No.

IN THE
Supreme Court of the United States

ANTHONY DARRELL DUGARD HINES,
Petitioner,

v.

STATE OF TENNESSEE,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE TENNESSEE SUPREME COURT

APPENDIX TO PETITION FOR WRIT OF CERTIORARI EXECUTION SCHEDULED FOR AUGUST 13, 2026 AT 10:00 A.M.

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IN THE SUPREME COURT OF TENNESSEE
AT NASHVILLE

STATE OF TENNESSEE v. ANTHONY DARRELL DUGARD HINES

Circuit Court for Cheatham County
No. 9852

No. M2025-00221-SC-DPE-DD

ORDER

In June 1989, Anthony Darrell Dugard Hines was sentenced to death for the 1985 murder of Catherine Jean Jenkins.[1] Almost four decades later, Mr. Hines is scheduled to be executed on August 13, 2026. Less than a month before his execution, Mr. Hines has filed a motion asking this Court either to amend its September 30, 2025 Order setting his execution date to prohibit the Tennessee Department of Correction ("TDOC") from carrying out his execution "without first replacing Physician A with an appropriately skilled and qualified physician" or to grant him "a special master proceeding so that he may prove his likelihood of success on the merits of his chancery court Claim 1.2, as it narrowly pertains to the State's apparent intention to rely on Physician A in his upcoming execution." Upon due consideration, Mr. Hines's motion is denied.

I. PROCEDURAL BACKGROUND

On March 3, 1985, Anthony Darrell Dugard Hines killed Catherine Jean Jenkins ("the victim"), a maid at the Ce'Bon Motel in Kingston Springs, Tennessee. The victim suffered multiple stab wounds to her chest, vagina, and abdominal cavity. Mr. Hines was charged with murder, and the State sought the death penalty. A jury convicted Mr. Hines of murder and sentenced him to death based on three statutory aggravating circumstances. On direct appeal, the murder conviction was affirmed, but the sentence of death was set aside due to instructional error. *State v. Hines*, 758 S.W.2d 515, 524 (Tenn. 1988) (remanding for a new sentencing hearing). After a resentencing hearing in June 1989, a jury again imposed a sentence of death based on three aggravating circumstances. *State v. Hines*, 919 S.W.2d 573, 576–77 (Tenn. 1995), *reh'g denied*, (Tenn. Mar. 11, 1996), *cert. denied*, 519 U.S. 847 (1996). This Court affirmed. *Id.* at 584. Over the next two decades,

[1] Ms. Jenkins' family informed the State that her name is spelled "Catherine" despite prior misspellings in various court documents.

Mr. Hines unsuccessfully sought relief from his conviction and sentence in state post-conviction and federal habeas corpus proceedings.[2]

Mr. Hines also filed lawsuits challenging the constitutionality of the method by which he would be executed. In January 2025, TDOC adopted a revised single-drug lethal injection execution protocol that utilizes a single dose of pentobarbital ("the 2025 protocol"). On February 14, 2025, the State moved to set an execution date for Mr. Hines, citing his completion of the standard three-tier review. On March 14, 2025, Mr. Hines and eight other death-row inmates filed a declaratory judgment action in the Chancery Court for Davidson County ("the chancery court") challenging the constitutionality of the 2025 protocol. Complaint, *Burns v. Strada*, No. 25-0414-IV (Davidson Cnty. Ch. Mar. 14, 2025) ("Complaint").[3] The inmates raised four claims challenging the constitutionality of the 2025 protocol under the Eighth Amendment to the United States Constitution and Article I, sections 16 and 32 of the Tennessee Constitution.

On September 30, 2025, this Court entered an order setting Mr. Hines's execution for August 13, 2026. Meanwhile, Mr. Hines's declaratory judgment action remained pending in the chancery court. A bench trial was set for April 2026 but was cancelled, with no new trial date set.

On May 21, 2026, TDOC undertook to execute death-row inmate Tony Carruthers by lethal injection pursuant to the 2025 protocol. Regarding the setting of IV lines, the 2025 protocol provides:

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[2] *See Hines v. State*, No. M2002-01352-CCA-R3-PD, 2004 WL 112876, at *1, 39 (Tenn. Crim. App. Jan. 23, 2004), *perm. app. granted*, (Tenn. June 28, 2004) (remanding to the Court of Criminal Appeals to verify that the trial court used the correct version of the "heinous, atrocious, or cruel" aggravating circumstance in its instruction to the sentencing jury); *Hines v. State*, No. M2004-01610-CCA-RM-PD, 2004 WL 1567120, at *1, 37–39 (Tenn. Crim. App. July 14, 2004), *perm. app. denied*, (Tenn. Nov. 29, 2004) (affirming jury's consideration of proper version of aggravating circumstance); *Hines v. State*, No. M2006-02447-CCA-R3-PC, 2008 WL 271941, at *1, 8 (Tenn. Crim. App. Jan. 29, 2008), *perm. app. denied*, (Tenn. Dec. 8, 2008), *cert. denied*, 558 U.S. 837 (2009) (affirming denial of petition for DNA testing); *Hines v. Carpenter*, No. 3:05-0002, 2015 WL 1208684, at *3–4, 86 (M.D. Tenn. Mar. 16, 2015) (denying habeas corpus petition following two administrative closures); *Hines v. Carpenter*, No. 3:05-0002, 2015 WL 5037845, at *3 (M.D. Tenn. Aug. 25, 2015) (denying motion to alter or amend); *Hines v. Carpenter*, No. 3:05-0002, 2015 WL 5715453, at *1–5, 7–8 (M.D. Tenn. Sep. 29, 2015) (amending issues included in the certificate of appealability following remand from Sixth Circuit Court of Appeals); *Hines v. Mays*, 814 F. App'x 898, 901 (6th Cir. 2020) (per curiam), *rev'd*, 592 U.S. 385, 386 (2021) (per curiam) (reversing grant of relief based on ineffective assistance of counsel).

[3] The complaint originally included the following plaintiffs: Kevin Burns, Byron Black, Jon Hall, Kennath Henderson, Anthony Darrell [Dugard] Hines, Henry Hodges, Farris Morris, William Glenn Rogers, and Oscar Smith. Plaintiffs Smith and Black have since been executed under the 2025 protocol.

IV TEAM

The IV team is responsible for establishing properly functioning IV lines for administration of the LIC [Lethal Injection Chemicals].

PHYSICIAN

The Physician is responsible for determining that the inmate is deceased using accepted medical standards and establishing central line IV access if necessary.

. . .

1. IV Team: consists of at least two members who are either physicians, physician assistants, nurses, emergency medical technicians ("EMTs"), paramedics, military corpsman with relevant medical training, or other certified or licensed personnel including those trained in the United States Military. All team members are currently certified, licensed and/or qualified within the United States to place IV lines. IV Team members are selected by the Commissioner.

2. The Physician is selected by the Commissioner.

. . .

5. The IV Team determines the IV sites. The IV Team members insert a primary IV catheter and a backup IV catheter. The primary IV catheter is used to administer the LIC. The backup catheter is reserved in case the primary fails.

6. The Special Operations Team Leader ensures that the catheters are properly secured, properly connected to the IV lines, and out of reach of the inmate's hands. The Special Operations Team Leader opens the IV line to start a flow of sterile saline solution in each line and administers at a slow rate to keep the lines open. Any failure of an IV line shall be immediately reported to the Commissioner.

7. If necessary, the Physician will insert a central line.

2025 Protocol, at 8, 11, 20.

According to the pleadings now before this Court, during the attempted execution of Mr. Carruthers on May 21, 2026, the IV Team allegedly attempted for thirty minutes to

establish a backup IV line. TDOC then called upon Physician A to direct the IV Team's efforts. Additional attempts were made to establish a backup IV line, but these efforts were unsuccessful. Physician A then allegedly attempted to place a central line as provided in the 2025 protocol but was unable to do so. Approximately one hour into the execution procedure, counsel for Mr. Carruthers filed an emergency motion for a stay in this Court. Moments later, Mr. Carruthers received a one-year gubernatorial reprieve, and this Court subsequently denied the motion for a stay as moot.

On June 17, 2026, Mr. Hines served the defendants in his chancery court declaratory judgment action with a request for admission, asking TDOC to admit whether it intends to rely on Physician A for Mr. Hines's execution. When the defendants lodged objections to the request for admission, Mr. Hines filed a motion to compel. The chancery court sua sponte rewrote the request for admission to ask TDOC whether it intended to use the same physician for Mr. Hines's execution as it had used for Mr. Carruthers' attempted execution. After a hearing on July 16, 2026, the chancery court entered an order on July 17, 2026, that granted Mr. Hines's motion as to the modified question but stayed "service of the [defendants'] response . . . pending resolution of the underlying issues by a higher court *pursuant to an appropriate procedural vehicle*" (emphasis added).

Neither Mr. Hines nor the State has pursued an interlocutory or extraordinary appeal from the chancery court's order. *See* Tenn. R. App. P. 9, 10. Instead, on July 20, 2026, Mr. Hines filed the instant motion in this Court.

Mr. Hines "invites" this Court to review the defendants' answer to his request for admission. He moves for a conditional stay of execution if TDOC refuses to replace Physician A. He states that TDOC should be able to proceed with his August 13, 2026 execution if it replaces Physician A by hiring "an appropriately credentialed replacement from among the 20,000 active physicians in the State of Tennessee." Because in his view his request will not require a stay or delay of his execution, he says no further showing is required on his part. But if the Court concludes that a further showing is required, Mr. Hines asserts he can meet the requisite showing if the Court will grant him a special master proceeding and a conditional stay.

II. ANALYSIS

First, this Court declines Mr. Hines's invitation to review the chancery court's discovery order by exercise of its "inherent power." As the chancery court recognized, to the extent its order would be reviewed by a higher court, such review must occur "pursuant to an appropriate procedural vehicle." A motion by the prevailing party in the discovery dispute inviting this Court to exercise inherent authority and review the interlocutory order is not "an appropriate procedural vehicle." *See* Tenn. R. App. P. 9, 10.

Furthermore, to the extent Mr. Hines suggests that Tennessee Supreme Court Rule

12(4)(E) creates a "backdoor" avenue for appealing discovery orders issued in lawsuits challenging the method of execution TDOC has adopted, he is mistaken. Rule 12(4)(E) states that this Court will not grant an inmate's motion to stay or delay an execution date pending resolution of state collateral litigation "unless the prisoner can prove a likelihood of success on the merits in that litigation." Tenn. Sup. Ct. R. 12(4)(E). It also provides that, in certain circumstances, the Court may appoint a special master to conduct fact-finding to aid the Court in its assessment of a stay motion. *See id.* (amended Dec. 5, 2025).

Mr. Hines contends the State should be able to accommodate his request for a physician other than Physician A without delaying his scheduled execution. He says that he requested a conditional stay only because the Court has indicated that motions under Rule 12(4)(E) should be accompanied by a motion for a stay. Mr. Hines asserts that he has shown a likelihood of success on the merits of this claim in the chancery court lawsuit. But if the Court concludes he has not, Mr. Hines asks for the appointment of a special master so that he can satisfy the required showing through discovery and litigation in the special master proceeding. As explained below, we decline to appoint a special master and conclude that, even taking Mr. Hines's assertions as true, he has failed to establish a likelihood of success on the merits or circumstances warranting appointment of a special master.

A. Likelihood of Success

As stated many times by a multitude of courts, "capital punishment is constitutional." *Glossip v. Gross*, 576 U.S. 863, 869 (2015). And because capital punishment is constitutional, "there must be a [constitutional] means of carrying it out." *Id.* (alteration in original) (quoting *Baze v. Rees*, 553 U.S. 35, 47 (2008)). "[T]he Eighth Amendment 'does not demand the avoidance of all risk of pain in carrying out executions.'" *Bucklew v. Precythe*, 587 U.S. 119, 134 (2019) (quoting *Baze*, 553 U.S. at 47). "[T]he Eighth Amendment does not guarantee a prisoner a painless death—something that, of course, isn't guaranteed to many people, including most victims of capital crimes." *Id.* at 132–33. After all, "[s]ome risk of pain is inherent in any method of execution—no matter how humane—if only from the prospect of error in following the required procedure." *Baze*, 553 U.S. at 47. If the Eighth Amendment "demand[ed] the elimination of essentially all risk of pain," that "would effectively outlaw the death penalty altogether." *Glossip*, 576 U.S. at 869. So, the mere fact that "an execution method may result in pain, either by accident or as an inescapable consequence of death, does not establish the sort of 'objectively intolerable risk of harm' that qualifies as cruel and unusual." *Baze*, 553 U.S. at 50 (quoting *Farmer v. Brennan*, 511 U.S. 825, 846 & n.9 (1994)). "To the contrary, the Constitution affords a 'measure of deference to a State's choice of execution procedures' and does not authorize courts to serve as 'boards of inquiry charged with determining 'best practices' for executions.'" *Bucklew*, 587 U.S. at 134 (quoting *Baze*, 553 U.S. at 51–52 & nn.2–3). "[W]hen it comes to determining whether a punishment is unconstitutionally cruel because of the pain involved, the law has always asked whether the punishment 'superadds'

pain well beyond what's needed to effectuate a death sentence." *Id.* at 136–37. "And answering that question has always involved a comparison with available alternatives, not some abstract exercise in 'categorical' classification." *Id.* at 137.

Thus, to bring an Eighth Amendment method-of-execution challenge, a death-row inmate must: (1) establish that the method of execution "presents a risk that is '*sure or very likely* to cause serious illness and needless suffering,' and give[s] rise to 'sufficiently *imminent* dangers,'" *Glossip*, 576 U.S. at 877 (quoting *Baze*, 553 U.S. at 50), and (2) "identify an alternative [method of execution] that is 'feasible, readily implemented, and in fact significantly reduce[s] a substantial risk of severe pain,'" *id.* (second alteration in original) (quoting *Baze*, 553 U.S. at 52). With respect to errors occurring during the execution process, the United States Supreme Court has remarked that "an isolated mishap alone does not give rise to an Eighth Amendment violation, precisely because such an event, while regrettable, does not suggest cruelty, or that the procedure at issue gives rise to a 'substantial risk of serious harm.'" *Baze,* 553 U.S. at 50 (quoting *Farmer,* 511 U.S. at 842). These elements and principles also apply to method-of-execution challenges brought under article I, sections 16 and 32 of the Tennessee Constitution. *West v. Schofield*, 519 S.W.3d 550, 567–68 (Tenn. 2017) (first citing *Glossip*, 576 U.S. at 877; then citing *Baze*, 553 U.S. at 50, 52); *see also State v. Brimmer*, 876 S.W.2d 75, 88 (Tenn. 1994).

Mr. Hines argues that he has a likelihood of success sufficient to obtain a stay based on his claim of an intolerable risk of severe suffering during his execution under the 2025 protocol caused by "TDOC's culture of noncompliance, recklessness, and secrecy," which is "substantially increased if the individuals involved in setting the IV line, preparing the syringes, or administering the chemicals are not sufficiently trained." Complaint, Claim 1.2, at 138–139. Mr. Hines submits that a single modification to the 2025 protocol, i.e., removal of Physician A and replacement with a "qualified physician," will eliminate his constitutional concern about the protocol as written.

We disagree with both assertions. First, the chancery court's July 17, 2026 order, which is not before this Court, requires TDOC to respond to a request for admission about whether Physician A will be part of the team for Mr. Hines's execution. It does not declare Physician A unqualified, nor has Mr. Hines established, through anecdotal evidence or otherwise, that Physician A is unqualified to perform the responsibilities assigned by the 2025 protocol. Accepting Mr. Hines's allegations as true, he has established at most that Physician A was unable to place a central IV line for Mr. Carruthers' attempted execution. But, as already noted, "an isolated mishap alone does not give rise to an Eighth Amendment violation, precisely because such an event, while regrettable, does not suggest cruelty, or that the procedure at issue gives rise to a 'substantial risk of serious harm.'" *Baze*, 553 U.S. at 50 (quoting *Farmer*, 511 U.S. at 842).

As characterized by the State in its response to the instant motion, Mr. Hines "guesses that the State *might* use a physician who *might* be unqualified to establish a

backup central IV line during his execution, *if* needed." He further suggests that his declining health *may* make it more difficult for the IV team to establish a primary IV line, thus increasing the likelihood that placement of a central line will be necessary. But mere possibilities or hypotheticals, like Mr. Hines's allegations about the "risks of maladministration," are not sufficient to establish a substantial risk of severe pain. *West*, 519 S.W.3d at 564–65 (quoting *Baze*, 553 U.S. at 62). Accordingly, Mr. Hines's maladministration claim is "all but foreclosed," *Cooey v. Strickland*, 589 F.3d 210, 225 (6th Cir. 2009), as a matter of law because an alleged "potential flaw" in administration is too speculative "to state an Eighth Amendment claim," *Zink v. Lombardi*, 783 F.3d 1089, 1101 (8th Cir. 2015). Additionally, Mr. Hines's assertion that he is not relying on speculation but on the events that occurred at Mr. Carruthers' execution does not elevate his claim beyond the speculative risk of maladministration, which is not sufficient as a matter of law.

III. CONCLUSION

For all these reasons, this Court declines Mr. Hines's invitation to review the chancery court's discovery order and denies his request for a special master proceeding and a conditional stay of execution. Accordingly, his motion is denied in all respects.

This order is not subject to rehearing under Rule 39 of the Tennessee Rules of Appellate Procedure, and the Clerk is directed to certify this order as final and to immediately issue the mandate. As provided by this Court's order of September 30, 2025, the Warden of the Riverbend Maximum Security Institution, or his designee, shall carry out the execution of Anthony Darrell Dugard Hines in accordance with Tennessee law on the **13th day of August, 2026**, unless a stay is entered by this Court or by a federal court. Counsel for Anthony Darrell Dugard Hines shall provide to the Office of the Appellate Court Clerk in Nashville a copy of any order of stay. The Clerk shall expeditiously furnish a copy of any stay order to the Warden of the Riverbend Maximum Security Institution.

This order is designated for publication pursuant to Rule 4 of the Rules of the Tennessee Supreme Court.

PER CURIAM

DEATH PENALTY CASE
EXECUTION DATE: AUGUST 13, 2026
Case No. M2025-00221-SC-DPE-DD

IN THE TENNESSEE SUPREME COURT
AT NASHVILLE

STATE OF TENNESSEE

v.

ANTHONY DARRELL HINES

MOTION TO AMEND ORDER SETTING EXECUTION DATE, TO APPOINT SPECIAL MASTER, AND FOR CONDITIONAL STAY OF EXECUTION

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In January 2025, the Tennessee Department of Correction ("TDOC") finalized and released a redacted version of its current lethal injection protocol ("Protocol"). Movant Darrell Hines promptly filed a grievance raising various concerns about the Protocol, and on March 14, 2025—the day after his grievance was exhausted—he joined several other plaintiffs in filing suit regarding several problematic aspects of the Protocol and TDOC's capacity to carry it out. On September 30, 2025, with that lawsuit pending, this Court entered an Order setting an execution date for Mr. Hines of August 13, 2026.

On May 21, 2026, TDOC attempted—and ultimately failed—to execute Tony Von Carruthers. It appears, from all available evidence, that a central actor in the lengthy, excruciating, and ultimately unsuccessful attempt to execute Mr. Carruthers was a TDOC-selected execution physician, "Physician A,"[1] who tried and failed for nearly 45 minutes to obtain intravenous access.

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[1] This individual's name is public knowledge, and he has personally spoken to the press. However, the Davidson County Chancery Court has requested that Mr. Hines refer to him by a pseudonym when including his name on its public docket, and Mr. Hines will continue that practice here. He has redacted attachments accordingly.

As part of his ongoing, preexisting litigation, Mr. Hines served a request for admission (RFA No. 1) on TDOC, asking the agency to admit or deny that it intends to rely on Physician A for Mr. Hines' scheduled execution. TDOC refused to answer. After a July 16, 2026 hearing on the matter, the Davidson County Chancery Court granted the motion, made several on-the-record findings in support of that conclusion, and ordered TDOC to answer Mr. Hines' RFA No. 1, but stayed service of that answer pending consideration of the relevant issues by a higher court.[2] Ex. 1 (Order of July 17, 2026).

Mr. Hines therefore invites this Court to review Defendants' answer to RFA No. 1 and moves for a conditional stay of execution if TDOC refuses to replace Physician A. Because Mr. Hines assumes—and common-sense dictates—that TDOC should be able to proceed with Mr. Hines' execution on August 13, 2026, by hiring an appropriately credentialed replacement from among the 20,000 active physicians in the

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[2] It appears that the Chancery Court selected this language, rather than the ordinary approach of staying an order pending an appeal, because the court recognized that this Court's procedural framework for considering requests for equitable relief in connection with executions meant that there was a meaningful likelihood that the matter might be resolved through a mechanism other than an appeal.

State of Tennessee, Mr. Hines maintains that addressing this issue is well within this Court's inherent authority, without the need for significant additional litigation. However, insofar as this Court concludes that Mr. Hines must establish a likelihood of success on the merits in collateral litigation in order to obtain his requested conditional stay of execution, he can meet that standard for the reasons set forth herein and requests the appointment of a special master for the appropriate consideration of his request.

I. BACKGROUND

A. Mr. Hines has alleged an intolerable risk that he will experience severe suffering due to the 2025 Protocol's allowance for the use of insufficiently qualified medical personnel and has pursued his claim expeditiously.

On March 14, 2025, several Tennessee death row prisoners, including Mr. Hines, filed a Complaint in Davidson County Chancery Court seeking a declaratory judgment regarding the legality of TDOC's plans for carrying out their executions pursuant to the then newly unveiled Protocol. Ex. 2 (Complaint, *Burns v. Strada*, No. 25-0414-IV (Davidson County Ch.)). The Complaint contained four claims—Claims 1.1 through 1.4—based on the Eighth Amendment prohibition on cruel

and unusual punishment and the corresponding protections of Article I, §§ 16 and 32 of the Tennessee Constitution. The Complaint also set forth claims based on the First Amendment that, while mostly still pending, are minimally relevant to the current Motion. *Id.*

Defendants moved the chancery court to dismiss all of the plaintiffs' claims. The court granted that motion in part—dismissing Claim 1.3, which challenged the constitutionality of lethal injection generally, as time-barred; and dismissing most plaintiffs' Claim 1.4, which involved individual medical conditions, as unripe. *See* Ex. 3 (Order on Motion to Dismiss) at 23–24. Since that time, the two plaintiffs with surviving Claim 1.4 claims—Mr. Byron Black and Mr. Oscar Smith—were executed. Consequently, there remain two sets of Eighth Amendment claims pending in the plaintiffs' case—Claim 1.1 and Claim 1.2.

The claim more relevant to this matter, Claim 1.2, alleges that the plaintiffs face an intolerable risk of severe suffering due to TDOC's current inability to perform executions in a reliable, consistent, and appropriately humane manner under the Protocol in light of TDOC's culture, practices, and policies, as well as the unusual amount of discretion afforded by the Protocol's vague and undemanding terms. For

example, under the Protocol, intravenous catheterization is attempted, in the first instance, by an "IV Team." The previous protocol had required that intravenous catheterization be performed by certified EMTs. *See* Ex. 4 (Second 2018 Protocol) at 31, 42. The current Protocol, by contrast, replaces that clear requirement with a vague, open-ended set of qualifications copied nearly verbatim from the now-abandoned lethal injection protocol of Commissioner Strada's former employer, the Arizona Department of Corrections:

> IV Team: consists of at least two members who are either physicians, physician assistants, nurses, emergency medical technicians ("EMTs"), paramedics, military corpsman with relevant medical training, *or other certified or licensed personnel* including those trained in the United States Military. All team members are currently *certified, licensed and/or qualified within the United States to place IV lines.* IV Team members are selected by the Commissioner.

Compl. ¶ 335 (quoting Ex. 5 (Protocol) at 11); *compare* Ex. 6 (2022 Arizona Protocol) at 6.

As Plaintiffs warned in their Complaint, those requirements are functionally meaningless, because they provide no limitation on the type of license sufficient for participation and set out no limitations on the form of "certification" or "qualifications" sufficient for an unlicensed individual to participate. Accordingly, the Protocol permits reliance on

both meaningless pay-to-play certifications and licenses to perform services with no meaningful connection to intravenous catheterization. *See, e.g.,* Tenn. Code Ann. § 63-18-116 (granting a healthcare license for message therapy); Att'y Gen. of Conn., *Attorney General Warns of Bogus Medical Board Certification Scam Targeting Immigrant Doctors* (Apr. 8, 2009).[3] The Protocol, moreover, offers no explanation of what it means to be "certified, licensed and/or qualified within the United States to place IV lines." There is, to undersigned counsel's knowledge, no nationwide (or statewide) regime for specifically authorizing individuals "to place IV lines." *See* Compl. ¶¶ 335–50.

Based on that unnecessary vagueness and other instances of insufficiently defined safeguards, the plaintiffs alleged in their Complaint that the terms of the revised Protocol, combined with other risk factors, "create a significant, unnecessary, and avoidable risk that errors will occur in an execution performed pursuant to [the Protocol]." *Id.* ¶ 367. They likewise asserted that:

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[3] Available at https://portal.ct.gov/AG/Press-Releases-Archived/2009-Press-Releases/Attorney-General-Warns-Of-Bogus-Medical-Board-Certification-Scam-Targeting-Immigrant-Doctors.

> The risk of a [torturous] death by pentobarbital poisoning is also increased if the individuals charged with . . . setting the intravenous ("IV") line . . . are incompetent, insufficiently trained, insufficiently dedicated to doing their jobs properly, and/or insufficiently attentive.

Ex. 2 (Complaint) ¶ 315; *see also id.* at ¶¶ 324, 325, 332, 342, 348, 644.[4]

The plaintiffs pursued their concerns regarding IV catheterization zealously and expeditiously by, among other things, propounding Interrogatory No. 6 and Request for Production No. 11 on April 8, 2025, and July 1, 2025, respectively. Interrogatory No. 6 asked Defendants to "identify all forms of licensure, certification, or qualification that you consider sufficient for an individual to serve as one of the licensed, certified, or qualified members of the IV Team under the 2025 Protocol." Ex. 7 (Pl. Interrog. No. 6). Plaintiffs also asked that, "[f]or any form of qualification that does not involve the issuance of a license or certification confirming a satisfactory completion of requirements, [Defendants] identify the standard by which the adequacy of the team member's qualification will be assessed." *Id.*

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[4] Plaintiffs likewise alleged that TDOC suffers from a culture of recklessness with regard to the retention of demonstrably unreliable participants in executions. *Id.* ¶¶ 176, 181, 378.

In response to the interrogatory, Defendants lodged no specific objection, but instead chose to "answer" the interrogatory by copying and pasting the very language that the plaintiffs were seeking to clarify:

> Qualified IV Team members must be either physicians, physician assistants, nurses, emergency medical technicians, paramedics, military corpsman with relevant medical training, *or other certified or licensed personnel* including those trained in the United States Military. All IV team members *are currently certified, licensed, and/or qualified within the United States to place IV lines.*

Ex. 8 (Def. Resp. to Interrog. No. 6) (emphasis added).

Request for Production No. 11 asked Defendants to produce "all documents, policies, guidelines, memoranda, communications, training materials, protocols, or other records that describe, reflect, or relate to the forms of licensure, certification, or other qualifications considered sufficient for an individual to serve as a licensed, certified, or otherwise qualified member of the IV Team under the 2025 Execution Protocol." Ex. 9 (Pl. Req. for Prod. No. 11). Defendants objected to this request on the grounds that the information sought might identify execution participants. Ex. 10 (Def. Resp. to Req. for Prod. No. 11).

On October 7, 2025, the plaintiffs filed a Motion to Compel, covering several issues raised by Defendants' aggressive stonewalling of discovery.

They specifically alleged that Defendants' responses to Interrogatory No. 6 and Request for Production No. 11 were inadequate, Ex. 11 (Oct. 2025 Mot. to Compel) at 20, and argued that Defendants were not entitled to withhold this information under the court's protective order. The plaintiffs likewise contended that the risk of severe suffering due to TDOC's reliance on insufficiently qualified medical personnel was not merely "speculative," as Defendants alleged:

> A sufficiently qualified IV Team is indispensable to the reliability of any lethal injection protocol. IV errors have led to earlier botched executions . . . *See* Compl. ¶¶ 334– 54; 361–67. . . . [T]here is no reasonable basis for disputing that a botched IV catheterization can lead to a prolonged, torturous execution. At most, Defendants can simply suggest that there is no such risk here—a question of fact on which discovery is necessary. And there is no more important issue underlying that question of fact than what TDOC considers to be the minimum requirements for serving on the IV Team.

Id. at 20. The plaintiffs therefore asked the chancery court to compel defendants to substantively respond to Request for Production No. 11 and Interrogatory No. 6. *Id.*

The chancery court has yet to rule on this outstanding discovery motion. There is, accordingly, very little evidence by which to judge most of TDOC's intravenous catheterization personnel beyond the thin

requirements for their selection and their track record. The qualifications of one team member responsible for IV catheterization, however, are known—that of Physician A.

Physician A is, or at least was, the State's execution physician, whom the Protocol entrusts with "establishing central line IV access if necessary" due to an inability to set a peripheral line. Ex. 5 at 8. Physician A was deposed in Mr. Hines' chancery court litigation on October 27, 2025. During the deposition, Physician A seemed unaware that the 2025 Protocol required him to be able to set a central line, until that requirement was pointed out to him by undersigned counsel:

> Q. Okay. Can you tell me what you believe your role to be under that protocol as the physician?
>
> A. Certify the death of the inmate.
>
> Q. Okay. Anything else?
>
> A. That's it.
>
> MR. BRAZER: . . . [Physician A], I'm directing you to Page 8 of the 2025 Lethal Injection Protocol. . . . [Physician A], would you mind reading the paragraph under the word physician on Page 8?
>
> A. "The physician is responsible for determining that the inmate is deceased using acceptable -- acceptable medical standards and establishing central IV access if necessary."

Ex. 12 (Redacted Deposition) at 29. Physician A—having apparently learned for the first time that the State of Tennessee was expecting him to be capable of setting a central line—testified that he had not done so since 2013 and that, of the roughly twelve times he had performed the procedure, he erroneously inserted a guide wire into a patient's carotid vein during one such instance:

> Q. . . . How many times have you placed a central IV line?
>
> A. A dozen or more.
>
> Q. Okay. When was that?
>
> A. When I was in the emergency room, primarily.
>
> Q. Okay. So when was the last time you placed a central IV line?
>
> A. Probably somewhere close to the last aspect of my tenure in the emergency room.
>
> Q. Okay. So if I could have here, let me just refer back to your CV. So that would be around 2013; is that correct?
>
> A. Yes, sir.
>
> Q. Okay. And you stated that you never had any complications establishing a central IV line in those cases?
>
> A. I didn't say that.

> Q. Okay. Did you ever have complications in establishing a central IV line in those cases?
>
> A. Just one time.
>
> Q. Could you tell me what happened?
>
> A. The guide wire wound up in the carotid vein, which is an undesirable placement, but you can reverse that fairly quickly.

Id. at 32.

B. Mr. Hines' fears regarding TDOC's reliance on insufficiently qualified medical personnel were realized during the botched execution of Tony Carruthers.

The concerns raised by Claim 1.2 and the plaintiffs' October 7, 2025 Motion to Compel were, unfortunately, realized on May 21, 2026, when Defendants attempted, and ultimately failed, to execute Tony Von Carruthers.[5] According to Mr. Carruthers' attorney witness, Maria DeLiberato, members of the IV Team tried and failed for approximately 30 minutes to establish a back-up peripheral IV line—puncturing Mr. Carruthers six to seven times in his left arm and hand. *See* Ex. 13 (Decl. of Maria DeLiberato).

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[5] Mr. Carruthers is represented by the undersigned in some matters but is not a plaintiff in the chancery court litigation in which Mr. Hines is a plaintiff.

After failing to obtain peripheral IV access in Mr. Carruthers' left arm and hand, TDOC called upon Physician A to assist. Upon entering the execution chamber, Physician A identified himself by name and proceeded to direct the IV Team's efforts to obtain peripheral IV access in Mr. Carruthers' feet. *Id.* This effort also failed, whereupon Physician A began his attempts to place a central line. *Id.*

Physician A first attempted to place a central line in Mr. Carruthers' jugular vein. He asked whether any of the members of the IV Team had experience with jugular access and one of the members said that they did. Physician A and the IV Team member then assessed Mr. Carruthers' neck using an infrared vein finder (a device which cannot, in fact, be used to locate the internal jugular vein). *Id.* After the IV Team member who had volunteered expressed his misgivings about attempting the jugular placement, they abandoned this effort. *Id.*

Physician A then attempted to set a central line in Mr. Carruthers' chest—specifically his subclavian vein (under the right collar bone). *Id.* Before proceeding with the insertion, Physician A asked if Mr. Carruthers was allergic to lidocaine. No one in the room knew the answer. *Id.* Physician A nevertheless injected Mr. Carruthers' shoulder

with lidocaine and proceeded to wait five minutes for the lidocaine to take effect.

Concerned about the already harrowing ordeal that Mr. Carruthers was undergoing, Ms. DeLiberato used this opportunity to call undersigned counsel, Amy Harwell, from a wall phone in the Death Watch Area. Ms. Harwell informed Ms. DeLiberato that undersigned counsel had deposed Physician A and that Physician A was not qualified to place a central line. *Id.*

Ms. DeLiberato immediately returned to the execution chamber, where she objected to Physician A's attempts to place a central line in Mr. Carruthers, arguing that he was insufficiently qualified. *Id.* Physician A snapped back that he *was* qualified and proceeded with his attempts. *Id.*

Physician A then poked Mr. Carruthers with a needle in the area where he had administered the lidocaine and asked Mr. Carruthers if it hurt. Mr. Carruthers replied that it did. *Id.* However, instead of administering a second dose of lidocaine, as is the proper standard of care, Physician A proceeded with his attempts to place the subclavian central line. According to Ms. DeLiberato, Mr. Carruthers groaned in

pain during these attempts and said "it hurts, it hurts." Later, a tearful Mr. Carruthers told Ms. DeLiberato that Physician A "was hurting me and he knew he was hurting me." *Id.*

During this time, undersigned counsel communicated with Assistant Attorney General John W. Ayers, counsel for TDOC, to express their own objections to the State's use of Physician A for central line placement. Undersigned counsel reminded Mr. Ayers that Physician A had admitted under oath that he had not placed a central line in over 13 years and did not have privileges to do so at any hospital in the United States. Indeed, Mr. Ayers' team and TDOC were aware of this information because they had defended Physician A's deposition. Nevertheless, Mr. Ayers expressed that Defendants "could not agree" that Physician A was not qualified to place a central line. Undersigned counsel thereafter requested that the Attorney General's office stop the execution, to give them time to litigate whether Physician A was qualified to proceed. Mr. Ayers stated that he would "run that request up."

At 11:40 AM, after over an hour of failed IV catheterization attempts—wherein Mr. Carruthers was subjected to over a dozen puncture wounds, potential internal injuries, extreme terror, pain, and

humiliation—Governor Lee intervened to stop the execution and granted Mr. Carruthers a one-year reprieve. *See* Ex. 14 (Reprieve).

C. Mr. Hines established in Davidson County Chancery Court that any protection that would prevent TDOC from confirming whether it intends to rely on Physician A for Mr. Hines' execution has been waived.

Mr. Hines hoped and expected that TDOC would expeditiously announce that it would no longer rely on Physician A for executions. When it failed to do so, Mr. Hines issued a June 17, 2026 request for admission (RFA No. 1) in *Burns v. Strada*, asking TDOC to admit whether it expects to continue to rely on Physician A for Mr. Hines' scheduled execution on August 13, 2026. The defendants refused to answer and responded with objections—arguing that the State has a confidentiality interest in Physician A's identity as a future execution participant. The plaintiffs filed a motion to enforce the request, and, before the scheduled hearing on that motion, the Davidson County Chancery Court *sua sponte* proposed a revision to RFA No. 1 to remove Physician A's name and to instead ask whether TDOC intended to use the same physician as they did for Mr. Carruthers' attempted execution. Defendants reiterated their objections. After a hearing on July 16, 2026, the chancery court granted Mr. Hines' motion with regard to the

reformulated question but stayed service of Defendants' response pending resolution of the underlying issues by a higher court through an appropriate mechanism. *See* Ex. 1 (Order).

The chancery court made several specific holdings, including that TDOC had sufficiently waived any protection owed to Physician A to support the granting of the motion. *Id.* Defendants themselves first inadvertently disclosed Physician A's identity to media witnesses orally during the execution of Byron Black on August 5, 2025. *See* Steve Cavendish, Podcast: *Exploring the Unusual Execution of Byron Black*, Nashville Banner, Aug. 10, 2025, https://nashvillebanner.com/2025/08/10/execution-tennessee-byron-black-defibrillator/. Based on the resultant reporting, *id.*, undersigned counsel noticed Physician A for deposition. Shortly thereafter, the defendants filed a Motion to Quash directed at other noticed depositions, and included Physician A's full, unredacted name in an exhibit. *See* Ex. 15 (Motion to Quash and Redacted Exhibit).

In the hearing on that motion, counsel for the plaintiffs pointed out the fact that the defendants had, in so doing, published the full, unredacted name of a direct execution participant on the public docket.

Counsel for the defendants immediately objected—not to complain about the plaintiffs' drawing attention to the apparent error, but to dispute any suggestion that there had even been an error at all. Counsel for the defendants explained that the name was unredacted because the defendants were being "very judicious with their redactions" and did "not make redactions where they don't have a supportable interest and supportable justification in asserting that redaction." Ex. 16 (Chancery Court Transcript) at 45.

Protection for Physician A's identity was affirmatively waived again in connection with his deposition. Early in the deposition, Physician A expressed a mistaken belief that the deposition was being taken "under seal." Undersigned counsel informed him that he was mistaken and, following a brief exchange and a short period of going off the record, confirmed Physician A's understanding of that fact:

> Q. Okay. So I -- are you aware that this deposition is not being conducted under seal?
>
> A. I am now.
>
> Q. Okay. All right, [Physician A], I'd like to proceed with the questions if that's okay.
>
> A. Sure.

Ex. 12 at 23–25.

With full knowledge that the deposition was not under seal, Physician A testified regarding what he "believe[d] [his] role to be under the protocol as the physician," *id.* at 29, thereby acknowledging that he had not merely been the execution physician in the past, but was, in fact, serving in that role on a continuing basis.

The chancery court's protective order expressly permits the designation of deposition testimony as "Protected Material" "within thirty (30) days of receipt of the final transcript." Ex. 17 at 9. The defendants could have designated Physician A's deposition as Protected Material, but did not avail themselves of that process.

Finally, during the botched execution attempt of Tony Carruthers, as noted *supra*, Physician A affirmatively identified himself to Mr. Carruthers' attorney witness, Ex. 13 (Decl. of Maria DeLiberato), and he later confirmed his involvement by choosing to speak to an NBC News reporter to defend the quality of the work he performed. Erik Ortiz and Abigail Brooks, *Doctor in failed Tennessee execution says he didn't want prisoner to suffer,* NBC News (June 1, 2026),

https://www.nbcnews.com/news/us-news/tennessee-execution-botched-death-penalty-lethal-injection-rcna347362.

Mr. Hines therefore argued that the defendants repeatedly waived their confidentiality interest in Physician A's identity pursuant to the framework set out in *Castillo v. Rex*, 715 S.W.3d 321, 337–38 (Tenn. 2025), and the chancery court agreed. In light of that waiver, the chancery court ordered the defendants to answer Mr. Hines' RFA No. 1, but stayed the service of that answer pending the opportunity for review by a higher court.[6]

D. Mr. Hines has already suffered due to the incompetence of TDOC's contracted medical personnel and reasonably fears that he will endure additional suffering if TDOC is allowed to use Physician A for his scheduled execution.

Between the filing of Mr. Hines' Complaint in *Burns v. Strada* and the failed attempt to execute Mr. Carruthers, Mr. Hines' health aggressively deteriorated—in significant part due to TDOC's failure to

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[6] The Chancery Court's decision to phrase its stay in that manner—rather than simply staying pending an interlocutory appeal—appears to have been a recognition of the unique structure of Rule 12.4(E) and the likely need for the relevant issues to be raised directly before this Court, in order for all issues to be resolved in a timely manner.

provide him with necessary medical care. As Mr. Hines' medical records indicate, Mr. Hines suffered an ischemic stroke in early December 2025, whereupon an ambulance was called to Riverbend Maximum Security Institution to transport him for treatment at an outside hospital. Ex. 18 (Hines Medical Records) at 1. An employee with TDOC's contracted medical provider, Centurion, however, turned the ambulance away, writing that "urgent imaging is warranted, but not ER transfer."

Although imaging could be performed "in house" at the prison's DeBerry Special Needs Facility, TDOC's medical contractor inexplicably failed to perform Mr. Hines' CT scan until three weeks later, on December 22, 2025—at which point they confirmed that Mr. Hines had indeed suffered an ischemic stroke. *Id.* at 2, 5. The physician then waited another two weeks (until January 6, 2026) to prescribe Mr. Hines aspirin—which, according to the standard of post-stroke care, should have been given to Mr. Hines daily within 24 hours of his stroke. *Id.* at 3, 5. The physician likewise prescribed Mr. Hines an anti-coagulant medication, Eliquis, which Centurion subsequently denied because the drug was not in their formulary. *Id.* at 6-8. Centurion made no effort to provide Mr. Hines with a comparable medication. Unsurprisingly then,

Mr. Hines appeared to suffer a second stroke a week later (on January 13, 2026)—collapsing in his cell and hitting his head. *Id.* at 4. He has since been in the infirmary, and is paralyzed on his left side, with partial left-sided blindness and muscular atrophy.

Having already suffered the trauma of a debilitating stroke due to the negligence of TDOC's contracted medical personnel, Mr. Hines reasonably fears that he will suffer like Mr. Carruthers did if TDOC is allowed to use insufficiently qualified medical personnel—such as Physician A—for his scheduled execution. In support of this concern, Mr. Hines notes that, in addition to the facts stated *supra* regarding Physician A's qualifications, actions, and performance, Physician A, according to Mr. Carruthers' attorney witness, made no effort to place Mr. Carruthers in Trendelenburg position prior to attempting to place a central line in Mr. Carruthers' jugular and subclavian veins—which further calls into question his familiarity with accepted practices for central line catheterization.

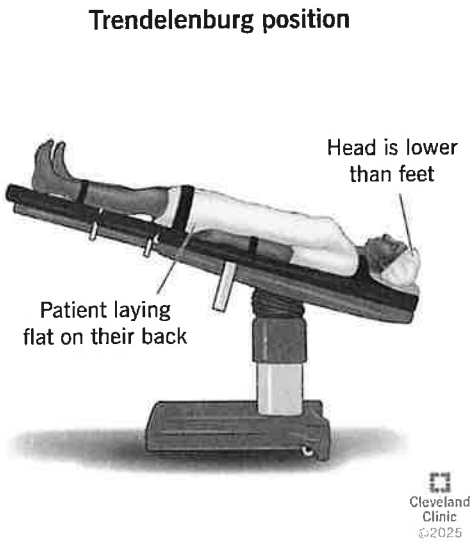

Figure 1 "Trendelenburg Position," Cleveland Clinic, https://my.clevelandclinic.org/health/procedures/trendelenburg-position

It is the medical standard of care to place a patient in Trendelenburg position (where the feet are raised above the head) prior to attempting subclavian or jugular central line placement. Ex. 19 (Decl. of Dr. Sina Khoshbin). When a patient is in Trendelenburg position, gravity causes their blood to pool in the upper body, which dilates the subclavian and jugular veins. This dilation makes the blood vessels significantly easier to locate, puncture, and cannulate. *Id.* The head-down tilt position also elevates the patient's right atrium above the puncture site, which ensures that any atmospheric-to-venous pressure

gradient favors bleeding out, as opposed to air being sucked into the patient's venous system. *Id.*

If a patient is not placed in Trendelenburg position, there is a risk of venous air embolism—wherein air is sucked into the IV line and enters the patient's venous system. *Id.* Trendelenburg position ensures that even if air enters the venous system, it will rise to the patient's feet, not their head. *Id.* If the patient is *not* in Trendelenburg position, however, an air embolism could enter the patient's vein and travel to the heart. If the patient has a patent foramen ovale (PFO)—a small hole between the left and right atria of the heart that is present in approximately 25% of individuals—the air embolism could cross over into the patient's arterial system, whereupon it could rise to the patient's brain and potentially cause a stroke. *Id.*

A reasonable physician would have either tilted the execution gurney to ensure that Mr. Carruthers was in Trendelenburg position or, in the event that the gurney does not tilt, notified the Department ahead of time that they would need to bring in a gurney from the prison infirmary with such capability. *Id.* If the Department, for whatever reason, was unable to use a gurney that tilts, a reasonable physician

might have attempted central line placement in the person's femoral vein instead—which does not require Trendelenburg position. Physician A's failure to take these reasonable steps—despite being put on notice by undersigned counsel that he might be called on to place a central line, Ex. 12 at 29—evinces his recklessness and inexperience. So too does the fact that, despite not having placed a central line in over 13 years (and having only limited experience before then), Physician A attempted to place a central line in Mr. Carruthers' subclavian vein (which carries the highest risk of complications), without the use of an ultrasound (which is recommended), and ultimately failed to do so, despite his lengthy efforts. These facts strongly suggest that Mr. Hines will suffer greatly if TDOC is allowed to use Physician A for Mr. Hines' scheduled execution.

Finally, the risk that TDOC will be unable to establish either the primary or secondary peripheral IV lines and will be forced to resort to a central line during Mr. Hines' scheduled execution is not speculative. Mr. Hines is 66 years old, extremely thin, and has suffered significant muscular atrophy as a result of his stroke—all of which will complicate peripheral IV access. Mr. Carruthers, by contrast, is nearly a decade younger than Mr. Hines and had no foreknown medical issues that could

complicate vascular access. Nevertheless, TDOC's IV team was incapable of establishing secondary peripheral IV access in Mr. Carruthers and was forced to resort to a central line.

II. JURISDICTION

This Court has held that it possesses exclusive authority over all requests for equitable relief that would "effectively and practically operate[] as a stay" of a pending order scheduling an execution. *Black v. Strada*, 721 S.W.3d 223, 228 (Tenn. 2025). The Court has interpreted that requirement to extend not only to stay requests or requests for injunctive relief forbidding or postponing an execution, but also to requests for relief that would give rise to a violation of the obligation imposed if the State went forward with the execution without complying. *Id.*

Mr. Hines is aware of no reason why the narrow issues he raises here should or will necessitate a postponement of the scheduled execution. Nevertheless, it is true that, if he were granted his requested relief by a trial court, and the State simply refused to comply and went forward with Mr. Hines' execution, that would be a violation of the trial

court's order. Accordingly, this Court provides the only forum in which he can seek relief in Tennessee state courts.

Requests for execution-related relief from this Court while an execution date is pending are largely governed by this Court's Rule 12.4(E).[7] This Court has suggested that a motion seeking relief pursuant

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[7] On December 5, 2025, the Tennessee Supreme Court amended Rule 12.4 to adopt a framework for "commenc[ing]" "any state court collateral litigation that would potentially affect the method or timing of execution" "[a]fter a date of execution is set." Tenn. R. Sup. Ct. 12.4(E) ("December 2025 Amendment"). As has been raised to this court in other currently pending litigation, the December 2025 Amendment was unlawful because it (1) improperly amends Tenn. R. Civ. P. 3 ("All civil actions are commenced by filing a complaint with the clerk of the court.") without following the procedures set out in Tenn. Code Ann. § 16-3-404; (2) improperly amends the Rules of this Court without following the procedures set out in Tenn. Code Ann. § 16-3-404; (3) violates the edict, in Article VI, § 2 of the Tennessee Constitution, that this Court's "jurisdiction . . . shall be appellate only"; (4) violates Tenn. Const. art. II, §§ 1–2 by "'creat[ing], defin[ing], and regulat[ing] the rights, duties, and powers of parties," *Willeford v. Klepper*, 597 S.W.3d 454, 475 (2020) (Kirby, J., concurring) (citation omitted), without legislative authorization; (5) violates Tenn. Code Ann. § 16-3-403 by "abridg[ing], enlarg[ing] or modify[ing]" existing rights; (6) permits this Court to extinguish vested causes of action without either due process or compensation; (7) is unconstitutionally vague in its scope; and (8) violates due process by failing to provide notice regarding the procedures that will govern the consideration of claims commenced through the Rule 12.4(E) process. The infirmities in the December 2025 Amendment, however, do not preclude the relief that Mr. Hines seeks because (1) Mr. Hines filed a Complaint encompassing the underlying concerns well before his execution date was set and (2) all of the relief that he requests would be within the Court's power regardless of the December 2025 Amendment. Mr. Hines notes these objections, however, to preserve them, should the Court construe the December 2025 Amendment as bearing on these proceedings.

to Rule 12.4(E) must incorporate a request for a stay of execution. *See* Ex. 20 (*Pike* order). Mr. Hines has therefore styled this motion as incorporating a request for a conditional stay, not because he anticipates the need for such a stay but because this Court requires him to take that formal step in order to seek relief. Mr. Hines stresses, however, that there has been no showing—and Mr. Hines highly doubts that the State could make a showing—that complying with his request would require the postponement of an execution.

III. LEGAL STANDARD

For reasons set out *infra*, this Court has broad discretion to address the issues raised by and underlying this motion. To the extent that Mr. Hines' request requires him to establish a likelihood of success on the merits regarding a pending claim in collateral litigation, the relevant claim is Claim 1.2 of *Burns v. Strada*, as limited to the specific possibility of an execution going forward with Physician A serving as TDOC's execution physician. That claim alleges that TDOC's plans for carrying out Mr. Hines' execution are inconsistent with the Eighth Amendment in light of (1) the breadth of discretion granted to TDOC by revisions to Tennessee's protocol; (2) the specific risks and demands of performing an

execution by lethal injection of pentobarbital; and (3) TDOC's established culture of recklessness and noncompliance surrounding executions, including, in particular, its refusal to part ways with execution participants whose actions and/or statements have proven them to be unreliable. *See* Ex. 2 (Complaint) ¶¶ 176, 181, 309–11, 369–401, 426–87, 684–94.

To succeed on the merits of an Eighth Amendment claim involving an anticipated execution, a plaintiff typically must make two showings. First, he must show that the challenged course of action poses an "'objectively intolerable risk of harm' that qualifies as cruel and unusual." *Baze v. Rees*, 553 U.S. 35, 50 (2008) (quoting *Farmer v. Brennan*, 511 U.S. 825, 846 (1994)). Although Eighth Amendment cases routinely discuss such harm using the shorthand of "pain," it is well-established that, consistent with the Framers' expectations, the Eighth Amendment encompasses more than what modern medicine would classify as physical pain. Rather, the Eighth Amendment considers all forms of sufficiently severe "needless suffering," *Glossip*, 576 U.S. at 877 (quoting *Baze*, 553 U.S. at 50), including the "'superadd[ition]' of 'terror, pain, or disgrace,'" *Bucklew*, 587 U.S. at 133 (quoting *Baze*, 553 U.S. at 48).

Second, when an individual challenges some aspect of his proposed execution, "the Eighth Amendment requires [him] to plead and prove a known and viable alternative." *Glossip*, 576 U.S. at 880. If there is no viable alternative method of execution, the reasoning goes, then the challenge is to the sentence, not the method, and should be treated accordingly. *Id.* at 879–80.

A plaintiff can establish that his challenge is to a method or circumstance, rather than the death penalty itself, by establishing that there exists at least one alternative course of action that "'is feasible, readily implemented, and in fact significantly reduce[s]' the risk of harm involved." *Nance v. Ward*, 597 U.S. 159, 164 (2022) (quoting *Glossip*, 576 U.S. at 877); *see also Abdur'Rahman v. Parker*, 558 S.W.3d 606, 616 (Tenn. 2018). ("[U]nder the federal or state constitution, a death-sentenced inmate must establish . . . that the risk is substantial compared to the known and available alternatives."). As long as that plausible alternative course of action exists, then the plaintiff's challenge does not allege, either explicitly or by implication, that "the death penalty is categorically unconstitutional." *Glossip*, 576 U.S. at 880.

IV. ARGUMENT

A. This Court has authority to resolve the present dispute through its inherent powers and should do so by requiring Physician A not to be used in the carrying out of its Order setting Mr. Hines' execution.

This Court, as the "repository of the inherent power of the judiciary in this State," *Petition of Burson*, 909 S.W.2d 768, 772 (Tenn. 1995) (collecting cases), possesses "broad authority over the Tennessee Judicial Department," *Moore-Pennoyer v. State*, 515 S.W.3d 271, 276 (Tenn. 2017), that is "inherent" and "not a matter of legislative largess but derive[s] from the common law as it existed at the time of the adoption of the constitution of Tennessee and of the power inherent in a court of last resort," *id.* (cleaned up).

The Court's power in the area of pending executions is particularly strong for at least three reasons. First, because this Court enters the underlying order setting an execution date, *see* Tenn. Sup. Ct. R. 12.4, it possesses the inherent power to amend that order pursuant to its "power to supervise and control [its own] own proceedings." *State v. Welch*, 586 S.W.3d 399, 404 (Tenn. Crim. App. 2019) (citing *State v. Bragan*, 920 S.W.2d 227, 239 (Tenn. Crim. App. 1995)). Second, as a matter of both judicial policy and substantive rule, this Court possesses a recognized

particular interest in the administration of a sentence of death during the period after the entry of such an order. *See Black v. Strada*, 721 S.W.3d 223, 228 (Tenn. 2025). Third, this Court has recognized that "the penalty of death is qualitatively different from any other sentence and this qualitative difference between death and other penalties calls for a greater degree of reliance when the death sentence is imposed." *Van Tran v. State*, 66 S.W.3d 790, 807 (Tenn. 2001) (cleaned up). The unique nature of the death penalty also makes its proper administration uniquely important to public faith in the broader legal system and, therefore, uniquely important to this Court.

As Tenn. Code Ann. § 16-3-401 permits, this Court has promulgated certain rules guiding its own power to intervene in issues surrounding in executions—most prominently, Rule 12.4(E) and its limitations on the Court's power to "stay or delay of an execution date *pending resolution of collateral litigation*" (emphasis added). By the Rule's plain language, this request falls outside those restrictions. First, while the State will undoubtedly take the position that Mr. Hines' request is, in practical effect, a request for a *potential* delay, the State has not established that any delay would be necessary or even likely, and Mr. Hines doubts their

ability to do so, for the reasons stated *infra*. Second, the relevant Rule 12.4(E) restrictions, on their face, apply only to delays "pending resolution of collateral litigation." Any delay in this case would be during the time it takes TDOC to hire an appropriately qualified physician, not during the pendency of collateral litigation.

Nevertheless, in litigation surrounding the execution of Byron Black, this Court elected to apply the likelihood of success standard, notwithstanding the fact that Mr. Black had not sought a stay "pending resolution of collateral litigation." *See* Ex. 21 (Order of August 1, 2025, *Black v. State*, No. M2000-00641-SC-DPE-CD (Tenn.)) at 4. Mr. Hines does not dispute that the Court had the power to do so. Indeed, as far as Rule 12.4(E) is concerned, this Court may, within its equitable discretion, analyze a request that is not "pending resolution of collateral litigation" by whatever standard it chooses, so long as that standard comports with

due process[8] and any other non-dischargeable legal obligation. Mr. Hines suggests, however, that his situation is materially distinguishable from Mr. Black's in ways that would support a conditional stay pursuant to a standard that would forgo a need for a lengthy inquiry into Mr. Hines' claims in chancery court.

Mr. Black's request involved the need for a specialized, pre-execution medical procedure that plausibly could have led to a relatively open-ended stay. Mr. Hines, by contrast, is aware of no reason why the narrow issues he raises here should or will necessitate a postponement of the scheduled execution. The defendants did not establish in chancery court that complying with Mr. Hines' request would require the postponement of his execution. And Mr. Hines sincerely doubts that they

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[8] To that end, Mr. Hines does raise and preserve an objection that it is inconsistent with due process to treat all requests for injunctive relief bearing on an execution as requests for a stay as a matter of law, without any requiring of a factual showing that a delay is actually likely. Mr. Hines does not dispute the well-settled caselaw establishing the relatively disfavored status of "last-minute" requests for relief that would delay an execution. However, he contests any suggestion that it comports with due process to treat every request for relief as a "last-minute request for delay," by operation of law, with no reference to the reality of the underlying situation. He also disputes whether it is consistent with due process to attribute culpability for risk of delay in such a situation to the movant, regardless of the actions, policies, or litigation conduct of the respondent.

could have made such a showing. There are nearly 20,000 active physicians in Tennessee, *see* KFF, *State Health Facts/Providers & Service Use/Physicians*, https://www.kff.org/state-health-policy-data/state-indicator/total-active-physicians/. A substantial subset of those 20,000 physicians (which include anesthesiologists, ER doctors, trauma surgeons, etc.) undoubtedly have substantially more experience in central line placement than Physician A and privileges to do so at hospitals in the United States. Tennessee's lethal injection protocol requires no complex or lengthy process for replacing the execution physician—the choice is made entirely at the discretion of the Commissioner. *See* Ex. 5 (Protocol) at 11. Defendants therefore failed to establish that they could not proceed with Mr. Hines' scheduled execution by simply hiring a different physician. [9]

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[9] Were it not for the extreme secrecy that TDOC maintains regarding its staffing of executions, Mr. Hines would readily engage in discovery to further support the fact that TDOC could easily find a new execution physician. In light of that secrecy, however, Mr. Hines can, at this point, appeal only to the Court's common sense and the public record. If the Court appoints a special master, however, that special master may be able to use appropriate procedures to better assess the likelihood of an actual delay, including, as needed, by relying on *ex parte* and under seal procedures to evaluate the State's factual assertions regarding logistical aspects of the execution process.

Mr. Black's situation, moreover, arose ultimately out of a genuinely challenging feature of Mr. Black's medical condition—his ongoing need for an implanted cardioverter defibrillator (ICD)—that was not, in the first instance, a result of any fault of TDOC. Meanwhile, the present risks to Mr. Hines are entirely of the State's own making.

Finally, while Mr. Black maintained that he pursued his issues expeditiously, it is undeniable that the time pressures facing Mr. Hines have been more significant, and any argument that he engaged in some manner of culpable delay is strikingly weak. While Mr. Hines has long had concerns about TDOC's execution personnel—and, later, specific concerns about Physician A based on facts revealed in Physician A's deposition—the true extent of the risks that Mr. Hines faces were not apparent until the failed attempt to execute Mr. Carruthers on May 21, 2026. Even then, Mr. Hines hoped that TDOC would part ways with Physician A after Physician A's prolonged and embarrassing failure to perform the functions that had been entrusted to him by the State on behalf of the people of Tennessee. Mr. Hines has acted as expeditiously as could reasonably be expected to have this matter addressed.

Mr. Hines is well aware of the consistent laments that this Court and others have made about the demands of "last-minute" litigation surrounding executions. What is required here, however, is not complex, demanding litigation. What is needed is an entity with appropriate authority to step in to fix a small, but extremely important, defect in Tennessee's current plans to execute Mr. Hines. This Court can and should do so by relying on its inherent authority to forbid reliance on Physician A without an unnecessary detour into the more complex forms of litigation required when an individual seeks a delay pending the resolution of ongoing collateral litigation.[10]

B. Insofar as Mr. Hines is required to prove a likelihood of success on the merits of his underlying constitutional claim, he can do so, if granted a special master proceeding.

If the Court does conclude that the "likelihood of success on the merits" stay-of-execution standard applies to this Motion, Mr. Hines can prove a likelihood of success on the merits of his underlying

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[10] Indeed, such an order would obviate any need for an expedited consideration of whether or not Physician A's participation in upcoming executions is shielded by the state's secrecy laws, because this Court can forbid reliance on Physician A regardless of whether or not TDOC was *actually* intending to rely on him in the first place.

constitutional claim. To be clear, Mr. Hines does *not* here assert that he can presently establish a likelihood of success on his entire chancery court lawsuit or even the entirety of the relevant claim, Claim 1.2. Mr. Hines asserts only that he can establish a sufficient likelihood of success on the merits with regard to Claim 1.2 as it applies to TDOC's apparent intention to rely on Physician A in his upcoming execution, particularly if granted the opportunity to do so in a special master proceeding.

To that end, Mr. Hines contends that Defendants' apparent intention to rely on Physician A for his scheduled execution on August 13, 2026 is "very likely to cause . . . needless suffering," *Baze*, 553 U.S. at 50 (quoting *Helling v. McKinney*, 509 U.S. 25, 33, 34–35 (1993)), for the reasons set forth *supra*.

Physician A is insufficiently qualified to perform one of the two duties assigned to him by the Protocol—namely, the placement of a central intravenous line. As noted above, Physician A has not placed a central line in over 13 years, does not have privileges to do so at any hospital in the United States, and, of the dozen or so central lines he placed in the distant past, at least one involved significant complications. Nevertheless, Physician A recklessly tried and failed repeatedly to place

a central line in Mr. Carruthers on May 21, 2026, after having tried and failed to assist in the placement of a peripheral line as well. Physician A's inexperience in central line placement was evidenced not only by his repeated failures, but also by the fact that he attempted to place the central line in Mr. Carruthers' subclavian vein (which carries the highest risk of complications), using the landmark method (i.e., without the use of an ultrasound—which is recommended), and without first placing Mr. Carruthers in what is called "Trendelenburg position" (an inclined position, where the patient's feet are above their head—which is the standard of care). These facts, as well as others that Mr. Hines intends to develop in a special master proceeding, establish that TDOC is very likely to cause Mr. Hines to endure needless suffering if they rely on Physician A for his execution.

It is not merely speculative that Physician A will be called on to place a central line in Mr. Hines or will otherwise participate in peripheral IV catheterization attempts—as he did in the attempted execution of Mr. Carruthers, well before he was called on to attempt a central line. *See* Ex. 13 (Decl. of Maria DeLiberato) ¶¶ 32–43. Indeed, it is substantially likely that TDOC's IV team will be unable to obtain

primary and/or secondary peripheral IV access in Mr. Hines—requiring the placement of a central line by the Physician, pursuant to the Protocol. *See* Ex. 5. Mr. Hines is 66 years old, is extremely thin, and has suffered from extensive muscular atrophy as a result of a stroke—all of which will complicate finding a suitable peripheral vein.

Moreover, while it is difficult to fully assess the competency of TDOC's other IV team members (i.e., the non-Physician members responsible for obtaining peripheral IV access) due to Defendants' invocation of state secrecy protection with respect to their qualifications, the available evidence strongly suggests that they will be unable to establish peripheral IV access in Mr. Hines. TDOC's IV Team proved incapable of establishing secondary peripheral IV access in Mr. Carruthers, notwithstanding the fact that Mr. Carruthers is roughly a decade younger than Mr. Hines and had no foreknown medical conditions that would make vascular access difficult. While Defendants might argue that the IV Team was able to establish peripheral IV access during the executions of Oscar Smith (May 22, 2025), Byron Black (August 5, 2025), and Harold Nichols (December 11, 2025), Defendants have not established that the individuals who served on the IV Team for those

executions were same individuals who served on the IV Team for Mr. Carruthers' attempted execution on May 21, 2026. It is distinctly possible that TDOC's current IV Team has a 0 for 1 track-record with respect to establishing both primary and secondary peripheral IV access.

Finally, insofar as the likelihood that the physician will need to place a central line is uncertain, Mr. Hines asserts that it is appropriate to commit that question to a special master who can, if necessary, consider the sufficiency of TDOC's planned IV Team. Mr. Hines and his co-plaintiffs have been diligent in seeking information about the reliability of TDOC's IV Team for over a year. They served an interrogatory seeking clarification regarding the team's qualifications in April 2025. *See* Ex. 7 (Pl. Interrog. No. 6). They filed notices seeking to perform anonymized depositions of IV Team members in October 2025. *See* Ex. 22 (Notice of Depositions). These requests have been disputed, briefed, and argued for months, and the chancery court has yet to rule. A special master could consider the sufficiency of the IV Team—with

appropriate procedures for maintaining confidentiality—and evaluate the actual likelihood of the underlying risks.[11]

Mr. Hines therefore maintains that he is likely to require the placement of a central line and that TDOC's reckless reliance on Physician A would subject him to an intolerable risk of severe suffering, in violation of the Eighth Amendment. With respect to the second prong of *Baze/Glossip/Bucklew* test, he proposes the obvious alternative: The use of a physician other than Physician A who is appropriately credentialed in the placement of central intravenous lines.

Mr. Hines points out that Rule 12.4(E) does not require a likelihood of success on the merits to be "overwhelming," or even "substantial."

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[11] Indeed, Mr. Hines would welcome a special master who could review the IV Team's qualifications and competency, and recommend any appropriate steps if it is, in fact, shown that any member of that team is unqualified. Judicial tools for handling confidential information are routinely recognized as sufficient to protect information that is no less sensitive—and oftentimes far more valuable—than would be at issue in such an inquiry. *See, e.g.*, *Doe v. Sarah Lawrence Coll.*, No. 19-CIV-10028-PMH-JCM, 2021 WL 197132, at *5 (S.D.N.Y. Jan. 20, 2021) (using protective order to facilitate disclosure of mental health records of sexual assault victim); *United States v. Concord Mgmt. & Consulting LLC*, 404 F. Supp. 3d 67, 75 (D.D.C. 2019) (collecting cases in which protective orders were used to facilitate discovery of national security-related information); *Takata v. Hartford Comprehensive Emp. Ben. Serv. Co.*, 283 F.R.D. 617, 622 (E.D. Wash. 2012) (using protective order to facilitate disclosure of trade secrets involving the internal operations of multi-billion-dollar insurance company).

Rather, the Rule directly mirrors the well-worn language of the established temporary/preliminary injunction standard that has been interpreted to require only that the movant establish "at a minimum, serious questions going to the merits" of his claim. *Luxshare, Ltd. v. ZF Auto. US, Inc.*, 15 F.4th 780, 783 (6th Cir. 2021) (quoting *Mich. Coal. of Radioactive Material Users v. Griepentrog*, 945 F.2d 150, 153–54 (6th Cir. 1991)).

Mr. Hines anticipates that the State will argue that his claim is categorically bound to fail because it is based on a risk of execution errors, which, the State will assert, are so disfavored by current caselaw as to be effectively foreclosed. Such arguments, however, ignore the well-established caselaw distinguishing between claims based on the generic risk of negligence and claims based on specific, identified risk factors that are being knowingly and recklessly disregarded. Plaintiffs do not dispute that the former type of claim is highly disfavored. However, the relevant caselaw clearly distinguishes between the two categories of claims and recognizes that the latter must be evaluated based on the facts at issue, not dismissed out of hand. *See Cooey v. Strickland*, 589 F.3d 210, 224 (6th Cir. 2009) ("Consequently, Biros's general claim that the possibility of

maladministration of the IV could lead to severe pain is without merit. To demonstrate a likelihood of success on this ground, therefore, Biros must distinguish his maladministration claims from those rejected in *Baze*.").

The concern that Mr. Hines has raised—Physician A's potential participation in his execution—is neither generic, speculative, nor limited to fears about mere negligence. Physician A is an individual who participated in executions without bothering to learn that he might be expected to place a central line, was informed of that fact in litigation, and yet still proved incapable of doing so when the time arrived. TDOC, in turn, affirmatively chose to retain Physician A after his deposition revealed his lack of preparation or appropriate qualifications. That those knowing, reckless decisions were bound to result in serious maladministration is not speculative. It actually happened.

Mr. Hines also expects that the State will argue that his claims are foreclosed by *West v. Schofield*, 460 S.W.3d 113 (Tenn. 2015), in which this Court held, among other things, that the particular maladministration-focused claim presented in that case—which was based on bare speculation "that one or more individuals may cause the

Protocol to be carried out in an unconstitutional manner in the future"—did not present a "justiciable controversy." *Id.* at 131. The Court, however, appended a footnote to that analysis stating that its "holding in this interlocutory proceeding does not preclude appropriate as-applied challenges to the Protocol that may arise in the future."[12] *Id.* at 132 n.12.

Moreover, the holding in *West* was expressly premised on the principle that "public officials in Tennessee are presumed to discharge their duties in good faith and in accordance with the law." *Id.* at 131. That presumption, however, is rebuttable. *See, e.g.*, *State v. Mangrum*, 403 S.W.3d 152, 165 (Tenn. 2013) (recognizing the presumption of regularity as merely placing a burden on the party asserting otherwise); *City of Oak Ridge v. Brown*, No. E2004-01574-COA-R3CV, 2005 WL 1996620, at *1 (Tenn. Ct. App. Aug. 19, 2005) (finding "a presumption of regularity and validity" that is "rebuttable"); *Tremewan v. State*, No. 71, 1989 WL 76319,

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[12] Mr. Hines anticipates that the State may, based on this language from *West*, suggest that Mr. Hines is foreclosed from relief because he has not expressly styled Claim 1.2 as being "as applied." Any such suggestion would be baseless. The question of whether a claim based on a risk of maladministration that is *specific to certain conditions* but not necessarily limited to a *specific individual* is an "as applied" claim may pose an interesting terminological puzzle, but it has no bearing on Mr. Hines' right to relief. "The label is not what matters," but rather a plaintiff's "claim and the relief that would follow." *John Doe No. 1 v. Reed*, 561 U.S. 186, 194 (2010).

at *2 (Tenn. Crim. App. July 12, 1989) ("In the first place, any presumption of regularity . . . was obviously rebutted by the record and the testimony in this case."). Any presumption of regularity originally owed regarding Physician A has been thoroughly rebutted by (1) the fact that he apparently participated in executions without realizing the extent of his responsibilities, which he later learned during a deposition; (2) the fact that he has conceded that he had not performed a successful central line placement in over thirteen years; and (3) the fact that he actually botched an execution, after having been alerted to these issues.

Mr. Hines also anticipates that the State will argue that, because courts have sometimes held that prolonged executions and repeated catheterization attempts do not, in and of themselves, automatically violate the Eighth Amendment, Mr. Hines cannot establish that the specific risks posed here are sufficient to warrant relief. Mr. Hines, however, is not asking this Court to make any holding about the general topic of prolonged executions, or even the general topic of executions involving multiple attempts at intravenous catheterization. Mr. Hines is asking this Court only to address the specific risks posed by TDOC's

current protocol and personnel—risks that, as Mr. Carruthers' ordeal showed, are likely to cause terror, pain, suffering, panic, and humiliation.

What Mr. Hines faces is the possibility that he, a severely disabled victim of two recent strokes, will be pierced over and over again, in numerous parts of his body, including his chest and neck, while knowing that each successive stab may be the one that the State uses to kill him. Then, if an attempt to administer pentobarbital goes forward, Mr. Hines will face that attempt with full knowledge that, because TDOC's intravenous catheterization personnel are unreliable, he may receive only some or none of the poison into his circulatory system due to IV infiltration or leakage—resulting in a prolonged and agonizing death or near-death that leaves him further disabled. *See* Ex. 2 (Complaint) ¶¶ 324–33, 357–64. The extraordinary suffering that such an experience will entail cannot be overstated. *See* Ex. 23 (Decl. of Kate Porterfield).

Finally, while Rule 12.4(E) does not expressly incorporate the other equitable considerations that typically complete the temporary/preliminary injunction standard, *see Fisher v. Hargett*, 604 S.W.3d 381, 394 (Tenn. 2020), there is little doubt that this Court may and should incorporate such considerations—particularly the public

interest—in exercising its equitable powers in response to this request. *See Haley v. Univ. of Tenn.-Knoxville*, 188 S.W.3d 518, 523 (2006) ("The inherent power of the Court consists of all powers reasonably required to enable a court to perform efficiently its judicial functions, to protect its dignity, independence and integrity, and to make its lawful actions effective.") (cleaned up). In this instance, the public interest, the interests of justice, and the legitimate interests of the parties all point in the same direction—to the removal of Physician A.

The State's extraordinary intransigence in refusing to replace Physician A serves no purpose other than to spare certain Tennessee public officials—particularly TDOC Commissioner Frank Strada—the short-term embarrassment of implicitly admitting a misstep in relying on Physician A in the first place. Commissioner Strada—whom Tennessee's Lethal Injection Protocol grants sole and exclusive authority to select an execution physician, *see* Ex. 5 at 11—was appointed by the Governor as an explicit part of the Governor's efforts to resolve the problems that led to the rescission of the State's previous lethal injection protocol. *See* Ex. 24 (December 28, 2022 Press Release) at 1–2 (identifying the hiring and onboarding of a new commissioner as part of the state's

"decisive actions to ensure that the department adheres to established protocol"). Commissioner Strada was apparently selected based on his perceived success as the Arizona official charged with "[o]verseeing executions," including by "[f]ormulating teams" to carry them out. *See* Ex. 25 (Excerpt of Deposition of Frank Strada) at 19–20.

That appearance of success, however, has since thoroughly collapsed under the scrutiny of the very Arizona government that once employed Commissioner Strada. In a letter to the Governor of Arizona on November 22, 2024—well after Commissioner Strada had procured his new position overseeing TDOC—Arizona Department of Corrections, Rehabilitation, and Reentry Director Ryan Thornell explained that his agency had performed a "full review" of the state's execution policies "in order to confidently proceed with an execution" and concluded that numerous "improvements" from the Strada-era status quo were necessary in order to go forward. *See* Ex. 26 at 1.

Particularly prominent in Director Thornell's findings was Arizona's mishandling of procedures surrounding intravenous catheterization. Director Thornell concluded that it was necessary to overhaul the design and training of Arizona's IV Team and specifically

faulted the fact that execution run-throughs did not "include live insertion of the IV catheter (with saline) to assist in preparing for real-time scenarios." *Id.* at 4. In Tennessee, however, Commissioner Strada doubled down on Arizona's discarded approach by (1) weakening Tennessee's requirements for the IV Team to copy Arizona's pre-revision requirements virtually verbatim, *compare* Ex. 6 (2022 Arizona Protocol) at 6 *with* Ex. 5 (2025 Tennessee Protocol) at 11, and (2) actually abolishing Tennessee's pre-existing policy of performing live insertion of the IV catheter in execution practice sessions, *compare* Ex. 4 (2018 Tennessee Protocol) at 32 *with* Ex. 5 (2025 Tennessee Protocol) at 12. It is, in short, difficult to deny Commissioner Strada's personal interest in avoiding any impression that errors were made.

What should matter to this Court, however, are the interests of the State and its people, including the interests of the judicial system that convicted Mr. Hines, sentenced him, and has now ordered his execution. The State's use of an incompetent physician during the attempted execution of Mr. Carruthers and TDOC's refusal to say whether it now plans to use that same demonstrably under-qualified physician for the scheduled execution of Mr. Hines has enormously undermined—and

continues to undermine—public confidence in Tennessee's judicial process and executive branch.

In a letter to Governor Lee, several high-ranking Republican members of the Tennessee General Assembly recently called on Governor Lee to order an independent review of TDOC's "failed execution of Tony Von Carruthers"—"including a full accounting of how the personnel involved were selected, what credentials they held, and whether they were qualified to perform the procedures the protocol requires." Ex. 27. The lawmakers stated that every deficiency identified by such a review—including the use of unqualified personnel—should be made public and ought to be corrected "*before* the State attempts another execution." *Id.* (emphasis added). According to the representatives, such actions are necessary to ensure that the law is "carried out as it should be"—the quintessential public interest. *Id.*

The State's decision to ignore the legislators' request and to move forward with Mr. Hines' scheduled execution without replacing Physician A undermines public confidence in the rule of law. As the lawmakers themselves stated, if one supports "the lawful administration of the death penalty," one "cannot accept its incompetent administration." *Id.* Thus,

the interests of the public—and, indeed, the interests of *the State itself*, decoupled from the political concerns of individual Tennessee officials—strongly support Mr. Hines' requested relief.

V. REQUEST FOR RELIEF

For the reasons set forth herein, Mr. Hines respectfully requests that this Court grant the following relief:

1. Amend its Order of September 30, 2025, setting Mr. Hines' execution date to prohibit the Tennessee Department of Corrections from carrying out Mr. Hines' scheduled execution without first replacing Physician A with an appropriately skilled and qualified physician; or

2. Grant Mr. Hines a special master proceeding so that he may prove his likelihood of success on the merits of his chancery court Claim 1.2, as it narrowly pertains to the State's apparent intention to rely on Physician A in his upcoming execution.

Respectfully submitted this the 20th day of July, 2026,

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CERTIFICATE OF SERVICE

I, Katherine Dix, certify that on July 20, 2026, a true and correct copy of the foregoing was served via electronic mail to opposing counsel, Nicholas W. Spangler, Associate Solicitor General.

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IN THE SUPREME COURT OF TENNESSEE
AT NASHVILLE

STATE OF TENNESSEE,	)	
	)	**No. M2025-00221-SC-DPE-DD**
***Respondent*,**	)	
	)	**Cheatham County**
v.	)	**Circuit Court No. 9852**
	)	
ANTHONY DARRELL DUGARD HINES,	)	**CAPITAL CASE**
	)	
	)	**Execution: August 13, 2026**
Movant.	)	

STATE'S RESPONSE IN OPPOSITION TO THE MOTION FOR AN AMENDED EXECUTION ORDER, A SPECIAL MASTER, AND A CONDITIONAL STAY OF EXECUTION

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INTRODUCTION

More than forty-one years ago, Anthony Darrell Dugard Hines brutally murdered Catherine[1] Jean Jenkins, a maid at the Ce'Bon Motel off I-40 in Kingston Springs. She died from knife stab wounds to her chest and vagina. A Cheatham County jury convicted Hines after considering overwhelming proof of his guilt, including his admission to stabbing someone at the motel and his possession of Jenkins' car and car keys shortly after her murder. *State v. Hines*, 758 S.W.2d 515, 518-19 (Tenn. 1988). This Court affirmed Hines' death sentence in 1995 on the strength of two aggravating circumstances, including that the stab wound to Jenkins' vagina "was sufficient to support a finding that . . . [her] murder involved torture." *State v. Hines*, 919 S.W.2d 573, 581 (Tenn. 1995).

But Jenkins' family has yet to see justice done. Nearly four decades after his crime, Hines completed the three-tier appeals process. *Mays v. Hines*, 141 S. Ct. 2693 (2021). This Court later set an execution date under Tenn. Sup. Ct. R. 12(4)(E). Order, *State v. Hines*, No. M2025-00221-SC-DPE-DD (Tenn. Sept. 30, 2025).

Now, just twenty-four days before his scheduled execution on August 13, 2026, Hines seeks a conditional stay, discovery review, and specific injunctive relief prohibiting the State from employing a particular physician to attend his execution. Hines only guesses that the

[1] Jenkins' family has assured that this is the correct spelling of her first name despite prior misspelling in some court documents.

State *might* use a physician who *might* be unqualified to establish a *backup* central IV line during his execution. He frets that the physician *might* not be able to establish a *backup* central IV line *if* needed. And he wildly suggests—in a desperate attempt to implicate the Eighth Amendment—that all these stacked, remote *possibilities* "present[] a risk that is *sure or very likely* to cause serious illness and needless suffering and give rise to sufficiently imminent dangers." *West v. Schofield*, 519 S.W.3d 550, 563 (Tenn. 2017) (cleaned up and emphasis added).

But this Court cannot grant discovery or specific injunctive relief in the first instance, and it "will not grant a stay or delay of an execution date pending resolution of collateral litigation in state court unless the prisoner can prove a likelihood of success on the merits." Tenn. Sup. Ct. Rule 12(4)(E). And Hines cannot. His claim that the State's "execution method *may* result in pain, *either by accident* or as an inescapable consequence of death, does not establish the sort of objectively intolerable risk of harm that qualifies as cruel and unusual" because "[s]ome risk of pain is inherent in any method of execution—no matter how humane—if only from the *prospect of error in following the required procedure*." *Baze v. Rees*, 553 U.S. 35, 47, 50 (2008) (plurality op.) (cleaned up and emphasis added). "[M]ere possibilities" or "hypothetical[s]"—like Hines' allegations about the "risk of maladministration"—"are not sufficient to satisfy [his] burden to establish a substantial risk of severe pain." *West*, 519 S.W.3d at 564-65 (quoting *Baze*, 553 U.S. at 62). Thus, Hines' maladministration claim is "all but foreclosed," *Cooey v. Strickland*, 589

F.3d 210, 225 (6th Cir. 2009), *as a matter of law* because an alleged "potential flaw" in administration is too speculative "to state an Eighth Amendment claim," *Zink v. Lombardi*, 783 F.3d 1089, 1101 (8th Cir. 2015).

The U.S. Supreme Court has never struck down a method of execution as cruel and unusual under the Eighth Amendment. *Barr v. Lee*, 591 U.S. 979, 980 (2020) (per curiam). And this Court has upheld Tennessee's lethal-injection procedures against every challenge. *Abdur'Rahman v. Parker*, 558 S.W.3d 606 (Tenn. 2018); *West*, 519 S.W.3d 550; *Abdur'Rahman v. Bredesen*, 181 S.W.3d 292 (Tenn. 2005). Hines has no likelihood of any different outcome with his latest grasping attack.

Jenkins' family has a constitutional right to "a prompt and final conclusion of the case after the conviction or sentence." Tenn. Const. art. I, § 35. Hines' delay-seeking motion subverts that grave public interest in finality. And his egregious delay in filing the motion is reason enough to deny it.

The Court should deny Hines' motion.

BACKGROUND

I. Legal Background

The Eighth Amendment bars the infliction of "cruel and unusual punishments." U.S. Const. amend. VIII. "Similarly to the federal constitution, the Tennessee Constitution provides that 'excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.'" *West*, 519 S.W.3d at 567 (quoting Tenn. Const.

art. I, § 16). Because there is "no difference in language" that would warrant "application of a different standard," this Court analyzes the two constitutional provisions using the U.S. Supreme Court's Eighth Amendment framework. *Id.* at 568 n.16; *accord Abdur'Rahman*, 558 S.W.3d at 616.

A. The U.S. and Tennessee Constitutions do not demand avoidance of all pain in executions.

The U.S. "Constitution allows capital punishment." *Bucklew v. Precythe*, 587 U.S. 119, 129 (2019). That approval reflects the death penalty's status as an "accepted punishment at the time of the adoption of the Constitution and the Bill of Rights." *Glossip v. Gross*, 576 U.S. 863, 867-68 (2015). This Court, too, "repeatedly has upheld the death penalty as permissible under the Tennessee Constitution." *West*, 519 S.W.3d at 568 n.17 (collecting cases).

"[B]ecause it is settled that capital punishment is constitutional, it necessarily follows that there must be a constitutional means of carrying it out." *Glossip*, 576 U.S. at 869 (quoting *Baze*, 553 U.S. at 47). That "recognition" has "animated" this Court's and the U.S. Supreme Court's interpretation of the cruel-and-unusual punishment prohibition. *Id.*; *see Abdur'Rahman*, 558 S.W.3d at 615 (discussing *Baze*, 553 U.S. at 47). A few general principles from the precedents are particularly relevant here.

To begin, "the Eighth Amendment does not guarantee a prisoner a painless death—something that, of course, isn't guaranteed to many people, including most victims of capital crimes." *Bucklew*, 587 U.S. at 132-33. After all, "[s]ome risk of pain is inherent in any method of

execution—no matter how humane—if only from the prospect of error in following the required procedure." *Baze*, 553 U.S. at 47. If the Eighth Amendment "demand[ed] the elimination of essentially all risk of pain," that "would effectively outlaw the death penalty altogether." *Glossip*, 576 U.S. at 869. So, the mere fact that "an execution method may result in pain, either by accident or as an inescapable consequence of death, does not establish the sort of 'objectively intolerable risk of harm' that qualifies as cruel and unusual." *Baze*, 553 U.S. at 50 (quoting *Farmer v. Brennan*, 511 U.S. 825, 842, 846, and n.9 (1994)).

Instead, the cruel-and-unusual-punishment provision prohibits only "long disused (unusual) forms of punishment that intensified the sentence of death with a (cruel) superaddition of terror, pain, or disgrace." *Bucklew*, 587 U.S. at 133 (citation omitted). That emphasis on the State's "malevolence," *Baze*, 553 U.S. at 50, in carrying out a "wanton infliction of pain," *Abdur'Rahman*, 181 S.W.3d at 306, reflects Founding-era history. As ratified, the provision draws from the English Bill of Rights "to ensure that the new Nation would never resort" to "certain barbaric punishments" previously practiced. *City of Grants Pass v. Johnson*, 603 U.S. 520, 542 (2024). Among them: "disemboweling, quartering, public dissection, and burning alive," *id.*, as well as "the use of the rack or the stake," "breaking on the wheel, flaying alive, rending asunder with horses, maiming, mutilating, and scourging to death," *Bucklew*, 587 U.S. at 131 (cleaned up). Uniting these off-limits methods is their "unnecessary cruelty"—meaning the method chosen "savored of

torture" and reflected the executioners' being "pleased with hurting others." *Id.* at 130-31.

To help draw that line, courts look to the modes of execution the Eighth Amendment was understood to forbid with those it was understood to permit. Hanging was the predominant method of execution at the Founding and for decades thereafter. *Glossip*, 576 U.S. at 867. Yet "[m]any and perhaps most hangings were evidently painful for the condemned person because they caused death slowly." *Bucklew*, 587 U.S. at 132 (quoting S. Banner, The Death Penalty: An American History 48 (2002) (Banner)). But hanging's use was "virtually never questioned" under the Eighth Amendment. *Id.* (quoting Banner, *supra*, at 48). As the U.S. Supreme Court observed, hanging's lawful status presumably reflects that it was not "*intended* to be painful"; instead, the risk of pain involved was considered "unfortunate but inevitable." *Id.* at 131 (quoting Banner, *supra*, at 170). The U.S. Supreme Court has employed similar reasoning to uphold death by firing squad, *Wilkerson v. Utah*, 99 U.S. 130, 134-135 (1879), the electric chair, *In re Kemmler*, 136 U.S. 436 (1890); *Louisiana ex rel. Francis v. Resweber*, 329 U.S. 459, 463-464 (1947) (plurality opinion) (upholding electrocution of prisoner despite initial failed attempt), and lethal injection, *Bucklew*, 587 U.S. 119; *Glossip*, 576 U.S. 863; *Baze*, 553 U.S. 35.

To sum up: The U.S. and Tennessee Constitutions do not "demand the avoidance of all risk of pain in carrying out executions," meaning a method is permissible even if pain occurs by "accident or as an

inescapable consequence of death." *Bucklew*, 587 U.S. at 130, 134. Instead, punishments are constitutionally suspect only when the method "'superadds' pain well beyond what's needed to effectuate a death sentence." *Id.* at 137. Any other rule would impermissibly coopt "courts to serve as boards of inquiry charged with determining best practices for executions," "with each ruling supplanted by another round of litigation touting a new and improved methodology." *Id.* at 134 (citation omitted); *Baze*, 553 U.S. at 101.

B. Method-of-execution claims face an exceedingly high bar to prevail.

The U.S. Supreme Court "has yet to hold that a State's method of execution qualifies as cruel and unusual." *Lee*, 591 U.S. at 980 (quoting *Bucklew*, 587 U.S. at 133). "[U]nderstandably so." *Bucklew*, 587 U.S. at 133. Tennessee and other States, working "through the initiative of the people and their representatives," have historically endeavored to adopt "less painful modes of execution." *Id.*

Courts facing method-of-execution claims like Hines' apply a "two-prong test" under both the U.S. and Tennessee Constitutions. *West*, 519 S.W.3d at 567; *see Bucklew*, 587 U.S. at 133-34. Challengers face an "exceedingly high bar" to relief. 91 U.S. at 980. The demanding two-step standard reflects that "the Constitution affords a measure of deference to a State's choice of execution procedures." *Bucklew*, 587 U.S. at 134. It also helps prevent "method-of-execution claims from becoming a backdoor means to abolish the death penalty." *Id.* at 137 (cleaned up).

First, an inmate must establish that a given method "presents a risk that is *sure or very likely* to cause serious illness and needless suffering and give rise to sufficiently *imminent* dangers." *West*, 519 S.W.3d at 563 (cleaned up) (quoting *Glossip*, 576 U.S. at 877). The method must "present[] a 'substantial risk of serious harm'—serious pain over and above death itself." *Nance v. Ward*, 597 U.S. 159, 164 (2022) (quoting *Glossip*, 576 U.S. at 877). "[M]ere possibilities" or "hypothetical[s]"—like allegations of the "risk of maladministration" or "improper" handling of drugs—"are not sufficient to satisfy [an inmate's] burden to establish a substantial risk of severe pain." *West*, 519 S.W.3d at 564-65 (quoting *Baze*, 553 U.S. at 62) (collecting cases).

Second, the inmate must "show a feasible and readily implemented alternative method of execution that would significantly reduce a substantial risk of severe pain and that the State has refused to adopt without a legitimate penological reason." *Bucklew*, 587 U.S. at 134. "A minor reduction in risk is insufficient; the difference must be clear and considerable." *Id.* at 143. Further, a challenger must establish that the State "could carry . . . out" the alternative method "'relatively easily and reasonably quickly.'" *Id.* at 141 (citation omitted).

C. Tennessee's uniformly upheld methods of execution.

Tennessee historically executed "by hanging." *Shipp v. State*, 172 S.W. 317, 318 (Tenn. 1914) (quoting Shannon's Code § 6442). Although never deemed an unconstitutional punishment, Tennessee eventually followed other States' lead to replace it with electrocution. *Id.* Tennessee

used electrocution as its method of execution for decades, with the Tennessee Supreme Court holding—time and again—that this was not a "cruel and unusual punishment." *See, e.g.*, *State v. Suttles*, 30 S.W.3d 252, 263 (Tenn. 2000) (collecting cases).

Tennessee adopted lethal injection as a method of execution in 1998, Tenn. Code Ann. § 40-23-114 (Supp. 1998), because it was widely touted as a "more humane" alternative to "electrocution." *State v. Adkins*, 725 S.W.2d 660, 664 (Tenn. 1987); *see Suttles*, 30 S.W.3d at 264 (citing 1998 Tenn. Pub. Acts ch. 982; 2000 Tenn. Pub. Acts ch. 2000). Two years later, it became the State's default method of execution and has remained so ever since.[2] Tenn. Code Ann. § 40-23-114 (Supp. 2000); *State v. Morris*, 24 S.W.3d 788, 797 (Tenn. 2000). In 2004, this Court upheld the use of lethal injection as a constitutionally permissible means of execution. *State v. Robinson*, 146 S.W.3d 469, 529 (Tenn. 2004) (appendix). But challenges to the particulars of the State's lethal-injection protocols continued to proliferate.

Three-Drug Protocol. At first, Tennessee used a common three-drug "protocol" (using utilizing sodium pentothal, pancuronium bromide, and potassium chloride) to effectuate lethal injections. *Abdur'Rahman*, 181 S.W.3d at 300. The drugs in that protocol "put[] the inmate to sleep,"

[2] If lethal injection is held unconstitutional or lethal-injection drugs are unavailable, then the method of execution shifts to electrocution. Tenn. Code Ann. § 40-23-114(e). Persons sentenced to death for offenses committed before 1999 may also choose to be executed by electrocution. *Id.* § 40-23-114(b).

then "stop[ped his] breathing," then "stop[ped his] heart." *Id.* This Court repeatedly upheld three-drug protocols across multiple challenges. *See id.* at 297-98; *accord Abdur'Rahman*, 558 S.W.3d at 610 (upholding protocol using midazolam, vecuronium bromide, and potassium chloride). The U.S. Supreme Court did the same in *Baze* and *Glossip*.

But opponents of capital punishment continue to make lethal-injection methods difficult for States to pursue. States' need for injectable drugs made them more dependent upon drug manufacturers, who in turn were "lobbied" to cease participation in executions by "[a]nti-death-penalty advocates." *Glossip*, 576 U.S. at 871. States like Tennessee faced "ongoing difficulty in obtaining" required drugs and had to continue to revise their protocols accordingly. *Abdur'Rahman*, 558 S.W.3d at 611-12, 616; *see Glossip*, 576 U.S. at 869-72 (describing this widespread problem).

Single-Drug Protocol with Pentobarbital. In 2013, the State adopted a single-drug protocol that causes sedation and death through the injection of pentobarbital. *See West*, 519 S.W.3d at 552 (citing Tenn. Code Ann. § 40-23-114(c) (2012)). As used in executions, pentobarbital works to "repress the brain's respiratory impulses, causing the body to become oxygen deficient and resulting in the cessation of cardiac activity." *West*, 519 S.W.3d at 556. But it causes "a quick and complete loss of consciousness" first. *Id.* at 557; *see id.* at 560-61.

Given its efficacy, the "single-dose pentobarbital" protocol has "been repeatedly invoked by prisoners as a *less* painful and risky alternative to

the lethal-injection protocols of other jurisdictions. *Lee*, 591 U.S. at 980. That goes for Hines too. *See Abdur'Rahman*, 558 S.W.3d at 612 (inmates cited single-dose pentobarbital as "alternative" preferred method). And Justices of the U.S. Supreme Court have cited single-dose pentobarbital as a "significantly less risky alternative" method given that pentobarbital "does not carry the risks" of other drugs and "is widely conceded to be able to render a person fully insensate." *Zagorski v. Parker*, 586 U.S. 938, 939 (2018) (Sotomayor, J., dissenting).

As it stands, pentobarbital "has become a mainstay of state executions." *Lee*, 591 U.S. at 980. As of 2020, it had "been used to carry out over 100 executions, without incident." *Id.* And its use has been upheld by the U.S. Supreme Court, federal circuit courts, and several state courts of last resort. *See, e.g.*, *Bucklew*, 587 U.S. at 119; *Whitaker v. Collier*, 862 F.3d 490, 497-99 (5th Cir. 2017); *Jones v. Comm'r*, 811 F.3d 1288, 1296 (11th Cir. 2016); *Zink v. Lombardi*, 783 F.3d 1089, 1098-1101 (8th Cir. 2015); *Gissendaner v. Comm'r*, 779 F.3d 1275, 1283 (11th Cir. 2015); *West*, 519 S.W.3d at 564-65; *State ex rel. Johnson v. Blair*, 628 S.W.3d 375, 388-90 (Mo. 2021) (en banc); *Owens v. Hill*, 758 S.E.2d 794, 802-03 (Ga. 2014); *Valle v. Florida*, 70 So.3d 530, 541 (Fla. 2011).

This Court, for its part, rejected constitutional challenges to the State's 2013 one-drug pentobarbital protocol. In *West*, the Court applied the two-prong method-of-execution test to conclude that the use of a single dose of compounded pentobarbital did not violate the U.S. or Tennessee Constitutions' prohibition on cruel and unusual punishments.

519 S.W.3d at 568. The Court rejected speculations about pain that might occur if pentobarbital did not work as intended. *Id*. at 564. It also rejected the claim that pentobarbital exposed inmates to "an unacceptable risk of a lingering death" when pentobarbital "causes unconsciousness within seconds." *Id*. at 567. And "mere possibilities" of protocol maladministration, the Court explained, are "not sufficient to satisfy the [inmates'] burden to establish a substantial risk of severe pain." *Id*. at 564.

Later and Current Protocols. The shifting availability of lethal-injection drugs has forced TDOC to change its lethal-injection procedures several times in the past decade. When pentobarbital became unavailable, TDOC had to revise procedures again, adopting a new three-drug alternative protocol using midazolam (a sedative in the benzodiazepine family of drugs) followed by vecuronium bromide (a paralytic agent) and potassium chloride (a heart-stopping agent). *Abdur'Rahman*, 558 S.W.3d at 611, 616. In late 2018, TDOC adjusted the protocol to make the three-drug alternative "the exclusive method of execution by lethal injection in Tennessee." *Id*. at 611-12. In early 2025, the State reverted to a pentobarbital protocol.[3]

II. Factual Background

On March 3, 1985, Anthony Hines murdered Catherine Jean Jenkins, a maid at the Ce'Bon Motel off I-40 in Kingston Springs. *Hines*,

[3] *TDOC Completes Lethal Injection Protocol Review*, (Dec. 27, 2024), https://tinyurl.com/2xftey5t

758 S.W.2d at 517. She died from multiple stab wounds to her chest by a large knife. *Id.* She also sustained a stab wound to her vagina, and the medical examiner described several defensive wounds on her hands and arms. *Id.*

Two days earlier, Hines left Raleigh, North Carolina, after his girlfriend's mother bought him a $20 bus ticket that he could not afford. *Id.* at 517-18. Concealed beneath his shirt was a hunting knife that he always carried. *Id.* at 518. Hines checked into the Ce'Bon Motel in the predawn hours of March 3. *Id.* Around 9:30 that morning, the motel manager left Jenkins in charge and gave her a bank bag to make change for guests. *Id.* at 517.

That afternoon, a motel guest, Ken Jones, contacted law enforcement after discovering Jenkins' body wrapped in a sheet in one of the motel rooms. *Id.* Her clothing had been pulled up to her breasts, and her torn underwear was found elsewhere in the room. *Id.* Jenkins' bloody and empty bank bag was also in the room, but her car keys and billfold were missing. *Id.* Around the same time Jenkins' body was discovered, a motel employee saw a man speed away in Jenkins' Volvo. *Id.* at 518. Stab marks on the walls of Hines' motel room resembled the stab wounds on Jenkins' body. *Id.* at 518-19.

Later that day, motorists on I-65 near Bowling Green, Kentucky, offered Hines a ride after finding him with Jenkins' broken-down Volvo and dried blood on his shirt. *Id.* at 518. The group drove Hines to his sister's house. *Id.* When his sister noticed the blood on Hines' shirt, he

admitted stabbing someone at the motel but claimed it was a man who assaulted him. *Id*. When Hines' family noticed he had keys to a Volvo, he said he took them during a struggle with a different man who tried to rob him. *Id*. Hines also purchased a barbeque grill for his sister, insisting that he had come into a substantial sum of money despite not having $20 for a bus ticket just a few days earlier. *Id*.

After hiding for eight days in the hills of Cave City, Kentucky, Hines turned himself in and offered up a new story, insisting that he took Jenkins' car but did not murder her. *Id*. He also offered to confess to the murder if he could be guaranteed a death sentence. *Id*.

III. Procedural Background

A. Hines' death sentence survived exhaustive review.

This Court affirmed Hines' murder conviction in 1985, *Hines*, 758 S.W.2d at 524, and it affirmed his death sentence in 1995 after an initial remand for resentencing, *Hines*, 919 S.W.2d at 584. Hines next unsuccessfully sought state post-conviction relief. *Hines v. State*, No. M2004-01610-CCA-RM-PD, 2004 WL 1567120, at *39 (Tenn. Crim. App. July. 14, 2004), *perm. app. denied* (Tenn. Nov. 29, 2004). The U.S. Supreme Court then denied federal habeas relief after fifteen more years of litigation. *Mays v. Hines*, 592 U.S. 385 (2021) (per curiam).

B. Hines repeatedly attacks execution procedures.

Having failed in overturning his criminal judgment, Hines then turned to attacking the State's execution procedures. Eight years ago, after the State stopped using pentobarbital in executions due to

unavailability, Hines unsuccessfully sued to force use of that drug for his execution. *Abdur'Rahman*, 558 S.W.3d at 612 n.6. Then on March 14, 2025, more than two months after the State reverted to a single-drug pentobarbital protocol, he filed a second method-of-execution suit in Davidson County Chancery Court. He attacks that protocol through a 148-page complaint raising seven distinct claims. Mot. Ex. 2.

Relevant here, in Claim 1.2, Hines alleges that even if using pentobarbital were constitutional, the protocol carries an intolerable risk of maladministration that inflicts severe suffering. Mot. Ex. 2 at ¶¶ 684-94. He says that the risk of an unconstitutional execution is "substantially increased" if the protocol is administered by persons "not sufficiently trained," Mot. Ex. 2 at ¶ 687, or conducted by persons without "a consistent, universally shared commitment to complying with all applicable laws and policies," Mot. Ex. 2 at ¶ 688. He believes the risk of a "tortuous death by pentobarbital poisoning" is enhanced "if the individuals charged with preparing the pentobarbital, setting the intravenous ('IV') line, and administering the pentobarbital are incompetent, insufficiently trained, insufficiently dedicated to doing their jobs properly, and/or insufficiently attentive." Mot. Ex. 2 at ¶ 315. But he concedes that if execution by pentobarbital is constitutional, it is a readily available and feasible method of execution "*after*" TDOC has taken "adequate remedial steps." Mot. Ex. 2 at ¶ 691.

In support of Claim 1.2, Hines has repeatedly sought information about execution participants. The media publicized the name of the

physician who participated in Byron Black's execution after a document from the Davidson County Medical Examiner revealed that information.[4] Hines deposed that physician on October 27, 2025. Mot. Ex. 12.

Hines then sought an admission that the deposed physician would serve the same role in Hines' execution. Resp. Ex. 1. The State objected, arguing that the identities of future execution participants are privileged and confidential under Tenn. Code Ann. § 10-7-504(h)(1), *West v. Schofield,* 460 S.W.3d 113, 126 (Tenn. 2015), and a common-law privilege. Resp. Ex. 2. The State argued that even if the identity of a past physician was known, protection over the identity of a future attending physician had not been waived. Resp. Ex. 2. The State also argued that a future physician's identity was irrelevant to Claim 1.2. Resp. Ex. 2.

On July 17, 2026, the chancery court found that any protection of the physician's identity had been waived. Mot. Ex. 1. The court also found that the identity of the physician for Hines' execution was relevant. Mot. Ex. 1. It ordered the State to respond to Hines' request for admission but stayed service of that response "pending resolution of the underlying issues by a higher court *pursuant to an appropriate procedural vehicle*." Mot. Ex. 1 (emphasis added).

[4] Catherine Sweeney, *Autopsy sheds light on Byron Black's painful execution* (Sept. 11, 2025), https://tinyurl.com/7v5xcdba.

C. Hines moves for a conditional stay or special master.

On July 20, 2026—sixteen months after filing suit in chancery court—Hines filed a motion under Tenn. Sup. Ct. R. 12(4)(E) to amend this Court's order setting his execution date, to appoint a special master, and to seek a "conditional stay of execution." Mot. at 1. He first invites this Court to review the State's opposition to his discovery request for the identity of the physician who will attend his execution. Mot. at 3. He then demands a "conditional stay of execution" if the State refuses to replace the physician who participated in a prior aborted execution of another inmate. Mot. at 3. Finally, he "requests the appointment of a special master" for the opportunity to prove a likelihood of success on Claim 1.2 of his pending civil suit.

LEGAL STANDARD

After an execution date is set, "any state court collateral litigation that would potentially affect the method or timing of execution must commence with the filing of a motion" in this Court. Tenn. Sup. Ct. R. 12(4)(E). "If the collateral litigation may involve fact-finding, the moving party must request the appointment of a special master, consistent with the procedures outlined in Tennessee Rule of Civil Procedure 53." *Id.* "[T]he Court will not grant a stay or delay of an execution date pending resolution of collateral litigation in state court unless the prisoner can prove a likelihood of success on the merits in that litigation." *Id.*

Hines' "pending challenge to the lethal injection protocol clearly constitutes collateral litigation" for the purposes of Rule 12. *State v.*

Irick, 556 S.W.3d 686, 689 (Tenn. 2018). So, to receive a stay "he must prove that he has a likelihood of succeeding on the merits of that litigation." *Id.* "In order to establish a likelihood of success on the merits of a claim, [Hines] must show more than a mere possibility of success." *Id.* (quoting *Six Clinics Holding Corp. II v. Cafcomp Sys.*, 119 F.3d 393, 402 (6th Cir. 1997)). He must show "a significant possibility of success on the merits." *Hill v. McDonough*, 547 U.S. 573, 584 (2006). That is, he must "raise questions going to the merits so serious, substantial, difficult, and doubtful as to make them a fair ground for litigation and thus for more deliberate investigation." *Six Clinics Holding Corp., II*, 119 F.3d at 402.

REASONS TO DENY THE MOTION

I. Rule 12 Does Not Offer Conditional Stays or Interlocutory Review of Discovery Orders.

This Court has power under Rule 12 to stay an execution, but it does not have original jurisdiction to adjudicate the merits of collateral litigation or resolve discovery disputes. That is what Hines' "conditional stay" motion seeks—an order from this Court requiring the State to swap out the physician that Hines assumes will participate in his execution. As this Court's recent orders confirm, Rule 12 authorizes a stay of execution and nothing more. It does not confer original jurisdiction to decide the merits of any collateral litigation, let alone the power to issue specific injunctive relief based on pending state-court claims. And it is certainly not a backdoor for appealing discovery orders. Hines' motion should be denied.

A. The Court should deny a conditional stay.

Hines' request for a conditional stay of execution seeks specific injunctive relief on his original collateral litigation—relief that Rule 12(4)(E) does not offer. Rule 12(4)(E) provides only for a temporary stay of execution to "facilitate[] existing state collateral proceedings." Order, *State v. Carruthers*, No. W1997-00097-SC-DDT-DD (Feb. 17, 2026).

Hines rightly concedes that his request "falls outside" "Rule[] [12's] plain language." Mot. at 33. He then makes an atextual plea to this Court's "inherent authority." Mot. at 4, 32, 38, 49. But "[t]he inherent powers of a court do not increase its jurisdiction; they are limited to such powers as are essential to the existence of the court and necessary to the orderly efficient exercise of its jurisdiction." *Anderson Cty. Quarterly Court v. Judges of 28th Judicial Circuit*, 579 S.W.2d 875, 879 (Tenn. Ct. App. 1978) (citing 20 Am.Jur.2d Courts § 78 (1964)). And granting Hines specific injunctive relief on Claim 1.2 in the first instance would be contrary to the exercise of the Court's appellate jurisdiction.

This Court has no original jurisdiction to adjudicate or grant specific and permanent injunctive relief on Claim 1.2 in the first instance. The Tennessee Constitution provides that "[t]he jurisdiction of this court shall be appellate only, under such restrictions and regulations as may from time to time be prescribed by law." Tenn. Const. Art. VI, § 2. And this Court has consistently observed that limitation on its jurisdiction for more than a century. *See Peck v. Tanner*, 181 S.W.3d 262, 265-66 (Tenn. 2005) (collecting cases). As the Court recently explained, "the December

2025 amendment to Rule 12(4)(E) neither created a new procedural avenue nor granted this Court original jurisdiction to adjudicate an eleventh-hour . . . claim." Order, *State v. Carruthers*, No. W1997-00097-SC-DDT-DD (Apr. 30, 2026).

This Court has now twice held that "a motion under Rule 12(4)(E) must 'incorporate [a] . . . motion for a stay of execution.'" Order, *Pike v. Skrmetti*, No. M2026-00667-SC-UNK-CV (Jul. 10, 2026) (quoting Order, *Pike v. Skrmetti*, No. M2026-00667-SC-UNK-CV (May 12, 2026)). That is because a stay of execution is the only relief offered by Rule 12. "[B]ecause [Hines'] motion [essentially] asks this Court to permanently enjoin state officials from carrying out h[is] execution" unless his demands are met, the Court should simply "construe h[is] motion as requesting a stay of execution." *Id.* And the Court should deny it because, as explained below, *infra* Part II, Hines cannot "prove a likelihood of success on the merits." Tenn. Sup. Ct. Rule 12(4)(E).

B. The Court should deny review of a discovery order.

The Court should also deny Hines' passing invitation to review the State's response to his discovery request for the identity of the physician employed to attend his execution. Mot. at 3. Hines effectively seeks this Court's interlocutory review of the chancery court's discovery order. Mot. Ex. 1. But nothing in the text of Rule 12 supports that request. And the Court's inherent authority does not expand its jurisdiction to directly evaluate the discovery order outside the recognized avenues for interlocutory review prescribed by law—avenues Hines has not even

pursued. Nor does it allow the Court to order the discovery of irrelevant information about the identity of a future execution participant.

This Court has no original or appellate jurisdiction to settle Hines' discovery dispute. Appeals of interlocutory orders like the discovery order here are "an exception to the general rule that requires a final judgment before a party may appeal as of right." *State v. Gilley*, 173 S.W.3d 1, 5 (Tenn. 2005). Such appeals are generally disfavored and authorized only under the rules of appellate procedure. *Id*. (citing *United States v. MacDonald*, 435 U.S. 850, 853 (1978)); *see also Reid v. State*, 197 S.W.3d 694, 699 (Tenn. 2006). Indeed, "[u]nless an appeal from an interlocutory order is provided by the rules or by statute, appellate courts have jurisdiction over final judgments only." *Bayberry Assocs. v. Jones*, 783 S.W.2d 553, 559 (Tenn. 1990) (citing *Aetna Cas. & Sur. Co. v. Miller*, 491 S.W.2d 85, 86 (Tenn. 1973)).

The path for Hines to seek an interlocutory appeal is Tenn. R. App. P. 9(a) and (c), which requires the permission of both the trial court and appellate court upon application. Or in exceptional circumstances, Tenn. R. App. P. 10(a) provides that "[a]n extraordinary appeal may be sought on application and in the discretion of the appellate court alone of interlocutory orders of a lower court." But the filing deadlines to this Court under Rule 9(c) and 10 are jurisdictional. Tenn. R. App. P. Rule 2; *see also In re Malone*, 691 S.W.3d 365, 370 (Tenn. 2024) ("[W]ith an interlocutory appeal, the appellate court's jurisdiction is limited to the issues specified in the appellate court's order granting permission for the

appeal, and the balance of the case remains in the province of the trial court[.]")

Hines has not sought interlocutory review of the chancery court's discovery order under either Rule 9 or 10. Thus, this Court lacks jurisdiction—much less inherent authority—to review that order. *In re Estate of Boykin*, 295 S.W.3d 632, 636 (Tenn. Ct. App. 2008).

In any event, Hines' demand for the identity of the attending physician is contrary to law. Parties have no right to discover privileged or irrelevant information. Tenn. R. Civ. P. 26.02(1); *West*, 460 S.W.3d at 121. And the identity of the physician who will attend Hines' execution is both privileged and irrelevant.

The identities of past, present, and future execution participants are privileged, confidential, and not subject to disclosure under Tenn. Code Ann. § 10-7-504(h)(1). That statute protects the identity of anyone "who [is] or that has been *or may in the future* be directly involved in the process of executing a sentence of death." Tenn. Code Ann. § 10-7-504(h)(1) (emphasis added). When the General Assembly amended § 10-7-504(h)(1) in 2014, it "intended . . . to protect the identities of all persons and entities participating in the execution of a convicted murderer sentenced to death." *West*, 460 S.W.3d at 122. That protection extends over attending physicians.

And that protection was never waived by the State. A *past* attending physician's identity was first revealed to the public in a document from the Davidson County Medical Examiner that was

reported in the media in September 2025.[5] Later media accounts attributed the unmasking of the past attending physician to court filings by the Federal Public Defender's office.[6] While the media may have outed that *past* physician, it is not publicly known whether that same physician will attend Hines' *future* execution—hence Hines' present illegal discovery demand.

The identity of any future attending physician is also irrelevant to Hines' Claim 1.2, which includes no alleged risk of maladministration due to *contingent* physician participation or their *contingent* procedure for placing a *backup* central IV line. Mot. Ex. 2 at 64-69. The complaint includes no allegation that there is any risk of maladministration due to the physician or the procedure to place a central line. Mot. Ex. 2. Given this failure to plead any particular facts about physician participation or central line placement, discovery about any future physician who may or may not place a central line is "not relevant." *West*, 460 S.W.3d at 126.

Even if this Court finds it has jurisdiction to directly supervise Hines' discovery dispute in chancery court, it should conclude that the identity of the attending physician is privileged, irrelevant, and not subject to compelled disclosure.

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[5] Catherine Sweeney, *Autopsy sheds light on Byron Black's painful execution* (Sept. 11, 2025), https://tinyurl.com/7v5xcdba.

[6] Steven Hale, *Questions Raised About the Doctor Who Was Overseeing Tony Caruthers' Execution* (May 22, 2026), https://tinyurl.com/3hybpn26.

II. Claim 1.2 Has No Likelihood of Success.

Many courts, including this one, have held that claims merely speculating about the risks of execution maladministration do not state Eighth Amendment violation. Claim 1.2 could not be more speculative or present a more tenuous case for risk of maladministration. It has no likelihood of success *as a matter of law*. Thus, it presents no grounds for a stay—conditional or otherwise—or fact-finding by a special master.

Hines only guesses that the State *might* use a physician who *might* be unqualified to establish a *backup* central IV line. He frets that the physician *might* not be able to establish a *backup* central IV line *if* needed. And he implausibly suggests that all these stacked, remote *possibilities* "present[] a risk that is *sure or very likely* to cause serious illness and needless suffering and give rise to sufficiently imminent dangers." *West*, 519 S.W.3d at 563 (cleaned up and emphasis added).

All these allegations that the State's "execution method *may* result in pain, *either by accident* or as an inescapable consequence of death, do[] not establish the sort of objectively intolerable risk of harm that qualifies as cruel and unusual" because "[s]ome risk of pain is inherent in any method of execution—no matter how humane—if only from the *prospect of error in following the required procedure*." *Baze*, 553 U.S. at 47, 50 (plurality op.) (cleaned up and emphasis added). "[M]ere possibilities" or "hypothetical[s]"—like Hines' allegations about the "risk of maladministration"—"are not sufficient to satisfy [his] burden to establish a substantial risk of severe pain." *West*, 519 S.W.3d at 564-65

(quoting *Baze*, 553 U.S. at 62). Thus, Hines' maladministration claim is "all but foreclosed," *Cooey v. Strickland*, 589 F.3d 210, 225 (6th Cir. 2009), *as a matter of law* because an alleged "potential flaw" in administration is too speculative "to state an Eighth Amendment claim," *Zink v. Lombardi*, 783 F.3d 1089, 1101 (8th Cir. 2015).

"[E]ven proof[] of medical negligence in the past or in the future are not sufficient to render a facially constitutionally sound protocol unconstitutional." *Id.* at 556 (cleaned up). Courts have consistently held that problems arising in prior executions do not prove an imminent future Eighth Amendment violation. *See Jackson v. Danberg*, 594 F.3d 210, 227 (3d Cir. 2010) (past failures to follow execution protocol did not establish a constitutional violation); *Barber v. Governor of Alabama*, 73 F.4th 1306, 1319 (11th Cir.) (rejecting the premise that "protracted efforts to obtain IV access (i.e., 'repeatedly pricking [an inmate] with a needle') would give rise to an unconstitutional level of pain"); *Workman v. Bredesen*, 486 F.3d 896, 907-08 (6th Cir. 2007) ("The risk of negligence in implementing a death-penalty procedure . . . does not establish a cognizable Eighth Amendment claim.").

The panoply of safeguards in the protocol itself renders the risk of maladministration to almost nothing. For example, the protocol requires (1) that the IV team consist of two medical professionals certified, licensed, and/or qualified to place IV lines, (2) that members of the Special Operations Team receive annual training in vascular access and IV therapy from a qualified third party, (3) that the execution team read

the protocol upon selection and annually thereafter, (4) that the execution team attend monthly practice sessions with simulations of all steps of the execution process, and (5) that the execution team attend additional practice sessions as least twice weekly starting two weeks before an execution. Mot. Ex. 5 at 11-12.

The execution team must also secure Hines' arms on the gurney and confirm both circulation and Hines' inability to manipulate the IV lines. Mot. Ex. 5 at 19. The IV team must insert a backup IV line in case the primary IV fails. Mot. Ex. 5 at 20. And the protocol requires an initial flow of sterile saline solution in each IV to keep the lines open. Mot. Ex. 5 at 20; *see Raby v. Livingston*, 600 F.3d 552, 558 (5th Cir. 2010) (finding no risk of pain where protocol required IV to flow properly for several minutes before lethal drugs are administered). In sum, the protocol provides abundant safeguards against the risks of maladministration.

The Eighth Amendment's purpose is to prevent cruel and unusual punishment, "not to substitute the court's judgment of best practices for each detailed step in the procedure for that of corrections officials." *Cooey*, 589 F.3d at 225. To avoid "transform[ing] courts into boards of inquiry charged with determining 'best practices' for executions," Hines must do more than "merely . . . show[] a slightly or marginally safer alternative" such as "additional monitoring by trained personnel." *Baze*, 553 U.S. at 51.

This Court and others have already found speculations like Hines' insufficient to show an Eighth Amendment violation. The protocol contains extensive, well-established safeguards—including qualified personnel, contingency plans, and rigorous training/practice—to mitigate any unconstitutional risk of harm. Hines has no likelihood of success on Claim 1.2 as a matter of law. There is no basis for a stay to facilitate his collateral litigation or for rushed fact-finding by a special master.

III. Hines' Objections to Rule 12 Are Waived.

Hines does not properly preserve his cursory objections to Rule 12 by minimally addressing them in footnotes without any developed argument just twenty-four days before his scheduled execution.

In a single footnote, Hines says that "the December 2025 Amendment [to Rule 12] was unlawful" for eight enumerated reasons. Mot. at 28 n.7. In another footnote without citation to any authority, Hines says "it is inconsistent with due process to treat all requests for injunctive relief bearing on an execution as requests for a stay as a matter of law, without any requiring of a factual showing that a delay is actually likely"; "it [does not] comport with due process to treat every request for relief as a 'last-minute request for delay,' by operation of law, with no reference to the reality of the underlying situation"; and "it is [not] consistent with due process to attribute culpability for risk of delay in such a situation to the movant, regardless of the actions, policies, or litigation conduct of the respondent." Mot. at 35 n.8.

All these undeveloped arguments, raised in footnotes just three weeks before Hines' scheduled execution, are waived. "Arguments raised only in footnotes are waived." *Charles v. McQueen*, 693 S.W.3d 262, 273 (Tenn. 2024). Briefs to this Court "shall contain . . . [a]n argument . . . setting forth the contentions of the appellant with respect to the issues presented . . . with citations to the authorities and appropriate references to the record." Tenn. R. App. P. 27(a). "It is not the role of the courts, trial or appellate, to research or construct a litigant's case or arguments for him or her, and where a party fails to develop an argument in support of his or her contention or merely constructs a skeletal argument, the issue is waived." *Yebuah v. Ctr. for Urological Treatment, PLC*, 624 S.W.3d 481, 491 (Tenn. 2021) (quoting *Sneed v. Bd. of Pro. Resp.*, 301 S.W.3d 603, 615 (Tenn. 2010)). Hines' two footnotes "merely mention[] potential 'constitutional problems' [with Rule 12 and its application] without properly explaining or giving adequate legal support for such claims." *Id.* These "late-raised, minimally addressed" arguments are waived. *In re M.L.P.*, 281 S.W.3d 387, 394 (Tenn. 2009) (quoting *In re Adoption of Female Child*, 42 S.W.3d 26, 32 (Tenn. 2001)).

But if the Court declines to find these issues waived, the State welcomes the opportunity to address their lack of merit in supplemental briefing. *See* Order, *State v. Pike*, No. No. M2020-01156-SC-DPE-DD (Tenn. July 10, 2026).

IV. Hines' Egregious Delay Is Plenty Cause to Deny His Motion.

Hines' tactical delay in seeking a stay just twenty-four days before his execution is an affront to the State, the Court, and Jenkins' family. It is well known that "capital petitioners might deliberately engage in dilatory tactics to prolong their incarceration and avoid execution of a sentence of death." *Rhines v. Weber*, 544 U.S. 269, 277-78 (2005). "[I]t is the same strategy adopted by many death-row inmates with an impending execution: bring last-minute claims that will delay the execution, no matter how groundless." *Price v. Dunn*, 587 U.S. 999, 1008 (2019) (Thomas, J., concurring in denial of certiorari).

But given the significant interests at stake, "[l]ast-minute stays should be the extreme exception, not the norm." *Bucklew*, 587 U.S. at 150 (cleaned up). "[A] stay of execution is an equitable remedy. It is not available as a matter of right, and equity must be sensitive to the State's strong interest in enforcing its criminal judgments." *Hill*, 547 U.S. at 584. Indeed, the State and victims have a "powerful and legitimate interest in punishing the guilty." *Calderon v. Thompson*, 523 U.S. 538, 556 (1998) (cleaned up). They also "have an important interest in the timely enforcement of a [death] sentence." *Bucklew*, 587 U.S. at 149 (cleaned up). Moreover, Tennessee crime victims have the constitutional right to "a prompt and final conclusion of the case after the conviction or sentence." Tenn. Const. art I, § 35. Once post-conviction proceedings "have run their course . . . finality acquires an added moral dimension." *Calderon*, 523 U.S. at 556. "Only with an assurance of real finality can

the State execute its moral judgment in a case" and "the victims of crime move forward knowing the moral judgment will be carried out." *Id.* "To unsettle these expectations is to inflict a profound injury." *Id.*

To avoid such injury, "the last-minute nature of an application that could have been brought earlier, or an applicant's attempt at manipulation, may be grounds for denial of a stay." *Bucklew*, 587 U.S. at 150 (cleaned up). Indeed, federal courts apply "a strong equitable presumption against the grant of a stay where a claim could have been brought at such a time as to allow consideration of the merits without requiring entry of a stay." *Nelson v. Campbell*, 541 U.S. 637, 650 (2004).

Unfortunately, tactical delay is commonplace in Tennessee end-stage litigation. It is unsurprising then that Hines follows this unacceptable trend. After the State's latest protocol adoption, Hines sued two months later. He then inexplicably waited around nine months after this Court's execution order and after deposing the challenged physician to seek relief under Rule 12.

"The proper response to this maneuvering is to deny [Hines'] meritless request[] expeditiously." *Price*, 587 U.S. at 1008. After all, "[t]he people of [Tennessee], the surviving victims of [Hines'] crimes, and others like them deserve better." *Bucklew*, 587 U.S. at 149. The Court should reset appropriate norms for timely end-stage litigation by citing Hines' gross delay as an additional ground for denying his motion.

* * *

The basis of Hines' belated motion—a challenge to a mainstay-lethal-injection procedure previously espoused by Hines and uniformly upheld by this Court, the U.S. Supreme Court, and many others—is the very kind of "[s]erial relitigation" that "undermines the finality . . . essential to both the retributive and deterrent functions of criminal law." *Shinn v. Ramirez*, 596 U.S. 366, 391 (2022). In the end, Hines' motion is nothing more than grasping speculation about the "risk of maladministration," *West*, 519 S.W.3d at 564 (quoting *Baze*, 553 U.S. at 62). But speculation is not proof that Hines' collateral litigation is likely to succeed. After more than four long decades of near-constant litigation scrutinizing and re-scrutinizing Hines' death sentence and the State's execution methods, the Court should give that sentence true meaning by enforcing the principle of finality and allowing the State to enforce its lawful judgment without further interference or delay.

CONCLUSION

Hines' motion should be denied.

Respectfully submitted,

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CERTIFICATE OF REDACTION COMPLIANCE

In accord with Tenn. R. App. P. 20B, undersigned counsel certifies that this filing submitted to *State v. Hines*, No. M2025-00221-SC-DPE-DD, complies with the omission and redaction requirements of Rule 20B. The certification is made per review on July 27, 2026.

s/ Nicholas W. Spangler
Special Counsel

DEATH PENALTY CASE
EXECUTION DATE: AUGUST 13, 2026
Case No. M2025-00221-SC-DPE-DD

IN THE TENNESSEE SUPREME COURT
AT NASHVILLE

STATE OF TENNESSEE

v.

ANTHONY DARRELL HINES

REPLY IN SUPPORT OF MOTION TO AMEND ORDER SETTING EXECUTION DATE, TO APPOINT SPECIAL MASTER, AND FOR CONDITIONAL STAY OF EXECUTION

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Mr. Hines files this Reply to address arguments raised in Defendants' July 27, 2026 Response in Opposition to Plaintiffs' Motion to Amend Order Setting Execution Date, to Appoint Special Master, and for Conditional Stay of Execution.

I. Mr. Hines can establish a likelihood of success with respect to his Eighth Amendment claim.

To succeed on the merits of an Eighth Amendment claim involving an anticipated execution, a plaintiff typically must make two showings: First, he must show that the challenged course of action poses an "'objectively intolerable risk of harm' that qualifies as cruel and unusual." *Baze v. Rees*, 553 U.S. 35, 50 (2008) (quoting *Farmer v. Brennan*, 511 U.S. 825, 846 (1994)). While Eighth Amendment cases routinely discuss such harm using the shorthand of "pain," it is well-established that, consistent with the Framers' expectations, the Eighth Amendment encompasses more than what modern medicine would classify as physical pain. Rather, the Eighth Amendment considers all forms of sufficiently severe "needless suffering," *Glossip*, 576 U.S. at 877 (quoting *Baze*, 553 U.S. at 50), including the "'superadd[ition]' of 'terror, pain, or disgrace,'" *Bucklew*, 587 U.S. at 133 (quoting *Baze*, 553 U.S. at 48).

Second, when an individual challenges some specific aspect of his proposed execution, "the Eighth Amendment requires [him] to plead and prove a known and viable alternative." *Glossip*, 576 U.S. at 880. If there is no viable alternative method of execution, the reasoning goes, then the challenge is to the sentence, not the method, and should be treated accordingly. *Id.* at 879–80.

A plaintiff can establish that his challenge is to a method or circumstance, rather than the death penalty itself, by establishing that there exists at least one alternative course of action that "'is feasible, readily implemented, and in fact significantly reduce[s]' the risk of harm involved." *Nance v. Ward*, 597 U.S. 159, 164 (2022) (quoting *Glossip*, 576 U.S. at 877); *see also Abdur'Rahman v. Parker*, 558 S.W.3d 606, 616 (Tenn. 2018). ("[U]nder the federal or state constitution, a death-sentenced inmate must establish . . . that the risk is substantial compared to the known and available alternatives."). As long as that plausible alternative course of action exists, then the plaintiff's challenge does not allege, either explicitly or by implication, that "the death penalty is categorically unconstitutional." *Glossip*, 576 U.S. at 880.

A. *Baze-Glossip* Prong 1: Defendants' plan to rely on Physician A for Mr. Hines' upcoming execution poses an objectively intolerable risk of causing Mr. Hines to experience severe, needless suffering.

Defendants have not disputed that they intend to rely on Physician A for Mr. Hines' upcoming execution—notwithstanding the fact that Physician A is obviously unqualified to perform one of the two duties assigned to him under the Protocol (namely, the placement of a central IV-line). TDOC's planned reliance on Physician A poses an objectively intolerable risk of causing Mr. Hines to experience needless suffering, in violation of the Eighth Amendment. Moreover, this risk is not merely speculative; it *already occurred* in TDOC's last attempted execution on May 21, 2026. And TDOC has done *nothing* to address the defects in their Protocol that led to that botched execution attempt in the first place—most saliently, the Protocol's allowance for the selection of a demonstrably unqualified physician.

1. TDOC is likely to rely on Physician A for Mr. Hines' execution.

Defendants argue that Mr. Hines has not established that TDOC actually intends to rely on Physician A for his upcoming execution. *See* Response at 25 ("Hines only guesses that the State *might* use a physician

who *might* be unqualified. . . ."). Ignoring the fact that Mr. Hines has been forced to "guess" about Physician A's involvement because Defendants have refused to answer Mr. Hines' RFA No. 1 on this exact issue, it is incontrovertible that Mr. Hines has *already* established a reasonable likelihood that TDOC intends to rely on Physician A for his upcoming execution. Indeed, after a July 16, 2026 hearing on Mr. Hines' Motion to Compel, the Davidson County Chancery Court found that there was a reasonable likelihood that TDOC intended to rely on Physician A for Mr. Hines' upcoming execution and ordered Defendants to answer Mr. Hines' RFA No. 1, but stayed service of that answer. *See* Pl. Mot. Ex. 1 (Order of July 17, 2026). If Defendants' object to this factual finding, they should appeal the trial court's Order. Having failed to do so, they cannot now complain that Mr. Hines' has failed to establish a reasonable likelihood that TDOC intends to rely on Physician A.

Mr. Hines notes that if TDOC does *not* intend to rely on Physician A, Defendants surely would have said so in response to Mr. Hines' request for admission, rather than waste this Court's and the chancery court's time with needless litigation. In any case, Mr. Hines invites this Court or a special master to review TDOC's answer to Mr. Hines RFA

No. 1, to determine whether TDOC, in fact, intends to rely on Physician A.

2. The IV Team will very likely struggle to establish peripheral IV access—requiring the assistance of Physician A and/or the placement of a central line.

Defendants suggest that even if TDOC intends to rely on Physician A for Mr. Hines' execution, there is no guarantee that he will be called on to place a central line or assist with peripheral IV catheterization. *See* Resp. at 25. Nevertheless, it is highly likely that TDOC's IV Team will struggle to obtain peripheral IV access in Mr. Hines—requiring the assistance of Physician A and/or the placement of a central line.

Dr. Gail Van Norman is a cardiothoracic anesthesiologist and an expert in IV catheterization—having placed more than 5,000 central IV-lines and thousands of peripheral IV-lines over the course of her career. As Dr. Van Norman explains in her attached Declaration (Ex. 1), in any given lethal injection execution, it is significantly likely that the IV team will struggle to place a peripheral IV line. A study she conducted of 29 autopsies reports from lethal injection executions in the United States between 2001 and 2025 found that there were difficulties establishing peripheral IV access in over half of executions (56%) and one-quarter

required placement of a central IV-line. *Id.* at 6–7. Thus, the baseline likelihood that TDOC's IV Team will struggle to obtain peripheral IV access in Mr. Hines—without any consideration of situation-specific circumstances—is very high.

But as Dr. Van Norman points out, Mr. Hines has certain medical conditions that dramatically increase the likelihood that the IV Team will struggle to obtain peripheral IV access during his upcoming execution. *Id.* at 7–9. First, Mr. Hines is 66 years old. Vascular access is often complicated in people over the age of 65 due to the physiological effects of aging—"including loss of vein elasticity, weakened vein walls, and reduced subcutaneous tissue support, which make veins fragile, prone to "rolling" (which means they slip away when a needle is pressed against them), and highly susceptible to collapsing or bruising during IV catheterization." *Id.* at 7. Moreover, the rate of difficulty establishing peripheral IV access is even higher in elderly patients like Mr. Hines who have required hospitalization. Dr. Van Norman notes that almost 60% of such patients are classified as having difficult IV access. *Id.*

Second, Mr. Hines is very thin and has suffered significant muscular atrophy in the aftermath of his recent strokes—particularly on

his left side. Decl. of Aly Finn (Ex. 2) at 1–2. As Dr. Van Norman explains, "[m]uscular atrophy often complicates vascular access because the patient's loss of muscle tissue undermines the subcutaneous support structure that helps keep veins in place. This means that the patient's veins in the affected limb might be prone to rolling." Ex. 1 at 7.

TDOC's IV Team already demonstrated that they are incapable of reliably placing both a primary and secondary peripheral IV line when the prisoner's veins are prone to "rolling." As Mr. Carruthers' attorney-witness, Maria DeLiberato, explained in her declaration, TDOC's IV Team struggled to place a peripheral IV line in Mr. Carruthers for approximately 45 minutes, and complained that Mr. Carruthers' veins were "rolling." Pl. Mot. Ex. 13 at 2. Several times, the IV Team seem to have inserted the introducer needle into a vein (indicated by a "flash" of blood), but failed to properly place the catheter (no "flow"). *Id.* at 2–3. According to Dr. Van Norman, "[t]his suggests that they were collapsing or infiltrating Mr. Carruthers' veins." Ex. 1 at 8. Thus, the fact that Mr. Hines' veins are prone to "rolling" due to his age and muscular atrophy will very likely cause the IV Team to struggle to obtain peripheral IV access.

Third, Mr. Hines suffers from stroke-induced spasticity in his left arm—wherein his left arm remains bent at the elbow and his left hand is involuntarily clenched in a fist. Ex. 2 (Decl. of Aly Finn) at 1. Mr. Hines is unable to unclench his left hand or extend his left arm by himself, and it is very painful when others try to do so. *Id.* According to Dr. Van Norman, "muscle spasticity often complicates vascular access in a stroke-affected limb because contracted muscles compress blood vessels and reduce blood flow. Moreover, the rigidity of the affected arm can make it physically challenging to properly position the stroke-affected arm (e.g., to access the antecubital fossa), insert the needle, and/or secure the cannula." Ex. 1 at 7–8. Thus, the IV Team will very likely be unable to access Mr. Hines' left arm—which dramatically reduces the number of sites available to them for peripheral IV access. *Id.*

Dr. Van Norman therefore concludes that, based on Mr. Hines' age, muscular atrophy, and left-sided muscle spasticity, as well as the IV Team's failure to obtain peripheral IV access in Mr. Carruthers, it is "very likely" that TDOC's IV Team will struggle to obtain peripheral IV access in Mr. Hines. *Id.* at 8. Physician A will therefore very likely be called on to assist the IV Team in obtaining peripheral IV access and/or

to place a central IV-line in Mr. Hines—as he was during Mr. Carruthers' attempted execution.

3. Physician A is not qualified to place a central line and will very likely cause Mr. Hines to experience needless suffering if he attempts to do so.

In his October 27, 2025 deposition, Physician A admitted that he has not placed a central line in at least 13 years, has only placed a total of about a dozen central lines in his entire career, has never used ultrasound to place a central line, and only uses the subclavian approach—a method that is associated with significantly higher severe vascular and thoracic complications. Pl. Mot. Ex. 12 (Redacted Deposition) at 6; Ex. 1 (Decl. of Dr. Van Norman) at 5. Physician A also admitted that during one of his previous central line placements, he placed a guidewire into the carotid "vein" [1] —which, as Dr. Van Norman explains, "is an injury to a 'great vessel,' and is considered a major vascular complication that by itself can cause stroke and death." Pl. Mot. Ex. 12 at 6; Ex. 1 at 5.

[1] Dr. Van Norman notes that there is no such thing as a carotid "vein." Physician A presumably meant carotid "artery." Ex. 1 at 5.

Dr. Van Norman oversaw the granting of privileges at the University of Washington Medical Center for central IV-line placement for approximately ten years. She explains that "[d]ue to the special skills needed for central line placement, healthcare systems (including the University of Washington Medical Center) now generally require proof that a practitioner has both appropriate training in central line placement and also recently demonstrated competency in the procedure." *Id.* at 3–4. "By requiring that providers have recent, demonstrated competency in central line placement (in addition to appropriate training), healthcare systems minimize the risk that patients will suffer complications during central line placement due to the provider's lack of continued proficiency." *Id.* at 4. Dr. Van Norman notes that, having not placed a central line in at least thirteen years, "Physician A does not have the current experience or training that would be required to obtain or retain privileges to place central lines at many, if not most, major healthcare institutions today." *Id.* at 5.

Dr. Van Norman likewise states that "Physician A's lack of sufficient qualifications to perform central line placement are evidenced by his actions on May 21, 2026, during the attempted execution of Tony

Carruthers." *Id.* She explains that during Physician A's failed attempts to establish a central line in Mr. Carruthers' subclavian vein, Physician A violated the standard of care by failing to use ultrasound guidance and by failing to place Mr. Carruthers in Trendelenburg position. *Id.* at 6. She also notes that Physician A's apparent attempt to locate Mr. Carruthers' internal jugular vein using an infrared vein finder (which cannot be used for that purpose) evinces his lack of knowledge and experience. *Id.* Thus, Dr. Van Norman concludes that "[b]ased on Ms. DeLiberato's recitation of Physician A's actions and his ultimate failure to establish central IV access, as well as the representations that Physician A made during his deposition about his lack of recent experience in central line placement, it is my professional and ethical opinion that Physician A lacks the competency to place central lines of any kind, and that he should not have attempted to place a central line in Mr. Carruthers." *Id.* at 6.

At no point have Defendants offered any information to establish that Physician A is, in fact, qualified to establish central IV-lines. Instead, Defendants seem to take the bold position that it *does not matter* whether Physician A is qualified to perform one of the two duties assigned to him under the Protocol, because, they argue,

maladministration claims are simply not cognizable. *See* Def. Resp. at 25. This position is absurd and would lead to the wholesale evisceration of the Eighth Amendment right against cruel and unusual punishment—effectively granting the State *carte blanche* to torture people by hiring patently unqualified individuals to perform complex, painful medical procedures as part of the lethal injection process.

4. Mr. Hines will endure not just future physical injury at the hands of Physician A, but also present psychological injury—knowing that he is very likely to suffer due to TDOC's reckless reliance on Physician A.

Having already suffered extensively due to TDOC's reliance on incompetent medical personnel, Mr. Hines reasonably fears that he will suffer even greater injury due to TDOC's reckless reliance on Physician A for his upcoming execution. As Dr. Siddhartha Nadkarni, a neurologist who examined Mr. Hines on February 2, 2026, explains in his attached Declaration (Ex. 3), Mr. Hines' second stroke in January 2026 was proximately caused by the recklessness of TDOC's contracted medical personnel—who unreasonably countermanded Mr. Hines' transfer to an ER after his first stroke in early December 2025, unreasonably failed to perform diagnostic brain imaging for two weeks, unreasonably failed to administer Mr. Hines aspirin until January 6, 2026, unreasonably

countermanded his physician's prescription for anticoagulation medication, and failed to perform necessary cardiovascular testing to determine the cause of Mr. Hines' initial stroke. Ex. 3 at 3–4. Dr. Nadkarni concludes that "[i]n my professional opinion, TDOC's contracted medical personnel acted recklessly with respect to Mr. Hines' care in the aftermath of his stroke in December 2025 and violated universally accepted standards for stroke and post-stroke treatment." *Id.* at 4.

TDOC has therefore demonstrated that it is more than willing to recklessly rely on incompetent or willfully negligent medical personnel both for prisoner medical care and lethal injection executions. Mr. Hines—who is now paralyzed on one side, partially blind, and cognitively impaired as a result of TDOC's recklessness—should not now be forced to face an intolerable risk of additional severe suffering due to TDOC's continued reliance on a demonstrably unqualified execution physician.

B. *Baze-Glossip* Prong 2: A known and viable alternative exists that would substantially reduce the risk of harm—namely, the use of an appropriately credentialed alternate physician.

Defendants do not dispute in their Response that TDOC could simply hire a different, appropriately credentialed physician for Mr.

Hines' scheduled execution. Indeed, Defendants are obviously and unambiguously the parties best situated to present evidence regarding any logistical challenges involved in identifying an alternate physician. Their failure to do so suggests that TDOC would suffer no undue hardship from an order requiring that they use an alternate, appropriately credentialed physician. Thus, the balance of the equities weighs in favor of granting Mr. Hines' request.

Having failed to dispute Mr. Hines' representation about the availability of appropriately credentialed physicians, Defendants have constructively conceded that Mr. Hines has sufficiently pled a known and available alternative. As Justice Alito correctly explained on behalf of the U.S. Supreme Court in *Alexander v. S.C. State Conf. of the NAACP*, 602 U.S. 1 (2024), "a factfinder may draw an adverse inference when a party fails to produce highly probative evidence that it could readily obtain if in fact such evidence exists." *Id.* at 36 (citing *Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 226 (1939); 2 J. Wigmore Evidence in Trials at Common Law § 291, pp. 227–29 (Chadbourn rev. 1979)). "'[T]his rule can be traced as far back as 1722' and 'has been utilized in scores of modern cases.'" *Id.* (*quoting Int'l Union, United Auto., Aerospace & Agr.*

Implement Workers of Am. (UAW) v. N.L.R.B., 459 F.2d 1329, 1336 (D.C. Cir. 1972)).

Mr. Hines notes that Defendants' concession with respect to the second *Baze-Glossip* prong is appropriate. Among the subset of nearly 20,000 actively licensed physicians in Tennessee who are appropriately credentialed to place central IV-lines, a substantial percentage are likely willing to participate in Mr. Hines' execution. Indeed, the last comprehensive survey of physicians on this issue (by Dr. Neil Farber in 2000) found that an overwhelming majority of physicians in the United States (74%) said that it is acceptable for doctors to pronounce an executed prisoner dead, and almost half of respondents (43%) said there is nothing wrong with doctors actually injecting condemned prisoners with lethal drugs. Ex. 4 (Farber Article). If 43% of physicians were willing to actually inject condemned inmates with lethal drugs, an even larger percentage would surely be willing to participate in IV catheterization (which is less directly responsible for causing the prisoner's death). Given the fact that the American public's opinion of the death penalty has only marginally shifted since 2000—*see* Gallup, "Death Penalty," https://news.gallup.com/poll/1606/death-penalty.aspx (finding 66% of

respondents "in favor" of the death penalty in 2001 and 52% "in favor" in 2025)—there is no reason to conclude that physician sentiments have drastically changed since Dr. Farber's study was conducted. Thus, TDOC should be able to identify and hire an appropriately credentialed replacement for Physician A and have not disputed their ability to do so.

Furthermore, nothing in *Baze*, *Glossip*, or *Bucklew* requires a plaintiff to resolve every logistical detail of his identified alternative method of execution. Rather, he simply must show that the alternative method is "feasible and readily implemented." *Bucklew*, 587 U.S. at 134. The Court in Bucklew explained that the phrase "feasible and readily implemented" "means [that] the inmate's proposal must be sufficiently detailed to permit a finding that the State could carry it out 'relatively easily and reasonably quickly.'" *Id.* at 141 (internal citations omitted).

While the Court did not opine on what timeframe it would consider "reasonably quickly," it indicated that substantial delays may be tolerable. Indeed, the Court held that "[a]n inmate seeking to identify an alternative method of execution is not limited to choosing among those presently authorized by a particular State's law." *Id.* at 139–40. If a method of execution can still be "feasible and readily implemented" even

if implementing it requires entirely new legislation, it cannot possibly be the case that a method stops being "feasible and readily implemented" because it requires the replacement of one member of the execution team from hundreds—if not thousands—of potential alternatives.

II. Maladministration claims based on concrete, situation-specific factors are cognizable.

In *West v. Schofield*, 460 S.W.3d 113 (Tenn. 2015), this Court held, among other things, that the particular maladministration claim presented in that case—which was based on bare speculation "that one or more individuals may cause the Protocol to be carried out in an unconstitutional manner in the future"—did not present a "justiciable controversy." *Id.* at 131. That holding, the Court explained, was consistent with the principle that "public officials in Tennessee are presumed to discharge their duties in good faith and in accordance with the law"—that is, the presumption of regularity. *Id.* The Court, however, appended a footnote to its maladministration analysis stating that its "holding in this interlocutory proceeding does not preclude appropriate

as-applied challenges to the Protocol that may arise in the future."[2] *Id.* at 132 n.12.

Whether or not such a footnote had been included, recognizing at least some pathway for maladministration-based claims is required by the law, for at least two reasons. First, as the Supreme Court has held, the Eighth Amendment bars any approach to executions that creates an "'objectively intolerable risk of harm' that qualifies as cruel and unusual." *Baze v. Rees*, 553 U.S. 35, 50 (2008) (quoting *Farmer v. Brennan*, 511 U.S. 825, 846 (1994)). There is no carve-out for risks related to maladministration. If there were such a carve-out, it would permit egregiously unacceptable practices such as having executions performed by volunteers recruited off the street or through an internet raffle and given no training at all. While it may often be the case that maladministration-based risks do not rise to an intolerable level, the law is clear that, where they do, such claims are cognizable.

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[2] As Mr. Hines discussed in his initial motion, this analysis is unaffected by whether he has characterized his claim as "as applied" or even whether that appellation would be appropriate. The substance of the allegations controls the Court's analysis, not the State's habit of "using the phrase 'as-applied challenge' as if it is some kind of talisman to ward off constitutional obligations." *Does #1-9 v. Lee*, 574 F. Supp. 3d 558, 561 n.4 (M.D. Tenn. 2021).

Second, this Court's reliance on the presumption of regularity means that any rule disfavoring maladministration-based claims must be rebuttable—as the presumption of regularity itself is. *See, e.g.*, *State v. Mangrum*, 403 S.W.3d 152, 165 (Tenn. 2013) (recognizing the presumption of regularity as merely placing a burden on the party asserting otherwise); *City of Oak Ridge v. Brown*, No. E2004 01574 COA R3CV, 2005 WL 1996620, at *1 (Tenn. Ct. App. Aug. 19, 2005) (finding "a presumption of regularity and validity" that is "rebuttable"); *Tremewan v. State*, No. 71, 1989 WL 76319, at *2 (Tenn. Crim. App. July 12, 1989) ("In the first place, any presumption of regularity . . . was obviously rebutted by the record and the testimony in this case."). If maladministration claims are disfavored because of the presumption of regularity, it must be the case that, where the presumption is rebutted, so is the disfavor.

Under the *West* framework, then, a plaintiff facing execution cannot state a justiciable claim simply by musing that maladministration could occur, but he can present a justiciable claim based on the risk of maladministration arising out of concrete, situation-specific factors that raise that risk sufficiently above a speculative level.

The State attempts to bypass the well-established caselaw recognizing the cognizability of claims based on concerns such as Mr. Hines' by suggesting that the Eighth Amendment considers only suffering inflicted solely out of *subjective* cruelty—such that no Eighth Amendment claim relating to an execution will be cognizable as long as the State's anticipated course of action had some purported rationale other than the intentional infliction of unnecessary pain. Such an approach, however, would be inconsistent with nearly half a century of Supreme Court caselaw recognizing Eighth Amendment violations with no such showing. *See, e.g.*, *Kennedy v. Louisiana*, 554 U.S. 407, 413 (2008); *Roper v. Simmons*, 543 U.S. 551, 575 (2005); *Atkins v. Virginia*, 536 U.S. 304, 321 (2002); *Enmund v. Fla.*, 458 U.S. 782, 797 (1982); *Coker v. Georgia*, 433 U.S. 584, 598 (1977).

III. This Court may consider issues relating to Mr. Hines' Request for Admission No. 1.

A. Mr. Hines prevailed on his Motion to Compel, and any obligation to appeal belonged to Defendants.

The State's suggestion that Mr. Hines is improperly seeking review of the chancery court's ruling regarding his Motion to Compel, *see* Resp. at 21, fails for one straightforward reason: Mr. Hines prevailed on that

motion, and it is the State's responsibility—not his—to seek review if it disagrees with the chancery court's decision. "[O]nly a party aggrieved [can] appeal from the decree of a chancery court, and have that decree reviewed." *Peoples Bank v. Baxter*, 298 S.W.2d 732, 739 (1956); *accord S. Auto Source Fin., LLC v. Airways Towing & Recovery, LLC*, No. W2025-01053-COA-R10-CV, 2026 WL 1785473, at *8 (Tenn. Ct. App. June 22, 2026) ("Only a party aggrieved by the trial court's order may appeal and obtain review of that order."). Mr. Hines is not aggrieved by the chancery court's ruling, which granted him the relief he sought and merely conditioned the completion of that relief on a higher court's consideration.

Mr. Hines believes that he can and should prevail, if that higher court's consideration involves review on the merits. But if attorneys for the State choose to forfeit their opportunity to press their position in such review, the costs of that forfeiture should fall on their client, not Mr. Hines. If the Defendants *choose* not to appeal the chancery court's ruling, and the attorneys for the State simultaneously *choose* to waive any opportunity to argue the related issues in these proceedings, Mr. Hines is happy to go back to the chancery court, inform it of those choices, and

request service of Defendants' response. The ball, though, is not in Mr. Hines' court.

In any event, the State misunderstands Mr. Hines' request as simply mirroring an ordinary appeal. Mr. Hines believes that it would be appropriate for the State to serve him their answer to RFA No. 1 and believes that this Court can order the State to do so. Mr. Hines also recognizes, however, that this Court has other tools at its disposal to which RFA No. 1 is relevant—including performing *in camera* review of the currently-withheld answer. Mr. Hines is not seeking an out-of-order appeal; if someone needs to appeal, it is Defendants, not him. Mr. Hines is instead asking this Court to use its inherent authority—and the authority it has arrogated to itself in *Black v. Strada* and Rule 12.4(E)—to address these issues in connection with the August 13, 2026 execution date that this Court set.

B. There is no unwaivable privilege protecting the identities of direct execution participants, and Defendants have waived any applicable protection vis-à-vis Physician A's identity.

In *West v. Schofield*, 460 S.W.3d 113 (Tenn. 2015), this Court expressly declined to "adopt[] . . . a common-law privilege that would prohibit the disclosure in civil litigation of the identities of those persons

involved in the execution of condemned inmates." *Id.* at 125. This decision was supported not only by the State's "broad policy" in favor of discovery, *Lee Med., Inc. v. Beecher*, 312 S.W.3d 515, 525 (Tenn. 2010), but also by the fact that the General Assembly, in adopting the statutory language on which such a privilege would be based, already selected the level of protection that should, as a matter of policy, be owed to such information: not *privilege*, but *confidentiality*. *See* Tenn. Code Ann. § 10-7-504(h)(1) ("Notwithstanding any other law to the contrary, those parts of the record identifying an individual or entity as a person or entity who or that has been or may in the future be directly involved in the process of executing a sentence of death shall be treated as confidential and shall not be open to public inspection."); *Univ. of Pennsylvania v. E.E.O.C.*, 493 U.S. 182, 192 (1990) (discussing distinction between confidentiality and privilege).

Protections for confidential information are robust and meaningful. They may, in context, result in information being treated as non-discoverable in light of the underlying risks of hardship and the trial court's assessment of the importance of the information sought. *See* Tenn. R. Civ. P. 26.02(1). Indeed, that has been the case in *Burns v. Strada*; although the chancery court has recognized no privilege owed to

execution identities, it has repeatedly shielded those identities from discovery based on their confidential nature, and Mr. Hines and his co-plaintiffs have repeatedly accepted and abided by those rulings. Only a privilege, however, can *categorically* exempt information from disclosure, absent waiver. *See* Tenn. R. Evid. 501.

The Tennessee General Assembly is well aware of how to create a privilege when it chooses to. *See, e.g.*, Tenn. Code Ann. § 23-3-105 (attorney-client privilege); Tenn. Code Ann. § 24-1-201 (spousal privilege); Tenn. Code Ann. § 68-11-272(c)(1) (QIC privilege). Indeed, the General Assembly knows how to make information *both* confidential *and* privileged. *Compare* Tenn. Code Ann. § 24-1-204(b) (establishing confidentiality of crisis intervention communications) with Tenn. Code Ann. § 24-1-204(c)–(d) (creating narrower testimonial privilege regarding crisis intervention communications); *see also* Tenn. Code Ann. § 68-11-272(c)(1) (designating records "confidential and privileged"). The General Assembly's decision to recognize only confidentiality with respect to the identities of execution participants reflects a considered policy judgment that this Court should not disturb.

In any event, whatever level of protection was initially owed to Physician A's identity as an ongoing execution participant has been waived. Typically, even the categorical protections afforded by privilege can be waived if the beneficiary of that privilege affirmatively acts in a manner inconsistent with maintaining it. *See Castillo v. Rex*, 715 S.W.3d 321, 337–38 (Tenn. 2025). The State acted inconsistently with maintaining secrecy regarding Physician A's identity through its affirmative, voluntary litigation conduct—including (1) asserting no protection for his deposition testimony acknowledging his ongoing role as the State's execution physician, and (2) explicitly asserting, on the record and directly to the chancery court, that the State was no longer treating the identity as protected. Insofar as Physician A's consent would be necessary for that waiver to be sufficient—which Mr. Hines disputes—Physician A joined the State's approach by voluntarily discussing his role as TDOC's execution physician with NBC News.

The State argues that, even if it has waived protection with regard to Physician A's participation in past executions, it continues to have the right to refuse to confirm whether he will participate in any future execution. That argument, however, fails for two reasons: first, it

misunderstands both the role of the execution physician under the 2025 Protocol and what information has already been disclosed; and, second, it is inconsistent with the fairness doctrine that this Court has held to govern questions of the scope of waiver.

The State's argument treats the 2025 Protocol as simply calling, in each execution, for *some* physician to perform certain tasks, leaving it an open question, at any given moment and for any given execution, who that physician will be. That, however, is not how the 2025 Protocol is written. Under the protocol, "Physician" is a specific title and position with an express, textual selection mechanism. *See* 2025 Protocol at 11. The Physician holds that office not merely during executions, but also continuously following his selection—as demonstrated by the fact that the Physician is required to review the Protocol "after [his or her] *selection*," *id.* at 12, not simply before the execution. And that is exactly how Physician A discussed his role in his never-designated-confidential deposition: as a position that he was actually, presently occupying on an ongoing basis. It is simply not true that only his past involvement has been disclosed.

In any event, even if one splits hairs finely enough to suggest that waiver theoretically could be limited to exclude Physician A's future actions, such a holding would, under the current facts, be inconsistent with this Court's edict that "[t]he scope of [a] waiver by disclosure is defined by the 'fairness doctrine,' which aims to prevent the prejudice and distortion that may be caused by one party's selective disclosure of otherwise protected information." *Castillo*, 715 S.W.3d at 340 (quoting *Arnold v. City of Chattanooga*, 19 S.W.3d 779, 787 (Tenn. Ct. App. 1999)). The State and Physician A have freely treated his identity as unprotected when their objectives were avoiding attorney embarrassment or touting Physician A's supposedly strong performance to the press. It is inconsistent with basic principles of fairness to allow them to reassert an interest in secrecy when the topic is accountability, not reputation-bolstering.

Mr. Hines has sought an extraordinarily narrow piece of information. He seeks only to know whether Physician A—who is already widely known as the state's execution physician and who has himself spoken to the national news media about that role—will continue to serve in that capacity for Mr. Hines' execution. Mr. Hines does not dispute that,

as the execution physician, Physician A is, in the eyes of the State, a direct execution participant and that his identity was, therefore, initially confidential.[3] Any such protection, however, was waived long ago without incident, and there is no meaningful additional hardship associated with confirming whether Physician A's service will encompass the execution of Mr. Hines.

IV. Conclusion

For the reasons set forth in this Reply and Mr. Hines' original Motion, Mr. Hines respectfully asks that this Court grant his requested relief.

Respectfully submitted this the 27th day of July, 2026,

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[3] Although the General Assembly has arguably afforded relatively robust protection for upstream individuals and entities "involved in the procurement or provision of" execution chemicals and other physical "items" or "supplies," the protection afforded outside of that context requires "direct involvement." Tenn. Code Ann. § 10-7-504(h)(1).

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CERTIFICATE OF SERVICE

I, Katherine Dix, certify that on July 27, 2026, a true and correct copy of the foregoing was served via electronic mail to opposing counsel, Nicholas W. Spangler, Associate Solicitor General.

/s/ *Katherine Dix*
Katherine Dix, BPR #22778
Counsel for Movant

EXHIBIT 2

State v. Hines
Tennessee Supreme Court
M2025-00221-SC-DPE-DD
Motion to Amend Order Setting Execution Date, to Appoint Special Master, and for Conditional Stay of Execution

IN THE CHANCERY COURT OF DAVIDSON COUNTY, TENNESSEE

KEVIN BURNS, BYRON BLACK, JON HALL, KENNATH HENDERSON, ANTHONY DARRELL HINES, HENRY HODGES, FARRIS MORRIS WILLIAM GLENN ROGERS, and OSCAR SMITH, Plaintiffs, vs. FRANK STRADA, in his official capacity as Tennessee's Commissioner of Correction, and KENNETH NELSEN, in his official Capacity as Warden of Riverbend Maximum Security Institution, Defendants.	)	No. 25-0414-IV

COMPLAINT

Kevin Burns, Byron Black, Jon Hall, Kennath Henderson, Anthony Darrell Hines, Henry Hodges, Farris Morris, William Glenn Rogers, and Oscar Smith hereby bring this civil action seeking a declaration of certain rights in connection with the State of Tennessee's plans for carrying out their executions.

171. On Thursday July 5, 2018—four days before trial began in Chancery Court on the First 2018 Protocol—the defendants, which included the TDOC Commissioner and RMSI Warden, filed notice that TDOC had adopted a new lethal injection protocol ("Second 2018 Protocol"), signed by the Commissioner that very day. Defendant's Notice of Filing (July 5, 2018) (Ex. 11).

172. The Second 2018 Protocol detailed a death by a three-drug combination of midazolam, vecuronium bromide, and potassium chloride. (Ex. 12).

173. As with Tennessee's previous lethal injection protocols, the Second 2018 Protocol provided no meaningful guidance as to how the required lethal injection chemicals would be obtained, and it entrusted that responsibility, not to a trained, dedicated professional, but simply to a preexisting TDOC employee—known in later documents as the "Drug Procurer"—who took on the additional responsibility "off the books" and who received "no direction." *See* Tennessee Lethal Injection Protocol Investigation, Report and Findings 5 (Dec. 13, 2022) ("Stanton Report") (Ex. 13); 2018 Protocol at 37 (Ex. 12).

174. That individual's research consisted primarily of Googling pharmaceutical suppliers and cold calls. Stanton Report at 5–6 (Ex. 13).

175. The result of those efforts was a deal with a compounding pharmacy that proved incapable of providing drugs that reliably complied with the Second 2018 Protocol's requirements.

176. TDOC was fully aware that its pharmacy could not be trusted to perform its obligations effectively, because TDOC knew that the pharmacy, upon being hired

by TDOC, openly misrepresented its ability to compound drugs with a consistent potency.

177. Specifically, in text messages between TDOC's Drug Procurer and the compounding pharmacy's owner in August 2018, the pharmacy owner informed the Drug Procurer that his "methodology is good for any batch of midazolam," such that potency testing "isn't required for every lot" and would merely confirm that "how we process the compound yields the intended dosing within an acceptable range." Stanton Report at 24–25 (Ex. 13); Text Messages of Aug. 7, 2018 (Ex. 14). The pharmacy nevertheless consented to such testing "given the sensitive nature of its intended use." Text Messages of Aug. 7, 2018 (Ex. 14).

178. Only months later, on November 7, 2018, midazolam provided for potential use in the execution of Edmund Zagorski badly failed potency testing, with a potency of merely 54.2%. *See* Stanton Report at 26 (Ex. 13). That failure directly contradicted the representation that the pharmacy's "methodology is good for any batch of midazolam."

179. As of that date, TDOC was on notice that the pharmacy owner had affirmatively misrepresented the reliability of his processes and product, while arguing that mandatory quality testing was unnecessary.

180. Insofar as TDOC had any reason to believe that the November 7, 2018 failed potency testing was an isolated occurrence, that possibility was contradicted when compounded midazolam obtained for potential use on the next individual slated to be executed, David Earl Miller, also failed potency testing. *See id.* at 26–27.

181. However, TDOC continued to rely on the pharmacy, including for the drugs used in the execution of Donnie Johnson. *See id.* at 27–28.

182. Indeed, every single execution by lethal injection performed or planned under the Second 2018 Protocol was characterized by failures to adhere to the Second 2018 Protocol.

183. Most of the individuals executed by Tennessee during the relevant time chose to be executed by electrocution—reflecting the degree of well-founded mistrust that had grown to surround the State's lethal injection process. Even for electrocution-based executions, however, TDOC obtained lethal injection chemicals pursuant to the Second 2018 Protocol in the event of a change in preference.

184. Time and again, the chemicals that TDOC obtained for potential use were inadequate by the State's own standards. Specifically:

a. Billy Ray Irick was executed on August 9, 2018, with midazolam that was not tested for either potency or endotoxins. *See* Stanton Report at 25.

b. The midazolam obtained for potential use in the execution of Edmund Zagorski on November 1, 2018, was not tested for endotoxins and failed potency testing, which was known only after his execution, because the testing results did not arrive on time. *See id.* at 26.

c. The midazolam obtained for potential use in the execution of David Earl Miller on December 6, 2018, was not tested for endotoxins and failed potency testing. *See id.* at 26–27.

d. Donnie Edward Johnson was executed on May 16, 2019, with midazolam that was not tested for endotoxins and was shipped to TDOC prior to receiving results for sterility testing. *See id.* at 27.

e. Lethal injection chemicals obtained for potential use in the August 15, 2018 execution of Stephen West were shown repeatedly to have been inadequate. TDOC's preexisting batch of potassium chloride had expired, requiring it to turn to the compounding pharmacy from which it was receiving midazolam to receive compounded potassium chloride, as well. Its first batch of potassium chloride failed to fall within the required range for potency testing. *See id.* at 29. Then, the pharmacy informed TDOC that it was struggling to compound potassium chloride at all—with the drug "falling out of solution." When the pharmacy did finally send the potassium chloride, the pharmacy owner told TDOC that sterility testing was unnecessary, only to retract that representation shortly thereafter. The pharmacy ultimately used an "in-house sterility report," rather than the outside testing called for by the Second 2018 Protocol. The lethal injection chemicals were not tested for endotoxins, and West was ultimately executed by electrocution. *See id.* at 30–31.

f. Both the midazolam and the potassium chloride prepared for potential use in the December 5, 2019 execution of Lee Hall failed potency testing and had to be scrapped. Replacements were provided, but the testing confirming the sterility of the potassium chloride was not returned until two weeks after

the execution, which was performed by electrocution. None of the chemicals were tested for endotoxins. *See id.* at 32.

g. Lethal injection chemicals obtained for potential use in the February 20, 2020 execution of Nicholas Sutton were not tested for endotoxins, and it does not appear that the results of testing for potency or sterility were provided to TDOC prior to Mr. Sutton's execution by electrocution. *See id.* at 32–33.

G. TDOC's history of mishandling lethal injections began to become apparent after its aborted effort to execute Plaintiff Oscar Smith.

185. Under the Second 2018 Protocol, still in place in 2022, Tennessee used a combination of three drugs—the sedative midazolam, the paralytic vecuronium bromide, and heart-stopping agent potassium chloride—to perform executions.

186. Although the sedative and paralytic used were not exactly the same as those used in Dr. Chapman's original Oklahoma protocol, Tennessee's three-drug combination was still fundamentally modeled on Dr. Chapman's method.

187. TDOC had abandoned the pentobarbital option because it had been unable to develop the capacity to perform executions with pentobarbital.

188. Plaintiff Oscar Smith was scheduled to be executed pursuant to that protocol on April 21, 2022.

189. On April 20, 2022, Mr. Smith's attorney, Kelley Henry, sent an email to TDOC Deputy Commissioner/General Counsel Debbie Inglis inquiring whether the chemicals intended for Mr. Smith's execution had been subjected to the full testing for sterility, potency, and endotoxins required by the Second 2018 Protocol.

190. The chemicals had not, in fact, been tested for endotoxins, as required by the Second 2018 Protocol, a fact of which Inglis was aware no later than shortly after Ms. Henry's email.

191. Despite the fact that TDOC knew that it had failed to comply with the Second 2018 Protocol and would be unable to do so in time for the planned execution, it initially prepared to go forward with the killing.

192. On the day of the planned execution, TDOC officials went as far as preparing the syringes for the use of the noncompliant drugs in Mr. Smith's execution.

193. Mr. Smith had begun to receive communion in anticipation of his imminent death.

194. The execution of Mr. Smith was only halted because the Governor intervened and granted Mr. Smith a reprieve.

195. It quickly became clear to the Governor that TDOC's wrongdoing was not limited to the planned execution of Mr. Smith.

196. TDOC had, in fact, never fully complied with the Second 2018 Protocol in any execution by lethal injection.

197. TDOC's failures to comply with the Second 2018 Protocol were not limited to failures to perform endotoxin testing.

198. TDOC executed at least one person with drugs that were not tested for potency.

199. In addition to the errors that TDOC made in connection with the executions themselves, TDOC officials also misrepresented its compliance with its procedures in connection with litigation in federal court by two men, Donald Middlebrooks and Terry King, who have been sentenced to death in Tennessee but are not Plaintiffs in this case.

200. Counsel for TDOC has now admitted to several such misstatements—including ones that involved their counsel's overt scoffing at opposing counsel's now-vindicated concerns as "speculative" and "baseless." *See* Defendants' Notice of Corrections of Inaccuracies and/or Misstatements at 3–5 (Ex. 15).

201. Because those misrepresentations took place in ongoing litigation, they were disclosed. The sheer number of times that TDOC misrepresented the truth to the public, attorneys, its prisoners, and others will likely never be known.

202. On May 2, 2022, the Governor directed former U.S. Attorney Ed Stanton to conduct an independent investigation of (1) the "[c]ircumstances that led to testing the lethal injection chemicals for only potency and sterility but not endotoxins preparing for the April 21 execution"; (2) the "[c]larity of the lethal injection process manual that was last updated in 2018, and adherence to testing policies since the update"; and (3) TDOC staffing considerations. *See* Ex. 16 at 2.

203. In acknowledgment of the State's loss of confidence in the Second 2018 Protocol, as implemented by TDOC, Governor Lee "paus[ed] scheduled executions through the end of 2022 in order to allow for the review and corrective action to be put in place." *Id.*

H. The aftermath of the aborted execution of Mr. Smith revealed more TDOC wrongdoing and deficiencies, and TDOC was forced to take ostensible remedial steps.

204. On December 13, 2022, Mr. Stanton issued the Report and Findings of his investigation, also known as the "Stanton Report." *See* Ex. 13.

205. Mr. Stanton publicly confirmed, for the first time, that TDOC had been routinely failing to follow its procedures related to lethal injection chemicals.

206. Mr. Stanton publicly revealed, for the first time, that TDOC had never fully complied with the Second 2018 Protocol in connection with any execution by lethal injection.

207. Mr. Stanton expressly concluded, as part of his published report, that the agency's failures were a direct result of the fact that "TDOC leadership viewed the lethal injection process through a tunnelvision, result-oriented lens." Stanton Report at 40.

208. Mr. Stanton also set out a number of "concrete recommendations":

- Consider hiring a full-time employee or retaining a consultant with a pharmaceutical background to provide guidance in connection with the lethal injection process.
    - Conduct an exhaustive review of the current Protocol.
    - Review the current Protocol's testing requirements.
    - Establish testing guidelines for any compounded [lethal injection chemicals ("LIC")] with procedures for confirming that the appropriate tests are being performed.
    - Establish a procedure for storing and maintaining test results.
    - Establish a procedure for storing and maintaining LIC, including recommendations regarding suitable equipment for storage.
    - Assist with locating LIC sources and communicating pertinent information to same.

- Ensure that a copy of any current or future version of the TDOC Protocol is provided to the LIC provider.
- Evaluate the roles and outline the duties of all TDOC employees, as well as any third parties, tasked with participating in the lethal injection process.
- Consider hiring a full-time employee or retaining a consultant with a healthcare background to provide scheduled guidance and training to the Execution Team.
    - Determine whether any Execution Team members should be required to obtain any certifications and/or licenses.
- Establish a team/committee to review all relevant testing data prior to each scheduled execution to ensure that there are no deviations from the Protocol.
    - Consider incorporating deadlines to obtain testing results in sufficient time to ensure that failing LIC are not made available or used during a scheduled execution.
    - Consider annual audits to ensure compliance and to evaluate Protocol efficiencies and best practices.

Id. at 41–42.

209. On December 28, 2022, Governor Lee issued a formal statement in response to the Stanton Report, stating that he was "proactively sharing . . . [his] administration's next steps to ensure continued transparency for the people of Tennessee." *See* Ex. 17 at 1–2.

210. The Governor identified four "proactive steps to ensure TDOC adheres to established protocol," which, he stated, "will occur in the following sequence": (1) make staffing changes at the department's leadership level; (2) hire and onboard a permanent TDOC commissioner in January 2023; (3) revise the State's lethal injection protocol; and (4) review all training associated with the revised protocol and make appropriate operational updates. *See id.*

211. Around the time of the release of the Stanton Report, TDOC fired Deputy Commissioner/General Counsel Debbie Inglis.

212. On information and belief, Inglis was fired for wrongdoing related to executions, including making misrepresentations.

213. Around the same time, TDOC fired Inspector General Kelly Young

214. On information and belief, Young was fired for issues related to executions.

215. On May 1, 2023, the defendants filed a Notice of Corrections of Inaccuracies and/or Misstatements admitting to several false statements made in the course of litigating the *King* and *Middlebrooks* cases. *See* Ex. 15.

I. After over two years, TDOC finalized a new protocol and immediately misrepresented the contents or circumstances of that protocol more than once.

216. TDOC's process of developing a new protocol for performing executions following the Stanton Report was performed behind closed doors, with no public participation.

217. TDOC's limited public comments during that period confirmed that the agency was attempting to formulate a lethal injection protocol, but did not indicate that any particular approach had been finalized. *See,* e.g., Ex. 18.

218. Step One of the Method of Execution Statute requires TDOC to attempt to formulate a method for performing executions by lethal injection, before it can certify to the Governor that no feasible option was available. Accordingly, the fact that TDOC acknowledged that it was working on a lethal injection protocol could not

likely to remain conscious and sensate as he experiences the physical effects of the drug, including, in most cases, pulmonary edema.

313. Based on the foregoing issues, pentobarbital that has been improperly procured, manufactured, transported, handled, and/or stored poses a greater risk of severe suffering than licit, properly processed pentobarbital.

314. That risk is intolerable.

2. The risk of tortuous death in an execution by pentobarbital is increased if the individuals preparing the syringes, setting the IV line, and administering the drug are not competent, sufficiently trained, and qualified.

315. The risk of a tortuous death by pentobarbital poisoning is also increased if the individuals charged with preparing the pentobarbital, setting the intravenous ("IV") line, and administering the pentobarbital are incompetent, insufficiently trained, insufficiently dedicated to doing their jobs properly, and/or insufficiently attentive.

316. An error in the preparation or administration of the syringes of pentobarbital increases the likelihood that the individual to be executed will receive a dosage that causes extreme suffering but is insufficient to render him unconscious or insensate.

317. The 2025 Protocol entrusts the preparation of the syringes to be used in the execution to an individual identified as the "Special Operations Team Leader." 2025 Protocol at 18.

318. The 2025 Protocol entrusts the administration of the syringes through the affixed IV line—that is, the killing act—to the Special Operations Team Leader, as well. *See id.* at 21.

319. The 2025 Protocol does not require that the Special Operations Team Leader, an RMSI employee, have any particularized training.

320. The 2025 Protocol does not require that the Special Operations Team Leader have any form of healthcare licensure whatsoever. *See id.* at 9.

321. The 2025 Protocol does not require that the Special Operations Team Leader have any form of healthcare certification whatsoever. *See id.*

322. The 2025 Protocol does not require that the Special Operations Team Leader have any form of healthcare experience whatsoever. *See id.*

323. As a result, the 2025 Protocol calls for the person to be executed to be killed by a pharmaceutical agent that has been prepared and administered by a layperson, giving rise to an increased risk of errors resulting in severe suffering.

324. In addition to the risks associated with the preparation and administration of the syringes, an improperly set IV line can cause less than the intended dosage of pentobarbital to enter the executed person's bloodstream, increasing the likelihood that he will remain conscious and sensate as he experiences the poisonous effects of the drug, including pulmonary edema.

325. An IV line that is not fully and squarely inserted into the vein at a proper angle, without piercing through to the other side of the vein, is likely to leak some of the drug into the surrounding tissue.

326. If pentobarbital leaks into the surrounding tissue, that leakage is likely to cause excruciating pain.

327. If pentobarbital leaks into the surrounding tissue, the leaked portion will not contribute to the immediate sedation of the individual, causing the equivalent of an underdose.

328. An IV line that is set in a manner that does too much damage to the targeted vein can cause the vein to rupture, leading to some of the drug escaping from the circulatory system.

329. Medications that are administered via syringe too forcefully might cause the vein to rupture, leading to some of the drug escaping from the circulatory system.

330. The rupturing of the vein and the consequent dumping of pentobarbital into the surrounding tissue is likely to cause excruciating pain.

331. If the vein ruptures and pentobarbital escapes from the circulatory system, the escaped portion will not contribute to the immediate sedation of the individual, causing the equivalent of an underdose.

332. An IV line that is not sufficiently firmly affixed can come loose during the administration of the drug, leading to an underdose. This is especially likely if the IV solutions are pushed too forcefully—as is possible if the LIC is being manually administered by the Special Operations Team leader.

333. If the IV line comes loose before the full dose is administered, a lower dose of pentobarbital will enter the bloodstream.

334. An individual who is executed pursuant to the 2025 Protocol but receives a lower-than-intended dosage of pentobarbital, is more likely to remain conscious and sensate as he experiences the physical effects of the drug, including, in most cases, pulmonary edema.

335. The 2025 Protocol calls for an IV line to be set by a TDOC-selected "IV Team," defined as follows:

> IV Team: consists of at least two members who are either physicians, physician assistants, nurses, emergency medical technicians ("EMTs"), paramedics, military corpsman with relevant medical training, or other certified or licensed personnel including those trained in the United States Military. All team members are currently certified, licensed and/or qualified within the United States to place IV lines. IV Team members are selected by the Commissioner.

2025 Protocol at 11.

336. The 2025 Protocol does not require that members of the IV team have any kind of professional licensure, as long as they are "certified" or "qualified."

337. The 2025 Protocol does not identify any particular entity from which a certification must be obtained.

338. The 2025 Protocol does not define "qualified."

339. The State of Tennessee has recently asserted authority, by its executive branch, to declare a person "qualified" for a position based on a unilateral assessment of the person's general fitness—in direct contravention of the usual requirements for that type of "qualification". *See* Tenn. Att'y Gen. Op. No. 24-007 (Apr. 23, 2024) (asserting that the statutory requirement that the Commissioner of Education be

"qualified to teach in the school of the highest standing over which the commissioner has authority," Tenn. Code Ann. § 4-3-802(b)–(c), is merely a "general standard to be administered principally by the Governor through the appointment and removal process" and permits the Governor to select a Commissioner who is not, as a matter of law, qualified to teach in any Tennessee public school).

340. That understanding of the term "qualified," as applied to the IV Team, would result in the equivalent absolute, unreviewable discretion by TDOC to select team members, untethered to any actual, formal licensing or training regime.

341. Not all physician assistants are capable of effectively setting an IV line.

342. Not all physicians are capable of effectively setting an IV line.

343. Not all military corpsmen with medical training are capable of effectively setting an IV line.

344. Not all nurses are capable of effectively setting an IV line.

345. The 2025 Protocol does not bar the participation of individuals with a history of reported medical errors.

346. The 2025 Protocol does not bar the participation of individuals with a history of malpractice claims.

347. The 2025 Protocol does not prescribe a particular training regimen for members of the IV team.

348. The 2025 Protocol does not set a minimum number of times in which a member of the IV Team must have previously set an IV line in a professional setting.

349. The 2025 Protocol does not require that a member of the IV Team ever have set an IV line in a professional setting.

350. The 2025 Protocol calls for "Monthly Practice Sessions," but it specifically provides that "[n]o IV is inserted into the person playing the role of the inmate" during those sessions, meaning that the individuals on the IV Team do not receive monthly practice in actually setting an IV line in a human being. 2025 Protocol at 12.

351. The Second 2018 Protocol also called for monthly practice sessions, but did not exempt the setting of the IV from those sessions. *See* Second 2018 Protocol at 32. The 2025 Protocol, accordingly, reflects an affirmative change to require less practice in setting an IV.

352. The Second 2018 Protocol also included lengthy instructions for assessing both the adequacy of the IV line and whether drugs were being administered properly. For example, it specifically required the individual pushing the drugs through a syringe to pull back if he experienced pressure. *See* Second 2018 Protocol at 46. This instruction is important because continuing to push medication despite experiencing pressure could cause the prisoner's vein to rupture or the IV line to become dislodged.

353. The 2025 Protocol, however, has removed essentially all of those detailed instructions.

354. The difficulty of properly setting IVs has led to errors and complications in numerous American executions.

365. The 2025 Protocol acknowledges that the work of the IV Team must be assessed for sufficiency before the execution can proceed and requires that an individual check to "ensure[] that the catheters are properly secured, properly connected to the IV lines, and out of reach of the inmate's hands." 2025 Protocol at 20.

366. The individual charged with performing that assessment, however, is the Special Operations Team Leader—an individual who is not required to have any medical qualifications whatsoever. *See id.* at 20.

367. The lax, vague requirements for the IV Team, the improper reliance on the Special Operations Team Leader, and the lack of adequate mandatory training create a significant, unnecessary, and avoidable risk that errors will occur in an execution performed pursuant to that protocol. As a result, pentobarbital that is administered pursuant to the 2025 Protocol presents a higher risk of a tortuous death than pentobarbital administered by a competent, appropriately trained and licensed team of capable professionals.

368. That risk is intolerable.

L. TDOC has come to suffer from a culture of noncompliance and disregard for professional standards that is incompatible with execution by intravenous pentobarbital poisoning.

369. Every failed Tennessee lethal injection protocol is tied together by a single thread: TDOC, in its form as an actually existing entity with an established culture and workforce.

370. The adequacy of a set of instructions depends on the qualities of the person or entity to whom the instructions are directed.

371. For example, instructions minimally sufficient to tell a seasoned pilot how to land a particular aircraft would be woefully insufficient to tell a layperson how to do the same, and instructions minimally sufficient to tell a skilled carpenter how to make an ornate table would be insufficient for a beginner.

372. A version of the same principle holds true at the organizational level: the adequacy of a set of instructions depends on the organization to whom the instructions are directed.

373. For example, instructions minimally sufficient to tell a construction crew how to erect a structure would be insufficient for a law firm charged with the same task.

374. For the same reasons, instructions minimally sufficient for a well-trained government agency with a dedication to compliance will often be insufficient for an agency with an organizational culture of noncompliance and/or insufficiently trained personnel.

375. The 2025 Protocol does not—and cannot—eliminate the need for a competent, appropriately skilled and trained agency to carry it out in good faith.

376. The effectiveness of any written protocol will depend on the individuals carrying it out, because no protocol can eliminate either (1) the need for good faith, competent execution of its steps or (2) the inevitable need to make interstitial,

implementing decisions in the face of events that were not contemplated by the protocol.

377. For example, the 2025 Protocol calls for an IV catheter to be inserted by the IV Team. The effectiveness of that step is inherently inseparable from the ability of the IV Team to carry it out. The Protocol requires competent, good faith execution.

378. The importance of interstitial decision making, in turn, is demonstrated by the numerous errors made in handling the relationship between TDOC and its pharmacy under the Second 2018 Protocol. The Second 2018 Protocol gave TDOC no guidance regarding how to communicate with or assess the performance of its supplier, which led to both breakdowns of communication regarding testing and a decision to stay with a questionable pharmacy after numerous red flags had arisen.

379. Implementation of the 2025 Protocol will undoubtedly present its own set of unforeseen situations and factors that the Protocol's written instructions do not address.

380. The 2025 Protocol, on its face, entrusts its execution and implementation to TDOC. Accordingly, the adequacy of the 2025 Protocol depends, in no small part, on the ability of the actually existing TDOC to carry it out.

381. TDOC has developed an internal culture of noncompliance with the law.

382. TDOC has developed an internal culture of noncompliance with its own policies.

383. TDOC has developed an internal culture of opacity and, in some instances, outright dishonesty regarding its failures of compliance.

384. TDOC's ineffective leadership and broken internal culture create an intolerable risk that errors or wrongdoing in the procurement, transportation, handling, storage, and/or administration of pentobarbital will result in a tortuous death by Plaintiffs.

1. TDOC's procurement processes have been plagued by legal noncompliance, shortcuts, and corruption.

385. TDOC has a well-established history of untrained, sloppy, and/or legally noncompliant behavior in its procurement decisions and oversight of vendors.

386. TDOC's failure to impose sufficient oversight or accountability on the compounding pharmacy it used in connection with the Second 2018 Protocol is one example of those problems.

387. However, TDOC's procurement-related failures were not limited to the Drug Procurer or to the purchase of drugs for executions.

388. From 2012 through 2020—that is, for most of the years leading up to the current protocol—TDOC's finances were overseen by Deputy Commissioner and Chief Financial Officer Wesley Olan Landers.

389. Deputy Commissioner Landers was responsible for, among other things, ensuring that the State paid for the services necessary for its prisons to be humane places in which prisoners could be constitutionally housed.

390. According to the U.S. Department of Justice, Deputy Commissioner Landers used his personal email account to leak confidential information to the ultimately successful corporate bidder for a $123 million TDOC behavioral health contract, after which he left for an executive position created for him at that very

company to which he helped steer those millions of dollars. Ex-Deputy Commissioner Landers was federally indicted for his alleged attempts to cover up those actions late last year. *See* Former Tennessee State Public Official and a Corporate Executive Charged with Conspiracy to Obstruct Justice and Commit Perjury in Connection with a $123 Million State Contract, available at https://www.justice.gov/usao-mdtn/pr/former-tennessee-state-public-official-and-corporate-executive-charged-conspiracy.

391. There is no publicly available evidence that TDOC has taken meaningful steps to rectify the culture of noncompliance and self-interestedness that Deputy Commissioner Landers represented.

2. TDOC has a demonstrated history of misrepresenting its compliance with the law and concealing issues with the state's lethal injection processes.

392. Government employees, like all people, make errors.

393. One of the most essential bulwarks against maladministration in government is a norm of forthrightness and transparency, by which employees are expected to disclose, and not conceal, errors.

394. TDOC has demonstrated a lack of a culture of forthrightness and transparency on multiple occasions.

395. For example, attorneys for the State were required to retract multiple statements made before the Middle District of Tennessee in the *King* and *Middlebrooks* litigation after the agency's wrongdoing was exposed.

422. Although the "move fast and break things" approach to government is far from universally shared, it has some high-profile and powerful adherents. The popularity of this new hostility to compliance means that Tennessee officials who wish to advance professionally now face new incentives to disregard legal constraints and norms of professionalism.

423. The existence of these incentives is an objective fact, independent of any person's opinions about the wisdom or desirability of the underlying approach: A governing philosophy that emphasizes a willingness to violate the law in favor of achieving specific outcomes will, by definition, encourage poor compliance with the law.

424. These incentives have the potential to bear directly on many of the individuals who would ordinarily have the responsibility for ensuring that Tennessee executions are carried out lawfully and appropriately.

425. The result is that one of the ordinary baseline constraints that would ensure the competent performance of the government's tasks—the desire of ambitious or otherwise reputation-sensitive officials to avoid the embarrassment of having broken the law—has been substantially weakened by a countervailing force.

N. The 2025 Protocol and TDOC's post-2022 actions do nothing to protect against the agency's culture of noncompliance.

426. One of the key tasks that TDOC faced, in formulating the 2025 Protocol, was to attempt to prevent instances, like those that occurred in connection with the Second 2018 Protocol, in which TDOC personnel failed to follow the protocol's requirements.

427. The primary approach to this issue in the 2025 Protocol is not to take steps to increase accountability or transparency, but rather simply to reduce the number of requirements that TDOC can fail to meet.

428. The 2018 Protocol was over 100 pages in length; the 2025 Protocol is only 44 pages—having eliminated entire sections' worth of specifications and requirements.

429. Most notably, the 2018 Protocol included extensive instructions regarding the preparation, handling, storage, and testing of the chemicals to be used in the lethal injection process. *See* Second 2018 Protocol at 35–40.

430. In reviewing TDOC's pre-2022 procedures, the Stanton Report recommended that TDOC "review the current Protocol's testing requirements" and "[e]stablish testing guidelines for any compounded [lethal injection chemicals ("LIC)] with procedures for confirming that the appropriate tests are being performed." Stanton Report at 41. The Report recommended that TDOC establish a procedure for storing and maintaining those test results. *See id.*

431. The Stanton Report also recommended that TDOC "[e]stablish a procedure for storing and maintaining LIC, including recommendations regarding suitable equipment for storage." *Id.*

432. Instead, the 2025 Protocol appears to have eliminated nearly all of those requirements, with only a few scant, redacted portions of the document that appear,

based on the context, to address how the pentobarbital should be procured, handled, or administered.[3] *See* 2025 Protocol at 13.

433. The Second 2018 Protocol also included detailed instructions regarding the administration of lethal injection chemicals via IV line. *See* Second 2018 Protocol at 40–46. The 2025 Protocol mostly eliminates those detailed instructions. *See* 2025 Protocol at 16, 18–20.

434. The result is a protocol that poses a potentially lower risk of superficially obvious "violations," because it imposes significantly fewer concrete obligations that TDOC could violate.

435. The Eighth Amendment, however, is not simply, or even primarily, a bar on technical administrative errors. It bars cruel and unusual punishment, and the elimination of requirements intended to prevent cruel and unusual punishment likely will, if anything, increase the risk of an Eighth Amendment violation, even if it decreases the risk of a violation of the protocol itself.

436. The Eighth Amendment forbids the State of Tennessee from executing any person in a manner posing an "'objectively intolerable risk of harm' that qualifies

[3] Counsel for the Plaintiffs have been involved in discussions with counsel for the State of Tennessee about obtaining an unredacted version of the protocol for use in other, preexisting litigation. Attorneys for the State, however, have refused to consent to the use of an unredacted protocol in connection with new litigation, until a protective order is put in place by the relevant court. Accordingly, Plaintiffs have relied entirely on the redacted protocol for the formulation of this Complaint.

as cruel and unusual." *Baze v. Rees*, 553 U.S. 35, 50 (2008) (quoting *Farmer v. Brennan*, 511 U.S. 825, 846 (1994)).

437. One of the most important indications of whether a particular risk is "intolerable" by contemporary standards is whether it "is in fact" tolerated by democratically accountable governments—that is, whether individual states and/or the federal government have found a particular approach to executions to be acceptable. *See id.*

438. The State of Tennessee is the only government that relies on TDOC to perform executions.

439. The Governor is the chief executive of the government of the State of Tennessee.

440. In 2022, the Governor concluded that he could not tolerate the risk associated with TDOC's continuing to perform executions unless substantial remedial measures were taken.

441. The Governor selected Mr. Stanton to assess the nature of TDOC's problems related to executions.

442. Mr. Stanton concluded that TDOC's errors were not solely the result of inadvertence but reflected cultural problems within the agency.

443. In response to the Stanton Report, the Governor directed TDOC to take certain remedial actions.

444. The Governor expressly called for those actions to be taken sequentially.

445. The first two of the Governor's proposed actions were to "[m]ake staffing changes at the department's leadership level" and "[h]ire and onboard a permanent TDOC commissioner."

446. TDOC now has a new Commissioner.

447. TDOC also replaced Ms. Ingles, Mr. Young, and the warden of RMSI.

448. TDOC has announced no other changes to its leadership team that appear to be related to the need to address issues surrounding the performance of executions.

449. It is a common public relations tactic, when an entity's wrongdoing has been publicly exposed, to terminate one person or a small number of individuals to create an appearance of responsiveness.

450. This strategy is so common that there are multiple widely recognized terms to describe the person offered up for termination: "fall guy," "scapegoat," and "sacrificial lamb," for example.

451. In reality, while individual leadership is often important to an entity's success, superficial changes in leadership frequently fail to solve problems in companies, agencies, and other large organizations.

452. A change in leadership is especially unlikely to be effective if the change was made to satisfy public relations objectives and was not accompanied by an actual change in the organization's culture.

453. It would, therefore, be improper to assume that the appointment of a new Commissioner, the hiring of a new warden of RMSI, or the replacement of Ingles and Young necessarily changed TDOC's culture in any significant way.

454. The Governor's third directive was to adopt a new lethal injection protocol.

455. TDOC has adopted what it represents to be a new lethal injection protocol, but it has not publicly released the full protocol, choosing instead to redact several of its key portions.

456. The Governor's fourth directive was for TDOC to review and overhaul its execution training practices after the completion of the new protocol.

457. Such an approach would ensure that the new training regimen was appropriately tailored to the protocol itself.

458. TDOC represented to the U.S. District Court for the Middle District of Tennessee that it would complete all of the Governor's directed remedial steps. *See* Ex. 38 at 2 (asking the court to "extend the stay of the proceedings until the completion of corrective actions called for by the report and the Governor's directives based on the report").

459. TDOC has made no public indication that it intends to complete the post-drafting review and overhaul of training that the Governor directed.

460. Mr. Stanton also made a number of recommendations in the Stanton Report.

461. TDOC represented to the U.S. District Court for the Middle District of Tennessee that it would complete all of Mr. Stanton's proposed remedial steps. *See id.*

462. Mr. Stanton recommended that TDOC consider "hiring a full-time employee or retaining a consultant with a pharmaceutical background to provide guidance in connection with the lethal injection process." Stanton Report at 41.

463. TDOC has made no public indication that it complied with that recommendation.

464. Nor is there any evidence that TDOC has taken steps to ensure that anyone, let alone a qualified person, performs several of the tasks for which Stanton suggested TDOC consider hiring a full-time, specialized employee: (1) [e]stablish[ing] testing guidelines for any compounded LIC with procedures for confirming that the appropriate tests are being performed"; (2) "[e]stablish[ing] a procedure for storing and maintaining test results"; and (3) "[e]stablish[ing] a procedure for storing and maintaining LIC, including recommendations regarding suitable equipment for storage." Stanton Report at 41.

465. TDOC has taken no other publicly revealed steps to rectify its culture of noncompliance, despite the fact that many potential remedial steps are available to the agency.

466. For example, there is a substantial body of evidence that the most effective deterrent to wrongdoing is certainty of detection. *See United States v.*

Corchado-Aguirre, No. CR 15-0393 JB, 2015 WL 10383207, at *16 (D.N.M. Aug. 31, 2015) (collecting literature).

467. Consistently with that principle, courts have long recognized that one of the principal evils of government secrecy is its use as a tool for "obscuring incompetence." *Brown & Williamson Tobacco Corp. v. F.T.C.*, 710 F.2d 1165, 1179 (6th Cir. 1983).

468. TDOC could have provided a safeguard against maladministration by making its processes more transparent.

469. Instead, TDOC has increased the secrecy surrounding the execution process by including fewer details about its practices in its newer, shorter written protocol.

470. TDOC also could revise its disciplinary policies to impose higher expectations of professionalism and compliance from its employees involved in the execution process.

471. TDOC has given no indication that it has done so.

472. Although TDOC has not yet used the 2025 Protocol to execute a single person, it has already demonstrated its continuing culture of noncompliance by departing from the Protocol's requirements several times.

473. The 2025 Protocol instructs the Warden to "[c]ollect[] the Affidavit For Method of Execution from the inmate (if applicable)" thirty days prior to the scheduled date of execution. 2025 Protocol at 14.

474. Forcing an individual to complete his Affidavit For Method of Execution at an earlier date would deprive the individual of the benefit of the most up-to-date information about the respective options.

475. That issue is particularly acute with regard to the 2025 Protocol, which is new and has only been made publicly available in redacted form. Individuals facing execution under the 2025 Protocol are diligently trying to assess it, but that process has only just begun.

476. Plaintiff Oscar Smith currently has a scheduled date of execution of May 22, 2025.

477. Accordingly, TDOC should seek his Affidavit of Method of Execution no earlier than April 22, 2025.

478. Plaintiff Byron Black currently has a scheduled date of execution of August 5, 2025.

479. Accordingly, TDOC should seek his Affidavit of Method of Execution no earlier than July 6, 2025.

480. Donald Middlebrooks, who is not a party in this case, has a scheduled execution date of September 24, 2025.

481. Accordingly, TDOC should seek his Affidavit of Method of Execution no earlier than August 25, 2025.

482. On or around March 7, 2025, employees of TDOC—including, potentially, an attorney—approached Mr. Smith, Mr. Black, and Mr. Middlebrooks

outside the presence of, and with no prior notice to, their counsel and attempted to have each man complete an Affidavit For Method of Execution.

483. On information and belief, TDOC likely took this premature step with regard to each individual with a currently set execution date, despite the fact that seeking the election was, in each instance, premature.

484. Not only were TDOC's actions a departure from the 2025 Protocol, but they were also contrary to repeated insistences by counsel for Mr. Smith, Mr. Black, and Mr. Middlebrooks that they, and others in their position, should not be approached with an Affidavit for Method of Execution without counsel present.

485. TDOC's casual, open violation of its own processes confirms that it is, at heart, still the agency that it was in 2022—one that is simply focused on bringing executions about, with little, if any, attention being paid to whether applicable rules are being followed or appropriate caution is being exercised.

486. The 2025 Protocol depends on the competency, good faith, professionalism, and dedication to compliance of TDOC personnel.

487. Insofar as the 2025 Protocol could be sufficient, on its face, for some theoretical agency to carry out without an intolerable risk of severe pain and suffering, it is not sufficient for TDOC to do so.

O. Several Plaintiffs have medical conditions that increase the risk of a botched or otherwise tortuous execution by pentobarbital, but the 2025 Protocol provides no mechanism for addressing those heightened risks.

488. As the Plaintiffs have already asserted, pentobarbital, as a method of execution, poses a substantial risk of causing a tortuous death, and that risk is only

the Protocol's "Lethal Injection Execution Recorder Checklist." *See id.* at 32, 35. Moreover, the Protocol does not explicitly state that the witnesses will be able to observe the closed-circuit TV. Finally, while the 2025 Protocol instructs execution team members to disengage the camera during the Physician's death check, it does not instruct for it to be reengaged. *See id.* at 21.

644. Given the intolerably high risk of Plaintiffs being subjected to cruel and unusual punishment during the setting of their IV lines and as a result of the administration of pentobarbital through an improperly placed IV, it is critical that Plaintiffs' attorney-witness be able to personally view the IV catheterization up close—or, barring that, by closed-circuit video with an adequate view. Otherwise, it is possible that the attorney-witness will be unable to detect dysfunction in the IV line from their limited vantage in the witness room; they would therefore not know to access the courts on their client's behalf to vindicate the client's right against cruel and unusual punishment.

645. The attorney-witness must likewise be able to observe a closed-circuit feed of the IV line during and after the Physician's death check—particularly if it is determined that the prisoner is not deceased. More likely than not, the prisoner's survival would be due to an improperly placed IV line; as such, it is critical that the attorney-witness be permitted to observe the closed-circuit feed at all stages of the execution process. Otherwise, the attorney-witness might not know to access the courts on their client's behalf, in the event of a botched execution.

EXHIBIT 5

State v. Hines
Tennessee Supreme Court
M2025-00221-SC-DPE-DD
Motion to Amend Order Setting Execution Date, to Appoint Special Master, and for Conditional Stay of Execution

TENNESSEE DEPARTMENT OF CORRECTION

LETHAL INJECTION EXECUTION PROTOCOL

NON-DEPARTMENT PERSONNEL

IV TEAM

The IV Team is responsible for establishing properly functioning IV lines for administration of the LIC.

PHYSICIAN

The Physician is responsible for determining that the inmate is deceased using accepted medical standards and establishing central line IV access if necessary.

CLERGY

Clergy, [redacted], may be approved in accordance with state law and Department policy to deliver chaplaincy services to the inmate and the inmate's family as requested.

Exhibit 12

State v. Hines
Tennessee Supreme Court
M2025-00221-SC-DPE-DD

Motion to Amend Order Setting Execution Date, to Appoint Special Master, and for Conditional Stay of Execution

IN THE CHANCERY COURT OF DAVIDSON COUNTY, TENNESSEE
TWENTIETH JUDICIAL DISTRICT PART IV

KEVIN BURNS ET AL.,
Plaintiffs,

vs. NO. 25-0414-IV

FRANK STRADA, ET AL.,
Defendants.

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DEPOSITION OF

Physician A [redacted]

October 27, 2025
12:53 p.m. (ET)

Holiday Inn Express Union City
810 Bream Boulevard
Union City, Tennessee 38261

Chloe Fry, 1088
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supporters?

A. No, and I certainly hope your office will handle this responsibly --

Q. Of course.

A. -- and that I won't be reading about myself in The Nashville Banner or The Guardian.

Q. Understood, Physician A. Have you told anyone else that --

A. That was understood, that was not an acknowledgement in the grievance. So you're going to agree to that?

Q. Sir, this is a deposition.

A. I understand what it is.

Q. I'll be asking the questions.

A. Now, you asked me about confidentiality. I've seen some of the things that you all have said. I'm asking you -- of course I know the answer to this, this is supposed to be under seal. I have certainly trust that your staff will not be talking off record to newspapers.

Q. Sir, we have signed -- we are a party to a protective order in this case, which specifies the legal grounds by which we are supposed to keep information secret in this case.

A. Well, that's lawyer talk. Is it yes or no?

Can you say yes or no?

MS. HENRY: Excuse me, can we go off the record for just a moment, so I can consult with my --

THE WITNESS: Yeah.

MS. HENRY: Okay.

THE REPORTER: Okay. We're off the record.

(Off the record.)

BY MR. BRAZER:

Q. Physician A you mentioned a moment ago that -- or seemed to indicate that you thought this deposition was under seal. Are you aware that at a hearing on Friday, October 24th, Defendants filed our notice of deposition on the record with the Court?

A. I have no knowledge of who filed what.

Q. Okay. And when Plaintiffs brought that up to the Court, the fact that this deposition was not filed under seal, Defendants' Counsel stated that they were exercising their privilege to redact judiciously.

A. To redact judiciously?

Q. Yes.

A. Is that what you said?

Q. Yes. That's what Defendants' Counsel said.

A. Got it.

Q. Okay. So I -- are you aware that this deposition is not being conducted under seal?

A. I am now.
Q. Okay. All right, Physician A I'd like to proceed with the questions if that's okay.
A. Sure.
Q. Okay. I want to circle back to this one: Have you told anyone about your involvement in Tennessee's executions?
A. Yes.
MR. WICKENHEISER: I just want to object to the extent it might discuss attorney-client communication.
MR. BRAZER: Oh, I'm sorry. Yes.
BY MR. BRAZER:
Q. Absent -- you know, with the exception of you attorneys who, I assume, know your role, have you told anyone about your involvement in Tennessee's executions?
A. No.
Q. No. No family members?
A. Did I just say no?
Q. Okay. Understood, sir. Now you were the physician for the Byron Black and Oscar Smith executions, correct?
A. Yes.
Q. Okay. Have you participated in any other executions in Tennessee?

A. Yes.
Q. Okay. Were you aware of that?
A. Yes.
Q. Okay. Where would you normally establish a central IV line?
A. Subclavian vein.
Q. Subclavian vein. All right. Are there other veins in which you would consider to establish the central IV line?
A. Not myself.
Q. Not yourself. But would other practitioners?
A. Possibly.
Q. Okay. What is the standard practice for establishing a central IV line?
A. Which one are you referring to?
Q. For a subclavian vein.
A. For a subclavian vein you prepare the patient with antiseptic, you open the kit and check the inventory of the kit to make sure everything is there. Once you've established that you have the complete and correct kit and the kit is sterile, you identify the appropriate location under the clavicle. You anesthetize that with lidocaine, you introduce a syringe with a trocar on it.
When you have entered the vein, you draw back

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EXHIBIT 2

Burns v. Strada
Chancery Court for Davidson County
No. 25-0414-IV

Plaintiff's Motion to Compel

IN THE CHANCERY COURT OF DAVIDSON COUNTY, TENNESSEE
TWENTIETH JUDICIAL DISTRICT PART IV

KEVIN BURNS ET AL.,
Plaintiffs,

vs. NO. 25-0414-IV

FRANK STRADA, ET AL.,
Defendants.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

DEPOSITION OF

Physician A

October 27, 2025
12:53 p.m. (ET)

Holiday Inn Express Union City
810 Bream Boulevard
Union City, Tennessee 38261

Chloe Fry, 1088
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injection protocol?

A. Yes.

Q. Okay. Can you tell me what you believe your role to be under that protocol as the physician?

A. Certify the death of the inmate.

Q. Okay. Anything else?

A. That's it.

MR. BRAZER: Okay. Could I have a copy of the 2025 protocol, please? And we have a copy for the reporter as well, please. Physician A, I'm directing you to Page 8 of the 2025 Lethal Injection Protocol. And we are marking this as Exhibit 5.

(Exhibit 5 was marked for identification.)

BY MR. BRAZER:

Q. Thank you. All right. Physician A, would you mind reading the paragraph under the word physician on Page 8?

A. "The physician is responsible for determining that the inmate is deceased using acceptable -- acceptable medical standards and establishing central IV access if necessary."

Q. Okay. Is your understanding from reading that paragraph, in addition to determining death, you would be responsible for establishing a central IV line if the IV team is unable to establish a peripheral IV line?

A. I have no idea.
Q. All right. Okay. How many times have you placed a central IV line?
A. A dozen or more.
Q. Okay. When was that?
A. When I was in the emergency room, primarily.
Q. Okay. So when was the last time you placed a central IV line?
A. Probably somewhere close to the last aspect of my tenure in the emergency room.
Q. Okay. So if I could have here, let me just refer back to your CV. So that would be around 2013; is that correct?
A. Yes, sir.
Q. Okay. And you stated that you never had any complications establishing a central IV line in those cases?
A. I didn't say that.
Q. Okay. Did you ever have complications in establishing a central IV line in those cases?
A. Just one time.
Q. Could you tell me what happened?
A. The guide wire wound up in the carotid vein, which is an undesirable placement, but you can reverse that fairly quickly.

Exhibit 13

State v. Hines
Tennessee Supreme Court
M2025-00221-SC-DPE-DD
Motion to Amend Order Setting Execution Date, to Appoint Special Master, and for Conditional Stay of Execution

DECLARATION OF MARIA DeLIBERATO

I, Maria DeLiberato, hereby DECLARE:

1. I am Senior Counsel for the Capital Punishment Project of the American Civil Liberties Union.
2. I represent Tony Von Carruthers.
3. On May 21, 2026, I was present at Riverbend Maximum Security Institution (RMSI) as Mr. Carruthers' attorney witness for his scheduled execution.
4. I arrived at RMSI at 7:30 AM and placed my cell phone in a locker. I visited with Tony until approximately 9 AM. After our visit, I was escorted back to the front building.
5. At approximately 9:50 AM, I was escorted to RMSI's Death Watch Area alongside a lawyer with the state Attorney General's office.
6. I asked the lawyer and Warden Kenneth Nelson whether there had been any word from the courts regarding Mr. Carruthers' three outstanding claims. Both indicated they did not know the answer.
7. The Warden informed me, however, that he had been instructed to proceed with the execution.
8. I told the Warden that if there were any claims still pending, I would need access to a phone.
9. When we arrived at the Death Watch Area, Tony was in his cell, wearing a prayer shawl.
10. The execution gurney was rolled into the hallway in front of his cell. The Warden informed Tony that officers wearing tactical gear were going to enter his cell to strap him to the execution gurney.
11. As soon as the officers were about to enter Tony's cell, I heard a frantic knock at the door, and a female opened the door and shook her head and told them not to proceed. They wheeled the gurney back out of that same door.
12. The Warden then said that they were going to wait for the court to resolve Mr. Carruthers' outstanding claims before proceeding with the extraction.
13. I was escorted back to the front building. They allowed me to access my phone as long as I promised to not call the media.
14. Shortly thereafter, before I was able to get any signal to call co-counsel, the Warden's secretary informed me that they were going to proceed.

15. At 10:15 AM, as we were walking back to the Death Watch Area, I again asked the Warden whether the court had denied Tony's outstanding claims. The Warden just reiterated that they had permission to proceed.
16. At 10:17 AM, the corrections officers entered Tony's cell, told him to put his knees on his bunk and his forehead against the wall, whereupon they cuffed him. They walked him out of his cell and then lifted Tony and put him on the gurney.
17. As the officers began to strap Tony to the gurney, Tony held his hands in prayer.
18. At approximately 10:22 AM, the corrections officers wheeled Tony to the Execution Chamber, where they secured the gurney to the floor.
19. At approximately 10:24 AM, three members of TDOC's IV Team began their attempts to place a peripheral IV line in Tony's right arm.
20. During this process, I observed from about six feet away.
21. From the outset, I could tell that the IV Team members were struggling. One of them commented that Tony's veins were "rolling."
22. At approximately 10:31 AM, the IV Team managed to establish peripheral IV access in Tony's right arm.
23. They then attempted to place a second peripheral IV line in Tony's left arm.
24. Throughout this process, a TDOC corrections officer was handing needles back and forth with the IV Team member who was attempting to place the line. I saw the officer dispose of the used needles in a receptacle and heard the needles "clink" as they were thrown away.
25. From approximately 10:32 AM to 10:44 AM, the IV Team attempted to place the second IV line in Tony's left arm. They stuck him approximately 6 to 7 times.
26. At one point, the IV Team member who was attempting to place the line thought she had gotten it in and announced that she "saw a flash," but that it wouldn't flow.
27. At 10:44 AM, the IV Team member said that the line was not infiltrating but was also not flowing.
28. The IV Team member repeatedly shook her head and she wore an expression of visible effort as she tried to gain access.
29. Tony was wincing through most of the needle sticks.
30. At 10:48 AM, the IV Team member seemed to have established a peripheral line in Tony's left hand. But she quickly began shaking her head and said that it was not flowing.

31. At 10:54 AM, "Physician A" entered the Execution Chamber and identified himself by name.
32. Physician A instructed the IV Team members to take off Tony's socks to look for veins in his feet.
33. At 10:56 AM, they took out an infrared vein finder and dimmed the lights.
34. At 10:57 AM, Physician A said that they "got a flash, but it won't run." I could not see whether they had managed to set a line in Tony's foot.
35. At this point, I asked the Warden whether he was going to stop this. He said that he would not intervene until instructed to do so.
36. I then asked for a phone. The Warden and the lawyer with the Attorney General's office both had cell phones on them. But they did not offer to let me use their cell phones. Likewise, TDOC refused to let me use the wall phone in the Execution Chamber or the one in the adjoining Official Witness Room.
37. The Warden's secretary began looking for a phone that I could use and eventually escorted me back to the Death Watch Area.
38. The phones in the Death Watch Area were not plugged in. The Warden's secretary proceeded to plug in a phone, while I stood there and waited for it to dial up.
39. During this time, I could not hear or see Tony.
40. Once the phone was working, I called counsel at the Capital Habeas Unit of the Federal Public Defenders for the Middle District of Tennessee, and briefly explained the situation. I asked them whether TDOC was permitted to place a central line under its execution protocol. They informed me that TDOC was allowed to place a central line.
41. I then returned to the Execution Chamber at 11:06 AM, where I observed that Physician A and the IV Team were still trying to obtain peripheral IV access in Tony's left foot.
42. Tony was wincing during these efforts and seemed to be in pain.
43. Physician A then announced that he was going to place a central line.
44. At 11:09 AM, Physician A asked the members of the IV Team if any of them had experience with jugular access. One of the members said that they did.
45. They proceeded to undo Tony's chest straps and turned his head to the side. They then felt around Tony's neck.
46. At 11:10 AM they turned down the lights and brought out the infrared vein finder—which they used to assess Tony's neck. At this point, the IV Team member who volunteered to assist in finding jugular access said that he didn't "feel like he could do this."

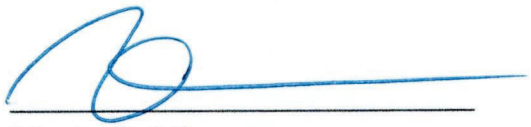
47. Physician A then placed a drape over Tony's face and body—which they repositioned after realizing they had placed it on backwards.
48. Physician A got out the central line kit and asked whether someone could confirm that the kit was not expired. Someone said that it was not expired.
49. At 11:14 AM, Physician A asked whether "the patient" was allergic to lidocaine. The prison staff did not know.
50. At 11:15 AM, Physician A stuck Tony with a needle and administered the lidocaine below his right clavicle.
51. Physician A asked for a razor, but the prison staff did not have one.
52. Physician A then said that they were going to wait 5 minutes for the lidocaine to take effect.
53. At this point, I asked to access the phone. I was again taken out of the Execution Chamber and was out of sight of Tony.
54. Once again, I called counsel at the Capital Habeas Unit. I informed them that Physician A was attempting to place a central line. They explained that the physician had previously been deposed as part of their state court litigation and that he was not qualified to place a central line.
55. I immediately returned to the Execution Chamber, where I saw Physician A standing over Tony. I objected that Physician A was not qualified to place a central line. Physician A snapped back to me, "yes, I am qualified." The Warden then said "Doctor, do your job."
56. At 11:20 AM, Physician A began poking Tony with a needle in the area where he had administered the lidocaine (below the right clavicle). He asked Tony if it hurt. Tony said "yes," he could feel it. Physician A responded, "well, it may just be some pressure."
57. Physician A then proceeded to insert a needle under Tony's right clavicle.
58. Tony began gutturally groaning and said, "it hurts, it hurts." I would later learn this groaning was audible to media witnesses.
59. There was about a half-dollar size amount of blood in the area where Physician A stuck the needle.
60. Physician A wiped the blood away and attempted a second time to insert the needle. I could observe at least two puncture wounds.
61. Physician A then attempted to thread something into one of the spots where he had inserted the needle.
62. Tony was moaning and groaning in pain. He looked at me and I assured him that I had called the rest of his legal team and that they knew what was happening.

63. At 11:22 AM, Physician A said that they would not be able to set a central line.
64. Physician A then attempted to obtain peripheral IV access in Tony's right shoulder.
65. At 11:28 AM, Physician appeared to set a line in Tony's right shoulder. I observed blood in the line.
66. At approximately 11:30 AM, someone announced that they "had flow."
67. Tony now had a line sticking out of his right arm and right shoulder, and there was blood visibly backfilling the right shoulder line.
68. At approximately 11:34 AM, the Warden left the room and came back shortly thereafter.
69. At 11:40 AM, one of the phones on the wall of the Execution Chamber rang and the Warden answered. After a brief conversation, the Warden hung up and said that they would not be moving forward with the execution "now."
70. I asked him to clarify and the Warden said that all he knew was that they would not be moving forward "now."
71. The IV Team then began removing the IVs from Tony's right arm and right shoulder. Blood continued to fill the lines, and Tony was clearly in pain.
72. Over the course of this entire process, I observed the IV Team and Physician A stick Tony over a dozen times.
73. I asked the prison staff if they would have Tony evaluated by medical and they assured me that they would.
74. They then took Tony back to his cell.
75. I was escorted out of the Execution Chamber and back to the front building, where I was able to access my phone.
76. Eventually, I was escorted out to a tent near the press conference tent, where I sat in a chair. An employee of TDOC told me that I could not go over to the press conference tent, but that I could listen from where I was sitting.
77. There, I listened to the media witnesses describe what they could hear from the Official Witness Room.
78. At this point, I texted reporter Steven Hale to let him know where I was sitting, because TDOC would not let me go over to the press conference tent.
79. Mr. Hale and other reporters came over to ask me questions. They informed me that the Governor had granted Tony a one-year reprieve.
80. I then went back into the prison to see Tony, where he was being held in Unit 2.

81. Tony was sweaty, pale, tearful, and he seemed to be in shock and pain.
82. The Warden informed me that Tony had been evaluated by medical, who said that Tony was "okay" and had given him ibuprofen.
83. I asked Tony what he needed, and he informed me that he was having trouble balancing and did not have any strength in his legs. I observed this to be true, as he could barely stand or walk.
84. Tony said that Physician A "was hurting me and knew he was hurting me."
85. I asked Tony if he would allow an independent doctor to come evaluate him, and he said that he would. I told him that we would try to get a doctor out to see him in the next couple days. To date, the prison has declined to allow an independent doctor to evaluate Tony.
86. When I was leaving the prison for the second time, I spoke briefly to the Warden. I observed him carrying a stack of papers, and the top paper was a document titled "syringe log."

I declare under penalty of perjury and the laws of the United States and the State of Tennessee that the foregoing is true and correct to the best of my knowledge.

Date this 20th day of July, 2026.



Maria DeLiberato

EXHIBIT 1

State v. Hines
Tennessee Supreme Court
M2025-00221-SC-DPE-DD
Reply in Support of Motion to Amend Order Setting Execution Date, to Appoint Special Master, and for Conditional Stay of Execution

DECLARATION OF DR. GAIL A. VAN NORMAN

I, Gail A. Van Norman, M.D., being of lawful age, declare as follows:

Qualifications

1. I attended the University of Washington School of Medicine in Seattle, Washington from 1977 to 1981, graduating with an M.D. with honors. During medical school training, I received the following honors: Medical-Scientist Traineeship Grant 1978, invitation to Alpha Omega Alpha, the medical school honor society in 1980, the Merck Manual Medicine Award in 1981, and the John J. Bonica Anesthesiology Award in 1981.
2. My postgraduate medical training consisted first of internal medicine residency training at Virginia Mason Medical Center in Seattle, Washington, and board certification from the American Board of Internal Medicine (ABIM) in 1984.
3. I practiced internal medicine from 1984 to late 1986, including experience in intensive care medicine.
4. I underwent residency training in anesthesiology from 1986 to 1988 at the University of Washington, obtaining board certification in 1990.
5. I completed cardiothoracic anesthesia fellowship training in 1989.
6. After 5 years in private practice, I returned to the University of Washington as faculty, where I served as the acting Chief of Cardiothoracic Anesthesiology and as Medical Director of the PreAnesthesia Clinic.
7. I became certified in clinical ethics, and also served as the co-chair of the University of Washington Medical Center Committee on Ethics.
8. I was recruited in 1992 to serve on the Committee on Ethics for the American Society of Anesthesiology, the national professional organization for the specialty of Anesthesiology. I served for 22 years on the committee, and served as the Chair of the ASA Committee on Ethics for three years. I attended the Bracher Foundation in Geneva, Switzerland, as an ethics scholar-in-residence in 2011.
9. In 2000, I was recruited to join a private practice anesthesia group, Pacific Anesthesia, in Tacoma, Washington, where I served as the Clinical Director, Director of Perioperative Echocardiography, and as Vice-President of Pacific Anesthesia, but I returned to the University Washington Medical Center to serve as Director of the PreAnesthesia Clinic and the Compliance Officer for the Department of Anesthesiology and Pain Medicine.

10. I currently hold positions as Professor Emeritus of Anesthesiology and Pain Medicine and past Adjunct Professor of Bioethics at the University of Washington.
11. Until March 2026, I maintained an active clinical practice.
12. I have over 168 publications in peer-reviewed journals, textbooks, and other venues that include topics of cardiac anesthesia research, ethics, geriatric medicine, perioperative medicine and intensive care. I have also served as a journal reviewer for journals such as Anesthesia and Analgesia, Anesthesiology, Journal of Obstetrics and Gynecology, Mayo Clinic Proceedings, Journal of Philosophy, Ethics and Humanities, and European Journal of Anaesthesiology. I was Consulting Editor for the ASA Syllabus on Ethics from 1997 to 2003, and an Associate Editor for the Journal of Bioethical Inquiry, an international journal, from 2012 to 2017. I published a textbook entitled "The Cambridge Textbook of Clinical Ethics for Anesthesiologists," with Cambridge University Press in 2011, and I have expertise and publications in end-of-life issues, including physician assisted suicide, euthanasia, and lethal injection executions.
13. As an expert in cardiovascular and perioperative issues, I have served nationally and internationally as an invited speaker at such venues as the American Society of Anesthesiologists, American Society of Interventional Pain Physicians, Harvard Medical School, American Society of Bioethics and Humanities, World Congress of Anesthesiologists, the Royal College of Anaesthetists and many others.
14. As an expert in ethical issues in anesthesia care, I have been an invited speaker in Canada, Great Britain, Ireland, Italy, Austria, the Czech Republic, Hong Kong, Chile, Switzerland, Spain, Denmark, Northern Ireland and throughout the United States.
15. Full details of my qualifications, awards, publications, and invitational lectures can be found in the attached curriculum vitae (C.V.).

Licensure, Certification, and Privileges - Generally

16. In the United States, there is no single, unitary system to define what procedures an individual healthcare provider may perform. Rather, there are several related, but distinct systems for assessing qualifications and authorizing practice for particular purposes.
17. Generally speaking, “licensure” refers to a government-issued authorization to practice as a particular form of healthcare provider in a jurisdiction. For example, someone can be “licensed” to practice medicine.

18. There are numerous classes of healthcare licensure under state law, many of which would not be suggestive of competence or skill in the placement of an intravenous catheter. For example, a healthcare provider may be a licensed acupuncturist without any qualifications to place an IV.
19. "Certification" typically refers to a status conferred to demonstrate that an individual has met certain conditions recognized by a certifying body. Although some certifications are government-issued, certifications are also widely issued by private bodies, such as the American Board of Medical Specialties.
20. The fact that an individual possesses some form of healthcare certification is not sufficient to establish that he or she possesses the skill or experience sufficient to participate in intravenous catheterization. The significance of any certification must be assessed in the context of the certification itself and its issuing body.
21. "Privileges" typically refer to the specific permission and rights granted to a healthcare provider by a hospital to practice medicine at that hospital generally, and to perform certain medical procedures within that facility.
22. In general, competence and qualifications to perform specific medical procedures is typically assessed in the context of (1) whether it is consistent with the standard of care for the individual at issue to perform the procedure, and (2) whether that individual possesses—or, if assessed, would be granted—privileges to perform that procedure at a facility.

Privileges to Place Central Intravenous Lines

23. I have extensive experience in the placement of peripheral intravenous lines and central intravenous lines.
24. For over 35 years, I have clinical privileges at the University of Washington Medical Center to do so.
25. I estimate that I have placed well over 5000 central intravenous lines and thousands of peripheral IV lines over the course of my career.
26. At the University of Washington Medical Center, I was in charge of central line placement credentialing for approximately 10 years. In this role, I oversaw the granting of hospital privileges to perform central line placements, including training, testing and certifying practitioners in the departments of anesthesiology and cardiology to place central lines.
27. Due to the special skills needed for central line placement, healthcare systems (including the University of Washington Medical Center) now generally require proof that a practitioner has both appropriate training in

central line placement and also recently demonstrated competency in the procedure.[1]

28. Training and a recent demonstration of competency is typically required for each central line insertion site separately (i.e., for the femoral, subclavian, internal jugular veins), since the techniques for each approach differ.
29. Professional guidelines and recommendations, professional publications, and many institutions now require also the use of ultrasound for central line placement,[2] which entails additional specialized training as well.[3]
30. The University of Washing Medical Center requires that physicians re-apply for privileges every two years by demonstrating recent experience in central line placement (and providing an auditable patient list) or by 1) completing an specific teaching experience that demonstrates competency in the procedure and then 2) placing a central line under the direct observation of a practitioner who is privileged to place central lines.
31. By requiring that providers have recent, demonstrated competency in central line placement (in addition to appropriate training), healthcare systems minimize the risk that patients will suffer complications during central line placement due to the provider's lack of continued proficiency.

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[1] Johns Hopkins Hospital. Vascular access device (VAD) policy, adult. Effective date 3/1/2008. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/hai/clabsi-tools/vascular-access-device-policy.pdf Accessed July 26, 2026; Carilion Clinic Medical Education Policy: Central Venous Catheter (CVC) Placement. Updated 2019. Available at: https://www.carilionclinic.org/gme-cvc-placement Accessed July 26, 2026; UCSF Medical Center. Central line placement and temporary nontunnelled central venous dialysis catheter insertion (Adults, peds). Updated March 2016. Available at: https://medicalaffairs.ucsf.edu/sites/g/files/tkssra856/f/wysiwyg/ahpPrivileges/Central%20lines.pdf Accessed July 26, 2026; Erlanger. Central line management practice management guideline (Tennessee hospitals only). Available at: https://www.erlanger.org/-/media/file/stg/central-line-management-practice-management-guideline.ashx Accessed July 26, 2026; University of Washington Medicine. Vascular Access Management in Adult Patients. Updated 2023. Available at: https://one.uwmedicine.org/sites/Policies/Policies%20Live/uwm-ea-3338.pdf#search=vascular%20access%20management%20adult Accessed July 26, 2026

[2] Johnston AJ, Simpson MJ, McCormack V, et al. Association of Anaesthetists guidelines: safe vascular access 2025. Anaesthesia 2025; 80:1382-96

[3] Vegas A, Wells B, Braum P, et al. Guideline for performing ultrasound-guided vascular cannulation: recommendations fo the American Society of Echocardiography. J Am Soc Echocardiogr 2025; 38:57-91; McGee DCl, Gould MK. Preventing complications of central venous catheterization. New Eng J Med 2003; 348:1123-33

32. Indeed, whether central line placement is successful and relatively pain-free is significantly affected by the number of lines and the frequency with which the physician places them.[4]
33. The incidences of line infiltration and inadvertent placement into an artery instead of a vein are high for physicians without significant, ongoing and routine practice of those lines, even if they have technical knowledge about how they are done.[5]
34. Repeat attempts to establish peripheral or central venous access, line infiltration and/or inadvertent intra- arterial injection of pentobarbital sodium are excruciating events and poor line placement can result in slow suffocation if only partial injection of the execution drug is achieved, and a lingering and extremely painful death and/or failure of the execution altogether.

Physician A's Qualifications to Attempt Central Line Placement

35. In his deposition on Oct. 27, 2025, "Physician A" admitted that he has not placed a central line in over 12 years, has only placed a total of about a dozen central lines in his entire career, has never used ultrasound to place a central line, and only uses the subclavian approach—a method that is associated with significantly higher severe vascular and thoracic complications.
36. Physician A admitted that during one of his previous central line placements, he placed a guidewire into the carotid "vein"— by which he must mean carotid artery, since there is no carotid "vein." Placement of a guidewire into a major artery like the carotid is an injury to a "great vessel," and is a major vascular complication of central line placement that by itself can cause stroke and death.
37. He also stated that he does not perform femoral cut-down IV placements.
38. Based on his admissions, Physician A does not have the current experience or training that would be required to obtain or retain privileges to place central lines at many, if not most, major healthcare institutions today.
39. Physician A's lack of sufficient qualifications to perform central line placement are evidenced by his actions on May 21, 2026, during the attempted execution of Tony Carruthers.

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[4] McGee DCl, Gould MK. Preventing complications of central venous catheterization. New Eng J Med 2003; 348:1123-33

[5] Theodoro D, Krauss M, Kollef M, Evanoff B. Risk factors for acute adverse events during ultrasound-guided central venous cannulation in the emergency department. Acad Emerg Med 2010; 17:1055

40. According to the Declaration of Maria DeLiberato, Physician A tried and failed to establish a central line in Mr. Carruthers' subclavian vein without ultrasound guidance, which is a violation of the current standard of care.
41. It is unclear whether Physician A also attempted to place a central line in Mr. Carruthers' internal jugular vein, or whether he was assessing Mr. Carruthers' external jugular for peripheral IV line placement. If the former, Physician A's inexperience in internal jugular central line placement is demonstrated by his attempt to use an infrared vein finder to locate the internal jugular vein. Infrared vein finders cannot be used for that purpose.
42. It does not appear from Ms. DeLiberato's declaration that Physician A made any effort to place Mr. Hines in Trendelenburg position prior to attempting to place a central in line in Mr. Carruthers' jugular and subclavian veins. Placing a patient in Trendelenburg position prior to attempting subclavian or internal jugular placement is part of the standard of care, not only because it mitigates the risk of the patient suffering from complications due to venous air embolism, but because it fills the target vein (jugular or subclavian) with blood, and distends the vessel, making it easier to find with the needle and easier to place a catheter into with a minimal numbers of tries.
43. Based on Ms. DeLiberato's recitation of Physician A's actions and his ultimate failure to establish central IV access, as well as the representations that Physician A made during his deposition about his lack of recent experience in central line placement, it is my professional and ethical opinion that Physician A lacks the competency to place central lines of any kind, and that he should not have attempted to place a central line in Mr. Carruthers.

Likelihood that Mr. Hines Will Require Central Line Placement

44. As I understand TDOC's execution protocol, the Physician is called on to attempt central line placement if the IV Team is unable to establish the primary and/or secondary peripheral IV lines.
45. In any given execution, it is likely that the execution team will be unable to establish peripheral IV access. Eyewitnesses are not allowed to watch the venous access procedure, but autopsy information can demonstrate signs of problems with venous access, including multiple punctures, multiple bruises, punctures over the typical central vein access sites, and/or the presence of an indwelling central vein catheter.

46. I personally reviewed a random selection of 29 autopsy reports from lethal injection executions in multiple states in the United States between 2001 to 2025 and found that there were difficulties establishing peripheral IV access in over half of the executions, (56%) and placement of a central vein catheter in one-quarter of executions.
47. Mr. Hines, moreover, has certain risk factors that dramatically increase the already significant likelihood that TDOC's IV Team will struggle to obtain peripheral IV access during his upcoming execution.
48. First, according to Mr. Hines' medical records, he is 66 years old.
49. Vascular access is often complicated in patients over the age of 65 due to the physiological effects of aging—including loss of vein elasticity, weakened vein walls, and reduced subcutaneous tissue support, which make veins fragile, prone to "rolling" (which means they slip away when a needle is pressed against them), and highly susceptible to collapsing or bruising during IV catheterization.
50. The rate of difficult IV access is even higher in elderly patients like Mr. Hines who have required hospitalization—almost 60% are classified as having difficult IV access.[6]
51. Second, the Declaration of Aly Finn indicates that Mr. Hines is very thin and has suffered significant muscular atrophy in the aftermath of recent strokes—particularly on his left side.
52. Mr. Hines' medical records reflect severe left-sided weakness, consistent with muscular atrophy.
53. Muscular atrophy often complicates vascular access because the patient's loss of muscle tissue undermines the subcutaneous support structure that helps keep veins in place. This means that the patient's veins in the affected limb might be prone to rolling.
54. Third, according to Ms. Finn, Mr. Hines appears to be suffering from spasticity in his left arm in the wake of his stroke—wherein his left arm remains bent at the elbow and his left hand is involuntarily clenched in a fist.
55. Ms. Finn reports that Mr. Hines is unable to unclench his left hand or extend his left arm by himself. She reports that when she tried to help Mr. Hines extend his left arm and unclench his fist, it was painful for him.
56. Muscle spasticity often complicates vascular access in a stroke-affected limb because contracted muscles compress blood vessels and reduce blood flow.

[6] Bahl A, et al. An improved definition and SAFE rule for predicting difficult intravascular access (DIVA) in hospitalized adults. J Infusion Nursing 2024; 47:97-107

57. Moreover, the rigidity of the affected arm can make it physically challenging to properly position the stroke-affected arm (e.g., to access the antecubital fossa), insert the needle, and/or secure the cannula.
58. While Mr. Hines' left-sided muscle spasticity might not impair access to veins in Mr. Hines' feet, establishing peripheral IV access in a patient's feet is notoriously difficult because the veins in the feet are smaller, more fragile, and often "hide" behind the bones of the foot.
59. Thus, Mr. Hines' age, muscular atrophy, and left-sided muscle spasticity make it very likely that TDOC's IV Team will struggle to obtain peripheral IV access—in large part because Mr. Hines' left-sided muscular atrophy and spasticity dramatically reduce the number of insertion sites available to the IV Team.
60. The fact that Mr. Hines may have had blood drawn recently does not change the high likelihood that the IV Team will struggle to obtain peripheral IV access in Mr. Hines, in fact, recent venipuncture *increases* the likelihood of clotting and narrowing in the vein that may make it more difficult to pass an IV catheter.
61. Blood is typically drawn using a smaller (higher gauge) needle, and does not have to be inserted as far into the vein as a catheter.
62. While venipuncture (blood draws) can be accomplished even with the needle almost perpendicular to the vein, placing a IV catheter requires that the medical personnel introduce the IV needle at a much more shallow angle in order to allow the catheter (a flexible plastic tube) to slide over the needle and into the vein without piercing and exiting the backside of the vein. Mr. Hines' contracted right arm and hand would be expected to not impact blood draws as dramatically as it does the ability to place a catheter inside a vein in that limb.
63. Thin or rolling veins might allow a quick needle stick for a blood draw, but can collapse when attempting to thread an IV catheter over the introducer needle.
64. Establishing an IV catheter in a patient with thin or rolling veins takes significant skill and experience.
65. According to Ms. DeLiberato's declaration, the IV Team struggled to place a peripheral IV line in Tony Carruthers for approximately 45 minutes, and complained that Mr. Carruthers' veins were "rolling." Several times, the IV Team seem to have inserted the introducer needle into a vein (indicated by a "flash" of blood), but failed to properly place the catheter (no "flow"). This suggests that they were collapsing or infiltrating Mr. Carruthers' veins.

66. Based on the IV Team's inability to establish peripheral IV access in Mr. Carruthers—who, according to his attorneys had no foreknown medical conditions that would complicate IV access—it seems even more likely that the IV Team will struggle to obtain peripheral IV access in Mr. Hines.
67. Ms. Finn reports that Mr. Hines' left hand and left arm appear swollen and purple. This is consistent with deoxygenated blood pooling in Mr. Hines' left arm due to impaired venous return—which, in turn, might be caused by spasticity or reduced muscle activity in the affected limb.
68. Venous congestion and swelling reduces the ability to see or palpate (feel) the veins in that arm.
69. One review suggests that the odds of having a difficult IV start or failure of IV start are raised 9-fold if the vein is not palpable, and 7-fold if it is not visible.[7]

Risk Attendant to Stroke-Preventative Blood Thinner Medication

70. Mr. Hines' medical records indicate that he has been taking aspirin (an antiplatelet medication) since January 2026—which he was prescribed in the aftermath of a stroke.
71. A blood thinner like aspirin would likely cause Mr. Hines to bleed into the tissues if his veins are infiltrated during the IV catheterization process, making repeated attempts at IV access less and less likely to be successful.
72. That said, taking Mr. Hines off aspirin early puts him at significant risk of a recurrent stroke, and he would have to be off of aspirin for a significant length of time—approximately 1 week—to decrease venous oozing related to aspirin.

I declare under penalty of perjury and the laws of the United States and the State of Tennessee that the foregoing is true and correct to the best of my knowledge.

Dated this 27th day of July, 2026.

[7] Bahl A, et al. An improved definition and SAFE rule for predicting difficult intravascular access (DIVA) in hospitalized adults. J Infusion Nursing 2024; 47:97-107

Gail A. Van Norman, M.D.

Appendix I: Curriculum Vitae for Gail A. Van Norman MD

CURRICULUM VITAE
Gail A. Van Norman, M.D.

Education:

1973-1977	University of Washington, Seattle, Washington	Honors B.S, Microbiology
1977-1981	University of Washington School of Medicine, Seattle, Washington	M.D. with Honors

Postgraduate Training:

1981-1982	Virginia Mason Hospital, Seattle Washington	Internship	Internal Medicine
1982-1984	Virginia Mason Hospital, Seattle, Washington	Residency	Internal Medicine
1986-1988	University of Washington, Seattle, Washington	Residency	Anesthesiology
1988-1989	University of Washington, Seattle, Washington	Fellowship	Cardiothoracic Anesthesiology
1992-1993	University of Washington, Seattle, Washington, Department of Biomedical Ethics	Certification	Health Care Ethics
2001	Perioperative Transesophageal Echocardiography Examination	Testamur	
2011	ASA Business Management Certification	Certification	

Faculty Positions Held:

1989-1994	Clinical Acting Instructor, Department of Anesthesiology, University of Washington, Seattle, Washington
1994-1995	Acting Instructor, Department of Anesthesiology, University of Washington, Seattle, Washington
1995-1997	Acting Assistant Professor, Department of Anesthesiology, University of Washington, Seattle, Washington
1997-2000	Assistant Professor, Department of Anesthesiology, University of Washington, Seattle, Washington
1997-2000	Adjunct Assistant Professor, Department of Internal Medicine, University of Washington, Seattle, Washington
2000-2001	Clinical Assistant Professor, Department of Anesthesiology, University of Washington, Seattle, Washington
2001 -2008	Clinical Associate Professor, Department of Anesthesiology, University of Washington, Seattle, Washington
2008-2022	Professor, Department of Anesthesiology, University of Washington, Seattle, Washington

2008-2022	Adjunct Professor, Department of Biomedical History and Ethics, University of Washington, Seattle, Washington
July 2022-present	Professor Emeritus, Department of Anesthesiology and Pain Medicine, University of Washington, Seattle, Washington

Hospital Positions Held:

1984-1985	Attending Internist, Jefferson Memorial Hospital, Port Townsend, Washington
1985-1986	Attending Internist, Highline Community Hospital, Burien, Washington
1989-1992	Staff Anesthesiologist, Northwest Hospital, Seattle, Washington
1992-1994	Staff Anesthesiologist, Swedish Hospital, Seattle, Washington
2000 – 2008	Staff Anesthesiologist, St. Joseph Medical Center, Tacoma, Washington
2000 – 2006	Director, Transesophageal Echocardiography Education, Department of Anesthesiology, St. Joseph Medical Center, Tacoma, Washington
2003-2004	Clinical Director, Department of Anesthesiology, St. Joseph Medical Center, Tacoma, Washington
2008-2013	Medical Director, PreAnesthesia Clinic, University of Washington Medical Center, Seattle, Washington
2010-2021	Physician Champion, Compliance Officer, Dept of Anesthesiology and Pain Medicine, University of Washington, Seattle WA

Non-Hospital Positions Held:

1984-1985	Consulting Internist, Spokane Urban Indian Health Center, Spokane, Washington
1985-1986	Consulting Internist, Seattle Community Health Clinics serving economically disadvantaged patients; for Group Health Cooperative of Puget Sound, Seattle, Washington
2005-2006	Chair CQI Process, Pacific Anesthesia, Inc., Tacoma, Washington
2006 -2008	Board of Directors, Pacific Anesthesia, Inc., Tacoma, Washington
2007-2008	Vice President, Pacific Anesthesia, Inc., Bellevue, Washington

Honors:

1978	Medical-Scientist Traineeship Grant, University of Washington, Seattle, Washington
1980	Alpha Omega Alpha
1981	Merck Manual Medicine Award
1981	John J. Bonica Anesthesiology Award, Department of Anesthesiology, University of Washington
1985	Award of Merit for Service to the Health Care Needs of Native Americans, Spokane Urban Indian Health Service
2000	President's Award, Pacific Anesthesia, Inc. Tacoma, Washington
2008	Mary Jane Kugel Award, Medical Science Review Committee, Juvenile Diabetes Research Foundation International
2011	Brocher Foundation Residency in Ethics

Board Certification:

1984	American Board of Internal Medicine
1990	American Board of Anesthesiology

License to Practice:

1981-	Washington State
1991-2003	Wisconsin

Professional Organizations:

1984-1987	American Society of Internal Medicine
1989-2000	King County Medical Society
1989-2000	Washington State Society of Anesthesiologists; Co-chair, Medical Education Committee, 1994-1997
1989-2013	American Society of Anesthesiologists; Committee on Ethics, 1992-2013
2003-2007	Society of Cardiovascular Anesthesiologists; Committee on Ethics; 2003-2007
2008-2013	American Society of Bioethics and Humanities
2015-present	International Academy of Law and Mental Health
2015-present	Overseas Fellow, Royal Society of Medicine

Teaching Responsibilities:

Lectures:

Undergraduate Student Lectures:

1999-2008	University of Washington, Undergraduate Introduction to Bioethics Course (MHE 411) "Informed Consent"
2001	University of Washington, Seattle Biomedical Ethics for Medical Students Lecture Series, "Informed Consent"
2008	University of Washington Dept. of Biomedical History and Ethics: MHE 597C, Informed Consent in Clinical Practice
2009-2017	University of Washington Dept. of Biomedical History and Ethics: MHE 597C, Informed Consent

Resident Lectures:

1992-1994	University of Washington, Department of Anesthesiology, "Clinical Ethical Issues in Anesthesia Practice"
1994-2000	University of Washington, Department of Anesthesiology, Resident Core Lecture series, "Perioperative Diabetes Management"
1994-2000	University of Washington, Department of Anesthesiology, Resident Core Lecture Series "Anesthetic Implications of Neuromuscular Disease"
1994-2000	University of Washington, Department of Anesthesiology, Resident Core Lecture Series, "Pathophysiology of Ischemic Heart Disease"
1994-2000	University of Washington, Department of Anesthesiology, Resident Core Lecture Series, "Intraoperative Management of the Patient with Ischemic Heart Disease"
1994-2000	University of Washington, Department of Anesthesiology Resident Core Lecture Series, "Preoperative Evaluation of the Patient for Anesthesia and Surgery"
1994-2000	University of Washington, Department of Anesthesiology, Resident Core Lecture Series, "CQI: Quality Improvement in Practice"
1994-2000	University of Washington, Department of Anesthesiology, Resident Core Lecture Series, "Post Operative Cognitive Dysfunction"
1994-	University of Washington, Department of Anesthesiology, Resident Core Lecture Series, "Clinical Ethical Issues in the Practice of Anesthesiology,"
1994-	University of Washington, Department of Anesthesiology R2 Core Lecture series, "Ethical Issues of Informed Consent"

1994-	University of Washington, Department of Anesthesiology R2 Core Lecture series, "Do Not Resuscitate Orders in the Operating Room"
1994-	University of Washington, Department of Anesthesiology R3 Core Lecture series, "Ethics of Surrogate Consent"
1994-	University of Washington, Department of Anesthesiology R3 Core Lecture series, "Ethical Issues in Organ Transplantation"
1994-	University of Washington, Department of Anesthesiology R4 Core Lecture series, R4 Seminar: "Allocation of Scarce Resources in a Managed Care Environment"
1995	University of Washington, Department of Anesthesiology, Resident Special Evening Lecture Series: Forum on Ethical Issues in Anesthesiology, "Informed Consent and Surrogate Consent: Who Speaks for the Patient?"
1995	University of Washington, Department of History and Ethics, Ethics Black Bag Lecture Series, "Ethical Dilemmas in the Operating Room"
1995, 1997	University of Washington Department of Anesthesiology, Evening Resident Special Workshop, " Fiberoptic Intubation and Management of the Difficult Airway"
1996	University of Washington, Department of Anesthesiology, Resident Special Evening Lecture Series: Forum on Ethical Issues in Anesthesiology, "Ethical Issues in Organ Transplantation, and The Impaired Practitioner"
1997	University of Washington, Department of Anesthesiology, Resident Special Evening Lecture Series: Forum on Ethical Issues in Anesthesiology, "Physician-Assisted Suicide, and the Impaired Physician,"
1997	University of Washington, Department of History and Ethics; Ethics Black Bag Lecture Series "DNR in the Operating Room: Should Different Rules Apply?"
1997	University of Washington, Department of History and Ethics, Ethics Black Bag Lecture Series "Ethical Pain Management in the Addicted Patient Undergoing Surgery--Is There A Duty to Rescue?"
1999	University of Washington, Department of Biomedical Ethics and History, Master's Course in Biomedical Ethics, "Informed Consent."
1999	University of Washington, Department of Biomedical Ethics and History Ethics, Black Bag Lecture Series, "Who is Captain of the Ship on the Multidisciplinary Team: Lessons from the Operating Room"
2004	University of Washington, Department of Anesthesiology, Resident Special Evening Lecture Series: Forum on Ethical Issues in Anesthesiology "Ethics of Organ Transplantation"
2008-	University of Washington, R2 Core lecture "Introduction to Preoperative Evaluation."
2008-present	University of Washington CA1 PAC lecture series: "informed Consent/Informed Refusal"
2010-present	University of Washington Resident Introductory Lecture series: "EHR Integrity"
2010-present	University of Washington R2 and R3 Core Lectures: "Coding and Documentation"
2021-present	University of Washington Resident Core Lectures, CA1-3, Ethical Responsibilities of Anesthesiologists

Grand Rounds Lectures

1994-1996	New England Deaconess Hospital, Boston, Massachusetts: "Ethical Issues in Anesthesia Practice"
1994	University of Washington, Ethics Grand Rounds, "DNAR in the Operating Room"

1996	University of Washington, Hematology Grand Rounds, "Antifibrinolytics, Use, Clinical Efficacy, and Cost Effectiveness"
1998	Providence Medical Center, Department of Surgery, Surgery Grand Rounds "Ethical Issues in Surgical Care: A Panel Discussion"
1998	University of Washington School of Medicine: Combined Cardiothoracic Surgery/Cardiology Grand Rounds, "Brain Death and Organ Donation"
2001	Rush-Presbyterian-St. Luke's Medical Center, Anesthesia Grand Rounds, Department of Anesthesiology Chicago, Illinois, "Historical Perspectives on the Ethics of Clinical Research"
2002	University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania, Department of Anesthesiology, Anesthesia Grand Rounds, "Ethical Issues in Brain Death"
2008	University of Washington Anesthesiology Grand Rounds: "Perioperative Management of Pacers and AICDs"
2009	University of Washington Medical Center Combined Anesthesiology and Surgery Grand Rounds "Preoperative Evaluation: Where Have We Been, Where are We Going?"
2009	University of Oklahoma Anesthesiology Grand Rounds, "Is a Free Pen Just a Free Pen? Conflicts of Interest in Clinical Practice, Research and Industry." February, 2009.
2009	University of Washington Department of Anesthesiology; DNR in the Operating Room April, 2009
2010	University of Washington Department of Orthopedics; Preoperative Testing: Should Your Patient have a Preoperative Chest XRay? April, 2010.
2010	University of Washington Department of Obstetrics and Gynecology: Preoperative Testing: Less is More. May, 2010
2011	MD Anderson Cancer Center; Houston Texas. Dept of Anesthesiology. Fraud and Plagiarism in Medical Research. February 14, 2011
2012	MD Anderson Cancer Center: Houston Texas. Dept of Anesthesiology. Physician Assisted Suicide and Euthanasia. April 18, 2012
2012	MD Anderson Cancer Center, Houston Texas. Risk Management Department. Fraud and Plagiarism in Medical Research. April 18 2012
2012	Overlake Medical Center Department of Anesthesiology: Lifeboat Ethics. April, 2012 Bellevue, WA
2018	University of Washington "Respecting Patient Privacy". Feb 28, 2018
2021	University of Washington. Compliance and Key Documentations Changes in EPIC. January 20, 2021

Resident Journal Club:

1995	University of Washington, Department of Anesthesiology "Use of Magnesium for Cardiac Surgery Patients"
1996	University of Washington, Department of Anesthesiology; "Anesthesia for IVF, Teratogenicity of Anesthetics, and Anesthesia and the Breast-Feeding Patient"
1996	University of Washington, Department of Anesthesiology, "N2O: Friend or Foe?"

Faculty Lectures:

1995	University of Washington, Department of Anesthesiology, CME lecture, "Ethics and the Examiners"

Workshops:

1994-1996	University of Washington, Department of Anesthesiology, CME Workshop, "Difficult Airway"
1996	University of Washington School of Medicine CME Workshop, "Aprotinin and Other Antifibrinolytics," Blood Therapy: Applications and Alternatives"

Nursing Lectures:

1996-1997	University of Washington Medical Center, Pre-Surgical Clinic Nursing Lecture Series; "Preoperative Assessment of the Patient for Anesthesia"
1999	University of Washington Medical Center Operating Room, Nurses Weekly Conference, "Informed Consent in the Operating Room."
1999	University of Washington, Association of Operating Room Nurses, Perioperative Nursing Internship Program "Informed Consent in the Operating Room"
2000	University of Washington, Department of Radiology Nursing Staff Lectures, "Sedation of the Patient with Severe Liver Disease for TIPS Procedure"
2008	University of Washington Medical Center Operating Room Nursing Conference, "Informed Consent in the Operating Room."
2011	Overlake Medical Center, Bellevue WA. Perioperative Nursing Education. DNR in the OR.
2020-present	PreAnesthesia Clinic Daily Huddle "Covid Moment"—developments in covid pandemic, including viral behavior, vaccine development and variants of the virus.

Editorial Responsibilities:

1997-2003	Consulting Editor, ASA Syllabus on Ethics, American Society of Anesthesiologists, Park Ridge, Illinois
2004-	Editor, ASA Syllabus on Ethics, American Society of Anesthesiologists, Park Ridge, Illinois.
2009	Editor-in-Chief, *Clinical Ethics for Anesthesiologists, a Cambridge University Press Case-Based Textbook.*
2012-2017	Associated Editor, North America Clinical Ethics, Journal of Bioethical Inquiry.
2019	Editorial Board Member, ClinicalKey Procedures, Elsevier Inc, Philadelphia PA
2021	Editorial Board Member, ClinicalKey Clinical Reviews, Elsevier Inc, Philadelphia PA
2020-2021	Invited Editor, Journal of Bioethical Inquiry, Springer, Australia
2021-present	Board Member and Editor: Elsevier Clinical Reviews, Elsevier Inc, Philadelphia PA
2023-2024	Co-editor (with Neal Cohen MD), Anesthesiology Clinics Ethical approaches to the practice of anesthesiology—Part 1. Overview of ethics in clinical care: history and evolution. Elsevier Inc, Philadelphia PA. September 2024.
2023-24	Co-editor (with Neal Cohen MD), Anesthesiology Clinics Ethical approaches to the practice of anesthesiology—Part 2. Accepted. Publication Anticipated December 2024.

Special National/International Responsibilities:

1992-2014	Committee on Ethics, American Society of Anesthesiologists, Park Ridge, Illinois

1994	Panelist, American Society of Anesthesiologists Annual Meeting, Panel on Ethics: Ethical Issues in Anesthesiology
1995	Moderator Ethics Panel, American Society of Anesthesiologists, Annual Meeting, "Is There a Role for the Anesthesiologist in Physician-Assisted Suicide?"
1996-2006	Moderator Clinical Forum, American Society of Anesthesiologists, Annual Meeting, "Ethics/Geriatrics"
1996-1999	Moderator Problem-Based Learning Discussion, American Society of Anesthesiologists Annual Meeting, Ethics cases
1997	Panelist, American Society of Anesthesiologists Annual Meeting Panel on Education, "Can Ethics be Taught?"
1998	Workshop Organizer and Lecturer, American Society of Anesthesiologists, "Teaching Clinical Ethics in Anesthesia Residency"
1999	Invited Participant, Duke University, Durham, North Carolina, Second Duke Conference on Surgery and the Elderly
2001	Panelist, American Society of Anesthesiologists Annual Meeting Panel on Professionalism, "Defining and Demanding Excellence in Anesthesia Job Performance"
2004	Panelist International Liver Transplantation Society Annual Meeting, "Ethics of Liver Transplantation, NHB/DCD Donors: Perioperative Issues in Liver Transplantation"
2005	Representative for the American Society of Anesthesiologists (one of four), First National (UNOS) Conference on Donation After Cardiac Death, Philadelphia [please see Bernat J.L. et al. Report of a National Conference on Donation After Cardiac Death. Am J Transpl 6: 281-91, 2006.]
2005-	Ethics Reviewer, Research and Funding Department, Juvenile Diabetes Research Foundation, New York
2006	Panelist, American Society of Anesthesiologists Annual Meeting, Panel on Professionalism, "Role of the Anesthesiologist in End-of-Life Care –Do physicians have conflicts of interest?"
2006	Panel Moderator, American Society of Anesthesiologists Annual Meeting, Panel on Professionalism, "Working Hard—or Sleeping at the Wheel. Should the ASA adopt aviation-style standards for work hours for anesthesiologists?"
2006	Panel Moderator, American Society of Anesthesiologists Annual Meeting: Panel on Ethics, "Should Anesthesiologists Participate in Executions?"
2006-2008	Ethicist, Medical Science Review Committee, Juvenile Diabetes Research Foundation International.
2007	Panelist, ASA Panel on Ethical Issues in Perioperative Medicine
2007	Panelist, ASA Panel on Professionalism in Multidisciplinary Teams: Palliative Care and Multidisciplinary Pain Management
2007	Panelist, ASA Panel "What is Professionalism? Do I Need it? Do I Have it?"
2007	ASA Clinical Forum: Special Topics in Bioethics
2008-2011	Chair, American Society of Anesthesiologists Committee on Ethics
2008	Panelist, ASA Panel "Lethal Injection."
2008	Panelist, ASA Panel "DCD—do we need it? Con."
2008	Moderator, ASBH panel "Opioid Pain Medication for Chronic Nonmalignant Pain: A Right or a Wrong?" American Society of Bioethics and Humanities
2008	Invited lecturer: 37th Annual Advances in Family Practice and Primary Care, August. Seattle WA: "DNR and Other Advance Directives in the OR"
2008	Invited Lecturer: AANA. "Preoperative Testing" and "Perioperative beta blockade." September. Spokane, WA
2009	Refresher Course Lecture: Ethics for Anesthesiologists in the 21st Century. New Orleans LA.
2010	Refresher Course Lecture: Protecting Vulnerable Subjects in Research: Ethical Obligations to Human and Animal Research Subjects. San Diego, CA
2010	Panelist, ASA Panel "Health Care Reform." ASA Annual Meeting, San Diego, CA.

2011	Invited lecturer: "DNR Orders in the Perioperative Period." Overlake Medical Center, Bellevue Washington.
2011	Should Anesthesiologists Participate in Physician-Assisted Suicide? Pro and Con. American Society of Anesthesiologists Annual Meeting. Chicago, Il. 2011
2012	Invited Lecturer: Informed Consent and Informed Refusal in the OR. Puget Sound Multi-Chapter AORN Coalition. Kent, WA Jan 2012
2012	Invited lecturer, American Society of Interventional Pain Physicians Refresher Course and Review. Fraud in Anesthesia Research, and Ethics of Interventional Pain Management. April 2012 Phoenix, AZ
2012	Invited lecturer, American Society of Interventional Pain Physicians Refresher Course and Review. Fraud in Anesthesia Research, and Ethics of Interventional Pain Management. August 2012 San Francisco, AZ
2012	Invited Lecturer: 41st Annual Refresher Course for Nurse Anesthetists. Ethics of Informed Consent; Ethics of Informed Refusal; Ethical Issues in Preoperative Testing. Nov 2012 Orlando, FL.
2012	Invited Lecturer: Idaho State Society of Anesthesiologists: The Ethics of Preoperative Testing. Boise, Idaho, Spring 2012.
2013	Invited lecturer, American Society of Interventional Pain Physicians Refresher Course and Review. Ethics of Interventional Pain Management. February 2012 Phoenix, AZ
2013	Invited lecturer, American Society of Interventional Pain Physicians Refresher Course and Review. Ethics of Interventional Pain Management. October 2013 Denver, CO
2013	Panelist: Controversial Cases in Organ Donation and End-of-Life Care, American Society of Anesthesiologists Annual Meeting, San Francisco CA.
2014	Panelist: Controversies in Organ Transplantation, American Society of Anesthesiologists Annual Meeting, New Orleans LA
2014	Ethical Issues Regarding Open Access Journals, American Society of Bioethics and Humanities Annual Meeting, San Diego CA.
2015	Harvard Anesthesia Update 2015. Point/Counterpoint. Physician Involvement in Lethal Injection. May 2015
2015	Invited lecturer, American Society of Interventional Pain Physicians Refresher Course and Review. Ethics of Interventional Pain Management. Chicago Il, July 2015
2015	Faculty, Moya Annual CRNA Refresher Course. Orlando, FA. Nov 2015
2020	Invited Panelist, When does the anesthesiologist get to decide? Conscientious Objection: What it Is—and What it Isn't. American Society of Anesthesiologists Annual Meeting. (held virtually due to COVID 19)
2022	Invited panel moderator. International Academy of Law and Mental Health. Lyons, France. July, 2022
2022	Invited speaker, Joint Session of the WSSA and BCA, Vancouver BC. Ethics in Anesthesia Practice November 2022
2023	Invited speaker, 11th International Conference on Ethics in Biology, Engineering and Medicine. Off-Label Marketing: Risks to the Clinician and Researcher. Seattle, WA. April 2023
2023	Invited speaker, 16th Brocher Foundation Meetup: "Three approaches to Death and Dying: Japanese, Sub-Saharan African and American". Virtual international conference. Aug 21, 2023

Special Regional Responsibilities:

1991-1993	Member, Medical Ethics and Practice Committee, King County Medical Society, Seattle, Washington

1992-1994	Member, Professional Liability Panel, King County Medical Society, Seattle, Washington
1992-1996	Co-chair, Committee on Education, Washington State Society of Anesthesiologists, Seattle, Washington
1995	Program Chair, Washington State Society of Anesthesiologists Spring Meeting, "Controlling Our Destiny: Leadership Opportunities Beyond the Operating Room"
1995	Program Chair, Washington State Society of Anesthesiologists Fall Meeting, "The Difficult Airway: Clinical Approaches and Risk Management"
1996	Program Co-Chair, Washington State Society of Anesthesiologists Spring Meeting, "Preoperative Issues for the Surgical Patient"
1996	Representative, Washington State Society of Anesthesiologists, ASA Legislative Session, Washington, DC
2021	Group/Discussion leader for University of Washington Department of Bioethics and Humanity's annual Summer Seminar in Healthcare Ethics. Seattle WA. August 2021

Special Local Responsibilities:

1991-1993	Ethics Committee, Swedish Hospital, Seattle, Washington
1995-2000	Associate Medical Director, Pre-surgery Clinic, University of Washington Medical Center, Seattle, Washington
1996-1997	Member, Advisory Committee on Ethics, University of Washington Medical Center, Seattle, Washington
1998-2000	Chair, Continual Quality Improvement University of Washington Medical Center, Department of Anesthesiology
1997-2000	Co-chair, Advisory Committee on Ethics, University of Washington Medical Center, Seattle, Washington
1999-2000	Acting Chief, Cardiothoracic Anesthesia, University of Washington Department of Anesthesiology
2006 -	Regional Ethics Committee member, Franciscan Health Care Systems, Tacoma, Washington
2006-2008	Member, Regional Committee on Organ Transplantation, Franciscan Health Care System, Tacoma, Washington
2008-2009	Member, Joint Transfusion Committee, HMC and UWMC
2009-2010	Member, Standards and Finance Committee, University of Washington Department of Anesthesiology and Pain Medicine
2010-2016	Member, Business Excellence Committee, University of Washington Physicians
2010-	Chair/co-chair Standards and Finance Committee, University of Washington Department of Anesthesiology and Pain Medicine
2010-present	Compliance Officer, Department of Anesthesiology and Pain Medicine, University of Washington, Seattle WA.
2014-present	Member, Dept of Anesthesiology and Pain Medicine Promotions Committee

Research Funding:

University of Washington Department of Anesthesiology; "The Effects of PTCA vs. CABG in Reducing Postoperative Cardiac Morbidity in Patients Undergoing Noncardiac Surgery"; 1995; $500 [Investigators: Chan V, Van Norman G, Posner K]

Washington State Society of Anesthesiologists; The Effects of PTCA vs. CABG in Reducing Postoperative Cardiac Morbidity in Patients Undergoing Noncardiac Surgery; 1995; $2000; [Investigators: Chan V, Van Norman G, Posner K]

Washington State Society of Anesthesiologists: Echocardiography Screening in the PreAnesthesia Clinic. 2010. $5000 [Investigators: Wako E, Van Norman GA, Rooke A, Otto C.]

APPENDIX I

BIBLIOGRAPHY

Publications in Refereed Journals or Websites:

1. Van Norman G., Groman N.. A Method of Quantitating Sensitivity to a Staphylococcal Bacteriocin. Infection and Immunity 26(2): 787-789, 1979.

2. Dreis D., Winterbauer R., Van Norman G, Sullivan S., Hammer S. Cephalosporin-Induced Interstitial Pneumonitis. Chest 86(1): 138-140, 1984.

3. Winterbauer R., Hammer S., Van Norman G. Histiocytosis X, Case Report and Discussion. J Resp Dis February 1985.

4. Van Norman G, Pavlin E, Eddy C, Pavlin J. Hemodynamic and Metabolic Effects of Aortic Unclamping Following Emergency Surgery for Traumatic Thoracic Aortic Tear in Shunted and Unshunted Patients. J Trauma 31(7): 1007-1016, 1991.

5. Van Norman, G. Diabetes in the Operating Room: Metabolic Challenges for the Anesthesiologist. Seminars Anesth 14(3): 210-220,1995

6. Van Norman, G. Preoperative Assessment of Common Diseases in the Outpatient Setting. Anesthesiology Clinics of North America. 14(4): 631-654,1996.

7. Van Norman G. Preoperative Management of Common Minor Medical Issues in the Outpatient Setting. Anesthesiology Clinics of North America. 14(4): 655-678, 1996.

8. Aziz S, Haigh W, Van Norman G, Kenney R, Kenney M. Blood Ionized Magnesium Concentration During Cardiopulmonary Bypass and Their Correlation with Other Circulating Cations. J Card Surg Sep-Oct 11(5): 341-7, 1996.

9. Van Norman G, Gernsheimer T, Chandler W, Cochran P, and Spiess B. Indicators of Fibrinolysis During Cardiopulmonary Bypass After Exogenous Antithrombin III Administration for Acquired Antithrombin III Deficiency. J. Cardiothoracic Vasc Anesth 11(6): 760-763, 1997.

10. Jackson S, Palmer S, Van Norman G, et al. Ethical Issues in Anesthesia. Adv Anesth 14:227-260, 1997.

11. Van Norman G. A Matter of Life and Death: What every anesthesiologist should know about the medical, legal, and ethical aspects of declaring brain death. Anesthesiology 91(1): 275-287, 1999.

12. Posner K, Van Norman G, Chan V. Adverse Cardiac Events Following Noncardiac Surgery in Patients with Coronary Artery Disease Undergoing Prophylactic PTCA. Anesth Analg 89: 553-60, 1999.

13. Reilly DF, McNeely JM, Doerner D, Greenberg DL, Staiger TO, Geist MJ, Vedovatti PA, Coffey JE, Mora MW, Johnson TR, Guray Ed, Van Norman GA, Fihn S. Self-Reported Exercise Tolerance and the Risk of Serious Perioperative Complications. Arch Int Med 159: 2185-92,1999.

14. Van Norman G. Ethics and The Elderly Patient. Current Anesth Rep 1:13-17, 1999.

15. Pavlin DJ, Arends RH, Gunn H, Van Norman G, Keorschgen M, Shen D. Optimal Propofol-Alfentanil Combinations for Supplementing Nitrous Oxide for Outpatient Surgery. Anesthesiology 91(1): 97-108, 1999.

16. Jackson S, Van Norman, G. Goals and Values Directed Approach to Informed Consent in the "DNR" Patient Presenting for Surgery--More Demanding of the Anesthesiologist? Editorial. Anesthesiology 90:3-6, 1999.

17. Pavlin JD, Colley PS, Weymuller EA, Van Norman GA, Gunn HC and Koerschgen M. Propofol Versus Isoflurane For Endoscopic Sinus Surgery. Am J Otolaryn; 10: 96-101, 1999.

18. Van Norman, G. Angioplasty and Noncardiac Surgery: Risks of Myocardial Infarction. Current Opinion in Anesthesiology, 12(1):15-20, 1999.

19. Van Norman, G. Response: Re: Can Brain Death Testing Be Perfect? Anesthesiology. 92(4): 1204-5, 2000.

20. Van Norman G, Patel MA, Robledo J, Chandler W, and Vocelka C. Effect of Hemofiltration on Serum Aprotinin Levels in Patients Undergoing Cardiopulmonary Bypass. J. Cardiothor Vasc Anesth 14(3): 253-256, 2000.

21. Van Norman G, Palmer S. Coercion and Restraint in Anesthesia Practice. International Clinics of Anesthesiology. Medical Ethics 39(3): 131-143, 2001.

22. Van Norman G. Misinformed consent: A problem in the operating room? Ethical principles of informed consent and their application for the anesthesiologist. ASA Refresher Courses in Anesthesiology 2001; 29:215-23

23. Van Norman, G. Ethical Issues and the Role of Anesthesiologists in Non-Heart-Beating Organ Donation. Current Opinion Anesthesiology 16(2): 215-9, 2003

24. Van Norman G. Another Matter of Life and Death; What Every Anesthesiologist Should Know About the Ethical, Legal and Policy Implications of the Non-Heart-Beating Organ Donor. Anesthesiology 2003. 98(3):763-73.

25. Van Norman G, Jackson S, Waisel D. Ethical Issues in Informed Consent. Current Opinions in Anesthesiology 17(2): 177-81, 2004.

26. Van Norman GA. Ethical Issues of Importance to Anesthesiologists Regarding Organ Donation After Cardiac Death. Current Opinion Organ Transplant 10(2): 105-109, 2005.

27. Van Norman GA. Controversies in Organ Donation: Donation After Cardiac Death. Periop Nurs Clin, 3(3):233-240, 2008

28. Van Norman GA. Ethical Issues in Informed Consent. Periop Nurs Clin 3(3):213-222, 2008

29. Ivashkov Y, Van Norman GA. Informed Consent and Ethical Management of the Elderly Patient. Anesthesiology Clinics 2009; 27(3):569-80

30. Souter M, Van Norman GA. Ethical Controversies at End-of-Life After Traumatic Brain Injury: Defining Death and Organ Donation. Crit Care Med 2010; 38(9 suppl): S502-9

31. Souter M, Van Norman GA. [Letter to the Editor] Reply to: Concerns regarding definition of brain death. Critical care medicine 2011;39(3):606-7

32. Sara Kim, PhD; Sinan Jabori, BS; Jessica O'Connell, MD, FACS; Shanna Freeman, APRN; Cha Chi Fung, PhD; Sahrish Ekram, BA; Amruta Unawame, MD; Gail Van Norman, MD. Current Trends of Research Methodologies in Informed Consent Studies: Time to Re-examine? Patient Educ Couns 2013; 93:559-66

33. Van Norman G. Physician Aid-in-Dying: Cautionary Words. Curr Opinion Anesthesiol 2014; 27:177-82

34. Van Norman GA. Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital. Book Review. Anesth Analg 2014; 199:494

35. Van Norman GA. Abusive and Disruptive Behavior in the Surgical Team. *AMA Journal of Ethics*. 2015; 17:215-220. . http://journalofethics.ama-assn.org/2015/03/ecas3-1503.html. Accessed March 3, 2015.

36. Van Norman GA. A Matter of Mice and Men: Ethical Controversies in Animal Experimentation. Int Anesthesiol Clin. 2015; 53:63-78.

37. Rooke GA, Lombaard SA, Dziersk J, Natrajan KM, Van Norman G, Larson LW, Poole JE. Initial experience of an anesthesiology-based service for perioperative management of pacemakers and implantable cardioverter defibrillators. Anesthesiology 2015; 123:1024-32.

38. Nair BG, Grunzweig K, Peterson GN, Horibe M, Nerdilek MB, Newman SF, Van Norman G, et al. Intraoperative blood glucose management: impact of a real-time decision support system on adherence to institutional protocol. J Clin Monitor Comput June 12, 2015; epub ahead of print

39. Grunzweig K, Nair BG, Peterson GN, Horibe M, Neirdilek MB, Newman SF, Van Norman G, et al. Decisional practices and patterns of intraoperative glucose management in an academic medical center. 2016; 32:214-23

40. Rooke GA, Lombaard SA, Van Norman GA, Dziersk J, Natrajan KM, Larson L, Poole JE. In Reply [re: . Initial experience of an anesthesiology-based service for perioperative management of pacemakers and implantable cardioverter defibrillators]. Anesthesiology 2016; 124:1195

41. Van Norman G. Drugs, devices and the FDA: an overview of the approval processes: Part 1 Approval of drugs. JACC Basic Translation Sci 2016; 1: 170-9

42. Van Norman G. Drugs, devices and the FDA: an overview of the approval processes: Part 2 Approval of medical devices. JACC Basic Translation Sci 2016; 1:277-87

43. Van Norman G. Drugs and Devices Part 3: a Comparison of U.S. and European Processes. JACC Basic Translation Sci 2016; 1:399-412

44. Van Norman GA. Decisions regarding foregoing life-sustaining treatments. Curr Opin Anesth 2016; Nov 30 [epub ahead of print].

45. Van Norman GA, Eisenkott R. Technology Transfer: From the Research Bench to Commercialization. Part 1. Intellectual Property Rights-Basics of Patents and Copyrights. JACC Basic Translation Sci 2017; 2:85-97

46. Van Norman GA, Eisenkott R. Technology Transfer. Part 2. The Commercialization Process. JACC Basic Translation Sci 2017; 2:197-208

47. Van Norman GA. Overcoming the declining trends in innovation and investment in cardiovascular therapeutics: beyond EROOM's law. JACC Basic Translational Sci 2017; 2:613-25

48. Van Norman GA. Expanding Patient Access to Investigational Drugs: Single Patient INDs and "Right to Try". JACC Basic Translational Sci 2018; 3:280-91

49. Van Norman GA. Expanding Patient Access to Investigational Drugs: Overview of Intermediate and Widespread Treatment INDs, and Emergency Authorization in Public Health Emergencies. JACC Basic Translational Sci 2018; 3:403-14

50. Van Norman GA. Expanded patient access to investigational new devices: review of emergency and non-emergency expanded use, custom and 3D printed devices. JACC Basic Translational Sci. 2018; 3:533-44

51. Shah AC, Ma K, Faraoni D, Oh D, Rooke A, Van Norman GA. Self-reported functional status predicts post-operative outcomes in noncardiac surgery patients with pulmonary hypertension. PLOS ONE. Aug 16, 2018. https://doi.org/10.1371/journal.pone.0201914

52. Van Norman GA. The problem of Phase II clinical trials: reducing costs and predicting success. JACC Basic Translational Sci 2019; 4:428-37

53. Van Norman GA. Limitations of animal studies for predicting toxicity in clinical trials: part 1: is it time to rethink our current approach? JACC Basic Transl Sci. 2019; 4:845-54

54. Suhre W, Van Norman GA. Anesthesia at the Edge of Life. Ethical issues in organ transplantation at end of life: defining death. Anesth Clin 2020; 38:231-46

55. Van Norman GA, Jackson S. The anesthesiologist and global climate change: an ethical obligation to act. Curr Opin Anesth 2020; 33:577-83.

56. Van Norman GA. Limitations of animal studies for predicting toxicity in clinical trials part 2: potential alternatives to the use of animals in preclinical trials. JACC Basic Transl Sci 2020; 5:387-97

57. Van Norman GA. "Warp Speed" operations in the COVID-19 pandemic: moving too quickly? JACC Basic Trans Sci 2020; 5:730-4

58. Van Norman GA. Update to Drugs, Devices and the FDA. How recent legislative changes have impacted approval of new therapies. JACC Basic Transl Sci. 2020; 5:831-9

59. Van Norman GA. Translational perspective. Decentralized clinical trials: the future of medical product development? J Am Coll Cardiol Basic Trans Science 2021; 6:384-7s

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61. Van Norman GA. Data safety and monitoring boards should be required for both early and late phase clinical trials. JACC Basic Trans Sci 2021; 6:887-96 PMID 34869954

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81. Jackson S, Hunter JM, Van Norman GA. [Letter to the Editor] Reply to: Ethics of mandatory pregnancy testing: concerns for the adolescent patient. Anesth Analg 2024; 139:e41-e42

82. Van Norman GA, Cohen N. Preface: Ethical approaches to the practice of anesthesiology Part 1. Overview of ethics I clinical care: history and evolution. Anesth Clin. September 2024

83. Van Norman GA, Cohen N. Preface: Ethical approaches to the practice of anesthesiology Part 2. Anesthsiol Clin 2024; 42:xv-xvi

84. Lucero J, Van Norman G. Invited Editorial: Keeping the patient at the center of conscientious objection while respecting our colleagues. Anesthesiology 2024; 141:822-4

Books:

Cambridge Textbook of Clinical Ethics for Anesthesiologists. Van Norman G, Ed. Palmer S, Jackson S, Rosenbaum S co-eds. Cambridge University Press, 2011. London, UK.

Anesthesiology Clinics. Ethical Approaches to the practice of anesthesiology—Part 1: Overview of ethics in clinical care: history and evolution. Cohen N, Van Norman GA Eds. Elsevier Inc, Philadelphia PA. September 2024.

Anesthesiology Clinics. Ethical Approaches to the practice of anesthesiology—Part 2. Cohen N, Van Norman GA Eds. Elsevier Inc, Philadelphia PA. Accepted, publication anticipated December 2024.

Book Chapters:

1. Van Norman, G. Jehovah's Witnesses, in Atlee, J. (ed): *Complications in Anesthesiology*. WB Saunders, Philadelphia., 1999, pp. 937-939.

2. Van Norman, G. Patient Confidentiality, in Atlee, J. (ed): *Complications in Anesthesiology*. WB Saunders, Philadelphia, 1999. Pp. 931-933.

3. Van Norman, G. DNR in the Operating Room, in Atlee, J (ed): *Complications in Anesthesiology*. WB Saunders, Philadelphia, 1999, pp. 934-936.

4. Van Norman G. Ethical Considerations: Informed Consent, Advanced Directives, DNR Orders. In Hanson, E.(ed): *Medical Clerkship Companion 2*. Harcourt Brace, Chestnut Hill, MA, 2003.

5. Van Norman G. Ethical Decisions/End-of-Life Care in Patients with Vascular Disease. In Kaplan, J. (ed): *Vascular Anesthesia, 2nd Edition*. Churchill Livingstone, Philadelphia, PA, 2004, pp. 387-406.

6. Van Norman, G. DNR in the Operating Room. In Atlee, J. (ed): *Complications in Anesthesiology, 2nd Edition*. WB Saunders, Philadelphia. 2005.

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9. Van Norman GA. Anesthesiology Ethics. *IN* Singer P, Viens A (eds): *The Cambridge Textbook of Clinical Ethics.* 2008. Cambridge University Press, London.

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16. Van Norman GA. Sexual Harassment, Discrimination, and Faculty-Student Intimate Relationships in Anesthesia Practice. *IN* Van Norman GA, Ed. 2011 *Cambridge Textbook of Ethics for Anesthesiologists.* Cambridge University Press, London, UK..

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18. Wako E, Van Norman GA. Laboratory Testing in Spine Disease. *IN* Chapman JR, Dettori JR, Norvell, DC (2011) *Measurements in Spine Care*. 1st ed. Stuttgart New York: Thieme.

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40. Kooner P, Van Norman GA. Ethics of off-label marketing of drugs: patient safety versus commercial profits. In: *Business Ethics in the Healthcare Industry*. Faintuch J, Ed. Springer USA, New York, NY. Submitted, Anticipated publication January 2026.

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2. Van Norman G. Ethics of Informed Consent. ASA Newsletter 58(8): 15-17, 1994

3. Van Norman, G. Special Paper: Implementation of an Ethics Curriculum: Getting Started. In Waisel D, Van Norman G (eds): *ASA Syllabus on Ethics: Informed Consent.* ASA publications, Park Ridge, Illinois. 1997, pp. 1-6.

4. Jackson S, Fine P, Palmer S, Rosenbaum S, Truog R, Van Norman G. Letter to Editor, Comment on Bastron, D. Response to: Ethical Concerns in Anesthetic Care for Patients with Do-Not-Resuscitate Orders. Anesthesiology 87(1): 176-177, 1997.

5. Van Norman, G. Who Speaks for the Patient? Ethical Principles in Assessing Patient Competence and Appropriate Use of Proxy Decision-Makers in the Practice of Anesthesiology. In Waisel D, Van Norman G (eds*): ASA Syllabus on Ethics: Informed Consent.* ASA publications, Park Ridge, Illinois. 1997, pp. B2-B34.

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8. Van Norman G. Chapter 17: Misinformed Consent--A Problem in the OR? In: *ASA Refresher Courses in Anesthesiology*. ASA Publications, Chicago Ill. 1999, pp.215-223.

9. Van Norman G, and Posner K. Coronary Stenting or Percutaneous Transluminal Coronary Angioplasty Prior to Noncardiac Surgery Increases Adverse Perioperative Cardiac Events; the Evidence is Mounting. (letter to the editor). J Amer Coll Cardiol 36(7): 2351, 2000.

10. Van Norman, G, Palmer S. When Should Anesthesiologists Restrain Uncooperative Patients? ASA Newsletter 65(3), 2001.

11. Van Norman G. The Student-Teacher Relationship in Medicine: Are Intimate Relationships Between Faculty and Medical Trainees Ethical? In Van Norman G, Waisel D. (eds): *ASA Syllabus on Ethics: Ethics of Professional and Personal Relationships in Anesthesiology Training and Practice*. ASA, Park Ridge, Illinois. 2004.

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14. Black S, Van Norman G. Compassion and Choice in End-of-Life Decisions. Editorials and Opinions, *The Seattle Times*, April 1, 2005

15. Van Norman GA. Practical Ethical Concerns Regarding Intimate Relationships in the Operating Room. ASA Newsletter 2007, 71(5).

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17. Van Norman GA. Contributing Writer: *Handbook of Anesthesia and Co-Existing Disease.* Elsevier publications, Philadelphia PA. 2009.

18. Sweitzer BJ, Vidoga M, Milokjic, et al. Resident's knowledge of ACC/AHA Guidelines for Preoperative Cardiac Evaluation is Limited. Cleveland Clinic J Med 2010; 77(ESuppl):eS11-eS12.

19. Palmer SK, Van Norman GA, Jackson SL. Letter to the editor. Routine pregnancy testing before elective anesthesia is not an American Society of Anesthesiologists standard. Anesth Analg. 2009; 208(5):1715-6.

20. Van Norman GA, Jackson SL. Back to our roots: the importance of enforcing professionalism at the ASA. ASA Newsletter. May, 2011. 75(5):10-12

21. Jackson SL, Van Norman GA. Ethical issues in the publication of medical research. ASA Newsletter. May 2011. 75(5):14-15

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23. Van Norman GA. Ethics of Ending Life; Physician-Assisted Suicide and Euthanasia, Part 1. California Society of Anesthesiologists Bulletin, CA. Winter 2012.

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25. Van Norman GA. Ethics of Ending Life; Physician-Assisted Suicide and Euthanasia, Part 2. California Society of Anesthesiologists Bulletin, CA. Summer 2012.

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27. Rooke A, Natrajan K, Lombaard S, Dziersk J, Van Norman GA, Poole J. Letter to the Editor In Reply: Initial experience of an anesthesiology based service for perioperative management of pacemakers and implantable cardioverter defibrillators. Anesthesiology 2016; 124: 1195

28. Van Norman GA. Saving Grace: What Patients Teach Their Doctors About Life, Death, and the Balance in Between. Anesthesiology 2023; 138:670. Doi:10.1097/ALN0000000000004492.

29. Van Norman GA. Living in a Glass House: Challenges to Ethics Committees and Consultation Services in Rural and Small Community Hospitals. The Physicians Report. Physicians Insurance Newsletter. February 2024

30. Jackson S, Hunter JM, Van Norman GA. In response [Letter: ethics of mandatory pregnancy testing]. Anesth Analg 2024; 139:e41-42. Doi: 10.1213/ANE.0000000000007154

31. Hunter J, Jackson S, Van Norman G. Letter to the Editor: Anesthetic Agents are Not Harmful During Pregnancy. JAMA Surg 2025; 160:231-2

Web publications

1. Update Author, *Sleisinger and Fordtran's Gastrointestinal and Liver Disease, 7th Edition,* on-line version. Mark Feldman MD, Editor. Elsevier Scientific Publications, Philadelphia *[www.sfgastro.com],* 2003 to 2006.

2. Update Author, *Anesthesia, 6th Edition,* on-line version. Ron Miller MD, Editor. Elsevier Scientific Publications, Philadelphia. *[www.anesthesiatext.com]* 2004 to present.

3. Update Author, *Diseases of the Heart, 6th Edition,* on-line version. Eugene Braunwald MD, Editor. Elsevier Scientific Publications, Philadelphia [*www.branwalds.com],* 2004 to present.

4. Update Author, *Murry and Nadel's Textbook of Respiratory Medicine,* on-line version. Robert J. Mason MD, John F. Murray MD, V. Courtney Broaddus MD, and Jay A Nadel MD, editors. Elsevier Scientific Publications, Philadelphia *[www.respmedtext.com],* 2005-2006.

5. Update Author, *Drugs for the Heart,* on-line version. Lionel H Opie MD and Bernard J Gersh MD, editors. Elsevier Scientific Publications, Philadelphia *[www.opiedrugs.com],*, 2005 to 2008

6. Update Author, *Clinical Gastroenterology and Hepatology,* on-line version, Wilfred M Weinstein MD, C J Hawkey MD, J Bosch MD, editors. Elsevier Scientific Publications, Philadelphia *[www.clingastrotext.com],* 2005-2006.

7. Medifile author for *FirstConsult*, Medical website for primary care physicians. Elsevier Scientific Publications, London UK *[www.firstconsult.com],* 1998 to 2008.

8. Topic Editor, *First Consult.* Medical website for primary care physicians. Elsevier Scientific Publications, London UK, *[www.firstconsult.com],* 1998 to 2008

9. Medical writer, *Clinical Procedures*, Elsevier Scientific Publications, PhiladelphiaPA, 2008 to present

10. Medical editor and writer, *Clinical Reviews*, Elsevier Scientific Publications, Philadelphia, 2021

Abstracts:

1. Van Norman G, Pavlin E, Eddy C, and Pavlin J. Hemodynamic and Metabolic Effects of Aortic Unclamping Following Emergency Surgery for Traumatic Thoracic Aortic Tear in Shunted and Unshunted Patients. Presented to the 50th Annual Meeting of the American Association for the Surgery for Trauma, 1989.

2. Van Norman G, Pavlin E, Eddy C, and Pavlin J. Hemodynamic and Metabolic Effects of Aortic Unclamping Following Emergency Surgery for Traumatic Thoracic Aortic Tear in Shunted and Unshunted Patients. Presented to the American Society of Anesthesiologists Annual Meeting, 1989.

3. Van Norman G, Spiess B, Lu J, et al. Aprotinin Versus Aminocaproic Acid in Moderate-to-High-Risk Cardiac Surgery: Relative Efficacy and Costs of Transfusion. Anes Anal Supplement, March 1995.

4. Kenney M, Van Norman G, Hague G, et al. Variations in Ionized Magnesium During Cardiopulmonary Bypass. Presented to the Cardiopulmonary Bypass Meeting, San Diego, California, 1995.

5. Pavlin J, Gunn H, Van Norman G, et al. Optimal Propfol/Alfentanil Combinations for Supplementing N20 For Outpatient Surgery. Presented to the Annual Meeting of the American Society of Anesthesiologists, 1997. Anesthesiology 87(3S) Supplement 308A, 1997.

6. Van Norman G, Posner K, Wright I, et al. Adverse Cardiac Events Following Noncardiac Surgery in Patients with Prior PTCA versus Normal Patients, and Patients with Nonrevascularized CAD. Presented to the Scientific Sessions of the American Heart Association, Orlando, Florida, 1997, published in supplement to Circulation, October 1997.

7. Simmons E, Van Norman G, Robledo J, et al. Effect of Hemofiltration on Aprotinin Activity in Patients Undergoing Cardiopulmonary Bypass. Presented to WARC (Western Anesthesia Residents Conference, 1998.

8. Lee J, Karjeker S, Van Norman GA et al. Advance Directives in the Perioperative Period. Presented to WARC (Western Anesthesia Residents Conference), 2009

9. Karjeker S, Van Norman G, et al. Advance Directives in the PreAnesthesia Clinic. Presented at the American Society of Anesthesiologists' Annual Meeting, New Orleans, LA. 2009

10. Rooke, G.A., Natrajan, K., Lombaard, S., Dziersk, J., Van Norman, G., Poole, J.: Initial experience of an anesthesia-based service for perioperative management of CIEDs. Anesthesiology 117:A835, 2012.

11. Shah A, Ma K, Rooke GA, Van Norman G. Pulmonary HTN in the perioperative patient. (working title). Accepted to IARS Annual Meeting, Honolulu HI. March 2015.

12. Rooke A, Natrajan K, Lombaard S, Dziersk J, Van Norman G, Poole J. Poster: Initial experience of an anesthesia-based service for perioperative management of CIEDs. ASA American Society of Anesthesiologists Annual Meeting, Washington DC, 2012

OTHER

International and National Invitational Lectures:

1. "DNR in the OR: Am I a Bad Doctor if I Let My Patient Die?" American Society of Anesthesiologists, Refresher Course, San Francisco, CA, June 29, 1996.

2. "Misinformed Consent: Is This a Problem in the Operating Room?" American Society of Anesthesiologists Refresher Course, San Francisco, CA, June 29, 1996.

3. "Ethics: A New Hot Topic in Resident Education," The Society for Education in Anesthesia Fall Meeting: Educational Strategies for the 21st Century, New Orleans, 1996.

4. "Ethics: A New Hot Topic in Resident Education," The Society for Education in Anesthesia Fall Meeting: Educational Strategies for the 21st Century, San Diego, CA, October 1997.

5. "Misinformed Consent: A Problem in the Operating Room?" American Society of Anesthesiologists Workshop in Practical Bioethics for the Anesthesiologist, Boston, MA, 1997.

6. "Brain Dead, or Only Mostly Dead? What's the Difference, I'm Just the Anesthesiologist!" American Society of Anesthesiologists Workshop in Practical Bioethics for the Anesthesiologist, Boston, MA, 1997.

7. "PTCA prior to Noncardiac Surgery." World Congress of Cardiovascular Anesthesiologists, Santiago, Chile, 1998.

8. "Ethics Case Discussion: Assessing Cardiac Risks for Patients with Coronary Artery Disease Undergoing Noncardiac Surgery" and "Ethics Case Discussion: Assessing Brain Death" Rush-Presbyterian-St. Luke's Medical Center, Chicago Illinois, Visiting Professorship, 1998

9. "Brain Death: What Every Anesthesiologist Should Know" Midwest Anesthesia Conference and Peri-Anesthesia Care Symposium, Chicago, Il, 1999.

10. "Ethical Issues in the Operating Room," American Society of Anesthesia Technologists and Technicians, Seattle, WA, 2000.

11. "Ethical Issues in the Operating Room," American Society of Extracorporeal Technologists, Seattle, WA, 2000.

12. "Ethical Boundaries of Persuasion: Coercion and Restraint in Pediatric Anesthesia Practice," Mid-Year SAMBA meeting, New Orleans, LA, 2001.

13. "Ethics: Brain Death and Organ Donation" Rush-Presbyterian-St. Luke's Medical Center and Rush University, Chicago, Illinois Department of Anesthesiology and Undergraduate Medical School; Inaugural Speaker, Katalin Selemczi MD Memorial Lecture Series in 2001

14. "Donation After Cardiac Death—Stretching the Definitions of Death Too Far?" Invited lecturer; European Society of Anesthesiology, Copenhagen Denmark, May 2008.

15. "Conflicts of Interest: Industry Reps." February 2009; Visiting Professor, University of Oklahoma Department of Anesthesiology. Oklahoma City, OK

16. "DNR in the Patient Undergoing Surgery and Anesthesia." Sept 2009 Primary Care Medicine. Seattle, WA

17. Perioperative Beta Blockers." National Association of Nurse Practitioners. Aug 2010. Seattle, WA

18. Ghosts of OR Cancellations Past and Present." Combined WSSA, BCAA international meeting. Dec 2010 (Elizabeth Wako MD and Gail Van Norman MD speakers)

19. Ethics of Organ Donation After Cardiac Death. Society for Cardiovascular Anesthesiologist. Annual Meeting, April 2011. Savannah, Georgia.

20. Ethics of Organ Donation After Cardiac Death. Dept of Anaesthesiology and Intensive Care, St. Mary's Hospital. London, UK. August 2011.

21. Physician-assisted Suicide and Euthanasia. Brocher Foundation. Hermance, Switzerland, August 2011.

22. Fraud in Publication and Medical Research. Dept of Anaesthesiology and Intensive Care Medicine, University of Geneva. Geneva, Switzerland. Sept 2011.

23. Informed Consent and Informed Refusal in the Operating Room. AORN annual meeting, Seattle, WA Jan. 2012

24. Fraud and Plagiarism in Research. Risk Management Division, MD Anderson Medical Center, Houston TX, April 18, 2012

25. Physician-Assisted Suicide and Euthanasia, Department of Anesthesiology, MD Anderson Medical Center, Houston TX, April 18, 2012

26. Ethics in Anesthesiology. Annual Review Course for Certified Nurse Anesthetists. Orlando Florida, November 2012

27. Invited Lecturer: Ethics of Interventional Pain Management. ASIPP. Phoenix, AZ. Feb 2012

28. Invited Lecturer: Ethics of Interventional Pain Management. ASIPP. San Francisco CA Aug 2012.

29. Invited Lecturer: Ethics of Interventional Pain Management. ASIPP. Phoenix, AZ. July 2013

30. Invited Lecturer: Ethics of Interventional Pain Management. ASIPP. Denver CO; Oct 2013

31. Invited Lecturer; Controversial Cases in Organ Transplantation: clinical forum. American Society of Anesthesiologists Annual Meeting. San Francisco CA. Oct 2013

32. Invited Lecture: Ethics of DCD Organ Donation. St. Mary's Hospital Dept of Anesthesiology and Critical Care, London UK. Dec 2014

33. Invited Lecture: DNR in the OR. London Soc Anesthesiology, UK. Dec 2014

34. International Academy of Law and Mental Health. Moderator: Brain Death, Personhood, Body Integrity: Ethical and Legal Considerations in Vital Organ Transplantation. Vienna Austria July 2015

35. Invited Lecturer: Harvard Anesthesia Update Spring 2015. Pro/Con Debate: Should Physicians Participate in Lethal Injection.

36. Invited Lecturer: Ethics of Interventional Pain Management. ASIPP, Chicao Il. July, 2015

37. Keynote Speaker: Terminal Sedation in Pediatric Sedation: Suffering, Palliation and Transcendance (working title). Conference for Pediatric Sedation Outside of the Operating Room. Cancun, Mexico Sept 2015

38. Invited Ethics Lecturer: Moya Review Course for Nurse Anesthetists. Orlando Fl, November 2015

39. Invited Participant; 2015 Alumni Meeting of the Scholars of the Brocher Foundation, Geneva Switzerland, June 16-18, 2015.

40. Invited Speaker: 2016 World Congress of Anesthesiologists. Ethics Section. Hong Kong, Aug 27-Sept 1, 2016

41. Invited Lecturer; Medical Professionalism. St. Mary's Hospital Department of Anesthesiology and Critical Care. London, UK. July 2016

42. 2017 International Academy of Law and Mental Health. Invited panelist, moderator. Ethics of Psychosurgery. Prague, Czech Republic, July 2017

43. 2017 Mazama Spine Summit, Mazama WA. Invited Speaker: What is Professionalism and the Practice of Medicine? Lessons from the Michael Jackson Case.

44. 2019 International Academy of Law and Mental Health. Invited panelist, moderator. Physician Assisted Suicide in the United States: Current Status. Rome, Italy. July 2019.

45. 2019. Brocher Foundation Reunion of Scholars, 2019. Lethal Injection in the United States: personal experience as an expert witness for the prisoner. Geneva, Switzerland. June 2019

46. 2022 International Academy of Law and Mental health. Invited panelist and moderator. Legal and Philosophical Issues in Brain Injury and Death, and Artificial Intelligence. Lyon, France. July 2022.

47. 2022. Animal Testing: History and Limitations. Successful Alternatives to Animal Testing. Elsevier Life Science Webinar Series. Invited speaker. September 28, 2022

48. 2022. Ethical Issues in Anesthesia Practice. Invited Commentator, WSSA/BCA joint meeting. Vancouver, British Columbia. November 12, 2022

49. 2024. Invited Panel Moderator and Speaker. Session Title: Truth.... and Doubt. Perspectives on Appellate Lethal Injection Cases in the United States: Perspective from an Expert Witness—What is the Truth? International Academy of Law and Mental Health. Barcelona Spain, July 2024

50. 2024. Invited Speaker. Ethics of Mandatory Pregnancy Testing for Surgery and Anesthesia. 6th World Surgeons Congress 2024. Las Vega, NV. USA. October 7, 2024.

51. 2025. Invited Keynote Speaker. Ethics of Conscientious Objection. Royal College of Anaesthetists Annual Meeting. Belfast, Ireland. May 22, 2025

Regional Invitational Lectures:

1. "Treatment of Intraoperative Emergencies: Wheezing; Inability to Ventilate" CME Lecture, Washington State Society of Anesthesiologists, Seattle, WA, 1991.
2. "Ethical Issues in Anesthesiology," Washington State Society of Anesthesiologists, Moderator and CME Lecturer, Seattle, WA, 1993.
3. Washington State Association of Nurse Anesthetists, Tukwila, Washington "Ethical Issues in Anesthesia Practice", 1995.
4. Washington State Association of Nurse Anesthetists "Ethical Issues in Anesthesia Practice" Seattle, WA, 1998.
5. "Management Issues In the Preoperative Clinic." Society for Ambulatory Anesthesia (SAMBA), Seattle, Washington, 1999.
6. "Physiology of Perioperative Myocardial Blood Flow." Washington State Society of Nurse Anesthetists, Seattle, WA, 1999.
7. "Ethical Issues in the Operating Room." American Society of Anesthesiology Technologists, Seattle, WA, 2000.
8. "DNR orders in the Operating Room," Combined Anesthesia and Surgery Grand Rounds, Southwest Washington Medical Center, Vancouver, WA, 2001.
9. "Medical Ethics: Balancing Patient Advocacy and Managed Care." Western Pension and Benefits Conference, Seattle, WA, 2003.
10. "Conscious Sedation for Radiological Procedures in the Outpatient," Northwest Hospital Radiology Department, Seattle, WA, 1991.
11. Instructor, Certified Post Anesthesia Nurse (CPAN) Certification Course, Northwest Hospital, Seattle, WA, 1991.
12. Conflicts of Interest with Industry. AORN winter meeting, Kent WA, 2009
13. "Preoperative Testing." Wash. State Nurse Anesthetists. Sept 2009, Spokane, WA
13. "Implementing Intra-Operative Glucose Control: What Does it Take?" Washington State Hospital Association. April 2014, Seattle, WA
14. "Who's Doing Your Surgery and Anesthesia? Ethical Issues in Informed Consent in Medical Direction and Overlapping Surgeries." Washington Ambulatory Surgery Association 2018 Conference. November 2018, Seattle WA.
15. The MAD physician and why he is a constant danger to your patients and your institution. Ethical management of the abusive physician in the operating room. Washington Ambulatory Surgery Association 2019 Conference. November 2019, Everett WA.

16. Would You Like Some Fish with Your Propofol? Reducing environmental contamination from the Operating Room. Washington Ambulatory Surgery Association Conference, November 2021

17. Off-Label Marketing of Drugs. Washington Ambulatory Surgery Association Conference, November 2024

Invited Journal Reviews:

1. Invited Journal Reviewer, cardiovascular anesthesia, *Anesthesia and Analgesia,* 1998 to present.
2. Invited Journal Reviewer, medical ethics, *Anesthesiology*, 1998 to present.
3. Invited Journal Reviewer, medical ethics, *Journal of Obstetrics and Gynecology*, 1998.
4. Clinical Reviewer, *FirstConsult*. Medical website for primary care physicians, Elsevier publications, London UK. *[www.firstconsult.com]* ,1998 to present.
5. Invited Journal Reviewer, medical ethics, *Mayo Clinic Proceedings*, 2006-2009.
6. Invited Journal Reviewer, *Journal of Philosophy, Ethics, and Humanities*, 2007.
7. Invited Journal Reviewer, *European Journal of Anaesthesiology,* 2013
8. Invited Journal Reviewer, *PLos One,* 2021

Web Authorships

1. Update Author, *Anesthesia, 6th Edition,* on-line version. Ron Miller MD, Editor. Elsevier Scientific Publications, Philadelphia. *[www.anesthesiatext.com]* 2004 to present.

2. Update Author, *Sleisinger and Fordtran's Gastrointestinal and Liver Disease, 7th Edition,* on-line version. Mark Feldman MD, Editor. Elsevier Scientific Publications, Philadelphia *[www.sfgastro.com],* 2003 to 2006.

3. Update Author, *Diseases of the Heart, 6th Edition,* on-line version. Eugene Braunwald MD, Editor. Elsevier Publications, Philadelphia [*www.branwalds.com],* 2004 to present.

4. Update Author, *Murray and Nadel's Textbook of Respiratory Medicine,* on-line version. Robert J. Mason MD, John F. Murray MD, V. Courtney Broaddus MD, and Jay A Nadel MD, editors. Elsevier publications, Philadelphia *[www.respmedtext.com],* 2005-2006.

5. Update Author, *Drugs for the Heart,* on-line version. Lionel H Opie MD and Bernard J Gersh MD, editors. Elsevier publications, Philadelphia *[www.opiedurgs.com],* 2005 to present.

6. Update Author, *Clinical Gastroenterology and Hepatology,* on-line version, Wilfred M Weinstein MD, C J Hawkey MD, J Bosch MD, editors. Elsevier publications, Philadelphia *[www.clingastrotext.com],* 2005-2006

7. Medifile Author for *FirstConsult*, Medical website for primary care physicians. Elsevier publications, London UK *[www.firstconsult.com],* 1998 to 2006

8. Medical Writer, *Procedures Consult*, Anesthesia Procedures. Elsevier publications, Philadelphia, PA. 2007-2008

9. Review and update Procedures Consult for Anesthesia, Surgical, Cardiovascular, and Primary Care Procedures. Elsevier publications, Philadelphia PA. 2020-2021

10. Review and update Procedures Consult for Anesthesia, Surgical, Cardiovascular, Orthopedic, and Primary Care Procedures. Elsevier publications, Philadelphia PA. 2023

Broadcasts, Media interviews

Oct 26, 2022	FDA: is there something rotten here? *Calling Bullshit*. Available at: https://www.callingbullshitpodcast.com/is-there-something-rotten-fda/
Jan 2023	Interview for Xtalks. Kovacevic V. Decentralized Clinical Trials.
Feb 2023	Interview for Medical Ethics Advisor. Kusterbeck S. Court case centers on physician autonomy if patients request ineffective treatments. Published Feb 2023, vol 39(2):17-32
July 2023	Ready, T. Off-Label Meds: Promising Long-COVID Treatments? Medscape Anesthesiology. July 24, 2023.

Miscellaneous:

Consulting Anesthesiologist, Woodland Park Zoological Society, 1992-2002.
Medical writer Handbook for Stoelting's Anesthesia and Co-Existing Disease, 3rd Edition 2009
Content/formatting editor, Journal of American College of Cardiology 2015-2020
Medical Writer, Journal of American College of Cardiology 2016-present

Updated, January 2025

Appendix II:

Gail A. Van Norman MD
Expert Witness Deposition or Testimony During the Last 4 Years (2021-2025):

1. **2021:** Expert regarding the effects of lethal injection drugs on prisoners undergoing judicial execution. **Roane, et al. v Barr.** Declaration and testimony before the Washington DC Federal Court of Appeals, January 2021. Case decided **in favor** of the prisoners. Overturned by U.S. Supreme Court without hearing.
2. **2021:** Expert testimony for **Kim v. Washington State Medical Commission**. Testimony in favor of defendant. Ethics of physician requests and use of patients, employees, models, social partners and others for educational physical examination. Case decided in favor of defendant.
3. **2022: King v. Parker, et al.** State of Tennessee lethal injection protocol. Deposition only.
4. **2022: Glossip v. Chandler.** State of Oklahoma lethal injection protocol. **For plaintiffs.** Deposition and court testimony. Case decided in favor of defendants.
5. **2022: The State of Texas, ex rel. Health Choice Advisory LLC vs. Shire PLC; Baxter International Inc; Baxalta Inc; and Viropharma Inc.** Ethical issues in off-label marketing. **For plaintiffs.** Deposition. Case settled.
6. **2023: Mosher N v. PeaceHealth.** Ethical issues of patient-doctor relationship. **For the plaintiff. Deposition scheduled** July 2024. Case settled.

Appendix III

Names of Prisoners Whose Autopsy Reports Were Reviewed Following Lethal Injection Execution with Single-Drug Barbiturate

1. Daniel Wayne Cook. Executed in Arizona August 8, 2012 using single-drug pentobarbital, 5 gm
2. Thomas Arnold Kemp. Executed in Arizona April 25, 2012 using single-drug pentobarbital, 5 gm
3. Samuel Villegas Lopez. Executed in Arizona June 27, 2012, using single-drug pentobarbital, 5 gm
4. Robert Henry Moorman. Executed in Arizona February 29, 2012, using single-drug pentobarbital, 5 gm
5. Robert Charles Towry. Executed in Arizona March 8, 2012, using single-drug pentobarbital, 5 gm
6. Thomas Paul West. Executed in Arizona July 19, 2011, using 3-drug protocol with pentobarbital, 5 gm
7. Donald Edward Beaty. Executed in Arizona May 25, 2011, using 3-drug protocol with thiopental, 5 gm
8. Richard Lynn Bible. Executed in Arizona June 30, 2011, using 3-drug protocol with thiopental, 5 gm
9. Marshall Gore. Executed in Florida October 1, 2013, using 3-drug protocol with pentobarbital, 5 gm
10. Joshua Daniel Bishop. Executed in Georgia March 31, 2016 using single-drug protocol with pentobarbital, 5 gm
11. Robert Earl Butts Jr. Executed in Georgia May 4, 2018, using single-drug protocol with pentobarbital, 5 gm
12. Roy W. Blankenship. Executed in Georgia June 23, 2011, using single-drug protocol with pentobarbital, 5 gm
13. Andrew Howard Brannan. Executed in Georgia Jan 15, 2015, using single-drug protocol with pentobarbital, 5 gm
14. John Conner. Executed in Georgia July 15, 2016 using single-drug protocol with pentobarbital, 5 gm
15. Andrew Cook. Executed in Georgia February 21, 2013 using single-drug protocol with pentobarbital, 5 gm
16. Kenneth E. Fults. Executed in Georgia April 12, 2016 using single-drug protocol with pentobarbital, 5 gm
17. Kelly Renee Gissendaner. Executed in Georgia September 20, 2015 using single-drug protocol with pentobarbital, 5 gm
18. Warren Lee Hill Jr. Executed in Georgia January 27, 2015 using single-drug protocol with pentobarbital, 5 gm
19. Travis Hitson. Executed in Georgia February 17, 2016 using single-drug protocol with pentobarbital, 5 gm
20. Robert Wayne Holsey. Executed in Georgia December 9, 2014 using single-drug protocol with pentobarbital, 5 gm

21. Marcus Ray Johnson. Executed in Georgia November 19, 2015 using single-drug protocol with pentobarbital, 5 gm
22. Brandon A. Jones. Executed in Georgia February 3, 2016 using single-drug protocol with pentobarbital, 5 gm
23. Danieal Anthony Lucas. Executed in Georgia April 27, 2016 using single-drug protocol with pentobarbital, 5 gm
24. Bryan Terrell. Executed in Georgia December 9, 2015 using single-drug protocol with pentobarbital, 5 gm
25. Marcus Wellons. Executed in Georgia June 17, 2014 using single-drug protocol with pentobarbital, 5 gm
26. Michael Wilson. Executed in Oklahoma January 9, 2014 using a 3-drug protocol with pentobarbital, 5 gm
27. Llyod Lafevers. Executed in Oklahoma January 30, 2001 using a 3-drug protocol with thiopental, 5 gm
28. Marion Bowman, Executed in South Carolina January 31, 2025, using a single drug protocol with pentobarbital.

FILED
07/10/2026
Clerk of the
Appellate Courts

IN THE SUPREME COURT OF TENNESSEE
AT NASHVILLE

STATE OF TENNESSEE v. CHRISTA GAIL PIKE

Criminal Court for Knox County
No. 58183A

No. M2020-01156-SC-DPE-DD

ORDER

Christa Gail Pike, a death-row inmate scheduled for execution on September 30, 2026, has filed a "Motion and Request to Appoint a Special Master Pursuant to Tenn. Sup. Ct. R. 12(4)(E)."[1] In her motion, Ms. Pike asserts facial and as-applied challenges to Tennessee's current lethal injection protocol and requests the appointment of a special master "to develop the facts to support these claims." Ms. Pike also contends that Tennessee Supreme Court Rule 12(4)(E) is unconstitutional and otherwise unlawful and requests that the Court reconsider and amend the rule. The State filed a response in opposition.

As this Court clarified in a previous order, a motion under Rule 12(4)(E) must "incorporate [a] . . . motion for a stay of execution." Order, *Pike v. Skrmetti*, No. M2026-00667-SC-UNK-CV (May 12, 2026). Ms. Pike's motion does not expressly request a stay of her execution. But because the motion asks this Court to permanently enjoin state officials from carrying out her execution pursuant to the current lethal injection protocol, in the interest of judicial economy we will construe her motion as requesting a stay of execution.

Upon due consideration, the Court appoints a special master under the conditions set forth below:

(1) The Honorable Mark Ward, Senior Judge, is hereby appointed as

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[1] This Court's execution order was entered under case number M2020-01156-SC-DPE-DD. Ms. Pike mistakenly filed this motion in *Pike v. State*, No. M2026-00667-SC-UNK-CV, which concerns a Davidson County Chancery Court proceeding challenging the constitutionality of Tennessee's lethal injection protocol. Despite the error, we dispose of her application under the correct case number, and we order that all future filings related to this application shall be directed to this case number.

Special Master to conduct an evidentiary hearing and any other additional hearings the Special Master deems appropriate on the matters specifically referred by this order;

(2) The Special Master, pursuant to Rule 53 of the Tennessee Rules of Civil Procedure, is hereby directed to receive evidence and fix the time and place for beginning and closing the hearings on the issues referred by this order;

(3) The Special Master shall have and exercise such other powers as are appropriate and applicable under Rule 53 of the Tennessee Rules of Civil Procedure;

(4) Upon completion of the hearing, the Special Master shall transmit to this Court the record of the proceedings and the Special Master's report of findings of fact and conclusions of law not later than August 21, 2026;

(5) Any objections to the Special Master's report shall be filed within five days of the filing of the report but no later than August 28, 2026; and

(6) The clerk of the trial court shall make all necessary accommodations required by the Special Master, including making a courtroom available for hearings.

The Court refers the following specific issues to the Special Master:

(1) Given Ms. Pike's diagnosis of thrombocytosis, whether achieving peripheral IV access pursuant to the current lethal injection protocol would make it "*sure or very likely*" that the challenged protocol will "cause [Ms. Pike] serious illness and needless suffering," *see Baze v. Rees*, 553 U.S. 35, 50 (2008) (plurality opinion) (quoting *Helling v. McKinney*, 509 U.S. 25, 33 (1993));

(2) Given Ms. Pike's cited history of sexual assault and asserted diagnosis of Post Traumatic Stress Disorder ("PTSD"), whether the movement of Ms. Pike to Riverbend Maximum Security Prison before the execution, where she would be observed by male prison officials for two weeks prior to the execution, would make it "sure or very likely" that the challenged protocol will "cause [Ms. Pike] serious illness and needless suffering," *see id.*;

(3) Given Ms. Pike's allegedly small and compromised veins, whether achieving peripheral IV access pursuant to the current lethal injection protocol would make it "sure or very likely" that the challenged protocol will

"cause [Ms. Pike] serious illness and needless suffering," *see id*.;

(4) Whether Ms. Pike's proposed alternative methods of execution would "significantly reduce a substantial risk of severe pain," *id.* at 52; and

(5) Whether TDOC is required to permit or would be willing to permit Ms. Pike to have a clergy member or spiritual advisor in the execution chamber during her execution.

Issues not specifically referred to the Special Master are hereby held in abeyance pending completion of the Special Master's report. The Court will set a briefing schedule on those issues upon receipt of the Special Master's report.

Ms. Pike's motion also raises challenges to Tennessee Supreme Court Rule 12(4)(E). Those challenges do not require factual development and can be decided based on the parties' briefs. Additional briefing regarding Ms. Pike's challenges to Rule 12(4)(E) may be filed by no later than July 17, 2026.

PER CURIAM

Kyle A. Hixson, J., not participating.

FILED
12/05/2025
Clerk of the
Appellate Courts

IN THE SUPREME COURT OF TENNESSEE
AT NASHVILLE

IN RE: AMENDMENT OF TENNESSEE SUPREME COURT RULE 12.4(E)

No. ADM2025-01930

ORDER

Upon due consideration, the Court hereby amends Rule 12.4(E) of the Rules of the Tennessee Supreme Court in the form set out in the appendix to this Order. Rule 12.4(E), as amended by this Order, shall be effective upon the filing of this Order.

The Clerk shall provide a copy of this Order to LexisNexis and to Thomson Reuters. In addition, this Order shall be posted on the Tennessee Supreme Court's website.

PER CURIAM

APPENDIX

AMENDMENT TO TENN. SUP. CT. R. 12.4(E)

**[Deleted text is indicated by overstriking,
and new text is indicated by underlining.]**

Rule 12.4. Setting Execution Date at Conclusion of Standard Three-Tier Appeals Process

. . .

(E) Date of Execution/Stays and Reprieves.
Upon the grant of a State's motion to set an execution date, the Court shall set the date of execution no less than thirty (30) days from the date of the order granting the State's motion. Where the date set by the Court for execution has passed by reason of a stay or reprieve, this Court shall sua sponte set a new date of execution when the stay or reprieve is lifted or dissolved, and the State shall not be required to file a new motion to set an execution date. In the latter event, any new date of execution shall be no less than seven (7) days from the date of the order setting the new execution date.

After a date of execution is set, any state court collateral litigation that would potentially affect the method or timing of execution must commence with the filing of a motion in this Court. Any response to the motion must be filed within five (5) days of the motion, unless a different response time is ordered by the Court. If the collateral litigation may involve fact-finding, the moving party must request the appointment of a special master, consistent with the procedures outlined in Tennessee Rule of Civil Procedure 53. Any response in opposition to the motion for a special master must be filed within five (5) days of the motion, unless a different response time is ordered by the Court. If the Court grants the motion for a special master, the Court may appoint a special master, consistent with the procedures outlined in Rule 53. Any objection to the findings of the special master shall be by motion filed in this Court not later than five (5) days after being served with notice of the filing of the report, unless a different response time is ordered by the Court.

After a date of execution is set, the Court will not grant a stay or delay of an execution date pending resolution of collateral litigation in federal court. Likewise, the Court will not grant a stay or delay of an execution date pending resolution of collateral litigation in state court unless the prisoner can prove a likelihood of success on the merits in that litigation.

The State Attorney General shall provide a copy of any judicial or executive order staying the execution or granting a reprieve to the Office of the Clerk of the Appellate Courts in Nashville. The Clerk shall expeditiously furnish a copy of the order to the Warden of the Riverbend Maximum Security Institution. In addition, the State Attorney General shall expeditiously provide a copy of any judicial or executive order lifting or dissolving the stay or reprieve to the Office of the Appellate Court Clerk in Nashville.

[As amended by order filed November 25, 1987; by order filed June 1, 1992; by order filed October 2, 1996; by order filed October 29, 1997; by order filed May 27, 1999; by order filed October 27, 2000; by order filed March 5, 2003; and by order filed December 20, 2013, effective January 1, 2014; and by order filed March 25, 2015 effective July 1, 2015].

Explanatory Comment:

Section 4(E) was amended to set forth the procedures for state court collateral litigation potentially affecting the method or timing of execution that is filed after a date of execution is set.