from the moment a warrant of execution was issued through the execution being completed. Additionally, we reviewed records of execution-related activities not included in the individual files, including records associated with the acquisition of the lethal injection drugs, hand-written notes from the past administrations, and details of the former medical/IV team members, among other records. This initial effort helped frame subsequent actions.

Next, the review involved touring ADCRR's execution unit at ASPC-Florence, and the storage room where the lethal injection drugs are kept. During this tour, we learned from staff previously involved in executions about the protocols utilized, the basic functionality of various components in the unit (i.e. audio equipment, restraints, etc.), and what functions worked well and what challenges were encountered. During these early months, we toured the execution unit several times to ensure we were well-acquainted with the area, its use, and to properly address any associated concerns. We also engaged with the Drug Enforcement Administration (DEA) to validate the current drug storage protocols, records related to the acquisition of the drugs, and on-going monitoring of the drug contents.

During this time, it is also important to note that our team met with the state crime lab's team at the Department of Public Safety (DPS), learning about the efficacy testing protocol associated with testing compounded pentobarbital prior to its use. Historically, the DPS crime lab team conducted efficacy testing following the compounding of pentobarbital from raw material into liquid, once a warrant of execution was ordered. During this meeting, we learned about the chemical testing protocol utilized by DPS to ensure drug effectiveness, shelf-life testing protocols, and practical steps to be taken if a warrant of execution is issued to initiate this process going forward.

Several other important meetings took place across this period of time, including with the Department's supplier of the pentobarbital, to validate the acquisition and validity of the Department's supply. These discussions provided necessary information and context regarding the drug supply, its shelf life, and aided our understanding of the direction from the previous administration surrounding the acquisition of the supply. Additionally, our team identified and met with the pharmacy compounder responsible for compounding the pentobarbital prior to use. These meetings allowed for a review of the compounder's qualifications and protocols for future executions. And lastly, our team met with the Pinal County Medical Examiner. This meeting was very informative, providing key information regarding past executions, protocols following an execution, and recommendations based on lessons learned.

The methodical process followed in the course of the review logically led to communicating with other state Departments of Corrections, learning about their execution protocols. These efforts focused on states that were actively preparing for executions and that had procedures that closely

aligned with the improvements we knew were necessary in Arizona. Our communications with other states involved telephonic interviews and discussions, as well as on-site visits to observe and learn. During these conversations and visits, we were able to compare prior ADCRR practices with the procedures of other states, which subsequently informed several of our policy revisions.

One such area identified for improvement was the composition and role of the medical/IV team. During the review, we thoroughly considered the pros and cons of continuing to use the previous medical/IV team used by ADCRR for executions. This included reviewing the qualifications and experiences of the previous medical/IV team, speaking to the previous doctor involved, and ultimately deciding to not retain their services. We then began building a new, larger medical/IV team, ensuring the team had the necessary qualifications and training that would effectively contribute to an improved process.

Once we were comfortable with the extent of the review, the information compiled, and the knowledge we had, we began drafting revisions to DO 710. We also assembled a new team of staff to support the work of carrying out an execution, led by a centralized administrative team, and began practicing execution protocols under our draft policy, in collaboration with the new medical/IV team. It was during these practices that we were able to determine the best protocols, address challenges, and problem-solve effective solutions using the information we gleaned during the review. This all informed a final version of DO 710, which I signed and made effective October 23, 2024.

As a result of this comprehensive review, I recognized the need for improvement in the following areas and have taken actions necessary to make substantive improvements, solidifying the new process. Overall, the revisions to DO 710, outlined below, are designed to ensure policy aligns with operational practice and new expectations, and to reflect the changes made regarding the execution procedures.

- 1. DO 710, Execution Procedures |
 - *Administrative team* | The Department created one centralized Administrative Team to oversee the execution process providing consistent, streamlined oversight and decision making.
 - *Size and training of medical/IV team* | Historically, the medical/IV team consisted of two members, with resource support from ADCRR staff. The Department improved this, increasing the team to four members and having the team operate independent of ADCRR staff support. Previously, the team was only required to participate in at least one training session with multiple scenarios within one day prior to the scheduled execution, without any other regular training requirements. Changes made increase

the requirement of the medical/IV team to train quarterly in addition to the day prior to the execution, and also add the requirement that quarterly training will include live insertion of the IV catheter (with saline) to assist in preparing for real-time scenarios. The medical/IV team will also receive necessary health information (i.e. height, weight) about the subject inmate ahead of an execution, ensuring they are properly informed and prepared to carry out the execution. The medical/IV team will also now conduct a health assessment of the inmate in the execution holding cell ahead of any execution.

- Medically informed decision making | The Department has faced criticism in relation to the medical decisions made and differing communication between the Director and medical/IV team throughout the execution process, including types of IV placements and reasons for medical protocols. State statute requires that "the penalty of death shall be inflicted . . . under the supervision of the state department of corrections."
 A.R.S. § 13-757(A). As the Director of ADCRR, I recognize the critical role I play in ensuring the supervision of inflicting the penalty of death successfully and humanely. A critical reason for bringing on a new medical/IV team is to clarify and set apart my role in decision-making and the role of the medical/IV team leader to provide medical information and advice. I will not make decisions without the advice of the trained and qualified medical/IV team.
- **Post-execution review** / It is important that each execution be properly debriefed and thoroughly reviewed following the event. The Department has established a process to conduct a post-execution review, within 14 days of each execution. This will allow for a thorough analysis of the procedure, identification of needed revisions, and other important considerations. Each review will be documented and become part of the official execution file. This review will be separate and independent from the death investigation conducted by the Office of the Inspector General.
- **Documentation** / The Department has added many necessary requirements for proper documentation of execution training, preparation activities, and other activities required in policy. Each new document will become part of the official execution file.
- *Watch protocol* | The previous version of DO 710 required a 35 day "death watch" i.e. moving an inmate from their living area to an isolation cell on "death watch" once a warrant for execution is issued. This period of time is unnecessarily long, isolating, and also unnecessarily staff intensive and burdensome. The Department reviewed a number of other state policies and procedures around death watch practices and

subsequently made changes to shorten this period from 35 days to 7 days.² This allows the inmate to remain around other inmates and staff in the time leading up to an execution, until 7 days prior, at which time they are placed on a constant watch.

- *Last meal and available property allowances* / Previously, the Department had strict protocols limiting the duration of an inmate's last meal and other food and drink items, and requirements for discontinuing food and drink items far-in-advance of the scheduled execution. Additionally, the Department strictly limited property allowances for inmates while on "death watch" and prior to an execution, unnecessarily. The Department considered policies and procedures in other states, and reviewed the safety and security concerns relating to these restrictions, and subsequently revised DO 710 to allow more time for the last meal, drinks, and expanded property allowances. There were no reasonable security issues identified to further these restrictions.
- *Restraint protocols* / The Department improved the protocols for escorting an inmate during pre-execution activities and eventual movement into the lethal injection room. Previously, full restraints (hand, leg, waist, and lead restraints) were required for every movement of an inmate, even when 4 to 6 escorting staff were present. The Department, in consultation with the restraint team, revised practices to individualize restraint protocols based upon each inmate's security risk, allowing a more inmate-specific and risk-based approach. Additionally, the Department improved the execution table, installing humane/therapeutic restraints in place of improper restraints (previously utilized), and allowing more accessibility for the medical/IV team.
- 2. <u>New Medical/IV Team</u> | Historically, the Department's medical/IV team consisted of a doctor and a nurse in addition to non-medical ADCRR staff. The Department spoke to members of the past medical/IV team, including the previous doctor, and visited other states to learn more about their practices and perspectives on what went well, was most effective, and what could be improved. As a result, the Department assembled a new medical/IV team including 2 medical doctors. The team has also been expanded from 2 members to 4 members and we have discontinued ADCRR staff from having roles related to the medical/IV team. One additional team member is a phlebotomist, providing

https://www.tn.gov/correction/statistics/executions/death-

watch.html#:~:text=The%20three%2Dday%20period%20before,orderly%20operations%20of%20the%20prison (last visited Nov. 20, 2024); North Carolina, during the week of execution, N.C. DEPT. OF ADULT CORRECTION, EXECUTION PROCEDURE MANUAL FOR SINGLE DRUG PROTOCOL (PENTOBARBITAL) (Oct. 24, 2013); Kentucky, 24 hours, KY. DEPT. OF CORRECTIONs, 9.5, EXECUTION (Sept. 20, 2005); Ohio, 24 hours, OHIO DEPT. OF REHABILITATION & CORRECTION, 01-COM-11, EXECUTION (Oct. 7, 2016); Oregon, 2 days, *Or. Death Penalty*, OR. DEPT. OF CORRECTIONS, https://www.oregon.gov/doc/about/pages/oregon-death-penalty.aspx (last accessed Nov. 20, 2024); Texas, day of, TEX. DEPT. OF CRIM. JUSTICE, CORRECTIONAL INSTITUTIONS DIVISION, EXECUTION

PROCEDURE (April 2021).

² Oklahoma, 35 days, OKLA. DEPT. OF CORRECTIONS, OP-040301, EXECUTION PROCEDURES (FEB. 20, 2020); Tennessee, 3 days, *Death Watch*, TENN. DEPT. OF CORRECTION,

a level of expertise to the team related to IV placement procedures. This team provides a significant level of relevant knowledge and experience to properly inform and carry out their duties.

The Department has made changes to ensure only the medical/IV team completes the medical-related processes, including the IV administration of the chemicals and monitoring of the EKG. As discussed above, the Department also increased the requirement of the medical/IV team to train quarterly and added the requirement that training would include live insertion of the IV catheter (with saline) to assist in preparing for real-time scenarios.

- 3. <u>Femoral central line IV placement</u> | The IV placement procedures utilized in recent executions (through 2022) were scrutinized for the length of time they took in the process, leading to executions lasting longer than expected. Past documentation indicates that at times, the IV placement included a femoral central line ("cut down" procedure), an extensive and intrusive IV placement process. There is inconsistency in the record about if and why this procedure was used in the last three executions, indicating unclear documentation, inconsistent expectations, and differing communication between the previous Director and the medical/IV team. Nonetheless, the Department has now clearly identified the Director's role in decision-making and the role of the medical/IV team leader in informing the Director to aid this. To reiterate, I will not make decisions without the advice of the trained and qualified medical/IV team.
- 4. <u>Compounder</u> | The Department has identified, and been in communication with, the compounding pharmacist used by the previous administration. The Department has reviewed the qualifications and competency of the compounding pharmacist along with the process used to compound the current supply of lethal injection drugs. The Department's discussions with the compounder have included testing, analysis, and pre and post compounding procedures.

Further, the Department has confirmed the pharmacist's willingness to sign appropriate documentation required by the Department for future compounding and to assist with this process moving forward.

• *Beyond-use-dates ("BUD")* | BUD's for compounded chemicals have been a topic of litigation in capital punishment. The Department has familiarized itself with the requisite guidelines in place for compounded drugs. Further, the Department has confirmed with its compounder that new guidelines released November 2022 have changed the maximum BUD from 90 days to 45 days, if the compounded drugs have not had a stability study and not passed a sterility test. With a sterility test and

stability study, the BUD increases to 90 days from the date of compounding.³ Given these BUD's, the Department intends to utilize its compounder only after a warrant is issued.

- *Post-compound testing* | The Department has re-confirmed its ability to use the state crime lab for post-compound efficacy testing.
- 5. <u>Previously compounded drugs</u> | The Department identified an existing supply of previously compounded lethal injection drugs from the prior administration, with identified expiration dates. The compounded drugs were past their established shelf life. The Department utilized a hazardous waste disposal vendor contracted with the State of Arizona to properly dispose of the waste and ensure that the forms required by the DEA were completed. At this time, the Department only maintains raw material pentobarbital that is ready for compounding, and is not expired.
- 6. <u>Supplier of pentobarbital</u> | It is the Department's understanding that the supplier of the current pentobarbital was identified by a former Attorney General.⁴ The Department has spoken to the supplier of its current supply of raw material pentobarbital regarding the drug's shelf life, expiration dates, and proper testing protocols. These discussions also inquired as to the reason for the material to have been sent to the Department in unlabeled and unmarked jars.

Based on those conversations, the Department understands that this was done at the request of the previous administration to maintain confidentiality, and available documentation confirms this. Additionally, the Department has complied with the DEA to ensure all necessary storage and documentation protocols continue to be adhered to for the storage of the drug.

- 7. <u>Discussions with other states</u> | Historically, conversations surrounding execution procedures with other states have been largely non-existent. Where conversations may have occurred in the past, they have been shrouded in secrecy due to the confidentiality obligations enshrined in law and general reluctance to be affiliated with the process. However, the Department has been in discussion with multiple other states to discuss their execution procedures and has traveled to 2 states as part of its review and preparation process.
- 8. <u>Closed Circuit Television and Audio</u> | The Department's closed circuit television system was previously in need of maintenance to ensure audio and visual access to the execution process. The Department's Information Technology (IT) and Facilities Divisions have

³ See United States Pharmacopeia, General Chapter 797, Pharmaceutical Compounding - revised as of November 2022.

⁴ See Letter re: Death Row Inmates, <u>www.azag.gov</u> (last accessed November 14, 2024)

worked together to provide maintenance and testing to ensure proper functioning of these systems. During training, the Department utilizes the audio and video systems, and ensures proper functionality, to replicate the process.

9. <u>Documentation and contracts for services</u> | Proper documentation and record-keeping from previous administrations was severely lacking. This presented challenges, initially, when trying to assemble required information and make decisions on actions including, but not limited to, agreements with the compounding pharmacy and medical/IV team.

The Department has since established a documentation/record-keeping mechanism which protects individual identities to comply with state law while ensuring a meaningful way to collect and retain information.

10. <u>Pinal County Medical Examiner</u> | The Department met with the Pinal County Medical Examiner on August 1, 2024 to discuss their role in the execution process, historically, and to establish a relationship moving forward. The Department solidified the partnership and obtained insight from that meeting.

As is evident by the scope of these review efforts across the last 20 months, and the extent of the procedural changes implemented, we have systematically reviewed, addressed, and improved the necessary protocols related to the Department's execution process.

I am confident in the methodology I used in leading this effort and am satisfied with the outcome. As such, I write to inform you that the Department is operationally prepared to proceed with an execution.

Respectfully,

Ryan Thornell, Ph.D. Director