*** CAPITAL CASE ***

No. _____

IN THE

Supreme Court of the United States

JESSE GUARDADO,

Petitioner,

v.

RICHARD COMERFORD, SECRETARY,
FLORIDA DEPARTMENT OF CORRECTIONS, ET AL.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

EXECUTION SCHEDULED FOR NOVEMBER 5, 2026, AT 6:00 P.M.

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Eleventh Circuit Order

Denying Motion for Stay of Execution

November 2, 2026

In the

United States Court of Appeals

For the Eleventh Circuit

No. 26-14027

JESSE GUARDADO,

Plaintiff-Appellant,

versus

SECRETARY, DEPARTMENT OF CORRECTIONS,
WARDEN, FLORIDA STATE PRISON,

Defendants-Appellees.

Appeal from the United States District Court
for the Middle District of Florida
D.C. Docket No. 3:26-cv-02596-MMH-SJH

Before WILLIAM PRYOR, Chief Judge, and JILL PRYOR and LUCK, Circuit Judges.

BY THE COURT:

On September 13, 2004, while he was on conditional release from an earlier stint in prison for armed robbery, Jesse Guardado beat Jackie Malone with a breaker bar and stabbed her with a knife, again and again and again, until she was dead so he could rob her

and buy crack with the loot he stole. *Guardado v. Sec'y, Fla. Dep't of Corr.*, 112 F.4th 958, 962–63 (11th Cir. 2024), *cert. denied*, 145 S. Ct. 2822 (2025). Guardado's guilt was never in doubt. He confessed and pleaded guilty. *Id.* at 963–64.

After a penalty phase, the state trial court, following the jury's unanimous recommendation, sentenced Guardado to death. *Id.* at 964–73. His direct appeals were denied. *See Guardado v. State*, 965 So. 2d 108 (Fla. 2007), *cert. denied*, 552 U.S. 1197 (2008). And his state and federal postconviction challenges were also rejected. *See Guardado v. State*, 176 So. 3d 886 (Fla. 2015); *Guardado v. State*, 238 So. 3d 162 (Fla. 2018); *Guardado*, 112 F.4th at 995; *Guardado v. State*, —So. 3d—, 2026 WL 3267707 (Fla. Oct. 29, 2026).

More than twenty years after his death sentence, and on the cusp of his execution on November 5, 2026, Guardado sued the Secretary of the Florida Department of Corrections and the Warden of Florida State Prison under 42 U.S.C. section 1983, claiming that the method the state will use to execute him violates his Eighth Amendment right to be free from cruel and unusual punishment. The state's lethal-injection protocol, Guardado alleged, is supposed to be administered in three stages. First comes a large dose of etomidate, which is a sedative that renders the prisoner unconscious and insensate to pain. Next is rocuronium bromide, which is a paralytic agent that keeps the prisoner from moving. The last drug is potassium acetate, which causes cardiac arrest.

Guardado alleged that, in one of five ways, there's a substantial risk the state will fail to administer properly this lethal-injection

protocol: (1) the state will not use etomidate during the execution; (2) the state will use an insufficient amount of etomidate; (3) the state will use an expired dose of etomidate; (4) the state will use insufficient doses of the other two drugs; and (5) the state will use drugs that are not part of the protocol. As a result, Guardado alleged that there's a substantial risk he will consciously suffocate during the execution, which would be cruel and unusual under the Eighth Amendment. Along with his complaint, Guardado moved to stay his execution while his method-of-execution claim was pending.

The district court ordered limited discovery on the expired etomidate issue and held an evidentiary hearing on the stay motion. After the hearing, the court denied the motion because Guardado was not likely to succeed on the merits of his Eighth Amendment method-of-execution claim. "His concern regarding the potential use or future use of expired etomidate" was "not supported by the evidence," the district court explained. "And his various other concerns [were] far too speculative to support a finding that [the state's] planned execution protocol present[ed] a risk that [was] sure or very likely to cause serious illness or needless suffering."

Guardado has appealed the denial of his stay motion. And he has moved for a stay of execution pending his appeal. We take up that motion now.

I.

"To obtain a stay of his execution pending appeal," Guardado "must show that '(1) he has a substantial likelihood of success on the merits' of his appeal, '(2) he will suffer irreparable injury unless the injunction issues; (3) the stay would not substantially harm the other litigant; and (4) if issued, the injunction would not be adverse to the public interest.'" *See Humphreys v. Comm'r, Ga. Dep't of Corr.*, 161 F.4th 1300, 1306 (11th Cir. 2025) (quoting *James v. Sec'y, Dep't of Corr.*, 130 F.4th 1291, 1295 (11th Cir. 2025)). We start with the first stay factor.

II.

"A death row inmate may attempt to show that a [s]tate's planned method of execution, either on its face or as applied to him, violates the Eighth Amendment's prohibition on 'cruel and unusual' punishment." *Nance v. Ward*, 142 S. Ct. 2215, 2219–20 (2022). "To succeed on that claim . . . he must satisfy two requirements." *Id.* at 2220. "First, he must establish that the [s]tate's method of execution presents a 'substantial risk of serious harm'—severe pain over and above death itself." *Id.* (quoting *Glossip v. Gross*, 576 U.S. 863, 877 (2015)). Second, "he 'must identify an alternative [method] that is feasible, readily implemented, and in fact significantly reduce[s]' the risk of harm involved." *Id.* (alterations in original) (quoting *Glossip*, 576 U.S. at 877).

A.

As to the first requirement, Guardado argues that there's a substantial risk the state will improperly apply its lethal-injection

protocol during his execution. This will happen in one of five ways, he says: (1) the state will not administer etomidate; (2) the state will not administer enough etomidate to render him unconscious; (3) the state will use expired etomidate; (4) the state will use insufficient dosages of the other two drugs in the protocol; and (5) the state will use unlisted drugs in addition to the three called for under the protocol. Misapplying the protocol, Guardado contends, will result in a substantial risk that he will consciously suffocate.

Guardado has not met his burden on the first method-of-execution requirement. As to each alleged misapplication, the district court found that there was no substantial likelihood that Guardado was "sure or very likely" to experience needless suffering. Having carefully reviewed the record, we believe these findings were not clearly erroneous. *See Brooks v. Warden*, 810 F.3d 812, 824 (11th Cir. 2016) (reviewing findings made by the district court in denying a stay of execution for clear error); *Grayson v. Allen*, 491 F.3d 1318, 1324–25 (11th Cir. 2007) (same).

1.

Guardado first contends the state will not use etomidate during his execution. In support, he points to the drug log entries for three prisoners—Thomas Gudinas, Michael Bell, and Edward Zakrzewski—showing no documented removal of etomidate from the state's pharmacy for their executions. From this, Guardado assumes that the three prisoners must not have been administered etomidate during their executions. And, he argues, there's a substantial risk the same will happen to him.

But Guardado's assumption is off. The district court found that the three prisoners did receive etomidate during their executions and the drug log entries were merely recordkeeping errors. Its finding was well supported by the evidence. *See Grayson v. Comm'r, Ala. Dep't of Corr.*, 121 F.4th 894, 896 (11th Cir. 2024) (Under "clear error review," "a finding 'that is plausible in light of the full record—even if another is equally or more so—must govern.'" (quoting *Cooper v. Harris*, 581 U.S. 285, 293 (2017))). Agent Adam Graff, a state law enforcement officer who participated in Bell's execution, testified that etomidate was administered. And the post-execution toxicology reports for the three prisoners undisputably showed that they had etomidate in their blood after the executions. That could only have come from administration of etomidate during their executions. So, we know as a scientific fact that they received the first drug in the protocol.

2.

Next, Guardado asserts that the state will not give him enough etomidate to render him unconscious, which means there's a substantial risk he will consciously suffocate as the other two drugs are administered. He cites the post-execution toxicology reports of two prisoners—Bell and Samuel Smithers—which show a tenfold disparity in post-mortem etomidate levels between them. And he points to disparities (albeit much smaller) in the post-execution toxicology reports of other prisoners. Guardado contends that the lower blood levels show that the prisoners received less

etomidate than would be necessary to render them unconscious during their executions.

Guardado's contention assumes that the prisoners' post-mortem blood levels would have been similar to the etomidate in their blood at the time of their executions. Yet the science does not back up his assumption. As the district court observed, the etomidate level to render someone insensate and unconscious is measured based on plasma blood. But the toxicology reports Guardado relies on measured "whole blood," which is "'absolutely not' a one-to-one measurement." The comparison fails out of the gate.

And as the district court further found, post-mortem blood levels don't tell us much about the drug levels at the time of the execution because, even after death, drugs redistribute and metabolize in the body, which impacts toxicology blood levels that are taken hours later. The record evidence supports this finding. Guardado's medical expert conceded that "[p]ost[-]mortem drug redistribution [*i.e.*, circulation] is well known, and post[-]mortem drug concentrations may be unreliable proxies for circulating blood levels while alive." And the state's medical expert explained that post-mortem readings do not reflect conditions during the execution because etomidate continues circulating and degrading in the blood for some period after death. Post-mortem etomidate levels also depend on individual prisoners' unique "physiological makeup," like their metabolisms, health conditions, and body compositions, making comparisons between individuals even more difficult.

3.

Guardado also maintains that the state will likely use expired etomidate during his execution. He relies on drug log entries showing that expired etomidate was used in six executions in 2025. Expired etomidate loses its potency, he explains, which creates a substantial risk that it will be ineffective to render him unconscious during the execution.

But the district court found these entries were also record-keeping errors, and the record supports this finding. The state's chief of pharmaceutical services, Dr. Renea Marcano, testified that the 2025 expiration dates on the logs were mistaken. The expiration dates should have been listed as January 2027 because that is when the etomidate will actually expire. Two law enforcement officers, Agent Graff and Agent Kevin James, saw the vials of etomidate before they were administered in five of the six executions and the agents confirmed that they were not expired. And the state's receipts and lot numbers for its stock of etomidate showed that the etomidate used in the six executions had an expiration date of January 2027. In fact, the state never had etomidate with a January 31, 2025 expiration date, as the mistaken entries had shown.

As to Guardado's execution, specifically, Dr. Marcano averred that she had set aside the proper dose of etomidate, and the

expiration date was January 2027. So, there is no substantial likelihood that the state will use expired etomidate for his execution.[1]

4.

Additionally, Guardado contends that there's a substantial risk he will not receive proper doses of the other two drugs in the lethal-injection protocol. In support, he highlights the drug log entries showing the doses of rocuronium bromide and potassium acetate withdrawn for the executions of two prisoners—Anthony Wainwright and Gudinas—were less than the amount required by the protocol.

But as the district court found, there was no substantial risk of serious harm to Guardado from the lower doses of the other two drugs because the etomidate would render him insensate during his execution. He would never know he received less of the other two drugs than he was supposed to because he would be deeply unconscious (based on the amount of etomidate the prisoner is given under the protocol).

Guardado speculates that "an insufficient dosage of one drug could lead to unnecessary suffering from another," but there's no evidence in the record to support his speculation. And even if there were evidence to support it, Guardado has to show a substantial

[1] The district court also found that, at best for Guardado, expired etomidate has only the "potential" to degrade, which was insufficient to show a substantial risk of serious harm. Guardado does not address this finding in his stay motion.

risk of serious harm. *See Glossip*, 576 U.S. at 877. Could is not enough.

5.

Finally, Guardado argues that there's a substantial risk the state will use lidocaine (a drug not listed in the protocol) during his execution, in addition to the other three drugs in the protocol. He draws this inference from the state's drug logs, which show that lidocaine was removed from the pharmacy and taken to the prison where the state conducts the executions.

But as the district court found, Guardado "fail[ed] to present evidence to support th[e] notion" that the state's "rare use of lidocaine" would "cause needless suffering." Dr. Marcano testified that lidocaine is used only if the state needs to get access to a prisoner's vein through a cutdown procedure as outlined in the lethal-injection protocol. The lidocaine, which is a local anesthetic, is on the medical cart in the execution chamber in case the cutdown happens.

But the state has not "done a cutdown in a long time." And Agent Graff testified that in all the thirteen executions he's witnessed, he had never seen lidocaine used in an execution. There is no evidence—and Guardado does not argue—that he will need a cutdown procedure for his execution. So, there is no substantial likelihood that lidocaine will be used on him. In any event, while Guardado's expert witnesses testified that using lidocaine "could" lead to seizures and other life-threatening conditions, the unspecified chance that lidocaine could cause a problem for some prisoners

is not enough to show a substantial risk of that result as required under the Eighth Amendment. Guardado has not shown a substantial likelihood of success on the first requirement of his method-of-execution claim.

B.

And his stay motion is silent on the second requirement. To obtain a stay on a method-of-execution claim, Guardado has the burden to show a substantial likelihood that there's a feasible, readily implemented, alternative method-of-execution that will significantly reduce the substantial risk of serious harm from the maladministration of the lethal-injection protocol. *See Nance*, 142 S. Ct. at 2220. Guardado submitted a firing squad as his preferred alternative below. But his stay motion doesn't mention anything about a feasible and readily implemented alternative method of execution. Not once. Nor does it explain why his failure to proffer an alternative is excusable. This failure to address a necessary element of his claim is fatal to a stay.

C.

While he doesn't mention the second requirement of his method-of-execution claim, Guardado does make an additional argument for why he's entitled to a stay. The district court, he contends, curtailed the discovery process and held a compressed evidentiary hearing, which made it hard to carry his burden.

But "[a] district court has wide discretion in discovery matters and our review is accordingly deferential." *Arthur v. Comm'r, Ala. Dep't of Corr.*, 840 F.3d 1268, 1304 (11th Cir. 2016) (quoting

Bradley v. King, 556 F.3d 1225, 1229 (11th Cir. 2009)). "[A] district court's denial of additional discovery must result in substantial harm to a party's case in order to establish an abuse of discretion." *Id.* (quoting *Bradley*, 556 F.3d at 1229).

There is no substantial harm here. The district court allowed limited discovery on the state's use of expired etomidate, requiring the state to turn over updated drug logs showing drug names, withdrawal dates, and expiration dates through the present. And even before that order, the state had already filed as exhibits state execution checklists and autopsy/toxicology reports for a number of prisoners, and had filed a list of expert and fact witnesses who would speak to execution protocol and pharmaceutical recordkeeping. The district court later ordered the state to submit for in camera review unredacted drug logs showing the lot and invoice numbers from when the state purchased the etomidate. And it held an evidentiary hearing where Guardado had the opportunity to present the testimony of two expert witnesses and to cross-examine the state's expert and fact witnesses.

Other than arguing that his "claim necessitated further discovery and inquiry into [the state's] practices," Guardado does not detail the substantial harm he suffered from the district court's discovery rulings.[2] "Considering the district court's broad discretion,

[2] In his reply in support of the stay motion, Guardado reiterates that he "learned additional new facts that . . . called for further development." But other than referencing the use of lidocaine—which he already knew about and

we cannot say its decision about discovery resulted in substantial harm to [Guardado's] case." *See id.* at 1305 (citation modified).

III.

The other factors also weigh against staying Guardado's execution. "[B]efore granting a stay of execution, a court must 'consider not only the likelihood of success on the merits . . . but also the extent to which the inmate has delayed unnecessarily in bringing the claim." *Long v. Sec'y, Dep't of Corr.*, 924 F.3d 1171, 1176 (11th Cir. 2019) (quoting *Nelson v. Campbell*, 541 U.S. 637, 649–50 (2004)). "There is 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.'" *Id.* (quoting *Nelson*, 541 U.S. at 650).

Here, Guardado could have raised his method-of-execution claim at least nine months earlier when Frank Walls brought a similar Eighth Amendment claim based on some of the same records that Guardado relies on.[3] He could have raised his claim eight

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was alleged in his complaint—he doesn't explain what the further development would show.

[3] In his reply, Guardado argues that he filed his method-of-execution claim "at the earliest opportunity, just weeks after he became warrant-eligible." But Guardado is mistaken. In Florida, a prisoner sentenced to death is "warrant-eligible" after initial state and federal postconviction proceedings are completed. *Cf. Silvia v. State*, 228 So. 3d 1144, 1146 (Fla. 2013) ("The transcript further reflects that Silvia understood that if the court granted his request to discharge his attorneys and waive postconviction proceedings, he would become warrant-eligible—that is, the governor could sign a warrant for his execution."); *Jones v. State*, 419 So. 3d 619, 625–26 (Fla. 2025) ("[T]he Clerk of this

months earlier when Ronald Heath brought a similar method-of-execution claim in state court based on similar evidence. *See Heath v. State*, 426 So. 3d 1253, 1261–62 (Fla. 2026) (describing similar claim). And he could have raised his claim seven months earlier when Melvin Trotter brought a similar claim in state court based on similar evidence. *See Trotter v. State*, 428 So. 3d 68, 71–73 (Fla. 2026) (describing a similar claim). Instead, Guardado delayed more than half-a-year before raising his method-of-execution claim.

"We have refused to grant stays in cases involving delayed filings before, and [Guardado's] delay was even more pronounced and less justifiable." *See Long*, 924 F.3d at 1178 (citing *Brooks*, 810 F.3d at 826; *In re Hutcherson*, 468 F.3d 747, 749–50 (11th Cir. 2006); *Diaz v. McDonough*, 472 F.3d 849, 851 (11th Cir. 2006); *Jones v. Allen*, 485 F.3d 635, 640 (11th Cir. 2007)). We refuse to do so here as well.

Guardado argues that we shouldn't refuse because the state didn't move forward with the execution warrant until after he filed his claim. But pointing to when the state issued the warrant

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Court certified to the Governor on October 4, 2013, that Jones had completed his direct appeal and initial postconviction proceedings in state court and his habeas corpus proceedings and appeal therefrom in federal court. Thus, in addition to the thirty-two years of notice since the imposition of his death sentences, Jones has been on notice for nearly twelve years that he is 'warrant-eligible,' meaning 'the [G]overnor could sign a warrant for his execution.'" (citation modified)). Guardado became warrant-eligible in 2025 when the Supreme Court denied certiorari review in his federal postconviction appeal. *See Guardado*, 145 S. Ct. at 2822. In any event, the accrual of Guardado's method-of-execution claim—which is when he could have brought his claim—is not the same as his warrant-eligibility.

doesn't answer or explain why he delayed nine months to bring his claim. Because he offers no explanation, we should apply the strong equitable presumption against granting the stay.

"The remainder of the factors we apply when considering a stay amount to a weighing of the equitable interests of [Guardado], the [state], and the public." *See Ray v. Comm'r, Ala. Dep't of Corr.*, 915 F.3d 689, 701 (11th Cir. 2019). On the state and the public's side of the scale, "the Supreme Court has recognized [that] the state, the victim, and the victim's family . . . 'have an important interest in the timely enforcement of [Guardado's] sentence.'" *See Brooks*, 810 F.3d at 825 (quoting *Hill v. McDonough*, 547 U.S. 573, 584 (2006)). "[E]quity must be sensitive to the [s]tate's strong interest in enforcing its criminal judgments without undue interference from the federal courts." *Hill*, 547 U.S. at 584. For that reason, "we have rejected the argument that" a prisoner "will suffer irreparable harm if he is executed, whereas the state will only suffer a minimal inconvenience, because the state, the victim, and the victim's family also have an important interest in the timely enforcement of [the prisoner's] sentence." *Bowles v. DeSantis*, 934 F.3d 1230, 1247–48 (11th Cir. 2019) (citation modified).

IV.

Because Guardado has not shown a substantial likelihood that he will prevail in his appeal, and the other equitable factors

caution against granting a stay, we DENY his motion for a stay of execution.[4]

MOTION DENIED.

[4] We GRANT Guardado's motion to proceed in forma pauperis.

JILL PRYOR, Circuit Judge, Concurring:

So far this year, Florida has executed eighteen prisoners. Later this week, it plans to execute Jesse Guardado. It plans to carry out his execution using the same protocol it used for its other executions this year. During the execution, Florida will administer to Mr. Guardado three drugs: etomidate (a sedative), rocuronium bromide (a paralytic agent), and potassium acetate (which causes cardiac arrest).

Before Florida obtained a warrant to execute Mr. Guardado, he filed a lawsuit in federal court making a constitutional challenge to his execution. The primary basis for his method-of-execution challenge was his claim that Florida had used expired etomidate in earlier executions and would use the expired drug for his execution, which would result in him being awake and aware during the administration of the other two drugs.

The basis for Guardado's troubling allegations was, at least in part, inventory records from the Florida Department of Corrections. The Department's Chief of Pharmacy Services oversees the storage of the drugs used in executions and maintains logs concerning the storage of each drug. When the Department acquires a supply of one of the drugs, it records on a log the date it acquired the drug, the vendor who provided the drug, the lot number of the drug, the expiration date of the drug, and the quantity of the drug. The log is also supposed to reflect each time the Department uses any of its inventory of a drug, such as when it carries out an execution. It is undisputed that the logs the Department maintained

showed that Florida had used expired etomidate in several previous executions and, for three more executions, included no entries showing that it had used any etomidate at all.

After discovery and an evidentiary hearing on Mr. Guardado's claim, the district court found that the Department was not using expired etomidate or failing to administer the drug at all. Based on its findings of fact, the district court correctly concluded that Mr. Guardado has not shown a substantial likelihood of success on the merits of his method-of-execution claim. I agree with the majority that based on the district court's fact findings, which are not clearly erroneous, Mr. Guardado is not entitled to a stay of his execution. Accordingly, I join parts I, II.A, II.C, and IV of the Court's order.[1]

Still, this case has brought to light concerning facts about the Florida Department of Corrections' failure to maintain accurate records for drugs used in its executions. We now know that the Department of Corrections was not taking care to ensure that its logs contained accurate information. Testimony from the evidentiary hearing showed that the person preparing the logs improperly recorded the expiration date of the etomidate because English was not his first language, and he did not understand that the log was requesting the expiration date for the drug, not the current year.

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[1] I do not join parts II.B or III, which address whether Mr. Guardado has shown a feasible alternative method of execution and whether factors other than substantial likelihood of success on the merits support a stay, respectively. It is unnecessary to address these issues to decide the appeal before us.

But even more concerning is Florida's response once it learned during litigation about the errors in its drug log. When the Department realized that its logs contained inaccurate information about drug expiration dates, its solution was to use Wite-Out liquid eraser to alter the logs. It did not make any attempt to document either in the log or elsewhere that a change had been made to the log, when the change was made, who made the change, or why the change had been made. The evidence in this case shows that these types of untraceable edits to a log tracking the storage of a drug is "completely inappropriate" and indeed "invalidates the point[] of the records," which should be a contemporaneous record of each drug that was acquired and used. Doc. 54 at 30, 41.[2]

Although the recordkeeping failures in this case do not rise to the level of a constitutional tort, the State's lack of transparency and failure to maintain accurate records is deeply concerning. It would be troubling if a State pharmacy failed to adequately track the storage of drugs in its possession. But, here, the failure occurred with the storage of drugs used to carry out executions. In this context, a State must maintain accurate and thorough records of its practices to be able to demonstrate that it is carrying out executions according to its protocols and in compliance with the Constitution. As Justice Sotomayor recently emphasized in another Florida case, such records are needed to "instill[] confidence in the [execution] protocol for everyone—prisoners, the courts, and the public alike." *Trotter v. Florida*, 146 S. Ct. 755, 756 (2026)

[2] "Doc." numbers refer to the district court's docket entries.

(Sotomayor, J., statement respecting the denial of the application for stay of execution and denial of certiorari). And, as this case demonstrates, a State's failure to maintain accurate records will invariably lead to concerns and questions about whether the State is adhering to its protocol as well as the efficacy and constitutionality of that protocol.

One final note. Our conclusion today that Mr. Guardado is not entitled to a stay of execution should not in any way signal or suggest that we condone the Department of Corrections' failure to meet its basic responsibility to maintain accurate records.

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ELBERT PARR TUTTLE COURT OF APPEALS BUILDING
56 Forsyth Street, N.W.
Atlanta, Georgia 30303

David J. Smith
Clerk of Court

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November 02, 2026

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Appeal Number: 26-14027-P
Case Style: Jesse Guardado v. Secretary, Department of Corrections, et al
District Court Docket No: 3:26-cv-02596-MMH-SJH

The enclosed order has been ENTERED.

Electronic Filing
All counsel must file documents electronically using the Electronic Case Files ("ECF") system, unless exempted for good cause. Although not required, non-incarcerated pro se parties are permitted to use the ECF system by registering for an account at www.pacer.gov. Information and training materials related to electronic filing are available on the Court's website.

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MOT-2 Notice of Court Action

A2

District Court Order Denying Stay of

Execution and Emergency Injunction

October 30, 2026

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

JESSE GUARDADO,

Plaintiff,

v. Case No. 3:26-cv-2596-MMH-SJH

RICHARD COMERFORD, in his official capacity as the Secretary, Florida Department of Corrections, and RANDALL POLK, in his official capacity as the Warden of Florida State Prison,

Defendants.

ORDER

I. Status

Plaintiff, Jesse Guardado, a death row inmate of the Florida penal system, filed, through counsel on September 28, 2026, a Complaint under 42 U.S.C. § 1983 alleging, inter alia, that during executions carried out in 2025 and 2026 via Florida's lethal injection protocol, corrections officials used expired drugs, lower dosages of the drugs than required, and unauthorized drugs. See generally Doc. 1 (Complaint). As Defendants, Guardado names the Secretary of the Florida Department of Corrections (FDOC) (Richard Comerford) in his official capacity, and the Warden of Florida State Prison (Randall Polk) in his official capacity. Id. ¶¶ 10-12. On October 5, 2026, seven

days after Guardado filed his Complaint, Governor Ron DeSantis signed a death warrant to carry out the death sentence. The FDOC then scheduled Guardado's execution for November 5, 2026.

Before the Court is Guardado's "Emergency Motion for an Injunction Under the All Writs Act or, Alternatively, for a Stay of Execution." See Doc. 11 (Motion to Stay). Defendants filed a Response to the Motion to Stay. See Doc. 16 (Response Motion to Stay). And, with the Court's permission, Guardado filed a Reply. See Doc. 17 (Reply). On October 22, 2026, the Court conducted a limited evidentiary hearing on Guardado's Motion to Stay. See Doc. 52 (Minute Entry); Doc. 54 (E.H. Transcript). The parties filed their written closing arguments following the evidentiary hearing on October 26, 2026. See Docs. 57; 58. Guardado's Motion to Stay is ripe for review.

II. Guardado's Allegations

In the Complaint, Guardado alleges that FDOC's routine maladministration of critical phases of Florida's written lethal injection protocol renders it unconstitutional. See generally Complaint. According to Guardado, records and documents he recently obtained show that throughout the 34 executions that FDOC has carried out since February 2025, "corrections officials deviated from the protocol on numerous occasions, using expired drugs, lower dosages of the drugs than required, and unauthorized drugs." Id. ¶¶ 2-3. Guardado asserts that etomidate, the first drug administered in

Florida's lethal injection protocol, is known to have a "short duration of action," and the use of expired drugs exacerbates the chance that a prisoner will awaken before the administration of the paralytic second drug, rocuronium bromide. Id. ¶¶ 37, 41-42, 66. According to Guardado, "[a]bsent a ventilator, a conscious prisoner will be fully awake and aware as they experience a slow suffocation, struggling for air as the diaphragm becomes paralyzed." Id. ¶ 41. He also contends the prisoner will then, while paralyzed and suffocating, experience the well-known intense burning, pain, and irritation of the third drug, potassium acetate. Id. ¶¶ 43-45.

Guardado also asserts that "etomidate is known to cause pulmonary edema," because its acidic properties burn and cause the lungs to "fill with blood as the heart continues to circulate blood." Id. ¶¶ 49-50. He contends the presence of such lung injuries and documentation of prisoners "gasping" and breathing heavily during an execution is "death by choking and drowning in one's own blood." Id. ¶¶ 63-64. And he notes that the Eleventh Circuit recently found one-to-three minutes of conscious suffocation violates the Eighth Amendment. Id. ¶ 42. (citing Lee v. Comm'r, Ala. Dep't of Corr., No. 26-11864, 2026 WL 1651147 (11th Cir. June 8, 2026)). Guardado acknowledges that while pulmonary edema is a known side effect of FDOC's protocol, his claim here "is distinguishable because he provides evidence of the high likelihood of the

administration of an expired sedative and resultant awareness" of experiencing that pulmonary edema. Id. ¶ 86.

In support of his allegations, Guardado provides redacted FDOC drug inventory logs (Doc. 1-5; Redacted FDOC Drug Logs), that, according to Guardado, show FDOC used etomidate that expired on January 31, 2025, during the August 19, 2025 execution of Kayle Bates; the August 28, 2025 execution of Curtis Windom; the September 17, 2025 execution of David Pittman; and the September 30, 2025 execution of Victor Jones. Id. ¶ 23; see also Redacted FDOC Drug Log at 25.[1] Guardado also provides the toxicology reports for Michael Bell and Samuel Smithers (Doc. 1-8; Toxicology Reports); eleven autopsy reports (Doc. 1-9; Autopsy Reports); the written expert Declaration of Dr. Michaela Almgren (Doc. 1-6; Almgren Declaration); and the written expert Report of Dr. Joel Zivot (Doc. 1-7; Zivot Report).

According to the Declaration of Dr. Almgren, the expiration date of a drug "represents the point beyond which the manufacturer no longer guarantees that the product will continue to meet its established specifications for potency, purity, and quality." Almgren Declaration at 12. She explains that "[e]xpiration dates are established [ ] based on extensive stability studies, and products used beyond their expiration dates may no longer meet established

[1] For purposes of reference to documents in the Court record, the Court will cite the document page numbers assigned by the Court's electronic docketing system.

quality specifications, including those for strength, purity, and other critical quality attributes." Id. And "[a]n expiration date established by the manufacturer cannot simply be extended through additional testing; extending the expiration date requires supporting stability studies conducted by the manufacturer in accordance with applicable regulatory requirements." Id. at 12-13. Dr. Almgren asserts that she reviewed the Redacted FDOC Drug Logs that Guardado had provided and found the logs for etomidate "identified 10 vials of etomidate that had expired on January 31, 2025, and were subsequently removed from inventory on each date corresponding to execution dates: August 19, 2025 (Kayle Bates), August 29, 2025 (Curtis Windom), September 17, 2025 (David Pittman), and September 30, 2025 (Victor Jones)" Id. at 11. According to Dr. Almgren, because no other etomidate vials were documented as being removed from inventory on those dates, "[th]e timing and quantity of these removals (10 vials for each execution) therefore appear consistent with the use of these vials in the respective executions." Id.

Similar to Dr. Almgren's assessment, in his unverified Report, Dr. Zivot states that Redacted FDOC Drug Logs "reflect that drugs were used beyond their expiration dates in the executions of Victor Jones, David Pittman, Curtis Windom, and Kayle Bates; [and] that doses were not consistently prepared and documented as the protocol specifies in the executions of Anthony Wainwright and Thomas Gudinas . . . ." Zivot Report at 4. Dr. Zivot also reviewed the

toxicology reports generated after the July 2025 execution of Michael Bell and the October 2025 execution of Samuel Smithers and found that the difference in their postmortem etomidate levels "raises concerns about the efficacy of the drug as administered." Id. at 10-11. According to Dr. Zivot's observations, "Samuel Smithers' postmortem etomidate level was 0.13 mcg/mL. For etomidate to maintain a hypnotic state, blood levels should be equal to or higher than 0.23 mcg/mL. Michael Bell's postmortem toxicology report documented an etomidate level ten times higher than Smithers'—1.3 mcg/mL." Id. at 11.[2] Dr. Zivot explains that while "[p]ostmortem drug redistribution is well known, and postmortem drug concentrations may be unreliable proxies for circulating blood levels while alive[,] this disparity does not support the conclusion that the protocol reliably delivers a consistent dose of etomidate to each prisoner." Id. He states that "[i]ndividual factors like BMI could plausibly account for some variation, but a tenfold difference, especially between men sedated under the same fixed-dose protocol, is difficult to explain by body composition alone." Id.

[2] Guardado's exhibits reflect that Bell was executed in July of 2025, see Toxicology Reports at 3, before the Redacted FDOC Drug Logs show Defendants had begun using expired etomidate, see Redacted FDOC Drug Logs at 26. And Smithers was executed in October of 2025, see Toxicology Reports at 5-6, after the Redacted FDOC Drug Logs show Defendants had been using expired etomidate, see Redacted FDOC Drug Logs at 26.

Based on these facts and evidence, Guardado contends Defendants' lethal injection protocol creates a substantial risk of severe pain and suffering in violation of his Eighth Amendment rights. Complaint ¶¶ 81-83. He submits that "the firing squad is a reasonable, readily available alternative to the current iteration . . . ." Id. ¶ 96. He asserts that states are now employing this alternative, and he proposes that FDOC could easily implement Utah's four-step firing squad procedure. Id. ¶¶ 99-101. As relief, he requests, inter alia, declaratory and injunctive relief preventing Defendants from executing him using the current lethal injection procedure. Id. ¶ 111(a).

III. Evidentiary Hearing and In Camera Review of Drug Logs

Upon review of Guardado's allegations regarding FDOC's use of expired etomidate, the Redacted FDOC Drug Logs reflecting when FDOC purportedly began using the expired drug and its repeated use of it, and the tenfold discrepancy in the etomidate levels reflected in the Toxicology Reports of Bell and Smithers with Bell having been executed before the logs reflected the use of expired etomidate and Smithers having been executed after the use of the expired etomidate began, the Court ordered a limited evidentiary hearing on Guardado's Motion to Stay. See Doc. 19. Prior to the hearing, the Court ordered Defendants to provide Guardado's counsel with updated redacted drug logs for executions from September 30, 2025 to the present. See Doc. 38 at 3.

At the start of the evidentiary hearing, pursuant to a stipulation, the Court admitted into evidence all of the parties' exhibits and permitted them to publish the exhibits or use them in any manner. See E.H. Transcript at 6-7.

Guardado submitted the following exhibits: FDOC's written lethal injection protocol (Doc. 55-1; Pl. Ex. 1); a copy of the Redacted FDOC Drug Logs (Doc. 55-2; Pl. Ex. 2; Dr. Almgren's CV (Doc. 55-3; Pl. Ex. 3); Michael Bell's and Samuel Smithers's toxicology reports (Doc. 55-4; Pl. Ex. 4); redacted autopsy reports (Doc. 55-5; Pl. Ex. 5); Dr. Zivot's CV (Doc. 55-6; Pl. Ex. 6); 30 combined autopsies and toxicology reports (Doc. 55-7; Pl. Ex. 7); and FDOC's updated redacted drug inventory logs (Doc. 55-8; Pl. Ex. 8; the Updated Redacted FDOC Drug Logs). Defendants submitted the following exhibits: the redacted FDOC execution checklists for – Kayle Bates (Doc. 56-1; Def. Ex. 1); Curtis Windom (Doc. 56-2; Def. Ex. 2); David Pittman (Doc. 56-3; Def. Ex. 3); Victor Jones (Doc. 56-4; Def. Ex. 4); and Samuel Smithers (Doc. 56-5; Def. Ex. 5); and the redacted autopsy/toxicology packets for – Kayle Bates (Doc. 56-6; Def. Ex. 6); Curtis Windom (Doc. 56-7; Def. Ex. 7); David Pittman (Doc. 56-8; Def. Ex. 8); Victor Jones (Doc. 56-9; Def. Ex. 9); and Samuel Smithers (Doc. 56-10; Def. Ex. 10).

Guardado presented the testimony of two witnesses – Dr. Almgren and Dr. Zivot – who both largely testified to the statements made in their Declaration and Report, respectively. See generally E.H. Transcript at 13-57, 81-141. Dr Almgren, who testified as an expert in pharmacy, pharmaceutical

manufacturing, and ethics, explained that etomidate is a fast-acting hypnotic that typically peaks within a minute and lasts three-to-five minutes when given in clinical doses. Id. at 18, 20-22. She explained that etomidate "does not have a linear relationship between the level of the drug [dose] and the length of how long the patient is asleep"; meaning "if you give ten times the dose, it does not mean that the patient . . . . will be unconscious for 30 to 50 minutes." Id. at 21. Dr. Almgren stated that instead, literature about etomidate suggests that the depth of sleep can increase with a higher dose, but the patient will "not necessarily" remain unconscious for a longer time. Id. at 22. She gave no opinion as to how long a patient given a 200 milligram dose of etomidate would remain sedated.

Dr. Almgren reviewed the Redacted FDOC Drug Logs and noted that the Exhibit (Pl. Ex. 2 at 26) shows etomidate used during executions in August and September 2025 had an expiration date of January 31, 2025. E.H. Transcript at 35-37. She then explained the importance of an expiration date, stating the manufacturer establishes an expiration date after performing several stability tests, and up until that expiration date, the manufacturer of that drug can guarantee it is meeting all quality standards. Id. at 37. She asserted "[s]o the expiration date really just tells you: Up to this date we know all of the vials that were made on this date with this lot number are good, and you should not be using them past that date." Id. at 38. According to Dr. Almgren, once you

reach that expiration date, the medication may degrade and even become dangerous. Id. at 37-38. She testified that it is very important that Defendants' drug inventory logs be correct, and what she found "particularly disturbing" with the Redacted FDOC Drug Logs is that the use of expired drugs is documented multiple times, rather than something that should have been caught and corrected after one documented use. Id. at 39 (discussing Pl. Ex. 2 at 26).

Dr. Almgren then reviewed the Updated Redacted FDOC Drug Logs. Id. (discussing Pl. Ex. 8 at 8). She found the updated logs to be "really interesting" because the same entries in the expiration date column, which previously read "January 31, 2025," had now been corrected to "2027" and this correction appeared to be made using "Wite-Out" or "a heavy-handed correction" on those numbers. Id. at 40 (discussing Pl. Ex. 8 at 8). Dr. Almgren stated that using "Wite-Out" to make corrections is completely inappropriate in pharmacy recordkeeping, and instead the best practice would be to mark over "2025" and write "wrong date" before writing the correct date and initialing the correction. Id. at 41. Dr. Almgren was then directed to page 12 of the Updated Redacted FDOC Drug Logs, which shows what she found to be "a prime example" of how to make a proper correction as someone marked over a line, wrote "error," and initialed it. Id. at 42 (discussing Pl. Ex 8 at 12). According to Dr. Almgren, she cannot imagine why they would apply this correction practice inconsistently,

and she stated that if these were pharmacy records she was auditing, she would initiate an investigation into the changing of "2025" to "2027." Id. at 42-43. With that said, Dr. Almgren testified that she has no personal knowledge about whether FDOC used expired etomidate during any execution, and she does not know which version of the FDOC drug logs is correct. Id. at 51.

Dr. Zivot, who testified as an expert in anesthesiology, stated that he had no disagreements with Dr. Almgren's testimony about the use of expired drugs. Id. at 98-99. He also testified that based on his review of the Redacted FDOC Drug Logs, it appeared that expired etomidate was used during executions in August and September 2025. Id. at 103 (discussing Pl. Ex. 2 at 26). Dr. Zivot stated that he is familiar with toxicology generally and routinely draws blood to be sent to the lab and makes medical decisions based on toxicology reports. Id. at 112. He explained that he reviewed the thirty toxicology reports in Plaintiff's Exhibit 7 and noted that the "reference comments" in the reports mirror the package insert for etomidate, which "specifies a plasma level of 0.23" is needed to reach "basic entry-level hypnosis." Id. at 115-16. He further testified that the manufacturer's 0.23 mcg/mL plasma level is the threshold for both living-people and postmortem tests, though he acknowledged that drug levels will move after death. Id. at 116-17. According to Dr. Zivot, blood drawn from a femoral source is better than heart blood to determine plasma levels in a living person, but femoral blood can sometimes be difficult to obtain after

death. Id. at 117. Dr. Zivot testified that there is also a difference between plasma and whole blood and since he works with live patients, he mostly works with plasma. Id. at 119. When asked about etomidate's postmortem stability, Dr. Zivot opined that etomidate is fairly stable, and while it does undergo some metabolism during circulation, it can sit in a tube for up to a week without changing much. Id. at 119-20. He stated that one-third of the thirty toxicology reports he reviewed showed postmortem etomidate levels below the manufacturer's 0.23 mcg/mL plasma level. Id. at 120. According to Dr. Zivot, he believes the postmortem etomidate levels shown in those toxicology reports would be close to the blood-plasma levels of etomidate circulating at the time of execution. Id. at 133. He explained that he believes he can reliably draw conclusions based on these toxicology reports because while there is some redistribution after death, if femoral blood is used, the lack of plasma-based metabolism will mean the level is fixed at the time of death. Id. at 140-41. Dr. Zivot further testified that he would expect to see much less variation in etomidate levels in thirty toxicology reports and seeing so much variation in just thirty reports, "was quite surprising and quite disturbing . . . ." Id. at 141.

Defendants presented testimony from Dr. Joseph Antognini, Dr. Milad Webb, Florida Department of Law Enforcement (FDLE) Agents Adam Graff and Kevin James, and Dr. Renea Marcano. Dr. Antognini testified that the dose of etomidate called for in FDOC's lethal injection protocol is "a massive

overdose" that is "between about 7 to 10 times the dose that you would give in the clinical situation." Id. at 64. When asked how a dose like that affects a person once it reaches circulation, Dr. Antognini explained:

> Well, the etomidate as it first goes in, it starts entering into the circulation, just the very first part of that dose would be sufficient to make that person unconscious because that's a -- the first part is what we would give anyway.
>
> And then, you know, you continue to push that drug more and more until you get to the 200 milligrams. You're pushing that overdose. And so the person would be unconscious within 15 to 20, 30 seconds. And then you continue to give more etomidate per the protocol, and then that just builds up the concentration, basically, of etomidate in the bloodstream. So it's going to last a lot longer because of that.

Id. at 64. According to Dr. Antognini, based upon that dosage, it is his opinion that the individual would be in a state of unconsciousness for at least 30 minutes. Id. Dr. Antognini testified that the estimate that an individual will only remain unconscious for three to five minutes is true for clinical doses because of etomidate's redistribution. Id. at 65-66. But Dr. Antognini explained that with the massive overdose FDOC provides, "it takes longer for that drug['s] [ ] concentration to fall off because it's such a high dose." Id. at 66.

Dr. Webb became the District Eight Chief Medical Examiner for North Central Florida in March 2026, and his office conducts all postmortem reports for inmates executed in Florida. Id. at 170. Dr. Webb testified that under his leadership, his office takes postmortem blood samples from the iliac veins, or

a peripheral source. Id. He explained that before taking his current role, the office would draw postmortem blood samples from central sources, "particularly, the heart." Id. at 171. But because Dr. Webb was trained that the "gold standard for postmortem toxicology testing," and the site endorsed by the National Association of Medical Examiners, is peripheral blood or iliac, that is the blood source his office uses unless the body has significant trauma and there are no other options. Id.

According to Dr. Webb, postmortem etomidate levels vary based on the location from which the blood sample is taken. Id. If the sample is heart blood, the etomidate level "is going to be predictably higher . . . multiple-fold higher, maybe four to tenfold higher," compared to iliac, "because of the postmortem redistribution of the drug." Id. Dr. Webb further explained that the volume of distribution depends on your individual tissue composition, or how heavy you might be. Id. at 171-72. When asked why, if FDOC administers 200 milligrams (mg) of etomidate, the postmortem levels are so low in the autopsies, Dr. Webb explained:

> So you would have to first establish what would be the expected concentration. So to say something is low is to say that you know what it should be. So I would ask, well, . . . -- once you give 200 milligrams of etomidate [ ] to a human and you expect distribution, you expect plasma redistribution, postmortem redistribution, what do you expect that number to be? And then why . . . do you think it's high or low? We know that peripheral blood concentrations are going to be lower than central blood concentrations because of the way the drug binds to your organ

> systems. And then when you die, those drugs can release from the organs, central organs, and go into circulation.
>
> And it happens that all of our major organ systems are in the thoracic cavity. So when we take blood from the peripheral, it is going to be the most accurate to . . . when that individual died and what the drug concentration was in life.
>
> When we take it from the central source, it's going to have a lot more variability, and that number is going to be artificially increased.

Id. at 172-73. He also explained that there is a difference between plasma readings and whole blood readings: whole-blood readings are "absolutely not" indicative of or a one-to-one of a person's plasma readings as plasma and whole blood are two completely different volumes of fluid, and as a medical examiner, he only works with whole blood. Id. at 173-74.

Dr. Webb testified that there are reports that etomidate breaks down in the liver and data shows that after someone dies, if their body temperature stays within a physiological range (probably in the low 90s), etomidate will continue to metabolize, since all metabolism does not instantaneously cease at the time of death. Id. at 174, 179. Dr. Webb explained that while he cannot give an opinion about the rate etomidate continues to decrease after death as no studies have been done, he does know that some appreciable rate of degradation occurs. Id. at 174-75. Because etomidate has a half-life within two-and-one-half hours, Dr. Webb stated that ideally to get a fairly accurate etomidate number, you would need to take a sample within that period of time.

Id. at 175. Dr. Webb was not sure if postmortem etomidate samples taken after that time would be accurate because he has never been asked to compare the two. Id. at 175-76.

Dr. Webb further testified that postmortem etomidate levels cannot predict whether the etomidate used in an execution was expired. Id. at 176. He added that he reviewed the toxicology reports for Michael Bell and Samuel Smithers and saw a tenfold difference in the readings of the two cases. Id. at 176. Even so, Dr. Webb testified that this large disparity does not mean the two men received different amounts of etomidate during their executions; rather these postmortem concentrations were drawn from different body sites (Michael Bell – heart blood; Samuel Smithers – iliac blood) and the difference in these two individuals' body type, blood concentration, etc. must be considered. Id. at 177.

Dr. Webb testified that he reviewed the toxicology reports in Plaintiff's Exhibit 7 and none of the postmortem etomidate levels gave him any concern that an inmate did not receive 200mg of etomidate during the execution process. Id. at 184-85. He also testified that these reports provided no evidence indicating to him that any of the individuals had consciousness at the time of the execution. Id. at 186. Finally, as to the 0.23 mcg/ML plasma level reference code, Dr. Webb explained that number is "completely inconsequential" to him, as that number does not relate to a postmortem whole blood sample; and the

way you test consciousness is with tactile touch or response to pain, not with postmortem blood testing. Id. at 192, 196.

FDLE Agent Graff testified that he was responsible for checking the expiration dates and witnessing the drawing up of the required drugs during the August 19, 2025 execution of Kayle Bates; the September 17, 2025 execution of Joseph Pittman; the September 30, 2025 execution of Victor Jones; the July 15, 2026 execution of Michael Bell; and the October 28, 2025 execution of Norman Grim. Id. at 145-46. He reviewed the packaging and the individual vials of the etomidate used in each of those executions and confirmed the drug was etomidate and it was not expired. Id. at 151-52. According to Agent Graff, on each occasion, after he did so, the etomidate was then handed to the person that would draw the medication who would show it to another member of the execution team who also would confirm the name of the drug and checks the expiration date. Id. at 148, 150, 163. He explained that if a drug was found to be expired, the team would let the team warden know even if it meant potentially delaying the execution. Id. at 164-65.

FDLE Agent Kevin James testified that he was responsible for checking expiration dates and witnessing the drawing of the required drugs during the October 14, 2025 execution of Samuel Smithers. Id. at 198. He reviewed the packaging and vials of the etomidate used in Smithers's execution and confirmed the etomidate was within its expiration date. Id. at 199, 200-01.

Similar to Agent Graff, he testified that after he confirmed the etomidate was not expired, the pharmacist then presented the drug to "two separate [F]DOC employees to confirm the drug name and expiration date as well." Id. at 201.[3]

Dr. Renea Marcano testified that she is a licensed pharmacist who currently works for the FDOC. See E.H. Transcript at 209. On July 4, 2025, FDOC promoted her to the position of Bureau Chief of Pharmacy Services, overseeing all pharmaceutical matters for the FDOC. Id. at 210, 220. In her postition, she regularly monitors the drugs Florida uses in its lethal injection protocol, and routinely audits records for the lethal injection drugs, including purchasing and inventory logs. Id. at 210. According to Dr. Marcano, she is very familiar with the procurement, storage, monitoring, and chain of custody

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[3] Agent James gave seemingly contradictory answers during his testimony regarding the Smithers execution:

> Q. So our date is October 14, 2025. You were shown both the packaging as well as the vial. Had the etomidate which you were shown, had that expired as of that date?
> A. It had not expired.

Id. at 200

> . . . .
> Q. All right. Let's go to the actual execution of Mr. Smithers. What was the expiration of the etomidate in the Smithers execution?
> A. I'm not sure the exact date, but I know it was prior to October of 2025.

Id. at 206

> . . . .
> Q. Even though you didn't remember the actual expiration date?
> A. Correct. I remember that they – every execution I've been a part of has been within the expiration date.

Id. at 207. Taking into account the entirety of Agent James's testimony, the Court credits his statements that the etomidate used in the Smithers execution had not yet reached its expiration date.

procedures for the three main drugs used in the protocol. Id. at 211. She explained when received, every drug comes with a lot number that is associated with an expiration date; and "[a] lot number is indicative of the batch that the manufacturer made," so if something happened with that particular batch, the manufacturer would be able to identify it for recall. Id. Dr. Marcano described the multiple-lock cabinetry system where the lethal injection drugs are stored and stated only authorized personnel have access to the keys used to enter the secure room housing these drugs. Id. at 212. Once an authorized personnel member is within the secure room, there are two containers – one container houses all the unexpired medications, and one container (the quarantine cabinet) contains all the damaged or expired products. Id. at 212, 226. She explained that each of the lethal injection drugs are stored in conditions "pharmaceutically required for the drug," including rocuronium bromide, which is stored in a locked commercial refrigerator, and that all drugs remain sealed in their unopened boxes with packaging inserts until needed. Id. at 213, 225.

According to Dr. Marcano, personnel have a procedure for handling drugs close to their expiration day – usually this procedure depends on whether an execution is scheduled, meaning they will move soon-to-be expired drugs to the expired container earlier if there are no other executions expected that month, but if there are, they will not move them in advance. Id. at 214. Dr.

Marcano explained, "[w]e can move them up to one business day after they expire"; and they do not permit expired drugs to remain in the good cabinet for months after expiration. Id. Once an expired drug is moved to the "bad cabinet," it is never moved back, and it is never used for an execution. Id. Dr. Marcano stated that she specifically trains all authorized individuals that under no circumstance are expired drugs to be used in executions. Id. at 215.

According to Dr. Marcano, on the day of an execution, two members of the execution team come to the secure pharmacy location to transport the drugs to Florida State Prison. Id. Once they arrive, two caretakers onsite at the secure pharmacy pull out a set of the drugs that will be used and a spare set. Id. at 228. The caretakers check the expiration dates of the drugs, and once custody of the drugs is transferred to the two transporters, the two transporters also check the expiration dates. Id. at 215. She explained they also check for signs of damage or alterations, and once everyone is satisfied with the inspections, the caretakers tightly bag up the spare drugs with staples "to make it not easy to use," and the other set is bagged for easy access. Id. at 229. The transporters then place the drugs into a locked box with a code and take them to the execution site. Id. at 216. After the event, the transporters return to the pharmacy and provide the caretakers with the spare set of drugs that was not used. Id. at 229. According to Dr. Marcano, "at that point, then we document on these logs what was used"; and they return to stock any room-

temperature drug like etomidate and place rocuronium into quarantine because it was out of the refrigerator. Id.

Dr. Marcano testified that FDOC keeps and maintains drug inventory logs tracking the purchase, storage, and use of the lethal injection drugs. Id. at 216. She explained that in December 2025 or January 2026, after becoming Bureau Chief, she discovered entries made in those logs that concerned her. Id. at 216, 221. Specifically, Dr. Marcano identified a number of dates that stood out to her – August 19, 2025; August 29, 2025; September 17, 2025; September 30, 2025; October 14, 2025; and October 28, 2025. Id. at 216-17. Notably, those log entries appeared to show expired etomidate (expiration date of January 31, 2025) was used on those dates. Id. Dr. Marcano advised her supervisor of the concerns and she and her supervisor agreed that Dr. Marcano should conduct an internal investigation. Id. 216, 221, 222-23.

Dr. Marcano testified that she did three things to resolve her concerns about these entries. Id. First, Dr. Marcano traced the lot number and National Drug Code (NDC)[4] number at the top of the log back to three invoices they had previously received, and each of those three invoices indicated that the true expiration date was January 2027, not January 2025. Id. at 217-18. Second, Dr. Marcano looked for etomidate with that NDC number at the top of that log,

[4] The NDC number at the top of the redacted drug logs identifies the manufacturer. E.H. Transcript at 230.

and after searching through all the FDOC invoices, she could not identify ever receiving etomidate with an expiration date of January 31, 2025. Id. at 218. And third, Dr. Marcano explained that she reached out to transporters and asked if they recalled checking all expiration dates, and if they could recall a time that anything could "have went awry"; and they advised her that "they have always checked the expiration date and there has never been expired product that left that site." Id. She testified that her investigation concluded that the initial drug logs that had a 2025 expiration date were not an accurate reading of the date but rather "human error." Id. at 218-19.

Dr. Marcano then explained that based on her investigation, at her direction someone went back and corrected the logs to reflect the correct expiration date: January 31, 2027. Id. at 219, 260-61. Since discovering this error, Dr. Marcano has instituted new procedures to bring more accuracy to the logs, including terminating the individual who made the error; appointing new individuals to handle the logs; and requiring that on days of executions, the two caretakers and the two transporters, along with Dr. Marcano, review the logs for accuracy. Id. at 219, 241. When asked if the individual explained why he had written the wrong expiration date for those entries, Dr. Marcano testified, "English is not his first language. And I believe the year was 2025, so it was just – it was just an error in writing down the current year." Id. at 233.

When asked why 120 vials of etomidate with an expiration date of July 2022, were removed on December 8, 2022, Dr. Marcano explained that they record the movement of expired and unexpired drugs on the drug logs, so they know the drugs are not going somewhere else; thus even if a drug is expired and had been moved to the quarantine cabinet, it is not removed from the drug log until the drug ships out of the facility for destruction or "reverse distributor." Id. at 235, 237 (discussing Pl. Ex. 2 at 3).

Dr. Marcano acknowledged that the drug logs contain discrepancies in dates of executions and dates that drugs were logged out. Id. at 238-39. She also noted that the drug logs indicate 7 vials of potassium acetate were removed on June 12, 2025, but the corresponding execution occurred on June 10, 2025. Id. at 238-39. Similarly, the logs show that 17 vials of potassium acetate were removed on June 25, 2025, but the corresponding execution occurred on June 24, 2025. Id. at 239-40. But since she was not yet in her current position, she had no personal knowledge of why this occurred and could not make a conclusion based on any objective investigation. Id. at 239-40. Dr. Marcano also acknowledged that there were several other drug log entries made the day before or after an execution but clarified that the new procedure she has now implemented requires that entries be made on the same day as the event. Id. at 241, 253, 254. And as to any errors in the amounts or purported shortage of the amount removed for an execution, Dr. Marcano

stated that while she cannot explain those entries, she knows the individuals involved in the process and is confident they would not have left the pharmacy facility shorthanded. Id. at 242-43. Likewise, Dr. Marcano spoke to the execution team members about all discrepancies in log entries made days before or after an execution, and they reassured her that on the day of every execution, the right amount of each drug was brought to the execution site. Id. at 254. Dr. Marcano acknowledged the drug logs did not contain entries for the withdrawal of etomidate for use in the June 24, 2025 execution of Thomas Gudinas and the July 15, 2026 execution of Michael Bell but stated that transporters assured her etomidate was transported to both those executions. Id. at 256-59.

Finally, when asked about the Updated Redacted FDOC Drug Logs and how it appears that someone just "whited out" the "5" in "2025" and put a "7" making it "2027," Dr. Marcano testified "[t]hat's how the person handling the log corrected it upon instruction to change the log to what the investigation had found, that it was 2027." Id. at 260-61 (referring to Pl. Ex. 8 at 8). But she acknowledged that no memorandum was prepared to explain the change. Id. at 261-62.

Following the evidentiary hearing, in light of Dr. Marcano's testimony regarding her investigation and findings, the Court ordered Defendants to submit to the Court, for in camera review, copies of "all pages of the Etomidate

logs in evidence showing the Invoice Numbers and Lot Numbers." See Doc. 53. Defendants then provided the Court with three sets of documents. The first set included page 8 of Plaintiff's Exhibit 8, showing the unredacted Lot Number and Invoice Number that coincided with the January 2027 expiration date; a photograph of a package and vials of etomidate with the same Lot Number and January 2027 expiration date found on page 8 of Plaintiff's Exhibit 8; and three invoices showing receipt of etomidate with the matching Lot Number and a January 2027 expiration date. The second set of documents Defendants provided included an unredacted version of the etomidate logs in Plaintiff's Exhibit 2 showing Invoice Numbers and a Lot Number for each entry. And finally, the third set of documents contained an unredacted version of the etomidate logs in Plaintiff's Exhibit 8, again showing Invoice Numbers and a Lot Number for each entry.

Using the first set of documents, the Court was able to confirm that January 2027 was the correct expiration date for the etomidate used in the August 19, 2025 execution of Kayle Bates; the August 29, 2025 execution of Curtis Windom; the September 17, 2025 execution of David Pittman; and the September 30, 2025 execution of Victor Jones. The other two sets of documents allowed the Court to trace more Lot Numbers back to one of the Invoices provided and confirm that FDOC had ample unexpired etomidate for use in executions that occurred between April 8, 2025 and October 20, 2026.

IV. Law

Eighth Amendment Method-of-Execution Claim

To state an Eighth Amendment method-of-execution claim, a plaintiff must plead facts sufficient to satisfy the two-prong test established in Glossip v. Gross, 576 U.S. 863 (2015), and Baze v. Rees, 553 U.S. 35 (2008). First, the plaintiff must allege that "the method challenged presents a risk that is 'sure or very likely to cause serious illness and needless suffering,' and gives rise to 'sufficiently imminent dangers.'" Price v. Comm'r, Dep't of Corr., 920 F.3d 1317, 1325-26 (11th Cir. 2019) (quoting Glossip, 576 U.S. at 877; Baze, 553 U.S. at 50) (emphasis in originals)). The possibility that the prisoner may suffer pain is not sufficient to establish a "substantial risk of serious harm." Id. Rather, the conditions must establish the sort of "objectively intolerable risk of harm that qualifies as cruel and unusual punishment prohibited by the Eighth Amendment." Id. (quotations omitted). As such, to prevail, "the inmate must show a substantial risk of serious harm, an objectively intolerable risk of harm that prevents prison officials from pleading that they were subjectively blameless for purposes of the Eighth Amendment." Id. (quotations omitted)

Second, the plaintiff must identify "'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.'" Id. (quoting Bucklew v. Precythe, 587 U.S. 119, 134

(2019)). "[T]he state must be able to implement and carry out that [alternative] method of execution relatively easily and reasonably quickly, and in a manner that 'in fact significantly reduces a substantial risk of pain' relative to the intended method of execution." Boyd v. Warden, Holman Corr. Facility, 856 F.3d 853, 866 (11th Cir. 2017) (quoting Glossip, 576 U.S.at 877). Further, in Bucklew, the United States Supreme Court clarified 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." 587 U.S. at 139-40. Thus, a plaintiff can identify a "well-established protocol in another State as a potentially viable option." Id. at 140.

All Writs Act, 28 U.S.C. § 1651(a)

Under the All Writs Act, courts "may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law." Klay v. United Healthgroup, Inc., 376 F.3d 1092, 1097, 1099 (11th Cir. 2004). In Dunn v. McNabb, 583 U.S. 941 (2017), the United States Supreme Court addressed whether the All Writs Act can be used to enjoin a death penalty inmate's execution. There, the Court held that "inmates seeking time to challenge the manner in which the State plans to execute them must satisfy all the requirements for a stay, including a showing of a significant possibility of success on the merits . . . . The All Writs Act does not excuse a court from making these findings." Id. (citation omitted); see also

Lecroy v. United States, 975 F.3d 1192, 1197 (11th Cir. 2020) (finding that the All Writs Act cannot be used to evade the requirements for a preliminary injunction). And in Hill v. McDonough, 547 U.S. 573 (2006), the Court emphasized that "a stay of execution is an equitable remedy," and "equity must be sensitive to the State's strong interest in enforcing its criminal judgments without undue interference from the federal courts." Id. at 584. The court "must also 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.'" Id. (quoting Nelson v. Campbell, 541 U.S. 637, 650 (2004)).

A stay of execution is available "only if the prisoner 'establishes that (1) he has a substantial likelihood of success on the merits, (2) he will suffer irreparable injury unless the injunction issues, (3) the injunction would not substantially harm the other litigant, and (4) if issued, the injunction would not be adverse to the public interest.'" Barwick v. Governor of Fla., 66 F.4th 896, 900 (11th Cir. 2023) (quoting Bowles v. DeSantis, 934 F.3d 1230, 1238 (11th Cir. 2019)). The Court must also consider "the extent to which the inmate has delayed unnecessarily in bringing the claim," Walls v. Sec'y, Dep't of Corr., 161 F.4th 1281, 1284 (11th Cir. 2025) (quoting Nelson, 541 U.S. at 649–50), because "[l]ast-minute stays should be the extreme exception, not the norm, and 'the last-minute nature of an application' that 'could have been brought'

earlier . . . 'may be grounds for denial of a stay.'" Bucklew, 587 U.S. at 150 (quoting Hill, 547 U.S. at 584).

V. Analysis

Here, Defendants do not argue that Guardado unduly delayed bringing this action. As such, the disposition of the Motion to Stay will turn on the four stay factors.

(1) Substantial Likelihood of Success on the Merits

Guardado argues that he has made a substantial showing that he is likely to succeed on the merits. Motion to Stay at 17. He states that the Redacted FDOC Drug Logs underlying his expired drugs claim first became public in October 2025 during Frank Walls's post-warrant § 1983 litigation in the Northern District of Florida. Id. at 2-3. Having reviewed those Redacted FDOC Drug Logs, Guardado obtained autopsy reports, toxicology reports, and new expert opinions to expand on what Walls argued. He contends his Complaint adequately describes that "due to Defendants' repeated administration of expired etomidate, inmates are not rendered sufficiently unconscious and are thus awake and aware during the procedure, experiencing the physical and mental torture inflicted by the chemical paralytic which immobilizes the diaphragm, and the drowning sensation of pulmonary edema." Id. at 17-18. Guardado equates this terror to Alabama's use of Nitrogen Hypoxia, which the Eleventh Circuit found unconstitutional in Lee, No. 26-

11864, 2026 WL 1651147. Motion to Stay at 18. He also asserts that he has proffered an adequate alternative method of execution – firing squad – which is feasible, readily implemented, and reduces the risk of pain associated with Florida's lethal injection protocol. Id. at 22. To that end, he asserts he has demonstrated a substantial likelihood of success on the merits. Id. at 18.

In response, Defendants argue Guardado has not shown a substantial likelihood of success on the merits. Response Motion to Stay at 9. According to Defendants, the Eleventh Circuit's conclusion in Lee that Alabama's use of Nitrogen Hypoxia violates the Eighth Amendment was dependent upon the inmate being conscious during the use of the gas, which is a fact inapplicable to Florida's protocol. Id. at 10. Defendants maintain that Guardado's claim regarding edema ignores the protocol's "consciousness check" that is mandated after the administration of etomidate; and since Guardado will be unconscious, he will not experience the sensation of suffocating or any "pulmonary edema that occurs during execution." Id. at 10-12. According to Defendants, Guardado's attempt to add allegations that FDOC is possibly using expired etomidate to enhance his pulmonary edema claim "is speculative" but "[s]uch speculation cannot substitute for evidence." Id. at 13.

To determine Guardado's likelihood of success on the merits, the Court must begin by examining FDOC's written protocol and then his specific challenges to it. Florida's current lethal injection protocol provides for

intravenous administration of: (1) 200mg of etomidate (a sedative); (2) 1000mgs of rocuronium bromide (a paralytic agent); and (3) 240 milliequivalents of potassium acetate (a substance to stop the heart). See Doc. 1-4 at 12-14 (etomidate protocol). If the inmate is not fully unconscious when either rocuronium bromide or potassium acetate is injected, it is undisputed that the prisoner will suffer pain. See Lightbourne v. McCollum, 969 So. 2d 326, 351 (Fla. 2007) ("If the inmate is not fully unconscious when either pancuronium bromide or potassium chloride [the second and third drugs in the protocol] is injected, or when either of the chemicals begins to take effect, the prisoner will suffer pain."); see also Baze, 553 U.S. at 53 ("[F]ailing a proper dose of sodium thiopental that would render the prisoner unconscious, there is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride.").

Guardado first learned about the Redacted FDOC Drug Logs in late 2025 when Walls filed in the Northern District of Florida a post-warrant § 1983 action and motion to stay his execution, raising an as-applied challenge to the etomidate protocol. Complaint at 8 (citing Walls v. Dixon, No. 4:25-cv-488-MW/MAF (N.D. Fla.)). In addition to the Redacted FDOC Drug Logs, Walls provided an affidavit from Dr. Zivot, in which he discussed Walls's various health conditions that might prolong suffering during the execution. The

district court denied Walls's motion to stay, and the Eleventh Circuit affirmed the denial, concluding that Walls unduly delayed in bringing his challenge because the pulmonary edema associated with the etomidate protocol is a complication "well-documented for years" and Walls was likewise aware of his own health conditions for years. Walls, 161 F.4th at 1285. Neither the district court nor the Eleventh Circuit addressed the merits of Walls's claim and the case was rendered moot by his execution.

Since Walls, two other death-warrant inmates have used the same Redacted FDOC Drug Logs to challenge, in state court, the etomidate lethal injection protocol. First, after the issuance of his January 2026 death warrant, Ronald Heath filed with the trial court a Florida Rule of Criminal Procedure 3.851 motion, attaching the Redacted FDOC Drug Logs and arguing FDOC deviated from its protocol during recent executions, including, inter alia, the possible use of expired drugs. Heath v. State, 426 So. 3d 1253, 1261 (Fla. 2026). Heath also provided a declaration from Dr. Zivot, describing the risks posed by FDOC's alleged recklessness in administering the etomidate protocol. Id. The trial court denied Heath's Rule 3.851 motion. Id. Heath appealed and the Florida Supreme Court affirmed the denial, finding in relevant part:

> The question is not whether protocol deviations occurred but whether the defendant's allegations would demonstrate a substantial and imminent risk that is sure or very likely to cause serious illness and needless suffering. Heath's allegations would not demonstrate such a risk. The alleged failure to document the

> removal of drugs from inventory until one or two days after an execution would not, **without more**, show a substantial and imminent risk that is sure or very likely to cause serious illness and needless suffering during an execution. Nor would the alleged failure to log the removal of etomidate from inventory establish such a risk where the autopsy indicates the drug was, in fact, administered. The allegation that lidocaine was administered on two occasions certainly would not establish a risk of needless suffering. Heath's suggestion that inventory removals on dates that "seemingly correspond[ ]" to executions and reflect amounts less than required by the protocol show that incorrect doses were used is speculative and Heath does not allege that such incorrect doses would create a demonstrated risk of severe pain. The same is true of the alleged use of expired drugs and the execution that took twenty minutes and allegedly involved movement. None of Heath's allegations would establish that the method of execution presents a substantial and imminent risk that is sure or very likely—in other words, a virtual certainty—to cause serious illness and needless suffering.

Id. (emphasis added).

When the Florida Supreme Court issued the Heath decision, Melvin Trotter was litigating a post-warrant Rule 3.851 motion raising similar challenges to the etomidate protocol and relying on the same drug inventory logs and an expert affidavit warning that expired drugs could diminish pharmacological effects or cause complications. State v. Trotter, No. 1986-CF-001225 (Fla. 12th Cir. Ct.). Using the reasoning in Heath to support its decision, the trial court denied the Rule 3.851 motion, finding "none of the heavily redacted FDOC log pages contain any executed defendant's name or indicate that any of the drugs listed were used during any execution, [ ] prompting a finding that [Trotter's] purported 'evidence' of . . .

maladministration . . . is based on speculation and conjecture." Id. Trotter appealed and the Florida Supreme Court affirmed the denial, finding the trial court correctly found the evidence that Trotter provided was "speculative" and Trotter failed to identify an alternative method of execution. Trotter v. State, 428 So. 3d 68, 73 (Fla. 2026).

Trotter sought a stay of his execution from the United States Supreme Court. Trotter v. Florida, 607 U.S. ---, 146 S. Ct. 755 (2026). The Supreme Court denied the stay without discussion. Id. But Justice Sotomayor, who voted to deny the stay "because evidentiary support for [Trotter's] claim is lacking," also issued a written statement expressing her "concern about Florida's implementation of its execution protocol and the secrecy surrounding it." Id. at 755. Justice Sotomayor explained that while "Florida argued . . . that Trotter's claim is speculative because the records at issue do not conclusively show any errors occurred, [ ] the State provides no assurances that it has not (and will not) use expired substances in its executions." Id. She then highlighted her apprehensions:

> At this point, the evidence Trotter has assembled is not, in my view, enough to show that Florida's administration of its lethal-injection protocol is "'sure or very likely to cause serious and needless suffering,'" as the Court's Eighth Amendment precedents require. Even so, the record to date is troubling.
>
> The record reflects at least the possibility that recent Florida executions have involved—in addition to expired drugs—incorrect drug doses, the use of nonprotocol drugs, and recordkeeping lapses

> that could mask yet additional failings. The Florida Supreme Court, moreover, has thus far not allowed further inquiry into these potential problems and has recently denied requests for records that would prove or disprove claims like Trotter's. See, e.g., Heath, [426 So. 3d at 1253]. In doing so, the Florida Supreme Court appears to be placing prisoners in a Catch-22: It has affirmed the denial of requests for records on these issues, at least in part, because the prisoners do not yet have enough information to raise a "colorable" Eighth Amendment claim. The very reason the prisoners are seeking the records, however, is to gather enough information to raise a colorable Eighth Amendment claim.
>
> Individuals seeking to challenge the method of their execution should not have to guess at whether the State is, or is not, following its execution protocol. Nor does the State appear to have any legitimate confidentiality interest in shielding from inspection basic facts about the implementation of its execution protocol, such as whether the State is using expired drugs. If the protocol is in fact being followed, then transparency instills confidence in the protocol for everyone – prisoners, the courts, and the public alike. If it is not, then secrecy is intolerable, and disclosure of the relevant records is indispensable for determining whether the lapses at issue are likely to lead to an Eighth Amendment violation. Cf. Smith v. Hamm, 601 U. S. ---, 144 S. Ct. 414, 416 (2024) (KAGAN, J., dissenting from application for stay and denial of certiorari) (suggesting that the Court's Eighth Amendment precedents "can work fairly only when more is capable of being known about an execution method").
>
> Going forward, I hope that Florida and its courts will recognize the paramount importance of ensuring that it conducts executions consistently with its approved protocol, and assuring all involved that it is preventing any infliction of needless suffering on those being executed in the State. By continuing to shroud its executions in secrecy, Florida undermines both the integrity of its own execution process and, potentially, this Court's ability to ensure the State's compliance with its constitutional obligation

Id. (citations and footnotes omitted).

Seemingly hearing Justice Sotomayor's concerns, Guardado has provided more evidence compared to that presented in Heath and Trotter. In addition to the Redacted FDOC Drug Logs used in Heath and Trotter, Guardado provided Dr. Almgrens's Declaration, and the toxicology reports from Michael Bell and Samual Smithers that show a tenfold decrease in postmortem etomidate levels between an execution where records showed unexpired etomidate had been used and an execution completed after records showed FDOC began using expired etomidate. These pieces of evidence prompted this Court to conduct an evidentiary hearing. Upon consideration of the evidence and testimony presented at that hearing, the Court finds that Guardado has failed to show a substantial likelihood of success on the merits of his Eighth Amendment claim.

First, as to the contention that the Redacted FDOC Drug Logs show expired etomidate was used during the August 19, 2025 execution of Kayle Bates; the August 28, 2025 execution of Curtis Windom; the September 17, 2025 execution of David Pittman; and the September 30, 2025 execution of Victor Jones, Defendants presented evidence that those drug log entries were erroneous. Dr. Marcano testified about her investigation in which using the Invoice Number and Lot Number of the etomidate used in each of those executions, she determined that the true expiration date was January 2027. E.H. Transcript at 217-18. In the Court's in camera review of the Redacted and

Updated Redacted FDOC Drug Logs showing the Invoice Numbers and Lot Numbers, the Court was able to confirm the accuracy of this testimony. The in camera submission included a copy of page 26 of the Redacted FDOC Drug Logs (Pl. Ex. 2), the page of the Log relating to the executions at issue and showing the May 23, 2025 receipt of etomidate with the corresponding Invoice Number, Lot Number, and expiration date of January 31, 2027. The in camera submission also included a copy of page 18 of the Redacted FDOC Drug Logs which is a copy of the invoice for the purchase of the etomidate received on May 23, 2025, showing the Invoice Number and Lot Number of the drug. See Pl. Ex. 2 at 18. The invoice shows the purchase of etomidate which matches the Invoice Number and Lot Number in the drug logs as having an expiration date of January 2027. Consistent with Dr. Marcano's testimony, the submission also included two other April 2025 invoices reflecting the purchase of additional etomidate with the same Lot Number and the January 2027 expiration date. Also, the submission included a photograph of the packaging and vials of etomidate and the expiration date and lot number stamped on the packaging vials by the manufacturer. The expiration date for the specific Lot Number at issue here reads "EXP 2027-1." And that same Lot Number matches the Lot Number shown in the in camera submission of the Redacted FDOC Drug Logs and the three invoices referenced by Dr. Marcano. The same is true for the two additional executions for which the Updated Redacted FDOC Drug Logs

showed FDOC had changed the expiration dates; those also reflected the same Lot Number, which would correspond to an expiration date of January 2027. Dr. Marcano also testified that she found no record of FDOC having any etomidate with an expiration date of January 31, 2025,[5] and that as part of her investigation, she confirmed with execution team members that no expired drugs had been used. This evidence combined with the execution checklists and the testimony of Agents Graff and James that they each checked the expiration dates of the etomidate, and no expired etomidate was used in any execution they attended is sufficient to overcome Guardado's contention that expired etomidate was used in the executions that occurred in August, September, or October of 2025. And to that end, to the extent Guardado questions whether FDOC has enough unexpired etomidate to continue carrying out executions, the Court's in camera review confirms FDOC's receipt of additional etomidate from the same Lot Number that has an expiration date of January 2027. Also, Plaintiff's Exhibit 2 at page 20 shows an additional shipment of etomidate with an expiration date of March 2027. See Pl. Ex. 2 at 20. As such, it appears FDOC currently has an ample supply of etomidate to carry out executions as required by Florida's lethal injection protocol.

[5] The Redacted and Updated Redacted FDOC Drug Logs show no etomidate with an expiration date of January 2025 in FDOC inventory.

In any event, even if expired etomidate had been used in the past, Guardado has failed to present evidence to support a finding that FDOC will use expired etomidate in his execution or that the potential use of expired etomidate would result in him not being rendered sufficiently insensate to the pain that accompanies the administration of the second and third drugs in the lethal injection protocol. Dr. Almgren testified that a drug's expiration date is established by the manufacturer and guarantees that the drug will meet all quality standards up until that date. E.H. Testimony at 37. And she explained that anything past the expiration date has "a potential" to degrade. Id. But this "potential" for degradation does not show a risk that is "sure or very likely" to cause serious harm. And Dr. Almgren provided no other more specific opinion on this issue.

To be sure, the Court does not endorse or condone the use of expired drugs in any manner or for any reason. Indeed, the Court's concern regarding the possible use of expired etomidate weighed heavily in the determination that an evidentiary hearing was warranted here. But in resolving the matter at hand, the question before the Court is whether Guardado has shown a likelihood of success on his claim that the method of execution Florida intends to use in his execution "presents a risk that is 'sure or very likely' to cause serious illness and needless suffering and gives rise to sufficiently imminent dangers.'" Glossip, 576 U.S. at 877 (quoting Baze, 553 U.S. at 501) (emphasis

in original)). Based upon the evidence presented regarding the use of potentially expired etomidate, Guardado has not made this showing.

Guardado's allegations about Defendants' use of improper drug dosages during executions also falls short. He contends that the logs show only 7 of the required 12 vials of potassium acetate were removed for the June 10, 2025 execution of Anthony Wainwright, and that only half of the required 20 vials of rocuronium bromide were removed for the June 24, 2025 execution of Thomas Gudinas. See Doc. 57 at 16. But Guardado offers no evidence to overcome the undisputed proposition that if etomidate sufficiently renders him insensate, he will not experience the pain associated with the other two drugs in the protocol. See Baze, 553 U.S. at 49 (recognizing that proper administration of an effective anesthetic "eliminates any meaningful risk that a prisoner would experience pain from the subsequent injections . . . ."); cf. id. at 53 ("[F]ailing a proper dose of sodium thiopental that would render the prisoner unconscious, there is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride."). And thus evidence that an inmate received less rocuronium bromide or potassium acetate than that which is called for in the protocol, without more, does not present a risk that is "sure or very likely" to cause needless suffering.

Guardado also contends that Defendants' lack of contemporaneous recordkeeping indicates that Defendants are not using all drugs called for in the protocol during executions. He argues that "[a]t a minimum, there were three executions where according to the logs, no etomidate was removed for use" – the June 24, 2025 execution of Thomas Gudinas; the July 31, 2025 execution of Edward Zakrzewski; and the August 28, 2025 execution of Curtis Windom. See Doc. 57 at 18-21. According to Guardado, the logs reflect either no etomidate was removed on the date of the execution, or it was removed the day before or after the execution. Id. at 18-19. But the toxicology reports which Guardado has presented, and on which he relies, show that etomidate was administered to each of these three inmates during his execution. Pl. Ex. 7 at 202 (Gudinas's postmortem etomidate level of 0.57), 281 (Windom's postmortem etomidate level of 0.62), 288 (Zakrzewski's postmortem etomidate level of 0.59). While the records may well reflect a failure to record the withdrawal from inventory of the sedative etomidate required by the protocol, the evidence establishes that it was indeed administered to each of the three individuals. And, "the alleged failure to log the removal of etomidate from inventory" does not show a substantial and imminent risk that is sure or very likely to cause serious illness or needless suffering "where the autopsy indicates the drug was, in fact, administered." See Heath, 426 So. 3d at 1261.

As to Guardado's allegations about FDOC's use of lidocaine presenting a risk because it is not a drug in the protocol, he again fails to present evidence to support that notion. Indeed, Dr. Almgren testified that the only real concern with the inclusion of lidocaine is that the protocol is very specific, and it has no mention of how much lidocaine one might need. E.H. Transcript at 35. And Dr. Zivot explained that lidocaine is a local anesthetic that is "used classically to create like a local sensation of numbing to the skin . . . ." Id. at 102. He speculated that lidocaine could cause a seizure depending on how much lidocaine might be administered or cause an allergic reaction. Id. But neither he nor Dr. Almgren testified that the addition of lidocaine would present a danger of additional pain or suffering. Without more, the Court cannot find that evidence of the rare use of lidocaine presents a risk "sure or very likely" to cause needless suffering. Heath, 426 So. 3d at 1262 ("The allegations that lidocaine was administered on two occasions certainly would not establish a risk of needless suffering.").

Guardado maintains that the protocol's minimal specifications for how lethal injection drugs are stored or handled amplify Defendants' recklessness with an already risky protocol. Doc. 57 at 24-26. But Dr. Marcano's in-depth testimony about how FDOC stores and maintains its lethal injection drugs overcomes Guardado's speculation on this matter. Dr. Marcano explained that expired drugs are quarantined from the unexpired drugs, and each group is

kept in separate cabinets under a multi-lock system. E.H. Testimony at 212-14. She specifically trains anyone authorized to handle the drugs and instills in them that under no circumstances are expired drugs to be used in executions. Id. at 215. In her testimony she discussed examples of records reflecting FDOC's routine removal of expired drugs from its inventory. Id. at 214. Dr. Marcano also testified that the rocuronium bromide is kept in one of two commercial refrigerators, one for unexpired rocuronium and a quarantine refrigerator for expired rocuronium or the rocuronium transported back to the pharmacy facility because it was included in the spare set of drugs. Id. at 180, 229. While Guardado points to evidence that FDOC fails to maintain an accurate drug log, he points to no evidence undermining Dr. Marcano's explanation about the storage and maintenance of the drugs or evidence of any failure to properly do so. And while it is entirely true that FDOC did not contemporaneously log the use of etomidate and that its records contain a concerning number of errors, this poor record keeping "without more" does not show a substantial and imminent risk that is sure or very likely to cause serious illness and needless suffering during an execution. See Heath, 426 So. 3d at 1261. Moreover, Guardado must show that he risks being subjected to added suffering. But Dr. Marcano's testimony that she has overhauled FDOC's record keeping practices stands unrebutted. She explained that drugs are now logged contemporaneously and that multiple witnesses confirm the accuracy of

the log. E.H. Transcript at 219; see also Cole v. State, 392 So. 3d 1054, 1065 (Fla. 2024) ("[T]he Department of Corrections is entitled to the presumption that it will comply with the lethal injection protocol."). Thus, Guardado's concerns regarding FDOC's past record keeping practices provide little support for his claim that his execution may not be accomplished in accordance with the State's protocol.

Finally, Guardado has failed to present evidence to support his allegation that the disparity in postmortem etomidate levels presents evidence of the necessary "risk" he must show. Dr. Webb testified that the tenfold difference in the postmortem etomidate levels of Michael Bell and Samuel Smithers could be the result of several factors unrelated to the potency or efficacy of the etomidate given to each inmate. Indeed, Dr. Webb explained that Bell's test sample came from heart blood which will show a "multiple-fold" ("maybe four to tenfold") increase in concentration compared to the iliac blood sample measured for Smithers. E.H. Transcript at 171, 177. Dr. Webb further opined that postmortem etomidate levels cannot show if expired etomidate was used during an execution, and variation in postmortem etomidate levels can be the result of the location of the blood draw, and an individual's specific characteristics. Id. at 176. And, likely of more import, the Court's in camera review of the etomidate logs does not support a finding that expired etomidate was used in Samuel Smithers's execution.

Additionally, Dr. Zivot's concern that one-third of the toxicology reports he reviewed showed etomidate levels below 0.23 mcg/mL is unavailing. While Dr. Zivot testified that the manufacturer recommends a plasma level of 0.23 mcg/mL to reach "basic-level hypnosis," Dr. Webb explained that the toxicology reports here measured etomidate levels in "whole blood" not plasma, which are "absolutely not" a one-to-one measurement. E.H. Transcript at 173. And both Dr. Zivot and Dr. Webb testified that following death, there is evidence of drug redistribution and metabolism, which can also affect these toxicology numbers. Id. at 174. While Dr. Webb did not know exactly what rate etomidate continues to decrease after death, he opined that some circulation and degrading continues until the body has become cool. Id. at 175. According to Dr. Webb, it takes his office about two-to-three hours to collect a body from the execution site and transport it to his office where it is refrigerated until the morning when he then obtains the blood samples, and during this travel time, etomidate levels are continuing to degrade. Id. at 179-81. Based on all these possible influences, Dr. Webb stated, "that there is no evidence that [he] reviewed in these cases that would indicate to [him] that any one of the cases [he] reviewed has consciousness at the time of the procedure." Id. at 186. Dr. Webb's testimony regarding the variation of etomidate levels based on the location of the blood draw, the fact that the toxicology reports are based on an analysis of whole blood, not plasma, the fact that individual factors can affect the

etomidate level readings, and the reality that there will be some postmortem drug redistribution and metabolism of etomidate, combined overcome Guardado's allegation that the disparities in the etomidate levels in the 30 toxicology reports reviewed by Dr. Zivot support any suggestion of a risk that is "sure or very likely" to cause needless suffering.[6] Considering all of these arguments, on this record, the Court cannot find that Guardado has demonstrated a substantial likelihood of success on the merits of his Eighth Amendment claim as to warrant a stay of his execution.[7]

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[6] Notably, while Dr. Zivot opined that the disparity of postmortem etomidate levels "does not support the conclusion that the protocol reliably delivers a consistent dose of etomidate to each prisoner," Zivot Report at 11, what Guardado must show is that the protocol does not reliably deliver a sufficient dose to render him unconscious throughout the execution. He has not done so.

[7] Dr. Zivot's discussion of pulmonary edema fails to support the challenge Guardado raises here. As the district court in Walls noted the "'intense pain and suffering' from pulmonary edema' . . . is [a] publicly known, well-documented" side effect "that [the condemned] could have challenged" long ago. Walls, No. 4:25-cv-488-MW-MAF. Indeed, the court noted that the etomidate protocol, including pulmonary edema, has been the subject of a facial challenge in the Middle District of Florida since 2013. Id. at n.5 (citing Brant v. Palmer, No. 3:13-cv-412-MMH-SJH (M.D. Fla.)). Regardless, neither Dr. Zivot nor any other witness provided evidence suggesting that the pulmonary edema that commonly occurs in an execution by lethal injection happens before the condemned has lost consciousness. See Barr v. Lee, 591 U.S. 979, 981 (2020) (noting that the government presented testimony that "any pulmonary edema occurs only after the prisoner has died or been rendered fully insensate").

(2) Remaining Factors

Because the Court has found that Guardado cannot demonstrate a substantial likelihood of success as to his Eighth Amendment claim, he cannot prevail on his Motion to Stay. And thus, the Court need not determine whether any of the three remaining factors weigh in his favor. See, e.g., Chavez v. Florida SP Warden, 742 F.3d 1267, 1273 (11th Cir. 2014) (finding that because the plaintiff failed to show a substantial likelihood of success on the merits, "his motion for a stay of execution [was] due to be denied without regard to the other three requirements for issuance of one").

V. Conclusion

A condemned inmate seeking to stay an execution bears a heavy burden particularly in a case such as this where he challenges Florida's lethal injection protocol that the Florida Supreme Court has found not to violate the Constitution. Asay v. Florida, 210 So. 3d 1 (Fla. 2016); Muhammad v. Florida,132 So. 3d 176 (Fla. 2013) (finding of Florida's midazolam protocol constitutional); Valle v. State, 70 So. 3d 530 (Fla. 2011) (finding Florida's sodium thiopental protocol constitutional). To obtain the relief he seeks Guardado must show that he has a substantial likelihood of establishing that allowing FDOC to proceed with his execution utilizing its current lethal injection protocol presents a risk "that is 'sure or very likely to cause serious illness and needless suffering,' and gives rise to 'sufficiently imminent

dangers.'" Price, 920 F.3d at 1325-26 (quoting Glossip, 576 U.S. at 877; Baze, 553 U.S. at 50) (emphasis in originals)). He cannot prevail by showing that he will experience pain as that is not a "substantial risk of serious harm." Id. Rather, he must present evidence likely to show the sort of "objectively intolerable risk of harm that qualifies as cruel and unusual punishment prohibited by the Eighth Amendment." Id. (quotations omitted). Guardado's evidence falls well short of satisfying this heavy burden. His concern regarding the potential use or future use of expired etomidate is not supported by the evidence. And his various other concerns are far too speculative to support a finding that Florida's planned execution protocol presents a risk that is sure or very likely to cause serious illness or needless suffering.

Accordingly, it is

ORDERED that Guardado's "Emergency Motion for an Injunction under the All Writs Act or, Alternatively, For a Stay of Execution" (Doc. 11) is **DENIED**.

DONE AND ORDERED at Jacksonville, Florida, this 30th day of October, 2026.

Marcia Morales Howard

MARCIA MORALES HOWARD
United States District Judge

Jax-7
c: counsel of record

A3

Redacted Evidentiary Hearing Transcript

October 22, 2026

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

JESSE GUARDADO,

Plaintiff,

v.

RICHARD COMERFORD, Secretary, Florida Department of Corrections, in his official capacity,

and

RANDALL POLK, Warden, Florida State Prison, in his official capacity,

Defendants.

Case No. 3:26-cv-2596-MMH-SJH

October 22, 2026

9:39 a.m. - 5:44 p.m.

Courtroom 10B

EVIDENTIARY HEARING

BEFORE THE HONORABLE MARCIA MORALES HOWARD
CHIEF UNITED STATES DISTRICT JUDGE

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P R O C E E D I N G S

October 22, 2026 9:39 a.m.

- - -

COURT SECURITY OFFICER: All rise. The United States District Court in and for the Middle District of Florida is now in session. The Honorable Chief Judge Marcia Morales Howard presiding.

Please be seated.

THE COURT: Test, one, two, three. All right. That's better.

This is Case No. 3:26-cv-2596. It is *Jesse Guardado vs. Richard Comerford, Secretary of the Department of Corrections, and Randall Polk, Warden of Florida State Prison*, both sued in their official capacities.

Counsel, beginning with the plaintiff, if you would please make your appearances for the record.

MS. McDERMOTT: Good morning, Your Honor. Linda McDermott on behalf of Jesse Guardado.

MR. GUNN: Sean Gunn on behalf of Jesse Guardado.

MS. ELLICOTT: Bailey Ellicott on behalf of Jesse Guardado.

THE COURT: All right. And the other folks seated with you-all, if you could just -- and good morning, Mr. Guardado.

MR. GUARDADO: Good morning, ma'am.

MS. WARD: Michelle Ward, also on behalf of Jesse.

MS. McDERMOTT: Your Honor, then we have your investigators here that are going to run our tech for us, Ms. Andrea Tinoco and Mr. Daniel Ashton.

THE COURT: Okay.

MS. McDERMOTT: Thank you.

THE COURT: And for the defendants?

MR. RODRIGUEZ: Good morning, Your Honor. Jason Rodriguez for all defendants.

MS. MILLSAPS: Charmaine Millsaps for all defendants.

MR. MERVINE: And Michael Mervine for all defendants.

THE COURT: This is backwards from the way my courtroom usually is, so forgive me if I -- I'm used to the plaintiff being on the left and the defendants being on the right.

All right. We are scheduled for an evidentiary hearing. Ms. McDermott, are you prepared to proceed?

MS. McDERMOTT: Yes, Your Honor. If we could just address one quick matter.

THE COURT: Sure.

MS. McDERMOTT: We're prepared to, in an abundance of trying to save some time here, to stipulate to defendants's exhibits and to ask the Court to admit all of the exhibits, plaintiff's and defendants's, now rather than as we're going with the witnesses, if there's no objection from the -- from

defendants.

MR. RODRIGUEZ: And, Your Honor, we agree. Our only objections would be the ones that we've already made regarding outside the scope of the hearing, potentially, and --

THE COURT: Well, but I ruled against that. So you've preserved it.

MR. RODRIGUEZ: And that's all I want to make sure is clear on the record, is that any objections we've made previously we reassert for preservation.

THE COURT: But with that objection reserved, you're fine with all plaintiff's and all defendants's exhibits being moved in?

MR. RODRIGUEZ: Yes, Your Honor.

THE COURT: All right. So all of those --

(Zoom interruption.)

THE COURT: This is why I don't like doing hearings.

All of the exhibits are admitted. And then -- so you-all can publish them as you wish. They're all in and you can use them in whatever manner you see fit.

MS. McDERMOTT: Thank you, Your Honor. And when we initially reference them, we'll definitely state what they are just for the record so it's clear, with the number and then the exhibit.

THE COURT: Okay.

MR. McDERMOTT: Thank you. So we are ready to

proceed. Ms. Ellicott is going to --

THE COURT: Let me just --

MS. McDERMOTT: Sorry.

THE COURT: No, I just want to make sure Mr. Rodriguez doesn't have anything he wants us to address before we start.

MR. RODRIGUEZ: So yes, Your Honor. We had requested to take Dr. Antognini out of order because he has a previously scheduled deposition that he's got to get to by 12:45 our time, 9:30 his time.

He is currently in a parking lot, where he'll be trying to give his testimony.

And we would also request the Court to swear him in. We had indicated those two things in our motion and --

THE COURT: I don't think that's legal.

MR. RODRIGUEZ: Your Honor, there is a statute that allows for it, and I can --

THE COURT: You'll have to present it to me because I haven't seen it. And this is not something that you raise the morning of.

MR. RODRIGUEZ: Your Honor -- and I apologize. It was raised. We had indicated that in our documents when we moved for their -- the amended motion for defense exhibits, Dr. Joseph Antognini, it's Document 42 [verbatim]. And as part of that, we had pointed this Court to 28 U.S.C., Section 459,

which provides each justice or judge of the United States may administer oaths or affirmations and take acknowledgements. We pointed out that the statute has no limits of location, and that Rule 34 of the Federal Rules of Civil Procedure provides the Court may permit testimony in open court by contemporaneous transmission upon a showing of good cause, and that Federal Rule of Evidence 611(a) notes the Court should adopt procedures effective for determining truth and avoid wasting time.

THE COURT: Okay. Ms. -- hold on.

Ms. Wiles, somehow I have neither Federal Rules of Civil Procedure or criminal rules books up here.

COURTROOM DEPUTY: I think they're behind you.

THE COURT: Where?

COURTROOM DEPUTY: Where did they go?

THE COURT: They're supposed to be there. I don't know.

None of -- none of those addresses what I've always understood to be the case, that -- none of this says that I can swear somebody virtually. I've always understood it to be -- and I haven't looked at this probably in 15 or 20 years -- but that the witness has to be sworn by an individual at the location.

MR. RODRIGUEZ: And Your Honor, my understanding -- and I've had evidentiary hearings in front of Judge Hinkle in the Northern District where he has sworn individuals in, but my

understanding is that that was always the old rule because you couldn't see the witnesses when they were just appearing telephonically, versus now, via Zoom, they are in person.

THE COURT: I guess, Ms. McDermott, in not opposing the witness, you had agreed to this? In not opposing the amended motion?

MS. McDERMOTT: Well, we agreed to the Zoom appearance, but we -- I'm not familiar with that rule. And I would leave it to the Court's discretion, certainly, in terms of -- we do have someone present for our witness to swear them in.

THE COURT: Well, did you advise Mr. Rodriguez that you didn't oppose the supplemental motion?

MS. McDERMOTT: Only as to the Zoom appearance. I wasn't asked about whether they could be sworn in. I don't think that that's within my authority to permit. So I was asked if I had any objection to their Zoom appearance, and I said I did not.

THE COURT: And that same motion also, as did the previous one, asks for the witness to be taken out of order. Was that something that you had agreed to or not?

MS. McDERMOTT: Well, we would have no objection to that, but our witness also has a commitment. Dr. Almgren, who's also going to appear by Zoom, she's waiting, and she's ready to proceed. But I don't think she would take very long.

So we're happy to then allow them to take their witness out of the order -- out of order if that's what the Court decides.

THE COURT: All right. Here's what we'll do. We'll go -- we'll do Dr. Almgren, and then, Mr. Rodriguez, we'll do your witness. I will -- I'll swear the witness, subject to determining later whether it's legally enforceable, because that is not my understanding. Maybe it has changed. I haven't had occasion to deal with it because in the past when I've said that somebody has to be present to swear the person, everybody has complied with that order.

MR. RODRIGUEZ: Your Honor --

THE COURT: And frankly, I'm not sure I should even allow the witness since you simply chose to disregard what my order said.

MR. RODRIGUEZ: So, Your Honor, and for the record, we did not choose to disregard. I do want to lay the record on that. We were trying and attempted to try to get someone there, but it is 6:30 in California. He is not in his normal location. We didn't even know what hotel he was going to be at until I believe last night. So we had difficulty doing that. This was not an abject disregard of this Court's order. So I apologize, but --

THE COURT: It's not that hard to find a notary public. It's not even that hard to find a notary public to be someplace at 6:30 in the morning. But we will proceed, and

depending on my determination of whether it is permissible, the evidence will be considered or it won't. But that's -- that's your decision.

MR. RODRIGUEZ: Thank you, Your Honor.

THE COURT: All right. Ms. McDermott, go ahead.

MS. McDERMOTT: Your Honor, Ms. Ellicott is going to do the direct of Dr. Almgren.

MS. ELLICOTT: We're going to call Dr. Michaela Almgren, who's on the Zoom now.

DR. ALMGREN: Hello. Good morning.

THE COURT: Dr. Almgren, can you either get closer to the microphone or maybe speak a little bit more loudly? We didn't hear you very well.

DR. ALMGREN: Sure. Can you hear me now?

THE COURT: That's much better, yes.

DR. ALMGREN: Okay. All right. I'll just raise my voice a little bit.

THE COURT: Is the notary present to swear you?

DR. ALMGREN: Yes.

NOTARY PUBLIC: Yes, I am.

THE COURT: All right. Go ahead.

NOTARY PUBLIC: Raise your right hand. Do you solemnly swear that the testimony you're about to make will be the truth, the whole truth, and nothing but the truth?

DR. ALMGREN: I swear.

NOTARY PUBLIC: Thank you.

The witness has been sworn.

MS. ELLICOTT: Your Honor, Dr. Almgren requested just a moment to walk the notary out.

THE COURT: (Nods head.)

MS. ELLICOTT: Okay.

THE COURT: Go ahead. You can.

DR. ALMGREN: Thank you.

(Pause in proceedings.)

DR. ALMGREN: I'm ready.

MS. ELLICOTT: Okay. Thank you, Dr. Almgren.

DR. MICHAELA ALMGREN, PLAINTIFF'S WITNESS, SWORN,

DIRECT EXAMINATION

BY MS. ELLICOTT:

Q. Good morning.

A. Good morning.

Q. Can you please introduce yourself to the Court.

A. So my name is Michaela Almgren and I'm an associate professor at the University of South Carolina College of Pharmacy, where I teach in our pharmacy program.

Q. Okay. And I'm going to refer to what's already been admitted as Exhibit 3, which is your CV. And we're going to discuss your background a little bit.

So can you provide a brief overview of your educational background?

A. Sure. So I have a bachelor's degree from Columbia College. I have a bachelor's degree in chemistry and biology. I have a master's degree from the University of Florida in pharmaceutical manufacturing. And so I have a master's in pharmacy and I have also doctorate in pharmacy. So I'm a pharmacist. I'm a licensed pharmacist. I graduated with my Pharm.D. from the University of South Carolina College of Pharmacy.

Q. And you teach courses concerning pharmaceutical standards?

A. Yes, yes. So I teach, really, a wide variety of courses. So I actually teach pharmacy law. That's one of the classes that I teach. And I talk in this class about, you know, how to comply with pharmacy standards on the federal and state level.

I teach classes in pharmacotherapy, where I talk about medications and, you know, the proper medication selection, talk about which medications to use when, drug interactions.

I also teach class in pharmacology and pharmacokinetics. So in a pharmacokinetics course I talk about how your body distributes medications, how, basically, medications get metabolized. I talk about pharmacology of medications, meaning how -- what the drugs actually do to your body, how they work in your body.

And I also teach courses in compounding. That's area of my expertise and really a lot of interest. I teach

students, and I also teach continuing education classes for pharmacists about compounding. Specifically, I specialize in the pharmacy sterile compounding, but I also can talk about non-sterile compounding. And I basically teach about all of the standards that are related to, you know, sterile compounding, the recordkeeping, drug management.

Q. Okay. And have you worked in the industry?

A. Yes, I also experienced working in drug industry.

Q. Okay. Can you explain briefly what a pharmacist does?

A. So a pharmacist is truly a drug specialist. And, you know, really depending on what your practice setting is, you will work in, you know, different areas. But in general, the -- your activities would be very similar regardless of where you work.

You are basically in charge of medication management. So you keep medication records, you dispense.

If you work in a compounding pharmacy, clearly you'll compound. If you work in, like, a community setting, you'll be dispensing medications. If you work in a hospital, you'll probably be helping with medication dispensing but also selection and dosing.

So really, wide range of activities kind of depending on your practice setting. But we all have the same thing in common: that we are drug specialists.

Q. Okay. And does your work pertain to drugs that are

designed for injection?
A. Yes, yes. That's kind of area of my interest and my specialty.
Q. And do you also have expertise in manufacturing drugs for injection?
A. I do. I do. So I practice in the industry, and basically I have a lot of experience with just drug manufacturing, also drug compounding under 503B regulations, which is a 503B section of the Food, Drug & Cosmetic Act. So there's 503A compounding that refers to compounding for -- you know, on a smaller scale for a patient's specific needs.

So if you have a prescription in a hospital, you would compound under 503A. If you are compounding like to satisfy drug shortage, for example, so you're compounding hundreds, or maybe thousands, of preparations, that would be considered kind of almost like manufacturing, right, and so that would be regulated under 503B regulations.
Q. So are you familiar with the best practices for professionals who are handling pharmaceuticals?
A. Yes, yes. And I also teach this. Again, when I teach pharmacy law, I talk a lot about, you know, practice standards and what are the expectations. And I teach my students about everything, from, you know, how is -- how to handle medications, how to dispense, what's required in terms recordkeeping, what's required in terms of dispensing, what

goes on the label, what are the features that are really important to, you know, keep track of.

Q. Okay. And have you testified before as an expert witness?

A. I have.

Q. Have you testified in federal court as an expert witness?

A. Yes, I have.

Q. Okay.

MS. ELLICOTT: At this time plaintiff is going to offer Dr. Almgren as an expert witness in the fields of pharmacy, pharmaceutical manufacturing, and ethics.

MR. RODRIGUEZ: No objection, Your Honor.

THE COURT: All right. The witness can testify as to her opinions.

MS. ELLICOTT: Okay.

BY MS. ELLICOTT:

Q. Dr. Almgren, did you review Florida's lethal injection protocol in your preparation for this case?

A. I did.

Q. Okay. And I'm going to refer to the lethal injection protocol, which has been admitted as Plaintiff's Exhibit 1. Can you briefly describe the three-drug protocol?

A. So the three-drug protocol basically contains three medications. So there is the etomidate, which is agent that basically is used as a general anesthesia type of agent. So we see this drug used in the regular pharmacy practice as well.

We use it a lot when we are maybe using it for procedural anesthesia, where this agent has a very fast onset, really short time that it works. So it's really an excellent agent to use in certain patients where you're doing something relatively fast, or maybe it could also be used for, like, induction of general anesthesia. So basically you use it to kind of put the patient to sleep, to make them unconscious, and so this way they don't remember anything that's happening while they are under the influence of this drug.

Like I said, again, it is a very fast-acting drug, and at the same time the patients can recover really fast.

The nice feature about this agent is that it doesn't really have impact on your cardiovascular functionality, and so it's really useful in patients who maybe have weak heart or maybe they are in shock and so they have issues with stabilizing blood pressure. And so this will be a great agent to use for that as well.

So the second drug that's used in the Florida lethal injection protocol is the rocuronium. And the rocuronium is a paralyzing agent. So, again, commonly used in general anesthesia when you basically have patient that, you know, needs to have some type of procedure done, some type of a surgery, perhaps. And so you will use this drug typically to incapacitate the patient. So this way they will not move during surgery. Even, you know, the reflexes that could

potentially occur, this basically gets the patient to be completely still.

And then the third agent that's used in the Florida lethal protocol is the potassium acetate. And in a regular patient care this would be used to collect -- to correct electrolyte imbalance, but in -- it has different purpose in the Florida lethal injection protocol, where it's basically meant to stop the heart from functioning and induces, I guess, cardiac arrest.

Q. And based on your pharmaceutical background, did you have any concerns about any of the drugs used in the protocol?

A. So, yes. I definitely have concerns about this particular drug combination just because I really believe that there should be some changes made to the protocol. For example, the protocol does not really have any type of a pain-relieving medication on board, so there's really no analgesic protocol.

The etomidate itself I think has issues, and that's just based on the fact that the etomidate, the way that this works is this drug has a really fast onset. And then as the activity of the drug peaks, typically within a minute, the activity starts kind of dropping off. So what's happening, basically, this is a drug that's very highly lipophilic, and so that's why it reacts so fast, because basically when you infuse it into the patient or give, like, a bolus injection, the levels of etomidate really go really high.

And the drug has no problem crossing blood-brain barrier. And so as it crosses the blood-brain barrier, of course it starts working, and so the patient will lose consciousness, fall asleep.

So as that effect peaks within a minute, it lasts certain amount of time. Three to five minutes is what's typically listed in literature and in the package insert. So it will last three to five minutes and then it starts rapidly dropping off.

Now, the metabolism of the drug is (Zoom glitch), so the drug does not instantly get metabolized. Of course, there's a portion that's being metabolized, but this drug is what we consider a two-compartment model. So you see what -- two different sets of activities going on with this drug, or kind of two different things that are happening in terms of the distribution of this drug.

So like I said, in the first compartment you have this central compartment distribution, so the drug crosses the blood-brain barrier --

THE COURT: Excuse me.

THE WITNESS: -- blood-brain barrier.

Yes?

THE COURT: You glitched out there for a moment, so if you could go back about two seconds, or two sentences.

THE WITNESS: Sure, sure.

A. So the -- the distribution -- in the first compartment, when it reaches -- when it's injected, it basically crosses the blood-brain barrier and it reaches the brain (Zoom glitch) consciousness, and then it's basically starting to distribute as it's getting into that second compartment model. It starts distributing throughout the body. So you'll see this peak, and then the drug is reaching other areas, other organs at that point. And so you'll actually start seeing the levels of the drug dropping off.

And so as the levels of the drug dropping off, like I said, in literature it's identified as the time span of about three to five minutes you start. That's the peak activity, and then the levels start going down. And so the patient's consciousness is returning.

Now, one thing to keep in mind with this particular drug is that it is -- it does not have -- it does not have linear relationship between the level of the drug and the length of how long the patient is asleep.

So what that means is if you expect activity of this drug to be three to five minutes, if you give ten times the dose, it does not mean that the patient -- that now the patient (Zoom glitch) out and will be unconscious for 30 to 50 minutes. That's not how this drug works because of its two-compartment mechanism.

So the -- it's true that potentially the period of

activity will get longer, but what's interesting from literature, it appears that actually the sleep gets deeper. So that's what you're seeing when you look at the literature. There is a vigilosomnogram in one of the articles that kind of illustrates this point.

THE COURT: I'm sorry, ma'am. There's a what in the literature?

THE WITNESS: It's called vigilosomnogram. So basically it shows you how deep the person sleep during this exposure to this medication. And what's interesting, you will see that the depth of the sleep is getting deeper. So the person is more unconscious but not necessarily for a longer period of time. And so that's what happens when you increase the dose.

So my concern is that basically with this drug, the -- depending, of course, on whether the full dose is given, how much is given, the size of the patient, you know, what are his other physical attributes, meaning, you know, is the person overweight, how are -- how is his kidney function, how is his liver function. So all that plays into role of affecting your drug level, right.

And so based on that, the person will basically reach that peak of having -- losing consciousness, and then they basically start coming up. And that time for how long really depends on all these additional factors that I just mentioned.

And so one of the concerns I have with the Florida protocols is that there's a potential, if, let's say, the drug quality is not good, let's say the drug is not at the full potency, if that's combined potentially with a patient being on the larger side, that window, time window of when the person is unconscious, may be potentially relatively, you know, shorter than expected.

And so with that, when we add those additional drugs, like the rocuronium and like the potassium acetate, there is a potential that a person could still perceive some of those sensations.

Lot of times when patient is coming out of deep sleep or deep anesthesia, they may still appear they are asleep; like they are laying there, they are still, but they're getting some of the consciousness back. They just, you know -- really, it just takes while for person to fully respond and fully to, you know, come about.

And so I am not sure of what type of a check is done at that point in terms of the -- whether the person is checking if the condemned is still, you know, unconscious or not. I'm not sure how that check is done and, you know, what techniques are used. But it would be really important to assure that this person is qualified to perform these checks, so this way, you know, it's assured that that transitional period has been -- that it had reached yet when a person is coming out of

unconsciousness.

Q. And Dr. Almgren, I just want to clarify one thing with you. The relationship between a massive dose of etomidate and the duration of consciousness, is that a linear relationship?

A. It is not. Yes, it's definitely not a linear relationship because this is a two-compartment model.

So the difference here is if you look at the smaller typical doses that we use in patient care, you can see the linearity just because with the smaller doses, that second compartment doesn't come into play in the same way it does with the larger doses. And so that's why that relationship is not linear.

So yeah, as I said earlier, if you give patient, let's say, ten times the dose of etomidate, it does not mean that if -- in the normal -- in the normal (Zoom glitch), if it takes three to five minutes to come out of the unconsciousness that with the 10 times the dose it would take 30 to 50 minutes, that's not what that means. There is no linearity between those two factors.

Q. Okay. Thank you. And while you reviewed the protocol, did you see any guidelines or information regarding how the drugs are being stored and handled?

A. No, no specific guidance that would basically line out what needs to be done in terms of the medications, in what conditions they should be stored, you know, room temperature,

where they should be stored that was mentioned.

And, you know, sometimes medications, a good example is rocuronium, for example. Some of the formulations of rocuronium may need be to refrigerated. Not all the formulations, but some of the formulations require refrigeration.

And so it would be important within the protocol to discuss how the medications are to be stored, in what conditions, depending on, you know, what -- which drug and what the storage conditions are required by the manufacturer.

Also, you should have within the protocol, you know, some type of a log or recommend keeping log of temperatures, humidity, especially in Florida, where temperatures can be sometimes, you know, more difficult to maintain the room temperature. So it would be really important to make sure that the -- that there is -- there are some instructions that basically require the -- whoever is taking care of the medications, that requires them to maintain those logs and maintain the temperature in the proper levels for the drugs to basically stay functional.

Q. And why is outlining this information in the protocol so important?

A. Because it's really important that the medications are stored properly.

So there is a USP compendium, which is kind of a

reference for all of us pharmacists. And the USP compendium has multiple chapters on proper storage of medications.

The reason why the storage conditions are so important is that if the drugs are not stored in proper conditions, the medications can degrade, break down, and basically not work as expected.

Q. And are these guidelines something that all pharmacists should be aware of?

A. Yes, yes. Typically during pharmacy training you absolutely will have some dedication -- some time dedicated to, you know -- whether it's in the pharmacy law or pharmacy lab, at some point in time in your curriculum typically we teach our students about how to, you know, manage records and how to manage medications and what happens. I mean, it's important that students know, our future professionals know, how to handle medications. It's a part of the, really, responsibility of the pharmacist.

Q. Is it similarly important that a protocol would have guidelines for the recordkeeping behind handling drugs?

A. Yes, that would be helpful to provide that, especially if maybe there are folks that are not professionals, not pharmacy professionals. If you have other people involved in drug handling or storing, it would be important to have, you know, good guidelines so you can assure that the medication are stored properly and that the records are kept properly.

Q. Okay. What happens to the drug when it has degraded?
A. So that's one thing that's important to keep in mind, that you don't always -- are not always able to tell if the drug degraded. So when you look at the vial, the drug may appear perfectly fine, so you don't really know that the medication -- there's anything going on.

But at the same time, the medication can lose potency, so it may not be at the strength that it was to -- it was originally made to be at. It may change pH, so it will become more acidic or it may become more basic. And that, of course, will impact how it will be absorbed and how it will react within body. It can precipitate. I mean, there are a lot of things that can happen. Sometimes the molecule itself, the active ingredient, will degrade. And when that happens, all of a sudden your potency is lower.

And not only that, but sometimes depending on what the -- what it degrades to, it may even have a completely different pharmacological activity. So a molecule that was initially designed to be a sedative may actually become a stimulant when it converts during this degradation process.

So it's very hard to say what would happen because the degradation process, you know, is impacted by what is the degradation; you know, is it because of the high temperature, it is the light exposure, or whatever it may be.

Q. And based on your professional experience, how important

is accurate recordkeeping in your line of work?
A. Oh, it's very important. Recordkeeping is one of the major responsibilities for a pharmacist because, really, we are the ones that are medication experts and we are the ones responsible for medication distribution. So you want to make sure that your -- that you have close track of your medications. You know, in regular pharmacy practice, we are pretty much the ones responsible for making sure the medications have proper records, we know when they came in, when they were received, how many of what we received, when do they expire, what's the lot number. All of that information is very relevant to practice.
Q. Okay, Dr. Almgren. I'm going to -- did you also review DOC's internal drug logs?
A. Yes, I did.
Q. I'm going to point you to Exhibit 2. Have you seen that before?
THE COURT: I'm sorry, you need to say Plaintiff's 2.
BY MS. ELLICOTT:
Q. Plaintiff's Exhibit 2, which is FDOC's drug inventory logs.
A. Yes, I have it in front of me.
Q. Thank you.
Did anything stand out to you at the outset when you were looking over FDOC's method of recordkeeping?

A. So I notice in general -- of course, there are parts that are redacted, and so that's -- it's really difficult to kind of perform audit when you are missing portions of the really important information.

But I notice this is all handwritten. And a few things I noticed, for example, were there really should be an area where the person that's recording the information should sign or initial. That's a part of, you know, kind of requirements.

Like I previously said, we had USP compendium, which is kind of like a list of all the regulations that relate to pharmacy and pharmaceutical industry. And there's actually a USP chapter, 1029, that is dedicated to describing the requirements of good documentation practices.

And so one of the attributes of the -- of your recordkeeping is making sure that the records are actually readable so you know who actually made the record, who actually wrote it.

So one of the things I noticed on these records, there's no slot for, like, initials or anything like that. So it would be difficult, for example, to trace back who made the -- you know, who made the correction or who made the note, who actually received the drugs and who wrote them in.

So the records are not really, you know, very transparent. And it's difficult to kind of audit them because

you see this, you know, medications, and at times there appears to be, like, some write-overs that are difficult to decipher. And I want to say I even saw some Wite-Out used in the records, which is completely inappropriate.

Q. Okay. Let's look at page 3 of Plaintiff's Exhibit 2.

A. Okay.

Q. And Dr. Almgren, I'm going to point you to an entry that's about fourth up from the bottom dated January 3rd, 2025.

A. Okay. I see it.

Q. Okay. Can you tell me what it says in the middle column labeled Expiration Date?

A. So I believe it says 11/2024.

Q. And can you get a good idea of what's happening in this entry?

A. So from this, it appears that there were 40 vials that were removed from the inventory on, I'm assuming, January 3rd, 2025. That's that first column. And those vials were already expired because the vials expired in November of 2024.

Q. Is it good practice for that long of time to go on before expired drugs are disposed of?

A. No. You should not have in stock mixed your expired vials along with your usable vials. So what we would normally do in practice is if I'm -- if I have a stock of drugs and I see some of them are close to expiring -- for example, in a hospital, we actually remove them the month before. So if the drug was

expiring in November of 2024, probably we would remove them by the end of October of 2024. They would be removed from the stock and put in, like, a quarantined area because those drugs are coming close on expiration. And they should absolutely be removed by end of November of 2024.

Q. Okay. I'm going to point you to another entry on the same page. It's about in the middle. It's dated December 8th of 2022. Do you see that entry?

A. Yes.

Q. Can you tell me what's happening there?

A. So in that entry it appears that vials were removed. 120 vials were, I guess, removed on December 8th of 2022 that actually expired, looks like, July of 2022.

Q. So does it look like the same thing happened that we were just discussing?

A. Yes. That's exactly what's happening here as well. So I guess they realized that the stock was expired and they removed it. But once again, the drugs were supposed to be removed in July of 2022 or before, not in December. I mean, that's a very, very large time passage when we're talking about five months that these drugs were expired for a long period of time, and I guess they were still in the stock of the non-expired medications.

Q. And Dr. Almgren, let's move to page 6 of this same exhibit.

A. Okay.
Q. What medication is being tracked on this page?
A. So this is potassium acetate.
Q. Okay. And what is the potency of this particular medication being tracked?
A. So this medication is 2 milligrams per milliliter. That's the strength. It comes in a 20-milliliter vial. So I guess the total is 40 milliequivalents in each vial.
Q. Okay. Doing some quick math here, for the requisite 480 milliequivalents, how many vials would need to be prepared for an execution?
A. You would need 12.
Q. Okay. Thank you.
Do you see an entry third up from the bottom dated June 12th of 2025?
A. June 12th, 2025, yes, I do see it.
Q. How many vials were removed on that date?
A. Seven.
Q. If I told you that there was an execution on June 10th, do you have any indication here that that person received potassium acetate at all?
A. No, because there does not seem to be anything that was removed on June 10th.
Another important attribute, or one of the kind of like key elements of an appropriate recordkeeping in a pharmacy

is that the records are supposed to be contemporaneous. So what that means, whenever we handle the medication, this is the time when you record the medication.

So if they were removed on the 10th, then there should have been an entry in this log on the 10th of June.

Q. Okay. And for an execution that corresponds to this entry on the 12th, would that person have gotten enough potassium acetate?

MR. RODRIGUEZ: Objection, speculation.

MS. ELLICOTT: Your Honor, she's just speaking from the records. She's --

THE COURT: Let me have you rephrase the question.

MS. ELLICOTT: Okay, I'll rephrase.

BY MS. ELLICOTT:

Q. If there was an execution corresponding to that entry on June 12th, did that person get enough potassium acetate?

MR. RODRIGUEZ: Objection, speculation.

THE COURT: Sustain the objection. You can ask your question differently about whether it complies with the protocol, but I don't know how she can -- unless you lay the foundation of how she can know whether that person received enough potassium acetate to accomplish its stated purpose. That's a different thing, so...

MS. ELLICOTT: Okay.

BY MS. ELLICOTT:

Q. And you do not see an entry for June 10th, correct?
A. No, I do not see entry for June 10th at all. And you would really need 12 vials of the medication, and this says it's 7.
Q. Right. Okay.
On page 16, what medication -- or we'll turn to page 16 first. I'll give you some time.
THE COURT: I'm sorry, 16?
MS. ELLICOTT: Yes.
THE COURT: Thank you.
A. Okay.
Q. What medication is being tracked here?
A. It's lidocaine.
Q. When you reviewed the protocol, did you see lidocaine mentioned anywhere?
A. No, no, I did not see lidocaine. The only additional drug in addition to the three that are part of the protocol was hydroxyzine, which is used for anxiety.
Q. What potential dangers could arise from the administration of drugs not written in the protocol?
A. Well, the protocol would specify --
MR. RODRIGUEZ: Objection, overbroad, focus on lidocaine.
THE COURT: Yeah, I do think that we need to clarify that question, please.

MS. ELLICOTT: Okay.

BY MS. ELLICOTT:

Q. What potential dangers could arise by administering lidocaine when it's not called for in the protocol?

A. Well, the concern there is that the protocol is pretty specific about how much of what to add, where you add it to. And the problem here is that this could lead to medication error because it doesn't really tell people at all in terms of how to use it. Like do you use 1 milliliter? Do you use 5 milliliters? Do you use that as an injection? I mean, there's really no information in the protocol at all about how much you would use, how would you use, when do you use it, you know, do you use it separately as a -- you know, this is -- this is clearly a numbing agent, but it -- you know, it does not at all say anything in the protocol about at what point of time you would use it and how you would dose it, and do you use it as a separate medication or do you mix it with the ones that you already have prepared? So there's just no information.

Q. Okay. Can we turn to page 26, please.

Dr. Almgren, have you seen this page before?

A. Yes, I have. This was in my original packet when I looked at the case initially.

Q. Okay. If I told you that there was an execution on August 28th, can you find the etomidate used in that execution?

MR. RODRIGUEZ: Objection, speculation again.

THE COURT: I'll allow it. Go ahead.

A. There is nothing -- there is not a specific data entry that relates to the 28th of August.

Q. Why would it be important for there to be an entry on every date of an execution?

A. Because if the medications are removed on those dates, those would be the dates that you would enter the medication records. That's why -- the point is when you write down you retrieved the vials, how many you retrieved, the expiration date, the lot number, who retrieved it, all that would be recorded. So, of course, again, in the spirit of the good documentation practices, you would make the note in the records contemporaneously, meaning when it's happening.

Q. Okay. Can you please look at the bottom four entries starting on August 19th through September 30th of 2025.

A. Yes.

Q. What do you see in those entries?

A. So I see that the vials that were removed, 10 at a time, were all expired. So they actually expired on January 31st, 2025. But, for example, on September 30th of 2025, they were used. So that would mean that that medication is well past its expiry. And it's basically the case in all of them. There are some used in August and some in September. They're all well past their expiration dates.

Q. And based on your understanding of that Received/Used

column, what does that refer to?

A. Basically it says that 10 vials were removed at each of those data -- dates.

Q. What is an expiration date for a drug?

A. So the expiration date for a drug, it's established by the manufacturer, and it basically is the date after which you should not be using the drug. So the manufacturer can guarantee that up through the end of January of 2025, for example, the etomidate was meeting all the quality standards.

So typically the manufacturer performs number of stability studies, where we study the drug and make sure that we have a point that we can say, yes, up through this point, all of the vials -- whether we made a batch of 20 or a batch of 20,000, all of the vials at that time are all meeting quality standards.

So once you reach that expiration date, anything past that, the -- there's a potential that the medication may degrade. There may be changes in some of the vials, even though it may not be across all of the vials. And this is why, for example, I would not recommend extending expiration without first doing stability studies, because the -- the expiration date basically is where we guarantee all the vials are good. And so if you were trying to extend, let's say, the vial expiration, let's say you test one of the vials; just because one of the vials had passed doesn't mean that all of them

within the batch had passed. So you would have to really extend it by using more extensive studies to assure that the pattern continues.

So the expiration date really just tells you: Up to this date we know all of the vials that were made on this date with this lot number are good, and you should not be using them past that date.

Q. Can it be dangerous to administer expired drugs?

A. Of course, of course. It really depends, you know, on, you know, what type of a drug it is. But different medications have different degradation profiles, and so some may cause harm.

Q. Is it important for this to be correct in defendants's records?

A. Yes, absolutely, because basically it tells you, you know, that the medication was still in date and that it was okay to use.

Q. In your experience from working in the pharmaceutical field, would recordkeeping violations like this be investigated?

A. Typically, yes. And even in the pharmacy, if we are seeing, you know -- if I worked in a pharmacy, or in the industry, if I come in the -- you know, and look at the records and I see that we have been using expired medication, that would absolutely raise alarms within where -- whether in a

hospital or in the industry because that's just -- that's simply not acceptable. That's not something that we normally do.

And so this is, again, where it would be helpful to have the initials of who had made those entries so you could go back to this person and potentially initiate investigation trying to figure out how did this happen.

What I find particularly disturbing is that it happened multiple times. So this is -- if, you know, there was only one entry in August, then you would think that when they made the next entry on August 29th that they would notice, oh, I see I guess we're using expired drug. But this kept on going and it did not seem to catch anybody's attention.

Q. Okay. Thank you.

We are going to move on to what's already been admitted as Plaintiff's Exhibit 8, which are updated logs from defendants. And Dr. Almgren, can you please turn to page 8 of that exhibit.

A. Okay.

Q. Based on the dates in that first column -- based on the dates in that first column, did you see any entries for July 31st of 2025?

A. There is July 28th, 2025. You mean expiration or you mean like the entry, the actual entry?

Q. The entry.

A. The entry. Yeah, no, there is just July 28, 2025, and there's August 1st, but there's nothing for July 31st.

Q. Okay. And I'm going to ask you the same question: Do you see anything -- do you see any entries dated July 15th of 2025?

A. No, there are no entries from that date.

Q. Okay. And on that page, in the middle, what -- what do you see in the Expiration Date column for the entries corresponding to August 19th, August 29th, September 17th, and September 30th of 2025?

A. So this is really interesting because we just looked at the previous records that were indicating different expiration. And so looking at those same entries in this column, now what previously was January 31st, 2025, now has been corrected to 2027. And so it looks like maybe a Wite-Out was used or maybe just like a heavy-handed correction was made on those numbers.

Q. Does it look like that happened anywhere else on this document?

A. So there are a couple other -- there are a couple entries above and below, but these are really obvious. And like I said, you can see use of Wite-Out, which is completely inappropriate in proper recordkeeping. You would not be using Wite-Out to make corrections.

Q. Does this new version give you any indication of what actually happened on those dates?

A. You mean like if...

Q. Can you --

A. I mean, I guess I'm -- go ahead.

Q. Yeah. Can you understand what happened on those dates?

A. No, I really don't know why, I guess, the numbers were changed.

Q. Okay.

A. I mean, in the pharmacy, when we do any kind of corrections, we typically mark over. So let's say if I wrote the date and it was supposed to be January 31st, 2027, and I wrote 2025, what I would normally do, and what I would expect normally, you know, trained pharmacists who works in -- you know, in the hospital or in the, you know, pharmacy, or anywhere, really, that they would come and they would just mark over the -- you know, the incorrect entry. So if it says 2025 and you meant to write 2027, you just mark over it and you're going to say "wrong date," and then you're going to write the correct date and you're going to initial it. So this way, whoever comes after you, anybody who's auditing the records can say, oh, I see you made a correction; you wrote the wrong date. So that's how we typically handle corrections.

You should not be using Wite-Out to make the corrections because then it just does not look right. Like what was underneath? Why was the correction made? Who made the correction? I mean, this really kind of invalidates the points of the records -- the recordkeeping, because you can

just come and Wite-Out random data and input whatever looks better. And really, that's not how it should be. It should be, you know, whatever is happening. The records should reflect your practice and any corrections should be clearly visible.

Q. Can you turn to page 12 of Exhibit 8.

A. Yes.

Q. Do you see anything in the margin of this document?

A. Yeah. So this actually is a prime example of what I was talking about in terms of making a proper correction. You would mark over the line and basically just say "error."

And it almost looks like, I would say, that maybe there is -- maybe it's initials or a date. But I would definitely mark over it, put the date and the initials, an explanation, like this person said error. And that's perfectly acceptable. Yes, the record maybe doesn't look the neatest, but at the same time, it truly reflects, you know, what's happening and ultimately does not create any questions because you realize, okay, maybe they used the wrong log; maybe they meant to record this line in another log.

Q. And based on your expertise of professional standards, is there any justification for why this practice is being followed inconsistently?

A. I cannot imagine why they are not applying this across the board. I mean, this is very straightforward.

Q. Why is it important to keep track of who handles drugs and what they're doing with it?

A. Because this way we can go back and we can trace back if there are any questions.

So let's say you wrote a wrong lot number. We can look -- and then you made a correction. Now we know who did that. And we can go and ask and say, you know, what happened? And the person can explain, I'm sorry, I looked at a wrong bottle, or I misread the number. So you can easily figure out what happened, why this correction was made.

So it's important to have accurate records, contemporaneous, legible, and, you know, easy to track everything, because ultimately this is part of our practice.

Q. And would that sort of investigation usually become part of the records themselves?

A. So, yes, typically if we had -- so prime example I think would be the change of all those dates from 2025 to 2027. If this were my pharmacy, I would probably initiate an investigation and probably include that as a record in case that we get an audit whether from a regulatory body, whether from the Board of Pharmacy or from FDA or from, you know, wherever, whoever oversees our practice. I would want to be able to document and show them: Yes, we investigated. There were five dates that were changed. And so we have performed investigation and this is what we found and this is what

happened.

Q. And in your expertise, who would be the best fit to do that investigation?

A. So it really kind of depends on the pharmacy and its policy. So if you have, like, a pharmacist in charge, that would be a good person to do it, somebody probably a -- somebody who was not really involved in the error. But it really kind of depends. Could be a manager.

Q. Why is it best that someone not involved in the error is doing the investigation?

A. Because they basically have no interest. They are -- you know, they're not trying to maybe hide their mistakes. They -- when a third person or a different person is involved, they can typically, you know, be -- just don't really have any -- you know, they're just trying to find what happened. They don't really have any interest in, you know, protecting themselves or anything. You can just easily, you know, investigate and interview the person and write down what happened.

Q. Do these records from defendants give you any confidence that defendants are investigating their own conduct fully?

A. I don't see any reports that would indicate that they have done any investigations. And so, no, I would be very wary and concerned with these records because there are a number of corrections. And in particular, that Wite-Out practice is just absolutely terrible.

Q. In your professional opinion, is there room for error here in a system that tracks drugs the way FDOC does?

A. I would say yes, because you really should have some oversight. If you had this one person who is doing the records, there should be maybe somebody who performs regular audits and comes and just verifies that everything is correct.

Also, it would be helpful, maybe have another person to verify -- if these errors are happening, maybe have another person who comes after the person makes records and records what's happening and verifies that everything was correct.

Q. Okay.

MS. ELLICOTT: Your Honor, may I confer with co-counsel?

THE COURT: Yes.

MS. ELLICOTT: Okay.

(Pause in proceedings.)

MS. ELLICOTT: Thank you, Dr. Almgren.

THE COURT: Mr. Rodriguez.

MR. RODRIGUEZ: Yes, ma'am.

CROSS EXAMINATION

BY MR. RODRIGUEZ:

Q. Good morning, Dr. Almgren. Can you see and hear me?

A. Yes.

Q. Excellent. Just one moment.

All right. I wanted to begin discussing etomidate

generally before we get into some of the records issues and things like that.

So the first thing that I wanted to ask you is how long has it been known about etomidate, in your view, that it does not scale linearly, that it -- and that it drops off quickly?

A. So there is a study from 19, I think, 82 that's published in a British Journal of Anesthesiology that basically shows correlation between the sleep and the EEGs of patients who received doses of etomidate, regular doses, and then higher doses.

Q. So -- and please correct me if I'm wrong. Everything that you testified to about etomidate, how long it works, how fast acting it is, how someone will come up out of consciousness, is something that's been known for over four years, correct?

THE COURT: I'm sorry, four --

A. Since 1980s.

Q. Since the 1980s. So it has been known since the 1980s that etomidate does not scale linearly?

A. Yeah.

Q. It's been known since the 1980s that etomidate has a quick-acting life of three to five minutes in a normal dose?

A. Yes.

Q. It has been known that the person can quickly come up out of etomidate after an average dose since the 1980s?

A. Yes, probably even '70s, because the drug was really discovered back then.

Q. Okay. Thank you.

So you'd agree that the average dose of etomidate is about .3 milligrams per kilogram, right?

A. Yes.

Q. And that produces about three to five minutes of hypnosis, right?

A. Yes.

Q. Okay. During those three to five minutes, is the individual consciously experiencing pain?

A. They should not be. They -- the three to five minutes is the typical range where they reach that deep sleep.

Q. Okay. You'd also agree that the level of hypnosis produced by etomidate is dose-dependent. The insert says that, right?

A. Can you repeat the question? You kind of broke up, I'm sorry.

Q. Sure. The length of hypnosis for etomidate is dose-dependent. That's what the insert says, right?

A. So the insert says that it is dose-dependent, but that is in those lower doses that we typically use. So the -- like I said earlier, there is not a linear relationship between dose to when it gets to these higher doses that you're talking about. And in general, it is not a linear relationship between

those two.

Q. But does it go up? The more that you give someone, will they be under longer even if it doesn't scale precisely linearly?

A. Right, scale will be longer, but really, what the article from the Journal of the British -- of the British Journal of Anesthesia says that, actually, the people reach deeper sleep. So they stay under little longer, but it is not proportionate.

So as I said earlier, three times the dose does not guarantee three times longer state of unconsciousness.

Q. So now you used the words "does not guarantee." Does that mean that it absolutely will not?

If you give someone three times -- I apologize. Let me clarify the question.

If you give someone three times the dose of etomidate, does that mean that they absolutely will not be under for three to five times longer?

A. Well, that's hard to tell because it really depends on each patient because, you know, this is an average patient. Does the patient have kidney disease? Does the patient have liver failure? I mean, you can't really make these assumptions that it always works or it never works.

Q. Sure. So let's isolate. Let's assume a perfectly average patient. I'm only looking for is -- can you tell me with certainty that three times the dose of etomidate will not put

him under for three times longer?
A. I mean, I can't really say either way because it depends. And it depends on a lot of factor. Even with the average patient, there are a lot of factors to consider with that.
Q. So you're not actually able to testify to how long Florida's 200-milligram protocol will keep Jesse Guardado under the effect of etomidate?
A. I don't think anybody can. I don't think there have been studies done utilizing this dose.
Q. Excellent. All right.
And you're not aware of Jesse Guardado's weight, are you?
A. No, no.
Q. You're not aware of his age?
A. No.
Q. Are you aware that -- are you aware of whether there have been studies done indicating that etomidate is more effective with an older population?
A. I didn't think it's -- since I don't know what this particular person -- really, honestly, I was asked to opine on the protocol itself, so not patient specific.
Q. Thank you.
All right. Now let's turn to the concerns that you -- oh, I apologize. Oh, yeah, let's turn to the concerns about the records logs and the notations.

So first, as a broad question, you're aware that the FDA does extend the life of drugs at times, particularly during shortages, right?

A. Sometimes, yes.

Q. Sometimes.

Are you aware that they did so on December 20th, 2022, with etomidate specifically?

A. No. I did not look into that.

Q. So you conducted no research into whether the life of etomidate has ever been extended by the FDA?

A. Not for -- not at this time, no.

Q. Okay. Thank you.

A. Has it been? I mean, I'm unaware completely. And a lot of times it will only pertain to certain lots and only certain products.

Q. Yes.

Now, I just wanted to get some things clear on the record. You do not work for the Department of Corrections, correct?

A. I do not work for the Department of Corrections.

Q. And you've never worked for the Department of Corrections?

A. I never worked for the Department of Corrections.

Q. You have no personal knowledge about whether expired etomidate was used, correct?

A. I have no -- I do not have any knowledge whether it was

used or not. I'm strictly making the assumption based on the records that were provided to me.

Q. Okay. And you don't know -- because there were two versions of the records, one that showed -- indicated potentially expired etomidate and one that indicated unexpired. You don't know which one of those is right?

A. Well, I only saw the -- when I received my data, I only saw the one that was indicated use of expired drugs.

Q. But now you've been given an updated copy that shows an expiration date of January 31st, 2027, for those same dates you reviewed initially, right?

A. Yes.

Q. And you don't know which one is correct?

A. Exactly.

Q. Would the best -- well, I'll leave that alone, actually.

The expiration date for a drug is the date past which it is no longer guaranteed to be as effective, right?

A. Correct.

Q. Okay. That does not mean that it, in fact, is not effective, right?

A. Well, that's really not a discussion here because we don't know.

Q. Well, no, but if you just answer --

A. I assume that it is. If the drug company says that it's not to be used past that date, then in my opinion, I would

not -- we normally, in a clinical practice, do not use expired drugs on patients. I mean, we assume that that -- that expiration date is there for a reason.

Q. Absolutely. But you do not, in fact, know how many months it takes for etomidate past expiration date to stop working, right?

A. Well, the drug company knows because they do stability studies.

Q. And the expiration date is the last possible date where the drug stops working in those stability studies?

A. Well, what this indicates is that that's the date at which we can guarantee that all the product, that particular lot, that particular product, can -- we can guarantee that the quality -- that they meet all quality attributes. And after that date, there is no guarantee.

So it may still have some potency; it may not have the same potency. There may be other attributes that have changed, like the pH or other -- the other quality attributes of that drug.

Q. So after the expiration date, could it still have 100 percent potency?

A. Theoretically, yes.

Q. Okay. And you just don't know. You would have to actually test the etomidate to know on that day how effective it was?

A. Well, that would be the safest thing. The problem with that is that you can only test -- if you test that one vial that you were to use, then you can't use that vial, right, because you opened it and it's not sterile anymore.

So this is why this is not really something practical, and it really is not something that you would normally do. So you can't just, like, take one vial out of the batch after expiration and test it and then say, okay, well, because this one vial passed, we can extend the expiration. That's really not how that works.

Q. Absolutely. All I'm trying to understand fully is you do not know how effective etomidate is -- the particular vials that you think were used, you don't have any indication of how effective they were at that point in time?

A. Right. I don't think anybody can --

Q. Right.

A. -- with certainty say whether they were effective or not.

Q. Right. You can't say that they were likely only 50 percent effective, right?

A. Right. Nobody can say that, right. I agree.

Q. And you can't say that they were not 100 percent effective. You just don't know?

A. We don't know.

Q. Okay. Thank you.

And you're aware of no researches or studies

indicating that etomidate past expiration date is either, you know, effective or ineffective?

A. So you see the catch here is that when we're talking about past expiration, the -- when we're talking about these types of studies, the study -- if you were to extend -- if you were to extend an expiration of a product, it has to be for that specific formulation, in that specific presentation, in that specific manufacturer's lot.

So you cannot extend -- just because at one point of time three years ago they were able to extend etomidate expiry beyond what the expiration was initially, and maybe it was Pfizer and now we have these Baxter vials, we can't just assume that, oh, these Baxter vials are okay to use because Pfizer three years ago extended their expiration date. That's really not at all how it works because the stability and the quality of the product is tied to that specific product, that specific manufacturer, that specific formulation, because there might be even formulation differences between different manufacturers of etomidate product. And so there are too many differences. And so I would not apply that rule to assume that the products are within expiry.

Q. Absolutely. But just for clarity, you do not know whether the etomidate that you believe had an expiration date of January 31st, 2025, if used in an execution would not have been fully potent? You just don't know?

A. I don't think anybody knows, that's true, because it was past -- if it was past expiration, then we just don't know. Yes, that's true.

Q. Right. Thank you.

Again, last three questions. You were not present for any Florida execution?

A. I have not been, no.

Q. You did not personally see the expiration date for the etomidate used in any execution?

A. No, I did not see any of those.

MR. RODRIGUEZ: And we'll end with those two. Thank you so much, Dr. Almgren.

THE WITNESS: Sure.

THE COURT: Any redirect?

MS. ELLICOTT: Yes.

REDIRECT EXAMINATION

BY MS. ELLICOTT:

Q. Hi, Dr. Almgren. Just a few more questions.

You're going off of these records because in your field, they should be reliable, right?

A. Absolutely. Yes. I mean, this is -- in clinical practice, this is all we have is the records, because once the drug is used, you throw away the vial and there's really nothing left. So all you have is the records.

Q. So in your field, it's important to be able to trust

records?
A. Yes, yes.
Q. And in your field, are the training of standards there for a reason?
A. Yes.
Q. And the errors -- or the violations we discussed today from August and September of 2025, those errors directly implicate etomidate's efficacy?
A. Well, it puts it in question because now we don't know what the expiration of the vial was. So we don't know whether the vials were expired or not. So it does put it in question because we just don't know.
Q. And aren't expiration -- or are expiration dates a product of a study by the manufacturer?
A. Yes, yes. This is exactly how we establish the stability, through these extensive stability studies, to determine what -- for how long is the product good. And these are really large-scale studies that we do. And we make them -- they are very specific, like I said, to the product formulation, to the vial that this product is stored in.

So when we do these studies, for example, if the -- even if the packaging sits, has changed -- I'm just giving you an example how important this is. Then let's say we have a 10 mills-per-milliliter vial, we have 20-mill vial, let's say we go to a 10-milliliter vial, so let's say we scale down. We

would have to do new studies because we need to verify that a change in volume and a change in the container did not impact the expiration. So that's how important it is.

MS. ELLICOTT: Okay. Thank you.

I'm just going to confer with co-counsel. Thank you.

(Pause in proceedings.)

MS. ELLICOTT: Thank you, Dr. Almgren. That's all from me.

THE COURT: Mr. Rodriguez, anything else?

MR. RODRIGUEZ: No, Your Honor.

THE COURT: All right. Dr. Almgren, that completes your testimony and you're free to log off.

THE WITNESS: Thank you.

THE COURT: Do you want -- do y'all want to take about five minutes so that you can get your doctor?

MR. RODRIGUEZ: Yes, Your Honor.

THE COURT: And then we'll do whatever we need to do to get the next witness. We'll come back on at 11:05.

COURT SECURITY OFFICER: All rise.

MR. RODRIGUEZ: I apologize, he's actually in the waiting room already, so we -- so we can take him now. I apologize to the Court. I didn't realize --

(Mr. Guardado confers with counsel.)

THE COURT: Is there a problem that I need to address?

MS. McDERMOTT: Well, Your Honor, could we have Mr. Guardado's -- he's in a black box. Can we just have it loosened? Just because it's cutting off his circulation.

MR. GAURDADO: Yeah, my wrists are actually starting to swell a little bit. I've been in them since about 6:30 this morning. I realize that this is -- you know, this is a difficult situation for everybody involved, but, I mean, I can assure you I have no ill intentions. I just would like to be as comfortable as possible.

THE COURT: I'll tell you what, we'll take a five-minute break. I'll -- who's -- who's in charge?

MARSHAL: (Raises hand.)

THE COURT: May I see you for a moment in the robbing room?

(Recess, 10:59 a.m. to 11:11 a.m.)

COURT SECURITY OFFICER: All rise. This Honorable Court is back in section.

Please be seated.

THE COURT: Ms. Wiles, may I see you.

(The judge confers with the courtroom deputy.)

THE COURT: All right, Mr. Rodriguez, are we ready to go?

MR. RODRIGUEZ: Yes, Your Honor.

THE COURT: Okay.

MR. RODRIGUEZ: Mr. Mervine will be directing this

witness.

THE COURT: Oh, I'm sorry. All right. Come on up, Mr. Mervine. And if you'll, for purposes of the record, call the witness.

MR. MERVINE: Yes, Your Honor. On behalf of respondents, defendants, the next witness would be Dr. Joseph Antognini.

COURTROOM DEPUTY: You're going to have to swear him.

THE COURT: Sir, would you raise your right hand, please. Do you solemnly swear or affirm that the testimony you're about to give before this Court will be the truth, the whole truth, and nothing but the truth, so help you God?

DR. ANTOGNINI: I do.

THE COURT: Please state your name for the record and spell it for the court reporter, please.

DR. ANTOGNINI: Joseph Antognini. The last name is spelled A-n-t-o-g-n-i-n-i.

THE COURT: All right. Mr. Mervine, go ahead.

MR. MERVINE: Thank you.

DR. JOSEPH ANTOGNINI, DEFENSE WITNESS, SWORN,

DIRECT EXAMINATION

BY MR. MERVINE:

Q. Doctor, what is your professional position?

A. I currently am a clinical researcher for a research company in the Los Angeles area. I also am a chief scientific

officer for a pre-clinical pharmaceutical company. But my professional position really is a physician.

Q. And could you describe your education for the Court.

A. I went to Berkeley for my undergraduate degree in economics. Then I went to the University of Southern California for my medical degree, which I got in 1984. I then did my anesthesiology training at UC Davis and finished there and then became board certified after that.

Q. What clinical --

THE COURT: I'm sorry, board certified in?

THE WITNESS: Anesthesiology.

THE COURT: Thank you.

BY MR. MERVINE:

Q. What clinical experience do you have administering etomidate?

A. Well, I was a clinician and professor at UC Davis, which is a Level I trauma center. And etomidate is a drug that we used quite often in patients who have blood pressure problems, trauma, things of that nature. So I used etomidate quite a bit during my time in the operating rooms at UC Davis.

Q. And what experience do you have in assessing the anesthetic depth and return of consciousness?

A. Well, that's obviously -- well, maybe not obvious to everybody, but that's obviously something we have to do. As an anesthesiologist, we have to address the depths of anesthesia

and consciousness when we give the drugs that we use, especially during the induction period, which is when we begin, and then also during the emergence period, when patients are starting to wake up. But, of course, we also have to do that during the surgery to make sure that we have the proper depth of anesthesia.

MR. MERVINE: At this time, Your Honor -- or, excuse me.

BY MR. MERVINE:

Q. Doctor, have you been recognized as an expert in federal court before?

A. Yes, numerous times.

Q. As well as in state court?

A. Yes. Not much in state court, but I have been, yes.

MR. MERVINE: Your Honor, at this time the respondents would tender Dr. Antognini as an expert in anesthesiology and the pharmacology of anesthesia agents, including etomidate.

THE COURT: Any objection?

MS. McDERMOTT: We would object to the pharmacology and anesthesiology agents. But I have no objection to him being qualified as anesthesiologist.

THE COURT: All right. Well, I will let you raise an objection to a specific question that you believe goes outside the bounds of his expertise.

Go ahead.

BY MR. MERVINE:

Q. Doctor, what is etomidate?

A. Etomidate is one of the drugs that we use in anesthesiology for induction, primarily of anesthesia, so to produce unconsciousness right at the beginning of the anesthetic. Most patients actually receive something called propofol, but in some cases we choose etomidate. But it basically starts the anesthetic process and makes somebody unconscious, and then we can put in the what's called endotracheal tube and then administer other anesthetics.

Q. And how does unconsciousness differ from paralysis?

A. Well, I think it's best defined first by just addressing what is consciousness. That is the ability of people to take in the world, basically the stimuli from the world, visual stimuli, auditory, and so forth, and integrate that and have a perception, have perceptions.

And then unconsciousness is the inability to do that. You may -- or a person may actually get stimuli and they can be recorded, to a certain extent, in the brain when they're unconscious, but they can't integrate that to produce a -- that -- that picture of the world and those perceptions. So it's basically an -- unconsciousness is a disconnect, essentially, of that process of integrating all those stimuli, basically, that we have in the world.

Q. And would those stimuli include pain?
A. Well, they would include what I call noxious stimuli or noxious stimulation. People do -- people do interchange pain and noxious stimulation. But pain is the conscious awareness of a noxious stimulus.

So I do not think -- it's my opinion that people cannot experience pain when they are unconscious. They can certainly -- you can record some different parts of the brain and spinal cord and show that there is a response to the stimulus, but they don't have that perception. They are not conscious.

And just to put a point on that, even people who are brain dead, you can record responses in the nervous system. But of course, they're brain dead, so they don't have the experience of pain.
Q. In preparation for your testimony, did you examine the Florida Department of Corrections' lethal injection protocol, which is Plaintiff's Exhibit 1?
A. Yes, I did.
Q. Okay. And specifically, the doses and methods of etomidate called for by that protocol?
A. Yes, I did.
Q. Okay. And how does the dosage differ from a normal clinical dose?
A. Well, it's a massive overdose. Depending on the

individual, it's between about 7 to 10 times the dose that you would give in the clinical situation. So it's a -- it's quite an overdose.

Q. And assuming that the dose pursuant to that protocol, 200 milligrams of etomidate, at its label potency reaches the circulation of a person via two administrations as established by the protocol, can you explain how that would affect the person, or the condemned?

A. Well, the etomidate as it first goes in, it starts entering into the circulation, just the very first part of that dose would be sufficient to make that person unconscious because that's a -- the first part is what we would give anyway.

And then, you know, you continue to push that drug more and more until you get to the 200 milligrams. You're pushing that overdose. And so the person would be unconscious within 15 to 20, 30 seconds. And then you continue to give more etomidate per the protocol, and then that just builds up the concentration, basically, of etomidate in the bloodstream. So it's going to last a lot longer because of that.

Q. Based upon that dosage, would it last a minimum of 30 minutes, the state of unconsciousness?

A. In my opinion, yes. The dose is so high that even given the dis- -- the redistribution of the drug, it would be at that point above the concentration that's needed to produce

unconsciousness.

Q. A defense witness -- or, rather, a witness for the plaintiff testified that the effect of etomidate may last or be effective for three to five minutes. How can you explain the difference between that estimate and your testimony that you just gave?

A. Well, the drug -- etomidate is not the only drug like this in our specialty. But the drug is not -- or the -- the effect of three to five minutes for a clinical dose, that is, occurs because of what we call the redistribution of the drug. So it's not like it's metabolized or anything like that. What happens is you get this large concentration in the bloodstream, and it just starts to circulate.

Our brains and our heart and our kidneys, and the liver to some extent, are what are called the vascular-rich organs, that is, that the blood flow to those organs is quite high relative to other. And you, of course, can understand that. I mean, we need a lot of blood flow to our brains because they're very metabolically active.

So that blood gets to the brain, and then what happens, it just -- it starts to redistribute. And so it will go to other organs. So you get this peak, and then it starts to fall off. And that's a pretty rapid fall-off. But then -- again, I'm talking about a clinical dose. But then it starts to level off a little bit. And then you get into other

redistribution aspects of it. And then eventually, after several hours -- or I should say probably sooner than that, you get into -- the metabolism starts to play a role.

So that three to five minutes is not due to metabolism, per se, it's really more to the redistribution. But if you give a massive overdose, it just -- it takes longer for that drug to -- concentration to fall off because it's such a high dose. So that's why there's this discrepancy there.

I have no dispute with the opinion that a clinical dose of etomidate would wear off after three to five minutes. But that's not the dose that's used in this protocol.

Q. And I apologize if you've already stated this, but do you know what a -- or can you give the Court what a clinical dose would be in terms of measurement?

A. Well, it's going to be in the range of probably .2, .3 milligrams per kilogram, in that range. So, you know, for a 100-kilogram person, it might be 20 milligrams or something like that, maybe 30 milligrams.

MR. MERVINE: May I have a moment, Your Honor?

THE COURT: Yes.

(Pause in proceedings.)

BY MR. MERVINE:

Q. So, Doctor, can you give a professional opinion based within medical certainty concerning the duration of unconsciousness caused by a 200-milligram injection of

etomidate administered in two 100-milligram injections?
A. Well, it -- well, let me just sort of answer that in one -- so if you gave 200 milligrams to somebody and you supported their circulation, airways, and so forth, outside this protocol, you would have unconsciousness, in my opinion, for 30 minutes or longer.

So in the sense of an execution, though, in the Florida protocol, you give -- or they give the muscle relaxant and then they give the potassium. And the potassium, of course, stops the heart. So at that point the person is dead and there's no circulation.

So -- I'm sorry, I'm not sure I answered your question. Please rephrase it or state it again if I didn't.
Q. I apologize.

So within a reasonable degree of medical certainty, based upon your training, experience, and your education, a 200-milligram dose of etomidate would keep a person unconscious, unaware of pain, for at least 30 minutes?
A. Yes. That's my opinion, my medical opinion, yes.

MR. MERVINE: Okay. I have no further questions, Your Honor.

THE COURT: Ms. McDermott.

CROSS EXAMINATION

BY MS. McDERMOTT:
Q. Good morning, Dr. Antognini.

A. Good morning.
Q. Can you hear me okay?
A. I can, yes.
Q. So I just wanted to ask you a few questions. Are there any studies relating to giving someone a massive quantity of etomidate that would show that at this amount you could extrapolate and maintain the depth of consciousness or the depth of anesthesia for 30 minutes?
A. I am not aware of that. I don't know that there's any studies like that.
Q. And are you aware of any studies where it has actually been shown that the more etomidate that is given could increase the depth of anesthesia but not the length of anesthesia?
A. There is -- there are some studies, I'm not sure I can remember off the top of my head, but I do recall reviewing some studies where there was a correlation between the depth -- I'm sorry, the dose and the depth. But I do believe that the -- you probably will reach a point -- and I don't know what that is -- where you do not get a greater depth of anesthesia by a larger dose.

As an example, with barbiturates, you can give more and more barbiturates, and then once you finally get to the point where the electroencephalogram, or the brainwaves, are flat, it doesn't matter if you give more or not. So I think your -- yeah, I think the answer to that question is yeah, at

some point you're going to be giving more etomidate and you're not going to get a deeper level of anesthesia because of it. It just prolongs the effect.

Q. So you're saying that you -- that that study is the opposite of what you think in terms of the dosing correlates to length versus depth?

A. I'm not sure I'd say that it's opposite. I'm not sure what you interpret from my answer to say that. Could you maybe rephrase your question?

Q. Yeah. So I thought I heard you say that it would be the length of time; and the depth of anesthesia would sort of remain the same, but the depth -- the length of time would increase. Is that not what you said?

A. Yes, that is what I said, but I'm not sure that's what I understood you to ask. But yes, that's what I said. You would get to a point of anesthesia and you're not going to get more of it because of a larger dose, you're just going to get a prolongation of that effect.

Q. So your opinion is in conflict with the studies that show that -- or the study that's been referenced here this morning, at least, that shows that the conscious -- the depth of anesthesia increases but not the necessarily the length of time?

A. Well, I'm not sure, not having whatever the study is that you're referring to. But let me explain, make sure I'm getting

this clear, is that when you begin to give, let's say, .1 milligrams per kilogram, or .2, and you start to get the person to become unconscious, as you give more, you will get a deeper level of anesthesia. But then you reach a point where you can give more and you don't get a deeper -- you're as deep as you're going to go.

So on the lower-dose range, yeah, you get -- yes, you will get an increasing effect, but then you reach basically what's called the ceiling, and you're not going to get more of an effect, you just get a prolongation of the effect.

I hope that's a little bit more clear.

Q. I understand your answer. I guess I wanted -- so you don't think there's a ceiling in terms of the length of time of the dosing?

A. Well, theoretically, I suppose, there is not a ceiling because if you just gave more and more of the drug, of etomidate, you're not going to increase the depth, but you could increase the time because it takes longer for the drug to be metabolized in that way so...

Q. Well, I thought you said that it's the redistribution that we focus on when we're talking about length of time, not metabolism. Did I misunderstand you?

A. Normally, it would be redistribution. In this dose, there's still going to be the redistribution that's going to begin to cause the effect to dissipate, or to -- and so forth,

but you're now talking about, in my opinion, doses, where it's not just redistribution, but it's also metabolism. So it's not like there's a time period that's only redistribution and no metabolism and there's a time period where it's only metabolism and no redistribution. It's sort of an overlapping area.

Q. So both of those things, redistribution and metabolism, are causing the drug to wear off, correct?

A. Well, there is going to be some metabolism. In -- okay. Just to make sure we're talking about the right setting here. In somebody who's not given potassium and whose heart is allowed to continue to beat, blood is going to continue to flow and you're going to be able to metabolize that drug.

But in the setting of an execution, where the potassium is given somewhere around 10 or 12 minutes after the etomidate, approximately, I'm not sure exactly the time, once the heart stops, you're not going to really metabolize anything.

So I think you're focused a little bit on this -- and maybe because of the questions that were asked earlier -- focused on this 30-minute time period. But you need blood flow for metabolism to occur. So it's primarily going to be redistribution effect that we're talking about.

Q. Okay. Let me ask you this: What did you review today in terms of preparing to give this opinion?

A. I looked at my reports that I had submitted in the *Brant*

case. And I also looked at one of the reports from Dr. Almgren. Maybe there's only one. And then I looked at maybe some reports from Dr. Zivot. I -- this all happened very suddenly. To my knowledge -- well, I did not submit a report to this -- for this particular case. And I'm not sure if the reports that I saw from Dr. Zivot and Dr. Almgren are for this specific one. They might be for the *Brant* case, I just don't recall.

Q. Okay.

A. As far as articles that I reviewed, I don't think I reviewed any articles, as I recall.

Q. Okay.

A. I'm not sure I did.

Q. And I just wanted to mention -- or go back to when you were giving your credentials. Do you currently see patients?

A. I see patients. I am seeing patients. Not as an anesthesiologist, but in clinical research, I have to evaluate patients for research protocols.

Q. Okay. When is the last time you administered anesthesia?

A. I would say it's probably running now on -- it was before the pandemic.

Q. Do you remember testifying in the *Nance* case in federal court in Georgia?

A. Yes.

Q. And would it be -- do you remember what you said in that

case about how many -- how many years it had been since you had administered anesthesia?

A. No. So I am not sure exactly what I said, but I probably -- it was before the pandemic. I wasn't really clinical -- after I retired from UC Davis I did go back to the OR sometimes. But it was really before 2016 where I was really more active.

Q. Okay.

A. So it's before the pandemic at least.

Q. So you're -- currently, you do not administer anesthesia to anyone?

A. I -- I do not.

Q. And the other thing you mentioned is that you were asked about what kind of happens with the administration of anesthesia, and you talked about how you did sort of a pre-anesthetic and then you monitored that, and then you monitored, like, when one is coming out of, you said, I think unconsciousness, like back to consciousness, and then you said you also monitor that during the whole time. Do you remember that?

A. Yes.

Q. Okay. Do you know in Florida's lethal injection protocol what they do to monitor consciousness --

A. My --

Q. -- after giving etomidate? Sorry.

A. My understanding is that they do a consciousness -- somebody does a consciousness check, which I believe is a verbal stimulus and also I believe a tactile stimulus; that is, touching the person.

I don't -- I do not know if they do anything else beyond that. I don't know if -- I'm not aware of any monitors that they use for depth of anesthesia.

Q. And are you aware of what kind of monitoring goes on in, you know, any OR in the country today with an anesthesiologist who's administering anesthesia and trying to bring someone into that anesthetic depth that you talked about?

A. We monitor the electrocardiogram, the breathing, the blood pressure, quite often the electroencephalogram. We monitor muscle function with a nerve stimulus, basically. So there's no question that we use a lot more monitoring in the operating room than what I think is done in the execution chamber.

Q. Do you know if today people use the BIS? Do you know what the BIS is?

A. Yes.

Q. What is that?

A. It is the -- it is one way of monitoring the electroencephalogram, or the brainwaves. And it provides, basically, a number for us to evaluate the depth of anesthesia.

Q. Have you ever used that when you were in the operating room? Have you ever used the BIS to monitor patients who were

under your care and --
A. Yes, many times.
Q. And did you -- was that a -- sort of a good measure, in your opinion, of consciousness? One part of how you were maintaining anesthesia for them?
A. Yes.
Q. You also mentioned just that there were other drugs given, and you referred to a muscle relaxer. Do you know, is that the same thing as a paralytic?
A. Yes.
Q. And is that given in Florida's protocol?
A. Yes, it is, to my knowledge.
Q. And what would be the effect of someone who has been given anesthesia, given a paralytic, and then regains consciousness?
A. In that setting, the person would be unable to move, unable to breathe. And when that has happened, it has been, for quite a number of people, a terrifying experience.
Q. And just to go back one moment to the consciousness. In your medical practice, there would be a medical professional who is evaluating or monitoring your level of consciousness, correct?
A. Yes, that's correct.
Q. And when a paralytic is given, does that impede the ability to monitor consciousness?
A. Yes, it would. It wouldn't be, you know, as if you

couldn't do it altogether, but it would take away one of the ways in which we monitor patients in terms of depth of anesthesia.

Q. And in Florida's protocol, the individual or individuals who are monitoring the anesthesia, would they have any medical training?

A. I don't know what kind of training they have. I have no idea.

Q. Are medical professionals permitted to assist in executions?

A. Well, the AMA and other medical organizations do have ethical guidelines which say that medical professionals should not be participating in executions. That doesn't mean that people don't do it or, you know, prevent them from doing it, but the ethical guidelines say that you're not supposed to do that.

Q. And just, I know you talked -- when you talked about etomidate, I just wanted to make sure there's some other things about it, correct, that are sort of like features of it for why it might be a good drug and why it might be -- there might be drawbacks to it. Is it an analgesia?

A. In my opinion, it is. Now, analgesia is a term that we use in terms of basically something that would prevent pain. In my opinion -- and I'm not the only one thinking this. In my opinion, if someone is unconscious from an anesthetic drug,

they cannot experience pain. Because of that, in my opinion, it has that analgesic property in that sense. It prevents the experience of pain.

So there are tests that you can do in somebody who's awake and ask them, oh, if I give you this drug, do you feel like the pain's gotten less, and they'll say yes. So you would say, oh, that drug's an analgesic because it lessens the pains.

But if you give a drug like etomidate, where they're unconscious, they have not experienced the pain. So in that sense, it does have analgesic properties in my opinion.

Q. But the drug itself, the drug itself, doesn't have analgesia. You're just saying the effect of the drug would cause you not to have concern about someone experiencing pain?

A. Well, the effect of the drug and the drug itself are basically the same thing. I'm not sure -- so let me just elaborate a little bit about this. Typically, when we talk about a drug having analgesic properties, what we do is in a test is we would apply a noxious stimulus to somebody and we say, on a scale of 0 to 10, how painful was that? And the person says, oh, that was an 8. That really hurt. Then we give them a drug and we repeat that and we say, well, what's the pain level -- what was the pain level that time? Well, it was about a 4. So it was less. So we say, oh, that drug has analgesic properties. And then maybe if we gave more, maybe it gets down to 1 out of 10.

But you can't do that with a drug like etomidate and other drugs we use that produce unconsciousness at the dose, basically, where you could demonstrate that kind of analgesic property. So -- but the fact that you make somebody unconscious makes -- makes them unable to experience pain, and therefore, in that respect, they don't have pain, and that means that the drug does have some analgesic properties.

Q. Does the manufacturer say that it's not an analgesic?

A. I don't know what the PI -- the package insert says about that off the top of my head.

Q. Does the research say that?

A. Well, people do say that etomidate doesn't provide analgesia, but I think they're talking more about the situation where you give it in low-enough dose where the person is still awake and can respond. You know, I don't have any dispute about that. But, again, when you give a larger dose, make somebody unconscious, it's a different story.

Q. Is it painful on injection?

A. It can be, yes.

Q. And does it have a risk of impacting or compromising someone's airway?

A. Absolutely, yes, it does.

Q. And is it fast acting?

A. Yes.

MS. McDERMOTT: If I can just have one moment, Your

Honor.

THE COURT: Of course.

(Pause in proceedings.)

BY MS. McDERMOTT:

Q. When you provided the 30-minute estimate for the -- Florida's protocol for the effects of the etomidate, does that contemplate a slower administration of the drug?

A. No. That was based on an injection of the drug over about a three- to four-minute period. I would -- let's -- I believe it's about the time it takes, maybe two minutes to three minutes, in that range, that the drug is injected in the protocol, but I don't think that would materially affect the -- my opinion; you know, that there's a slight difference there.

MS. McDERMOTT: If I could just have one moment, Your Honor.

(Pause in proceedings.)

MS. McDERMOTT: I have nothing further, Your Honor. Thank you.

THE COURT: Thank you.

MS. McDERMOTT: Thank you, Doctor.

THE WITNESS: Thank you.

THE COURT: Mr. Mervine?

REDIRECT EXAMINATION

BY MR. MERVINE:

Q. Doctor, counsel asked you about ongoing monitoring of

consciousness in the OR and other clinical settings. Yes? Is that correct?

A. Yes, that is correct.

Q. And so that would involve clinical doses, not the 200 milligrams which is called for by the protocol?

A. That is correct. We're talking about clinical doses of drugs in that setting.

Q. The dosages called for by the protocol, based upon your training and experience, can you give an estimate how quickly a person would lose consciousness?

A. In the range of 15, 20, 30 seconds. Once the -- once the drug -- the clinical dose that we would normally use enters the inmate, or that the -- you know, the first, let's say, tenth of that 200-milligrams dose, the first 20 milligrams, once that enters the circulation of the inmate, I would estimate between 15, 20, 30 seconds, in that range.

It's not when the etomidate is started to being injected into the tubing, but when the actual, let's say, first 20 milligrams enters into the inmate. And 15, 20 seconds, 30 seconds after that is when I would expect the inmate to lose consciousness.

MR. MERVINE: Thank you. I have no other questions.

THE COURT: All right. Ms. McDermott -- or Doctor, that -- anything further?

MS. McDERMOTT: Nothing further, Your Honor. Thank

you.

THE COURT: Doctor, that completes your testimony and you're free to log off.

THE WITNESS: Thank you.

THE COURT: Next witness?

MS. McDERMOTT: Dr. Joel Zivot, please.

THE COURT: Sir, if you'll come up here to be sworn, please.

DR. ZIVOT: Thank you.

COURTROOM DEPUTY: Please raise your right hand. Do you solemnly swear that the testimony you're about to give before this Court will be the truth, the whole truth, and nothing but the truth, so help you God?

DR. ZIVOT: I do.

COURTROOM DEPUTY: Thank you. You may have a seat. And if you could please state your name for the record and spell your last name.

DR. ZIVOT: Joel Zivot. The last name is Z-i-v-o-t.

DR. JOEL ZIVOT, PLAINTIFF'S WITNESS, SWORN,

DIRECT EXAMINATION

BY MS. McDERMOTT:

Q. Good morning, Dr. Zivot.

A. Good morning.

Q. Can you just please tell me a little bit about your background. Can you start with your education?

A. Sure. I went to -- my medical school was the University of Manitoba in Winnipeg, Canada. I was there from 1984 to 1988. Prior to that I completed four years of college at University of Manitoba and the University of Toronto. I did not obtain a bachelor of science degree. It was not required. Just the -- just the college years was the requirement.

I finished my medical training in 1988 and got a -- my MD. And from there I went to the University of Toronto. And I completed a year of -- one year of post-graduate education. And then I entered the anesthesiology residency at the University of Toronto. That was a four-year training program. I completed that in 1993.

Then I went to the Cleveland Clinic in Cleveland, Ohio, and did two additional years of training. And in that time I was able to qualify, first of all, I guess for my -- the specialist certification in Canada. That's called the Royal College. So I was granted my FRCPC, which is the Fellow of the Royal College of Physicians of Canada. And then after my two years at the Cleveland Clinic I was qualified, certified, and board certified in both anesthesiology from the American Board of Anesthesiology and critical care medicine from the American Board of Anesthesiology.

And in the last ten years, my additional training, I earned an MA in bioethics at Emory University, and then subsequently I earned a master's of jurisprudence at Emory

University Law School.

Q. And currently what is your practice like?

A. So my current practice, I'm an anesthesiologist and intensive care physician. In the last few years I've provided pretty well full-time critical care. I work in intensive care units.

I have specialties; so subspecialties in cardiac, thoracic, and vascular cases. So I focused caring for patients in those situations. They're really the sickest patients in the hospital, who undergo major cardiac, thoracic, and vascular procedures, transplants.

And I also work in a community within the Emory system, a medical -- intensive medical slash surgical intensive care unit, where I care for a variety of patients under a number of different clinical situations.

Q. So on a day-to-day basis, are you administering anesthesia to patients?

A. So as an anesthesiologist and intensivist, you know, my pattern of practice involves the use of many anesthetic-type agents that are combined with critical care.

So in critical care we're dealing with states of awareness and unresponsiveness and also pain control. And all of those things are certainly, you know, party to what I'm doing in the intensive care units. Sometimes we do a formal surgical procedure within the intensive community, and there I

might deliver kind of a classic anesthetic as well. But I'm not these days working in the operating room, per se, and providing anesthesia in that setting.

Many of the drugs, of course -- all the drugs that we've talked about here are all within the drugs that I still currently use and, you know, use quite commonly.

Q. And do you also hold a position with the medical school, Emory Medical School?

A. So I'm a professor of anesthesiology and surgery within the Emory Medical School. I also have a position, I'm a Senior Fellow in the Emory Center for Bioethics.

Q. And do you -- in that role, do you actually train residents and fellows and med students in terms of the practice of anesthesiology?

A. Yes, I do.

Q. Have you testified previously in court?

A. I have.

Q. In state court, federal court? Do you --

A. I believe both; both, I believe.

Q. Have you been qualified as an expert previously?

A. I have.

MS. McDERMOTT: Your Honor, I would offered Dr. Zivot as an expert in anesthesiology.

THE COURT: Any objection?

MR. RODRIGUEZ: No objection to anesthesiology.

THE COURT: The doctor may provide his opinions.

MS. McDERMOTT: Thank you.

BY MS. McDERMOTT:

Q. Now, in terms of your practice, do you have -- you handle drugs?

A. Yes.

Q. And in terms of what you're actually doing when you administer anesthesia, are you also, you know, having to start IVs and oversee IVs?

A. Yes. On occasion I'll have to start an IV, yes.

Q. And you have to monitor those when you're...

A. Yes. Well, you know, if I'm going to be administering a drug, you know, if I -- certainly if I'm administering it myself, then of course I'm -- you know, my finger is on the syringe and I'm watching it, monitor it, as it's injected. Sometimes I'll work with, you know, other physicians or nurses, where I'm directing them to do it. But I'm doing it, you know, in a supervisory capacity. I'm either there or close by when certain things are being given.

Q. Also, Doctor, I failed to ask you -- if you could put up Plaintiff's Exhibit 6; Plaintiff's Exhibit 6 which has been introduced. I think it will show you on your screen.

A. Oh, yes, okay.

Q. And you can start scrolling through it and go down to the first page. Is this your current CV? The date on it

October 17th?
A. Yes, yes.
Q. Okay.
MS. McDERMOTT: And so just for the record, Your Honor, we've introduced Plaintiff's Exhibit 6, which is Dr. Zivot's curriculum.
A. I think the first page -- can you just go back up to the -- back up to this -- it doesn't actually list my MA degree there as well. It is in a spot on the CV, but that kind of cover page excludes my MA.
Q. Okay. But otherwise, that's the most current --
A. Yes.
Q. -- CV you have?
A. Yes.
Q. All right. And so when you were -- when you were asked to be involved in Mr. Guardado's case as an expert, were you provided some records?
A. Yes, I was.
Q. And do you remember what you were provided?
A. I was provided, you know, the protocol, the FDOC protocol for lethal injection. I was provided with some logs, you know, drug logs. I was provided with some documents that were depositions of other -- other individuals.
Q. Were you provided with some toxicology and autopsy reports?

A. Yes, of course, the tox- -- yes, provided with autopsies. That included kind of both gross examinations in many cases of the body plus toxicology reports that specifically looked at drug levels and detections and so forth.

Q. And in terms of that particular group of records -- and can you put up Plaintiff's Exhibit 7? So can you scroll just to the first page there?

Does this sort of -- I mean, do you remember this collection? It's about 200 -- 200 to 300 pages of documents related to --

A. Yeah. Yes, I recall this, yes.

Q. And that's been introduced as Plaintiff's Exhibit 7.

So you -- and did you consider these various things that you've identified in forming your conclusions today?

A. Yes.

Q. Now, you said you were familiar with the Florida Department of Corrections' lethal injection protocol. Can we talk about the various drugs that are used?

A. Yes.

Q. I know you've been sitting, listening, so, you know, you don't have to restate everything that you've heard if you agree with it, or you can say you agreed with something.

But so with etomidate, can you just tell me a little bit about what that drug is and what that drug does?

A. So etomidate is a drug that we inject. It's a liquid.

It's given through intravenous. And the purpose of that drug is, you know, classically referred to as an induction agent.

So induction is the beginning of an anesthetic. And that -- what you're trying to induce, I guess, is the first, kind of, stage where you're trying to get into a kind of depth of awareness that would be sufficient for the purposes of undergoing surgery.

Sometimes people get etomidate not because they are going to have an operation, per se, but they're in a, you know, significant state of critical illness where there's a need to place a breathing tube in their mouth that would then end up in their trachea, to be attached to a mechanical ventilator because they have other kinds of illnesses. And usually there's some degree of -- it would be in a setting where there's a significant amount of respiratory distress, and so they would need to have this done.

And in order to have a tube put in your mouth, it requires your cooperation. It's painful. And so we -- you know, we do a combination of things, etomidate being part of that, to try to get a person into a state, you know, of transient lack of awareness to tolerate that tube being placed.

What's good about etomidate -- and not everything is good, but one thing that's good about it is that its profile is such that when it's injected, it really has no -- or very little impact on the strength of a pumping heart, of

circulation. So it doesn't drop the blood pressure, where other kinds of induction agents can do that. So that's I think, you know, sort of its niche market, in patients that are kind of unstable with their blood pressure need something that's very brief and long lasting -- or rather brief, you know, in terms of how long it lasts and can kind of get you where you need to go.

Once it's given, we don't give any more of it. It's not a drug that we would give as a continuous infusion. For example, I know that Dr. Antognini mentioned propofol. That's a drug that we can sometimes use as well. That drug can be used as a constant infusion after it's given, but not etomidate, for kind of a specific reason.

So etomidate also works via something called GABA-A. A lot of drugs like this work this way. They work kind of in the brain to create this -- kind of facilitate this kind of chemically-induced state of being -- you know, of this hypnotic state. And it's kind of a system. It's like a -- the term we may use is that it's saturate-able.

But to kind of make that more simply, imagine that you've got a glass of water and you're going to take a pitcher and you're going to pour the water from the pitcher into the glass. And your target, you know, is to have the glass, you know, three-quarters full. But you've got a big pitcher there, you know, which is kind of like here. All the etomidate is

this huge pitcher of water. So you pour it in there, and at some point it comes to the lip of the glass, and then it just spills over. And so adding more water there does nothing to what it is that you're trying to do.

And so that's how etomidate works. So once it kind of has done its job, so to speak, once it's kind of saturated, you know, its GABA-A receptors, simply adding more of it gives you nothing. It's just spilling out all over the table at that point.

So that's how etomidate works.

Q. And can you tell me a little bit more about the properties of etomidate in terms of what are the -- some of the bad sort of...

A. Yeah. Well, so, I mean, while etomidate is -- so I've trained in Canada originally. And I worked in the U.S. and Canada. And I'll tell you, Canada has never permitted the release of etomidate. It's a drug that is not used at all in Canada because it has this specific kind of effect on what's called adrenal function, the adrenal glands. It suppresses adrenal function. So even in a small dose, the adrenal glands, you know, stop functioning.

And so if I'm using etomidate in a clinical setting, and I need to use it, I must also then follow up that with some subsequent use of steroids, of a drug called hydrocortisone, which I would have to also inject because the withdrawal, this

absence of adrenal function, be can be quite serious.

So it just never actually got clinically released in Canada. I never used it until I came to the United States.

So -- so that's why it's really kind of one-and-done. It's not given, you know, continuously.

It does, you know, burn when it's given. It does have some kind of movement that can be associated with it. And it's not -- you know, it is not -- according to the package insert, and I think I would agree, it's not classically an analgesic. So it has no capacity at any dose to relieve anything that is pain.

And I think that this idea that, you know, you have to be awake to experience pain, to a certain degree that's true. But the body undergoes, you know, the trauma of the pain that can be registered in other places. That's, of course, critically important in an anesthetic. Like no one, for example, would design an anesthetic that just targets the absence of recall. You know, that would be -- and then say, well, as long as you don't remember it, it doesn't count, and that's what we're going to do. That would be absurd.

So we understand that there are these other sorts of, you know, responses to pain that do have an impact, that are measured. And just simply because they can't be recalled, it does not mean that they've had no impact or are not important.

Q. Does that also mean that they haven't been experienced?

A. Well, you know, I think that like -- so where anesthesia and execution, you know, depart, there are many places. In anesthesia, what we're trying to do is create this kind of, you know, lack of recall. Like you're trying to sort of say that, yes, we understand that some things can happen to you here, but if you don't recall it, you know, then that's sort of what we're trying to do.

And, you know, anesthesia is both extremely sophisticated and also not well understood, you know, in terms of some of these kind of impacts that there can be harm, you know, to a patient where it can be hard to measure.

So in anesthesia, of course, again, we rely on, we try to focus on -- or one of the things we try to provide is this lack of recall.

Now, in an execution, there is no after. So all that matters is during. You know, is it experienced during? And certainly in my -- you know, my extensive experience in the operating room, people can have experiences in the operating room. They move; their heart rate can go up; their blood pressure can go up. Even when they're under what I would consider to be a deep plane of anesthesia, I see this all the time. And so we make adjustments, and we have to kind of keep doing it.

Now, afterwards, it's my normal practice to ask people what do they recall, do they recall any of that. And

though it can appear quite frightening in the operating room, and it's certainly, I imagine, frightening to them in the moment, sometimes it's -- usually, often, it's just not recalled. And so that's kind of how we make it -- you know, how we provide the care that we're providing.

Q. And just moving on to rocuronium, is that also called for in the protocol?

A. So yes, rocuronium is the second chemical.

Q. And what does that do?

A. Rocuronium is something called a muscle relaxant. And there are three kinds of muscles in the body. There's heart muscle; there's the muscles of the intestine called smooth muscle; and then there's something called skeletal muscles, which is kind of the muscles that we think of that move our body and that we breathe with.

So when someone is given a drug like rocuronium, it works specifically to make those skeletal muscles incapable of contracting. So -- and it works kind of at the muscle level. It has no effect on the brain. So the brain may say, you know, arm, you know, move, or -- you know, or breathe, or anything. It can send those kind of signals to the -- you know, that we do all the time to make us walk and do everything we do. But the signal gets blocked. So there's no way to kind of propagate that signal to the muscle. And as long as the muscle relaxant occupies that kind of space at the nerve, no matter

how hard you try, you can't move a muscle. But you are awake, you are aware, you know, and you can feel pain. So, you know, all the muscle relaxants do is they make it impossible to move any of those skeletal muscles.

Q. And what would happen if someone is not properly anesthetized and they have been given a paralytic?

A. Well, you know, I think it would be -- you know, it's -- that -- and I think Dr. Antognini also mentioned this, is that this is a thing that can happen. You know, it can happen by mistake. It's not intended.

But if a person should find themselves paralyzed and unable to move and be fully awake, it would be a terrifying experience. It would be suffocation. And, you know, death in this way, death by suffocation, is an easily relatable and terrifying experience for people.

Q. And when you say "suffocation," is that because the drug paralyzes the lungs?

A. Well, it paralyzes -- you know, the lungs primarily move by a muscle called the diaphragm. It's a big, flat muscle kind of in the base of the chest that find of flattens and expands. And it's that movement that causes the lungs themselves to move. And so because that diaphragm muscle is paralyzed, it's impossible to take a breath.

Q. And can you tell me the third drug, the potassium chloride, what does that do?

A. So potassium is a normal circulating element in the bloodstream. And it's a highly regulated, you know, quantity that normally -- you know, that we measure in milliequivalents as to how much would be there. There's kind of a low end and a high end. And, you know, all kind of muscle systems require it. And also the heart specifically requires a finely regulated amount of potassium to cause this kind of contraction of the muscles.

And as potassium rises, it can start to interfere with the natural ability of the heart muscle cell to contract, to at some point where when the potassium is high enough, then the heart muscle will stop contracting. We actually use that to specifically make the heart stop in cases of cardiopulmonary bypass, where I've been an anesthesiologist in many of those cases, we'll direct potassium into the heart directly specifically because we understand that when the level is of a certain height, the heart will just stop beating. And then, of course, the person is on the heart-lung machine, that's why they don't die. But, of course, if it's done without that, then once the heart stops, death follows.

Q. And is there any particular sort of characteristics about potassium in terms of its --

A. Well, its formulation is such that it's quite painful when it's injected. So in a clinical setting, we would use -- you know, if someone has a low serum potassium, then I might order,

you know, to give potassium. It can be given orally as a tablet or a liquid or as an injection. And so when we give potassium as an injection, you know, we either will give it through what's called a peripheral intravenous, you know, something in the arm, which I think normally FDOC is using, or occasionally something called a central line, which is a line that might be placed in the neck or under the collarbone or in the groin.

So in those kind of bigger catheters and bigger veins you can give a little bit more and a little bit faster. But through a peripheral intravenous, you know, our practice pattern is to probably not give more than 20 milliequivalents, as compared to, I think, 240 milliequivalents. And we give that over a couple of hours. It will be given slowly.

So to give that -- and it's because it burns. It burns the vein, it burns the tissue. You know, it's very noxious. So to give 240 milliequivalents of potassium in one shot would be extremely, extremely painful, you know, for anyone. It's not idiosyncratic, that's guaranteed.

Q. And when you're dealing with drugs, do you have to understand the issue about expiration date, contamination, things like that?

A. Yeah. I mean, I think that those things would, you know, have been discussed already. These are all the -- and these are all the normal practice patterns of the safe profession of

medicine. So all of these terms that are used here, you know, these describe medical practice. Where, of course, execution is an impersonation of a medical act. You know, it's not a medical act. It doesn't use these things. It may aspire to, but clearly it does not. It falls short.

So -- and the reason why we do all of these things is because we're trying to create safe practice. That's our guarantee to the public, that we practice safely and responsibly, with all of those kinds of checks and balances.

But, you know, as to what FDOC is doing, I can't speak to that. Or I can, but it's not -- it certainly isn't working at all like if this was a medical practice.

Q. So none of the sort of safety mechanisms that you have in your practice appear in the Florida Department of Corrections' protocol, at least to the extent that you employ them in your practice?

A. Yeah, and to the extent that I can evaluate that they're not redacted or hidden. So there are things that they do that I guess I don't know, you know, that can't be known.

So -- but certainly looking at it impartially, trying to just look at it, I can see a lot of places where I would think if this was a medical practice, it would be completely, you know, impossible and would not be allowed.

Q. Well, I mean, just to sort of focus in, I mean, you've seen the protocol?

A. I have.
Q. And that's sort of the information that tells everybody related to the execution procedure what their jobs are and what's going to happen. So you have seen that, and so you do know --
A. I've read the documents, yes.
Q. Yeah. So, I mean, in that regard, it's not that you -- what they have is the protocol, correct?
A. Yeah, I mean, what the --
MR. RODRIGUEZ: Objection. This is speculation about what they have.
THE COURT: Overruled.
Go ahead.
A. I mean, I've looked at the protocol. And I understand the protocol, you know, is a series of steps that -- you know, that is used for the purposes of executing someone. It involves a series of chemicals. And I used the word "chemicals" specifically because, of course, etomidate, in my hand, is a medicine, but in the State's hands it's a poison. So it's really death by poisoning using a series of chemicals to poison to cause death.
Q. Okay. And so in terms of just -- you heard what Dr. Almgren said this morning about using expired drugs and how you're not allowed to do that. Do you have any disagreement with her --

A. No, I don't.
Q. About --
THE COURT: Please let her finish the question.
THE WITNESS: I'm sorry. Yeah, yeah.
BY MS. McDERMOTT:
Q. And I was going to show you what's been introduced as Plaintiff's Exhibit 2 and ask you to look at, when it comes up on the screen, page 6. And so do you see that this is a log of the potassium acetate?
A. Yes.
Q. Okay. And I was going to ask you to look at the bottom three entries there. And in terms of if there were executions on June 10th, June 24th, and July 15th, do these appear to be the withdrawals for those dates of the potassium acetate?
A. So, I'm sorry, I see like 6/12/25. So, for example, that's June 6th -- or sorry, June 12th. Is that what you're asking me?
Q. Right. So you see those dates?
A. Yes.
Q. Okay. And in terms of if those were to correspond to executions by the Department of Corrections, they're certainly not contemporaneously written, correct, the withdrawal of the drugs?
A. I don't know, you know.
Q. Well, let me ask you about the June 12th withdrawal.

A. Okay.
Q. Okay. And that is minus 7 vials; is that right?
A. Yes.
Q. Okay. And what would that equate to in terms of the amount of dosage?
A. I think that would be 140 milliequivalents of potassium.
Q. And what is the -- what is the required amount under the protocol?
A. It's 240 milliequivalents of potassium.
Q. And also then on the next line, the withdrawal was minus 17.
A. Uh-hmm.
Q. And is that, then, more than what should have been withdrawn if that corresponds to the execution on June 24th?
A. Yeah. I mean, the correct number would be 12.
Q. Okay.
A. So, you know, below it would be not sufficient quantity and above it would be, I guess, more than is needed.
Q. When you remove drugs from a drug locker or however you store them, do you record when you remove them?
A. Yes. When drugs are taken -- you know, if a drug is, say, ordered, then it's taken from a machine that then -- and the vial -- and depending on how much I need, you know, it will -- it will -- different sort of sizes, aliquots, might be available. So then I will take this drug, I will use the drug,

document that I've used it, and if I don't use it, then, of course, I have to return it, or if I use some of it -- all of it has to be accounted for. It has to happen, you know, continuously and contemporaneously.

Q. And can I ask you to look at page 16? So this is the log for what appears to be lidocaine. And do you know if there's anything in the protocol that references lidocaine?

A. No.

Q. And is this an intravenous type of lidocaine?

A. I can't tell. Like lidocaine can be used intravenously, or it can be used as an injection directly into the skin.

Q. But it's liquid?

A. It's liquid.

Q. That's what I should have said.

A. Yes.

Q. Okay. It's liquid. Do you --

A. Well, I believe it is. There's lidocaine preparations that are topical, you know, that are creams, but I -- this, you know, would be 10 -- 1 percent solution, 10 -- that looks like a liquid, so...

Q. And does the protocol have any indication that lidocaine is called for during an execution?

A. It's not in the protocol.

Q. Does lidocaine have any sort of contrary drug interactions?

A. Well, so lidocaine, you know, is something called an amide local anesthetic. It can be used classically to create like a local sensation of numbing to the skin or it can be injected into an intravenous to create some numbing in the vein.

It's also used classically in people who have certain kinds of heart problems. So if you have an abnormal heart rhythm, then lidocaine is what's called an anti-arrhythmic. It's used like that frequently.

Now, depending upon how much is given, it has a toxicity. So -- and it depends kind of how fast and how much and what location it's injected. So if lidocaine, for example, is injected in quantity through an intravenous, or certainly through a central line, then it can actually cause a seizure sometimes, depending upon how much is given and where it's given.

And even in a lower dose, patients frequently will complain of a kind of un- -- you know, unpleasant like odd sensation, disquieting sensation, in their -- you know, in their brain that they'll remark on.

So if I'm using lidocaine as a numbing medication, injected, I'm going to kind of break it up into smaller amounts and be careful about not giving too much all at once.

Q. Do people have, sometimes, allergic reactions to lidocaine?

A. There -- yes.

Q. And what can that -- impact could that have?
A. Well, allergic reactions, you know, can come in different varieties, but in the worst example, there's something called anaphylaxis, you know, which can be a life-threatening kind of self-perpetuating reaction that will cause death until it's intervened on.
Q. Okay. I'm going to have us go to page 26. And looking at the bottom four entries there -- and I know you were here for Dr. Almgren's testimony. Do you agree that those -- those four entries show that expired etomidate was withdrawn from the drug storage at DOC?
A. Yes, it looks -- yes.
Q. And then I also wanted to ask you, on this -- on this sheet, do you see any withdrawal for -- on July 31st?
A. No.
Q. Do you see any withdrawal on July 15th?
A. No.
Q. So in terms of -- I know you mentioned a little bit that you are -- you know, things have to be logged; or the way it works with you is if you take something out, there's a record made. If you put something back, there's a record made. And why -- why are those things in place when you're dealing with drugs?
A. Well, I think, again, that, you know, I -- I would say that, like, as an anesthesiologist, my profession, I think, has

undergone a kind of revolution over the last several decades in the way that it conducts itself. And we are -- how we changed is, you know, we became obsessed with safety. So we are -- we formed something called the Anesthesia Patient Safety Foundation. And the -- you know, the profession really changed itself to become very, you know, chiefly concerned with what it did so it causes no harm.

So this obsession with safety, you know, is so patients can be reassured that what they're getting is the best quality care and that the anesthesia itself will not hurt them. When a patient comes to the hospital for care, say, you know, they come for an operation, for surgery, they don't come for anesthesia; they need it. So to think that part of their risk, you know, that would be separate from the surgery, that the anesthesia could hurt them, you know, that's something that was just unacceptable. And so anesthesiology really revolutionized itself.

For example, there may be a drug that we may use that may have a 1-in-100,000 chance of hurting someone. And 1 in 100,000 is too often. And so we won't do it. So we are extremely careful with everything that we do, with the way that we account for what we do, with the way that we check what we do, with drugs that we use and how we handle them, because the obsession is to provide the safest possible medical care that, you know, we can provide.

Q. And in terms of thinking about safety, and I asked Dr. Antognini about this as well, but are there multiple ways to ensure safety in relation to keeping someone in sort of the depth of anesthesia?

A. So anesthesiology, again, is not sort of simple and singular. So it requires -- like there are -- for example, in any anesthetic, there are standard monitors that are applied. There are actually seven standard monitors that a patient will get. That's the minimum. And that could be for the simplest of cases. And it only goes up from there.

So there's not only -- there's the -- you know, there's the monitoring, there's also fact that there's the presence of someone there. So, you know, we wouldn't, for example, give an induction, you know, of anesthesia and then walk out into the hallway. We would always be there. So we're constantly looking at monitors. You know, I'm looking at the operation. I want to see what's happening there. I'm looking at the patient.

One of the actual standard monitors of anesthesia is an exposed piece of skin, okay. And what it means is that sometimes, you know, the way that a patient is positioned for a big operation can be quite elaborate in the way that they're draped and so on. And so sometimes it's even difficult to actually get your own physical hand to be able to touch the skin of your patient. So it's -- so it's needed, you know,

that there is a standard capacity, a necessity, that I should be able to put my hand on the patient, touch their skin, feel the way their skin feels, examine their intravenouses. That's at all times a standard monitor.

Q. And Florida Department of Corrections' protocol, does the paralytic interfere with monitoring of anesthesia?

A. There is no anesthesia here. There is no monitoring. Or monitoring, perhaps, is done in some location, not seen. So I believe that there's electrocardiogram monitoring. And I believe that when they decided that the -- that the prisoner has died, they are looking at a monitor in another room. That's the electrocardiogram. So I don't think that there's anything in the protocol that describes any kind of ongoing monitoring.

The only intervention are injections and then this what's, you know, called -- and I would use it in quotations -- the consciousness check. And that's it. And then the next thing is the pronouncement of death, which could be 10 minutes or so later.

Q. And so -- well, let me ask it this way: Would the paralytic interfere with determining the awareness of the prisoner?

A. Well, so I'm -- I believe that, you know, what's happening, what's intended here, is that this is not meant -- although I do think that this is death by suffocation. I think

that's why a person is dying here, whether the potassium probably finishes them off, but what they're -- the reason why we don't just do death by chemical suffocation and leave it as that as a paralytic, so another drug is given, a chemical is given at the very beginning, to try to create this, you know, belief that while a person is dying of suffocation they don't know it, or it's not painful to them. And so that's what the etomidate does.

Now, once you've given the paralytic, of course, you have no way of knowing whether or not they are aware or not. It's just a belief. And there's no investigation of that. So that's a very distressing part of this protocol, that there is no way to know, to guarantee, that at all times -- and certainly you can't ask someone, or they can't move to indicate that they're distressed because they're paralyzed now. So, you know, it creates this serious opportunity for a situation where there could very well be some awareness and there would be no way of knowing it.

Q. That brings me to my next point about the dosing of the etomidate. And so the call for the 200 milligrams of etomidate, what is your opinion as to whether or not that elongates the time of anesthesia?

A. There's no data. There's no data. So no one has -- will ever do that in a clinical setting. There will be no way to investigate that ethically. My understanding of the way that

the drug works is that it's creating this sort of plane of hypnosis.

And I'm uncomfortable even using the word "conscious" and "unconscious." You know, these are terms of art. But they're not as understood as they may be -- you know, may be used here.

What's happening under anesthesia is not blank. There is something going on there at all times. It's not that you awaken -- or even the word "awake" and "asleep" are highly problematic. There's nothing about anesthesia that is sleep at all. It doesn't look anything like that using an electroencephalogram. That has a very different kind of signature.

So I think that the -- actually, ask me your question again, I'm sorry.

Q. Well, I'm just asking you if there was, you know, this notion that the 200 milligrams --

A. Oh, right.

Q. -- of the etomidate elongates the length of time of whatever you want to call that --

A. Yeah.

Q. -- awareness or -- what would you call that in terms of etomidate?

A. I think it's this hypnotic state, is the best that I can say. So it's a kind of altered state where it's -- where

most -- where practically the recall of what happens to you at that particular time, you know, is not -- is not at all certain; that you likely won't recall it, if you live to recall it.

But the idea here, you know, I believe, is that the reason for giving such a large dose is because the belief is such, as I think has been advanced, that what the claim here is that if we give a very large dose, it will just last longer. And there's no evidence that that happens.

In fact, it's not at all -- what evidence we do have is the opposite, that it's like a saturate-able kind of thing. So you give the drug, it causes this kind of hypnosis that can be probably, you know, of a deeper and deeper plane, like think of it maybe -- try to use an example, I suppose, of maybe intoxication. So, you know, if you're becoming intoxicated with alcohol, there's differing amounts of consumption that can lead to finally, ultimately, to unresponsiveness or something like that. But there are sort of lighter planes, if you will.

So you're trying to kind of create this state of intoxication, and then you are suggesting that it will last a long time simply by more dose. But, you know, I would recall, again, my description of the glass of water, that it's saturate-able. That once you have kind of occupied what it's going to do, it doesn't do more and more and more of that. There is redistribution. We know that that happens. We know

that patients kind of regain awareness in a short period of time.

So I would push back, you know, for the lack of data and also from the pharmacokinetics of these drugs that more of them, you know, simply don't make it last forever. At some point, you know, the system can only accommodate what it can accommodate, and adding an additional thing adds you nothing.

Q. And are there sometimes other variables related to dosing that you consider in like a clinical practice about a patient that you take into account?

A. Well, again, every patient, of course, is unique and different and -- so as is, you know, every anesthetic choice: which drugs I select, the dosages, whether I repeat them or not, whether I use, you know, other kinds of combinations, what sort of additional monitors I would use. That's all based upon, you know, the operation and on the patient.

So in execution, the operation is death. And the technique is singular. So there is no variation at all based upon anything that is measurable. And so it's entirely unsurprising that you're going to have a bit of a scattergram of result based upon a technique that varies not at all, and that clearly all of the prisoners all come in different shapes, sizes, and states of health.

Q. Well, and that brings me to my next point. You reviewed -- in Plaintiff's Exhibit 7 you had an opportunity to

have -- to review multiple autopsy and toxicology reports over the past for the executions in 2025 and then through the first half of the 2026, correct?

A. Yes.

Q. And do you know what number that was?

A. 30.

Q. And in terms of that collection of information, was there anything about that that you thought was concerning or significant? Or what did you sort of come to realize from looking at these documents?

A. There are I think two, three things that are very important. The first thing is this very, very common finding of -- you know, of pulmonary edema, fluid in the lungs, that occurred almost always. And that was really, I think, a surprise. I don't think anyone thought that that was happening. I didn't think it was happening until I started looking at autopsies. And that's a very common finding.

Pulmonary edema is basically fluid in the lungs outside of blood vessels. It starts to be in tissues, and then eventually it works its way into the airways, into the little air sacs, the alveoli.

I've taken care of countless patients in pulmonary edema. It's a terrifying experience for them. They're short of breath, you know, they can't lie flat, and sometimes they need to be intubated. Or in the worst case, you know, we have

to put them on something called ECMO, which is like a heart-lung bypass.

I was a clinician, you know, during all of COVID. And those patients had pulmonary edema. And sometimes they died of it. Sometimes we were able to put them on ECMO for long periods of time. You know, it was a very difficult, challenging thing to deal with. And that's very common that we see in this -- in this group of autopsies.

The second thing is the toxicology, which I think is very relevant. What's happening here is that these --

MR. RODRIGUEZ: Objection, Your Honor. We've now moved from anesthesiology to toxicology.

THE COURT: I need to hear the question. So why don't you hold off and let's hear the next question.

BY MS. McDERMOTT:

Q. So Dr. Zivot, do -- are you familiar with toxicology generally?

A. As a critical care physician and anesthesiologist I deal with drug levels all the time.

Q. And do you draw blood specifically to be sent to the lab so you can make conclusions about your care based on the toxicological results?

A. Blood and urine.

Q. And is it -- in your experience, is dosing of various drugs also based on toxicology and research studies and things?

A. You know, of course, toxicology, it would be, I think, you know, an adverse description. The trick is to dose drugs so you're not dosing them in a toxic range. So you're trying to kind of dose them below that.

But yes, you know, that's something that's certainly part of the standard practice of medicine.

Q. And do you understand and sort of have to -- in your practice have to know how toxicology is performed, what the results mean, and those types of things?

A. Yes. And, I mean, I would offer that I'm uniquely positioned here because I have reviewed over 300 autopsies of executed individuals with toxicology reports in a variety of various techniques, including the 30 that you've mentioned here. So I have -- you know, I've gained specific knowledge and experience in this particular area of discussion.

Q. So I'm just going to ask the question again. So what did the toxicology -- in terms of what you reviewed here, what significance did it have to you?

MR. RODRIGUEZ: Your Honor, we would object again. He's indicated he's got some experience with toxicology in living individuals. These are post-mortem autopsies. I assume he doesn't know whether this was whole blood or plasma that was utilized. So based on his experience seemingly only going to toxicology in living individuals and not post mortem, we would object under *Daubert*.

THE COURT: Ms. McDermott, what...

MS. McDERMOTT: Judge, I think the field of toxicology is what it is, essentially. It's an area of medicine where blood samples, urine samples, are tested and conclusions are made by doctors, just like Dr. Zivot, based on those results. And so I don't think there's any distinction between living individuals and results of these kinds of tests post mortem.

THE COURT: I think that certainly from his review of the toxicology results he can testify as to what he observed. I have a bigger question as to whether you have established that he can testify as to the meaning of those results. But we can start with the factual observations, which I don't think there's a --

MR. RODRIGUEZ: No, Your Honor, we don't object to factual observations.

THE COURT: Yeah, please don't interrupt me because I'm thinking and speaking.

MR. RODRIGUEZ: I apologize.

THE COURT: So I don't think that there can be an objection to the factual observation. The question is whether he can testify as to the meaning of that. So let's start with the factual observation and I'll think about the next part.

Go ahead.

MS. McDERMOTT: Thank you, Your Honor.

BY MS. McDERMOTT:

Q. So Dr. Zivot, just don't draw any conclusions, but like what did you sort of notice in these 30 different autopsies?

Some -- I should say, there's not 30 autopsies, because there were a few individuals who didn't have the autopsy. But the 30 different inmates who had post-mortem procedures related to their death through the ME's office and the toxicology that happened after that, what were some of your observations of the records?

A. So what was present in the record is that etomidate blood levels are measured. They're measured either from cardiac blood or sometimes from femoral vein blood. There's a reason why those things are different.

The blood in this case would be whole blood, not plasma. And the -- what is seen is a wide variation, as much as tenfold, between this group, where -- you know, which the numbers I think range from maybe 1.2 to .18 or .12, or I can't recall exactly, but at least a tenfold difference in the group.

The other piece of information, of course, is that the package insert for etomidate specifies a plasma level of .23, that it should -- that should be exceeded to create kind of the basic entry-level hypnosis.

So the facts are that in -- on more than one occasion in this group there are instances where the blood level is below .23, you know, on more than one occasion.

Q. I'm just going to ask us to take a quick look at page 167.

THE COURT: Of Exhibit 7, Plaintiff's 7?

MS. McDERMOTT: Yes, Your Honor. I'm sorry. Plaintiff's Exhibit 7, page 167.

BY MS. McDERMOTT:

Q. And this is Kayle Bates' toxicology results; is that correct?

A. Yes.

Q. And then I wanted to ask you, you just mentioned the package insert about etomidate. And is that what is sort of included in those Reference Comments?

A. Yes.

Q. And so the manufacturer doesn't have any concern that looking at etomidate levels in living people versus looking at them in people who have -- are deceased changes what they believe should be the threshold that you should have --

A. No.

Q. -- to achieve that -- sorry -- to achieve that plane of hypnosis?

A. Yes.

Q. So -- and just -- you mentioned a couple of other things. You mentioned femoral blood, I believe, and heart blood. Is there research -- like what is the research on the -- what is more preferable in determining the accuracy of various drugs through blood or plasma tests; do you know?

A. Yes, I know. So the -- the -- when a drug is measured, there can be two questions. The first question is just present or absent. That's one question. The other question is, you know, present how much? And how much matters a great deal, you know, in clinical medicine.

In this case, this .23 is, of course, in a living person. And once a person has died, it's -- there's no more circulation. There is movement; drugs will move after death. And specifically, and why I think it's -- you know, and the other thing, I guess, it's easy to notice is that each of these autopsies, they're all done a little bit differently. The autopsies themselves are not all done in the standard way. So sometimes they're using cardiac blood, sometimes they're using femoral blood. I will say that the practice is to look at femoral blood as a better, you know, proximate indicator of what plasma levels would be in a living person.

And so there are some of these that I notice only report cardiac blood; some of them report femoral blood; and some of them report both I think.

Q. Are you aware that sometimes it's difficult to obtain femoral blood after death?

A. Well, I mean, certainly. Like, there's no -- you know, blood, of course, stays as -- kind of as an easy liquid, accessible liquid through circulation. Once there's no more circulation, the blood can kind of congeal and can form some

clots. It can also liquify too. So it requires some -- you know, you have to be able to kind of find it. And sometimes you end up getting something that's more like a slushy, you know, than kind of -- sorry to be so graphic -- than what blood would normally be like.

Q. And are you aware of the distinction between what you might see in drug levels related to plasma versus whole blood?

A. There is a difference. I mean, like the standard, you know, within -- in the living, which is where I, you know, spend most of my time, is that we generally are looking at plasma.

So plasma, basically -- if you think of blood, it's like there are cells, you know, that are small and can't be seen without a microscope kind of suspended in this clear liquid. And so what we do is that you would take a -- draw blood and you put it in something called a centrifuge. And the centrifuge is just a thing that spins. And then the blood is kind of spun in the centrifuge. And then kind of all the cell parts get kind of crumped up to the kind of bottom of the tube, and then above it there's this kind of yellowish liquid. That's the plasma. And so we're trying to kind of look at the plasma in the clinical setting.

That's not done here. It doesn't work like that. You're just kind of using the whole thing together. And, you know, it's -- there are differences. But I think the

differences are small. And so we make clinical decisions all the time, you know.

And autopsies are done, you know, to wonder, to ask questions, you know, sometimes, like what happened? Why did a person die? And so we look for things like this, you know, in the blood level.

And I look at autopsies of my patients that have died in the ICU, in the operating room, and I look at them, they're sent to me, you know, and I read them, and if they have clinical questions, like what happened, and if we didn't fully understand it. So they're meant as, you know, pedagogical tools to help us be better.

Q. Are you -- are you familiar with the research about whether or not etomidate -- what its stability is outside of the body? So like post mortem, the stability of etomidate?

A. Etomidate actually is fairly stable. Like there is this concern that certain drugs, you know, even, you know, within a deceased body will begin to kind of break down. And etomidate actually is pretty stable. Like up until like a week I think it can sit there and not change much.

Etomidate does undergo some metabolism. I mean, in a living person, etomidate metabolism is in the liver. So that's why it kind of gets broken down and, you know, eliminated. But it actually can sit in a tube, you know, for a week and not change.

Q. And did you also have any observations about the different -- you said that there was a wide variety in the levels?

A. Yes.

Q. And did you also notice that there were at least ten of the results that were below the level that is in the Reference Comments?

A. Yes.

Q. And is that approximately a third of the autopsies you reviewed?

A. That would be exactly a third.

Q. So is -- was this concerning to you? Is this concerning to you?

A. I mean, I think that, like, the thing I want to say about the .23 also is that remember that .23, as in the autopsy here, is talking about to achieve this state of hypnosis. There's nothing in here that says this is the quantity of etomidate that you need so when you execute a person with this drug, it's creating, you know, kind of a pain-free and awareness-free experience. I don't know what that dose is. I would think it would be higher than .23 because .23 is just basic hypnosis, you know.

Like when we provide an anesthetic and we give a dose, we think this should do it. We'll do this thing that's, you know, somewhat crude, where a surgeon will take a surgical

clamp, you know, with teeth on the end of it and will clamp the skin and just kind of pull it up, you know. And everyone just kind of looks and sees if there's any reaction, because, of course, what we're doing there is we need to make sure that the depth of anesthesia is such that you can take a knife and put it into someone's body and open up their intestines with it, or their chest; you can saw through the sternum. That's the kind of thing that we're trying to achieve, not simply some state of hypnosis.

So how painful is it to die, how much does that hurt, is not at all here. There's just this target of hypnosis, you know, that in no way represents the kind of pain control that I think you would need to be killed.

Q. In terms of just one more question that I just remembered about the pulmonary edema, did you observe that in the toxicology report there were indications of froth or fluid in some of the reports?

A. Yes. That's a common finding.

Q. And what -- what did that -- what does that tell you in terms of what you understand about the -- what happens with -- what would make that happen?

A. So there are probably two mechanisms that that can happen with, and one of these references a patient that -- or, rather, a paper that Dr. Antognini I think included in his report, that it is possible, if you take a lung, healthy lung, and you cut

into it, you can create some froth. It's possible. There's some -- that was kind of the development of what we now understand -- the discovery of what we now understand to be something called surfactant. You can make bubbles like that. But that's basically created by you squeezing the lung and cutting it.

In these cases, there's froth that's in the airway when you open up the lung. You're not cutting it. So that froth there is not the kind of surfactant froth from cutting into a healthy lung. That's the froth that you make when you are breathing and the heart is pumping the blood into the lungs and you're breathing and the blood is mixing with your inhaled, you know, breaths and creating this kind of froth. So that's what that is.

Q. And does that sort of give you any indication about what's happening in the execution procedure?

A. Well, you know, what I know is that, you know, to breathe and to have circulation means you're still alive. What you know, I can't know. But I do know that that is not something that's happening after you're dead. You need to have a beating heart and working lungs to create that kind of froth within the airway itself.

Q. And as an anesthesiologist and looking at the various results on the etomidate, do you have any confidence that a sufficient amount of etomidate is -- etomidate is sufficiently

administered in the lethal injection protocol to obtain a level of anesthetic depth for the entire procedure?

A. There's -- you know, I have no confidence that that is taking place.

Q. One other thing I wanted to ask you is did you -- did you notice -- were you asked to review some descriptions of executions by media accounts and things like that?

A. Yes.

Q. And then did you have an opportunity to speak to some of witnesses, legal representatives, who attended executions?

A. Yes.

Q. And did those conversations confirm the various media accounts that you had reviewed?

A. Yes.

Q. So in terms of Bryan Jennings, who was executed on November 13th, did you find that it was concerning that there were movements well into his execution that lasted 20 minutes?

A. Yes, that's very concerning.

Q. And with Billy Kearse, his execution lasted 24 minutes and there were also movements happening well into the execution?

A. Yes.

Q. Would you have expected that if they were adequately anesthetized?

A. Well, if they were adequately -- if they were paralyzed, then they should not be able to move. So the fact that they

moved at all, you know, could be a combination of both a lack of etomidate, you know, sufficient to cause them not to move, plus the fact that the movement at all made me think, well, did they even get the rocuronium at all? So they shouldn't move once the rocuronium circulates.

Q. So based on the DOC logs and the autopsy and toxicology reports and then these media accounts that you were asked to look at, do you think that the Florida Department of Corrections' lethal injection protocol creates a substantial risk of serious harm?

A. I do.

Q. And what would that be based on? Like what would you say your reasoning for that is?

A. It's based on the fact that etomidate, first of all, is known to be a short-acting drug. That's the first thing. The second thing is that it's known that rocuronium is a long-acting drug. And when the etomidate -- and the third thing is that the consciousness check is done as a single moment, not in a continuous way. And calling a prisoner's name and touching their shoulders in no way, to my mind, represents -- can be used to assume that if they don't respond to that, that would be the same thing as that they would not have any sense of the pain as they died.

So I think that the protocol, taken in -- you know, in total, creates this real risk, measurable risk, that

prisoners -- and I can't say which prisoner exactly, but in the totality of looking at it, prisoners are -- you know, some are awake, aware, paralyzed, drowning in their own pulmonary edema, then given a very large excruciating injection of potassium, and then they die. And that's what this looks like.

MS. McDERMOTT: If I could just have a moment to confer.

THE COURT: Yes.

(Pause in proceedings.)

MS. McDERMOTT: I have nothing further. Thank you.

Thank you, Doctor.

THE COURT: Mr. Rodriguez, I think I should let people take a break rather than torture them, so --

MR. RODRIGUEZ: Absolutely, Your Honor. I apologize.

THE COURT: No, no, no. I mean, I'd love to muscle through, but that's not going to be very kind of me.

Can you tell me about how long you think you have with this witness?

And Ms. McDermott, this is your last witness; is that right?

MS. McDERMOTT: Yes, Your Honor.

THE COURT: How long do you think your afternoon witnesses will take once you finish him? Those are my two questions to you.

MR. RODRIGUEZ: I suspect that Dr. Marcano with

direct and cross would likely take about an hour and a half. The rest of them should go fairly quickly. Two are FDLE fact witnesses. I don't anticipate them taking longer than 30 minutes in total, together. And then Dr. Webb is the last individual, and I'd safely say an hour.

THE COURT: Okay. Hopefully we'll get through this. And your cross?

MR. RODRIGUEZ: 30 minutes, max, I would think.

THE COURT: All right. How about if we start back at 2 o'clock. Please be here promptly to start back at that time.

And sir, you're still under oath until then, okay?

COURT SECURITY OFFICER: All rise.

THE COURT: We'll be in recess.

(Lunch recess, 1:06 p.m. to 2:05 p.m.)

COURT SECURITY OFFICER: All rise. This Honorable Court is back in session.

Please be seated.

THE COURT: All right. Mr. Rodriguez, the witness is yours.

MR. RODRIGUEZ: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. RODRIGUEZ:

Q. Good afternoon, Dr. Zivot.

A. Good afternoon.

Q. All right. I want to begin with one thing from your

declaration. Do you agree with me that post-mortem drug redistribution is well known and post-mortem drug concentrations may be unreliable proxies for circulating blood levels while alive, correct?

A. Those are two questions.

Q. Okay.

A. Ask me the first question.

Q. Post-mortem drug redistribution is well known?

A. Yes.

Q. And post-mortem drug concentrations may be unreliable proxies for circulating blood while alive?

A. I don't think I can answer that in the affirmative.

Q. Even though you placed it in your -- do you have a copy of your declaration?

A. I'm sure that one can be produced.

Q. Absolutely.

A. Yeah.

Q. Read the last paragraph silently to yourself, please.

THE COURT: I'll ask you to wait until you get to the microphone to speak.

MR. RODRIGUEZ: I apologize, Your Honor.

THE COURT: Thank you.

A. The last large paragraph? Because there's a piece of another paragraph there.

Q. Correct, the last large paragraph. And it is I believe

about four sentences down.
A. Okay. I see that.
Q. So you in your declaration stated that; is that correct?
A. Yes, yes.
Q. Okay. Now, when we discussed the .23 levels, that is blood plasma levels, correct?
A. Correct.
Q. And I believe you stated in your direct that you know the autopsies did not use blood plasma levels, right?
A. Correct.
Q. They used what kind of blood?
A. Whole blood.
Q. Okay. So they used a different type of blood than what the etomidate insert uses to get that .23 number, correct?
A. Yes.
Q. All right. Big-picture wise, if you testified in 2020 other than the records that you've received, and by those I mean the DOC records, and the most recent Florida autopsies you reviewed, what would be different about your testimony?
A. I'm sorry, I don't follow your question.
Q. I'll break it down a little bit more.

You've been testifying about the effects of pulmonary edema in lethal injection protocols since around 2016, 2018, right?
A. Yes.

Q. Okay. So pulmonary edema is not a new feature of your testimony?

A. Correct.

Q. Okay. And Florida's protocol has utilized etomidate since 2017, correct?

A. I don't know that number, but if that's what you say.

Q. All right. Now, you made one note that in a clinical setting, a 1-in-100,000 chance is too often, correct?

A. Sometimes, yes.

Q. Okay. So when you are giving your conclusion, I believe the end of your testimony was there is a substantial risk that somebody may awaken under Florida's protocol and experience a torturous death thereafter. To what degree are you actually making that determination? Is there a 10 percent chance? Is there a 20 percent chance?

A. Well, I think that there's a 100 percent chance somebody will have that happen.

Q. What level of certainty do you have that Jesse Guardado will have that experience?

A. All I know is that the -- I'm really here to say that the protocol itself, in the way that it's created, creates this very high likelihood that there are people who are knowing that it's happening to them. I can't know with Jesse Guardado, you know, until it, I suppose -- until it happens, which -- so I can't know in advance.

Q. And you used the word "know." How do you know that individuals were awake during their execution?

A. Well, it's based, again, upon several different pieces of information, that -- you know, based upon my experience, my understanding of the way that these drugs work, of what the levels mean and don't mean, and based upon, you know, a now series of 30 cases. That's my opinion.

Q. Okay. But what pieces of physical evidence is that based on?

A. It's based on the -- you know, the very common finding of pulmonary edema. It's based on the tenfold difference in etomidate blood levels. It's based on the concern that the consciousness check is a singular and ineffective method to determine what it sets out to determine. It's based on, you know, the post-mortem findings that I think, I guess, I've already mentioned.

Q. Okay. So you listed three things: pulmonary edema, the differences in the post-mortem etomidate levels, and the consciousness checks, correct?

A. Yes.

Q. But somebody experiencing pulmonary edema doesn't tell you they subjectively experienced that mentally and could perceive pain, does it?

A. "Somebody" who?

Q. Anyone.

A. I don't know what you mean. A patient of mine?
Q. Someone who is knocked unconscious, are they able to subjectively experience the sensation of pain?
A. Somebody who is -- who is -- I know the term "consciousness" is troubling, but -- so someone who is, in your lexicon, conscious? Is that what you're asking me?
Q. Unconscious.
A. Okay. So I don't know exactly what that means. So you're going to have to be more specific what you mean by that.
Q. Well, at what point do you think that somebody is sedated enough that they do not feel pain?
A. It depends on the nature of the pain.
Q. Okay. So -- well, let's just use the pain that we are talking about here, potassium acetate being put in -- the pain of suffocation for rocuronium bromide.
A. I think that's extremely painful.
Q. Yes.
A. Extremely painful.
Q. But if you are not perceiving pain, you're not sensating anything, correct?
A. I don't think that's quite right. So I think that, you know, that yes, pain -- and the easiest pain to bear is someone else's. So fair enough to say that hard to know how much pain the other person is having. But I do know as an anesthesiologist that I've seen countless occasions where I

believe a patient is under a significant plane, you know, depth of anesthesia, and yet they move and they react and they have a heart rate acceleration and they have a blood pressure spike and all these things that, you know, we understand to mean that they felt something that was noxious --

Q. Now --

A. -- and then they reacted to it.

Q. Now, with etomidate, you talked about myoclonus. And what is that?

A. Myoclonus is an abnormal muscle contraction, you know, sort of asymmetric muscle contraction that can occur.

Q. And that would not be indicative of pain, correct?

A. It's hard to know when you're looking whether you're looking at myoclonus or looking at movement.

Q. So you really don't know from -- that somebody who is undergoing Florida's protocol is actually going to experience pain?

A. I know someone is; I don't know which person.

Q. And how often is that going to happen --

A. Well, I think --

Q. -- 100 executions?

A. I think it should be zero. I think it should be never. So it's some -- you know, some -- at least in this series, at least I think a third of the prisoners had at least had etomidate blood levels that were less than .23. So I think it

could be a more common, you know -- certainly not never. And enough that it's, you know, hardly idiosyncratic. I don't think this is a glitch; this is a feature.

Q. So you think -- you're guessing based on the autopsy reports that a third, based on the etomidate levels?

A. I'm not guessing. I would push back on that term "guess."

Q. Well, let's talk about them again. You conceded in your deposition -- or your declaration, rather, that because of redistribution, post-mortem levels are not good proxies?

A. That doesn't mean that they are -- that they're incapable of being a proxy. They, and other things, you know, and the way the drug works make it seem that they can be. Like in isolation, you know, narrowly, that sentence, I think I would stand by that. But it needs caveats. It needs explanation.

Q. So you are assuming that the amount of etomidate in those post-mortem levels is the level that was there at the time circulating in the blood plasma at the time of execution?

A. I think it's close. I think it's close.

Q. And -- well --

A. Sorry.

Q. No, no, I apologize. Please finish.

A. No, no, I'm done. It's close.

Q. All right. So you cannot provide an opinion for how long Jesse Guardado will be able to experience pain at his execution?

A. I think that my opinion is based on the fact that it's kind of a scattergram, you know, that those 30 -- so someone will. You know, it's like winning the lottery: I can't say who will win it, but someone will.

Q. Okay. And you mentioned that etomidate levels are fairly stable, I think your testimony was, when they're sitting in a tube. What experience do you have to be able to say they're stable in a person who has been recently executed?

A. Well, that's literature-based. You know, I can't recall the paper, but I can tell you that looking at etomidate, you know, in -- when -- when -- in a solution or, you know, in the blood can actually -- doesn't -- it doesn't degrade considerably over at least a week in what I've read.

Q. And are those studies based on living patients or deceased patients?

A. You know, anything that -- once the blood is removed from the body it's not really living or dead. So it's a fluid that sits there and so it now becomes a reservoir of a drug. So the reservoir, it contains etomidate, is neither living nor dead --

Q. No, a person --

A. -- it's just fluid.

Q. I apologize. The person that the studies that you're relying on, were they conducted on individuals who were living or were those individuals deceased at the time when they were trying to measure?

A. I don't know.
Q. Okay.
Apologies. I will try to get you out of here as quickly as possible.
You reviewed several autopsies, I believe you said 30, right, of executed inmates?
A. Correct. Some of those were not the whole autopsy, just the tox report.
Q. Was etomidate absent in any of those autopsies that you reviewed?
A. I'd have to verify. I think maybe on -- like -- let me say that when you look at the report, there is something that will say the report limit, okay, like "RPT" something. It's on -- and what it will say is it will be report limit like .2. So what that means is if the level is less than .2, it can't give you a number. So it could be anywhere from, you know, .1999999 to 0. So that's it. Something less. Sometimes they just can't -- they just -- you know, it's limit of the report. So I don't think it's knowable whether -- if there's a case you can refresh my memory, but I don't recall that.
Q. Well, and I'll refer by name first. Are you familiar with Michael Bell's execution? Did you review his autopsy?
A. I reviewed them all, but if there's something in there -- I'm sorry, I cannot recall the details. You'll have to show it to me.

Q. Sure. What did the report state of his blood level?
A. Show it to me.
Q. All right.
A. Yeah.
Q. Do you still have your declaration?
A. This?
Q. Yes.
A. Yes.
Q. Yes.
A. Yeah.
Q. In that same paragraph, is Michael Bell one of the condemned inmates that you referenced?
A. I'm sorry, could you remind me the page?
Q. Page 10. It will be the last large paragraph.
A. Yes, right.
Q. Okay.
A. Yeah.
Q. And so the report indicated that he did have etomidate in his system, correct?
A. I think that also was cardiac blood, too, in Bell.
Q. Yes, that is correct.
A. Yeah. So it's going to be higher, yeah.
Q. Yes. All right. Just to be clear, you were not present for any Florida execution, correct?
A. Correct.

Q. You have no personal knowledge beyond the lethal injection protocol that you've reviewed and the autopsy reports about what Florida does in its lethal injection protocol?
A. I'm not -- I believe so. I'm not sure what -- if there's something that you're asking me that I don't recall.
Q. It's not a trick question.
A. Yeah. No.
Q. All right. Now, you discussed sometimes you would have patients that were undergoing anesthesia and they would wake up and not recall pain, correct?
A. Again, I think that the word "wake up" is problematic. So I think that the anesthetic state would be complete and I would ask them afterwards, and they would not recall anything. Not just pain, they would recall nothing. So that's a common experience under the anesthetic state.
Q. And that includes individuals that you were concerned were experiencing pain?
A. Yes.
Q. But you could not confirm those suspicions because they didn't remember?
A. Well, they couldn't recall it. But to my eye, you know, because we are granted with the capacity to be empathetic, I can -- you know, that's what we utilize here -- it appears that it is uncomfortable. And, you know, we rely on that.
Q. And can your eye determine what someone is subjectively

feeling in their brain?
A. No. No one's can.
Q. All right.
A. It could be surmised, you know.
MR. RODRIGUEZ: Those are all the questions that I. Thank you, Dr. Zivot. I appreciate it.
THE WITNESS: Thank you.
MS. McDERMOTT: Just a few, Your Honor, please.
THE COURT: Go ahead.

REDIRECT EXAMINATION

BY MS. McDERMOTT:
Q. Dr. Zivot, the -- what you prepared prior to -- let me see the date. Do you still have it there in your -- what's been referred to as your declaration?
A. The report, the one that -- yes.
Q. That's actually a report, correct?
A. Right.
Q. Okay. Sort of a study of cases?
A. Yes.
Q. Okay. And that's dated September 24th, 2026?
A. Correct.
Q. When you look at page 10, the sentences that you were asked to affirm, do you see the sentence that follows those that starts with "even so"?
A. Yes.

Q. Can you read that next sentence, please.
A. "Even so, this disparity does not support the conclusion that the protocol reliably delivers a consistent dose of etomidate to each prisoner."
Q. And that's your opinion, correct?
A. Yes.
Q. The other thing, you were asked about, you know, what would -- what's changed or what is contributing to your current opinion, you know, that has been added since the protocol went into effect in 2017. And I just wanted to ask you, like, were there multiple data points at this point that had not been known anytime before, you know, this group of autopsies could be collected and those records were given over to defense counsel or -- well, defense counsel for Mr. Guardado? Were those sort of like the data points that have now crystallized the problems that we may have thought were problems but now we see information that shows they really are problems?
A. Yes. They -- you know, the autopsies were critical in the formation of this -- you know, of my opinion here.
Q. And also the records and the way that the records were --
A. Yes, all of the information that I didn't have, you know, initially.
Q. And when you were asked about the pieces of info, I think on direct, you know, you also mentioned just knowing what you know about the drugs, the etomidate, the rocuronium, those were

also pieces that contribute to your ultimate conclusion here?
A. Yes.
Q. And then is etomidate hepatic? And can you tell me what that is?
A. You mean its metabolism, is that what you're asking me?
Q. Where does it get metabolized in the body?
A. So, you know, drugs can be metabolized in different sorts of ways. There can be something that's kind of just plasma based. There can be -- and then beyond that, it's usually some kind of combination of either metabolized in the liver and then kind of excreted in the bowels; metabolized in the kidney and excreted into the urine; or exhaled.

So etomidate's pathway of metabolism, this is separate from redistribution, is hepatic based. So that's where, you know, etomidate breaks down and is ultimately excreted.
Q. And so upon death, are any of those processes working?
A. No.
Q. So in terms of the stability of etomidate in the blood, does that tell you that you can reliably draw some conclusions on the toxicology of the blood taken post mortem?
A. Yes. The etomidate won't -- what happens is there is some redistribution. But again, that's why we look at femoral blood. And the belief is, you know, there is no plasma-based metabolism. There is barely any plasma, really. So whatever

is there is fixed. You know, at that moment, that's what's going to be there.

Q. And one other thing about the lottery. So when I think about the lottery, I think about the one-in-a, you know, hundred-million chance, Powerball, versus like the scratch-off that might be a lot lower. And so I didn't know if maybe that's not the best way to really encapsulate the risk.

A. Well, I think -- sure. I mean, I think the point that I'm making is that in a -- you know, we can use a much smaller number, okay. So what's the prevalence of it is really the question. You know, the prevalence in -- and I'll tell you that 30 cases is not a lot of cases. And what I would expect to see in the 30, it would be quite -- you know, there would be much less variation than we're seeing. And that's what I think it was quite surprising and quite disturbing to me, that there would be so much variation.

So I don't think this is a rare event. I don't think this is a one-in-a-million event. I think this is easily -- this is probably more than 1 in 30, you know. And maybe, you know, more than 1 in 5. So it's happening with repeated regularity.

MS. McDERMOTT: Okay. Thank you, Your Honor.

Thank you, Dr. Zivot. I have nothing further.

THE COURT: Mr. Rodriguez, anything further?

MR. RODRIGUEZ: Nothing further, Your Honor.

THE COURT: You may step down. You're free to go.

MS. McDERMOTT: And with that, Your Honor, we don't have any further evidence to present.

THE COURT: All right.

Mr. Rodriguez.

MR. RODRIGUEZ: Yes, Your Honor. I would call Dr. Milad Webb, who I'm hoping is in the waiting room of the Zoom.

COURTROOM DEPUTY: No.

MR. RODRIGUEZ: We'll call one of the FDLE agents.

THE COURT: All right.

MR. MERVINE: At this time, Your Honor, the respondents would call Florida Department of Law Enforcement Agent Graff.

THE COURT: Mr. Graff, if you'll come all way up here to the witness stand and remain standing for Ms. Wiles to swear you in.

THE WITNESS: Yes, ma'am.

COURTROOM DEPUTY: If you could please raise your right hand. Do you solemnly swear that the testimony you're about to give before this Court will be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: Yes, ma'am.

COURTROOM DEPUTY: All right. You may a seat. If you could please state your name for the record and spell your

last name.

THE WITNESS: My name is Adam Graff. And my last name is spelled G-r-a-f-f.

THE COURT: Go ahead.

ADAM GRAFF, DEFENSE WITNESS, SWORN,

DIRECT EXAMINATION

BY MR. MERVINE:

Q. What is your professional position, Mr. Graff?

A. I'm a Special Agent Supervisor with the Florida Department of Law Enforcement.

Q. And what duties does that entail?

A. I'm in charge; one of the supervisors in the Office of Executive Investigations. And as part of your mission with that office, we are observers for the executions with the State of Florida.

Q. And how long has that task been within your professional purview?

A. I've been taking part in those since March of 2025.

Q. And can you estimate how many executions you've attended?

A. I've attended 13 of them.

Q. Where did the executions occur?

A. The executions take place at the Florida State Prison, in Raiford, Florida.

Q. And within the prison is there an area dedicated to the executions?

A. Yes, there is.
Q. Would you please describe that for the Court.
A. The area that it is, there's several different sections of it. There's a section where the condemned is housed prior to the execution. There's also an execution chamber where the condemned is placed when they are to be executed. And then there's also a room for the executioners and also for the drawing of the medications used.
Q. Okay. And so there's an injection room. And is there something called a chemical room as well?
A. The chemical room, injection room are about the same. They're referred to as injection room, chemical room, or executioner's room.
Q. Okay. And what instructions or training did you receive prior to attending any of these executions?
A. Prior to them we're provided with the Florida Department of Corrections' execution protocol for lethal injection. We're also provided it for the -- for the electric chair, because we use both of them still in the state of Florida. We're required to read over that and have an understanding of it. And then we also attend before each execution as a practice, so that way scenarios can be ran, everybody's on step to know exactly what's going on. And it's a time-scaled practice. So we attend those.
When the execution pace isn't what it is, there's

usually quarterly trainings for people who don't get the experience. But a lot of for, like, my position is on-the-job training.

THE COURT: Sir, can I get you to slow down just a bit?

THE WITNESS: Yes, ma'am. I'm sorry.

THE COURT: Go ahead.

BY MR. MERVINE:

Q. At the executions which you've attended, how many FDLE agents have been present?

A. On average, with FDLE there are three people, three agents that show up. One will observe the -- in the execution chamber. And then there's two that go to the execution -- the executioner's room or injection room. And that facilitates being able to have eyes on the chemicals that are used.

Q. I'm going to draw you to several condemned defendants and the dates of their execution. And if you could just tell me whether you have -- whether you, one, attended them, and two, whether you have an independent recollection of your observations of those executions.

A. Yes, sir.

Q. Kayle Bates, August 19th, 2025?

A. Yes, sir.

Q. And what role did you play at that execution?

A. I was the primary in the injection room.

Q. Meaning?
A. Meaning I was the one responsible for witnessing the drawing up of the medications, or chemicals, whichever we want to call them, as well as keeping an eye on them until the execution, and then watching the executioner actually insert the chemicals into the IV line that goes to the condemned.
Q. David Joseph Pittman on September 17th, 2025?
A. Yes, sir.
Q. And what role did you play?
A. The same role.
Q. Victor Tony Jones, September 30th, 2025?
A. Yes, sir.
Q. And what role did you play there?
A. The same role.
Q. Michael Bell on July 15th, 2025, what role did you play at that execution?
A. The same one.
Q. And then finally, Norman Grim on October 28th, 2025?
A. The same.
THE COURT: I didn't -- I didn't catch that date.
MR. MERVINE: October 28th, 2025.
THE WITNESS: Yes, sir.
BY MR. MERVINE:
Q. Now, executions at least begin at 6 p.m. When does your role -- or when did your role at these executions begin?

A. So we show up at the prison about 1:30. When we get there, what we do is we end up going back into the injection room and start drawing up the chemicals, or medications, at 3 o'clock p.m.

Q. You described the various rooms which are involved. Is each within sight of one another?

A. Yes, yes. And in the injection room there's actually a separate room off to the side where we do fill up -- or we draw up the chemicals, or medications, which is separate from the executioner's room. It's just a separate room.

Q. If -- if identical for all of these executions which we've gone through, can you describe what you observed or how the process begins?

A. Yes, sir. So the process begins, we'll go into a room. Within there there's myself, the second FDLE agent, the team warden is there. And team warden is the one who is responsible for the overall operation of the execution. There's also usually two DOC employees who are there who are completing logs. And then there is two pharmacists and then there's three to five other medical professionals. That can range from paramedics to nurses, possibly doctors, I'm not 100 percent sure.

Q. And approximately at 3 p.m. at each of these executions, what did you observe? And again, I don't want to glob these all together if there are differences in terms of your

independent recollection of them. But just for purposes of time, what did you observe?

A. So with these, everything is pretty much -- this is one of the most professional operations I've seen. You could set your watch by it most of the time it goes on. So, you know, give an example of how it goes would cover everything.

But what happens is when we go in, there's a metal table in the middle that we sit around. I sit next to a pharmacist. The pharmacist will then pull out the medications in the main packaging that they have it in. What they'll do is they'll show the medications. So starting with the etomidate, they'll show the medication for etomidate on the package and then they'll show the expiration date. They'll then pull the individual vials out of that package, and they'll show them to me to verify it's etomidate. Then they'll show me the expiration date to show that it's within expiration.

From there, the pharmacist will hand it to the medic, who is responsible for drawing the medications out of the vials. That person will then show it to the DOC person next to them to go ahead and show that -- what the name of the medication is and the expiration date on it.

Once the appropriate amount's been provided and verified by the vials, because there's several vials, that medic will pop off the tops, wipe everything down with alcohol, and then begin drawing up the medications into the syringes.

So for etomidate there's four syringes. They will fill up four syringes to the required amount on them.

Q. And the drawing of the medicine into the syringes, this was done within your sight? You observed this?

A. Yes.

Q. And then what happens?

A. So from there what they do is once that first medic fills them up to the appropriate levels, they pass it to a second medic. That medic verifies how much is in it, knocks the bubbles out of the solution, changes the needle that they used to draw it out with into a blunt cannula, and then hands it to a third medic, who will then place it on the tray to be taken out to the executioner's room afterwards.

Q. And thereafter, what is your role?

A. After all the medications are done, we actually escort it out to the executioner's room and we wait with it until it's time for the execution.

Q. So do the syringes containing the various chemicals, drugs, do they ever -- are they ever out of your sight during that period of time?

A. No. And that's the reason why we have two agents, is to make sure there's an FDLE agent who can actually keep physical eyes on it to make sure nobody's tampered with it, changed it, or anything else.

Q. And you watch the actual execution?

A. Yes, I do.
Q. And we've been talking in generalities rather than specific executions, but were those procedures followed in each of the executions which we described earlier?
A. Yes. They've been followed on all 13 that I've been a part of.
Q. Does FDLE or the protocol have any contingency plans should you be shown a drug and there be something wrong with it or it be expired?
A. Yes. If it was expired we'd let the team warden know and he'd make a determination to change it out. We've actually had a scenario where when they went to draw up the medications, part of drawing them up is you've got to pressurize the bottle to get the medications out.
THE COURT REPORTER: I'm sorry.
THE WITNESS: I'm sorry. Too fast again?
THE COURT REPORTER: Yes, sir.
THE WITNESS: All right. I apologize.
THE COURT REPORTER: "Part of drawing them up" --
A. So as they're drawing it out, you got to pressurize the vial. So part of that pressurizing, what we found on one of the times that we did it, the bottle was actually compromised and cracked. So instead of continuing to use that, they threw it away and got a whole new syringe, whole new vial of medications instead of using compromised medications.

Q. And did that -- was that involved in any of the executions which we went through earlier?
A. I can't remember exactly which one it was because we got rid of it and they moved on with a new medication for that syringe.
Q. In the Kayle Bates October 19th, 2025, execution, were you shown etomidate by the pharmacist?
A. Yes, I was.
Q. And was it unexpired?
A. It was within the expiration dates, yes, sir.
Q. And that's based upon your viewing the packaging as well as the vial?
A. Yes, sir.
Q. At the Victor Jones September 30th, 2025, execution, did you have an opportunity to view the packaging and the vial of etomidate?
A. Yes, sir, I did.
Q. Were they unexpired?
A. They were unexpired.
Q. They were not --
A. Yes, they were within expiration dates.
Q. At the Victor Jones September 30th, 2025, execution, did you have an opportunity to view the vial and the expiration date of the etomidate?
A. Yes, sir.

THE COURT: I think you just asked that question.

MR. MERVINE: Did I? There are a few defendants. I thought I was on the third. I could be right. I have Kayle Bates, David Pittman, Victor Jones, Michael Bell.

THE COURT: I think you had not asked about Pittman, you had asked about Jones.

MR. MERVINE: I apologize, Your Honor.

BY MR. MERVINE:

Q. David Pittman on September 17th, 2025, did you have an opportunity to view the packaging and the vial of the etomidate?

A. Yes, I did, sir.

Q. And was it unexpired?

A. It was within expiration dates.

Q. At the Michael Bell execution, which was on July 15th, 2025, were you shown the vial and the packaging of the etomidate?

A. Yes, sir, I was.

Q. Was the etomidate unexpired?

A. It was within expiration dates, yes, sir.

Q. And at the Norman Grim execution on October 28th, 2005, did the pharmacist show you the etomidate packaging and vial?

A. Yes, sir.

Q. Were -- did they reflect that the chemical was unexpired?

A. Yes, sir. It was within the expiration date.

Q. Now, also I'm going to draw your attention to the Michael Bell execution. Again, that was on July 15th, 2025. Among the drugs you were shown, was lidocaine one of them?

A. No, sir. I've never seen lidocaine on any of the executions.

MR. MERVINE: May I have a moment, Your Honor?

THE COURT: You may.

BY MR MERVINE:

Q. To follow up on that question, have you ever observed lidocaine being administered during any of these executions which we've gone through?

A. No, sir, I've not.

MR. MERVINE: At this time, Your Honor, the respondent has no further questions.

THE COURT: All right. Who's got this witness?

Go ahead, Mr. Gunn.

CROSS EXAMINATION

BY MR. GUNN:

Q. Good afternoon, Mr. Graff.

A. Yes, sir.

Q. So you mentioned you participated in the executions of Bates, Pittman, and Jones; is that right?

A. Yes, sir.

Q. Did you also participate in the execution of Curtis Windom, which would have been August 28, 2025?

A. I don't believe I have, no, sir.
Q. Okay. You don't believe you have?
A. No, sir.
Q. I just want to back up a little bit and talk about your training and your practicing. So you said there's three FDLE monitors assigned to each execution; is that right?
A. Yes, sir.
Q. Okay. And there's two in the executioner's room and one in the chamber?
A. Yes, sir.
Q. Okay. Have you been in both of those roles or are you always in the executioner's room?
A. I'm always in the executioner's room.
Q. And you said you've done it 13 times total?
A. Yes, sir.
Q. How were you selected for the first execution team? How did that come about?
A. It's part of our responsibilities within the Office of Executive Investigations. Our unit's the one that's been assigned to witness those.
Q. Okay. But you didn't have any special experience or qualifications for the position?
A. No, sir.
Q. Okay. And you have no qualifications in healthcare or pharmaceuticals?

A. I have history with medical.
Q. Okay. And what is that?
A. When I was in the military I was in the Navy, and I spent about a year cross training as a corpsman, which is a medic within the Navy, for my last year while I was in there.
Q. And was that part of the reason you were selected for the team?
A. I don't know if it was part of it. Another part of it is my general location. I'm in the Jacksonville region, as far as where my area of operation is.
Q. And did you undergo any training after being selected other than reading the protocol and practicing?
A. Reading the protocol and practicing has been the major part of it, you know, with explanations by, you know, the team warden on what goes on as well as also from other agents or supervisors within FDLE who were there have been a part of it as well.
Q. Okay. And you talked about checking the expiration dates on all these vials. Is there anything in the protocol that specifies how the expiration should be checked or where it's located?
A. It's shown to me by the actual pharmacist. He shows me and says, this is the expiration date. And basically he -- it's been explained to me by the team warden, also by the pharmacist, the expiration dates are good until the last month

unless an actual date of the month is specified. So say if it was -- the expiration date was October of 2026, the actual expiration is the end of the month.

Q. Okay. And so when does that explanation happen? Is that each execution when you're in the room they tell you where the expiration date --

A. Whenever we go --

Q. -- is located?

A. -- to the practice part it's explained --

THE COURT: Sir, you have to let him finish before you start answering.

THE WITNESS: Yes, ma'am. I'm sorry.

THE COURT REPORTER: Can you repeat your answer?

THE WITNESS: I'm sorry, what was the question again now?

BY MR. MERVINE:

Q. So you were talking about how the pharmacist shows you where the expiration date is located on the vial on the box. When does that happen? It happens in the executioner's room?

A. When we're in the executioner's room, there's a room next to that where we actually draw the chemicals and stuff. That's where the medical personnel wait during the execution and, you know, while we're drawing up the medications.

But prior to that, I mean, most of us have experience checking expiration dates on common things day-to-day, so...

Q. Okay. And does that have to be explained to you for each execution, or it was explained once and now you remember for every execution?

A. It was explained to me from the beginning. But he shows it to me every time that, you know, they're there. The pharmacist is like, here's the name of the medication. Here's the expiration date.

Q. For each one of the executions you said you participated in, do you do a practice run?

A. Yes. Practice run is done to time scale the day before.

Q. I'm sorry, two times?

A. The day before.

Q. Okay.

A. And it's to scale as far as the time goes. So it's not something that they squeeze into 30 minutes; it's something that goes to the operation by the time.

Q. Okay. Other than the fact that the inmate is not present, do the practices differ at all from an actual execution?

A. No, not really, other than we're not drawing up physical medications for that.

Q. Is that simulated?

A. It is. We sit in the room, we wait, and then we go through, we have conversations about it.

Q. But do you draw liquid out of a vial?

A. No.

Q. Okay. So it does differ in that way from an actual execution?

A. Yes, sir. We don't draw up the chemicals.

Q. Do you simulate checking the expiration date?

A. No, sir.

Q. I'd like to show Defendants's Exhibit 1 at page 17.

Can you see that on your screen?

A. Yes, sir, I can.

Q. Do you recognize this as a practice execution checklist?

A. So this would be the checklist that is filled out by the Department of Corrections personnel. This is not a checklist I would fill out.

Q. Why does it say "simulated" instead of actual times in the middle there?

A. Because it would have been simulated.

Q. Okay. Why are there some times on it?

A. Because those would be the times, I guess, they do bring physical -- the trays physically out to the executioner's room. They do have empty syringes on them. But DOC is the one who fills that out. I could not give you a clear answer as to why they would put "simulated."

Q. All right. Let me move on to the verification of the etomidate expiration in the specific executions you said you were part of. I think you said you have an independent memory of verifying the expiration of the etomidate used in the Bates,

Pittman, and Jones executions?
A. Yes, sir.
Q. What was the expiration date on those vials?
A. I did not write it down, so I wouldn't know. Alls I remember is that they were within the expiration date.
Q. Okay. But you have an independent memory of that? Nobody has had to remind you of that?
A. No, nobody's had to remind me that they were within the expiration dates.
Q. Okay. So you remember that they were within the dates, but you don't remember the dates?
A. No, I do not.
Q. For none of the executions?
A. No, sir. We didn't write down the expiration dates.
Q. Okay. Did anybody try to show you any records so that it could refresh your recollection about the expiration date?
A. No, sir.
Q. And so you said -- are you already at the prison when the drugs arrive from, I'll just call it the pharmacy, wherever the drugs are stored? Are you already there?
A. When we get there, basically there's a pharmacist that provides them. Where the pharmacist gets it from I could not tell you.
Q. Okay. What kind of container are the vials in?
A. Usually they're in the manufacturer's packaging or whatnot

like that. They're in a box.
Q. But there's several vials, right? They're all in a box together?
A. Yes.
Q. And you said you're not in the executioner's room when you check the expiration dates; you're in the room to the side?
A. Yes.
Q. Can we show Defendants's Exhibit 1 at page 5, please.
Do you recognize this as the actual execution checklist from the Bates execution?
A. That would have been the one that the DOC people filled out.
Q. Okay. So you never see these checklists?
A. I've seen them, but not specifically this one. I'm aware of what they look like, but I do not complete their checklist. We have our own checklist that we complete.
Q. You do have your own checklist that you complete?
A. Yes.
Q. And does that talk about expiration dates?
A. No, sir.
Q. I'd like to focus, if you could look at the -- I think it's the third line on this exhibit. It indicates the expiration date of lethal chemicals was verified, but it doesn't separate the chemicals out. What order do you check them in?

A. So the first order that's checked would be etomidate. So they provide the etomidate, we verify the expiration dates on them, and then they fill the syringes for the etomidate and then place the etomidate syringes on the tray.

The next one they do would be the rocuronium bromide. They check the expiration dates on that; they go ahead and fill up the syringes on that as well, there's four of them; and then they place that over on the trays.

And then they do the potassium acetate.

Q. For each execution, how many vials are there total of each of the drugs?

A. Depends on the size of the vials.

Q. Okay. What's --

A. Each one comes in various sizes. It depends. I mean, they've been various different sizes for it, so...

Q. Okay. And is that for all three of the drugs, or is there only one drug that differs in the size of the vial?

A. All three of them have come in different sizes. But they also draw up sodium chloride as well, and then the hydroxyzine. And we check the expiration dates on those as well.

Q. If we look back at the third line on this exhibit again, I'm curious, is the time written here -- so I see -- actually, starting with the second, I see 3 p.m.; the next line says 3 p.m.; and the next line says 3 p.m. Are those the times that it was started or completed?

A. I couldn't answer to what they're putting on there. We basically -- with FDLE, on our logs we mark the time that we started drawing chemicals and the time that we finished. These look kind of appropriate to that idea.

Q. Well, I'm a little confused because the first one says that you verified the syringes in the stands. The second one says the expiration date of the lethal chemicals, three of them, was verified through all these vials. And then the next one says you observed the preparation of the lethal injection chemical mix. That seems like a lot to do all at 3 p.m.

A. It -- I don't know what they put on there. Like I said, I know when we do it it's done in the stages. Etomidate's done first. When etomidate's finished we move to rocuronium bromide. When that's finished we go to potassium acetate. When that's finished they then fill the sodium chloride syringes. When that's finished they fill the hydroxyzine syringes. And then after that we move the tray out to the executioner's room.

Q. How long total would you say it takes you to verify the expiration on all of the lethal chemicals?

A. Usually the entire process can take about 20 minutes; anywhere from 20 to 25 minutes.

Q. Okay. So this checklist would be inaccurate then if it's listing 3 p.m. for all of those activities?

A. I couldn't say. I'm not the one who filled this out,

so -- on that day I'd have to look at, you know, mine. And I don't have access to that at the moment.

Q. Would you say that you're checking these expiration dates quickly?

A. It doesn't take long to really look at it. It's like, you know, etomidate, it's reading one word, the date. I mean, it would be like looking at your watch and seeing what today's date was.

Q. Okay. Well, let's say in a typical execution there's 10 vials of etomidate, 20 of rocuronium bromide, and 12 of the potassium. You're picking up each vial, you said, and taking a very quick look at it and put it back?

A. The pharmacist is showing it. So the pharmacist and me are both looking at it and making sure it's within date. And then they hand it to the medic, and then the medic shows the DOC personnel. And then she wipes the top of the bottles off with alcohol and then draws them up.

Q. So you're not dividing up the task of checking the expiration date. Everybody's looking at the same one after the other?

A. Yes.

Q. What does the vial or whatever the etomidate is stored in look like?

A. It's a glass vial with a rubber stopper on the top, piece of metal around it, plastic cap on top, and then a wrapper, a

label, around the side of the bottle.
Q. And I'm sorry if I asked you this. Where is the expiration date on the bottle?
A. It's on the label, usually, that's attached to the bottle.
Q. And what's the -- what format is the expiration date? Is it month/year, month/day/year?
A. It depends. A lot of times it's just month/year. Some of them will have month/day/year.
Q. Is there sufficient lighting in the room for everybody crowded around to be able to see the numbers easily?
A. Yes, sir. I'd say it's probably one of the brightest rooms in that section.
Q. And you said you don't record the expiration date, nobody does?
A. No, sir. We just make sure it's within the expiration.
Q. Is there a reason for that it? Seems like it would be a good idea for that to be written down so that if questions arise it could be checked.
A. No, sir, because we have several people checking to make sure that it's within the expiration, so...
Q. And you said there's a procedure for what you're supposed to do if one of the vials is expired?
A. Basically we're not supposed to use it if it's expired. We let the team warden know.
Q. Okay. So if you determine the drugs were expired, you

would let the team warden know?
A. Yes.
Q. Would you be concerned that might delay the execution that everybody has been practicing for and gathered for?
A. If it does, it's part of the contingencies we deal with. That way, we make sure the condemned, you know, is able to have that decent, humane execution.
Q. When did you first learn that questions had been raised over whether expired drugs had been used in these executions you participated in?
A. It's been in the news since last year.
Q. You learned about it from the news?
A. Yes, sir.
Q. And that was last year that you learned it?
A. Yes, sir.
Q. Okay. Did you bring that to anybody's attention at the Attorney General's Office?
A. No, sir, because everything's been in expiration.
Q. Okay. So you thought the news reports were inaccurate?
A. Absolutely.
Q. But nobody from the State came to you last December to talk about this issue?
A. No, sir.
Q. And when you first heard about these concerns, did you independently recollect the expiration date in those

executions?
A. I independently remembered that they were all within expiration.
Q. Okay. So you had no concerns at all that you may have participated in an execution with expired drugs?
A. No, sir, I did not.
MR. GUNN: May I have a moment, Your Honor?
THE COURT: Go ahead.
(Pause in proceedings.)
BY MR. GUNN:
Q. Just one more thing on your independent memory. Do you remember what time you stopped checking the expiration dates in these executions?
A. The expiration dates, I mean, we check them every time. But the expiration dates are checked as we go through. So, I mean, we're checking the expiration date on something before we draw it up. So like I said, the etomidate was done. We checked the etomidate. They draw it up and then place it on the tray. We check the expiration date on the rocuronium bromide, they draw it up, place it on the tray.
Q. I understand. I'm asking about the length of time it takes. So, I mean, you've talked about how this is a very well-oiled operation, starts promptly at 3 p.m. and you've done 13 of these. Do you have some sense now about when you finish the check?

A. Yeah. It takes about 20 to 25 minutes.
Q. 20 to 25 minutes?
A. Yeah. So usually by about 3:18, 3:20 we're done. Sometimes we start a few minutes early.
Q. But that's not documented anywhere?
A. It's documented on the time sheets -- or the checklist, obviously what they have here. Plus, on ours, I have a spot on my checklist where it says time syringe fills started, time syringe fills ended.
Q. Okay. So unlike the executioner's room checklist, yours has a start and a stop time for each activity?
A. Yes.

MR. GUNN: Nothing further.

THE COURT: Any questions?

MR. MERVINE: No, Your Honor.

THE COURT: All right. You may step down.

THE WITNESS: All right. Thank you.

MR. RODRIGUEZ: We would at this point call Dr. Milad Webb, who is hopefully now in the waiting room.

THE COURT: Yes, he is. You don't have someone to swear him either?

MR. RODRIGUEZ: No. There is someone there to swear him. No, no, him we have.

THE COURT: Okay.

MR. RODRIGUEZ: Good morning, Mr. Webb.

DR. WEBB: Good afternoon, sir.

MR. RODRIGUEZ: All right. Now, you've got a notary in there to swear you in?

DR. WEBB: I do.

MR. RODRIGUEZ: Okay. Can that process go forward? So can the notary swear you in?

DR. WEBB: Yes.

NOTARY PUBLIC: Raise your right hand. Do you solemnly swear or affirm the testimony you're about to give in this matter will be the truth, the whole truth, and nothing but the truth?

DR. WEBB: I do.

MR. RODRIGUEZ: All right. Would you like any of the information from the notary? License numbers or anything?

THE COURT: Yeah, that would probably be a good idea, please.

DR. WEBB: Okay. Come sit.

NOTARY PUBLIC: Good afternoon.

THE COURT: Just give us your name and your registration number.

NOTARY PUBLIC: Yes, ma'am. Rachel Hildreth, H-i-l-d-r-e-t-h, and my commission number is HH601822.

THE COURT: All right. Thank you. You can go.

NOTARY PUBLIC: Thank you.

DR. MILAD WEBB, DEFENSE WITNESS, SWORN,

DIRECT EXAMINATION

BY MR. RODRIGUEZ:

Q. All right. Dr. Webb, can you begin by stating your name for the record and spelling, it please, your full name.

A. Yes, thank you. My name is Milad Webb. First name is spelled M-i-l-a-d, last name W-e-b-b.

Q. All right. Thank you. Now --

MS. McDERMOTT: Mr. Rodriguez, we're willing to stipulate to his expertise if you would like.

MR. RODRIGUEZ: I will take the stipulation.

BY MR. RODRIGUEZ:

Q. All right. And so --

THE COURT: Wait. Just for purposes of the record, the parties have now stipulated to the qualifications of Dr. Webb to present his testimony.

Is that correct, Ms. McDermott?

MS. McDERMOTT: Yes, Your Honor.

THE COURT: Mr. Rodriguez?

MR. RODRIGUEZ: Yes, Your Honor.

THE COURT: All right. So you can go ahead and proceed with his testimony.

MR. RODRIGUEZ: All right. Excellent.

BY MR. RODRIGUEZ:

Q. So Dr. Webb, can you give me just a little bit of information, though, about your current role? What is your

current role?
A. Yes. I'm the District 8 Chief Medical Examiner for North Central Florida.
Q. And how does your role relate to executions that are conducted in Florida?
A. It happens that Florida State Penitentiary is located within my jurisdiction. And all of the executions that occur there, the decedents come to me for examination and then preparation of the post-mortem reports.
Q. And when did you begin serving in this role?
A. I started in my position this year in March.
Q. Excellent.
So I do want to discuss with you etomidate and autopsies. You have conducted roughly how many autopsies on condemned inmates?
A. About a dozen.
Q. Okay. And what regions of the body are post-mortem blood samples taken from and later tested for etomidate?
A. Specifically for the inmates or post-mortem examination in general?
Q. Specifically the condemned inmates.
A. Under my leadership, we take post-mortem blood from the iliac veins, which are considered a peripheral source.
Q. But prior to you coming into that role they were taken from what sources?

A. From central sources; particularly, the heart.
Q. And why did you switch to iliac blood?
A. I was trained that that is the gold standard for post-mortem toxicology testing. And it is the site that is endorsed by the National Association of Medical Examiners. And other sources of blood are typically only sought when peripheral blood is not available; namely, when there's significant trauma to the body and there are no other options.
Q. Does the post-mortem level of etomidate vary based on where the sample is taken from, iliac or --
A. Yes, it does.
Q. And is the sample when taken from heart blood unpredictable?
A. It actually -- in relation to the peripheral blood, it is going to be predictably higher, you know, multiple-fold higher, maybe four to tenfold higher, because of the post-mortem redistribution of drugs.
Q. Excellent.

Does the post-mortem level of etomidate that you would find in either of these regions vary based on a person's physiological makeup?
A. Yes, it can. So the -- the volume of distribution is a pharmacological term where a drug can distribute throughout your organs and your tissues. Depending on what your tissues are composed of, if you have a lot of adipose tissue, or if

you're very lean, if you're very large, very small, that can change. And it -- that's why drugs like etomidate are dosed based on body weight.

Q. Excellent.

If the Florida Department of Corrections administers 200 milligrams of etomidate, why are the post-mortem levels so low in the autopsies under your jurisdiction?

A. So you would have to first establish what would be the expected concentration. So to say something is low is to say that you know what it should be. So I would ask, well, what -- what do you assume that -- once you give 200 milligrams of etomidate to a -- to a human and you expect distribution, you expect plasma redistribution, post-mortem redistribution, what do you expect that number to be? And then why would it -- why -- why do you think it's high or low?

We know that peripheral blood concentrations are going to be lower than central blood concentrations because of the way the drug binds to your organ systems. And then when you die, those drugs can release from the organs, central organs, and go into circulation.

And it happens that all of our major organ systems are in the thoracic cavity. So when we take blood from the peripheral, it is going to be the most accurate to when the -- when that individual died and what the drug concentration was in life.

When we take it from the central source, it's going to have a lot more variability, and that number is going to be artificially increased.

Q. Now, can you explain the difference between plasma and whole blood?

A. Yes. So plasma is the liquid component of blood. So if you take blood and you spin it down in a centrifuge, the red blood cells and all of the protein -- pro- -- large proteinaceous material and cell material is going to sink to the bottom and you get a liquid component of the blood, which is called plasma.

Q. So etomidate whole-blood readings, are they indicative of what a person's plasma readings were? Is it a one-to-one?

A. No, absolutely not.

Q. Which one is higher and which one is lower?

A. I would -- I would think that the -- if you are taking a plasma concentration reading, you are looking at a smaller volume of material. And if you do your math based on a smaller volume, you may see a completely different number than if you were to do whole blood concentrations, which is a larger volume. So I am not -- I don't work with plasma. I'm a -- I'm a medical examiner. So plasma has no value to me. When an individual passes away, their red blood cells and all the cellular material lyse, or they break apart, and all of their protein and all of the internal components of the cells are

released. So getting just the plasma component of blood doesn't have any value to me.

So because I don't deal with that as much, I can't really give you a comparison to what I would predict the difference would be. But that's -- it is two completely different volumes of fluid.

Q. Excellent.

Does etomidate continue to break down in the executed inmate's bloodstream after death?

A. So there are -- there are reports that -- so first you have to know that etomidate breaks down primarily through the liver. There are some other organ systems, like within the brain or within the lungs, there are specific proteins like esterases that can break down drugs like etomidate. But the bulk of all the metabolism for etomidate takes place within the liver.

There is data that shows that in a liver for somebody that has passed away, there are active esterases. And as long as the temperature of the body stays within a physiological range, those esterases can continue to work.

So although we think that all metabolism will instantaneously cease at the time of death, we know that that is not exactly the case.

Q. So are you able to give any opinion on what rate etomidate continues to decrease after death?

A. No. Unfortunately, there's no studies that have been done to show that, but we know that it -- there is some appreciable rate of degradation.

Q. What time stamp would you want to take a sample of blood from a body to get an accurate etomidate reading?

A. Most ideally, you would -- immediately after the administration of the execution procedure, I would say, you know, you have the -- you have the intravascular lines present right there, you can very quickly access the peripheral blood and you can get a circulating concentration.

The tube that you would place that blood in would have sodium chloride in it, which is what is selected for post-mortem toxicology. And that would immediately stop the proteins that are within the blood from functioning, so that you essentially are hitting pause on any of the compounds that are within the blood.

Up until -- I would say, you know, up until the body becomes cool, I would say we know that the half-life of etomidate is within like approximately two-and-a-half hours. I would say if you can take a sample of the blood within that period of time, you are going to have a fairly accurate number to what was circulating in the blood at the time of death.

Q. So you would not use post-mortem samples of etomidate taken after that point to determine what the individual's premortem levels of etomidate were?

A. I don't know if it would be accurate or not. I would have to see what the two different numbers show, if they would be close or not. But I would also -- that's never been a question that has been posed to me and never been a question of value to -- for me to investigate what the premortem concentration would have been.

Q. Can you rely on post-mortem etomidate tests to tell whether etomidate's expired?

A. No.

Q. You've reviewed the autopsies of Michael Bell and Samuel Smithers, right?

A. I have.

Q. Okay. And did you note a large disparity between those two readings?

A. I saw that there is I believe a tenfold difference in the readings in the two cases.

Q. Does the large disparity between the post-mortem levels mean they did not receive the same amount of etomidate during their executions?

A. No, that's not what that means.

Q. And can you explain?

A. Post-mortem concentrations are -- first of all, those two that are being compared were drawn from totally different body sites. Based on looking at the -- all of the other examinations of all the other executions that were done, we

know any one -- any one of those that were taken from central sites show like multiple-fold increase in concentrations than the ones that were drawn from peripheral sites. So we know for a fact there is a significant contribution to the difference in concentrations from those two reports based on where the blood was drawn.

Secondly, you have to take into account the composition of the individual, the size of the individual, the adiposity of the individual, plus any underlying health problems that may result in changes in the blood concentration within the plasma.

So no two individuals are going to be identical. I think even in a very controlled environment, if you gave two very ideally similar individuals the same drug compound and tested them in a same manner shortly after, you would see disparity between the two. And that's just because every human's body functions differently. Some people have high metabolism; some people have low metabolism; some people's body composition is different.

THE COURT: Doctor, what is adiposity?

THE WITNESS: Fat.

THE COURT: I thought so, but...

THE WITNESS: It's the more polite way.

MR. RODRIGUEZ: With that, Doctor, I have no more direct questions for you. I'll turn you over to opposing

counsel. Thank you.

CROSS EXAMINATION

BY MS. McDERMOTT:

Q. Good afternoon, Dr. Webb.

A. Good afternoon, ma'am.

Q. Can you hear me okay?

A. I can.

Q. So to distill a few things, peripheral blood is a more accurate reading of a drug level than heart blood post mortem?

A. Yes.

Q. And whole blood will actually be potentially higher than if plasma was tested, to --

A. I'm not -- because I don't have -- I don't regularly test plasma and I don't have access to -- to do purely plasma testing, I don't know if plasma -- if I did the same -- if I checked the same specimen only testing plasma, or doing it versus the whole blood, I don't know what the difference in concentrations would be. But they are two different components of blood.

Q. Okay. And you mentioned that the metabolism happens in the liver for etomidate, correct?

A. You know, primarily, yes.

Q. Primarily, sorry.

And that you -- you indicated that if the temperature of the body is maintained, that then the liver could actually

still metabolize some of the etomidate. Is that what I understood you to say?

A. Yeah. The liver will continue to function for quite awhile even after circulation has stopped because the cellular mechanisms will continue until all energy is depleted. So even if the decedent is -- dies, general metabolism stops because circulation stops, there is still some ongoing cellular processes that take place even immediately after death.

Q. But you don't know to what extent?

A. Correct. I can't quantify that.

Q. And I guess what is the temperature that you'd have to maintain the body at in order to --

A. That's a good question. So there are multiple different proteins that can lose functionality at various times. But we know that your body can go into probably the low 90s and you can still be functional. You can probably even go down to the high 80s and still have some -- your body functions still working. So I can't tell you exactly at which point the proteins would break down, etomidate would stop functioning or they would degrade, but we know this just from general biochemistry.

Q. So when the medical examiner gets a phone call from Florida State Prison saying the execution has been carried out, you can come, do you go -- does your office go and actually obtain the body, or do they bring it to the medical examiner?

A. We have a transport service. So the same transport service that the medical examiner uses for all of their other cases will go to the site and recover the decedent.

Q. And when it's -- when the body is recovered and it's brought to your office, where is it stored?

A. In the refrigerator.

Q. And so at that point, the body temperature presumably would drop well below the 80s?

A. Right. And it would -- but that would occur slowly, depending, again, on the composition of the body. So somebody who is, you know, per se, wire thin, 80 pounds, they will get cold very quickly. Somebody else who might be like 300 pounds, they have multiple layers of soft tissue, they may cool a little slower. So it's not instantaneous.

Q. But the body starts cooling immediately, is that correct, upon death?

A. The temperature starts to drop, that's correct.

Q. So do you know, just generally, what the kind of time table is for the Medical Examiner's Office to receive the body from Florida State Prison, bring it back to your office and place it in the refrigerator, or the cooling area?

A. So we are -- I want to say -- we are, let's say, an hour and a half away, or let's say it takes two hours for our transport service to recover the decedent. Some of that depends on what time of day the decedent -- the procedure is

done. So the decedent is transported back, let's say it takes up to, let's say, three hours for the decedent to be transported back, placed in the refrigerator.

I -- we do our examinations every morning. So depending on what time of day the procedure had taken place, let's say it was 4 o'clock in the afternoon, I don't examine that individual until the following morning.

Q. Okay. But by the time you examine the individual, presumably the body temperature has dropped to well below 80 degrees?

A. Oh, yes.

Q. Now, in terms of the -- you know, the conclusion that can be drawn from these blood draws -- do you know Dr. Thogmartin?

A. I do, yes.

Q. And have you ever -- are you aware of why he directed that these blood levels of etomidate should be determined by the lab?

A. I'm sorry, I don't understand your question. That he directed them to determine them, or -- or how? Or what is the question? I'm sorry.

Q. No, it's -- I'm not being very clear.

So when you took over, did you at all kind of talk to Dr. Thogmartin about -- and he's the prior medical examiner, correct?

A. That's correct.

Q. Predecessor to you?
A. Yes.
Q. So were you aware that he was the one who instituted the procedure to actually spend money to have the etomidate level measured?
A. No, I didn't know that. I -- I just believed that that was a requirement, a state requirement, because of the evaluation process following the executions, and so I just continued what was -- how they were doing the procedures prior to me coming on. I didn't -- I naively did not inquire about why.
Q. Okay. And have you reviewed -- I know I had asked that you get a copy of Plaintiff's Exhibit 7 yesterday. And I know it was a good chunk of documents, but did you have an opportunity to go through those?
A. I did. I tried to go through them as much as I could. I did flip through everything, though.
Q. Okay. And did it -- did you see where the etomidate levels for peripheral blood, either being iliac or femoral, were significantly lower than the heart blood --
A. Yes, I did.
Q. -- levels? Okay. And in your opinion, those would be more reliable if you were --
A. Those levels, yes. So in terms of post mortem -- so it minimizes the effect of post-mortem redistribution. So those

are the more reliable numbers in terms of what is accurate to life, or at the time of death.

Q. Okay. And so just -- to sort of just put a conclusion on this, so that is the more reliable of that dataset for --

A. Yes.

Q. -- what level of etomidate is in an individual's system following an execution?

A. Yes.

Q. And we don't know if -- we don't know how much it may have decreased due to metabolism --

A. Right.

Q. -- but we do know that once the body temperature drops below about 80, in your opinion, that metabolism would stop?

A. Yeah, I don't know if the 80 number is correct, but once the body cools enough, at some point that -- all metabolism is going to stop. But immediately following when the body is still very close to physiologic temperature, there are still protein processes that are going on.

Q. And what is physiological temperature?

A. 98.6, plus or minus.

Q. And you're saying that it has to get how far away before you think that the metabolism stops? Do you know?

A. I think generally, you know, in the -- we know that just people being sick or very, very infirm can get down to the low 90s and they can still recover from that. So I'm not sure at

what point the cellular processes will all shut down. I'm sure there's a publication somewhere where we can find that material.

MS. McDERMOTT: If I could just have a moment to confer.

THE COURT: Sure.

(Pause in proceedings.)

MS. McDERMOTT: Dr. Webb, thank you so much. We really appreciate your time.

THE WITNESS: Thank you.

MS. McDERMOTT: Oh, I'm sorry, Jason. I was thinking he was my witness.

REDIRECT EXAMINATION

BY MR. RODRIGUEZ:

Q. Just briefly, Dr. Webb. You mentioned that the iliac is the most accurate place to get the post-mortem levels, right?

A. Yes.

Q. But even still, viewing Smithers having a .03, you have -- that does not give you doubt that he was administered 200 milligrams of etomidate at the time of his execution?

A. No doubt.

THE COURT: I'm sorry, was Smithers .03?

MR. RODRIGUEZ: .13, I apologize.

BY MR. RODRIGUEZ:

Q. You've reviewed -- well, you reviewed the Plaintiff's

Exhibit 7. Did any of the numbers give you concern that a defendant or a condemned inmate was not given 200 milligrams of etomidate during execution?

A. No.

Q. Okay. Now, can you reconcile that again with the fact that .13 is obviously a lot less than 200 milligrams?

A. Yes. So the 200 milligrams is going to be dissolved into the volume of your body. And when we take a portion of your blood to test, we are testing that concentration in that portion, so how much of that drug is within a unit of your blood.

So how much is in the blood is not exactly how much you put into that body. And how much the size of that body or the volume in which that blood is dissolved in is going to change from person to person.

In addition, not everything that you put into the body is going to be within the blood because some of it is going to escape into the tissues. How much escapes into the tissues is not the same for me as it would be for you. And so there's going to be a variable amount.

And so I don't expect that I'm going to see exactly the same numbers. Even if I saw, you know, a full difference in the numbers, I don't have any suspicion -- until -- until there is something that is circumstantially important that I am told, like there was some kind of physiological difference at

the time the drug was administered, where I can then associate a concentration to some kind of a physiologic reaction where I would say that that requires further investigation. But in all of these cases, there's nothing there that is out of the ordinary from what is expected in the administration of etomidate.

Q. Does the autopsies that you reviewed give you any concern that at the time of execution, there was at least .3 -- .23 milligrams of -- milliliters of -- milligrams of circulating etomidate in their plasma?

A. I will answer that I know that number you are using is how you are judging consciousness. And I will say that there is no evidence that I reviewed in these cases that would indicate to me that any one of the cases I reviewed had consciousness at the time of the procedure.

MR. RODRIGUEZ: All right. Thank you. No more questions.

MS. McDERMOTT: Your Honor, may I ask a couple of follow-ups?

THE COURT: Yes.

MS. McDERMOTT: Thank you.

RECROSS EXAMINATION

BY MS. McDERMOTT:

Q. Dr. Webb, I'm just kind of curious. So if the manufacturer believes that you would need to have

.23 milligrams in your plasma, right, if tested by your plasma, in order to say that the drug had worked as it was intended --

A. Okay.

Q. -- you are saying that you don't agree with that?

A. I'm saying that every anesthesia textbook that I have looked at regarding the use of etomidate don't say .23. It says anywhere between .2 and .6. And so there's a threefold difference in that number given by the experts who wrote the book. So I don't think the manufacturer has some secret recipe to know exactly when consciousness is going to be lost.

Further, to further complicate their decision to give that number is how do they even know what consciousness is? I'm a doctor, and I've been a doctor for a very long time, and I can tell you that I don't know what consciousness is. I don't know when it's lost. I know how they test when it's lost. But there is no magic number that tells you that somebody is conscious or not.

Q. Well, do you have any -- I know you're a medical doctor, but do you have any specialty in anesthesia?

A. I do not. But because this is -- these are the decedents that I examine, I have to be familiar with the compounds that are used and how they function and at what concentrations.

Q. Well, when you referred to the manufacturer's "secret recipe," they do dosing studies, correct?

A. They -- they claim to, yes, as they report in their

studies.
Q. Do you -- do you doubt that the manufacturers of etomidate have done dosing studies to determine --
A. I will tell you that when I need to refer to the pharmacokinetics of a drug, I do not read the documents that are published by the company that made it. I read the textbooks from the physicians who studied that drug to determine the effects of that drug.
Q. Okay. And those -- so did you do any research for your testimony today?
A. Outside of just understanding what -- just the material that you gave me.
Q. Okay. You didn't consult any -- with any anesthesiologist?
A. Not to -- regarding any of the testimony.
Q. Okay. And...
MS. McDERMOTT: If I could just have a moment, Your Honor.
(Pause in proceedings.)
BY MS. McDERMOTT:
Q. Couple more questions. So what was the textbook that you consulted?
A. I believe it's called -- there's a couple. One is a toxicology book for -- it's called -- it's written by Besalt. It's a toxicology book that most medical examiners use.

THE COURT: Can you spell that for my court reporter?

THE WITNESS: B-e-s-a-l-t. That's the -- it's a very well-known post-mortem toxicology textbook.

The other one is a reference that I have for etomidate I use. I believe it's called *Clinical Anesthesiology*, that has all of the sedative drugs and their clinical effects.

BY MS. McDERMOTT:

Q. And in *Clinical Anesthesiology*, when is the last time you consulted that?

A. I believe a few -- maybe a week ago, two weeks ago I looked into it.

Q. About etomidate?

A. Yes.

Q. And were you asked to do that?

A. I was told about the -- there were questions about the use of etomidate, so I looked it up --

Q. And did you look at --

A. -- just to refresh.

Q. Did you look at any other sources in the research or did you speak to -- well, let me ask you that. Did you look at any sources in -- other than that textbook and the toxicology textbook?

A. No. Those were just really to refresh my memory.

Q. Did you speak to any pharmacists?

A. No.
Q. Anybody with a background in pharmacokinology?
A. Pharmacokinetics. No.
Q. Sorry, pharmacokinetics.
A. No.
That's not a problem.
Q. You didn't speak to -- and did you speak to any anesthesiologists?
A. Not regarding this.
Q. Okay. And have you seen -- and I can show it to you, but do you have Exhibit 7 in front of you?
A. Yes, I do.
Q. So if you can -- this is Plaintiff's Exhibit 7. And if you could go to page 163, please.
A. Mr. Bates, is that what I'm looking at?
Q. That's exactly right, Mr. Bates. And then I just wanted you to be able to find his name super quickly, but then if you can look at page 167.
A. Yes.
Q. And the lab includes this Reference Comment --
A. Yes.
Q. -- about the etomidate and what you should expect to see --
A. Yes.
Q. -- for someone who has been given a dose of etomidate.

A. Yep.
Q. And that is .23?
A. Yeah, it's completely inconsequential to me what they decide to put on their paperwork.
Q. So the lab that you're sending the blood to for testing, you do not --
A. This is not the lab I sent -- I do not send my testing to this lab. But I -- that's regardless. I do not care about what they write. First of all, they're writing about plasma concentration levels when they're testing whole blood samples. So right away you know that this is -- this is a copy/paste job just to fill up paperwork and to make something more substantial.

So no, this is not -- this is not relevant to the post-mortem testing that I've requested.
Q. So this lab, NMS, you don't find this lab to be reliable in --
A. No, their testing is -- their testing is absolutely reliable. I don't find this Reference Comment to be of any significance to me.
Q. Okay. So the fact that -- if you just look up a few -- an inch or so above that comment.
A. Yeah.
Q. The fact that the etomidate level for Mr. Bates was .22 --
A. Yes.

Q. -- and that's below the reference sample, that has no meaning for you?

A. No.

Q. So what's the point of doing the test?

A. To check for the presence -- first of all, I didn't do -- I wasn't the one who thinks that this is a good idea to do the test at all because you give the drug to them and then I'm just checking that you gave the drug to them is -- the whole thing, I think, is of questionable value. Unless you can tell me you can -- you can say, okay, there is a -- this is a person, I gave them this amount of drug, and then I tested their blood and they're unconscious, they're -- then show me that number and then I will tell you, okay, now do it in every person of every size and then give me a range.

This number comes from a clinical study of individuals going to the hospital to have surgical procedures done and that they are -- I don't -- I don't see what -- how that that relates to a post-mortem sample, that is tested in a completely different fraction of blood, is going to relate one-to-one.

I understand what you're asking is is there a possibility that this person could have been conscious. The way you test that isn't with the post-mortem blood, it's at the time, were they conscious. And the way you test that is with tactile touch, with verbal response, with response to pain

stimuli, not with post-mortem blood testing.

Q. And that's based on what experience?

A. I'm a doctor. I went to medical school. I studied -- I literally check -- every time a doctor makes a mistake and their patient dies, I have to go back and check every single procedure, every single drug, and make sure that they did it to standard based on what is written in their published standards and colleges.

So every -- so I have to know a certain amount of how a procedure and how a drug has to be administered in order to do my job and in order to determine a cause and manner of death.

So, no -- am I an anesthesiologist? No. But do I know an anesthesiologist has to check consciousness with tactile touch, with verbal and pain stimuli, before continuing on with a surgical procedure? Yes, I do know that.

Q. Would you be qualified to go administer anesthesia later today?

A. Absolutely not.

Q. And so would it be better suited for anesthesiologists to explain what level of etomidate they would expect to see after its administration so that they could try to understand if it had the intended effect?

A. Well, I mean, I -- again, I understand what you're saying. You're saying that maybe I'm out of my league in this. But I

know post-mortem toxicology. And I read a statement, exhibit number -- I don't know which it was -- from Dr. Zivot, who is an anesthesiologist, and -- talking about post-mortem toxicology. I hope that you had said the same thing to him about being out of his position.

Q. Well, I'm sorry, what exhibit are you referring to?

A. I don't know what exhibit it was.

Q. So what did you -- what were you given so that you could testify today?

A. I was given a protocol for the execution, and I was given the autopsies for whatever -- Exhibit Number 7, and I was shown the declaration by Dr. Zivot.

Q. What -- he didn't render a declaration. Did you have something -- did you have a report?

A. I don't know what you want to call it, but yes, I read a 12-page interpretation of the Florida Department of Corrections' protocol written by Dr. Zivot.

Q. Okay. And so in terms of -- it sounds to me like you've said that you have no faith in the drug manufacturer's information that they supply related to what levels they would want to see for anesthesiologists to obtain an anesthetic state for patients. Is that fair?

A. I think that's a bit of a sensational summary, so no.

Q. Can you tell me -- when I said that the manufacturer says that it should be .23, you said you didn't -- you didn't agree

with that.
A. So do you think that the -- wait, are you saying that the NMS is the manufacturer?
Q. No.
A. Okay. So which manufacturer, then, are you referring to?
Q. Have you ever read the package insert of etomidate?
A. I don't administer etomidate, so I do not have access to the package insert. But I have access to the research articles and textbooks where those who study anesthesia learn about etomidate.
Q. So you told me a few minutes ago that you didn't do any research. The only thing you looked at was two different textbooks. So I just want to be clear --
A. I am -- I'm familiar with -- I'm sorry.
THE COURT: Doctor, you need to let her finish her questions.
THE WITNESS: I'm sorry. I apologize.
BY MS. McDERMOTT:
Q. Yeah. Well, when is the last time you looked at any research on etomidate and blood levels unrelated to these textbooks?
A. I can't be sure about a date.
Q. Okay. And so in terms of the autopsies that you looked at, the tenfold difference that you're seeing in the various blood samples, that has no meaning to you whatsoever?

A. They come from two completely different sites. So -- and as a medical examiner, I understand that those differences in concentration in large part are due to the site in which the blood was drawn.

Q. Okay. So just -- but just going back to the manufacturer, you do not think that the -- what they have produced based on their own dosing studies is accurate. You think that what is in the textbooks is more accurate?

A. I think -- certainly, yes.

Q. What's --

A. If you want to summarize that do I believe the clinical anesthesia textbooks are more accurate than the manufacturer's package inserts, I will say absolutely, yes.

Q. And as far as the labs, you put no significance in what they have said in their report related to the blood level?

A. Right. As I said, it's their little -- their reference comment is inconsequential to me.

Q. And in fact, in your opinion, the -- well, strike that. So -- so in terms of you said you don't know why it's being done, are you going to stop having it being done?

A. No. I mean, as long as there is interest in -- and it provides value to those who are ensuring that the process is done in the manner that it was supposed to be and based on this proceeding here, it seems that there is some interest and value to the quantification of etomidate, I will continue to do so.

MS. McDERMOTT: Thank you again, Dr. Webb.

MR. RODRIGUEZ: Your Honor, may I have a very brief follow-up?

THE COURT: I do direct, cross, redirect, recross.

MR. RODRIGUEZ: Understood.

THE COURT: All right, sir. You've completed your testimony. Thank you. You're free to log off.

THE WITNESS: Thank you.

THE COURT: Next witness.

MR. MERVINE: Respondents call Kevin James.

COURTROOM DEPUTY: If you could please raise your right hand. Do you solemnly swear that the testimony you're about to give before this Court will be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

COURTROOM DEPUTY: You may have a seat. And if you can please state your name for the record and spell your last name.

THE WITNESS: My name is Kevin James, last name is spelled J-a-m-e-s.

THE COURT: Go ahead.

KEVIN JAMES, DEFENSE WITNESS, SWORN,

DIRECT EXAMINATION

BY MR. MERVINE:

Q. Mr. James, what is your professional position?

A. I'm an inspector with the Florida Department of Law Enforcement assigned to the Office of the Executive Investigations.

Q. And what does your position entail? What duties do you have?

A. Part of my duties involves monitoring the executions within the state of Florida.

Q. And do you have other roles as well?

A. Yeah. I also investigate election crimes and assist with political corruption investigations.

Q. And how long have you held that position?

A. Just under two years now.

Q. During those two years, have you had an opportunity to attend executions?

A. Yes, sir.

Q. And can you estimate how many?

A. I've done seven executions.

Q. And is one of those Samuel Smithers' execution on October 14th, 2025?

A. That's correct, sir.

Q. And where did that occur?

A. That occurred at Florida State Prison in Raiford, Florida.

Q. And on that date at approximately 3 p.m., can you describe where you were?

A. At 3 p.m. on the day of the execution I was in the

chemical room monitoring the chemicals being filled within the syringes.

Q. And if you could describe to the Court what you observed.

A. When I enter the room it's myself, another FDLE member, along with I believe two pharmacists, three DOC employees, and then anywhere from three to five medical professionals.

We secure the room when we are all seated. The pharmacist will then present a box of each chemical that's used. The box is presented to me to verify the name and expiration date and then the box is opened. Each vial is then presented as well to confirm the name and expiration date of each vial.

Q. Now, prior to this, what training would you have had regarding your attendance at the execution?

A. Prior to being involved in any execution we're given the operate -- the protocol. So we are expected to read over it, be familiar with it. And then prior to being a primary role with FDLE in the executions, we shadow an experienced member of FDLE with an execution. We are briefed pretty in depth by DOC employees about the standards that they expect and the reason behind each -- each procedure.

Q. So again, referencing this case, which would be Samuel Smithers on October 14th, 2025, do you have an independent recollection of that?

A. I do, yes, sir.

Q. And so at approximately 3 p.m. you're describing who all was in the injection room --

A. Yes, sir.

Q. -- and the pharmacist, what he or she did. Can you describe or do you recall what chemicals or vials or boxes he or she showed?

A. Yeah. It's -- it would be an order of etomidate. Once the etomidate is presented, the expiration date on the box and each vial is confirmed by myself. It is then confirmed by DOC employees.

Once the appropriate amount of etomidate is presented, the medical professional will then sanitize each vial and fill the syringes appropriately.

Q. And what do you recall regarding the etomidate's expiry date in this case?

A. It was within expiration date.

Q. Okay. So as of October 14th, 2025, it was not unexpired?

A. Correct.

Q. No. Lot of negatives in that sentence.

THE COURT: Try without the double negative.

MR. MERVINE: Yes, ma'am.

BY MY MERVINE:

Q. So our date is October 14th, 2025. You were shown both the packaging as well as the vial. Had the etomidate which you were shown, had that expired as of that date?

A. It had not expired.
Q. Okay. And then you indicated someone else looked at them. And then what happened?
A. So once the pharmacist presented to me, it is then -- the pharmacist hands it to another medical professional, which she then -- he or she then presents it to two separate DOC employees for them to confirm the drug name and expiration date as well. And then it is placed within our line of sight, never leaving our line of sight, onto a table, where once all of the vials are checked and lined up, they are then fill -- the syringes are then filled.
Q. And you're talking in the present tense, but you're referring to this execution in particular?
A. That's correct, yes, sir.
Q. And so this is somewhere around 3 p.m. What happens next?
A. Once each drug or chemical is checked and filled, the syringes are placed on a tray. The trays are then -- once everything is filled and the trays are filled, the trays are then -- we monitor the trays being transported into the executioner's room, where they are placed in a specific area to be monitored until they are administered.
Q. And if the execution took place at approximately 6 p.m., you would be monitoring that for approximately two and a half, three hours?
A. That is correct, sir.

Q. Did the syringes, including the one containing the etomidate, did that ever lose -- or was there ever a time when you didn't observe it during that period?
A. No, sir. It was always within our line of sight.
Q. And were you present during the execution?
A. Yes, sir.
Q. And the drugs which you were shown -- or, rather, the syringes which you were shown were the ones which were used?
A. That is correct, sir.

MR. MERVINE: I have no further questions, Your Honor.

THE COURT: Mr. Gunn.

CROSS EXAMINATION

BY MR. GUNN:
Q. Hello, Mr. James.
A. Hello, sir.
Q. Were you in the courtroom for Mr. Graff's testimony?
A. Yes, sir.
Q. Okay. Then I'll try to keep this a little shorter. Is there anything about his description of the procedures at the executions that you take issue with or was he accurately describing everything?
A. I would say he accurately described everything, sir.
Q. And you participated in the execution of Mr. Smithers. Did you also participate in the Curtis Windom execution on

August 28, 2025?

MR. MERVINE: Your Honor, I would object to the word because, I mean -- "participate," just due to the --

THE COURT: Just rephrase it and ask it --

BY MR. GUNN:

Q. Were you part of the execution team for the Curtis Windom execution?

A. Not that I recall, sir.

Q. Well, wouldn't you recall if you were part of a -- or you were part of the team of an execution?

A. I have -- I know I have a list of executions that I have been a part of, but at this time I can't recall if that was one of them.

Q. And are you always assigned to be the FDLE -- one of the FDLE monitors inside the executioner's room?

A. That's correct, sir.

Q. And you've done that seven times?

A. Yes, sir.

Q. Did you have any special experience or qualifications for this position?

A. Just the standard training that I spoke about earlier, sir.

Q. Which is reading the protocol?

A. Reading the protocol and then shadowing. I believe I shadowed twice before I was assigned as a primary.

Q. Okay. So in that case, are there three FDLE people inside the room, the shadow and then the two that are assigned there?
A. No, sir. The shadow would be the third.
Q. Okay. How is that a shadow then?
A. So you're shadowing the primary.
Q. Okay. But doesn't there always have to be two in the executioner's room? Are you basically just the second?
A. You would be -- yeah. You'd be the third FDLE member involved in the -- in the monitoring of the execution, but the second in the chemical room.
Q. Okay. So there's no difference between a shadow and the second person in the execution room?
A. Not always.
Q. Okay. Sometimes?
A. Right. The third person would -- is essentially a backup in case the second person couldn't fulfill their duties. But I -- even after being a primary, I've been what we refer to as FDLE No. 3, which is that same shadow role that was referenced.
Q. Okay. And do you practice verifying the expiration dates when you go through the practice executions?
A. Yes, sir.
Q. You do practice that?
A. We -- we -- well, during the practice run, is that what you mean?
Q. Correct.

A. No. That is -- the timing is all the same. So at 3 o'clock we move to that same room, but no, no drugs or chemicals are presented.

Q. Okay. You don't pretend to check expiration dates?

A. No, sir.

Q. Would you say in these practices that the execution team personnel are taking the practices seriously?

A. Absolutely, sir.

Q. Could we please put up Defendants's Exhibit 5 at page 23, please.

Do you recognize this as a statement from a practice execution for Mr. Smithers?

A. I've not seen this before, sir.

Q. Okay. Does this look like a document that would be created in a practice execution?

A. Not by myself or -- potentially by an FDOC employee, but this is not anything I've seen before, sir.

Q. Well, it says at the top "practice" and it says Inmate Last Statement. So I assume this is a simulated statement?

A. Again, I can't confirm. I've never seen a document like this, sir.

Q. Okay. And the statement says: I would like to apologize to nobody -- no one?

A. Yes, sir.

Q. Does that reflect the kind of humanity and dignity of the

process, creating this fake statement during a practice? That's supposed to be a joke, right?

A. I think it's potentially an accurate statement that was maybe taken from a prior inmate. Just speculating.

Q. Okay. You don't have --

THE COURT: Let's not speculate.

THE WITNESS: Yes, ma'am.

BY MR. GUNN:

Q. You don't have any reason to believe --

A. I don't have -- no, sir.

Q. All right. Let's go to the actual execution of Mr. Smithers. What was the expiration of the etomidate in the Smithers execution?

A. I'm not sure the exact date, but I know that it was prior to October of '25.

Q. Okay. But you didn't record that anywhere?

A. No, sir.

Q. Okay. Nobody recorded that anywhere?

A. Not that I'm aware of.

Q. Is there a procedure you're supposed to follow if the vials are expired?

A. We are to notify the team leader, which would then make the determination of what the appropriate actions would be for that contingency.

Q. And you wouldn't hesitate to do that even if it delayed

the execution?
A. Absolutely not.
Q. When did you first learn that questions had been raised about expired etomidate in the execution that you participated in?
A. I believe a coworker brought it up maybe within the last six months --
Q. Okay.
A. -- just in passing, that it had been in the news.
Q. Okay. And were you concerned at all when you heard this that it could be true?
A. No, sir.
Q. You were not?
A. No.
Q. Even though you didn't remember the actual expiration date?
A. Correct. I remember that they -- every execution I've been a part of has been within the expiration date.
MR. GUNN: May I have a moment, Your Honor?
THE COURT: Yes.
(Pause in proceedings.)
MR. GUNN: No more questions. Thank you.
MR. MERVINE: Nothing further from the respondents, Your Honor.
THE COURT: You may step down.

MR. MERVINE: Your Honor, our last witness will be Dr. Marcano.

THE COURT: Come right up here to be sworn, please, and if you'll remain standing.

COURTROOM DEPUTY: If you could please raise your right hand. Do you solemnly swear that the testimony you're about to give before this Court will be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: Yes, I do.

COURTROOM DEPUTY: You may have a seat. And if you can please state your name for the record and spell your last name.

THE WITNESS: Yes. My name is Renea Marcano. It's spelled R-e-n-e-a, M-a-r-c-a-n-o.

DR. RENEA MARCANO, DEFENSE WITNESS, SWORN,

DIRECT EXAMINATION

BY MR. RODRIGUEZ:

Q. Thank you, Dr. Marcano. Before we get any further, you have never actually been in the execution room with the team there looking at the drugs or anything of that nature, right?

A. That's correct.

Q. Okay. So you have never been onsite during an actual execution as it took place?

A. That's correct.

Q. Could you briefly explain your educational background for

the Court.
A. I hold a doctorate in pharmacy from the University of Florida.
Q. All right. And briefly, just your undergrad and MBA, anything.
A. Yes. I graduated from University of Florida -- I mean, I'm sorry, from University of Central Florida with a business degree. I also have a master's degree from University of Central Florida. And then I went on to get my doctorate in pharmacy from University of Florida.
Q. Could you describe to the Court what's required for an individual to obtain a license as a pharmacist in Florida.
A. So there's certain prerequisites that you need to complete before you get into pharmacy school. Pharmacy school is four years. And then at that point you need to take, like, an exam that proves your competency and pass it.
Q. And you passed that exam?
A. Yes, sir, I did.
Q. And are you currently a Florida Department of Corrections employee?
A. Yes, I am.
Q. When did you -- oh, when did you first obtain your license to practice as a pharmacist in the state of Florida?
A. In 2009.
Q. And when did you first begin working with the Florida

Department of Corrections?

A. In 2010.

Q. What was your role at that time when you started?

A. I was a Senior Pharmacist at the regional pharmacy, which is located in Raiford. It supplies pharmaceuticals throughout the state of Florida. I became an assistant manager, then a manager at that site.

From there, I promoted to the Reception Medical Center in Lake Butler, where I oversaw the hospital pharmacy as well as the oncology pharmacy.

And then last year I promoted to Bureau Chief of Pharmacy Services in Central Office.

Q. And what month did you begin serving as the Bureau Chief?

A. In July of 2025.

Q. All right. Could you please describe your responsibilities as Bureau Chief of Pharmaceutical Services.

A. I oversee all pharmaceutical issues for the Florida Department of Corrections.

Q. In your role as Bureau Chief of Pharmaceutical Services, do you regularly monitor the drugs that Florida uses in its procedure?

A. Yes, I do.

Q. Do you regularly audit the records associated with the lethal injection drugs, such as purchasing and inventory?

A. Yes, I do.

Q. And you've been doing that since you began your role as Bureau Chief, right?
A. Shortly -- yeah, shortly thereafter, yes.
Q. Given your responsibilities, how familiar are you with the procurement, storage, monitoring, chain of custody procedures for the drugs Florida Department of Corrections uses in its lethal injection protocol?
A. I'm very familiar.
Q. What are the three main drugs that Florida uses in its lethal injection procedure?
A. Etomidate, rocuronium, and potassium acetate.
Q. All right. And when you purchase those drugs, does each of those come in lot numbers?
A. Yes. Every drug comes with a lot number, yes.
Q. And that lot number is associated with an expiration date, or no?
A. Yes, it is.
Q. Okay. Can you explain what a lot number is?
A. A lot number is indicative of the batch that the manufacturer made. So in case there was something that went awry with that particular batch, they'd be able to recall it back to them.
Q. How are the lethal injection drugs secured?
A. They're secured in a secret location. You want me to walk you through kind of the doorways and so forth?

Q. Yes.
A. Okay. The first doorway would have two locks on it. You enter into that room, and then there's another room that you would need a key to to access that particular room.
When you go inside, there's steel cabinetry. There's multiple steel cabinetries in there. One of those cabinets you would need a key to. And inside that cabinet is a steel box, similar in shape maybe to a shoebox. There's a hidden key that would access that box. And inside that box is the key that would open other containers in that room that would have these drugs in them.
Q. Is access to these drugs restricted to only authorized personnel?
A. Yes, it is.
Q. And are access to the keys limited exclusively to authorized personnel?
A. Yes, they are.
Q. Can you describe how etomidate is stored in the secure room?
A. Inside the secure room there's two containers. One of the containers houses all of the medications that's within -- that's not expired, that's viable medication that would be used, you know, for the execution.
There's another container that contains all of the damaged or expired or adulterated product. It's two separate

containers.

Q. And within the container, the unexpired etomidate, how are the drugs arranged as far as the expiration dates go?

A. They're in order of expiration date. So what would be used next would be first and then the date that would maybe be furthest out would be at the end of the line. So it's in date order by expiration date.

Q. All right. What are you looking for as you monitor the drugs used in executions?

A. So in regards to the drugs themselves, you're looking to make sure that what was received was actually what's ordered, what's needed, based on the protocol. And then you're looking at, you know, the strength, the size of the vial. You're looking at the solution; if it's supposed to be clear, is it clear; is there particles; is it discolored. Is there any -- is there anything wrong with the labeling. The safety cap that's on top needs to be intact.

Q. And are each of the drugs used in Florida's lethal injection protocol stored in keeping with what is pharmaceutically required for the drug?

A. Yes, they are.

And can I just correct something real quick? I apologize. There is a commercial refrigerator that houses the rocuronium, and it is locked as well.

Q. Thank you. When one of the lethal injection drugs is

close to its expiration date, what's your procedure for handling that drug?

A. The procedure is it -- we know when these executions are going to occur. We usually know usually around a month out. So if -- like, for example, if we had product that was going to expire at the end of this month and there was no other execution this month, we could go ahead and move them over into the other container. If there is an execution, say, scheduled before -- before they expire, then we would not necessarily move them in advance. We can move them up to one business day after they expire.

Q. All right. Now, once a drug is moved to the bad cabinet, the expired cabinet --

A. Yes.

Q. -- is it ever moved back?

A. It is never moved back, never.

Q. It is never used for execution?

A. It is never used for execution.

Q. Do you permit expired drugs to remain in the good cabinet, the active-use cabinet, for months after expiration?

A. No, we do not.

Q. Do you have a method of -- without getting into what it is, do you have a method of getting rid of the expired lethal injection drugs?

A. Yes, we do.

Q. Do you specifically train anyone authorized to handle these drugs that absolutely under no circumstances are expired drugs to be used in executions?
A. Absolutely.
Q. When you were trained for your current role as Bureau Chief, were you also trained that absolutely under no circumstances are expired drugs to be used in executions?
A. That's correct.
Q. When your pharmacists are training any pharmacy technicians, do they -- do you -- do they also instruct those technicians that you do not use expired drugs under any circumstances?
A. That's correct.
Q. Before we get to recordkeeping, can you explain how the drugs are moved from storage to use in executions?
A. So there's two people that's on the execution team that would be -- that would pick them up for -- from the secure location and transport them to FSP.
Q. Okay. Do the individuals that are picking up the drugs check whether they expired before they take them to FSP?
A. Yes, they do. There's four people involved in that process. So there's two people onsite at the secure location that are caretakers of those drugs. They check the expiration date. The two people picking them up checks the expiration date as well.

Q. When they pick them up, are they also checking to see if they are damaged or adulterated in some way?
A. Yes. They're checking them in every way.
Q. After inspecting the drugs, where do they place them?
A. There's a box that they place them into. And that box is a locked box with a code.
Q. Thank you.
Now, does the Florida Department of Corrections keep and maintain an inventory of the logs [verbatim] that are purchased, stored, and used in Florida's lethal injection process?
A. Yes, we do.
Q. And during your time as Bureau Chief, were there entries made in those logs that concerned you as warranting investigation?
A. Yes, there were.
Q. Are there particular dates that stood out to you in that regard?
A. Yes. I would have to pull my notes, unless you would like to show it to me, but yeah, yes.
Q. Sure. Was August 19th, 2025, one of those dates?
A. Can I pull my notes? Is that okay?
Q. Yes, yes.
A. Okay. August 19th is one of those dates.
Q. Was August 29th, 2025, one of those dates?

A. Yes, sir, it is.
Q. And August 9th -- or, sorry, I apologize, September 17th, 2025?
A. Yes, it is.
Q. And then September 30th, 2025?
A. Yes, it is.
Q. All right. Now, were there an additional two dates that concerned you regarding etomidate specifically?
A. Yes, 10/14/2025, 10/28/2025.
Q. All right. Thank you. And so in light of your concern, what did you do? What steps did you take to determine whether expired etomidate was used in an execution, in violation of the protocol?
A. So I did three things to resolve this issue, because it does look concerning. So the first thing that I did is in that blackened area, I believe that's on the copy that you have, that's redacted.
Q. Don't tell me about anything that's in the redactions, please.
A. Okay. So I can just -- so under there is a lot number. I won't say specifically what's under there, but there is a lot number. And I traced that lot number back to the three invoices that we had previously received. We had received that NDC number that's at the top of this handout, and that lot number, we had received it on three different invoices. And

each invoice indicated that the true expiration date was January 2027, not January 2025. So that's one thing that I did.

So the second thing that I did was I looked just for etomidate with that NDC number. And I looked through all of our invoices, and I could not identify ever receiving etomidate that had an expiration date of January 31st, 2025. That's the second thing I did.

The third thing I did was I reached out to the execution team members and I just had a discussion, and I said, this is -- this is, you know, what -- what I found on the log, and this is just what I did.

And I asked the transporters do they recall checking, you know, the expiration date, was there ever a time that anything could have went awry. And they said that they have always checked the expiration date and there has never been expired product that left that site.

Q. So based on your investigation, are the inventory logs an accurate reading of the actual expiration dates of the drugs that were used?

A. As of now, with the corrections? Is that what you're asking me?

Q. Previously. I apologize.

A. Previously, when they said 2025?

Q. Right.

A. No. That was, I deemed, a human error.
Q. Okay. And was that the only human error that you found in the drug logs?
A. No, I found other issues.
Q. Okay. So based on the investigation that you conducted, did somebody go back and correct the logs?
A. Yes, they did. Yes, they did.
Q. Is there any likelihood that you and those working under you missed 8- to 10-month-old expired etomidate in the good -- that was kept -- I apologize.

Is there any likelihood that 8- to 10-month-expired etomidate was kept in the good cabinet for --
A. No chance. No chance.
Q. Now, I do want to discuss a little bit, what procedures have you instituted now to try to bring more accuracy to the logs?
A. The person that was handling the logs is no longer with us. So we have a different team handling these logs. And all four members, the -- two caretakers and the two transporters, review the logs for accuracy along with myself. So there's more people reviewing the logs than before.
Q. All right.

MR. RODRIGUEZ: Those are all the questions that I have for you. Thank you, Dr. Marcano.

THE WITNESS: Thank you.

THE COURT: Go ahead, Ms. McDermott.

CROSS EXAMINATION

BY MS. McDERMOTT:

Q. Good afternoon, Dr. Marcano.

A. Yes. Good afternoon.

MS. McDERMOTT: Your Honor, may I look at -- may I have leave to look at Dr. Marcano's notes that she refreshed her recollection with pursuant to 612(b) of the Federal Rules of Evidence?

THE COURT: Any objection, Mr. Rodriguez?

MR. RODRIGUEZ: No objection.

THE COURT: All right.

She's going to take a look at your notes.

Go ahead.

MS. McDERMOTT: I can see it just standing right here.

Your Honor, we've run into a little tech issue. The screen has turned --

COURTROOM DEPUTY: I just switch it between --

MS. McDERMOTT: Oh, I'm so sorry about that. Okay.

BY MS. McDERMOTT:

Q. Okay. So Dr. Marcano, when did you take the position that you now hold?

A. July 4th, 2025.

Q. Okay. Easy to remember that date.

A. For sure.
Q. And when did this -- these errors come to your attention?
A. When -- around, I would say, December.
Q. How --
A. Possibly December.
Q. Sorry, I didn't mean to --
A. Maybe January.
Q. And how did they come to your attention?
A. So up to that point I had other people reviewing these logs. And I had been in the job with a lot to do initially. And I had reached the point where I could review these logs myself, and that's how it was uncovered.
Q. Were you aware that there was litigation about the logs going on in November and December of 2025?
A. I was aware of litigation just in general about death penalty issues, but not, per se, about the logs.
Q. Not specific to the logs?
A. Yes, right.
Q. When you -- when you noticed these discrepancies, who did you alert to them?
A. So I talked to my director, my supervisor, which is the Director of Health Services, and then I commenced an investigation.
Q. Did you notify, at that time it would have been Warden Polk?

A. I talked to the execution team. So I won't say precisely who I talked to, but I talked to the execution team. And then I talked to the transporters who are on the transport -- you know, execution team as well. And then my staff as well.

Q. So you didn't talk to Warden Polk?

A. I am not sure if he was in that position at that time, but I would say no, I did not talk to Warden Polk.

Q. I think he took over right around end of November, December, if I remember correctly.

A. Okay.

Q. But in any event, did you alert legal, DOC legal?

A. I believe my supervisor might have. And then in regards to Warden Polk's position, I went to the level above him is who I talked to.

Q. Is that Regional Director?

A. Yes.

Q. Okay. And do you know if the information, just to your knowledge, was ever provided to the Attorney General's Office?

A. I don't know.

Q. The governor's office?

A. I don't know either.

Q. Okay. And so when you decided to institute the investigation, was that your decision?

A. It was probably a combined decision with my supervisor, the director.

Q. The Regional Director?
A. No, the Director of Health Services.
Q. A lot of directors.
Okay. So that was with your supervisor, you said. And how did -- how was it decided that the investigation would be an internal investigation? Someone within its own department was going to investigate the department?
A. Well, I think -- I'm not exactly sure. Just a conversation between me and my supervisor was had, and he wanted me to look into it first. I was fairly new to the position, so it wasn't -- I wasn't involved, per se, you know, in this part of it, in documenting the log, you know. So he felt like it could be an independent person that looks into it.
And then after the three parts that I told you I did, I determined it to be human error, so -- so the investigation did not go further.
Q. Did anyone ever contemplate -- or did you contemplate notifying the Inspector General's Office?
A. I did not contemplate that. That, I believe, would be a decision that my supervisor would activate, but I did not personally.
Q. Okay. And you've talked about what you did, so I wanted to ask -- let me see. We've gone through -- so how are the expiration dates tracked of the drugs that are in -- are we -- can I call it a pharmacy even though it's not really a

traditional pharmacy, but it's an area where you maintain drugs?

A. Yes.

Q. So can I -- is that what you call it?

A. Yeah, I would call it pharmacy, yeah.

Q. Okay. So how are the drugs that are in the pharmacy tracked for determining expiration date?

A. You mean tracked as visually, like how we line up the expiration dates, or you're talking about is there a master copy that includes the expiration dates?

Q. More along -- I'm sorry to interrupt you. More along the lines of someone who can know when expiration dates of the drugs are approaching. How does that happen?

A. So it's basically a -- this process is almost like a continuous process in motion. Almost every day we're involved in some aspect of this, the caretakers are. So there's a constant review of our holdings. It's not a -- you know, it's three major drugs. It's not a large amount of drugs like a typical pharmacy would have. So it is something that you can look at, like an inventory sheet, you can constantly scan for expirations. And then we also have them lined up in the cabinetry in subsequential date for expiration.

Q. And when you just said the three drugs, are other drugs stored in that same cabinet?

A. Anything associated with this event. So like sodium

chloride, 20 mLs is in there, hydroxyzine, lidocaine. Sodium chloride bags is in that area.

Q. Okay. So there's actually multiple drugs that are being stored in that cabinet?

A. There is multiple, but it's still a small amount compared to a typical pharmacy. It's a fairly small amount.

Q. Right. Correct. All right. And they're maintained in their boxes?

A. They are.

Q. Is the package insert kept with the drugs?

A. Yes, they are. But they remain unopened until we need -- you know, like, say if we have, say, several boxes, we -- and we need to open, say -- potassium has 25 in a box and we need to pull out, say, 12 or something like that, then one box would be opened, the rest would be sealed. So we don't have multiple boxes open is what I'm trying to indicate. I don't know if that's too much information.

Q. I understand what you're saying.

So -- and you indicated that you were able to consult some of the invoices from the past. Do you maintain every single invoice?

A. We do.

Q. From how far back do you go?

A. There's records at that site; I don't know how far back. I was filtering through records from 2017 the other day, but I

don't know how far back they go. But there's a lot of records.
Q. Okay. And you said that the expired drugs moved to a -- or someone actually moves them to a different cabinet?
A. That's correct.
Q. And then where do they go from there?
A. There's two paths that they can take from there. Can I go into any detail or...
Okay. So there's -- one path could be a reverse distributor and the other path is simply waste. It goes to incineration.
Q. And how long do they remain in the quarantine cabinet before they would be entirely removed from the facility?
A. So there's not a set time. There's -- whenever we send them to waste, we try to fill the container, the waste container. So there's not like a set month or anything, or a set time frame, not like every month -- we're not moving out product every month. We try to fill the container that's going to incineration.
Q. Is the container the same as the quarantine cabinet?
A. That is the -- that is the quarantine cabinet.
Q. Those are the same thing?
A. Yeah.
Q. And when you said you have a lot of documentation, you have invoices?
A. Yes.

Q. Do you have shipment information?
A. Do you mean like invoices or packing slips or --
Q. Packing slips.
A. Yes, uh-hmm.
Q. Do you keep any handwritten notes in these -- with these documents?
A. No, I did not see any handwritten notes.
Q. Okay. Do you have any memos in there related --
A. No.
Q. Now, you said on execution day -- and I know it's -- I'm not asking you to reveal anything that you shouldn't. So the pharmacy is not located onsite?
A. That's correct.
Q. Okay. At FSP?
A. That's correct.
Q. And on execution day, two individuals come to the pharmacy to pick up the drugs and transport them back to FSP?
A. That's correct.
Q. And are the drugs logged out at that point?
A. So the process for -- for that day, the drugs are moved on the day of the event. So what happens is the -- our caretakers will pull enough for the event. So it would be enough for Stand A and Stand B and then a second set. So there's a spare in case one is dropped or something like that or there's some problem, you know, in transport or something. So there's --

there's multiple sets taken.

So our caretakers will pull out the set that they want to be used and then a spare set. There's a handwritten note that indicates the set that they want to be used -- that they want used, and there's -- on that note is also the information about the spares. And then at that point, when the two transporters come, they review everything in entirety as well, you know, along with the caretakers, and then they take the drugs to the event.

Q. Okay. So, for example, would potassium acetate at the 2 milliequivalents per 20 milliliters, you take out 12 vials, correct, or --

A. It depends on the size. We have two sizes.

Q. Okay. I'm sorry.

A. We have a 20 mL size, and yes, it would be 12.

Q. 25 by 20 would be the 12?

A. Right. So 25 means that there's 25 vials in a box and 20 mLs is the amount in each vial. And so to get to the appropriate dose, or the appropriate protocol, there would be 12 of the 20 mLs.

Q. And so you're saying that you take out 12 for the execution, for the A and the B, and then you take out another 12 as a backup to the execution drugs?

A. Correct.

Q. Okay. And at the time that those are taken out of the

cabinet, is that reflected in the log contemporaneously?
A. Not at that moment. There's a worksheet, and so it identifies which drugs, you know, are identified to be used. And it shows what drugs are the spare.

And the drugs are bagged up for the spare. They're bagged up tightly with staples to make it not easy to use at the site unless they absolutely have to gain access to it. The other ones are bagged up for easy access. But they're bagged up after the team comes.

Q. Okay. So this paper that's created, you said it's a -- you just referred to it as a --

A. It's a worksheet.

Q. -- worksheet?

A. And then we destroy it. So once the drugs circle back that evening, they circle back, the transporters bring it back to that site. It's pretty late at night at that site. And then at that point it's determined, okay, in fact, what returned was the spare. So at that point, then we document on these logs what was used.

And then if it's a -- if it's a room-temperature drug, such as potassium or etomidate, it's placed back into stock. And then if it's rocuronium, which is refrigerated and has now been out, then it's placed into quarantine. We have a quarantine refrigerator. So we place that in the quarantine and it would not be used again.

Q. So the rocuronium, once it's removed from the pharmacy, even if it's not used at the execution when it comes back, it goes into the quarantine?
A. It does, yes, it does.
Q. And this worksheet --
A. Can I just modify something real quick?
Q. Yes.
A. The package insert does say it's still good for 50 days at room temperature, but we still don't use it, just to clarify.
Q. The worksheet that is filled out, who's filling that out?
A. One of the caretakers is filling -- filling out the worksheet. And that same caretaker is then responsible for the log upon the return of the product.
Q. And what information is included on the worksheet?
A. The same information that's on the log.
Q. So without telling me anything that's redacted, just generally, you said there's lot numbers?
A. Right. The lot numbers, the NDC -- the drug name, the NDC, the lot numbers, the expiration date, the amount, and so forth, yeah. I believe that's it.
THE COURT: NDC?
THE WITNESS: NDC. It's the National Drug Code. It's on the top of the sheet here. It's indicative of the manufacturer.
THE COURT: Okay. Is that -- okay.

BY MS. McDERMOTT:

Q. And someone hand writes that?

A. Right. On both, the log and on that worksheet. They're all handwritten.

Q. But the worksheet, when it's removed, someone hand writes it on the worksheet?

A. Right. When it's leaving, when those drugs are leaving, the drugs are sitting here, the worksheet is here. And it's written down exactly what we intend for them to use and what the spare is. And the worksheet lays right there on the table with the product. The team coming in to pick up evaluates the information. Then the spare product is placed in like a Ziploc and stapled. We make it difficult to gain access to the spare. It's placed in the bottom of the box. And then the rest of it is placed into a Ziploc and placed in the top of the box, and it's easy to pop the Ziploc.

Q. And then you said that that paper gets --

A. Destroyed.

Q. -- destroyed?

A. Yes.

Q. It doesn't just get kept with the log?

A. We don't. I'm not sure why. That's -- we just don't keep the worksheet.

Q. Okay. In terms of this system, who -- and one more thing about the paper, or the worksheet, is how many people are

putting eyes on that worksheet at the pharmacy?
A. Two caretakers and two transporters.
Q. Does the -- when the worksheet -- if you know, based on your position, when the worksheet gets to the execution or the chemical room --
A. Yes.
Q. -- do other people see the worksheet?
A. They don't. They just see the product that arrives.
Q. Okay. Now, what training occurs for the people -- first of all, the people that are in the pharmacy, what training do they get?
A. So I will -- I will train them. Since I've taken this position over, we've gone over these -- these procedures.
Q. And prior to you, was there a predecessor in that position?
A. Prior -- in this position I'm in?
Q. Yes.
A. Yes, there was.
Q. And would that person have had the responsibility for training at that point?
A. Yes, he would have had that responsibility.
Q. Okay. And are you -- beyond just showing people what you do, do you introduce any sort of, you know, information from the -- like the -- from like, you know, pharmacy divisions or anything about why you have to keep good records or what -- how

these drugs can, you know -- how they are stored best? Do you have any training on that sort of thing, or is it more just the training revolves around "this is what we do"?

A. I have trained them, yes. We even sit down and do calculations together. So if you received this vial, this is the calculation, this is what the protocol calls for, this is how you calculate the number of vials. Yes.

Q. Now, did you actually, when you did your investigation, speak to the person -- could you identify the person who had written down the date incorrectly with those -- I think you had six different execution dates that corresponded with --

MR. RODRIGUEZ: Your Honor, we would object to the extent that person was on the execution team. And I don't know the answer to that.

THE COURT: Well, I think the first question was did she speak to them. She hasn't asked for the identity yet.

A. Yes, I did.

Q. And without revealing anything about the person related to their identity, was there an explanation about how those expired dates had been written down?

A. He -- English is not his first language. And I believe the year was 2025, so it was just -- it was just an error in writing down the current year.

Q. Do you know how long etomidate lasts before it expires? Like if you -- do you always get -- when you get a shipment, is

there always the same amount of time between shipment date and expiration date?

A. I haven't really looked too deep into that. I will -- I [redacted]

Q. But just generally, you're not sure how long these drugs have between shipment and expiration, whether it's like a standard amount of time based on the -- you know, based on the volume and based on the drug, or if it's -- it varies? Do you know?

A. I mean, it does vary. As I was looking at the log, sometimes we were -- you know, some products we were receiving had dates of like -- we were in 2025, had dates of 2027. I believe there was other products we had received that had, say, like a year expiration on them. I mean, it does vary. I don't know the manufacturer's rule of thumb on an expiration date --

Q. Okay.

A. -- if that's what you're asking.

Q. Can I ask you -- they're going to bring up -- or they brought up Exhibit 2 -- Plaintiff's Exhibit 2, and we're going to look at page 3 of that exhibit. This is etomidate. And I

wanted to just draw your attention to the December 8th, 2022, date that's in the very first column. And then if you trace that across, can you tell me what the expiration date is?

A. It looks like July 2022.

Q. And so that -- that etomidate had been expired for seven -- I guess almost eight months before it was removed from the -- from the cabinet; is that correct?

A. We keep -- okay, I'm not sure if I misunderstood your previous question, so let me just kind of clarify.

So that entry there does look like it was moving out, like it was expired. But just like a controlled substance, we keep -- on these logs -- we keep expired and unexpired on a drug log. So just like a controlled substance, if you had morphine that was expired or unexpired, they still -- you still need to know what the outcome is. So that expired product does not get removed from these drug logs until they ship.

So I don't know if I'm -- if I'm making myself clear or not. But you still want to know -- there's 120 that expired there. You do not remove them from a drug log until they ship out of your inventory. You need to know that those drugs are still here and that they're still expired. You don't want them going somewhere else.

Q. Okay. And I also did the math backwards. So just -- just so you know. So it being expired 7/22 and then being removed 12/22, it's only four months, it's not eight months. So I just

wanted to correct myself as well.

But based on what you just said, if you drop down to the second-from-last entry, which in that far left column is January 3rd, 2025 --

A. Okay.

Q. -- and then you come across and you see that the expiration date was 12/2024, and 50 vials were removed?

A. So the way I -- I conduct pharmacy practice -- so I was not in the position at that point. I -- not every pharmacist possibly does things the same way. But those logs -- those drugs -- so those -- so I believe we're talking about the same thing. So in January there was drugs that expired a month before. Is that what you're indicating?

Q. Correct.

A. Okay. So they shipped out, is what that looks like. I mean, it's blackened to me so I can't say for sure that that says expired, but that's what it looked like happened because the balance zeroed.

Q. So these three entries from January 3rd, 2025, one of them expires in November, right, the first of the three?

A. Uh-hmm, uh-hmm.

Q. And then the third of the three expires in December of 2024.

A. Okay.

Q. So my question is that if they're being removed from the

facility entirely, how can you be removing the drugs that expired on November 2024 on the same day as December 2024?

A. Because they go into a quarantine situation. So November is in there, possibly December, they go into quarantine and they remain in that locker, which is locked up, until they ship.

So it looks like -- on January 3rd, it looks like they went to the locker and got out, you know, 140 vials that had been expired. It's an expensive process to send to incineration, so -- the equipment alone that these things are sent in is expensive. So they fill up, you know, the equipment that goes to incineration.

So that's what it looks like to me, is on January 3rd, it looks like they potentially went to the locker -- I wasn't in the position, but it looks like they went to the locker and pulled out 140 vials that, you know, went to incineration.

Q. Okay. So -- I think I misunderstood something. So then the drugs don't get logged until they actually leave the facility. So they could move to the quarantine locker and not leave the facility until --

A. Right.

Q. -- the date --

A. Until they're sent for destruction or reverse distributor.

Q. If you could look at page 6 for a moment. I know you said

that you had noticed in addition to the expired issue that there were other discrepancies?

A. Yes.

Q. So I wanted to ask you, were you alerted to the fact that the drugs were being logged after the execution date?

A. I am not familiar with the process that occurred before me. The process that I speak of is the process that has been -- that I put into place. I believe it was a similar process, but there is dates where it's logged the next day. So I can't speak to what happened before I took this position.

Q. So -- so you just don't know if those drugs were used in the execution or if they were removed for some other reason?

A. Which drugs are you talking about?

Q. Oh, I'm sorry, that's my fault.

So if you look at the date of June 12th 2025, which is the third row from the bottom of this sheet, the third row that's filled out from the bottom, and you have the date of 6/12/25, and then you go across and it's got an expiration date of 10/25, minus 7 vials --

A. Yes.

Q. -- and then it reduces the amount, the balance.

A. Right.

Q. And so if there's no execution on June 12th, do you know what happened to these drugs?

A. Can I just take a quick look at my...

Q. Yeah, of course.

MS. McDERMOTT: Your Honor, may I also look at the notes that Dr. Marcano is going to refresh her recollection with?

MR. RODRIGUEZ: No objection.

THE COURT: Why don't you let her finish looking at them and then...

A. Okay. Would you like to see them?

Q. You can look first. Sorry, didn't mean to interrupt you.

A. Okay. I do see that the execution occurred on 6/10. So there was a late entry, yes.

Q. Can I look at those?

A. Yes.

Q. And just looking at your notes, you identified this as an issue, or a --

A. Yes.

Q. -- an error or a discrepancy?

A. Yes.

Q. So do we know -- I know you weren't in the position. Did you do any investigation into this particular discrepancy?

A. I did, but I wasn't able to resolve why that says negative 7, if that's why you're asking, yeah.

Q. Okay. And then the next entry is on June 25th of 2025. 17 vials are removed with an expiration date of October 2025. Are you aware that there was no execution on June 25th?

A. Correct. I have the date as June 24th.
Q. Okay. So do you know -- again, would you know whether or not on June 24th the correct amount of drugs were used in that execution?
A. I was not in this position, so I would not personally know, but I just -- I know the process. I know the transporters. So I do not feel like that drug could have been shorted or over- -- or there could have been an overage. So I don't know.
Q. But you couldn't make that conclusion based on any kind of objective investigation?
A. Right, I could not.
Q. And then, finally, the last entry on that page, the 7/16/2025 entry, again, with the expiration date of 10/2025, 12 vials are removed. Do your notes also reflect that there was no execution on 7/16/2025?
A. I have it listed as there was an execution.
Q. On July 16th, 2025?
A. Bear with me for one second.
Q. Take your time.
A. 7/15 -- you're asking about 7/16, right?
Q. Yes, ma'am.
A. I have it listed as 7/15.
Q. And so likewise, did you look into that entry to determine whether or not the required amount of drugs, the correct amount

of drugs, was used in the July 15th execution?
A. It indicates 12 was taken.
Q. Right. On July 16th?
A. Right.
Q. The execution was --
A. Right. The entry was made the day after the event. But, again, I implemented the protocol of how we're -- we're entering it on the same day as the event. These events go very long, so I could -- I can understand why they came back in the next day and entered it. I can understand that. But as I've reviewed these logs, the right thing to do is to make it on the same day as the event.
Q. Well, doesn't someone have to go back to the pharmacy to bring the drugs that haven't been used in the execution back?
A. They do.
Q. And so they didn't just write down what was on the piece of paper that evening?
A. I can't speak for them. I don't know.
Q. Well, in your investigation --
A. Maybe they got the day wrong. Maybe they just accidentally wrote the wrong date. I don't know. But either way, I understand what you're saying.
Q. In your investigation, you couldn't make a conclusion that on July 15th, the execution that occurred on that date, that inmate, the required amount of drugs had been used in his

execution?
A. I believe it had. I do believe -- there's a lot of people involved in these events. I believe these inmates are receiving the correct dose.
Q. And I don't -- I understand what you are saying, but I'm asking you, is there any objective information to support that?
A. Well, I would indicate for that entry, I know it says 7/16, but it indicates 12 vials were used. So that is the correct number of vials.
Q. But for the wrong date?
A. Right.
Q. Okay. Then I would ask that we could look at -- let me just make sure. Just one other point to make about that. On 6/12 and 6/25, it wasn't 12 vials that were removed on either of those dates, correct?
A. I can only speculate. I don't know.
Q. Yeah, sorry, I don't mean to interrupt you, but I don't want you to speculate.
A. Okay.
Q. There was no -- you couldn't form any conclusion about whether or not the inmates that were executed, you know, close in time to those dates received the drugs that they were -- that are called for on the protocol, the number -- the amount?
A. Again, I know the people that are involved in the process. They would have not -- they would not have left the site with

only 7 vials. I don't know why that was written, but they would not have left the site shorthanded.

Q. Okay. If we could just look at page 8, please. And this is the rocuronium. I wanted to ask you in -- there's an entry starting with, on the left-hand side, April 2nd, 2025. And if you trace that across, it appears that there -- that was a date where there shipment may have come in because there's added 200 vials.

A. Okay.

Q. And then if you look in that next Balance column, there's -- there appears to have been something that was changed there. Do you see that?

A. I do, yes.

Q. And how was that changed?

A. It is not clear to me how that was changed. I mean, the correct balance -- you're talking about the 400? Like there's a smudge or something to the left of the 400. Is that what you're asking me about?

Q. I guess when I look at the records, it appears that something has been whited out and then a number has been written in on the right side. Is that your interpretation?

A. I -- I don't know. I don't know what it is.

Q. Okay. Going down further onto the page, looking at the left-hand column again, there's a date of June 9th, 2025. And if you trace that across, you have 10 vials being removed.

A. Yes.
Q. And then if you look underneath that you have June 12th, 2025, and you have 10 vials being removed. Was there an execution on either June 9th or June 12th? I think we've talked about June 12th, but just if you want to consult your record.
A. So I'm indicating on my records that on June 12th that that product was damaged and sent for -- you know, sent for reverse distributor or destruction, is what I'm showing.
Q. Okay. And so then -- oh, and then beneath it is another June 12th with a different expiration date. It's now March 2026, and there's another 10 taken out. So my first question to you is do you know why the June 9th rocuronium was removed?
A. Okay. I apologize. It was the June 9th that I believe was damaged. I would have to look back into my records to be certain of that.

June 12th, there was two different lots used for an execution, is what I have, that occurred on June 10th. So there was two different lot numbers and two different expiration dates used.
Q. And is that a determination you made based on your investigation?
A. Yes.
Q. And what -- what is that based on?

A. Researching our records, our destruction records, in regards to June 9th. And then, yes, through the investigation, it looks like we used the June 12th entries for June 10th with Wainwright.

Q. Okay. And again, this is the same date you said, well, I wasn't there. But in this case, did you actually -- were you able to determine that that was what was used in the Wainwright execution on June 10th?

A. I was -- that's what it appeared like to me. I was not there, that's true. I was not there.

Q. Okay. Sorry. I think I had one more thing. Oh, okay, yes. On June 25th, 2025, with the expiration date of March 26th, 10 vials of the rocuronium are removed?

A. Yes.

Q. Was there an execution on June 25th?

A. On June 24th.

Q. Okay. And so why were there only 10 vials removed? How many vials would have had to have been removed in this dosage, the 10 by 10, for each execution?

A. So 200 mLs is required.

Q. And that would be 20 vials?

A. That's true.

Q. And so that reflects that only 10 vials were removed?

A. That's correct.

Q. Do you have any explanation for whether or not I believe

it was Mr. Gudinas on the June 25th date received the amount of rocuronium that he was supposed to receive?

I apologize, before you start I should also correct myself. He was executed on June 24th, so...

A. Yes, that's correct.

It is not clear to me what happened on that entry.

Q. Okay. Okay. Can I ask you to look at page 15 of these logs? And in particular, this is the hydroxyzine? Is that the correct pronunciation?

A. Yes, hydroxyzine, yes.

Q. And looking at the April 16th, 2025, date in the left-hand column, it appears that those were removed on -- or, I'm sorry, those had expired on March 2025, 17 vials?

A. Right.

Q. So is that the same as that they had already been moved to quarantine but then they were sent somewhere and left the facility on April 16th?

A. That could indicate -- that could indicate that they were -- that they were sent to waste, is what the negative 17 -- I'd have to -- I'm not sure if I have it on my paperwork, but that could -- that negative 17 could indicate that they expired and were sent on that date.

Q. Okay. And then just to sort of round out the bottom three entries, again, the June 12th, June 25th, and July 16th, those do not correspond to execution dates?

A. Are they one day off? For example -- well, for example, we had an event on June 10th, so that would more than likely correspond to the 12th. And then the 25th, the event was on the 24th. And then the 16th, there was an event on the 15th.
Q. And I know you said that it would be understandable because of the lateness of the execution not to log when you go back to the pharmacy, but what would be the explanation for doing it two days later?
A. That's not clear to me. I don't know.
Q. Okay. On page 16 I wanted to ask you about the lidocaine.
A. Okay.
Q. So you're familiar with the protocol, correct?
A. Yes, I am.
Q. Is there anything in the protocol about lidocaine?
A. There's nothing that indicates lidocaine.
Q. And so on two dates that do correspond to executions, the March 20th, 2025, and the April 8th, 2025, lidocaine was removed and taken over to the execution chamber or the chemical room?
A. They're placed in a stock cart there. To my knowledge, they're used if there needs -- for a venous cutdown. Venous cutdown is outlined in the protocol.
Q. The cutdown is outlined, but is there any information about additional drugs that would be used in the cutdown?
A. There's not.

Q. And then I wanted to ask you why on May 1st, 2025, was an entry logged but nothing was removed? And that date does correspond to an execution for Jeffrey Hutchinson.

A. Can I look at my notes?

My log doesn't have a May 1st on it.

Q. Can I come and look at your log that you're --

MS. McDERMOTT: May I approach?

THE COURT: Go ahead.

BY MS. McDERMOTT:

Q. So the log that you just reviewed doesn't even resemble this log?

A. It does resemble it. Well, it does resemble it. It just doesn't have the May 1st entry.

Q. Do you know what happened to the May 1st entry?

A. I don't.

Q. Do you know -- and I understand you were not in your position at this time. Do you know why lidocaine was removed on March 20th and then again on April 8th? Did Mr. James have a cutdown?

A. To my knowledge, they haven't done a cutdown in a long time. It's just to replenish a cart in case it's needed, a medication cart. So when it expired -- the product that was on the cart had expired, so they were just requesting, you know, replacement of an expired product.

Q. Except for the fact that it hadn't expired according to

the log.
A. There was -- there was product that -- on another lidocaine sheet that the product did -- had expired. I know -- I know -- like maybe they were keeping four on the cart, I'm not sure. I'm not saying like April was to replace March. I'm not saying that. I'm saying maybe -- maybe they just took two extra, maybe. You know -- there was -- there was expired product on there, and that would have required that March entry, so maybe they took two extra just to place additional product on the cart. But to my knowledge, these medications -- that medication was not used.
Q. How is the drugs that are on the cart tracked for expiration date?
A. In -- you would have to ask the execution team members on that because that cart is at their site. We look at the lidocaine within this -- this special location.
Q. To your knowledge, is there a quarantine box at the execution chamber?
A. They have a method for destruction from that site, so medication that's left over from an execution would be destroyed from that site. Expired drugs would also be destroyed.
THE COURT: Ms. McDermott, we need to pause a moment. We have to do a swap-out here.
MS. McDERMOTT: Okay.

THE COURT: Thank you, Ms. Healey.

(Court Reporter Heather Randall reports the remainder of the proceedings.)

THE COURT: Ms. McDermott, my apologies for the interruption. You may continue.

MS. McDERMOTT: Not at all. Thank you for your patience, Your Honor.

BY MS. McDERMOTT:

Q. Okay. How would we get the logs that are -- are logs kept at the execution chamber site as to the drugs that are on the cart?

A. You would have to ask the team.

Q. Okay.

A. I don't know.

Q. That wouldn't come under your purview in this position that you have at this point?

A. Correct. We supply the product.

Q. Okay. Now I am going to move on to Exhibit 8. And I would like for you to look at page -- oh, no, I'm so sorry.

Still on Exhibit 2 and page 26. So this is what Mr. Rodriguez spoke to you about on direct related to -- at least in some part related to the bottom four entries, and those being the use of the expired etomidate.

So I understand you did your investigation and you found that it was actually a scrivener's error writing that in?

A. Correct.
Q. A couple of points. Going up two lines from those four, on July 28, 2025, do you know if that corresponded to an execution?
A. July 28th, I do have that as a date of -- the execution was 7/31.
Q. Okay. But it doesn't correspond to an execution?
A. Correct.
Q. So are drugs actually removed earlier than the execution?
A. The practice that took place before -- before I became chief and became actively engaged in this was handled -- was overseen by someone else. So they had -- they dated things maybe differently than I did -- than -- differently than -- than we're doing now, which is on the exact date of the execution is when that log is written.
Q. But for the July 31, 2025, execution of Edward Zakrzewski, did you investigate the fact that it does not appear that the roc- -- I'm sorry, the etomidate -- there's no entry corresponding to his actual date of execution?
A. That's correct. It's not the actual date of the execution, that's correct.
Q. Okay. And so there's two days -- I'm sorry, three days before and there's one day after in this? There's a 7/28/25 entry and then there's an 8/1/25 entry?
A. Right. That's correct.

Q. And do we know what those correspond to?
A. The 8/1 was product that was -- was expired out, the 8/1 for 20 was expired. The 7/28 was the product that was used for the 7/31 execution.
Q. Did you -- did you find -- so it was taken out three days early. Where did it go?
A. I can't speak for how they handled the log at that point. I know whenever I became actively involved, I treated this log just like a narcotic log. When you do -- whenever the action is taken -- like, for example, when this drug leaves this pharmacy to go into an execution, it needs to have the date of the execution.

So there is nuances here where it was written early, slightly early, or it was a day late. There is nuances in these logs before that change was made.

Q. Well, was it actually removed on July 28, 2025?
A. No. That drug would not have left that site until the day of execution.
Q. How do you know that?
A. Because that's the process. The transporters only come on the day of execution.
Q. But isn't it part of the process not to write down on the log something that hasn't even been used in the execution yet?
A. It's correct. It is correct, they should not have wrote it down early. They should not have wrote it down. More than

likely, there was something that occurred where maybe the person handling this drug bagged it up and prepped the log, because possibly they were off a couple of days or something like that. But I'm speculating. But --

Q. Okay.

THE COURT: Please don't speculate.

THE WITNESS: It should have been written the day of the execution.

I apologize.

BY MS. McDERMOTT:

Q. Okay. So for Mr. Zakrzewski's -- what we can say is that there's no corresponding entry here for Mr. Zakrzewski's execution of etomidate?

A. I believe there is an entry, though. I believe it's an early entry.

Q. Based on what?

A. Because we would not have written -- we would not have written it in a log if it wasn't intentional for it to be used for an execution. We would not have written it.

Q. But it's not written down in the process until after the execution, in the process you described. These don't --

A. The 7/28 event? It was written before.

Q. But that would be out of the practice and the process that you've described to us, about --

A. It is. But -- it is out of the practice. And it is an

abnormality. But, in my opinion, that drug was used for him because there is an entry.

Q. But do you have any proof that that is what happened?

A. I mean, the proof is somebody wrote it on the log. But that's all I can say, is it was written early. There could be -- there could be reasons they wrote it early. It is not something that we should do, that's correct. But there would be no reason to write it in the log if it didn't occur.

Q. What would be a reason to write it early?

A. Somebody --

MR. RODRIGUEZ: Objection. This gets to the speculation we read earlier.

THE COURT: Sustained.

BY MS. McDERMOTT:

Q. So, again, do you have any proof -- did you speak to anyone? Did anyone confirm that that entry corresponded to Edward Zakrzewski's execution on July 31st?

A. I spoke to the execution team about these nuances. And we had discussions about them. And they reassured me that on the day of every event, there was a valid dose there. There was -- the right amount was brought to the event.

Q. And did you specifically ask about the 7/28 entry?

A. I went over all discrepancies. So that would be yes.

Q. Do your logs reflect that discrepancy?

A. Yes. That it's written on 7/28?

Q. Yes.
A. Yes.
Q. Okay. Now, on -- I'm sorry. Okay. I know where I'm at. So on June 24th there was an execution. And you're welcome to check your notes to see that.
A. That's correct.
Q. It's Thomas Gudinas. Okay. And on this log, the etomidate log, is there an entry that corresponds to that execution date?
A. There's no entry.
Q. Okay. And can you be certain that Thomas Gudinas received the required amount of etomidate at his execution --
A. Yes.
Q. -- based -- I apologize, I took too long of a pause -- based on this log?
A. Based on the log, the entry is missing on the log.
Q. Okay.
A. So -- but I know the process. I know the workings of the -- of the process. I know the right amount of drug arrived there.
Q. How -- how can you know that?
A. Because the execution could not have occurred without it. And it is a methodical process. And so the folks that are involved in the transport, the folks that are involved with the team at that site, they're very methodical.

Q. You just gave a deposition in the *Brant* case?
A. Yes.
Q. Did you, in that deposition, indicate that -- that it was potentially -- the correct amount of the drug was potentially used in the Gudinas execution?
A. That the correct amount was potentially used?
Q. Yes.
A. I mean, the correct amount was used. I mean, I can't --
Q. So do you recall being deposed?
A. Yes, I was.
Q. Was that just this week or last week?
A. It was last week.
Q. Last week?
A. Or -- I'm not sure. It was --
Q. And --
A. Yeah, it was last week.
Q. Do you remember what you said about that entry -- or non-entry for Mr. Gudinas in this deposition?
A. I don't remember word for word. But if you have it, you could -- I mean, you can show me and I can validate it.
MS. McDERMOTT: May I approach, Your Honor?
THE COURT: You may.
MS. McDERMOTT: You can read as much on this page as you want.
THE COURT: Ma'am, if you would make sure you're at a

microphone before you're speaking.
BY MS. McDERMOTT:
Q. Can you tell me what page you're on of that deposition?
A. 125.
Q. Okay. And can you read that, please? And you can read it to yourself. And when you're done reading, just let me know.
A. I can -- yes, I said that. And I can kind of explain.
Q. Can I --
A. Yeah.
Q. So when asked about this non-entry, you indicated that you had spoke to the transporters and that the drug potentially could have been used in the execution?
A. What -- there was etomidate used in that execution if that's what you're asking me. Yes, etomidate was used.
Q. Well --
A. Are you asking me about the next entry? That's -- the negative 50 that's on this page? I can clarify that that's what I was indicating.
Q. So you were asked about this non-entry and you said, "So what I'm being told is the drug was not expired, correct. The date of the execution was on the 24th. The drug was not expired. They said it expired on 6/30 and that they potentially -- you know, that that particular drug -- and then they did not log it correctly. The drug, again, was not expired."

A. So what I'm indicating by what you're reading is, on the sheet that's on my screen here, at the top it says number two, previous balance 330, there's an entry on 7- -- on 7/28/25. There's an entry on this sheet that says 7/28/25, has an expiration date of 6/30.

And what I was trying to indicate to them is that when I investigated this situation, why this 6/24 entry was not on this log, whenever the execution team members looked at this log with me, they indicated that more than likely what happened -- yes, the entry was not on the log, yes.

But what they indicated they believe had happened is the drugs were sequestered in the cabinet for June 30th expiration, right. There was drugs sequestered in the cabinet and that they took from that pile, at which the event was on 6/24. The drug expired on 6/30, so it was within expiration date. So that's what they indicated that they used for that particular event.

Q. But that wasn't certain, was it?

A. That's what they indicated. I don't know to what degree of certainty, but that's what they indicated when I questioned why that inmate was not on this log.

Q. Okay. Same -- same log. Is there an entry for the execution of the July 15, 2025, execution of Michael Bell?

A. There is not.

Q. So we have two instances of non-entries for the etomidate

on that log?
A. That's correct.
Q. When you talked to individuals like the transport team, were they entirely relying on memory when they told you, explained to you things that happened or they thought could have happened, or did they have any notes or documents supporting their hypotheses?
A. They did not refer to notes.
Q. And just as sort of a double-check, from those executions, for 7/16 -- I'm sorry, page 6 again. We're looking at the potassium acetate.
A. Okay.
Q. And if you look at the very last line, the 7/16/25, which is the day after the Michael Bell execution on July 15th, rocuronium was taken out, correct?
A. I would have to look at that. You're talking about the potassium?
Q. The very bottom line.
A. Yes.
Q. I'm so sorry. I'm so sorry. Potassium acetate, the very bottom line, that was removed --
A. It was.
Q. -- on July 16th? So there was a corresponding entry for the potassium acetate, but there's nothing mentioned in the etomidate?

A. That's correct.
Q. Okay. I think I have just a few more questions. So just now I have one question about the -- what's Plaintiff's Exhibit 8 and page 8. And these are just -- these are documents received this week to us.
A. Okay.
Q. And I wanted to ask you -- so on -- if you look at this document, and it's the etomidate, and it appears to be sort of the continuation of the log that we were just looking at in Plaintiff's 2.
A. Okay.
Q. I think I might have misspoke and called this defendants's. This is Plaintiff's 8. And we were looking at Plaintiff's 2.
A. Okay.
Q. So if you look at those execution dates -- or those dates in the left-hand column, we've got 8/19, 8/29, 9/17, and 9/30, those were the expired drugs -- what I'm going to refer to as the expired drugs, because in Plaintiff's 2, the expiration date shows expired.

And now here on this one, that date has been changed.

A. Right.
Q. And it appears to me it was just whited out.
A. That's how the person handling the log corrected it upon instruction to change the log to what the investigation had

found, that it was 2027.

Q. And -- well, one thing on -- let me go to this thing first.

On October 14, 2025, was there an execution?

A. On October?

Q. 14th.

A. 14th?

Q. Yes. Sorry, 14th.

A. I have -- I do have one.

Q. Okay. And -- and then October 28, 2025, was that the Norman Grim execution?

A. I do have that.

Q. Okay. And when you look at those expiration dates, were those also at one time incorrectly entered?

A. I had a total of six --

Q. Okay. So there were --

A. -- is what I had.

Q. So there were six consecutive entries where, in Plaintiff's 2, it shows -- well, in Plaintiff's 2 it shows four. And then clearly continuing on, two additional entries showed expired drugs.

A. There was a total of six errors.

Q. Okay.

A. You know, writing errors made.

Q. Okay. And then in whiting that out, was a memo prepared

to explain anything about this and why this was changed?
A. There was not a memo prepared. No, there was not.
Q. Were you aware that there was active litigation going on related to these logs?
A. I was not aware. You know, I -- I was not aware. I know there was some -- some discussion about other things but not related to the log. There were discussions about other execution-related issues.
Q. Okay. A couple of just brief questions based on the -- continuing on from the direct.

You indicated that all of the drugs, the etomidate, the roc- -- the etomidate, the potassium, they would all be stored in the same vault -- or, I'm sorry, cabinet?
A. Yes.
Q. Okay. And --
A. So maybe I should clarify. All of the drugs that is viable, not expired, not damaged, is in one cabinet. There's a second cabinet that's quarantined for all the damaged, expired, and so forth.
Q. Understood.

MS. McDERMOTT: If I could have just one moment.

(Pause in proceedings.)

MS. McDERMOTT: Dr. Marcano, I appreciate your time. Thank you.

THE WITNESS: Thank you.

THE COURT: Mr. Rodriguez?

MR. RODRIGUEZ: No redirect.

THE COURT: You may step down.

THE WITNESS: Thank you, ma'am.

MR. RODRIGUEZ: Your Honor, that concludes defendants's presentation.

THE COURT: All right. You may step down, ma'am -- actually, Dr. Marcano, can I get -- can I ask you a couple of questions?

Is there anything about a lot number that would disclose the manufacturer of the etomidate?

THE WITNESS: Yes. I believe it would identify the manufacturer. They have their own unique sequencing of numbers and -- of letters and numbers. I believe it would be able to identify the manufacturer.

THE COURT: And is that also the case with the invoice number?

THE WITNESS: That could potentially identify a vendor, yes.

THE COURT: You don't know?

THE WITNESS: I mean, I'm not certain, but they all do have -- they have different ways of invoice -- of different -- of listing invoice numbers. So I believe it could identify a vendor.

THE COURT: You may step down.

THE WITNESS: Thank you.

THE COURT: Mr. Rodriguez, it seems to me, based on the witness's testimony, that, at a minimum, the Court should review the etomidate logs without the lot number and invoice number redacted, but that would be an in camera review for the Court's eyes only. When can you provide those to the Court?

MR. RODRIGUEZ: Your Honor, may I confer with DOC counsel who's also here?

THE COURT: Yes.

MR. RODRIGUEZ: Thank you.

(Pause in proceedings.)

MR. RODRIGUEZ: Your Honor, I've spoken with DOC general counsel, Deborah Rescigno. And she's not sure. She's contacting now the general counsel, Bill Gwaltney. So she's stepping out to make that call.

I do not have the unredacted logs, so I certainly don't.

THE COURT: I understand. But given the testimony, I don't really think there's any option but for the Court to conduct an in camera review of -- and I'm saying in camera, because I'm sensitive to the identification of the manufacturers, which is why I asked my questions.

But under the circumstances, I do not think the record will be complete without the Court examining those documents.

Do you-all -- well, is there any argument that you-all want to present now, or do you want me to give you a deadline, which would be probably Monday, to file any additional argument for the Court's consideration?

And I'll ask -- start with the plaintiff and then I'll hear from you, Mr. Rodriguez.

MR. GUNN: Monday's acceptable to us, Judge, to file a written memo.

THE COURT: Mr. Rodriguez?

MR. RODRIGUEZ: Your Honor, Monday is acceptable. We would prefer to just give oral closings now given we're all intimately familiar with the information. There is no need to put it off.

THE COURT: I think we've had a lot to digest, Mr. Rodriguez. I think I'll just direct you-all -- and that will also -- you-all can perhaps -- perhaps, wisely, you might want to get the transcript, because I find that, otherwise, what you do is, the argument you make is based on what you expected the testimony to be as opposed to what the testimony actually is, which makes it not as helpful.

So I'm going to direct that no later than 5 p.m. on Monday, you present any written closing arguments that you wish for me to consider with respect to the motion to stay.

Well -- and I'll just say that if the logs need to be presented to the Court for in camera review, I don't see any

reason why you wouldn't be able to get them to me by tomorrow if there's -- by the close of business tomorrow. If you can't do it by close of business tomorrow, you can file a motion. But I am going to direct that those be provided to the Court for in camera review.

MR. RODRIGUEZ: Understood, Your Honor.

THE COURT: All right. Anything else or forever hold your peace, or at least until Monday at 5 p.m.?

MR. GUNN: No, Your Honor.

MR. RODRIGUEZ: Nothing further, Your Honor.

THE COURT: Give me one second. Let me just look at a calendar to make sure I'm not boxing myself in here.

All right. With that, we are in recess.

COURTROOM SECURITY OFFICER: All rise.

(Proceedings concluded at 5:44 p.m.)

- - -

CERTIFICATE OF OFFICIAL COURT REPORTER

UNITED STATES DISTRICT COURT)
MIDDLE DISTRICT OF FLORIDA)

I hereby certify that the foregoing transcript is a true and correct computer-aided transcription of my stenotype notes taken at the time and place indicated herein.

DATED this 24th day of October, 2026.

/s/ Katharine M. Healey
Katharine M. Healey, RPR, RMR, CRR, FPR-C
Official Court Reporter

A4

Florida Department of Corrections

2025 Execution Drug Logs

EXHIBIT 2

FDOC Drug Inventory Logs (Appendix B to the Complaint)

DRUG NAME: Etomidate 2mg/mL (20mg/10mL) **PACKAGE SIZE:** 10 x 10mL

NDC# [redacted]

DATE	INVOICE NAME/#	LOT#	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
6/24/25	[redacted]		3/2027	[redacted]	+100	100 ✓

DRUG NAME Etomidate 2mg/10ml PACKAGE SIZE 10x10ml

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
9-30-19	[redacted]		06-2021	[redacted]	+ 100 X	100
6-14-19			June 202		+ 100 X	200
8-27-20			06-2021		+ 160 X	
8-27-20			01-2022		+ 40 X	400
9-11-20			06-2021		+ 60 X	460
12-14-20			06-2021		+ 30	490
12-14-20			01-2022		+ 110 ✓	600
6-28-21					- 450	150
8-26-21			07-2022		+ 120 ✓	270
2-3-22			01-2022		- 150	120
12-08-22			07-2022		- 120	-0-
2-20-23			11-2024		+ 40	40
3-02-23			12-2024		+ 50	90
3-06-23			12/2024		+ 50	140
1-3-25			11-2024		-40	100
1-3-25			12-2024		-50	50
1-3-25			12-2024		-50	0
4/21/25			01-2027		+100	100

✓

DRUG NAME: Etomidate 2mg/mL (40mg/20mL) **PACKAGE SIZE:** 10 x 20mL

NDC# [redacted]

DATE	INVOICE NAME/#	LOT#	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
6/24/25	[redacted]		3/2027	[redacted]	+ 100	100

DRUG NAME Etomidate 40mg/20mL PACKAGE SIZE 10 x 20mL

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
4-23-25	Balance From Previous Page	[redacted]		[redacted]		330
4-8-25			5-25		-10	320
5-1-25			5-25		-10	310
5-15-25			5-25		-10	300
5-23-25			1-27		+100	400
5-29-25			5-25		-10	390
6/12/25			6-25		-10	380
6/25/25			6-25		-50	330

DRUG NAME Potassium Acetate 2mEq/mL 20mL PACKAGE SIZE 25x20mL

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
6/14/23	Balance					361
6/19/23	[redacted]		6/2023	[redacted]	-12	349
7/19/23			06/2023		-2	347
9/3/23			12/2024		-12	335
10/3/23			10/2025		-47	288
10-3-23			12/2024		-12	276
8-29-24			12/2024		-12	264
1-3-2025			12-2024		-64	200
2-13-25			10-2025		-12	188
3/20/25			10-2025		-12	176
3/18/25			11/30/26		+25	201
3/18/25			9/30/26		+50	251
4/7/25			9/30/26		+25	276
4/7/25			4/30/27		+50	326
4/8/25			10-2025		-12	314
4/16/25			9/30/26		-25	289
5/1/25			10-2025		-12	277
5/15/25			10-2025		-12	265
6/12/25			10-2025		-7	258
6/25/25			10-2025		-17	241
7/16/25			10-2025		-12	229

DRUG NAME: Potassium Acet 2mEq/mL **PACKAGE SIZE:** 25 x 20mL vials

NDC# [redacted]

DATE	INVOICE NAME/#	LOT#	EXP. DATE	MFR	1 vial = #1 RECEIVED/USED (+/-)	BALANCE
5/23/25	[redacted]		12/2026	[redacted]	+ 100	100

DRUG NAME Rocuronium 100mg/10ml PACKAGE SIZE 10 X 10 ml

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
3-07-24	[redacted]	[redacted]	JAN 2025	[redacted]	+ 10	10
3/11/24			JUN 2025		+ 80	90
1-3-2025			03/2026		+ 30	120
3-6-2025			03/2026		+ 100	220
3/20/25			JUN 2025		- 20	200
4-2-25			Mar 2026		+ 200	400
4-8-25			JUN 2025		- 20	380
4-16-25			JUN 2025		- 10	370
5/1/25			JUN 2025		- 20	350
4/23/25			10/2026		+ 30	380
4/23/25			3/2026		+ 70	450
5/23/25			10/2026		+ 100	550
6/9/25			JUN 2025		- 10	540
6/12/25			JUN 2025		- 10	530
6/12/25			3/2026		- 10	520
6/25/25			3/2026		- 10	510
7/16/25			3/2026		- 20	490

DRUG NAME ROCURONIUM 50 mg / 5 ml PACKAGE SIZE 10 x 5 ml

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
3-07-24	[redacted]		JUN 2025	[redacted]	+ 40	40
1-3-2025			Sep 2025		+90	130
4-2-2025			APR 2026		+80	210
4-2-2025			AUG 2026		+40	250
5-15-2025			JUN 2025		-40	210

DRUG NAME Rocuronium 50mg/5ml PACKAGE SIZE 10 vial of 5ml

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
8-15-23	[redacted]		01-2026	[redacted]	+ 100	100

DRUG NAME: Sodium CL 0.9% (BAG) **PACKAGE SIZE:** 10 x 1000 mL

NDC# [redacted]

(1 bag = #1)

DATE	INVOICE NAME/#	LOT#	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
5/23/25	[redacted]		2/2026	[redacted]	+ 20	20

DRUG NAME: Sodium CL 0.9% (BAG) PACKAGE SIZE: 12 x 1000mL

NDC# [redacted]

DATE	INVOICE NAME/#	LOT#	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
5/7/25	[redacted]		01/2027	[redacted]	+ 12	12

DRUG NAME Sodium Cl 0.9% PACKAGE SIZE 12 x 1000 ml

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
5-20-2021	[redacted]		9-2023	[redacted]	+ 24	24
3-15-2023			4-2025		+ 12	36
5/3/23			9/2023		-4	32
10-2-23			9-2023		- 20	12
02-01-24			01-2026		+ 12	24
8-29-24			4-2025		-2	22
2-13-25			4-2025		-2	20
3-17-25			2-2027		+24	44
3-17-25			2-2027		+24	44
3/20/25			1-2026		-2	42
4/8/25			4-2025		-8	34
4/8/25			1-2026		-4	30
5/1/25			1-2026		-2	28
5/15/25			1-2026		-2	26
5/29/25			7-2027		+12	38
6/2/25			8-2027		+24	62
6/12/25			1-2026		-2	60

DRUG NAME Sodium Chloride 0.9% PACKAGE SIZE 25 x 20mL

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
8/14/24	[redacted]	[redacted]	Oct-01-2025	[redacted]	+50	+50
2-13-25			Oct-01-2025		-6	44
~~3-6-25~~			~~Jul-31-202~~		~~+25~~	~~69~~ Incorrect Invoice # -MZ
3-6-25			Jul-31-2026		+25	69
3/20/25			10-01-2025		-6	63
4/2/25			07-31-2026		+50	113
4/8/25			10-01-2025		-6	107
5/1/25			10-01-2025		-6	101
5/15/25			10-01-2025		-6	95
5/23/25			7-31-2026		+50	145 ✓
6/12/25			Jul-31-2026		-6	139
6/25/25			10-01-2025		-6	133
7/16/25			10-01-2025		-7	126

DRUG NAME HYDROXYZINE HCl 25mg / ml PACKAGE SIZE 25 x 1 ml

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
02-01-2024	[redacted]		MAR 2025	[redacted]	+ 25	25
8-29-2024			Mar 2025		- 2	23
1-3-2025			08-2026		+25	48
2-13-25			Mar 2025		-3	~~45~~ 45
3/20/25			Mar 2025		-3	42
4-2-25			Aug 2026		+25	67
4/8/25			Aug 2026		-4	63
4/16/25			MAR 2025		-17	46
5/1/25			Aug 2026		-4	42
5/15/25			Aug 2026		-3	39
5/23/25			Aug 2026		+25	64
6/12/25			Aug 2026		-3	61
6/25/25			Aug 2026		-2	59
7/16/25			Aug 2026		-2	57

DRUG NAME Lidocaine Hcl 1% 10ml PACKAGE SIZE 25 x 10ml

NDC# [redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
1-3-2025	[redacted]		Sep 2026	[redacted]	+25	25
3/20/25			Sep 2026		-2	23
4-08-25			Sep 2026		-2	21
5/1/25			Sep 2026		0	21

[redacted]

[redacted]

INVOICE DATE 05/07/2025
PO
ORDER DATE 03/05/2025
SHIP DATE 05/07/2025 **PIECES INVOICED** 1

LINE	ITEM	NDC/UPC	ORIG ORDER QTY	ORDER QTY	INVOICED QTY	OMIT CODE	UOM	DESCRIPTION	SIZE	FORM	CLASS	MSG	DEPT/ACC/CC2	UNIT PRICE	EXTENDED PRICE	NOTE CODE
[redacted]			[redacted]				[redacted]	SODIUM CHLORIDE IS 0.9% 12X1000ML LF ✓	12X10 IS			[redacted]	EXP: 1/27 [redacted]	62.83	62.83	[redacted]

SUMMARY

TOTAL RX	62.83
TOTAL OTC	0.00
NET AMOUNT	62.83

[redacted]

[redacted]

[redacted]

SUB TOTAL	62.83
GRAND TOTAL	**62.83**
TOTAL DUE BY	**06/06/2025**

[redacted]

INVOICE DATE 05/23/2025
PO
ORDER DATE 05/22/2025
SHIP DATE 05/23/2025 PIECES INVOICED 29

LINE	ITEM	NDC/UPC	ORIG ORDER QTY	ORDER QTY	INVOICED QTY	OMIT CODE	UOM	DESCRIPTION	SIZE	FORM	CLASS	MSG	DEPT/ACC/CC2	UNIT PRICE	EXTENDED PRICE	NOTE CODE
[redacted]																
			2	2	2 ✓			SODIUM CL IS 0.9% 10X1000ML [redacted]	10X10	IS		EXP: 2/26		26.82	53.64	
			4	4	4 ✓			POTASS ACET SD 2MEQ/ML25X20ML FTV [redacted]	25X20	SD		EXP: 12/26		123.34	493.36	
			10	10	10 ✓			ROCURONIUM MD 10MG/ML 10X10ML [redacted]	10X10	MD		EXP: 10/26		41.29	412.90	
			10	10	10 ✓			ETOMIDATE SD 2MG/ML 10X20ML [redacted]	10X20	SD		EXP: 1/27		39.35	393.50	
			1	1	1 ✓			HYDROXYZ HCL SD 25MG/ML 25X1ML [redacted]	25X1M	SD		EXP: 8/26		441.59	441.59	
			2	2	2 ✓			SODIUM CL SF 0.9% 25X20ML [redacted]	25X20	SF		EXP: 7/31/26		22.24	44.48	

----------SUMMARY----------

TOTAL RX	1,839.47
TOTAL OTC	0.00
NET AMOUNT	1,839.47

[redacted]

[redacted]

[redacted]

SUB TOTAL	1,839.47
GRAND TOTAL	1,839.47
TOTAL DUE BY	06/22/2025

[redacted]

INVOICE DATE	05/29/2025
PO	
ORDER DATE	03/05/2025
SHIP DATE	05/29/2025

PIECES INVOICED 1

LINE	ITEM	NDC/UPC	ORIG ORDER QTY	ORDER QTY	INVOICED QTY	OMIT CODE	UOM	DESCRIPTION	SIZE	FORM	CLASS	MSG	DEPT/ACC/CC2	UNIT PRICE	EXTENDED PRICE	NOTE CODE
[redacted]			1	1	1			SODIUM CL IS 0.9% 12X1000ML EXC	12X10	IS		[redacted]	EXP: 7/27	29.99	29.99	

----------SUMMARY----------

TOTAL RX	29.99
TOTAL OTC	0.00
NET AMOUNT	29.99

[redacted]

[redacted]

SUB TOTAL	29.99
GRAND TOTAL	29.99
TOTAL DUE BY	06/28/2025

[redacted]

INVOICE DATE	06/24/2025
PO	
ORDER DATE	04/01/2025
SHIP DATE	06/24/2025

PIECES INVOICED 20

LINE	ITEM	NDC/UPC	ORIG ORDER QTY	ORDER QTY	INVOICED QTY	OMIT CODE	UOM	DESCRIPTION	SIZE	FORM	CLASS	MSG	DEPT/ACC/CC2	UNIT PRICE	EXTENDED PRICE	NOTE CODE
[redacted]			10	10	8	X	[redacted]	ETOMIDATE SD 2MG/ML 10X20ML	10X20	SD		[redacted]	EXP: 3/27	41.96	335.68	[redacted]
			10	10	8	X		ETOMIDATE SD 2MG/ML 10X10ML	10X10	SD			[redacted] EXP: 3/27	30.03	240.24	
			10	10	2	X		ETOMIDATE SD 2MG/ML 10X10ML	10X10	SD				30.03	60.06	
			10	10	2	X		ETOMIDATE SD 2MG/ML 10X20ML	10X20	SD			[redacted] EXP: 3/27	41.96	83.92	

SUMMARY

TOTAL RX	719.90
TOTAL OTC	0.00
NET AMOUNT	719.90

[redacted]

[redacted]

SUB TOTAL	719.90
GRAND TOTAL	719.90
TOTAL DUE BY	07/24/2025

[redacted]

INVOICE DATE	06/02/2025
PO	
ORDER DATE	04/01/2025
SHIP DATE	06/02/2025 PIECES INVOICED 2

LINE	ITEM	NDC/UPC	ORIG ORDER QTY	ORDER QTY	INVOICED QTY	OMIT CODE	UO M	DESCRIPTION	SIZE	FORM	CLAS:	MSG	DEPT/ACC/CC2	UNIT PRICE	EXTENDED PRICE	NOTE CODE
[redacted]			2	2	2		[redacted]	SODIUM CL IS 0.9% 12X1000ML EXC	12X10	IS		[redacted]	EXP 8/27 [redacted]	29.99	59.98	[redacted]

----------SUMMARY----------

TOTAL RX	59.98
TOTAL OTC	0.00
NET AMOUNT	59.98

[redacted]

[redacted]

SUB TOTAL	59.98
GRAND TOTAL	59.98
TOTAL DUE BY	07/02/2025

DRUG NAME: Etomidate 2mg/mL **Package Size:** 10 x 10 mL **Page:** 1

[redacted]

PREVIOUS BALANCE: Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
6/24/25	[redacted]			3/31/2027	+ 100	100

DRUG NAME: Etomidate 20mg/10mL *Package Size:* 10 x 10mL **Page:** 2

[redacted]

PREVIOUS BALANCE: Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
4/21/25	[redacted]			1/31/2027	+ 100	100

DRUG NAME: Etomidate 2mg/mL (20mg) *Package Size:* 10 x 10mL

Page: 1

[redacted]

PREVIOUS BALANCE: Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
9/22/2025	[redacted]			04/30/2027	+48	48
9/22/2025				04/30/2027	+2	50

DRUG NAME: Etomidate 2mg/mL (40mg/20mL) *Package Size:* 10 x 20 mL

[redacted]

Page: 1

PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
6/24/25	[redacted]			3/31/2027	+ 100	100
7/28/25				3/31/2027	+ 50	150

DRUG NAME: Etomidate 40mg/20mL Package Size: 10 x 20mL (10 vials) [redacted] Page: 2

PREVIOUS BALANCE: 330

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
4/8/25	[redacted]			5/31/2025	-10	320
5/1/25				5/31/2025	-10	310
5/15/25				5/31/25	-10	300
5/23/25				1/31/2027	+100	400
5/29/25				5/31/2025	-10	390
6/12/25				6/30/2025	-10	380
6/25/25				6/30/2025	-50	330
7/28/25				7/31/2025	-10	320
8/1/25				7/31/2025	-20	300
8/19/25				1/31/2025	-10	290
8/29/25				1/31/2025	-10	280
9/17/25				1/31/2025	-10	270
9/30/25				1/31/2025	-10	260

DRUG NAME: Hydroxyzine HCL 25mg/mL Package Size: 25 x 1 mL

[redacted]

Page: 1

PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
2/1/2024	[redacted]			03/31/2025	+ 25	25
8/29/2024				3/31/2025	- 2	23
1/3/2025				8/31/2026	+ 25	48
2/13/2025				3/31/2025	- 3	45
3/20/2025				3/31/2025	- 3	42
4/2/2025				8/31/2026	+ 25	67
4/8/2025				8/31/2026	- 4	63
4/16/2025				3/31/2025	- 17	46
5/1/2025				8/31/2026	- 4	42
5/15/2025				8/31/2026	- 3	39
5/23/2025				8/31/2026	+ 25	64
6/12/25				8/31/2026	- 3	61
6/25/25				8/31/2026	- 2	59
7/16/25				8/31/2026	- 2	57
7/28/25				8/31/2026	+ 25	82
7/28/25				8/31/2026	- 2	80
8/19/25				8/31/2026	- 2	78
8/29/25				8/31/2026	- 2	76
9/17/25				8/31/2026	- 2	74
9/30/25				8/31/2026	- 2	72

DRUG NAME: Lidocaine HCL 1% (10mL) Package Size: 25 x 10mL

[redacted]

Page: 1

PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
1/3/25	[redacted]			09/30/2026	+25	25
3/20/25				9/30/2026	-2	23
4/8/25				9/30/2026	-2	21
7/28/25				9/30/2027	+50	71

DRUG NAME: Potassium Acetate 2mEq/ml *Package Size:* 25 x 20mL

[redacted]

Page: 4

PREVIOUS BALANCE: 193

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
9/17/25	[redacted]			10/31/2025	-12	181
9/30/25				10/31/2025	-12	169

DRUG NAME Potassium Acetate 2mEq/mL 20mL PACKAGE SIZE 25x20mL

[redacted]

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
6/14/23	Balance	[redacted]		[redacted]		361
6/15/23			6/2023		-12	349
7/19/23			06/2023		-2	347
9/3/23			12/2024		-12	335
10/3/23			10/2025		-47	288
10-3-23			12/2024		-12	276
8-29-24			12/2024		-12	264
1-3-2025			12-2024		-64	200
2-13-25			10-2025		-12	188
3/20/25			10-2025		-12	176
3/18/25			11/30/26		+25	201
3/18/25			9/30/26		+50	251
4/7/25			9/30/26		+25	276
4/7/25			4/30/27		+50	326
4/8/25			10-2025		-12	314
4/16/25			9/30/26		-25	289
5/1/25			10-2025		-12	277
5/15/25			10-2025		-12	265
6/12/25			10-2025		-7	258
6/25/25			10-2025		-17	241
7/16/25			10-2025		-12	229
7/28/25			10-2025		-12	217
8/19/25			10-2025		-12	205
8/29/25			10-2025		-12	193

DRUG NAME: Potassium Acet. 2mEq/mL **Package Size:** 25 x 20mL **Page:** 1

[redacted]

PREVIOUS BALANCE: Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
5/23/25	[redacted]			12/31/2026	+ 100	100
7/28/25				12/31/2026	+125	225

DRUG NAME: Potassium Act. 2 mEq/mL **Package Size:** 25 x 50mL **Page:** 1

[redacted]

PREVIOUS BALANCE: Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
7/28/25	[redacted]			10/31/2026	+ 50	50

DRUG NAME Sodium chloride 0.9% [redacted] PACKAGE SIZE 25 x 20mL

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
8/14/24	[redacted]	[redacted]	Oct-01-2025	[redacted]	+50	+50
7-13-25			Oct-01-2025		-6	44
~~3-6-25~~			~~Jul-31-202~~		~~+25~~	~~69~~ Incorrect Invoice # [redacted]
3-6-25			Jul-31-202		+25	69
3/20/25			10-01-202		-6	63
4/2/25			07-31-2026		+50	113
4/8/25			10-01-2025		-6	107
5/1/25			10-01-2025		-6	101
5/15/25			10-01-2025		-6	95
5/23/25			7-31-2026		+50	145
6/12/25			Jul-31-2026		-6	139
6/25/25			10-01-2025		-6	133
7/16/25			10-01-2025		-7	126
7/28/25			10-31-2026		+50	176
7/28/25			10-01-2025		-6	170
8/19/25			10-01-2025		-1	169
8/19/25			7-31-2026		-5	164
8/28/25			7-31-2026		-6	158
9/17/25			7-31-2026		-6	152
9/30/25			7-31-2026		-6	146

DRUG NAME: Sodium CL 0.9% (BAG) *Package Size:* 10 x 1000mL **Page:** 1

[redacted]

PREVIOUS BALANCE: Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
5/23/25	[redacted]			2/28/2026	+ 20	20

DRUG NAME: Sodium CL 0.9% (BAG) *Package Size:* 12 x 1000mL **Page:** 1

[redacted]

PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
5/1/2025	[redacted]			01/31/2027	+12	12

DRUG NAME Sodium Cl 0.9% [redacted] PACKAGE SIZE 12 x 1000 ml

DATE	INVOICE NAME/#	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
5-20-2021	[redacted]	[redacted]	9-2023	[redacted]	+ 24	24
3-15-2022			4-2025		+ 12	36
5/3/23			9/2023		-4	32
10-2-23			9-2023		- 20	12
02-01-24			01-2026		+ 12	24
8-29-24			4-2025		-2	22
2-13-25			4-2025		-2	20
3-17-25			2-2027		+24	44
3-17-25			2-2027		+24	44
3/20/25			1-2026		-2	42
4/8/25			4-2025		-8	34
4/8/25			1-2026		-4	30
5/1/25			1-2026		-2	28
5/15/25			1-2026		-2	26
5/29/25			7-2027		+12	38
6/2/25			8-2027		+24	62
6/12/25			1-2026		-2	60

DRUG NAME: Rocuronium 50mg/5mL Package Size: 10 x 5mL

[redacted]

Page: 1

PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
3/7/2024	[redacted]			06/31/2025	+ 40	40
1/3/2025				9/30/2025	+ 90	130
4/2/25				4/30/2026	+ 80	210
4/2/25				8/30/2026	+ 40	250
5/15/25				6/31/2025	− 40	210
7/28/25				10/31/2026	+360	570
8/19/25				9/30/2025	−40	530
8/29/25				9/30/2025	−40	490
9/17/25				9/30/2025	−10	480

DRUG NAME: Rocuronium 50mg/5mL **Package Size:** 10 x 5mL **Page:** 1

[redacted]

PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
8/15/2023	[redacted]			01/31/2026	+ 100	100

DRUG NAME: Rocuronium 100mg/10mL Package Size: 10 x 10mL (10 per box) Page: 1

[redacted] PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
3/7/24	[redacted]			06/31/2025	+ 10	10
3/11/24				06/31/2025	+ 80	90
1/3/2025				3/31/2026	+ 30	120
3/6/25				3/31/2026	+ 100	220
3/20/25				6/31/2025	- 20	200
4/2/25				3/31/2025	+ 200	400
4/8/25				6/31/2025	- 20	380
4/16/25				6/31/2025	- 10	370
4/23/25				10/31/2026	+ 30	400
4/23/25				3/31/2026	+ 70	470
5/1/25				6/31/2025	- 20	450
5/23/25				10/31/2026	+ 100	550
6/9/25				6/31/2025	-10	540
6/12/25				6/31/2025	-10	530
6/12/25				3/31/2026	-10	520
6/25/25				3/31/2026	-10	510
7/16/25				3/31/2026	-20	490
7/28/25				10/31/2026	+240	730
7/28/25				3/31/2026	- 20	710
7/28/25				10/31/2026	-10	700
9/17/25				3/31/2026	-15	685
9/30/25				3/31/2026	-20	665

[redacted]

[redacted]

INVOICE DATE 07/28/2025
PO
ORDER DATE 07/25/2025
SHIP DATE 07/28/2025 PIECES INVOICED 77

LINE	ITEM	NDC/UPC	ORIG ORDER QTY	ORDER QTY	INVOICED QTY	OMIT CODE	UOM	DESCRIPTION	SIZE	FORM	CLASS	MSG	DEPT/ACC/CC2	UNIT PRICE	EXTENDED PRICE	NOTE CODE
[redacted]			5	5	4			POTASS ACET SD 2MEQ/ML25X20ML FTV	25X20	SD			EXP: 12/26	77.38	309.52	
			24	24	21			ROCURONIUM MD 10MG/ML 10X10ML	10X10	MD			10/26	21.66	454.86	
			24	24	3			ROCURONIUM MD 10MG/ML 10X10ML	10X10	MD			10/26	21.66	64.98	
			36	36	22			ROCURONIUM MD 10MG/ML 10X5ML	10X5M	MD			10/26	20.48	450.56	
			36	36	14			ROCURONIUM MD 10MG/ML 10X5ML	10X5M	MD			10/26	20.48	286.72	
			5	5	5			ETOMIDATE SD 2MG/ML 10X20ML	10X20	SD			3/27	41.73	208.65	
			1	1	1			HYDROXYZ HCL SD 25MG/ML 25X1ML	25X1M	SD			8/26	459.02	459.02	
			2	2	2			LIDOCAINE HCL MD 1% 25X10ML	25X10	MD			4/27	18.93	37.86	
			5	5	1			POTASS ACET SD 2MEQ/ML25X20ML FTV	25X20	SD			12/26	77.38	77.38	
			2	2	2			POTASS ACET SD 2MEQ/ML25X50ML FTV	25X50	SD			10/26	254.65	509.30	
			2	2	2			SODIUM CL SF 0.9% 25X20ML	25X20	SF			10-31-26	54.38	108.76	

SUMMARY

TOTAL RX	2,967.61
TOTAL OTC	0.00
NET AMOUNT	2,967.61

[redacted]

SUB TOTAL	2,967.61
GRAND TOTAL	2,967.61
TOTAL DUE BY	08/27/2025

Invoice

[redacted]

Invoice Date: 9/18/2025

[redacted]

Order Date 9/15/2025

[redacted]

Customer P.O.	Terms: Due Date	Account Manager:	Ship VIA	Customer Number:
[redacted]	Net 30: 10/18/2025	[redacted]	GROUND	[redacted]

NDC#	Ordered	Shipped	Remaining	Price Each	Amount
[redacted]	50.00	50.00	0.00	69.00	3,450.00

ETOMIDATE 20MG SDV 10X10ML

[redacted]

Expiration date: 4/30/2027 Lot Qty: 48.00

Expiration date: 4/30/2027 Lot Qty: 2.00

[redacted]

[redacted]

Net Invoice:	3,450.00
Less Discount:	0.00
Freight:	36.49
Sales Tax:	0.00
Invoice Total:	3,486.49

A5

Florida Department of Corrections

2026 Execution Drug Logs

EXHIBIT 8

FDC Etomidate Log. (Redacted)

DRUG NAME: Etomidate 40mg/20mL **Package Size:** 10x20mL **Page:** 1

NDC# Section 945.10(1) [redacted] **Manufacturer:** Section 945.10(1) [redacted] **PREVIOUS BALANCE:**

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
9/23/26	Section 945.10(1) [redacted]		Section 945.10(1) [redacted]	4/30/2028	160	160
10/8/26				3/31/2028	40	200

DRUG NAME: Etomidate 2mg/mL (20 mg) **Package Size:** 10 x 10mL **Page:** 1

NDC# [redacted] Section 945.10(1) **Manufacturer:** [redacted] Section 945.10(1) **PREVIOUS BALANCE:** Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
9/22/2025	[redacted] Section 945.10(1)			04/30/2027	+48	480
9/22/2025				04/30/2027	+2	500

DRUG NAME: Etomidate 2mg/mL (40mg/20mL) *Package Size:* 10 x 20mL **Page:** 1

NDC# [redacted] Section 945.10(1) *Manufacturer:* [redacted] Section 945.10(1) **PREVIOUS BALANCE:** 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
6/24/25	[redacted] Section 945.10(1)			3/31/2027	+100	100
7/28/25				3/31/2027	+50	150

DRUG NAME: Etomidate 2mg/mL **Package Size:** 10 x 10 mL **Page:** 1

NDC# Section 945.10(1) [redacted] (20mg/10 mL) **Manufacturer:** Section 945.10(1) [redacted] **PREVIOUS BALANCE:** Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
6/24/25	Section 945.10(1) [redacted]			3/31/2027	+ 100	100

DRUG NAME: Etomidate 40mg/20mL Package Size: 10 x 20mL (10 vials) Page: 3

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 170

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
6/25/26	Section 945.10(1)		Section 945.10(1)	1/31/2027	-10	160
7/14/26				1/31/2027	-10	150
7/28/26				1/31/2027	-20	130
8/18/26				1/31/2027	-10	120
9/1/26				1/31/2027	-10	110
9/10/26				1/31/2027	-10	100
9/29/26				1/31/2027	-10	90
10/13/26				1/31/2027	-10	80

DRUG NAME: Etomidate 20mg/10mL Package Size: 10 x 10 mL Page: 2

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
4/21/25	Section 945.10(1)		Section 945.10(1)	01/31/2027	+100	100
11/13/2025	Section 945.10(1)			01/31/2027	-20	80
11/20/25				01/31/2027	-20	60
12/9/25				01/31/2027	-20	40
12/18/25				01/31/2027	-20	20
2/10/26				01/31/2027	-20	0

DRUG NAME: Etomidate 40mg/20mL Package Size: 10 x 20mL (10 vials) Page: 2

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 330

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
4/8/25	Section 945.10(1)		ction 945.10(1)	5/31/2025	-10	320
5/1/25				5/31/2025	-10	310
5/15/25				5/31/25	-10	300
5/23/25				1/31/2027	+100	400
5/29/25				5/31/2025	-10	390
6/12/25				6/30/2025	-10	380
6/25/25				6/30/2025	-50	330
7/28/25				7/31/2025	-10	320
8/1/25				7/31/2025	-20	300
8/19/25				1/31/2027	-10	290
8/29/25				1/31/2027	-10	280
9/17/25				1/31/2027	-10	270
9/30/25				1/31/2027	-10	260
10/14/25				1/31/2027	-10	250
10/28/25				1/31/2027	-10	240
2/24/26				1/31/2027	-10	230
3/3/26				1/31/2027	-10	220
3/17/26				1/31/2027	-10	210
4/21/26				1/31/2027	-10	200
4/30/26				1/31/2027	-10	190
5/21/26				1/31/2027	-10	180
6/2/26				1/31/2027	-10	170

EXHIBIT 8

FDC Rocuronium Bromide Log. (Redacted)

DRUG NAME: Rocuronium 100mg/10mL Package Size: 10 x 10mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
9/23/26	Section 945.10(1)	Section 945.10(1)	Section 945.10(1)	11/22/2027	320	320
10/8/26				11/22/2027	10	330

DRUG NAME: Rocuronium **Package Size:** 10 x 5mL **Page:** 1

NDC# [redacted] Section 945.10(1) **Manufacturer:** [redacted] Section 945.10(1) **PREVIOUS BALANCE:** Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
9/23/26	[redacted] Section 945.10(1)	[redacted] Section 945.10(1)		10/31/2027	320	320

DRUG NAME: Bocuronium 100mg/10mL Package Size: 10 x 10 mL

NDC# Section 945.10(1) Manufacturer: Section 945.10(1)

Page: 2

PREVIOUS BALANCE: 665

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
10/14/25	Section 945.10(1)		Section 945.10(1)	03/31/2026	-20	645
11/13/25				03/31/2026	-20	625
~~11/20/25~~				~~03/31/2026~~	~~-15~~	~~610~~ ERROR -ML
12/9/25				03/31/2026	-15	610
3/17/26				3/3/2026	-20	590
4/21/26				10/31/2026	-20	570
4/30/26				10/31/2026	-20	550
5/21/26				10/31/2026	-20	530
6/2/26				10/31/2026	-20	510
6/25/26				10/31/2026	-20	490
7/14/26				10/31/2026	-20	470
7/28/26				10/31/2026	~~-20~~ -40	~~450~~ 430
9/1/26				10/31/2026	-20	410
9/10/26				10/31/2026	-20	390
9/29/26				10/31/2026	-20	370
10/13/26				10/31/2026	-20	350

DRUG NAME: Rocuronium 100mg/10mL Package Size: 10 x 10mL (10 per box) Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
3/7/24	Section 945.10(1)		Section 945.10(1)	06/31/2025	+ 10	10
3/11/24				06/31/2025	+ 80	90
1/3/2025				3/31/2026	+ 30	120
3/6/25				3/31/2026	+ 100	220
3/20/25	Section 945.10(1)			6/31/2025	- 20	200
4/2/25				3/31/2026	+ 200	400
4/8/25				6/31/2025	- 20	380
4/16/25				6/31/2025	- 10	370
4/23/25	(			10/31/2026	+ 30	400
4/23/25				3/31/2026	+ 70	470
5/1/25				6/31/2025	- 20	450
5/23/25	Section 945.10(1)			10/31/2026	+ 100	550
6/9/25				6/31/2025	-10	540
6/12/25	Section 945.10(1)			6/31/2025	-10	530
6/12/25				3/31/2026	-10	520
6/25/25				3/31/2026	-10	510
7/16/25				3/31/2026	-20	490
7/28/25				10/31/2026	+240	730
7/28/25				3/31/2026	- 20	710
7/28/25				10/31/2026	- 10	700
9/17/25				3/31/2026	- 15	685
9/30/25				3/31/2026	- 20	665

DRUG NAME: Rocuronium 50mg/5mL Package Size: 10 x 5 mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 0

BY VIAL

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
3/7/2024	Section 945.10(1)	Section 945.10(1)	Section 945.10(1)	06/31/2025	+ 40	40
1/3/2025				9/30/2025	+ 90	130
4/2/2025				4/30/2026	+ 80	210
4/2/2025				8/30/2026	+ 40	250
5/15/2025		Section 945.10(1)		6/31/2025	- 40	210
7/28/2025				10/31/2026	+ 320	530
7/28/2025				8/30/2026	+ 40	570
8/19/2025				9/30/2025	- 40	530
8/29/2025				9/30/2025	-40	490
9/17/2025				9/30/2025	-10	480
2/10/2026				4/30/2026	-30	450
2/24/2026				4/30/2026	-40	410
3/3/2026				4/30/2026	-10	400
3/3/2026				8/30/2026	-30	370
8/18/2026				8/30/2026	- 40	330

DRUG NAME: Rocuronium 50mg/5mL Package Size: 10 x 5 mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: New

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE	
11/18/2025	Section 945.10(1)	Section 945.10(1)	Section 945.10(1)	03/31/2027	+ 150	150	
11/18/2025				03/31/2027	+ 410	560	
12/1/2025				04/30/2027	+ 320	880	MK
12/8/2025				04/30/2027	- 320	560	
12/9/2025				04/30/2027	+ 280	840	
12/9/2025				04/30/2027	+ 300	1140	
12/16/2025				04/30/2027	+ 310	1450	
12/18/2025				03/31/2027	-30	1420	
2/10/2026				3/31/2027	-10	1410	MK

DRUG NAME: Rocuronium 50mg/5mL Package Size: 10 x 5mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
8/15/2023	Section 945.10(1)	Section 945.10(1)	Section 945.10(1)	01/31/2026	+100	100
10/28/25	Section 945.10(1)			01/31/2026	-40	60
11/20/25				01/31/2026	-40	20
12/9/25				01/31/2026	-10	10
12/18/25				01/31/2026	-10	0

EXHIBIT 8

FDC Potassium Acetate Log. (Redacted)

DRUG NAME: Potassium Acetate 2meq/mL Package Size: 25 x 20mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: Ø

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
9/23/26	Section 945.10(1)	Section 945.10(1)	Section 945.10(1)	3/31/2028	25	25
9/23/26				11/30/2027	25	50
9/23/26				4/30/2027	25	75
10/8/26				3/31/2028	50	125

DRUG NAME: Potassium Act. 2 mEq/mL Package Size: 25 x 50 mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	# of Vials RECEIVED/USED (+/-)	BALANCE
7/28/25	Section 945.10(1)		Section 945.10(1)	10/31/2026	+50	50
2/2[illegible]/26				10/31/2026	-5	45
3/3/26				10/31/2026	-5	40
3/13/26				08/31/2027	+25	65
3/13/26				08/31/2027	+100	165
5/21/26				10/31/2026	-5	160
6/2/26				10/31/2026	-5	155
6/25/26				10/31/2026	-5	150
7/14/26				10/31/2026	-5	145
7/28/26				10/31/2026	~~-5~~ -10	~~140~~ 135
8/18/26				10/31/2026	-5	130
9/1/26				10/31/2026	-5	125
9/10/26				8/31/2027	-5	120
10/13/26				8/31/2027	-5	115

DRUG NAME: Potassium Acet. 2mEq/mL Package Size: 25 x 20mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
5/23/25	Section 945.10(1)		Section 945.10(1)	12/31/2026	+ 100	100
7/28/25				12/31/2026	+ 125	225
4/21/26				12/31/2026	- 35	190
4/30/26				12/31/2026	~~- 15~~ -12	~~+75~~ 178
9/29/26				12/31/2026	- 12	166

DRUG NAME: Potassium Acetate 2mEq/mL Package Size: 25 x 20mL Page: 4

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 193

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
9/17/25	Section 945.10(1)		Section 945.10(1)	10/31/2025	-12	181
9/30/25				10/31/2025	-12	169
10/14/25				10/31/2025	-12	157
10/28/25				10/31/2025	-12	145
11/13/25				09/30/2026	-12	133
11/13/25				10/31/2025	-20	113
11/18/25				07/30/2027	+25	138
11/20/25				09/30/2026	-12	126
12/9/25				09/30/2026	-12	114
12/18/25				09/30/2026	-12	102
2/10/2026				09/30/2026	-2	100
2/10/2026				11/30/2026	-11	89
3/17/26				11/30/2026	-12	77
4/21/26				11/30/26	-2	75
4/21/26						
9/23/26				7/31/2027	+25	100

DRUG NAME Potassium Acetate 2mEq/mL 20mL PACKAGE SIZE 25x20mL

NDC# Section 945.10(1)

DATE	INVOICE NUMBER	LOT #	EXP. DATE	MFR	RECEIVED/USED (+/-)	BALANCE
6/14/23	Section 945.10(1)	Section 945.10(1)		Section 945.10(1)		361
6/15/23			6/2023		-12	349
7/19/23			06/2023		-2	347
9/3/23			12/2024		-12	335
10/3/23			10/2025		-47	288
10-3-23			12/2024		-12	276
8-29-24			12/2024		-12	264
1-3-2025			12-2024		-64	200
2-13-25			10-2025		-12	188
3/20/25			10-2025		-12	176
3/18/25			11/30/26		+25	201
3/18/25			9/30/26		+50	251
4/7/25			9/30/26		+25	276
4/7/25			4/30/27		+50	326
4/8/25			10-2025		-12	314
4/16/25			9/30/26		-25	289
5/1/25			10-2025		-12	277
5/15/25			10-2025		-12	265
6/12/25			10-2025		-7	258
6/25/25			10-2025		-17	241
7/16/25			10-2025		-12	229
7/28/25			10-2025		-12	217
8/19/25			10-2025		-12	205
8/29/25			10-2025		-12	193

EXHIBIT 8

FDC Hydroxizine Log. (Redacted)

DRUG NAME: Hydroxyzine hcl 25mg/mL Package Size: 25 x 1mL Page: 2

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 68

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
11/13/25	Section 945.10(1)		Section 945.10(1)	08/31/2026	-1	67
11/20/25				08/31/2026	-2	65
12/9/25				08/31/2026	-2	63
12/18/25				08/31/2026	-2	61
2/10/26				08/31/2026	-2	59
2/24/26				08/31/2026	-2	57
3/3/26				08/31/2026	-2	55
3/17/26				08/31/2026	-2	53
4/22/26				08/31/2026	-2	51
4/30/26				08/31/2026	-1	50
5/21/26				08/31/2026	-2	48
6/2/26				08/31/2026	-2	46
6/3/26		Section 945.10(1)		2/1/2027	+50	96
6/25/26				08/31/2026	-1	95
7/14/26				08/31/2026	-2	93
7/28/26				08/31/2026	-6	87
8/18/26				2/1/2027	-2	85
9/1/26				2/1/2027	-2	83
9/10/26				2/1/2027	-2	81
9/29/26				2/1/2027	-2	79
10/13/26				2/1/2027	-2	77

DRUG NAME: Hydroxyzine HCL 25mg/mL Package Size: 25 x 1 mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 0 (N/A)

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
2/1/2024	Section 945.10(1)	)(1)	Section 945.10(1)	03/31/2025	+ 25	25
8/29/2024				3/31/2025	- 2	23
1/3/2025		)		8/31/2026	+25	48
2/13/2025				3/31/2025	-3	45
3/20/2025				3/31/2025	-3	42
4/2/2025		10(1)		8/31/2026	+25	67
4/8/2025				8/31/2026	-4	63
4/16/2025				3/31/2025	-17	46
5/1/2025				8/31/2026	-4	42
5/15/2025				8/31/2026	-3	39
5/23/2025		0(1)		8/31/2026	+25	64
6/12/25				8/31/2026	-3	61
6/25/25				8/31/2026	-2	59
7/16/25				8/31/2026	-2	57
7/28/25		10(1)		8/31/2026	+25	82
7/28/25				8/31/2026	-2	80
8/19/25				8/31/2026	-2	78
8/29/25				8/31/2026	-2	76
9/17/25				8/31/2026	-2	74
9/30/25				8/31/2026	-2	72
10/15/25				8/31/2026	-2	70
10/28/25				8/31/2026	-2	68

EXHIBIT 8

FDC Lidocaine Log. (Redacted)

DRUG NAME: Lidocaine HCL 1% (10mL) Package Size: 25 x 10mL Page: 1

NDC# Section 945.10(1) Manufacturer: Section 945.10(1) PREVIOUS BALANCE: 0

DATE	VENDOR NAME	INVOICE NUMBER	LOT#	EXP. DATE (MM/DD/YYYY)	RECEIVED/USED (+/-)	BALANCE
1/3/25	Section 945.10(1)	Section 945.10(1)	Section 945.10(1)	09/30/2026	+25	25
3/20/25	Section 945.10(1)			9/30/2026	-2	23
4/8/25				9/30/2026	-2	21
7/28/25		Section 945.10(1)		4/30/2027	+50	71
9/29/26				4/30/2027	-2	69

A6

Florida Department of Corrections

Executioners' Logs

EXHIBIT 1

OFFICIAL WITNESS SIGN-IN

INMATE NAME: BATES, Kayle
DC#: 088568
DATE OF EXECUTION: August 19, 2025
TIME: 6:00 PM

	NAME	SIGNATURE
1	Brandi Manley	
2	Lisa Kinard	
3	Cynthia McNichols	
[redacted]		
6	Larry Basford	
[redacted]		
8	Darryl Sanders	
9	Abby Scholes	
10	Karen Cox	
11	Ernest Wynn	
[redacted]		
13	Hollie Hodgson	
14	Amanda Rewis	
15	Scottie Pleasant	
16	Lasonica Lockridge	
17	Kellie Williams	
18	Shawna Evans	
19	Chatlie Moore	
20	Linda McDermott	
21	James Abdur-Rahman	

EXECUTION CHECKLIST

INMATE NAME Kayle B. Bates **NUMBER** 088568 **DATE:** 8/19/2025

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:45	[redacted]		
Arrive on site	2:00			
Telephone check	2:00			
Obtain keys/Key check/Key log	2:02			
Public Address System check	2:04			
Radio check/Radio accountability	2:07			
Visual Monitor/Video Equipment Check	2:03			
Confirm cell phones are on vibrate/silenced	2:04			
Equipment bag check	2:06			
Suit/Undergarments present	2:03			
Shower supplies	2:02			
Search shower	2:04			
Search holding cell	2:01			
Ensure sheets pressed and several back-ups	2:05			
Ensure IV Pole is on medical cart	2:10			
Checked Phase Light system	2:06			
Medical Equipment Check: Wireless Telemetry Monitors	2:14			
UPS for Wireless Telemetry Monitors	2:14			
Cardiac Monitors	2:15			
Cardiac Monitor Leads	2:15			
Drug test completed	4:50			
Verify checklist complete at this time: **Team Warde** [redacted]	5:58			

EXECUTION [redacted]PARATION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS	CONTINGENCY LOG:	TIME
Receive Inmate/Obtain log book	3:30	[redacted]		
Complete shower refused	3:45			
Secure in holding cell	3:59			
Issue clothing	5:00			
Explanation to inmate of lethal injection	3:30			

Revised 5/25/2021-added Minster of Religion entry and exit

Inmate offered injection for anxiety – one (1) hour prior	4:59	
Inmate accepted/declined injection for anxiety	4:59	
Open phone line with Governor's Office	5:27	
Read Warrant – Waived reading of the Warrant	4:00	
Restraints applied at holding cell	5:31	
Escorted to gurney	5:31	
Security Team Restraint process begun/completed	Begins 5:32	Ends 5:37
Technical Team process begun/completed. IV method utilized: Peripheral Femoral	Begins 5:33	Ends 5:42
Security Team and Technical Team depart execution chamber	5:43	
Official/Media Witnesses Entered and Secured in witness room	5:44	
Confirm Witnesses Secured in Witness Room	5:44	
Escort Minister of Religion into the execution chamber	5:51	
Death Chamber Entrance Door Secured	5:52	
Verify checklist completed/Executioners Room ready to proceed: **Team Warde** [redacted]	5:58	
Curtain Opened	6:00	
Communication with Governor's Office reference any last stays	6:00	
Activate Public Address (PA) System	6:00	
Last statement	6:01	
Execution Phase Begins	6:01	
Deactivate Public Address (PA) System	6:01	
Initiate phases	6:01	
Physician pronounces death/Team Warden in agreement	6:17	
Notification that sentence has been carried out to Governor's Office	6:17	
Activate Public Address (PA) System	6:17	
Notification that sentence has been carried out to witnesses	6:17	
Deactivate Public Address (PA) System	6:17	
Curtain Closes	6:17	
Official/Media Witnesses departed witness room	6:21	
Escort Minister of Religion out of execution chamber	6:18	
Medical Team departs	6:23	
Body Removal Team	Enters 6:21	Exits 6:28
Debriefing	5:45	

[redacted]

Team Warden [redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Kayle B. Bates NUMBER 088568 DATE 8/19/25

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)	2:59 p	[redacted]
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)	3:00 p	
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals	3:00 p	
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix	3:00 p	
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)** Syringe #3: **Saline Solution, Trays A &B (Total 2)** Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)** Syringe #6: **Saline Solution, Trays A & B (Total 2)** Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**	3:05p 3:24p 3:17p 3:24p 3:21p	
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)	3:24p	
Verify Expiration Date of Hydroxyzine	3:25p	
Verify Drawing of syringes and disposal of remainder of Hydroxyzine	3:25p	
Stand A and Stand B transported to Execution Room	3:26p	
Execution Room secured	3:27p	

TEAM WARD [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 8/19/2025

EXECUTION PHASE BEGINS	TIME	STM Number
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:44p	[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:58p	
Phase 1 Begins	6:01p	
Syringe 1 Etomidate	Begins 6:01p / Ends 6:03p	
Syringe 2 Etomidate	Begins 6:03p / Ends 6:04p	
Syringe 3 Saline Solution	Begins 6:04p / Ends 6:05p	
Phase 1 Ends	6:05p	
Team Warden checks for consciousness	6:05p	
Inmate medically checked for consciousness	6:06p	
Phase 2 Begins	6:06p	
Syringe 4 Rocuronium Bromide	Begins 6:06p / Ends 6:07p	
Syringe 5 Rocuronium Bromide	Begins 6:07p / Ends 6:09p	
Syringe 6 Saline Solution	Begins 6:09p / Ends 6:10p	
Phase 2 Ends	6:09p	
Phase 3 Begins	6:10p	
Syringe 7 Potassium Acetate	Begins 6:10p / Ends 6:11p	
Syringe 8 Potassium Acetate medical advises flatline @ 6:15p	Begins 6:12p / Ends	
Phase 3 Ends		
Sentence has been carried out	6:17p	
All materials/chemical mix disposed of according to State and Federal Law	6:23p	
CONTINGENCY LOG:		

2/21/2023 Removed diazepam and added Hydrozyzine

EXECUTION PREPARATIONS CHECKLIST

TEAM WARDEN

EXECUTION PREPARATIONS	DATE	TIME
Receipt of Warrant from Institutional Warden	7/18/25	5:30
Advised of Execution Scheduled For Kayle B. Bates 088568 By Institutional Warden	7/18/25	4:10
Selection of Executioners	7/18/25	4:30
• Provided Executioners with copy of procedure	7/18/25	4:30
• Explained to Executioners respective duties/responsibilities	7/18/25	4:30
• Explained to Executioners training will occur	7/18/25	4:30
• Designate Executioners as Primary and Secondary	7/18/25	4:30
Ensure purchase/ maintenance of chemicals by assigned team member	7/23/25	2:05
Approximately one (1) week prior to Execution, Team Warden designates execution team members to:	8/12/25	9:00
• Review of Inmate Medical File	8/12/25	9:00
• Limited Physical Examination	8/12/25	9:10
• Execution Team Members report findings to Team Warden	8/12/25	9:15
Review of examination/confer with designated team members, the Team Warden shall conclude the more suitable method of venous access	8/12/25	9:15
Contingency Log:		

TEAM WARDEN [redacted] **DATE** 8/15/25

T[redacted]: KAYLE BATES
Observer: [redacted]
Date: 8/19/25
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30 PM	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:58 PM	Inmate moved to chamber prep. Cell # Q1101	
SEE NOTE	Explanation of lethal injection procedures to inmate	VARIOUS STAGES
4:58 PM	Sedative offered to inmate	Accepted/Declined
5:26 PM	**Communication link established with EOG**	
5:31 PM	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:34 PM	Restraint process initiated	
5:37 PM	Restraint process continued	
5:35PM		
5:37PM	Restraint process completed	
5:38PM	IV initiated L & R arm	
5:40 PM	IV placement continued	
5:41 PM	IV placement completed	
5:43 PM	5:45PM 5:47PM 5:49PM 5:51PM	
5:52 PM	**Minister of Religion escorted into chamber**	
5:54PM	5:56 PM	
5:57PM	IV final check by medical personnel	
5:59PM		
6:00PM	**Warden check with EOG for last minute stays**	
6:01PM	Inmate final statement	Rendered/Declined
6:01 PM	**Warden authorizes Execution Phase One initiated**	
6:03 PM	6:05PM	
6:06 PM	Execution Phase One complete	
6:06PM	**Check for unconsciousness by Warden**	
6:06PM	Execution Phase Two initiated	
6:08 PM		
6:10 PM	Execution Phase Two complete	
6:10PM	Execution Phase Three initiated	
6:12 PM	6:14PM	6:15 PM FLATLINE
N/A	Execution Phase Three complete	
6:16 PM	Check for cardiac activity by medical personnel	
6:17PM	Medical Personnel notifies Warden time of death	
6:19PM	**EOG notified of time of death**	
6:17 PM	**Death pronounced and announced by Warden**	
6:18PM	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Observer: [redacted]
Date: 8-18-25
Location: INJ. Room

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1330	**Arrived Florida State Prison (Time)**	
1459	Syringe fill begin	
1325	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
N/O	Inmate moved to chamber prep. Cell # Q1101	
N/O	Explanation of lethal injection procedures to inmate	
N/O	Sedative offered to inmate	Accepted/Declined
N/O	**Communication link established with EOG**	
1731	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
1731	Restraint process initiated	
1733	Restraint process continued	
1735		
1737	Restraint process completed	
1737	IV initiated L & R arm	
1739	IV placement continued	
1741		
1742	IV placement completed	
1744	1746, 1748, 1750	
1751	**Minister of Religion escorted into chamber**	
1753	1755	
1757	IV final check by medical personnel	
1759		
1800	**Warden check with EOG for last minute stays**	
1801	Inmate final statement	Rendered/Declined
1801	**Warden authorizes Execution Phase One initiated**	
1803	1805	
1805	Execution Phase One complete	
1805	**Check for unconsciousness by Warden**	
1806	Execution Phase Two initiated	
1808		
1809	Execution Phase Two complete	
1810	Execution Phase Three initiated	
1812	1814	
1815	Execution Phase Three complete	
1816	Check for cardiac activity by medical personnel	
1817	Medical Personnel notifies Warden time of death	TOD: 1817
1817	**EOG notified of time of death**	
1817	**Death pronounced and announced by Warden**	
1818	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

FLORIDA DEPARTMENT OF CORRECTIONS
HOUSING UNIT LOG

Florida State Prison
(INSTITUTION)

HOUSING UNIT Kayle Bates DC# 088568 Death Watch Cell-front Monitor **DATE** 8-19- 2025

TIME	LOG OF EVENTS	INITIALS
3:59 PM	Inmate placed in holding cell. [redacted] explaining the execution process.	[redacted]
4:15 PM	[redacted] speaking with inmate. Inmate sitting on bunk speaking with [redacted]	
4:30 PM	Inmate sitting quietly on bunk.	
4:45 PM	Inmate Sitting quietly on bunk	
4:50 PM	[redacted] Speaking with inmate.	
4:58 PM	Inmate offered and refused sedative.	
5:01 PM	Inmate changed into dress clothes.	
5:02 PM	Inmate using the restroom	
5:07 PM	[redacted] speaking with inmate.	
5:15 PM	[redacted] speaking with inmate Cell front	
5:31 PM	Inmate removed from holding cell and escorted to Chamber	

Housing Sergeant Signature:	
Housing Officer Signature:	

Each Correctional Officer and Correctional Officer Sergeant will make entry as to the time she/he assumed duties for the housing unit and the time relieved. Signature of the Housing Officer and Sergeant indicates that she/he has relieved the preceding shift, read the previous entries on the Housing Unit Log, and assumes the responsibility for any corrective action or follow-up action required. This log will be forwarded daily to the office of the Chief of Security at the conclusion of the Day Shift.

Name: Kayle B. Bates

DC#: 088568

Inmate's Last Statement

no.

Date: _____

Recorded by: [redacted]

Name: Kayle B. Bates

DC#: 088568

Inmate's Last Statement

NO

Date: 8/19/2025

Recorded by [redacted]

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number
[redacted]

[redacted] 8-19-25

DATE

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	1:02	N
		1:04	N
		1:46	N
		1:04	N
		1:42	N
		1:02	N
		1:02	N
		1:05	N
		1:09	N
		1:40	N
		1:07	N
		—	—
		1:35	N
		1:22	N
		1:30	N
		1:40	N
[redacted]		1:18	N
		1:05	N
TECHNICAL TEAM MEMBERS			
		1:49	N
		1:48	N
[redacted]			
		1:18	N
		1:45	N
		1:49	N
		4:55	N
		4:55	N
		1:35	N
EXECUTIONERS			
		4:45	N
		4:45	N
		—	—

TEAM WARDEN [redacted]

DATE 8-19-25

Revised 12/13/18

EXECUTION CHECKLIST

INMATE NAME Practice NUMBER 1 DATE: 8/18/2025

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:45	[redacted]		
Arrive on site	2:00			
Telephone check	2:02			
Obtain keys/Key check/Key log	2:01		2:06 – Communication issue – Com box under chamber phone inoperable – other units are operable. FSP advised of issue.	
Public Address System check	2:06			
Radio check/Radio accountability	2:10			
Visual Monitor/Video Equipment Check	2:06			
Confirm cell phones are on vibrate/silenced	2:07			
Equipment bag check	2:08			
Suit/Undergarments present	2:07			
Shower supplies	2:03			
Search shower	2:04			
Search holding cell	2:05			
Ensure sheets pressed and several back-ups	2:07			
Ensure IV Pole is on medical cart	2:10			
Checked Phase Light system	2:07			
Medical Equipment Check: Wireless Telemetry Monitors	2:14			
UPS for Wireless Telemetry Monitors	2:14			
Cardiac Monitors	2:15			
Cardiac Monitor Leads	2:15			
Drug test completed	4:55			
Verify checklist complete at this time: Team Warden [redacted]	5:58			

EXECUTION PRE[redacted]TION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS	CONTINGENCY LOG:	TIME
Receive Inmate/Obtain log book	3:30	[redacted]	Combative inmate	
Complete shower (Sim) refused	3:45		3:58 – 4 man carry – restrained secured in cell @ 3:59.	
Secure in holding cell	3:59			
Issue clothing (Sim)	5:01			
Explanation to inmate of lethal injection	3:30			

Revised 5/25/2021-added Minster of Religion entry and exit

Inmate offered injection for anxiety – one (1) hour prior	5:00	
Inmate accepted/declined injection for anxiety	5:00	
Open phone line with Governor's Office (5 m)	5:25	
Read Warrant – Waived reading of the Warrant	5:25	
Restraints applied at holding cell	5:35	
Escorted to gurney	5:36	
Security Team Restraint process begun/completed	Begins 5:36	Ends 5:41
Technical Team process begun/completed. IV method utilized: Peripheral Femoral	Begins 5:38	Ends 5:43
Security Team and Technical Team depart execution chamber	5:44	
Official/Media Witnesses Entered and Secured in witness room	5:46	
Confirm Witnesses Secured in Witness Room	5:46	
Escort Minister of Religion into the execution chamber	5:50	
Death Chamber Entrance Door Secured	5:50	
Verify checklist completed/Executioners Room ready to proceed: **Team War** [redacted]	5:58	
Curtain Open[redacted]	6:00	
Communicati[redacted]h Governor's Office reference any last stays	6:00	
Activate Public Address (PA) System	6:00	
Last statement	6:00	
Execution Phase Begins	6:00	
Deactivate Public Address (PA) System	6:00	
Initiate phases	6:00	
Physician pronounces death/Team Warden in agreement	6:09	
Notification that sentence has been carried out to Governor's Office	6:10	
Activate Public Address (PA) System	6:10	
Notification that sentence has been carried out to witnesses	6:10	
Deactivate Public Address (PA) System	6:10	
Curtain Closes	6:10	
Official/Media Witnesses departed witness room	6:12	
Escort Minister of Religion out of execution chamber	6:11	
Medical Team departs	6:13	
Body Removal Team	Enters 6:11	Exits 6:14
Debriefing		

[redacted]

Team Warden [redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Real Time Training **NUMBER** Time Specific Training **DATE** 8/18/2025

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)		
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)		
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals		
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix		
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)** Syringe #3: **Saline Solution, Trays A &B (Total 2)** Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)** Syringe #6: **Saline Solution, Trays A & B (Total 2)** Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**		
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)		
Verify Expiration Date of Hydroxyzine		
Verify Drawing of syringes and disposal of remainder of Hydroxyzine		
Stand A and Stand B transported to Execution Room		
Execution Room secured		

Simulated

TEAM WARDEN [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 8/19/2025

EXECUTION PHASE BEGINS	**TIME**		**STM Number**
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:45 p		[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:50 p		
Phase 1 Begins	6:00 p		
Syringe 1 Etomidate	Begins	Ends	
	6:00 p	6:02 p	
Syringe 2 Etomidate	Begins	Ends	
	6:02 p	6:03 p	
Syringe 3 Saline Solution	Begins	Ends	
	6:03 p	6:04 p	
Phase 1 Ends	6:04 p		
Team Warden checks for consciousness	6:04 p		
Inmate medically checked for consciousness	6:04 p		
Phase 2 Begins	6:04 p		
Syringe 4 Rocuronium Bromide	Begins	Ends	
	6:04 p	6:05 p	
Syringe 5 Rocuronium Bromide	Begins	Ends	
	6:05 p	6:07 p	
Syringe 6 Saline Solution	Begins	Ends	
	6:07 p	6:08 p	
Phase 2 Ends	6:08 p		
Phase 3 Begins	6:08 p		
Syringe 7 Potassium Acetate	Begins	Ends	
Medical advises flatline @ 6:08p	6:08 p		
Syringe 8 Potassium Acetate	Begins	Ends	
Phase 3 Ends			
Sentence has been carried out	6:09 p		
All materials/chemical mix disposed of according to State and Federal Law	6:14 p		
CONTINGENCY LOG:			

2/21/2023 Removed diazepam and added Hydrozyzine

Type: PRACTICE
Observer: [redacted]
Date: 8/19/25
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30 PM	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:49 P	Inmate moved to chamber prep. Cell # Q1101	
N/A	Explanation of lethal injection procedures to inmate	
4:59 P	Sedative offered to inmate	Accepted/Declined
5:25 PM	**Communication link established with EOG**	
5:35 PM	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:35 PM	Restraint process initiated	
5:37 PM	Restraint process continued	
5:39 PM		
5:40 PM	Restraint process completed	
5:41 PM	IV initiated L & R arm	
5:43 PM	IV placement continued	
5:43 PM	IV placement completed	
5:45 PM	5:47 PM 5:49 PM	
5:50 PM	**Minister of Religion escorted into chamber**	
5:52 PM	5:54 PM 5:56 PM	
5:57 PM	IV final check by medical personnel	
5:59 PM		
6:00 PM	**Warden check with EOG for last minute stays**	
6:00 PM	Inmate final statement	Rendered/Declined
6:00 PM	**Warden authorizes Execution Phase One initiated**	
6:02 PM	6:04 PM	
6:04 PM	Execution Phase One complete	
6:04 PM	**Check for unconsciousness by Warden**	
6:04 PM	Execution Phase Two initiated	
6:06 PM	6:08 PM	
6:08 PM	Execution Phase Two complete	
6:08 PM	Execution Phase Three initiated	6:08 PM FLATLINE
N/A	Execution Phase Three complete	
6:09 PM	Check for cardiac activity by medical personnel	
6:09 PM	Medical Personnel notifies Warden time of death	
6:09 PM	**EOG notified of time of death**	
6:10 PM	**Death pronounced and announced by Warden**	
6:10 PM	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Observer: [redacted]
Date: 8-18-25
Location: FSP - TwI Room

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1330	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
N/O	Inmate moved to chamber prep. Cell # Q1101	
N/O	Explanation of lethal injection procedures to inmate	
N/O	Sedative offered to inmate	Accepted/Declined
N/O	**Communication link established with EOG**	
1735	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
1735	Restraint process initiated	
1737	Restraint process continued	
1739		
1740	Restraint process completed	
1740	IV initiated L & R arm	
1742	IV placement continued	
~~1744~~		
1743	IV placement completed	
~~1745~~ 1747, 1749		
1751	**Minister of Religion escorted into chamber**	
1753	1755	
1757	IV final check by medical personnel	
1759		
1800	**Warden check with EOG for last minute stays**	
1800	Inmate final statement	Rendered/Declined
1800	**Warden authorizes Execution Phase One initiated**	
1802	1804	
1804	Execution Phase One complete	
1804	**Check for unconsciousness by Warden**	
1804	Execution Phase Two initiated	
1806	1808	
1802	Execution Phase Two complete	
1808	Execution Phase Three initiated	
1808	Execution Phase Three complete	
1808	Check for cardiac activity by medical personnel	
1809	Medical Personnel notifies Warden time of death	
1809	**EOG notified of time of death**	TOD: 1807
1810	**Death pronounced and announced by Warden**	
1810	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number
[redacted]

[redacted] 8/18/25

DATE

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	1:02	N
		1:09	N
		1:45	N
		1:06	N
		1:40	N
		1:35	N
		1:02	N
		1:02	N
		1:23	N
		1:30	N
		1:06	N
		1:16	N
		1:28	N
		1:08	N
		1:32	N
		1:07	N
[redacted] 1:15 Neg		1:10	N
		1:04	N
TECHNICAL TEAM MEMBERS		1:41	N
		1:43	N
		—	—
		1:20	N
		1:40	N
		1:41	N
		4:53	N
		4:53	N
		1:28	N
EXECUTIONERS		4:44	N
		4:44	N
		—	—

TEAM WARDEN [redacted]

DATE 8/18/25

Revised 12/13/18

EXHIBIT 2

OFFICIAL WITNESS SIGN-IN

INMATE NAME: Curtis Windom
DC#: 368527
DATE OF EXECUTION: Thursday, August 28, 2025
TIME: 6:00 pm

	NAME	SIGNATURE
1	Brandi Manley	Brandi Manley
[redacted]		Not in attendance
3	Lisa Kinard	
4	Erik Howard	
[redacted]		Not in attendance
[redacted]		
8	Cole Dixon	
9	Staci Mortham	Staci Mortham
10	Maggie Chandronnet	
11	Hollie Hodgson	Hollie Hodgson
12	Amanda Rewis	
13	Scott Pleasant	
14	Lasonica Lockridge	
15	Kellie Williams	
16	Jeffrey Kennedy	
17	Christopher Givens	
18	Michael Mills	
19	Garry Adams	
20	Tyler Wainwright	
21	Brad Thomas	
22	Brian Sutton	
23	Chatlie Moore	

EXECUTION CHECKLIST

INMATE NAME Curtis Windom **NUMBER** 368527 **DATE:** 8/28/2025

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:45	[redacted]		
Arrive on site	1:57			
Telephone check	1:58			
Obtain keys/Key check/Key log	1:59			
Public Address System check	2:03			
Radio check/Radio accountability	2:08			
Visual Monitor/Video Equipment Check	2:06			
Confirm cell phones are on vibrate/silenced	2:02			
Equipment bag check	2:10			
Suit/Undergarments present	2:00			
Shower supplies	2:01			
Search shower	2:02			
Search holding cell	1:59			
Ensure sheets pressed and several back-ups	2:09			
Ensure IV Pole is on medical cart	2:10			
Checked Phase Light system	2:03			
Medical Equipment Check: Wireless Telemetry Monitors	2:12			
UPS for Wireless Telemetry Monitors	2:12			
Cardiac Monitors	2:13			
Cardiac Monitor Leads	2:13			
Drug test completed	4:47			
Verify checklist complete at this time: **Team Warden** [redacted]	5:58			

EXECUTION PR[redacted]RATION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS	CONTINGENCY LOG:	TIME
Receive Inmate/Obtain log book	3:30	[redacted]		
Complete shower refused	3:45			
Secure in holding cell	3:59			
Issue clothing	5:00			
Explanation to inmate of lethal injection	3:30			

Revised 5/25/2021-added Minster of Religion entry and exit

Inmate offered injection for anxiety – one (1) hour prior	5:00		
Inmate accepted/declined injection for anxiety	5:00		
Open phone line with Governor's Office	5:22		
Read Warrant – Waived reading of the Warrant	4:00		
Restraints applied at holding cell	5:31		
Escorted to gurney	5:31		
Security Team Restraint process begun/completed	Begins 5:32	Ends 5:37	
Technical Team process begun/completed. IV method utilized: Peripheral Femoral	Begins 5:33	Ends 5:42	
Security Team and Technical Team depart execution chamber	5:43		
Official/Media Witnesses Entered and Secured in witness room	5:45		
Confirm Witnesses Secured in Witness Room	5:45		
Escort Minister of Religion into the execution chamber N/A	5:44		Confirm no Minister of Religion
Death Chamber Entrance Door Secured	5:44		
Verify checklist completed/Executioners Room ready to proceed: **Team Warden** [redacted]	5:58		
Curtain Opened	6:00		
Communication with Governor's Office reference any last stays	6:00		
Activate Public Address (PA) System	6:00		
Last statement	6:02		
Execution Phase Begins	6:02		
Deactivate Public Address (PA) System	6:02		
Initiate phases	6:02		
Physician pronounces death/Team Warden in agreement	6:17		
Notification that sentence has been carried out to Governor's Office	6:18		
Activate Public Address (PA) System	6:18		
Notification that sentence has been carried out to witnesses	6:18		
Deactivate Public Address (PA) System	6:18		
Curtain Closes	6:18		
Official/Media Witnesses departed witness room	6:21		
Escort Minister of Religion out of execution chamber N/A			No minister of religion
Medical Team departs	6:22		
Body Removal Team	Enters 6:22	Exits 6:30	
Debriefing	6:44		**Team Warden** [redacted]

[redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Curtis Windom **NUMBER** 368527 **DATE** 8/28/2025

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)	2:56p	[redacted]
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)	2:58p	
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals	3:00p	
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix	3:00p	
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)** Syringe #3: **Saline Solution, Trays A &B (Total 2)** Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)** Syringe #6: **Saline Solution, Trays A & B (Total 2)** Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**	3:03p 3:22p 3:15p 3:22p 3:20p	
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)	3:23p	
Verify Expiration Date of Hydroxyzine	3:24p	
Verify Drawing of syringes and disposal of remainder of Hydroxyzine	3:25p	
Stand A and Stand B transported to Execution Room	3:26p	
Execution Room secured	3:26p	

TEAM WARDEN [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 8/26/2025

EXECUTION PHASE BEGINS	TIME	STM Number
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:42p	[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:58p	
Phase 1 Begins	6:02p	
Syringe 1 Etomidate	Begins 6:02p / Ends 6:03p	
Syringe 2 Etomidate	Begins 6:03p / Ends 6:04p	
Syringe 3 Saline Solution	Begins 6:05p / Ends 6:05p	
Phase 1 Ends	6:05p	
Team Warden checks for consciousness	6:05p	
Inmate medically checked for consciousness	6:06p	
Phase 2 Begins	6:06p	
Syringe 4 Rocuronium Bromide	Begins 6:06p / Ends 6:07p	
Syringe 5 Rocuronium Bromide	Begins 6:07p / Ends 6:09p	
Syringe 6 Saline Solution	Begins 6:09p / Ends 6:09p	
Phase 2 Ends	6:09p	
Phase 3 Begins	6:09p	
Syringe 7 Potassium Acetate	Begins 6:09p / Ends 6:11p	
Syringe 8 Potassium Acetate	Begins 6:11p / Ends 6:16p	
Phase 3 Ends Medical Advises Flatline @ 6:16p	6:16p	
Sentence has been carried out	6:17p	
All materials/chemical mix disposed of according to State and Federal Law	6:26p	
CONTINGENCY LOG:		

2/21/2023 Removed diazepam and added Hydrozyzine

T. Curtis Windom
Observer: [redacted]
Date: 8/28/25
Location: Chem Room

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30	**Arrived Florida State Prison (Time)**	
2:58	Syringe fill begin	
3:25	Syringe fill complete	
N/A	Inmate moved from death watch cell to shower	Shower Accepted/Declined
N/A	Inmate moved to chamber prep. Cell # Q1101	
N/A	Explanation of lethal injection procedures to inmate	
N/A	Sedative offered to inmate	Accepted/Declined
5:31	**Communication link established with EOG**	
5:31	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:32	Restraint process initiated	
5:34	Restraint process continued	
5:36		
5:37	Restraint process completed	
5:38	IV initiated L & R arm	
5:40	IV placement continued	
5:41	IV placement completed	
5:43		
N/A	**Minister of Religion escorted into chamber**	
5:45	5:47, 5:49, 5:51, 5:53, 5:55	
5:57	IV final check by medical personnel	
5:59		
6:00	**Warden check with EOG for last minute stays**	
6:02	Inmate final statement	Rendered/Declined
6:02	**Warden authorizes Execution Phase One initiated**	
6:04		
6:05	Execution Phase One complete	
6:05	**Check for unconsciousness by Warden**	
6:06	Execution Phase Two initiated	
6:08		
6:09	Execution Phase Two complete	
6:09	Execution Phase Three initiated	
6:11	6:13 6:15	
6:16	Execution Phase Three complete	
6:17	Check for cardiac activity by medical personnel	
6:17	Medical Personnel notifies Warden time of death	
6:18	**EOG notified of time of death**	
6:18	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

ype: Curtis Windom
Observer: [redacted]
Date: 8/28/25
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30PM	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:58PM	Inmate moved to chamber prep. Cell # Q1101	
	Explanation of lethal injection procedures to inmate	VARIOUS STAGES
4:59 PM	Sedative offered to inmate	Accepted/Declined
5:21PM	**Communication link established with EOG**	
5:31 PM	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:31PM	Restraint process initiated	
5:33 PM	Restraint process continued	
5:35PM		
5:37 PM		
5:39PM	Restraint process completed	
5:38PM	IV initiated L & R arm	
5:40PM	IV placement continued	
5:40PM	IV placement completed	
5:42PM	5:44PM 5:46PM 5:48PM	
N/A	**Minister of Religion escorted into chamber**	
5:50PM	5:52PM 5:54PM 5:56PM	
5:50PM	IV final check by medical personnel	
5:54PM		
6:00PM	**Warden check with EOG for last minute stays**	
6:01PM	Inmate final statement	Rendered/Declined
6:02PM	**Warden authorizes Execution Phase One initiated**	
6:04PM		
6:05PM	Execution Phase One complete	
6:05 PM	**Check for unconsciousness by Warden**	
6:06PM	Execution Phase Two initiated	
6:08PM		
6:09PM	Execution Phase Two complete	
6:09PM	Execution Phase Three initiated	
6:11PM	6:13PM	
6:16 PM	Execution Phase Three complete	6:19PM FLATLINE
6:17PM	Check for cardiac activity by medical personnel	
6:19 PM	Medical Personnel notifies Warden time of death	
6:18PM	**EOG notified of time of death**	
6:18PM	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

FLORIDA DEPARTMENT OF CORRECTIONS
HOUSING UNIT LOG

Florida State Prison
(INSTITUTION)

HOUSING UNIT Curtis Windom DC# 368527 Death Watch Cell-front Monitor **DATE** 8/28/2025

TIME	LOG OF EVENTS	INITIALS
3:58 PM	Inmate placed in holding cell. [redacted] standing Cell front.	[redacted]
4:00 PM	Inmate quietly lying on bunk.	
4:15 PM	Inmate quietly lying on bunk. [redacted] standing Cell front	
4:30 PM	Inmate quietly lying on bunk. [redacted] standing Cell front	
4:45 PM	[redacted] speaking with inmate. Inmate sitting on bunk.	
4:48 PM	Inmate using the restroom	
4:52 PM	[redacted] speaking with inmate Cell front	
5:00 PM	Inmate offered and refused the Sedative	
5:03 PM	Inmate changed into dress clothes.	
5:15 PM	Inmate quietly lying on bunk. [redacted] standing Cell front	
5:22 PM	Inmate using the restroom	
5:31 PM	Inmate removed from holding cell and escorted to Chamber	

Housing Sergeant Signature:

Housing Officer Signature:

Each Correctional Officer and Correctional Officer Sergeant will make entry as to the time she/he assumed duties for the housing unit and the time relieved. Signature of the Housing Officer and Sergeant indicates that she/he has relieved the preceding shift, read the previous entries on the Housing Unit Log, and assumes the responsibility for any corrective action or follow-up action required. This log will be forwarded daily to the office of the Chief of Security at the conclusion of the Day Shift.

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number
[redacted]

[redacted] 8/28/25

SIGNATURE DATE

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	1:03	N
		—	—
		1:31	N
		1:27	N
		1:35	N
		1:10	N
		1:04	N
		1:08	N
		1:27	N
		1:40	N
		1:08	N
		1:23	N
		—	—
		1:14	N
		1:14	N
[redacted] 1:24 N		1:10	N
		1:09	N
		1:07	N
TECHNICAL TEAM MEMBERS		1:45	N
		1:50	N
		—	—
		1:12	N
		1:45	N
		1:45	N
		4:50	N
		4:50	N
		—	—
EXECUTIONERS		4:45	N
		4:45	N
		—	—

TEAM WARDEN [redacted]

DATE 8/28/25

Revised 12/13/18

Name: Curtis Windom

DC#: 368527

Inmate's Last Statement

I, My last statement is for someone looking at death row they need to look @ something different

Date: 8/28/25

Recorded by [redacted]

EXECUTION PREPARATIONS CHECKLIST

TEAM WARDEN

EXECUTION PREPARATIONS	DATE	TIME
Receipt of Warrant from Institutional Warden	7/29/25	4:13
Advised of Execution Scheduled For Curtis Windom #368527 By Institutional Warden	7/29/25	4:15
Selection of Executioners		
• Provided Executioners with copy of procedure	7/29/25	4:30
• Explained to Executioners respective duties/responsibilities	7/29/25	4:30
• Explained to Executioners training will occur	7/29/25	4:30
• Designate Executioners as Primary and Secondary	7/29/25	4:30
	7/29/25	4:30
Ensure purchase/ maintenance of chemicals by assigned team member	8/21/25	10:00
Approximately one (1) week prior to Execution, Team Warden designates execution team members to:		
• Review of Inmate Medical File	8/21/25	8:30
• Limited Physical Examination	8/21/25	8:15
• Execution Team Members report findings to Team Warden	8/21/25	8:15
	8/21/25	8:25
Review of examination/confer with designated team members, the Team Warden shall conclude the more suitable method of venous access	8/21/25	8:30
Contingency Log:		

TEAM WARDE [redacted] **DATE** 8/28/25

EXECUTION CHECKLIST

INMATE NAME Practice NUMBER 1 DATE: 8/27/25

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:50	[redacted]		
Arrive on site	2:03			
Telephone check	2:04			
Obtain keys/Key check/Key log	2:04			
Public Address System check	2:11			
Radio check/Radio accountability	2:15			
Visual Monitor/Video Equipment Check	2:10			
Confirm cell phones are on vibrate/silenced	2:08			
Equipment bag check	2:09			
Suit/Undergarments present	2:05			
Shower supplies	2:06			
Search shower	2:07			
Search holding cell	2:08			
Ensure sheets pressed and several back-ups	2:17			
Ensure IV Pole is on medical cart	2:10			
Checked Phase Light system	2:06			
Medical Equipment Check: Wireless Telemetry Monitors	2:11			
UPS for Wireless Telemetry Monitors	2:11			
Cardiac Monitors	2:11			
Cardiac Monitor Leads	2:11			
Drug test completed	5:30			
Verify checklist complete at this time: **Team Warden** [redacted]	5:58			

EXECUTION PRE[redacted]ATION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS	CONTINGENCY LOG:	TIME
Receive Inmate/Obtain log book	3:30	[redacted]	3:59 - Combative inmate – resolved w/o further incident or injury and secured in holding cell	
Complete shower SIM / ref	3:45			
Secure in holding cell	4:00			4:00
Issue clothing				
Explanation to inmate of lethal injection	3:40			

Revised 5/25/2021-added Minster of Religion entry and exit

Inmate offered injection for anxiety – one (1) hour prior	4:58		
Inmate accepted/declined injection for anxiety	4:59		
Open phone line with Governor's Office	5:25		
Read Warrant – Waived reading of the Warrant	4:00		
Restraints applied at holding cell	5:36		
Escorted to gurney	5:36		
Security Team Restraint process begun/completed	Begins 5:36	Ends 5:41	
Technical Team process ~~begun~~/completed. IV method utilized: Peripheral / Femoral	Begins 5:37	Ends 5:43	
Security Team and Technical Team depart execution chamber	5:44		
Official/Media Witnesses Entered and Secured in witness room	5:47		
Confirm Witnesses Secured in Witness Room	5:47		
Escort Minister of Religion into the execution chamber N/A	5:45		Confirmed no Minister of Religion
Death Chamber Entrance Door Secured	5:45		
Verify checklist completed/Executioners Room ready to proceed: **Team Warde** [redacted]	5:58		
Curtain Opened	6:00		
Communication with Governor's Office reference any last stays	6:00		
Activate Public Address (PA) System	6:00		
Last statement	6:00		
Execution Phase Begins	6:00		
Deactivate Public Address (PA) System	6:00		
Initiate phases	6:00		
Physician pronounces death/Team Warden in agreement	6:08		
Notification that sentence has been carried out to Governor's Office	6:08		
Activate Public Address (PA) System	6:08		
Notification that sentence has been carried out to witnesses	6:06		
Deactivate Public Address (PA) System	6:08		
Curtain Closes	6:09		
Official/Media Witnesses departed witness room	6:15		
Escort Minister of Religion out of execution chamber N/A	N/A		NO minister
Medical Team departs	6:13		
Body Removal Team	Enters 6:09	Exits 6:17	
Debriefing	6:20		

[redacted]

Team Warden [redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Time Specific Training NUMBER _____ DATE 8/27/2025

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)		
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)		
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals		
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix		
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)** Syringe #3: **Saline Solution, Trays A &B (Total 2)** Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)** Syringe #6: **Saline Solution, Trays A & B (Total 2)** Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**		
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)		
Verify Expiration Date of Hydroxyzine		
Verify Drawing of syringes and disposal of remainder of Hydroxyzine		
Stand A and Stand B transported to Execution Room		
Execution Room secured		

5 simulated

TEAM WARDEN [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 8/27/2025

EXECUTION PHASE BEGINS	TIME	STM Number
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:44p	[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:58p	
Phase 1 Begins	6:00p	
Syringe 1 Etomidate	Begins 6:00p / Ends 6:01p	
Syringe 2 Etomidate	Begins 6:02p / Ends 6:03p	
Syringe 3 Saline Solution	Begins 6:03p / Ends 6:03p	
Phase 1 Ends	6:03p	
Team Warden checks for consciousness	6:03p	
Inmate medically checked for consciousness	6:04p	
Phase 2 Begins	6:04p	
Syringe 4 Rocuronium Bromide	Begins 6:04p / Ends 6:05p	
Syringe 5 Rocuronium Bromide	Begins 6:05p / Ends 6:06p	
Syringe 6 Saline Solution	Begins 6:06p / Ends 6:07p	
Phase 2 Ends	6:07p	
Phase 3 Begins	6:07p	
Syringe 7 Potassium Acetate — Medical advises Halted @ 6:07p	Begins 6:07p / Ends	
Syringe 8 Potassium Acetate	Begins / Ends	
Phase 3 Ends		
Sentence has been carried out	6:08p	
All materials/chemical mix disposed of according to State and Federal Law	6:11p	
CONTINGENCY LOG:		

2/21/2023 Removed diazepam and added Hydrozyzine

Observer: [redacted]
Date: 8/29/25
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30 PM	**Arrived Florida State Prison (Time)**	
N/A	Syringe fill begin	
N/A	Syringe fill complete	
N/A	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:57 PM	Inmate moved to chamber prep. Cell # Q1101	
N/A	Explanation of lethal injection procedures to inmate	
4:58 PM	Sedative offered to inmate	(Accepted)/Declined
5:25 PM	**Communication link established with EOG**	
5:36 PM	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:36 PM	Restraint process initiated	
5:38 PM	Restraint process continued	
5:40 PM		
5:40 PM	Restraint process completed	
5:41 PM	IV initiated L & R arm	
	IV placement continued	
5:42 PM	IV placement completed	
N/A	**Minister of Religion escorted into chamber**	
5:44 PM	5:46 PM 5:48 PM 5:50 PM 5:52 PM 5:54 PM 5:56 PM	
5:58 PM	IV final check by medical personnel	
5:59 PM		
6:00 PM	**Warden check with EOG for last minute stays**	
6:00 PM	Inmate final statement	(Rendered)/Declined
6:00 PM	**Warden authorizes Execution Phase One initiated**	
6:02 PM		
6:03 PM	Execution Phase One complete	
6:03 PM	**Check for unconsciousness by Warden**	
6:04 PM	Execution Phase Two initiated	
6:06 PM		
6:07 PM	Execution Phase Two complete	
6:07 PM	Execution Phase Three initiated	
		6:07 PM FLATLINE
N/A	Execution Phase Three complete	
6:08 PM	Check for cardiac activity by medical personnel	
6:08 PM	Medical Personnel notifies Warden time of death	
6:08 PM	**EOG notified of time of death**	
6:09 PM	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Observer: [redacted]
Date: 8/27/25
Location: Chem Room

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30	**Arrived Florida State Prison (Time)**	
	Syringe fill begin	
	Syringe fill complete	
	Inmate moved from death watch cell to shower	Shower Accepted/Declined
	Inmate moved to chamber prep. Cell # Q1101	
	Explanation of lethal injection procedures to inmate	
4:58	Sedative offered to inmate	Accepted/Declined
	Communication link established with EOG	
5:36	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:36	Restraint process initiated	
5:38	Restraint process continued	
5:40		
5:41	Restraint process completed	
5:41	IV initiated L & R arm	
5:43	IV placement continued	
5:43	IV placement completed	
N/A	**Minister of Religion escorted into chamber**	
5:44	IV final check by medical personnel	
5:46		
5:48	5:50, 5:52, 5:54, 5:56, 5:58	
6:00	**Warden check with EOG for last minute stays**	
6:00	Inmate final statement	(Rendered)/Declined
6:00	**Warden authorizes Execution Phase One initiated**	
6:02	6:03	
6:03	Execution Phase One complete	
6:04	**Check for unconsciousness by Warden**	
6:04	Execution Phase Two initiated	
6:06		
6:07	Execution Phase Two complete	
6:07	Execution Phase Three initiated	
6:09		
N/A	Execution Phase Three complete	
6:08	Check for cardiac activity by medical personnel	
6:08	Medical Personnel notifies Warden time of death	
6:08	**EOG notified of time of death**	
6:09	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number [redacted]

[redacted] 8/27/25

SIGNATURE DATE

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	1:02	N
		—	—
		1:55	N
		1:09	N
		1:51	N
		1:35	N
		1:04	N
		1:04	N
		1:40	N
		1:41	N
		1:04	N
		1:26	N
		—	—
		1:10	N
		1:05	N
		1:17	N
[redacted] 1:12 N		1:15	N
		1:03	N
TECHNICAL TEAM MEMBERS		1:50	N
		1:50	N
		—	—
		1:07	N
		1:47	N
		1:50	N
		4:55	N
		4:55	N
		—	—
EXECUTIONERS		4:45	N
		4:45	N
		—	—

TEAM WARDEN [redacted]

DATE 8/27/25

Revised 12/13/18

Name: Pradio

DC#: 1

Inmate's Last Statement

I'm not guilty

Date: 8/27/25

Recorded by [redacted]

EXHIBIT 3

OFFICIAL WITNESS SIGN-IN

INMATE NAME: PITTMAN, David
DC#: 351997
DATE OF EXECUTION: September 17, 2025
TIME: 6:00 PM

	NAME	SIGNATURE
1	Brandi Manley	[redacted]
2	Rochelle Kemple	
3	Lisa Kinard	
[redacted]		
		Not Present
20	Holly Hodgson	[redacted]
21	Amanda Rewis	
22	Scottie Pleasant	
[redacted]		Not Present
24	Chatlie Childs	[redacted]
25	John LoBianco	

EXECUTION PREPARATIONS CHECKLIST

TEAM WARDEN

EXECUTION PREPARATIONS	DATE	TIME
Receipt of Warrant from Institutional Warden	8/15/25	5:35pm
Advised of Execution Scheduled For David J. Pittman #351997 By Institutional Warden	8/15/25	4:15pm
Selection of Executioners	8/15/25	4:30pm
• Provided Executioners with copy of procedure	8/15/25	4:30pm
• Explained to Executioners respective duties/responsibilities	8/15/25	4:30pm
• Explained to Executioners training will occur	8/15/25	4:30pm
• Designate Executioners as Primary and Secondary	8/15/25	4:30pm
Ensure purchase/ maintenance of chemicals by assigned team member	8/27/25	1:30pm
Approximately one (1) week prior to Execution, Team Warden designates execution team members to:	9/11/25	9:00am
• Review of Inmate Medical File	9/11/25	9:00am
• Limited Physical Examination	9/11/25	9:10am
• Execution Team Members report findings to Team Warden	9/11/25	9:20am
Review of examination/confer with designated team members, the Team Warden shall conclude the more suitable method of venous access	9/11/25	9:45am
Contingency Log:		

TEAM WARDEN [redacted] **DATE** 9/17/25

EXECUTION CHECKLIST

INMATE NAME David J. Pittman **NUMBER** 351997 **DATE:** 9/17/2025

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:45	[redacted]		
Arrive on site	1:58			
Telephone check	1:57			
Obtain keys/Key check/Key log	2:02			
Public Address System check	2:03			
Radio check/Radio accountability	2:04			
Visual Monitor/Video Equipment Check	2:04			
Confirm cell phones are on vibrate/silenced	2:04			
Equipment bag check	2:06			
Suit/Undergarments present	2:00			
Shower supplies	1:59			
Search shower	1:59			
Search holding cell	1:58			
Ensure sheets pressed and several back-ups	2:02			
Ensure IV Pole is on medical cart	2:03			
Checked Phase Light system	2:05			
Medical Equipment Check: Wireless Telemetry Monitors	2:06			
UPS for Wireless Telemetry Monitors	2:06			
Cardiac Monitors	2:06			
Cardiac Monitor Leads	2:06			
Drug test completed	4:45			
Verify checklist complete at this time: **Team Warden** [redacted]	5:58			
EXECUTION PR [redacted]	**TIME**	**RESPONSIBLE TEAM MEMBERS**	**CONTINGENCY LOG:**	**TIME**
Receive Inmate/Obtain log book	3:30	[redacted]		
Complete shower refused	3:45			
Secure in holding cell	4:00			
Issue clothing	5:01			
Explanation to inmate of lethal injection	3:30			

Revised 5/25/2021-added Minster of Religion entry and exit

Inmate offered injection for anxiety – one (1) hour prior	5:00	
Inmate accepted/declined injection for anxiety	5:00	
Open phone line with Governor's Office	5:28	
Read Warrant / Waived reading of the Warrant	3:45	
Restraints applied at holding cell	5:29	
Escorted to gurney	5:30	
Security Team Restraint process begun/completed	Begins: 5:30	Ends: 5:36
Technical Team process begun/completed. IV method utilized: Peripheral Femoral	Begins: 5:31	Ends: 5:41
Security Team and Technical Team depart execution chamber	5:42	
Official/Media Witnesses Entered and Secured in witness room	5:44	
Confirm Witnesses Secured in Witness Room	5:44	
Escort Minister of Religion into the execution chamber N/A	5:44	
Death Chamber Entrance Door Secured	5:42	
Verify checklist completed/Executioners Room ready to proceed:		
Team Warden [redacted]	5:56	
Curtain Opened	6:00	
Communication with Governor's Office reference any last stays	6:00	
Activate Public Address (PA) System	6:01	
Last statement	6:01	
Execution Phase Begins	6:01	
Deactivate Public Address (PA) System	6:01	
Initiate phases	6:01	
Physician pronounces death/Team Warden in agreement	6:12	
Notification that sentence has been carried out to Governor's Office	6:13	
Activate Public Address (PA) System	6:13	
Notification that sentence has been carried out to witnesses	6:13	
Deactivate Public Address (PA) System	6:13	
Curtain Closes	6:16	
Official/Media Witnesses departed witness room	6:17	
Escort Minister of Religion out of execution chamber N/A		
Medical Team departs	6:19	
Body Removal Team	Enters: 6:16	Exits: 6:26
Debriefing		

[redacted]

9

Verified no Minister of Religion

Team Warden [redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME David J. Pittman **NUMBER** 351997 **DATE** 09/17/2025

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)	2:58	[redacted]
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)	2:58	
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals	2:59	
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix	2:59	
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)** Syringe #3: **Saline Solution, Trays A &B (Total 2)** Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)** Syringe #6: **Saline Solution, Trays A & B (Total 2)** Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**	3:03 3:19 3:11 3:19 3:17	
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)	3:20	
Verify Expiration Date of Hydroxyzine	3:21	
Verify Drawing of syringes and disposal of remainder of Hydroxyzine	3:21	
Stand A and Stand B transported to Execution Room	3:22	
Execution Room secured	3:22	

TEAM WARDEN [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 9/17/25

EXECUTION PHASE BEGINS	TIME	STM Number
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:43	[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:58	
Phase 1 Begins	6:01	
Syringe 1 Etomidate	Begins 6:01 / Ends 6:03	
Syringe 2 Etomidate	Begins 6:03 / Ends 6:04	
Syringe 3 Saline Solution	Begins 6:04 / Ends 6:05	
Phase 1 Ends	6:05	
Team Warden checks for consciousness	6:05	
Inmate medically checked for consciousness	6:05	
Phase 2 Begins	6:06	
Syringe 4 Rocuronium Bromide	Begins 6:06 / Ends 6:07	
Syringe 5 Rocuronium Bromide	Begins 6:07 / Ends 6:08	
Syringe 6 Saline Solution	Begins 6:08 / Ends 6:09	
Phase 2 Ends	6:09	
Phase 3 Begins	6:09	
Syringe 7 Potassium Acetate	Begins 6:09 / Ends	
Syringe 8 Potassium Acetate	Begins / Ends	
Phase 3 Ends	6:	
Sentence has been carried out	6:13	
All materials/chemical mix disposed of according to State and Federal Law	6:20	
CONTINGENCY LOG:		

medical advises of flat line @ 6:11 pm

2/21/2023 Removed diazepam and added Hydrozyzine

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	107	N
		113	N
		133	N
		114	N
		143	N
		114	N
		107	N
		113	N
		124	N
		131	N
		108	N
		116	N
[redacted]		119	N
		—	—
		114	N
		115	N
		120	N
		107	N
		118	N
		—	—
TECHNICAL TEAM MEMBERS		150	N
		135	N
		—	—
		108	N
		142	N
		150	N
		455	N
		455	N
		119	N
EXECUTIONERS		4:45	N
		4:45	N
		—	—

TEAM WARDEN [redacted]

DATE 9/17/25

Revised 12/13/18

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number
[redacted]

[redacted]

9/17/25

DATE

Name: David J. Pittman

DC#: 351997

Inmate's Last Statement

I know yall come to see an innocent man murdered by the state of Florida. I did not kill anyone, I'm innocent. That's it.

Date: 9.17.25

Recorded by: [redacted]

Name: David J. Pittman

DC#: 351997

Inmate's Last Statement

I know yall came to see .... I'm innocent I didn't kill anyone.

Date: 9/17/25

Recorded by [redacted]

Type: DAVID J. PITTMAN
Observer: [redacted]
Date: 9/17/2025
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30PM	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:58PM	Inmate moved to chamber prep. Cell # Q1101	
4:00 PM	Explanation of lethal injection procedures to inmate	5:30 PM – 5:45 PM 5:59PM
5:00 PM	Sedative offered to inmate	(Accepted)/Declined
5:28 PM	**Communication link established with EOG**	
5:30 PM	**Inmate moved to Death Chamber**	
5:30PM	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:30PM	Restraint process initiated	
5:32PM	Restraint process continued	
5:34PM		
5:36PM	Restraint process completed	
5:37 PM	IV initiated L & R arm	
5:39PM	IV placement continued	
5:39PM	IV placement completed	
5:41PM	5:43PM 5:45PM 5:47PM 5:49PM	5:51PM 5:53PM 5:55PM
N/A	**Minister of Religion escorted into chamber**	
5:57 PM	IV final check by medical personnel	
5:59PM		
6:00PM	**Warden check with EOG for last minute stays**	
6:01PM	Inmate final statement	(Rendered)/Declined
6:01PM	**Warden authorizes Execution Phase One initiated**	
6:03PM		
6:05PM	Execution Phase One complete	
6:05PM	**Check for unconsciousness by Warden**	
6:06PM	Execution Phase Two initiated	
6:08PM		
6:09PM	Execution Phase Two complete	
6:09PM	Execution Phase Three initiated	
6:11PM		6:11PM FLATLINE
~~6:13PM~~	Execution Phase Three complete N/O	
6:12PM	Check for cardiac activity by medical personnel	
6:12PM	Medical Personnel notifies Warden time of death	
6:13PM	**EOG notified of time of death**	
6:13PM	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Tyl DAVID ATKINS
Observer: [redacted]
Date: 9-17-25
Location: Injection Room

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1330	**Arrived Florida State Prison (Time)**	
1458	Syringe fill begin	
1521	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
N/O	Inmate moved to chamber prep. Cell # Q1101	
N/O	Explanation of lethal injection procedures to inmate	
N/O	Sedative offered to inmate	Accepted/Declined
N/O	**Communication link established with EOG**	
1730	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
1730	Restraint process initiated 1732	
1732	Restraint process continued	
1734		
1736		
1736	Restraint process completed	
1736	IV initiated L & R arm	
1738	IV placement continued	
1740	IV placement completed	
1742		
N/A	**Minister of Religion escorted into chamber**	
1744	1746, 1748, 1750, 1752, 1754, 1756	
1757	IV final check by medical personnel	
1759		
1800	**Warden check with EOG for last minute stays**	
1801	Inmate final statement	Rendered/Declined
1801	**Warden authorizes Execution Phase One initiated**	
1803		
1805	Execution Phase One complete	
1805	**Check for unconsciousness by Warden**	
1805	Execution Phase Two initiated	
1807		
1809	Execution Phase Two complete	
1809	Execution Phase Three initiated	
1811		
1811	Execution Phase Three complete	
1811	Check for cardiac activity by medical personnel	
1812	Medical Personnel notifies Warden time of death	TOD: 1812
1813	**EOG notified of time of death**	
1813	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

FLORIDA DEPARTMENT OF CORRECTIONS
HOUSING UNIT LOG

Florida State Prison
(INSTITUTION)

HOUSING UNIT Death Watch Cell-front Monitor David Pittman DC# 351997 **DATE** 9-17- 2025

TIME	LOG OF EVENTS	INITIALS
4:00 pm	Inmate placed in holding cell. [redacted] explaining the execution process.	[redacted]
4:15 pm	[redacted] speaking with inmate cell front.	
4:30 pm	[redacted] speaking with inmate cell front.	
4:45 pm	[redacted] speaking with inmate cell front.	
5:00 pm	Inmate offered and received sedative	
5:05 pm	Inmate changed into dress clothes.	
5:08 pm	[redacted] speaking with inmate cell front.	
5:15 pm	[redacted] speaking with inmate cell front	
5:29 pm	Inmate removed from holding cell and escorted to chamber	

Housing Sergeant Signature: [redacted]

Housing Officer Signature:

Each Correctional Officer and Correctional Officer Sergeant will make entry as to the time she/he assumed duties for the housing unit and the time relieved. Signature of the Housing Officer and Sergeant indicates that she/he has relieved the preceding shift, read the previous entries on the Housing Unit Log, and assumes the responsibility for any corrective action or follow-up action required. This log will be forwarded daily to the office of the Chief of Security at the conclusion of the Day Shift.

EXECUTION CHECKLIST

INMATE NAME Practice NUMBER 1 DATE: 9/16/2025

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER
All team members present	1:59	[redacted]
Arrive on site	2:06	
Telephone check	2:05	
Obtain keys/Key check/Key log	2:06	
Public Address System check	2:13	
Radio check/Radio accountability	2:20	
Visual Monitor/Video Equipment Check	2:10	
Confirm cell phones are on vibrate/silenced	2:08	
Equipment bag check	2:09	
Suit/Undergarments present	2:08	
Shower supplies	2:07	
Search shower	2:07	
Search holding cell	2:06	
Ensure sheets pressed and several back-ups	2:09	
Ensure IV Pole is on medical cart	2:15	
Checked Phase Light system	2:07	
Medical Equipment Check: Wireless Telemetry Monitors	2:11	
UPS for Wireless Telemetry Monitors	2:11	
Cardiac Monitors	2:11	
Cardiac Monitor Leads	2:11	
Drug test completed	4:45	
Verify checklist complete at this time:	5:58	
Team Warden [redacted]		

CONTINGENCY LOG:	TIME

EXECUTION P[redacted]ATION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS
Receive Inmate/Obtain log book	3:30	[redacted]
Complete shower	3:30	
Secure in holding cell	3:59	
Issue clothing	5:00	
Explanation to inmate of lethal injection	3:30	

CONTINGENCY LOG:	TIME
3:58 Restraint inmate — escort team secured compliant 3:59	

Revised 5/25/2021-added Minster of Religion entry and exit

Inmate offered injection for anxiety – one (1) hour prior	4:59	
Inmate accepted/declined injection for anxiety	4:59	
Open phone line with Governor's Office (SIM)	5:25	
Read Warrant – Waived reading of the Warrant	3:45	
Restraints applied at holding cell	5:35	
Escorted to gurney	5:35	
Security Team Restraint process begun/completed	Begins 5:36	Ends 5:42
Technical Team process begun/completed. IV method utilized: Peripheral Femoral	Begins 5:37	Ends 5:44
Security Team and Technical Team depart execution chamber	5:40	
Official/Media Witnesses Entered and Secured in witness room	5:45	
Confirm Witnesses Secured in Witness Room	5:45	
Escort Minister of Religion into the execution chamber N/A	5:47	
Death Chamber Entrance Door Secured	5:47	
Verify checklist completed/Executioners Room ready to proceed: **Team Warden** [redacted]	5:58	
Curtain Open	6:00	
Communicati[redacted]h Governor's Office reference any last stays	6:00	
Activate Public Address (PA) System	6:00	
Last statement	6:00	
Execution Phase Begins	6:01	
Deactivate Public Address (PA) System	6:01	
Initiate phases	6:01	
Physician pronounces death/Team Warden in agreement	6:09	
Notification that sentence has been carried out to Governor's Office	6:09	
Activate Public Address (PA) System	6:09	
Notification that sentence has been carried out to witnesses	6:09	
Deactivate Public Address (PA) System	6:09	
Curtain Closes	6:09	
Official/Media Witnesses departed witness room	6:15	
Escort Minister of Religion out of execution chamber N/A	N/A	
Medical Team departs	6:12	
Body Removal Team	Enters 6:10	Exits 6:12
Debriefing	6:20	

[redacted]

5:38 Combative inmate resisted restraints. Security team quickly gained compliance & applied leather restraints 5:38

Confirmed no MR

No minister

Team Warde[redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Tim-specific NUMBER _____ DATE 9/16/25

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)	2:20	[redacted]
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)	2:20	
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals		
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix		
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)** Syringe #3: **Saline Solution, Trays A &B (Total 2)** Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)** Syringe #6: **Saline Solution, Trays A & B (Total 2)** Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**	Seconds	
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)		
Verify Expiration Date of Hydroxyzine		
Verify Drawing of syringes and disposal of remainder of Hydroxyzine		
Stand A and Stand B transported to Execution Room	2:20	
Execution Room secured	2:25	

TEAM WARDEN [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 9/16/25

EXECUTION PHASE BEGINS	TIME		STM Number
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:47		[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	555		
Phase 1 Begins	6:00		
Syringe 1 Etomidate	Begins	Ends	
	6:00	6:01	
Syringe 2 Etomidate	Begins	Ends	
	6:02	6:03	
Syringe 3 Saline Solution	Begins	Ends	
	6:03	6:03	
Phase 1 Ends	6:03		
Team Warden checks for consciousness	6:04		
Inmate medically checked for consciousness	6:04		
Phase 2 Begins	6:04		
Syringe 4 Rocuronium Bromide	Begins	Ends	
	6:04	6:05	
Syringe 5 Rocuronium Bromide	Begins	Ends	
	6:05	6:07	
Syringe 6 Saline Solution	Begins	Ends	
	6:07		
Phase 2 Ends	6:07		
Phase 3 Begins	6:07		
Syringe 7 Potassium Acetate	Begins	Ends	
	6:07		
Syringe 8 Potassium Acetate	Begins	Ends	
Phase 3 Ends — medical action of flat line @ 6:08 pm			
Sentence has been carried out	6:09		
All materials/chemical mix disposed of according to State and Federal Law	Sim [illegible]		
CONTINGENCY LOG:			

2/21/2023 Removed diazepam and added Hydrozyzine

Observer: [redacted]
Date: 9/16/2025
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30 PM	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:58PM	Inmate moved to chamber prep. Cell # Q1101	
N/A	Explanation of lethal injection procedures to inmate	
4:59 PM	Sedative offered to inmate	Accepted/Declined
5:25 PM	**Communication link established with EOG**	
5:36 PM	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:36 PM	Restraint process initiated	
5:38 PM	Restraint process continued	
5:40 PM		
5:41 PM	Restraint process completed	
5:42 PM	IV initiated L & R arm	
	IV placement continued	
5:43 PM	IV placement completed	
5:45 PM	5:47 PM 5:49PM 5:51PM 5:53PM	5:55PM
N/A	**Minister of Religion escorted into chamber**	
5:57 PM	IV final check by medical personnel	
5:59 PM		
6:00 PM	**Warden check with EOG for last minute stays**	
6:00PM	Inmate final statement	Rendered/Declined
6:00 PM	**Warden authorizes Execution Phase One initiated**	
6:02PM		
6:03 PM	Execution Phase One complete	
6:04PM	**Check for unconsciousness by Warden**	
6:04 PM	Execution Phase Two initiated	
6:06PM		
6:07 PM	Execution Phase Two complete	
6:07 PM	Execution Phase Three initiated	6:08PM FLATLINE
N/A	Execution Phase Three complete	
6:08PM	Check for cardiac activity by medical personnel	
6:09PM	Medical Personnel notifies Warden time of death	
6:09 PM	**EOG notified of time of death**	
6:09PM	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Ty. Arnold
Observer: [redacted]
Date: 9-16-25
Location: Injection Room

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1330	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
N/O	Inmate moved to chamber prep. Cell # Q1101	
N/O	Explanation of lethal injection procedures to inmate	
N/O	Sedative offered to inmate	Accepted/Declined
N/O	**Communication link established with EOG**	
1736	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
1736	Restraint process initiated	
1738	Restraint process continued	
1740		
1741	Restraint process completed	
1742	IV initiated L & R arm	
1744	IV placement continued	
1744	IV placement completed	
1746	1748	
N/A	**Minister of Religion escorted into chamber**	
1750	1752, 1754, 1756	
1757	IV final check by medical personnel	
1759		
1800	**Warden check with EOG for last minute stays**	
1800	Inmate final statement	Rendered/Declined
1800	**Warden authorizes Execution Phase One initiated**	
1802		
1804	Execution Phase One complete	
1804	**Check for unconsciousness by Warden**	
1804	Execution Phase Two initiated	
1806		
1807	Execution Phase Two complete	
1807	Execution Phase Three initiated	
1808	Execution Phase Three complete	FLAT LINE.
1808	Check for cardiac activity by medical personnel	
1809	Medical Personnel notifies Warden time of death	TOD: 1809
1809	**EOG notified of time of death**	
1809	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number

[redacted]

9/16/25

DATE

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	1114	N
		1115	N
		1118	N
		1118	N
		1140	N
		1137	N
		1114	N
		1116	N
		1130	N
		1132	N
		1114	N
		1116	N
[redacted]		1128	N
		—	—
		1113	N
		1120	N
		1129	N
		1115	N
TECHNICAL TEAM MEMBERS		1145	N
		1140	N
		—	—
		1114	N
		1150	N
		1145	N
		1450	N
		1450	N
		1128	N
EXECUTIONERS		1445	N
		1445	N

TEAM WARDE [redacted]

DATE 9/16/25

Revised 12/13/18

Name: Practice

DC#: 1

Inmate's Last Statement

I'm not guilty

Date: 9/16/25

Recorded b [redacted]

EXHIBIT 4

OFFICIAL WITNESS SIGN-IN

INMATE NAME: JONES, Victor Tony
DC#: 420481
DATE OF EXECUTION: September 30, 2025
TIME: 6:00 PM

	NAME	SIGNATURE
1	Rochelle Kemple	[redacted]
2	Lisa Kinard	
3	Erik Howard	
[redacted]		
10	Myran Piggot	
11	Hollie Hodgson	
12	Amanda Rewis	
13	Scottie Pleasant	
[redacted]		Not in Attendance
15	Kellie Williams	[redacted]
16	Suzanne Keffer	
17	Chatile Moore	
18	Gregory Whitney	
19	Heather Clower	
20	Veronica Perkins	
21	Kayla Hettich	

EXECUTION PREPARATIONS CHECKLIST

TEAM WARDEN

EXECUTION PREPARATIONS	DATE	TIME
Receipt of Warrant from Institutional Warden	8/29/25	
Advised of Execution Scheduled For Victor T. Jones #420481 By Institutional Warden	8/29/25	12:15pm
Selection of Executioners	8/29/25	1:30pm
• Provided Executioners with copy of procedure	8/29/25	1:30pm
• Explained to Executioners respective duties/responsibilities	8/29/25	1:30pm
• Explained to Executioners training will occur	8/29/25	1:30pm
• Designate Executioners as Primary and Secondary	8/29/25	1:30pm
Ensure purchase/ maintenance of chemicals by assigned team member	8/27/25	1:30pm
Approximately one (1) week prior to Execution, Team Warden designates execution team members to:	9/23/25	9:00am
• Review of Inmate Medical File	9/23/25	9:00am
• Limited Physical Examination	9/23/25	9:00am
• Execution Team Members report findings to Team Warden	9/23/25	9:00am
Review of examination/confer with designated team members, the Team Warden shall conclude the more suitable method of venous access	9/23/25	9:45am
Contingency Log:		

TEAM WARDEN [redacted] DATE 9/30/25

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Victor T. Jones NUMBER 420481 DATE 9/30/2025

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)	2:59	[redacted]
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)	2:59	
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals	3:00	
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix	3:00	
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)**	3:03 3:08	
Syringe #3: **Saline Solution, Trays A &B (Total 2)**	3:11	
Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)**	3:18	
Syringe #6: **Saline Solution, Trays A & B (Total 2)**	3:16	
Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**	3:19	
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)	3:20	
Verify Expiration Date of Hydroxyzine	3:20	
Verify Drawing of syringes and disposal of remainder of Hydroxyzine	3:21	
Stand A and Stand B transported to Execution Room	3:21	
Execution Room secured		

TEAM WARDEN [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 9/30/25

EXECUTION PHASE BEGINS	TIME		STM Number
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:53		[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:58		
Phase 1 Begins	6:02		
Syringe 1 Etomidate	Begins	Ends	
	6:02	6:03	
Syringe 2 Etomidate	Begins	Ends	
	6:03	6:04	
Syringe 3 Saline Solution	Begins	Ends	
	6:04	6:05	
Phase 1 Ends	6:05		
Team Warden checks for consciousness	6:05		
Inmate medically checked for consciousness	6:05		
Phase 2 Begins	6:05		
Syringe 4 Rocuronium Bromide	Begins	Ends	
	6:05	6:06	
Syringe 5 Rocuronium Bromide	Begins	Ends	
	6:06	6:08	
Syringe 6 Saline Solution	Begins	Ends	
	6:08	6:08	
Phase 2 Ends	6:08		
Phase 3 Begins	6:08		
Syringe 7 Potassium Acetate	Begins	Ends	
	6:08	6:10	
Syringe 8 Potassium Acetate needed redraw Pint line @ 6:11pm	Begins	Ends	
	6:10		
Phase 3 Ends			
Sentence has been carried out	6:13		
All materials/chemical mix disposed of according to State and Federal Law	6:20		
CONTINGENCY LOG:			

2/21/2023 Removed diazepam and added Hydrozyzine

EXECUTION CHECKLIST

INMATE NAME Victor T. Jones **NUMBER** 420481 **DATE:** 9/30/2025

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:45	[redacted]		
Arrive on site	1:58			
Telephone check	1:58			
Obtain keys/Key check/Key log	2:00			
Public Address System check	2:04			
Radio check/Radio accountability	2:07			
Visual Monitor/Video Equipment Check	2:00			
Confirm cell phones are on vibrate/silenced	2:03			
Equipment bag check	2:08			
Suit/Undergarments present	1:59			
Shower supplies	2:00			
Search shower	2:00			
Search holding cell	2:00			
Ensure sheets pressed and several back-ups	2:08			
Ensure IV Pole is on medical cart	2:09			
Checked Phase Light system	2:07			
Medical Equipment Check: Wireless Telemetry Monitors	2:09			
UPS for Wireless Telemetry Monitors	2:09			
Cardiac Monitors	2:09			
Cardiac Monitor Leads	2:09			
Drug test completed	4:53			
Verify checklist complete at this time: **Team Warden** [redacted]	5:56			

EXECUTION PREPARATION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS	CONTINGENCY LOG:	TIME
Receive Inmate/Obtain log book	3:30	[redacted]		
Complete shower	refused			
Secure in holding cell	3:59			
Issue clothing	5:01			
Explanation to inmate of lethal injection	3:30			

Revised 5/25/2021-added Minster of Religion entry and exit/08212025 Extra signature space

Inmate offered injection for anxiety – one (1) hour prior	4:59	
Inmate accepted/declined injection for anxiety	5:00	
Open phone line with Governor's Office	5:26	
Read Warrant – Waived reading of the Warrant	5:45	
Restraints applied at holding cell	5:27	
Escorted to gurney	5:28	
Security Team Restraint process begun/completed	Begins 5:28	Ends 5:35
Technical Team process begun/completed. IV method utilized: Peripheral Femoral	Begins 5:29	Ends 5:53
Security Team and Technical Team depart execution chamber	5:56	
Official/Media Witnesses Entered and Secured in witness room	5:44	
Confirm Witnesses Secured in Witness Room	5:45	
Escort Minister of Religion into the execution chamber	NA	
Death Chamber Entrance Door Secured	5:58	
Verify checklist completed/Executioners Room ready to proceed: **Team Warden** [redacted]	5:56	
Curtain Opened	6:00	
Communication with Governor's Office reference any last stays	6:00	
Activate Public Address (PA) System	6:01	
Last statement	6:01	
Execution Phase Begins	6:02	
Deactivate Public Address (PA) System	6:02	
Initiate phases	6:02	
Physician pronounces death/Team Warden in agreement	6:13	
Notification that sentence has been carried out to Governor's Office	6:13	
Activate Public Address (PA) System	6:13	
Notification that sentence has been carried out to witnesses	6:13	
Deactivate Public Address (PA) System	6:13	
Curtain Closes	6:13	
Official/Media Witnesses departed witness room	6:17	
Escort Minister of Religion out of execution chamber	NA	
Medical Team departs	6:19	
Body Removal Team	Enters 6:17	Exits 6:25
Debriefing	6:30	

[redacted]

eam Warden [redacted]

Type: [illegible] JONES
Observer: [redacted]
Date: 9-30-25
Location: Inj. Room

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1330	**Arrived Florida State Prison (Time)**	
1500	Syringe fill begin	
1520	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
N/O	Inmate moved to chamber prep. Cell # Q1101	
N/O	Explanation of lethal injection procedures to inmate	
N/O	Sedative offered to inmate	Accepted/Declined
N/O	**Communication link established with EOG**	
1728	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
1728	Restraint process initiated	
1730	Restraint process continued	
1732		
1734	Restraint process completed	
1734	IV initiated L & R arm	
1736	IV placement continued	
1738	1740, 1742, 1744, 1746, 1748, 1750	
1752	IV placement completed	
1754	1756	
N/O	**Minister of Religion escorted into chamber**	
1757	IV final check by medical personnel	
1759		
1800	**Warden check with EOG for last minute stays**	
1801	Inmate final statement	Rendered/(Declined)
1802	**Warden authorizes Execution Phase One initiated**	
1804		
1805	Execution Phase One complete	
1805	**Check for unconsciousness by Warden**	
1805	Execution Phase Two initiated	
1807		
1808	Execution Phase Two complete	
1808	Execution Phase Three initiated	
1810		
1811	Execution Phase Three complete	FLATLINE
1811	Check for cardiac activity by medical personnel	
1813	Medical Personnel notifies Warden time of death	TOD: 1813
1813	**EOG notified of time of death**	
1813	**Death pronounced and announced by Warden**	
N/O	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Type: VICTOR T. JONES
Observer: [redacted]
Date: 9/30/2025
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30PM	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:58PM	Inmate moved to chamber prep. Cell # Q1101	
4:36PM	Explanation of lethal injection procedures to inmate	5:28PM - 5:30PM 5:58PM
5:00PM	Sedative offered to inmate	Accepted/Declined
5:21PM	**Communication link established with EOG**	
5:28PM	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:28PM	Restraint process initiated	
5:30PM	Restraint process continued	
5:32PM		
5:34PM		
5:34PM	Restraint process completed	
5:36PM		
5:37PM	IV initiated L & R arm	
5:39PM	IV placement continued	
5:41PM	5:43PM 5:45PM 5:47PM 5:49PM	
5:50PM	IV placement completed	
N/A	**Minister of Religion escorted into chamber**	
5:52PM	5:54PM	
5:56PM	IV final check by medical personnel	
5:58PM		
6:00PM	**Warden check with EOG for last minute stays**	
6:01PM	Inmate final statement	Rendered/Declined
6:01PM	**Warden authorizes Execution Phase One initiated**	
6:03PM		
6:05PM	Execution Phase One complete	
6:05PM	**Check for unconsciousness by Warden**	
6:05PM	Execution Phase Two initiated	
6:07PM		
6:08PM	Execution Phase Two complete	
6:09PM	Execution Phase Three initiated	
6:11PM		6:11 PM FLATLINE
N/A	Execution Phase Three complete	
6:11PM	Check for cardiac activity by medical personnel	
6:13PM	Medical Personnel notifies Warden time of death	
6:13PM	**EOG notified of time of death**	
6:13PM	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

FLORIDA DEPARTMENT OF CORRECTIONS
HOUSING UNIT LOG

Florida State Prison
(INSTITUTION)

HOUSING UNIT Victor Jones DC# 420481 Death Watch Cell-front Monitor **DATE** 9-30- 2025

TIME	LOG OF EVENTS	INITIALS
3:59 PM	Inmate placed in holding cell. [redacted] explaining the execution process	[redacted]
4:15 PM	[redacted] speaking with inmate cell front	
4:19 PM	[redacted] speaking with inmate cell front.	
4:30 PM	[redacted] speaking with inmate cell front.	
4:45 PM	[redacted] speaking with inmate cell front.	
5:00 PM	Inmate offered and received the Sedative	
5:04 PM	Inmate using the restroom	
5:05 PM	Inmate changed into dress clothes	
5:15 PM	Inmate sitting quietly on bunk.	
5:21 PM	Inmate asked the [redacted] for a small cup of water.	
5:22 PM	[redacted] gave inmate a bottle of water.	
5:27 PM	Inmate removed from holding cell and escorted to Chamber	

Housing Sergeant Signature:

Housing Officer Signature:

Each Correctional Officer and Correctional Officer Sergeant will make entry as to the time she/he assumed duties for the housing unit and the time relieved. Signature of the Housing Officer and Sergeant indicates that she/he has relieved the preceding shift, read the previous entries on the Housing Unit Log, and assumes the responsibility for any corrective action or follow-up action required. This log will be forwarded daily to the office of the Chief of Security at the conclusion of the Day Shift.

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number [redacted]

[redacted]

9/30/25

DATE

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	103	N
		110	N
		140	N
		105	N
		136	N
		—	—
		105	N
		106	N
		122	N
		120	N
		109	N
		105	N
		124	N
		105	N
		110	N
		—	—
		107	N
		103	N
TECHNICAL TEAM MEMBERS		142	N
		127	N
		148	N
		106	N
		146	N
		142	N
		450	N
		450	N
		124	N
EXECUTIONERS		448	N
		446	N
		—	—

TEAM WARDEN [redacted]

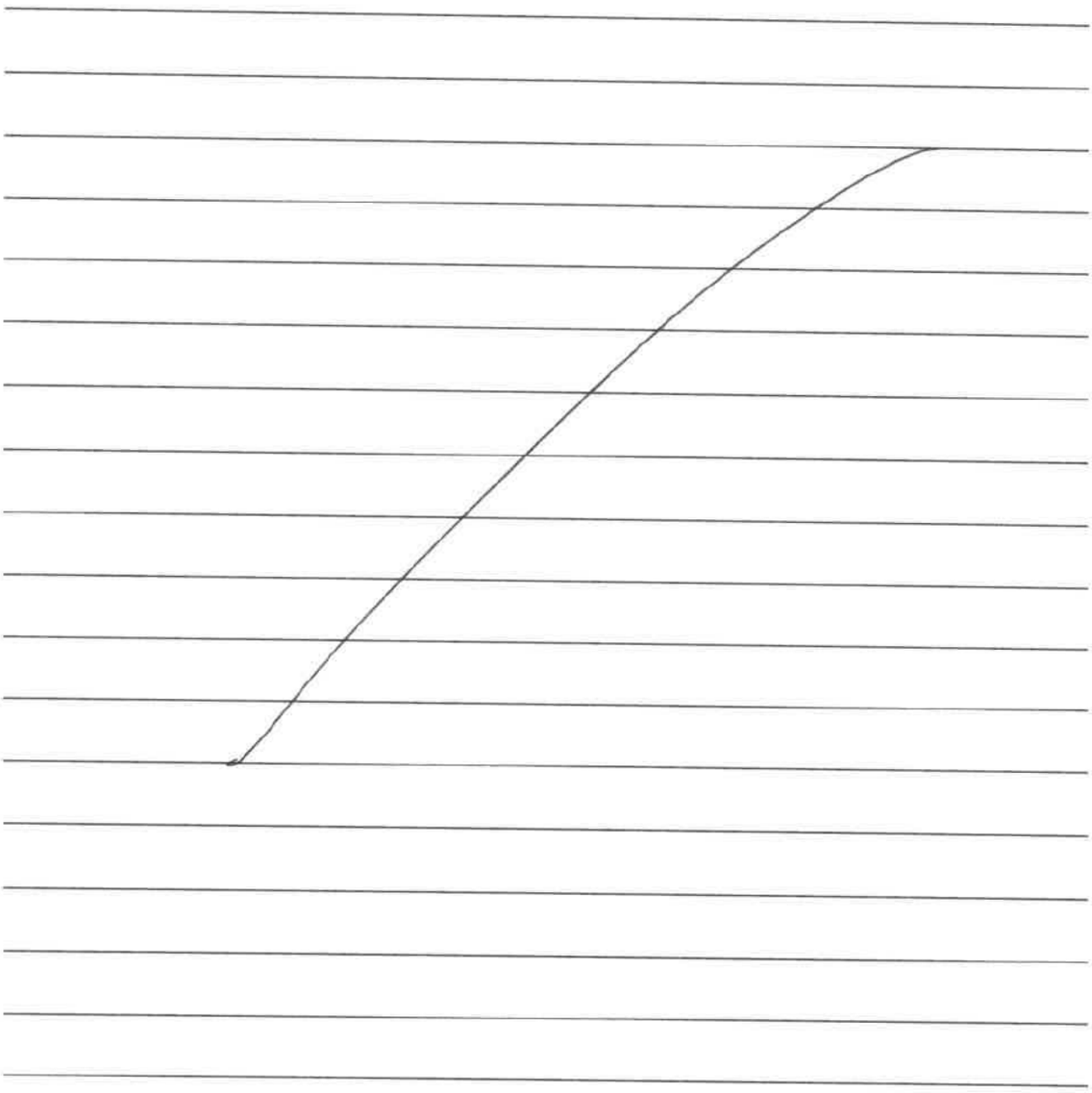
DATE 9/30/25

Revised 12/13/18

Name: Victor T. Jones

DC#: 480481

Inmate's Last Statement



Date: 9.30.25

Recorded by: [redacted]

EXECUTION CHECKLIST

INMATE NAME Practice NUMBER _____ DATE: 9.29.25

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:55	[redacted]		
Arrive on site	2:00			
Telephone check	2:03			
Obtain keys/Key check/Key log	2:02			
Public Address System check	2:07			
Radio check/Radio accountability	2:08			
Visual Monitor/Video Equipment Check	2:06			
Confirm cell phones are on vibrate/silenced	2:07			
Equipment bag check	2:09			
Suit/Undergarments present	2:05			
Shower supplies	2:04			
Search shower	2:03			
Search holding cell	2:04			
Ensure sheets pressed and several back-ups	2:10			
Ensure IV Pole is on medical cart	2:12			
Checked Phase Light system	2:10			
Medical Equipment Check: Wireless Telemetry Monitors	2:15			
UPS for Wireless Telemetry Monitors	2:15			
Cardiac Monitors	2:15			
Cardiac Monitor Leads	2:15			
Drug test completed	4:56			
Verify checklist complete at this time: **Team Warden** [redacted]	5:58			

EXECUTION PREPARATION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS	CONTINGENCY LOG:	TIME
Receive Inmate/Obtain log book	4:00	[redacted]		
Complete shower refused	sim			
Secure in holding cell	4:00			
Issue clothing	5:01			
Explanation to inmate of lethal injection	3:30			

Revised 5/25/2021-added Minster of Religion entry and exit/08212025 Extra signature space

Inmate offered injection for anxiety – one (1) hour prior	5:00	
Inmate accepted/declined injection for anxiety	5:00	
Open phone line with Governor's Office	5:30	
Read Warrant – Waived reading of the Warrant	5:30	
Restraints applied at holding cell	5:31	
Escorted to gurney	5:32	
Security Team Restraint process begun/completed	Begins 5:33	Ends 5:41
Technical Team process begun/completed. IV method utilized: Peripheral Femoral	Begins 5:34	Ends 5:42
Security Team and Technical Team depart execution chamber	5:42	
Official/Media Witnesses Entered and Secured in witness room	5:45	
Confirm Witnesses Secured in Witness Room	5:45	
Escort Minister of Religion into the execution chamber	NA	
Death Chamber Entrance Door Secured	5:43	
Verify checklist completed/Executioners Room ready to proceed: **Team Warden** [redacted]	5:58	
Curtain Opened	6:00	
Communication with Governor's Office reference any last stays	6:00	
Activate Public Address (PA) System	6:00	
Last statement	6:00	
Execution Phase Begins	6:00	
Deactivate Public Address (PA) System	6:00	
Initiate phases	6:00	
Physician pronounces death/Team Warden in agreement	6:08	
Notification that sentence has been carried out to Governor's Office	6:09	
Activate Public Address (PA) System	6:09	
Notification that sentence has been carried out to witnesses	6:09	
Deactivate Public Address (PA) System	6:09	
Curtain Closes	6:09	
Official/Media Witnesses departed witness room	6:11	
Escort Minister of Religion out of execution chamber	NA	
Medical Team departs	6:12	
Body Removal Team	Enters 6:10	Exits 6:12
Debriefing		

[redacted]

Team Warden [redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Tina Spirfi NUMBER _____ DATE 9/29/25

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)	2:12	[redacted]
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)	2:12	
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals		
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix		
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)** Syringe #3: **Saline Solution, Trays A &B (Total 2)** Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)** Syringe #6: **Saline Solution, Trays A & B (Total 2)** Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**		
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)		
Verify Expiration Date of Hydroxyzine		
Verify Drawing of syringes and disposal of remainder of Hydroxyzine		
Stand A and Stand B transported to Execution Room	2:12	
Execution Room secured	2:13	

TEAM WARDEN [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 9/29/25

EXECUTION PHASE BEGINS	TIME		STM Number
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:42		[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:58		
Phase 1 Begins	6:00		
Syringe 1 Etomidate	Begins	Ends	
	6:00	6:01	
Syringe 2 Etomidate	Begins	Ends	
	6:01	6:03	
Syringe 3 Saline Solution	Begins	Ends	
	6:03	6:03	
Phase 1 Ends	6:03		
Team Warden checks for consciousness	6:03		
Inmate medically checked for consciousness	6:03		
Phase 2 Begins	6:04		
Syringe 4 Rocuronium Bromide	Begins	Ends	
	6:04	6:05	
Syringe 5 Rocuronium Bromide	Begins	Ends	
	6:05	6:06	
Syringe 6 Saline Solution	Begins	Ends	
	6:06		
Phase 2 Ends	6:07		
Phase 3 Begins	6:07		
Syringe 7 Potassium Acetate	Begins	Ends	
	6:07		
Syringe 8 Potassium Acetate	Begins	Ends	
Phase 3 Ends Medical witness of flat line @ 6:07			
Sentence has been carried out			
All materials/chemical mix disposed of according to State and Federal Law			
CONTINGENCY LOG:			

2/21/2023 Removed diazepam and added Hydrozyzine

Observer: [redacted]
Date: 9-29-25
Location: INJ. Room

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1330	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
N/O	Inmate moved to chamber prep. Cell # Q1101	
N/O	Explanation of lethal injection procedures to inmate	
N/O	Sedative offered to inmate	Accepted/Declined
N/O	**Communication link established with EOG**	
1733 ~~N/O~~	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
1733	Restraint process initiated	
1735	Restraint process continued	
1737		
1738	Restraint process completed	
1738	IV initiated L & R arm	
	IV placement continued	
1740	IV placement completed	
1742	1744, 1746, 1748, 1750	
N/O	**Minister of Religion escorted into chamber**	
1752	1754, 1756	
1757	IV final check by medical personnel	
1759		
1800	**Warden check with EOG for last minute stays**	
1800	Inmate final statement	(Rendered)/Declined
1800	**Warden authorizes Execution Phase One initiated**	
1802		
1803	Execution Phase One complete	
1803	**Check for unconsciousness by Warden**	
1804	Execution Phase Two initiated	
1806		
1807	Execution Phase Two complete	
1807	Execution Phase Three initiated	
1807	Execution Phase Three complete	FLAT LINE.
1808	Check for cardiac activity by medical personnel	
1808	Medical Personnel notifies Warden time of death	TOD: 1808
1809	**EOG notified of time of death**	
1809	**Death pronounced and announced by Warden**	
N/O	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Observer: [redacted]
Date: 9/29/2025
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30PM	Arrived Florida State Prison (Time)	
N/A	Syringe fill begin	
N/A	Syringe fill complete	
N/A	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:58P	Inmate moved to chamber prep. Cell # Q1101	
N/A	Explanation of lethal injection procedures to inmate	
4:59PM	Sedative offered to inmate	Accepted/Declined
5:25PM	Communication link established with EOG	
5:33 PM	Inmate moved to Death Chamber	
**********	BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:33PM	Restraint process initiated	
5:35PM	Restraint process continued	
5:37PM		
5:38PM	Restraint process completed	
5:39PM	IV initiated L & R arm	
	IV placement continued	
5:40PM	IV placement completed	
5:42 PM	5:44PM 5:46PM 5:48PM 5:50PM	5:52PM 5:54PM
N/A	Minister of Religion escorted into chamber	
5:56PM		
5:57PM	IV final check by medical personnel	
5:59PM		
6:00PM	Warden check with EOG for last minute stays	
6:00PM	Inmate final statement	Rendered/Declined
6:00PM	Warden authorizes Execution Phase One initiated	
6:02PM		
6:03PM	Execution Phase One complete	
6:03PM	Check for unconsciousness by Warden	
6:04PM	Execution Phase Two initiated	
6:06PM		
6:07PM	Execution Phase Two complete	
6:07PM	Execution Phase Three initiated	6:07 PM FLATLINE
N/A	Execution Phase Three complete	
6:08PM	Check for cardiac activity by medical personnel	
6:08PM	Medical Personnel notifies Warden time of death	
6:09PM	EOG notified of time of death	
6:09PM	Death pronounced and announced by Warden	
N/A	Minister of Religion escorted from chamber	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number [redacted]

[redacted]

9/29/25

DATE

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	109	N
		109	N
		128	N
		117	N
		138	N
		—	—
		109	N
		110	N
		122	N
		130	N
		113	N
		115	N
		129	N
		115	N
		113	N
		—	—
		110	N
		110	N
		—	—
		—	—
TECHNICAL TEAM MEMBERS		141	N
		139	N
		152	N
		109	N
		145	N
		142	N
		455	N
		455	N
		130	N
EXECUTIONERS		447	N
		447	N
		—	—

TEAM WARDEN [redacted]

DATE 9/29/25

Revised 12/13/18

EXHIBIT 5

OFFICIAL WITNESS SIGN-IN

INMATE NAME: SMITHERS, Samuel
DC#: 124639
DATE OF EXECUTION: October 14, 2025
TIME: 6:00 PM

	NAME	SIGNATURE
[redacted]		
2	Lisa Kinard	
3	Jay Arnold	
4	Leda Kelly	
[redacted]		
6	Hollie Hodgson	
7	Amanda Rewis	
8	Scottie Pleasant	
9	Lasonica Lockridge	
10	Kellie Williams	
11	Emma Perron	
12	Jordan Stark	
13	Lisa Tyre	
14	Mike Kelly	
15	Mary Rose Vanderveur	
16	John Blitch	
17	Kri Oberschlake	
18	Jeremy King	
19	Melody Jacquay-Acosta	
20	Chatlie Moore	
[redacted]		

EXECUTION CHECKLIST

INMATE NAME Samuel Smithers **NUMBER** 124639 **DATE:** 10/14/2025

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:47	[redacted]		
Arrive on site	2:00			
Telephone check	2:07			
Obtain keys/Key check/Key log	2:00			
Public Address System check	2:07			
Radio check/Radio accountability	2:13			
Visual Monitor/Video Equipment Check	2:06			
Confirm cell phones are on vibrate/silenced	2:07			
Equipment bag check	2:11			
Suit/Undergarments present	2:04			
Shower supplies	2:05			
Search shower	2:09			
Search holding cell	2:04			
Ensure sheets pressed and several back-ups	2:10			
Ensure IV Pole is on medical cart	2:09			
Checked Phase Light system	2:07			
Medical Equipment Check: Wireless Telemetry Monitors	2:08			
UPS for Wireless Telemetry Monitors	2:08			
Cardiac Monitors	2:08			
Cardiac Monitor Leads	2:09			
Drug test completed	4:50			
Verify checklist complete at this time: [redacted] **Team Warden**	5:58	[redacted]		

EXECUTION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS	CONTINGENCY LOG:	TIME
Receive Inmate/Obtain log book	3:30	[redacted]		
Complete shower refused	3:45			
Secure in holding cell	4:00			
Issue clothing	5:02			
Explanation to inmate of lethal injection	5:01			

Revised 5/25/2021-added Minster of Religion entry and exit/08212025 Extra signature space

Inmate offered injection for anxiety – one (1) hour prior	5:00		
Inmate accepted/declined injection for anxiety	5:00		
Open phone line with Governor's Office	5:25		
Read Warrant – Waived reading of the Warrant	4:02		
Restraints applied at holding cell	5:28		
Escorted to gurney	5:29		
Security Team Restraint process begun/completed	Begins 5:29	Ends 5:34	
Technical Team process begun/completed. IV method utilized: Peripheral Femoral	Begins 5:31	Ends 5:38	
Security Team and Technical Team depart execution chamber	5:39		
Official/Media Witnesses Entered and Secured in witness room	5:44		
Confirm Witnesses Secured in Witness Room	5:41		
Escort Minister of Religion into the execution chamber N/A	5:40		Confirmed no Minister of Religion
Death Chamber Entrance Door Secured	5:40		
Verify checklist completed/Executioners Room ready to proceed: **Team Warden** [redacted]	5:28		
Curtain Opened	6:00		
Communication with Governor's Office reference any last stays	6:00		
Activate Public Address (PA) System	6:01		
Last statement	6:01		
Execution Phase Begins	6:02		
Deactivate Public Address (PA) System	6:02		
Initiate phases	6:02		
Physician pronounces death/Team Warden in agreement	6:15		
Notification that sentence has been carried out to Governor's Office	6:15		
Activate Public Address (PA) System	6:15		
Notification that sentence has been carried out to witnesses	6:15		
Deactivate Public Address (PA) System	6:15		
Curtain Closes	6:15		
Official/Media Witnesses departed witness room	6:18		
Escort Minister of Religion out of execution chamber	N/A		NO Minister of Religion
Medical Team departs	6:19		
Body Removal Team	Enters 6:18	Exits 6:24	
Debriefing	6:35		Team Warden [redacted]

[redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Samuel Smithers **NUMBER** 123639 **DATE** 10/14/2025

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)	2:55	[redacted]
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)	2:55	
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals	3:00	
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix	3:00	
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)**	3:05	
Syringe #3: **Saline Solution, Trays A &B (Total 2)**	3:20	
Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)**	3:13	
Syringe #6: **Saline Solution, Trays A & B (Total 2)**	3:22	
Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**	3:19	
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)	3:22	
Verify Expiration Date of Hydroxyzine	3:24	
Verify Drawing of syringes and disposal of remainder of Hydroxyzine	3:24	
Stand A and Stand B transported to Execution Room	3:26	
Execution Room secured	3:26	

TEAM WARDE [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

DATE: 10/14/25

EXECUTION PHASE BEGINS	**TIME**	**STM Number**
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:38	[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:58	
Phase 1 Begins	6:02	
Syringe 1 Etomidate	Begins 6:02 / Ends 6:03	
Syringe 2 Etomidate	Begins 6:03 / Ends 6:05	
Syringe 3 Saline Solution	Begins 6:05 / Ends	
Phase 1 Ends	6:06	
Team Warden checks for consciousness	6:06	
Inmate medically checked for consciousness	6:06	
Phase 2 Begins	6:06	
Syringe 4 Rocuronium Bromide	Begins 6:06 / Ends 6:08	
Syringe 5 Rocuronium Bromide	Begins 6:08 / Ends 6:10	
Syringe 6 Saline Solution	Begins 6:10 / Ends	
Phase 2 Ends	6:10	
Phase 3 Begins	6:10	
Syringe 7 Potassium Acetate	Begins 6:10 / Ends 6:13	
Syringe 8 Potassium Acetate medical advises 1st Line 6:14	Begins 6:13 / Ends	
Phase 3 Ends		
Sentence has been carried out	6:15	
All materials/chemical mix disposed of according to State and Federal Law	6:20	
CONTINGENCY LOG:		

2/21/2023 Removed Diazepam and added Hydroxyzine

Type: SAMUEL SMITHERS
Observer: [redacted]
Date: 10/14/25
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30 PM	**Arrived Florida State Prison (Time)**	
N/O	Syringe fill begin	
N/O	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:58PM	Inmate moved to chamber prep. Cell # Q1101	
4:00PM	Explanation of lethal injection procedures to inmate	5:28PM-5:40PM 5:56PM-6:00PM
5:00PM	Sedative offered to inmate	Accepted/Declined
5:25 PM	**Communication link established with EOG**	
5:28 PM	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:28PM	Restraint process initiated	
5:30PM	Restraint process continued	
5:32PM		
5:34PM	Restraint process completed	
5:35PM	IV initiated L & R arm	
	IV placement continued	
5:37 PM	IV placement completed	
5:39PM	5:41PM 5:43PM 5:45PM 5:47PM 5:49PM	
N/A	**Minister of Religion escorted into chamber**	
5:51 PM	5:53PM 5:55PM	
5:57 PM	IV final check by medical personnel	
5:59PM		
6:00 PM	**Warden check with EOG for last minute stays**	
6:01 PM	Inmate final statement	Rendered/Declined
6:02PM	**Warden authorizes Execution Phase One initiated**	
6:04 PM		
6:06 PM	Execution Phase One complete	
6:06 PM	**Check for unconsciousness by Warden**	
6:06PM	Execution Phase Two initiated	
6:08PM		
6:10 PM	Execution Phase Two complete	
6:10 PM	Execution Phase Three initiated	
6:12PM		6:14 PM FLATLINE
N/O	Execution Phase Three complete	
6:14 PM	Check for cardiac activity by medical personnel	
6:15 PM	Medical Personnel notifies Warden time of death	
6:15 PM	**EOG notified of time of death**	
6:15 PM	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Type: SMITHERS
Observer: [redacted]
Date: 10.14.2025
Location: CHEM

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30	**Arrived Florida State Prison (Time)**	
3:00	Syringe fill begin	
3:25	Syringe fill complete	
N/O	Inmate moved from death watch cell to shower	Shower Accepted/Declined
N/O	Inmate moved to chamber prep. Cell # Q1101	
N/O	Explanation of lethal injection procedures to inmate	
N/O	Sedative offered to inmate	Accepted/Declined
N/O	**Communication link established with EOG**	
5:28	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:28	Restraint process initiated	
5:30	Restraint process continued	
5:32	5:34	
~~5:34~~ RR		
5:34	Restraint process completed	
5:35	IV initiated L & R arm	
5:37	IV placement continued	
5:39	IV placement completed	
5:41	5:43, 5:45, 5:47, 5:49, 5:51, 5:53, 5:55	
N/O	**Minister of Religion escorted into chamber**	
5:57	IV final check by medical personnel	
5:59		
6:00	**Warden check with EOG for last minute stays**	
6:01	Inmate final statement	Rendered/Declined
6:02	**Warden authorizes Execution Phase One initiated**	
6:04	6:06	
6:06	Execution Phase One complete	
6:06	**Check for unconsciousness by Warden**	
6:06	Execution Phase Two initiated	
6:08	6:10	
6:10	Execution Phase Two complete	
6:10	Execution Phase Three initiated	
6:12	6:14	
N/A	Execution Phase Three complete	FLATLINE AT 6:14
6:15	Check for cardiac activity by medical personnel	
6:15	Medical Personnel notifies Warden time of death	
6:15	**EOG notified of time of death**	
6:15	**Death pronounced and announced by Warden**	
N/O	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

FLORIDA DEPARTMENT OF CORRECTIONS
HOUSING UNIT LOG

Florida State Prison
(INSTITUTION)

HOUSING UNIT Samuel Smithers DC# 124639 Death Watch Cell-front Monitor **DATE** 10.14. 2025

TIME	LOG OF EVENTS	INITIALS
4:00 PM	Inmate placed in holding cell. [redacted] explaining the execution process.	[redacted]
4:15 PM	[redacted] speaking with inmate cell front.	
4:30 PM	[redacted] speaking with inmate cell front.	
4:45 PM	[redacted] speaking with inmate cell front.	
4:48 PM	Inmate using the restroom	
4:54 PM	[redacted] speaking with inmate cell front.	
5:00 PM	Inmate offered and received the sedative	
5:04 PM	Inmate changed into dress clothes.	
5:15 PM	[redacted] speaking with inmate cell front.	
5:26 PM	Inmate using the restroom.	
5:28 PM	Inmate removed from holding cell and escorted to chamber	

Housing Sergeant Signature:	
Housing Officer Signature:	

Each Correctional Officer and Correctional Officer Sergeant will make entry as to the time she/he assumed duties for the housing unit and the time relieved. Signature of the Housing Officer and Sergeant indicates that she/he has relieved the preceding shift, read the previous entries on the Housing Unit Log, and assumes the responsibility for any corrective action or follow-up action required. This log will be forwarded daily to the office of the Chief of Security at the conclusion of the Day Shift.

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	130	N
		148	N
		136	N
		140	N
		134	N
		140	N
		130	N
		152	N
		138	N
		150	N
		142	N
		139	N
		130	N
		147	N
		139	N
		133	N
		—	—
		132	N
		132	N
		—	—
TECHNICAL TEAM MEMBERS		140	N
		—	—
		142	N
		148	N
		152	N
		141	N
		450	N
		450	N
		150	N
EXECUTIONERS		445	N
		445	N
		—	—

TEAM WARDEN [redacted]

DATE 10/14/2025

Revised 12/13/18

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number

[redacted]

[redacted]

10/14/2025

DATE

EXECUTION PREPARATIONS CHECKLIST

TEAM WARDEN

EXECUTION PREPARATIONS	DATE	TIME
Receipt of Warrant from Institutional Warden	9/12/25	6:10
Advised of Execution Scheduled For Samuel Smithers 124639 By Institutional Warden	9/12/25	5:00
Selection of Executioners		
• Provided Executioners with copy of procedure	9/12/25	5:05
• Explained to Executioners respective duties/responsibilities	9/12/25	5:05
• Explained to Executioners training will occur	9/12/25	5:05
• Designate Executioners as Primary and Secondary	9/12/25	5:05
	9/12/25	5:05
Ensure purchase/ maintenance of chemicals by assigned team member	9/12/25	5:15
Approximately one (1) week prior to Execution, Team Warden designates execution team members to:		
• Review of Inmate Medical File	10/7/25	9:00
• Limited Physical Examination	10/7/25	9:05
• Execution Team Members report findings to Team Warden	10/7/25	9:10
	10/7/25	9:10
Review of examination/confer with designated team members, the Team Warden shall conclude the more suitable method of venous access	10/7/25	9:15
Contingency Log:		

TEAM WARDEN [redacted] **DATE** 10/14/25

Name: Samuel Smithers

DC#: 124639

Inmate's Last Statement

No, sir

Date: 10/14/2025

Recorded b [redacted]

Name: Samuel Smithers

DC#: 124639

Inmate's Last Statement

No statement.

Date: 10/14/25

Recorded by: [redacted]

EXECUTION CHECKLIST

INMATE NAME Practice NUMBER 1 DATE: 10/13/2025

EXECUTION PREPARATION – PRIOR TO RECEIVING INMATE	TIME	RESPONSIBLE TEAM MEMBER	CONTINGENCY LOG:	TIME
All team members present	1:51	[redacted]		
Arrive on site	2:00			
Telephone check	2:02			
Obtain keys/Key check/Key log	2:01			
Public Address System check	2:05			
Radio check/Radio accountability	2:38			
Visual Monitor/Video Equipment Check	2:04			
Confirm cell phones are on vibrate/silenced	2:10			
Equipment bag check	2:04			
Suit/Undergarments present	2:01			
Shower supplies	2:03			
Search shower	2:04			
Search holding cell	2:03			
Ensure sheets pressed and several back-ups	2:08			
Ensure IV Pole is on medical cart	2:08			
Checked Phase Light system	2:05			
Medical Equipment Check: Wireless Telemetry Monitors	2:09			
UPS for Wireless Telemetry Monitors	2:09			
Cardiac Monitors	2:09			
Cardiac Monitor Leads	2:09			
Drug test completed	5:20			
Verify checklist complete at this time: **Team Warden** [redacted]	5:58	[redacted]		

EXECUTION PR[redacted]TION PROCESS	TIME	RESPONSIBLE TEAM MEMBERS	CONTINGENCY LOG:	TIME
Receive Inmate/Obtain log book	3:30	[redacted]		
Complete shower	3:30			
Secure in holding cell	4:00			
Issue clothing	5:01			
Explanation to inmate of lethal injection	3:45			

Revised 5/25/2021-added Minster of Religion entry and exit/08212025 Extra signature space

Inmate offered injection for anxiety – one (1) hour prior	5:00		
Inmate accepted/declined injection for anxiety	5:00		
Open phone line with Governor's Office SIM	5:25		
Read Warrant – Waived reading of the Warrant	5:45		
Restraints applied at holding cell	5:34		
Escorted to gurney	5:35		
Security Team Restraint process begun/completed	Begins 5:35	Ends 5:39	
Technical Team process begun/completed. IV method utilized: Peripheral / Femoral	Begins 5:36	Ends 5:43	
Security Team and Technical Team depart execution chamber	5:44		
Official/Media Witnesses Entered and Secured in witness room	5:45		
Confirm Witnesses Secured in Witness Room	5:45		
Escort Minister of Religion into the execution chamber N/A	5:43		Confirmed no minister of religion
Death Chamber Entrance Door Secured	5:41		
Verify checklist completed/Executioners Room ready to proceed: **Team Warden** [redacted]	5:58		
Curtain Opened	6:00		
Communication with Governor's Office reference any last stays	6:00		
Activate Public Address (PA) System	6:00		
Last statement	6:00		
Execution Phase Begins	6:01		
Deactivate Public Address (PA) System	6:01		
Initiate phases	6:01		
Physician pronounces death/Team Warden in agreement	6:09		
Notification that sentence has been carried out to Governor's Office	6:10		
Activate Public Address (PA) System	6:10		
Notification that sentence has been carried out to witnesses	6:10		
Deactivate Public Address (PA) System	6:10		
Curtain Closes	6:10		
Official/Media Witnesses departed witness room	6:13		
Escort Minister of Religion out of execution chamber N/A	N/A		
Medical Team departs	6:12		
Body Removal Team	Enters 6:11	Exits 6:12	
Debriefing	6:22		

[redacted]

Team Warden [redacted]

EXECUTIONERS ROOM CHECKLIST

INMATE NAME Tim Speight NUMBER _____ DATE 10/13/25

PREPARATION CHECKLIST	TIME	Responsible Team Member
8 syringes labeled to include chemical name – Verified (Stand A & B)	2:14	[redacted]
8 syringes w/18 gauge needle for chemical draw – Verified (Stand A & B)	214	
Two (2) Team Members along w/FDLE verify expiration date of lethal chemicals		
Two (2) Team Members along w/FDLE observe preparation of lethal injection chemical mix		
Syringes filled with chemicals: Syringe #1 and #2: **Etomidate, Trays A & B (Total 4)** Syringe #3: **Saline Solution, Trays A &B (Total 2)** Syringe #4 and #5: **Rocuronium Bromide, Trays A & B (Total 4)** Syringe #6: **Saline Solution, Trays A & B (Total 2)** Syringe #7 and #8: **Potassium Acetate, Trays A & B (Total 4)**		
All syringes secured in Stands A & B w/18 gauge, 1 inch blunt cannula Verified (Total 16)		
Verify Expiration Date of Hydroxyzine		
Verify Drawing of syringes and disposal of remainder of Hydroxyzine		
Stand A and Stand B transported to Execution Room	2:14	
Execution Room secured	2:15	

TEAM WARDEN [redacted]

2/21/2023 Removed Diazepam and added Hydroxyzine

EXECUTION TEAM DRUG TEST

POSITION	TEAM MEMBER STM#	DRUG TEST TIME	DRUG TEST RESULT
SECURITY TEAM MEMBERS	[redacted]	1:05	N
		134	N
		141	N
		106	N
		141	N
		133	N
		105	N
		108	N
		126	N
		132	N
		109	N
		115	N
		122	N
		112	N
		117	N
		110	N
		—	—
		105	N
		120	N
		—	—
TECHNICAL TEAM MEMBERS		—	—
		—	—
		145	N
		110	N
		150	N
		138	N
		455	N
		455	N
		122	N
EXECUTIONERS		445	N
		445	N
		—	—

TEAM WARDEN [redacted]

DATE 10/13/2025

Revised 12/13/18

DATE: 10/13/25

EXECUTION PHASE BEGINS	TIME	STM Number
Two (2) Standard IV infusion sets and extension sets that will be clearly marked #1 and #2	5:45	[redacted]
Technical Team confirmed with Executioners that **LINE #1** is the **PRIMARY LINE**	5:58	
Phase 1 Begins	6:00	
Syringe 1 Etomidate	Begins 6:00 / Ends 6:02	
Syringe 2 Etomidate	Begins 6:02 / Ends 6:03	
Syringe 3 Saline Solution	Begins 6:03 / Ends 6:04	
Phase 1 Ends	6:04	
Team Warden checks for consciousness	6:04	
Inmate medically checked for consciousness	6:04	
Phase 2 Begins	6:04	
Syringe 4 Rocuronium Bromide	Begins 6:04 / Ends 6:06	
Syringe 5 Rocuronium Bromide	Begins 6:06 / Ends 6:07	
Syringe 6 Saline Solution	Begins 6:07 / Ends 6:08	
Phase 2 Ends	6:08	
Phase 3 Begins	6:08	
Syringe 7 Potassium Acetate	Begins 6:08 / Ends	
Syringe 8 Potassium Acetate	Begins / Ends	
Phase 3 Ends		
Sentence has been carried out	6:09	
All materials/chemical mix disposed of according to State and Federal Law		
CONTINGENCY LOG:		

medical release of flat line @ 6:09

2/21/2023 Removed diazepam and added Hydrozyzine

Type: INJECT
Observer: [redacted]
Date: 10/13/25
Location: CHAMBER

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1:30PM	Arrived Florida State Prison (Time)	
N/A	Syringe fill begin	
N/A	Syringe fill complete	
N/A	Inmate moved from death watch cell to shower	Shower Accepted/Declined
3:58 PM	Inmate moved to chamber prep. Cell # Q1101	
N/A	Explanation of lethal injection procedures to inmate	
5:00 PM	Sedative offered to inmate	(Accepted)/Declined
5:25 PM	Communication link established with EOG	
5:34PM	Inmate moved to Death Chamber	
**********	BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:34PM	Restraint process initiated	
5:36PM	Restraint process continued	
5:38 PM		
5:39PM	Restraint process completed	
5:39PM	IV initiated L & R arm	
5:41 PM	IV placement continued	
5:42PM	IV placement completed	
5:44PM	5:46 PM 5:48 PM 5:50PM 5:52 PM	5:54PM 5:56PM
N/A	Minister of Religion escorted into chamber	
5:57PM	IV final check by medical personnel	
5:59PM		
6:00PM	Warden check with EOG for last minute stays	
6:00 PM	Inmate final statement	(Rendered)/Declined
6:01 PM	Warden authorizes Execution Phase One initiated	
6:03PM		
6:04PM	Execution Phase One complete	
6:04PM	Check for unconsciousness by Warden	
6:04PM	Execution Phase Two initiated	
6:06PM	6:08PM	
6:08PM	Execution Phase Two complete	6:09PM FLARING
6:08 PM ~~N/A~~ PHASE 1	Execution Phase Three initiated	
N/A	Execution Phase Three complete	
6:09PM	Check for cardiac activity by medical personnel	
6:09PM	Medical Personnel notifies Warden time of death	
6:10PM	EOG notified of time of death	
6:10PM	Death pronounced and announced by Warden	
N/A	Minister of Religion escorted from chamber	

N/A = Not Applicable
N/O = Not Observed

Revised 06/23/2025

Typ MATUTE
Obser [redacted]
Date: 10/13/21
Location: CHam

LETHAL INJECTION LOG

TIME/OBS	EVENT	COMMENTS / ISSUES
1330	**Arrived Florida State Prison (Time)**	
N/A	Syringe fill begin	
	Syringe fill complete	
	Inmate moved from death watch cell to shower	Shower Accepted/Declined
	Inmate moved to chamber prep. Cell # Q1101	
	Explanation of lethal injection procedures to inmate	
	Sedative offered to inmate	Accepted/Declined
N/O	**Communication link established with EOG**	
5:55	**Inmate moved to Death Chamber**	
	********** BEGIN TWO MINUTE INCREMENTAL ENTRIES **********	
5:36	Restraint process initiated	
5:38	Restraint process continued	
5:39	Restraint process completed	
5:40	IV initiated L & R arm	
5:42	IV placement continued	
5:42	IV placement completed	
5:44	5:46 5:48 5:50 5:52 5:54	
5:56		
5:57	IV final check by medical personnel	
5:59		
N/A	**Minister of Religion escorted into chamber**	
6:00	**Warden check with EOG for last minute stays**	
6:00	Inmate final statement	Rendered/Declined
6:00	**Warden authorizes Execution Phase One initiated**	
6:02	6:01	
6:04	Execution Phase One complete	
6:04	**Check for unconsciousness by Warden**	
6:04	Execution Phase Two initiated	
6:04	6:06 6:06 6:06	
6:06	Execution Phase Two complete	
6:08	Execution Phase Three initiated	
		FLATLINE @ 6:09 PM
N/A	Execution Phase Three complete	
6:09	Check for cardiac activity by medical personnel	
6:09	Medical Personnel notifies Warden time of death	
6:10	**EOG notified of time of death**	
6:10	**Death pronounced and announced by Warden**	
N/A	**Minister of Religion escorted from chamber**	

N/A = Not Applicable
N/O = Not Observed

Revised 02/04/2022

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number
[redacted]

10/13/2025

DATE

Name: Pratico

DC#: 1

Inmate's Last Statement

I would like to apologize to no one.

Date: 10/13/25

Recorded by [redacted]

EXECUTION TEAM TRAINING SIGN-IN SHEETS

Team Number
[redacted]

*

*Make-up training held 10/12/2025

[redacted]

10/13/2025

DATE

A7

Toxicology and Autopsy Reports

(February 2025-July 2026)

EXHIBIT 7

Combined Autopsies & Toxicology Reports

FLORIDA DISTRICT EIGHT
OFFICE OF THE MEDICAL EXAMINER

3217 SW 47th AVENUE
GAINESVILLE, FLORIDA 32608
medistrict8@alachuacounty.us

ALACHUA · BAKER · BRADFORD · DIXIE · GILCHRIST · LEVY · UNION

EXAMINATION REPORT

NAME: JAMES DUCKETT
AGE: 68 YEARS
DATE OF BIRTH: [redacted]
RACE/SEX: WHITE MALE
CASE NUMBER: ME26–0526
DATE OF DEATH: JULY 28, 2026
DATE OF EXAMINATION: JULY 29, 2026

AUTOPSY FINDINGS:

1. Multi-substance toxicity
    a. Execution by lethal injection
2. Hypertensive cardiovascular disease
    a. Dilated cardiomegaly with left ventricular hypertrophy
3. Obesity
    a. Class III, 43.5 kg/m²
    b. Hepatosplenomegaly
4. Postmortem toxicology
    a. Caffeine
    b. Etomidate

CAUSE OF DEATH: Multi-substance toxicity
MANNER OF DEATH: Homicide
HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium bromide, and potassium acetate

Milad Webb, M.D., Ph.D.
Medical Examiner

8/23/2026
Date

EXTERNAL EXAMINATION:

Normally developed 68-year-old White male measuring 71 inches in length and weighing 312 pounds (BMI 43.5 kg/m^2). The body is cool to the touch after refrigeration, with fully developed rigor mortis. Livor mortis is red-purple, posterior, and fixed. The body is neither decomposed nor embalmed.

The scalp hair is gray and measures less than 1 inch in maximal length. There is male-pattern baldness. The facial hair consists of a short beard and mustache. The irides are brown, and the corneas are clear. There is arcus senilis. The sclerae and conjunctivae are unremarkable, with no petechial hemorrhages. The oral cavity is atraumatic and contains natural dentition. The frenula are intact.

The neck is atraumatic, and the trachea is midline. The chest is normally developed and symmetrical. The abdomen is rounded and soft to palpation. The external genitalia are those of a normally developed, circumcised adult male. The back and extremities are normally developed and atraumatic. There is a hypopigmented, complex-appearing scar on the anterior left leg. There are no other identifying marks, scars, or tattoos.

Intravascular lines are present in the right and left antecubital fossae. Electrocardiogram sensors are present on the decedent's body.

INJECTION SITE EXAMINATION:
Examination of the injection sites reveal intravascular catheters appropriately within the lumen of the vessels within the antecubital fossa. Photos were taken to document the findings. There is no infiltration of the injection sites and no surrounding hemorrhage.

INTERNAL EXAMINATION:

Body Cavities: The serosal cavities have no adhesions or abnormal collections of fluid. The visceral organs are congested, in normal anatomic positions, and have no decomposition.

Head: The galeal aponeurosis is unremarkable. The vault and base of the skull have no fractures. There are no epidural, subdural, or subarachnoid hemorrhages. The dura mater and falx cerebri are intact. The brain weighs 1500 grams and has normally developed cerebral hemispheres. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The cerebral vessels are unremarkable with no atherosclerosis or aneurysmal dilatations.

Cut surfaces of the cerebral hemispheres, brainstem, and cerebellum reveal no structural lesions. The cerebral ventricles are of normal shape.

Neck: The laryngeal cartilage, and hyoid bone have no fractures or other abnormalities. The cervical spinal column is stable on internal palpation. The strap muscles of the neck are unremarkable. Examination of the pharynx, larynx, and trachea reveal patchy foci of erythema and no significant abnormalities or obstructions.

Cardiovascular: The aorta and its major branches have no significant atherosclerosis. There is no saddle embolus on in situ evaluation of the pulmonary trunk. The pulmonary arteries are patent. The pericardial sac is intact and contains a small amount of clear, straw-colored serous fluid. The heart weighs 550 grams which is significantly enlarged for sex and stature. The epicardial surface is smooth and glistening, with a thin layer of yellow adipose tissue.

The coronary arteries arise normally, have patent orifices, and follow a right-dominant distribution. They are of normal caliber and have no significant atherosclerosis. The endocardium is without mural thrombi or fibrous thickening. The valves are normally formed and free of vegetations and degenerative changes. The chordae tendineae and papillary muscles are unremarkable. The foramen ovale is closed.

The chambers of the heart are dilated. The thickness of the myocardium measures 1.0 cm in the left ventricular wall and interventricular septum. The myocardial cut surfaces are firm, dark red-brown, and unremarkable.

Pulmonary: The right lung weighs 850 grams; the left lung weighs 620 grams. The pleural surfaces are smooth and unremarkable with mildly dense subpleural network of black pigment. The upper and lower airways are unobstructed, and the mucosal surfaces are smooth. The parenchymal cut surfaces are dark red-purple and congested. The cut surfaces have no masses. The peripheral pulmonary arteries are without thromboemboli.

Liver, Gallbladder and Pancreas: The liver is enlarged and weighs 2520 grams and has smooth glistening capsule. The parenchyma is moderately soft and without focal lesions. The hepatic veins are patent.

The gallbladder contains a measured 10 milliliters of dark green, viscous bile, and no calculi. Its mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent. The pancreas has congested, tan-brown lobulated parenchyma with clear ducts and is without fibrosis, masses, or calcifications.

Spleen and Lymphatic: The spleen weighs 380 grams and has a smooth, intact capsule with dark maroon, semi-liquefied parenchyma. The lymph nodes are not enlarged. The vertebral marrow is brick red, homogeneous, moist, and firm. The thymus gland is predominantly fat-replaced.

Genitourinary: The right and left kidneys weigh 220 grams and 240 grams, respectively. There is no increase in hilar adipose tissue of the kidneys. The capsules are smooth, thin, and strip with ease. The cortical surfaces are dark red, smooth, and without lesions. The cortices are well delineated from the underlying medullary pyramids and have no focal lesions.

The calyces, pelves, and ureters are not dilated and have unremarkable tan-white mucosa. The urinary bladder contains a measured 115 milliliters of straw-colored urine. Its mucosa is tan-white and smooth, without focal lesions.

The seminal vesicles are unremarkable. The testes and spermatic cords have unremarkable stringy tan cut surfaces, with no hemorrhages or other abnormalities.

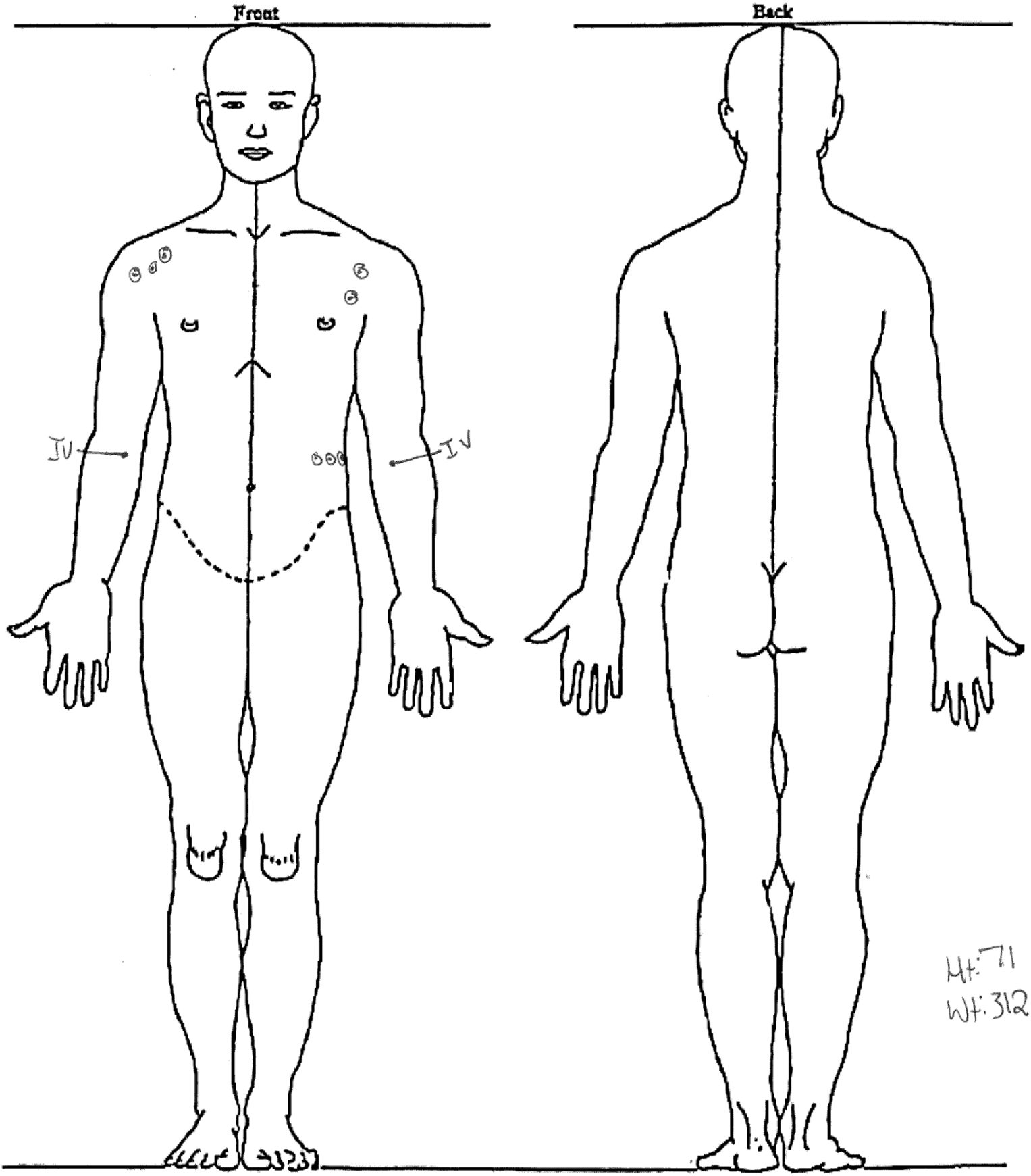
Endocrine: The pituitary gland is of normal size and has no lesions. The adrenal glands are unremarkable. The thyroid gland is normal in size and has red-brown, uniform, monomorphic cut surfaces without lesions.

Digestive: The esophagus is lined by a smooth, gray-white mucosa, with no lesions. The gastroesophageal junction is unremarkable and the gastric mucosa is autolyzed. The stomach lumen contains a measured 25 milliliters of partially digested food and liquid. The duodenum has no lesions. The small and large bowels are unremarkable. The colon contains semiformed stool. The appendix is identified.

Musculoskeletal: There are no acute fractures. There are no significant degenerative changes. The musculature is normally developed. The cut surfaces of a section of representative lumbar vertebral body are hard and unremarkable.

ME26-0526 Duckett, James 68, W, M DOB: [redacted] DOD: 7/28/2026

PATHOLOGIST: BODY EXAMINATION **Prisoner:** [X] **Infectious:**



Pathologist Milad Webb, MD | Date Body Viewed 7/29/26 | Time 1050

ME26-0526
Duckett, James
7/28/2026

DC ☐
Dictated ☐
Autopsy / External / Tox

Case Number: 26 - 0526

FLORIDA DISTRICT 8 OME
External Examination

Exam Date/Time: 7/29/26 10:05 Inmate: ☒ Hospital: ☐ Decomposed: ☐

Cool / Warm Rigor: Fix / Partial / Waning / Passed Livor: Fixed / Blanching / Mixed
R / L A / P

Hair: BLK / BR / BL / Red / W / GRY LL mpB

Facial Hair: B / M / G

Eyes: BR / BLU/ GR / HZL / GRY / AS

Mouth/Teeth: NAT / ABS / DENT / Poor

Abdomen: Sc / Flat / Round / Soft / Protub

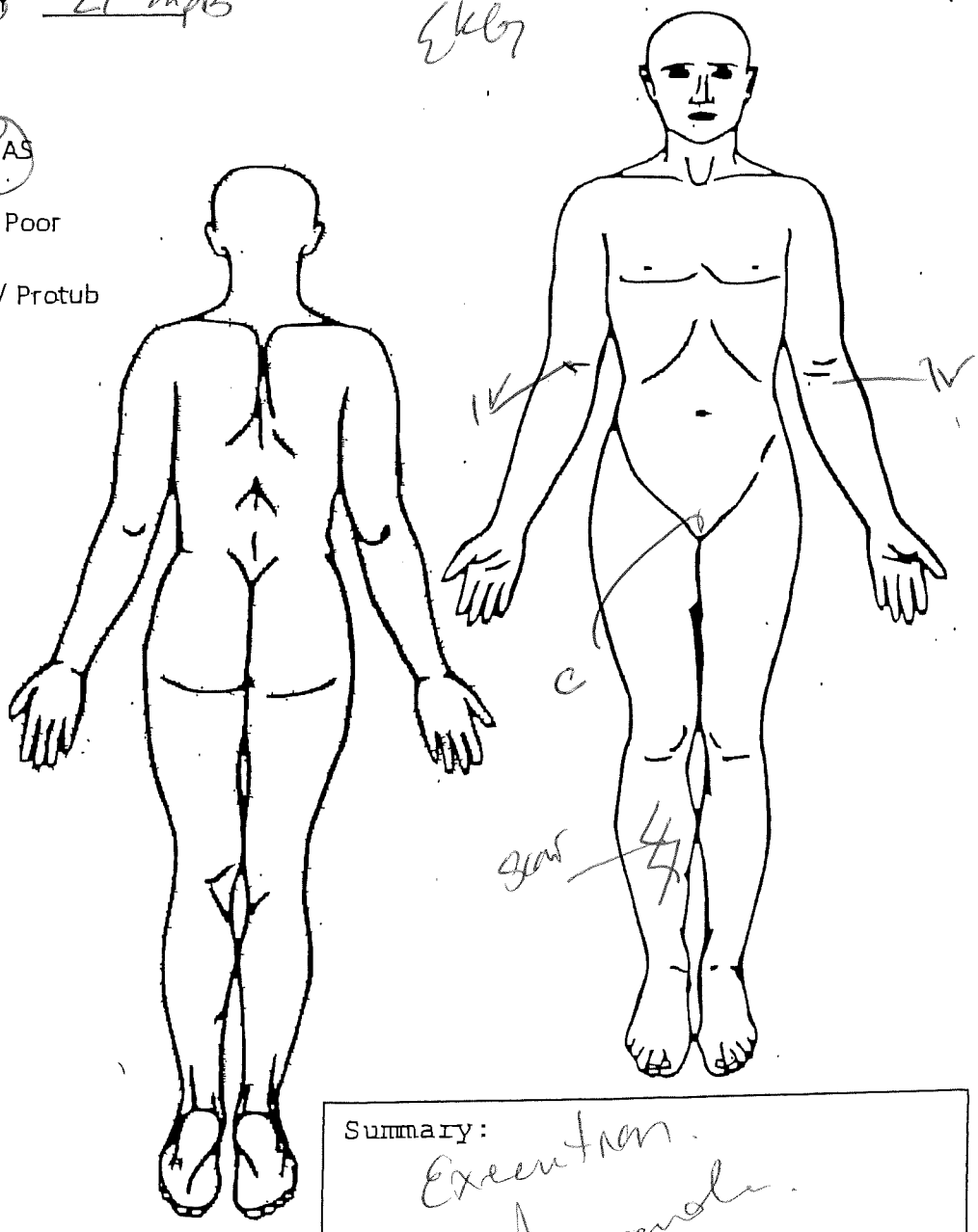
Mark/Scars/Tattoos:

R Ant leg

Injuries/Other:

none.

EKG



Summary:

Execution.
Homicide.

Office of the Medical Examiner District Eight

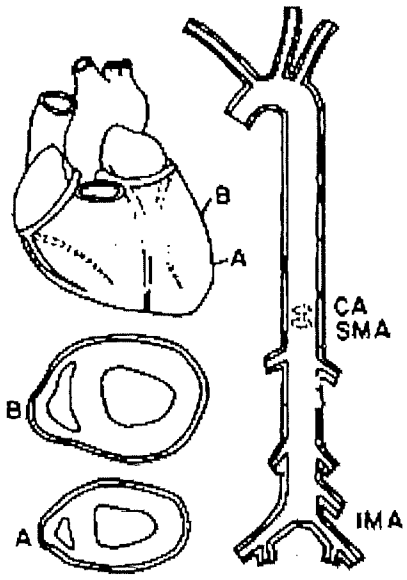
www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

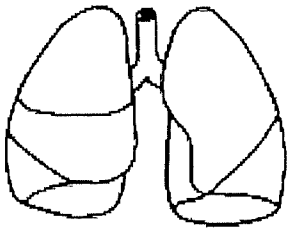
3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-273-9292
Fax 352-273-9288

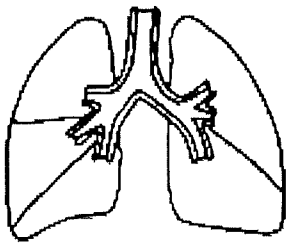
ME26-0526
Duckett, James
7/28/2026

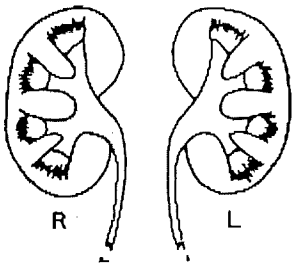
Physician: Webb Date: 7/29/26 @ 1050
Case #: ME 26-0526 Name: Duckett, James

Heart: 550 Spleen: 380 Age: 68
R. Lung: 850 R. Kidney: 220 Sex: M
L. Lung: 620 L. Kidney: 240 Ht.: 71
Liver: 2520 Brain: 1500 Wt.: 312





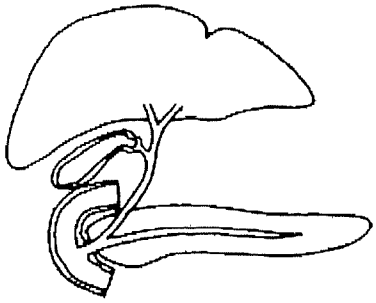


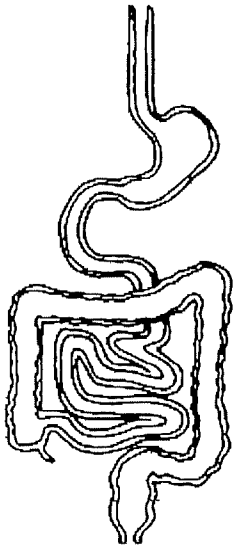


Urine: 115
Stones: _____

Dominant: RT / LT
LAD: _____ CFX: _____ RCA: _____
LV: _____ RV: _____ IVS: _____
TV: _____ RV: _____ MV: _____ AV: _____







Bile: 10
Stones: _____

Stomach Contents: 25
Appendix: +
Stool: _____
Tics: _____
Fat: _____

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Duckett, James** **ME26-0526**

Race	Gender	DOB: MM	DD	YYYY	Age
White	Male	[redacted]	[redacted]	[redacted]	68 years 10 months 24 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

James Duckett is a 68-year-old white male death row inmate at Union Correctional Institution. The decedent was executed by lethal injection on 07/28/2026 and pronounced by Dr. Hashani Perkins at 1319 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	07/28/2026	13:00	Florida State Prison	Bradford	Correctional Institution	
Onset						

Last Seen Alive		Name & Title	
Date of Death	07/28/2026 13:19	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026
Pronounced or Found by		Name & Title	Dr. Perkins
M.E.O. Notified	07/28/2026 14:24	Name & Title	Asst Warden McClellen

County of Death	Inside City Limits	On the Job	Billing Agency/County
Bradford	○Yes ○No	○Yes ○No	Bradford

Agency	Officer / Agent	Case Number

NARRATIVE

On 07/28/26 at approximately 1424 hours, this office was contacted by Assistant Warden Jeff McClellen. He was reporting the death of James Duckett, a 68-year-old white male inmate at the Florida State Prison. He has been incarcerated since 1988 on a first-degree murder charge. The decedent was executed by lethal injection at the Florida State Prison on 07/28/26. The execution began at approximately 1300 hours, and the decedent was pronounced by Dr. Hashani Perkins at 1319 hours.

NOK was notified of the MEO involvement by Florida State Prison.

Archer-Milton Funeral Home was dispatched by FSP to transport the decedent to the Medical Examiner's Office.

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Gracie Quarles		7/29/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3357847**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 SW 47th Ave Gainsville, FL 32608

Subject's Name:	**DUCKETT, JAMES**
Agency Case #:	ME26-0526
Date of Death:	07/28/2026
Investigator:	GRACIE QUARLES
Date Received:	07/31/2026
Date Reported:	08/10/2026

Laboratory Specimen No: **41371529** **Date Collected:** 07/29/2026 10:20
Container(s): 01:BB Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	Negative					
ANESTHETICS	POSITIVE					
Etomidate	POSITIVE	0.1	0.1	0.1 - 0.5	mcg/mL	
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	Negative					
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	Negative					
ANTIPSYCHOTICS	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					
CARDIOVASCULARS	Negative					
GASTROINTESTINALS	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41371529** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	POSITIVE					
Caffeine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41371530** **Date Collected:** 07/29/2026 10:20
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41371530** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

The toxicology findings are based on a single urine test.

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41371531** **Date Collected:** 07/29/2026 10:20
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note

< Volatile Testing Not Performed >

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41371532** **Date Collected:** 07/29/2026 10:20
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41371533** **Date Collected:** 07/29/2026 10:20
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

DUCKETT, JAMES
Laboratory Case #:3357847
Print Date/Time:08/10/2026, 14:48
Page: 7 of 7

Case Reviewer

Stuart Kurtz, M.S., D-ABFT -FT

Unless otherwise noted, testing performed at 5780 W 71st Street, Indianapolis, IN 46278. This individual may not have performed any of the analytical work.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: Heath, Ronald
AGE: 64
GENDER: Male
RACE: White
CASE NUMBER: ME26-0115
DATE OF DEATH: February 10, 2026
DATE OF EXAMINATION: February 12, 2026

AUTOPSY FINDINGS:

1. Mild, patchy cerebrovascular atherosclerosis
2. Cardiomegaly (460 grams)
3. Mild to severe coronary artery atherosclerosis
4. Mild to focally moderate aortic atherosclerosis
5. Pulmonary congestion and edema
6. Cholesterolosis, gallbladder
7. Cyst, right lobe of thyroid gland

CAUSE OF DEATH: Multi-Substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Kailee A. Imperatore, M.D.
Associate Medical Examiner

Completed: February 12, 2026

EXTERNAL EXAMINATION:

The body is that of a normally developed, well-nourished, 5 foot 11 inch, 202 pound male who appears the reported age of 64 years. The body is refrigerated and well-preserved.

The scalp has dark and gray, short, straight hair. Facial hair consists of dark and gray stubble. The irides are brown, and the pupils are round and equal. The sclerae are white. The conjunctivae are clear and have no petechiae. The ears, nose, and mouth are normally formed. The external auditory canals are unremarkable. The earlobes have creases. The nasal bones and nasal septum are intact. The lips are uninjured. The frenula are not lacerated. The teeth are natural and in fair condition.

The neck and chest are symmetrical. The nipples and breasts are unremarkable. The abdomen is slightly protuberant and soft. The back and buttocks are symmetrical and have no deformities. A linear area of hyperpigmentation is centrally located and on the right side of the lower back. A scar is on the right buttock. A scar and area of hyperpigmentation are on the left buttock. The external genitalia are those of a fully developed, circumcised male. Both testes are palpable in the scrotum. The anus is unremarkable.

The bilateral upper and lower extremities are symmetrical and have no palpable fractures. No track marks are on the arms. The wrists have no scars. Few scars are on the upper and lower extremities. The hands and feet are symmetrical, and the nails are intact.

TATTOOS:

Tattoos are on the chest, left upper extremity, and lower extremities.

EVIDENCE OF MEDICAL PRESENCE:

Electrocardiogram lead pads are adhered to the torso.

A band aid overlying a puncture wound is on the right arm. Clear tape is on the upper extremities. Catheters extend from the bilateral antecubital fossae. The skin and subcutaneous tissues of the antecubital fossae were dissected to confirm intravenous locations of the catheters.

INTERNAL EXAMINATION:

The reflected scalp has no hemorrhages. The calvarium and skull base have no fractures. The cranial vault has no epidural, subdural, or subarachnoid hemorrhages. The leptomeninges are thin and transparent. The 1400 gram brain is symmetrical, and the cerebrum has normal gyral configuration. The cranial nerves and vessels at the base of the brain are normally positioned and formed. The vessels of the circle of Willis have no aneurysms and mild, patchy atherosclerosis. The deep gray nuclei have no gross pathologic abnormalities. The subcortical and deep white matter has no gross pathologic abnormalities. The substantia nigra is normally pigmented. The brainstem and cerebellum are intact and have no gross pathologic abnormalities.

The anterior muscles of the neck are free of hemorrhages. The hyoid bone and laryngeal cartilages have no fractures. The large vessels of the neck are unremarkable. The pharynx and larynx have no obstructing foreign bodies or abnormal secretions. The epiglottis and vocal cords are unremarkable.

The pleural cavities have no abnormal fluid collections or adhesions. The pericardial sac has no abnormal fluid collections or adhesions. The peritoneal cavity has no abnormal fluid collections or adhesions. The diaphragm and organs of the thorax and abdomen are in their normal anatomic locations.

The 460 gram heart has a smooth epicardial surface and slightly increased epicardial adipose tissue. The coronary ostia are normally positioned and patent. The coronary arterial circulation is right dominant. The coronary arteries have normal anatomic courses. The left main coronary artery is thin-walled and patent. The left anterior descending and left circumflex coronary arteries have up to approximately 75 percent stenosis by atherosclerosis. The right coronary artery has up to approximately 30 percent stenosis by atherosclerosis. The four-chambered heart has a normal configuration. The cardiac chambers are not dilated. The myocardium is tan-red and has no fibrosis, pallor, or hemorrhages. The interatrial and interventricular septa are normally developed. The fossa ovalis is closed. The mural and valvular endocardium is thin, transparent, and free of mural thrombi. The papillary muscles and chordae tendineae are slightly thickened. The cardiac valves are thin, pliable, and free of vegetations and calcifications. The aorta has a normal caliber, no aneurysms, and mild to focally moderate atherosclerosis. The venae cavae have normal anatomic courses and are free of thrombi.

The right lung is 850 grams and the left lung is 800 grams. The pleural surfaces are pink to red-purple, smooth, and glistening. The boggy pulmonary parenchyma is pink-purple, expresses abundant bloody and frothy fluid, and has no masses, granulomata, or discrete areas of consolidation. The pulmonary vasculature is patent and has no thromboemboli. The trachea and bronchi are patent and have no foreign bodies or obstructions.

The 1860 gram liver has a smooth and intact capsule. Its parenchyma is brown, soft, and free of masses and fibrosis. The thin-walled gallbladder contains approximately 15 milliliters of green-yellow bile and no calculi. Its mucosa is green-yellow, velvety, and has a yellow, lace-like pattern. The biliary tree is normally formed. The ductal lumina are patent. The vessels of the porta hepatis are unremarkable. The pancreas has tan-pink, lobulated parenchyma without masses.

The tongue has no bite marks or hemorrhages. The serosal and mucosal surfaces of the esophagus are unremarkable. The stomach contains approximately 50 milliliters of dark brown liquid. Its mucosa is tan, has normal rugal folds, and no ulcers or masses. The serosal surfaces and calibers of the small intestine and large intestine are normal and have no palpable masses or obstructions. The appendix is unremarkable.

The 220 gram spleen has a smooth and intact capsule covering mostly soft, red-purple parenchyma. The bone marrow of the ribs is red and soft. The lymph nodes of the neck, thorax, abdomen, and pelvis are not enlarged.

The right kidney is 160 grams and the left kidney is 170 grams. The capsules are thin, and the cortical surfaces are smooth with rare pits. The renal parenchyma is red-purple, has moderately-defined corticomedullary junctions, and no masses. The renal vessels are patent. The pelvicalyceal systems are unremarkable. The ureters have normal course and calibers to the urinary bladder. The bladder contains approximately 85 milliliters of clear, yellow urine and its mucosa is tan-white and trabeculated. The prostate gland is unremarkable.

The thyroid gland is normal in size and shape and has red-purple parenchyma. A 1.5 centimeter circumscribed cyst is in the right lobe of the thyroid gland. The adrenal glands have normal yellow cortices and brown medullae.

The skeletal muscles of the thorax, abdomen, and pelvis are red-brown and soft. The clavicles, sternum, ribs, vertebral bodies, and pelvis have no acute fractures.

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Heath, Ronald Palmer** **ME26-0115**

Race	Gender	DOB: MM	DD	YYYY	Age
White	Male	[redacted]	[redacted]	[redacted]	64 years 7 months 4 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	Yes / No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Ronald Palmer Heath is a 64-year-old white male inmate at Florida State Prison. The decedent was executed by lethal injection on 2/10 and pronounced by Dr. Astrid Clark at 1812 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	02/10/2026	18:00	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026	Bradford	Correctional Institution	
Onset						
Last Seen Alive			Name & Title			
Date of Death	02/10/2026	18:12	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026		
Pronounced or Found by			Name & Title			
M.E.O. Notified	02/10/2026	19:34	Name & Title	Assistant Warden McClellen		
County of Death	Bradford	Inside City Limits Yes No	On the Job Yes No	Billing Agency/County Bradford FSP		

Agency	Officer / Agent	Case Number

NARRATIVE

On 02/10 at approximately 1934 hours, this office received a call from Assistant Warden McClellen. He was reporting the death of Ronald Heath, a 64-year-old white male inmate at Florida State Prison. He has been incarcerated at Florida State prison since 1990 on first degree murder charges. The decedent was executed by lethal injection on 02/10/26. The execution began at approximately 1800 hours, and the decedent was pronounced by Dr. Astrid Clark at 1812 hours.

NOK was notified of the MEO involvement by Florida State Prison.

Deceased: eat , R a d a mer ME26-0 5

Archer Funeral home was dispatched by FSP to transport the decedent to the MEO.

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Rachel Hildreth		2/10/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3345000**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 WE 47th Avenue Gainsville, FL 32608 FX: 352-384-3365

Subject's Name:	**HEATH, RONALD P**
Agency Case #:	ME26-0115
Date of Death:	02/10/2026
Investigator:	RACHEL HILDRETH
Date Received:	02/25/2026
Date Reported:	03/12/2026

Laboratory Specimen No: **41331803** **Date Collected:** 02/12/2026 13:55
Container(s): 01:BB Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	Negative					
ANESTHETICS	Negative					
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	Negative					
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	POSITIVE					
Hydroxyzine	POSITIVE	25.1	10	50 - 100	ng/mL	
ANTIPSYCHOTICS	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					
CARDIOVASCULARS	Negative					
GASTROINTESTINALS	Negative					

Kailee A Imperatore
3/17/2026

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41331803** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	POSITIVE					
Caffeine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41331804** **Date Collected:** 02/12/2026 13:55
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41331804** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41331805** **Date Collected:** 02/12/2026 13:55
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< Volatile Testing Not Performed >						

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41331806** **Date Collected:** 02/12/2026 13:55
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41331807** **Date Collected:** 02/12/2026 13:55
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

HEATH, RONALD P
Laboratory Case #:3345000
Print Date/Time:03/12/2026, 18:20
Page: 7 of 7

Case Reviewer

Laureen J. Marinetti, Ph.D., F-ABFT

FLORIDA DISTRICT EIGHT
OFFICE OF THE MEDICAL EXAMINER

3217 SW 47th AVENUE
GAINESVILLE, FLORIDA 32608
medistrict8@alachuacounty.us

ALACHUA · BAKER · BRADFORD · DIXIE · GILCHRIST · LEVY · UNION

EXAMINATION REPORT

NAME: JAMES HITCHCOCK
AGE: 70 YEARS
DATE OF BIRTH: [redacted]
RACE: WHITE
SEX: MALE
CASE NUMBER: ME26–0317
DATE OF DEATH: APRIL 30, 2026
DATE OF EXAMINATION: MAY 1, 2026

AUTOPSY FINDINGS:

1. Multi-Substance Toxicity
    a. Lethal injection
2. Arteriosclerotic cardiovascular disease
    a. Multivessel coronary artery disease
    b. Aortic atherosclerosis
3. Chronic pancreatitis
    a. Fibrotic pancreas

CAUSE OF DEATH: Multi-Substance Toxicity
MANNER OF DEATH: Homicide
HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Milad Webb, M.D., Ph.D.
Medical Examiner

6/8/2026
Date

EXTERNAL EXAMINATION:

The decedent is a normally developed 70-year-old white male measuring 69 inches in length and 173 pounds (BMI 25.5 kg/m^2). The body is cool to the touch after refrigeration. Rigor mortis is fully developed. Livor mortis is red-purple, posterior, and fixed. The body is neither decomposed nor embalmed.

The scalp hair is gray-white and measures less than 1 inch in maximal length. Male pattern baldness is present. The facial hair consists of a short beard and mustache. The irides are blue. The sclerae and conjunctivae are unremarkable, with no evidence of petechial hemorrhages. The oral cavity is unremarkable with absent dentition. The frenula are intact.

The neck is atraumatic, and the trachea is midline. The chest is normally developed and symmetrical. The abdomen is rounded and soft to palpation. The external genitalia are those of a normally developed circumcised adult male. The back and extremities are normally developed and atraumatic. Purpura involves the upper extremities, with associated superficial bruising noted on the right arm.

A tattoo is present on the posterior aspect of the left forearm. No other identifying marks or scars are noted.

Intravascular lines are present in the right and left antecubital fossae. Electrocardiogram sensors are present on the decedent's body.

INJECTION SITE EXAMINATION:
Examination of the injection sites reveal intravascular catheters appropriately within the lumen of the vessels within the antecubital fossa. Photos were taken to document the findings. There is no infiltration of the injection sites and no surrounding hemorrhage.

INTERNAL EXAMINATION:

Body Cavities: The serosal cavities have no adhesions or abnormal collections of fluid. The visceral organs are congested, in normal anatomic positions, and have no decomposition.

Head: The galeal aponeurosis is unremarkable. The vault and base of the skull have no fractures. There are no epidural, subdural, or subarachnoid hemorrhages. The dura mater and falx cerebri are intact. The brain weighs 1490 grams and has normally developed cerebral hemispheres. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The cerebral vessels are unremarkable with no atherosclerosis or aneurysmal dilatations.

Cut surfaces of the cerebral hemispheres, brainstem, and cerebellum reveal no structural lesions. The cerebral ventricles are of normal shape.

Neck: The laryngeal cartilage, and hyoid bone have no fractures or other abnormalities. The cervical spinal column is stable on internal palpation. The strap muscles of the neck are

unremarkable. Examination of the pharynx, larynx, and trachea reveal patchy foci of erythema and no significant abnormalities or obstructions.

Cardiovascular: The aorta and its major branches have significant atherosclerosis. There is no saddle embolus on in situ evaluation of the pulmonary trunk. The pulmonary arteries are patent. The pericardial sac is intact and contains a small amount of clear, straw-colored serous fluid. The heart weighs 410 grams which is within normal range for gender and stature. The epicardial surface is smooth and glistening, with a thin layer of yellow adipose tissue.

The coronary arteries arise normally, have patent orifices, and follow a right-dominant distribution. There is significant obstructive calcific atherosclerosis of the left anterior descending and right coronary artery with 70 to 80% stenosis. The endocardium is without mural thrombi or fibrous thickening. The valves are normally formed and free of vegetations and degenerative changes. The chordae tendineae and papillary muscles are unremarkable. The foramen ovale is closed.

The chambers of the heart are not dilated. The thickness of the myocardium measures 1.0 to 1.2 cm in the left ventricular wall and interventricular septum. The myocardial cut surfaces are firm, dark red-brown, and unremarkable.

Pulmonary: The lungs are edematous and heavy. The right lung weighs 810 grams; the left lung weighs 770 grams. The pleural surfaces are smooth and unremarkable with mildly dense subpleural network of black pigment. The upper and lower airways are unobstructed, and the mucosal surfaces are smooth. The parenchymal cut surfaces are dark red-purple and congested. The cut surfaces have no masses. The peripheral pulmonary arteries are without thromboemboli.

Liver, Gallbladder and Pancreas: The liver weighs 1910 grams and has smooth glistening capsule. The parenchyma is moderately soft and without focal lesions. The hepatic veins are patent.

The gallbladder contains a measured 5 milliliters of dark green, viscous bile, and no calculi. Its mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent. The pancreatic ductal system is grossly unremarkable without marked dilation or obstructing calculi. No focal mass, hemorrhage, or necrosis is identified.

Spleen and Lymphatic: The spleen weighs 310 grams and has a smooth, intact capsule with dark maroon, semi-liquefied parenchyma. The lymph nodes are not enlarged. The vertebral marrow is brick red, homogeneous, moist, and firm. The thymus gland is fat-replaced.

Genitourinary: The right and left kidneys weigh 120 grams and 170 grams, respectively. The capsules strip with difficulty, revealing a granular, scarred, cystic cortical surface and focal depressions. On sectioning, the cortices are thinned and uneven, with loss of normal corticomedullary distinction in areas. The medullae are relatively preserved. The calyces, pelves, and ureters are not dilated and have unremarkable tan-white mucosa. The urinary bladder contains a measured 550 milliliters of straw-colored urine. Its mucosa is tan-white and smooth, without focal lesions. The seminal vesicles are unremarkable. The testes and spermatic cords

have unremarkable stringy tan cut surfaces, with no hemorrhages or other abnormalities. The prostate gland is of normal size. The external surface is smooth and intact. The parenchyma is homogeneous, firm and without significant nodules, cysts, or areas of hemorrhage or necrosis.

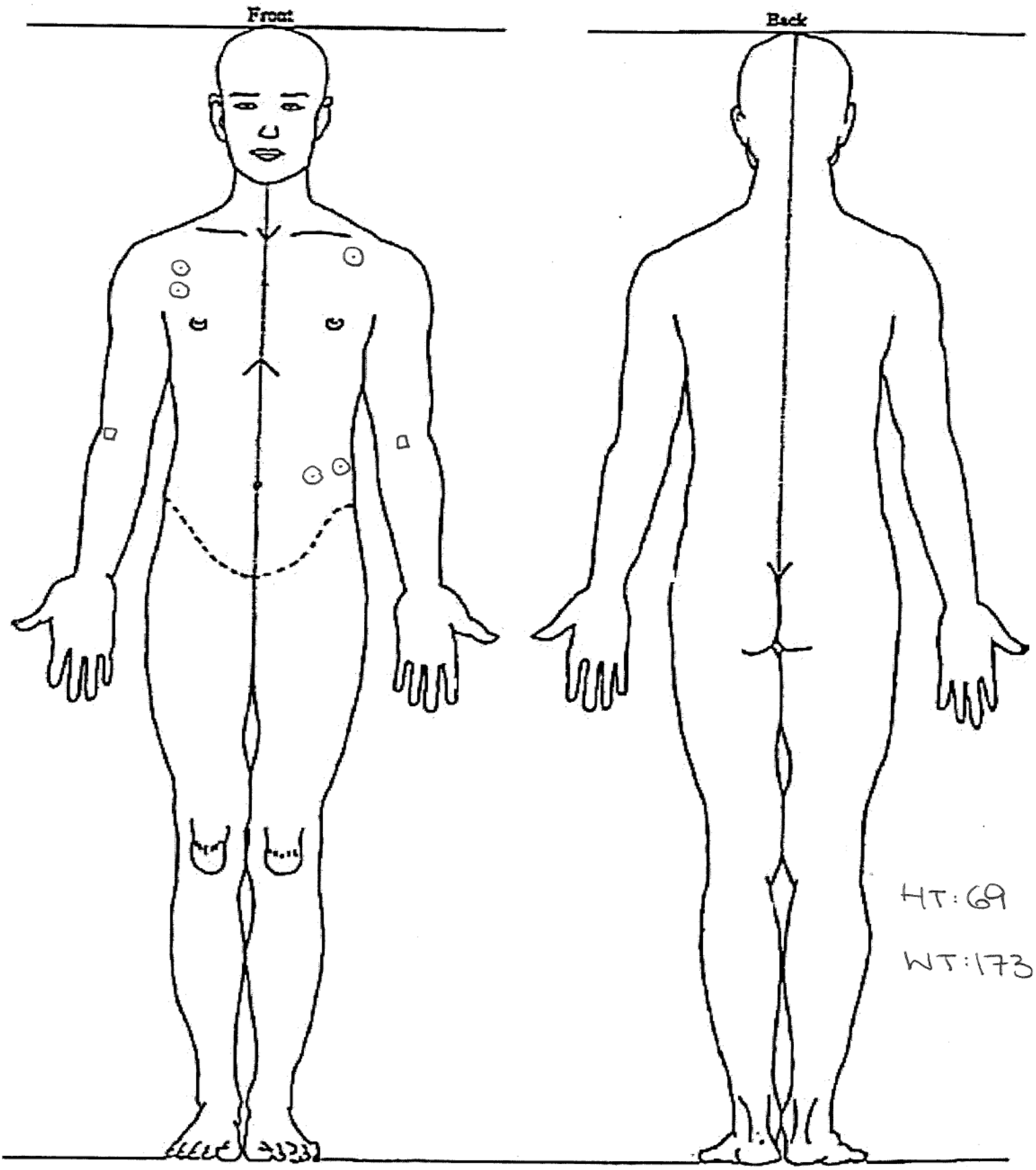
Endocrine: The pituitary gland is of normal size and has no lesions. The adrenal glands are unremarkable. The thyroid gland is normal in size and has red-brown, uniform, monomorphic cut surfaces without lesions.

Digestive: The esophagus is lined by a smooth, gray-white mucosa, with no lesions. The gastroesophageal junction is unremarkable, and the gastric mucosa is autolyzed. The stomach lumen contains a measured 400 milliliters of partially digested food and liquid. The duodenum has no lesions. The small and large bowels are unremarkable. The colon contains semiformed stool. The appendix is identified.

Musculoskeletal: There are no acute fractures. There are age-related degenerative changes of the axial skeleton. The musculature is normally developed. The cut surfaces of a section of representative lumbar vertebral body are hard and unremarkable.

ME26-0317 Hitchcock, James Ernest 70, W, M DOB: [redacted] DOD: 4/30/2026

PATHOLOGIST: BODY EXAMINATION Prisoner: [X] Infectious:



Pathologist Milad Webb, MD Date Body Viewed Time

ME26-0317
Hitchcock, James Ernest
04/30/2026

DC ☐
Dictated ☐
Autopsy / External / Tox

Case Number: 26 - 0317

FLORIDA DISTRICT 8 OME
External Examination

Exam Date/Time: 5/1/26 1046 Inmate: ☐ Hospital: ☐ Decomposed: ☐

Cool / Warm **Rigor:** Fix / Partial / Waning / Passed **Livor:** Fixed / Blanching / Mixed
R / L A / P

Hair: BLK / BR / BL / Red / W / GRY 4 mpB

Facial Hair: B / M / G short

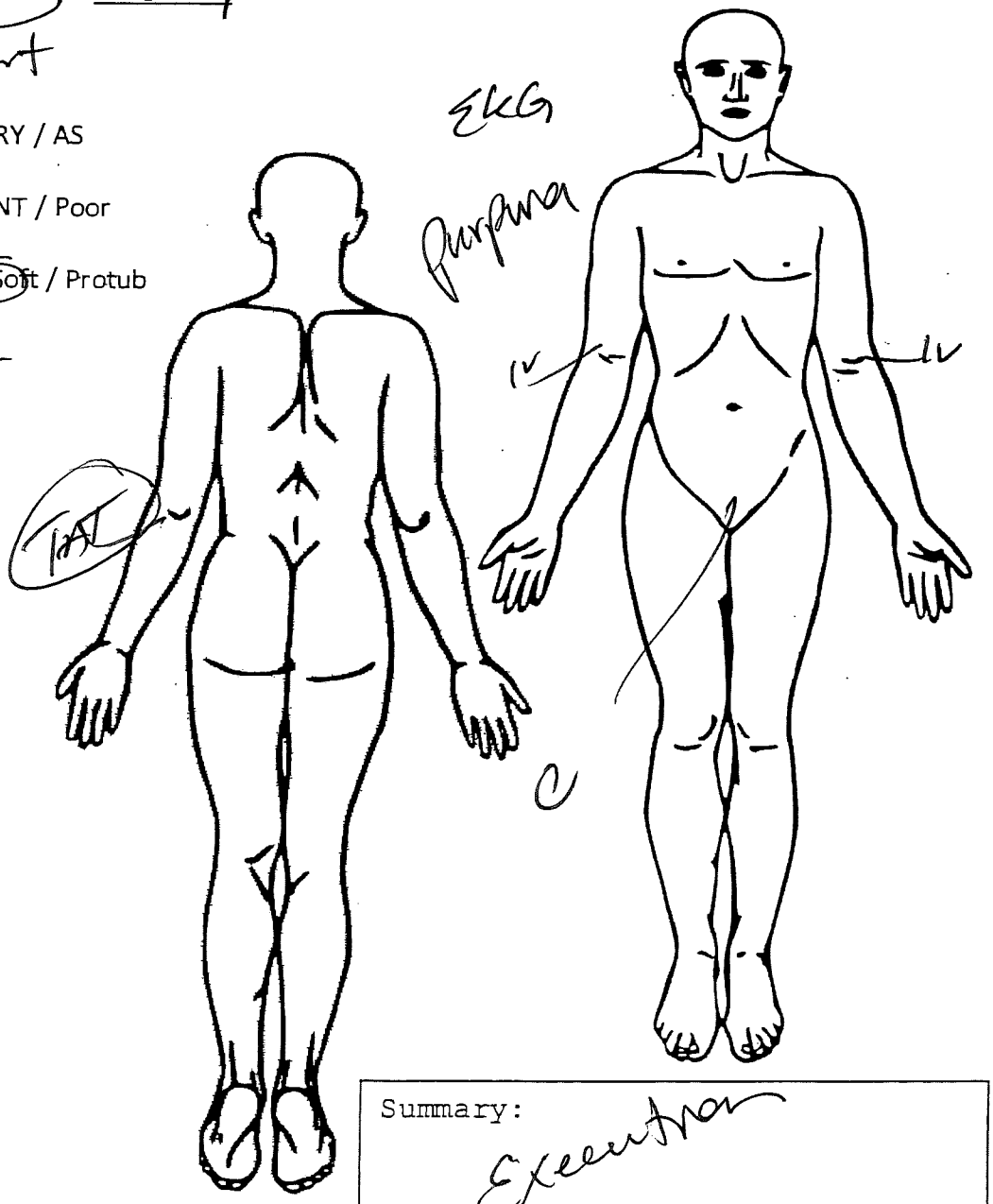
Eyes: BR / BLU / GR / HZL / GRY / AS

Mouth/Teeth: NAT / ABS / DENT / Poor

Abdomen: Sc / Flat / Round / Soft / Protub

Mark/Scars/Tattoos:
L forearm

Injuries/Other:
None.



Summary:
Execution

Office of the Medical Examiner District Eight

www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-273-9292
Fax 352-273-9288

ME26-0317
Hitchcock, James Ernest
04/30/2026

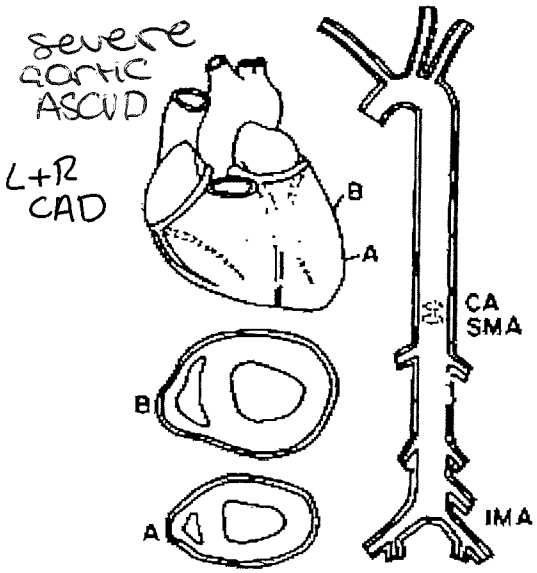
Physician: Webb
Case #: 0317

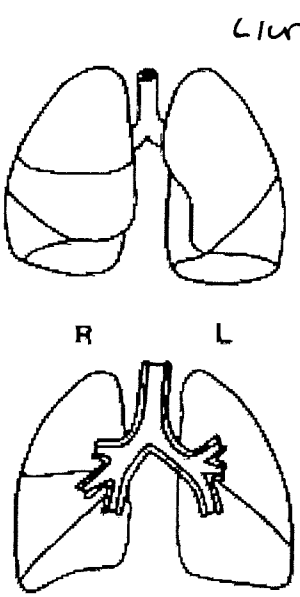
Date: 5/1/2026 @ 1130
Name: Hitchcock, James Ernest

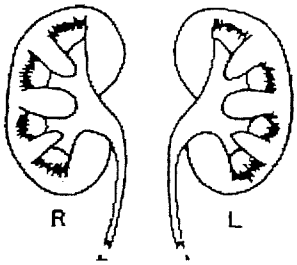
Heart: 410
R. Lung: 810
L. Lung: 770
Liver: 1910

Spleen: 310
R. Kidney: 120
L. Kidney: 170
Brain: 1490

Age: 70
Sex: M
Ht.: 69
Wt.: 173

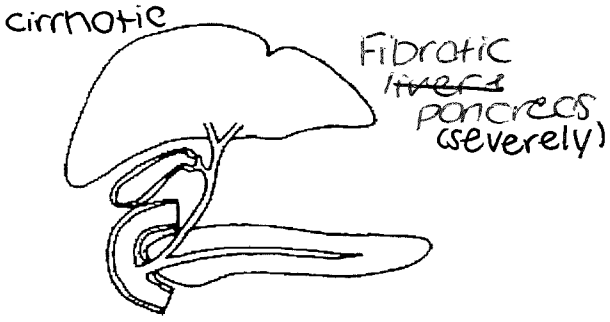




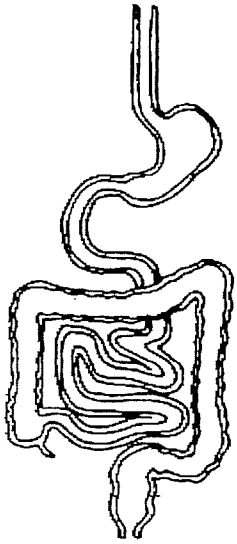


Urine: 550
Stones:

Dominant: RT / LT
LAD: CFX: RCA:
LV: RV: IVS:
TV: RV: MV: AV:



Bile: 5
Stones:





Stomach Contents: 400
Appendix: (+)
Stool:
Tics:
Fat:

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Hitchcock, James Ernest** **ME26-0317**

Race	Gender	DOB: MM	DD	YYYY	Age
White	Male	[redacted]	[redacted]	[redacted]	70 years 25 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○ Yes ○ No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

James Ernest Hitchcock is a 70 year old white male who was a death row inmate at the Florida State Prison. He was executed via lethal injection on 4/30 and death was pronounced at 1812 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	04/30/2026	18:00	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026	Bradford	Correctional Institution	
Onset						
Last Seen Alive			Name & Title			
Date of Death	04/30/2026	18:12	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026		
Pronounced or Found by	04/30/2026	18:12	Name & Title	Dr. Hashani Perkins		
M.E.O. Notified	04/30/2026	19:31	Name & Title	Asst. Warden Jeffrey McClellan		
County of Death	Bradford	Inside City Limits ○ Yes ○ No	On the Job ○ Yes ● No	Billing Agency/County Bradford FSP		

Agency	Officer / Agent	Case Number

NARRATIVE

On April 30, 2026 at 1931 hours this office was contacted by Assistant Warden Jeffrey McClellan with the Florida State Prison to report the judicial execution of James Ernest Hitchcock, a 70 year old white male.

Mr. Hitchcock (058293) was a death row inmate at Florida State Prison and has been incarcerated since February 1977. He was sentenced to death for first degree murder committed in July 1976. He was executed via lethal injection on 4/30 at 1800 hours. Death was pronounced at 1812 hours by Dr. Hashani Perkins.

Archer FH transported the decedent to the MEO.

NOK is unknown at this time.
-Inv. Newbanks

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Lauren Newbanks		4/30/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3350707**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 SW 47th Ave Gainsville, FL 32608

Subject's Name:	**HITCHCOCK, JAMES E**
Agency Case #:	ME26-0317
Date of Death:	04/30/2026
Investigator:	LAUREN NEWBANKS
Date Received:	05/07/2026
Date Reported:	06/04/2026

Laboratory Specimen No: **41349891** **Date Collected:** 05/01/2026 11:00
Container(s): 01:BB Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	Negative					
ANESTHETICS	POSITIVE					
Etomidate	POSITIVE	0.2	0.1	0.1 - 0.5	mcg/mL	
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	Negative					
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	POSITIVE					
Hydroxyzine	POSITIVE	13.6	10	50 - 100	ng/mL	
ANTIPSYCHOTICS	POSITIVE					
9-Hydroxyrisperidone	POSITIVE					
Risperidone	POSITIVE	7.2	5	2 - 20	ng/mL	
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41349891** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
CANNABINOIDS	Negative					
CARDIOVASCULARS	Negative					
GASTROINTESTINALS	Negative					
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	POSITIVE					
Caffeine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
Cotinine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41349892** **Date Collected:** 05/01/2026 10:55
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41349892** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

The toxicology findings are based on a single urine test.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41349893** **Date Collected:** 05/01/2026 11:00
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note

< Volatile Testing Not Performed >

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41349894** **Date Collected:** 05/01/2026 11:00
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

FORENSIC TOXICOLOGY

Testing Report

Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41349895** **Date Collected:** 05/01/2026 11:00

Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

HITCHCOCK, JAMES E
Laboratory Case #:3350707
Print Date/Time:06/04/2026, 15:35
Page: 7 of 7

Case Reviewer

Laureen J. Marinetti, Ph.D., F-ABFT

Unless otherwise noted, testing performed at 5780 W 71st Street, Indianapolis, IN 46278.

This individual may not have performed any of the analytical work.

FLORIDA DISTRICT EIGHT
OFFICE OF THE MEDICAL EXAMINER

3217 SW 47th AVENUE
GAINESVILLE, FLORIDA 32608
medistrict8@alachuacounty.us

ALACHUA · BAKER · BRADFORD · DIXIE · GILCHRIST · LEVY · UNION

EXAMINATION REPORT

NAME: BILLY LEON KEARSE
AGE: 53 YEARS
DATE OF BIRTH: [redacted]
RACE: BLACK
SEX: MALE
CASE NUMBER: ME26–0169
DATE OF DEATH: MARCH 3, 2026
DATE OF EXAMINATION: MARCH 4, 2026

AUTOPSY FINDINGS:

1. Multi-Substance Toxicity
    a. Judicial execution via lethal injection
2. Hypertensive Cardiovascular Disease
    a. Cardiomegaly
    b. Left ventricular hypertrophy
    c. Chronic kidney disease
3. Atraumatic Examination

CAUSE OF DEATH: Multi-Substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial Execution with Etomidate, Rocuronium, and Potassium Acetate

4/5/2026

Milad Webb, M.D., Ph.D.
Medical Examiner

EXTERNAL EXAMINATION:

The decedent is a normally developed a black male measuring 69 inches in the length and 183 pounds (insert BMI). The body is cool to the touch after refrigeration with fully developed rigor mortis. Livor mortis is red–purple, posterior and fixed. The body is neither decomposed nor embalmed.

The scalp hair is black–gray. The facial hair consists of a short beard and mustache. The irides are brown with arcus senilis. The sclera and conjunctiva are unremarkable with no evidence of petechial hemorrhages. The oral cavity contains natural dentition and the frenula appear intact.

The skin is unremarkable. The neck is atraumatic. The chest is symmetrical. The abdomen is rounded and soft to palpation. The external genitalia are those of a normally developed circumcised adult male with no injuries. The back and extremities are normally developed and atraumatic.

There are multiple tattoos of various styles and motives present on the decedent's body including the surfaces of the chest and arms.

Electrocardiogram sensors are present on the decedent's body. Intravascular lines are present in the right biceps and left antecubital fossa. Examination of the injection sites reveal appropriate placement of the catheter into the lumen of the vessel. Photographs were taken for documentation.

INTERNAL EXAMINATION:

Body Cavities: The serosal cavities have no adhesions or abnormal collections of fluid. The visceral organs are congested, in normal anatomic positions, and have no decomposition.

Head: The galeal aponeurosis is unremarkable. The vault and base of the skull have no fractures. There are no epidural, subdural, or subarachnoid hemorrhages. The dura mater and falx cerebri are intact. The brain weighs 1320 grams and has normally developed cerebral hemispheres. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The cerebral vessels are unremarkable with no atherosclerosis or aneurysmal dilatations.

Cut surfaces of the cerebral hemispheres, brainstem, and cerebellum reveal no structural lesions. The cerebral ventricles are of normal shape.

Neck: The laryngeal cartilage, and hyoid bone have no fractures or other abnormalities. The cervical spinal column is stable on internal palpation. The strap muscles of the neck are unremarkable. Examination of the pharynx, larynx, and trachea reveal patchy foci of erythema and no significant abnormalities or obstructions.

Cardiovascular: The aorta and its major branches have no significant atherosclerosis. There is no saddle embolus on in situ evaluation of the pulmonary trunk. The pulmonary arteries are patent. The pericardial sac is intact and contains a small amount of clear, straw-colored serous

fluid. The heart weighs 510 grams which is significantly increased for gender and stature. The epicardial surface is smooth and glistening, with a thin layer of yellow adipose tissue.

The coronary arteries arise normally, have patent orifices, and follow a right-dominant distribution. They are of normal caliber and have no significant atherosclerosis. The endocardium is without mural thrombi or fibrous thickening. The valves are normally formed and free of vegetations and degenerative changes. The chordae tendineae and papillary muscles are unremarkable. The foramen ovale is closed.

The chambers of the heart are not dilated. The thickness of the myocardium measures 2.0 to 2.2 cm in the left ventricular wall and interventricular septum. The myocardial cut surfaces are firm, dark red-brown, and unremarkable.

Pulmonary: The right lung weighs 850 grams; the left lung weighs 700 grams. The pleural surfaces are smooth and unremarkable with mildly dense subpleural network of black pigment. The upper and lower airways are unobstructed, and the mucosal surfaces are smooth. The parenchymal cut surfaces are dark red-purple and congested. The cut surfaces have no masses. The peripheral pulmonary arteries are without thromboemboli.

Liver, Gallbladder and Pancreas: The liver weighs 1950 grams and has smooth glistening capsule. The parenchyma is moderately soft and without focal lesions. A capillary hemangioma is noted within the parenchyma (4 x 3 cm). The hepatic veins are patent.

The gallbladder contains a measured 25 milliliters of dark green, viscous bile, and no calculi. Its mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent. The pancreas has congested, tan-brown lobulated parenchyma with clear ducts and is without fibrosis, masses, or calcifications.

Spleen and Lymphatic: The spleen weighs 180 grams and has a smooth, intact capsule with dark maroon, semi-liquefied parenchyma. The lymph nodes are not enlarged. The vertebral marrow is brick red, homogeneous, moist, and firm. The thymus gland is predominantly fat-replaced.

Genitourinary: The right and left kidneys weigh 200 grams and 150 grams, respectively. The capsules are smooth, thin, and strip with ease. The capsules are thick and adherent to the cortical surface. The cortical surface is finely granular and scarred. The cortices are well delineated from the underlying medullary pyramids and have no focal lesions.

The calyces, pelves, and ureters are not dilated and have unremarkable tan-white mucosa. The urinary bladder contains a measured 180 milliliters of straw-colored urine. Its mucosa is tan-white and smooth, without focal lesions. The seminal vesicles are unremarkable. The testes and spermatic cords have unremarkable stringy tan cut surfaces, with no hemorrhages or other abnormalities.

The prostate gland is of normal size. The external surface is smooth and intact. The parenchyma is homogeneous, firm and without significant nodules, cysts, or areas of hemorrhage or necrosis.

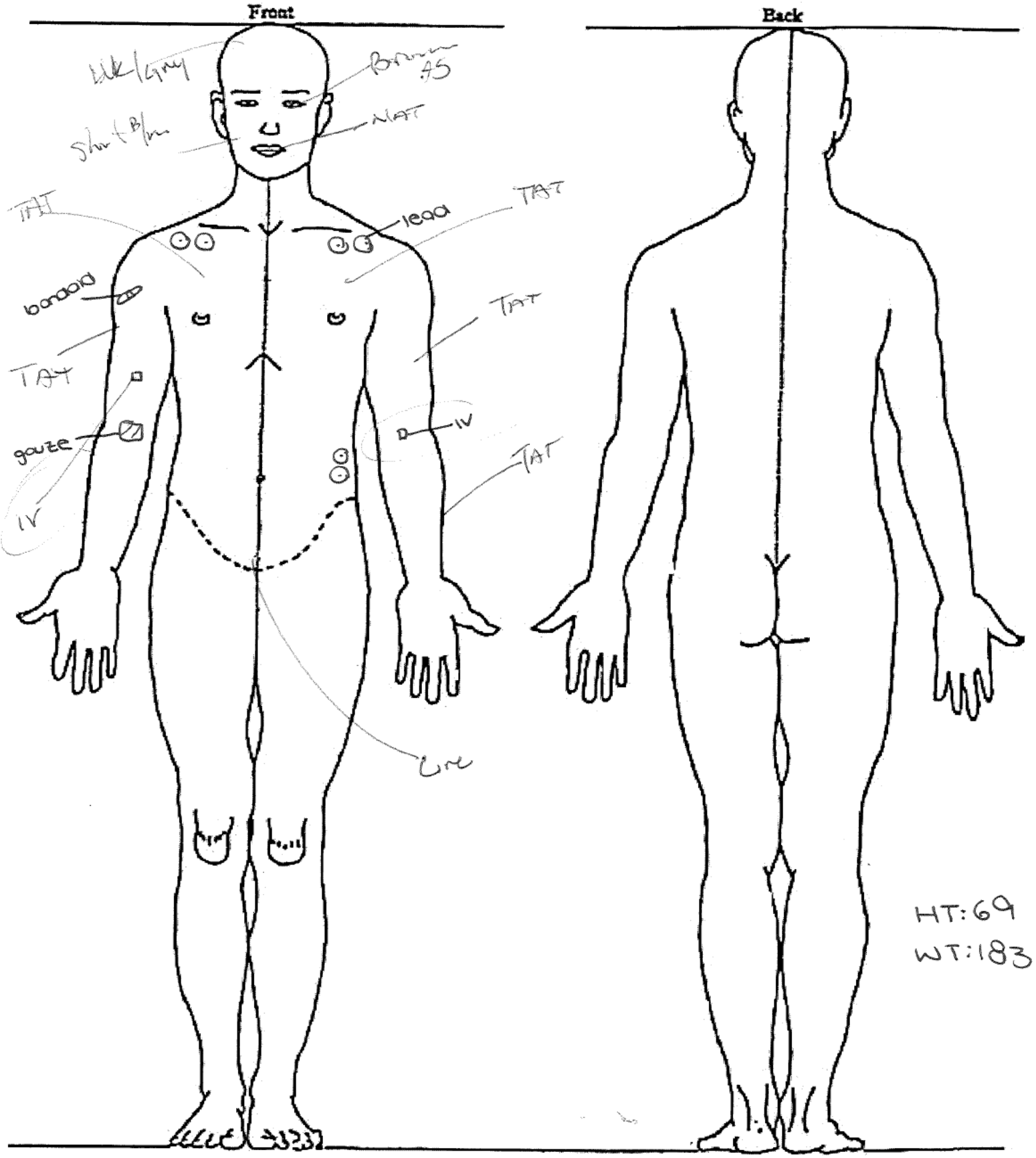
Endocrine: The pituitary gland is of normal size and has no lesions. The adrenal glands are unremarkable. The thyroid gland is normal in size and has red-brown, uniform, monomorphic cut surfaces without lesions.

Digestive: The esophagus is lined by a smooth, gray-white mucosa, with no lesions. The gastroesophageal junction is unremarkable and the gastric mucosa is autolyzed. The stomach lumen contains a measured 30 milliliters of partially digested food and liquid. The duodenum has no lesions. The small and large bowels are unremarkable. The colon contains semiformed stool. The appendix is identified.

Musculoskeletal: There are no acute fractures. There are no significant degenerative changes. The musculature is normally developed. The cut surfaces of a section of representative lumbar vertebral body are hard and unremarkable.

ME26-0169 Kearse, Billy Leon 53, B, M DOB: [redacted] DOD: 3/3/2026

PATHOLOGIST: BODY EXAMINATION Prisoner: [X] Infectious:



Pathologist Milad Webb, MD Date Body Viewed Time

Office of the Medical Examiner District Eight

www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-273-9292
Fax 352-273-9288

ME26-0169
Kearse, Billy Leon
3/3/2026

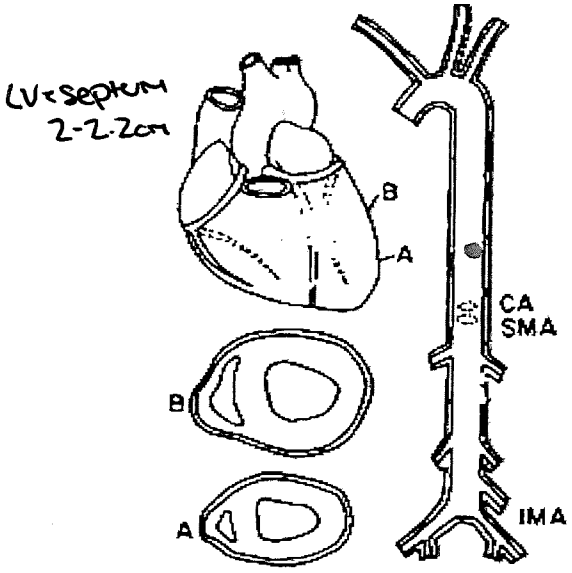
Physician: Webb
Case #: 0169

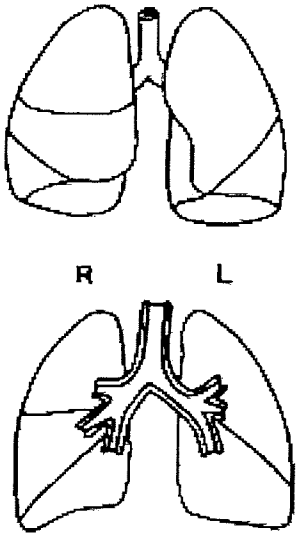
Date: 3/4/26 @ 1130
Name: Kearse, Billy Leon

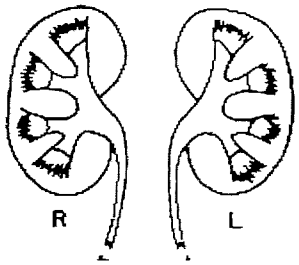
Heart: 510
R. Lung: 850
L. Lung: 700
Liver: 1950

Spleen: 180
R. Kidney: 200
L. Kidney: 150
Brain: 1320

Age: 53
Sex: M
Ht.: 69
Wt.: 183

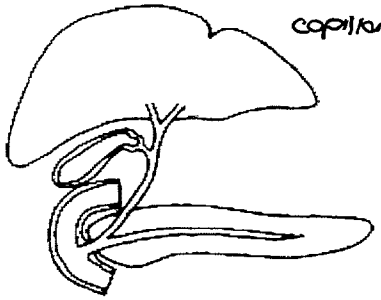




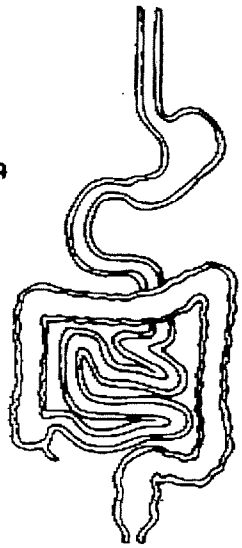


Urine: 180
Stones: _____

Dominant: RT / LT
LAD: _____ CFX: _____ RCA: _____
LV: _____ RV: _____ IVS: _____
TV: _____ RV: _____ MV: _____ AV: _____



Bile: 25
Stones: ø





Stomach Contents: 30 green
Appendix: (+)
Stool: _____
Tics: _____
Fat: _____

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Kearse, Billy Leon** **ME26-0169**

Race	Gender	DOB: MM	DD	YYYY	Age
Black	Male	[redacted]	[redacted]	[redacted]	53 years 4 months 5 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Billy Kearse is a 53-year-old black male inmate at Florida State Prison. The decedent was executed by lethal injection on 03/03 and pronounced by Dr. Astrid Clark at 1824 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	03/03/2026	18:00	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026	Bradford	Correctional Institution	
Onset						
Last Seen Alive			Name & Title			
Date of Death	03/03/2026	18:24	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026		
Pronounced or Found by			Name & Title			
M.E.0. Notified			Name & Title			

County of Death	Inside City Limits	On the Job	Billing Agency/County
Bradford	○Yes ○No	○Yes ○No	Bradford FSP

Agency	Officer / Agent	Case Number

NARRATIVE

On 03/03/2026 at approximately 1922 hours, this office received a call from Assistant Warden Jeff McClellen. He was reporting the death of Billy Kearse, a 53-year-old black male inmate at Florida State Prison. He has been incarcerated at Florida State prison since 1991 on first degree murder charges. The decedent was executed by lethal injection on 03/03/26. The execution began at approximately 1800 hours, and the decedent was pronounced by Dr. Astrid Clark at 1824 hours.

NOK will be notified of the MEO involvement by Florida State Prison

Deceased: **Kearse, e** **ME26-0 6**

Archer Funeral Home was dispatched to transport the decedent to the MEO.

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Rachel Hildreth		3/3/2026
Lead Investigator	Signature	Date

- CONFIDENTIAL -

University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R26-00410
NAME: Kearse, Billy
CASE NO: 26-169
RECEIPT DATE: 03/04/2026

Forensic Toxicology Laboratory

SUBMITTER: Dr. Milad Webb, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2600410 - 01/ CC 04/07/26 [0001, 1503]
PRINTED: 04/07/26

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Toxicology Report

Report Issued 04/07/2026 10:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	KEARSE, BILLY
Patient ID	R26-00410
Chain	NMSCP523381
DOB	Not Given
Sex	Male
Workorder	26109672

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.57**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	7.5 mL	03/04/2026 14:02	Heart Blood	R26-00410

All sample volumes/weights are approximations.
Specimens received on 03/11/2026.

NMS LABS

CONFIDENTIAL

Workorder	26109672
Chain	NMSCP523381
Patient ID	R26-00410

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.57	mcg/mL	0.040	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.040 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: King, Michael
AGE: 54
GENDER: Male
RACE: White
CASE NUMBER: ME26-0207
DATE OF DEATH: March 17, 2026
DATE OF EXAMINATION: March 20, 2026

AUTOPSY FINDINGS:

1. Cardiomegaly (480 grams)
2. Minimal atherosclerosis of left anterior descending coronary artery
3. Mild aortic atherosclerosis
4. Pulmonary congestion and edema
5. Cholesterolosis, gallbladder
6. Splenule

CAUSE OF DEATH: Multi-Substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Kailee Imperatore

Kailee A. Imperatore, M.D.
Associate Medical Examiner

Completed: March 27, 2026

EXTERNAL EXAMINATION:

The body is that of a normally developed, obese, 5 foot 7 inch, 203 pound male who appears the reported age of 54 years. The body mass index (BMI) is 31 kilograms per meter-squared. The body is refrigerated and well-preserved.

The scalp has gray, short, straight hair in a pattern consistent with androgenic alopecia. Facial hair consists of dark and gray stubble. The irides are blue, and the pupils are round and equal. The sclerae are white. The conjunctivae are clear and have no petechiae. The ears, nose, and mouth are normally formed. The external auditory canals are unremarkable. The earlobes have creases. The nasal bones and nasal septum are intact. The lips are uninjured. The frenula are not lacerated. The teeth are natural and in fair condition.

The neck and chest are symmetrical. The nipples and breasts are unremarkable. The abdomen is slightly protuberant and soft. A linear, vertical scar is centrally located on the upper abdomen. The back and buttocks are symmetrical and have no deformities. The external genitalia are those of a fully developed, uncircumcised male. Both testes are palpable in the scrotum. The anus is unremarkable.

The bilateral upper and lower extremities are symmetrical and have no palpable fractures. No track marks are on the arms. The wrists have no scars. Few scars are on the lower extremities. A scab is on the posterior aspect of the left ankle. The hands and feet are symmetrical, and the nails are intact. The body has no tattoos.

EVIDENCE OF MEDICAL PRESENCE:

Electrocardiogram lead pads are adhered to the torso.

Catheters extend from the bilateral antecubital fossae. The skin and subcutaneous tissues of the antecubital fossae were dissected to confirm intravenous locations of the catheters.

INTERNAL EXAMINATION:

The reflected scalp has no hemorrhages. The calvarium and skull base have no fractures. The cranial vault has no epidural, subdural, or subarachnoid hemorrhages. The leptomeninges are thin and transparent. The 1380 gram brain is symmetrical, and the cerebrum has normal gyral configuration. The cranial nerves and vessels at the base of the brain are normally positioned and formed. The vessels of the circle of Willis have no aneurysms or atherosclerosis. The deep gray nuclei have no gross pathologic abnormalities. The subcortical and deep white matter has no gross pathologic abnormalities. The substantia nigra is normally pigmented. The brainstem and cerebellum are intact and have no gross pathologic abnormalities.

The anterior muscles of the neck are free of hemorrhages. The hyoid bone and laryngeal cartilages have no fractures. The large vessels of the neck are unremarkable. The pharynx and larynx have no obstructing foreign bodies or abnormal secretions. The epiglottis and vocal cords are unremarkable.

The pleural cavities have no abnormal fluid collections or adhesions. The pericardial sac has no abnormal fluid collections or adhesions. The peritoneal cavity has no abnormal fluid collections or adhesions. The diaphragm and organs of the thorax and abdomen are in their normal anatomic locations.

The 480 gram heart has a smooth epicardial surface and slightly increased epicardial adipose tissue. The coronary ostia are normally positioned and patent. The coronary arterial circulation is right dominant. The coronary arteries have normal anatomic courses. The left main, left circumflex, and right coronary arteries are thin-walled and patent. The left anterior descending coronary artery has up to approximately 10 percent stenosis by atherosclerosis. The four-chambered heart has a normal configuration. The cardiac chambers are not dilated. The myocardium is tan-red and has no fibrosis, pallor, or hemorrhages. The interatrial and interventricular septa are normally developed. The fossa ovalis is closed. The mural and valvular endocardium is thin, transparent, and free of mural thrombi. The papillary muscles and chordae tendineae are slightly thickened. The cardiac valves are thin, pliable, and free of vegetations and calcifications. The aorta has a normal caliber, no aneurysms, and mild atherosclerosis. The venae cavae have normal anatomic courses and are free of thrombi.

The right lung is 700 grams and the left lung is 600 grams. The pleural surfaces are pink to red-purple, smooth, and glistening. The boggy pulmonary parenchyma is pink-purple, expresses abundant bloody and frothy fluid, and has no masses, granulomata, or discrete areas of consolidation. The pulmonary vasculature is patent and has no thromboemboli. The trachea and bronchi are patent and have no foreign bodies or obstructions.

The 2260 gram liver has a smooth and intact capsule. Its parenchyma is brown, soft, and free of masses and fibrosis. The thin-walled gallbladder contains approximately 10 milliliters of red-brown bile and no calculi. Its mucosa is red-brown, velvety, and has a yellow, lace-like pattern. The biliary tree is normally formed. The ductal lumina are patent. The vessels of the porta hepatis are unremarkable. The pancreas has tan-pink, lobulated parenchyma without masses.

The tongue has no bite marks or hemorrhages. The serosal and mucosal surfaces of the esophagus are unremarkable. The stomach contains approximately 100 milliliters of tan fluid and food. Its mucosa is tan, has normal rugal folds, and no ulcers or masses. The serosal surfaces and calibers of the small intestine and large intestine are normal and have no palpable masses or obstructions. The appendix is unremarkable.

The 390 gram spleen has a smooth and intact capsule covering mostly soft, red-purple parenchyma. The bone marrow of the ribs is red and soft. The lymph nodes of the neck, thorax, abdomen, and pelvis are not enlarged.

The right and left kidneys are 220 grams, each. The capsules are thin, and the cortical surfaces are smooth. The renal parenchyma is tan-red, has moderately-defined corticomedullary junctions, and no masses. The renal vessels are patent. The pelvicalyceal systems are unremarkable. The ureters have normal course and calibers to the urinary bladder. The bladder

contains approximately 300 milliliters of clear, yellow urine and its mucosa is tan-white and trabeculated. The prostate gland is unremarkable.

The thyroid gland is normal in size and shape and has homogeneous, tan parenchyma and no masses. The adrenal glands have normal yellow cortices and brown medullae.

The skeletal muscles of the thorax, abdomen, and pelvis are red-brown and soft. The clavicles, sternum, ribs, vertebral bodies, and pelvis have no acute fractures.

Office of the Medical Examiner District Eight

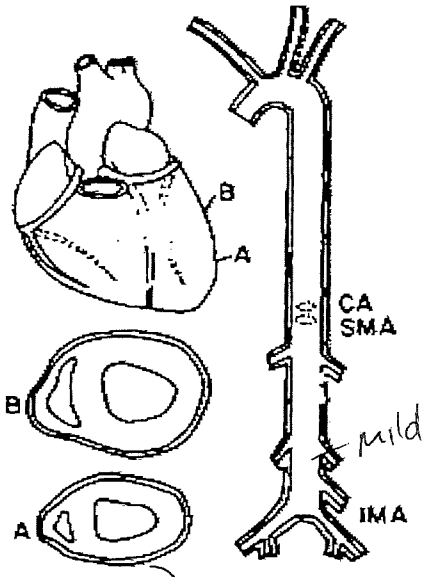
www.district8me.com
achua, Baker, Bradford, Dixie,
christ, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-273-9292
Fax 352-273-9288

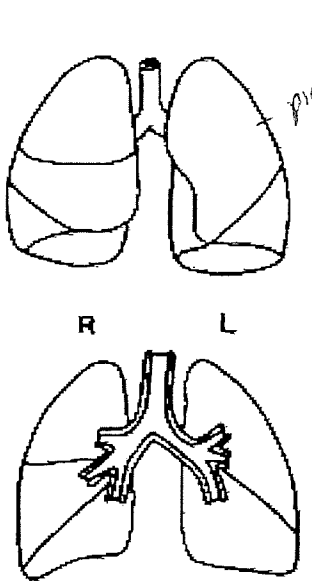
ME26-0207
King, Michael Lee
3/17/2026

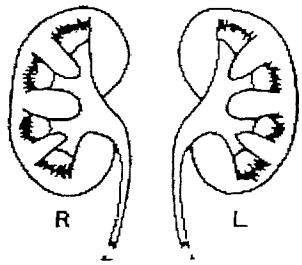
Physician: Impecatore Date: 3/20/26 1145
Case #: 26-0207 Name: King, Michael Lee

Heart: 480 Spleen: 390 Age: 54
R. Lung: 700 R. Kidney: 220 Sex: M
L. Lung: 600 L. Kidney: 220 Ht.: 67
Liver: 2260 Brain: 1380 Wt.: 203



Dominant (RT) / LT
LAD: 10 CFX: 0 RCA: 0
LV: ____ RV: ____ IVS: ____
TV: ____ RV: ____ MV: ____ AV: ____

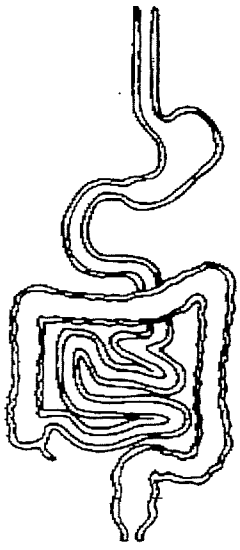


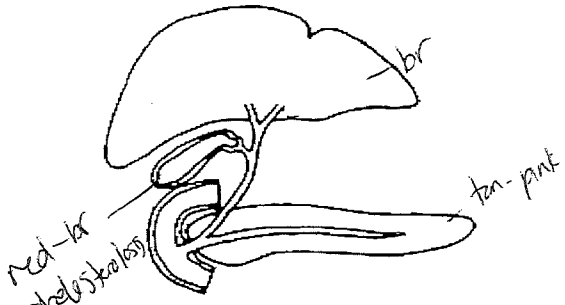


Urine: 300
Stones: ____



tan thyr



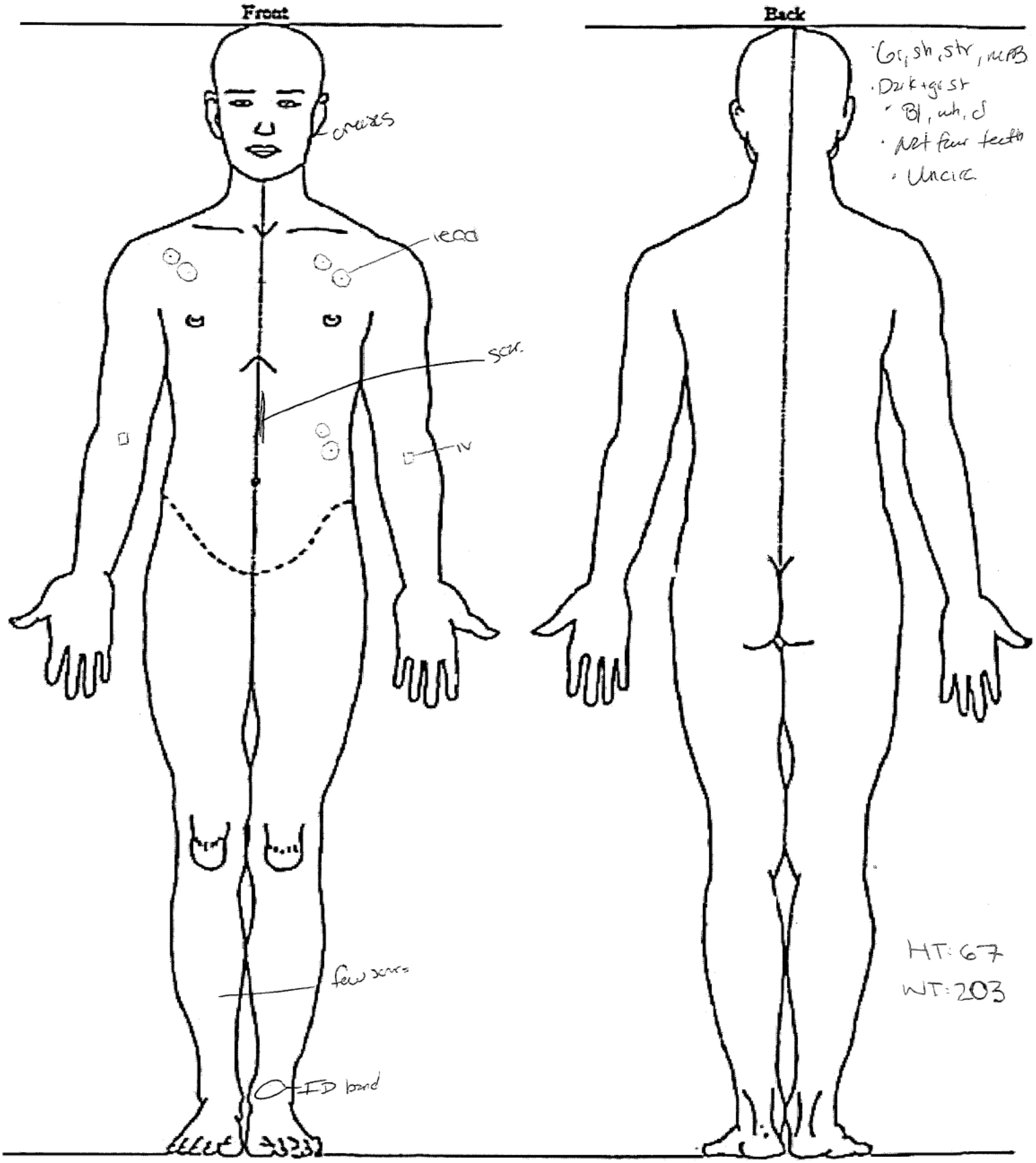


Bile: 10
Stones: X

Stomach Contents: 100 tan + food
Appendix: (+)
Stool: ____
Tics: ____
Fat: ____

ME26-0207 King, Michael Lee 54, W, M DOB: [redacted] DOD: 3/17/2026

PATHOLOGIST: BODY EXAMINATION Prisoner: [X] Infectious:



Pathologist Kailee Imperatore, MD Date Body Viewed 3/20/26 Time

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **King, Michael Lee** **ME26-0207**

Race	Gender	DOB: MM	DD	YYYY	Age
White	Male	[redacted]	[redacted]	[redacted]	54 years 10 months 13 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Michael Lee King is a 54 year old white male who was a death row inmate at the Florida State Prison. He was executed via lethal injection on 3/17 and death was pronounced at 1813 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	03/17/2026	18:00	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026	Bradford	Correctional Institution	
Onset						

Last Seen Alive			Name & Title	
Date of Death	03/17/2026	18:13	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026
Pronounced or Found by	03/17/2026	18:13	Name & Title	Dr. Hashani Perkins
M.E.0. Notified	03/17/2026	19:12	Name & Title	Asst. Warden Jeffrey McClellan

County of Death	Inside City Limits	On the Job	Billing Agency/County
Bradford	○Yes ○No	○Yes ●No	Bradford FSP

Agency	Officer / Agent	Case Number

NARRATIVE

On March 17, 2026 at 1912 hours this office was contacted by Assistant Warden Jeffrey McClellan with the Florida State Prison to report the judicial execution of Michael Lee King, a 54 year old white male.

Mr. King (132254) was a death row inmate at Florida State Prison and has been incarcerated since December 2009. He was sentenced to death for first degree murder committed in January 2008. He was executed via lethal injection on 3/17 at 1800 hours. Death was pronounced at 1813 hours by Dr. Hashani Perkins.

Archer FH transported the decedent to the MEO.

Deceased: K , M c ae ee ME26-020

NOK is unknown at this time.
-Inv. Newbanks

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Lauren Newbanks		3/18/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3347088**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 WE 47th Avenue Gainsville, FL 32608 FX: 352-384-3365

Subject's Name:	**KING, MICHAEL L**
Agency Case #:	ME26-0207
Date of Death:	03/17/2026
Investigator:	LAUREN NEWBANKS
Date Received:	03/24/2026
Date Reported:	04/02/2026

Laboratory Specimen No: **41338376** **Date Collected:** 03/20/2026 10:35
Container(s): 01:GRT Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	Negative					
ANESTHETICS	POSITIVE					
Etomidate	POSITIVE	0.2	0.1	0.1 - 0.5	mcg/mL	
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	Negative					
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	Negative					
ANTIPSYCHOTICS	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					
CARDIOVASCULARS	Negative					
GASTROINTESTINALS	Negative					

Kailee A Imperatore

4/7/2026

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41338376** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	POSITIVE					
Caffeine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41338379** **Date Collected:** 03/20/2026 10:35
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41338379** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41338381** **Date Collected:** 03/20/2026 10:30
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note

< Volatile Testing Not Performed >

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41338382** **Date Collected:** 03/20/2026 10:35
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41338383** **Date Collected:** 03/20/2026 10:35
Container(s): 01:BB Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

KING, MICHAEL L
Laboratory Case #:3347088
Print Date/Time:04/02/2026, 15:21
Page: 7 of 7

Case Reviewer

Stuart Kurtz, M.S., D-ABFT -FT

Unless otherwise noted, testing performed at 5780 W 71st Street, Indianapolis, IN 46278. This individual may not have performed any of the analytical work.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3352544**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 SW 47th Ave Gainsville, FL 32608

Subject's Name:	**KNIGHT, RICHARD**
Agency Case #:	ME26-0356
Date of Death:	05/21/2026
Investigator:	LAUREN NEWBANKS
Date Received:	05/29/2026
Date Reported:	07/14/2026

Laboratory Specimen No: **41355442** **Date Collected:** 05/22/2026 10:10
Container(s): 01:BB Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

** * AMENDED REPORT * **

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	Negative					
ANESTHETICS	POSITIVE					
Etomidate	POSITIVE	0.2	0.1	0.1 - 0.5	mcg/mL	
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	Negative					
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	Negative					
ANTIPSYCHOTICS	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					
CARDIOVASCULARS	Negative					
GASTROINTESTINALS	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355442** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	Negative					
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

PLEASE NOTE: This is a revised report. Previous report on 06/08/2026 did not indicate Comprehensive Panel tesing results on specimen ID 41355442.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355445** **Date Collected:** 05/22/2026 10:10
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355445** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

The toxicology findings are based on a single urine test.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355447** **Date Collected:** 05/22/2026 10:05
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< Volatile Testing Not Performed >						

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355448** **Date Collected:** 05/22/2026 10:10
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

AXIS FORENSIC TOXICOLOGY

Testing Report

Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355449** **Date Collected:** 05/22/2026 10:10

Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

KNIGHT, RICHARD
Laboratory Case #:3352544
Print Date/Time:07/14/2026, 11:06

Case Reviewer

Laureen J. Marinetti, Ph.D., F-ABFT

Unless otherwise noted, testing performed at 5780 W 71st Street, Indianapolis, IN 46278.

This individual may not have performed any of the analytical work.

FLORIDA DISTRICT EIGHT
OFFICE OF THE MEDICAL EXAMINER

3217 SW 47th AVENUE
GAINESVILLE, FLORIDA 32608
medistrict8@alachuacounty.us

ALACHUA · BAKER · BRADFORD · DIXIE · GILCHRIST · LEVY · UNION

EXAMINATION REPORT

NAME: RICHARD KNIGHT
AGE: 47 YEARS
DATE OF BIRTH: [redacted]
RACE: BLACK
SEX: MALE
CASE NUMBER: ME26–0356
DATE OF DEATH: MAY 21, 2026
DATE OF EXAMINATION: MAY 22, 2026

AUTOPSY FINDINGS:

1. Multi–substance toxicity
    a. Lethal injection
2. Arteriosclerotic cardiovascular disease
    a. Coronary artery disease
3. Atraumatic examination

CAUSE OF DEATH: Multi-substance toxicity
MANNER OF DEATH: Homicide
HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Milad Webb, M.D., Ph.D.
Medical Examiner

6/23/2026
Date

EXTERNAL EXAMINATION:

The decedent is a normally developed 47-year-old Black male measuring 68 inches in length and weighing 171 pounds (BMI 26.0 kg/m²). The body is cool to the touch following refrigeration

and exhibits fully developed rigor mortis. Livor mortis is red-purple, posterior, and fixed. The body is neither decomposed nor embalmed.

The scalp hair is black, curly, and measures approximately 1 inch in maximal length. Facial hair consists of a beard and mustache. The irides are brown. The sclerae and conjunctivae are unremarkable, with no evidence of petechial hemorrhages. The oral cavity is unremarkable with natural dentition. The frenula are intact.

The neck is atraumatic, and the trachea appears midline. The chest is normally developed and symmetrical. The abdomen is rounded and soft to palpation. The external genitalia are those of a normally developed adult male. The back and extremities are normally developed and atraumatic.

There are no identifying marks, scars, or tattoos.

Intravascular catheters are present within the right and left antecubital fossae. Electrocardiographic monitoring electrodes are present on the body.

INJECTION SITE EXAMINATION:
Examination of the injection sites reveal intravascular catheters appropriately within the lumen of the vessels within the antecubital fossa. Photos were taken to document the findings. There is no infiltration of the injection sites and no surrounding hemorrhage.

INTERNAL EXAMINATION:

Body Cavities: The serosal cavities have no adhesions or abnormal collections of fluid. The visceral organs are congested, in normal anatomic positions, and have no decomposition.

Head: The galeal aponeurosis is unremarkable. The vault and base of the skull have no fractures. There are no epidural, subdural, or subarachnoid hemorrhages. The dura mater and falx cerebri are intact. The brain weighs 1440 grams and has normally developed cerebral hemispheres. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The cerebral vessels are unremarkable with no atherosclerosis or aneurysmal dilatations.

Cut surfaces of the cerebral hemispheres, brainstem, and cerebellum reveal no structural lesions. The cerebral ventricles are of normal shape.

Neck: The laryngeal cartilage, and hyoid bone have no fractures or other abnormalities. The cervical spinal column is stable on internal palpation. The strap muscles of the neck are unremarkable. Examination of the pharynx, larynx, and trachea reveal patchy foci of erythema and no significant abnormalities or obstructions.

Cardiovascular: The aorta and its major branches have no significant atherosclerosis. There is no saddle embolus on in situ evaluation of the pulmonary trunk. The pulmonary arteries are patent. The pericardial sac is intact and contains a small amount of clear, straw-colored serous

fluid. The heart weighs 400 grams which is within normal range for gender and stature. The epicardial surface is smooth and glistening, with a thin layer of yellow adipose tissue.

The coronary arteries arise normally, have patent orifices, and follow a right-dominant distribution. There is significant obstructive calcific atherosclerosis with up to 70% stenosis of the left anterior descending coronary artery. The endocardium is without mural thrombi or fibrous thickening. The valves are normally formed and free of vegetations and degenerative changes. The chordae tendineae and papillary muscles are unremarkable. The foramen ovale is closed.

The chambers of the heart are not dilated. The thickness of the myocardium measures 1.2 to 1.3 cm in the left ventricular wall and interventricular septum. The myocardial cut surfaces are firm, dark red-brown, and unremarkable.

Pulmonary: The right lung weighs 510 grams; the left lung weighs 500 grams. The pleural surfaces are smooth and unremarkable with mildly dense subpleural network of black pigment. The upper and lower airways are unobstructed, and the mucosal surfaces are smooth. The parenchymal cut surfaces are dark red-purple and congested. The cut surfaces have no masses. The peripheral pulmonary arteries are without thromboemboli.

Liver, Gallbladder and Pancreas: The liver weighs 1470 grams and has smooth glistening capsule. The parenchyma is moderately soft and without focal lesions. The hepatic veins are patent.

The gallbladder contains a measured 20 milliliters of dark green, viscous bile, and no calculi. Its mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent. The pancreas has congested, tan-brown lobulated parenchyma with clear ducts and is without fibrosis, masses, or calcifications.

Spleen and Lymphatic: The spleen weighs 190 grams and has a smooth, intact capsule with dark maroon, semi-liquefied parenchyma. The lymph nodes are not enlarged. The vertebral marrow is brick red, homogeneous, moist, and firm. The thymus gland is predominantly fat-replaced.

Genitourinary: The kidneys weigh 170 g, each. There is no increase in hilar adipose tissue of the kidneys. The capsules are smooth, thin, and strip with ease. The cortical surfaces are dark red, smooth, and without lesions. The cortices are well delineated from the underlying medullary pyramids and have no focal lesions.

The calyces, pelves, and ureters are not dilated and have unremarkable tan-white mucosa. The urinary bladder contains a measured 14 milliliters of straw-colored urine. Its mucosa is tan-white and smooth, without focal lesions.

The seminal vesicles are unremarkable. The testes and spermatic cords have unremarkable stringy tan cut surfaces, with no hemorrhages or other abnormalities.

Endocrine: The pituitary gland is of normal size and has no lesions. The adrenal glands are unremarkable. The thyroid gland is normal in size and has red-brown, uniform, monomorphic cut surfaces without lesions.

Digestive: The esophagus is lined by a smooth, gray-white mucosa, with no lesions. The gastroesophageal junction is unremarkable and the gastric mucosa is autolyzed. The stomach lumen contains a measured 150 milliliters of partially digested food and liquid. The duodenum has no lesions. The small and large bowels are unremarkable. The colon contains semiformed stool. The appendix is identified.

Musculoskeletal: There are no acute fractures. There are no significant degenerative changes. The musculature is normally developed. The cut surfaces of a section of representative lumbar vertebral body are hard and unremarkable.

ME26-0356
Knight, Richard
05/21/2026

DC ☐
Dictated ☐
Autopsy / External / Tox

Case Number: 26 - 0356

FLORIDA DISTRICT 8 OME
External Examination

Exam Date/Time: 5/22/26 0956 Inmate: ☒ Hospital: ☐ Decomposed: ☐

Cool / Warm **Rigor:** Fix / Partial / Waning / Passed **Livor:** Fixed / Blanching / Mixed

R / L ~~A / P~~

Hair: BLK / BR / BL / Red / W / GRY curly 1"

Facial Hair: ~~B~~ / M / G

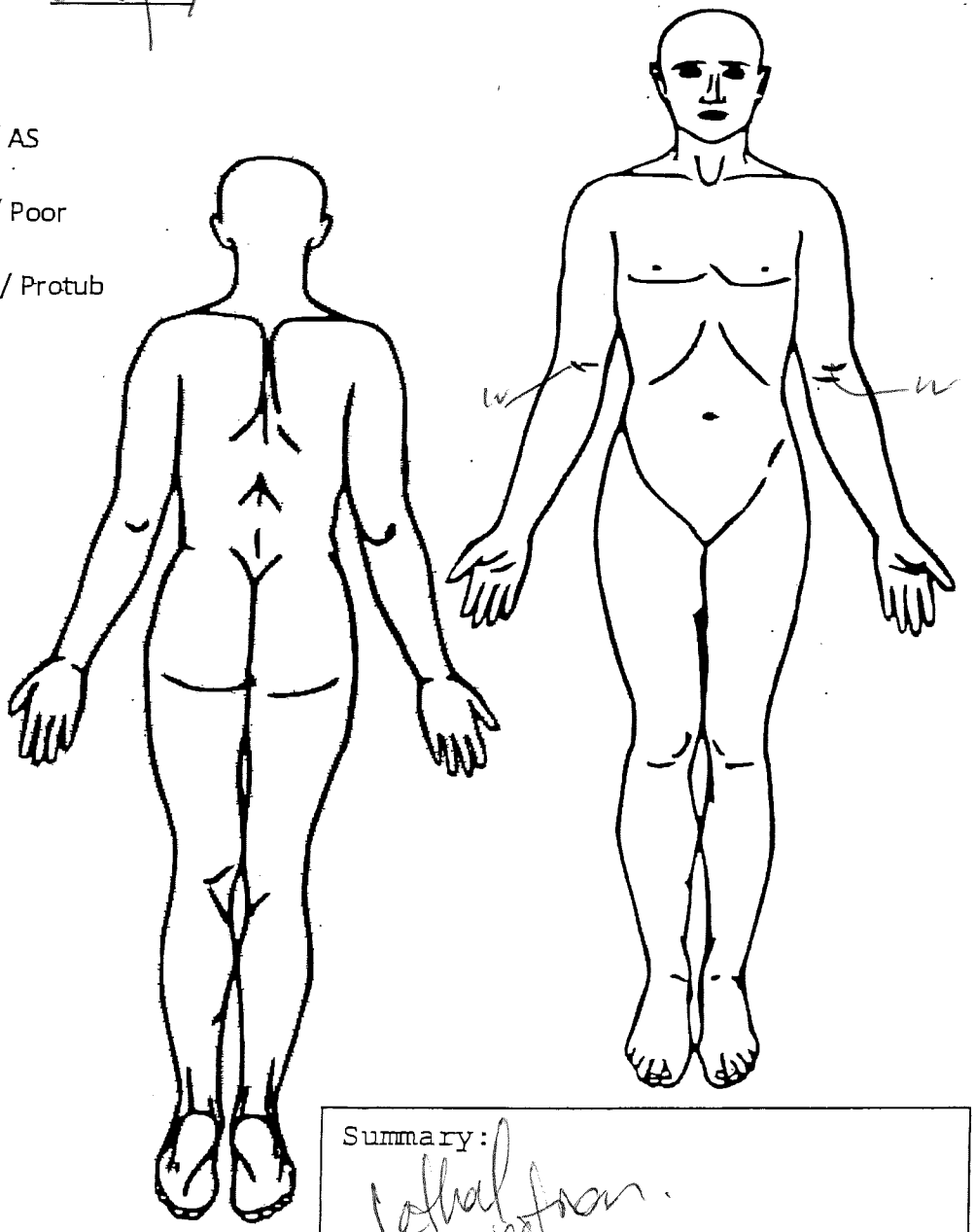
Eyes: BR / BLU/ GR / HZL / GRY / AS

Mouth/Teeth: NAT / ABS / DENT / Poor

Abdomen: Sc / Flat / Round / Soft / Protub

Mark/Scars/Tattoos:
none

Injuries/Other:
lethal Injections



Summary:
lethal injection.

Office of the Medical Examiner District Eight

www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

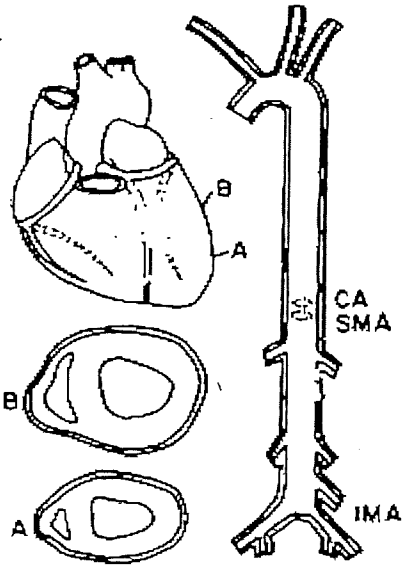
3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-273-9292
Fax 352-273-9288

ME26-0356
Knight, Richard
05/21/2026

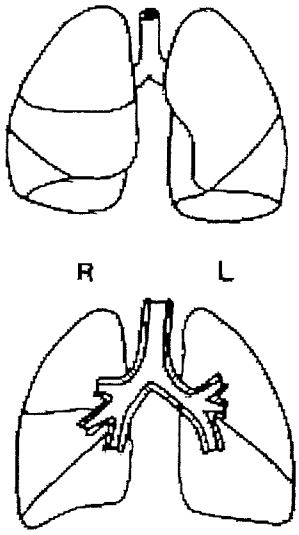
Physician: Webb
Date: 5/22/26 @ 1030
Case #: ME26-0356
Name: Knight, Richard

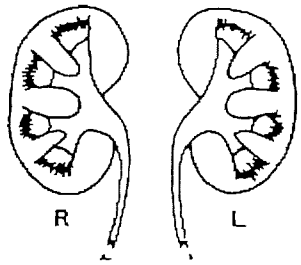
Heart: 400
R. Lung: 510
L. Lung: 500
Liver: 1470
Spleen: 190
R. Kidney: 170
L. Kidney: 170
Brain: 1440
Age: 47
Sex: M
Ht.: 68
Wt.: 171

Up to 70% L. ant



Coronary artery disease

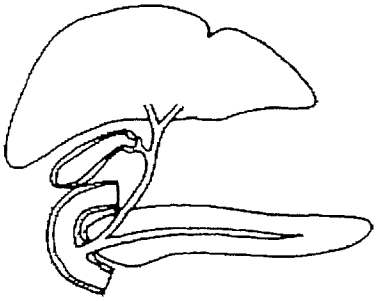


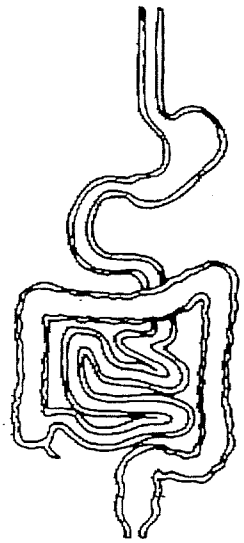


Urine: 14
Stones:

Dominant: RT / LT
LAD: up to 70% CFX: RCA:
LV: RV: IVS:
TV: RV: MV: AV:





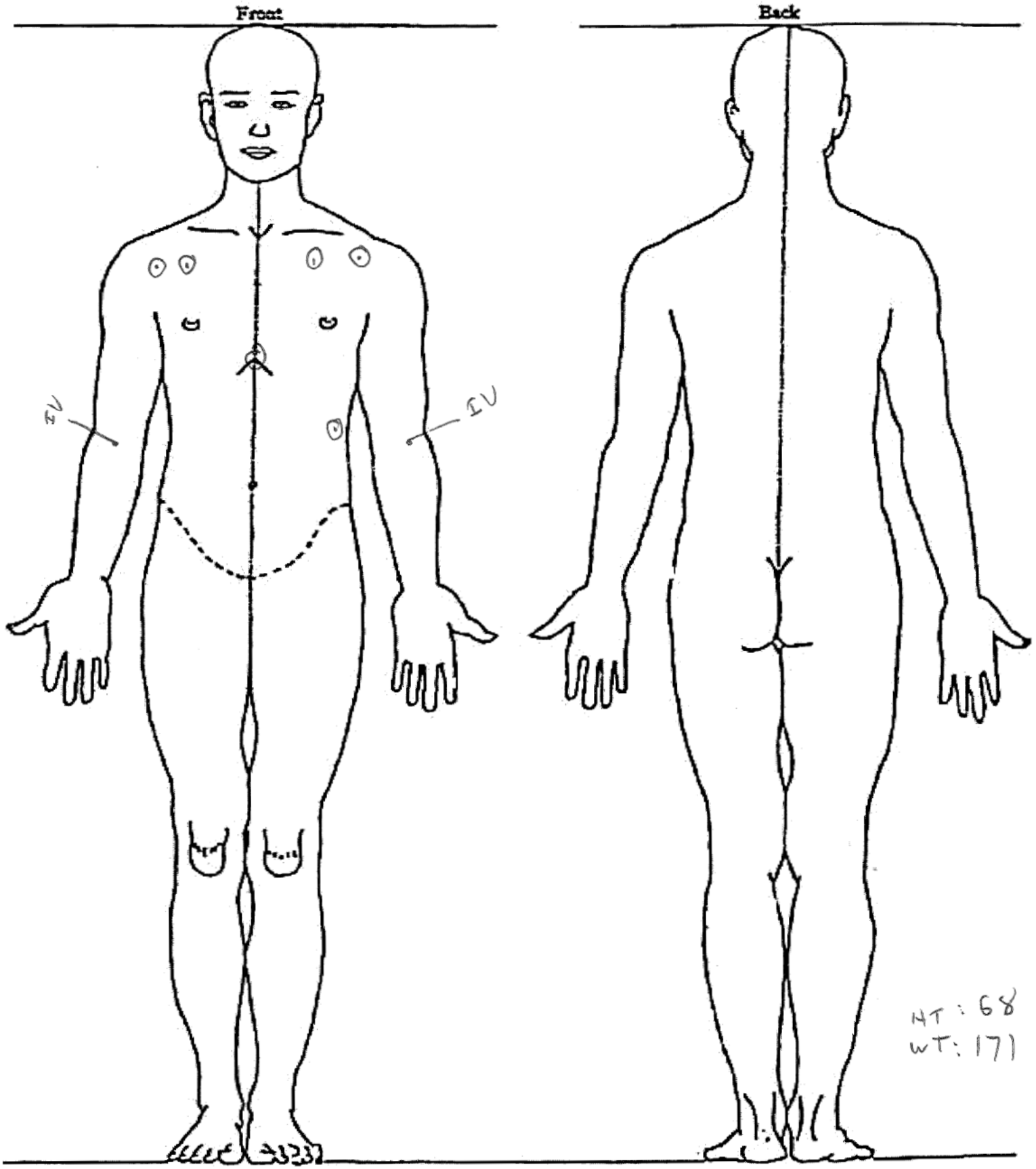


Bile:
Stones:
Gallbladder: 20

Stomach Contents: 150
Appendix: +
Stool:
Tics:
Fat:

ME26-0356 Knight, Richard 47, B, M DOB: [redacted] DOD: 5/21/2026

PATHOLOGIST: BODY EXAMINATION Prisoner: [X] Infectious:



Pathologist Milad Webb, MD Date Body Viewed Time

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Knight, Richard** **ME26-0356**

Race	Gender	DOB: MM	DD	YYYY	Age
Black	Male	[redacted]	[redacted]	[redacted]	47 years 10 months 15 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Richard Knight is a 47 year old black male who was a death row inmate at the Florida State Prison. He was executed via lethal injection on 5/21 and death was pronounced at 1813 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	05/21/2026	18:00	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026	Bradford	Correctional Institution	
Onset						
Last Seen Alive			Name & Title			
Date of Death	05/21/2026	18:13	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026		
Pronounced or Found by	05/21/2026	18:13	Name & Title	Dr. Astrid Clarke		
M.E.O. Notified	05/21/2026	19:28	Name & Title	Mr. Pleasant, Acting Assistant Warden/Classifications Supervisor		
County of Death	Bradford	Inside City Limits ○Yes ○No	On the Job ○Yes ●No	Billing Agency/County Bradford FSP		

Agency	Officer / Agent	Case Number

NARRATIVE

On May 21, 2026 at 1928 hours this office was contacted by Acting Assistant Warden and Classifications Supervisor Mr. Pleasant with the Florida State Prison to report the judicial execution of Richard Knight, a 47 year old black male.

Mr. Knight (L36345) was a death row inmate at Florida State Prison and has been incarcerated since March 2007. He was sentenced to death for first degree murder committed in June 2000. He was executed via lethal injection on 5/21 at 1800 hours. Death was pronounced at 1813 hours by Dr. Astrid Clarke.

Archer FH transported the decedent to the MEO.

Deceased: K t, R c ard ME26-0 56

NOK is unknown at this time.
-Inv. Newbanks

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Lauren Newbanks		5/21/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3352544**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 SW 47th Ave Gainsville, FL 32608

Subject's Name:	**KNIGHT, RICHARD**
Agency Case #:	ME26-0356
Date of Death:	05/21/2026
Investigator:	LAUREN NEWBANKS
Date Received:	05/29/2026
Date Reported:	06/08/2026

Laboratory Specimen No: **41355442** **Date Collected:** 05/22/2026 10:10
Container(s): 01:BB Blood,ILIAC **Test(s):** 70530 Drugs of Abuse Panel, Blood

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					
HALLUCINOGENS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
STIMULANTS	Negative					

Specimens will be kept for at least one year from the date of initial report.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355445** **Date Collected:** 05/22/2026 10:10
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355445** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

The toxicology findings are based on a single urine test.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355447** **Date Collected:** 05/22/2026 10:05
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< Volatile Testing Not Performed >						

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355448** **Date Collected:** 05/22/2026 10:10
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41355449** **Date Collected:** 05/22/2026 10:10
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

KNIGHT, RICHARD
Laboratory Case #:3352544
Print Date/Time:06/08/2026, 07:59

Case Reviewer

Kevin Shanks, M.S., D-ABFT -FT

FLORIDA DISTRICT EIGHT
OFFICE OF THE MEDICAL EXAMINER

3217 SW 47th AVENUE
GAINESVILLE, FLORIDA 32608
medistrict8@alachuacounty.us

ALACHUA · BAKER · BRADFORD · DIXIE · GILCHRIST · LEVY · UNION

EXAMINATION REPORT

NAME: ANDREW LUKEHART
AGE: 53 YEARS
DATE OF BIRTH: [redacted]
RACE: WHITE
SEX: MALE
CASE NUMBER: ME26–0386
DATE OF DEATH: JUNE 2, 2026
DATE OF EXAMINATION: JUNE 3, 2026

AUTOPSY FINDINGS:

1. Multi-substance toxicity
    a. Lethal injection
2. Arteriosclerotic and hypertensive cardiovascular disease
    a. Cardiomegaly with left ventricular hypertrophy
    b. Multivessel coronary artery disease
    c. Chronic kidney disease
3. Intracranial mass
    a. Consistent with meningioma, benign
4. Intra-abdominal mass
    a. Fibrotic mass around the sigmoid colon
5. Obesity
    a. Class I, 31.7 kg/m²
6. Postmortem toxicology
    a. Caffeine
    b. Etomidate
    c. Hydroxyzine

CAUSE OF DEATH: Multi-substance toxicity
MANNER OF DEATH: Homicide
HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate



Milad Webb, M.D., Ph.D.
Medical Examiner

7/28/2026
Date

EXTERNAL EXAMINATION:

The decedent is a normally developed 53-year-old White male measuring 73 inches in length and weighing 240 pounds at the time of examination (BMI 31.7 kg/m²). The body is cold to the touch after refrigeration, with fully developed rigor mortis. Livor mortis is red-purple, posterior, and fixed. The body is neither decomposed nor embalmed.

The scalp hair is brown-gray and measures approximately 1/2 inch in length. The facial hair consists of a beard and mustache. The irides are blue. The sclerae and conjunctivae are unremarkable, with no petechial hemorrhages. The oral cavity is atraumatic and contains natural dentition. The frenula are intact. The neck is atraumatic, and the trachea is midline. The chest is normally developed and symmetrical. The abdomen is rounded and soft to palpation. The external genitalia are atraumatic and consistent with those of a normally developed adult male. The back and extremities are normally developed and atraumatic.

There are multiple tattoos of various styles and motifs present on the decedent's body, including the hands, arms, left chest, left leg, and thighs.

Medical intervention consists of intravascular catheters present in the right and left antecubital fossae and electrocardiographic monitoring electrodes on the chest.

INJECTION SITE EXAMINATION:
Examination of the injection sites reveals intravascular catheters appropriately positioned within the lumen of the vessels within the antecubital fossa. Photos were taken to document the findings. The left injection site shows a minor perforation of the vessel wall with low volume perivascular hemorrhage.

INTERNAL EXAMINATION:

Body Cavities: The serosal cavities have no adhesions or abnormal collections of fluid. The visceral organs are congested, in normal anatomic positions, and have no decomposition.

Head: The galeal aponeurosis is unremarkable. The vault and base of the skull have no fractures. There are no epidural, subdural, or subarachnoid hemorrhages. The dura mater and falx cerebri are intact. A white, fibrous mass is attached to the meningeal surface of the dura (2 x 2 x 2 cm) in the region of the left parietal lobe and consistent with a benign meningioma. The brain weighs 1520 grams and has normally developed cerebral hemispheres. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The cerebral vessels are unremarkable with no atherosclerosis or aneurysmal dilatations.

Cut surfaces of the cerebral hemispheres, brainstem, and cerebellum reveal no structural lesions. The cerebral ventricles are of normal shape.

Neck: The laryngeal cartilages and hyoid bone have no fractures or other abnormalities. The cervical spinal column is stable on internal palpation. The strap muscles of the neck are unremarkable. Examination of the pharynx, larynx, and trachea reveals patchy foci of erythema and no significant abnormalities or obstructions.

Cardiovascular: The aorta and its major branches have no significant atherosclerosis. There is no saddle embolus on in situ evaluation of the pulmonary trunk. The pulmonary arteries are patent. The pericardial sac is intact and contains a small amount of clear, straw-colored serous fluid. The heart weighs 620 grams, which is significantly enlarged for sex and stature. The epicardial surface is smooth and glistening, with a thin layer of yellow adipose tissue.

The coronary arteries arise normally, have patent orifices, and follow a right-dominant distribution. There is significant obstructive calcific atherosclerosis with up to 90% stenosis of the left anterior descending coronary artery and 80% stenosis of the right coronary artery. There is fibrous thickening of the endocardium. The valves are normally formed and free of vegetations and degenerative changes. The chordae tendineae and papillary muscles are unremarkable. The foramen ovale is closed.

The chambers of the heart are not dilated. The thickness of the myocardium measures 2.1 to 2.2 cm in the left ventricular wall and interventricular septum. The myocardial cut surfaces are firm, dark red-brown, and unremarkable.

Pulmonary: The right lung weighs 630 grams; the left lung weighs 750 grams. The pleural surfaces are smooth and unremarkable with a mildly dense subpleural network of black pigment. The upper and lower airways are unobstructed, and the mucosal surfaces are smooth. The parenchymal cut surfaces are dark red-purple and congested. The cut surfaces have no masses. The peripheral pulmonary arteries are without thromboemboli.

Liver, Gallbladder and Pancreas: The liver weighs 2400 grams, and has smooth glistening capsule. The parenchyma is moderately soft and without focal lesions. The hepatic veins are patent.

The gallbladder contains a measured 30 milliliters of dark green, viscous bile, and no calculi. Its mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent. The pancreas has

congested, tan-brown lobulated parenchyma with clear ducts and is without fibrosis, masses, or calcifications.

Spleen and Lymphatic: The spleen weighs 490 grams and has a smooth, intact capsule with dark maroon, semi-liquefied parenchyma. The lymph nodes are not enlarged. The vertebral marrow is brick red, homogeneous, moist, and firm. The thymus gland is predominantly fat-replaced.

Genitourinary: The right and left kidneys weigh 120 and 250 grams, respectively. There is significant degeneration of the right kidney. The capsules strip with difficulty, revealing a granular, scarred, cystic cortical surface and focal depressions. On sectioning, the cortices are thinned and uneven, with loss of normal corticomedullary distinction in areas. The medullae are relatively preserved.

The calyces, pelves, and ureters are not dilated and have unremarkable tan-white mucosa. The urinary bladder contains a measured 80 milliliters of straw-colored urine. Its mucosa is tan-white and smooth, without focal lesions.

The seminal vesicles are unremarkable. The testes and spermatic cords have unremarkable stringy tan cut surfaces, with no hemorrhages or other abnormalities. The prostate gland is of normal size. The external surface is smooth and intact. The parenchyma is homogeneous, firm and without significant nodules, cysts, or areas of hemorrhage or necrosis.

Endocrine: The pituitary gland is of normal size and has no lesions. The adrenal glands are unremarkable. The thyroid gland is normal in size and has red-brown, uniform, monomorphic cut surfaces without lesions.

Digestive: The esophagus is lined by a smooth, gray-white mucosa, with no lesions. The gastroesophageal junction is unremarkable, and the gastric mucosa is autolyzed. The stomach lumen contains a measured 100 milliliters of partially digested food and liquid. The duodenum has no lesions. The small bowel is unremarkable. There is a fibrous mass in the region of the sigmoid colon. Grossly, the lesion does not appear malignant and is more consistent with dense fibrous scar tissue. The lesion is of sufficient size and location that it may have resulted in partial mechanical obstruction of fecal flow. The colon contains firm stool. The appendix is identified.

Musculoskeletal: There are no acute fractures. There are age-related degenerative changes. The musculature is normally developed. The cut surfaces of a representative section of lumbar vertebral body are hard and unremarkable.

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Lukehart, Andrew Richard** **ME26-0386**

Race	Gender	DOB: MM	DD	YYYY	Age
White	Male	[redacted]	[redacted]	[redacted]	53 years 1 month 23 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected
MV Occupant			Vehicle Type			

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Andrew Lukehart is a 53-year-old white male death row inmate at Florida State Prison. The decedent was executed by lethal injection on 06/02 and pronounced by Dr. Astrid Clark at 1819 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	06/02/2026	18:00	Florida State Prison	Bradford	Correctional Institution	
Onset						

Last Seen Alive		Name & Title	
Date of Death	06/02/2026 18:19	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026
Pronounced or Found by		Name & Title	
M.E.0. Notified	06/02/2026 18:55	Name & Title	Asst. Warden McClellen

County of Death	Inside City Limits	On the Job	Billing Agency/County
Bradford	○Yes ○No	○Yes ○No	Bradford FSP

Agency | Officer / Agent | Case Number

NARRATIVE

On 06/2/2026 at approximately 1855 hours, this office received a call from Assistant Warden Jeff McClellen. He was reporting the death of Andrew Lukehart, a 53-year-old white male inmate at Florida State Prison. He has been incarcerated since 1997 on first degree murder charges. The decedent was executed by lethal injection at the Florida State Prison on 06/2/26. The execution began at approximately 1800 hours, and the decedent was pronounced by Dr. Astrid Clark at 1819 hours.

NOK was notified of the MEO involvement by Florida State Prison.

Deceased: uke art, dre R c ard ME26-0 6

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Rachel Hildreth		6/2/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3353155**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 SW 47th Ave Gainsville, FL 32608

Subject's Name:	**LUKEHART, ANDREW R**
Agency Case #:	ME26-0386
Date of Death:	06/02/2026
Investigator:	RACHEL HILDRETH
Date Received:	06/05/2026
Date Reported:	07/16/2026

Laboratory Specimen No: **41357292** **Date Collected:** 06/03/2026 11:00
Container(s): 01:BB Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

** * AMENDED REPORT * **

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	Negative					
ANESTHETICS	POSITIVE					
Etomidate	POSITIVE	0.1	0.1	0.1 - 0.5	mcg/mL	
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	Negative					
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	POSITIVE					
Hydroxyzine	POSITIVE	14.7	10	50 - 100	ng/mL	
ANTIPSYCHOTICS	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					
CARDIOVASCULARS	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41357292** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
GASTROINTESTINALS	Negative					
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	POSITIVE					
Caffeine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

PLEASE NOTE: This is a revised report. Previous report on 06/14/2026 did not indicate Comprehensive Panel testing results on specimen ID 41357292.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41357294** **Date Collected:** 06/03/2026 11:00
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41357294** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

The toxicology findings are based on a single urine test.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41357295** **Date Collected:** 06/03/2026 10:40
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< Volatile Testing Not Performed >						

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41357296** **Date Collected:** 06/03/2026 11:00
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

FORENSIC TOXICOLOGY

Testing Report

Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41357297** **Date Collected:** 06/03/2026 11:00

Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

LUKEHART, ANDREW R
Laboratory Case #:3353155
Print Date/Time:07/16/2026, 12:15
Page: 7 of 7

Case Reviewer

Stuart Kurtz, M.S., D-ABFT -FT

Unless otherwise noted, testing performed at 5780 W 71st Street, Indianapolis, IN 46278. This individual may not have performed any of the analytical work.

FLORIDA DISTRICT EIGHT
OFFICE OF THE MEDICAL EXAMINER

3217 SW 47th AVENUE
GAINESVILLE, FLORIDA 32608
medistrict8@alachuacounty.us

ALACHUA · BAKER · BRADFORD · DIXIE · GILCHRIST · LEVY · UNION

AUTOPSY REPORT

NAME: Sochor, Dennis
AGE: 74
GENDER: Male
RACE: White
CASE NUMBER: ME26-0487
DATE OF DEATH: July 14, 2026
DATE OF EXAMINATION: July 16, 2026

AUTOPSY FINDINGS:

1. Mild to focally moderate cerebrovascular atherosclerosis
2. Cardiomegaly (440 grams)
3. Mild to focally severe coronary artery atherosclerosis
4. Mild aortic atherosclerosis
5. Pulmonary congestion and edema
6. Neoplasm of right adrenal gland consistent with cortical adenoma

CAUSE OF DEATH: Multi-substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Kailee Imperatore

Kailee Imperatore, M.D.
Associate Medical Examiner

Completed: July 18, 2026

EXTERNAL EXAMINATION:

The body is that of a normally developed, well-nourished, 5 foot 9 inch, 170 pound male who appears the reported age of 74 years. The body is refrigerated and well-preserved.

The scalp has gray, short, straight, thin hair in a pattern consistent with androgenic alopecia. Facial hair consists of dark and gray stubble. The irides are brown, and the pupils are round and equal. The sclerae are white. The conjunctivae are clear and have no petechiae. The ears, nose, and mouth are normally formed. The external auditory canals are unremarkable. The nasal bones and nasal septum are intact. The lips are uninjured. The frenula are not lacerated. The teeth are natural and in fair condition. Numerous teeth are remotely absent.

The neck and chest are symmetrical. The nipples and breasts are unremarkable. The abdomen is slightly protuberant and soft. The back and buttocks are symmetrical and have no deformities. The external genitalia are those of a fully developed, circumcised male. Both testes are palpable in the scrotum. The anus is unremarkable.

The bilateral upper and lower extremities are symmetrical and have no palpable fractures. No track marks are on the arms. The wrists have no scars. A scar is on the left shoulder and arm. Few scars are on the left upper extremity. The skin of the elbows is rough. Few scars are on the lower extremities. The skin of the hips and lower extremities has multiple patches of raised, rough, and red-purple to tan-white skin. A scab is on the posterior aspect of the left leg. The hands and feet are symmetrical, and the nails are intact. The body has no tattoos.

EVIDENCE OF MEDICAL PRESENCE:

Electrocardiogram lead pads are adhered to the shoulders and torso.

Catheters extend from the left antecubital fossa and the right forearm. The skin and subcutaneous tissues of the left antecubital fossa and right forearm were dissected to confirm intravenous locations of the catheters.

A band-aid overlying a puncture wound is on the right arm. A bandage overlying a puncture wound is on the right antecubital fossa.

INTERNAL EXAMINATION:

The reflected scalp has no hemorrhages. The calvarium and skull base have no fractures. The cranial vault has no epidural, subdural, or subarachnoid hemorrhages. The leptomeninges are thin and transparent. The 1230 gram brain is symmetrical, and the cerebrum has normal gyral configuration. The cranial nerves and vessels at the base of the brain are normally positioned and formed. The vessels of the circle of Willis have no aneurysms and mild to focally moderate atherosclerosis. The deep gray nuclei have no gross pathologic abnormalities. The subcortical and deep white matter has no gross pathologic abnormalities. The substantia nigra is normally pigmented. The brainstem and cerebellum are intact and have no gross pathologic abnormalities.

The anterior muscles of the neck are free of hemorrhages. The hyoid bone and laryngeal cartilages have no fractures. The large vessels of the neck are unremarkable. The pharynx and larynx have no obstructing foreign bodies or abnormal secretions. The epiglottis and vocal cords are unremarkable.

The pleural cavities have no abnormal fluid collections or adhesions. The pericardial sac has no abnormal fluid collections or adhesions. The peritoneal cavity has no abnormal fluid collections or adhesions. The diaphragm and organs of the thorax and abdomen are in their normal anatomic locations.

The 440 gram heart has a smooth epicardial surface and slightly increased epicardial adipose tissue. The right coronary ostium is normally positioned and patent. The left coronary ostium is situated immediately superior to the sinotubular junction and is patent. The coronary arterial circulation is right dominant. The coronary arteries have normal anatomic courses. The left main, coronary artery has up to approximately 10 percent stenosis by atherosclerosis. The left anterior descending coronary artery has up to approximately 20 percent stenosis by atherosclerosis. The left circumflex coronary artery has up to approximately 40 percent stenosis by atherosclerosis. The right coronary artery has up to approximately 75 percent stenosis by atherosclerosis. The four-chambered heart has a normal configuration. The cardiac chambers are not dilated. The myocardium is tan-red and has no fibrosis, pallor, or hemorrhages. The interatrial and interventricular septa are normally developed. The fossa ovalis is closed. The mural and valvular endocardium is thin, transparent, and free of mural thrombi. The papillary muscles and chordae tendineae are slightly thickened. The cardiac valves are thin, pliable, and free of vegetations and calcifications. The aorta has a normal caliber, no aneurysms, and mild atherosclerosis. The venae cavae have normal anatomic courses and are free of thrombi.

The right lung is 740 grams and the left lung is 720 grams. The pleural surfaces are pink to red-purple, smooth, glistening, and have mild black pigment deposition. The boggy pulmonary parenchyma is red-purple, expresses abundant bloody and frothy fluid, and has no masses, granulomata, or discrete areas of consolidation. The pulmonary vasculature is patent and has no thromboemboli. The trachea and bronchi are patent and have no foreign bodies or obstructions.

The 1890 gram liver has a smooth and intact capsule. Its parenchyma is brown, soft, and free of masses and fibrosis. The thin-walled gallbladder contains approximately 10 milliliters of green bile and no calculi. Its mucosa is green and velvety. The biliary tree is normally formed. The ductal lumina are patent. The vessels of the porta hepatis are unremarkable. The pancreas has tan, lobulated parenchyma without masses.

The tongue has no bite marks or hemorrhages. The serosal and mucosal surfaces of the esophagus are unremarkable. The stomach contains approximately 50 milliliters of brown fluid. Its mucosa is tan-green, has normal rugal folds, and no ulcers or masses. The serosal surfaces and calibers of the small intestine and large intestine are normal and have no palpable masses or obstructions. The appendix is unremarkable.

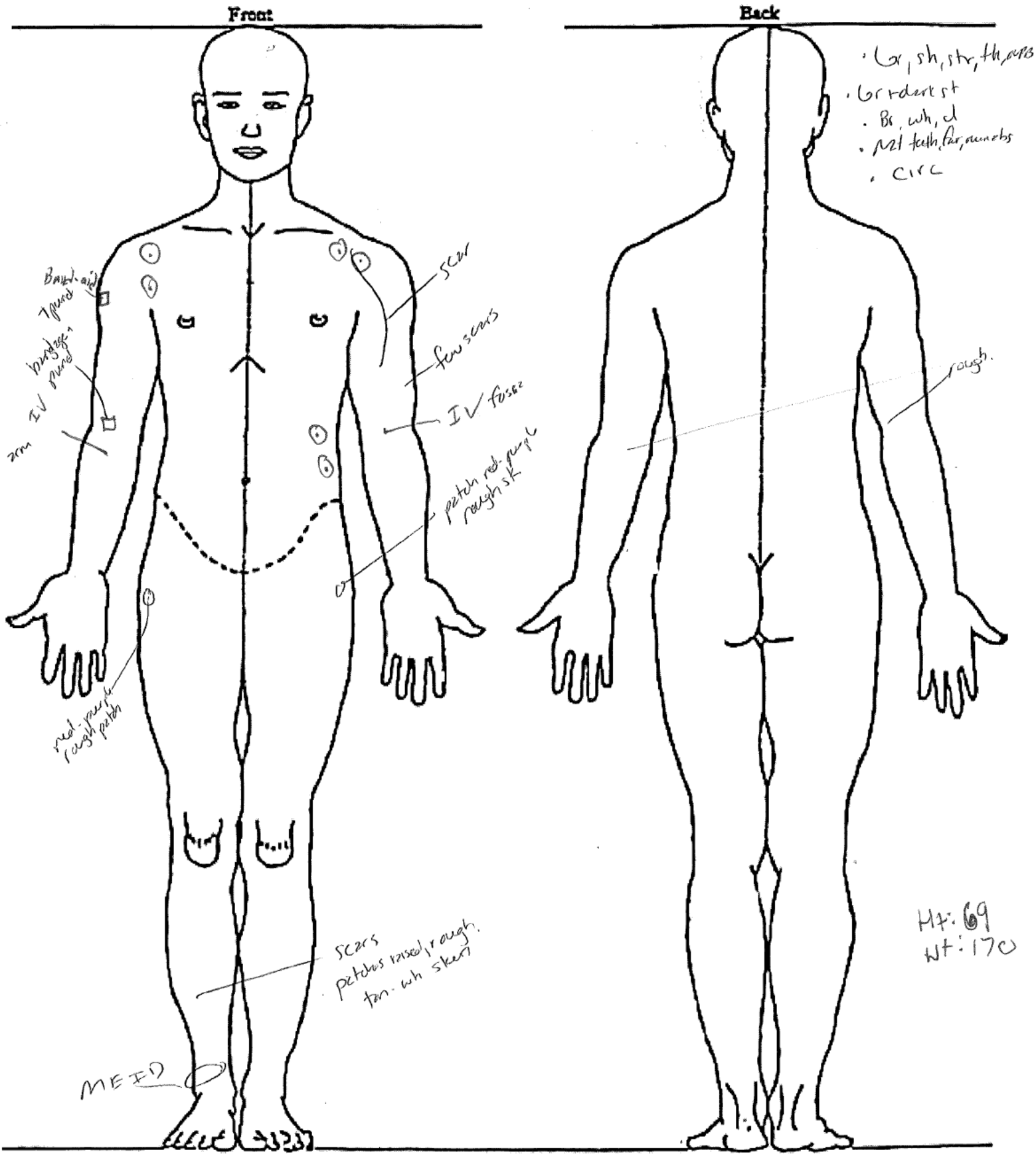
The 360 gram spleen has a smooth and intact capsule covering mostly soft, red-purple parenchyma. The bone marrow of the ribs is red and of normal consistency. The lymph nodes of the neck, thorax, abdomen, and pelvis are not enlarged.

The right kidney is 190 grams and the left kidney is 200 grams. The capsules are thin, and the cortical surfaces are smooth. The renal parenchyma is red-purple, has moderately-defined corticomedullary junctions, and no masses. The renal vessels are patent. The pelvicalyceal systems are unremarkable. The ureters have normal course and calibers to the urinary bladder. The bladder contains approximately 700 milliliters of clear, yellow urine and its mucosa is tan-white and trabeculated. The prostate gland is unremarkable.

The thyroid gland is normal in size and shape and has homogeneous, tan-red parenchyma and no masses. The adrenal glands have normal yellow cortices and brown medullae. A 1.0 centimeter circumscribed, yellow mass is in the cortex of the right adrenal gland.

The skeletal muscles of the thorax, abdomen, and pelvis are red-brown and soft. The clavicles, sternum, ribs, vertebral bodies, and pelvis have no acute fractures.

PATHOLOGIST: BODY EXAMINATION **Prisoner:** [X] **Infectious:**



Pathologist Kailee Imperatore, MD | Date Body Viewed 7/16/26 | Time 1355

Office of the Medical Examiner District Eight

ME26-0487
Sochor, Dennis
7/14/2026

www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-273-9292
Fax 352-273-9288

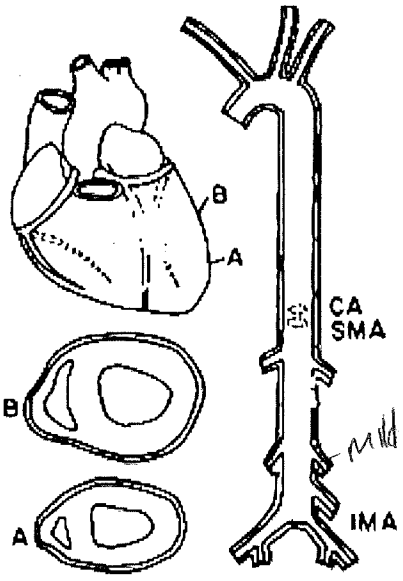
Physician: Imperatore
Case #: ME26-0487

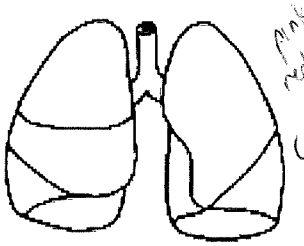
Date: 7/16/26 @ 1355
Name: Sochor, Dennis

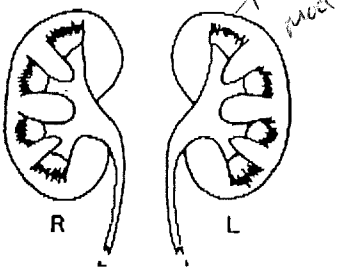
Heart: 440
R. Lung: 740
L. Lung: 720
Liver: 1890

Spleen: 360
R. Kidney: 190
L. Kidney: 200
Brain: 1230

Age: 74
Sex: M
Ht.: 69
Wt.: 170

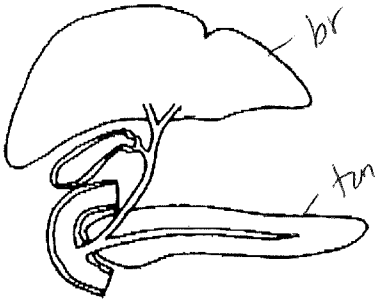




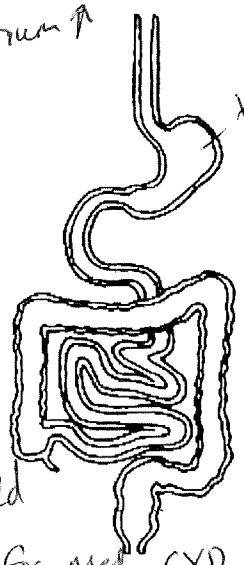


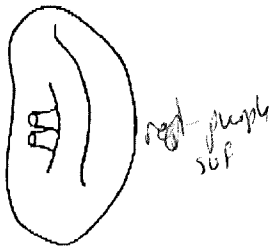
Urine: 700
Stones: X

Dominant: (RT) / LT
LAD: 20 CFX: 40 RCA: 75
LV: ____ RV: ____ IVS: ____
TV: ____ RV: ____ MV: ____ AV: ____



Bile: 10 gr
Stones: ____





Stomach Contents: 50 brown
Appendix: (+)
Stool: ____
Tics: ____
Fat: ____

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Sochor, Dennis** **ME26-0487**

Race	Gender	DOB: MM	DD	YYYY	Age
White	Male	[redacted]	[redacted]	[redacted]	74 years 4 months 19 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected
MV Occupant			Vehicle Type			

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Dennis Sochor is a 74-year-old white male death row inmate at Florida State Prison. The decedent was executed by lethal injection on 07/14 and pronounced by Dr. Astrid Clark at 1816 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	07/14/2026	18:00	Florida State Prison	Bradford	Correctional Institution	
Onset						

Last Seen Alive		Name & Title	
Date of Death	07/14/2026 18:16	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026
Pronounced or Found by		Name & Title	
M.E.O. Notified	07/14/2026 19:10	Name & Title	Asst Warden McClellen

County of Death	Inside City Limits	On the Job	Billing Agency/County
Bradford	○Yes ○No	○Yes ○No	Bradford FSP

Agency | Officer / Agent | Case Number

NARRATIVE

On 07/14/2026 at approximately 1910 hours, this office received a call from Assistant Warden Jeff McClellen. He was reporting the death of Dennis Sochor, a 74-year-old white male inmate at Union Correctional Institution. He has been incarcerated at Union Correctional since 1987 on first degree murder charges. The decedent was executed by lethal injection at the Florida State Prison on 07/14/26. The execution began at approximately 1800 hours, and the decedent was pronounced by Dr. Astrid Clark at 1816 hours.

NOK was notified of the MEO involvement by Florida State Prison.

Archer Funeral Home was dispatched by FSP to transport the decedent to the MEO.

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Rachel Hildreth		7/14/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3356791**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 SW 47th Ave Gainsville, FL 32608

Subject's Name:	**SOCHOR, DENNIS**
Agency Case #:	ME26-0487
Date of Death:	07/14/2026
Investigator:	RACHEL HILDRETH
Date Received:	07/18/2026
Date Reported:	08/03/2026

Laboratory Specimen No: **41368410** **Date Collected:** 07/16/2026 13:50
Container(s): 01:BB Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	Negative					
ANESTHETICS	POSITIVE					
Etomidate	POSITIVE	0.3	0.1	0.1 - 0.5	mcg/mL	
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	POSITIVE					
Paroxetine	POSITIVE	230	20	10 - 50	ng/mL	
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	POSITIVE					
Hydroxyzine	POSITIVE	30.3	10	50 - 100	ng/mL	
ANTIPSYCHOTICS	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41368410** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
CARDIOVASCULARS	Negative					
GASTROINTESTINALS	Negative					
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	POSITIVE					
Caffeine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41368411** **Date Collected:** 07/16/2026 13:50
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41368411** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

The toxicology findings are based on a single urine test.

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41368413** **Date Collected:** 07/16/2026 13:50
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note

< Volatile Testing Not Performed >

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41368414** **Date Collected:** 07/16/2026 13:50
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

FORENSIC TOXICOLOGY

Testing Report

Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41368415** **Date Collected:** 07/16/2026 13:50

Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

SOCHOR, DENNIS

Laboratory Case #:3356791

Print Date/Time:08/03/2026, 12:29

Case Reviewer

Stuart Kurtz, M.S., D-ABFT -FT

Unless otherwise noted, testing performed at 5780 W 71st Street, Indianapolis, IN 46278.

This individual may not have performed any of the analytical work.

FLORIDA DISTRICT EIGHT
OFFICE OF THE MEDICAL EXAMINER

3217 SW 47th AVENUE
GAINESVILLE, FLORIDA 32608
medistrict8@alachuacounty.us

ALACHUA · BAKER · BRADFORD · DIXIE · GILCHRIST · LEVY · UNION

EXAMINATION REPORT

NAME: DUSTY RAY SPENCER
AGE: 74 YEARS
DATE OF BIRTH: [redacted]
RACE / SEX: WHITE MALE
CASE NUMBER: ME26-0448
DATE OF DEATH: JUNE 25, 2026
DATE OF EXAMINATION: JUNE 26, 2026

AUTOPSY FINDINGS:

1. Multi-Substance Toxicity
    a. Lethal injection
2. Hepatic cirrhosis
    a. Massive splenomegaly
    b. Pancreatic fibrosis
3. Postmortem toxicology
    a. Caffeine
    b. Cotinine
    c. Etomidate
    d. Ibuprofen

CAUSE OF DEATH: Multi-substance toxicity
MANNER OF DEATH: Homicide
HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Milad Webb, M.D., Ph.D.
Medical Examiner

8/17/2026
Date

EXTERNAL EXAMINATION:

The decedent is a normally developed 74-year-old White male measuring 75 inches in length and weighing 207 pounds (BMI 25.9 kg/m²). The body is cool to the touch after refrigeration, with fully developed rigor mortis. Livor mortis is red-purple, posterior, and fixed. The body is neither decomposed nor embalmed.

The scalp hair is white and measures an estimated 2 to 3 inches in maximal length. The facial hair consists of a short beard and mustache. There is male-pattern baldness. The irides are blue, and the sclerae and conjunctivae are unremarkable, with no evidence of petechial hemorrhages. The oral cavity is atraumatic and contains natural dentition, with few teeth missing from the maxillary and mandibular arches. The frenula are intact.

The neck is atraumatic, and the trachea is midline. The chest is normally developed and symmetrical. The abdomen is flat and soft to palpation. The external genitalia are those of a normally developed circumcised adult male. The back and extremities are normally developed and atraumatic. There is a healing ulceration of the lateral surface of the left leg.

A tattoo is present on the lateral aspect of the right shoulder.

Medical interventions include intravascular lines in the right and left antecubital fossae and electrocardiogram pads/sensors on the body.

EXAMINATION OF INJECTION SITES

Examination of the injection sites reveals the right intravascular catheter to be appropriately positioned within the lumen of the right median vein in the antecubital fossa. The left intravascular catheter does not enter the lumen of the median basilic vein and instead terminates within the adipose tissue deep to the vessel. Photographs are taken to document these findings. There is no evidence of infiltration at either injection site and no associated surrounding hemorrhage.

INTERNAL EXAMINATION:

Body Cavities: The serosal cavities have no adhesions or abnormal collections of fluid. The visceral organs are congested, in normal anatomic positions, and have no decomposition.

Head: The galeal aponeurosis is unremarkable. The vault and base of the skull have no fractures. There are no epidural, subdural, or subarachnoid hemorrhages. The dura mater and falx cerebri are intact. The brain weighs 1450 grams and has normally developed cerebral hemispheres. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The cerebral vessels are unremarkable with no atherosclerosis or aneurysmal dilatations.

Cut surfaces of the cerebral hemispheres, brainstem, and cerebellum reveal no structural lesions. The cerebral ventricles are of normal shape.

Neck: The laryngeal cartilage, and hyoid bone have no fractures or other abnormalities. The cervical spinal column is stable on internal palpation. The strap muscles of the neck are unremarkable. Examination of the pharynx, larynx, and trachea reveal patchy foci of erythema and no significant abnormalities or obstructions.

Cardiovascular: The aorta and its major branches have no significant atherosclerosis. There is no saddle embolus on in situ evaluation of the pulmonary trunk. The pulmonary arteries are patent. The pericardial sac is intact and contains a small amount of clear, straw-colored serous fluid. The heart weighs 440 grams which is within normal range for gender and stature. The epicardial surface is smooth and glistening, with a thin layer of yellow adipose tissue.

The coronary arteries arise normally, have patent orifices, and follow a right-dominant distribution. They are of normal caliber and have no significant atherosclerosis. The endocardium is without mural thrombi or fibrous thickening. The valves are normally formed and free of vegetations and degenerative changes. The chordae tendineae and papillary muscles are unremarkable. The foramen ovale is closed.

The chambers of the heart are not dilated. The thickness of the myocardium measures 1.1 to 1.3 cm in the left ventricular wall and interventricular septum. The myocardial cut surfaces are firm, dark red-brown, and unremarkable.

Pulmonary: The lungs are edematous and heavy. The right lung weighs 950 grams; the left lung weighs 1090 grams. The pleural surfaces are smooth and unremarkable with mildly dense subpleural network of black pigment. The upper and lower airways are unobstructed, and the mucosal surfaces are smooth. The parenchymal cut surfaces are dark red-purple and congested. The cut surfaces have no masses. The peripheral pulmonary arteries are without thromboemboli.

Liver, Gallbladder and Pancreas: The liver weighs 1410 grams. The liver has a distorted, nodular external surface. The capsule is thickened and exhibits numerous variably sized regenerative nodules separated by a meshwork of fibrous tissue, imparting a mixed nodular appearance. The parenchyma is rubbery and firm. On sectioning, the cut surface shows diffuse nodularity with intervening bands of fibrous tissue consistent with cirrhosis.

The gallbladder contains a measured 10 milliliters of dark green, viscous bile, and no calculi. Its mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent. The pancreas is diffusely firm and fibrotic with loss of the normal lobulated architecture and mild glandular atrophy, consistent with chronic pancreatitis. No pseudocysts, focal mass lesions, hemorrhage, or necrosis are identified.

Spleen and Lymphatic: The spleen weighs 650 grams and has a smooth, intact capsule with dark maroon, fibrotic parenchyma. The lymph nodes are not enlarged. The vertebral marrow is brick red, homogeneous, moist, and firm. The thymus gland is not identified.

Genitourinary: The right and left kidneys weigh 180 grams and 190 grams, respectively. There is no increase in hilar adipose tissue of the kidneys. The capsules are smooth, thin, and strip with

ease. The cortical surfaces are dark red, smooth, and without lesions. The cortices are well delineated from the underlying medullary pyramids and have no focal lesions.

The calyces, pelves, and ureters are not dilated and have unremarkable tan-white mucosa. The urinary bladder contains a measured 350 milliliters of straw-colored urine. Its mucosa is tan-white and smooth, without focal lesions. The seminal vesicles are unremarkable. The testes and spermatic cords have unremarkable stringy tan cut surfaces, with no hemorrhages or other abnormalities. The prostate gland is of normal size. The external surface is smooth and intact. The parenchyma is homogeneous, firm and without significant nodules, cysts, or areas of hemorrhage or necrosis.

Endocrine: The pituitary gland is of normal size and has no lesions. The adrenal glands are unremarkable. The thyroid gland is normal in size and has red-brown, uniform, monomorphic cut surfaces without lesions.

Digestive: The esophagus is lined by a smooth, gray-white mucosa, with no lesions. The gastroesophageal junction is unremarkable and the gastric mucosa is autolyzed. The stomach lumen contains a measured 10 milliliters of partially digested food and liquid. The duodenum has no lesions. The small and large bowels are unremarkable. The colon contains semiformed stool. The appendix is identified.

Musculoskeletal: There are no acute fractures. The musculature is normally developed. The cut surfaces of a section of representative lumbar vertebral body are hard and unremarkable.

Office of the Medical Examiner District Eight

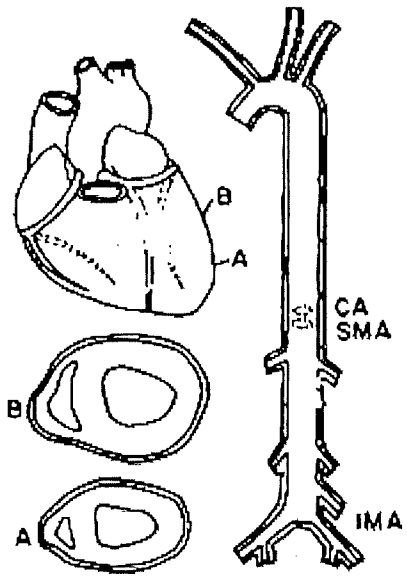
ME26-0448
Spencer, Dusty Ray
06/25/2026

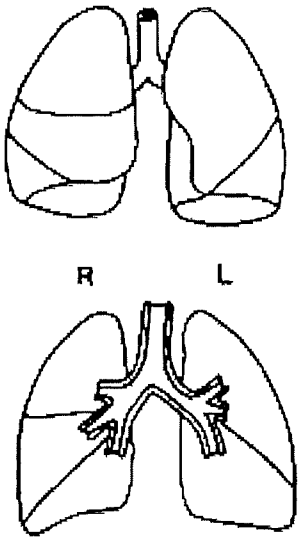
www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

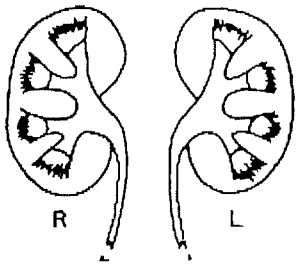
3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-273-9292
Fax 352-273-9288

Physician: Webb Date: 6/26/26@1106
Case #: ME26-0448 Name: Spencer, Dusty Ray

Heart: 440 Spleen: 650 (massively enlarged) Age: 74
R. Lung: 950 R. Kidney: 180 Sex: M
L. Lung: 1090 L. Kidney: 190 Ht.: 75
Liver: 1410 Brain: 1450 Wt.: 207



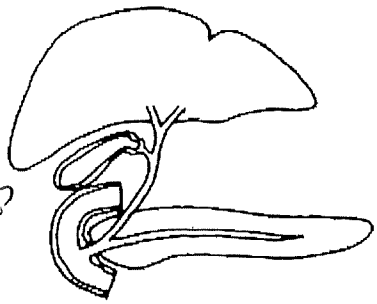




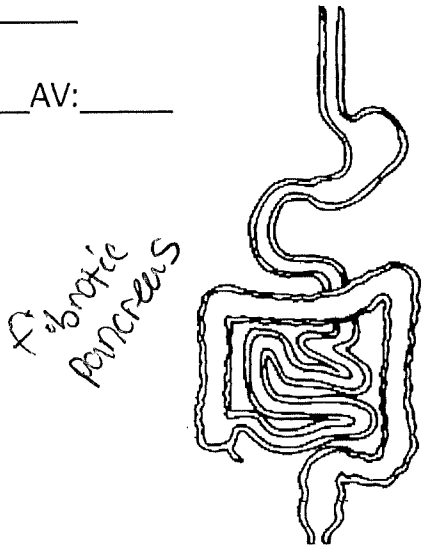
Urine: 350
Stones: +

Dominant: RT / LT
LAD:_____CFX:_____RCA:_____
LV:_____RV:_____IVS:_____
TV:_____RV:_____MV:_____AV:_____





Bile: 10
Stones:_____



Stomach Contents: 10
Appendix: +
Stool:_____
Tics:_____
Fat:_____

DC [ ]
Dictated [ ]
Autopsy / External / Tox

ME26-0448
Spencer, Dusty Ray
06/25/2026

Case Number: 26 - 0448

FLORIDA DISTRICT 8 OME
External Examination

Exam Date/Time: 6/26/26 1106 Inmate: ☒ Hospital: ☐ Decomposed: ☐

Cool / Warm Rigor: Fix / Partial / Waning / Passed Livor: Fixed / Blanching / Mixed
R / L A / P

Hair: BLK / BR / BL / Red / W / GRY 2-3

Facial Hair: B / M / G Short

Eyes: BR / BLU / GR / HZL / GRY / AS

Mouth/Teeth: NAT / ABS / DENT / Poor two teeth missing from mandible

Abdomen: Sc / Flat / Round / Soft / Protub

Mark/Scars/Tattoos:
R shoulder

Injuries/Other:
none.

74 wm
75, 207

JAW

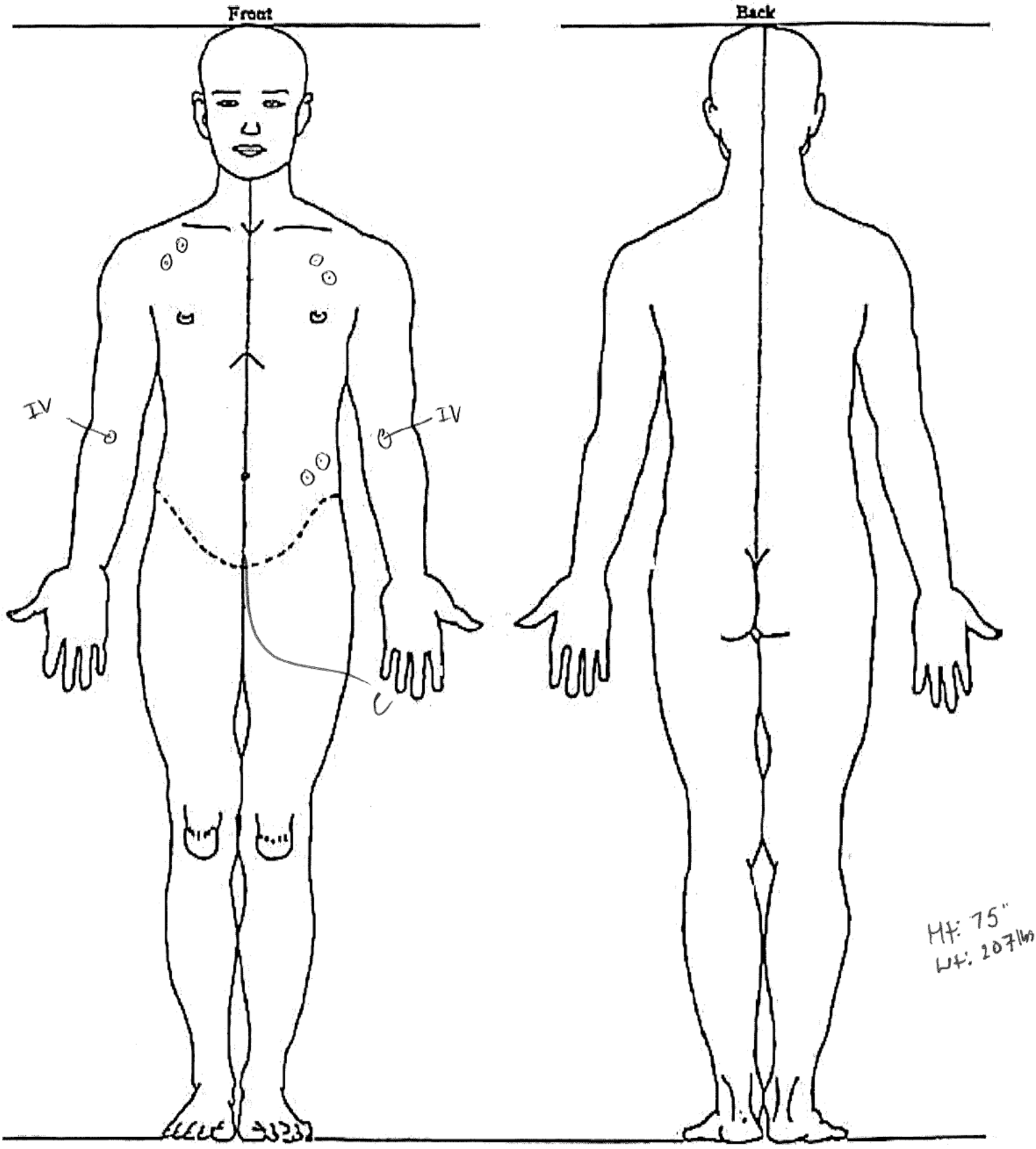
IV IV

ulcer w/ surrounding ecchymosis

Summary:
Execution

ME26-0448 Spencer, Dusty Ray 74, W, M DOB: [redacted] DOD: 6/25/2026

PATHOLOGIST: BODY EXAMINATION **Prisoner:** [X] **Infectious:**



Pathologist Milad Webb, MD | Date Body Viewed | Time

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Spencer, Dusty Ray** **ME26-0448**

Race	Gender	DOB: MM	DD	YYYY	Age
White	Male	[redacted]	[redacted]	[redacted]	74 years 4 months 12 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Dusty Spencer is a 74-year-old white male death row inmate Florida State Prison. The decedent was executed by lethal injection on 06/25 and pronounced by Dr. Hashani Perkins at 1810 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	06/25/2026	18:00	Florida State Prison	Bradford	Correctional Institution	
Onset						

Last Seen Alive		Name & Title	
Date of Death	06/25/2026 18:10	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026
Pronounced or Found by		Name & Title	
M.E.0. Notified	06/25/2026 18:43	Name & Title	Asst Warden McClellen

County of Death	Inside City Limits	On the Job	Billing Agency/County
Bradford	○Yes ○No	○Yes ○No	Bradford FSP

Agency | Officer / Agent | Case Number

NARRATIVE

On 06/25/2026 at approximately 1843 hours, this office received a call from Assistant Warden Jeff McClellen. He was reporting the death of Dusty Spencer, a 74-year-old white male inmate at Florida State Prison. He has been incarceratedl since 1993 on first degree murder charges. The decedent was executed by lethal injection at the Florida State Prison on 06/25/26. The execution began at approximately 1800 hours, and the decedent was pronounced by Dr. Hashani Perkins at 1810 hours.

NOK was notified of the MEO involvement by Florida State Prison.

Archer Milton funeral Home was dispatched by FSP to transport the decedent to the MEO.

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Rachel Hildreth		6/25/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3355488**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 SW 47th Ave Gainsville, FL 32608

Subject's Name:	**SPENCER, DUSTY R**
Agency Case #:	ME26-0448
Date of Death:	06/25/2026
Investigator:	RACHEL HILDRETH
Date Received:	07/06/2026
Date Reported:	07/27/2026

Laboratory Specimen No: **41364390** **Date Collected:** 06/26/2026 11:40
Container(s): 01:BB Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	POSITIVE					
Ibuprofen	POSITIVE	3.8	2.5	15 - 30	mcg/mL	
ANESTHETICS	POSITIVE					
Etomidate	POSITIVE	0.2	0.1	0.1 - 0.5	mcg/mL	
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	Negative					
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	Negative					
ANTIPSYCHOTICS	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					
CARDIOVASCULARS	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41364390** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
GASTROINTESTINALS	Negative					
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	POSITIVE					
Caffeine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
Cotinine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41364391** **Date Collected:** 06/26/2026 11:40
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41364391** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

The toxicology findings are based on a single urine test.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41364392** **Date Collected:** 06/26/2062 11:40
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< Volatile Testing Not Performed >						

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41364393** **Date Collected:** 06/26/2026 11:40
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

FORENSIC TOXICOLOGY

Testing Report

Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41364394** **Date Collected:** 06/26/2026 11:40

Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

SPENCER, DUSTY R
Laboratory Case #:3355488
Print Date/Time:07/27/2026, 12:40

Case Reviewer

Kevin Shanks, M.S., D-ABFT -FT

Unless otherwise noted, testing performed at 5780 W 71st Street, Indianapolis, IN 46278.

This individual may not have performed any of the analytical work.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

EXAMINATION REPORT

NAME: Melvin Trotter
AGE: 65
GENDER: Male
RACE: Black
CASE NUMBER: ME26-0145
DATE OF DEATH: 2/24/2026
DATE OF EXAMINATION: 2/26/2026

EXAMINATION FINDINGS:

1. No evidence of trauma
2. Intravascular catheters in the upper extremities
3. Obesity – BMI 43.6

CAUSE OF DEATH: Multi-substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate.

Andrew Koopmeiners, M.D.
Associate Medical Examiner

Completed: 4/15/2026

EXTERNAL EXAMINATION

The body is that of a well-developed well-nourished Black male appearing consistent with the offered age of 65 years. The body measures 68 inches in length and weighs 287 pounds. The body is well preserved.

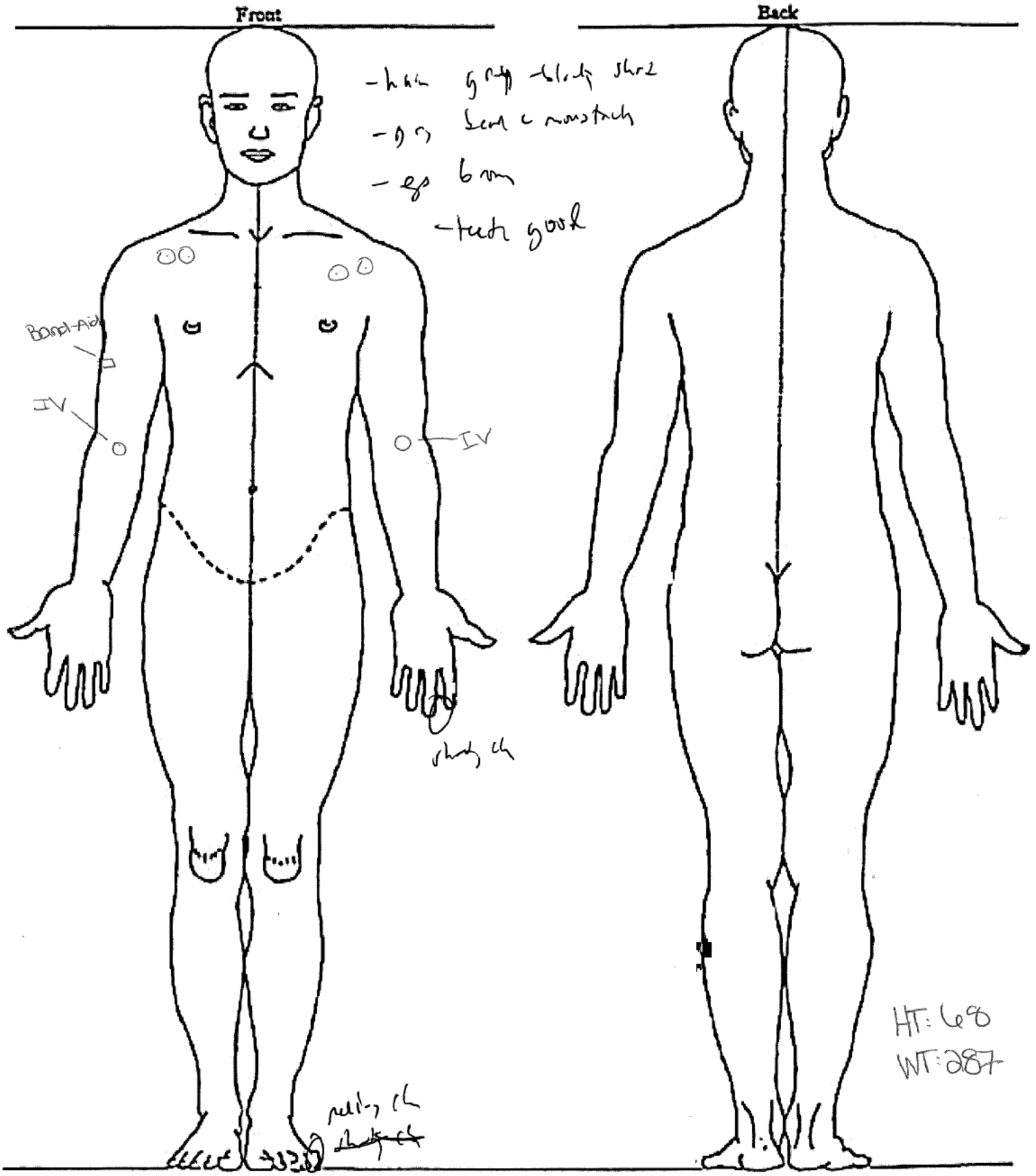
The scalp hair is grey-black and short. Facial hair consists of a grey beard and moustache. The irides appear brown and the pupils are equal. The corneas are clear and the sclerae and conjunctivae have no petechiae or other abnormalities. The ears are normally formed. The external ears have no injuries. The nasal bones are intact by palpation. The nares are patent and contain no foreign matter. The natural teeth are in good repair. The frenula are intact. The mucosa and tongue are free of injuries. There is no foreign material in the mouth. There are no palpable fractures of the bones of the face.

The symmetrical neck has no masses or injuries. The trachea is in the midline. The shoulders are symmetrical and are free of trauma. The chest is symmetrical and has no scars or injuries. The abdomen is soft and has no scars or injuries. There are cardiac monitor pads on the right upper chest, left upper chest, and left lower abdomen. The back is symmetrical and has no injuries. The external genitalia are those of a normally developed adult man.

The upper extremities are symmetrical and normally developed. There are intravascular catheters in the right and left antecubital regions. There is a 2 ½ inch linear scar of the anterior left wrist. The fingernails are short and clean. The lower extremities are symmetrical. The toenails are medium length and clean. There is no edema of the legs or ankles. Passive motion of the neck, shoulders, elbows, wrists, fingers, hips, and ankles fails to elicit any bony crepitus or abnormal motion.

ME26-0145 Trotter, Melvin 65, B, M DOB: [redacted] DOD: 2/24/2026

PATHOLOGIST: BODY EXAMINATION Prisoner: [X] Infectious:



Pathologist Andrew S. Koopmeiners, MD Date Body Viewed 2-26-26 Time 1215

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Trotter, Melvin** **ME26-0145**

Race	Gender	DOB: MM	DD	YYYY	Age
Black	Male	[redacted]	[redacted]	[redacted]	65 years 1 month 26 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Melvin Trotter is a 65-year-old black male inmate at Florida State Prison. The decedent was executed by lethal injection on 2/24 and pronounced by Dr. Antonio Munson at 1815 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	02/24/2026	18:00	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026	Bradford	Correctional Institution	
Onset						
Last Seen Alive			Name & Title			
Date of Death	02/24/2026	18:15	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026		
Pronounced or Found by	02/24/2026	18:15	Name & Title	Dr Antonio Munson		
M.E.0. Notified	02/24/2026	18:51	Name & Title	Assistant Warden McClellen		
County of Death	Bradford	Inside City Limits ○Yes ○No	On the Job ○Yes ○No	Billing Agency/County Bradford FSP		

Agency	Officer / Agent	Case Number

NARRATIVE

On 02/24 at approximately 1851 hours, this office received a call from Assistant Warden Jeff McClellen. He was reporting the death of Melvin Trotter, a 65-year-old black male inmate at Florida State Prison. He has been incarcerated at Florida State prison since 1987 on first degree murder charges. The decedent was executed by lethal injection on 02/24/26. The execution began at approximately 1800 hours, and the decedent was pronounced by Dr. Antonio Munson at 1815 hours.

NOK was notified of the MEO involvement by Florida State Prison.

Deceased: Tr tter, Me ME26-0 5

Archer Funeral Home was diapatched by FSP to transport the body to the MEO.

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Rachel Hildreth		2/24/2026
Lead Investigator	Signature	Date

- CONFIDENTIAL -

University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R26-00380
NAME: Trotter, Melvin
CASE NO: 26-145
RECEIPT DATE: 02/27/2026

Forensic Toxicology Laboratory

SUBMITTER: Dr. Andrew Koopmeiners, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, femoral
B. Blood, heart
C. Urine
D. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
C. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
	Trimethoprim	Positive	
C. Urine	Etomidate	Positive (tentative ID by GC-MS)	
	Trimethoprim	Positive	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2600380 - 01/ CC 04/13/26 [0001, 1503]
PRINTED: 04/13/26

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Toxicology Report

Report Issued 04/10/2026 19:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	TROTTER, MELVIN
Patient ID	R26-00380
Chain	NMSCP522031
DOB	Not Given
Sex	Male
Workorder	26100317

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.19**	**mcg/mL**	**001 - Femoral Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	4.75 mL	02/26/2026	Femoral Blood	R26-00380

All sample volumes/weights are approximations.
Specimens received on 03/05/2026.

NMS LABS

CONFIDENTIAL

Workorder	26100317
Chain	NMSCP522031
Patient ID	R26-00380

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.19	mcg/mL	0.080	001 - Femoral Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Femoral Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Femoral Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.080 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

DC ☐
Dictated ☐
Autopsy / External / Tox

ME26-0297
Willacy, Chadwick Scott
04/21/2026

Case Number: 26 - 0297

FLORIDA DISTRICT 8 OME
External Examination

Exam Date/Time: _____ Inmate: ☐ Hospital: ☐ Decomposed: ☐

Cool / Warm **Rigor:** Fix / Partial / Waning / Passed **Livor:** Fixed / Blanching / Mixed
R / L A / P

Hair: BLK / BR / BL / Red / W / GRY _____

Facial Hair: B / M / G

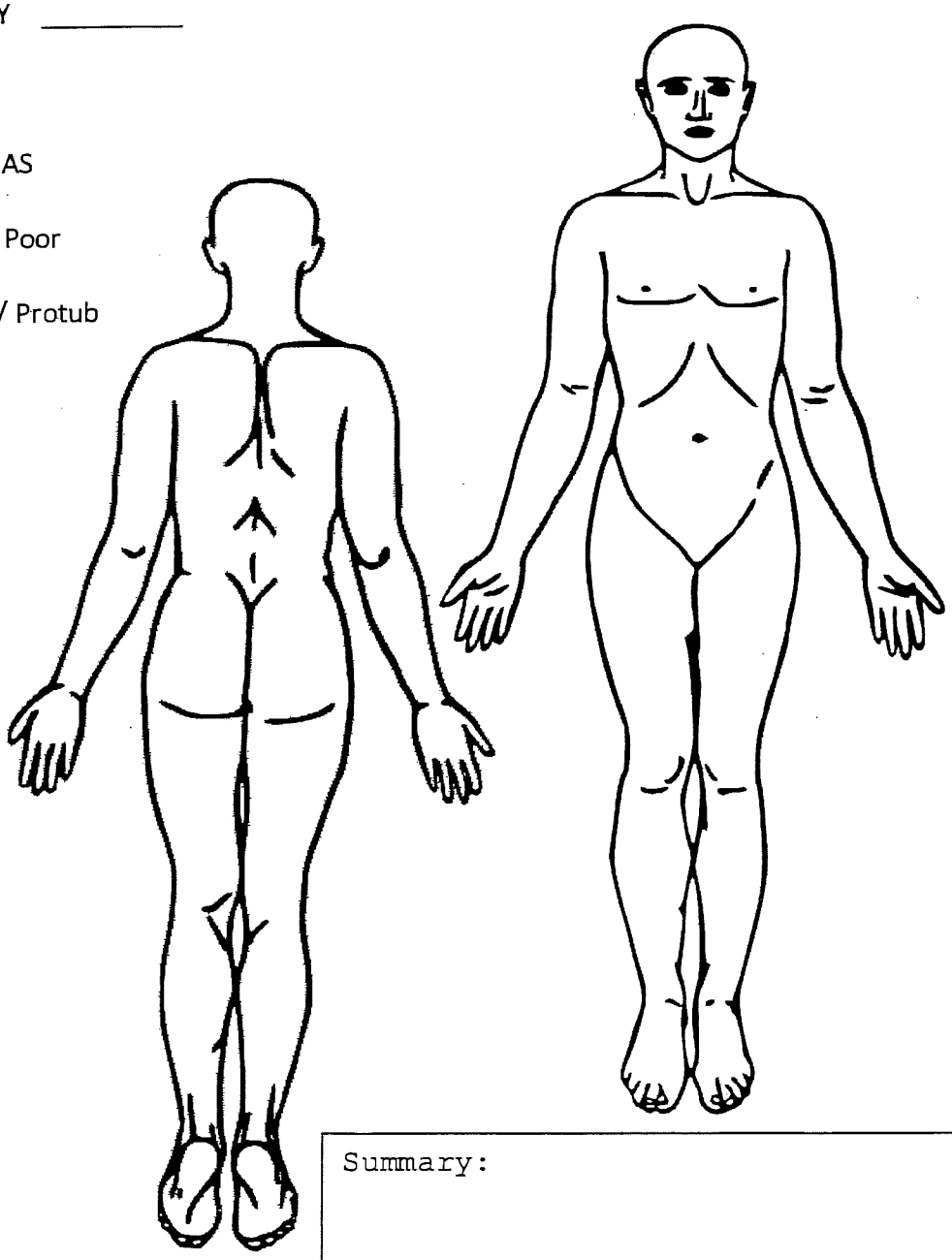
Eyes: BR / BLU/ GR / HZL / GRY / AS

Mouth/Teeth: NAT / ABS / DENT / Poor

Abdomen: Sc / Flat / Round / Soft / Protub

Mark/Scars/Tattoos:

Injuries/Other:



Summary:

Office of the Medical Examiner District Eight

www.district8me.com
Alachua, Baker, Bradford, Dixie,
Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-273-9292
Fax 352-273-9288

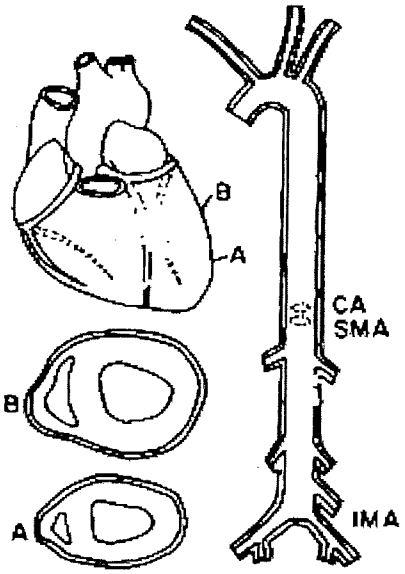
Physician: WEDD
Case #: 26-0297

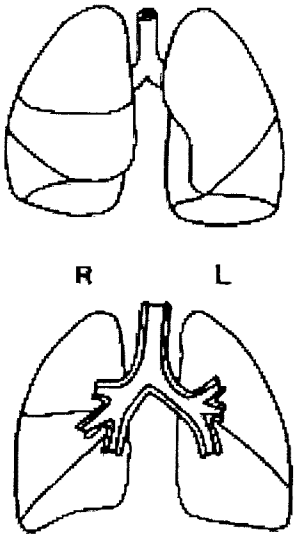
Date: 4/22/26 @ 1245
Name: Willacy, Chadwick S.

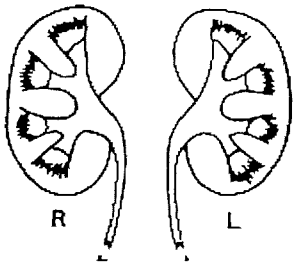
Heart: 610
R. Lung: 870
L. Lung: 900
Liver: 2100

Spleen: 100
R. Kidney: 190
L. Kidney: 220
Brain: 1390

Age: 58
Sex: M
Ht.: 72
Wt.: 221



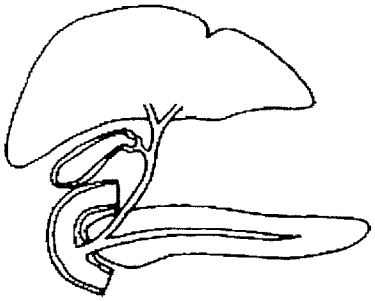




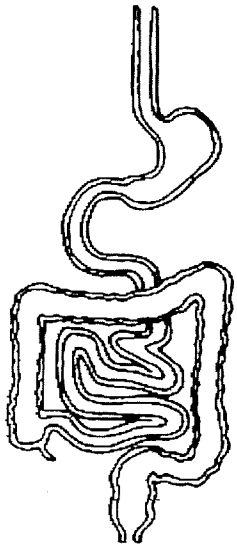
Urine: 190
Stones:

Dominant: RT / LT
LAD: CFX: RCA:
LV: RV: IVS:
TV: RV: MV: AV:





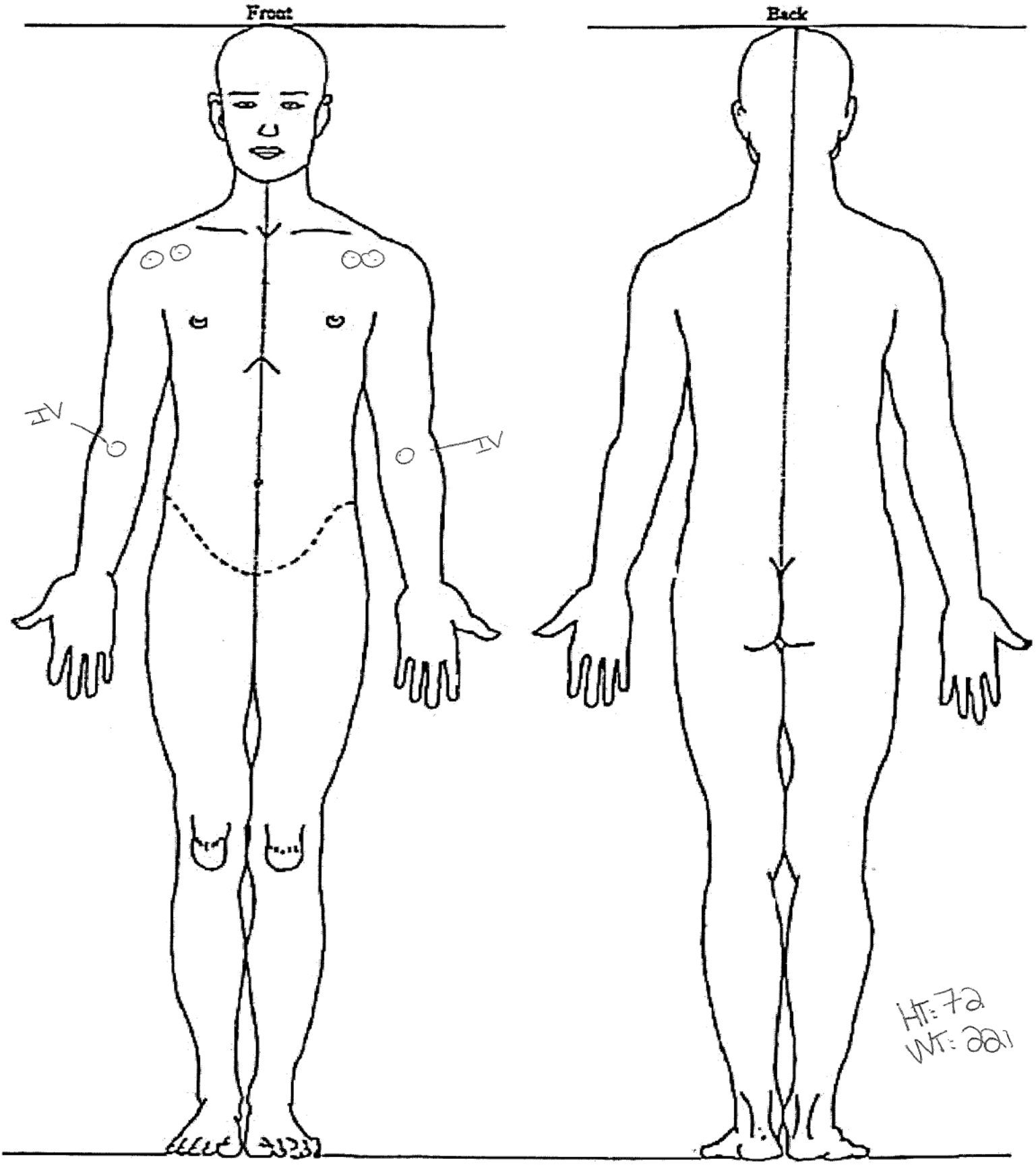
Bile: 5
Stones:



Stomach Contents: 250
Appendix: (+)
Stool:
Tics:
Fat:

ME26-0297 Willacy, Chadwick Scott 58, B, M DOB: [redacted] DOD: 4/21/2026

PATHOLOGIST: BODY EXAMINATION Prisoner: [X] Infectious:



Pathologist Milad Webb, MD Date Body Viewed Time

FLORIDA DISTRICT EIGHT
OFFICE OF THE MEDICAL EXAMINER

3217 SW 47th AVENUE
GAINESVILLE, FLORIDA 32608
medistrict8@alachuacounty.us

ALACHUA · BAKER · BRADFORD · DIXIE · GILCHRIST · LEVY · UNION

EXAMINATION REPORT

NAME: CHADWICK SCOTT WILLACY
AGE: 58 YEARS
DATE OF BIRTH: [redacted]
RACE: BLACK
SEX: MALE
CASE NUMBER: ME26–0297
DATE OF DEATH: APRIL 21, 2026
DATE OF EXAMINATION: APRIL 22, 2026

AUTOPSY FINDINGS:

1. Multi-Substance Toxicity
    a. Lethal injection
2. Hypertensive Cardiovascular Disease
    a. Cardiomegaly with left ventricular hypertrophy
3. Atraumatic Examination

CAUSE OF DEATH: Multi-Substance Toxicity
MANNER OF DEATH: Homicide
HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Milad Webb, M.D., Ph.D.
Medical Examiner

6/7/2026
Date

EXTERNAL EXAMINATION:

The decedent is a normally developed 58-year-old black male measuring 72 inches in length and 221 pounds (BMI 30.0 kg/m^2). The body is cool to the touch after refrigeration with fully developed rigor mortis. Livor mortis is red–purple, posterior and fixed. The body is neither decomposed nor embalmed.

The scalp hair is shaved the facial hair consists of a stubble length beard and mustache the irides are brown the sclera and conjunctiva are unremarkable with no evidence of petechial hemorrhages the oral cavity is atraumatic and contains natural dentition

The skin is unremarkable. The neck is atraumatic and the trachea appears midline the chest is normally developed and symmetrical the abdomen is rounded and soft to palpation the external genitalia are those of a normally developed circumcised adult male. The external genitalia are atraumatic. The back and extremities are normally developed and atraumatic. There are no identifying marks scars or tattoos noted medical intervention includes intravascular lines present in the right and left antecubital fossa electrocardiogram sensors are present on the decedent's body

INJECTION SITE EXAMINATION:

Examination of the injection sites reveal intravascular catheters appropriately within the lumen of the vessels within the antecubital fossa. Photos were taken to document the findings. There is no infiltration of the injection sites and no surrounding hemorrhage.

INTERNAL EXAMINATION:

Body Cavities: The serosal cavities have no adhesions or abnormal collections of fluid. The visceral organs are congested, in normal anatomic positions, and have no decomposition.

Head: The galeal aponeurosis is unremarkable. The vault and base of the skull have no fractures. There are no epidural, subdural, or subarachnoid hemorrhages. The dura mater and falx cerebri are intact. The brain weighs 1390 grams and has normally developed cerebral hemispheres. The leptomeninges are thin and delicate. The cerebrospinal fluid is clear. The cerebral vessels are unremarkable with no atherosclerosis or aneurysmal dilatations.

Cut surfaces of the cerebral hemispheres, brainstem, and cerebellum reveal no structural lesions. The cerebral ventricles are of normal shape.

Neck: The laryngeal cartilage, and hyoid bone have no fractures or other abnormalities. The cervical spinal column is stable on internal palpation. The strap muscles of the neck are unremarkable. Examination of the pharynx, larynx, and trachea reveal patchy foci of erythema and no significant abnormalities or obstructions.

Cardiovascular: The aorta and its major branches have no significant atherosclerosis. There is no saddle embolus on in situ evaluation of the pulmonary trunk. The pulmonary arteries are patent. The pericardial sac is intact and contains a small amount of clear, straw-colored serous fluid. The heart is globoid and weighs 610 grams which is significantly increased for gender and stature. The epicardial surface is smooth and glistening, with a thin layer of yellow adipose tissue.

The coronary arteries arise normally, have patent orifices, and follow a right-dominant distribution. They are of normal caliber and have no significant atherosclerosis. The

endocardium is without mural thrombi or fibrous thickening. The valves are normally formed and free of vegetations and degenerative changes. The chordae tendineae and papillary muscles are unremarkable. The foramen ovale is closed.

The chambers of the heart are not dilated. The thickness of the myocardium measures 1.8 to 2.1 cm in the left ventricular wall and interventricular septum. The myocardial cut surfaces are firm, dark red-brown, and unremarkable.

Pulmonary: The lungs are edematous and heavy. The right lung weighs 870 grams; the left lung weighs 900 grams. The pleural surfaces are smooth and unremarkable with mildly dense subpleural network of black pigment. The upper and lower airways are unobstructed, and the mucosal surfaces are smooth. The parenchymal cut surfaces are dark red-purple and congested. The cut surfaces have no masses. The peripheral pulmonary arteries are without thromboemboli.

Liver, Gallbladder and Pancreas: The liver weighs 2100 grams and has smooth glistening capsule. The parenchyma is moderately soft and without focal lesions. The hepatic veins are patent.

The gallbladder contains a measured 5 milliliters of dark green, viscous bile, and no calculi. Its mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent. The pancreas has congested, tan-brown lobulated parenchyma with clear ducts and is without fibrosis, masses, or calcifications.

Spleen and Lymphatic: The spleen weighs 100 grams and has a smooth, intact capsule with dark maroon, semi-liquefied parenchyma. The lymph nodes are not enlarged. The vertebral marrow is brick red, homogeneous, moist, and firm. The thymus gland is fat-replaced.

Genitourinary: The right and left kidneys weigh 190 grams and 220 grams, respectively. There is no increase in hilar adipose tissue of the kidneys. The capsules are smooth, thin, and strip with ease. The cortical surfaces are dark red, smooth, and without lesions. The cortices are well delineated from the underlying medullary pyramids and have no focal lesions.

The calyces, pelves, and ureters are not dilated and have unremarkable tan-white mucosa. The urinary bladder contains a measured 190 milliliters of straw-colored urine. Its mucosa is tan-white and smooth, without focal lesions.

The seminal vesicles are unremarkable. The testes and spermatic cords have unremarkable stringy tan cut surfaces, with no hemorrhages or other abnormalities.

Endocrine: The pituitary gland is of normal size and has no lesions. The adrenal glands are unremarkable. The thyroid gland is normal in size and has red-brown, uniform, monomorphic cut surfaces without lesions.

Digestive: The esophagus is lined by a smooth, gray-white mucosa, with no lesions. The gastroesophageal junction is unremarkable and the gastric mucosa is autolyzed. The stomach lumen contains a measured 250 milliliters of partially digested food and liquid. The duodenum

has no lesions. The small and large bowels are unremarkable. The colon contains semiformed stool. The appendix is identified.

Musculoskeletal: There are no acute fractures. There are no significant degenerative changes. The musculature is normally developed. The cut surfaces of a section of representative lumbar vertebral body are hard and unremarkable.

REPORT OF INVESTIGATION

Medical Examiner District 8
3217 SW 47th Avenue
Gainesville Florida 32608
Tel: 352-384-3366 Fax: 352-384-3365

Deceased: **Willacy, Chadwick Scott** **ME26-0297**

Race	Gender	DOB: MM	DD	YYYY	Age
Black	Male	[redacted]	[redacted]	[redacted]	58 years 6 months 29 days

Address

SCENE RESPONSE

Scene Investigator	Arrival Date	Time	Scene Pathologist	Arrival Date	Time	○Yes ○No Meds Collected

MV Occupant		Vehicle Type	

INFORMATION ABOUT OCCURRENCE

Reason for Assuming Jurisdiction

Initial Synopsis

Chadwick Willacy is a 58-year-old black male inmate at Florida State Prison. The decedent was executed by lethal injection on 04/21 and death was pronounced by Dr. Astrid Clark at 1815 hours.

	Date	Time	Location	County	Type of Premises	Other
Injury	04/21/2026	18:00	Florida State Prison	Bradford	Correctional Institution	
Onset						

Last Seen Alive		Name & Title	
Date of Death	04/21/2026 18:15	Location	Florida State Prison, 23916 NW 83rd Ave, Raiford, FL 32026
Pronounced or Found by		Name & Title	
M.E.0. Notified	04/21/2026	Name & Title	Assistant Warden McClellan

County of Death	Inside City Limits	On the Job	Billing Agency/County
Bradford	○Yes ○No	○Yes ○No	Bradford FSP

Agency	Officer / Agent	Case Number

NARRATIVE

On 04/21/2026 at approximately 1852 hours, this office received a call from Assistant Warden Jeff McClellen. He was reporting the death of Chadwick Willacy, a 58-year-old black male inmate at Florida State Prison. He has been incarcerated at Union Correctional Institution since 1991 on a first degree murder charge. The decedent was executed by lethal injection on 04/21/26. The execution began at approximately 1800 hours, and the decedent was pronounced by Dr. Astrid Clark at 1815 hours.

NOK was notified of the MEO involvement by Florida State Prison.

Deceased: ac , C ad ck Sc tt ME26-02

Archer Funeral Home was dispatched by FSP to transport the decedent to the MEO.

This Report of Investigation is subject to revision and / or amendment if additional information is obtained.

Rachel Hildreth		4/21/2026
Lead Investigator	Signature	Date

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Case Number:	**3350095**
Client Account:	21302 / D8FLME01
Report To:	District 8 FL Medical Examiner ATTN: District 8 Medical Exami 3217 SW 47th Ave Gainsville, FL 32608

Subject's Name:	**WILLACY, CHADWICK S**
Agency Case #:	ME26-0297
Date of Death:	04/21/2026
Investigator:	RACHEL HILDRETH
Date Received:	04/29/2026
Date Reported:	06/04/2026

Laboratory Specimen No: **41347967** **Date Collected:** 04/22/2026 10:20
Container(s): 01:BB Blood,ILIAC **Test(s):** 70510 Comprehensive Drug Panel, Blood

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
VOLATILES	Negative					
Methanol	Negative					
Ethanol	Negative					
Acetone	Negative					
Isopropanol	Negative					
AMPHETAMINES	Negative					
ANALGESICS	Negative					
ANESTHETICS	POSITIVE					
Etomidate	POSITIVE	0.3	0.1	0.1 - 0.5	mcg/mL	
ANTICHOLINERGICS	Negative					
ANTICONVULSANTS	Negative					
ANTIDEPRESSANTS	Negative					
ANTIDIABETICS	Negative					
ANTIFUNGALS	Negative					
ANTIHISTAMINES	Negative					
ANTIPSYCHOTICS	Negative					
BARBITURATES	Negative					
BENZODIAZEPINES	Negative					
CANNABINOIDS	Negative					
CARDIOVASCULARS	Negative					
GASTROINTESTINALS	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41347967** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
HALLUCINOGENS	Negative					
MISCELLANEOUS	Negative					
MUSCLE RELAXANTS	Negative					
OPIOID ANALGESICS	Negative					
SEDATIVE/HYPNOTICS	Negative					
STIMULANTS	POSITIVE					
Caffeine	POSITIVE					
Analyte is qualitatively POSITIVE, but has not been confirmed by an alternate analytical method.						
UROLOGICALS	Negative					

Specimens will be kept for at least one year from the date of initial report.

Reference ranges obtained from Schulz M, Iwersen-Bergmann S, Andresen H, Schmoldt A. Therapeutic and toxic blood concentrations of nearly 1,000 drugs and other xenobiotics. Crit Care. 2012;16(4):R136. Published 2012 Jul 26. doi:10.1186/cc11441

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41347969** **Date Collected:** 04/22/2026 10:15
Container(s): 01:YTT Urine, Random **Test(s):** 80080 Basic Drugs of Abuse, Urine

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
AMPHETAMINES	Negative					
Amphetamine	Negative					
Methamphetamine	Negative					
MDMA	Negative					
BENZODIAZEPINES	Negative					
7-Aminoclonazepam	Negative					
Alprazolam	Negative					
Alpha-Hydroxyalprazolam	Negative					
Lorazepam	Negative					
Nordiazepam	Negative					
Oxazepam	Negative					
Temazepam	Negative					
HALLUCINOGENS	Negative					
Phencyclidine	Negative					
MUSCLE RELAXANTS	Negative					
Meprobamate	Negative					
OPIOID ANALGESICS	Negative					
6-Acetylmorphine	Negative					
Buprenorphine	Negative					
Codeine	Negative					
EDDP	Negative					
Fentanyl	Negative					
Hydromorphone	Negative					
Hydrocodone	Negative					
Methadone	Negative					
Morphine	Negative					
Norfentanyl	Negative					
Norbuprenorphine	Negative					
O-Desmethyltramadol	Negative					
Oxycodone	Negative					
Oxymorphone	Negative					

AXIS FORENSIC TOXICOLOGY
Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41347969** **Continued..**

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
Tramadol	Negative					
STIMULANTS	Negative					
Benzoylecgonine	Negative					

The toxicology findings are based on a single urine test.

FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41347970** **Date Collected:** 04/22/2026 10:15
Container(s): 01:CTT Vitreous,EYE **Test(s):** 49901 Volatiles Not Performed

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note

< Volatile Testing Not Performed >

Due to negative blood volatile (Acetone, Ethanol,Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

AXIS FORENSIC TOXICOLOGY

Testing Report
Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41347971** **Date Collected:** 04/22/2026 10:20
Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

AXIS FORENSIC TOXICOLOGY

Testing Report

Web: www.axisfortox.com
Phone: (317) 759-4TOX

Laboratory Specimen No: **41347974** **Date Collected:** 04/22/2026 10:20

Container(s): 01:GRT Blood,ILIAC **Test(s):** 49900 Not Tested

Analyte Name	Qualitative Result	Quantitative Result	Reporting Limit	Reference Range	Units	Note
< No Testing Performed >						

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

Laureen J. Marinetti, PhD, F-ABFT

WILLACY, CHADWICK S
Laboratory Case #:3350095
Print Date/Time:06/04/2026, 15:35
Page: 7 of 7

Case Reviewer

Laureen J. Marinetti, Ph.D., F-ABFT

Unless otherwise noted, testing performed at 5780 W 71st Street, Indianapolis, IN 46278.

This individual may not have performed any of the analytical work.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

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Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: Bates, Kayle
AGE: 67
GENDER: Male
RACE: Black
CASE NUMBER: ME25-0562
DATE OF DEATH: August 19, 2025
DATE OF EXAMINATION: August 20, 2025 @ 0815 hrs.

CAUSE OF DEATH: **Multi-substance toxicity**

MANNER OF DEATH: **Homicide**

HOW INJURY OCCURRED: **Judicial execution with etomidate, rocuronium and Potassium acetate**

Noel A. Palma, M.D.
Associate Medical Examiner
Completed: August 20, 2025

EXTERNAL EXAMINATION:
The body was that of a well-nourished normally developed black man with the recorded age of 67 years. The body measured 73 inches in length and weighed 206 pounds. The body was received clothed (see separate list). The head was normocephalic and the scalp hair was bald. There was short black/gray facial hair. The eyes had white sclerae, pale conjunctivae, brown irides, and clear corneas. There were no petechial hemorrhages within the bulbar or palpebral conjunctivae. There was no crepitus to palpation over the bridge of the nose. The nasal bridge and septum appeared intact. The external nares were unremarkable. The dentition consisted of natural teeth. No lesions of the oral mucosa were identified. The lips had no injuries. There were no palpable fractures of the facial bones. The external ears were unremarkable. The external auditory canals were normal. There were no masses discernable in the neck and the larynx was in the midline. The neck was straight and was not hypermobile. The thorax was symmetrical and unremarkable. The abdomen was flat. The external genitalia were those of a normal adult male. The penis appeared atraumatic and appeared normally developed. There was no gross or palpable cervical, axillary, or inguinal lymphadenopathy. The back was atraumatic and was normally formed. The extremities were normally formed and were symmetric. There were no palpable fractures of the extremities. There were no scars on the wrists. Well- healed scars were present on the extremities. The right lateral arm region had tattoos. The torso also had scattered scars.

EVIDENCE OF TREATMENT:
ECG pads were on the extremities. The right antecubital fossa region had an intravascular catheter secured by clear/transparent adhesive tapes with no apparent surrounding soft tissue ecchymosis. The left antecubital fossa also had an intravascular catheter with no surrounding soft tissue ecchymosis and was also secured by several transparent adhesive tapes.

EVIDENCE OF RECENT INJURY: none.

- CONFIDENTIAL -

University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01538
NAME: Bates, Kayle
CASE NO: 25-562
RECEIPT DATE: 08/20/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Noel Palma, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, femoral
B. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

Noel A. Palma, MD
Signed October 7, 2025

R2501538 - 01/ CC 10/07/25 [0001, 1503]
PRINTED: 10/07/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Toxicology Report

Report Issued 10/06/2025 12:03

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	BATES, KAYLE
Patient ID	R25-01538
Chain	NMSCP477073
DOB	Not Given
Sex	Male
Workorder	25377102

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.22**	**mcg/mL**	**001 - Femoral Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	7.75 mL	08/20/2025	Femoral Blood	R25-01538

All sample volumes/weights are approximations.
Specimens received on 08/29/2025.

NMS LABS

CONFIDENTIAL

Workorder 25377102
Chain NMSCP477073
Patient ID R25-01538

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.22	mcg/mL	0.10	001 - Femoral Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Femoral Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Femoral Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.10 mcg/mL		

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie,
Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: Michael Bell
AGE: 54
GENDER: Male
RACE: Black
CASE NUMBER: 25-0485
DATE OF DEATH: 7/15/2025
DATE OF EXAMINATION: 7/17/2025

AUTOPSY FINDINGS:

1. Pulmonary edema
2. No evidence of trauma
3. Intravascular catheters in the upper extremities

CAUSE OF DEATH: Multi-substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate.

Andrew Koopmeiners, M.D.
Associate Medical Examiner

Completed: 8/5/2025

ME25-0485

EXTERNAL EXAMINATION

The body is that of a well-developed well-nourished Black male appearing consistent with the offered age of 54 years. The body measures 70 inches in length and weighs 186 pounds. The body is well preserved.

The scalp hair is grey and short. Facial hair consists of grey-black stubble. The irides appear brown and the pupils are equal. The corneas are clear and the sclerae and conjunctivae have no petechiae or other abnormalities. The ears are normally formed. The external ears have no injuries. The nasal bones are intact by palpation. The nares are patent and contain no foreign matter. The natural teeth are in poor repair. The frenula are intact. The mucosa and tongue are free of injuries. There is no foreign material in the mouth. There are no palpable fractures of the bones of the face.

The symmetrical neck has no masses or injuries. The trachea is in the midline. The shoulders are symmetrical and are free of trauma. The chest is symmetrical and has no injuries. The abdomen is soft and has no injuries. There are cardiac monitor pads on the right upper chest, left upper chest, and left abdomen. The back is symmetrical and has no injuries. The external genitalia are those of a normally developed adult man.

The upper extremities are symmetrical and normally developed. There are intravascular catheters in the posterior right forearm and the left antecubital region. The fingernails are short and clean. The lower extremities are symmetrical. The toenails are short and clean. There is no edema of the legs or ankles. Passive motion of the neck, shoulders, elbows, wrists, fingers, hips, and ankles fails to elicit any bony crepitus or abnormal motion.

SCARS, TATTOOS, AND OTHER IDENTIFYING FEATURES

Tattoos include, but are not limited to, the following:

- An image including a woman, dice, and playing cards on the left chest
- A banner and “Mike” on the lateral right upper arm
- “Loyalty” on the anterior right forearm
- A heart on the posterior right hand
- Letters on the medial right hand
- Hands and “Blessed” on the lateral left shoulder
- “Love” on the anterior left forearm
- Text and an image on the anterior left wrist
- A cross on the posterior left hand

Scars include a 1 ½ x ½ inch irregularly shaped scar of the right upper back. There are no other distinguishing features.

INTERNAL EXAMINATION

Body Cavities

The muscles of the chest and abdominal wall are normal in color and consistency. The right and left pleural cavities have no free fluid or adhesions. The mediastinum is in the midline. The pericardial sac has a normal amount of clear yellow fluid. The diaphragm has no abnormality. The abdominal cavity is lined with glistening serosa and has no collections of free fluid. The organs are normally situated. The mesentery and omentum are unremarkable.

Cardiovascular System

The heart weighs 410 grams. The epicardial surface has a normal amount of adipose tissue. The heart is of the usual configuration. The circumferences of the valves are within normal range. The endocardium is tan. The valvular tissues are thin, pliable, and without vegetation or calcification. The mural and valvular endocardia have no vegetations or thrombi. The papillary muscles and projecting myocardial muscle bundles are of normal prominence. The chordae tendineae have no abnormalities. The coronary ostia are in their usual location and give rise to normally distributed arteries. The major coronary arteries are free of atherosclerosis. The cut surfaces of the red-brown myocardium have no hemorrhage, necrosis, or scars. The right and left ventricles are of normal thickness.

The pulmonary trunk and arteries have no thromboemboli. The intimal surface of the aorta is free of atherosclerosis. The aorta and its major branches arise normally and are widely patent. The inferior vena cava and tributaries have no antemortem clots.

Respiratory System

The lungs weigh 630 grams and 600 grams, right and left, respectively. The upper airways are free of foreign material. The pleural surfaces are thin and free of exudates. The trachea and bronchi are lined by smooth tan epithelium. There is a small quantity of foam in the right and left main bronchi. The cut surfaces of the lungs are variegated red-purple and have moderate edema. The lung parenchyma is of the usual consistency. There is no bronchopneumonia, neoplasm, consolidation, fibrosis, or calcification.

Reticuloendothelial System

The spleen weighs 190 grams. The capsule is smooth and intact. The cut surfaces are dark red and firm. The lymphoid tissue in the spleen is within a normal range. The lymph nodes throughout the body are not enlarged.

Liver and Biliary System

The liver weighs 2490 grams. The liver edge is sharp. The capsule is intact. The cut surfaces are red-brown and of normal consistency. There are no focal lesions and no evidence of fatty change or cirrhosis. The gallbladder contains dark green bile. There are no stones. The mucosa is unremarkable. The large bile ducts are patent and non-dilated.

Gastrointestinal System

The esophagus is empty and the mucosa is unremarkable. The gastric mucosa is arranged in the usual rugal folds and has no inflammation or ulceration. The lumen of the stomach contains 100 milliliters of partially digested food. The remaining gastrointestinal tract has no major alterations to external inspection and palpation. The appendix is present.

Genitourinary System

The kidneys are of similar size and shape and each weigh 220 grams. The capsules are intact and strip with ease. The cortical surfaces are smooth and red-brown. The cut surfaces reveal a well-defined corticomedullary junction. The pelves and ureters are unremarkable without evidence of distention. The urinary bladder contains approximately 120 milliliters of clear yellow urine. The mucosa is unremarkable. The prostate gland is not enlarged. The cut surfaces are unremarkable.

Endocrine System

The adrenal glands have a normal configuration with the golden yellow cortices well demarcated from the underlying medullae. The maroon, gelatinous thyroid gland has no gross alterations. The tan, lobulated pancreas has no neoplasia, calcification, or hemorrhage.

Musculoskeletal System

The ribs, sternum, clavicles, pelvis, and vertebral column have no recent fractures. The muscles are normally formed.

Neck

The soft tissues and the strap muscles of the neck have no hemorrhage. The hyoid bone and the cartilages of the larynx and thyroid are intact and show no evidence of injury. The larynx and trachea are lined by smooth pink-tan mucosa, are patent, and contain no foreign matter. The epiglottis and vocal cords are unremarkable. The carotid arteries and jugular veins are unremarkable.

Central Nervous System

The reflected scalp has no hemorrhage or contusions. The calvarium is intact. The dura mater and falx cerebri are intact. There is no epidural, subdural, or subarachnoid hemorrhage. The brain is of a normal convolutional pattern and weighs 1350 grams. The meninges show no evidence of purulent infection. The cortical surfaces of the brain have no abnormalities. There is no uncal or tonsillar herniation. The structures of the base of the brain, including cranial nerves and blood vessels, are intact and unremarkable. The cerebral arteries are free of atherosclerosis and patent. The cut surfaces of the brain have normal relations of grey and white matter. There are no intraparenchymal hemorrhages and no evidence of neoplasm. The cerebral ventricles are of normal size and are filled with clear cerebrospinal fluid. There are no fractures of the base of the skull. The dura mater is free of stains and discolorations.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01310
NAME: Bell, Michael
CASE NO: 25-485
RECEIPT DATE: 07/18/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Andrew Koopmeiners, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2501310 - 01/ CC 10/07/25 [0001, 1503]
PRINTED: 10/07/25

NMS LABS

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 10/06/2025 12:02

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	BELL, MICHAEL
Patient ID	R25-01310
Chain	NMSCP468328
DOB	Not Given
Sex	Male
Workorder	25322496

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**1.3**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	6 mL	07/17/2025 11:02	Heart Blood	R25-01310

All sample volumes/weights are approximations.
Specimens received on 07/25/2025.

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Workorder 25322496
Chain NMSCP468328
Patient ID R25-01310

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	1.3	mcg/mL	0.20	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.20 mcg/mL		

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie,
Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: Geralds, Mark
AGE: 58
GENDER: Male
RACE: White
CASE NUMBER: ME25-0826
DATE OF DEATH: December 9, 2025
DATE OF EXAMINATION: December 11, 2025

AUTOPSY FINDINGS:

1. Mild atherosclerosis of left anterior descending coronary artery
2. Moderate atherosclerosis of right coronary artery
3. Mild aortic atherosclerosis
4. Pulmonary congestion and edema
5. Mucosal hemorrhages, left bronchus

CAUSE OF DEATH: Multi-Substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Kailee Imperatore

Kailee A. Imperatore, M.D.
Associate Medical Examiner

Completed: December 13, 2025

EXTERNAL EXAMINATION:

The body is that of a normally developed, well-nourished, 6 foot, 204 pound male who appears the reported age of 58 years. The body is refrigerated and well-preserved.

The scalp has gray, short, straight hair. Facial hair consists of gray stubble. The irides are brown, and the pupils are round and equal. The sclerae are white. The conjunctivae are clear and have no petechiae. The ears, nose, and mouth are normally formed. The external auditory canals are unremarkable. The nasal bones and nasal septum are intact. The lips are uninjured. The frenula are not lacerated. The teeth are natural and in fair condition.

The neck and chest are symmetrical. The nipples and breasts are unremarkable. A scar is on the left side of the chest. The abdomen is slightly protuberant and soft. The back and buttocks are symmetrical and have no deformities. The external genitalia are those of a fully developed, circumcised male. Both testes are palpable in the scrotum. The anus is unremarkable.

The bilateral upper and lower extremities are symmetrical and have no palpable fractures. No track marks are on the arms. The wrists have no scars. A scar is on the superior aspect of the right shoulder. Few scars are on the upper and lower extremities. A 0.1 centimeter wound is on the anterior aspect of the right wrist. The hands and feet are symmetrical, and the nails are intact.

TATTOOS:

A tattoo is on the left upper extremity.

EVIDENCE OF MEDICAL PRESENCE:

Electrocardiogram lead pads are adhered to the torso.

Catheters extend from the bilateral antecubital fossae. The skin and subcutaneous tissues of the antecubital fossae were dissected to confirm intravenous locations of the catheters.

INTERNAL EXAMINATION:

The reflected scalp has no hemorrhages. The calvarium and skull base have no fractures. The cranial vault has no epidural, subdural, or subarachnoid hemorrhages. The leptomeninges are thin and transparent. The 1560 gram brain is symmetrical, and the cerebrum has normal gyral configuration. The cranial nerves and vessels at the base of the brain are normally positioned and formed. The vessels of the circle of Willis have no aneurysms or atherosclerosis. The deep gray nuclei have no gross pathologic abnormalities. The deep white matter has no gross pathologic abnormalities. The substantia nigra is normally pigmented. The brainstem and cerebellum are intact and have no gross pathologic abnormalities.

The anterior muscles of the neck are free of hemorrhages. The hyoid bone and laryngeal cartilages have no fractures. The large vessels of the neck are unremarkable. The pharynx and

larynx have no obstructing foreign bodies or abnormal secretions. The epiglottis and vocal cords are unremarkable.

The pleural cavities have no abnormal fluid collections or adhesions. The pericardial sac has no abnormal fluid collections or adhesions. The peritoneal cavity has no abnormal fluid collections or adhesions. The diaphragm and organs of the thorax and abdomen are in their normal anatomic locations.

The 420 gram heart has a smooth epicardial surface and slightly increased epicardial adipose tissue. The right coronary ostium is normally positioned and patent. The left coronary ostium is situated immediately superior to the sinotubular junction and is patent. The coronary arterial circulation is right dominant. The left main, left circumflex, and right coronary arteries have normal anatomic courses. The midportion of the left anterior descending coronary artery superficially courses through the myocardium. The left main and left circumflex coronary arteries are thin-walled and patent. The left anterior descending coronary artery has up to approximately 30 percent stenosis by atherosclerosis. The right coronary artery has up to approximately 50 percent stenosis by atherosclerosis. The four-chambered heart has a normal configuration. The cardiac chambers are not dilated. The myocardium is tan-red and has no fibrosis, pallor, or hemorrhages. The interatrial and interventricular septa are normally developed. The fossa ovalis is closed. The mural and valvular endocardium is thin, transparent, and free of mural thrombi. The papillary muscles and chordae tendineae are unremarkable. The cardiac valves are thin, pliable, and free of vegetations and calcifications. The aorta has a normal caliber, no aneurysms, and mild atherosclerosis. The venae cavae have normal anatomic courses and are free of thrombi.

The right lung is 990 grams and the left lung is 760 grams. The pleural surfaces are pink to red-purple, smooth, and glistening. The boggy pulmonary parenchyma is pink-purple, expresses abundant bloody and frothy fluid, and has no masses, granulomata, or discrete areas of consolidation. The pulmonary vasculature is patent and has no thromboemboli. The trachea and bronchi are patent and have no foreign bodies or obstructions. A small amount of white, frothy fluid is within the trachea. Multiple, up to 0.5 centimeter, mucosal hemorrhages are on the left bronchus.

The 1740 gram liver has a smooth and intact capsule. Its parenchyma is brown-purple, soft, and free of masses and fibrosis. The thin-walled gallbladder contains approximately 5 milliliters of green bile and no calculi. Its mucosa is green and velvety. The biliary tree is normally formed. The ductal lumina are patent. The vessels of the porta hepatis are unremarkable. The pancreas has tan, lobulated parenchyma without masses.

The tongue has no bite marks or hemorrhages. The serosal surface of the esophagus is unremarkable. The mucosal surface of the distal esophagus is dusky and has few erosions. The stomach contains approximately 5 milliliters of dark brown liquid. Its mucosa is tan, has normal rugal folds, and no ulcers or masses. The serosal surfaces and calibers of the small intestine and large intestine are normal and have no palpable masses or obstructions. The appendix is unremarkable.

The 220 gram spleen has a smooth and intact capsule covering mostly soft, dark purple parenchyma. The bone marrow of the ribs is red and soft. The lymph nodes of the neck, thorax, abdomen, and pelvis are not enlarged.

The right kidney is 150 grams and the left kidney is 160 grams. The capsules are thin, and the cortical surfaces are smooth. The renal parenchyma is tan-red, has moderately-defined corticomedullary junctions, and no masses. The renal vessels are patent. The pelvicalyceal systems are unremarkable. The ureters have normal course and calibers to the urinary bladder. The bladder contains approximately 55 milliliters of clear, yellow urine and its mucosa is tan-white and trabeculated. The prostate gland is unremarkable.

The thyroid gland is normal in size and shape and has red-purple parenchyma. A 3.0 centimeter circumscribed, pale tan, solid mass is in the left lobe of the thyroid gland. The adrenal glands have normal yellow cortices and brown medullae.

The skeletal muscles of the thorax, abdomen, and pelvis are red-brown and soft. The clavicles, sternum, ribs, vertebral bodies, and pelvis have no acute fractures.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-02253
NAME: Geralds, Mark
CASE NO: 25-826
RECEIPT DATE: 12/12/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Kailee Imperatore, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2502253 - 01/ CC 01/20/26 [0001, 1503]
PRINTED: 01/20/26

Kailee A Imperatore
1/21/2026

NMS Labs
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e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 01/07/2026 10:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	GERALDS, MARK
Patient ID	R25-02253
Chain	NMSCP503124
DOB	Not Given
Sex	Male
Workorder	25543360

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.80**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	9 mL	12/11/2025	Heart Blood	R25-02253

All sample volumes/weights are approximations.
Specimens received on 12/18/2025.

NMS LABS

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Workorder	25543360
Chain	NMSCP503124
Patient ID	R25-02253

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.80	mcg/mL	0.20	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.20 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie,
Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: FORD, James Dennis
AGE: 64 years
GENDER: Male
RACE: White
CASE NUMBER: ME25-0117
DATE OF DEATH: February 13, 2025
DATE OF AUTOPSY: February 14, 2025 at 1150 hrs.

AUTOPSY FINDINGS

1. Intravascular catheters of the antecubital regions.
2. Pulmonary edema and congestion.
3. Cardiomegaly (heart weight: 600 g).
4. Marked coronary artery atherosclerosis with calcifications (maximal stenosis: 99%).
5. Area of fibrosis of the myocardium of the heart.
6. Nephrosclerosis.
7. Moderate aortic atherosclerosis with calcifications.
8. Atherosclerosis of some arteries of the base of the brain.
9. Old area of necrosis of the left cerebellar hemisphere of the brain.
10. Nodular enlargement of the prostate gland.
11. Edema of the shins and ankles.
12. Obesity (Body Mass Index: 32.28 kg/m2).

CAUSE OF DEATH: MULTI-SUBSTANCE TOXICITY

MANNER OF DEATH: HOMICIDE

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

M.D.

Wayne D. Kurz, M.D.
ASSOCIATE MEDICAL EXAMINER
Date signed: February 15, 2025

EXTERNAL EXAMINATION:

See evidence of medical intervention section. The body is that of a 225 pounds, 70 inch, normally-developed, overweight appearing, white male whose appearance is consistent with the reported age of 64 years. The scalp has hair stubble in a distribution of moderate to advanced male pattern baldness. The irides are blue. The eyes have mild vascular congestion, no petechia, and no hemorrhage. The nose has no palpable fractures. The ears are unremarkable. The skin of the right side of the upper lip region has a 1.1 cm, flesh-colored, smooth-surfaced nodule. Black and gray stubble is present in the distribution of a mustache and beard. The left cheek has a 0.5 cm, pale flesh-colored nodule. The native dentition appears in moderate to good condition. The front mandibular teeth have gingival recession and focal black discoloration. Small spaces are present between the maxillary front teeth. The visible mucosal surfaces of the oral cavity are unremarkable. The right side of the neck has a 0.5 cm, flesh-colored papule.

The chest is symmetric. The abdomen is protuberant and has numerous striae. The lateral aspects of the lower portion of the torso have striae. The male genitalia appear normally-developed and the testes are descended bilaterally. The back is symmetric. The posterior surfaces of the body have lividity with areas of blanching. The back has few, small scars, the largest of which measures ~1.5 cm. The upper portion of the central aspect of the back has a 6 x 3 cm brown, multi-nodular plaque. The upper portion of the left side of the back has a 0.5 cm, brown papule. The buttocks are unremarkable. The anus is unremarkable.

The arms are symmetric. The midportion of the right arm has multiple, red-maroon to purple-black ecchymoses, the largest of which measures 1.5 cm. The right forearm is otherwise unremarkable. The right hand and fingers are unremarkable.

The lateral aspect of the upper portion of the left arm has a tattoo. The lateral aspect of the upper portion of the left arm has a 4 x 1 cm, well healed scar. The posterior aspect of the left forearm has a 4 cm, linear scar. The anterior aspect of the distal portion of the left forearm has a roughly horizontally-oriented, 2 cm, curvilinear scar. The left hand and fingers are unremarkable.

The legs appear symmetric. The shins and ankles are edematous. The shins have multiple hypopigmented, well healed scars, the largest of which measures 2.5 cm. The soles of the feet have some scaly skin. The left thigh is unremarkable. The medial aspect of the left knee has few, punctate crusts over 1 cm. The left shin has scattered, small crusts, the largest of which measures 0.3 cm. The left foot and toes are unremarkable.

The right thigh is unremarkable. The proximal portion of the right shin has multiple, minute crusts over 8 cm, the largest of which measures 0.1 cm. The posterior aspect of the distal portion of the right calf has a 6 cm area with multiple, small crusts, the largest of which measures 0.2 cm.

EVIDENCE OF MEDICAL INTERVENTION: EKG pads are present on the body. A

band-aid is present on the lateral aspect of the upper portion of the right arm. No underlying abnormality is identified. The right antecubital region has a catheter which enters a vein and has no associated hemorrhage and no excess soft tissue fluid. The left antecubital region has a catheter which enters a vein and has no associated hemorrhage and no excess soft tissue fluid.

INTERNAL EXAMINATION:

BODY CAVITIES: The internal organs are in their normal anatomic locations. The body cavities contain typical quantities of unremarkable fluid. The stomach and portions of the intestines are minimally distended with gas. The spleen has a focal fibrous adhesions to the diaphragm.

ADRENAL GLANDS: The adrenal glands have thin, orange cortices and typical amounts of brown-gray medulla.

NECK: The soft tissues and layered musculature of the anterior aspect of the neck are unremarkable and have no hemorrhage. The hyoid bone is intact. The airways have no obstructions. The epiglottis, larynx, trachea, and bronchi have pink mucosal surfaces. The thyroid gland is maroon, typically-sized, and has no focal lesions.

RETICULOENDOTHELIAL SYSTEM: See body cavities section. The spleen has a smooth, intact, capsular surface and weighs 390 g. The splenic parenchyma is dark red, soft, and has no focal lesions. The respiratory system section. The remaining lymph nodes of the body are unremarkable in appearance and distribution.

HEAD: The scalp and temporalis muscles are unremarkable. The skull is unremarkable. The brain weighs 1310 g. The pituitary gland is unremarkable. There is no epidural, no subdural, and no subarachnoid hemorrhage. The leptomeninges, overlying the convexities of the cerebral hemispheres, appear slightly thickened. The convexities of the cerebral hemispheres are symmetric with no flattening of gyri or narrowing of the sulci. The convexities of the cerebral hemispheres have no areas of softening or discoloration. The inferior-medial aspect of the left cerebellar hemisphere of the brain has a 2.5 x 2.5 cm area with tan discoloration, softening, and retraction approximately 0.5 cm below the adjacent surface of the cerebellum. The underlying cerebellar parenchyma has softening and tan discoloration to a maximal depth of ~0.8 cm. The remaining portions of the cerebellum are unremarkable. The left posterior-inferior cerebellar artery has marked atherosclerosis with no discernable lumen. The right posterior-inferior cerebellar artery has atherosclerosis with a maximal stenosis of ~75 %. The left posterior cerebral artery has few atherosclerotic plaques with no significant stenosis. The right posterior cerebral artery has few atherosclerotic plaques and a maximal atherosclerotic stenosis of approximately 50%. The middle cerebral arteries, the anterior cerebral arteries, and the circle of Willis have no atherosclerosis. The substantia nigra is darkly pigmented. The mamillary bodies are unremarkable. The lateral ventricles appear enlarged. The cerebral hemispheres and brainstem appear to have a normal distribution of gray and white matter with no focal lesions.

GENITOURINARY SYSTEM: There are increased amounts of perinephric adipose tissue. The right kidney weighs 210 g and the left kidney weighs 200 g. The renal arteries have atherosclerosis with calcifications. The subcapsular surfaces of the kidneys have diffuse granularity. The subcapsular surface of the left kidney has few retracted scars, the largest of which measures 3 cm. The subcapsular surface of the right kidney has multiple, retracted scars, the largest of which measures approximately 2.5 cm. One pole of the right kidney has a subcapsular, 1.5 cm, clear thin fluid filled cyst. The subcapsular surface of the left kidney, adjacent to a retracted scar has a 0.5 cm, subcapsular, clear thin fluid filled cyst. The renal parenchyma is maroon. The corticomedullary junctions range from distinct to slightly ill-defined. The unremarkable urinary bladder contains approximately 250 mL of urine. The prostate gland is mildly enlarged and has some nodularity.

DIGESTIVE SYSTEM: See body cavities section. Portions of the mucosa of the esophagus are sloughing. The gastroesophageal junction is distinct. The mucosal surfaces of the stomach range from gray to pink-maroon. The wall of the stomach has multiple patches with mucosal petechiae. The mesentery and omentum have increased amounts of adipose tissue. The stomach contains approximately 600 mL of brown, viscous liquid with multiple portions of masticated material. The pancreas is pink-maroon, somewhat firm, lobulated, and has no focal lesions. The small intestines have a normal course and caliber. The appendix is present and unremarkable. The large intestines have a normal course and caliber.

HEPATOBILIARY SYSTEM: The unremarkable gallbladder contains approximately 10 mL of orange-brown, thin bile. The liver has a smooth, intact, capsular surface and weighs 2080 g. The liver parenchyma is dark red, soft, and has no focal lesions.

MUSCULOSKELETAL SYSTEM: The musculoskeletal system appears normally-developed. The sternum, ribs, clavicles, and spine are intact. The cervical spine has some vertebral lipping. The thoracic spine and lumbar spine have multiple osteophytes. The pelvic ring has no palpable fractures.

CARDIOVASCULAR SYSTEM: The great vessels appear normally-distributed. The aorta has moderate atherosclerosis with some infrarenal ulcerated plaques and multiple infrarenal calcifications. The heart weighs 600 g. The right ventricular free wall is mildly floppy. The left ventricle and interventricular septum are firm. The left anterior descending coronary artery has numerous atherosclerotic plaques and calcifications with a maximal atherosclerotic stenosis of approximately 99%. The left main coronary artery has calcifications and a maximal atherosclerotic stenosis of approximately 20%. The left circumflex coronary artery has numerous calcifications and a maximal identifiable atherosclerotic stenosis of approximately 90%. The coronary arteries are right dominant. The right coronary artery and the posterior descending coronary artery have a maximal atherosclerotic stenosis of approximately 50%. The right coronary artery has calcifications. The anterior-medial aspect of the left ventricular free wall and the left side of the interventricular septum have an area of white fibrosis over 4.5 cm in

the circumferential dimension, 1 cm in thickness and approximately 4.5 cm in the apical the basal dimension. The area of fibrosis involves the inner half of the myocardium. The anterior aspect of the left ventricular free wall, in the area fibrosis, is thinned to a minimal thickness of 1 cm. The remaining portion of the left ventricular free wall averages 2 cm in thickness. Two papillary muscles of the mitral valve appear to have areas of fibrosis. The atria are unremarkable. The foreman ovale is closed. The tricuspid valve is unremarkable. The pulmonary valve is unremarkable. The mitral valve is unremarkable. The aortic valve is unremarkable.

RESPIRATORY SYSTEM: The right lung weighs 700 g and the left lung weighs 610 g. The visceral pleural surfaces of the lungs are smooth, glistening, intact, and have mild anthracotic pigment in lacelike patterns. The pulmonary vessels are unremarkable. There are no pulmonary thromboemboli. The mucosal surfaces of the bronchi are pink to maroon. The lung parenchyma is spongy, pink-maroon, wet, and exudes white, foamy, thin liquid and dark red, thin liquid. The hilar lymph nodes of the lungs have anthracotic pigment.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-00336
NAME: Ford, James
CASE NO: 25-117
RECEIPT DATE: 02/14/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Wayne Kurz, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2500336 - 01/ CC 03/12/25 [0001, 1503]
PRINTED: 03/12/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 03/07/2025 17:12

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	FORD, JAMES
Patient ID	R25-00336
Chain	NMSCP429148
DOB	Not Given
Sex	Male
Workorder	25077990

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.89**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	7 mL	02/14/2025 13:21	Heart Blood	R25-00336

All sample volumes/weights are approximations.
Specimens received on 02/21/2025.

NMS

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Workorder 25077990
Chain NMSCP429148
Patient ID R25-00336

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.89	mcg/mL	0.10	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.10 mcg/mL		

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties
www.district8me.com

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: GRIM, Norman
AGE: 65
GENDER: Male
RACE: White
CASE NUMBER: ME25-0730
DATE OF DEATH: 10/28/2025
DATE AND TIME OF EXAMINATION: 10/31/2025 at 1100 hrs

AUTOPSY FINDINGS:

1. Intravenous catheters in antecubital fossae
2. Focal, mild peritoneal cavity adhesions
3. Mild aortic atherosclerosis
4. Pulmonary edema, congestion, and mild anthracosis
5. Nodular prostate gland

CAUSE OF DEATH: Multi-Substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Noel R. Agudo, M.D.
Associate Medical Examiner

Completed: 10/31/2025

EXTERNAL EXAMINATION:

The body is that of a normally developed, 65 inch, 159 pound adult male who appears compatible with the reported age of 65 years. The body is well-preserved.

The scalp has short, straight, gray hair in an androgenic alopecia pattern. Facial hair consists of a mustache and beard. The irides are brown and the corneas are clear. The sclerae are white. The conjunctivae are clear and have no petechiae. The ears, nose, and mouth are normally formed. The external auditory canals are unremarkable. The nasal septum is intact. The lips are not injured. The frenula are not lacerated. The oral cavity has natural dentition in fair condition.

The neck and chest are symmetrical. Electrocardiogram leads are adhered to the chest. The abdomen is flat and soft. The back and buttocks are symmetrical and have no deformities. The external genitalia are those of a fully developed, circumcised adult male. The anus is unremarkable.

The bilateral upper and lower extremities are symmetrical and have no palpable fractures. A 2 x 2 cm, raise lesion with scabbing is on the posterior surface of the left arm. A tourniquet is around the right arm. The arms have no track marks. Intravascular catheters extend from the bilateral antecubital fossae. A 2 by one cm scab is on the posterior surface of the right forearm. The wrists have no scars. An 11.5 x 0.5 cm, linear, oblique, hypopigmented surgical scar is on the right thigh. Scattered, up to one by 0.8 cm scabs are on the right shin. The hands and feet are symmetrical, and the nails are intact. A blue Medical Examiner identification band is around the left ankle.

TATTOOS:

Monochromatic and polychromatic tattoos are on the back and bilateral upper extremities.

INTERNAL EXAMINATION:

The reflected scalp is atraumatic. The calvarium and skull base have no fractures. The cranial vault has no epidural or subdural hemorrhages. The leptomeninges are thin and transparent. The 1380 g brain is symmetrical and the cerebrum has normal gyral duration. The cranial nerves and vessels at the base of the brain are normally positioned and formed. The vessels of the circle of Willis have no aneurysms or atherosclerosis. The cerebral cortical ribbon is well-demarcated from the white matter. The ventricles are unremarkable. The subcortical and deep white matter have no gross pathologic abnormalities. The deep gray nuclei have no gross pathologic abnormalities. The substantia nigra and locus coeruleus are normally pigmented. The cerebellum, brainstem, and proximal cervical spinal cord are intact and have no gross pathologic abnormalities.

The anterior muscles of the neck are free of hemorrhage. The large vessels of the neck are unremarkable. The hyoid bone and laryngeal cartilages have no fractures. The pharynx and larynx have no obstructing foreign bodies or abnormal secretions. The epiglottis and vocal cords are unremarkable. The retropharyngeal and prevertebral soft tissues have no hemorrhages or

abnormalities. The cervical vertebrae are intact; there are no atlantooccipital or atlantoaxial dislocations or fractures.

Focal, mild adhesions are between the cecum and the peritoneal cavity wall. The pleural cavities and pericardial sac have no adhesions or abnormal collections of fluid. The diaphragm is intact and the organs of the thorax and abdomen are in their normal anatomic locations.

The 310 g heart has a smooth epicardial surface and a normal epicardial adipose tissue distribution. The coronary ostia are normally positioned and are patent. The coronary arterial circulation is right dominant. The coronary arteries have normal anatomic courses. The coronary arteries are thin-walled and patent. The four chambered heart has a normal configuration and the cardiac chambers are not dilated. The myocardium is uniformly red-brown and has no areas of pallor, fibrosis, or hemorrhage. The interatrial and interventricular septa are normally developed. The fossa ovalis is closed. The mural and valvular endocardium is thin, transparent, and free of mural thrombi. The papillary muscles and chordae tendineae are unremarkable. The four cardiac valves are thin, pliable, and free of vegetations and calcifications. The aorta has a normal caliber and no aneurysms. The intima has patchy fatty and mild atherosclerosis, most prominent distally. The venae cavae have normal anatomic courses and are free of thrombi. The catheter in the bilateral antecubital fossae insert into their respective median cubital veins with no perforations or associated hemorrhages of the surrounding soft tissue.

The right and left lungs are 800 g and 680 g, respectively. The pleural surfaces are smooth, glistening, and have mild, reticular anthracotic and deposition. The boggy pulmonary parenchyma is red-purple and has no granulomata, masses, or discrete areas of consolidation. The right and left pulmonary arteries are free of thromboemboli. The trachea and bronchi are patent and have no obstructing foreign bodies or masses.

The 1680 g liver has a smooth and intact capsule. The soft hepatic parenchyma is red-brown and has no focal lesions. The thin-walled gallbladder contains 5 mL of orange bile and no choleliths. The gallbladder mucosa is green to orange and velvety. The biliary tree is normally formed. The ductal lumina are patent. The vessels of the porta hepatis are unremarkable. The pancreas has tan, lobular parenchyma, and no masses.

The tongue has no contusions or bite marks. The serosal and mucosal surfaces of the esophagus are unremarkable. The stomach contains 350 mL of tan, thickened fluid and partially digested food particles. The gastric mucosa is tan, has normal to flattened rugal folds, and no ulcers or masses. The serosal surfaces and calibers of the small intestine and large intestine are normal and have no palpable masses or obstructions. The appendix is unremarkable. The rectum contains soft, green-brown stool, and its mucosa is unremarkable.

The 180 g spleen has a smooth and intact capsule. The splenic parenchyma is red-purple and homogenous. The lymph nodes of the neck, thorax, abdomen, and pelvis are unremarkable. The bone marrow of the ribs is red and of normal consistency.

The right and left kidneys are 150 g and 140 g, respectively. The capsules are thin and the cortical surfaces are smooth. The renal parenchyma is red-brown, has well-defined

corticomedullary junctions, and no masses. The renal vessels are patent. The pelvicalyceal systems are unremarkable. The ureters are normal in caliber and course to the urinary bladder. The bladder contains 140 mL of clear, yellow urine. The bladder mucosa is tan-white and smooth. The prostate gland has 1.5 x 1 cm and 2 x 1 cm, poorly circumscribed, tan-white, firm nodules; the remaining prostate gland parenchyma is tan-white.

The thyroid gland is normal in size and shape. The thyroid parenchyma is red-brown and homogenous. The adrenal glands have normal orange cortices and brown medullae.

The skeletal muscles of the thorax, abdomen, and pelvis are red and are well developed. The clavicles, sternum, ribs, vertebral bodies, and pelvis have no acute fractures.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-02005
NAME: Grim Jr., Norman
CASE NO: 25-730
RECEIPT DATE: 10/31/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Noel Agudo, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2502005 - 01/ CC 12/01/25 [0001, 1503]
PRINTED: 12/01/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
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e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 11/25/2025 21:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	GRIM JR., NORMAN
Patient ID	R25-02005
Chain	NMSCP494615
DOB	Not Given
Sex	Male
Workorder	25494021

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.98**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	6.75 mL	10/31/2025 11:30	Heart Blood	R25-02005

All sample volumes/weights are approximations.
Specimens received on 11/14/2025.

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Workorder	25494021
Chain	NMSCP494615
Patient ID	R25-02005

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.98	mcg/mL	0.20	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.20 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties
www.district8me.com

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: GUDINAS, THOMAS
AGE: 51
RACE: W
GENDER: M
CASE NUMBER: ME25-0448
DATE OF DEATH: 06/24/2025
DATE OF AUTOPSY: 06/26/2025 1115 hrs.

AUTOPSY FINDINGS:

1. Pulmonary congestion and edema
2. No evidence of trauma
3. Intravascular lines in upper extremities

Cause of Death: Multi-substance Toxicity

Manner of Death: Homicide

How injury occurred: Judicial execution with etomidate, rocuronium, and potassium acetate

Jon R. Thogmartin, M.D.
Interim District Medical Examiner
Date: 06/26/2025

EXTERNAL EXAMINATION: the body is that of a 70 inch, 182 pound, man who appears the recorded age of 51 years. The body is clad in black socks black pants and a white shirt. Intravascular lines are in the antecubital fossae. The skin is light tan. The eyes are green/hazel without petechiae. The scalp is covered in short dark stubble. The mouth has natural dentition. There is razor stubble of the face. EKG pads are on the body. A plastic band is on the right ankle. The neck, chest, and abdomen have no trauma. The penis is circumcised and otherwise unremarkable. A cloth strip adhesive bandage is on the right deltoid area. The skin of the back has prominent non-fixed lividity without trauma. On the anterior surface of the right forearm is a 1.2 x 1.2 cm area of faint ecchymosis. A circular scar is on the left hip. On the posterior surface of the left arm is a cross tattoo. On the anterior surface of the left wrist is a vertically oriented 1.2 cm minute abrasion.

INTERNAL EXAMINATION: the pericardial and pleural cavities are free of adhesions or effusions. The diaphragm is intact. A few adhesions are noted in the lower abdomen and around the distal colon. The sternum is intact. The ribs are intact. The organs are in their usual anatomic relationships.

GASTROINTESTINAL SYSTEM: the stomach is normally located and light tan, pink. The stomach has no perforations. The mid esophagus appears intact and has light tan mucosa. The stomach contains ~25-40 cc of masticated food material. The large and small bowels are green tan and not remarkable. The stomach has light tan, pink mucosa with a few minute areas of congestion and petechiae. No ulceration is noted. The appendix is present. No appendicitis is noted.

ENDOCRINE SYSTEM: the pancreas is tan, lobular, and not remarkable. The omentum the omentum is remarkably fatty. The left adrenal gland is yellow red and not remarkable. The right adrenal gland is yellow red and not remarkable.

HEMOLYMPHATIC SYSTEM: the bone marrow of the ribs is not remarkable. No enlarged lymph nodes are detected. The spleen is 150 g and has an intact capsule and unremarkable dark red purple parenchyma.

MUSCULOSKELETAL SYSTEM: the muscles appear normally developed without obvious degeneration or atrophy. The thoracic spinal column has no trauma. There is minimal vertebral artery lipping.

NECK: the soft tissue the anterior neck has no hemorrhage or trauma. The hyoid bone is intact. The larynx is intact. The cervical spine is intact. The larynx has light tan unremarkable mucosa. The epiglottis is not remarkable. The esophagus has light tan, pink unremarkable proximal mucosa.

GENITOURINARY SYSTEM: the right and left kidneys are 180 g each. The kidneys are dark purple and firm. No tumors are noted. The cortices appear normally developed. No cysts are identified. The collecting systems have no visible stones. The testicles are palpable in the scrotal sac. The prostate gland is light tan and mildly enlarged. The urinary bladder contains 254 mL of urine and unremarkable mucosa.

CARDIOVASCULAR SYSTEM: the heart is 470 g and has a slightly globular shape. The myocardium is red-brown and soft. The coronary ostia are in their usual locations. The coronary arteries are normal in course and caliber without atherosclerosis. All coronary arteries are widely patent. The coronary ostia are not remarkable. The cardiac valves have no vegetations. The interventricular septum is not remarkable. The descending portion of the thoracic aorta has minimal atherosclerosis. The intravenous catheters are each installed in the antecubital veins. No fluid/medication infiltration or hemorrhage is noted.

HEPATOBILIARY SYSTEM: the liver is 1520 g. The capsule of the liver is intact and transparent. The liver is dark purple red without cirrhosis, tumors, cysts, or infarcts. The bile ducts and portal veins are not remarkable. The gallbladder is not remarkable and contains a small amount of bile.

RESPIRATORY SYSTEM: the right and left lungs are 800 and 540 g respectively. The lungs are dark purple red with a normal number of lobes. There is congestion and edema more prominent in the right lung than the left. The lungs have a normal number of lobes. Foamy fluid exudes from all lobes of the right lung lobe. The main bronchi are not remarkable and unobstructed. No tumors are noted.

CENTRAL NERVOUS SYSTEM: the scalp, skull, and 1530 g brain have no hemorrhage or trauma. The leptomeninges are thin and delicate. The arteries at the base of the brain have no aneurysms and appear unremarkable. The cranial nerves are not remarkable. No cerebral contusions are noted. No subdural, epidural, or subarachnoid hemorrhages noted. No abnormalities are noted in the cortical gray or white matter, midbrain, cerebellum, pons, or medulla. The ventricular system is free of hemorrhage.

- CONFIDENTIAL -

University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01206
NAME: Gudinas, Thomas
CASE NO: 25-448
RECEIPT DATE: 06/27/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Jon Thogmartin, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	None Detected		
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2501206 - 01/ CC 07/28/25 [0001, 1503]
PRINTED: 07/28/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 07/10/2025 10:08

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	GUDINAS, THOMAS
Patient ID	R25-01206
Chain	NMSCP462579
DOB	Not Given
Sex	Male
Workorder	2528536 4

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.57**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	6.5 mL	06/26/2025	Heart Blood	R25-01206

All sample volumes/weights are approximations.
Specimens received on 07/02/2025.

NMS LABS

CONFIDENTIAL

Workorder 25285364
Chain NMSCP462579
Patient ID R25-01206

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.57	mcg/mL	0.10	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.10 mcg/mL		

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

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Alachua, Baker, Bradford, Dixie,
Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME:	HUTCHINSON, JEFFREY
AGE:	62 years
GENDER:	Male
CASE NUMBER:	ME25-0323
DATE OF DEATH:	May 1, 2025
DATE OF AUTOPSY:	May 2, 2025

AUTOPSY FINDINGS

1. Intravenous catheters in left and right veins of antecubital fossae

2. Hypertensive cardiovascular disease
   a. Cardiomegaly
   b. Left ventricular hypertrophy

CAUSE OF DEATH: Multi-Substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate.

Heidi Reinhard, M.D.
Associate Medical Examiner
Date signed: 5/2/2025

EXTERNAL EXAMINATION

The body is received in a white human remains pouch; an identification tag with the inscription "FSP Hutchinson, Jeff" is affixed to the zipper. The body is that of a well-developed, well-nourished, male. The body is 213 pounds, 74 inches in length, and appears compatible with the reported age of 62 years.

The body is cold. Rigor mortis is present to an equal degree in all extremities. Fixed, purple lividity is distributed on the posterior surfaces of the body, except in areas exposed to pressure. The face is plethoric.

The scalp hair is gray and has a male balding pattern of distribution. Facial hair consists of gray stubble. The irides are blue, the corneae are clear, the sclerae are white, and the conjunctivae are tan and free of petechiae. The external auditory canals and external nares are free of foreign material and abnormal secretions. The nasal skeleton is palpably intact. The lips are atraumatic. The oral cavity contains brown debris. The teeth are in fair repair. Examination of the neck reveals no evidence of injury.

The chest is unremarkable. The abdomen is protuberant and soft. The atraumatic external genitalia are those of a normal adult male. The posterior torso is essentially without note. The anus is atraumatic.

The extremities show no gross bony deformities. Needle tracks are not observed. The fingernails and toenails are intact. The knees have dry scaly skin. The legs have dilated subcutaneous vasculature.

EVIDENCE OF INJURY

The antecubital fossae contain intravascular catheters which extend into the right and left medial cubital veins.

EVIDENCE OF MEDICAL INTERVENTION

Electrocardiogram pads are on the torso. A bandage overlying a punctate abrasion is on the right arm.

POSTMORTEM RADIOGRAPHS

None.

INTERNAL EXAMINATION

All present body organs are in their normal anatomic positions.

The reflected scalp is intact and has no hemorrhage. The skull has no fractures of the calvarium or the base of the skull.

The dura mater has no injury or membranes. The vessels at the base of the brain have minimal atherosclerotic luminal stenosis. There is no epidural, subdural, or subarachnoid hemorrhage. The 1530-gram brain has symmetrical cerebral hemispheres. The gyri are flat; the sulci are narrow. The gray/white matter junction is well-demarcated. The cortical ribbon is of the same width throughout. The white matter is without masses or areas of softening. The ventricles are not dilated and are unremarkable. The mammillary bodies are not shrunken or discolored. The symmetrical hippocampi are not shrunken, scarred, or hemorrhagic. The cerebellar hemispheres are symmetric; the dorsal cerebellar vermis is not atrophic. The brainstem and proximal spinal cord are unremarkable. The pituitary gland sits normally in the sella turcica.

The tongue has no bite marks or hemorrhage. The strap muscles and large vessels of the anterior neck are intact and unremarkable. The hyoid bone, thyroid cartilage, and larynx are symmetrical and intact. The thyroid gland has a normal size and shape and brown-tan, glistening parenchyma.

The upper airway, trachea, and mainstem bronchi are empty. The mucosal surfaces are smooth and red-tan. The pleural cavities have no adhesions. The right and left lungs are 970 grams and 900 grams, respectively. The pleurae of the lungs are red-tan with scattered anthracosis, smooth, and glistening. The pulmonary parenchyma is maroon-red, congested, exudes copious frothy fluid, and has no masses, granulomata, or areas of consolidation. The pulmonary arteries are patent and have no thromboemboli.

The pericardial sac contains no excess fluid or adhesions. The 570-gram heart has smooth epicardial surfaces. The normally positioned ostia of the left main and right coronary arteries are patent. The coronary arteries arise normally and follow a right-dominant distribution. Atherosclerosis produces luminal stenosis up to 10 percent in the left anterior descending coronary artery. The left circumflex coronary artery and right coronary artery are patent.. The four thin, pliable cardiac valves have no deformities or vegetations. The tricuspid valve is 13.0 centimeters, the mitral valve is 13.0 centimeters, the pulmonic valve is 8.0 centimeters, and the aortic valve is 8.0 centimeters in circumference. The mural endocardium is thin, smooth, and translucent. The maroon-tan myocardium has no fibrosis, necrosis, or hemorrhage. The right and left ventricles are 0.5 centimeters and 1.8 centimeters thick, respectively. The interventricular septum is 1.8 centimeters thick. The aorta has mild to moderate atherosclerosis.

The peritoneal cavity has no excess fluid or adhesions.

The esophagus is lined by gray-white, smooth mucosa, is not dilated or stenosed, and has no varices. The stomach has a normal size and shape and contains a thin film of tan, opaque fluid. The gastric mucosa is tan and has the usual folds. The small intestine has a normal length, configuration, and diameter and has a pink-tan, smooth serosal surface. The mesentery has a normal insertion. The large intestine has a smooth, pink-tan serosal surface and no palpable masses or obstructions. The appendix is vermiform.

The 2200-gram liver has an intact, smooth capsule covering maroon-brown parenchyma with no masses or focal lesions. The extrahepatic and intrahepatic vessels are patent. The gallbladder contains brown-yellow bile and is lined by brown-tan, velvety mucosa.

The soft pancreas has chalky tan, lobular parenchyma.

The 230-gram spleen has a gray-white, intact capsule covering maroon-red, soft parenchyma. The lymph nodes of the neck, chest, abdomen, and pelvis are unremarkable.

The adrenal glands have yellow-tan cortices and brown-tan medullae.

The right and left kidneys are 210 grams and 250 grams, respectively. The surfaces are maroon-red, lobulated, and finely granular. The parenchyma has well-defined corticomedullary junctions. The renal vessels are patent. The renal calyces are not dilated. The ureters have a normal course and caliber. The bladder contains 595 milliliters of clear, yellow urine and is lined by pink-tan, intact mucosa.

The prostate gland has white-tan, firm homogenous parenchyma. The intrascrotal testes have tan, fibrinous parenchyma with no masses.

The musculoskeletal system is well-developed. The maroon-red musculature has a normal, firm consistency. The ligaments of the craniocervical junction are intact. The clavicles, ribs, and sternum are intact. The bone marrow of the ribs is maroon-red. The pelvic bones and the vertebral bodies of the cervical, thoracic, and lumbar spine are intact.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-00836
NAME: Hutchinson, Jeffrey
CASE NO: 25-323
RECEIPT DATE: 05/07/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Heidi Reinhard, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	None Detected		
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2500836 - 01/ CC 06/10/25 [0001]
PRINTED: 06/10/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 06/09/2025 08:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	HUTCHINSON, JEFFREY
Patient ID	R25-00836
Chain	NMSCP451063
DOB	Not Given
Sex	Male
Workorder	25209406

Positive Findings:

Testing Canceled

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Tests Not Performed:

Part or all of the requested testing was unable to be performed. Refer to the **Analysis Summary and Reporting Limits** section for details.

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	5.75 mL	05/02/2025 14:52	Heart Blood	R25-00836

All sample volumes/weights are approximations.

Specimens received on 05/14/2025.

Detailed Findings:

Testing Canceled

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

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Workorder 25209406
Chain NMSCP451063
Patient ID R25-00836

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	N/A		

Testing Not Performed: Test was canceled due to [Sample Matrix Problem].



Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

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Office 352-384-3366
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AUTOPSY REPORT

NAME: JAMES, Edward
AGE: 63 years
GENDER: Male
RACE: White
CASE NUMBER: ME25-0229
DATE OF DEATH: March 20, 2025
DATE OF AUTOPSY: March 21, 2025 at 11:11 am

CAUSE OF DEATH: Multi-Substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate

Wayne D. Kurz, M.D.
ASSOCIATE MEDICAL EXAMINER
Date signed: March 23, 2025

AUTOPSY FINDINGS:

1. Intravenous catheter of the right forearm.
2. Intravenous catheter of the left antecubital region.
3. Pulmonary congestion and edema.
4. Moderate coronary artery atherosclerosis with a stent (maximal identifiable stenosis: 50%).
5. Moderate aortic atherosclerosis with calcifications.
6. Atrophy of the thyroid gland.
7. Remote appendectomy.

EXTERNAL EXAMINATION:
See evidence of medical procedures section. The body is that of a 187 pound, 70 inch, well-developed, well-nourished, white male whose appearance is consistent with the reported age of 63 years. The skin of the upper chest, neck, and head appear congested. The scalp has gray hair with frontal recession, bitemporal recession, apical balding and thinning of the hair of the top of the head. The posterior-superior aspect of the head has a 7.5 cm, faint purple ecchymosis. The eyebrows are bushy. The irides are blue. The eyes have minimal vascular congestion, no petechia, and no hemorrhage. The nose has no palpable fractures. The left earlobe has a punctate scar. The right ear is unremarkable. A gray mustache and beard are present on the face. The maxilla appears edentulous. The mandible has native teeth in good condition. Minimal, brown material is present between multiple, mandibular front teeth. The visible mucosal surfaces of the oral cavity are unremarkable. The contours of the neck are unremarkable.

The chest is symmetric. The abdomen is mildly protuberant. The central portion of the abdomen has a vertically-oriented, 20 cm, well healed, linear scar. The lower portion of the right side of the abdomen has a diagonally-oriented, 8 cm, well healed, linear scar. The lateral aspect of the lower-most portion of the right side of the abdomen has a 1 cm, diagonally-oriented, well healed, linear scar with suture marking scars. The male genitalia appear normally-developed and the testes are descended bilaterally. The posterior surfaces of the body have lividity with areas of blanching. The back is symmetric. The upper portion of the central aspect of the right side of the back has a 1 cm, slightly raised nodule.

The arms are symmetric. The lateral aspect of the upper portion of the right arm has a tattoo. The lateral aspect of the upper portion of the right arm has a 7 cm, diagonally-oriented, well healed, roughly linear scar with suture scar markings.

The right forearm is otherwise unremarkable. The right hand and fingers are unremarkable.

The upper portion of the left arm is unremarkable. The left forearm is unremarkable.

The anterior aspect of the left wrist has a 1.5 cm scar. The palm of the left hand has a 1.5 cm area of scaly skin.

The legs are symmetric. The shins have some scaly skin. The shins and calves have scattered, punctate crusts. The feet have some scaly skin. The right thigh has 2, well healed, linear scars, the longer of which measures 5 cm. The posterior-lateral aspect of the right ankle has a 0.5 cm crust with surrounding, scaly skin. The right foot and toes are unremarkable.

The left thigh is unremarkable. The left foot and toes are unremarkable.

EVIDENCE OF MEDICAL PROCEDURES: EKG pads present on the body. The lateral aspect of the right antecubital region has a bandage overlying 2 puncture marks. The posterior aspect of the right forearm has an intravascular-type catheter which enters a vein. The left antecubital region has an intravascular-type catheter with enters a vein and has minimal, associated, soft tissue hemorrhage over 0.5 cm.

INTERNAL EXAMINATION:

BODY CAVITIES: The internal organs are in their normal anatomic locations. The body cavities contain typical quantities of unremarkable fluid. The upper lobe of the left lung has few fibrous adhesions to the chest wall. The greater omentum and the large intestines have some fibrous adhesions to the lower portion of the right side of the abdominal wall, underlying the previously described scar.

ADRENAL GLANDS: The adrenal glands have thin, orange cortices and typical amounts of brown-gray medulla.

RETICULOENDOTHELIAL SYSTEM: The spleen has a smooth, intact, capsular surface and weighs 260 g. The splenic parenchyma is dark red, soft, and has no focal lesions. The lymph nodes of the body are unremarkable in appearance and distribution.

GENITOURINARY SYSTEM: The right kidney weighs 150 g and the left kidney weighs 160 g. The subcapsular surfaces of the kidneys are smooth. The calyces, pelves, and the proximal portions of ureters are unremarkable. The renal pyramids range from pale pink to dark red. The remaining portions of renal parenchyma are maroon-dark red. The kidneys have no focal lesions. The unremarkable urinary bladder contains approximately 530 mL of clear, yellow urine. The prostate gland does not appear enlarged and has no nodularity.

HEAD: Underlying the previously described ecchymosis, the posterior-superior aspect of the head has an underlying, 6 cm area of scalp hemorrhage. The temporalis muscles are unremarkable. The skull is unremarkable. The meninges are unremarkable. There is no epidural, no subdural, and no subarachnoid hemorrhage. The pituitary gland is unremarkable. The brain weighs 1530 g. The convexities of the cerebral hemispheres are symmetric with no flattening of the gyri or narrowing of the sulci. The arteries of the

base of the brain appear normally-distributed. The right posterior cerebral artery has a focal atherosclerotic plaque with a maximal stenosis of approximately 20%. The remaining portions of the cerebral arteries have no atherosclerosis. The substantia nigra is darkly pigmented. The mamillary bodies are unremarkable. The lateral aspect of the left basal ganglia has a possible, 0.5 cm lacuna with no discoloration. The cerebral hemispheres, cerebellum, and brainstem have a normal distribution of gray and white matter.

HEPATOBILIARY SYSTEM: The unremarkable gallbladder contains approximately 30 mL of maroon, thin bile. The liver has a smooth, intact, capsular surface and weighs 2080 g. The liver parenchyma is red-brown and soft.

DIGESTIVE SYSTEM: See body cavities section. The esophagus is unremarkable. The mucosa of the esophagus is white. The gastroesophageal junction is distinct. The stomach has mild rugal folding. The mucosal surfaces of the stomach are somewhat mottled tan and pale maroon. The stomach contains approximately 75 mL of brown, thin liquid and tan and brown-green, viscous material. The pancreas is tan-pink, slightly firm, lobulated, and has no focal lesions. The small intestines have a normal course and caliber. The appendix is not identified. Portions of the small intestines have some brown and green discoloration. The large intestines have a normal course and caliber.

NECK: The soft tissues and layered musculature of the anterior aspect of the neck are unremarkable and have no hemorrhage. The hyoid bone is intact. The airways have no obstructions. The epiglottis, larynx, trachea, and bronchi have white-pink to pink mucosal surfaces. The thyroid gland appears atrophic and white-tan and increased in firmness.

MUSCULOSKELETAL SYSTEM: The musculoskeletal system appears normally-developed. The clavicles are intact. The sternum is intact. The ribs are intact. The spine is intact. The lumbar spine has some osteophytes and vertebral lipping. The pelvic ring has no palpable fractures.

CARDIOVASCULAR SYSTEM: The aorta has moderate, infrarenal atherosclerosis with some calcifications. The heart weighs 380 g. The heart has a normal shape. The left anterior descending coronary artery has myocardial bridging to a maximal depth of approximately 0.2 cm. A diagonal branch of the left anterior descending coronary artery has a focal atherosclerotic stenosis of approximately 20% with calcifications. The left anterior descending coronary artery has multiple calcifications and a maximal atherosclerotic stenosis of approximately 40%. The left main coronary artery has an atherosclerotic stenosis of approximately 50%. The left circumflex coronary artery has multiple calcifications and a maximal atherosclerotic stenosis of approximately 20%. The coronary arteries are left dominant. The posterior descending coronary artery has no significant atherosclerosis. The proximal portion of the right coronary artery has identifiable wire metal stent. The right coronary artery has identifiable atherosclerosis with calcifications. The left ventricle, right ventricle, and interventricular septum have red-brown myocardium with no focal lesions. The atria are unremarkable. The foreman

ovale is closed. The tricuspid valve is unremarkable. The pulmonary valve is unremarkable. The mitral valve is unremarkable. The aortic valve is unremarkable.

RESPIRATORY SYSTEM: The right lung weighs 1000 g and the left lung weighs 730 g. The visceral pleural surfaces of the lungs are smooth, glistening, intact, and have minimal to moderate anthracotic pigment. There are no pulmonary thromboemboli. The pulmonary arteries have minimal atherosclerosis. The bronchi have white-pink mucosal surfaces. The lung parenchyma is maroon-dark red to dark red, spongy, wet to markedly wet, and exudes tan, foamy, thin liquid and dark red, thin liquid. The lungs have a typical density.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-00562
NAME: James, Edward
CASE NO: 25-229
RECEIPT DATE: 03/21/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Wayne Kurz, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2500562 - 01/ CC 04/21/25 [0001, 1503]
PRINTED: 04/21/25

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Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 04/03/2025 21:03

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	JAMES, EDWARD
Patient ID	R25-00562
Chain	NMSCP438281
DOB	Not Given
Sex	Male
Workorder	25133836

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.84**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	3 mL	03/21/2025 13:36	Heart Blood	R25-00562

All sample volumes/weights are approximations.
Specimens received on 03/26/2025.

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Workorder 25133836
Chain NMSCP438281
Patient ID R25-00562

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.84	mcg/mL	0.20	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.20 mcg/mL		

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties
www.district8me.com

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: JENNINGS, BRYAN
AGE: 66
RACE: W
GENDER: M
CASE NUMBER: ME25-0769
DATE OF DEATH: 11/13/2025
DATE OF EXAM: 11/14/2025 1110 hrs.

AUTOPSY FINDINGS:

1. Intravenous catheters in the upper extremities
2. Right and left visceral and parietal pleural plaques
3. Pulmonary congestion and edema
4. Mild cardiomegaly (420 g)
5. Mild nephrosclerosis

Cause of Death: Multi-Substance Toxicity
Manner of Death: Homicide

How injury occurred: Judicial execution with etomidate, rocuronium, and potassium acetate

Jon R. Thogmartin, M.D.
Interim District Medical Examiner
Date: 11/16/2025

EXTERNAL EXAMINATION: the body is that of a 72 inch, 180 pound, man who appears recorded age of 66 years. The body is clad in black socks black pants and a white shirt. The skin is light tan. The scalp is covered in balding gray hair. The mouth has natural dentition. The face has a gray beard and mustache. Intravascular lines are in the antecubital fossae. EKG pads are on the body. An ID band with the decedent's name is on the left ankle. The eyes are blue hazel without petechiae. The neck, chest and abdomen appear normally developed. On the lateral surface of the right side of the thorax is a 6 cm faint horizontally oriented linear scar. On the right side of the torso near the axillary area is a faint 3 x 1.5 cm brown contusion. The skin of the back has blanching unremarkable lividity without trauma. On the superior portion of the left shoulder is a curvilinear well-healed scar with identifiable suture marks. On the left biceps area are multiple horizontally oriented linear slightly hypopigmented scars. On the posterior surface of the left forearm is a faint cross tattoo. On the anterior surface of the left hand over the thenar eminence is an obliquely oriented 1.5 cm linear scar. A few hypopigmented punctate macules are on the posterior surfaces of the forearms. Two minute obliquely oriented linear crusts are on the posterior surfaces of the third and fourth digits of the right hand. A minute punctate abrasion is on the anterior lateral surface of the right forearm. A faint slightly hypopigmented 5 x 4 cm irregular scar is on the anterior surface of the upper right thigh. The knees have a few somewhat hypopigmented to pink plaque-like scars. The shins have scattered slightly hypopigmented punctate scars. The skin over the calf areas has scattered hypopigmented punctate scars. Spider veins are on the ankles. On the lateral surface of the left knee is an obliquely oriented 3 cm linear scar.

INTERNAL EXAMINATION: the muscles of the of the chest and abdominal walls have no hemorrhage or trauma. The sternum is intact. On the lateral portion of the right thorax on along the anterior lateral portion of right ribs 3-5 are thick calcified right pleural plaques with adjacent adhesions. A calcified approximately 3.5 x 1.5 x 1 cm pleural plaque is noted on the right dome of the diaphragm. There are associated adhesions in the right pleural cavity. The left pleural cavity has no adhesions. The pericardial sac has no adhesions. The diaphragm is intact.

GENITOURINARY SYSTEM: the right and left kidneys are 160 and 200 g respectively. The capsules are firmly adherent to the kidneys. A few cortical scars are noted. The cortices are dark purple brown and slightly granular. The kidneys appears somewhat congested. No tumors are noted. No cysts are noted. The testicles are palpable in the scrotal sac. The urinary bladder is not remarkable. The prostate gland is light pink tan and unremarkable.

CARDIOVASCULAR SYSTEM: the abdominal and thoracic portions of the aorta appear intact and normal size. The thoracic aorta has minimal to moderate atherosclerosis without aneurysms. The heart is 420 g and has an intact unremarkable outer surface. The heart has a slightly globular shape. The fat covering the outer surface of the heart is not remarkable. The myocardium is dark red-brown and firm without scarring or fibrosis. The coronary ostia are in their usual locations. The left common coronary artery has mild to moderate calcified atherosclerosis. The left anterior descending coronary artery has minimal atherosclerosis. The circumflex coronary artery has minimal atherosclerosis. The right coronary artery appears to supply posterior interventricular septum and has no atherosclerosis. The cardiac valves have no vegetations. The interventricular septum is intact. The atria have no thrombi. The IV catheter in the right antecubital fossae is properly installed in the median cephalic vein without surrounding

tissue infiltration or hemorrhage. The IV catheter in the left antecubital fossae is properly installed in the median cephalic vein without hemorrhage or infiltration.

NECK: the soft tissue is of the anterior neck are not remarkable. The larynx is intact. No objects obstruct the throat. The hyoid bone is intact. The epiglottis is not remarkable. The larynx has intact light tan mucosa. The vocal cords appear atraumatic without nodules. The thyroid gland is dark purple without visible tumors.

RESPIRATORY SYSTEM: the right and left lungs are 980 and 1140 g respectively. There are visceral pleural plaques in the apex of the right lung. These are white and densely calcified. The outer surfaces of the lungs are pink, purple, tan with a few anthracotic macules. The lungs have moderate to severe congestion and edema with foamy fluid exuding from all lung lobes. The hilar lymph nodes are mildly anthracotic. The parenchyma of the lungs exudes an abundant amount of foamy fluid. No pulmonary emboli are noted. A few small calcified visceral pleural plaques are noted in the apical portion of the left upper lung lobe.

CENTRAL NERVOUS SYSTEM: the scalp and skull have no trauma. The brain is 1470 g. The sulci and gyri are not remarkable. The arteries at the base of the brain are not remarkable. The cerebral spinal fluid is clear and colorless. The ventricular system is not remarkable. No abnormalities are noted in the cortical gray or white matter, midbrain, cerebellum, pons, or medulla.

HEPATOBILIARY SYSTEM: the liver is 1890 g and is an intact transparent unremarkable smooth capsule. The dark purple parenchyma has no cirrhosis, tumors, cysts, or infarcts. The biliary system appears unremarkable. The gallbladder contains a scant amount of green, yellow bile without stones.

HEMOLYMPHATIC SYSTEM: the bone marrow of the ribs is not remarkable. A few mildly prominent 5 to 7 mm celiac lymph nodes are noted. The spleen is 210 g and has an intact unremarkable capsule and unremarkable firm purple red parenchyma without tumors, cysts, or infarcts.

ENDOCRINE SYSTEM: the adrenal glands are yellow red and not remarkable. The pancreas is tan, lobular, and not remarkable.

GASTROINTESTINAL SYSTEM: the outer surface of the distal esophagus is not remarkable. The stomach is normally located and is light tan. The omentum is not remarkable. The mesentery is not remarkable. The stomach has light tan mucosa with scattered minute petechiae. The stomach contains 10 mL of scant pink material. The appendix is not remarkable. The large and small bowels are normally rotated without perforations.

MUSCULOSKELETAL SYSTEM: the muscles are normally developed without obvious degeneration or atrophy. The thoracic spinal column along with the cervical spinal column have a mild vertebral body lipping.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-02104
NAME: Jennings, Bryan
CASE NO: 25-769
RECEIPT DATE: 11/14/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Jon Thogmartin, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2502104 - 01/ CC 12/12/25 [0001, 1503]
PRINTED: 12/12/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
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e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Toxicology Report

Report Issued 12/02/2025 20:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	JENNINGS, BRYAN
Patient ID	R25-02104
Chain	NMSCP496404
DOB	Not Given
Sex	Male
Workorder	25503207

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.71**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	7.75 mL	11/14/2025	Heart Blood	R25-02104

All sample volumes/weights are approximations.
Specimens received on 11/21/2025.

NMS LABS

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Workorder	25503207
Chain	NMSCP496404
Patient ID	R25-02104

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.71	mcg/mL	0.20	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.20 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties
www.district8me.com

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: JONES, VICTOR TONY
AGE: 64
RACE: B
GENDER: M
CASE NUMBER: 25-0655
DATE OF DEATH: 09/30/2025
DATE OF AUTOPSY: 10/03/2025 1000 hrs.

AUTOPSY FINDINGS:

1. Intravenous catheters in antecubital fossae
2. Pulmonary congestion and edema
3. Cardiomegaly (500 g)
4. Status post skull graft (remote)
5. Remote right frontal lobe injury with extension into the cerebral white matter

Cause of Death: Multi-Substance Toxicity

Manner of Death: Homicide

How injury occurred: Judicial execution with etomidate, rocuronium, and potassium acetate

Jon R. Thogmartin, M.D.
Interim District Medical Examiner

Date: 10/03/2025

EXTERNAL EXAMINATION: the body is that of a 69 inch, 179 pound, man who appears the recorded age of 64 years. The body is clad in a white shirt, white underpants, black pants, and black socks. The skin is brown. EKG pads are on the body. Intravascular lines are in each antecubital fossae. A plastic bandage strip is on the right deltoid area. A plastic bandage strip is on the anterior surface of the right forearm covering a minute punctate ecchymosis. Gray razor stubble is on the face. The scalp is covered in short gray black hair. On the posterior surface of the left scalp/upper left side of the neck is a 1 x 1 cm hypopigmented area of scarring with gray hair. The eyes are brown with arcus senilis. The mouth has natural dentition with a few missing teeth. On the left side of the scalp just posterior to the forehead extending onto the right side of the scalp is a coronally oriented 12-15 cm linear scar. The neck, chest, and abdomen are normally developed without obvious trauma. On the anterior portion of the forehead is a horizontally oriented 3 cm minute linear scar. Several minute vertical horizontal and obliquely oriented linear scars are on the anterior surface of the torso. The skin around the umbilicus has some faint somewhat punctate scarring. A few faint striae are on the hips. Several punctate scars are on the upper portion of the right leg. Scattered slightly hypopigmented punctate scars are on the shins. The toenails are somewhat thickened and brown. On the anterior surface of the left shoulder are several linear vertically oriented marks (scars/striae). On the anterior surface of the left forearm over the central portion of the left wrist is an obliquely oriented 2 cm linear scar. Several faint vertically oriented minute linear scars are on the anterior lateral surface of the left forearm. The skin of the back has a few punctate scars. The penis and scrotum are not remarkable.

RADIOGAPHY: the right frontal skull is absent and replaced with a graft. The graft has visible mesh and peripheral screws. No projectile or projectile fragments are noted.

INTERNAL EXAMINATION: the sternum is unremarkable. The ribs are intact. The panniculus is 3 cm. The muscles of the chest and abdominal walls have no trauma. The pericardial sac has no adhesions. The pleural cavities are smooth without adhesions. The diaphragm is intact. The omentum is not remarkable. The bowel appears unremarkable.

CARDIOVASCULAR SYSTEM: the thoracic and descending portions of the aorta have minimal atherosclerosis. The heart is 500 g and has a globular shape. The myocardium is red-brown and unremarkable without scarring or fibrosis. The right ventricle is not remarkable. The posterior portion of the right ventricle has a small amount of fatty infiltration near the septum. This area is no more than 4 x 5 x 3 mm. The coronary ostia are in their usual locations. Adjacent to the right coronary artery is a minute accessory coronary artery ostium. The right coronary artery appears to supply the posterior interventricular septum and has no atherosclerosis. The left anterior descending coronary artery has no atherosclerosis. The circumflex coronary artery has no atherosclerosis. The left common coronary artery appears widely patent without atherosclerosis. The interventricular septum is not remarkable. The catheter in the right antecubital fossae is installed in a deep small antecubital vein without surrounding hemorrhage or infiltration. There is some soft tissue hemorrhage inferior to the catheter associated with the previously described plastic strip and punctate ecchymosis. The left antecubital area has no infiltration of blood and has a catheter installed in the median cubital vein without perforation.

HEPATOBILIARY SYSTEM: the liver is 1630 g and has an intact transparent unremarkable capsule. The dark purple, brown parenchyma has no fibrosis, tumors, cysts, or infarcts. The gallbladder contains approximately 10 mL of green, tan bile without stones. The liver has a very slight nutmeg pattern without cirrhosis.

RESPIRATORY SYSTEM: the right and left lungs are 840 and 760 g respectively. The outer surfaces are dark purple pink and smooth. The bronchi contain foamy fluid. No fibrosis, tumors, cysts, or infarcts are noted. The hilar lymph nodes are not remarkable. No pulmonary emboli are noted.

ENDOCRINE SYSTEM: the adrenal glands are red brown and not remarkable. The pancreas is tan, lobular, and not remarkable.

NECK: the proximal esophagus has unremarkable pink mucosa. The larynx has is intact and has tan mucosa. The vocal cords are not remarkable. The thyroid gland is brown, red without tumors. The strap muscles of the neck are not remarkable.

GASTROINTESTINAL SYSTEM: the stomach contains approximately 5 mL of brown mostly liquid material. The gastric mucosa is pink, red with a few minute petechiae. No ulcerations are noted. The bowels appear normally rotated. No bowel perforations are noted. The appendix is not remarkable.

GENITOURINARY SYSTEM: the right and left kidneys are 170 g each. The capsules remove with difficulty. The kidneys are lobular and slightly granular. A few minute cortical cysts are noted in each kidney. The collecting systems have no stones. The prostate is light tan and somewhat enlarged and nodular. The urinary bladder contains approximately 500 mL of cloudy white yellow urine. The testicles are palpable in the scrotal sac.

HEMOLYMPHATIC SYSTEM: the spleen is 160 g and has an intact capsule. The parenchyma of the spleen is dark red purple without fibrosis, tumors, cysts, or infarcts. No enlarged lymph nodes are noted. The bone marrow of the ribs is not remarkable.

MUSCULOSKELETAL SYSTEM: the muscles are normally developed without degeneration or atrophy.

CENTRAL NERVOUS SYSTEM: the scalp has no trauma. The frontal scalp corresponding to the previously described scar has dense fibrous tissue. On the right frontal area is a green, brown skull implant/graft. The graft is 10 x 12 cm and is approximately 5 to 4 to 6 mm in thickness. The graft consists of metal mesh with green, brown material. There is associated silver metal visualized right temporal/frontal area. The brain is 1200 g. On the inferior surface of the right frontal lobe is a 3 x 3.5 cm cortical contusion with adhesions. The dura mater adjacent to this area is thickened. The brain is adherent to the dura in the frontal area. The cerebral cortex is fibrotic/contused, partially absent, and this extends through the full thickness of the inferior right frontal lobe and through the cerebral white matter extending to the anterior inferior lateral portion of the right lateral ventricle and inferior lateral portion of the right frontal cortex.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01843
NAME: Jones, Victor
CASE NO: 25-655
RECEIPT DATE: 10/03/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Jon Thogmartin, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2501843 - 01/ CC 11/06/25 [0001, 1503]
PRINTED: 11/06/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
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e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 11/03/2025 15:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	JONES, VICTOR
Patient ID	R25-01843
Chain	NMSCP485992
DOB	Not Given
Sex	Male
Workorder	25435564

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**1.2**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	8 mL	10/03/2025 10:00	Heart Blood	R25-01843

All sample volumes/weights are approximations.
Specimens received on 10/08/2025.

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Workorder	25435564
Chain	NMSCP485992
Patient ID	R25-01843

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	1.2	mcg/mL	0.20	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.20 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties
www.district8me.com

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: PITTMAN, DAVID JOSEPH
AGE: 63
RACE: W
GENDER: M
CASE NUMBER: ME25-0627
DATE OF DEATH: 09/17/2025
DATE OF AUTOPSY: 09/19/2025 1146 hours.

AUTOPSY FINDINGS:

1. Cardiomegaly (800 g)
2. Remote myocardial infarction
3. Moderate to severe coronary atherosclerosis
4. Pulmonary congestion and edema
5. Peripheral edema
6. Enlarged prostate
7. Intravenous catheters in upper extremities

Cause of Death: Multi-substance Toxicity

Manner of Death: Homicide

How injury occurred: Judicial execution with etomidate, rocuronium, and potassium acetate

Jon R. Thogmartin, M.D.
Interim District Medical Examiner
Date: 09/19/2025

EXTERNAL EXAMINATION: the body is that of a 75 inch, 246 pound, man who appears the recorded age of 63 years. The body is clad in black socks white underpants black pants and a white shirt. The skin is light tan. The scalp is covered in short gray hair. A gray beard and mustache are on the face. EKG pads are on the body. Intravascular lines are in each antecubital fossa. Striae are on the hips and lower abdomen. The neck, chest, and abdomen have no trauma. The lower extremities have moderate edema. The eyes are blue hazel without petechiae. The mouth has natural dentition. The anterior buccal mucosa has no trauma. In the left orbital area are several xanthelasma. A few punctate crusts are on the right side of the nose. A faint tattoo is on the upper portion of the right arm. Several faint tattoos are on the upper portion of the left arm. A small tattoo is on the left upper back. A plastic strip is on the upper portion of the right arm. On the medial surface of the left elbow is a somewhat obliquely oriented curvilinear 8 cm scar. A vertically oriented 6 x 2 mm crust is on the upper portion of the right knee. A few minute hypopigmented scars are on the shins. Multiple punctate crusts and minute abrasions are on the on the calves. A punctate crust is on the anterior surface of the left ankle. A few punctate crusts are on the left shin. On the lateral surface of the lower right calf is and linear 2 cm scar. The skin of the back has blanching lividity. The skin of the penis and scrotum is somewhat dried. The penis is circumcised and otherwise unremarkable.

INTERNAL EXAMINATION: the muscles of the chest and abdominal walls are not remarkable. The sternum is atraumatic. The ribs are intact. The left pleural cavity is smooth without adhesions. A few focal adhesions are noted along the posterior portion of the right pleural cavity. The pericardial sac is smooth without adhesions. The diaphragm is intact. No ascites is noted.

GASTROINTESTINAL SYSTEM: the stomach is normally located. Adhesions are noted of the omentum to the spleen. The stomach is normally located and is pink, tan without perforations. The stomach contains 20 mL of brown, red liquid. The large and small bowels are somewhat distended by gas. The cecum is distended by a large amount of gas. The bowels are tan to pink, green without perforations. The omentum is fatty. The mesentery is fatty. The omentum has adhesions to the left side of the peritoneal cavity. The stomach has intact purple, gray mucosa with slight congestion. No ulcerations are detected.

ENDOCRINE SYSTEM: the pancreas is tan, lobular, and not remarkable. No pancreatitis or tumors are noted. The left adrenal gland is yellow and not remarkable. The right adrenal gland is yellow brown and not remarkable.

HEMOLYMPHATIC SYSTEM: the bone marrow of the ribs is not remarkable. No enlarged lymph nodes are detected. The spleen is 390 g and has an intact capsule. The spleen has dark red congested mildly fibrotic parenchyma without tumors, cysts, or infarcts.

MUSCULOSKELETAL SYSTEM: the muscles are normally developed without obvious degeneration or atrophy. The thoracic spinal column is atraumatic. No scoliosis is noted.

NECK: the soft tissue of the anterior neck has no hemorrhage or trauma. The larynx is intact. The hyoid bone is intact. There are prominent osteophytes along the anterior portion of the cervical spine. No objects obstruct the throat. The thyroid cartilage is intact. The proximal

esophagus has light tan, pink unremarkable mucosa. The larynx has intact light tan, pink unremarkable mucosa. The thyroid gland is somewhat enlarged tan, pink, purple. No tumors are noted.

CENTRAL NERVOUS SYSTEM: the brain is 1410 g and is normally developed sulci and gyri and thin delicate leptomeninges. The arteries at the base of the brain have no aneurysms. The basilar artery shows mild to moderate atherosclerosis without occlusion. The sulci and gyri have no contusions. The pineal gland is not remarkable. The cerebral spinal fluid is clear and colorless. No subdural or subarachnoid hemorrhages are noted. No abnormalities are noted in the cortical gray or white matter, midbrain, cerebellum, pons, or medulla.

GENITOURINARY SYSTEM: the right and left kidneys are 250 and 330 g respectively. The right kidney shows an inferior accessory renal artery. The left kidney has a 1.2 cm diameter cyst on its posterior surface. The cyst is filled with clear serous fluid. The collecting systems have no visible stones. No tumors are noted. The external surfaces of the kidneys are dark purple brown and granular. The testicles are palpable in the scrotal sac. The scrotal sac is somewhat edematous. The prostate gland is enlarged tan and nodular. The urinary bladder is distended by 900 mL of clear yellow urine.

HEPATOBILIARY SYSTEM: the liver is 2140 g and has an intact transparent capsule. No hepatic trauma is noted. The brown, purple parenchyma has no fibrosis, tumors, cysts, or infarcts. The gallbladder has 5 mL of green bile without stones.

RESPIRATORY SYSTEM: the right and left lungs are 890 and 690 g respectively. The outer surfaces are pink purple and smooth. The lungs have congestion with foamy fluid exuding from all lung lobes. No tumors are noted. No cysts are noted. There is a background of mild interstitial anthracosis. The hilar lymph nodes are mildly anthracotic. No pulmonary emboli are noted.

CARDIOVASCULAR SYSTEM: the heart is 800 g and has a markedly globular shape. The heart has an abundant amount of fat on its external surface. The lateral anterior and posterior portion of the left ventricular free wall shows scattered areas of scarring. This extends from the apex of the heart to the base of the heart. The coronary ostia are in their usual locations. No ventricular aneurysm or appreciable thinning of the left ventricular free wall is noted. The right coronary artery appears to supply the posterior portion of the interventricular septum and has minimal atherosclerosis in its proximal portion. The posterior descending coronary artery shows no atherosclerosis. The left anterior descending coronary artery and its branches have severe occlusive atherosclerosis with approximately 50 to 90% calcified stenosis. The circumflex coronary artery shows severe atherosclerosis at a location approximately 1 cm from its origin with approximately 99-100% stenosis of its lumen. The left common coronary artery has severe atherosclerosis with approximately 90 to 95% stenosis with atherosclerotic plaque. The cardiac valves have no vegetations. The interventricular septum is intact. The descending aorta and aortic arch show moderate to severe somewhat ulcerative atherosclerosis. No aneurysms are noted. Examination of the antecubital fossae shows IV catheter is installed into the cephalic/antecubital veins. No infiltration or hemorrhage is noted in the soft tissue of the antecubital fossae.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01737
NAME: Pittman, David
CASE NO: 25-627
RECEIPT DATE: 09/19/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Jon Thogmartin, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
	Hydroxyzine	Positive (trace)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2501737 - 01/ CC 10/20/25 [0001, 1503]
PRINTED: 10/20/25

NMS Labs
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e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 10/15/2025 13:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	PITTMAN, DAVID
Patient ID	R25-01737
Chain	NMSCP485056
DOB	Not Given
Sex	Male
Workorder	25429459

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.37**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	8 mL	09/19/2025	Heart Blood	R25-01737

All sample volumes/weights are approximations.
Specimens received on 10/03/2025.

NMS LABS

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Workorder	25429459
Chain	NMSCP485056
Patient ID	R25-01737

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.37	mcg/mL	0.040	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.040 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

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3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

EXTERNAL EXAMINATION REPORT

NAME: Randolph, Richard
AGE: 63
GENDER: Male
RACE: Black
CASE NUMBER: ME25-0787
DATE OF DEATH: 11/20/2025
DATE OF EXTERNAL EXAMINATION: 11/21/2025

EXTERNAL EXAMINATION FINDINGS:

1. Appropriately developed male decedent
2. Toxicology (see separate report)

CAUSE OF DEATH:
Multi-substance toxicity

MANNER OF DEATH:
Homicide

HOW INJURY OCCURRED:
Judicial execution with etomidate, rocuronium and potassium acetate

A. Blank

Alexander Blank, MD
MEDICAL EXAMINER
DATE: 11/21/2025

EXTERNAL EXAMINATION:

The body is that of a well-developed, well-nourished, 65 inch, 163 pound man who appears the reported age of 63 years. The body is cool and well-preserved. Rigor mortis is fully developed in the upper and lower extremities. Livor mortis is posterior and blanches with pressure. The body mass index is 27.1 kilograms per meter squared. A medical examiner bracelet is around the left ankle. Scattered hyperpigmented patches are on the abdomen and the bilateral upper and lower extremities.

The head is normally formed. The scalp has less than 1 centimeter long dark gray hair with male pattern balding. Facial hair consists of dark gray stubble. Circumferential, grayish-white opacities are around the bilateral corneas. The sclerae are white. The irides appear brown. The conjunctivae have no petechiae. The nasal septum and nasal bones are intact. The orolabial and buccal mucosal surfaces have no lesions. The orolabial frenula are intact. The maxillary arch is edentulous, partial dentures are in the mandibular arch and remaining visible teeth appear in good condition. The external auditory canals are unremarkable. The neck is symmetrical and has masses. A faint, 3.0 x 0.4 centimeter obliquely oriented, linear scar is on the central aspect of the anterior lower neck.

The torso is symmetrical. The abdomen is slightly protuberant and soft. The back is symmetrical. The back and buttocks have no chronic deformities or ulcers. The anus and perineum have no lesions. The external genitalia are those of a fully developed adult man.

The bilateral upper and lower extremities are symmetrical and have no palpable fractures, dislocations, or needle track marks. A 13 x up to 1.8 centimeter slightly irregular, curvilinear scar is on the anterior aspect of the right forearm/wrist. The thumbnails, fingernails, and toenails are intact. A 4.0 x 3.0 centimeter hyperpigmented patch is on the anterior aspect of the left knee/leg.

EVIDENCE OF INTERVENTION:

Electrocardiogram pads are on the right side of the upper chest, the left side of the upper chest, and the left side of the abdomen. An adhesive bandage is on the lateral aspect of the right arm and no significant hemorrhage is in the underlying soft tissue. An intravenous catheter courses into the right antecubital fossa and terminates in a vein with no significant hemorrhage in the soft tissue adjacent. An intravenous catheter courses into the left antecubital fossa and terminates in a vein with no significant hemorrhage in the soft tissue adjacent.

EVIDENCE OF INJURY:

None.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-02137
NAME: Randolph, Richard
CASE NO: 25-787
RECEIPT DATE: 11/21/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Alexander Blank, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, femoral
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2502137 - 01/ CC 12/30/25 [0001, 1503]
PRINTED: 12/30/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 12/26/2025 17:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	RANDOLPH, RICHARD
Patient ID	R25-02137
Chain	NMSCP499476
DOB	Not Given
Sex	Male
Workorder	25522630

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.34**	**mcg/mL**	**001 - Femoral Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	8.25 mL	11/21/2025 11:00	Femoral Blood	R25-02137

All sample volumes/weights are approximations.
Specimens received on 12/05/2025.

NMS LABS

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Workorder	25522630
Chain	NMSCP499476
Patient ID	R25-02137

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.34	mcg/mL	0.040	001 - Femoral Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Femoral Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Femoral Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.040 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

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3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: ROGERS, GLEN EDWARD
AGE: 62
RACE: W
GENDER: M
CASE NUMBER: ME25-0344
DATE OF DEATH: 05/15/2025
DATE OF AUTOPSY: 05/16/2025 1050 hrs.

AUTOPSY FINDINGS:

1. Pulmonary congestion and edema
2. Severe coronary atherosclerosis
3. Early hepatic cirrhosis
4. Intravenous catheters in upper extremities
   -left arm catheter not installed

Cause of Death: Multi-substance Toxicity

Manner of Death: Homicide

How injury occurred: Judicial execution with etomidate, rocuronium, and potassium acetate

Jon R. Thogmartin, M.D.
Interim District Medical Examiner
Date: 05/17/2025

EXTERNAL EXAMINATION: the body is that of a 72 inch, 167 pound, man who appears the recorded age of 62 years. The body is clad in a white shirt white underpants black pants and black socks. The skin is light tan. The scalp is covered in brown hair with a few gray streaks. A gray beard and mustache are on the face. The mouth has natural dentition. The eyes are blue/hazel without petechiae. Intravascular lines are in the upper extremities. EKG pads are on the body. A gauze bandage is on the left antecubital fossae. The penis is circumcised and otherwise unremarkable. The chest and abdomen are normally developed. The extremities appear normally developed. A tattoo is on the upper portion of the right arm. A tattoo is on the left deltoid area. A small cloth adhesive bandage is on the right deltoid area. On the posterior surface of the right arm are several somewhat punctate round 2-9 mm ecchymoses. On the posterior surface of the left wrist and forearm are minute 1 to 4 mm punctate ecchymoses. Tattoos are on the digits of the right hand. A few scattered hypopigmented scars are on the shins and knees. A minute punctate crust is on the left shin. The skin of the back has blanching well developed lividity.

INTERNAL EXAMINATION: the muscles of the chest and abdominal walls have no evidence of trauma. The sternum and ribs are intact. The organs are in their usual anatomic relationships. The pericardial sac contains a scant amount of clear fluid. The pleural cavities have no adhesions. The diaphragm is not remarkable. The abdominal cavity has no ascites. The right pleural cavity has a focal single apical adhesions. A few adhesions are noted of the greater omentum to the left abdominal wall.

GASTROINTESTINAL SYSTEM: the stomach is normally located and is light tan. The stomach contains 450 mL of green, tan masticated food material. The large and small bowels are green to pink tan. No perforations are noted. The cecum is somewhat distended by gas. The appendix is not remarkable. The stomach has intact light tan mucosa with scattered minute petechiae. No ulcerations are noted.

ENDOCRINE SYSTEM: the pancreas is tan, lobular, and unremarkable. The left adrenal gland is yellow red and not remarkable. The right adrenal gland is gray yellow and not remarkable.

HEMOLYMPHATIC SYSTEM: the bone marrow of the ribs is not remarkable. The 310 g spleen has an intact capsule. No enlarged lymph nodes are found. The spleen has dark red mildly fibrotic parenchyma. Within the lower pole of the spleen is a minute 2 mm calcified nodule. No cysts or infarcts are noted.

MUSCULOSKELETAL SYSTEM: a few areas of vertebral body lipping are noted. The spine has no trauma. The muscles of the extremities appear normally developed.

NECK: the soft tissues of the anterior neck have no hemorrhage or trauma. The larynx is intact. The epiglottis is not remarkable. The hyoid bone is intact. The esophagus has unremarkable tan mucosa. The larynx has unremarkable mucosa. The vocal cords appear unremarkable. The thyroid gland is red-brown and mildly atrophic.

GENITOURINARY SYSTEM: the right and left kidneys are 150 and 180 g effectively. The outer surfaces are red brown lobular and granular. The corticomedullary ratios are somewhat reduced. No cysts or tumors are noted in the kidneys. The testicles are palpable in the scrotal sac. The urinary bladder contains approximately 50 mL of urine. The prostate gland is mildly enlarged.

CARDIOVASCULAR SYSTEM: the heart is 430 g and has an unremarkable shape. The epicardial surface of the heart is smooth and unremarkable. The myocardium is red brown without infarctions or scarring. The coronary ostia are in their usual locations. A minute accessory coronary artery is noted. The right coronary artery is small in diameter and has approximately 50% stenosis with atherosclerotic plaque. The left anterior descending coronary artery has severe occlusive atherosclerosis with approximately 80% stenosis of its lumen. The circumflex coronary artery has mild to moderate atherosclerosis. The left common coronary artery has severe occlusive atherosclerosis with approximately 90% stenosis of its lumen. The mitral valve has somewhat thickened and shortened leaflets. No vegetations are noted on the cardiac valves. The interventricular septum is not remarkable. The descending portion of the thoracic aorta has minimal atherosclerosis. An intravenous catheter is installed in each of the upper extremities in the antecubital fossae. The catheter of the right antecubital area is installed in the lumen of the median cubital vein without any evidence of surrounding hemorrhage or tissue infiltration of fluid. The catheter of the left antecubital area is not installed, and this catheter is covered in a bandage that is infiltrated by blood. The soft tissue in the left antecubital areas shows mild extravascular extravasated blood. The surrounding soft tissue has no detectable excessive fluid collection.

CENTRAL NERVOUS SYSTEM: the scalp, skull, and 1320 g brain have no apparent trauma. The sulci and gyri are not remarkable. The leptomeninges are thin and delicate. The arteries at the base of the brain have no aneurysms. No abnormalities are noted in the cortical gray or white matter, midbrain, cerebellum, pons, or medulla. The base of the skull has no fractures.

RESPIRATORY SYSTEM: the right and left lungs are 850 and 720 g respectively. The outer surfaces are dark purple to pink. There is anthracosis of the hilar lymph nodes. The lungs have congestion and edema with foamy fluid exuding from all lung lobes. No pneumonia is noted. No tumors are noted. No pulmonary emboli are noted.

HEPATOBILIARY SYSTEM: the liver is 2160 g and has an intact capsule. The liver has mild interstitial fibrosis/cirrhosis. The parenchyma of the liver is brown, purple. The portal veins are somewhat dilated. The gallbladder is present and contains a scant amount of mucoid clear bile without stones. The liver has no tumors, cysts, or infarcts.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-00918
NAME: Rogers, Glen
CASE NO: 25-344
RECEIPT DATE: 05/16/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Jon Thogmartin, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
	Hydroxyzine	Positive (trace)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
	Hydroxyzine	Positive	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2500918 - 01/ CC 06/20/25 [0001, 1503]
PRINTED: 06/20/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 06/16/2025 10:01

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	ROGERS, GLEN
Patient ID	R25-00918
Chain	NMSCP454947
DOB	Not Given
Sex	Male
Workorder	25236269

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.87**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	5.75 mL	05/16/2025	Heart Blood	R25-00918

All sample volumes/weights are approximations.
Specimens received on 05/30/2025.

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Workorder 25236269
Chain NMSCP454947
Patient ID R25-00918

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.87	mcg/mL	0.40	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.40 mcg/mL		

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3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME:	Smithers, Samuel
AGE:	72 y.o.
GENDER:	Male
RACE:	White
CASE NUMBER:	ME25-0692
DATE OF DEATH:	10/14/2025
DATE OF AUTOPSY:	10/16/2025

CAUSE OF DEATH: **Multi-Substance Toxicity**

MANNER OF DEATH: **Homicide**

Susan S. Ignacio, MD
Associate Medical Examiner

Date: 10/23/2025

AUTOPSY FINDINGS

1. Cardiomegaly, 560 g
2. Nephrosclerosis
3. Pulmonary edema and congestion
4. Moderate atherosclerosis
5. Intravenous cannulas x 2, antecubital fossae

EXTERNAL EXAMINATION:

The body is that of a well-developed, well-nourished, 75 inch, 245 pound, white male, who appears the reported age of 72 years. The scalp has gray hair with male pattern baldness. The eyes have gray irides. The mouth has native dentition in fair repair. Facial hair consists of a gray mustache and beard. The neck is free of visible scar or injury. The chest is free of visible scar, tattoo or injury. The abdomen is free of visible scar, tattoo or injury. The upper and lower extremities are free of visible injury. Hypopigmented scars are in the left upper arm, forearm and left knee. A firm raised lesion is on the dorsum of the right hand. The external genitalia are normally developed. The penis is circumcised. The back is free of visible injury.

Intravenous cannulas are in place in each antecubital fossa. A bandage overlying a needle mark is on the right upper arm.

EVIDENCE OF MEDICAL INTERVENTION:

EKG leads are on the chest and abdomen.

INTERNAL EXAMINATION:

The anterior chest wall and abdominal wall are free of extravasated blood. The ribs, clavicles and sternum are intact. The pleural and abdominal cavities are free of excess fluid, blood or exudate. The pericardium is intact and contains a minimal amount of yellow serous fluid.

The 560 g heart has a smooth pink epicardial surface. The coronary arteries arise from the aorta in a normal fashion. The coronary ostia are patent. The right coronary artery supplies the posterior interventricular septum. The left anterior descending artery has moderate atherosclerosis. The right and left circumflex coronary arteries are thin-walled and patent. The myocardium is red brown and uniform throughout. The valve cusps and leaflets are thin, pliable and free of vegetations or fenestrations. The endocardium is smooth-walled and free of mural thrombi. The superior vena cava, inferior vena cava and pulmonary veins are intact and patent. The aorta is intact and has a smooth yellow intima with minimal fatty streaks.

The right and left lungs are 770 and 880 g, respectively. The pleural surfaces are smooth. The parenchyma is congested, edematous and free of visible suppuration, induration, granuloma or neoplasm. The bronchi are patent and intact. The pulmonary arteries are intact and free of thromboemboli.

The adrenal glands have firm yellow cortices and inconspicuous gray brown medullae.

The 2750 g liver has a smooth capsular surface. The parenchyma is red brown and has a 2.5 x 2.5 x 2 cm pink tan circular doughy mass in the left lobe. The gallbladder is intact and contains approximately 20 mL of yellow-green bile and no calculi.

The 280 g spleen has a wrinkled gray capsular surface. The parenchyma is dark red and uniform throughout.

The esophagus has a smooth tan serosal surface and a pale gray mucosal surface. The stomach has a smooth tan serosal surface and a gray mucosal surface with normal rugal folds. The stomach contains approximately 100 mL of gray green digested food material and liquid. The small bowel has a smooth serosal surface and is unremarkable. The large bowel has normal haustral markings and a vermiform appendix. The pancreas is tan and lobulated.

The strap muscles of the neck are pink red and free of injury. The thyroid cartilage and hyoid bone are intact. The epiglottis, larynx and trachea are patent and intact. The thyroid gland is dark red and uniform throughout.

The right and left kidneys are 200 and 220 g, respectively. The cortical surfaces are smooth. The parenchyma is dark red with well-defined corticomedullary junctions. The pelvicalyceal systems are normal. The urinary bladder is intact and contains approximately 240 mL of urine.

The subgalea is free of hemorrhage. The calvarium and dura mater are intact. The epidural, subdural and subarachnoid spaces are free of blood. The 1410 g brain has symmetric cerebral and cerebellar hemispheres covered by congested, transparent leptomeninges. The cerebral cortex is tan and uniform throughout. The white matter is uniform throughout. The basal ganglia, thalami and mamillary bodies are symmetric and free of abnormalities. The cerebellum, midbrain, pons and medulla oblongata are free of lesions. The proximal cervical spinal cord is intact. The anterior, middle and posterior cranial fossae are intact. The cerebral vasculature is thin-walled and patent.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01928
NAME: Smithers, Samuel
CASE NO: 25-692
RECEIPT DATE: 10/17/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Susan Ignacio, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, iliac
B. Blood, heart
C. Urine
D. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
C. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
C. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2501928 - 01/ CC 11/12/25 [0001, 1503]
PRINTED: 11/12/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 11/03/2025 15:01

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	SMITHERS, SAMUEL
Patient ID	R25-01928
Chain	NMSCP489522
DOB	Not Given
Sex	Male
Workorder	25458925

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.13**	**mcg/mL**	**001 - Iliac Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	6.75 mL	10/16/2025	Iliac Blood	R25-01928

All sample volumes/weights are approximations.
Specimens received on 10/23/2025.

NMS LABS

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Workorder	25458925
Chain	NMSCP489522
Patient ID	R25-01928

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.13	mcg/mL	0.040	001 - Iliac Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Iliac Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Iliac Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.040 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties
www.district8me.com

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: TANZI, MICHAEL
AGE: 48
RACE: W
GENDER: M
CASE NUMBER: ME25-0287
DATE OF DEATH: 04/08/2025
DATE OF AUTOPSY: 04/10/2025 0950 hrs.

AUTOPSY FINDINGS:

1. Obesity (BMI 44.3)
2. Pulmonary congestion
3. Cardiomegaly (660 g)
4. Intravenous catheters in upper extremities

Cause of Death: Multi-Substance Toxicity

Manner of Death: Homicide

How injury occurred: Judicial execution with etomidate, rocuronium, and potassium acetate

Jon R. Thogmartin, M.D.
Interim District Medical Examiner
Date: 04/11/2025

EXTERNAL EXAMINATION: the body is that of a 78 inch, 383 pound, man who appears the recorded age of 48 years. The skin is light tan. The body is clothed in dark pants, black socks, and a white shirt. EKG pads are on the body. The scalp is covered in short gray hair with mild male pattern baldness. Intravascular lines are in the upper extremities. In the right arm the intravascular line is located on the posterior lateral portion of the right forearm just inferior to the antecubital fossae. On the skin of the right antecubital fossae is a piece of tape with gauze. Underneath the gauze is a needle puncture site with surrounding faint ecchymosis. In the left antecubital fossae is an intravascular line taped in place. The face has a short gray, brown beard and mustache. Two minute punctate crusts are on the chin. The lower lip is somewhat dry and congested. The anterior buccal mucosa has no trauma. The eyes are brown without petechiae. The mouth has natural dentition. The anterior buccal mucosa has no trauma. The abdomen is obese with numerous striae. A few punctate slightly hyperpigmented macules are on the abdomen. The skin of the back has blanching unremarkable lividity without trauma. On the anterior surface of the right wrist in the midline is a somewhat question mark-shaped well-healed scar with visible suture marks. On the posterior surface of the left upper arm in the brachial area is a 3 x 3.5 cm area of slightly erythematous slightly thickened and edematous skin. On the lateral surface of the right thigh is an 8 x 11 cm purple, yellow contusion/ecchymosis. On the left shin is a faint area of purple ecchymosis or contusion. This is slightly obliquely oriented and approximately 10 x 2 cm. On the left knee are two horizontally oriented faint linear scars. On the upper portion of the left shin are several minute punctate crusts. The lower extremities around the ankles are somewhat edematous. On the posterior surface of the left calf area is a faint yellow purple 1.8 x 1.8 cm contusion/area of ecchymosis. The penis has no trauma and is normally developed. The left side of the scrotal sac is slightly dry.

INTERNAL EXAMINATION: the panniculus is somewhat fatty at approximately 8 cm. No blood collections are noted in the body cavities. The organs are in the usual anatomic relationships. The sternum is intact. The ribs are intact. The pericardial sac is smooth and not remarkable. The diaphragm is intact. The left pleural cavity is smooth and unremarkable. The right pleural cavity is smooth and unremarkable. The omentum is somewhat fatty. The mediastinum has an abundant amount of fatty tissue.

GASTROINTESTINAL SYSTEM: the distal esophagus is not remarkable and light tan. The stomach is intact and contains approximately 350 mL of material. The stomach has slightly congested tan green mucosa with a few petechiae. No ulcerations or hemorrhages noted. The large and small bowels have a fatty mesentery. No perforations are noted. The appendix is not remarkable. The retroperitoneal area is massively fatty.

ENDOCRINE SYSTEM: the pancreas is tan, lobular, and unremarkable. The left adrenal gland is brown yellow and not remarkable. The right adrenal gland is yellow and not remarkable.

HEMOLYMPHATIC SYSTEM: the spleen is 340 g and has an intact capsule. The spleen has dark purple unremarkable parenchyma without tumors, cysts, or infarcts. No enlarged lymph nodes are detected. The bone marrow of the ribs is not remarkable.

MUSCULOSKELETAL SYSTEM: the muscles appear normally developed without gross degeneration or atrophy. The thoracic spinal column is not remarkable.

NECK: the soft tissue of the anterior neck has no hemorrhage or trauma. The hyoid bone is intact. The larynx is intact. The proximal esophagus has pink, purple unremarkable mucosal. The larynx has intact pink, purple mucosa. The thyroid gland is red brown without tumors.

GENITOURINARY SYSTEM: the right and left kidneys are 250 and 270 g respectively. The outer surfaces of the kidneys are somewhat lobular and brown red. The collecting systems are not remarkable. On the lateral portion of the cortex of the right kidney is a 5 mm spherical shaped cyst filled with clear serous fluid. No renal stones are noted. The prostate gland is light tan and not enlarged. The testicles are palpable in the scrotal sac. The urinary bladder contains approximately 140 mL of clear yellow urine.

HEPATOBILIARY SYSTEM: the liver has an intact capsule. The liver is 3220 g and has dark purple red parenchyma with unremarkable bile ducts and portal veins. No tumors are noted. No cysts are noted. The gallbladder contains approximately 10 mL of bile. No gallstones are present.

RESPIRATORY SYSTEM: the right and left lungs are 720 and 660 g respectively. The outer surfaces are purple pink and unremarkable. The lungs have a normal number of lobes. The lungs are somewhat congested. No pneumonia is noted. No pulmonary emboli, cysts, tumors, or infarcts are noted.

CARDIOVASCULAR SYSTEM: the aorta and the aortic arch have minimal atherosclerosis. No aneurysms are noted. The heart is 660 g and has a globular shape. The outer surface of the heart is not remarkable. The ventricular chambers appear slightly enlarged. The myocardium is soft and red brown. No fibrosis or infarcts are noted. A minute accessory coronary artery is noted near the right coronary artery ostium. The right coronary artery appears to supply the posterior interventricular septum. The branches of the left coronary artery are on structured and have minimal atherosclerosis. The cardiac valves have no vegetations. The interventricular septum is intact. The left coronary ostium is in the usual location. The catheter in the right arm is installed appropriately in a posterior lateral forearm vein inferior and lateral to the antecubital fossa (accessory cephalic vein) without infiltration. The intravenous catheter in the left arm is appropriately installed without infiltration in the left median cubital vein.

CENTRAL NERVOUS SYSTEM: the scalp and skull have no trauma. The sulci and gyri of the brain appear unremarkable. The arteries at the base of the brain are not remarkable. No aneurysms are noted. No subdural or subarachnoid hematoma is noted. The brain is 1450 g. The leptomeninges are thin and delicate. The lateral ventricles contain clear cerebral spinal fluid. No abnormalities are noted in the cortical gray or white matter, midbrain, cerebellum, pons, or medulla.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-00701
NAME: Tanzi, Michael
CASE NO: 25-287
RECEIPT DATE: 04/11/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Jon Thogmartin, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Acetaminophen	Positive	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2500701 - 01/ CC 05/21/25 [0001]
PRINTED: 05/21/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 05/12/2025 11:01

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	TANZI, MICHAEL
Patient ID	R25-00701
Chain	NMSCP445166
DOB	Not Given
Sex	Male
Workorder	25173919

Positive Findings:

Testing Canceled

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Tests Not Performed:

Part or all of the requested testing was unable to be performed. Refer to the **Analysis Summary and Reporting Limits** section for details.

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	5 mL	04/10/2025	Heart Blood	R25-00701

All sample volumes/weights are approximations.

Specimens received on 04/22/2025.

Detailed Findings:

Testing Canceled

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

NMS LABS

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Workorder 25173919
Chain NMSCP445166
Patient ID R25-00701

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	N/A		

Testing Not Performed: Test was canceled due to [Sample Matrix Problem].

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties
www.district8me.com

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: WAINWRIGHT, ANTHONY
AGE: 54
RACE: W
GENDER: M
CASE NUMBER: ME25-0411
DATE OF DEATH: 06/10/2025
DATE OF AUTOPSY: 06/11/2025 0930 hrs.

AUTOPSY FINDINGS:

1. Hepatic tumors with metastases to regional lymph nodes
   -Adenocarcinoma with desmoplastic and necrotic features
2. Severe coronary atherosclerosis
3. Cardiomegaly (440 g)
4. Mild nephrosclerosis
5. Properly installed IV catheters

Cause of death: Multi-Substance Toxicity

Manner of Death: Homicide

How injury occurred: Judicial execution with etomidate, rocuronium and potassium acetate

Jon R. Thogmartin, M.D.
Interim District Medical Examiner
Date: 07/08/2025

EXTERNAL EXAMINATION: the body is that of a 73-inch, 208-pound, man who appears recorded age of 54 years. The body is clothed in a white shirt, black pants and black socks. The skin is light tan. EKG pads are on the body. An intravascular line is in each antecubital fossa. The eyes are hazel green without petechiae. Razor stubble is on the face. The scalp is bald with some stubble. A 10 cm C-shaped/U-shaped well-healed scar with suture marks is on the posterior surface of the scalp. On the upper right vertex of the scalp is an elliptical shaped faint 2.5 x 0.7 cm scar. The mouth has natural dentition with a few missing upper incisors. The anterior buccal mucosa has no trauma. The chest and abdomen are normally developed without trauma. The penis is circumcised and otherwise unremarkable. The skin of the back has unremarkable blanching lividity. A few punctate hypopigmented scars are on the back. An adhesive plastic strip bandage is on the right deltoid area. On the lateral surface of the right upper arm is a 9 x 8 cm purple, yellow contusion. The right hand has several linear hypopigmented scars on its posterior surface. A tattoo is on the web of the right hand. On the medial surface of the upper portion of the right arm is a small tattoo. A tattoo is on the posterior surface of the left forearm. Several small punctate tattoos are on the posterior surface of the left wrist. A tattoo is on the medial surface of the upper portion of the left arm. A few minute punctate to linear scars are on the posterior surfaces of the left hand. Several somewhat hypopigmented, somewhat irregular round to oval scars are on the right shin. The right shin has several punctate and linear faint scars. A minute linear scar is on the medial anterior surface of the right knee. A punctate crust is on the right Achilles tendon area. On the left shin are several scattered small hypopigmented somewhat punctate scars.

INTERNAL EXAMINATION: the sternum is intact. The ribs are intact. The pericardial sac is smooth and not remarkable. The left pleural cavity is smooth and not remarkable. The diaphragm is intact. The right pleural cavity is smooth and not remarkable. A few adhesions are noted of the diaphragm to the upper portion of the spleen.

ENDOCRINE SYSTEM: the pancreas is not remarkable. The thyroid gland is brown red and not remarkable.

GASTROINTESTINAL SYSTEM: the stomach is light tan and unremarkable the stomach contains gray, tan mucoid fluid. The large and small bowels are green, tan. The cecum is somewhat distended by gas. The large and small bowels have no perforations. The stomach has intact light green, tan mucosa with a few petechiae along its lesser curvature. No ulcerations are noted.

HEMOLYMPHATIC SYSTEM: the bone marrow of the ribs is not remarkable. Multiple enlarged somewhat necrotic lymph nodes are noted around the celiac area. The largest node is approximately 4 cm in greatest diameter. The spleen is 190 g and has dark red brown unremarkable parenchyma without tumors, cysts, or infarcts.

MUSCULOSKELETAL SYSTEM: the muscles appear normally developed without degeneration or atrophy.

NECK: the soft tissues of the anterior neck are not remarkable. The strap muscles of the neck have no hemorrhage or trauma. The hyoid bone is intact. The larynx is intact. The proximal esophagus has unremarkable tan mucosa. The larynx has unremarkable tan mucosa.

GENITOURINARY SYSTEM: the right and left kidneys are 180 and 200 g respectively. The outer surfaces are red brown lobular and slightly granular. No cysts or tumors are noted. The collecting systems have no stones. The testicles are palpable in the scrotal sac. The prostate gland is light tan and not enlarged. No prostatic nodules are noted.

HEPATOBILIARY SYSTEM: around the common bile duct and subhepatic area are numerous enlarged lymph nodes and masses. These are approximately 1.2 to 1.5 cm in greatest diameter. Within the 1910 g liver are multiple tan to white tumor masses in the brown noncirrhotic parenchyma. The largest is 6 cm in greatest diameter. The central portions of the tumor masses are somewhat necrotic. These tumor masses are in the right and left lobes of the liver more concentrated around the biliary tract. The gallbladder is present and contains mucoid bile without visible stones.

CENTRAL NERVOUS SYSTEM: the brain is 1560 g and has an unremarkable external surface and normative developed sulci and gyri. The cranial nerves are not remarkable. The arteries at the base of the brain are not remarkable. The leptomeninges are thin and delicate. The lateral ventricles contain clear cerebral spinal fluid. The scalp skull and deer have no trauma. No intracranial hemorrhages are noted. No abnormalities are noted in the cortical gray or white matter, midbrain, cerebellum, pons, or medulla.

RESPIRATORY SYSTEM: the right and left lungs are 840 and 660 g respectively. The outer surfaces are purple pink and smooth. The lungs have congestion and mild edema without visible tumors. The hilar lymph nodes are mildly anthracotic. No pulmonary emboli are noted. The bronchi appear unobstructed.

CARDIOVASCULAR SYSTEM: the heart is 440 g and has a slightly globular shape. The epicardial surface of the heart is smooth and not remarkable. The myocardium is red-brown and firm without obvious scarring or fibrosis. The left common coronary artery has severe atherosclerosis. There is moderate to severe atherosclerosis of the proximal aorta surrounding the right coronary artery. The right coronary artery has severe occlusive atherosclerosis with approximately 90 to 95% stenosis of its lumen with atherosclerotic plaque. The left anterior descending coronary artery shows severe occlusive calcified atherosclerosis with approximately 80 to 90% stenosis of its lumen. The mitral valve has mildly thickened chordae tendinea and mildly thickened leaflets. The interventricular septum is intact. The circumflex coronary artery has moderate atherosclerosis. The descending aorta has moderate atherosclerosis. The abdominal aorta has moderate to severe atherosclerosis. The intravenous catheters previously described are each installed in the right and left median cubital veins. No hemorrhage or infiltration is found in the surround soft tissue.

MUSCULOSKELETAL SYSTEM: the muscles are normally developed without obvious degeneration or atrophy. The thoracic spinal column is not remarkable.

MICROSCOPIC EXAMINATION:

LIVER: ADENOCARCINOMA WITH NECROSIS AND DENSE SURROUNDING FIBROSIS

LYMPH NODE:	METASTATIC ADENOCARCINOMA
	DENSE FIBROSIS
	NECROSIS

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01097
NAME: Wainwright, Anthony
CASE NO: 25-411
RECEIPT DATE: 06/11/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Jon Thogmartin, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	Acetone	Positive	5 mg/dL
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2501097 - 01/ CC 08/27/25 [0001, 1503]
PRINTED: 08/27/25

NMS LABS

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
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Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Supplemental Report

Report Issued 08/26/2025 07:00
Last Report Issued 07/09/2025 09:01

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	WAINWRIGHT, ANTHONY
Patient ID	R25-01097
Chain	NMSCP459311
DOB	Not Given
Sex	Male
Workorder	25264554

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.67**	**mcg/mL**	**002 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood
2063B	Etomidate, Blood

Tests Not Performed:

Part or all of the requested testing was unable to be performed. Refer to the **Analysis Summary and Reporting Limits** section for details.

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	4.5 mL	06/11/2025 09:30	Heart Blood	R25-01097
002	Red Stopper Glass Tube	6.25 mL	06/11/2025 09:30	Heart Blood	R25-01097

002 FROM GT HEART TO RT

All sample volumes/weights are approximations.
Specimens received on 06/18/2025, 07/18/2025.

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Workorder 25264554
Chain NMSCP459311
Patient ID R25-01097

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.67	mcg/mL	0.040	002 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	N/A		

Testing Not Performed: Test was canceled due to [Analysis failed; QNS to repeat].

Test 2063B - Etomidate, Blood: 002 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.040 mcg/mL		

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie,
Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: Frank Walls
AGE: 58
GENDER: Male
RACE: White
CASE NUMBER: 25-0843
DATE OF DEATH: 12/18/2025
DATE OF EXAMINATION: 12/19/2025

AUTOPSY FINDINGS:

1. Pulmonary edema
2. No evidence of trauma
3. Intravascular catheters in the upper extremities
4. Obesity – BMI 50.1
5. Hepatomegaly
6. Splenomegaly

CAUSE OF DEATH: Multi-substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate.

Andrew Koopmeiners, M.D.
Associate Medical Examiner

Completed: 1/29/2026

EXTERNAL EXAMINATION

The body is that of a well-developed obese White male appearing consistent with the offered age of 58 years. The body measures 71 inches in length and weighs 359 pounds. The body is well preserved.

The scalp hair is grey-black and measures less than ¼ inch in length. Facial hair consists of grey-black stubble in the distribution of a beard and moustache. The irides appear blue and the pupils are equal. The corneas are clear and the sclerae and conjunctivae have no petechiae or other abnormalities. The ears are normally formed. The external ears have no injuries. The nasal bones are intact by palpation. The nares are patent and contain no foreign matter. The natural teeth are in good repair. The frenula are intact. The mucosa and tongue are free of injuries. There is no foreign material in the mouth. There are no palpable fractures of the bones of the face.

The symmetrical neck has no masses or injuries. The trachea is in the midline. The shoulders are symmetrical and are free of trauma. The chest is symmetrical and has no scars or injuries. The abdomen is soft and has no scars or injuries. There are cardiac monitor pads on the right upper chest, left upper chest, and left abdomen. The back is symmetrical and has no injuries. The are multiple seborrheic keratoses throughout the back. The external genitalia are those of a normally developed adult man.

The upper extremities are symmetrical and normally developed. There are intravascular catheters in the right and left antecubital regions. The fingernails are short and clean. The lower extremities are symmetrical. There is a 5 inch linear scar of the right knee. The toenails are medium length and clean. There is no edema of the legs or ankles. Passive motion of the neck, shoulders, elbows, wrists, fingers, hips, and ankles fails to elicit any bony crepitus or abnormal motion.

INTERNAL EXAMINATION

Body Cavities

The muscles of the chest and abdominal wall are normal in color and consistency. The right and left pleural cavities have no free fluid or adhesions. The mediastinum is in the midline. The pericardial sac has a normal amount of clear yellow fluid. The diaphragm has no abnormality. The abdominal cavity is lined with glistening serosa and has no collections of free fluid. The organs are normally situated. The mesentery and omentum are unremarkable.

Cardiovascular System

The heart weighs 540 grams. The epicardial surface has a normal amount of adipose tissue. The heart is of the usual configuration. The circumferences of the valves are within normal range. The endocardium is tan. The valvular tissues are thin, pliable, and without vegetation or calcification. The mural and valvular endocardia have no vegetations or thrombi. The papillary muscles and projecting myocardial muscle bundles are of normal prominence. The chordae tendineae have no abnormalities. The coronary ostia are in their usual location and give rise to normally distributed arteries. The major coronary arteries are free of atherosclerosis. The cut surfaces of the red-brown myocardium have no hemorrhage, necrosis, or scars. The right and left ventricles are of normal thickness.

The pulmonary trunk and arteries have no thromboemboli. The intimal surface of the aorta is free of atherosclerosis. The aorta and its major branches arise normally and are widely patent. The inferior vena cava and tributaries have no antemortem clots.

Respiratory System

The lungs weigh 870 grams and 770 grams, right and left, respectively. The upper and lower airways are free of foreign material. The pleural surfaces are thin and free of exudates. The trachea and bronchi are lined by smooth tan epithelium. The cut surfaces of the lungs are variegated red-purple and have moderate edema. The lung parenchyma is of the usual consistency. There is no bronchopneumonia, neoplasm, consolidation, fibrosis, or calcification.

Reticuloendothelial System

The spleen weighs 450 grams. The capsule is smooth and intact. The cut surfaces are dark red and firm. The lymphoid tissue in the spleen is within a normal range. The lymph nodes throughout the body are not enlarged.

Liver and Biliary System

The liver weighs 3260 grams. The liver edge is sharp. The capsule is intact. The cut surfaces are red-brown and of normal consistency. There are no focal lesions and no evidence of fatty change or cirrhosis. The gallbladder contains dark green bile. There are no stones. The mucosa is unremarkable. The large bile ducts are patent and non-dilated.

Gastrointestinal System

The esophagus is empty and the mucosa is unremarkable. The gastric mucosa is arranged in the usual rugal folds and has no inflammation or ulceration. The lumen of the stomach contains 50 milliliters of liquid. The remaining gastrointestinal tract has no major alterations to external inspection and palpation. The appendix is present.

Genitourinary System

The kidneys are of similar size and shape and weigh 620 grams and 760 grams, right and left, respectively. The capsules are intact and strip with ease. The cortical surfaces are smooth and red-brown. The cut surfaces reveal a well-defined corticomedullary junction. There are numerous cortical cysts throughout both kidneys that measure up to 3 centimeters in greatest dimension. The pelves and ureters are unremarkable without evidence of distention. The urinary bladder contains approximately 200 milliliters of clear yellow urine. The mucosa is unremarkable. The prostate gland is enlarged. The cut surfaces are nodular.

Endocrine System

The adrenal glands have a normal configuration with the golden yellow cortices well demarcated from the underlying medullae. The maroon, gelatinous thyroid gland has no gross alterations. The tan, lobulated pancreas has no neoplasia, calcification, or hemorrhage.

Musculoskeletal System

The ribs, sternum, clavicles, pelvis, and vertebral column have no recent fractures. The muscles are normally formed.

Neck

The soft tissues and the strap muscles of the neck have no hemorrhage. The hyoid bone and the cartilages of the larynx and thyroid are intact and show no evidence of injury. The larynx and trachea are lined by smooth pink-tan mucosa, are patent, and contain no foreign matter. The epiglottis and vocal cords are unremarkable. The carotid arteries and jugular veins are unremarkable.

Central Nervous System

The reflected scalp has no hemorrhage or contusions. The calvarium is intact. The dura mater and falx cerebri are intact. There is no epidural, subdural, or subarachnoid hemorrhage. The brain is of a normal convolutional pattern and weighs 1310 grams. The meninges show no evidence of purulent infection. The cortical surfaces of the brain have no abnormalities. There is no uncal or tonsillar herniation. The structures of the base of the brain, including cranial nerves and blood vessels, are intact and unremarkable. The cerebral arteries are free of atherosclerosis and patent. The cut surfaces of the brain have normal relations of grey and white matter. There are no intraparenchymal hemorrhages and no evidence of neoplasm. The cerebral ventricles are of normal size and are filled with clear cerebrospinal fluid. There are no fractures of the base of the skull. The dura mater is free of stains and discolorations.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-02295
NAME: Walls, Frank
CASE NO: 25-843
RECEIPT DATE: 12/19/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Andrew Koopmeiners, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Citalopram	Positive	2.7 mg/L
	Etomidate	Positive (tentative ID by GC-MS)	
	Hydroxyzine	Positive (trace)	
B. Urine	Citalopram	Positive	
	Etomidate	Positive (tentative ID by GC-MS)	
	Cetirizine	Positive	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2502295 - 01/ CC 01/28/26 [0001, 1503]
PRINTED: 01/28/26

NMS LABS

NMS Labs

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Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 01/22/2026 19:00

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.
Gainesville, FL 32607-4107

Patient Name	WALLS, FRANK
Patient ID	R25-02295
Chain	NMSCP509474
DOB	Not Given
Sex	Male
Workorder	26017955

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.39**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	7 mL	12/18/2025 18:11	Heart Blood	R25-02295

All sample volumes/weights are approximations.
Specimens received on 01/14/2026.

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Workorder	26017955
Chain	NMSCP509474
Patient ID	R25-02295

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.39	mcg/mL	0.040	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.040 mcg/mL		

End of Report

Digital data review may have taken place remotely by qualified NMS staff utilizing a secure VPN connection for some or all of the reported results. This is in accordance with and follows CLIA regulations.

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie,
Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: Curtis Windom
AGE: 59
GENDER: Male
RACE: Black
CASE NUMBER: 25-0585
DATE OF DEATH: 8/28/2025
DATE OF EXAMINATION: 8/29/2025

AUTOPSY FINDINGS:

1. Pulmonary edema
2. No evidence of trauma
3. Intravascular catheters in the upper extremities

CAUSE OF DEATH: Multi-substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate.

Andrew Koopmeiners, M.D.
Associate Medical Examiner

Completed: 9/19/2025

ME25-0585

EXTERNAL EXAMINATION

The body is that of a well-developed well-nourished Black male appearing consistent with the offered age of 59 years. The body measures 69 inches in length and weighs 256 pounds. The body is well preserved.

The scalp hair is grey-black and short. Facial hair consists of a grey goatee and moustache. The irides appear brown and the pupils are equal. The corneas are clear and the sclerae and conjunctivae have no petechiae or other abnormalities. The ears are normally formed. The external ears have no injuries. The nasal bones are intact by palpation. The nares are patent and contain no foreign matter. The natural teeth are in good repair. The frenula are intact. The mucosa and tongue are free of injuries. There is no foreign material in the mouth. There are no palpable fractures of the bones of the face.

The symmetrical neck has no masses or injuries. The trachea is in the midline. The shoulders are symmetrical and are free of trauma. There is a ½ x ½ inch scar of the top of the left shoulder. The chest is symmetrical and has no scars or injuries. The abdomen is soft and has no scars or injuries. There are cardiac monitor pads on the right upper chest, left upper chest, and left abdomen. The back is symmetrical and has no injuries. The external genitalia are those of a normally developed adult man.

The upper extremities are symmetrical and normally developed. There are intravascular catheters in the right and left antecubital regions. The fingernails are short and clean. The lower extremities are symmetrical. There is a 1 x ½ x ½ inch acrochordon of the proximal anterior right thigh. The toenails are short and clean. There is no edema of the legs or ankles. Passive motion of the neck, shoulders, elbows, wrists, fingers, hips, and ankles fails to elicit any bony crepitus or abnormal motion.

INTERNAL EXAMINATION

Body Cavities

The muscles of the chest and abdominal wall are normal in color and consistency. The right and left pleural cavities have no free fluid or adhesions. The mediastinum is in the midline. The pericardial sac has a normal amount of clear yellow fluid. The diaphragm has no abnormality. The abdominal cavity is lined with glistening serosa and has no collections of free fluid. The organs are normally situated. The mesentery and omentum are unremarkable.

Cardiovascular System

The heart weighs 510 grams. The epicardial surface has a normal amount of adipose tissue. The heart is of the usual configuration. The circumferences of the valves are within normal range. The endocardium is tan. The valvular tissues are thin, pliable, and without vegetation or calcification. The mural and valvular endocardia have no vegetations or thrombi. The papillary muscles and projecting myocardial muscle bundles are of normal prominence. The chordae tendineae have no abnormalities. The coronary ostia are in their usual location and give rise to normally distributed arteries. The major coronary arteries are free of atherosclerosis. The cut surfaces of the red-brown myocardium have no hemorrhage, necrosis, or scars. The right and left ventricles are of normal thickness.

The pulmonary trunk and arteries have no thromboemboli. The intimal surface of the aorta is free of atherosclerosis. The aorta and its major branches arise normally and are widely patent. The inferior vena cava and tributaries have no antemortem clots.

Respiratory System

The lungs weigh 790 grams and 520 grams, right and left, respectively. The upper and lower airways are free of foreign material. The pleural surfaces are thin and free of exudates. The trachea and bronchi are lined by smooth tan epithelium. The cut surfaces of the lungs are variegated red-purple and have mild edema. The lung parenchyma is of the usual consistency. There is no bronchopneumonia, neoplasm, consolidation, fibrosis, or calcification.

Reticuloendothelial System

The spleen weighs 280 grams. The capsule is smooth and intact. The cut surfaces are dark red and firm. The lymphoid tissue in the spleen is within a normal range. The lymph nodes throughout the body are not enlarged.

Liver and Biliary System

The liver weighs 2220 grams. The liver edge is sharp. The capsule is intact. The cut surfaces are red-brown and of normal consistency. There are no focal lesions and no evidence of fatty change or cirrhosis. The gallbladder contains dark green bile. There are no stones. The mucosa is unremarkable. The large bile ducts are patent and non-dilated.

Gastrointestinal System

The esophagus is empty and the mucosa is unremarkable. The gastric mucosa is arranged in the usual rugal folds and has no inflammation or ulceration. The lumen of the stomach contains 500 milliliters of yellow-brown digestate. The remaining gastrointestinal tract has no major alterations to external inspection and palpation. The appendix is not identified.

Genitourinary System

The kidneys are of similar size and shape and weigh 180 grams and 210 grams, right and left, respectively. The capsules are intact and strip with ease. The cortical surfaces are smooth and red-brown. The cut surfaces reveal a well-defined corticomedullary junction. The pelves and ureters are unremarkable without evidence of distention. The urinary bladder contains approximately 90 milliliters of clear yellow urine. The mucosa is unremarkable. The prostate gland is mildly enlarged and nodular.

Endocrine System

The adrenal glands have a normal configuration with the golden yellow cortices well demarcated from the underlying medullae. The maroon, gelatinous thyroid gland has no gross alterations. The tan, lobulated pancreas has no neoplasia, calcification, or hemorrhage.

Musculoskeletal System

The ribs, sternum, clavicles, pelvis, and vertebral column have no recent fractures. The muscles are normally formed.

Neck

The soft tissues and the strap muscles of the neck have no hemorrhage. The hyoid bone and the cartilages of the larynx and thyroid are intact and show no evidence of injury. The larynx and trachea are lined by smooth pink-tan mucosa, are patent, and contain a small quantity of foam. The epiglottis and vocal cords are unremarkable. The carotid arteries and jugular veins are unremarkable.

Central Nervous System

The reflected scalp has no hemorrhage or contusions. The calvarium is intact. The dura mater and falx cerebri are intact. There is no epidural, subdural, or subarachnoid hemorrhage. The brain is of a normal convolutional pattern and weighs 1210 grams. The meninges show no evidence of purulent infection. The cortical surfaces of the brain have

no abnormalities. There is no uncal or tonsillar herniation. The structures of the base of the brain, including cranial nerves and blood vessels, are intact and unremarkable. The cerebral arteries are free of atherosclerosis and patent. The cut surfaces of the brain have normal relations of grey and white matter. There are no intraparenchymal hemorrhages and no evidence of neoplasm. The cerebral ventricles are of normal size and are filled with clear cerebrospinal fluid. There are no fractures of the base of the skull. The dura mater is free of stains and discolorations.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01603
NAME: Windom, Curtis
CASE NO: 25-585
RECEIPT DATE: 08/29/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Andrew Koopmeiners, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2501603 - 01/ CC 10/07/25 [0001, 1503]
PRINTED: 10/07/25

NMS Labs
200 Welsh Road, Horsham, PA 19044-2208
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Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Toxicology Report

Report Issued 10/06/2025 12:03

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	WINDOM, CURTIS
Patient ID	R25-01603
Chain	NMSCP479210
DOB	Not Given
Sex	Male
Workorder	25390227

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.62**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Gray Stopper Glass Tube	6.5 mL	08/29/2025 10:41	Heart Blood	R25-01603

All sample volumes/weights are approximations.
Specimens received on 09/09/2025.

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Workorder 25390227
Chain NMSCP479210
Patient ID R25-01603

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.62	mcg/mL	0.20	001 - Heart Blood	GC/MS

Examination of the specimen(s) submitted did not reveal any reportable findings by procedure(s) outlined in the accompanying Analysis Summary, other than those listed above. Interpretation of reported findings should be based on the totality of available case information. Reference information is not case-specific but is provided as a general guide.

Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

The following test(s) were performed for this case; the scope of each test includes the analyte(s) listed along with the associated reporting limit(s). The reporting limit is the lowest concentration of the analyte that will be reported as positive. Only results that meet reporting criteria at or above the reporting limit appear in the Positive Findings section of the report.

Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.20 mcg/mL		

OFFICE OF THE MEDICAL EXAMINER DISTRICT EIGHT

www.district8me.com
Alachua, Baker, Bradford, Dixie, Gilchrist, Levy & Union Counties

3217 SW 47th Avenue
Gainesville, FL 32608
Office 352-384-3366
Fax 352-384-3365

AUTOPSY REPORT

NAME: Edward Zakrzewski
AGE: 60
GENDER: Male
RACE: White
CASE NUMBER: 25-0519
DATE OF DEATH: 7/31/2025
DATE OF EXAMINATION: 8/01/2025

AUTOPSY FINDINGS:

1. Pulmonary edema
2. No evidence of trauma
3. Intravascular catheters in the upper extremities

CAUSE OF DEATH: Multi-substance Toxicity

MANNER OF DEATH: Homicide

HOW INJURY OCCURRED: Judicial execution with etomidate, rocuronium, and potassium acetate.

Andrew Koopmeiners, M.D.
Associate Medical Examiner

Completed: 8/6/2025

ME25-0519

EXTERNAL EXAMINATION

The body is that of a well-developed well-nourished White male appearing consistent with the offered age of 60 years. The body measures 76 inches in length and weighs 239 pounds. The body is well preserved.

The scalp hair is grey and short. Facial hair consists of a grey stubble beard and moustache. The irides appear blue and the pupils are equal. The corneas are clear and the sclerae and conjunctivae have no petechiae or other abnormalities. The ears are normally formed. The external ears have no injuries. The nasal bones are intact by palpation. The nares are patent and contain no foreign matter. The teeth are natural. The frenula are intact. The mucosa and tongue are free of injuries. There is no foreign material in the mouth. There are no palpable fractures of the bones of the face.

The symmetrical neck has no masses or injuries. The trachea is in the midline. The shoulders are symmetrical and are free of trauma. The chest is symmetrical and has no injuries. The abdomen is soft and has no injuries. There are cardiac monitor pads on the right upper chest, left upper chest, and left abdomen. The back is symmetrical and has no injuries. The external genitalia are those of a normally developed adult man.

The upper extremities are symmetrical and normally developed. There are intravascular catheters in the right and left antecubital regions. The fingernails are short and clean. The lower extremities are symmetrical. The toenails are short and clean. There is no edema of the legs or ankles. Passive motion of the neck, shoulders, elbows, wrists, fingers, hips, and ankles fails to elicit any bony crepitus or abnormal motion.

SCARS, TATTOOS, AND OTHER IDENTIFYING FEATURES

Tattoos include an image and “Death before dishonor” on the right shoulder. There are no identifying scars and no other distinguishing features.

INTERNAL EXAMINATION

Body Cavities

The muscles of the chest and abdominal wall are normal in color and consistency. The right and left pleural cavities have no free fluid or adhesions. The mediastinum is in the midline. The pericardial sac has a normal amount of clear yellow fluid. The diaphragm has no abnormality. The abdominal cavity is lined with glistening serosa and has no collections of free fluid. The organs are normally situated. The mesentery and omentum are unremarkable.

Cardiovascular System

The heart weighs 600 grams. The epicardial surface has a normal amount of adipose tissue. The heart is of the usual configuration. The circumferences of the valves are within normal range. The endocardium is tan. The valvular tissues are thin, pliable, and without vegetation or calcification. The mural and valvular endocardia have no vegetations or thrombi. The papillary muscles and projecting myocardial muscle bundles are of normal prominence. The chordae tendineae have no abnormalities. The coronary ostia are in their usual location and give rise to normally distributed arteries. There is mild atherosclerosis of the left anterior descending coronary artery with maximum occlusion of 25%. The left main, left circumflex, and right coronary arteries have no significant atherosclerosis. The cut surfaces of the red-brown myocardium have no hemorrhage, necrosis, or scars. The right and left ventricles are of normal thickness.

The pulmonary trunk and arteries have no thromboemboli. The intimal surface of the aorta is free of atherosclerosis. The aorta and its major branches arise normally and are widely patent. The inferior vena cava and tributaries have no antemortem clots.

Respiratory System

The lungs weigh 1190 grams and 860 grams, right and left, respectively. The upper and lower airways are free of foreign material. The pleural surfaces are thin and free of exudates. The trachea and bronchi are lined by smooth tan epithelium. The cut surfaces of the lungs are dark purple and have marked edema. The lung parenchyma is of the usual consistency. There is no bronchopneumonia, neoplasm, consolidation, fibrosis, or calcification.

Reticuloendothelial System

The spleen weighs 400 grams. The capsule is smooth and intact. The cut surfaces are dark red and firm. The lymphoid tissue in the spleen is within a normal range. The lymph nodes throughout the body are not enlarged.

Liver and Biliary System

The liver weighs 2440 grams. The liver edge is sharp. The capsule is intact. The cut surfaces are red-brown and of normal consistency. There are no focal lesions and no evidence of fatty change or cirrhosis. The gallbladder contains dark green bile. There are no stones. The mucosa is unremarkable. The large bile ducts are patent and non-dilated.

Gastrointestinal System

The esophagus is empty and the mucosa is unremarkable. The gastric mucosa is arranged in the usual rugal folds and has no inflammation or ulceration. The lumen of the stomach contains 120

milliliters of liquid. The remaining gastrointestinal tract has no major alterations to external inspection and palpation. The appendix is present.

Genitourinary System

The kidneys are of similar size and shape and each weigh 220 grams. The capsules are intact and strip with ease. The cortical surfaces are smooth and red-brown. The cut surfaces reveal a well-defined corticomedullary junction. The pelves and ureters are unremarkable without evidence of distention. The urinary bladder contains approximately 320 milliliters of clear yellow urine. The mucosa is unremarkable. The prostate gland is not enlarged. The cut surfaces are unremarkable.

Endocrine System

The adrenal glands have a normal configuration with the golden yellow cortices well demarcated from the underlying medullae. The maroon, gelatinous thyroid gland has no gross alterations. The tan, lobulated pancreas has no neoplasia, calcification, or hemorrhage.

Musculoskeletal System

The ribs, sternum, clavicles, pelvis, and vertebral column have no recent fractures. The muscles are normally formed.

Neck

The soft tissues and the strap muscles of the neck have no hemorrhage. The hyoid bone and the cartilages of the larynx and thyroid are intact and show no evidence of injury. The larynx and trachea are lined by smooth pink-tan mucosa, are patent, and contain no foreign matter. The epiglottis and vocal cords are unremarkable. The carotid arteries and jugular veins are unremarkable.

Central Nervous System

The reflected scalp has no hemorrhage or contusions. The calvarium is intact. The dura mater and falx cerebri are intact. There is no epidural, subdural, or subarachnoid hemorrhage. The brain is of a normal convolutional pattern and weighs 1630 grams. The meninges show no evidence of purulent infection. The cortical surfaces of the brain have no abnormalities. There is no uncal or tonsillar herniation. The structures of the base of the brain, including cranial nerves and blood vessels, are intact and unremarkable. The cerebral arteries are free of atherosclerosis and patent. The cut surfaces of the brain have normal relations of grey and white matter. There are no intraparenchymal hemorrhages and no evidence of neoplasm. The cerebral ventricles are of normal size and are filled with clear cerebrospinal fluid. There are no fractures of the base of the skull. The dura mater is free of stains and discolorations.

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University of Florida Pathology Laboratories
Department of Pathology and Laboratory Medicine
1200 SW 34th Street
Gainesville, FL 32607
Phone: 352-627-2001 Fax: 352-265-9904

LAB NUMBER: R25-01406
NAME: Zakrzewski, Edward
CASE NO: 25-519
RECEIPT DATE: 08/01/2025

Forensic Toxicology Laboratory

SUBMITTER: Dr. Andrew Koopmeiners, District 8 Medical Examiners Office, 3217 SW 47th Ave., Gainesville, FL 32608.

SPECIMENS RECEIVED:

A. Blood, heart
B. Urine
C. Vitreous Humor

	Analyte	Qualitative Results	Quantitative Results
VOLATILES			
A. Blood	None Detected		
B. Urine	None Detected		
COMPREHENSIVE DRUG SCREEN			
A. Blood	Etomidate	Positive (tentative ID by GC-MS)	
B. Urine	Etomidate	Positive (tentative ID by GC-MS)	
DRUG IDENTIFICATION/QUANTITATION			
A. Blood	Etomidate	See Attached - 2 pages	

RESULT CERTIFICATION:

Results Certified by:

Chris W. Chronister, Ph.D., F-ABFT
Director of Toxicology

R2501406 - 01/ CC 09/03/25 [0001, 1503]
PRINTED: 09/03/25

NMS LABS

NMS Labs

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Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

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Toxicology Report

Report Issued 08/21/2025 15:02

To: **60168**
University of Florida Pathology Laboratories
1200 SW 34th St.

Gainesville, FL 32607-4107

Patient Name	ZAKRZEWSKI, EDWARD
Patient ID	R25-01406
Chain	NMSCP471327
DOB	Not Given
Sex	Male
Workorder	25341004

Positive Findings:

Analyte	Result	Units	Matrix Source
Etomidate	**0.59**	**mcg/mL**	**001 - Heart Blood**

See Detailed Findings section for additional information

Testing Requested:

Test	Test Name
2063B	Etomidate, Blood

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Red Stopper Glass Tube	5 mL	08/01/2025 12:19	Heart Blood	R25-01406

All sample volumes/weights are approximations.
Specimens received on 08/07/2025.

NMS LABS

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Workorder 25341004
Chain NMSCP471327
Patient ID R25-01406

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Etomidate	0.59	mcg/mL	0.20	001 - Heart Blood	GC/MS

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Reference Comments:

1. Etomidate (Amidate®) - Heart Blood:

   Etomidate is a non-barbiturate hypnotic without analgesic activity. It is especially used in patients with cardiovascular problems since it has few effects on this system. IV administration of etomidate produces rapid hypnosis, which lasts approximately 3 to 5 minutes.

   Reported plasma concentrations of etomidate necessary to induce anesthesia are approximately 2 mcg/mL. Hypnosis can then be maintained with plasma concentrations greater than or equal to 0.23 mcg/mL (230 ng/mL).

Chain of custody documentation has been maintained for the analyses performed by NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Analysis Summary and Reporting Limits:

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Test 2063B - Etomidate, Blood: 001 - Heart Blood

-Analysis by Gas Chromatography/Mass Spectrometry (GC/MS) for:

Analyte	Rpt. Limit	Analyte	Rpt. Limit
Etomidate	0.20 mcg/mL		