No. _____

IN THE

Supreme Court of the United States

KENNETH EUGENE SMITH,

Petitioner,

v.

COMMISSIONER, ALABAMA DEPARTMENT OF CORRECTIONS, et al.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS FOR
THE ELEVENTH CIRCUIT

PETITIONER'S APPENDIX—VOLUME II (APP'X F-J)

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

KENNETH EUGENE SMITH, Plaintiff, v. JOHN Q. HAMM, in his official capacity as Commissioner, Alabama Department of Corrections, and TERRY RAYBON, in his official capacity as Warden, Holman Correctional Facility, Defendants.	)	Case No. 2:23-cv-00656-RAH CAPITAL CASE EXECUTION SCHEDULED FOR JANUARY 25, 2024

SECOND AMENDED COMPLAINT

Plaintiff Kenneth Eugene Smith alleges as follows:

INTRODUCTION

1. Plaintiff Kenneth Eugene Smith is in the custody of the Alabama Department of Corrections ("ADOC") at William C. Holman Correctional Facility ("Holman") under a death sentence imposed by the State of Alabama despite the jury's recommendation by a vote of 11 to 1 that he be sentenced to life imprisonment without the possibility of parole. As the Eleventh Circuit has recognized, "if Smith's trial had occurred today, he would not be eligible for execution because, in 2017, Alabama amended its capital sentencing scheme" to repeal the authority of elected circuit court judges to override a jury's sentencing determination. *See Smith v. Comm'r*, 850 F. App'x 726, 726 n.1 (11th Cir. 2021). Because the amendment applied only prospectively, Mr. Smith has been denied relief from his death sentence, even though that same sentence could not be imposed today given his jury's sentencing vote.

2. Mr. Smith brings this action under 42 U.S.C. § 1983 to enjoin an imminent deprivation of his rights and privileges secured by the Constitution and laws of the United States.

3. The State already has tried to execute Mr. Smith once. On November 17, 2022, Mr. Smith survived ADOC's attempt to execute him by lethal injection when ADOC personnel were unable to place intravenous ("IV") lines to administer lethal drugs to him. Mr. Smith's was the third consecutive execution that ADOC botched and/or failed for the same reason—its inability to place IV lines in the condemned person. ADOC's failed attempt to execute Mr. Smith caused him severe and ongoing physical and psychological pain, including severe post-traumatic stress disorder ("PTSD"). ADOC remained willfully blind to the risk of that outcome by failing to investigate what happened and why during its immediate two previous botched and/or failed executions to prevent a recurrence before it attempted to execute Mr. Smith.

4. Now ADOC seeks to execute Mr. Smith by nitrogen hypoxia—an execution method that has "never been used to carry out an execution and ha[s] no track record of successful use." *Bucklew v. Precythe*, 139 S. Ct. 1112, 1130 (2019) (internal quotation marks and citation omitted).

5. For years, and as recently as just a few months ago, ADOC had taken the position that nitrogen hypoxia was not a feasible, alternative method of execution. Then, on the eve of being required to disclose information regarding its failed attempt to execute Mr. Smith by lethal injection, ADOC suddenly changed course, now claiming it is prepared to carry out executions using nitrogen hypoxia.

6. Mr. Smith's execution by nitrogen hypoxia would violate his constitutional rights. ADOC selected Mr. Smith for the first ever attempted execution by nitrogen hypoxia even though he has an appeal pending in the Alabama Court of Criminal Appeals from the dismissal of a non-

frivolous state postconviction petition that addresses the constitutional problem with attempting to execute Mr. Smith for a second time, and even though other condemned people in Alabama who elected to be executed by nitrogen hypoxia when that option was made available to them in 2018 have exhausted their appeals.

7. ADOC's selection of Mr. Smith as the test subject for this novel and experimental method is arbitrary and capricious and inconsistent with its own stated "'custom [to] wait[] to move for an inmate's execution until he has exhausted his conventional appeals: direct appeal, state postconviction, and federal habeas." *Woods v. Comm'r, Ala. Dep't of Corrs.*, 951 F.3d 1288, 1292 (11th Cir. 2020) (citation omitted in original). As such, moving Mr. Smith to the front of the line for execution by nitrogen hypoxia violates his rights to due process and equal protection under the Fourteenth Amendment to the U.S. Constitution.

8. Moreover, the protocol by which ADOC intends to execute Mr. Smith is constitutionally deficient. ADOC proposes to carry out Mr. Smith's execution by nitrogen hypoxia by following its recently released Execution Procedures as of August 2023 (the "Protocol"). Ex. 1.[1]

9. When Mr. Smith challenged his execution by lethal injection in 2022 and proposed nitrogen hypoxia as a feasible and available alternative, he did not agree to be executed without knowing the protocol, much less by ADOC using a protocol that he had never seen and that was hastily introduced as a means to moot Mr. Smith's pending litigation about ADOC's previous failed attempt to execute him by lethal injection and forestall discovery into it.

[1] Mr. Smith has filed a copy of the Protocol under seal. Mr. Smith has filed a copy of the "public version," which includes redactions, on the public docket.

10. It is clear that the consequences of attempting an execution by nitrogen hypoxia using ADOC's deficient Protocol will be dire. If not performed correctly, execution by nitrogen hypoxia can result in another botched execution that risks leaving Mr. Smith with permanent injuries. For example, hypoxemia (low levels of oxygen in the blood), which can lead to hypoxia (low levels of oxygen in organs), can cause severe and permanent injuries short of death, including a persistent vegetative state, stroke, or the painful sensation of suffocation. Therefore, it is critical that the procedures ADOC employs are designed to reduce those risks to the lowest possible levels.

11. The Protocol, if used to attempt to execute Mr. Smith by nitrogen hypoxia, exposes him to a severe risk of superadded pain during the execution process, including but not limited to hypoxemia and hypoxia short of death, in violation of his right to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments to the U.S. Constitution. There are several specific problems with the Protocol, which will exacerbate—rather than reduce—the risk of the dire consequences that can result from nitrogen hypoxia for at least the following reasons.

12. First, it appears that ADOC intends to deliver pure nitrogen to the condemned person from a cannister through tubing that flows into a "one size fits all" mask that a member of the Execution Team will place over the condemned person's face and adjust. *See* Protocol § X.A.v.; Appendix C, § 2 ¶¶ 26–29. But the Protocol does not provide any information on the type of mask that will be used, or how the mask will be secured so that it remains sealed and in proper position over the condemned person's face throughout the process. Indeed, the Protocol contemplates that the condemned person will be permitted to make a statement after the mask is placed over his face. The protocol therefore assumes the mask will be secured in such a way that the inmate will be able to speak after it is in place, which can dislodge the mask and break the seal. *Id.* § X.A.ix. If the mask is not sealed throughout the process, oxygen can leak inside the mask

and the condemned person can inhale it. If the condemned person can inhale oxygen, that likely would prolong the time to reach unconsciousness and could lead to a persistent vegetative state, stroke, or the painful sensation of suffocation.

13. Second, the Protocol does not contemplate any mechanism to remove the carbon dioxide under the mask as the condemned person exhales so that carbon dioxide does not build to dangerous levels in the condemned person. If the condemned person inhales carbon dioxide after the mask is placed on his face, he will experience the painful sensation of suffocating and other dire consequences. This is particularly a problem given the provision in the Protocol that contemplates that the condemned person will be permitted to make a statement after the mask is placed over his face. *Id.*

14. Third, the Protocol does not specify the purity of the nitrogen that will be used or how the tanks will be stored when not in use, which is critical to prevent contamination. If ADOC uses less than 100% pure nitrogen to execute a condemned person, that likely would prolong the time to reach unconsciousness and could lead to the same dire consequences.

15. Fourth, the Protocol does not contain any provisions both during the days leading up to the execution and during the execution to address the unique situation of Mr. Smith who survived a prior execution attempt and is experiencing PTSD as a result. People with PTSD, like Mr. Smith, can experience nausea when they are re-exposed to the traumatizing event. A second attempt to execute Mr. Smith undoubtedly is such an event. And the Protocol does not provide for any procedures if a condemned person vomits into the mask in which case the condemned person could choke on his own vomit. Nor does the Protocol make any accommodation for condemned people with PTSD as a result of a previous attempted execution who may experience symptoms

such as intense psychological distress, extreme panic, or sleep disruption leading up to another attempt.

16. Fifth the Protocol unconstitutionally burdens Mr. Smith's First Amendment rights and violates his rights under the Religious Land Use and Institutionalized Persons Act ("RLUIPA"), 42 U.S.C. § 2000cc, *et seq.* and the Alabama Religious Freedom Amendment ("ARFA"), Ala. Const. art. I, § 3.01(V). The Protocol provides that a mask will be placed over the condemned person's face before he is permitted to make a statement. In addition to the risk of dislodging the mask, those provisions of the Protocol will interfere with Mr. Smith's right to speak audibly and to pray audibly with or without a spiritual advisor. There is no compelling governmental interest that justifies that burden on Mr. Smith's rights and, in any event, there are less restrictive alternatives to accomplish any purported compelling governmental interest.

17. There are feasible and available alternatives, including amendments to the Protocol to address its inadequacies. Absent such amendments, executing Mr. Smith by nitrogen hypoxia according to the Protocol would violate his Eighth and First Amendment rights.

JURISDICTION AND VENUE

18. This is an action for a declaratory judgment, injunctive relief, and any other relief available from the Court.

19. The Court has subject matter jurisdiction under 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331, 1343(a)(3), 1367(a), and 2201(a).

20. Venue is proper in the Middle District of Alabama under 28 U.S.C. § 1391(b).

PARTIES

21. Plaintiff Kenneth Eugene Smith, a citizen of the United States and of the State of Alabama, is an inmate at Holman under Defendants' supervision and subject to execution under a state court judgment of conviction for capital murder.

22. Defendant John Q. Hamm is sued in his official capacity as the Commissioner of ADOC. ADOC is an administrative department of the State responsible for administering and exercising the direct and effective control over penal and corrections institutions within the State. At all relevant times, Defendant Hamm has been acting under color of state law and as the agent and official representative of ADOC, pursuant to ADOC's official policies and procedures.

23. Defendant Hamm is responsible for procedures governing the execution of condemned people in Alabama, including developing and implementing the Protocol, and approving changes or amendments to it. *See* Protocol § I.A ("Approval authority for changes or amendments to this protocol is the Commissioner of the Alabama Department of Corrections"). Additionally, he is statutorily charged with providing the materials necessary to execute condemned people in Alabama. *See* Ala. Code § 15-18-82 ("It shall be the duty of the Department of Corrections of this State to provide the necessary facilities, instruments, and accommodations to carry out the execution.").

24. Defendant Hamm also is responsible for ensuring that all prisoners committed to ADOC's custody are treated in accordance with the U.S. and Alabama Constitutions.

25. Defendant Terry Raybon is sued in his official capacity as the Warden of Holman. At all relevant times, Defendant Raybon has been acting under color of state law and as the agent and official representative of Holman and ADOC, pursuant to ADOC's official policies and procedures.

26. Defendant Raybon is the statutory executioner of all condemned people in Alabama. *See* Ala. Code § 15-18-82 ("The warden of the William C. Holman unit . . . shall be the executioner."). In that capacity, Defendant Raybon plays a direct role in each execution that takes place at Holman. Defendant Raybon organizes the execution team. *See* Protocol § V. He is responsible for implementing ADOC policies and procedures governing executions, managing the preparations for an execution, and supervising the execution site during the execution. Defendant Raybon has specific responsibilities to inventory, inspect, and activate the equipment used in executions by nitrogen hypoxia and to ensure that the equipment is available and functioning properly. *See id.* §§ V.D.ii, V.D.iv, V.D.v, IX.E.ii, IX.I.v, IX.I.vi, X.A.i, X.A.xii, X.A.xiv, XI.A.iii, XI.A.v.

27. Defendant Raybon also is responsible for ensuring that all prisoners incarcerated at Holman are treated in accordance with the U.S. and Alabama Constitutions.

CASE OR CONTROVERSY

28. There is a real and justiciable case or controversy between the parties. Defendants intend to execute Mr. Smith by nitrogen hypoxia within a time frame set by the Governor. Defendants intend to use the Protocol to attempt to accomplish that result, which will subject Mr. Smith to an objectively intolerable risk of superadded pain.

EXHAUSTION OF ADMINISTRATIVE REMEDIES

29. Mr. Smith has no available administrative remedies because State law exempts "[t]he policies and procedures of the Department of Corrections for executions of persons sentenced to death . . . from the Alabama Administrative Procedure Act, Chapter 22 of Title 41." Ala. Code § 15-18-82.1(g).

FACTUAL ALLEGATIONS

A. Mr. Smith Has PTSD Caused by ADOC's Failed Attempt to Execute Him by Lethal Injection with Deliberate Indifference to His Constitutional Rights

30. In November 2022, ADOC tried and failed to execute Mr. Smith because it was unable to place IV lines to deliver lethal drugs into his bloodstream. ADOC did so despite experiencing the same problem in its two immediately preceding attempts to execute condemned people and without doing any investigation about what happened and why to prevent a recurrence before it attempted to execute Mr. Smith. Given that, ADOC's attempts to establish intravenous access went "'so far beyond what [is] needed to carry out a death sentence that [it] could only be explained as reflecting pain for pain's sake.'" *Smith v. Hamm*, No. 2:22-cv-497, 2022 WL 4353143, at *7 (M.D. Ala. Jul. 5, 2023) (citation omitted). Among other things, ADOC's actions left Mr. Smith with PTSD. About one year later, ADOC seeks to make Mr. Smith the test case for its novel and largely secret nitrogen hypoxia Protocol.

31. On July 28, 2022, ADOC botched the execution of Joe Nathan James when it strapped him to a gurney and poked, prodded, and cut him, attempting multiple times over three hours to access a vein for IV injection of the lethal drugs. On September 22, 2022, ADOC unsuccessfully attempted to execute Alan Eugene Miller because ADOC personnel were unable to set IV lines to administer the lethal drugs after they "painfully punctured [him] with needles over various parts of his body for approximately 90 minutes," which caused "extreme physical pain as well as psychological pain . . . ." *Miller v. Hamm*, 640 F. Supp.3d 1220, 1241 (M.D. Ala. 2022). After the botched execution of Mr. James and the failed attempt to execute Mr. Miller, ADOC did nothing to investigate its lethal injection procedures to determine what happened and why in an effort to prevent a recurrence.

32. In August 2022, three weeks after Mr. James's botched execution, Mr. Smith commenced an action in this District against Defendant Hamm, alleging that his execution by lethal injection would violate his right to be free from cruel and unusual punishment under the Eighth Amendment and seeking declaratory and injunctive relief to prohibit ADOC from executing him by lethal injection. *See Smith v. Hamm*, No. 2:22-cv-497, Complaint (DE 1) (M.D. Ala.) ("Lethal Injection Action")

33. After the botched execution of Mr. James and the failed attempt to execute Mr. Miller, ADOC remained willfully blind to the insufficiency of its lethal injection procedures and forged ahead with Mr. Smith's execution, which was scheduled for November 17 at 6 p.m.[2]

34. Before it attempted to execute Mr. Smith, Defendants and ADOC knew or should have known based on the difficulties that occurred during Mr. James's execution and Mr. Miller's attempted execution that the IV Team would have great difficulty establishing intravenous access, resulting in severe physical and psychological pain to Mr. Smith.

35. They further knew or should have known that what they allegedly had done to Mr. Miller—as described in a pleading that he filed in this District—stated a plausible claim for violation of the Eighth Amendment right to be free from cruel and unusual punishment. *See Miller v. Hamm*, No. 2:22-cv-506, 2022 WL 16721093, at *13–15 (M.D. Ala. Nov. 4, 2022).

36. Despite all that, Defendants and ADOC recklessly and knowingly charged ahead with deliberate indifference to Mr. Smith's Eighth Amendment right to be free from cruel and unusual punishment.

37. As Mr. Smith foresaw, and as happened in the previous two executions, ADOC was unable to place IV lines for delivery of the lethal drugs to him and its repeated, unsuccessful

[2] All times referenced in this Complaint are Central Time.

attempts to do so caused Mr. Smith severe and ongoing physical and psychological pain. *See Barber v. Gov. of Ala.*, 73 F.4th 1306, 1324 (11th Cir. 2023) (J. Pryor, J., dissenting) ("Mr. Smith's horrifying experience was not a singular event; it was just the latest incident in an uninterrupted pattern of executions by Alabama's Department of Corrections ('ADOC') that involved protracted, severely painful, and grisly efforts to establish the intravenous lines necessary to carry the lethal drugs into his body.").

38. A little before 8:00 p.m. on November 17, corrections officers handcuffed and put leg irons on Mr. Smith, removed him from the holding cell where he was located, escorted him to the execution chamber, and strapped him to a gurney with restraints around his arms, legs, and feet. Mr. Smith remained strapped to the gurney unable to move for nearly four hours even though a stay of the execution issued by the United States Court of Appeals for the Eleventh Circuit was in place until it was vacated by the U.S. Supreme Court at approximately 10:20 p.m. *See Smith v. Comm'r Ala. Dep't of Corrs.*, No. 22-13846-P, 2022 WL 19831029 (11th Cir. Nov. 17, 2022), *vacated sub nom.*, *Hamm v. Smith*, 143 S. Ct. 440 (2022).

39. Mr. Smith was not told that the Eleventh Circuit had stayed his execution. Nor was Mr. Smith released from the gurney restraints and removed from the execution chamber while the stay was in place. He believed that when he was taken into the execution chamber, all of his appeals had been exhausted, and that he would be killed imminently.

40. As a man of faith, Mr. Smith sought to maintain his dialogue with God. He thanked God for the week he had just had with his family and quietly sang to himself the contemporary hymn, "I'm not alone."

41. As time passed with no apparent steps to accomplish the execution and no information from the three corrections officers who remained in the execution chamber with him,

Mr. Smith became increasingly distressed due to the lack of circulation caused by the restraints and because his witnesses, including his wife, son, and daughter-in-law, had not arrived and he feared he would be killed without the ability to address them and the victim's family as he had planned.

42. At around 10:00 pm, three men wearing medical scrubs (the "IV Team") who were not identified to Mr. Smith, and have not been identified to him since, entered the execution chamber. At the same time, two men and one woman dressed formally, one holding an accordion folder and two holding a notepad and pen, also entered the execution chamber. Those people also were not identified to Mr. Smith and have not been identified since. Nor has ADOC disclosed the roles they served in the execution process or otherwise explained their presence in the execution chamber, which was particularly distressing because some of them appeared to be taking pictures or video with their cell phones.

43. On information and belief, others, including Defendants, observed activities in the execution chamber from an adjacent room.

44. ADOC's then-governing protocol for executing condemned people by lethal injection authorized only two methods for establishing IV access: the "standard procedure" or, if that was unavailable, "a central line procedure."

45. It should be a straightforward process to establish IV access by those procedures or to determine that neither is achievable. According to the Emergency Nurses Association Clinical Practice Guideline for Difficult Intravenous Access, "[t]he average time requirement for peripheral IV cannulation is reported at 2.5 to 16 minutes, with difficult IV access requiring as much as 30 minutes." ENA Clinical Practice Guideline: Difficult Intravenous Access (Revised Oct. 2015). And "[p]atients experience increased and potentially significant pain in association with multiple

IV attempts." J. Fields, *et al.*, *Association between multiple IV attempts and perceived pain levels in the emergency department*, 15 J. Vasc. Access 514, 518 (2014); A. Bahl, *et al.*, *Defining difficult intravenous access (DIVA): A systematic review*, J. Vasc. Access 1, 1 (Nov. 2021) ("multiple venipuncture attempts sometimes required for successful [IV] insertion . . . can cause pain and anxiety for the patient").

46. But, as it had with Messrs. James and Miller, ADOC took well in excess of 30 minutes attempting unsuccessfully to obtain IV access to administer the lethal drugs to Mr. Smith.

47. In an unsuccessful attempt to establish two IV lines by the standard procedure, the IV Team jabbed Mr. Smith repeatedly, sliding the catheter needle continuously in and out of his arms and hands, while ignoring Mr. Smith's complaints that they were penetrating his muscles and causing severe pain.

48. Having failed to establish IV access by the standard procedure, the IV Team next tried to do so using a central line procedure. Toward that end, at the request of the IV Team, the corrections officers tilted the gurney backwards so that Mr. Smith lay in a reverse crucifixion position with his head below his feet. Neither the IV Team nor anyone else in the execution chamber explained why they requested that or informed Mr. Smith about the procedure they were about to attempt.

49. After placing a blue surgical drape with a clear plastic shield in the face area over Mr. Smith, one of the members of the IV Team, who was wearing a surgical gown, face mask, and clear plastic shield over his face, made five or six needle jabs with a clear syringe in Mr. Smith's collarbone area, causing him severe pain. Then, the same IV Team member inserted a large gauge needle into Mr. Smith's collarbone area and made multiple jabs, which caused Mr. Smith so much pain that he contorted against the restraints on the gurney injuring his right shoulder and had

difficulty breathing. After what seemed like an eternity to Mr. Smith, the needle jabs stopped. All the while the IV Team, the corrections officers, and the three other people in the execution chamber ignored Mr. Smith's complaints about the severe pain he was experiencing and his pleas to contact the court presiding over the Lethal Injection Action and/or his counsel.

50. ADOC and the IV Team abandoned their efforts to obtain IV access shortly before midnight, long after it should have been apparent that they would not succeed. Mr. Smith was unable to stand, walk, or dress and undress himself without assistance when his ordeal concluded and the corrections officers released him from the gurney restraints.

51. Mr. Smith experienced and continues to experience a great deal of physical and psychological pain from ADOC's attempt to execute him. After the execution, he experienced lingering pain in his arm from repeated needle jabs and in his collarbone from ADOC's attempted central line procedure. He also experienced back spasms from being restrained on the gurney for nearly four hours.

52. Mr. Smith also has had chronically severe psychological consequences, including severe PTSD. In addition to difficulty sleeping, Mr. Smith's symptoms include nightmares, hypervigilance, hyperarousal, and disassociation (a defense mechanism to suppress threatening thoughts).

B. ADOC's Decision to Make a Renewed Attempt to Execute Mr. Smith by Nitrogen Hypoxia and to Put Him in the Front of the Line

53. Even after its failed attempt to execute Mr. Smith by lethal injection in November 2022, ADOC insisted that it would attempt to do so again by that method. In late August 2023, ADOC suddenly switched its position, on the eve of discovery deadlines in the Lethal Injection Action, and announced that due to Mr. Smith's unique circumstances lethal injection is not an available method to execute him and that it would execute him instead by nitrogen hypoxia.

ADOC chose Mr. Smith as the first condemned person to be subject to execution by that novel and untested method of execution even though he has an appeal pending in the Alabama Court of Criminal Appeals from denial of a state postconviction petition and there are other condemned people who chose to be elected by nitrogen hypoxia five years ago and whose appeals have exhausted. In addition, ADOC's actions had the effect of rendering the Lethal Injection Action moot before ADOC was required to engage in discovery and disclose what happened during its botched execution of Mr. James and its failed attempts to execute Mr. Miller and Mr. Smith.

1. ADOC Selected Mr. Smith for the First Ever Nitrogen Hypoxia Execution Contrary to Its Custom of Waiting Until Condemned People Have Exhausted Their Appeals to Execute Them

54. In May 2023, Mr. Smith timely filed a petition in the Circuit Court of Jefferson County seeking an injunction preventing the State from attempting to execute him again by any method (the "State Court Petition").

55. The State Court Petition arises from ADOC's failed attempt to execute Mr. Smith in November 2022. Mr. Smith contends that another attempt to execute him is constitutionally prohibited because it would follow "a series of abortive attempts," including ADOC's "single, cruelly willful attempt" to execute Mr. Smith, *La. ex rel. Francis v. Resweber*, 329 U.S. 459, 471 (1947) (Frankfurter, J., concurring), which "demonstrate[s] an 'objectively intolerable risk of harm' that officials may not ignore." *Baze v. Rees*, 553 U.S. 35, 50 (2008) (plurality op.) (quoting *Farmer v. Brennan*, 511 U.S. 825, 846 & n.9 (1994)).

56. As the claim that Mr. Smith asserts in the State Court Petition did not arise until ADOC's failed attempt to execute him in November 2022, it could not have been asserted in any previous state or federal postconviction proceeding.

57. On August 11, the circuit court dismissed the State Court Petition. Mr. Smith's appeal from that dismissal is pending in the Alabama Court of Criminal Appeals.

58. Defendants seek to execute Mr. Smith by nitrogen hypoxia despite Mr. Smith's pending appeal from the dismissal of the State Court Petition in the Alabama Court of Criminal Appeals and contrary to ADOC's own stated "'custom [to] wait[] to move for an inmate's execution until he has exhausted his conventional appeals: direct appeal, state postconviction, and federal habeas." *Woods v. Comm'r, Ala. Dep't of Corrs.*, 951 F.3d 1288, 1292 (11th Cir. 2020) (citation omitted in original).

59. There are other condemned people in Alabama whose appeals have exhausted and who elected to be executed by nitrogen hypoxia.

60. In 2018, the State authorized nitrogen hypoxia as a method of execution and permitted condemned people whose capital convictions were then final to elect to be executed by that method instead of lethal injection. *See* Ala. Code § 15-18-82.1(b)(2). The authorizing legislation served to moot litigation brought by condemned people in Alabama challenging the constitutionality of execution by lethal injection. *See In re: Alabama Execution Protocol Litig.*, No. 1:12-cv-316, Joint Motion to Dismiss (Doc. 427) (M.D. Ala.).

61. Mr. Smith was not a party to that litigation and did not elect to be executed by nitrogen hypoxia in 2018. But "[n]early 50 . . . death sentenced inmates in Alabama elected nitrogen hypoxia during the election period," including death-sentenced inmates "who have exhausted their conventional appeals." *Woods*, 951 F.3d at 1291–92. Those inmates have yet to be executed because ADOC only recently finalized a protocol for doing so. *See id.*

62. In addition, on information and belief, ADOC gave at least one condemned person who it intends to execute by nitrogen hypoxia a grace period so that the condemned inmate and

his counsel could review the Protocol *before* the State moved for authority to execute him under its procedures.

63. ADOC did not provide Mr. Smith with any comparable grace period; the State moved for authority to execute him by nitrogen hypoxia on the same day it released a heavily redacted version of the Protocol.

64. Even though Mr. Smith has an appeal pending in the Alabama Court of Criminal Appeals and other condemned people who elected to be executed by nitrogen hypoxia five years ago have exhausted their appeals, the State chose Mr. Smith to be the first condemned person to be subject to execution pursuant to its experimental nitrogen hypoxia Protocol.

2. ADOC'S Selection of Mr. Smith for the First-Ever Nitrogen Hypoxia Execution Served to Moot the Lethal Injection Action

65. Shortly after ADOC's failed execution attempt, Mr. Smith amended his complaint in the Lethal Injection Action to add allegations about that attempt and to add defendants who participated in it. In his second amended complaint, Mr. Smith sought declaratory and injunctive relief to prohibit ADOC from making another attempt to execute him by lethal injection. He also served discovery requests on the defendants, seeking, among other things, the identities of the people who participated in and observed ADOC's attempt to execute him and documents concerning ADOC's attempt to execute him.

66. For ten months after ADOC's failed attempt to execute Mr. Smith by lethal injection, ADOC threatened Mr. Smith with another attempt by the same method. It consistently represented that it would do so and that nitrogen hypoxia was not a feasible, alternative method of execution. For example:

- In December 2022, Defendant Hamm filed a petition for a writ of certiorari in the U.S. Supreme Court challenging the Eleventh Circuit's holding in the Lethal

Injection Action that Mr. Smith had plausibly alleged "that nitrogen hypoxia is an available alternative method" of execution and "that nitrogen hypoxia will significantly reduce his pain." *Smith v. Comm'r, Ala. Dep't of Corrs.*, No. 22-13781, 2022 WL 17069492, at *5 (11th Cir. Nov. 17, 2022).

- In February 2023, the defendants in the Lethal Injection Action moved to dismiss Mr. Smith's Second Amended Complaint on the ground, among others, that nitrogen hypoxia supposedly was not an available method of execution, as Mr. Smith had alleged, despite the Eleventh Circuit's prior contrary determination. *See Smith v. Hamm*, No. 2:22-cv-497, Defendants' Motion to Dismiss (Doc. 78) at 24–25 (M.D. Ala.).
- On July 28, 2023, the State relied on supposed changes in its lethal injection procedures as a basis to seek dismissal of the State Court Petition. *See Smith v. State*, No. CC-89-1149.61, State of Alabama's Motion to Dismiss Smith's Successive Rule 32 Petition (Doc. 53) at 10–12 (Ala. Cir. Ct. Jefferson Cnty.)

67. In May 2023, the U.S. Supreme Court denied Defendant Hamm's petition for a writ of certiorari. *See Hamm v. Smith*, 143 S. Ct. 1188 (2023). In July 2023, the district court denied the defendants' motion to dismiss Mr. Smith's Eighth Amendment claim for declaratory and injunctive relief in the Lethal Injection Action. *See Smith v. Hamm*, No. 2:22-cv-497, 2023 WL 4353143 (M.D. Ala. July 5, 2023). Thus, by July 2023, there were no more obstacles to discovery after defendants had delayed it for nearly one year trying unsuccessfully in the District Court, Court of Appeals, and U.S. Supreme Court to have Mr. Smith's claims dismissed.

68. Under the District Court's scheduling order in the Lethal Injection Action, the parties' initial disclosures required by Federal Rule of Civil Procedure 26(a)(1) were due on

August 29. And, by operation of Rule 26(d)(2)(B), the defendants' responses to Mr. Smith's then nearly nine-month-old discovery requests were due by September 7.

69. On August 25—the eve of its discovery obligations ripening in the Lethal Injection Action—the State moved in the Alabama Supreme Court for an order authorizing ADOC to execute Mr. Smith by nitrogen hypoxia.

70. At the same time the State filed its motion, defendants reversed position and moved to dismiss the Lethal Injection Action on the ground that "Defendant Hamm has determined that nitrogen hypoxia is an available means of execution and will be used in the execution of" Mr. Smith and "Defendant Hamm has determined that lethal injection is not available as to Plaintiff and will not be used in any future execution attempt of" Mr. Smith. *Smith v. Hamm*, No. 2:22-cv-497, Defendants' Motion to Dismiss Pursuant to Rule 12(b)(1) of the Federal Rules of Civil Procedure (Doc. 104) at ¶ 3 (M.D. Ala.). And, on August 29, the defendants moved to stay discovery in the Lethal Injection Action.[3]

71. Defendants' efforts to avoid discovery in the Lethal Injection Action are consistent with the historical lack of transparency into ADOC's execution procedures. The State exercises no greater power than when it executes condemned people. Consequently, the process by which the State does so demands maximum transparency to ensure that it is consistent with the Constitution and the values of the State's citizens. ADOC's execution processes, however, are anything but transparent.

72. ADOC conceals the identity of the participants in executions, what they do, and what "pre-execution" procedures it performs on condemned people. The only witnesses to those

[3] On September 20, the District Court entered a judgment enjoining Defendants "from executing Kenneth Eugene Smith by lethal injection" and dismissed the Lethal Injection Action. *Smith v. Hamm*, No. 2:22-cv-497, Final Judgment and Order (Doc. 112) at 3 (M.D. Ala.).

"pre-execution" procedures are ADOC personnel and the condemned person (who with the rare exception of Mr. Miller and Mr. Smith) ordinarily do not live to describe it. And, as ADOC's statements after the botched execution of Mr. James and the failed attempts to execute Mr. Miller and Mr. Smith indicate, ADOC cannot be relied on for a forthcoming and accurate explanation about those events.

73. On November 1, a slim majority of six justices of the Alabama Supreme Court granted the motion for an order authorizing ADOC to execute Mr. Smith by nitrogen hypoxia, with two justices dissenting. On November 8, the Governor scheduled Mr. Smith's execution by nitrogen hypoxia during "a thirty-hour time-frame . . . beginning at 12:00 a.m. on Thursday, January 25, 2024, and expiring at 6:00 a.m. on Friday, January 26, 2024.

C. ADOC's Nitrogen Hypoxia Protocol Poses an Intolerable Risk of Superadded Pain to Mr. Smith

74. ADOC has never attempted to execute a condemned person by nitrogen hypoxia. Nor has any other state or the federal government.

75. When it moved for authorization to execute Mr. Smith by that method, ADOC released a heavily redacted copy of the Protocol, which includes procedures for executing condemned people by nitrogen hypoxia. Despite his requests through counsel, neither Mr. Smith nor his counsel were provided with an unredacted copy of the Protocol or any other information about the process by which ADOC intends to execute Mr. Smith until November 22, 2023 after this Court ordered Defendants to produce an unredacted copy of the Protocol. *See* Ex. 2.

76. As one commentator has described it, ADOC's nitrogen hypoxia Protocol is "'a vague, sloppy, dangerous and unjustifiably deficient protocol . . . .'" Ed Pilkington, *'Astonishingly cruel': Alabama seeks to test execution method on death row 'guinea pig'* (The Guardian Sept. 2,

2023), https://www.theguardian.com/world/2023/sep/02/alabama-execution-nitrogen-kenneth-smith.

77. Despite its vagueness, it is apparent that the Protocol is wholly inadequate to protect Mr. Smith from violation of his Eighth Amendment right to be free from cruel and unusual punishment.

78. There is sparse research on how long a human must be exposed to 100% pure nitrogen to cause death, what happens if a human is exposed to less than 100% pure nitrogen for a prolonged period of time, or on the pain or sensations that a human exposed to nitrogen might experience. The American Veterinary Medical Association has advised that nitrogen hypoxia is an acceptable method of euthanasia for pigs but "is unacceptable for other mammals" because nitrogen "create[s] an anoxic environment that is distressing for some species."[4]

79. If it does not cause death, nitrogen hypoxemia can cause dire consequences, including a persistent vegetative state, a stroke, or the painful sensation of suffocation.

80. A persistent vegetative state is characterized by a profound and long-lasting loss of consciousness and cognitive function, including awareness, reasoning, and memory, and is often considered a long-term or permanent condition.

81. A stroke is a serious medical condition involving brain damage that can cause failure of speech, paralysis of limbs, and other serious effects.

82. The Protocol fails to account for and instead exacerbates the risks of those dire consequences.

[4] American Veterinary Medical Association, AVMA Guidelines for the Euthanasia of Animals: 2020 Edition.

83. It appears that the Protocol provides for nitrogen gas to be delivered through tubing into a mask placed and adjusted over the condemned person's face by a member of the execution team:

> The mask will be placed and adjusted on the condemned inmate's face. One Execution Team member will monitor the pulse oximeter while the Execution Team Captain verifies that the mask has been properly placed. The Execution Team Members responsible for secondary posts will be dismissed from the execution chamber after the mask has been properly placed.

Protocol § X.A.v; *see also id.* Appendix C, § 2 ¶¶ 26–29.

84. The Protocol does not contain any guidance on the type of mask that will be used, how it will be placed and adjusted and by whom, what training the person(s) placing and adjusting the mask will receive on how to do that and who will provide the training, how and under what criteria it will be determined whether the mask has been "properly placed," or what will happen if the mask becomes displaced during the procedure.

85. It is critical that the mask be properly secured and sealed throughout the process. An acknowledgement form that ADOC intends to require spiritual advisors who serve condemned people being executed by nitrogen hypoxia expressly warns of the possibility that nitrogen can leak outside the mask. If nitrogen can escape outside the mask, it follows that oxygen can infiltrate inside the mask. In that event, the time to unconsciousness will increase, posing a severe risk of dire consequences to the condemned inmate, including being left in a persistent vegetative state, experiencing a stroke, or experiencing the painful sensation of suffocating.

86. Many variables affect proper placement and securing of a mask. Variations in nose structure, facial hair, obesity, and other anatomic characteristics can increase the difficulty of mask ventilation. The Protocol does not account for those variations among condemned people to ensure

that a mask is fitted securely to each condemned person that ADOC intends to execute by nitrogen hypoxia.

87. In addition, movement of the face or head can dislodge a mask and break the seal, which is more likely in an execution setting than, for example, in a medical setting. The protocol exacerbates that possibility because it affords the condemned person an opportunity to speak *after* the mask is placed over his face:

> [After mask is placed,] [t]he Warden will enter the execution chamber [**redacted – filed under seal**] and read the execution warrant. The condemned inmate will be given the opportunity to make a final statement (no more than two minutes).

Id. § X.A.ix.

88. Speaking or attempting to speak may dislodge or otherwise alter the placement of the mask, which may result in an imperfect seal and leaking. Although the Protocol contemplates that, after the condemned person speaks, "[t]he team members inside the execution chamber will make a final inspection of the mask," *id.* § X.A.xiii, there is nothing in the Protocol to explain how that inspection will be completed and what it will entail to ensure that the mask remains sealed after the condemned person speaks and, if not, adjusting the mask appropriately. Nor are there any procedures for what happens if the mask is dislodged thereafter.

89. The Protocol is constitutionally deficient because it does not specify any criteria for inspecting the mask. There are no provisions identifying how the "team members" will determine if the mask is secure and will prevent oxygen from leaking inside the mask. Furthermore, there are no provisions detailing the training the "team members" will receive, their level of experience with the masks being used, or the metrics that will be used to ensure that the mask is "properly placed" and passes the "final inspection."

90. Moreover, while it is important to ensure that oxygen is not present under the mask for the condemned person to inhale, it is equally important to ensure that the carbon dioxide that the condemned person exhales does not remain under the mask for the condemned person to inhale.

91. The theory underlying the novel method of execution by nitrogen hypoxia is that because nitrogen is odorless and colorless, a human inhaling it will continue to breathe normally and continue to exhale carbon dioxide. In theory, that would avoid a buildup of excess carbon dioxide, which is what causes the sensation and pain of suffocation when a human is deprived of oxygen by other means.

92. If carbon dioxide that the condemned person exhales is trapped under the mask for the condemned person to inhale, carbon dioxide will build up in the condemned person's body, causing him to experience the sensation and pain of suffocation. The Protocol contemplates that "breathing air" will be supplied to the condemned person after the mask is placed and before nitrogen is pumped into the mask. *Id.* §§ X.A.ii, X.A.iv. That means that carbon dioxide can be trapped under the mask even before nitrogen flows into the mask. There is nothing in the Protocol to indicate that there is any mechanism to remove the carbon dioxide that the condemned person exhales that otherwise will be trapped under the mask and can cause suffocation and other dire consequences. Absent such a mechanism, the theory on which execution by nitrogen hypoxia is based collapses.

93. The Protocol also is constitutionally deficient because it does not specify the purity of the nitrogen gas that will be used or any procedures to test or otherwise determine whether it has been contaminated. If ADOC uses less than 100% pure nitrogen for a prolonged period of time, that entails a severe risk of the dire consequences from nitrogen hypoxia. Moreover, even if ADOC has obtained 100% pure nitrogen for use in executions, the Protocol lacks any information

about testing to ensure the purity, the source of the nitrogen, how it is transported or stored. Without that information, it is impossible to assess whether there is a risk that the nitrogen has been contaminated in the process of manufacture, transportation, or storage.

94. The Protocol also provides that when the condemned person is escorted to the execution chamber and placed on a gurney a "pulse oximeter will be placed and secured on the condemned inmate." *Id.* § X.A.iii. A pulse oximeter measures the level of oxygen in the blood. Under the Protocol, an execution team member is responsible for monitoring the pulse oximeter while the mask is placed and adjusted on the condemned person's face and for two minutes thereafter. *Id.* §§ X.A.v, vi. There are no procedures for monitoring the pulse oximeter after pure nitrogen is introduced, which could reveal that the execution should be halted because oxygen is infiltrating the mask and raising the risk of dire consequences short of death.

95. The Protocol is constitutionally deficient in other respects. It fails to provide procedures for the unique circumstance of Mr. Smith who survived an attempted execution, has PTSD, and may experience nausea if he is re-exposed to the traumatizing experience. The Protocol fails to provide procedures for a condemned person who vomits inside the mask, which might cause the condemned person to choke.

96. In addition, the Protocol provides for procedures in the lead up to an execution, including for notifying the condemned person, providing the condemned person a schedule for the week of the execution, the "Death Watch observation period," the placement of the condemned person in a holding/observation cell, and visitation during the execution week. *Id.* §§ IV–VIII. But the Protocol fails to provide procedures and basic safeguards for condemned people like Mr. Smith who have survived an attempted execution, have PTSD, and may experience exacerbating symptoms—such as intense psychological distress, extreme panic, or sleep

disruption—as they are forced to re-experience the days and weeks leading up to another execution attempt.

97. Instead, ADOC's procedures exacerbate Mr. Smith's PTSD. Since November 8, when the Governor scheduled his planned execution, Mr. Smith has been on "single walk" status, which means that he cannot share the same space with other Holman inmates—some of whom he has developed familial relationships with over decades. Ex. 3. Although nothing in the Protocol addresses "single walk" status, Defendants intend to maintain Mr. Smith isolated from his brothers on that status for 78 days through his planned execution.

98. "Single walk" status deprives Mr. Smith of the fellowship of his brother inmates when he needs their friendship most. It also deprives him of the companionship of his family during this critical period. Holman has a common visiting space. While Mr. Smith is on "single walk" status, Mr. Smith's family cannot schedule a visit with him when any other Holman inmate has a scheduled visit. Mr. Smith's "single walk" status also interferes with his relationship with his counsel when he needs their advice most because their visits are constrained for the same reason. And while Defendants recently permitted Mr. Smith to select one religious service that he will be permitted to attend each week accompanied by two corrections officers, his "single walk" status also burdens the exercise of his religion. Ex. 4.

99. Finally, the Protocol burdens Mr. Smith's rights to free speech and to free exercise of his religion under the First Amendment and violates his rights under RLUIPA. Under the Protocol, Mr. Smith will be masked as soon as he enters the execution chamber and remain masked thereafter. *Id.* § X.A.v. In addition to the other deficiencies associated with the mask, it will prevent or substantially interfere with Mr. Smith's ability to make a statement as permitted by the Protocol, *id.* § X.A.ix, and to pray audibly as to which "there is a rich history . . . at the time of a

prisoner's execution, dating back well before the founding of our Nation." *Ramirez v. Collier*, 595 U.S. 411, 427 (2022). Any such statement or prayer may not be audible and may risk consequences associated with dislodging the mask and/or building the level of carbon dioxide under the mask.

100. Significantly, there may be other problems with the Protocol that are shielded beneath redactions. But based only on what is disclosed, execution by nitrogen hypoxia using the procedures in the Protocol poses a severe risk of superadded pain to Mr. Smith.

D There are Feasible and Available Alternatives to the Protocol

101. Feasible and available alternative methods of execution exist that would reduce the risk to Mr. Smith from the Protocol.

102. ADOC can amend the Protocol to cure its deficiencies by including provisions to:

- Measure each condemned person subject to execution by nitrogen hypoxia for a custom fit mask to reduce the risk that oxygen leaks under the mask or, alternatively, use a closed space or a hood;
- Provide a condemned person an opportunity to speak and to audibly pray without being masked.
- Disclose the training "team members" will receive in placing and adjusting the mask over the condemned person's face, their level of experience with the masks being used, and the metrics that will be used to ensure the mask is "properly placed" and passes the "final inspection."
- Add a mechanism to remove carbon dioxide that the condemned person exhales from under the mask.
- Disclose the source of the nitrogen to be used, and information about its transportation and storage to avoid contamination.

- Require testing of the nitrogen gas before use to ensure purity of the nitrogen gas.
- Add procedures to monitor the pulse oximeter throughout the process.
- Add procedures to halt the execution if the condemned person vomits into the mask;
- Add procedures for attempting to execute condemned people who have survived a previous attempt and are experiencing PTSD as a result.
- Employ a third-party licensed medical provider who will be permitted (1) to observe the execution process from the time the condemned person is taken into the execution chamber until completed, and (2) has the authority to call off or postpone the execution if, in his or her judgment, the condemned person is at risk of serious injury short of death.

103. Alternatively, if Defendants are unwilling or unable to amend the Protocol so that it complies with constitutional requirements, the firing squad is an available and feasible alternative that will substantially reduce the risk to Mr. Smith of superadded pain posed by the Protocol. Utah has a protocol for using a firing squad to carry out executions, which "is 'sufficiently detailed to permit a finding that the State could carry it out relatively easily and reasonably quickly.'" *Nance v. Comm'r, Ga. Dep't of Corrs.*, 59 F.4th 1149, 1155 (11th Cir. 2023) (quoting *Bucklew v. Precythe*, 139 S. Ct. 1112, 1129 (2019)); *see also* Deborah W. Denno, *The Firing Squad as "A Known and Available Alternative Method of Execution" Post-Glossip*, 49 U. Mich. J.L. Reform 749, 778–92 (2016).

CLAIMS FOR RELIEF

First Claim for Relief

Violation of Mr. Smith's Right to Due Process and to Equal Protection Under the Laws Under the Fourteenth Amendment to the U.S. Constitution

104. Mr. Smith incorporates paragraphs 1 through 101.

105. At all relevant times, Defendants have been acting under color of state law.

106. The Fourteenth Amendment to the U.S. Constitution provides, in relevant part, that "No State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1.

107. It is Defendants' "'custom [to] wait[] to move for an inmate's execution until he has exhausted his conventional appeals: direct appeal, state postconviction, and federal habeas." *Woods*, 951 F.3d at 1292 (citation omitted in original).

108. Mr. Smith has not exhausted his appeals.

109. The State Court Petition is a state postconviction proceeding.

110. Mr. Smith's appeal from the dismissal of the State Court Petition is pending in the Alabama Court of Criminal Appeals.

111. Other condemned people in Alabama who elected to be executed by nitrogen hypoxia five years ago have exhausted their appeals. *See id.* at 1291–92.

112. Defendants sought and obtained authority to execute Mr. Smith by nitrogen hypoxia even though he has not exhausted his appeals and even though other condemned people who elected to be executed by nitrogen hypoxia have exhausted their appeals.

113. Defendants' actions toward Mr. Smith are arbitrary and capricious and violate its own stated custom regarding selecting condemned people for execution.

114. Defendants' disparate treatment of Mr. Smith is not rationally related to a legitimate government interest.

115. Mr. Smith has the right to be treated the same as all other condemned people in Alabama.

116. Mr. Smith will suffer irreparable harm in the absence of an injunction.

Second Claim for Relief

Violation of Mr. Smith's Right to be Free from Cruel and Unusual Punishment Under the Eighth and Fourteenth Amendments to the U.S. Constitution

117. Mr. Smith incorporates paragraphs 1 through 101.

118. At all relevant times, Defendants have been acting under color of state law.

119. The Eighth Amendment to the U.S. Constitution, as applicable to the State through incorporation into the due process clause of the Fourteenth Amendment, prohibits "cruel and unusual punishments." U.S. Const. amend. VIII.

120. A method of execution violates the Eighth Amendment if "the risk of pain associated with the State's method is substantial when compared to a known and available alternative." *Bucklew*, 139 S. Ct. at 1125 (citations and internal quotation marks omitted).

121. The U.S. Supreme Court has described punishments as unconstitutionally cruel "when they involve torture or a lingering death," *In re Kemmler*, 136 U.S. 436, 447 (1890), or when they "involve the unnecessary and wanton infliction of pain, *Rhodes v. Chapman*, 452 U.S. 337, 346 (1981). The Eighth Amendment forbids "forms of punishment that intensified the sentence of death with a (cruel) superadd[ition] of terror, pain, or disgrace." *Bucklew*, 139 S. Ct. at 1124 (citation and internal quotation marks omitted, alterations in original).

122. Defendants intend to execute Mr. Smith by nitrogen hypoxia using the Protocol, which would expose Mr. Smith to a severe risk of a persistent vegetative state, a stroke, or the painful sensation of suffocation, *i.e.*, superadded pain.

123. There are feasible and available alternatives that would reduce the risk to Mr. Smith from executing him by nitrogen hypoxia using the Protocol, including amending the Protocol as indicated in paragraph 100 and execution by firing squad.

124. Mr. Smith will suffer irreparable harm in the absence of an injunction.

Third Claim for Relief

Violation of Mr. Smith's Right to Freedom of Speech and Free Exercise of His Religion Under the First Amendment to the U.S. Constitution

125. Mr. Smith incorporates paragraphs 1 through 101.

126. At all relevant times, Defendants have been acting under color of state law.

127. The First Amendment to the U.S. Constitution, as applicable to the State through incorporation into the due process clause of the Fourteenth Amendment, provides, in relevant part, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech."

128. Defendants' Protocol provides for Mr. Smith to be masked when he enters the execution chamber and to remain masked throughout the procedure.

129. Masking will interfere with Mr. Smith's right to make an audible statement and to pray audibly. Any statement or prayer may not be audible and may risk consequences associated with dislodging the mask and/or building the level of carbon dioxide under the mask.

130. Mr. Smith will suffer irreparable harm in the absence of an injunction.

Fourth Claim for Relief

Violation of Mr. Smith's Rights Under RLUIPA

131. Mr. Smith incorporates paragraphs 1 through 101.

132. At all relevant times, Defendants have been acting under color of state law.

133. RLUIPA provides: "No government shall impose a substantial burden on the religious exercise of a person residing in or confined to an institution . . . even if the burden results from a general applicability, unless the government demonstrates that imposition of the burden on that person—(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." 42 U.S.C. § 2000cc-1(a).

134. "In RLUIPA, in an obvious effort to effect a complete separation from the First Amendment case law, Congress deleted reference to the First Amendment and defined the 'exercise of religion' to include 'any exercise of religion, whether or not compelled by, or central to, a system of religious belief.'" *Burwell v. Hobby Lobby Stores*, 573 U.S. 682, 696 (2014) (*quoting* 42 U.S.C. § 2000cc-5(7)(A)). RLUIPA thus provides more "expansive protection" for religious liberty than the United States Supreme Court case law. *Holt v. Hobbs*, 574 U.S. 352, 358 (2015).

135. The Protocol that Defendants intend to use to execute Mr. Smith substantially burdens Mr. Smith's religious exercise to pray audibly because he will be masked as soon as he enters the execution chamber which may prevent Mr. Smith's prayers from being audible.

136. The Protocol further substantially burdens Mr. Smith's religious exercise to pray audibly by forcing Mr. Smith to choose between abstaining from his religious practice of audible prayer at the end of his life or face the dangerous consequences of dislodging the mask while

praying. *See id.* at 361 (policy that forced inmate to comply with policy in violation of his religious beliefs or face disciplinary action substantially burdened inmate's religious exercise).

137. Defendants cannot establish that the burden on Mr. Smith's religious exercise is justified by a compelling governmental interest and, even if they could, cannot establish that the burden on Mr. Smith's religious exercise is the least restrictive means to further any purported compelling governmental interest. *See id.* at 362.

138. Mr. Smith will suffer irreparable harm in the absence of an injunction.

Fifth Claim for Relief

Violation of Mr. Smith's Rights Under ARFA

139. Mr. Smith incorporates paragraphs 1 through 101.

140. At all relevant times, Defendants have been acting under color.

141. ARFA provides: "Government shall not burden a person's freedom of religion even if the burden results from a general rule of applicability, except . . . if it demonstrates that application of the burden to the person (1) Is in furtherance of a compelling governmental interest; and (2) Is the least restrictive means of furthering that compelling governmental interest." Ala. Const. art. I, § 3.01(V).

142. The Protocol that Defendants intend to use to execute Mr. Smith burdens Mr. Smith's religious exercise to pray audibly because he will be masked as soon as he enters the execution chamber which may prevent Mr. Smith's prayers from being audible.

143. The Protocol further burdens Mr. Smith's religious exercise to pray audibly by forcing Mr. Smith to choose between abstaining from his religious practice of audible prayer at the end of his life or face the dangerous consequences of dislodging the mask while praying. *See*

id. at 361 (policy that forced inmate to comply with policy in violation of his religious beliefs or face disciplinary action substantially burdened inmate's religious exercise).

144. Defendants cannot establish that the burden on Mr. Smith's religious exercise is justified by a compelling governmental interest and, even if they could, cannot establish that the burden on Mr. Smith's religious exercise is the least restrictive means to further any purported compelling governmental interest. *See id.* at 362.

145. Mr. Smith will suffer irreparable harm in the absence of an injunction.

PRAYER FOR RELIEF

WHEREFORE, Mr. Smith respectfully requests that this Court grant the following relief:

1. With respect to the First Claim for Relief,
    a. A declaration that attempting to execute Mr. Smith by nitrogen hypoxia before he has exhausted his pending appeals would violate his right to equal protection under the laws under the Fourteenth Amendment to the U.S. Constitution.
    b. A preliminary and permanent injunction prohibiting Defendants from executing Mr. Smith by nitrogen hypoxia until he has exhausted his pending appeals or, alternatively, a stay of execution pending completion of Mr. Smith's appeals.
2. With respect to the Second Claim for Relief,
    a. A declaration that attempting to execute Mr. Smith by nitrogen hypoxia using the procedures outlined in the Protocol would violate his right to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments to the U.S. Constitution.
    b. A preliminary and permanent injunction prohibiting Defendants from executing Mr. Smith by nitrogen hypoxia using the procedures outlined in the Protocol.

3. With respect to the Third Claim for Relief,

    a. A declaration that attempting to execute Mr. Smith by nitrogen hypoxia using the Protocol would violate his right to freedom of speech and free exercise of his religion under the First Amendment to the U.S. Constitution.

    b. A preliminary and permanent injunction prohibiting Defendants from attempting to execute Mr. Smith by nitrogen hypoxia using the Protocol.

4. With respect to the Fourth Claim for Relief,

    a. A declaration that attempting to execute Mr. Smith by nitrogen hypoxia under the current Protocol would substantially burden his right to religious exercise under RLUIPA.

    b. A preliminary and permanent injunction prohibiting Defendants from attempting to execute Mr. Smith by nitrogen hypoxia using the Protocol.

5. With respect to the Fifth Claim for Relief,

    a. A declaration that attempting to execute Mr. Smith by nitrogen hypoxia under the current Protocol would burden his right to religious exercise under ARFA.

    b. A preliminary and permanent injunction prohibiting Defendants from attempting to execute Mr. Smith by nitrogen hypoxia using the Protocol.

6. Such other relief as this Court deems just and proper.

Respectfully submitted, this 20th day of November, 2023.

/s/ Andrew B. Johnson

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CERTIFICATE OF SERVICE

I certify that on November 28, 2023, I electronically filed the foregoing with the Clerk of the Court using the Pacer system, which will send notification to the following:

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EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

KENNETH EUGENE SMITH Plaintiff, v. JOHN Q. HAMM, Commissioner, Alabama Department of Corrections, and TERRY RAYBON, in his official Capacity as Warden, Holman Correctional Facility,	Case No. 2:23-cv-00656-RAH CAPITAL CASE **EXECUTION SCHEDULED FOR JANUARY 25, 2024**

DECLARATION OF ROBERT JASON YONG, M.D. IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

I, Robert Jason Yong, declare under penalty of perjury as follows:

I have been asked by Arnold & Porter to provide an expert review on nitrogen hypoxia. Specifically, in preparing this report, I have referenced textbooks, journal articles, guidelines, and the Alabama Department of Corrections' Execution Protocol for Nitrogen Hypoxia dated August 2023 (the Protocol). I also rely on my medical training and clinical experience as an anesthesiologist. My expert opinions on the subject are set forth below. All the opinions stated in this medical report are stated to a reasonable degree of medical certainty.

I. Qualifications

I am the Chief of Pain Medicine and serve as the Medical Director of the Pain Management Center at Brigham and Women's Hospital in Boston, Massachusetts, which is affiliated with Harvard Medical School. I am on the faculty of Harvard Medical School, where I am an Assistant Professor in Anesthesia. In 2014, 2015, 2016, 2018, 2020, 2021, and 2023, I was awarded the Pain Attending of the Year Award for the Department of Anesthesiology at Brigham and Women's

Hospital. Prior to this, I was an Assistant Professor at Johns Hopkins Hospital in Baltimore, Maryland, where I was awarded Outstanding Teacher of the Year, Department of Anesthesiology in 2013.

I obtained my Medical Degree from Baylor College of Medicine. I completed my residency in anesthesiology, perioperative medicine, and pain medicine at Brigham and Women's Hospital, Harvard Medical School. As a resident at Brigham and Women's Hospital, I received recognition as the Distinguished Resident of the Year and was selected as a Foundation for Anesthesia Education and Research (FAER) Practice Management Scholar. During my last year of residency, I was elected as a Chief Resident of the Anesthesiology Department. Following residency, I completed a fellowship in Pain Medicine at Brigham and Women's Hospital, Harvard Medical School. I am licensed to practice medicine in Massachusetts and double-board certified in Anesthesiology and Pain Management.

I have significant expertise with the subject matter of this case. I have substantial knowledge, training, and experience in the physiology and pathophysiology of the respiratory system and ventilation. I have over 10 years of experience managing the airways of patients while monitoring and managing their ventilation. As an anesthesiologist managing adequate oxygen levels around the time of surgery is paramount, and I have developed substantial experience monitoring and maintaining oxygen levels. I have a deep understanding of physiology and pharmacology with board certification in Anesthesiology.

Attached as Exhibit 1 is a list of references considered in preparing my report. My CV is attached hereto as Exhibit 2.

I reserve the right to supplement or amend my opinions based upon any new information or medical literature that subsequently becomes available to me. I further reserve the right to

comment on any opinions offered by defendants' experts submitted in briefing, or at deposition or hearings. In addition, I reserve the right to discuss general concepts within the field of Anesthesiology to provide context for any of the opinions discussed in this report. Finally, I reserve the right to use graphics or demonstratives at hearings to illustrate the concepts discussed in my report.

I submit this Declaration in support of Kenneth Eugene Smith's Motion for Preliminary Injunction.

II. Background

A. Anatomy and Physiology

The human circulatory system or cardiovascular system allows the flow of blood throughout the body. The blood transports nutrients and oxygen to the tissues and carries carbon dioxide and waste products away to be metabolized or excreted. The heart serves as the main pump moving blood to the vital organs, including the heart, lungs, kidneys, liver, and brain[1].

The human respiratory system allows the exchange of vital gasses via the lungs into the bloodstream[2]. The gasses enter the respiratory system via the nose or mouth and pass through the trachea before branching into the bronchi then bronchioles and finally the alveoli. The blood from the right side of the heart pumps into the lungs and back to the left side of the heart before circulating through the rest of the body. As blood flows from the heart to the lungs, the blood vessels branch into smaller and smaller vessels ending as capillaries that surround the alveoli. It is at the level of the alveoli that gasses are exchanged from the air to the blood stream.

[1] InformedHealth.org [Internet]. Cologne, Germany: Institute for Quality and Efficiency in Health Care (IQWiG); 2006-. How does the blood circulatory system work? 2010 Mar 12 [Updated 2019 Jan 31]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK279250/

[2] Patwa A, Shah A. Anatomy and physiology of respiratory system relevant to anaesthesia. Indian J Anaesth. 2015 Sep;59(9):533-41. doi: 10.4103/0019-5049.165849. PMID: 26556911; PMCID: PMC4613399.

Inspired room air is comprised of nitrogen (~78%), oxygen (~21%), argon (~0.9%), carbon dioxide (0.035%), and other gasses. The gradient of particular gasses in the alveoli compared to the bloodstream allows for gasses to be exchanged from the air to the blood. In normal states, oxygen is delivered to the blood and carbon dioxide is taken out of the blood.

The cells in humans require the oxygen for normal physiologic functioning[3]. Hypoxemia describes a condition in which there is a lower-than-normal level of oxygen in the blood. It occurs when the oxygen saturation in the bloodstream is below the expected or necessary levels for the body to function correctly. Hypoxia describes a state in which the cells have insufficient oxygen to maintain normal functioning, while hypoxemia refers specifically to low oxygen levels in the blood. An individual experiencing hypoxemia or hypoxia is still capable of exhaling carbon dioxide. By contrast, asphyxia describes the inability to inhale oxygen and the inability to exhale carbon dioxide. Being unable to exhale excess carbon dioxide leads to a higher-than-normal level of carbon dioxide in the blood, a state known as hypercarbia. Asphyxia, and resulting hypercarbia, can lead to the distressing physical sensation of suffocation.

B. Nitrogen hypoxemia

Nitrogen hypoxemia is a condition that can occur when a person is exposed to very high- or very low-pressure environments, such as deep-sea diving or high-altitude locations. Nitrogen hypoxemia occurs when the increased pressure causes the body to take in more nitrogen than usual, which can dilute the amount of oxygen available for the body's tissues and cells. This can lead to a decrease in the body's oxygen levels, resulting in symptoms like dizziness, confusion, shortness of breath, and, in severe cases, even loss of consciousness.

[3] Ortiz-Prado E, Dunn JF, Vasconez J, Castillo D, Viscor G. Partial pressure of oxygen in the human body: a general review. Am J Blood Res. 2019 Feb 15;9(1):1-14. PMID: 30899601; PMCID: PMC6420699.

Insufficient blood oxygen (hypoxemia) leads to tissue damage and catastrophic damage to vital organs[4]. There are many causes of hypoxemia including anemia, acute respiratory distress syndrome, heart failure, etc. The brain has substantial energy demands, making it particularly susceptible to the effects of low oxygen in its cells (hypoxia). Despite its small size relative to the entire body, the brain consumes a significant portion of the oxygen supply (approximately 20%). Normally, when the brain requires more oxygen, the body responds by increasing blood flow to meet this demand. However, both hypoxemia and reduced blood supply (ischemia) can result in damage to the brain. The longer the brain is deprived of adequate oxygen or blood flow, the more extensive and widespread the resulting damage becomes. Specific regions of the brain, including the brainstem, hippocampus, and cerebral cortex, are particularly vulnerable to this type of injury. This damage can become permanent unless oxygen levels are promptly restored. When oxygen levels are insufficient, brain cells can undergo cell death, primarily through a process called necrosis, and delayed cell death known as apoptosis may also occur[5]. Environments deficient in oxygen can result in nausea, vomiting, dizziness, confusion, and impaired judgement[6].

Breathing in 100% nitrogen gas would result in hypoxemia, eventual end-organ damage, and ultimately death. However, there is a lack of data regarding exactly how long a person must be exposed to 100% nitrogen to lead to death, or what happens at exposures to slightly less than 100% nitrogen for prolonged periods of time. As noted below, if a person is exposed to less than 100% nitrogen, there is a risk that the person could transition to a persistent vegetative state, have a stroke, or experience the painful sensation of suffocation instead of dying.

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[4] Michiels C. Physiological and pathological responses to hypoxia. Am J Pathol. 2004 Jun;164(6):1875-82. doi: 10.1016/S0002-9440(10)63747-9. PMID: 15161623; PMCID: PMC1615763.
[5] Michiels C. Physiological and pathological responses to hypoxia. Am J Pathol. 2004 Jun;164(6):1875-82. doi: 10.1016/S0002-9440(10)63747-9. PMID: 15161623; PMCID: PMC1615763.
[6] Harding BE, Wolf BC. Case report of suicide by inhalation of nitrogen gas. Am J Forensic Med Pathol. 2008 Sep;29(3):235-7. doi: 10.1097/PAF.0b013e318183240c. PMID: 18725778.

C. Challenges with nitrogen hypoxemia

a. Challenges With Using Masks To Administer Gas

During administration of anesthetics in the operating room, the anesthesiologist's job is to reduce the risk that a patient experiences hypoxemia before the anesthesia becomes fully effective. In a clinical setting, patients are typically "pre-oxygenated" before receiving anesthesia: The mask is filled with 100% oxygen to flood the body's cells with oxygen. After pre-oxygenation, the patient can be delivered anesthesia via the mask or intravenously. Once the patient is no longer able to breathe independently, the anesthesiologist mask-ventilates the patient for the duration of the anesthesia.

When pre-oxygenating a patient, the priority is on ensuring the mask has a tight fit to make sure there is no leakage and that the maximum amount of oxygen is delivered to the patient. Masks generally come in a few sizes. Oftentimes, mask ventilation can be difficult if the mask does not appropriately fit[7]. Variations in nose structure, facial hair, obesity, and other anatomic variability can increase the difficulty of mask ventilation.

While mask ventilating a patient during anesthesia, the most common set-up places the anesthesiologist's left hand on the mask securing it to the patient's face and the right hand on the ventilation bag. The left hand is positioned such that the thumb is on the upper portion of the mask placing downward pressure on the nasal bridge, the pointer and middle fingers are placed on the lower portion of the mask placing downward pressure on the chin, and the ring finger and pinky are positioned on the patient's jaw or mentum applying upward pressure against the mask to create a tight seal. In a clinical setting, the anesthesiologist is close to the patient, holding the mask in

[7] Kapoor MC, Rana S, Singh AK, Vishal V, Sikdar I. Nasal mask ventilation is better than face mask ventilation in edentulous patients. J Anaesthesiol Clin Pharmacol. 2016 Jul-Sep;32(3):314-8. doi: 10.4103/0970-9185.168262. PMID: 27625477; PMCID: PMC5009835.

position and, at times, manually squeezing the ventilation bag. If there is a poor mask seal, the anesthesiologist would be in a position to feel air leaking out around the mask.

An alternative set-up utilizes straps around the back of the patient's head that attach to the mask and secure it to the patient's face without the anesthesiologist needing to hold the mask in place manually. Straps can be used if the patient is cooperative and has normal anatomy. However, if a patient resists or turns their head the mask can be dislodged or the seal broken. Because of these limitations with straps, the preferred practice is to have the anesthesiologist hold the mask.

In addition to pre-oxygenating a patient, masks are sometimes used in clinical practice to apply anesthesia directly. The mask is fitted to a person while they are conscious (whether by straps or otherwise), and then the person loses consciousness, which causes changes to the face as the facial muscles relax. These facial changes can cause the mask to dislodge or the seal to be broken. In a clinical setting, an anesthesiologist will be able to adjust their hand position or adjust the mask as the patient loses consciousness to ensure the seal is not broken. Additionally, when administering anesthesia, a broken seal that allows for the incursion of some oxygen entering the patient's mask is acceptable because the goal is not to completely limit the patient's oxygen levels.

Anesthesiology breathing circuits that have inspiratory and expiratory elements contain a "scrubber," an apparatus to eliminate carbon dioxide from the mask when the patient exhales (see Figure 1 below). Regardless of what mix of gasses a person inhales through a breathing circuit, normal physiological processes mean that a person will always continue to exhale carbon dioxide. Scrubbing carbon dioxide from the patient's air is essential to avoid re-breathing exhaled carbon dioxide, which could cause asphyxiation, hypercarbia, and the sensation of suffocation. The scrubber removes carbon dioxide from the mask by absorbing and storing it; a common carbon

dioxide-specific absorber is soda lime, a combination of sodium hydroxide and calcium hydroxide. Without a mechanism to remove carbon dioxide, a person may experience asphyxiation and the sensation of suffocation.

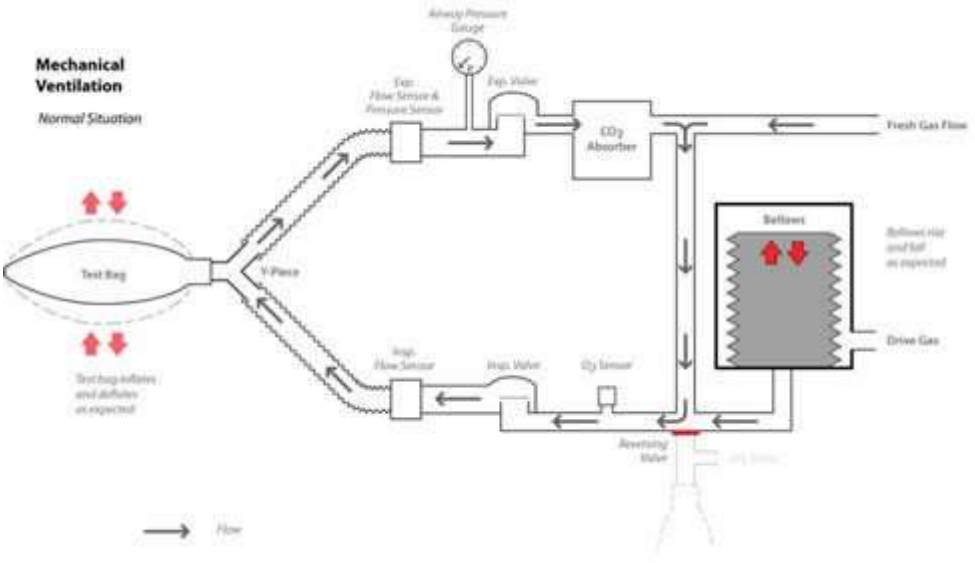


Figure 1: Example of carbon dioxide "scrubber" in a mechanical ventilation system with inspiratory and expiratory elements[8].

If a patient vomits into a mask during the administration of anesthesia, anesthesiologists use suction to remove any vomit from inside the mask. Often this requires removing the mask in order to properly suction out all material, to ensure the patient does not inhale and choke on their own vomit. The mask would then be cleaned or exchanged for a new mask.

b. Alabama Department of Corrections' Execution Protocol for Nitrogen Hypoxia

I have reviewed a redacted copy of the Protocol and the accompanying spiritual advisor waiver form. While the Protocol is heavily redacted, making it difficult to assess the complete

[8] George Mychaskiw II, Scott C. Carriker, Richard G. Cipolli, Measurement of Expiratory Limb Circuit Pressure: A Potential Anesthesia Machine Safety Issue, 25 Anesthesia Patient Safety Foundation Newsletter 2 (Summer 2010), https://www.apsf.org/article/measurement-of-expiratory-limb-circuit-pressure-a-potential-anesthesia-machine-safety-issue/.

process, based on the information provided I have identified several areas of concern. Each concern could result in the condemned person being transitioned to a persistent vegetative state, having a stroke, experiencing the painful sensation of suffocation, choking on aspirated vomit, or other complications if not properly rectified.

First, the Protocol does not provide adequate detail on the mechanism of delivery of the nitrogen or how a mask would be maintained in position throughout the process. If protocols are designed based on normal, standard operating procedures for the delivery of gasses, then there is likely an assumption of patient compliance and minimal movement. Without patient compliance and minimal movement, it is difficult to ensure that a mask will remain sealed and in the correct position.

Delivery of nitrogen gas would require a closed chamber or a tightly sealed mask. The Protocol provides little information on what is being done to secure the mask and confirm a tight seal. The Protocol notes that a mask will be placed and adjusted on the condemned person's face and that there will be a final inspection of the mask, but there is no information on how this will be done, the training of the persons(s) performing the inspection, what the inspection is looking for, and what (if anything) will be done if the team determines there is not a closed seal. The movement of the condemned person while speaking or otherwise moving their head, including small mouth movements such as quiet but audible prayer, along with changes to the facial muscles when they lose consciousness, may result in an imperfect seal resulting in leaking. The Protocol calls for the condemned person to give his final statement after the mask has been placed on him. Following the final statement, the Protocol indicates that team members will conduct a final inspection of the mask to verify proper placement. However, there is no information about how the team will monitor the seal of the mask once the nitrogen hypoxia system is activated.

If a mask does not fit or the chamber is not completely closed, entrainment of room air can occur allowing for some oxygen to be inspired. A mandatory waiver for spiritual providers remaining in the room highlights the possibility that nitrogen could leak into the room during the execution. If nitrogen can leak out of the mask, that would inversely mean that room air containing oxygen could be entrained into the mask. In the hospital setting, small amount of oxygen entering the patient's mask is acceptable because the patient is receiving breathable air. In contrast, in an execution by nitrogen hypoxia setting, breathing oxygen would likely prolong the time to reach unconsciousness which could lead to a persistent vegetative state or other complications.

In addition to a tight seal, a mask system must include a scrubber to remove carbon dioxide from the air the condemned person exhales. The Protocol does not specify whether the mask includes a carbon dioxide scrubber or any other mechanism to remove excess carbon dioxide. If the mask does not include a scrubber, the condemned person could re-breathe carbon dioxide and experience hypercarbia, asphyxiation, and the painful sensation of suffocation.

Second, the Protocol does not take into account what will happen if the condemned person vomits into the mask or has a seizure. As noted above, environments deficient in oxygen can result in nausea and vomiting. If vomit is not cleared from the mask, the condemned person could inhale the vomit and asphyxiate, resulting in painful physical sensations of choking and suffocation. The Protocol provides no instructions for clearing vomit out of the mask.

The Protocol also does not specify what should be done in the event of a seizure, either to ensure the mask remains secured to the condemned person's face despite the rapid movements associated with seizures or to identify criteria to stop the process of nitrogen administration if there is a risk the condemned person will not die but rather enter a persistent vegetative state or other damage short of death. Given the lack of data on nitrogen hypoxemia, the risk of vomiting or

seizure is unknown. However, the fact that the Protocol does not account for any risk of vomiting or seizure further indicates that the current Protocol is insufficient for humane administration of nitrogen hypoxia.

Third, the Protocol does not specify the purity of the nitrogen gas to be used. To the extent, the Protocol calls for anything less than 100% nitrogen gas then the condemned may transition to a persistent vegetative state, have a stroke, experience the painful sensation of suffocation or suffer other complications. Likewise, there is no discussion on what testing is performed to ensure purity of the gas being used, nor is there any information on where the nitrogen is sourced and how it is transported or stored. In a clinical setting, when we provide oxygen or any other type of gas to a patient, there are procedures in place to confirm the quality of the product and make sure it is transported and stored in an appropriate manner to avoid problems such as possible contamination.

Fourth, the Protocol does not provide for continued monitoring of blood oxygen levels or the condemned person's heart rate as the nitrogen is being administered, in order to assess whether the blood oxygen levels are reducing as planned. The Protocol states that a pulse oximeter, which reads blood oxygen levels, will be affixed to the condemned person before administration of nitrogen and will be monitored for two minutes. However, the Protocol provides no information on how blood oxygen levels or the condemned person's heart rate will be monitored *after* administration of nitrogen begins. Nor does the Protocol establish criteria for shutting down the nitrogen hypoxia system if the condemned person's blood oxygen or pulse gets low but not low enough to cause death. Given the lack of scientific data about blood oxygen levels necessary to cause death, the Protocol's failure to monitor blood oxygen levels and heart rate after nitrogen administration puts the condemned person at risk of entering a permanent vegetative state or experiencing other physiological damage short of death.

Lastly, there is a dearth of research regarding pain or sensations felt during nitrogen hypoxemia, and major questions remain for how long to administer 100% nitrogen before death occurs. The American Veterinary Medical Association (AVMA) has determined nitrogen hypoxia is acceptable for euthanasia of pigs but "is unacceptable for other mammals."[9] According to the AVMA euthanasia guidelines, nitrogen "create[s] an anoxic environment that is distressing for some species."[10] If incomplete or unsuccessful, one potential outcome is a transition to a persistent vegetative state.

D. Sensation of Suffocation

Suffocation refers to the state or process of dying as a result of being asphyxiated, which occurs when a person can neither inhale oxygen nor exhale carbon dioxide. An inability to rid the body of excess carbon dioxide leads to an accumulation of carbon dioxide in the blood (hypercarbia). When blood carbon dioxide levels rise too high, the blood pH levels become more acidic in a process called respiratory acidosis. The physical sensations associated with respiratory acidosis include anxiety, confusion, headache, drowsiness, and stupor[11].

E. Persistent Vegetative State

A persistent vegetative state (PVS) is a medical condition characterized by a profound and long-lasting loss of consciousness and cognitive function[12]. In PVS, individuals appear to be awake but lack awareness of themselves or their surroundings. They may have cycles of sleep and

[9] American Veterinary Medical Association, AVMA Guidelines for the Euthanasia of Animals: 2020 Edition, at 28.
[10] American Veterinary Medical Association, AVMA Guidelines for the Euthanasia of Animals: 2020 Edition, at 28.
[11] James L. Lewis III. Respiratory Acidosis. Merck Manual: Professional Version (Jul. 2023), https://www.merckmanuals.com/professional/endocrine-and-metabolic-disorders/acid-base-regulation-and-disorders/respiratory-acidosis.
[12] Zeman A. Persistent vegetative state. Lancet. 1997 Sep 13;350(9080):795-9. doi: 10.1016/S0140-6736(97)06447-7. PMID: 9298013.

wakefulness but do not exhibit purposeful responses to their environment or communicate in meaningful ways.

People in a persistent vegetative state experience significant damage to the cerebral cortex, the part of the brain responsible for conscious thought, perception, and decision-making. This damage results in the loss of cognitive functions like awareness, reasoning, and memory. Despite the loss of higher brain functions, individuals in a PVS may retain some basic bodily functions such as breathing, digestion, and reflexes. They may appear to move, make noises, or even open their eyes, but these actions are typically involuntary and not indicative of consciousness. The prognosis for individuals in a persistent vegetative state is generally poor. While some may recover partially or regain minimal awareness, many do not show significant improvement over time. PVS is often considered a long-term or permanent condition. The care of patients in PVS requires feeding, bathing, housing, and the personnel required to carry out those tasks. Costs of caring for individuals in a persistent vegetative state are estimated to be >$90,000 per year[13].

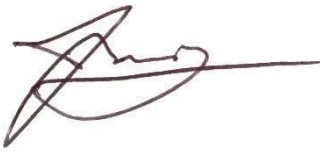
F. Stroke

If the patient does not develop PVS, an alternative scenario would be the development of a stroke where part of the brain is damaged. Depending on the area damaged, the residual effect could be failure of speech, movement of limbs, alterations of any of the senses, and much more. On average, the lifetime cost of stroke per person is estimated to be >$100,000[14].

[13] Fields AI, Coble DH, Pollack MM, Cuerdon TT, Kaufman J. Outcomes of children in a persistent vegetative state. Crit Care Med. 1993 Dec;21(12):1890-4. doi: 10.1097/00003246-199312000-00016. PMID: 8252894.
[14] Taylor TN, Davis PH, Torner JC, Holmes J, Meyer JW, Jacobson MF. Lifetime cost of stroke in the United States. Stroke. 1996;27:1459–1466. https://doi.org/10.1161/01.STR.27.9.1459. *See also* Johnson BH, Bonafede MM, Watson C. Short- and longer-term health-care resource utilization and costs associated with acute ischemic stroke. Clinicoecon Outcomes Res. 2016; 8:53-61. doi: 10.2147/CEOR.S95662. PMCID: PMC4770080. PMID: 26966382. (estimating $140,048 lifetime cost for ischemic strokes).

My engagement is ongoing, and should any additional material information become available to me, I reserve the right to modify or supplement my conclusions and opinions. The opinions expressed in this Declaration are my own and are made to a reasonable degree of medical certainty. I declare under penalty of perjury that the foregoing is true and correct under 28 U.S.C. § 1746.

Executed on this 17th day of November 2023,



R. Jason Yong, MD MBA

EXHIBIT 1

Exhibit 1: Materials Considered List

Alabama Department of Corrections, Execution Protocol for Nitrogen Hypoxia (Aug. 2023).
American Veterinary Medical Association, AVMA Guidelines for the Euthanasia of Animals: 2020 Edition, at 28.
Committee on Standards and Practice Parameters, Standards for Basic Anesthetic Monitoring, American Society of Anesthesiologists (Dec. 13, 2020), https://www.asahq.org/standards-and-practice-parameters/standards-for-basic-anesthetic-monitoring.
Fields AI, Coble DH, Pollack MM, Cuerdon TT, Kaufman J. Outcomes of children in a persistent vegetative state. Crit Care Med. 1993 Dec;21(12):1890-4. doi: 10.1097/00003246-199312000-00016. PMID: 8252894.
George Mychaskiw II, Scott C. Carriker, Richard G. Cipolli, Measurement of Expiratory Limb Circuit Pressure: A Potential Anesthesia Machine Safety Issue, 25 Anesthesia Patient Safety Foundation Newsletter 2 (Summer 2010), https://www.apsf.org/article/measurement-of-expiratory-limb-circuit-pressure-a-potential-anesthesia-machine-safety-issue/.
Harding BE, Wolf BC. Case report of suicide by inhalation of nitrogen gas. Am J Forensic Med Pathol. 2008 Sep;29(3):235-7. doi: 10.1097/PAF.0b013e318183240c. PMID: 18725778.
InformedHealth.org [Internet]. Cologne, Germany: Institute for Quality and Efficiency in Health Care (IQWiG); 2006-. How does the blood circulatory system work? 2010 Mar 12 [Updated 2019 Jan 31]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK279250/
James L. Lewis III, Respiratory Acidosis, Merck Manual: Professional Version (Jul. 2023), https://www.merckmanuals.com/professional/endocrine-and-metabolic-disorders/acid-base-regulation-and-disorders/respiratory-acidosis.
Johnson BH, Bonafede MM, Watson C. Short- and longer-term health-care resource utilization and costs associated with acute ischemic stroke. Clinicoecon Outcomes Res. 2016; 8:53-61. doi: 10.2147/CEOR.S95662. PMCID: PMC4770080. PMID: 26966382. (estimating $140,048 lifetime cost for ischemic strokes).
Kapoor MC, Rana S, Singh AK, Vishal V, Sikdar I. Nasal mask ventilation is better than face mask ventilation in edentulous patients. J Anaesthesiol Clin Pharmacol. 2016 Jul-Sep;32(3):314-8. doi: 10.4103/0970-9185.168262. PMID: 27625477; PMCID: PMC5009835.
Michiels C. Physiological and pathological responses to hypoxia. Am J Pathol. 2004 Jun;164(6):1875-82. doi: 10.1016/S0002-9440(10)63747-9. PMID: 15161623; PMCID: PMC1615763.
Morgan & Mikhail's Clinical Anesthesiology (John F. Butterworth IV, et al., eds., 7th ed. 2022).

Ortiz-Prado E, Dunn JF, Vasconez J, Castillo D, Viscor G. Partial pressure of oxygen in the human body: a general review. Am J Blood Res. 2019 Feb 15;9(1):1-14. PMID: 30899601; PMCID: PMC6420699.
Patwa A, Shah A. Anatomy and physiology of respiratory system relevant to anaesthesia. Indian J Anaesth. 2015 Sep;59(9):533-41. doi: 10.4103/0019-5049.165849. PMID: 26556911; PMCID: PMC4613399.
Stoelting's Anesthesia and Co-Existing Disease (Roberta L. Hines & Stephanie B. Jones, eds., 8th ed. 2022).
Taylor TN, Davis PH, Torner JC, Holmes J, Meyer JW, Jacobson MF. Lifetime cost of stroke in the United States. Stroke. 1996;27:1459–1466. https://doi.org/10.1161/01.STR.27.9.1459.
Zeman A. Persistent vegetative state. Lancet. 1997 Sep 13;350(9080):795-9. doi: 10.1016/S0140-6736(97)06447-7. PMID: 9298013.

EXHIBIT 2

The Faculty of Medicine of Harvard University
Curriculum Vitae

Date Prepared: November 17, 2023

Name: Robert Jason Yong

Office Address: Brigham and Women's Hospital
Department of Anesthesiology, Perioperative and Pain Medicine
75 Francis Street
Boston, MA 02115

Home Address: [redacted]

Work Phone: 617-983-7080

Work Email: ryong@bwh.harvard.edu

Education:

1998-2002	BA	Biology	University of Texas, Austin, TX
2002-2007	MD	Medicine	Baylor College of Medicine, Houston, TX
2004-2006	MBA	Business Administration	Rice University, Jones Graduate School of Management, Houston, TX

Postdoctoral Training:

2007-2008	Intern	General Surgery	Beth Israel Deaconess Medical Center
2008-2011	Resident	Anesthesiology	Brigham and Women's Hospital
2010-2011	Chief Resident	Department of Anesthesia	Brigham and Women's Hospital
2011-2012	Fellow	Pain Management	Brigham and Women's Hospital

Faculty Academic Appointments:

2012-2013	Assistant Professor	Anesthesia	Johns Hopkins Medical School, Baltimore, MD
2013-2019	Instructor	Anaesthesia	Harvard Medical School, Boston, MA
2019-	Assistant Professor	Anaesthesia	Harvard Medical School, Boston, MA

Appointments at Hospitals/Affiliated Institutions:

2012-2013	Attending	Anesthesia	Johns Hopkins Hospital
2013-	Attending	Anesthesia	Brigham & Women's Hospital

Other Professional Positions:

2016-2020	Scientific Advisory Board	axialHealthcare	12 days per year
2016-	Consultant	Medtronic	2 days per year
2017-	Consultant	Nevro	2 days per year
2019-2021	Consultant	Endo Pharmaceuticals	12 days per year
2019-	Consultant	Abbott	2 days per year

Major Administrative Leadership Positions:

Local

2013-2017	Founding Medical Director of Pain Management	Brigham and Women’s Faulkner Hospital
2013-	Founding Co-Director, Spine Center	Brigham and Women’s Faulkner Hospital
2014-2021	Associate Program Director of Pain Management	Brigham and Women’s Hospital
2014-	Co-founder and Facilitator: Fellow Lecture Series	Brigham and Women’s Faulkner

2017-	Medical Director of Pain Management Center	Brigham and Women's Hospital
2020-2021	Associate Chief of Pain Medicine Division	Brigham and Women's Hospital
2021-2023	Chief of Pain Medicine Division	Brigham and Women's Hospital
2023-	Associate Chief of Pain Medicine Division	Brigham and Women's Hospital

Committee Service:

Local

2010-2011	Residency Admissions Interview Committee	Department Anesthesiology, Brigham and Women's Hospital
2012-2013	Residency Admissions Interview Committee	Department Anesthesiology, Johns Hopkins Hospital
2013-2015	Medical Executive Committee	Brigham and Women's Faulkner
2013-	Fellowship Admissions Interview Committee	Brigham and Women's Hospital
2014-	Ambulatory Advisory Council	Brigham and Women's Faulkner
2014-	Pain Fellowship Clinical Competency Committee	Brigham and Women's Hospital
2014-	Program Evaluation Committee	Brigham and Women's Hospital
2015-2018	Opioid Management Subcommittee	Brigham and Women's Faulkner
2015-2019	Opiate Ad Hoc Committee	Harvard Medical School
2016-2020	Office for Multicultural Careers Advisory Committee	Brigham and Women's Hospital
2016-	B CORE Standards Committee	Brigham and Women's Faulkner
2017-	Residency Admissions Committee	Brigham and Women's Hospital

2017-	Residency Clinical Competency Committee	Brigham and Women's Hospital
2019-	Faculty Board, Department of Anesthesiology	Brigham and Women's Hospital

National

2014-	Program Director Committee, Representing BWH Pain Medicine Fellowship	American Board of Anesthesiology
2016-	MOCA Minute: Pain Medicine Subcommittee	American Board of Anesthesiology
2022-2022	Program and Evaluation Committee, Summer 2022 Meeting	Eastern Pain Association
2023-2023	Program and Evaluation Committee Chair, Annual Meeting	Eastern Pain Association

Professional Societies:

2007-2012	American Medical Association
2007-	American Society of Anesthesiologists
2007-	Massachusetts Medical Association
2007-	Massachusetts Society of Anesthesiologists
2011-2019	American Pain Society
2014-2016	International Spine Intervention Society
2014-	American Academy of Pain Medicine
2014-	American Society of Interventional Pain Physicians
2016	American Society of Regional Anesthesia

2016-	North American Neuromodulation Society	
2018-	Boston Pain Society	
	2018-	Board of Directors
	2023-2025	Co-Director of Fundraising and Industry Relations
2021-	Eastern Pain Association	

Editorial Activities:

Ad hoc Reviewer

Headache Journal

The Journal of Delivery Science and Innovation

Pain Practice

Spine Journal

Other Editorial Roles

2017	Editor in Chief	Pain Medicine: An Essential Review, 1st Ed. Springer International
2020	Editor	Interventional Management of Chronic Visceral Pain Syndromes, 1st Ed. Elsevier, 2020

Honors and Prizes:

1998	Texas Valedictorian Scholarship, Texas	University of Texas, Austin, TX
2002	Baylor College of Medicine Community Service Scholarship	Baylor College of Medicine, Houston, Texas
2005	Rice University's Jones Graduate School of	Rice University, Jones Graduate School of Management,, Houston, TX

	Management Academic Scholarship	
2011	Distinguished Resident of the Year	Anesthesia Department, Brigham & Women's Hospital, Boston, MA
2011	Foundation for Anesthesia Education and Research (FAER) Practice Management	Resident Scholar Program, Pittsburgh, Pennsylvania
2011	Grant Finalist, Center for Integration of Medicine and Innovative Technology (CIMIT) Research	CIMIT, Boston, MA
2011	National Collegiate Inventors and Innovators Alliance Award for participation in the Ventures Lab	Venture Lab, Cambridge, MA
2011	Young Innovator Award	Harvard School of Engineering & Applied Science, Boston, MA
2013	Distinguished Intraoperative Teaching and Clinical Mentorship	Department of Anesthesiology, Johns Hopkins Hospital, Baltimore, MD
2013	Outstanding Teacher of the Year	Department of Anesthesiology, Johns Hopkins Hospital, Baltimore, MD
2014, 2015, 2016, 2020, 2021	Pain Attending of the Year Award	Department of Anesthesiology, Brigham and

		Women's Hospital, Boston, MA
2014, 2018	Partners in Excellence Award for Leadership and Innovation	Brigham and Women's Hospital, Boston, MA
2018	Outstanding Mentoring Award	Department of Anesthesiology, Brigham and Women's Hospital, Boston, MA
2018	Pain Attending of the Year Award,	Department of Anesthesiology, Brigham and Women's Hospital, Boston, MA
2023	Pain Attending of the Year Award	Anesthesia Department, Brigham & Women's Hospital, Boston, MA

Report of Funded and Unfunded Projects

Past

2015-2019 Prediction of Persistent Post-Mastectomy Pain	Prediction of Persistent Post-Mastectomy Pain NIH (NIGMS); K23 GM110540 Co-Investigator (PI: K. Schreiber) This project investigates the ability of preoperatively assessed variables including psychosocial evaluation and QST to predict risk of chronic pain after surgery, and allow development of a study enrichment tool to investigate existing and novel perioperative preventive therapies
2016-2018	ReActiv8-B trial Mainstay Medical Limited Co-Investigator (PI: Christopher Gilligan) An international, multi-center, prospective randomized sham-controlled IDE trial at up to 40 clinical trial sites and for 128 randomized subjects to be implanted with an innovative implantable neurostimulation system (Reactiv8). Device is intended to reduce the pain and disability of Chronic Lower Back Pain (CLBP) by helping to restore control to the muscles that dynamically stabilize the lumbar spine

2018-2019	Algovita Post-Market Clinical Study: Spinal Cord Stimulation to Treat Chronic Pain Nuvectra Medical PI Multi-center, prospective post market study following patients implanted with Nuvectra's Algovita spinal cord stimulator ($1800 per patient with 10 estimated patients)
2018-2019	Pilot Study to Examine the Feasibility of the DISCSS (Dynamic Interferential Spinal Cord Stimulation System) Meagan Medical Inc PI Multi-center, prospective pilot study following patients using a spinal cord stimulator trial with a novel dynamic interferential system and measuring outcomes compared to traditional stimulation ($4490 per patient with 10 estimated patients).
2018-2019	Algovita Ultra High Pulse Width Clinical Study: Spinal Cord Stimulation to Treat Chronic Pain Nuvectra Medical PI Multi-center, prospective study following patients implanted with Nuvectra's Algovita spinal cord stimulator utilizing ultra high pulse width settings ($1800 per patient with 10 estimated patients).
2019-2020	Clonidine Micropellet Clinical Study for Radiculopathy Sollis Therapeutics, Inc. PI Prospective, multi-center, randomized, double-blinded, sham-controlled study to evaluate the efficacy and safety of clonidine micropellets for the treatment of pain associated with lumbosacral radiculopathy in adults ($9,633 per patient with 20 estimated patients).
2019-2022	PROLONG Neuromodulation Study for Post Laminectomy Syndrome Abbott PI prospective, multi-center, open-label, post-market study following patients who have failed stimulation previously and are now using BurstDR waveforms or Dorsal Root Ganglion stimulation with restored efficacy ($ per patient with 10 estimated patients).
2021	RELIEF Boston Scientific

PI ($25,941)
The primary objective of this study is to compile characteristics of real-world clinical outcomes for Boston Scientific commercially approved neurostimulation systems for pain in routine clinical practice, when used according to the applicable Directions for Use. The secondary objective of this study is to evaluate the economic value and technical performance of Boston Scientific commercially approved neurostimulation systems for pain in routine clinical practice

Current

2020- A Phase 3, Randomized, Double Blinded, Active Controlled, Multicenter Study to Evaluate the Efficacy, Safety and Pharmacokinetics of EXPAREL admixed with Bupivacaine vs Bupivacaine only administered as Combined Sciatic (in popliteal fossa) and Adductor Canal Nerve Block for Postsurgical Analgesia in Subjects Undergoing Lower Extremity Surgeries
Co-Investigator (PI: Srdjan Nedeljkovic)
This study will evaluate the efficacy of liposomal bupivacaine when given as a Sciatic (in popliteal fossa) and Adductor Canal nerve block following foot and ankle surgery compared to plain bupivacaine

2020- SCOPE Superion Study for Neurogenic Claudication
Boston Scientific
PI ($40,159.00)
Multi-center, propective, observational, single-arm, post-approval study to evaluate the Superion interspinous process spacer outcomes in patients with lumbar spinal stenosis resulting in neurogenic claudication

2020- SKOAP Sequenced strategy for improving outcomes in people with knee osteoarthritis pain
Co-Investigator (PI: Christopher Gilligan)
There is an urgent public health need to reduce our reliance on opioids for effective long-term pain management, particularly in knee osteoarthritis (KOA). This effectiveness trial will compare recommended treatments to reduce pain and functional limitations in KOA and identify clinical and patient-level factors associated with treatment response. These results will lead to improved patient selection for treatment and inform evidence-based guidelines by offering well-tested, effective, non-opioid alternatives.

2020- Dorsal spInal cord STImulatioN vs mediCal management for the Treatment of low back pain (DISTINCT)
Abbott BioResearch

Co-Investigator (PI: Christopher Gilligan)
The objective of this study is to evaluate the efficacy of BurstDR™ spinal cord stimulation, compared with conventional medical management, in improving pain and back pain-related physical function in patients suffering with chronic, refractory axial low back pain, who have not had lumbar spine surgery and for whom surgery is not an option.

2022- From Nerve to Brain: Toward a Mechanistic Understanding of Spinal Cord Stimulation in Human Subjects
NIH - HEAL; NCT05661903; RM1ActNS128741
Co-Investigator (PI: Brian Wainger)
This is a multicenter prospective study of patients who currently have stably implanted spinal cord simulators. The fundamental hypothesis for this study is that spinal cord stimulators modulate the excitability of primary afferent neurons to reduce pain, and that these changes can be detected by measurement of axonal excitability. This study will use robust, reproducible techniques to define the peripheral, central, and systemic effects of spinal cord stimulators.

2022- A Phase 3, multi-center, randomized, double-blind, placebo-controlled study, to evaluate the safety and efficacy of SB-01 for injection for the treatment of lumbar degenerative disc disease
Spine BioPharma
PI ($35,180)
Confirm the safety and effectiveness of SB-01 For Injection in adult patients with chronic low back pain and related disability due to Lumbar Degenerative Disc Disease.

2022- A Phase 3, Prospective, Multicenter, Randomized, Double-blind, Sham-controlled Study on the Efficacy and Safety of STX-015 in the Treatment of Pain Associated with Lumbosacral Radiculopathy
Sollis Therapeutics, Inc.
Co-Investigator (PI: Srdjan Nedeljkovic)
To compare the efficacy of STX-015 in treating pain at the location associated with the worst lumbar and lumbosacral radiculopathy at Week 12 (3 months) after a single injection of STX-015 into the targeted lumbar or lumbosacral epidural space, compared to that from a blinded, control group of subjects who will undergo a sham injection designed to mimic the actual epidural injection of STX-015.

2023- Delivery for Pulmonary Arterial Hypertension (PAH)
Medronic Inc.

Co-Investigator (PI: Aaron Waxman)
The purpose of this clinical trial is to evaluate the safety profile of the Medronic Model 10642 and Model 8201 Implantable Intravascular Catheter, a component of the PAH Implantable Vasodilator Therapy (PIVoT) system.

Unfunded Current Projects

2019- IRB pending Case Series Evaluating the Compliance and Efficacy of Smart Pill-bottles
PI
Single-center, prospective cohort evaluating patient compliance of Bluetooth enabled smart pill dispensers for opioid medication and efficacy of reducing opioid misuse and abuse

2020- IRB pending Utilizing a Cadaver-Training Simulator to Teach Interventional Spine Procedures
PI
Single-center, analyzing an innovative approach to educating fellows and residents on interventional spine procedures measuring accuracy, comfort, radiation exposure, and time

2022- Prospective Analysis of Health State Utility After Chronic Migraines by Patients Who Experienced This Diagnosis
PI
The primary aim of this study is to quantify the health utility states of people who experienced chronic migraines. Assessing patients' perception of chronic migraine pain will allow us to compare directly with layperson assessment of chronic migraine pain.

2023- Prospective Analysis of Health State Utility After Chronic Lower Back Pain by Patients Who Experienced This Diagnosis
PI
The primary aim of this study is to quantify the health utility states of people who experienced chronic low back pain. Assessing patients' perception of chronic low back pain will allow us to improve the understanding of the significance of the diagnosis and provide a quantitative significance to better inform the medical community of the value that should be assigned to efficacious treatments

Report of Local Teaching and Training
Teaching of Students in Courses:

2011	BUS 2107 Commercializing Science Class Clinical advisor to graduate students	Harvard Business School, Cambridge, MA 1 hour / year
2011	ES227 Medical Device Design Class graduate students	Harvard Graduate School of Engineering, Cambridge, MA 1 hour / year
2011	Introduction to Anesthesia: What does a career in anesthesia look like? medical students	Harvard Medical School 1 hour / week

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs):

2010	Interpretation of an Arterial Blood Gas Critical Care residents, fellows and staff	SICU Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 1 hour / year
2010	Malignant Hyperthermia. Residents/fellows	Sunrise Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 1 hour / year
2011	Hypertension in Pregnancy, OB anesthesia residents	OB Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 1 hour / week
2011-2012	High Yield Board Topics Anesthesia residents	Sunrise Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 1 hour / year 30 minute lecture annually
2012	Complex Regional Pain Syndrome Anesthesia residents, fellows	Sunrise Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 1 hour / week
2012	Complications of Back Surgery Anesthesia fellows	Fellow's Curriculum Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 1 hour / week

2012	Methadone Anesthesia residents, fellows	Sunrise Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 1 hour / week
2012-2013	Acute Pain Management medical students	College Day Lecture Series, Johns Hopkins Hospital, Dept of Anesthesia and Perioperative Medicine 1 hour / year
2012-2013	Cancer Pain medical students	College Day Lecture Series, Johns Hopkins Hospital, Dept of Anesthesia and Perioperative Medicine 1 hour / year
2013	Minimally Invasive Lumbar Decompression, residents, fellows	Pain Management Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 1 hour / week
2013-	Advanced Pain Medicine Department CA-2/3 Residents	BWH Dept. Anesthesia, Perioperative and Pain Medicine 3 hours / year
2013-	Basics of Pain Medicine Department CA-1 Residents	Residency Didactic Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 3 hours / year
2013-	Cancer Pain Medicine Department CA-2/3 Residents (	Residency Didactic Lecture Series, BWH Dept. Anesthesia, Perioperative and Pain Medicine 3 hours / year
2015-	Interventional Pain Management Coding and Billing, residents, fellows	Faulkner Pain Management Center Lecture Series, Brigham and Women's Faulkner Hospital, Department of Anesthesia 1 hour / year

Clinical Supervisory and Training Responsibilities:

2012-2013	Supervision Residents and CRNA's	Johns Hopkins Hospital, Department of Anesthesiology 8 hours / week
2013-	Supervision Residents, Fellows, Nurse Practitioners, and Physician Assistants	BWH APPM, Division of Pain Medicine 6 hours / week
2013-	Supervision Residents and CRNA's	BWH APPM, Department of Anesthesiology 2 hours / week

Other Mentored Trainees and Faculty:

2012-2013 Liang Shen, MD / Instructor, Weill Cornell Medical College
Career stage: Resident.
Mentoring role: Clinical guidance and performance evaluation.
Accomplishments: multiple first authored scholarship; Fellowship in Critical Care

2013-2014 Ehren Nelson, MD / Instructor, Brigham and Women's Hospital
Career stage: Resident and Fellow.
Mentoring role: Clinical guidance, performance evaluation, and academic mentoring.
Accomplishments: Multiple national and international invited lectures; Fellowship in Pain Medicine

2014-2015 Isaac Tong, MD / Pain Medicine Attending, San Antonio
Career stage: Resident and fellow, Brigham and Women's Hospital.
Mentoring role: Faculty mentor during Residency and Pain Fellowship with guidance and performance evaluation
Established a strong reputation as a key opinion leader and expert in pain medicine and practice development.

2014-2017 Jessica Hellums, MD / Pain Medicine Fellow, Brigham and Women's Hospital
Career stage: Resident.
Mentoring role: Faculty mentor during CA-1/2/3 year with guidance and performance evaluation
Established a strong reputation as a key opinion leader and expert in pain medicine and practice development.

2015-2016 Jeffrey McLaren, MD / Pain Medicine Fellow, Virginia Mason
Career stage: Resident, Brigham and Women's Hospital.
Mentoring Role: Faculty mentor during CA-3 year with guidance and performance evaluation
Established a strong reputation as a key opinion leader and expert in pain medicine.

2015-2016 Mona Patel, MD / Pain Medicine Attending, Irvine, California
Career stage: Fellow, Brigham and Women's Hospital.
Mentoring role: Faculty mentor during Pain Fellowship with guidance and performance evaluation
Established a strong reputation as a key opinion leader and expert in pain medicine and academic publications.

2015-2018 Brandon Napstad, MD / Anesthesiology Resident, Brigham and Women's Hospital
Career stage: Resident.
Mentoring role: Faculty mentor during CA-1-3 year with guidance and performance evaluation
Established a strong reputation as a clinical anesthesiologist.

2016-2017 Victor Wang, MD / Instructor, Brigham and Women's Hospital
Career stage: Fellow.
Mentoring role: Faculty mentor during Pain Fellowship with guidance and performance evaluation.
Accomplishments: Multiple first authored scholarship

2016-2019 Andrew Pisansky, MD / Anesthesiology Resident, Brigham and Women's Hospital
Career stage: Resident.
Mentoring role: Faculty mentor during CA-1-3 year with guidance and performance evaluation
Completed a pain fellowship and is now director of acute pain at Vanderbilt with significant academic productivity.

2016-2019 David Buric, MD / Anesthesiology Resident, Brigham and Women's Hospital
Career stage: Resident.
Mentoring role: Faculty mentor during CA-1-3 year with guidance and performance evaluation
Completed cardiac and ICU fellowships with significant academic productivity.

2017-2018	Fang Fang Xing, MD / Pain Management Fellow, Brigham and Women's Hospital Career stage: Fellow. Mentoring role: Faculty mentor during Pain Fellowship with guidance and evaluation. Accomplishments: multiple first authored scholarship
2017-2020	Shafiq Boyaji, MD / Anesthesiology Resident, Brigham and Women's Hospital Career stage: Resident. Mentoring role: Faculty mentor during CA-1-3 year with guidance and performance evaluation Established a strong reputation as a key opinion leader and expert in pain medicine and practice development with academic productivity.
2018-2019	Michael Lubrano, MD / Pain Management Fellow, Brigham and Women's Hospital Career Stage: Fellow. Mentoring role: Faculty mentor during Pain Fellowship with guidance and evaluation. Accomplishments: multiple first authored scholarship
2019-2020	Bilal Dar, MD / Pain Management Fellow, Brigham and Women's Hospital. Career Stage: Fellow Mentoring role: Faculty mentor during Pain Fellowship with guidance and evaluation. Accomplishments: case reports
2019-2022	Kunal Mandavawala, MD – Anesthesiology Resident, Brigham and Women's Hospital. Career Stage: Resident. Mentoring role: Faculty mentor during CA 1-3 year with guidance and performance evaluation Will be completing cardiac and ICU fellowships with significant academic productivity.
2020-2023	Michael Fiore, MD, pharmD – Anesthesiology Resident, Brigham and Women's Hospital. Career Stage: Resident. Mentoring role: Faculty mentor during CA 1-3 year with guidance and performance evaluation

Will be applying for pain with significant research involving medical education.

Formal Teaching of Peers (e.g., CME and other continuing education courses):

☒ *No presentations below were sponsored by 3rd parties/outside entities*

2015	Chronic Venous Insufficiency, Comprehensive Review of Pain Medicine, [Directed by Dr. Edgar Ross. Recorded CME video lecture] sponsored by Oakstone	single presentation Boston

Local Invited Presentations:

☒ *No presentations below were sponsored by 3rd parties/outside entities*

2014	Pain Treatment Modalities and Palliative Care for Cognitively Impaired and Terminally Ill Patients / Invited Lecture 2nd Annual Pain Management Lecture, Brigham and Women's Hospital
2014	Spine Views for Interventional Pain Procedures / Invited Lecture Massachusetts Society of Radiologic Technologists, Brigham and Women's Hospital
2016-	Pain Medicine Billing Primer / Invited Lecture Pain Medicine Lecture Series, Brigham and Women's Hospital
2018	Post-operative Pain and the Chronic Pain Patient / Invited Lecture PACU Lecture Series. Brigham and Women's Faulkner Hospital
2022-2022	Peri-operative Pain Management & Chronic Opioid Therapy / Grand Rounds Brigham and Women's Faulkner Hospital, Department of Anesthesiology
2023	Final Words of Wisdom / Invited Lecture BWH Pain Fellow Lecture SEries

<u>Report of Regional, National and International Invited Teaching and Presentations</u>

☒ *Those presentations below sponsored by outside entities are so noted and the sponsor(s) is (are) identified.*

Regional

2015	Advances in Chronic Pain Management / Grand Rounds Tufts University, Anesthesiology, Boston, MA
2021	Opioid Management / Invited Speaker New Hampshire Medical Society, Conway, NH
2023	Spine Interventions: MILD, Spacers, and Stimulation / Invited Lecture Combined MGH, BWH, BI Ortho Spine Attending Lecture Series

National

2013	Perioperative Pain Management, Optimal Anesthesia Management / Invited Lecture Johns Hopkins Anesthesia Continuing Education, Baltimore, MD
2013	Pharmacology of Anesthetics / Invited Lecture Johns Hopkins Regional Live Meeting Series, Boston
2013	Preoperative Patient Assessment / Invited Lecture Johns Hopkins Regional Live Meeting Series, Boston
2015	Cutting Edge Chronic Pain / Grand Rounds George Washington University, Anesthesiology, Washington, DC
2016	Innovation: Treatment and Prescribing Panelist and Moderator, Tennessee Pain Opioids Problems Solutions Forum / Symposium Nashville, TN
2017	Current Topics in Pain Medicine / Grand Rounds Kaiser Permanente, Department of Anesthesiology, San Diego, CA
2017	Novel Therapies in Pain Medicine / Grand Rounds Medical University of South Carolina, Department of Anesthesiology, Charleston, SC
2018	On and Off Label Applications for Pain Control / Invited Lecture NYC Neuromodulation Conference and NANS Summer Series, New York, NY

2019	Interpretation of Spinal Diagnostic Imaging Studies: Learning a Structured Approach / Invited Speaker American Society of Anesthesiology, Orlando, FL
2020	Lumbar Spinal Stenosis Novel Therapies / Invited Speaker Multi-institution COVID-19 Lecture Series, Sponsored by University of Washington
2020	Peripheral Nerve Stimulation / Invited Speaker American Society of Neuro Radiologists, Las Vegas, NV
2020	Waveform Innovation in Spinal Cord Stimulation / Invited Speaker Multi-institution COVID-19 Lecture Series, Sponsored by University of Washington
2021	Pain Medicine: Practice Management and Billing Compliance University of Miami
2022	Pain Management and Opioid Stewardship OhioHealth
2022	Spinal Cord Stimulation: New Devices and Advances / Invited Lecture Brown University, Medical School, Department of Anesthesiology
2022-2022	Keynote: CDC Opioid Prescribing Guidelines Update – Thoughts, Impacts & Where do we go from here / Keynote Lecture Eastern Pain Association Annual Meeting
2022-2022	Pathophysiology of Pain - A 2022 Update / Invited Lecture Harvard Medical School, Evaluating & Treating Pain Conference Lecture and Panel
2022-2022	Neuromodulation: From Bench to Bedside / Grand Rounds Cedar Sinai, Department of Anesthesiology, Department Grand Rounds
2022-2022	The Digital Transformation of Medicine / Invited Lecture New York City, New York
2023	Neuromodulation Advances / Invited Lecture Brown University, Medical School, Department of Anesthesiology
2023	Invasive Pain Management Techniques / Invited Lecture Medical & Life Care Consulting's **2023 INJURY INSIGHT** webinar series This four-part webinar series is designed to educate and inform adjusters,

employers, risk managers, and industry stakeholders of the rehabilitation and recovery process of injuries, illnesses, diagnoses, and treatments, both common and uncommon, within workers' compensation claims.

International

2017	Difficult Airway Management / Anesthesiology Grand Rounds Kanombe Military Hospital, Kigali, Rwanda
2017	Nerve Blocks for Facial Surgery / Anesthesiology Grand Rounds Santa Casa Hospital, Sao Paulo, Brazil
2019	Perioperative Pain Management and Alternatives to Opioids / Invited Speaker Korean American Spine Society Annual Meeting, Vancouver, CA
2019	State of the Art in Interventional Pain Procedures / Invited Speaker Korean American Spine Society Annual Meeting, Vancouver, CA
2023	Prospective Survey of Health Utility State of Chronic Migraine Patients to Assess Quality - Adjusted Life-Years / Platform Presentation European Society of Regional Anesthesiology, Paris, France

Report of Clinical Activities and Innovations

Past and Current Licensure and Certification:

2005-	American Heart Association, Basic and Advanced Cardiac Life Support
2008-	Permanent Licensee, State of Massachusetts
2012-2014	Permanent Licensee, State of Maryland
2012-	Diplomate, American Board of Anesthesiology
2012-	Diplomate, American Board of Anesthesiology Pain Medicine

Practice Activities:

2012-2013	General and regional anesthesia	Johns Hopkins Hospital, Baltimore, MD	40 hours / week
2013	Pain Medicine Physician	Brigham and Women's Hospital, Boston, MA	30 hours / week

2013-	General and regional anesthesia	Brigham and Women's Hospital, Boston, MA	10 hours / week

Clinical Innovations:

Cofounder of multidisciplinary spine center / BWF (2014)	As founding medical director of Brigham and Women's Faulkner Hospital's Pain Management Center, a high priority was increased collaboration with the other services in the hospital. After our initial collaboration with the Graham Headache Center proved to be successful, we decided to build a spine center with operative and non-operative services focused on comprehensive spine care. We used a wing of the newly built Orthopedic center at Faulkner to carve out 6 exam rooms and a multi-use work area to build a center where Orthopedics or Neurosurgery was collocated with Physiatry or Pain Medicine. Serving on the governance committee since the inception, I have actively been involved with the creation of workflows, marketing, and management of the spine center. The multi-disciplinary collaboration with physical therapy, pain psychology, rheumatology, neurology, and spine surgery has allowed a focus on developing non-opioid strategies to managing patients suffering with pain.
Implemented changes for practice efficiency / BWH Pain Ctr (2017)	Because of the significant clinical and financial growth of the Brigham and Women's Faulkner Hospitals Pain Management Center, I was selected to be the Medical Director of Brigham and Women's main Pain Management Center. In this position, I created several processes and work flow changes to improve efficiency. First, I changed the schedule to split out procedures and evaluations into separate sessions. Doing this provided each attending physician dedicated geography and resources to see more patients in less time while reducing wasted footsteps. Next, I worked with Epic to create several shortcuts and orders so providers could quickly enter an order for a procedure which would then automatically enter the work queue for managed care services to obtain prior authorization. The new orders have helped to minimize denials while ensuring the proper time and location are allocated for the desired procedure. I also helped create the new order system providers use to refer patients to our multiple locations of Pain Medicine.
Creator of new reporting for Pain Management Center / BWH pain Ctr (2017)	Also in my role as Medical Director of Brigham and Women's Pain Management Center, I created two new reports the administration and staff use monthly. The first report is a gaps analysis to determine sessions where we have inadequate provider coverage. The second report is a productivity report that marries our billing database with the scheduling system to provide the physicians aggregate productivity data that can then be drilled down into individual days. The report is now used by attending physicians

	to track their productivity and by the finance division to cross verify their reporting measures.
Introduction of Radiofrequency Identification to measure time driven activity based costing / (2018)	In collaboration with MIT and Harvard Business School I am coordinating the implementation of radiofrequency identification (RFID) tags and readers to more accurately and robustly calculate costs of a given activity using time driven activity based costing (TDABC). The current models utilizing TDABC in healthcare rely on manual recordings of each step in an activity. Utilizing RFID would minimize the measurement bias and allow for a larger sample size.

Report of Teaching and Education Innovations

Co-founder for the Faulkner Lecture Series (2014)	I co-created a lecture series for the Pain Medicine fellows. In the lecture series, we invite lecturers from other specialties including orthopedics, radiology, psychiatry, and law to discuss practical concepts in Pain Management to prepare them for their early careers. The feedback from the fellows is superb and an integral part of their education.
Creator and manager of Faulkner Hospital Pain rotation (2016)	Since founding the Brigham and Women's Faulkner Hospital's Pain Management Center in 2013, we have been asked to host rotation for interns, residents, and fellows. Each year we have a growing number of residents requesting the rotation for the CA-3's pain medicine elective – even for residents not specializing in Pain Medicine. Additionally, we now host Neurology Headache fellows, Regional Anesthesia fellows, and categorical anesthesia interns. I coordinate and evaluate all rotating trainees through the Pain Center.
Introduction of pain simulation (2018-)	Simulation in anesthesiology is now a standard for resident education, however, within Pain Medicine simulation has not gained traction. I worked with a company called Biotras to bring a spine simulator with cadaveric bone and ballistic gel to the Pain Management Center at Brigham and Women's Hospital. We organized two sessions for the 2018-2019 fellow class to practice obtaining the correct views and directing the needle for four of our most common procedures. The feedback was so overwhelmingly positive from the fellows that we curated an entire curriculum based on simulation. We have published on our findings demonstrating improvements in fellow comfort, accuracy, radiation exposure, and time for each procedure. Every year we have incrementally added new ad-hoc session in the second half of each fellowship year.

Report of Education of Patients and Service to the Community

☒ *No presentations below were sponsored by 3rd parties/outside entities*

Activities

1999	Medical Mission Medical mission to Guatemala with Sending Out Servants
2000-2002	Big Brothers Big Sisters Over 500 hours spent as a mentor in Austin, TX
2000-2002	Habitat for Humanity Habitat for Humanity via Texas Blazers
2010	Global Smile Foundation Medical Mission to Cote D'Ivoire, Global Smile Foundation (Anesthesiologist)
2011	Global Smile Foundation Medical Mission, Ecuador with the Global Smile Foundation (Anesthesiologist)
2012, 2015	Global Smile Foundation Medical Mission, Guatemala with the Global Smile Foundation (Anesthesiologist)
2017	Face the Future Foundation Medical Mission, Rwanda with Face the Future (Anesthesiologist)
2017	Global Smile Foundation Medical Mission, Brazil with Global Smile Foundation (Anesthesiologist)
2018, 2019	Face the Future Foundation Medical Mission, Rwanda with Face the Future Foundation (Anesthesiologist)

Educational Material for Patients and the Lay Community:

Patient educational material

2015	Managing with Low Back	BWF, Community Lecture Series
2016	Novel Techniques for Treating Low Back Pain	BWF, Community Lecture Series

Recognition:

2010	Featured in Brigham and Women's Hospital Bulletin	12/13/2010 article: Driving Clinical Innovations at BWH
2011	Featured in the Harvard Gazette (September 20, 2011) Surgical Precision at SEAS	9/20/2011 article: Innovation and Medical Device Design
2016	Featured in Tennessean (April 5, 2016)	4/5/2016 article: Health care leaders urge action on opioid abuse
2016	Highlighted in educational marketing video for Brigham and Women's Hospital	5/6/2016 video: Managing Back Pain
2016	Highlighted in marketing video for Faulkner Hospital Pain Management Center	5/12/2016 video: Pain Management Center at BWFH

Report of Scholarship

ORCID: 0000-0001-6960-9621

Peer-Reviewed Scholarship in print or other media:

Research Investigations

1. Brattain LJ, Floryan C, Hauser OP, Nguyen M, **Yong RJ**, Kesner SB, Corn SB, Walsh CJ. Simple and effective ultrasound needle guidance system. Annu Int Conf IEEE Eng Med Biol Soc. 2011;2011:8090-8093. PMID: 22256219, https://doi.org/10.1109/IEMBS.2011.6091995

2. **Yong RJ**, Nelson ER, Urman RD, Kaye AD. A primer for billing in interventional pain management. J Med Pract Manage. 2015;30(6 Spec No):51-54. PMID: 26062319

3. Imran TF, Malapero R, Qavi AH, Hasan Z, de la Torre B, Patel YR, **Yong RJ**, Djousse L, Gaziano JM, Gerhard-Herman MD. Efficacy of spinal cord stimulation as an adjunct therapy for chronic refractory angina pectoris. Int J Cardiol. 2017 Jan 15;227:535-542. PMID: 27836302, https://doi.org/10.1016/j.ijcard.2016.10.105

4. Kim AJ, **Yong RJ**, Urman RD. The Role of Transversus Abdominis Plane Blocks in Enhanced Recovery After Surgery Pathways for Open and Laparoscopic Colorectal Surgery. J Laparoendosc Adv Surg Tech A. 2017 Sep;27(9):909-914. PMID: 28742435, https://doi.org/10.1089/lap.2017.0337

5. Pak DJ, **Yong RJ**, Kaye AD, Urman RD. Chronification of Pain: Mechanisms, Current Understanding, and Clinical Implications. Curr Pain Headache Rep. 2018 Feb 5;22(2):9. PMID: 29404791, https://doi.org/10.1007/s11916-018-0666-8

6. Xing F, **Yong RJ**, Kaye AD, Urman RD. Intrathecal Drug Delivery and Spinal Cord Stimulation for the Treatment of Cancer Pain. Curr Pain Headache Rep. 2018 Feb 5;22(2):11. PMID: 29404792, https://doi.org/10.1007/s11916-018-0662-z

7. Aman, M.M., Jason Yong, R., Kaye, A.D.*et al.*Evidence-Based Non-Pharmacological Therapies for Fibromyalgia.*Curr Pain Headache Rep***22**, 33 (2018). https://doi.org/10.1007/s11916-018-0688-2

8. Simopoulos T, **Yong RJ**, Gill JS. Treatment of Chronic Refractory Neuropathic Pelvic Pain with High-Frequency 10-kilohertz Spinal Cord Stimulation. Pain Pract. 2018 Jul;18(6):805-809. PMID: 29106051, https://doi.org/10.1111/papr.12656

9. Wang VC, Preston MA, Kibel AS, Xu X, Gosnell J, **Yong RJ**, Urman RD. A Prospective, Randomized, Double-Blind, Placebo-Controlled Trial to Evaluate Intravenous Acetaminophen Versus Placebo in Patients Undergoing Robotic-Assisted Laparoscopic Prostatectomy. J Pain Palliat Care Pharmacother. 2018;32(2-3):82-89. PMID: 30645153, https://doi.org/10.1080/15360288.2018.1513436

10. Novak CJ, Khimani N, Kaye AD, Jason Yong R, Urman RD. Current Therapeutic Interventions in Lower Extremity Venous Insufficiency: a Comprehensive Review. Curr Pain Headache Rep. 2019 Mar 4;23(3):16. doi: 10.1007/s11916-019-0759-z. PMID: 30830460

11. Valimahomed AK, Haffey PR, Urman RD, Kaye AD, **Yong RJ**. Regenerative Techniques for Neuraxial Back Pain: a Systematic Review. Curr Pain Headache Rep. 2019 Mar 11;23(3):20. PMID: 30854599, https://doi.org/10.1007/s11916-019-0758-0

12. Morales A, **Yong RJ**, Kaye AD, Urman RD. Spinal Cord Stimulation: Comparing Traditional Low-frequency Tonic Waveforms to Novel High Frequency and Burst Stimulation for the Treatment of Chronic Low Back Pain. Curr Pain Headache Rep. 2019 Mar 14;23(4):25. PMID: 30868285, https://doi.org/10.1007/s11916-019-0763-3

13. Atkinson TJ, Pisansky AJB, Miller KL, **Yong RJ**. Common elements in opioid use disorder guidelines for buprenorphine prescribing. Am J Manag Care. 2019 Mar 1;25(3):e88-e97. PMID: 30875177

14. Boyaji S, Merkow J, Elman RNM, Kaye AD, **Yong RJ**, Urman RD. The Role of Cannabidiol (CBD) in Chronic Pain Management: An Assessment of Current Evidence.

Curr Pain Headache Rep. 2020 Jan 24;24(2):4. PMID: 31980957, https://doi.org/10.1007/s11916-020-0835-4

15. Coppes OJM, **Yong RJ**, Kaye AD, Urman RD. Patient and Surgery-Related Predictors of Acute Postoperative Pain. Curr Pain Headache Rep. 2020 Feb 18;24(4):12. PMID: 32072315, https://doi.org/10.1007/s11916-020-0844-3

16. Costelloe C, Burns S, **Yong RJ**, Kaye AD, Urman RD. An Analysis of Predictors of Persistent Postoperative Pain in Spine Surgery. Curr Pain Headache Rep. 2020 Feb 18;24(4):11. PMID: 32072357, https://doi.org/10.1007/s11916-020-0842-5

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* Co-author, ** Mentee

Narrative Report

As an academic anesthesiologist specializing in pain medicine at Brigham and Women's Hospital, my efforts are focused on developing clinical expertise, innovating pain medicine through novel implantable devices and opioid management strategies, and educating fellows and residents. My major supporting activity involves administrative and institutional service with leadership roles and committee service.

Approximately half of my time is devoted to direct patient care within pain medicine including time spent evaluating patients in clinic, performing office-based procedures, and surgically implanting devices to help manage pain. I spend twenty percent of my time as an anesthesiologist supervising

residents and nurse anesthetists with a focus on regional anesthesia and acute post-operative pain management. The remainder of my time is divided among administrative duties including institutional committee service and serving as the Associate Chief of Pain Medicine and Medical Director of the Pain Management Center.

Clinically, I have developed expertise in surgically implantable technologies for the treatment of chronic pain and opioid management strategies. Since fellowship, I have been fascinated by neuromodulation using spinal cord and peripheral stimulators to modulate pain signals. Using this passion, I have taught fellows and residents extensively on the technology, and introduced the Nevro high frequency stimulator to Brigham and Women's Hospital becoming the first implanting physician in New England. Since then I have continued as the major pioneering physician for other minimally invasive procedures in New England, such as Vertiflex Superion spacer implantation, Relievant Intracept, Saluda neuromodulation, Mainstay Reactiv8, Vertos MILD. I have tried to maintain an academic focus with new technology, and I am currently the Principal Investigator in several prospective case-series examining the efficacy of novel neuromodulation technologies. With my focus on neuromodulation, I have been fortunate enough to become the top implanter of spinal cord stimulators in the Northeast.

I am continuing to develop my career in research and have several active funded clinical studies involving neuromodulation and novel therapeutics. The unfunded project involve evaluating the health utility of different pain states, medical education utilization a novel pain simulator, and analyzing epidemiology of pain. In response to my personal struggles and those of fellows starting their careers, I conceptualized and was first editor for Pain Medicine: An Essential Review which focuses on relevant clinical pearls. I have published on several different topics within pain medicine and have a current H-index of 16 with a first authored paper titled Prevalence of chronic pain among adults in the United States cited over 300 times since publication in 2022. On a national level, I have been invited to give 5 grand rounds and was invited to serve on the American Board of Anesthesiology MOCA Minute for Pain Medicine question writing committee. Internationally, I participate in 1-2 medical missions per year providing anesthesia and have been invited to give multiple international presentations.

As the founding medical director of the Pain Management Center at Brigham and Women's Faulkner Hospital, I helped grow the pain medicine services at the hospital focusing on the integration of high quality pain management to all areas of the hospital. Our volume tripled to over 400 pain patients per month in the span of 3 years. Due in part to that success, in 2017, I was selected as the Medical Director of the Pain Management Center at Brigham and Women's Hospital. In this role, I am focused on operational efficiency and financial viability. With the early changes I helped manage and develop, our productivity has increased with an improvement in patient satisfaction. The rapid turnaround then led to the appointment as Associate Chief of the Division of Pain Medicine. I was also elected to serve on the Faculty Board in the Department of Anesthesiology. I serve as an active member on the Faculty Recruitment Committee and the Anesthesiology Social Committee.

In my current role and as the previous Associate Program Director for the Pain Management Center at Brigham and Women's Hospital, I am involved with recruitment, curriculum development, and overall management of the 10 fellows per year. My involvement in this role extends to committee service on a hospital and national level with the American Board of Anesthesiology. As a product of our own

residency and fellowship, I am appreciative of the extensive curriculum and mentorship by the world renown experts at our institution. I have strived to reciprocate using innovative teaching methods such as the introduction of medical simulation with pain procedures, and I am honored to have my passion in mentorship and teaching reflected in the Pain Fellow's Pain Attending of the Year award for excellence in teaching for 7 of the previous 10 years.

In addition to my clinical work, I have been an active member in our department and the hospital. I was elected to serve on the Medical Staff Executive Committee for Brigham and Women's Faulkner Hospital and currently serve on the Ambulatory Advisory Council at Brigham and Women's Faulkner Hospital and the Office for Multicultural Careers Advisory Committee at the Brigham and Women's Hospital.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

KENNETH EUGENE SMITH, Plaintiff, v. JOHN Q. HAMM, in his official capacity as Commissioner, Alabama Department of Corrections, and TERRY RAYBON, in his official Capacity as Warden, Holman Correctional Facility, Defendants.	)	Case No. 2:23-cv-00656-RAH CAPITAL CASE **EXECUTION SCHEDULED FOR JANUARY 25, 2024**

SUPPLEMENTAL DECLARATION OF ROBERT JASON YONG, M.D.

I, Robert Jason Yong, declare under penalty of perjury as follows:

1. I submit this declaration to supplement my declaration dated November 17, 2023 based on additional information I have received since that time.

2. I have testified as an expert in the following cases in the last four years:

Deposition Date	**Case**
4/15/2020	Staubus, et al., v. Purdue Pharma, L.P., et al., No. C-41916
2/18/2021	The People of the State of California, et al v. Purdue Pharma, L.P., et al.
8/11/2021	State of Alabama v. Endo Health Solutions, Inc., et al.
8/23/2021	Lynn Shulman v. Mall at Solomon Pond, LLC, et al.
9/20/2021	County of Dallas v. Purdue Pharma, L.P. et al., (In Re: Texas Opioid Litigation, MDL No. 18-0358)
11/3/2021	James Manning v. Georgia Anesthesiologists LLC
1/5/2022	Opioid Litigation
11/22/2022	Jacqueline Thompson v. Walter Hall, M.D.

3. My hourly rate in this matter is $650.00. My rate for testimony in this matter is $6,000 for a full day of testimony (>4.5 hours) and $3,500 for a half day of testimony (<4.5 hours).

4. I have reviewed the transcript of the December 14, 2023 deposition of Ms. Cynthia Stewart-Riley.

5. Based on that testimony, I understand the State of Alabama intends to follow the following procedures if a condemned person vomits into the mask prior to nitrogen being deployed: the team captain will remove the mask, place a bite plate in the condemned person's mouth, turn the condemned person's head to the side, conduct a finger sweep, and clean up the vomit and mask before placing the mask back on the condemned person's face. Based on my clinical experience, a finger sweep is insufficient to remove the vomit from a patient's airway and suction is required.

6. Additionally, I understand the State of Alabama will follow these procedures only if the nitrogen has not been deployed. According to Ms. Stewart-Riley's testimony, once nitrogen is deployed the State of Alabama will not remove the mask if the condemned person vomits into the mask. If a condemned person vomits once nitrogen is deployed and in a reclined position, he will likely inhale vomit and asphyxiate, resulting in painful sensations of choking and suffocations or even death from asphyxiation. Based on my clinical experience, vomiting still occurs when a patient is unconscious.

Executed on this 18th day of December 2023,

R. Jason Yong, MD MBA

EXHIBIT C

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

KENNETH EUGENE SMITH, Plaintiff, v. JOHN Q. HAMM, in his official Capacity as Commissioner, Alabama Department of Corrections, and TERRY RAYBON, in his official Capacity as Warden, Holman Correctional Facility, Defendants.	)	Case No. 2:23-cv-00656-RAH CAPITAL CASE **EXECUTION SCHEDULED FOR JANUARY 25, 2024**

DECLARATION OF KATHERINE PORTERFIELD, Ph.D. IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

KATHERINE PORTERFIELD, Ph.D. declares under penalty of perjury:

1. I am a clinical psychologist, licensed to practice in New York State. I received my Ph.D. in clinical psychology from the University of Michigan in 1998. I currently consult at Bellevue Hospital at the Bellevue Program for Survivors of Torture where I have evaluated, treated, and supervised the treatment of children, adolescents, and adults who have experienced war trauma and torture.

2. Counsel for Plaintiff Kenneth Eugene Smith asked me to evaluate Mr. Smith's psychological and emotional condition after the preparation for and experience of an attempt to execute him on November 17, 2022 and his reaction to another attempt to execute him. I submit this Declaration in support of Kenneth Eugene Smith's Motion for Preliminary Injunction.

3. On November 17, 2023, I prepared an Expert Report in connection with my work in this case that expresses my findings and opinions. A true and correct copy of my Expert Report, with exhibits, is attached as Exhibit 1.

4. A true and correct copy of my curriculum vitae is attached as Exhibit 2

5. I incorporate the contents of my Expert Report as if fully stated herein.

6. The opinions expressed in my Expert Report are my own and are made to a reasonable degree of psychological certainty.

I declare under penalty of perjury that the foregoing is true and correct under 28 U.S.C. § 1746.

Executed: November 18, 2023

KATHERINE PORTERFIELD, Ph.D.

EXHIBIT 1

Katherine Porterfield, Ph.D.
Licensed Psychologist
New York State License number 014105-1

Report of Psychological Evaluation
Name: Kenneth Smith
Evaluator: Katherine Porterfield, Ph.D.
Date of Report: November 17, 2023

Referral request from defense counsel

Counsel for Mr. Kenneth Smith retained me to evaluate Mr. Smith's psychological and emotional condition, specifically in relation to the preparation for and experience of an attempted execution that took place on November 17, 2022 at W.C. Holman Correctional Facility, as well as his potential reactions to a future attempt at executing him. I met with Mr. Smith on two occasions on 12/29/22 and 1/31/23 and have also had seventeen phone calls with him (dates below). I have been compensated at my hourly rate for this evaluation.

In this report, I will briefly discuss relevant clinical and research literature on the human response to mock execution and other imposed near-death experiences that informs my conclusions regarding Mr. Smith's experiences and functioning. Then I will describe Mr. Smith's psychosocial history and his experience on November 17, 2022 when an attempted execution by lethal injection was conducted on him. I will then describe Mr. Smith's clinical condition and functioning.

At the time of the writing of this report, Mr. Smith has a scheduled execution date of January 25, 2024.

Sources of information

1. Phone calls with Kenny Smith: 12/1/22, 12/9/22, 12/16/22, 12/22/22, 1/3/23, 1/16/23, 1/23/23, 2/14/23, 2/28/23, 3/14/23, 4/5/23, 5/9/23, 7/11/23, 8/10/23, 9/1/23, 11/6/23, 11/15/23
2. Visits with Kenny Smith: 12/29/22, 1/31/23
3. See attached appendix of materials considered

Methodology

An expert examination of the psychological impact of trauma on an individual requires that the expert have knowledge of the extensive body of research and clinical literature that address the deleterious impact of traumatic events on human functioning, as well as knowledge of the course and prognosis of trauma symptomatology and the therapeutic needs of a trauma survivor. An expert with this knowledge and competency is necessary not only for the proper analysis of the evaluation data, but also in order to conduct interviews that are trauma-focused and sensitive, and to observe proper methodology for maximizing the elicitation of valid and

relevant information from the subject. The clinical interview, characterized by open-ended questioning that is linked to empirically-derived information about diagnosis, trauma sequelae, treatment and prognosis, is the central source of data of an evaluation.[1] In forensic contexts, it is recommended that the clinical interview be supplemented with collateral data from records or other witnesses, as well as psychological measures that are reliable and valid.[2] Measures that include validity scales (scales that assess the likelihood that the individual is presenting themselves truthfully) or measures of malingering (intentionally producing false or exaggerated symptoms) are also useful in forensic contexts.[3]

The evaluation conducted for this report follows the standards laid out above: an evaluator with expertise in severe trauma and its sequelae; use of multiple data sources, including open-ended questioning over time; and malingering assessment and use of psychological measures.

Qualifications

My qualifications are outlined in my curriculum vitae, which is attached. In sum, I am a clinical psychologist, licensed to practice in the state of New York. I received my Ph.D. in clinical psychology from the University of Michigan in 1998. My pre-doctoral and postdoctoral training included extensive training in the evaluation and diagnosis of mental disorders. Since 1998, I have worked as a psychologist at Bellevue Hospital and NYU School of Medicine at the Bellevue/NYU Program for Survivors of Torture. I have evaluated, treated and supervised the treatment of numerous children, adolescents and adults who have experienced war trauma and torture. I have evaluated individuals and served as an expert witness in the Military Commissions in Guantanamo Bay, US Federal Courts, Southern and Eastern Districts of New York, Western District of Pennsylvania, Superior Court, Skagit County, Washington, and for immigration proceedings in courts through the Executive Office of Immigration Review. I have conducted evaluations of individuals held at Bagram Airbase, Guantanamo Bay Detention Center, and multiple "black site" prisons around the world.

I have co-authored several publications pertaining to the assessment and treatment of trauma and torture, including as a contributor to the United Nations' *Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman, or degrading treatment or punishment* and the Cambridge Handbook of Psychology and Human Rights. My peer-reviewed articles have been published in textbooks and professional journals, including *The Journal of Nervous and Mental Disease*; *The Prevention Researcher*; *Psychiatry: Interpersonal and Biological Processes*; *OMEGA – Journal of Death and Dying*; and *Journal of*

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[1] Melton GB, Petrila J, Poythress NG, et al. Psychological Evaluations for the Courts. New York: Guilford Press; 1997.
[2] Frankel, A. S., & Dalenberg, C. (2006). The forensic evaluation of dissociation and persons diagnosed with dissociative identity disorder: Searching for convergence. *Psychiatric Clinics of North America, 29*(1), 169–184.
[3] AAPL practice guideline for the forensic assessment (2015). *Journal of the American Academy of Psychiatry and the Law, 43*(2), s3–s53.

the American Academy of Child & Adolescent Psychiatry. I regularly serve as a reviewer on several peer-reviewed journals and academic presses. I have trained hundreds of health professionals and attorneys in the country on the evaluation and treatment of war trauma and torture survivors and have lectured or conducted seminars on issues of torture and complex trauma sponsored by a wide variety of organizations, including human rights organizations, governmental entities, universities, and the International Criminal Court.

Summary of conclusions:

Kenny Smith's experience on November 17, 2022 of living through an almost four-hour execution process (preceded by weeks of isolation and visits in which he said his final goodbyes to his family) subjected him to severe trauma, the intensity of which I have rarely seen in twenty-five years of practice as a trauma psychologist. During the attempted execution, he was repeatedly and painfully stuck with needles on various parts of his body, placed into stress positions, including an inverted angle with his head below his heart, and left for extended periods in painful, uncomfortable states with no verbal feedback from multiple staff members who were there, despite his attempts to ask for information and seek to contact his lawyer. The evidence indicates that, during the attempted execution, he fluctuated between states of fight/flight arousal and dissociative shut-down, and that each of these adaptive defenses have led to ongoing problems in multiple areas of his functioning. Having someone try to end one's life is one of the most viscerally terrifying and incapacitating human experiences there is. Clinical and research data demonstrate how the neuroendocrine and neurochemical human responses to near-death are highly altering of a person's functioning, leaving severe and sometimes permanent brain-based consequences in cognition, emotion, and perception. Kenny Smith suffers in multiple domains of functioning—that is, his bodily, his cognitive/emotional and his social capacities—indicative of such long-term, pervasive neurophysiological impairment. The results from over thirty-five hours of interview and behavioral observation, review of medical records and data from psychological standardized measures indicate that Mr. Smith is suffering from posttraumatic stress disorder (PTSD) with dissociative features and depression. Mr. Smith's symptoms include hyperarousal and anxiety, intrusive reexperiencing of the attempted execution, dissociation from his environment, avoidance of reminders of the events, social disconnection, and profoundly negative mood and thoughts.

Mr. Smith's functioning has notably declined since May 2023 after a brief period of some symptom improvement. It is my clinical opinion that the current plan of execution and the possibility of having to again face these procedures is completely terrifying for Mr. Smith and leading to ongoing deterioration. His fairly resilient style of coping is insufficient to manage the flood of reminders and the accompanying terror that he currently is experiencing, as he envisions his imminent execution. Like other survivors of life-or-death situations in which they dissociated, Mr. Smith is suffering with the emergence of increasing involuntary sensory experiences (flashbacks) and accompanying distress and avoidance that these engender. These symptoms have notably worsened and will likely continue to do so as he is faced with a repetition of the life-or-death experience of an execution and all of its preparation. As a clinician who has worked with survivors of severe trauma and torture for over twenty-five years, I have only encountered a situation like this—in which a person who was severely traumatized by something done to him was then forced to anticipate and suffer the experience again-- in contexts

of purposeful, state-sponsored torture. Having evaluated and treated people who suffered gang-rape, mock execution, and torture in which they almost died, it is impossible to fully quantify the level of anguish that a person would experience as they prepare for and suffer the events again. Mr. Smith's mental and emotional stability is currently being taxed to an intolerable degree as he is forced to again contemplate, prepare for, and suffer execution.

The Alabama Department of Corrections Execution Procedures (August 2023 and April 2019) do not include any guidelines for execution of a person who suffered a previously failed execution. Practically for Mr. Smith, each step of the execution will be a repeat of the steps taken in 2022 during the lead-up to his first execution attempt (with the new addition of steps required for execution by nitrogen hypoxia). Experiencing these traumatic events again—step by step—will severely trigger his posttraumatic stress disorder, likely thrusting him into states of disabling panic, fight or flight and dissociation that can only be characterized as devastating to the human body and mind.

Mock execution and other imposed near-death experiences: Empirical and clinical findings

It is widely understood in clinical and research literature on trauma that the stress of severe traumas, such as near-death experiences, leads to a set of neurophysiological responses in a human being's "fear network." When a person is in fear for his/her life, involuntary nervous system reactions take over and the person enters a mode of functioning that is driven by neurochemical and neuroendocrine responses designed to maximize survival. These responses are controlled by the sympathetic nervous system's hyperarousal ("fight or flight") and the parasympathetic nervous system's shut-down responses ("flag, faint").[4]

To understand the defensive cascade that occurs in conditions of inescapable trauma, it is helpful to conceptualize a curve in which the early stage of a life-threatening trauma results in the hyperarousal and nervous system "uproar" in order to fight against the encroaching threat. If this effort at fight or flight fails, mammals have been shown to experience a state of psychophysiological surrender or collapse, sometimes called "flag" and in its most extreme form, "faint." [See Figure 1]. In situations of inescapable life or death threat, mammals will often enter into states of "tonic immobility," a condition characterized by analgesia (pain relief), inhibition of movement and vocalization and physical tremors.[5] During tonic immobility, the individual is still aware of what is happening, as opposed to in a state of complete fainting. Each of these reactions can be triggered by life-or-death threats and a person can alternate between them during an event. (For example, having a racing heart when running from an assailant and then collapsing into immobility when caught by the assailant and then waking up into fear in the middle of the assault.)

[4] Maeng LY, Milad MR. (2017) Post-traumatic stress disorder: The relationship between the fear response and chronic stress. *Chronic Stress*. doi:10.1177/2470547017713297

[5] Kalaf et al., (2015). Peritraumatic tonic immobility in a large representative sample of the general population: Association with posttraumatic stress disorder and female gender. *Comprehensive Psychiatry*, July, 60 (68-72).

The experience of moving into a state of disconnection in the middle of life-threatening trauma involves not only lowered physiological arousal, but also changes in perceptions and cognitive awareness. Herman, a leader in the study of severe trauma describes this complex state:

> Sometimes situations of inescapable danger may evoke not only terror and rage but also, paradoxically, a state of detached calm, in which terror, rage and pain dissolve. Events continue to register in awareness, but it is as though these events have been disconnected from their ordinary meanings. Perceptions may be numbed or distorted, with partial anesthesia or the loss of particular sensations. Time sense may be altered, often with a sense of slow motion and the experience may lose its quality of ordinary reality.[6]

After such experiences, it has also been robustly proven that the same neurochemical and neuroendocrine reactions that may have helped a person survive a life-or-death event will also recur and reappear after the trauma, causing impairment in an individual's biopsychosocial functioning. This reliving of trauma and the accompanying triggering of states of fear and shut-down are the core difficulties faced by those with stress and trauma-related disorders, such as PTSD. [7]

Life or death situations that are manmade—that is, brought about intentionally by other people—are particularly damaging, as the victim not only must manage the physiological stress reactions brought about by the threat of death, but also the psychological and interpersonal meanings of having another human attempt to end their life. Research on survivors of torture has demonstrated how life-threatening maltreatment leads to worse psychological outcomes. For example, the perceived risk of being killed by a method of torture has been shown to worsen survivors' reactions in the aftermath.[8]

Mock execution has been studied as a particularly severe method of maltreatment that simulates a life-or-death threat. Mock execution is an experience in which a person is made to believe that he will be killed. It includes actions that mirror an actual execution, rather than only a threat of execution. Thus, in mock executions, people are smothered (wet or dry), have guns held to their heads, or are subjected to any number of life-threatening acts.[9] Those who have written about mock execution or studied its impact have noted that it is one of the most severely traumatizing events that a person can suffer. Researchers from Physicians for Human Rights describe the effects of mock execution:

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[6] Herman, J. (2015). *Trauma and Recovery*. pp. 42-43. Basic Books.

[7] Meyer-Parlapanis, D., Elbert, T., (2015). Torture and its consequences, Psychology of. In: James D. Wright (editor-in-chief), International Encyclopedia of the Social & Behavioral Sciences, 2nd edition, Vol 24. Oxford: Elsevier. pp. 434–441.

[8] Başoğlu, M., & Mineka, S. (1992). The role of uncontrollable and unpredictable stress in post-traumatic stress responses in torture survivors. In M. Başoğlu (Ed.), Torture and Its Consequences: Current Treatment Approaches (pp. 182–225). Cambridge University Press.

[9] This evaluator's experience with mock execution includes evaluating or treating multiple people who have suffered this method of torture, including by water, electric chair, threatened beheading, gun to the head, and being led into a cage with a lion.

> According to clinicians who treat torture survivors at the Minnesota-based Center for Victims of Torture, mock executions and other situations where death is threatened force victims to repeatedly experience their last moments before death, create a sense of complete unpredictability (never knowing when death might come), and induce chronic fear and helplessness. Victims who were threatened with death speak of feeling a sense that one is already dead. They often relive these near-death experiences in their nightmares, flashbacks, and intrusive memories. [10]

The severe stress of mock execution is capable of altering brain chemistry and brain structure, leading to chronic posttraumatic symptoms.[11] Researchers found that sensory memories of a severe trauma such as mock execution become "dislodged" from the narrative (linear) memory and are then able to create brain/body "alarm" or "excitation"—that is a terror response—in a survivor even when the person is not trying to "remember" the traumatic event.[12] This research has shown that functionally, a near death experience imposed on a person "has no time or place" in the aftermath—it is essentially able to trigger repeated experiences of terror and alarm in the survivor. Most importantly, this appears to occur through neuroplasticity—or rewiring of the survivor's brain chemistry in response to the trauma. These extreme stress events activate hormones, including cortisol, which are released into the body. Cortisol has been implicated in causing atrophy in brain structures associated with memory formation (hippocampus) and enlargement in brain structures involved in fear maintenance (amygdala).[13]

The above review is included in order to provide a framework, based in clinical and research literature, that is applicable to the experience of Kenny Smith. A mock execution is perhaps the closest parallel to what he experienced, in that he was brought to the point of believing he would be killed. Unlike in mock execution, however, the intent was to complete the execution. Mr. Smith's subjective experience, then, of believing he was about to die and going through the physiological and emotional responses to that, is parallel to others who have had such experiences and lived to describe them.

Psychosocial history[14]

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[10] Physicians for Human Rights, (2005). Break Them Down: Systematic Use of Psychological Torture by US Forces. Washington, DC.

[11] O'Mara, S. (2011). On the imposition of torture, an extreme stressor state, to extract information from memory: A baleful consequence of folk cognitive neurobiology. *Zeitschrift für Psychologie/Journal of Psychology, 219*(3), 159–166.

[12] Elbert, T., Schauer, M., Ruf, M., Weierstall, R., Neuner, F., Rockstroh, B., & Junghöfer, M. (2011). The tortured brain: Imaging neural representations of traumatic stress experiences using RSVP with affective pictorial stimuli. *Zeitschrift für Psychologie/Journal of Psychology, 219*(3), 167–174.

[13] O'Mara, S. (2018) The captive brain: Torture and the neuroscience of humane interrogation, *QJM: An International Journal of Medicine*, Volume 111, Issue 2, pp. 73–78.

[14] I will refer to Kenny Smith as Kenny in his childhood history and his father as Mr. Smith.

Kenny Smith was the oldest of five children born to Eugene and Linda Smith. Kenny's father was violent towards his mother, beating her in front of the children. Kenny remembers his father hitting his mother with a beer bottle and slamming her head into a TV set. Kenny's father left the family when he was four years old and would periodically reappear and take Kenny away without permission, essentially kidnapping him. These events were stressful in the family because Kenny's mother would be distressed, trying to find him. Mr. Smith did not support the family and they lived in poverty throughout his childhood. Kenny's father had children with other women, including while he was married to Mrs. Smith. Kenny suffered a head injury when he was an infant, when someone dropped luggage on his head while he was on a train.

When Kenny was six, his infant brother died, an event that deeply affected his mother's mental health and stability. She began to abuse alcohol, often becoming impaired and unable to function. He and his siblings often were alone or with babysitters because their mother was going out. Around age six or seven, Kenny was sexually abused on multiple occasions by two different female babysitters who were in their late teens. These events involved Kenny being fondled. He never told anyone at the time because they told him not to.

Kenny recalled that he was "fearful" throughout his childhood because of his father's erratic behavior. He struggled with migraines throughout childhood and adolescence, often missing school due to headaches. Kenny went on to use marijuana and drink in his adolescence, as well as use Valium, ultimately dropping out of high school. The valium was initially provided to him by his mother when he had migraines. At nineteen, he joined the Marines, and withdrew after several months. He had a car accident at age twenty but was not seriously injured. He does not recall other traumatic events in his life or times when he felt that his life was in danger. He noted that in prison, he has felt "scared" but never "terrified" or afraid for his life.

Criminal History

In April 1988, Mr. Smith was indicted in Colbert County, Alabama for murder for pecuniary gain. In May 1996, he was convicted and sentenced to death, although the jury recommended by a vote of 11 to 1 that he be sentenced to life imprisonment without the possibility of parole.[15] In December 2000, the Alabama Court of Criminal Appeals affirmed Mr. Smith's conviction and sentence. In March 2005 and October 2005, respectively, the Alabama Supreme Court and United States Supreme Court declined to hear Mr. Smith's appeal. Thereafter, Mr. Smith unsuccessfully sought post-conviction relief in the Alabama state courts and then in federal courts, culminating in the United States Supreme Court's declining to hear his appeal in February 2022.

Prior to the attempted execution

In the months leading up to the attempted execution, before he had been given a date, Mr. Smith was seen by a psychiatrist in the prison, Dr. Polanco, who prescribed Trazodone and Remeron for sleep. According to Mr. Smith, the psychiatrist told him that his symptoms had

[15] Kenny was first tried, convicted and sentenced to death in November 1989. He has been on death row since. His first conviction and sentence were overturned on appeal.

developed due to the impending execution and that, because he had no history of mental illness, there was not much else that could be done, except to prescribe the medication. He also saw a psychologist, Dr. Beech, in the months before his execution date and he noted that she was helpful to him by talking with him about anxiety and depression. Additionally, Mr. Smith worked with Dr. Beech in a meditation and creative writing group with other inmates.

In September 2022, Mr. Smith received a date of November 17, 2022 for his execution. He was notified by the warden, who called Mr. Smith to his office and informed him. In the weeks following that, following protocol, Mr. Smith was in a lock-down status in his cell. He was able to make calls to his family and talk to other inmates who sat outside his cell and talked with him. Over the next six weeks, he tried to get his affairs in order for his family, while continuing to communicate with his lawyers about his legal options.

On the Sunday before the scheduled execution, Mr. Smith began to have family visits in preparation for saying goodbye to his family. Various family members visited with him, including his mother and his wife, his sons, his sister, and nieces. A lay minister who served as his spiritual advisor provided communion to Mr. Smith and his family. He recalls these visits as profound for him and his family as they shared what they meant to each other and "cried like babies," in anticipation of the execution day. Throughout the evaluation, Mr. Smith wept trying to explain this and he focused intensely on how excruciating these goodbyes were for his family. He cried, speaking with particular anguish of watching his mother and grandson go through this process of saying goodbye.

On Tuesday, November 15th, Mr. Smith was taken to the infirmary to be examined with a "body chart." He was returned to his cell, where he gathered his belongings and said goodbye to many of his friends on his tier. He was moved to the cell outside the execution chamber—the death cell--on Tuesday and he continued to have family visits on Wednesday, November 16th.

Events of November 17, 2022[16]

On Thursday, November 17th, Mr. Smith visited with his wife, mother, sister and daughter-in-law. His son joined later and brought food for him. His lawyer also visited with him. He said goodbye to his family, something that he recounted in detail. Mr. Smith wept while recalling saying goodbye to family members. After his visits he was taken to the infirmary again for another "body chart."

He recalls being taken back to the death cell at approximately 4:45 pm. He was able to call his wife again and his spiritual advisor came to pray with him. Close to 6:00 pm, Mr. Smith stated that the guards ate a meal together, outside of his cell, while watching television. He found

[16] I will recount what Mr. Smith told me as his recollection of the events of November 17th. I will also include behavioral descriptions of symptoms that he demonstrated at certain points as he told what happened. Because PTSD is strongly evoked when individuals try to recall a trauma, the clinical presentation of a person while they recount can be very instructive to their symptoms. A parallel would be a stress test, where a cardiologist observes and monitors a patient's condition while they exert effort that affects the heart.

this disquieting, as he said that the tone among the staff was quite jovial and relaxed, while he was trying to pray with his spiritual advisor.

Mr. Smith's spiritual advisor was told that he had to leave and Mr. Smith spoke one more time with his wife.[17] He recalled that CO Earle came to the cell with handcuffs and said he had to take the phone away. Mr. Smith described this moment as starting to feel "surreal" and like he was "not present," a reaction that can be understood to likely be nervous system shut-down. When recounting this moment, Mr. Smith noted that he had no recollection of talking to his wife, but a vivid image of CO Earle holding the handcuffs in front of him. As he reached this part of the narrative, Mr. Smith began closing his eyes and looking downward and he stated he felt his heart racing. (This can be understood as a fight or flight response that was being involuntarily triggered by having to recount/remember the moment). CO Earle directed Mr. Smith to sit on the edge of the bed, which he did. Next, the cell was opened and an extraction team of approximately ten guards entered the cell and surrounded Mr. Smith. He was cuffed and had shackles placed on his feet, while also being held firmly under his arms. Mr. Smith was directed to stand up and he was led to the execution chamber. He recalled that there were three people dressed in business clothing in the chamber when he was led in. He was seated on the gurney and then swung around and placed into a prone position with his arms open and secured and his legs strapped down. CO Earle was giving directions to the others in the room and told one officer to secure a sheet over "the condemned." He remembers CO Earle asking the remaining officers, who he called Team 2, to "check that the prisoner is secure." At some point, leads were placed on his chest, as if to monitor his heart. The COs then stepped back into the corners of the room. CO Earle left the execution chamber and went to the witness area. The people in suits left the room after Mr. Smith was strapped onto the table. In addition, all but three of the corrections officers left the chamber, leaving three who remained in the room for the entire process over the next several hours.

Mr. Smith stated that, once he was strapped down, he figured that he had "only minutes left." In fact, at that point, the United States Court of Appeals for the 11th Circuit had issued a stay of the execution at 7:59 p.m. Mr. Smith was not informed of this information and thus, for the next several hours until the stay was lifted at 10:20 p.m., he was kept strapped to the gurney, anticipating that his execution would occur within minutes. Mr. Smith described trying to stay calm and going over his remarks to the witnesses in his head: he prepared to offer his apology to the witnesses on the victim's side and tell his family that he loved them. However, he recalled that he began to panic, thinking that the prison was going to execute him without bringing the witnesses. One of the guards told him to "calm down" and assured him that the witnesses would be brought in. Mr. Smith stated that it was "terrifying" to him at this point, because he was afraid that he would not be able to say goodbye to his family. He said that he lost his composure for a bit and had to try to "refocus." (Again, a description of the uproar of nervous system arousal.) He laid there for what felt like an hour and no one spoke in the room.

Mr. Smith began to pray in order to try to calm himself down. He noted that he was able to calm down and think of positive things and get himself to a state of "peace." When remembering this part of the execution, Mr. Smith wept and said, "God shows up."

[17] Phone records provided to me show that this call to his wife ended at 7:57 p.m.

As time passed, Mr. Smith began to feel cold and he was given a blanket. He felt tightness in his legs, like his circulation was not adequate. He asked what was happening and the guards told him they did not know. He spoke to Deputy Warden Woods for several minutes and noticed that it was approximately 9:30 p.m.

At approximately 10:00 p.m., there was a knock on the door and the three people in suits returned to the chamber. Also with them were two men with IVs and a man with a cart who took a position behind Mr. Smith's head, where he could not see him. No one spoke to Mr. Smith and he said that he was actively working to stay calm in that moment, but as he described it he said, "My head is swimming right now," a likely description of entering into a flashback of dissociation. The men were speaking to each other in a whisper and one of the men was speaking to the man behind Mr. Smith's head. Mr. Smith recalled that one of the personnel took photographs of him on the gurney, something that he found highly distressing.

The man on his left side told Mr. Smith, "I'm going to tie a tourniquet around your arm. It will feel snug." The man put a cotton cloth under his arm and began looking at Mr. Smith's veins. Within a few minutes, the man inserted a needle into his arm, telling him he would feel a "pinch." Mr. Smith felt a sharp pain and exclaimed, "You're in my muscle." The man behind Mr. Smith's head told the IV technician to "back it out," which he did, pulling out the needle slightly and taping it to Mr. Smith's arm. The men discussed whether it was "flowing" or not. While recounting this, Mr. Smith said, "I'm really detached now. Like I'm watching a movie," a description of traumatic dissociation.

Next, the man on his right side loosened the strap on Mr. Smith's arm and began to turn it. While describing this next set of events, Mr. Smith began to hiccup and take large gulps of air, a sign of likely respiratory hyperarousal. The man who had taken Mr. Smith's arm took his hands and tried to ball them up, using a butterfly needle to try to find a vein on his hand.

At this point, Mr. Smith became anxious and asked what the man was doing. He stated loudly in the room, "I need to speak to the judge or my lawyer." He stated his case number and asked to speak to his lawyer. No one responded to these remarks and the IV technician continued to try to insert the needle into his hand. Mr. Smith saw that the other technician had moved down to look at Mr. Smith's right foot and then his left foot, shaking his head no to the person behind Mr. Smith's head, who he could not see. The technicians began to shine a blue light on Mr. Smith's hands and arms, seemingly looking for a vein. One of the men started discussing a vein that "dives down and turns" in the arm and the technician began "sticking" Mr. Smith again in his arm. He recalled that he cried out more at this point, demanding to speak to his lawyer. No one responded to him. When he reached this point in the narrative, Mr. Smith continued to hiccup and state that he needed to use the bathroom. Both of these reactions are frequently seen when a person has been in a state of autonomic nervous system activation and the body is trying

to counter this activation by shutting down. These involuntary processes can bring about changes in breathing and swallowing, as well as bowel and bladder urgency.[18]

Mr. Smith recalled that after they discussed the veins, the man who had been behind his head, who had not touched him, came and stood at his right shoulder. Mr. Smith asked for his lawyer or to speak with the judge. He felt that the man on his right side was trying to find a vein and was "going in and out," of his arm, which was very painful.

Having not succeeded on the right arm, the man who had been sticking him with the needle, said, "Can we invert the table?" The men inverted the table so that Mr. Smith's head was below his body and he was held there, with no explanation of what was happening. Several of the men left the room, leaving Mr. Smith in this inverted position with the guards who had brought him into the chamber. He believes it was about 11 p.m.

Within a few minutes, the people in suits and the IV team filed back into the room and he noticed that one of the men now had a smock, surgical gloves and a mask and shield. This man asked a guard to raise the table so that it was up to the man's chest level, keeping Mr. Smith in an inverted position in which his head was still below his feet. Mr. Smith recalled that the man, who was now at his shoulder, then asked him to turn his head, which he refused to do. The man stepped back and Deputy Warden Woods stepped over to Mr. Smith and then a surgical sheet was placed over his face. At this point, Mr. Smith said "I lost it. I started crying out, asking 'What are you doing?' I'm shaking my head, trying to get the sheet off my face." Mr. Smith became quite anxious recounting this and he described Deputy Warden Woods telling him to "calm down." He again appeared to be experiencing a fight or flight "flashback" that was making his nervous system activate because of the memory trigger.

Mr. Smith, with his face covered, felt panicked and said he was "freaking out," and tried to look down from under the sheet. He recalled seeing a clear plastic sheet over his chest with an open center. He saw that the man had a syringe in his hand and he unbuttoned Mr. Smith's shirt and injected a yellow liquid into his chest. The man said, "You will feel something cool," and the man slid a long needle into his chest. He inserted the needle and, as Kenny perceived it, moved the needle around while it was inserted in his chest. Mr. Smith noted that he "lost all composure," at this point, describing, "Everything became surreal, everything went out the window." (This description of things becoming "surreal" indicated that Mr. Smith likely began again to dissociate at this moment of the execution and experience a rupture in his perception of reality.) He continued to ask, "Does anybody have the authority to contact the judge?" and received no response. Mr. Smith became terrified that he was being injected with a substance that would render him unable to communicate—something that he knew would violate an existing court order.[19] He was again panicked that he would not be able to say his final words to his family and the victim's family, given what he heard had happened in a previous execution. Mr.

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[18] Roy HA, Green AL. (2019). The central autonomic network and regulation of bladder function. *Front Neurosci.* Jun 13;13:535. doi: 10.3389/fnins.2019.00535. PMID: 31263396; PMCID: PMC6585191.

[19] *Smith v. Hamm*, No. 2:22-cv-00497, Memorandum Opinion and Order at 15 (DE 22) (M.D. Ala.).

Smith said he was breathing hard at this point, having never had needles in his chest before. He also believed that a numbing substance had been used and that he was being poked in an area that was not numb. He was becoming more anxious and according to him, "I started crying out for the judge and for [my lawyer], saying 'Please stop. You are violating a court order.'"

The man who had been injecting him in the chest and the IV team all stepped back. Mr. Smith tried to gather himself and then said that they stepped back up and the man from behind his shoulder had a large gauge needle with a large cylinder. Mr. Smith said he "freaked out," demanding that someone call his lawyer. Next, Deputy Warden Woods put his hands on Mr. Smith on both sides of his head and said, "This is for your own good," pulling his head to the side. Mr. Smith then recalled searing pain, as he was injected under his collar bone. He said, "It took my breath away" and he recalled that he was gasping and trying to get away by "bucking up" off the table. This also would likely have been a moment of a strong fight or flight reaction in Mr. Smith's nervous system. Mr. Smith recounted that he believed the man tried approximately five times to get this large needle into a vein under his collarbone.[20] He repeatedly asked to speak to his lawyer and to have someone reach out to the judge presiding over his pending case. He recalled giving his case number over and over and no one responding to him. He described himself at this point:

> I was pretty much giving up because nobody was answering—I'm on my own, I was trying to get through the moments because the next thing was to try to run the central line and that was so painful and I was completely gone then. That was hard, the pain, that was consuming…it gets quiet. My body was trying to come off the gurney. I was trying to endure and they just stopped, left me. I couldn't breathe, couldn't stop shaking, I had tears running down my eyes, then everybody just disappeared and I was just left there.

Mr. Smith recalled that he was shaking uncontrollably, unable to catch his breath and in "rough shape," still in an inverted position with his head below his body at this point. The men left, again leaving Mr. Smith with the guards. As he described these moments, Mr. Smith's face reddened and then slackened and he said he felt very "detached." Mr. Smith's reaction here again indicates a dissociative reaction.

After several minutes, the IV team returned and began to gather their equipment and put it away. He began thinking, "They're going to try something else," and felt frightened. One of the IV technicians said to him, "The pain will ease up soon." Mr. Smith said he still did not know what was happening, and when he asked, he was told, "Legal stuff." While Mr. Smith was still inverted with his head down, the IV tech began to talk to him about why lethal injection would be a better "way to go" than gas, because "gas is suffocation," whereas with lethal injection, "you go to sleep and don't wake up." Mr. Smith felt relief that someone was talking with him, but was still unclear what was going to happen next, particularly as this person was talking to him about methods of execution.

[20] Afterwards, in a press conference, the commissioner of the Alabama DOC confirmed that this was an attempt to use a central line procedure to establish intravenous access.

Soon, the other IV technician began unhooking Mr. Smith, narrating to him what he was doing as he took the tape off, pulled out the butterfly needle and put cotton and tape over the injection site. He recalled that the two IV technicians were comforting him and saying, "You're ok" and one of the men said he would pray for him. Mr. Smith wept while recounting this and put his head in his hands.

Once the medical personnel left, Mr. Smith was alone in the room with three officers who had been there throughout the execution. He remained in an inverted position. The guards lifted the gurney from the inverted position and unstrapped Mr. Smith's arms, lifted his hands and handcuffed him and then lifted him into a sitting position. Mr. Smith remembered that he felt very physically unstable when the guards lifted him up from the prone position on the gurney. His clothing was wet and he thought he had possibly lost control of his bladder.[21] He described himself as "drawn within," a likely description of being in a state of dissociation, which will be described below. Mr. Smith felt that he would pass out when he sat up and he was trembling. The guards asked if he could stand up and walk and he said that he couldn't. Two guards held him up by his arms—clasping his upper arms and his armpits to guide him out of the chamber. Feeling that he was "clumsy and had no equilibrium," he asked for a wheelchair, which was not provided to him. The guards had him sit right outside of the chamber and gather himself for a few minutes. He then walked with the guards the approximately five-minute walk to the infirmary, the guards still holding each side of his body. They helped lift him onto the examination table once they were inside the infirmary. This entire description of Mr. Smith after he was released from the gurney captures the process of nervous system "shut-down" that is seen in situations of life-threat and loss of control. (See Figure 1.) Physical tremors have been found to be associated with the nervous system response to life-or-death situations.[22]

In the infirmary, Mr. Smith was seen by a nurse. He continued to shake uncontrollably, and he was unable to move his shoulder or turn his head. The nurse began to examine him and because he could not move his arm and shoulder, two guards assisted him in getting him out of his clothes. The nurse asked about wounds and Mr. Smith pointed out needle marks on his hands, arm, and chest. He told the nurse that his shoulder and neck were hurting. The nurse and guards helped Mr. Smith get dressed after the examination, again, because he was in pain. He believes this examination took about twenty minutes.

After the examination, Mr. Smith was taken back to the cell outside the execution chamber. He remembered that as he was walking, he was "still in a shell, like someone else watching this." (This type of description also reflects a dissociative response.) When he returned to the cell, he was told by CO Earle, "We need your clothes for evidence." He was helped out of the clothes and provided other clothes. He asked if he could speak with his wife on the phone

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[21] In life or death situations, loss of bladder and bowel control can occur as the nervous system reacts to the threat. It is unclear if Kenny did, in fact, lose control of his bladder. Roy HA, Green AL. (2019). The central autonomic network and regulation of bladder function. *Front Neurosci.* Jun 13;13:535. doi: 10.3389/fnins.2019.00535. PMID: 31263396; PMCID: PMC6585191.

[22] Kalaf et al., (2015). Peritraumatic tonic immobility in a large representative sample of the general population: Association with posttraumatic stress disorder and female gender. *Comprehensive Psychiatry*, July, 60, (68-72).

and he spoke with her for several hours. He laid down in the cell but could not sleep. He was then moved back to his regular cell.

On the day after the failed execution, Mr. Smith was visited by two of his attorneys. On the following day, he was examined by a doctor retained by his lawyer with his lawyer present.

In the days following the failed execution, Mr. Smith found himself struggling with sleeplessness, nightmares, and intense emotionality. He would wake up and find himself unable to return to sleep and would lie in bed, crying. Early in the morning on the second day after the failed execution, he was taken to the infirmary when an officer saw him crying. At the infirmary, he was seen by a nurse and then returned to his cell. Shortly after this, he was called to the Captain's office in the prison. Mr. Smith noted that he became anxious as he approached the office, seeing that one of the staff members who had been in the execution chamber was in the office. The Captain assessed him for suicidality and noted that the officer who had seen him that morning said that Mr. Smith said he was suicidal. Mr. Smith denied this, telling the staff that he had just almost died and had no intention of trying to end his own life. He signed a contract with the Captain that he would not harm himself.

Dr. Polanco, the psychiatrist who had seen Mr. Smith in the months before the scheduled execution, met with him a few weeks after the failed execution. Mr. Smith said about this meeting: "I told him I'm anxious, agitated, snapping on people, having nightmares." Dr. Polanco restarted him on Trazodone and Remeron and added Prazosin, for nightmares. The medical records of these contacts will be summarized below, beginning with medical contacts related to mental health that occurred before the attempted execution.

Medical records

I was provided with Mr. Smith's medical records from the Alabama Department of Corrections. These records covered a variety of medical and dental procedures from 2004-2023. Below I will discuss records related to Mr. Smith's psychological condition and functioning.

A. Records before the failed execution:

There are several records related to Mr. Smith's psychological functioning before the events of November 17, 2022.

- July 18, 2022 (Provider: Dr. Beech): In a note from Dr. Beech, it is noted that Mr. Smith requested to be "placed on MH (mental health) caseload after being informed that he will be given an execution date in July." Regarding Mr. Smith's functioning, it is noted, "Patient reported increased anxiety, tension, depression and a feeling that he is 'spinning his wheels.' His sleep has been fitful when he tries to go back to sleep after breakfast due to anxious thoughts." Due to increased migraines, Mr. Smith asked "to be placed on psychiatric medication that might help with migraines." It is noted that his mindfulness meditation and interpersonal relationships are a source of support for him. He is described as "slightly depressed and anxious."

- July 19, 2022 (Provider: Dr. Polanco): Mr. Smith is noted to have "no history of mental illness prior to jail." Mr. Smith's mental status assessment by Dr. Polanco is unremarkable for symptoms of mental illness and it is noted, "No symptoms reported." He is diagnosed with a rule-out (R/O) of adjustment disorder.[23] He is also diagnosed with substance use disorder in sustained remission. Mr. Smith asks to be referred to a therapist. It is determined that he will not take psychiatric medication and that he will attend individual and group therapy.

- July 25, 2022 (Provider: Dr. Beech.) Mr. Smith is identified as having "tension" around the "current situation" (Presumably, the upcoming receipt of an execution date). He also reports nightmares and the clinician specifies that these nightmares are "not due to trauma." Dr. Beech reviews Mr. Smith's history of adverse childhood experiences (ACE factors) and notes that his history is positive for sexual abuse, emotional abuse, emotional neglect, intimate partner violence in his home, mother treated violently, substance abuse and parental separation/divorce. His substance use history is reviewed and his mood is noted to be "low."

- July 26, 2022 (Provider: Dr. Beech): Mr. Smith is identified as having been placed on the MH caseload and diagnosed with R/O adjustment disorder. It is noted, "He reported anxiety and depression secondary to potentially receiving an execution date within the month." He is described, "Patient expressed a desire to work on maintaining low levels of depression, anxiety and mood stability through the use of effective coping skills."

- August 8, 2022 (Provider: Dr. Beech): Mr. Smith's mood is described as "anxious and depressed." He is diagnosed with adjustment disorder and substance use disorder in remission. He is not prescribed medication at this time. It is noted, "He also reported increasing anxiety and depression regarding the likelihood of him being given an execution date."

- August 29, 2022 (Provider: Dr. Beech): Mr. Smith is diagnosed with R/O adjustment disorder and substance use disorder in remission. He is not prescribed medication at this time. The note states:

    - "Patient reported that he has discussed the possibility of preventative medication with medical and they have determined that there is no medication that they could give him at this point. He reported that he continues to have trouble sleeping at night, which makes his migraines worsen the morning. He is in constant communication with his family,

[23] Adjustment disorder is defined as: The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s). (American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA) "Rule/out" means that the clinician is suspecting an adjustment disorder but needs more information to determine if it is present.

> who as per his report is starting to be a little more comfortable talking about his getting a date of execution set. He still finds it incredibly difficult to communicate with his mother about this. He reported that he has a circle of close friends that are…able to socialize with, though they find it hard to discuss the above-mentioned matter, as this reminds them of their similar circumstances. He is focused on being present in the moment and not worrying about the future or dwelling on the past."

- October 4, 2022 (Provider: Dr. Polanco): Mr. Smith is identified as having decreased sleep, worry, anxiety and depression. He is quoted as saying, "I'm down, depressed. I was placed on dead [sic] row." He is diagnosed with adjustment disorder and substance use in remission. The note states that he is taking Trazodone and Remeron.

- October 18, 2022 (Provider: Dr. Polanco): Mr. Smith is noted to have "no symptoms" and is identified as saying, "I'm fine. The medications are working." He is to "continue present therapy."

B. Records after the failed execution

The first record that I have been provided that was after the failed execution was dated November 23rd, 2022, six days after the attempt. I have not seen medical records that document the contact Mr. Smith described with providers immediately following the failed execution.

- November 23 and 28, 2022 (Providers: Livingston/Stewart): This form, a Mental Health Referral form, appears to have two dates of activities. The first, dated November 23, 2022 identifies "anxiety, muscle tension, insomnia due to failed execution" as the reason for the referral. Then, the document is dated November 28 as having been received by RN Stewart who then marked, "Routine referral required" (in contrast to emergent or urgent referral).

- November 29, 2022 (Provider: Dr. Polanco): Mr. Smith is identified as saying "I'm very anxious, I have nightmares," and his target symptoms are listed as: "anxiety, worry/frustrated, angered, decreased sleep, nightmares." His mood is described as "anxious" and he is diagnosed with adjustment disorder and substance use disorder. Dr. Polanco recommends an increase in the doses of Remeron and Trazedone and the addition of Minipress (Prazosin).

- November 29, 2022 (Provider: Dr. Polanco): In an Informed Consent Form for Mental Health Medication on the same day as the previous form, the purpose of a medication being offered to Mr. Smith, Prazosin, is listed as: "treatment in post-traumatic stress-nightmares, reduce the severity and frequency of nightmare, sleep disturbances/insomnia." Mr. Smith signed the form.

- December 6, 2022 (Provider: Dr. Polanco): Mr. Smith is described as reporting, "I get stomach upset and diarrhea with Trazedone. I'm fine." Dr. Polanco notes "no symptoms reported" and continues Mr. Smith on Remeron and Prazosin but discontinues Trazedone. Mr. Smith is diagnosed with adjustment disorder in remission and substance use disorder in sustained remission.

- December 14, 2022: (Provider: Illegible): In a Chronic Disease Clinic Follow-up, Mr. Smith is identified as "neck pain since failed execution."

- January 26, 2023: (Provider: Dr. Beech): In a Multidisciplinary Treatment Form, Dr. Beech identifies problems of "Depression/Anxiety" that Mr. Smith will address in his individual and group treatment by "identifying triggers to depression" and "identifying effective coping skills to prevent anxiety/depression." These goals are updated from previous goals set in July 2022.

- February 2, 2023 (Provider: Dr. Polanco): In his progress note, Dr. Polanco notes that Mr. Smith reports: "I have less nightmares. I sleep better. Continue my medication." He is described as having symptoms of anxiety and depression and that he is taking Remeron and Prazosin. Mr. Smith is diagnosed with adjustment disorder in remission and substance use disorder and recommended to continue in therapy.

- March 7, 2023 (Witness: Wall): In this Release of Responsibility form, Mr. Smith signs a waiver that he is refusing his psychiatrist appointment and releases Wexford Health Services from responsibility for this missed appointment.

- March 7, 2023 (Provider: Dr. Polanco): In his progress note, Dr. Polanco notes that Mr. Smith "refuses to be seen. Appointment will be rescheduled."

- March 24, 23 (Provider: Unclear): In this Periodic Health Assessment it is noted that "patient refused to have lab work drawn due to anxiety."

- April 3, 2023 (Provider: Dr. Polanco): In his progress note, Dr. Polanco notes that the target symptoms for Mr. Smith are anxiety and depression. Mr. Smith is identified as saying "I have less nightmares. Please continue my medication." Mr. Smith's mood is described as "anxious" and he is diagnosed with adjustment disorder and substance use disorder. It is recommended that he continue therapy.

Summary of medical records: The records reviewed above demonstrate several facts about Mr. Smith's mental health as documented by the Alabama DOC medical providers:

1. He is noted throughout the record to have no mental illness previous to his incarceration, except substance use disorder in sustained remission.
2. He is diagnosed as either having adjustment disorder or being in the process of a R/O of adjustment disorder beginning in July 2022.
3. He is identified as having anxiety, depression and tension starting in July 2022 with these symptoms worsening in August 2022.
4. He is placed on medication sometime before October 2022 and he reports that by October 18, 2022, he is fine and has "no symptoms."
5. Six days after the failed execution, Mr. Smith is identified as having anxiety, muscle tension, insomnia.
6. Twelve days after the execution, his is described as having post-traumatic nightmares and he is placed on medication for nightmares, while his other medication is increased.
7. In December, 2022, he reports neck pain and upset stomach and diarrhea.
8. Between January and April, 2023, he continues to have mental health treatment for anxiety and depression, but his sleep problems and nightmares decrease.
9. He refuses a medical procedure (blood draw) in March 2023 due to anxiety about needles.

Results of Clinical Evaluation

I met with Mr. Smith at W.C. Holman Correctional Facility on December 29, 2022 and January 31, 2023 for approximately eight hours and have also had seventeen phone calls with him, totaling another twenty-eight hours. Over the course of these meetings, Mr. Smith has been polite and expressive, answering questions and describing his experiences and feelings. He has frequently been emotional, weeping and expressing intense distress as he discussed the events of November 17, 2022. In most conversations with me, he was affable and forthcoming, but when we would shift into talking about the events of November 17th, he would become more withdrawn, and take long pauses, sighing and hiccupping, as if gulping air. He has spoken of feeling "terrified," during and after the failed execution and, over time, has described a growing depression, withdrawal and sense of intense dread. Mr. Smith's thought process has been goal-directed and his speech and language are within normal limits. His attention was adequate, though at times he would stare and seem to lose his train of thought, or abruptly change the subject, when it was about the execution. He demonstrated good insight and an ability to reflect on his experience, despite having impairing symptoms of posttraumatic stress (which will be described below). He reported some lessening of depressive symptoms in May 2023, but these increased again in June. During recent phone calls (September-November 2023), Mr. Smith has demonstrated worsening signs of depression, specifically low mood, diminished energy, poor concentration and feelings of hopelessness, as well as increasing dissociation, as evidenced by flat affect, disconnection of emotion and spells of blankness when responding.

Mr. Smith is diagnosed with posttraumatic stress disorder, with dissociation, and depression, which will be described below.

Posttraumatic Stress Disorder (PTSD)

Earlier in this report, I reviewed information about the impact of life-or-death events on human functioning, based on clinical and research literature. Here, I will briefly explain the condition of PTSD with dissociation before describing Mr. Smith's symptoms. After I describe Mr. Smith's diagnosis in detail, I will review the standardized measures that I administered to Mr. Smith and their results.

Trauma, defined as a life-threatening event, or an event in which there is severe threat to the individual's bodily and/or psychic safety, mobilizes neurochemical and endocrine systems throughout the brain and body to react to the threat. These reactions—such as "fight or flight" activation and/or shut down and dissociation--while adaptive to the individual's survival in the moment of trauma, can lead to difficulties after the trauma. Memories of the traumatic events return intrusively, thereby activating the same brain and body reactions that occurred during the trauma and leading to severe discomfort and impairment in survivors. PTSD, then, entails symptoms across multiple domains, including intrusive reexperiencing of memories, alterations in arousal and mood, and avoidance and numbing.

Dissociation is a neurophysiological process emanating from the human nervous system in which neurochemical and neuroendocrine reactions to excessive stress cause alterations in consciousness, changing perceptions of the senses, the environment, and the self. Dissociation represents a lowering of consciousness, sometimes to the point of an actual rupture of consciousness and awareness. Clinical models of dissociation explain how humans, like other animals, when under severe threat, will sometimes experience the release of neurochemicals that are anesthetic and that lower the experience of pain and fear. When humans experience this peritraumatic ("during the trauma") dissociation, they are often left with residual difficulties after the trauma. If the individual suffers multiple traumatic events that lead to frequent and lengthy periods of peritraumatic dissociation, the after-effects will likely be more pervasive and more severe. These can include altered states of consciousness that linger after the traumatic events, such as time distortions, memory fragmentation or amnesia, bodily symptoms, and emotional numbing and perceiving reality or their body in a distorted way (derealization and depersonalization).[24]

Below, I will describe Mr. Smith's symptoms of PTSD, with dissociation following the DSM-5 criteria.[25]

A. Exposure to traumatic event:

Mr. Smith's experience of being prepared for execution, taken to the execution chamber and put through several hours of attempts by multiple men, holding him down, to try to end his life with lethal injection would constitute a series of severe traumas. Mr. Smith has experienced some early trauma, such as domestic violence in his family by his father, sexual abuse by a babysitter, loss of a sibling, and his mother's severe alcoholism. These traumas likely worsened his current

[24] Frewen, P. & Lanius, R. (2014). Trauma related altered states of consciousness: Exploring the 4-D model. *Journal of Trauma and Dissociation*. 15: (436-456).
[25] American Psychiatric Association. (2022). Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.).

symptom presentation, but none of these life events are central to his symptom presentation listed below. Additionally, the ongoing threat of being subjected to another attempt at execution, now by nitrogen hypoxia, is a unique traumatic stressor for Mr. Smith that is exacerbating the symptoms listed below.

B. Intrusive symptoms: One symptom required for diagnosis of PTSD, Mr. Smith meets criteria for all five symptoms

A hallmark posttraumatic symptom is intrusive reexperiencing of memories of and bodily reactions to traumatic events. These intrusions are highly uncomfortable, as they trigger physiological states of arousal (discussed below) which are central to a person's threat detection system. Mr. Smith has multiple symptoms of intrusive reexperiencing of the failed execution and accompanying distress.

- *Recurrent, involuntary and intrusive distressing memories of the event*: Mr. Smith struggled intensely in the immediate aftermath of the failed execution with frequent images and memories coming back to him. For example, he described a typical experience of trying to go to sleep in the weeks after the execution: "I couldn't go back to sleep because my mind was trying to go back to the crap –I started thinking about when they put me on the table and …I started reliving that part and was like, 'No, no, stop Kenny, I am not ready for that.'" On a visit with his wife and mother, several months after the execution, Mr. Smith described becoming anxious as he walked towards the visiting room and had a flashback to walking to the execution chamber. When discussing the guards, he stated, "I can see them now, with me on the gurney, looking through the observation window."

  In the evaluation, when discussing the possibility of being executed again, Mr. Smith spontaneously started describing that he could have "bled out" into his chest if the needle had punctured a vein in his neck. He described this in detail—an image of physical damage being done to his body. On another occasion, while speaking about his legal situation, he spontaneously began to talk about having a mask over his face as he is executed by gas, an image he noted comes at him "rapid-fire." Survivors of trauma frequently find their mind being consumed with images of the trauma and of other ways they could be hurt again.

- *Dissociative reactions (flashbacks) in which the individual feels as if the trauma were recurring:* In the weeks and months since the execution, Mr. Smith has had multiple experiences of flashbacks to the details of the execution. These can appear as flashbacks—quick images—or longer memories. For example, in mid-December, he described struggling with images of being on the gurney and having a staff member move his head forcefully to the side, so that a needle could be put into his neck. This image caused Mr. Smith intense anxiety when it would come back to him and when he recounted it to me. In March 2023, a canine search unit came onto Mr. Smith's tier, and he had what he called an "anxiety attack." In this moment, Mr. Smith could not calm down because he began thinking of the guard

force who entered the cell to take him to the execution chamber. He noted, "I started thinking, are they coming to get me?"

Mr. Smith also experiences dissociative flashbacks in which he is detached from his perceptions and feelings. When describing himself during the execution, Mr. Smith gave a hallmark description of dissociation:

> During it, I felt drawn in, like I was looking out windows…Like it was happening to someone else, and I get to watch. That first week back, it was like walking in a dream.

When recounting the events of November 17th, Mr. Smith stared into space at times and would take deep breaths. He described himself as feeling "hollow" at these moments, a likely dissociative experience.

- *Marked physiological reactions to external or internal reminders of the trauma event:* Mr. Smith described chronic difficulty with hyperarousal (See also Criteria E below) when he would be reminded of the attempted execution or try to describe it to people. Mr. Smith noted that he would tremble when he started thinking about being on the gurney and he would especially become physically activated when remembering the attempt to put a central line into his neck. On one occasion, Mr. Smith said that he felt that he was shaking uncontrollably when remembering this moment. He also noted that he woke up in the night for several weeks covered in sweat after intrusive nightmares of the execution. Once, when two staff members were passing by his cell, Mr. Smith described his heart beginning to race, as one of them made eye contact with him. A dental procedure in May, 2023 became terrifying for Mr. Smith when the dental practitioner approached him with a needle and he began to shake and tense up. He also noted that he is frequently nauseated, especially if he has a reminder of the attempted execution.

  Some of these symptoms occurred during the evaluation, when Mr. Smith recounted the failed execution and when he saw guards outside of the visiting room who had participated in the execution. During the description of the attempted execution, Mr. Smith would pause for long periods and take in and expel large gulps of air, sometimes hiccupping, a sign of anxious breathing. He would stare blankly at times as if he had lost his train of thought. He also suddenly required the bathroom while beginning to give the description of being strapped down onto the gurney. On the phone, he would pause and sigh heavily, as if gathering himself, when recounting certain details of the attempted execution. When discussing legal developments in his case, Mr. Smith noticed that his chest would tighten and he felt "tensed up and ready to fight." When describing his memories of the line being attempted in his neck, Mr. Smith stated, "I'm anxious right now, a little bit jittery. Shit, I can't avoid this." Mr. Smith described feeling "exhausted" and "drained" from reviewing what had happened

on several phone calls. After our two in-person meetings, Mr. Smith went to bed and had migraines that lasted for several days.

- *Intense psychological distress in response to external or internal reminders or cues of the trauma*: Mr. Smith's environment provides multiple reminders of the events of the failed execution, as the unit in which he is incarcerated is very close to the execution chamber. He has to pass by this area in order to go to the visiting room, the infirmary and the captain's office. He noted that when he has to see this area, he feels anxious and agitated. He has this reaction when he sees certain guards and officers who participated in the attempted execution, finding himself feeling agitated as he thinks about how they handled him in the chamber. His first visit with his family after the failed execution was anxiety-provoking for him and he realized that it was because he would be seeing them in the visiting room where he said goodbye to them.

  Internal reminders, such as thoughts of the execution, bring him even more anxiety. For example, Mr. Smith has described at length his intense fear of being put through an execution again. He described an excruciating process of remembering each aspect of what happened—such as saying goodbye to his family, being taken out of the death cell by multiple guards, being strapped down to the gurney and having the execution begin—and then attempting to block or stop each of these memories. When telling the story of the failed execution, he would alternate between crying and then becoming detached, as if losing his train of thought. For a survivor of a life-or-death experience, this process of intrusively remembering what happened, experiencing the accompanying physiological and psychological distress of the event and then attempting to stop this cascade of memories and anxiety is an arduous and exhausting process. Mr. Smith described this cycle, saying, "Sometimes when I think about it, Oh my God, saying goodbye, running the gauntlet…watching my family go through this…dragging my family through this again. And I think, I've got to get away from these thoughts." In further example of this, Mr. Smith became notably agitated when he spoke about future attempts to execute him, given new procedures, "They can work all night, there's no stopping time. Or if they did stop, they can start again tomorrow."[26]

- *Recurrent, distressing dreams in which the content or affect of the dream are related to the trauma:* In the days and weeks following the failed execution, Mr. Smith had nightmares many nights. These would be nightmares in which he would be saying goodbye to his family, giving away his belongings and then being strapped to the gurney in the execution chamber. He had recurrent nightmares of the staff members who participated in the failed execution and also of people trying to execute him with gas. He found the dreams highly distressing and would wake from them and have difficulty falling back to sleep. These

[26] Mr. Smith was referring to a procedural change announced by the Alabama DOC where death warrants will no longer expire at midnight.

dreams have diminished over the course of several months but they still occur and are linked to images from the failed execution.

C. Persistent avoidance of stimuli associated with the event: One required for diagnosis of PTSD, Mr. Smith meets criteria for two.

Mr. Smith tries to shut down his overwhelming feelings and block out memories of the attempted execution. This "strategy" of shutting down or numbing is common in victims of trauma. This conscious blocking of memories, thoughts and external reminders of a trauma is a hallmark symptom of PTSD. This is actually a remarkably ineffective strategy, for as trauma victims attempt to stop thoughts or memories from coming into their mind, they are often gripped with chronic intrusive memories that appear and startle them. Thus, survivors often feel like they are suffering a kind of psychic whiplash as they try to stop being reminded while being bombarded with involuntary physiological reactions to the trauma.

- *Avoidance of thoughts/memories/feelings about the event*: Mr. Smith described a concerted effort that he makes to not let his mind return to the memories of the attempted execution. He described how he can picture himself on the gurney but then actively stops his thoughts, saying, "[I] don't let myself go to images of once they started…not intentionally. [I] don't go past there." He described himself avoiding thinking about it, but having memories return unbidden. Mr. Smith had written regularly in his journal, but has been unable to do so since the failed execution, explaining, "I'm afraid I'll start writing about what happened." This kind of perception of the traumatic memory being involuntarily recalled is common in survivors.

- *Avoidance of external reminders of the event:* Mr. Smith has multiple external reminders of the attempted execution in his environment that he has attempted to avoid. These include seeing the staff members who participated in the failed execution and passing by the area of the unit where the execution chamber is. Mr. Smith described how he has to talk to himself when he is brought near the chamber, saying, "Ok, this ain't that, Kenny. It's not that," in order to calm himself. Seeing guards who participated in the attempted execution is highly triggering for him and he noted that he will try to stay in his cell or not look at guards or staff who were part of the process.

  Survivors of traumatic events often find that conversations about the trauma are exceedingly difficult, as symptoms of hyperarousal and dissociation come flooding in. Thus, many survivors report avoiding conversations. Mr. Smith noted that in the weeks following the failed execution, he was asked by many of the men on his unit about what happened, as well as by his lawyers. He described himself as trying to "back up" and "get away" from people when they would ask questions, knowing that he would become very distressed when remembering. He said that he tries to "not relive it," by not talking about what happened. When meeting for this evaluation and speaking on the phone, Mr. Smith would try to discuss other aspects of what happened, such as the days before the execution and

would avoid details of the actual failed execution, until directly queried. He said when other inmates talk about execution, "I get tightness. I draw up," so he tries to stop the conversation. When his lawyers send him legal work on his case, he stated that he cannot read it because he becomes too anxious, so his wife reads it for him. He avoids phone calls with family at times because he is afraid they will ask questions about what happened.

D. Negative alterations in cognitions and mood: Two required for diagnosis of PTSD, Mr. Smith meets criteria for four

- *Persistent negative emotional state:* Mr. Smith struggles with strong negative feelings about the execution attempt and how it affected him, as well as his family. He described feeling intensely distressed and angry about what happened. He wept on many occasions, as he recounted the events of the execution. He also noted that anger and tension will come over him quickly and he will have to try to calm these reactions down, saying, "I'll take really big breaths and just exhale and let [my] body settle, let the tension wash off me."

  Mr. Smith described other negative feelings that he struggles with from the failed execution, including shame and humiliation. Mr. Smith cried while describing the humiliation of people taking pictures of him on the gurney and watching him struggle. He noted how fear can get stirred up when he remembers certain details, such as when one of the personnel turned his head, in order to reach his collarbone area. He became agitated at one point, describing how he was "probed" during the failed execution and that he was just a "meat sack."

- *Persistent or exaggerated negative beliefs or expectations about oneself, others or the world.* Mr. Smith stated that he has struggled with his feelings about people, after the experience of the attempted execution. He described his understanding of the COs having to do their job, but noted that he cannot understand how the people in the room were capable of letting him be in pain and not responding to him. These thoughts recur when he sees certain staff members, leading him to feel angry, irritable and upset.

- *Markedly diminished interest or participation in significant activities:* Mr. Smith reported that he had no interest in engaging in his usual activities in the months after the failed execution. For instance, he stopped coming out of his cell for recreation time and had no interest in chess, something he usually spends a lot of time doing with friends. After about two months, this improved and he found himself more able to engage in some activities, like chess. However, as he has had to talk with his lawyers about an impending execution, he has become more withdrawn, wanting to stay in his cell.

- *Feeling detached or estranged from others:* Mr. Smith has experienced a marked change in his ability to feel connected to others since the failed execution. This began in the immediate aftermath of the execution when he found himself not

wanting to come out of his cell and socialize with his friends. He stated, "I don't let guys come over to me because I'm afraid I might snap at them." This experience of increased irritability leading to isolation from others is common after severe trauma. Mr. Smith noted that he has felt isolated from family and finds himself unable to talk with them as frequently. He described this, saying "This added another layer of detachment for me." He expressed feeling alone because no one can understand his experience but also expressed bewilderment, saying, "I can't explain why I don't want to talk to people."

E. Alterations in arousal and reactivity: Two required for diagnosis of PTSD, Mr. Smith meets criteria for five

Hyperarousal constitutes a set of posttraumatic symptoms of increased and inappropriate stress response in the body, often experienced with trouble breathing, heart racing and dread. Characterized by physiological discomfort, such as racing heart, perspiration and trembling, hyperarousal is understood to be the sympathetic nervous system activating a "fight or flight" response. The response, while necessary during a trauma, is activated involuntarily after trauma and it is one of the most difficult and impairing symptoms of PTSD, as it puts survivors through repeated states of terror and fear. Individuals in a state of hyperarousal are poised for danger. Mr. Smith reported that he was always "on guard" for danger in the days and months after the execution attempt. He reported some improvement in this symptom over the past months, though he noted that he still can feel "panicky" with a racing heart and feeling of dread. He also described difficulty focusing and paying attention, even on activities that he wants to complete, a sign of impaired concentration, possibly due to hyperarousal.

- *Irritable behavior and angry outbursts:* One of the most consistent symptoms that Mr. Smith reports is chronic irritability and anger. He has described numerous ways that he feels irritable since the events of November 17th, including feeling agitated by noise in his unit (something that never bothered him), feeling short-tempered with people when they talk with him, feeling jumpy when someone approaches him. He has noted that this symptom has diminished since the first few months after the failed execution, but that it is still a noticeable feeling, particularly when he sees things that remind him of the execution (certain personnel, the chamber, etc.)

- *Hypervigilance:* Mr. Smith described chronic hypervigilance over the months since the failed execution, something that he stated is a marked difference for him in how he usually feels. Mr. Smith noted that he has managed well during his incarceration, never getting into fights or having disciplinary issues. His demeanor has changed, however, as he finds himself vigilant to his environment and constantly watching for officers and guards. He stated that he finds himself imagining guards coming to get him to take him to the chamber. He described his "radar" being up in ways that he has not experienced for a long time in prison. After executions were permitted to go forward, Mr. Smith began to describe himself as "fearful" and described a "sickening feeling" taking over. With his recent execution date set for January 2024, he feels unbearably anxious and vigilant.

- *Exaggerated startle response:* Mr. Smith has experienced a chronically increased startle response since the failed execution. He has noted multiple ways he finds himself being "jumpy" or easily startled. For example, he described the noises of the unit as very agitating for him—sounds like weights being dropped, doors being slammed or people yelling. He described this across many months, though it has diminished somewhat.

- *Problems with concentration:* Mr. Smith described some difficulty with concentrating in the first months after the failed execution. For example, he had difficulty playing chess and struggled with his meditation practice. He has been able to return to these activities somewhat. However, he stated that he feels forgetful and like he is "not there," sometimes, forgetting what people tell him or feeling unable to focus on conversations.

- *Sleep disruption:* In the initial two months after the failed execution, Mr. Smith would awaken early—at approximately 4 a.m. and be unable to return to sleep, as he used to do. He also noted that he had night sweats in the first several days after being brought back from the execution chamber and placed in his cell. He also described feeling fatigued in a way that he has not before. He reported some improvement in his sleep over several months, but then a return to early awakening in February as he became anxious about another execution being attempted. He reported lying awake thinking about what would be done to him, feeling like his "brain will not shut up."

Depression

In addition to PTSD, Mr. Smith is diagnosed with depression, moderate. This condition worsened over the course of the evaluation, emerging approximately six weeks after the failed execution. Mr. Smith describes feeling withdrawn from others, low mood, diminished interest in activities, decreased energy and frequent tearfulness. In the earlier part of the evaluation, his mood was more defined by anxiety and irritability, but over the course of the months in which we spoke, he became more despairing, expressing deep despondence and hopelessness. He described having difficulty getting out of bed and just wanting to lie there. He noted, "I'm not equipped for this, for these feelings. I don't know how to navigate this." He stated that he has felt "heart-sick" since the failed execution, thinking about what his family has gone through and may still have to go through if he is executed. Mr. Smith's energy seemed diminished over time and he spoke in a flat tone in later conversations, saying he felt "apathetic" and "somber." He noted increased tearfulness a few months after the execution, saying that he felt near tears frequently. He cried frequently during phone calls and meetings for this evaluation. In May, Mr. Smith noted that he felt the depression had improved somewhat. As of the writing of this report, his depressive symptoms have once again worsened.

Psychological Measures

Mr. Smith was administered several measures in order to examine his functioning and self-report of symptoms in a standardized format with comparative norms. These measures were administered after several hours of open-ended interviewing in person and on the phone. The measures are summarized below. In short, the measures indicated:

- Mr. Smith demonstrated good effort to answer questions truthfully and complete tasks presented to him.
- There was no indication of malingering by Mr. Smith.
- The diagnosis of PTSD with dissociative features and depressive symptoms was confirmed by standardized measures.

1. Trauma Symptom Inventory-2 (TSI-2)[27]: The TSI-2 is a standardized test of trauma-related symptoms and behaviors. This measure is widely-used and has been validated across numerous settings and populations to assess a wide range of trauma-related symptoms emanating from various types of traumas. There are 12 clinical scales and 12 subscales on the TSI-2 that tap different domains of symptoms and a score is obtained for each scale, resulting in a four broad-band factors: Self-disturbance, Posttraumatic Stress, Externalization, and Somatization.

   Mr. Smith's results on the TSI-2 indicated that he is suffering **severe and pervasive psychological distress that is trauma-related across multiple dimensions of functioning**. **He scored in the clinically elevated range (T≥ 65) on all four broadband factor scores: Posttraumatic stress, Externalization, Self-disturbance and Somatization. His score on the Posttraumatic stress scale placed him in the 99th percentile of individuals tested.**

   He demonstrated problematic or clinically elevated scores—that is, scores that are identified as warranting significant clinical concern and that indicate impairment in the individual's functioning across multiple scales and subscales listed below.

   Problematic range (T = 60-65) scales (Area of clinical concern):
   Depression
   Relational avoidance
   Reduced self awareness
   Tension reduction behavior

   Clinically elevated range (T > 65) scales (Area of impairment):
   Anxiety
   Hyperarousal
   Anger
   Intrusive experiences
   Defensive avoidance
   Dissociation
   Pain
   General somatic problems
   Sexual Concerns

[27] Briere, J. (1995). Trauma Symptom Inventory Professional Manual. Psychological Assessment Resources.

This level and breadth of clinically significant impairment and distress is noteworthy, as his symptoms cut across multiple aspects of his functioning and in severe ways. These results are confirming of what was determined in the clinical interview.

2. Test of Memory Malingering (TOMM)[28]: The TOMM is a visual recognition test used to discern malingered vs. true memory impairments in individuals. FINDINGS: **Mr. Smith's performance on the TOMM was within normal limits. His scores indicated that he had put forth his best effort and was not attempting to portray his cognitive functioning in an impaired light in terms of learning and memory.**

3. The PTSD Checklist for DSM-5 (PCL-5)[29]: The PCL-5 is a validated, reliable self-report measure of symptoms of posttraumatic stress disorder. Research has shown that higher scores on the measure support the diagnosis of posttraumatic stress disorder. Data from this measure can be helpful in identifying an individual's need for treatment of PTSD and which areas are most severe. FINDINGS: **Mr. Smith surpassed the cut-off score for clinical indication of PTSD and need for treatment and he demonstrated high severity of symptoms in all symptom domains. Thus, his results on this measure support the diagnosis of PTSD, which will be described below.**

4. Beck Depression Inventory[30]: The Beck Depression Inventory is a validated, reliable self-report measure of characteristic attitudes and symptoms of depression. **FINDINGS: Mr. Smith's results on this measure indicated a moderate level of depression, including symptoms of chronic sadness, hopelessness, feeling guilty, irritable and having low energy and sleep problems.**

Physical symptoms

It is not within my clinical expertise to evaluate Mr. Smith's physical symptoms, but I will recount them here, as there were several physical symptoms that have troubled him since the failed execution. I have also not been provided with medical records regarding Mr. Smith's care before or after the failed execution. Mr. Smith's reported physical symptoms after the failed execution include: neck pain and stiffness, shoulder pain, swollen, bruised foot and increase in frequency of migraines and waxing and waning nausea. Mr. Smith noted that his neck, shoulder and foot pain emerged in the aftermath of his straining and moving in response to pain of being stuck with needles in multiple locations on his body. Mr. Smith recalled that he tried to "come off the table" at one point and his feet felt like they were violently curled in response to the pain. By his own report, he was given a shot in his neck by medical personnel several weeks after the

[28] Tombaugh, T. N. (1996). Test of Memory Malingering. North Tonawanda, NY: Multi-Health Systems.; Tombaugh, T. N. (1997). The test of memory malingering (TOMM): Normative data from cognitively intact and cognitively impaired individuals. *Psychological Assessment, 9*(3), 260–268.
[29] Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for *DSM-5* (PCL-5). Scale available from the National Center for PTSD.
[30] Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-571.

failed execution to address shoulder and neck pain and given Naproxen for the foot pain. He was also given an X-ray and told that his neck had arthritis and his shoulder had "old damage." Mr. Smith also has a lifelong history of chronic migraines and he reports that they have been frequent and severe since the events of November 17, 2022.

Resilience

Mr. Smith demonstrates remarkable resilience, both in terms of his use of internal resources, such as prayer, meditation, journaling and yoga, as well as his reliance on external resources, most importantly his relationships with his wife, his children, his grandchildren and other friends and family. Additionally, friendships with other incarcerated men have been helpful to him. These resources have served him in the aftermath of the failed execution, in that he has relied on family members as sources of comfort and support and has tried to use his meditation practice to manage his symptoms. He stated that the "grounding" he has in his faith and his relationships has helped him to survive what he went through. He has noted however, that many of his strategies that were helpful to him before, such as journaling and meditating, are more difficult for him to do since the failed execution and he feels that his "spirit" has been altered by the execution.

Mr. Smith's clinical condition in relation to the execution events and future execution

In my clinical experience of over twenty-five years of working with survivors of torture and war trauma, I have evaluated and treated many individuals who suffered near-death traumas, including mock execution, kidnapping, and torture. What Kenny Smith experienced was one of the most severely debilitating traumas a person can endure—that of being purposely brought almost to the point of death—and he suffers marked and profound psychological damage from this experience. The experience of anticipating one's death in real time has been shown to flood the body with neurophysiological survival responses that involve cardiac, respiratory, gastrointestinal, perceptual, and cognitive reactions in the short term and potential long-term changes in neurochemical functioning. Mr. Smith experienced these types of reactions during the attempted execution and his ongoing and severe symptoms suggest that his neurophysiological reactions are currently dysregulated.

During life-or-death threats, people often experience dissociation into a state of altered consciousness, as if they are not in their body or as if the external world is not real. Mr. Smith clearly experienced these dissociative reactions, and they continue to cause him impairment. These dissociative reactions include ongoing difficulty with his focus and concentration, bodily discomfort, spaciness, as well as feeling disconnected from other people. Unfortunately, it is widely proven empirically that individuals who suffered dissociation during a trauma will have poorer functioning after the trauma and will possibly develop more symptoms of intrusive remembering over the next months or years, as their sensory systems come back "online."[31] In addition to dissociating, Mr. Smith also experienced severely distressing thoughts during the

[31] Schauer M, Elbert T. (2010). Dissociation following traumatic stress. *Z Psychol/J Psychol.*; 218(2):109–27.

failed execution, such as imagining the destruction that the needles were doing to his chest and collar bone and perceiving the imminent entrance of deadly substances into his body. Survivors of near-death traumas often experience pointed concrete thoughts of the physical body destruction that is about to take place. Survivors have described feeling terror, horror, and gut-wrenching disgust about the literal destruction of the body that is about to take place. Mr. Smith also had these experiences of horror and disgust, as well as shame at imagining being watched during this and even photographed. In the aftermath of the failed execution, Mr. Smith's emotional reactions have coalesced into ongoing feelings of humiliation and dread, both of which cause Mr. Smith substantial discomfort that he attempts to manage by shutting off his feelings.

Like other survivors I have evaluated and, as documented in the literature, Mr. Smith experiences intrusive memories of the events of the failed execution with extreme dread and fear. In my clinical experience, individuals who are remembering and recounting having almost been killed become severely psychologically distressed and physically destabilized as they revisit these events. I have seen survivors panic, dissociate, aggressively resist and plead to not recount such events, as well as suffer nausea, pain, and urgency of the bowel and bladder. Mr. Smith also demonstrated this hyperarousal, physical discomfort, and vigorous avoidance attempts, even when he was seemingly choosing to talk about what happened, such as in our meetings.

Mr. Smith's depression is also a condition that I have seen in multiple individuals who faced a man-made near-death experience, such as torture or mock execution. Like others, Mr. Smith's initial relief at being alive, particularly in relation to his loved ones, has given way to a feeling of sickening dread and anguish, as he faces the next planned attempt on his life. His mood is frequently quite low and he feels diminished energy and motivation. Even his relationships with others feel muted for him, as he wards off connection to his loved ones in anticipation of having to say goodbye to them again. His fear of putting his family—especially his wife, mother and children—through another execution is paralyzing for him. Hence, like other patients I have seen who have been through torture or other uncontrollable experiences of harm, he has retreated inward into a state of serious depression.

All of these clinical findings indicate that Mr. Smith is highly impaired, with chronic symptoms of PTSD and depression. While he is able to function on the surface, he moves through his environment with a barely controlled panic and despair, always on edge that his symptoms can bring him back to the experience of the attempted execution. These events were destructive and damaging to Mr. Smith and have left serious, pervasive problems in his biopsychosocial functioning. Mr. Smith's ability to manage the reminders of the attempted execution that are all around him is impressive, but it is fragile. He is easily triggered into states of arousal and dissociation, which leave him exhausted and demoralized. Hence, he retreats into himself and tries to shut down his feelings, his activities, and his relationships. The new execution date set for Mr. Smith will begin a process of reexperiencing of reminders and details that are sure to be highly triggering for Mr. Smith. Procedures, such as moving him into lock-down status, examining him pre-execution, setting up visit protocols with his family to say goodbye to him again, managing his last meal and his personal effects will be highly distressing, as these events will flood him with memories and involuntary fear reactions from his experiences in November 2022. Additionally, the actual procedures of the execution, such as holding him in

the death watch cell, having multiple guards bring him into the chamber, strapping him to the gurney, and beginning physical procedures that will bring about his suffocation through nitrogen hypoxia will likely create a panic reaction that is completely destabilizing to his mind and nervous system. This clinical prediction is made based on the extensive scientific literature (cited throughout this report) on life or death traumatic experiences and the posttraumatic symptoms and conditions that they engender, as well as my own extensive clinical experience from twenty-five years working with survivors of severe trauma and torture.

Mr. Smith's impairments and clinical conditions warrant treatment. To be left in this impaired condition, in the environment where he was traumatized is likely to worsen his already tenuous psychological functioning. The threat of having to experience another execution and all of its procedures will most certainly cause him severe suffering, destabilization and psychological deterioration.

Please do not hesitate to contact me with questions or further relevant information.

Sincerely,

_____
Katherine Porterfield, Ph.D.
Licensed Psychologist
NY State License 014105-1

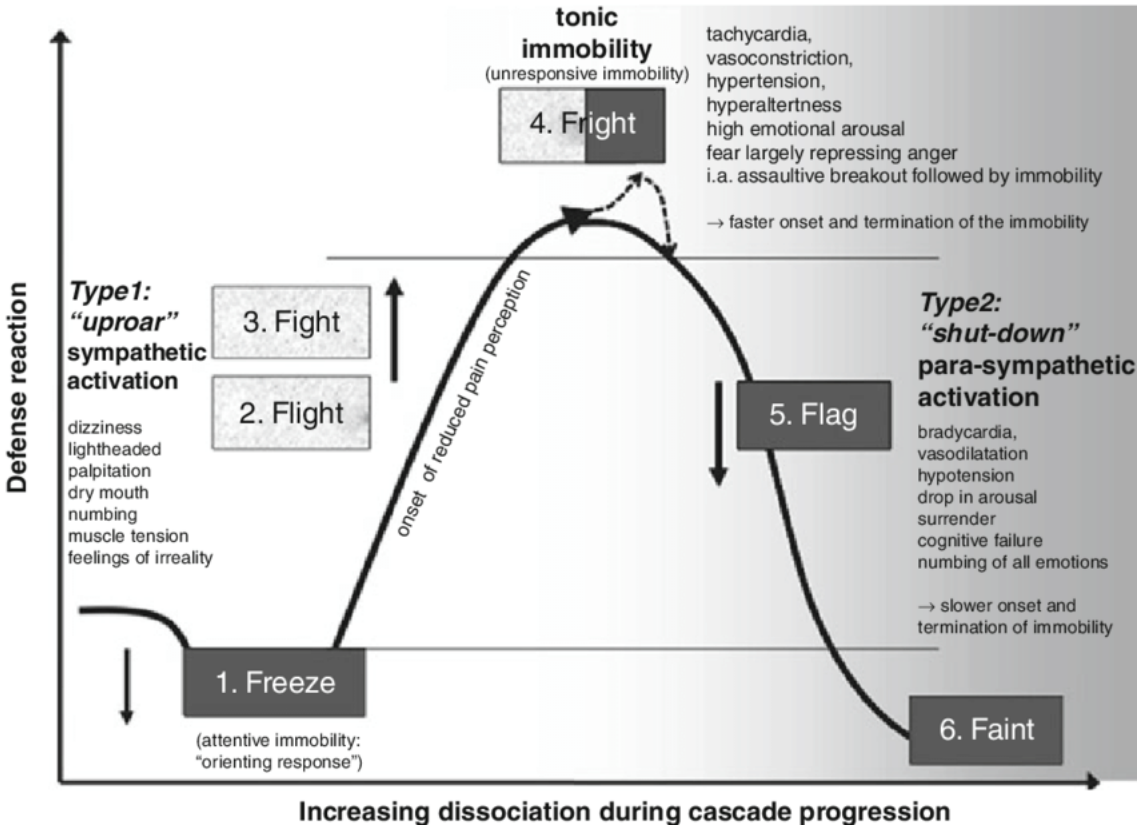

FIGURE 1: The freeze-flight-fight-fright-flag-faint defense cascade (Reproduced from Schauer M, Elbert T. (2010). Dissociation following traumatic stress. *Z Psychol/J Psychol*.; 218(2):109–27. doi:10.1027/0044-3409/a000018.)

Appendix: Materials Considered List

AAPL practice guideline for the forensic assessment (2015). *Journal of the American Academy of Psychiatry and the Law*, 43(2), s3–s53.
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Meyer-Parlapanis, D., Elbert, T., (2015). Torture and its consequences, Psychology of. In: James D. Wright (editor-in-chief), International Encyclopedia of the Social & Behavioral Sciences, 2nd edition, Vol 24. Oxford: Elsevier. pp. 434–441.
O'Mara, S. (2018). The captive brain: Torture and the neuroscience of humane interrogation, *QJM: An International Journal of Medicine*, Volume 111, Issue 2, pp. 73–78.
O'Mara, S. (2011). On the imposition of torture, an extreme stressor state, to extract information from memory: A baleful consequence of folk cognitive neurobiology. *Zeitschrift für Psychologie/Journal of Psychology*, 219(3), 159–166.
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Smith v. Hamm, No. 2:22-cv-497, Memorandum Opinion and Order at 15 (Doc. 22) (M.D. Ala.), issued on October 16, 2022.
State of Alabama's Motion to Set an Execution Date, filed in Ex parte Kenneth Eugene Smith, No. 1000976 (Ala. S. Ct.) on August 25, 2023.
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EXHIBIT 2

Katherine A. Porterfield, Ph.D.
[redacted]
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Kporterfield1@gmail.com

Education

University of Michigan, Ann Arbor, Michigan
Doctor of Philosophy, Clinical Psychology (1998)
Master of Philosophy, Clinical Psychology (1994)
Dissertation Topic: Meeting the Needs of Parentally Bereaved Children: A Model of Child-Centered Parenting
Awards: Regents Fellowship (1992-1996); Power Fellowship (1995-1996); Summer Research Fellowship (1994, 1995); Rackham Dissertation Grant (1997)

Georgetown University, Washington, D.C.
Bachelor of Arts, Interdisciplinary Studies: English, philosophy, history. (1986)
Awards: Graduated cum laude; National Jesuit Honor Society
Extensive extracurricular theater and social service experience

Licensure

New York State License # 014105-1

Professional and Board Memberships

Committee to Protect Journalists, Secondary Traumatic Stress Advisory Group (2019).

American Psychological Association, Member (2008-2012).

International Society for Traumatic Stress Studies, Member (Ongoing).

Warrior Relief, Board member. (2013).

826NYC, Advisory Board member (2005-present).

Hands of Change, Advisory Board member (2003-2008).

Editorial/Reviewer Positions

Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, Editorial working group contributor: Psychological evidence of torture. (2018-2021).

APA Books, Invited peer reviewer, American Psychological Association, Washington, DC (2018).

Journal of Traumatic Stress, Ad hoc reviewer. (2017-present).

Journal of Clinical Child and Adolescent Psychology, Ad hoc reviewer, American Psychological Association, Div. 53. (2015).

Journal of Clinical Psychology, Ad hoc reviewer, Wiley Periodicals. (2015).

Cambridge University Press Medical Group, Ad hoc reviewer, Cambridge, UK (2014).

Anxiety, Stress, and Coping: An International Journal, Ad hoc reviewer, Brunner-Routledge Press. (2013).

The Psychosocial Impact of Detention and Deportation on Migrant Families. Inter-American Commission on Human Rights, Washington, DC. Expert reviewer on report by authors Brabeck, K., Lykes, MB., Lustig, S. (2013).

International Journal of Law and Psychiatry, Ad hoc reviewer, Universite de Montreal. (2012).

American Psychological Association Task Force on the Psychosocial Effects of War on Children and Families Who Are Refugees From Armed Conflict Residing in the United States, Chair. American Psychological Association. (2008-2010).

Clinical Experience/Employment

New York University School of Medicine, New York, NY
Clinical Instructor, Psychiatry (5/03-9/21)

Bellevue/NYU Program for Survivors of Torture, New York, NY
Psychological Consultant (7/19-present)
Senior Psychologist (7/08-present)
Clinical Co-Director (11/01-7/08)
Staff Psychologist (9/99-11/01)
Provided clinical services to adults, children/adolescents and families at this clinic for survivors of torture and war trauma. Conducted evaluation and assessment services as well as individual, family, and group therapy. Provide trainings and consultations nationally on issues pertaining to trauma, torture, and refugee mental health. Supervised psychological, psychiatric and social work trainees. Currently, serve as consultant for individual grant-funded projects and trainings.

Journalist Trauma Support Network, Dart Center for Journalism and Trauma, Columbia University School of Journalism, New York, NY.
Consulting Psychologist (11/20-present)

Freedom House, Washington, DC.
Consultant (2/18-present)
Consulted with managers and teams at Freedom House on trauma-informed practices and conducted trainings and workshops on trauma-facing work in human rights across the organization.
Conducted trainings with Freedom House-funded programs in Iraq and Pakistan on trauma-informed human rights practices and addressing secondary traumatic stress.

United States District Court, Southern and Eastern Districts of New York, New York, NY.
Psychological expert/Consultant (Varied)
Served as evaluator/consultant in Federal District Court for several cases.

Office of Military Commissions Chief Defense Counsel, Washington, DC/Guantanamo Bay, Cuba
Psychological expert/Consultant (9/08-present)

Serve as evaluator/consultant for defense teams in Office of Military Commissions in Guantanamo Bay. Have conducted extensive evaluations of several detainees, including psychological testing, interview, and observation.

NYU Child Study Center, New York, NY
Post-Doctoral Fellow (9/98-8/99)
Recipient of clinical fellowship at this multidisciplinary mental health clinic for children and adolescents. Provided assessment, evaluation, and treatment services for children and families within the Center's Anxiety Disorders Clinic, Attention Deficit/Hyperactivity Clinic, Infant and Early Childhood Development Clinic, and Learning and Academic Achievement Institute. Consulted at The Children's Storefront in Harlem, NY. Provided parenting workshops through the Center's Parenting Institute.

University Center for the Child and Family, Ann Arbor, MI
Intern/Practicum Student (9/93-10/96)
Recipient of training fellowship on clinical and research issues pertaining to loss in families. Provided individual, couples, and family therapy. Conducted therapy groups with divorced parents, bereaved siblings, and children from violent homes. Administered psychological assessments for custody, forensic, and academic evaluations (WAIS/WISC, MMPI, Exner Rorschach). Areas of specialization: loss and bereavement in families, therapy with the deaf and hearing-impaired.

University of Michigan Hospital, Child and Adolescent Psychiatric Division, Ann Arbor, MI
Practicum Student (1/94-5/94)
Administered psychological assessment and co-led Social Skills Group for inpatient adolescents.

Preventive Intervention Project, Judge Baker Children's Center, Boston, MA
Project Coordinator (9/90-8/92)
Coordinated longitudinal project examining a family-based intervention for depressed parents. Contributed to development of assessment battery, coding systems, and reliability studies, participated in grant and manuscript writing.

McLean Hospital, Belmont, MA
Mental Health Worker (5/89-8/90)
Responsibilities on a 23-bed locked psychosocial unit included milieu management, treatment planning, case presentation at treatment conferences and crisis intervention. Co-led adolescent group.

Castle School, Cambridge, MA
Senior Counselor/Team Leader (2/87-3/89)
Responsibilities at a 12-bed residential school for emotionally disturbed adolescents included milieu and case management, crisis intervention, hiring and scheduling staff.

Adolescent and Family Development Project, Harvard University, Boston, MA
Research Assistant (6/89-1/91)
Coded interviews using Q-Sort of Ego Processes.

La Casa de la Mujer, Chimbote, Perú
Community Organizer (6/86-11/86)
Planned and participated in workshops providing psychological, legal, and educational information in impoverished communities.

Teaching/Training Experience

New York University Medical School, NY, NY
Clinical Instructor
Clinical Supervisor, Psychological Interns and Externs, Psychiatric Residents (1999-present)
Third year Residents Course Co-Director: Introduction to Clinical Work with Survivors of Torture (2003-2006)
Lecturer, Intern and Residents Seminars, (2001-present)

The Second City, Detroit, MI; New York, NY
Facilitator/Improvisation Instructor (1994-present)
Design and conduct intensive workshops for businesses, focusing on team-building, creativity, and communication skills in organizations. Clients include Pfizer Pharmaceuticals, Major League Baseball, MTV, and General Motors.

Performer/Understudy (1994-2001)
Served as performer and understudy for Main Stage company, corporate theater company and touring company of *The Second City*, Detroit, MI.

Zone, Sports Media Consulting, Cleveland, OH (2007-present)
Conduct sports media training and consultations for professional athletes, coaches, general managers and collegiate athletes and coaches, including NBA, NHL and MLB.

The American Musical and Dramatic Academy, New York, NY
Improvisation Instructor (1/99-12/99)
Designed and taught improvisation course for acting students in this conservatory program.

The University of Michigan, Ann Arbor, MI
Graduate Student Instructor (1994, 1996)
Utilized role-play, lecture and discussion formats in this course on introductory counseling skills. Supervised undergraduate teaching assistants.

Gilda's Club, New York, NY
Improvisation Instructor (2/97-2/99)
Taught course on improvisation at a wellness center for individuals with cancer.

Georgetown University, Washington, DC
Improvisation Instructor (Summer, 1997)
Taught course on improvisation at the Alumni College.

The Castle School, Cambridge, MA
Drama Teacher (2/87-2/89)
Taught drama and improvisation at this residential school for emotionally disturbed teens.

Publications

Porterfield, K. (2023). Trauma-informed client communication strategies for lawyers. In Maki, H., Florestal, M., McCallum, M., and Wright, J. (Eds.) *Trauma-informed law: A primer for lawyer resilience and healing.* American Bar Association (Chicago, IL).

UN Office of the High Commissioner for Human Rights (OHCHR), (2018). *Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment ("Istanbul Protocol")*. Contributing editor of updated manual.

Porterfield, K. (2020). Principles of care of survivors of organized violence in a global society, In Rubin, N and Flores, R. (Eds.) *The Cambridge handbook of psychology and human rights,* Cambridge University Press.

WITNESS. (2020). *Video as evidence field guide: Using video to support accountability for sexual and gender-based violence crimes (SGBV).* Invited contributor. Retrieved at https://vae.witness.org/video-as-evidence-field-guide/.

Brabeck, K.M., **Porterfield, K**., & Loughry, M. (2015). Psychosocial and mental health issues, assessment, and interventions with immigrant individuals and families facing detention and deportation in the United States. In D. Kanstroom and M.B. Lykes (eds). *The new deportations delirium: Interdisciplinary responses.* New York University Press.

Lindhout, A. & **Porterfield, K.** (2014). Healing in forgiveness: A discussion with Amanda Lindhout and Dr. Katherine Porterfield. *European Journal of Psychotraumatology, Vol. 5. Available online at: http://www.ejpt.net/index.php/ejpt*.

American Psychological Association. (2010). *Resilience and recovery after war: Refugee children and families in the United States: Report of the APA task force on the psychosocial effects of war on children and families who are refugees from armed conflict in the United States*. Washington, DC. Lead author/Chair.

Porterfield, K. & Akinsulure-Smith, A. (2007). Therapeutic work with children and families. In H. Smith & A. Keller (Eds.), *Like a refugee camp on First Avenue: Insights and experiences from the Bellevue/NYU Program for Survivors of Torture* (pp 299-335). New York, Grant-funded publication.

Keller, A., Lhewa, D., Rosenfeld, B., Sachs, E., Aladjem, A., Cohen, I., Smith, H., **Porterfield, K.**, Wilkinson, J., Perdomo, L., & Smith, Y. A. (2006). Traumatic experiences and psychological distress among an urban refugee population. *Journal of Nervous and Mental Disease, 194 (3), 188-194*.

Saldinger, A., Cain, A., & **Porterfield, K.** (2005). Traumatic stress in adolescents anticipating parental death. *The Prevention Researcher, 12(4), 17-20.*

Saldinger, A., Cain, A., **Porterfield, K.** & Lohnes, K. (2004). Facilitating attachment between school-aged children and a dying parent. *Death Studies, 915-938.*

Saldinger, A., **Porterfield, K.**, & Cain, A. (2004). Meeting the needs of parentally-bereaved children: A framework for child-centered parenting. *Psychiatry: Interpersonal and Biological Processes, 67(4)*, 331-352.

Saldinger, A., Cain, A., & **Porterfield, K.** (2003). Managing traumatic stress in children anticipating parental death. *Psychiatry: Interpersonal and Biological Processes,* 66 (2), 168-181.

Porterfield, A., Cain, A., & Saldinger, K. (2002-2003). The impact of early loss history on parenting of bereaved children: A qualitative study. *Omega: Journal of Death and Dying,* 47(3):203-220.

Beardslee, W, Salt, P., **Porterfield, K.**, et al. (1993). Comparison of preventive interventions for families with parental affective disorder. *J. Am. Acad. Child Adolesc. Psychiatry,* 32(2), 254-263.

Presentations

Porterfield, K. (July 23, 2023). *Trauma-informed reporting: Biopsychosocial approaches.* Training for Ochberg Fellows, Columbia University School of Journalism, NY, NY.

Porterfield, K. (June 8, 2023, March 10, 2023, December 15, 2022). *Trauma-informed journalism: Biopsychosocial approaches.* Training for the New York Times reporting staff.

Porterfield, K. (May 26, 2023). *Interviewing children affected by trauma*, Training for Romanian journalists sponsored by UNICEF and the Dart Center for Journalism and Trauma, (Virtual).

Porterfield, K. (May 20, 2023). *Coping with stress, trauma and burnout*, Training for San Antonio Association of Hispanic Journalists, (Virtual).

Porterfield, K. (May 3, 2023). *Trauma-informed coverage of gun violence*, Training for the Trace staff. Brooklyn, NY.

Porterfield, K. (April 3, 2023). *Interviewing survivors of trauma in a post-conflict setting.* Zan Times. Remote training for Afghani journalists.

Porterfield, K. (April 1, 2023). *Trauma-informed journalism.* Christopher J. Georges Conference on College Journalism. Nieman Foundation. Harvard University. Cambridge, MA.

Porterfield, K. (January 19-20, 2023). *Trauma-informed journalism: A biopsychosocial approach to well-being.* Training for the Nieman Foundation Fellows, Harvard University, Cambridge, MA.

Porterfield, K. (November 21, 2022). *Trauma-informed approaches to interviewing survivors of trauma.* International Rescue Committee. (Virtual).

Porterfield, K. (October 19, 2022). *Interviewing children in the context of trauma.* Presentation for Early Childhood Global Reporting fellows. Dart Center for Journalism and Trauma. (Virtual).

Porterfield, K. (September 8, 2022, July 25, 2022). *Trauma-informed interviewing: Biopsychosocial approaches.* Training for PBS NewsHour staff. (Virtual).

Porterfield, K. (June 27-28, 2022). *Creating a trauma-informed journalism practice.* Two-day training for IWMF: Reclaiming Voices conference for exiled Afghani women journalists. Washington, DC.

Porterfield, K. (May 5, 2022). *Trauma-informed interviewing: Biopsychosocial approaches.* Training for New York Times reporting staff. (Virtual).

Porterfield, K. (April 12, 2022, April 25, 2022). *The biopsychosocial imprint of secondary traumatic stress in journalism.* Training for Axios Media. (Virtual).

Einashe, I. & Porterfield, K. (March 18, 2022, March 25, 2022). *The biopsychosocial imprint of trauma in journalism: How to recognize, how to respond.* Two-day training for Refugee Journalism Project for 20 refugee journalists working in UK in exile. (Virtual)

Porterfield, K. (March 17, 2022). *Coping through the trauma of COVID-19: Cultivating biopsychosocial wellbeing in critical care staff.* Critical Care Grand Rounds, Columbia University, New York Presbyterian Hospital. (Virtual)

Porterfield, K. (March 15, 2022). *Trauma-informed journalism: Biopsychosocial approaches.* Training for Prologue podcast. (Virtual).

Porterfield, K. (March 8, 2022). *Trauma-informed interviewing: Biopsychosocial approaches.* Training for Religion News Service. (Virtual).

Porterfield, K. (March 2, 2022). *Trauma-informed journalism: Biopsychosocial approaches.* Training for Beech Hill podcast. (Virtual).

Porterfield, K. (February 14, 2022). *Trauma-informed journalism: Biopsychosocial approaches.* Training for NPR podcast "Louder Than a Riot." (Virtual).

Sachs, E., Newman, E., Shapiro, B., & Porterfield, K. (January 28 and February 4, 2022). *Treating journalists in distress.* Two-part training for Comcast/Compsych clinicians serving NBC News. CEs provided. (Virtual).

Akinsulure-Smith, A, and Porterfield, K. (January 27, 2022). *Trauma-informed work with persecuted minorities.* Two-part training for Hammurabi Human Rights Organization, Iraq. (Virtual).

Porterfield, K. and Meneses, R. (January 6 and 13, 2022). *Trauma and resilience: A workshop for freelance journalists.* Two-day workshop sponsored by Dart Center Europe and the Rory Peck Trust. (Virtual).

Porterfield, K. (December 13-14, 2021). *Trauma-informed practice for journalists.* Part of team for two-day training with Next Generation Safety and International Women's Media Foundation. (In-person).

Porterfield, K. (December 8, 2021). *The biopsychosocial imprint of trauma in journalism: Recognizing and developing a wellbeing practice*. Training for Insider Media staff. (Virtual).

Porterfield, K. (November 18, 2021). *The biopsychosocial imprint of trauma in journalism: Recognizing and developing a wellbeing practice*. Training for Time Magazine newsroom staff. (Virtual).

Porterfield, K. (October 26, 2021). *Trauma-informed lawyering: A biopsychosocial approach*. Training for Columbia University Government Program clinic. NY, NY. (Virtual)

Porterfield, K. (October 22, 2021). *Trauma-informed lawyering: a biopsychosocial approach*. Training for Columbia University Immigration and International human rights clinics. NY, NY. (Virtual)

Porterfield, K. (October 13, 2021). *Trauma-informed work with incarcerated people*. Training for NYU Solitary Confinement and Prison Teaching Projects. NY, NY. (Virtual)

Porterfield, K. (September 29, 2021). *Cultivating resilience in the ICU and ECMO team*. Invited panelist at 32nd Annual ELSO International Conference. (Virtual).

Porterfield, K. (September 13, 2021). *The biopsychosocial imprint of trauma in journalism: Recognizing and developing a wellbeing practice.* Training for Society for Professional Journalists. (Virtual).

Porterfield, K. (September 1-2, 2021). *The biopsychosocial imprint of trauma in journalism: Recognizing and developing a wellbeing practice.* Training for Dart Centre Europe: Red de Mujeres Comunicadoras de Internacional. (Virtual)

Porterfield, K. (August 27, 2021). *Managing stress amidst crisis: press-freedom work in Afghanistan.* Workshop presented for Dart Center for Journalism and Trauma. (Virtual).

Porterfield, K. (August 25, 2021, October 12, 2021). *Secondary traumatic stress in journalism: A biopsychosocial approach to wellbeing*. Two-part training for Patch Media staff. (Virtual).

Porterfield, K. (August 16, 2021). *Trauma-informed press freedom work: A biopsychosocial approach to wellbeing.* Training for staff at Free Press Unlimited. (Virtual).

Edwards, S, Colon, R. & Porterfield, K. (July 22, 2021). *Treatment of an adolescent victim of sex trafficking: Medical and mental health considerations.* Mental health and medical conference, Adolescent Health Center, Mt. Sinai Hospital. (Virtual).

Porterfield, K. (July 14, 2021). *The biopsychosocial imprint of trauma and trauma-informed interviewing.* Training for Lost in Europe staff. (Virtual).

Porterfield, K. (July 8, 2021). *The biopsychosocial imprint of trauma: Tips for journalists.* Training for Radiolab Staff. (Virtual).

Porterfield, K. (June 29, 2021, August 18, 2021). *Coping through trauma: Journalist well-being practice in a crisis.* Training for Miami Herald newsroom staff. (Virtual).

Porterfield, K. (June 24, 2021). *Secondary traumatic stress in journalism: A biopsychosocial approach to well-being.* Training for McClatchy News Organization staff. (Virtual).

Porterfield, K. (June 17, 2021). *The biopsychosocial imprint of trauma: How to recognize, how to respond.* Training for Journalist in Distress (JID) Network caseworkers. (Virtual).

Pradhan, A., Prasow, A., Sethi, A., & Porterfield, K. (May 4, 2021). *Guantanamo and beyond: A panel discussion on military commissions, torture and the way forward*. Invited participant. Webinar for American Bar Association, Criminal Justice Division.

Porterfield, K. (April 29, 2021). *Secondary traumatic stress in journalism: A biopsychosocial approach to well-being.* Training for Public Source News staff (Virtual).

Porterfield, K. (April 9, 2021). *Understanding the biopsychosocial imprint of complex trauma.* 2021 Annual Conference Tennessee Association of Criminal Defense Lawyers. (Virtual).

Porterfield, K. (April 7, 2021). *The biopsychosocial imprint of trauma: Working with traumatized clients.* 2021 Annual Conference (CLE's provided). The Public Defenders Association of Pennsylvania. (Virtual).

Sachs, E., Porterfield, K, Newman, E., & Shapiro, B. (March 26, 2021, April 4, 2021). *Trauma-informed therapeutic practice with journalists.* Training for pilot program of Journalist Trauma Support Network. Dart Center for Journalism and Trauma. (Virtual).

Einashe, I. & Porterfield, K. (March 3-4, 2021). *Trauma-informed field work with children and their families: Creating a frame for effective and ethical interviewing.* Training for *Norwegian Refugee Council* staff by the Dart Center for Journalism and Trauma. (Virtual)

Porterfield, K. (February 18, 2021). *Enhancing well-being during a time of chronic stress.* Webinar for Physicians for Human Rights staff. (Virtual)

Porterfield, K. (February 12, 2021). *Secondary trauma in the legal profession.* Invited panelist at Wake Forest Law Review Symposium. (Virtual)

Porterfield, K. (December 3, 2020). *Coping with the stress of COVID-19 in legal work.* Federal Public Defender Conference, District of Kansas. (Virtual)

Porterfield, K. (November 24, 2020, February 2, 2021). *Enhancing well-being during a time of chronic stress.* Webinars for Covid Tracking Project staff. (Virtual)

Porterfield, K. (November 12, 2020, February 18, 2021). *Enhancing well-being during a time of chronic stress.* Webinars for Physicians for Human Rights staff. (Virtual)

Porterfield, K. (October 27, 2020). *Working with traumatized client: the biopsychosocial imprint of trauma*. Advancing Real Change Seminar. (Virtual)

Porterfield, K. (October 19, 2020). *Secondary traumatic stress in journalism: A biopsychosocial approach to well-being.* Training for the International Women's Media Foundation, Hazardous Environments Training. Washington, DC. (Virtual)

Porterfield, K. (October 14, 2020). *Interviewing individuals in solitary confinement: Recognizing and responding to trauma.* Training for NYU Solitary Confinement Project. NY, NY. (Virtual)

Porterfield, K. (October 2, 2020). *Enhancing well-being during a time of chronic stress: Lessons from the trauma field.* Webinar for Federal Defenders of San Diego CJA conference. (Virtual)

Porterfield, K. (September 28, 2020). *The biopsychosocial imprint of complex childhood trauma.* Webinar for University of Texas Law School Capital Punishment Clinic. (Virtual)

Porterfield, K. (June 23, 2020). *Enhancing well-being during a time of stress: A model of self-assessment and care.* Webinar for CCR Intern class. NY, NY. (Virtual)

Porterfield, K. (June 18, 2020). *Trauma-informed work with incarcerated youth.* Webinar for Center for Motivation and Change. NY, NY. (Virtual)

Porterfield, K. (June 3, 2020). *Recognizing and responding to the biopsychosocial impact of stress: Enhancing well-being in yourself and your team.* Webinar for Freedom House international management team. Washington, DC. (Virtual)

Porterfield, K. (May 22, 2020). *Working with traumatized populations during a time of stress.* Webinar for International Women's Media Foundation staff. Washington, DC. (Virtual)

Porterfield, K. (May 2020-October 2020). *Coping through trauma: A biopsychosocial approach to managing stress and well-being in an ongoing trauma.* Webinars for New York Presbyterian Pulmonary Critical Care teams. NY, NY. (Virtual)

Porterfield, K. (April 30, 2020). *Enhancing well-being during a time of stress: A model of self-assessment and care.* Webinar for Military Commissions Defense Operations staff. Washington, DC. (Virtual)

Porterfield, K. (April 22, 2020). *Recognizing and responding to the biopsychosocial impact of stress: Enhancing well-being in yourself and your team.* Webinar for Center for Constitutional Rights management team. Washington, DC. (Virtual)

Porterfield, K. (April 9, 2020). *Enhancing well-being during a time of stress: A model of self-assessment and care.* Webinar for Center for Constitutional Rights staff. Washington, DC. (Virtual)

Porterfield, K. (April 8, 2020). *Enhancing well-being during a time of stress: A model of self-assessment and care.* Webinar for Freedom House Emergency Assistance Program. Washington, DC. (Virtual)

Porterfield, K. (March 30, 2020). *Making the world hurt less: Enhancing wellbeing during a time of stress.* Webinar for International Women's Media Foundation. Washington, DC. (Virtual)

Porterfield, K. (March 19, 2020). *Lessons learned from journalists covering pandemics.* Webinar for International Women's Media Foundation. NY, NY. (Virtual)

Porterfield, K. and Sachs, E. (February 28, 2020, March 27, 2020). *Secondary traumatic stress in journalism: A biopsychosocial approach to well-being.* Training for the Nieman Foundation Fellows, Harvard University, Cambridge, MA. (Virtual)

Porterfield , K. (February 14, 2020). *The biopsychosocial imprint of trauma in human rights work.* Training for Cardozo Law School, Immigrant Rights Project. New York, NY.

Porterfield, K. (December 11, 2019). *The biopsychosocial imprint of complex trauma: Implications for evaluation and treatment.* Grand Rounds, St. Elizabeth's Hospital, Washington, DC.

Porterfield, K. (November 14-15, 2019). *The biopsychosocial imprint of trauma; and secondary traumatic stress: Strategies for well-being.* Presentations at Federal Defenders Orientation Training, Santa Fe, NM.

Porterfield, K. (November 1, 2019). *The biopsychosocial imprint of trauma in vulnerable populations.* Columbia University Law School. Capital and immigration clinics. NY, NY.

Porterfield, K. (October 24, 2019). *The biopsychosocial imprint of trauma in human rights advocacy.* Columbia University Law School. International Human Rights Clinic. NY, NY.

Porterfield, K. (September 21, 2019). Interviewing traumatized children. Presenter at *Through the Eyes of Young Children: Reporting on Children and the International Refugee Crisis*. Conference sponsored by DART Center for Journalism and Trauma, Columbia School of Journalism, New York, NY.

Porterfield, K. (September 20, 2019). *Recognizing and preventing secondary traumatic stress in journalism; Safety training for female journalists.* Sponsored by ROAAAR and International Women's Media Foundation. Brooklyn, NY.

Porterfield, K. (September 18th, 2019). *The biopsychosocial impact of trauma: Recognizing trauma and enhancing well-being.* Training for Immigrant Justice Corps. New York, NY.

Porterfield, K. (April 19, 2019). *The biopsychosocial impact of trauma: Working with traumatized populations.* Training for Columbia Law School Immigration Clinic, NY, NY.

Porterfield, K. (April 4, 2019). *Recognizing and responding to traumatized patients in a medical setting.* Presentation at Global Health Conference, Physician Assistants for Global Health and Mount Sinai Health System Dept of PA Services. NY, NY.

Porterfield, K. (March 1, 2019). *The biopsychosocial impact of trauma: Human rights work with traumatized populations*. Training for staff of the Center for Constitutional Rights, NY, NY.

Porterfield, K. (January 26, 2019). *Secondary traumatic stress in journalism: A biopsychosocial approach to well-being.* Training to the Nieman Foundation Fellows, Harvard University, Cambridge, MA.

Porterfield, K. (November 16, 2018). *The biopsychosocial imprint of childhood trauma: Complex post-traumatic stress disorder.* Presentation at 26th Annual Virginia Bar Association Capital Defense Workshop, Richmond, VA.

Porterfield, K. (November 8, 2018). *The biopsychosocial imprint of trauma; Secondary traumatic stress: Strategies for well-being.* Presentations at Federal Capital Habeas Unit training, Santa Fe, NM.

Porterfield, K., Pradhan, A., Satterthwaite, M., Singh, A., (October 19, 2018). *The meaning of torture in national security.* Invited panelist. Why International Law Matters: 97th Annual Meeting of the American Branch of the International Law Association. Fordham Law School, New York, NY.

Porterfield, K. (October 3, 2018). *Uncompartmentalizing: Learning from a refugee health care experience.* Invited panelist at Critical Issues in Emergency Medicine Conference. Bellevue Hospital Emergency Medicine Department, NY, NY.

Porterfield, K. (June 19, 2018). *The biopsychosocial imprint of trauma*. Plenary Presentation. Federal Death Penalty Authorized Case Consultation and Training Conference, Administrative Office of the US Courts. Atlanta, GA.

Porterfield, K. (June 4, 2018*). The imprint of trauma in human rights work.* Training for Center for Reproductive Rights. New York, NY.

Haidt, J., Porterfield, K., Van Bavel, J. (June 3, 2018). *The roots of extremism: The fundamentalist in your brain.* Invited panelist. World Science Festival, New York, NY.

Porterfield, K. (May 15, 2018). *The imprint of trauma in human rights work.* Training for Reprieve. New York, NY.

Porterfield, K. (March 21, 2018). *The biopsychosocial imprint of trauma: How to recognize, how to respond.* Plenary Presentation. Capital Habeas Unit National Conference, Federal Judicial Center, Santa Fe, New Mexico.

Porterfield, K., Kleinman, S., Katz, C, Mukherjee, E. (February 26, 2018). Changes in policy and practice in asylum law. Invited panelist. New York County Psychiatric Society. New York, NY.

Porterfield, K. (February 13, 2018). The imprint of trauma in human rights work. Training for Physicians for Human Rights national and international staff. New York, NY.

Porterfield, K. and Smith, H. (February 16, 2018). *Building the foundation of trauma-based treatment for refugee clients.* Day-long training for mental health providers. Sponsored by Better Health for Northeastern New York & Alliance for Better Health Care. Albany, NY.

Porterfield, K. (January 18, 2018). *Interviewing survivors of trauma in a journalism context.* Presentation at Dart Center for Journalism and Trauma, Columbia University. New York, NY.

Porterfield, K. (January 10, 2018). *The biopsychosocial imprint of complex trauma: Implications for evaluation and treatment in forensic and community contexts.* Full-day training sponsored by Institute of Law, Psychiatry, and Public Policy at the University of Virginia, and by the Virginia Department of Behavioral Health and Developmental Services. Jointly provided by the Office of Continuing Medical Education of the University of Virginia School of Medicine.

Porterfield, K. (November 30, 2017). *The impact of enhanced interrogation and rendition.* Testimony at public hearings for North Carolina Commission of Inquiry on Torture. Raleigh, NC.

Porterfield, K. (July 7-10, 2017*). The biopsychosocial impact of trauma: Issues for journalists.* Training for International Women's Media Foundation, Hazardous Environment Training, Mexico City, Mexico.

Porterfield, K. (June 14, 2017). *Working with traumatized prisoners: barriers and strategies for attorneys.* Invited presentation to The Innocence Project staff and interns. New York, NY.

Porterfield, K. (May 17, 2017). *The biopsychosocial impact of trauma: Human rights work with traumatized populations.* Full day training for staff of MADRE, New York, NY.

Porterfield, K. (May 11, 2017). *Human rights and psychology: A view from Guantanamo.* Presentation at the Watkinson School. Hartford, CT.

Porterfield, K. (March 24, 2017). *The biopsychosocial impact of trauma: Treatment and care of survivors.* One-day workshop. Institute for Individual and Family Counseling, University of Miami School of Education and Human Development. Miami, FL.

Akinsulure-Smith, A; Porterfield, K.; Smith, H. (December 9, 2016). *Assessment and treatment of torture survivors: Resilience-centered healing.* Invited Webinar. American Psychological Association Division 56 Webinar Series.

Porterfield, K. (October 13, 2016) *Interviewing survivors of trauma and torture in a human rights context.* Invited lecturer at Columbia University Law School Human Rights Clinic. New York, NY.

Porterfield, K. (October 6, 2016). *Working with traumatized clients: Strategies for advocates and lawyers.* Presentation at CUNY Law School Family Law and Immigration and Human Rights Clinics. Brooklyn, NY.

Porterfield, K. (September 22-25, 2016). *International Criminal Court: Trial advocacy training program.* Office of the Prosecutor. Invited faculty. Hague, Netherlands.

Porterfield, K. (August 11, 2016). *Introduction to complex trauma.* Invited presenter to Federal Capital Habeas Corpus Conference. Washington, DC.

Akinsulure-Smith, A; Porterfield, K.; Smith, H. (August 4, 2016). *Assessment and treatment of torture survivors: Integrative approach to service provision.* Invited Symposium. American Psychological Association Convention. Denver, CO.

Porterfield, K. (June 8, 2016) *Human rights and psychology.* Grand Rounds, Maimonides Hospital, Brooklyn, NY.

Porterfield, K., Lebowitz, L. (May 13, 2016). *The impact of childhood trauma.* Federal Capital Habeas Project Annual Conference. Atlanta, Georgia.

Porterfield, K. (February 5, 2016). *Trauma and the refugee client: Barriers and strategies for care.* Webinar for SUNY Albany School of Public Health: Center for Public and Continuing Education Series: Advancing Cultural Competence in the Workplace.

Porterfield, K. and LeBoeuf, D. (January 23, 2016). *Childhood trauma: Moving past checklists and diagnoses*. Presentation (Via remote) to the Alabama Criminal Defense Lawyers Association. Birmingham, AL.

Porterfield, K. (November 3, 2015). *Impact of psychological torture: Perspectives from Guantanamo and the Bellevue/NYU Program for Survivors of Torture.* Invited presentation to the American Academies of Science, Engineering and Mathematics Human Rights Committee, Washington, DC.

Porterfield, K. (October 30, 2015) *Moving past checklists and diagnoses: Childhood trauma.* Federal Death Penalty Strategy Session, Administrative Office of the US Courts, Fort Lauderdale, FL.

Porterfield, K. (October 20, 2015). *A psychologist's view from death row and Guantanamo.* Presentation at the Watkinson School. Hartford, CT.

Porterfield, K. (October 16, 2015) *Interviewing survivors of trauma and torture in a human rights context.* Invited lecturer at Columbia University Law School Human Rights Clinic. New York, NY.

Porterfield, K. (October 14, October 21, 2015). W*orking with traumatized clients: Strategies for lawyers and advocates.* Training for the staff at The Bronx Defenders. New York, NY.

Porterfield, K., Figley, C, Smith, C., Gobin, R., Gold, S., Rom-Rymer, B., and Rhoades, G., (September 25, 2015) *The Hoffman Report: Division 56 discusses initial reactions and plans.* Webinar sponsored by APA Division 56.

Porterfield, K. (September 16, 2015). *Traumatic grief in victims and families.* Invited training for Administrative Office of the US Courts, Defense-Initiated Victim Outreach, Alexandria, VA.

Porterfield, K. (July 22-23, 2015). *Communication strategies with a traumatized client and Self-care for staff.* Presentations at "Building Awareness, Skills and

Knowledge: A Community Response to the Torture Survivor Experience" Conference sponsored by Refugee Services National Partnership for Community Training and Tennessee Office for Refugees, Nashville, TN.

Sowards, G, LeBoeuf, D., Holdman, S., Poteet, D., Nevin, D., Porterfield, K. (July 13, 2015). *From Death Row to Guantanamo: Practical ethics in the interface between law and mental health.* Panel presentation at the International Congress of Law and Mental Health, Vienna, Austria.

Porterfield, K. (May 28, 2015). *Impact of trauma on the refugee family with children: Clinical considerations and recommendations for care; Working with clients who have suffered trauma: Strategies for effective communication; Secondary trauma and self-care in working with traumatized refugee populations.* Intensive Case Management Training Conference, Lutheran Immigration and Refugee Service, Baltimore, MD.

Porterfield, K. (May 2, 2015) *Resilience and recovery after wrongful incarceration. Working with those who have experienced wrongful incarceration.* Invited speaker at the 2015 Innocence Network Conference. Orlando, FL.

Porterfield, K. (January 22, 2015). *Secondary trauma for lawyers and advocates conducting human rights work*. Invited presentation to the Innocence Project staff and students. New York, NY.

Porterfield, K. (November 19, 2014). *Working with traumatized clients: Strategies for advocates and lawyers.* Presentation to Georgia Capital Defenders Annual Conference, St. Simons Island, GA.

Porterfield, K. (October 23-25, 2014). *Complex trauma in mitigation.* National Association of Criminal Defense Lawyers: 16th Annual Making the Case for Life Seminar. (October 23-25, 2014). Charlotte, NC.

Porterfield, K. (October 16, 2014). *Working with traumatized clients: Strategies for advocates and lawyers.* Presentation at CUNY Law School Family Law and Immigration Clinics. Brooklyn, NY.

Porterfield, K. (June 6, 2014, September 18, 2014, October 21,2014) *Working with traumatized prisoners: Barriers and strategies for attorneys*. Invited presentation to The Innocence Project staff. New York, NY.

Porterfield, K. (May 13, 2014). *The psychological effects of chronic systematic child abuse and neglect: Lessons learned from the field.* Invited Speaker, 22nd

Annual Children's Justice Conference, Washington State Department of Social and Health Services, Spokane, WA.

Porterfield, K. (May 5-18, 2014). *Working effectively with traumatized children and families in the aftermath of torture and refugee trauma: Core principles.* Two week E-Learning Seminar for refugee service providers for Gulf Coast Jewish Family and Community Services, National Partnership for Community Training.

Porterfield, K. (April 23, 2014). *The unmaking of the underdog*. TEDx Presentation, TEDx Editors' Pick, Franklin and Marshall College, Lancaster, PA.

Porterfield, K. (April 9, 2014). *A graded therapeutic approach to the traumatized refugee client.* Webinar presented to staff of Jewish Family Services and affiliated clinicians, Syracuse, NY.

Porterfield, K. (March 26, 2014). *Human rights and the role of psychologists: A view from Guantanamo*. Invited speaker, The Watkinson School, Hartford, CT.

Porterfield, K. (March 13, 2014) *Childhood trauma: What the research—established and emerging—teaches us about clients*. Authorized Case Training and Consultation Conference, Federal Death Penalty Resource Counsel. Louisville, Kentucky.

Porterfield, K. (March 6, 2014) *Inhuman incarceration: an interdisciplinary discussion on the consequences of the prison industrial complex*. Invited panelist. CUNY School of Law, Queens, NY.

Porterfield, K. (November 21, 2013) *Working with traumatized prisoners: Barriers and strategies for attorneys.* Invited presentation to The Innocence Project staff and student lawyers. New York, NY.

Porterfield, K. (October 15-16, 2013) *Working clinically with traumatized refugee children and families; Complex marginalization and the refugee client; Unspoken human rights conference: Restoring dignity and healing from trauma and torture.* Interdisciplinary conference sponsored by Refugee Services National Partnership for Community Training. Utica, NY.

Porterfield, K. (October 15, 2013). *Working with traumatized immigrant and refugee clients in a legal context*. Presentation to CUNY School of Law Immigration Clinic. New York, NY.

Porterfield, K. (May 17, 2013). *Working clinically with the traumatized refugee child and family*. Two Week E-learning Seminar for Gulf Coast Jewish Family and Community Services Providers.

Porterfield, K. (April 16, 2013). *Working clinically with the traumatized refugee child and family and complex marginalization: Addressing the refugee experience in your agency.* Presentations at Building Bridges Conference: The Refugee Journey, Fargo, ND.

Porterfield, K. (March 13, 2013). *Managing secondary trauma in work with refugees*. Webinar Conference Call facilitated for Gulf Coast Jewish Family & Community Services.

Porterfield, K. (February 13, 2013). *Human rights abuses and the role of psychologists.* Presentation at Fordham Law School Seminar on International Law and Terrorism, New York, NY.

Porterfield, K. (February 12, 2013). *Psychological evaluations in the war on terror.* Presentation to The Watkinson School, Hartford, CT.

Porterfield, K. and Akinsulure-Smith, A. (December 6, 2012) *Human rights abuses: Impunity and advocacy: The view from Guantanamo and the Hague.* Presentation at City College of New York; Psychology Department.

Porterfield, K. (November 16, 2012) *Traumatized clients in capital cases: Barriers and strategies for attorneys*. Invited presenter, Virginia Bar Association Capital Defense Training, Richmond, VA.

Porterfield, K. and Akinsulure-Smith, A. (October 26, 2012) *Human rights abuses: Impunity and advocacy: The view from Guantanamo and the Hague.* Presentation at Bellevue Hospital Center Psychiatry Case Conference.

Porterfield, K. (June 6, 2012) *Traumatizing lives, traumatizing imprisonment: Working with multiply traumatized clients in prisons.* Presentation at Arnold and Porter Law Firm, New York, NY.

Porterfield, K. (May 15, 2012) *Traumatized clients: Signs, symptoms, and strategies for building relationships.* Office of the Appellate Defender, New York, NY.

Porterfield, K., Akinsulure-Smith, A, O'Hara, S. (April 19, 2012) *Refugees and psychosocial well-being*. Invited panelist at United Nations Psychology Day

conference, Human Rights for Vulnerable People: Psychological Contributions and the United Nations Perspective, New York, NY.

Porterfield, K. (April 17, 2012) *Working effectively with traumatized children and families in the aftermath of torture and refugee trauma: Core principles*. Webinar presented for National Partnership for Community Training, Florida Center for Survivors of Torture, New York, NY.

Porterfield, K. (March 23, 2012) *Clients traumatized by incarceration and security measures: Signs, symptoms and strategies for building relationships*. Presentation at Bureau of Prisons Homicides Authorized Case Training and Consultation Conference, Denver, CO.

Porterfield, K. (March 12, 2012) *Traumatized clients: Signs, symptoms, and strategies for building relationships.* Neighborhood Defenders Service, Harlem, NY.

Porterfield, K. (March 8, 2012) *Working effectively with traumatized children and families in the aftermath of torture and refugee trauma: Core principles,* Presentation at Fostering the Resilient Spirit: Holistic Responses in the Torture Treatment Field. Tulane University School of Social Work, New Orleans, LA.

Porterfield, K. (February 13, 2012) *Working clinically with traumatized children and families*. Half day training provided at Center for Family Life, Brooklyn, NY.

Porterfield, K. (November 11, 2011*) Harnessing knowledge: Advocacy and prevention and bearing witness: The experience of the media*. Invited panelist at Recovery from Trauma: Lessons from Ground Zero and Beyond. Peter C Alderman Foundation/NYU Hospital, New York, NY.

Porterfield, K., Keller, A., & Xenakis, S. (November 5, 2011) *Torture and maltreatment in the war on terror: Rupturing professional and clinical bonds,* Panelist at International Society for Traumatic Stress Studies, Baltimore, MD.

Porterfield, K., LeBoeuf D., Holdman, S., (November 4, 2011) *Traumatized clients: Signs, symptoms, and strategies for building relationships*. Invited speaker at Federal Death Penalty Resource Counsel, New Orleans, LA.

Porterfield, K. (June 8, 2011) *Multicultural issues in service provision to traumatized refugees.* Invited speaker at US Committee for Refugees and Immigrants Conference, Arlington, VA.

Porterfield, K. (May 13, 2011) *Complex trauma.* Invited speaker at Habeas Corpus Resource Center Spring Conference, San Francisco, CA.

Porterfield, K. and Keller, A. (January 14, 2011) *Interviewing trauma survivors in a legal context*. Half-day training for Open Society Institute Justice Initiative Team, New York, NY.

Porterfield, K. (January 13, 2011). *Inner healing after war*. Invited panelist at United Nations NGO on Mental Health, New York, NY.

Porterfield, K. (January 11, 2011). *Torturing the mind: U.S. involvement in psychological torture*. Invited panelist at New York Religious Campaign Against Torture, New York, NY.

Porterfield, K. (June 16, 2010). *Working with traumatized children in an asylum context.* Invited speaker at Asylum Officers' Training, Newark, NJ.

Porterfield, K (April 23, 2010). *Complex trauma as a factor in mitigation*. Invited speaker at Seventh National Seminar on the Development and Integration of Mitigation Evidence: New Science, New Strategies, Seattle, Washington.

Porterfield, K. (March 19, 2010). *Working with traumatized refugee populations*. Invited Panelist at Boston College Conference Deportation, Migration, Human Rights, Boston, MA.

Porterfield, K. (February 26, 2010). *Working with traumatized individuals in a legal/human rights context.* Presentation to Center for Constitutional Rights Staff, New York, NY.

Porterfield, K. (December 7, 2009) *Integrated treatment of a first responder from 9/11: CBT methods in a long-term treatment*. Grand rounds invited presenter, Manhattan Psychiatric Center, New York, NY.

Porterfield, K. (October 15, 2009). *Introduction to exposure therapy*. Counseling Methods Course, City College, New York, NY.

Porterfield, K. (September 11, 2009) *Integrated treatment of a first responder from 9/11: CBT methods in a long-term treatment*. Invited speaker for Bellevue Hospital Case Conference, New York, NY.

Porterfield, K., Akinsulure-Smith, A, Kia-Keating, M. and Betancourt, T. (August 7th, 2009). *War-affected children residing in the U.S.: Challenges and new directions for psychologists.* Chair of Panel at the American Psychological Association 2009 Convention, Toronto.

Porterfield, K. (July 19, 2009). *Working with traumatized children in a legal/human rights context*. Presentation to Kids in Need of Defense (KIND) staff retreat, Washington, DC.

Porterfield, K., Xenakis, S., and Keram, E. (June 12, 2009). *Psychological issues in working with detainees in Guantanamo.* Panel Presentation to Office of Military Commission Defense Counsel, Washington, DC.

Porterfield, K. (May 17, 2009). *Interviewing trauma survivors in a legal/human rights context.* Presentation at ACLU Human Rights Documentation Training, ACLU National Office, New York, NY.

Porterfield, K (March 29, 2009). *Interviewing survivors of torture and trauma in a legal context.* Seminar presented to Columbia University Law School, International Human Rights Clinic, New York, NY.

Porterfield, K (March 4, 2009). Recognizing and Responding to the Traumatized Refugee Child and Family. Presentation at Health Care for Immigrant Families: What the Pediatrician Should Know, Conference sponsored by New York Chapter 3, District II, of the American Academy of Pediatrics, New York, NY.

Porterfield, K. (February 24, 2009). *Interviewing survivors of torture and trauma in a legal context.* Seminar presented to CUNY Law School Immigration and International Women's Human Rights Clinics.

Porterfield, K., Keller, A. (June 28, 2008). *How to recognize, document and understand the effects of torture.* Training for Military Commissions Defense: Capital Case Consult, Washington College of Law, American University, Washington, DC.

Porterfield, K. (May 9, 2008). *Interviewing survivors of gender-based violence in a legal context.* Training for Human Rights USA, New York, NY.

Porterfield, K. and Keller, A. (April 18, 2008). *Interviewing Survivors of trauma in a legal context: Barriers and strategies.* Training for Office of Military Commissions, Office of the Chief Defense Counsel, Guantanamo Team.

Porterfield, K. (April 16, 2008). *Understanding the effects of refugee trauma and vicarious traumatization.* Full day staff training at Interfaith Migration Ministries, New Bern, North Carolina.

Porterfield, K. (April 16, 2008). *Working with refugee children in school*s. Training for Guidance and ESL staff, New Bern Public Schools, Craven District, New Bern, North Carolina.

Porterfield, K. (April, 2, 2008). *Trauma, testimony, and recovery: Human rights tensions and challenges in the treatment of torture survivors*. Invited lecturer for Human Rights: A Culture in Conflict, Georgetown University.

Porterfield, K. (February 14, 2008). *Interviewing survivors of trauma in a legal context*. Seminar presented to CUNY Law Immigration and Domestic Violence Clinics, New York.

Porterfield, K. & Gray, A. (January 23, 2008). *Serving children who are torture survivors.* Webinar provided for the National Consortium of Torture Treatment Centers.

Porterfield, K. (January 15, 2008). *Interviewing survivors of gender-based violence: clinical considerations.* Training provided for Human Rights Watch Research Staff.

Porterfield, K, Nguyen, L., Gutierrez, G., (November 15, 2007). *Psychology, law and torture: Retraumatization and reenactment in torture victims.* Panelist, ISTSS National Conference, Baltimore, MD.

Porterfield, K. (October 24, 2007). *Interviewing survivors of torture in a legal context.* Training provided for Center for Constitutional Rights Asylum Attorneys, Davis Polk Law Firm, New York.

Porterfield, K. (February 15, 2007) *Interviewing survivors of torture in a legal context.* Training provided for Center for Constitutional Rights Guantanamo Habeas Project, New York, NY.

Porterfield, K. (January 25, 2007). *Pinochet to Rumsfeld: Acountability to US officials for torture.* Invited panelist at event sponsored by the Center for Constitutional Rights and The Nation, New York, NY.

Porterfield, K (August 23, 2006). *Introduction to clinical issues with traumatized patients.* Psychological Interns Seminar, Bellevue Hospital, New York, NY.

Porterfield, K. (June 5, 2006). *From horror to hope: Clinical work with children and adolescents affected by war.* Invited presenter at Living in a State of High Alert: Traumatized Children and Families in a Stressful Society. Manhattan Child and Adolescent Services Committee Conference, Fordham University, New York, NY.

Porterfield, K. (March 6, 2006, November 30, 2005) *Interviewing survivors of torture in a legal context*. Training provided for Center for Constitutional Rights Guantanamo Habeas project, New York, NY.

Porterfield, K. (September 30, 2005). *Clinical work with war-traumatized children.* The University Center for the Child and Family, University of Michigan, Ann Arbor, MI.

Porterfield, K. (September 29, 2005). *From horror to hope: Clinical work with children and adolescents affected by war*. Invited Lecturer, University of Michigan Department of Psychology, Ann Arbor, MI.

Porterfield, K. and Schoen, S. (September 23, 2005). *Interviewing survivors of torture in a legal context*. Training provided for attorneys working on Guantanamo and Abu Ghraib cases, Center for Constitutional Rights, New York, NY.

Porterfield, K. and Schoen, S. (August 4, 2005). *Interviewing survivors of torture in a legal context*. Training provided for attorneys working on Guantanamo and Abu Ghraib cases, American Civil Liberties Union, New York, NY.

Porterfield, K. (July 14, 2005). *Through my eyes:Children's drawings from conflict zones.* Invited Panelist at Chelsea Art Museum Exhibit, Sponsored by Amnesty International.

Porterfield, K. (February 5, 2005) *Integrated treatment with a survivor of gang rape in Kosovo.* Presentation to William Alan White Institute, Refugee Trauma Study Group, New York, NY.

Porterfield, K. & Akinsulure-Smith, A. (November 15, 2004). *Two short term group treatment models for war trauma survivors.* Workshop presented at International Society for Traumatic Stress Studies 20th Annual Meeting: "War as a Universal Trauma." New Orleans, LA.

Porterfield, K. (April 21, 2004). *From horror to hope: Clinical work with children and adolescents affected by war.* Rachel Summerfield Memorial Lecture, University of Chicago, Chicago, IL.

Porterfield, K. (March 24, 2004) *Integrated treatment with a survivor of gang rape in Kosovo.* Presentation to Institute for Contemporary Psychotherapy, New York, NY.

Porterfield, K. & Akinsulure-Smith, A. (April 15, 2003). *Responding to disasters: mental health assessment and self-care.* Presentation for Beth Israel Social Work In-Service Training, New York, NY.

Porterfield, K. (September 12, 2002). *Psychiatry takes to the Streets: Bellevue Hospital responds to 9/11*. NYU Psychiatry Grand Rounds Panel Presentation, New York, NY.

Porterfield, K. (June 17, 2002). *Caring for traumatized refugee children: Identification, advocacy, and treatment; Traumatized youth and families: The road to recovery*. Eighteenth Annual Manhattan Child and Adolescent Services Committee Conference, New York, NY.

Porterfield, K. (June 6, 2002). *Psychological and physical consequences of torture and refugee trauma.* Presentation to Multicultural Integration Grantees, United States Department of State, New York, NY.

Porterfield, K. (May 29, 2002). *An integrated treatment approach of a traumatized rescue worker from September 11th*. Psychological Interns Seminar, Bellevue Hospital, New York, NY.

Porterfield, K. (May 20, 2002). *Recognizing and responding to traumatized children in schools.* Presentation for teachers/guidance counselors at Liberty High School, New York, NY.

Smith, H. & Porterfield, K. (April 9, 2002). *Psychological and physical consequences of torture and refugee trauma: Introduction to clinical issues; Caring for traumatized refugee children: Identification, advocacy, and treatment.* Presentations at World Relief Conference on Refugee Mental Health, Boise, Idaho.

Porterfield, K. (February 15, 2002). *Caring for traumatized refugee children: Identification, advocacy, and treatment.* Presentation for interns and post-doctoral fellows: The NYU Child Study Center, New York, NY.

Porterfield, K. (January 25, 2002). *Recognizing and responding to traumatized children in schools.* Presentation for teachers and guidance counselors at Brooklyn International Middle School, Brooklyn, NY.

Porterfield, K. (January 16, 2002). *Caring for traumatized refugee children: Identification, advocacy, and treatment.* Presentation for Child Life staff, Bellevue Hospital Center, New York, NY.

Porterfield, K. (November 19, 2001). *Recognizing and responding to traumatized Children in schools.* Presentation for guidance counselors: Manhattan Comprehensive Day and Night School, New York, NY.

Porterfield, K. (October 13, 2001). *Responding to children's needs in the wake of the World Trade Center attacks*. Presentation for parents at St. Ignatius Loyola School, New York, NY.

Porterfield, K. (October 3, 2001). *Recognizing and responding to traumatized children in schools.* Presentation for teachers and staff: Brooklyn International High School, Brooklyn, NY.

Leviss, J. & Porterfield, K. (January 16, 2001). *Working with traumatized refugee populations: Medical and psychological considerations*. Department of Community Medicine, St. Vincent's Hospital, New York, NY.

Porterfield, K. (January 8, 2001). *Effects of refugee trauma on children and families*. Metropolitan Hospital/Behavioral Health Services: Child and Adolescent Case Conference, New York, NY.

Porterfield, K. (November 17, 2000) *Competencies that social workers need to enter the field of international social welfare.* Invited panel member at the

International Social Welfare Symposium for the Columbia University School of Social Work, New York, NY.

Porterfield, K. and Leviss, J. (October 4, 2000). *Recognizing and responding to refugee trauma.* Training at the Floating Hospital, New York, NY.

Keller, A. and Porterfield, K. (September 13, 2000). *Psychological and physical consequences of torture: Introduction to clinical issues*. Training for Jamaica Clinic Staff, Queens, NY.

Porterfield, K. and Leviss, J. (August 2, 2000) *Psychological and physical consequences of torture: Introduction to clinical issues*. Training for Ryan Health Center Mental Health Staff: New York, NY.

Porterfield, K. (July 13, 2000) *Psychological and physical consequences of torture: Introduction to clinical issues*. Training at Coney Island Hospital Department of Behavioral Health, Brooklyn, NY.

Porterfield, K. (June 28, 2000, August 16, 2000) *Working with traumatized refugees in resettlement: Identification and advocacy*. Training for resettlement staff of Catholic Community Services, Newark, NJ.

Porterfield, K. (June 23, 2000). *Recognizing and responding to traumatized refugee children and families; Working with language interpreters*. Presentations at Interfaith Refugee Ministry Conference: "Kosovar Albanians in Connecticut: Honoring the Past, Building for the Future," Waterbury, CT.

Porterfield, K. (June 8, 2000). *Helping your child's adjustment after war*. Presentation to Kosovar Albanian parents at Yonkers Public Schools and Bilingual/ESL Department: Yonkers, NY.

Smith, H. and Porterfield, K. (May 13, 2000). *Mental health needs of the refugee family*. Presentation to Bosnian, Kosovar Albanian and Roma refugees, Bridge Refugee Services, Knoxville, TN.

Smith, H. and Porterfield, K. (May 12-13, 2000). *Psychological and physical consequences of torture and recognizing; Responding to traumatized refugee children in school.* Presentations at Post-traumatic Stress Disorder Conference for Bridge Refugee and Sponsorship Services, Knoxville, TN.

Porterfield, K. (March 30, 2000). *Caring for traumatized refugee children: identification, advocacy, and treatment; Recognizing and responding to traumatized refugee children in school.* Presentations at Bellevue/NYU/Solace Conference: Refugee Resettlement: Therapeutic Factors and Interventions: New York, NY.

Porterfield, K. (March 22, 2000). *Recognition of trauma in children and practical strategies for helping refugee children in school*. Presentation for Staff Development at Belleville School Number Four: Belleville, NJ.

Porterfield, K. (March 18, 2000). *Introduction to clinical issues in refugees traumatized by war.* Presentation to refugee community leaders, Lutheran Social Services, Fargo, North Dakota.

Porterfield, K. (March 16-17, 2000). *Psychological and physical consequences of torture; Recognizing and responding to traumatized refugee children; Helping the refugee family heal; Secondary traumatization and burnout, post-traumatic stress disorder; Clinical aspects of working with traumatized refugees, and working with interpreters and working multiculturally*. Presentations at Lutheran Social Services Conference: Building Bridges: From Newcomer to Citizen: Fargo, North Dakota.

Impalli, E, Porterfield, K., and Keller, A. (March 1, 2000). *Clinical assessment and interventions with survivors of torture and refugee trauma*. Presentation at Catholic Community Services: Newark, NJ.

Impalli, E. and Porterfield, K. (February 17, 2000). *Therapeutic and pragmatic issues in clinical interviewing with interpreters.* Presentation at International Institute of New Jersey's Cross Cultural Counseling Center: Jersey City, NJ.

Keller, A. and Porterfield, K. (January 20, 2000). *The impact of trauma on refugee children.* Presentation at International Rescue Committee: New York, NY.

Porterfield, K. (December 16, 1999). *Practical strategies for helping refugee children in school*. In-service training for District 10 Guidance Counselors, Bronx, NY.

Porterfield, K, and Rolovic, S (November 16, 1999). *The unpredictable nature of trauma in children: A family-based approach to working with families from Kosovo.* Presentation at the 1999 National ORR Conference: Resettlement Through the Eyes of a Refugee Child, Washington, DC.

Steinberg, D. and Porterfield, K. (June, 1999). *Separation anxiety and panic in a preschooler: Assessment and treatment*. Presentation at Child and Adolescent Psychiatry Grand Rounds, New York University Medical Center, New York, NY.

Porterfield, K. (April, 1999). *The transition towards adolescence: Influences on girls' self-feelings*. Presentation to parents at Marymount Middle School, New York, NY.

Porterfield, K. (May, 1999). *The family life cycle: Marriage and parenting.* Presentation to parents at St. Ignatius Loyola Elementary School, New York, NY.

Porterfield, K. and Saldinger, A. (April, 1998). *Child-centered parenting of the parentally bereaved child.* Presentation at the American Orthopsychiatry Conference, Washington, DC.

Porterfield, K. (May, 1998). *The family life cycle: Marriage and parenting.* Presentation to parents at St. Ignatius Loyola Elementary School, New York, NY.

Porterfield, K. (April, 1996). *Divorce groups for children: The parental component.* Presentation to the University Center for the Child and Family, Ann Arbor, MI.

Miller, J., Porterfield, K. and Litzenberger, B. (October, 1995). *Psychotherapy with the deaf and hearing-impaired*. Presentation to the University Center for the Child and Family, Ann Arbor, MI.

Porterfield, K. (April, 1995) *A time-limited, problem-focused psychotherapy with an eating-disordered adolescent*. Presentation to the University Center for the Child and Family, Ann Arbor, MI

Supplemental Declaration of Katherine Porterfield, Ph.D.

I, Katherine Porterfield, declare as follows:

1. My name is Dr. Katherine Porterfield. I have previously provided a report in the matter of *Mr. Kenneth Smith.*

2. This supplemental declaration is intended to expand on the opinions previously provided in my report dated November 17, 2023. Each opinion stated herein is made to a reasonable degree of psychological certainty based on expertise in the fields of psychology, trauma, and torture.

3. I have been provided a second set of medical records from the Alabama Department of Corrections (DOC) for Mr. Kenneth Smith dated from April 11, 2023 to October 4, 2023. Copies of those records with my highlighting to note key portions are attached as Exhibit 1. These records are in addition to records that I was provided by counsel for Mr. Smith that spanned from 2004 - April 2023.

4. In my previous report, I summarized issues pertaining to Mr. Smith's mental health as documented in the first set of DOC mental health records. In those records, Mr. Smith was diagnosed with adjustment disorder or a R/O of adjustment disorder beginning in July 2022. He was provided medication in October 2022 for anxiety and depression. After the failed execution in November 2022, he was identified as having "anxiety, muscle tension, insomnia" and "post-traumatic nightmares," for which he received medication. Between January and April, 2023, he continued to have mental health treatment for anxiety and depression, but his sleep problems and nightmares decreased.

5. The additional records that I have been provided have directly related to Mr. Smith's mental health, something about which I opined in my report. These records further confirm my opinion about Mr. Smith's mental health.

6. For summary purposes, the second set of records that I have been provided were from the Alabama Department of Corrections for the following dates:

October 4, 2023
September 5, 2023
August 23, 2023
August 9, 2023
August 2, 2023
July 31, 2023
July 25, 2023
July 25, 2023
July 10, 2023
June 13, 2023

May 16, 2023
May 4, 2023
April 11, 2023

7. The records that I have reviewed are consistent with my clinical opinion of Mr. Kenneth Smith, shared in my report dated November 17, 2023, which is that Mr. Smith is impaired with chronic conditions of PTSD and depression, conditions that emerged after the trauma of his attempted execution of November 17, 2023.

8. Below, I will review four areas in which DOC clinicians reported on Mr. Smith's functioning in ways that are consistent with my opinions: diagnosis, date of onset of conditions, symptoms, and experience of terror during the failed execution.

9. **DIAGNOSIS:** In multiple records, beginning in May 2024, Alabama DOC clinical staff diagnose Mr. Smith with posttraumatic stress disorder (PTSD) and a "rule/out" of major depressive disorder. (Rule/out means that the clinician is considering the diagnosis, given the clinical presentation, but may need further information for a full diagnosis.)

   a. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated May 4, 2023, Mr. Smith is diagnosed with PTSD, adjustment disorder, R/O major depression.

   b. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated July 24, 2023, Mr. Smith is diagnosed with PTSD, adjustment disorder, R/O major depression and substance use disorder.

   c. In a document called MENTAL HEALTH CODING FORM, dated July 25, 2023, and signed by Dr. Polanco, Mr. Smith is diagnosed with adjustment disorder, PTSD, and R/O major depressive disorder.

   d. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated August 9, 2023, Mr. Smith is diagnosed with PTSD, adjustment disorder, R/O major depression and substance use disorder.

   e. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated September 5, 2023, Mr. Smith is diagnosed with PTSD, adjustment disorder, R/O major depression and substance use disorder.

   f. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated October 4, 2023, Mr. Smith is diagnosed with PTSD, adjustment disorder, R/O major depression and substance use disorder. He is noted to be taking Buspar and Remeron and reports that he is "fine with" his medication.

10. **DATE OF ONSET***:* It is also relevant that on August 2, 2023, in a four-page record entitled MENTAL HEALTH MULTIDISCIPLINARY TREATMENT PLAN, three clinicians (Dr. Polanco, Dr. Brewer and MH Nurse Wall) who are working with Mr. Smith note that the "date of onset" of Mr. Smith's PTSD is "11/22," the month of the attempted execution. This also is consistent with my opinion that Mr. Smith's PTSD and depression were brought about by the experience of the failed execution.

11. **SYMPTOMS***:* There is also descriptive data in the medical records about Mr. Smith's symptoms in relation to PTSD that is consistent with my findings as reported in my report of November 17, 2023.

    a. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated May 4, 2023, Mr. Smith is noted to have endorsed "significant PTSD." He is described as in "no apparent distress" and "calm" and is prescribed Prazosin for "PTSD and nightmares" and Mirtazapine for "depression/anxiety."

    b. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated July 24, 2023, Mr. Smith is noted to have "anx" (i.e. Anxiety) as a symptom.

    c. On Page 3 of the August 2, 2023 MENTAL HEALTH MULTIDISCIPLINARY TREATMENT PLAN, it is noted, "He however appears to be quite fixated on his experience of November 2023." (It appears that this is an error and that the clinicians were referring to November 2022 because above this, under "Recent stressful/traumatic event", "failed execution" is listed.)

    d. On Page 3 of the August 2, 2023 MENTAL HEALTH MULTIDISCIPLINARY TREATMENT PLAN, it is noted, "Continues to have intrusive thoughts and nightmares."

    e. On Page 4 of the August 2, 2023 MENTAL HEALTH MULTIDISCIPLINARY TREATMENT PLAN, it is noted, that Mr. Smith has "Depression/anxiety" and the goal is to "Reduce overall symptoms"

    f. The August 2, 2023 PROGRESS NOTE stated: "Since then he has experienced frequent nightmares and frequent intrusive thoughts."

    g. The August 2, 2023 PROGRESS NOTE stated: "He was very tearful."

    h. The August 2, 2023 PROGRESS NOTE stated: "His recent experience has greatly increased his experience of fear and agitation."

i. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated August 9, 2023, Mr. Smith is noted to say, "I'm getting very anxious," and "nightmares" are noted.

j. In a document entitled PSYCHIATRIST/CRNP PROGRESS NOTE, dated September 5, 2023, it is noted "No symptoms reported but nightmares."

12. **EXPERIENCE OF TERROR AND PAIN DURING THE EXECUTION***:* There are references to Mr. Smith's experience of the failed execution that describe him as suffering pain and intense fear during the events. This is consistent with my findings in my evaluation of Mr. Smith and reported in my November 17, 2023 report.

a. The August 2, 2023 MENTAL HEALTH MULTIDISCIPLINARY TREATMENT PLAN documented that Mr. Smith's experience in the attempted execution is consistent with my findings about his experience. Specifically, it is noted: "Execution officials attempted his execution and the attempt failed. Mr. Smith suffered intense pain and [unintelligible] for a number of hours."

b. The PROGRESS NOTE dated August 2, 2023 stated: "Although the execution failed, Mr. Smith [sic] four hours of pain and intense fear."

13. **SUMMARY**: The above information confirms that the conclusions of the mental health practitioners at Alabama DOC are consistent with my conclusions, garnered over 36 hours of evaluation of Mr. Smith. Specifically, the Alabama DOC mental health clinicians working with Mr. Kenneth Smith reached the same conclusions regarding:

a. Diagnosis of Mr. Smith with PTSD and major depression (they qualified this as a rule/out)
b. The onset of Mr. Smith's condition of PTSD and major depression was after the experience of the failed execution in November 2022.
c. Mr. Smith's symptoms of PTSD and depression include: anxiety, tearfulness, intrusive thinking, nightmares.
d. Mr. Smith's experience during the failed execution itself included several hours of intense pain and fear.

I am available to review further information if it becomes available.

Dated this 15th day of December, 2023.

Katherine Porterfield, Ph.D.

Licensed Psychologist
New York State License number 014105-1

EXHIBIT 1

Alabama Department of Corr[illegible]s

[illegible]NTAL HEALTH: MULTIDISIPLINARY TREATMENT PLAN

Patient Name: Smith, Kenneth			
AIS #	2512	MH Code B	Date Plan Initiated: 8/2/23
D.O.B.	07/04/65	Date of Last Master Treatment Plan	7/26/22
Date Entered ADOC	11/14/89	Date Admitted Treatment Unit or Level	
Min Release Date	N	Date Added to Caseload	7/26/22
EOS Date	N	MHP Assignment	MBrewer, Ph.D, LP
		Housing Assignment	BR
		Security Level	7

Diagnosis (DSM-5)	SMI: Yes No	IVM: Yes No	Date of Onset
PTSD		X	11/22
Depression			11/22
Unspecified Anxiety			
Primary Medical Diagnoses			

Assigned Treatment Team present at this meeting:

STAFF	NAME (Print)	SIGNATURE	ATTENDED MEETING	REVIEWED NOTES	DATE REVIEWED
Psychiatrist/ CRNP	PPolanco MD	@Polanco MD	Mandatory*	(Y) N	8/2/23
QMHP**	MBrewer PhD, LPC	MBrewer Ph.D, LPC	Mandatory*	(Y) N	8/2/23
Psychologist			Y N	Y N	
MH Nurse	Atwell, Lpn	Atwell, Lpn	Y (N)	(Y) N	8-2-23
Activity Technician			Y N	Y N	
ADOC Officer			Y N	Y N	
Medical			Y N	Y N	
Other	TWyatt	TWyatt	(Y) N	Y N	8223
Inmate/ Patient ***	Kenneth Smith		(Y) N	N/A	8/2/23

*If the mandatory attendees cannot attend, must reschedule treatment plan for the next available time, and reason documented.

**The QMHP serves as the treatment team coordinator and MUST complete a progress note to include: date of meeting, attendees, issues discussed, any changes to the plan.

*** "No" requires a progress note indicating reason and the portion of the meeting the inmate/patient did not attend.

Non-mandatory members who did not attend the meeting are required to review the notes immediately, then time, date and sign above when you reviewed the notes.

If inmate has refused attendance at this Treatment Team meeting, QMHP completes the following section.

Inmate Name: Smith, Kenneth	AIS #: 2512	DOB: 7/4/65
Housing/Program Level: Intake GP RHU WR SLU RTU1 RTU2 RTU3 SU Crisis Cell PSU		Facility: Holman

Alabama Department of Corrections

MENTAL HEALTH: MULTIDISIPLINARY TREATMENT PLAN

ate Name: Smith, Kenneth	AIS #: 2512	Date of Team Meeting: 8/2/23
usal notification provided by (Name, sition, Date Notified):		
IHP Sign & Date: *signature confirms that the inmate specified ove has declined to participate in this Treatment am Meeting.*	Signature	Date Signed

urrent Treatment Level: pecify by marking "X" in box to left)	Current Plan Date	Update Frequency	Date Next Update Due
Suicide Watch		Daily	
MH Observation		Daily	
Stabilization Unit		Every 3 days	
RTU level 1		Every 7 days	
RTU level 2		Every 14 days	
RTU level 3		Every 30 days	
Structured Living Unit (SLU)		Every 90 days	
Outpatient		Every 6 months	

Complete a new Master Treatment Plan if any of the following occur:

- Movement into and/or out of Suicide Watch, MHO, RHU, the SU, the RTU, SLU, and return from outside psychiatric hospitalization.
- Any Change of Mental Health Code (e.g. MH-B to MH-C)
- Any change of level for Suicide Watch or RTU placement (e.g., ASW to NASW; or RTU Level 1 to RTU Level 2).
- If the Inmate is a candidate for IVM
- If there was Emergency Administration of Psychiatric Medications
- Clinical decision to discontinue ALL Mental Health Medications.
- Change in the Primary Mental Health Diagnosis of the Inmate

Deadlines for Finalization of new Master Treatment Plans (all signatures & updates):

14 Calendar Days for anyone added to the Mental Health caseload
3 Working Days* of SLU Placement and release from SLU
3 Working Days* of RTU Placement
3 Working Days* of RHU Placement and release from RHU
2 Working Days* of SU Placement
2 Working Days* of Return from Outside Psychiatric Hospital
2 Working Days* of Release from Crisis Placement (MHO, ASW, NASW)
1 Working Day* of Crisis Placement (MHO, ASW, NASW)
(* Working Day is defined as any day that vendor staff are required to work.)

Mark ("X") which of the following areas were reviewed and provide relevant comments:

Inmate Name: Smith, Kenneth	AIS #: 2512	DOB: 7/4/65
Housing/Program Level: Intake GP RHU WR SLU RTU1 RTU2 RTU3 SU Crisis Cell PSU		Facility: Holman

Alabama Department of Corrections

MENTAL HEALTH: MULTIDISIPLINARY TREATMENT PLAN

	Progress Notes Reviewed:	8/2/23
	Out-of-Cell or Out-of-Housing-Unit Activity Participation:	Patient engages in out of cell activities.
	Out-of-Cell Group therapy participation (Group and frequency):	
	Medication Adherence (if nonadherent, list counseling dates):	
	Crisis Placement (dates, duration):	
	Disciplinary Actions (behavior and sanction):	
	Recent Stressful/Traumatic Event (PREA, loss/death, family concerns, sentence, etc.):	Failed execution

Treatment Team Discussion Notes:

Patient was alert oriented X4. He, however, appears to be quite fixated on his experience of November 2023. He told his story and seemed to have some relief by telling. Executive officials attempted his execution, and the attempt failed. Mr. Smith suffered intense pain and despair for a number of hours. He continues to have intrusive thoughts and nightmares.

MASTER PROBLEM LIST:

Goal = Mutually agreed-upon long-term treatment outcome in objective, measurable terms.	**Intervention** = Specific tasks to address objectives, specifying frequency and duration.
Objective = Specific, short-term outcome expected to be able to reach goal.	**Responsible Staff** = Individuals responsible for ensuring treatment tasks are made available for the inmate to participate.

**Add additional problem list pages if necessary.

Inmate Name: Smith, Kenneth	**AIS #:** 2512	**DOB:** 7/4/65
Housing/Program Level: Intake GP RHU WR SLU RTU1 RTU2 RTU3 SU Crisis Cell PSU		**Facility:** Holman

Alabama Department of Corrections

MENTAL HEALTH: MULTIDISIPLINARY TREATMENT PLAN

Problem #1U Depression / Anxiety	Dates: Date Added	Target Date	Date Goal Achieved
Goal: Reduce overall symptoms	8/2/23		
Objective (a): Maintaining appropriate affect, thought			
Intervention: Group therapy, individual therapy			
Responsible Staff: M Brewer PhD, LPC			
Objective (b): Patient will identify two healthy reasons for not using substances.			
Intervention:			
Responsible Staff:			
Anticipated barriers and strategies to resolve:			

Problem #	Dates: Date Added	Target Date	Date Goal Achieved
Goal:			
Objective (a):			
Intervention: Group therapy, individual therapy			
Responsible Staff: M Brewer, PhD, LPC			
Objective (b):			
Intervention:			
Responsible Staff:			
Anticipated barriers and strategies to resolve:			

Inmate Name: Smith, Kenneth	AIS #: 256120	DOB: 7/4/65
Housing/Program Level: Intake GP RHU WR SLU RTU1 RTU2 **RTU3** SU Crisis Cell PSU		Facility: Holman

Alabama Department of Corrections

MENTAL HEALTH CODING FORM

Circle MH Code Below:		Indicators:
MH-A	Not on caseload	Indicates that the inmate is not currently receiving ongoing mental health services and is not on the caseload.
MH-B	Outpatient (Major/CWC/ WR)	Indicates that the inmate requires outpatient mental health services at intervals of ninety (90) to one-hundred twenty (120) days as designated by the provider. Inmate should demonstrate appropriate coping skills for period of six (6) months. The Psychiatrist at his/her discretion can permit an MH-B to be housed in facilities that do not provide daily on-site mental health staff.
MH-C	Outpatient (Major Facility)	Indicates that the inmate requires outpatient mental health services at intervals of thirty (30) to sixty (60) days, have any diagnosed mental disorder (excluding substance use disorders) currently associated with an impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and must be housed in facilities that provide daily on-site coverage by mental health.
MH-D	Residential	Indicates that the inmate is receiving chronic or acute mental health services due to psychological, cognitive or behavioral functioning that substantially interferes with the inmate's ability to meet the ordinary demands of living. Requires placement in a specialized mental health housing unit.

DSM 5 Diagnosis: adj Dis/PTSD r/o MDD

SMI Designation – Per Policy MH E-04 (a): ☐ Yes ☑ No

Comments:

Psychiatrist or Nurse Practitioner (Print):

Signature: Solanco MD **Date:** 11/25/23

Smith, Kenneth | Z-512 | Holman

Inmate Name | **AIS#** | **Facility**

Alabama Department of Corrections

MENTAL HEALTH: MULTIDISIPLINARY TREATMENT PLAN

Inmate Name: Smith, Kenneth | MH Code: B | Date Plan Initiated: 07/26/22

AIS #	Z 512	Date of Last Master Treatment Plan	N/A
D.O.B.	07/04/65	Date Admitted Treatment Unit or Level	
Date Entered ADOC	11/14/89	Date Added to Caseload	07/26/22
Min Release Date	N/A	MHP Assignment	D. Beech, Ph.D.
EOS Date	N/A	Housing Assignment	DR
		Security Level	7

Diagnosis (DSM-5) SMI: Yes (No) IVM: Yes (No) Date of Onset

Primary Medical Diagnoses Date of Onset

Assigned Treatment Team present at this meeting:

STAFF	NAME (Print)	SIGNATURE	ATTENDED MEETING	REVIEWED NOTES	DATE REVIEWED
Psychiatrist/ CRNP	Polanco MD	Polanco MD	Mandatory*	Y N	
QMHP**	D. Beech, Ph.D.	D. Beech PhD	Mandatory*	Y N	
Psychologist	D. Beech, Ph.D.	D. Beech PhD	Y N	Y N	
*If the mandatory attendees cannot attend, must reschedule treatment plan for the next available time, and reason documented.					
MH Nurse	S. O'Barr, Lpn	S. O'Barr, Lpn	Y N	Y N	
Activity Technician			Y N	Y N	
ADOC Officer			Y N	Y N	
Medical			Y N	Y N	
Other			Y N	Y N	
Inmate/ Patient ***	Kenny Smith		Y N	N/A	

- **The QMHP serves as the treatment team coordinator and MUST complete a progress note to include: date of meeting, attendees, issues discussed, any changes to the plan.
- *** "No" requires a progress note indicating reason and the portion of the meeting the inmate/patient did not attend.
- Non-mandatory members who did not attend the meeting are required to review the notes immediately, then time, date and sign above you reviewed the notes.

Alabama Department of Corrections

MENTAL HEALTH: MULTIDISIPLINARY TREATMENT PLAN

If inmate has refused attendance at this Treatment Team meeting, QMHP completes the following section.

Inmate Name:	AIS #:	Date of Team Meeting:
Refusal notification provided by (Name, Position, Date Notified):		
QMHP Sign & Date: *My signature confirms that the inmate specified above has declined to participate in this Treatment Team Meeting.*	Signature	Date Signed

Current Treatment Level: (specify by marking "X" in box to left)		Current Plan Date	Update Frequency	Date Next Update Due
	Suicide Watch		Daily	
	MH Observation		Daily	
	Stabilization Unit		Every 3 days	
	RTU level 1		Every 7 days	
	RTU level 2		Every 14 days	
	RTU level 3		Every 30 days	

Complete a new Master Treatment Plan if any

- Movement **into and/or out of** Suicide Watch, MHO, RHU, the SU, the RTU, SLU, and return from outside psychiatric hospitalization.
- Any Change of Mental Health Code (e.g. MH-B to MH-C)
- Any change of level for Suicide Watch or RTU placement (e.g., ASW to NASW; or RTU Level 1 to RTU Level 2).
- If the Inmate is a candidate for IVM
- If there was Emergency Administration of Psychiatric Medications
- Clinical decision to discontinue ALL Mental Health Medications.
- Change in the Primary Mental Health Diagnosis of the Inmate

Deadlines for Finalization of new Master Treatment Plans (all signatures & updates):

14 Calendar Days for anyone added to the Mental Health caseload
3 Working Days* of SLU Placement and release from SLU
3 Working Days* of RTU Placement
3 Working Days* of RHU Placement and release from RHU
2 Working Days* of SU Placement
2 Working Days* of Return from Outside Psychiatric Hospital
2 Working Days* of Release from Crisis Placement (MHO, ASW, NASW)
1 Working Day* of Crisis Placement (MHO, ASW, NASW)
(* Working Day is defined as any day that vendor staff are required to work.)

nmate Name: Smith, Kenneth	AIS #: Z512	DOB: 07/04/65
ıusing/Program Level: DR		Facility: Holman

Alabama Department of Corrections

MENTAL HEALTH: MULTIDISIPLINARY TREATMENT PLAN

MASTER PROBLEM LIST:

Goal = Mutually agreed-upon long-term treatment outcome in objective, measurable terms.	**Intervention** = Specific tasks to address objectives, specifying frequency and duration.
Objective = Specific, short-term outcome expected to be able to reach goal.	**Responsible Staff** = Individuals responsible for ensuring treatment tasks are made available for the inmate to participate.

**Add additional problem list pages if necessary.

Problem #1Depression/Anxiety	Dates		
	Date Added	Target Date	Date Goal Achieved
Goal: Pt will report depression and anxiety symptoms of no greater than 4/10 for the next 180 days	07/26/22	01/26/~~22~~ 23	
Objective (a): Pt will identify three triggers to depression	07/26/22	01/26/~~22~~ 23	
Intervention: Encourage sharing feelings of depression and anxiety in order to clarify them and gain insight as to the triggers (including novel triggers) for these feelings in monthly individual therapy session/group			
Responsible Staff: MHP/Psychologist/CRNP/Psychiatrist			
Objective (b): Pt will identify three effective coping skills to prevent anxiety/ depression; Medication compliance	07/26/22	01/26/~~22~~ 23	
Intervention: Assist pt in development of coping strategies for feelings of depression and anxiety and identify any novel coping skills during monthly individual counseling sessions/group. Education of the importance of medication compliance			
Responsible Staff: MHP/Psychologist/CRNP/Psychiatrist			
Problem resolution or barriers to achieving goal (describe): No known barriers			

Inmate Name: Smith, Kenneth	**AIS #: Z512**	**DOB:07/04/65**
Housing/Program Level: DR		**Facility: Holman**

Alabama Department of Corrections

MENTAL HEALTH: MULTIDISIPLINARY TREATMENT PLAN

Mark ("X") which of the following areas were reviewed and provide relevant comments:

X	**Progress Notes Reviewed:**	See summary below
X	**Out-of-Cell or Out-of-Housing-Unit Activity Participation:**	Pt engages in all unit activities
X	**Out-of-Cell Group therapy participation (Group and frequency):**	Pt assists in running courses on unit/ will join group when on caseload
X	**Medication Adherence (if non-adherent, list counseling dates):**	N/A
X	**Crisis Placement (dates, duration):**	None known
X	**Disciplinary Actions (behavior and sanction):**	None known
	Recent Stressful/Traumatic Event (PREA, loss/death, family concerns, sentence, etc.):	Pt will potentially be given an execution date within the next month

Treatment Team Discussion Notes:

Inmate Name: Smith, Kenneth	**AIS #: Z512**	**DOB: 07/04/65**
Housing/Program Level: DR		**Facility: Holman**

Alabama Department of Corrections

MENTAL HEALTH CODING FORM

Circle MH Code Below:		Indicators:
MH-A	Not on caseload	Indicates that the inmate is not currently receiving ongoing mental health services and is not on the caseload.
MH-B	Outpatient (Major/CWC/ WR)	Indicates that the inmate requires outpatient mental health services at intervals of ninety (90) to one-hundred twenty (120) days as designated by the provider. Inmate should demonstrate appropriate coping skills for period of six (6) months. The Psychiatrist at his/her discretion can permit an MH-B to be housed in facilities that do not provide daily on-site mental health staff.
MH-C	Outpatient (Major Facility)	Indicates that the inmate requires outpatient mental health services at intervals of thirty (30) to sixty (60) days, have any diagnosed mental disorder (excluding substance use disorders) currently associated with an impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living and must be housed in facilities that provide daily on-site coverage by mental health.
MH-D	Residential	Indicates that the inmate is receiving chronic or acute mental health services due to psychological, cognitive or behavioral functioning that substantially interferes with the inmate's ability to meet the ordinary demands of living. Requires placement in a specialized mental health housing unit.

DSM 5 Diagnosis: R/O Adjustment D/O ; SUD in Sustained Remission

SMI Designation – Per Policy MH E-04 (a): ☐ Yes ☒ No

Comments:

Psychiatrist or Nurse Practitioner (Print): P. Polanco, MD

Signature: Polanco MD **Date:** 7/19/22

Smith, Kenneth — **Inmate Name**

2512 — **AIS#**

Holman — **Facility**

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

PROGRESS NOTES

DATE	
	October 4, 2023
	Group Mental Health Therapy
	Leader: M. Brewer, PhD, LPC
	Name of Group: Foundations of Recovery
	Group therapy was cancelled today by the DOC due to staffing shortage. There was no one to accompany counselor to the group. This group session will be rescheduled as soon as possible.
	M. Brewer, PhD, LPC

INMATE NAME	AIS #	INSTITUTION
Lewis, Kenneth	2512	Holman

Disposition: Inmate Medical Record

Reference: ADOC AR: 604, 613, 614, 616, 622, 623, 627, 634, 628, 632, 633, 635, 638
ADOC Form MH-040 – Revised May 14, 2008

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems:

No symptoms reported

Medications: Buspar 15mg PO BID
Remeron 45mg qhs

Adherence?

Labs:

Weight/BMI: #227

AIMS (Date): NA

Consents (Date): due 12/2023

S/ No concerns re: my medications
PE denies SI/HI

O/

Appearance/behavior: Well groomed

Thought: Logical, goal directed

Cognition: Alert & Oriented

Perception: No hallucinations reported

Speech: Coherent

Insight/Judgment: Fair

Mood/affect: Euthymic

Harm to self/others: PE denies

A/ (Use DSM-5; Include differential diagnosis)

Adj Dis
PTSD r/o ADHD

P/

Labs were discussed
Ct present.

Return in: 60d **Physician/CRNP:** (Print) Polanco MD **Sign:** Polanco MD

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 10/4/23 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A (B) C D **SMI:** Y (N)

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	Z-512	7-4-65	WM	Holman

Alabama Department of Corrections
Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: No symptoms reported but night-mare.

Medications: Buspar 15 mg BID
Remeron 45 mg q hs

Adherence?

Labs:	**AIMS** (Date)	**Consents** (Date)
Weight/BMI: #223	Na	due 12/2023

S/ "I'm good c medication" but I still has nightmare."

O/ Pt denies SI/HI

Appearance/behavior: neat appropiate	Thought: Logical
Cognition: alert/oriented	Perception: No hallucination
Speech: coherent	Insight/Judgment: fair
Mood/affect: Mild anx	Harm to self/others: Pt denies

A/ (Use DSM-5; Include differential diagnosis)
PTSD, r/o MDD, adj Res
Subst use dis

P/ Cont present

Return in: 30d **Physician/CRNP:** (Print) Polanco MD **Sign:** Polanco MD

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 9/5/23 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A (B) C D **SMI:** Y (N)

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	Z512	7-4-65	WM	Holman

Alabama Department of Corrections

PROGRESS NOTES

(One note per sheet)

Date: 8/23/23	**Purpose:** Group Therapy	**MH Code:** B
Start Time: 2:30 PM	**Location:** Holman	**SMI:** ☐ Y ☒ N
End Time: 2:30 PM	**Confidential Location:** ☐ Y ☐ N **If No, explain:**	

Due to the fact patient refused therapy today. He also would not sign refusal slip. Patient will be rescheduled.

M. Brewer, Ph.D., LPC

INMATE NAME	AIS #	FACILITY
Smith, Russell	2572	Holman

YesCare
Say Yes to Exceptional Care

Informed Consent for Psychotropic Medication

DEMOGRAPHICS

Patient Name: Smith, Kenneth	AIS #: 7512
Facility: Holman	Date of Birth: 7-4-65
Location: DR	Sex: ☑ Male ☐ Female

MEDICATION

Medication Class	Medication	Dosage Range
Anxiolytic (Buspirone)	Buspar	15 mg po BID

REASON FOR USE OF PSYCHOTROPIC MEDICATION AND BENEFITS EXPECTED

Mental health disorder/diagnosis:

Patient education provided regarding:

- ☑ Nature of diagnosis, symptoms/signs for which medication(s) are prescribed
- ☑ Anticipated response to medication
- ☐ Alternative treatment options
- ☑ Type of medication, amount, frequency and route of administration and duration of treatment

BENEFITS

Benefits of taking the proposed medication are: (Check all that apply)

- ☑ Reduction in Symptoms:
- ☑ Improvement in Function
- ☐ Other benefits:

RISKS

Potential side effects associated with taking this medication include: (Check all that apply)

- ☐ Psychiatric:
- ☐ Neuro:
- ☐ Movement Related:
- ☑ GI: diarrhea, nausea
- ☑ Other: drowsiness, headache, fatigue, insomnia, blurred vision, nervousness
- ☐ Skin/Derm:
- ☐ Blood/Bone Marrow:
- ☐ Urogenital/Sexual:
- ☐ Musculoskeletal:

SIGNATURES

I have received verbal advisement and information for the medications prescribed. I understand the risks and benefits. I agree at this time to take the medication(s) and have had the alternatives explained to me. I understand that I may withdraw my consent at any time by informing any member of the medical/mental health staff.

Patient Signature X Kenneth Smith	Date 8-9-23
Provider Signature S Flanagan	Date 8-9-23

REFUSAL

My signature indicates that I understand the purpose of this medication, the benefits I may gain from taking it, the potential side effects and risks, and any alternative treatments. I also understand that I should discuss any questions or concerns with the doctor or nurse practitioner who prescribed this medicine At this time, I refuse to take the medication prescribed for me.

atient Signature	Date
Provider Signature	Date

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Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: anx
Worry, frustrated
Night Mare

Medications: Remeron 45 mg HS

Adherence?

Labs:

Weight/BMI: # 224

AIMS (Date) NA

Consents (Date) due 12/2023

S/ "I'm getting very anx"
"Night Mare"

O/ Denies SI/HI

Appearance/behavior: Neat appropriate	Thought: Logical
Cognition: alert oriented	Perception: Denies hallucinations
Speech: Coherent	Insight/Judgment: Fair
Mood/affect: anx	Harm to self/others: Denies

A/ (Use DSM-5; Include differential diagnosis) adj dis
PTSD, r/o MDD

P/ Start Buspar 15 mg BID
Remeron 45 mg HS

Return in: 30d **Physician/CRNP:** (Print) Blanco MD **Sign:** Blanco MD

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 8/9/23 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A B C D **SMI:** Y N

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	75172	7.4.65	WM	Holman

YesCare
Say Yes To Exceptional Care

Mental Health Group Progress Note

DEMOGRAPHICS

Facility Name: Holman Today's Date: 8/2/23 Time Seen: 9:00 ☑ AM ☐ PM

Inmate Name: Smith, Kendrick ID Number: Z512

Group Confidentiality Signed: ☐ Yes ☐ No Date of Birth: Sex: ☑ Male ☐ Female

GROUP INFORMATION/SESSION NUMBER

Title: Foundations of Character Topic: Kindness

☐ Session number: 4 of 5 or ☐ Ongoing

CLINICAL ASSESSMENT & GROUP PARTICIPATION

Subjective: (Inmate Comments) Patient was positive and participated in group.

Objective: Orientation: ☑ Person, Place, Time, Situation ☐ Other:

Mood / Affect: ☑ Stable affect/Mood ☐ Other:

Speech: ☑ Unremarkaable ☐ Other:

Hygiene: ☐ Adequate Grooming ☐ Other:

Cognition/Thoughts: ☐ Logical/Goal Directed ☐ Other:

Other:

Assessment: ☑ Stable ☐ Shows Progress ☐ Treatment Resistant ☐ Unstable

Quality of Participation: ☐ Participates Appropriately ☐ Disruptive ☐ Other:

Diagnosis:

Plan: ☑ Admit/Continue in Group ☐ Referral for Other Services-/specify:

☐ Terminate from Group-

Comments: Patient participated well in group. He seemed to be thinking and learning from the experience.

M. Brewer, Ph.D. LPC
Behavioral Health Staff Signature

332a

M. Brewer, Ph.D., LPC
Name/Title (Print/Stamp)

Alabama Department of Corrections

PROGRESS NOTES

(One note per sheet)

Date: 8/2/23	Purpose: Treatment Plan Meeting	MH Code: B
Start Time: 9:15 Am	Location:	SMI: ☐ Y ☐ N
End Time: 9:30 Am	Confidential Location: ☐ Y ☐ N If No, explain:	

Mr. Smith was seen this date in a confidential setting. A corrections officer was stationed outside of the counseling room.

Mr. Smith indicated a desire to continue his MH treatment. In November 2022 Mr. Smith underwent an attempted execution. Although the execution failed, Mr. Smith has bouts of pain and intense fear. Since then he has experienced frequent nightmares and frequent intrusive thoughts. Patient is compliant with his medications.

Patient was alert and ~~oriented~~ oriented to his situation. He was very tearful, but seemed to appreciate talking to someone who was trained to hear and give appropriate responses.

Patient is a white male who has been on death row for several decades. He recent experience has greatly increased his experience of fear and agitation

Encouraged patient to continue medication, church, and therapy groups. Will see him in a month. Dr. P. Palmer MD Psychiatrist
Dr. M. Brewer PhD.
Dr. Quarker-Smith
Nurse Wells, LPN

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	256712	Holman

Alabama Department of
Corrections

PROGRESS NOTES

(One note per sheet)

Date: 7/31/2023	Purpose: Individual Therapy Session	MH Code: B
Start Time: 10:15am	Location: KLM COMMUNITY	SMI: ☐ Y ☑ N
End Time: 10:15am	Confidential Location: x☐ Y ☐ N If No, explain:	

Patient refused clinical services on this date with the provider. Patient will be rescheduled to be seen with one of the providers in the Mental Health Department.

Teresa L. Quarker Smith, PhD, LPC
Behavioral Healthcare Director
Holman Correctional Facility

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	**Z512**	**Holman**

ADOC – Office of Health Services
08032020
Printed Front ONLY on Blue Paper

Reference: ADOC AR: 604, 613, 614, 616, 622, 623, 627, 634, 628, 632, 633, 635, 638
ADOC Form MH-040
Disposition: Inmate Health Record

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: anx

Medications: Remeron 45 mg q hs
Minipress 2mg q hs

Adherence?

Labs:

Weight/BMI: # 225

AIMS (Date): NC

Consents (Date): due 12/2023

S/ "My friend was executed last wks"

O/

Appearance/behavior: Pleasant, cooperative

Cognition: alert, oriented

Speech: coherent

Mood/affect: sad

Thought: Logical

Perception: NO hallucination

Insight/Judgment: fair

Harm to self/others: Pt denies

A/ (Use DSM-5; Include differential diagnosis)

adjus d/o
PTSD, r/o MDD

P/

Cont present Rx
Pt will be referred to the therapist

Return in: 2 WK **Physician/CRNP:** (Print) P. Balancon **Sign:** P. Balancon

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 7/24/23 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A (B) C D **SMI:** Y (N)

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	2512	7-4-65	W/M	Holman

Alabama Department of Corrections

PROGRESS NOTES

(One note per sheet)

Date: 07/10/2023	**Purpose: MONTHLY-Individual Therapy Session**	**MH Code:** B
Start Time: 4:00 pm	**Location: Shift Office**	**SMI:** ☐ Y ☑ N
End Time: 4:15 pm	**Confidential Location:** x☐ Y ☐ N **If No, explain:**	

(S) Pt was seen on this date in a confidential setting for individual therapy session. Patient denied any SI/HI on this date. Patient also did not present with any current clinical symptoms. Patient did not need any additional interventions on this date.

(O)Patient was alert, 0x4, and cooperative. WNLS, depressed mood congruent with affect. His thought process linear. Patient denied any SI/HI.

(A) Patient is a male with a MH diagnosis. Patient is following all treatment recommendations as outlined within his treatment plan. Patient appeared to understand all information shared within this session.

(P) MHP continued to assist patient in identifying ways in which he can continue to make progress on his goals as outlined within his treatment plan. Patient will continue to be seen per the established protocol for patients on the mental health caseload monthly. Individual therapy sessions will resume as needed.

Teresa L. Quarker Smith, PhD, LPC
Behavioral Healthcare Director

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	252	**Holman**

ADOC – Office of Health Services
08032020
Printed Front ONLY on Blue Paper

Reference: ADOC AR: 604, 613, 614, 616, 622, 623, 627, 634, 628, 632, 633, 635, 638
ADOC Form **MH-040**
Disposition: Inmate Health Record

Alabama Department of
Corrections

PROGRESS NOTES

(One note per sheet)

Date: 06/13/2023	Purpose: MONTHLY-Individual Therapy Session	MH Code: B
Start Time: 3:15pm	Location: Shift Office	SMI: ☐ Y ☑ N
End Time: 3:30 pm	Confidential Location: x☐ Y ☐ N If No, explain:	

(S) Pt was seen on this date in a confidential setting for individual therapy session. Patient denied any SI/HI on this date. Patient also did not present with any current clinical symptoms. Patient did not need any additional interventions on this date.

(O)Patient was alert, 0x4, and cooperative. WNLS, depressed mood congruent with affect. His thought process linear. Patient denied any SI/HI.

(A) Patient is a male with a MH diagnosis. Patient is following all treatment recommendations as outlined within his treatment plan. Patient appeared to understand all information shared within this session.

(P) MHP continued to assist patient in identifying ways in which he can continue to make progress on his goals as outlined within his treatment plan. Patient will continue to be seen per the established protocol for patients on the mental health caseload monthly. Individual therapy sessions will resume as needed.

Teresa L. Quarker Smith, PhD, LPC
Behavioral Healthcare Director

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	2512	Holman

ADOC – Office of Health Services
08032020
Printed Front ONLY on Blue Paper

Reference: ADOC AR: 604, 613, 614, 616, 622, 623, 627, 634, 628, 632, 633, 635, 638
ADOC Form MH-040
Disposition: Inmate Health Record

Alabama Department of Corrections

PROGRESS NOTES

(One note per sheet)

Date: 05/16/2023	Purpose: MONTHLY-Individual Therapy Session	MH Code: B
Start Time: 3:15pm	Location: Shift Office	SMI: ☐ Y ☑ N
End Time: 3:30pm	Confidential Location: x☐ Y ☐ N If No, explain:	

(S) Pt was seen on this date in a confidential setting for individual therapy session. Patient denied any SI/HI on this date. Patient also did not present with any current clinical symptoms. Patient did not need any additional interventions on this date.

(O)Patient was alert, 0x4, and cooperative. WNLS, depressed mood congruent with affect. His thought process linear. Patient denied any SI/HI.

(A) Patient is a male with a MH diagnosis. Patient is following all treatment recommendations as outlined within his treatment plan. Patient appeared to understand all information shared within this session.

(P) MHP continued to assist patient in identifying ways in which he can continue to make progress on his goals as outlined within his treatment plan. Patient will continue to be seen per the established protocol for patients on the mental health caseload monthly. Individual therapy sessions will resume as needed.

Teresa L. Quarker Smith, PhD, LPC
Behavioral Healthcare Director

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	2512	Holman

ADOC – Office of Health Services
08032020
Printed Front ONLY on Blue Paper

Reference: ADOC AR: 604, 613, 614, 616, 622, 623, 627, 634, 628, 632, 633, 635, 638
ADOC Form MH-040
Disposition: Inmate Health Record

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: Depression, PTSD.

Pt reports his initial execution was "botched" and now in court => Endorses significant PTSD

Medications: Prozac 10 mg P.O. QHS
Mirtazapine 45 mg P.O. QHS

Adherence? Compliant

Labs:

Weight/BMI:

AIMS (Date):

Consents (Date):

S/ "I've been on the meds for so long they are not working." "The state botched my execution and now things are stressful."

O/ NAD apparent distress, calm
Appearance/behavior: well groomed, cooperative
Cognition: A&O x3 person, place, time
Speech: Clear, normal tone, rate
Mood/affect: Euthymic, Full range
Thought: Linear, goal directed
Perception: Denies AVH / delusions
Insight/Judgment: Good
Harm to self/others: Denies SI / HI

A/ (Use DSM-5; include differential diagnosis) R.O. MDD, recurrent, moderate
PTSD
Adjustment DO.

PI/ Increase Prazosin to 2mg P.O. QHS: PTSD nightmares
Continue Mirtazapine 45 mg P.O. QHS: Depression/anxiety
RTC in 90 days

Return in: 90 **Physician/CRNP: (Print)** Roland Maldonado DNP **Sign:** R Maldonado, DNP

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 7/4/23 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A (B) C D **SMI:** Y (N)

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	7512	57		Holman

PROGRESS NOTES

(One note per sheet)

Date: 04/11/2023	Purpose: MONTHLY-Individual Therapy Session	MH Code: B
Start Time: 4:00 pm	Location: Shift Office	SMI: ☐ Y ☑ N
End Time: 4:15 pm	Confidential Location: x☐ Y ☐ N If No, explain:	

(S) Pt was seen on this date in a confidential setting for individual therapy session. Patient denied any SI/HI on this date. Patient also did not present with any current clinical symptoms. Patient did not need any additional interventions on this date.

(O)Patient was alert, 0x4, and cooperative. WNLS, depressed mood congruent with affect. His thought process linear. Patient denied any SI/HI.

(A) Patient is a male with a MH diagnosis. Patient is following all treatment recommendations as outlined within his treatment plan. Patient appeared to understand all information shared within this session.

(P) MHP continued to assist patient in identifying ways in which he can continue to make progress on his goals as outlined within his treatment plan. Patient will continue to be seen per the established protocol for patients on the mental health caseload monthly. Individual therapy sessions will resume as needed.

Teresa L. Quarker Smith, PhD, LPC
Behavioral Healthcare Director

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	2572	Holman

ADOC – Office of Health Services
08032020
Printed Front ONLY on Blue Paper

Reference: ADOC AR: 604, 613, 614, 616, 622, 623, 627, 634, 628, 632, 633, 635, 638
ADOC Form MH-040
Disposition: Inmate Health Record

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: anxs, + depress

Medications: Remeron 45mg q hs
Minipress 1mg q hs

Adherence?

Labs:
Weight/BMI: #215

AIMS (Date): NA

Consents (Date): due 12/2023

S/ I have less nightmare. Please continue my medication

O/

Appearance/behavior: Neat appropriate
Cognition: Oriented x3
Speech: Coherent
Mood/affect: anxs

Thought: Logical
Perception: No hallucination
Insight/Judgment: fair
Harm to self/others: SI/HI denies

A/ (Use DSM-5; Include differential diagnosis) Adj. Dis
Anxs mix dis

P/ Cont present tx

Return in: 30 days **Physician/CRNP:** (Print) Polanco MD Sign: Polancons

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 4/3/23 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A (B) C D **SMI:** Y (N)

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	Z512	7-4-65	WM	Holman

Wexford Health SOURCES INCORPORATED

Release of Responsibility Form

Name: Smith, Kenneth Date: 3-7-23 Time: _____

ID Number: Z512 DOB/Age: 7-4-65 /

I hereby refuse to accept the following treatment/recommendations:

MH Psychiatrist appt

I acknowledge I have been fully informed of, and understand the above treatment or recommendations and the risk(s) involved in refusing. I hereby release and agree to hold harmless Wexford Health Sources, Inc., its employees and its agents from all responsibility and ill effects which may result from this action.

X Kenn Smith — Inmate Signature

3-7-23 — Date/Time

Witness

3-7-23 — Date/Time

The aforementioned inmate has refused the listed medical treatment/recommendations and has refused to sign this form.

Witness

Witness

Witness

Witness

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems:		
Medications: Remeron 45 mg q hs, Minipress 1mg q hs,		
Adherence?		
Labs: Weight/BMI:	AIMS (Date) N/A	Consents (Date) due 12/2023

S/

O/	
Appearance/behavior:	Thought:
Cognition:	Perception:
Speech:	Insight/Judgment:
Mood/affect:	Harm to self/others:

A/ (Use DSM-5; include differential diagnosis)
P/ Pt referred to be seen appt will be rescheduled

Return in:	Physician/CRNP: (Print) Polanco MD	Sign:
My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:		

Date: 3/7/23 Housing: GP RTU SU RHU SLU PSU WR MH Code: A (B) C D SMI: Y (N)

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	Z512	7-4-65	WM	Holman

Alabama Department of
Corrections

PROGRESS NOTES

(One note per sheet)

Date: 03/03/2023	Purpose: MONTHLY-Individual Therapy Session	MH Code: B
Start Time: 4:00pm	Location: Shift Office	SMI: ☐ Y ☑ N
End Time: 4:15pm	Confidential Location: x☐ Y ☐ N If No, explain:	

(S) Pt was seen on this date in a confidential setting for individual therapy session. Patient denied any SI/HI on this date. Patient also did not present with any current clinical symptoms. Patient did not need any additional interventions on this date.

(O)Patient was alert, 0x4, and cooperative. WNLS, depressed mood congruent with affect. His thought process linear. Patient denied any SI/HI.

(A) Patient is a male with a MH diagnosis. Patient is following all treatment recommendations as outlined within his treatment plan. Patient appeared to understand all information shared within this session.

(P) MHP continued to assist patient in identifying ways in which he can continue to make progress on his goals as outlined within his treatment plan. Patient will continue to be seen per the established protocol for patients on the mental health caseload monthly. MHP also spoke with patient in regards to participating in the groups as scheduled. Individual therapy sessions will resume as needed.

Teresa L. Quarker Smith, PhD, LPC
Behavioral Healthcare Director

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	2512	Holman

ADOC – Office of Health Services
08032020
Printed Front ONLY on Blue Paper

Reference: ADOC AR: 604, 613, 614, 616, 622, 623, 627, 634, 628, 632, 633, 635, 638
ADOC Form MH-040
Disposition: Inmate Health Record

Alabama Department of
Corrections

PROGRESS NOTES

(One note per sheet)

Date: 02/03/2023	Purpose: MONTHLY-Individual Therapy Session	MH Code: B
Start Time: 3:15pm	Location: Shift Office	SMI: ☐ Y ☑ N
End Time: 3:30pm	Confidential Location: x☐ Y ☐ N If No, explain:	

(S) Pt was seen on this date in a confidential setting for individual therapy session. Patient denied any SI/HI on this date. Patient also did not present with any current clinical symptoms. Patient did not need any additional interventions on this date.

(O)Patient was alert, 0x4, and cooperative. WNLS, depressed mood congruent with affect. His thought process linear. Patient denied any SI/HI.

(A) Patient is a male with a MH diagnosis. Patient is following all treatment recommendations as outlined within his treatment plan. Patient appeared to understand all information shared within this session.

(P) MHP continued to assist patient in identifying ways in which he can continue to make progress on his goals as outlined within his treatment plan. Patient will continue to be seen per the established protocol for patients on the mental health caseload monthly. Individual therapy sessions will resume as needed.

Teresa L. Quarker Smith, PhD, LPC
Behavioral Healthcare Director

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	2512	Holman

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: Anx, ↓ depression

Medications: Remeron 45 mg PO HS 10 days
Mini-Press 1 mg PO HS 10 days

Adherence?

Labs: **Weight/BMI:** #213.2	**AIMS (Date)** N/A	**Consents (Date)** due 12/2023

S/ "I have less night mare's & I sleep better" Cont my medication

O/ Pt denies SI/HI

Appearance/behavior: Well groomed	**Thought:** Logical Linear
Cognition: Oriented	**Perception:** NO hallucination
Speech: Coherent	**Insight/Judgment:** fair
Mood/affect: anx	**Harm to self/others:** Pt denies

A/ (Use DSM-5; Include differential diagnosis) Adjustment Dis
Substance use dis

P/ Cont present tx

Return in: 30d **Physician/CRNP: (Print)** Polanco MD **Sign:** Polancoms

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 2/2/23 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A B C D **SMI:** Y N

Patient Name: (Last, First)	**AIS#**	**Age**	**R/S**	**Facility**
Smith, Kenneth	Z512	11-4-65	WM	Holman

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: No symptoms reported

Medications: Remeron 45
Trazodone 200 mg

Adherence?

Labs:

Weight/BMI:

AIMS (Date)

Consents (Date) 12-6-22

S/ "I get stomach upset + diarrhea c Trazodone"
10 for sure"

O/ Pt denies SI/HI

Appearance/behavior: appropriate	Thought: Logical
Cognition: oriented x	Perception: Denies hallucination
Speech: Coherent	Insight/Judgment: Good
Mood/affect: Euthymic	Harm to self/others: Pt denies

A/ (Use DSM-5; Include differential diagnosis) Adj dis w mixed anx
Substance dis in sustained remission

P/ Cont Remeron 45 mg PO HS / Mirtazapine 15 mg PO HS
D/C Trazodone

Return in: 60d **Physician/CRNP:** (Print) Polanco MD **Sign:** Polanco MD

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 12/6/22 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A B C D **SMI:** Y N

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	2512	7-4-65		Holman

Informed Consent for Mental Health Medication

Inmate Name: Smith Kenneth Inmate Number: Z-512

Wexford Health

DOB: 7-4-65 Institution: Holman

MEDICATION: Prazosin DOSAGE RANGE: 1mg

PURPOSE AND BENEFITS: Treatment in post-traumatic stress-nightmares; Reduce the severity + frequency of nightmare sleep disturbances insomnia.

SIDE EFFECTS/RISKS OF THIS TREATMENT:
Change in Blood Pressure - dizziness, fainting, Headache tiredness, blurred vision, Nausea, vomiting, diarrhea, constipation frequent urination, ankle swelling, mood changes (depression) SOB.

RISKS OF REFUSING THIS TREATMENT include, but are not limited to: Continuation or worsening of your symptoms and distress, becoming violent towards others or yourself, and becoming less able to care for yourself. Other:

LENGTH OF CARE: The medication usually begins to act within _____. Reliable benefits require regular, long term usage. Your doctor may adjust the dosage during treatment, in most cases, to the minimum dosage that is needed. Your doctor may order laboratory tests from time to time to make sure that the medication is being administered properly and is not causing medical problems.

NOTIFICATION: Do not stop taking this medication without discussing it with your doctor. You have the right to stop taking this medication any time by notifying the doctor or mental health staff orally or in writing. If you decide to stop taking the medication, it will not affect your ability to receive other health care. For female inmates: Notify your physician if there is a possibility that you are pregnant.

I understand that by signing this form I am agreeing to be treated with this medication. Mental health staff have given me information about this treatment, including the reasons I am being treated and the information on this form. I have had a chance to ask any questions about my treatment I wished to ask. I understand that I can discuss any other questions I might have about my treatment with the doctor and that a signed copy of this form will be given to me.

Time/Date: 11/29/22 Inmate Signature: Kenneth Smith

Time/Date: 11/29/22 Prescribing Practitioner Signature: Polanco M
Name/Title Stamp

I have been advised to take this medication, but I am unwilling to take it as prescribed. The risks of not taking this medication have been explained to me.

Time/Date: _____ Inmate Signature: _____

Time/Date: _____ Prescribing Practitioner Signature: _____
Name/Title Stamp

Rev. 3/26/2018

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems:
anxiety
worry/frustrated, angered, + sleep
Nightmare

Medications: Remeron 30 Mg PO HS
Trazadone 150 Mg PO HS

Adherence?

Labs:

Weight/BMI:

AIMS (Date)

Consents (Date)

S/ "I'm very anx, I had nightmare"

O/ Pt denies SI/HI

Appearance/behavior: Neat/appropriate	Thought: Logical
Cognition: Alert/oriented.	Perception: No hallucination
Speech: Coherent	Insight/Judgment: fair
Mood/affect: anx	Harm to self/others: Pt denies

A/ (Use DSM-5; Include differential diagnosis) Adj. Dis
Subs. use dis

P/ ↑ Remeron ~~15~~ 45 Mg HS
↑ Trazadone 200 Mg HS
Mind spress 1 Mg PO HS

Return in: 7d **Physician/CRNP:** (Print) Polanco MD **Sign:** Polancoms

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 11/29/22 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A B C D **SMI:** Y N

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith Kenneth	2512	11-4-65	WM	Holman

Alabama Department of Corrections

Mental Health Referral Form

Inmate/Patient Information:

Name: [illegible] Smith	AIS#: 257
Facility: Ut Limon	Housing Unit:
Date of referral: 11/23/22	Time: 1300

Reason for Referral:

Anxiety (Muscle tension, Insomnia) 2° [illegible] execution

Person Making Referral: Huntington CMHP

Name: H. Huntington

Title: CMHP Date: 11/23/22 Time: 1300

- ☐ ADOC Employee
- ☐ Medical/Mental Health Staff
- ☐ Patient (Self-Referral)
- ☐ Other

Additional Info:

Referral Received by Triage* Registered Nurse:

Name: J. Stewart	Title: RN
Date Received: 11-28-22	Time Received: 1350

Triage* Registered Nurse Completing Information Below:

Signature: J Stewart RN

Date: 11-28-22	Time: 1350

Nurse Determination

- ☐ Emergent referral required (Notify On-Call MHP or Psychologist) **
- ☐ Urgent referral required (Notify On-Call MHP or Psychologist) **
- ☑ Routine referral required (Notify MH next business day)

MHP or Psychologist Notified?	Name: Date Time:

Referral to Psychiatrist indicated?

Comments: Received 11-29-22 @ 0815

***Triage nurse must be an R.N. with mental health training**

****Emergent or Urgent Referrals- Notify MHP or Psychologist within 1 hour**

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: No symptoms reported

Medications: Trazadone 150 Mg PO HS
Risperidone 3D Mg PO HS

Adherence?

Labs: | **AIMS** (Date) | **Consents** (Date)

Weight/BMI:

S/ "I'm fine" Medication are working

O/ SE denies. S/I/H/I

Appearance/behavior: Neat/appropriate	Thought: Logical
Cognition: alert/oriented	Perception: No hallucination
Speech: Coherent	Insight/Judgment: Good
Mood/affect: Euthymic	Harm to self/others: SE denies

A/ (Use DSM-5; Include differential diagnosis) Adj Dis

Sub. use dis in sustain remission

P/ Cont present Tx

Return in: 30d **Physician/CRNP:** (Print) Polanco MD Sign: Polanco MD

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 10/18/22 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A B C D **SMI:** Y N

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	2512			Holman CF

Informed Consent for Mental Health Medication	Inmate Name: Smith, Kenneth	Inmate Number: 2-512	Wexford Health
	DOB:	Institution:	

Mixed-Action Antidepressant Medication

Duloxetine HCL (Cymbalta)	Mirtazapine (Remeron)	Buproprion (Wellbutrin)
Venlafaxine (Effexor)	Trazodone (Desyrel)	

DOSAGE RANGE:

PURPOSE AND BENEFITS: These medications are used to treat symptoms associated with depression and anxiety. They are called "mixed action" antidepressants because they work on more than one system in the brain at the same time. This category of medication may relieve undesirable symptoms better and more quickly than other treatments alone. Alternative treatments may include other medications, activity therapies, and talk therapies.

SIDE EFFECTS/RISKS OF THIS TREATMENT: Dizziness and drowsiness, nausea, dry mouth, constipation, diarrhea, loss of appetite, slight increases in blood pressure, fatigue, increased sweating, blurred vision, problems with urination, difficulty sleeping, and male sexual difficulties. Males taking Trazodone have a risk for uncontrolled, painful, persistent erections and should seek immediate medical care if this occurs. Abrupt withdrawal or discontinuation of medication may cause medical problems. In rare cases, these medications may cause increased suicidality in depressed patients who are less than 24 years old.

RISKS OF REFUSING THIS TREATMENT include, but are not limited to: Continuation or worsening of your symptoms and distress (including periods of depressed mood, irritability, loss of interest and enjoyment, and hopelessness), becoming violent towards others or yourself, and becoming less able to care for yourself.

LENGTH OF CARE: The medication usually begins to act within 2-3 weeks. Reliable benefits require regular, long term usage. Your doctor may adjust the dosage during treatment, in most cases, to the minimum dosage that is needed. Your doctor may order laboratory tests from time to time to make sure that the medication is being administered properly and is not causing medical problems.

NOTIFICATION: Do not stop taking this medication without discussing it with your doctor. You have the right to stop taking this medication any time by notifying the doctor or mental health staff orally or in writing. If you decide to stop taking the medication, it will not affect your ability to receive other health care. Avoid excessive heat or dehydration while taking this medication. For female inmates: Notify your physician if there is a possibility that you are pregnant.

I understand that by signing this form I am agreeing to be treated with this medication. Mental health staff have given me information about this treatment, including the reasons I am being treated and the information on this form. I have had a chance to ask any questions about my treatment I wished to ask. I understand that I can discuss any other questions I might have about my treatment with the doctor and that a signed copy of this form will be given to me.

Time/Date: 10/4/22 Inmate Signature: Kenneth Smith

Time/Date: 10/4/22 Prescribing Practitioner Signature/ Name/Title Stamp: [illegible] MD

I have been advised to take this medication, but I am unwilling to take it as prescribed. The risks of not taking this medication have been explained to me.

Time/Date: _____ Inmate Signature: _____

Time/Date: _____ Prescribing Practitioner Signature/ Name/Title Stamp: _____

Rev. 3/26/2018

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems:
& sleep
Worry, anx, Depress

Medications: Ø

Adherence?

Labs:

Weight/BMI:

AIMS (Date)

Consents (Date)

S/ "I'm down depress"
Dr Q was place on dead row"

O/ SC denies SI/HI

Appearance/behavior: Neat/appropriate	Thought: Logical
Cognition: Alert & Oriented	Perception: NO hallucination
Speech: Coherent	Insight/Judgment: Good
Mood/affect: anx	Harm to self/others: SC denies

A/ (Use DSM-5; Include differential diagnosis) Adjustment Dis
Sub use dis in sustain remission

P/
Trazadone 100mg PO HS
Remeron 30mg PO HS

Return in: 2 wks **Physician/CRNP:** (Print) PolancoMD Sign: Polanco MD

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 11/4/22 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A B C D **SMI:** Y N

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	2-512			Holman CF

Alabama Department of Corrections

PROGRESS NOTES

(One note per sheet)

Date: 08/29/22	**Purpose: MH f/u appt - telepsych**	**MH Code: B**
Start Time: 08:55am	**Location: Holman**	**SMI: Y X N**
End Time: 09:20am	**Confidential Location: ☒ Y ☐ N** **If No, explain:**	

Pt seen for MH appt. in a confidential setting (old DR shift office) with officers posted outside of room not within hearing distance. Pt reported that he has discussed the possibility of preventative medication with medical and they have determined that there is no medication that they could give him at this point. He reported that he continues to have trouble sleeping at night, which makes his migraines worse in the morning. He is in constant communication with his family, who as per his report is starting to be a little more comfortable talking about his getting a date of execution set. He still finds it incredibly difficulty to communicate with his mother about this. He reported that he has all of his finances, family matters, etc in order and that his wife is taking care of things as needed. On the unit, he has a circle of close friends that are he is able to socialize with, though they find it hard to discuss the above-mentioned matter, as this reminds them of their similar circumstances. He is focused on being present in the moment and not worrying about the future or dwelling on the past.

Pt was alert, Ox3, cooperative. His mood was euthymic and his affect was full ranging and appropriate. His speech was clear and coherent. Thought process was linear and logical. He denied S/HIs, A/VHs, and delusions.

Pt is a W/M with R/O Adjustment Disorder, and SUD, in sustained remission. He is not prescribed medication at this time.

Continue to meet with pt for monthly MH appts. Encouraged utilization of effective coping skills, compliance with medication, and abstinence from illicit substances for mood stability. Pt encouraged to seek MH if his symptoms worsen at any time.

Danielle Beech, Ph.D.

Danielle Beech, Ph.D. – Licensed Clinical Psychologist

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	**Z512**	Holman

Alabama Department of Corrections

PROGRESS NOTES

(One note per sheet)

Date: 08/08/22	**Purpose: MH f/u appt - telepsych**	**MH Code: B**
Start Time: 09:45am	**Location: Holman**	**SMI: Y X N**
End Time: 10:15am	**Confidential Location: ☒ Y ☐ N** **If No, explain:**	

Pt seen for MH appt. in a confidential setting (old DR shift office) with officers posted outside of room not within hearing distance. Pt reported that he has an appointment with his doctor today to discuss the possibility of getting some preventative migraine medication. He also reported increasing anxiety and depression regarding the likelihood of him being given an execution date. He stated that it is unlikely that his lawyers will be able to get him and emergency pardon. He is trying to keep his family free from the burden of worrying about how he is taking this news. He tries to keep busy by helping others on the unit and focusing on the current moment. Despite this, there are times that pt is keenly aware of his circumstances and this is distressing to him.

Pt was alert, Ox3, cooperative. His mood was anxious and slightly depressed and his affect was full ranging and appropriate. His speech was clear and coherent. Thought process was linear and logical. He denied S/HIs, A/VHs, and delusions.

Pt is a W/M with R/O Adjustment Disorder, and SUD, in sustained remission. He is not prescribed medication at this time.

Continue to meet with pt for monthly MH appts. Encouraged utilization of effective coping skills, compliance with medication, and abstinence from illicit substances for mood stability. Pt encouraged to seek MH if his symptoms worsen at any time.

Danielle Beech PhD

Danielle Beech, Ph.D. – Licensed Clinical Psychologist

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	**Z512**	Holman

Alabama Department of Corrections

PROGRESS NOTES

(One note per sheet)

Date: 07/25/22	Purpose: MH f/u appt - telepsych	MH Code: B
Start Time: 09:25am	Location: Holman	SMI: Y X N
End Time: 09:45am	Confidential Location: ☒ Y ☐ N If No, explain:	

Pt seen for MH appt. in a confidential setting (old DR shift office) with officers posted outside of room not within hearing distance. Initial intake form was completed now that pt has been officially placed on caseload. Pt reported that he is doing well, with exception to continuing migraine pain. He worries at times, but makes efforts daily to remain hopeful and positive, despite his circumstances.

Pt was alert, Ox3, cooperative. His mood was euthymic, and his affect was full ranging and appropriate. His speech was clear and coherent. Thought process was linear and logical. He denied S/HIs, A/VHs, and delusions.

Pt is a W/M with R/O Adjustment Disorder, and SUD, in sustained remission. He is not prescribed medication at this time.

Continue to meet with pt for monthly MH appts. Encouraged utilization of effective coping skills, compliance with medication, and abstinence from illicit substances for mood stability. Pt encouraged to seek MH if his symptoms worsen at any time.

Danielle Beech Ph.D

Danielle Beech, Ph.D. – Licensed Clinical Psychologist

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	Z512	Holman

Alabama Department of Correctio...

PROGRESS NOTES

(One note per sheet)

Date: 07/26/22	**Purpose: Treatment Team Meeting**	**MH Code: B**
Start Time: 10:15am	**Location: Holman**	**SMI: Y x N**
End Time: 10:20am	**Confidential Location: ☒ Y ☐ N** **If No, explain:**	

Pt was seen on this day out of cell in the KLM group room (confidential setting with an officer stationed outside the office not within hearing distance) for treatment plan development. In attendance were the undersigned staff. Pt expressed a desire to work on maintaining low levels of depression, anxiety, and mood stability through the use of effective coping skills.

Pt was placed on the MH caseload on 7/19/22 and given a diagnosis of R/O Adjustment Disorder. He reported anxiety and depression secondary to potentially receiving an execution date within the month. He has no history of MH treatment.

Treatment Team discussed treatment goals and established a treatment plan to reflect these agreed upon goals. Discussed the following information with pt: the importance of compliance with all scheduled appts, medication compliance (if prescribed), and abstinence from substances. Pt agreed to the above discussed Treatment Plan and agreed to engage in his treatment.

Pt was alert, Ox3, and cooperative. His mood was euthymic and affect was congruent with mood. His speech was clear and coherent. His thought process was linear and logical. He denied S/HI, A/VHs, delusions.

Pt is a W/M with a diagnosis of r/o Adjustment Disorder and SUD in sustained remission. He is not prescribed medication at this time.

Encouraged pt to work toward goals and instructed on how to reach mental health between follow ups. MHP will continue to provide patient with psycho-education on depression, and anxiety during monthly MH sessions. Pt encouraged to continue to utilize healthy coping skills to manage stressors, maintain medication compliance, and maintain abstinence from illicit substances. Will follow up with the pt in 30-days or as needed.

Dr. Polanco, MD (psychiatrist)

Dr. Beech, Ph.D. (psychologist-chair) Danielle Beech PhD

Dr. Quarker-Smith, Ph.D., LPC (site administrator)

Mrs. O'Barr, LPN

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	**Z512**	Holman

Alabama Department of Corrections

PROGRESS NOTES

(One note per sheet)

Date: 07/18/22	**Purpose: MH f/u appt - telepsych**	**MH Code: A**
Start Time: 09:35am	**Location: Holman**	**SMI: Y X N**
End Time: 11:05am (broken session due to institutional issue)	**Confidential Location: ☒ Y ☐ N** **If No, explain:**	

Pt seen for MH appt. in a confidential setting (old DR shift office) with officers posted outside of room not within hearing distance secondary to pt's request to be placed on the MH caseload. Pt stated that he was informed that he would most likely be given an execution date by the end of July. He has informed his family and friends of this. His lawyers are working on filing a motion to stop this. Pt reported increased anxiety, tension, depression, and a feeling that he is "spinning his wheels." His sleep has been fitful when he tries to go back to sleep after breakfast due to anxious thoughts. He stated that mindfulness mediation is helpful for now, but it has been getting more difficulty to manage. He reported that he is eating well and denied anhedonia. He also has a very good group of friends on Death Row who are very supportive of him. He stated that in addition to this, his migraines have been increasing and worsening in intensity since he began losing his cases in federal court. He is currently on Imatrex, but he wants a preventative medication to stop the migraine before they occur. He noted that he is in significant pain when he gets migraines and that he does not fully recover from the migraine for a few days. He believes that he needs to have a 'clear head' to face the potential of his execution date being soon and that the migraines hinder his ability to think clearly and effectively. He is hoping that if he is placed on psychiatric medication that it might be one to help him with the migraines.

Pt was alert, Ox3, cooperative. His mood was slightly depressed and anxious, and his affect was full ranging and appropriate. His speech was clear and coherent. Thought process was linear and logical. He denied S/HIs, A/VHs, and delusions.

Pt is a W/M with a no mental health diagnosis.

Refer to Dr. Polanco for potential entry to the caseload.

Danielle Beech PhD

Danielle Beech, Ph.D. – Licensed Clinical Psychologist

INMATE NAME	AIS #	FACILITY
Smith, Kenneth	**Z512**	Holman

Alabama Department of Correction

Psychiatric Evaluation

[Psychiatrist / CRNP Module]

Reason for Evaluation and Chief Complaint: D.O.B = / /

White 57 y/o DOC Male who reported Hx of Psychiatric illness

Referral is: ☐ emergent ☐ urgent ☑ routine

Present Problems and Symptoms:

BC stated that he was angry because he's thinking that his date for execution is coming soon. BC stated that he does not want medication because he does not want to be drowsy but alert to make the best decision. Medical Hx for him for HTN, GERD, obesity, Chronic Migraines.

Psychiatric Treatment History (lifetime):

Y ☐ N ☑	Inpatient:
Y ☐ N ☑	Outpatient:
Y ☐ N ☑	MH Tx in jail:

History of Psychiatric Medications / Other Somatic Tx (lifetime): *(Note response/tolerance.)*

Y ☐ N ☑	Antipsychotic
Y ☐ N ☑	Mood Stabilizer
Y ☐ N ☑	Antidepressant
Y ☐ N ☑	Anxiolytic
Y ☐ N ☑	Stimulant
Y ☐ N ☑	Hypnotic
Y ☐ N ☐	Other Medications:
AIMS done today? ☐ Y ☐ N ☑ N/A	
Additional Info:	

Data Reviewed by psychiatrist/CRNP (see primary care module)

EKG Y ☑ N ☐	see medical
Labs Y ☑ N ☐	
Psychiatrist/CRNP Name (print):	Date: 7/19/2022

Inmate Name: Smith, Kenneth	AIS #: 512

Alabama Department of Correction

Psychiatric Evaluation

[Psychiatrist / CRNP Module]

Family History

(Check all items. Provide details and dates.)

Y ☐ N ☑ Suicide	Y ☐ N ☑ Suicide attempt
Y ☐ N ☑ Depression	Y ☐ N ☑ Bipolar D/O
Y ☐ N ☑ Schizophrenia Spectrum	Y ☐ N ☑ Anxiety D/O
Y ☐ N ☑ Substance Abuse/Addiction	Y ☐ N ☑ PTSD
Y ☐ N ☑ Incarceration	Y ☐ N ☑ OCD
Other/details:	

Mental Status Examination

(Add pertinent details.)

Consciousness	☑ Alert ☐ Drowsy ☐ Attentive ☐ Distractible
Appearance	☑ Neat ☐ Clean ☐ Posture upright ☐ Slumped ☐ Unkempt ☐ Body odor
Behavior/ Attitude	☑ Calm ☑ Cooperative ☐ Evasive ☐ Defensive ☐ Agitated ☐ Withdrawn ☐ Slowed
Cognition	Oriented X ☑ Time ☑ Place ☑ Person
Speech:	☑ Coherent ☐ Soft ☐ Loud ☐ Pressured ☐ Rapid ☐ Circumstantial ☐ Over-inclusive
Mood/affect:	☑ Euthymic ☐ Sad/down ☐ Elevated ☐ Irritable ☐ Angry ☐ Blunted/flat ☐ Inappropriate
Thought Content	☑ Appropriate ☐ Over-valued ideas ☐ Delusions ☐ Obsessions
Thought Process	☑ Logical ☐ Tangential ☐ Loose associations ☐ F.O.I. ☐ Concrete
Perception:	☑ Normal *Hallucinations:* ☐ Auditory ☐ Visual ☐ Olfactory ☐ Somatic ☐ Tactile
Insight & Judgment	☑ Good insight ☐ Partial insight ☐ No insight

Psychiatrist/CRNP Name (print): Polavico MD Date: 7/19/22

Inmate Name: Smith, Kenneth AIS #: 2512

Alabama Department of Correction

Psychiatric Evaluation

[Psychiatrist / CRNP Module]

Suicidality and self-harm (lifetime history, including childhood) *Check all applicable items.*

Y ☐ N ☐ **SRA** completed today		Y ☐ N ☐ **SRA** previously completed on / /	
Suicide attempts (lifetime)	☑ **Never** ☐ Once ☐ Multiple times ☐ Unreported ☐ Emergency care ☐ Hospitalized	☐ Firearm ☐ Hanging ☐ Asphyxiation ☐ Poisoning ☐ Jumping ☐ Vehicle crash	Other/Details: None reported
Non-suicidal self-harm	☐ **Never** ☐ Cut/Scratch ☐ Hit/Head-bang ☐ Burn ☐ Other	☐ Visible scars ☐ Provides relief	Other/Details:
Tempting fate	☐ Y ☐ N (Actions with indifference to death):		

Aggression and Harm to Others (lifetime history, including childhood) *Check all applicable items.*

Altercations / assaults	☑ No injuries ☐ Other injured ☐ Fatal outcome	☐ No weapons ☐ Firearm used ☐ Other weapon	Other/Details: None reported
Fantasies of harming someone	☐ Current ☐ Prior ☐ Planned ☐ Acted	☐ Persecutory ☐ Obsessive ☐ Has intent ☐ Has means	Other/Details:

Diagnosis (*Use DSM-5 terminology*)

DSM-5 Diagnoses: r/o Adjustment dis Subs ind dis in sustain remission
Primary Care Diagnoses:

SMI status: ☐ Y ☑ N	**MH CODE:** ☐ A ☑ B ☐ C ☐ D

Inmate Name: Smith, Kenneth	AIS #: Z 512

Alabama Department of Correction

Psychiatric Evaluation

[Psychiatrist / CRNP Module]

Treatment Plan

Pt will receive ind. + Group Psychotherapy

Psychiatric Medications:

Pt did not want to take any Psychiatric Medication

Risks, benefits and alternatives discussed, and **consents signed** for all medication prescribed for psychiatric treatment: ☐ Y ☐ N

Labs ordered: ☐ Y ☑ N/A **AIMS due:** ☐ Y ☐ N ☑ N/A **If Yes, date due by:** / /

Other:

F/U scheduled in: 90 ☐ **days** ☐ **weeks** ☐ **months**	
Housing move clinically indicated? ☐ Y ☐ N	If yes, from: to:
Primary Medical Referral/Consultation: ☐ Y ☐ N/A	
Prior health record from community needed? ☐ Y ☐ N	If Yes, Release of Information signed? ☐ Y ☐ N

Psychiatrist/CRNP Name/Credentials:	Signature:	Date and Time:
	Solarcomus	7/19/22@ AM/PM

My signature verifies that I have reviewed the psychosocial and primary care modules, and have personally interviewed and examined this individual in an out-of-cell setting that provides sound confidentiality.

See **Psychosocial Module** [pages 5-7] and **Primary Care Module** [pages 8-9]

Alabama Department of Corrections

Psychiatrist / CRNP Progress Note

Target Symptoms and Problems: Jail. Hx of mental illness prior to Jail. No symptoms reported

Medications: ∅

Adherence?

Labs:

Weight/BMI:

AIMS (Date)

Consents (Date)

S/ "I do not need medication". I would like to be follow by the therapist

O/

Appearance/behavior: appropriate	Thought: Logical
Cognition: Oriented	Perception: No hallucination
Speech: Coherent	Insight/Judgment: fair
Mood/affect: Mildly anx	Harm to self/others: St denies

A/ (Use DSM-5; Include differential diagnosis) No dx at this time @ R/O adjustment dis Subs use/dis in sustain remission

P/ Pt is being referred to the therapist

Return in: 90d **Physician/CRNP:** (Print) Polan CoMD Sign: Polancoms

My signature verifies this person was seen out-of-cell in a setting that provided sound confidentiality. Note any exceptions:

Date: 7/19/22 **Housing:** GP RTU SU RHU SLU PSU WR **MH Code:** A B C D **SMI:** Y N

Patient Name: (Last, First)	AIS#	Age	R/S	Facility
Smith, Kenneth	2512			Holman

Alabama Department of Correction

Psychiatric Evaluation

[Psychosocial Module]

Review of Symptoms	None	Current	Past	Comments
Anxiety				
Panic attacks				
Phobias				
Anxious avoidance				
↑ Worry		LPP ✓	✓	
↑ Restless/tense		✓	LPP	due to patient on (current)
Somatic anxiety symptoms				
Posttraumatic				
Intrusive memories				
Flashbacks/Dreams				Not due to trauma (nightmares)
Avoidance				
↑Reactivity				
Dissociative symptoms				
Psychosis				
Hallucinations				
Delusions				
Obsessions/Compulsions				
Other:				

Clinician completing this Psychosocial Module:

Signature:	Danielle Beech PhD
Print name / credentials:	Danielle Beech PhD
Date:	7/25/22

Psychosocial Module reviewed by psychiatrist or CRNP (initial/date):	PP	Date: / /

Inmate Name: Smith, Kenneth	AIS #: 2512

Alabama Department of Correction

Psychiatric Evaluation

[Psychosocial Module]

Social History: *Provide details.*

Family / Youth circumstances:	
Education:	☐ <HS ☐ HS/GED ☐ Post HS coursework ☒ College ☐ Other: Associates - "Science"
Military	☒ Y ☐ N Details: Honorable DIC - Marines (Basic) (training only
Relationship Status / Social Supports:	☐ Single ☒ Married ☐ "Common Law" married ☐ Divorced ☐ Other:
Children:	3 - 2 boys, 1 girl
Spiritual / Faith:	Christian
Employment prior to incarceration	☐ Never employed Details: ☒ Full time ☐ Part-time mechanic

Adverse Childhood Experiences (ACE):

Y ☒ N ☐ Sexual abuse	Y ☐ N ☒ Physical neglect	Y ☐ N ☒ Household mental illness
Y ☐ N ☒ Physical abuse	Y ☒ N ☐ Intimate partner violence	Y ☐ N ☒ Incarcerated family member
Y ☒ N ☐ Emotional abuse	Y ☒ N ☐ Mother treated violently	Y ☒ N ☐ Parental separation/divorce
Y ☒ N ☐ Emotional neglect	Y ☒ N ☐ Substance abuse in home	Y ☐ N ☐ Other:

Adult emotionally traumatic events:	Sexual - outside of family; neglect "at times Mom - ETOH; Dad - "speed"; Parents divorced
First Incarceration? Y ☒ N ☐ Adjustment to incarceration:	
Year entered ADOC: 1988	Year minimum release (EOS): N/A
Year of most recent parole hearing, if applicable: N/A	Date next parole hearing, if applicable: N/A
Other info: Death Row	

Substance Abuse/Addiction History (Lifetime) *(Include details)*

Y ☐ N ☒	Outpatient tx/rehab
Y ☐ N ☒	Residential tx/rehab
Y ☐ N ☒	Overdose (accidental)
Y ☒ N ☐	Withdrawal symptoms From ETOH when first locked up
Y ☒ N ☐	Hx IVDA X1 - Never again

Clinician Completing this module (print): Danielle Beech PhD Date: 7/25/22

Alabama Department of Correction

Psychiatric Evaluation

[Psychosocial Module]

Substance Abuse/Addiction History (continued)		(Include dates of onset and last use; amount)
Y ☐ N ☒	Tobacco	
Y ☒ N ☐	Alcohol	First - 13yr.o ; last - last yr.
Y ☒ N ☐	Cannabis	First - 16yr.o; last - 5 years ago
Y ☐ N ☒	Opioids	
Y ☒ N ☐	Stimulants	First - 16yr.o; last - at that time
Y ☒ N ☐	Hallucinogens	First - 18yr.o ; last 2/4.0.
Y ☐ N ☒	Inhalants	
Y ☒ N ☐	Sedative/anxiolytics	Valium, Xanax. First - 12yr.o; last - 1988
Y ☒ N ☐	Synthetics	First - 7 years ago last 16 mths ago
Y ☐ N ☒	Other:	

Choice drug ★

Review of Symptoms	None	Current	Past	Comments
Depression				
Low mood		✓	✓	when migraines come on.
Anhedonia				
↑ ↓ Weight				
↓ ↑ Sleep				
↓ ↑ Psychomotor activity				
↓ Energy				
Worthless/guilt		(✓)	✓	when first locked up
↓ Concentration				
Thoughts death/suicidality				
Mania				
Elevated/expansive				
Irritable				· NONE denied
Grandiosity				
↓ Sleep need				
↑ Talkative				
Flight of ideas				
Distractible				
↑ Goal-directed behavior				
↑ Risky behavior				

Clinician Completing this module (print): Danielle Beech PhD Date: 7/25/22

Alabama Department of Correction

Psychiatric Evaluation

[Primary Care Module]

Primary Care Medications:

Lisinopril	Emitrex
Claritin	
Lopressor	
Prilosec	
Tylenol	

Lab	Date	Result
Glucose	8/2/21	121
A1c	3/26/21	5.0
T. Chol	8/2/21	244
HDL	8/2/21	45
LDL	8/2/21	157
TG	8/2/21	209
H/H	8/2/21	Hgb 14.3 Hct 43.3

Lab	Date	Result
TSH	/ /	
T4	/ /	N/A
T3RU	/ /	N
FTI	/ /	
Na^+	8/2/21	140
BUN	8/2/21	13
Creat.	8/2/21	0.78

Weight: 212 # Abdominal Circumference: N/A inches Date: 6/14/22

Height: 5'9 in. BMI: 31.3

Y☒ N☐ EKG Date: 8/2/21

Other labs/data: N/A

Nurse completing this Primary Care module:

Signature: S. O'Barr, LPN (LPN) RN

Print name: S. O'Barr, LPN

Date: 7/19/22

Primary Care Module reviewed by Psychiatrist or CRNP (initial/date): PP Date: 7/19/22

Alabama Department of Correction

Psychiatric Evaluation

[Primary Care Module]

Primary Medical History *Check all that apply & add details.*

Neuro	Y☐ N☒ TBI *If Yes,* with concussion symptoms? ☐ Y ☐ N Y☐ N☒ Seizures / Epilepsy Y☐ N☒ Neurodegenerative / Neurocognitive D/O
CV	Y☒ N☐ HTN Y☐ N☒ CAD/MI
Pulmonary	Y☐ N☒ COPD Y☐ N☒ Asthma
GI	Y☐ N☒
Mus/Skeletal	Y☐ N☒
Metabolic	Y☐ N☒ Diabetes Y☒ N☐ Obesity Y☐ N☒ Thyroid D/O
Infectious	Y☐ N☒ Hepatitis A B C Y☐ N☒ TB Y☐ N☒ HIV Y☐ N☒ STD
Cancer	Y☐ N☒
Other info:	Chronic Migraines

Y☒ N☐ **Allergies and Adverse Drug Reactions:** Topamax, clindamycin

Y☐ N☒ **Hx surgery:**

Y☐ N☒ **Hx serious injuries**

Y☐ N☒ **Hx medical hospitalization:**

If female: Gravida (# times pregnant): N/A **Para (# pregnancies to viability):**

Y☐ N☒ **Prenatal alcohol exposure:**

Y☐ N☒ **Other prenatal complications/risks:**

Y☐ N☒ **Hx childhood illnesses or injuries:**

Nurse completing primary care module (print name): S. O'Barr, LPN Date: 7/19/22

Inmate Name: Smith, Kenneth AIS #: 2512

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

REVIEW OF SEGREGATION INMATES

Date Review Completed: 3/18/16 Date Placed in Segregation: 11/14/15

☐ 30 DAY REVIEW ☑ 90 DAY REVIEW M.H. Code: O

ADOC Psychologist/Psychological Associate Conducting Review: Shelia Brown, MS

MENTAL STATUS EXAMINATION: Institution: Holman

Affect: ☐ Anxious/nervous ☐ Flat ☑ Appropriate	*Appearance:* ☐ Unkempt ☐ Disorganized ☑ Appropriate
Concentration: ☑ Focused ☐ Distracted	*Intellectual Functioning:* ☑ Normal ☐ Borderline ☐ Retarded
Mood: ☐ Depressed ☐ Elevated ☑ Euthymic ☐ Irritable ☐ Manic	*Speech & Thoughts:* ☑ Normal ☐ Pressured ☐ Slurred ☐ Stuttering ☐ Incoherent ☐ Tangential ☐ Poverty of speech ☐ Flight of Ideas
Orientation: ☐ Disoriented ☑ Oriented to time, place and person	*Memory:* Short-term ☑ Good ☐ Poor Long-term ☑ Good ☐ Poor

BEHAVIORAL OBSERVATIONS:

☐ Aggressive	☐ Irrational	☐ Passive	☐ Paranoia
☐ Agitated	☐ Suicidal ideation	☑ Rational	☐ Hyperactivity
☐ Delusional	☐ Lethargic	☐ Crying	☐ Hallucinating
☐ Eye Contact	☐ Loose Associations	☐ Withdrawn	☐ Manipulative
☐ Fearful	☑ Calm	☐ Other:	

COMMENTS:

Stable

RECOMMENDATIONS:

☑ SEGREGATION PLACEMENT NOT IMPACTING INMATE'S MENTAL HEALTH
☐ SEGREGATION PLACEMENT IMPACTING INMATE'S MENTAL HEALTH
☐ REFERRED FOR PSYCHIATRIC EVALUATION
☐ Other: _____

Inmate Name: Smith, Kenneth AIS # 2512

Disposition: Inmate Medical Record, Institutional Inmate File, Reference: Central Records File

ADOC AR: 623, 625, 635
ADOC Form MH-039 - November 14, 2005

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

REVIEW OF SEGREGATION INMATES

Date Review Completed: 12/15/15 Date Placed in Segregation: 11/14/89

☐ 30 DAY REVIEW ☒ 90 DAY REVIEW M.H. Code: O

ADOC Psychologist/Psychological Associate Conducting Review: Thelia Bruce Williams

MENTAL STATUS EXAMINATION: Institution: Holman

Affect: ☐ Anxious/nervous ☐ Flat ☒ Appropriate	*Appearance:* ☐ Unkempt ☐ Disorganized ☒ Appropriate
Concentration: ☒ Focused ☐ Distracted	*Intellectual Functioning:* ☒ Normal ☐ Borderline ☐ Retarded
Mood: ☐ Depressed ☐ Elevated ☒ Euthymic ☐ Irritable ☐ Manic	*Speech & Thoughts:* ☒ Normal ☐ Pressured ☐ Slurred ☐ Stuttering ☐ Incoherent ☐ Tangential ☐ Poverty of speech ☐ Flight of Ideas
Orientation: ☐ Disoriented ☒ Oriented to time, place and person	*Memory:* Short-term ☒ Good ☐ Poor Long-term ☒ Good ☐ Poor

BEHAVIORAL OBSERVATIONS:

☐ Aggressive	☐ Irrational	☐ Passive	☐ Paranoia
☐ Agitated	☐ Suicidal ideation	☒ Rational	☐ Hyperactivity
☐ Delusional	☐ Lethargic	☐ Crying	☐ Hallucinating
☐ Eye Contact	☐ Loose Associations	☐ Withdrawn	☐ Manipulative
☐ Fearful	☒ Calm	☐ Other:	

COMMENTS: Stable

RECOMMENDATIONS:

☒ SEGREGATION PLACEMENT NOT IMPACTING INMATE'S MENTAL HEALTH
☐ SEGREGATION PLACEMENT IMPACTING INMATE'S MENTAL HEALTH
☐ REFERRED FOR PSYCHIATRIC EVALUATION
☐ Other: _____

Inmate Name: Smith, Kenneth AIS # 2512

Disposition: Inmate Medical Record, Institutional Inmate File, Reference: Central Records File

ADOC AR: 623, 625, 635
ADOC Form MH-039 - November 14, 2005

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

REVIEW OF SEGREGATION INMATES

Date Review Completed: 9/18/15 Date Placed in Segregation: 11/14/89

☐ 30 DAY REVIEW ☑ 90 DAY REVIEW M.H. Code: 0

ADOC Psychologist/Psychological Associate Conducting Review: Shelia Brown, MS

MENTAL STATUS EXAMINATION:

Institution: Holman

Affect: ☐ Anxious/nervous ☐ Flat ☑ Appropriate	*Appearance:* ☐ Unkempt ☐ Disorganized ☑ Appropriate
Concentration: ☑ Focused ☐ Distracted	*Intellectual Functioning:* ☑ Normal ☐ Borderline ☐ Retarded
Mood: ☐ Depressed ☐ Elevated ☑ Euthymic ☐ Irritable ☐ Manic	*Speech & Thoughts:* ☑ Normal ☐ Pressured ☐ Slurred ☐ Stuttering ☐ Incoherent ☐ Tangential ☐ Poverty of speech ☐ Flight of Ideas
Orientation: ☐ Disoriented ☑ Oriented to time, place and person	*Memory:* Short-term ☑ Good ☐ Poor Long-term ☑ Good ☐ Poor

BEHAVIORAL OBSERVATIONS:

☐ Aggressive	☐ Irrational	☐ Passive	☐ Paranoia
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☐ Delusional	☐ Lethargic	☐ Crying	☐ Hallucinating
☐ Eye Contact	☐ Loose Associations	☐ Withdrawn	☐ Manipulative
☐ Fearful	☑ Calm	☐ Other:	

COMMENTS:

Stable

RECOMMENDATIONS:

☑ SEGREGATION PLACEMENT NOT IMPACTING INMATE'S MENTAL HEALTH
☐ SEGREGATION PLACEMENT IMPACTING INMATE'S MENTAL HEALTH
☐ REFERRED FOR PSYCHIATRIC EVALUATION
☐ Other: _____

Inmate Name: Smith, Kenneth	AIS # 7512

Disposition: Inmate Medical Record, Institutional Inmate File, Reference: Central Records File

ADOC AR: 623, 625, 635
ADOC Form MH-039 - November 14, 2005

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

REVIEW OF SEGREGATION INMATES

Date Review Completed: 6/19/15 Date Placed in Segregation: 11/14/89

☐ 30 DAY REVIEW ☑ 90 DAY REVIEW M.H. Code: O

ADOC Psychologist/Psychological Associate Conducting Review: Oletia Brown, MS

MENTAL STATUS EXAMINATION: Institution: Holman

Affect: ☐ Anxious/nervous ☐ Flat ☑ Appropriate	*Appearance:* ☐ Unkempt ☐ Disorganized ☑ Appropriate
Concentration: ☑ Focused ☐ Distracted	*Intellectual Functioning:* ☑ Normal ☐ Borderline ☐ Retarded
Mood: ☐ Depressed ☐ Elevated ☑ Euthymic ☐ Irritable ☐ Manic	*Speech & Thoughts:* ☑ Normal ☐ Pressured ☐ Slurred ☐ Stuttering ☐ Incoherent ☐ Tangential ☐ Poverty of speech ☐ Flight of Ideas
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☐ Delusional	☐ Lethargic	☐ Crying	☐ Hallucinating
☐ Eye Contact	☐ Loose Associations	☐ Withdrawn	☐ Manipulative
☐ Fearful	☑ Calm	☐ Other:	

COMMENTS: Stable

RECOMMENDATIONS:

☑ SEGREGATION PLACEMENT NOT IMPACTING INMATE'S MENTAL HEALTH
☐ SEGREGATION PLACEMENT IMPACTING INMATE'S MENTAL HEALTH
☐ REFERRED FOR PSYCHIATRIC EVALUATION
☐ Other: _____

Inmate Name: Smith, Kenneth	AIS # 2512

Disposition: Inmate Medical Record, Institutional Inmate File, Reference: Central Records File

ADOC AR: 623, 625, 635
ADOC Form MH-039 - November 14, 2005

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

REVIEW OF SEGREGATION INMATES

Date Review Completed: 3/19/15 Date Placed in Segregation: 11-14-89

☐ 30 DAY REVIEW ☑ 90 DAY REVIEW M.H. Code: O

ADOC Psychologist/Psychological Associate Conducting Review: Sheila Brown, MS

MENTAL STATUS EXAMINATION: Institution: Holman

Affect: ☐ Anxious/nervous ☐ Flat ☑ Appropriate	*Appearance:* ☐ Unkempt ☐ Disorganized ☑ Appropriate
Concentration: ☑ Focused ☐ Distracted	*Intellectual Functioning:* ☑ Normal ☐ Borderline ☐ Retarded
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☐ Fearful	☑ Calm	☐ Other:	

COMMENTS:

Stable

RECOMMENDATIONS:

☑ SEGREGATION PLACEMENT NOT IMPACTING INMATE'S MENTAL HEALTH
☐ SEGREGATION PLACEMENT IMPACTING INMATE'S MENTAL HEALTH
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☐ Other: _____

Inmate Name: Smith, Kenneth	AIS # 2512

Disposition: Inmate Medical Record, Institutional Inmate File, Reference: Central Records File

ADOC AR: 623, 625, 635
ADOC Form MH-039 - November 14, 2005