No. 14-7955

In the Supreme Court of the United States

RICHARD E. GLOSSIP, ET AL.,
Petitioners,

v.

KEVIN J. GROSS, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

BRIEF FOR STATE OF FLORIDA AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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INTRODUCTION AND STATEMENT OF AMICUS INTEREST

Florida has an interest in ensuring that it may continue to carry out its lawful judgments using the humane (and constitutional) means it has selected. Although this case relates to a specific drug in a specific three-drug lethal injection protocol, Petitioners' arguments—if accepted—would have a much wider impact. They would undermine this Court's holding in *Baze v. Rees*, 553 U.S. 35 (2008), and threaten the ability of Florida and other States to carry out the punishments their citizens have selected.

The record in this case offers no basis to overturn the lower courts' recognition that midazolam is an effective and constitutional component of a lethal injection protocol.[1] Florida has had eleven successful and uneventful executions using midazolam. And along the way, Florida has addressed virtually identical challenges with virtually identical expert testimony, including testimony from many of the same experts who participated in this case. Weighing that testimony,

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[1] Petitioners highlight the Clayton Lockett execution, *see* Pet'rs' Br. 19, which involved a different quantity of midazolam in a different protocol. It is important to distinguish between the drug combination used in an execution protocol and the overall execution protocol itself. *See infra* Part III. As Oklahoma explains, the issues in the Lockett execution arose from execution procedures, not from the selection of midazolam. *See* Resp. Br. 14-16.

state and federal courts have found—without exception—that Florida's use of midazolam does not violate the Eighth Amendment.

Florida concurs in the arguments presented by Alabama and other states as amici, *see* Amicus Br. of Ala., et al.; it submits this brief separately to highlight its extensive experience with executions involving midazolam.

SUMMARY OF ARGUMENT

Florida's history demonstrates that midazolam, when properly administered, reliably and effectively renders an inmate unconscious for execution by lethal injection. This Court should consider the extensive prior litigation on this issue, which repeatedly affirmed the appropriateness, effectiveness, and constitutionality of Florida's use of midazolam. State and federal courts addressing Florida's use of the drug have thoroughly addressed—and unanimously rejected—the arguments Petitioners present here.

ARGUMENT

I. FLORIDA'S EXPERIENCE DEMONSTRATES THAT MIDAZOLAM CAN BE USED IN HUMANE, CONSTITUTIONAL EXECUTIONS.

In September 2013, facing shortages of previous execution drugs, Florida adopted midazolam as the first drug in its three-drug protocol. *See Chavez v. Fla. SP Warden*, 742 F.3d 1267, 1269 (11th Cir.), *cert. denied sub. nom. Chavez v. Palmer*, 134 S. Ct. 1156 (2014). Florida's protocol calls for (1) 500

milligrams of midazolam, followed by doses of (2) vecuronium bromide and (3) potassium chloride, in that order. *Id.* Midazolam serves as an anesthetic; the second drug is a paralytic that stops muscle movement and respiration; the third drug stops the heart. *Id.*

After Florida adopted the change, the Florida Supreme Court ordered an evidentiary hearing regarding "the safety and efficacy of the new drug in the lethal injection procedure." *Muhammad v. State*, 132 So. 3d 176, 188 (Fla. 2013), *cert. denied*, 134 S. Ct. 894 (2014). And after that evidentiary hearing, the trial court rejected the claim that the use of midazolam would produce a substantial risk of serious harm; it upheld the protocol as constitutional. *See id.* The Florida Supreme Court affirmed. *Id.* at 197.

Since the adoption of its current protocol, Florida has successfully carried out eleven lethal injection executions.[2] Each of these executions relied on 500 milligrams of midazolam to produce unconsciousness, and not one involved any sign of suffering or of consciousness following a check specifically designed to determine consciousness, *see infra*.[3] Although now interrupted as a result of this

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[2] The Florida Department of Corrections website maintains a list of Florida executions. *See* Execution List: 1976-present, *available at* http://www.dc.state.fl.us/oth/deathrow/execlist.html (last visited April 14, 2015).

[3] Although there were reports of head movements during William Happ's execution, courts concluded that those movements did not support a finding of pain. *See*

case,[4] Florida's record of consistent, successful executions using midazolam undermines any argument that the drug introduces substantial risk of harm.

While Petitioners rely on speculative allegations and discredited expert testimony, the Court can look to Florida's experience. But even without this track record, the pertinent expert evidence demonstrates that when properly administered, midazolam will produce a level of unconsciousness sufficient to yield a humane and constitutional execution.

Chavez, 742 F.3d at 1271 (quoting district court's finding that "Happ's movement (and Muhammad's, if his eye opened) does not necessarily equate to pain or with consciousness"); *Howell v. State*, 133 So. 3d 511, 519-20 (Fla.), *cert. denied*, 134 S. Ct. 1376 (2014) (quoting trial court's discussion of reported minor movement and conclusion that movement does not equate to consciousness); *Muhammad*, 132 So. 3d at 188 (noting that inmate's expert "acknowledged the movement during Happ's execution did not mean that he was actually harmed") (quoting trial court).

[4] Based on the certiorari grant in this case, the Florida Supreme Court stayed Florida's then-pending execution. *Correll v. State*, No. SC15-147 (Fla. Feb. 17, 2015). This Court denied Florida's application for review. *Florida v. Correll*, 135 S. Ct. 1491 (2015).

II. FLORIDA'S EXPERIENCE WITH MIDAZOLAM IS CONSISTENT WITH FINDINGS OF FACT OF ALL OTHER COURTS WEIGHING EVIDENCE ON PETITIONERS' CLAIM.

Despite Florida's history of successful executions using midazolam, Petitioners insist that a scientific consensus finds midazolam incapable of producing the unconsciousness necessary for a constitutional execution. Pet'rs' Br. 26. But there is no scientific consensus to support Petitioners' claims, and the courts that have considered competing expert evidence (including the district court below) have unanimously resolved factual disputes in favor of the states.

Florida's three-drug protocol is one of the most litigated protocols in the country. There have been no fewer than five evidentiary hearings in state and federal courts addressing its appropriateness for use in executions. Courts have routinely rejected allegations like those Petitioners and some amici assert here, and not one court has concluded that Florida's use of midazolam violates the Eighth Amendment.

First, litigation in Florida has conclusively established that midazolam will render an inmate unconscious within minutes, even with dosages much smaller than the 500 milligrams Florida's protocol requires. *See Muhammad*, 132 So. 3d at 193-94 (noting that experts, including an inmate's expert, acknowledged that midazolam will render an inmate unconscious); *Howell*, 133 So. 3d at 518-20 (noting expert testimony that midazolam would

induce unconsciousness within one or two minutes); *Henry v. State*, 134 So. 3d 938, 947-48 (Fla.), *cert. denied*, 134 S. Ct. 1536 (2014) (noting expert testimony that intravenously delivered midazolam will end consciousness within one or two minutes); *Chavez v. Palmer*, No. 3:14-cv-110-J-39JBT, 2014 WL 521067, at *13 (M.D. Fla. Feb. 10, 2014) (finding expert testimony established that "when midazolam is properly administered," individual will be promptly unconscious), *aff'd Chavez*, 742 F.3d at 1267; *Davis v. State*, 142 So. 3d 867, 873 (Fla.), *cert. denied*, 135 S. Ct. 15 (2014) ("Dr. Evans further testified that midazolam will render an individual unconscious within the span of time necessary to count down from ten to one, and would effectively place an individual in a coma within '5 to 10 minutes.' Dr. Zivot [testifying for the inmate] similarly testified that fifty milligrams of midazolam, which is ten times less than the dose administered under Florida's lethal injection protocol, would render an individual unconscious within 'a matter of a few minutes.'") (quoting circuit court order).

Petitioners in fact acknowledge that midazolam can produce unconsciousness,[5] Pet'rs' Br. 13, but

[5] In an amicus brief ostensibly supporting neither side, a group of pharmacologists assert that "[m]idazolam cannot induce unconsciousness at any dose." Amicus Br. of Sixteen Professors of Pharmacology in Support of Neither Party at 9. This statement, which has not been subject to cross-examination or courtroom fact-finding, is contrary to a consensus among all professionals who have testified in Florida (including inmates' experts). These

they argue that a consensus finds midazolam will not produce unconsciousness deep or persistent enough for use in executions. More specifically, they argue that midazolam is inappropriate for use as an anesthetic in otherwise painful surgeries, so it cannot suffice as an anesthetic for executions. *Id.* at 32. And they argue that any unconsciousness produced could be threatened by the introduction of noxious stimuli—in this case the drugs injected after midazolam. *Id.* But Petitioners' assertions of consensus cannot square with the evidence in cases that considered the issue.

Midazolam is, in fact, used as an anesthetic for painful procedures. Mark Dershwitz—a medical doctor, practicing anesthesiologist, professor of anesthesiology at the University of Massachusetts Medical School, and Ph.D. in pharmacology—testified in Florida that he "has used midazolam as 'the first and primary drug to induce anesthesia' in neurosurgeries during a drug shortage." *Howell*, 133 So. 3d at 522. Although Dr. Dershwitz's experience involved a 50 milligram dose (one tenth the amount at issue here), he testified "based on his direct experience, where a 50 mg dose prevented his patients from perceiving the noxious stimuli

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experts agree that even in much smaller doses than utilized in Florida's and Oklahoma's protocols, midazolam does indeed induce unconsciousness within minutes. *See supra* at 5-6; *see also Howell*, 133 So. 3d at 519; *Muhammad*, 132 So. 3d at 193-94; *Davis*, 142 So. 3d at 873. And Florida's experience has shown that the inmate is quickly rendered unconscious after the administration of midazolam.

associated with neurosurgery, that it was clear a 500 mg dose would prevent the recipient from being 'able to perceive any noxious stimuli whatsoever.'" *Id.* (quoting trial court).

Dr. Dershwitz's testimony is consistent with testimony of Mark Heath, a board certified anesthesiologist at the New York Presbyterian Hospital at Columbia University. Testifying on behalf of an inmate, Dr. Heath, too, acknowledged the efficacy of midazolam in producing full unconsciousness, even at doses far lower than in Florida's protocol. "Dr. Heath testified that midazolam hydrochloride is an FDA-approved drug in the class of drugs called 'benzodiazepine.' He testified that it is used in the operating room as both a pre-anesthetic and an anesthetic to cause sedation and reduce anxiety, and 'in very high doses will completely ablate consciousness.'" *Muhammad*, 132 So. 3d at 193. While Dr. Heath used small amounts, "such as one milligram" to reduce patient anxiety, he testified that in his experience, a larger dose of 10 or 15 milligrams "will reliably produce a much deeper level of unconsciousness." *Id.* (quoting testimony). Most importantly, Dr. Heath testified that when successfully delivered, midazolam "will have full efficacy as an anesthetic." *Id.* He also opined that "the dosage of midazolam hydrochloride called for in the protocol, 500 milligrams, is a much larger dose than that needed to produce unconsciousness and in that amount would, with certainty, produce death." *Id.* at 194.

Facing all of this, Petitioners rely on the testimony of Dr. David Lubarsky, who said that

midazolam cannot produce sufficient unconsciousness. JA 231; *see also* Pet'rs' Br. 13. But Dr. Lubarsky's testimony about midazolam has been repeatedly rejected, *see, e.g.*, *Chavez v. Palmer*, 2014 WL 521067, at *11 (rejecting Dr. Lubarsky's testimony after making detailed credibility findings); *id.* ("[T]aken as a whole, Dr. Lubarsky's testimony is essentially speculative and insufficient to meet Plaintiff's burden.") (note omitted); *Howell*, 133 So. 3d at 520-22*; cf. Harbison v. Little*, 723 F. Supp. 2d 1032, 1042-44 (M.D. Tenn. 2010) (rejecting challenge to effectiveness of sodium thiopental that included Dr. Lubarsky's testimony), and regardless, his lone opinion could not establish a consensus.[6]

Petitioners also cite a 1985 article, Pet'rs' Br. 13, but that cannot establish any consensus either. Moreover, the cited article does nothing to suggest

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[6] Dr. Lubarsky's opposition to the death penalty is well known; he co-authored an article advocating that physicians work to abolish "lethal injection and all other state sponsored killing." Teresa A. Zimmers & David A. Lubarsky, *Physician participation in lethal injection executions*, 20 Current Opinion in Anesthesiology 147 (2007). He also co-authored a study concluding that a number of executions proceeded with inadequate anesthesia. *See* David A. Lubarsky, et al., *Inadequate Anaesthesia in Lethal Injection for Execution*, 365 Lancet 1412 (2005). As the plurality noted in *Baze*, this study was subject to peer-response criticism in the same journal for its methodology. *See Baze*, 553 U.S. at 51 n.2 (plurality op.) (citing Jonathan I. Groner, *Inadequate Anaesthesia in Lethal Injection for Execution*, 366 Lancet 1073 (2005)).

that in the amounts specified in the Florida and Oklahoma protocols (500 milligrams), midazolam would be ineffective in rendering an inmate unconscious before administration of the second and third drugs. In fact, this article indicates that midazolam, while relatively new at the time of the article's publication, was effective at both the induction and maintenance of anesthesia in much smaller doses than 500 milligrams. The authors concluded that the drug was quickly absorbed and well tolerated, and that its effects are dose related.[7] They then concluded that "[t]here are many uses for midazolam in the perioperative period including premedication, *anesthesia induction and maintenance*, and sedation for diagnostic and therapeutic procedures." J.G. Reaves, et al., *Midazolam: Pharmacology and Uses*, 62 Anesthesiology 310, 320 (1985) (emphasis added); *see also* 1 Ronald D. Miller, et al., *Miller's Anesthesia*, 842 (8th Ed. 2015) ("Midazolam is the benzodiazepine of choice for induction of anesthesia."); *see also supra* at 7-8.

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[7] Notably, another source Petitioners cited (for a different proposition), *Pharmacology & Physiology in Anesthetic Practice* (Pet'rs' Br. 14-16), also recognizes that midazolam can be used to induce anesthesia in a fraction of the dose provided for in the Oklahoma and Florida protocols (.1 to .2mg/kg by IV, or 9-18 mg for a 90kg person). Robert K. Stoelting & Simon C. Hillier, *Pharmacology & Physiology in Anesthetic Practice* 146 (4th ed. 2005). This same authority also recognizes that "[p]atients maintained at higher plasma concentrations of midazolam take longer to awaken than patients maintained at lower plasma concentrations." *Id*. at 147.

Contrary to Petitioners' assertions about scientific consensus, ample authority from multiple evidentiary hearings and published research support midazolam's use as an anesthetic.[8]

Petitioners also contend that the final drug, potassium chloride, could reverse the unconsciousness, waking the inmate who—because of the paralytic—would be unable to demonstrate outward signs of pain. However, the second and

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[8] Other published research has also shown that midazolam compares favorably in its effect to thiopental for induction of anesthesia. *See*, *e.g.*, Michael E. Crawford, et. al., *A Randomized Comparison Between Midazolam And Thiopental for Elective Cesarean Section Anesthesia*, 68 Anesthesia & Analgesia 229, 229, 232 (1989) (noting that "[m]any studies have established [midazolam's] suitability for induction of anesthesia" and concluding that "midazolam is a suitable alternative to thiopental for induction and maintenance of anesthesia for elective cesarean section"); Frank H. Sarnquist, et. al., *A Bioassay of a Water-soluble Benzodiazepine Against Sodium Thiopental*, 52 Anesthesiology 149, 152 (1980) ("[T]he pharmacologic profile described above makes midazolam maleate a suitable alternative to thiopental for the induction of anesthesia. Midazolam maleate is about 20 times as potent as thiopental for the induction of anesthesia . . ."); James T. Conner, et al., *RO 21-3981 for Intravenous Surgical Premedication and Induction of Anesthesia*, 57 Anesthesia & Analgesia 1, 5 (1978) (concluding that RO 21-3981 (midazolam) "may be more advantageous" than thiopental for induction of anesthesia in certain patients and for others, "does not offer an obvious advantage over thiopental but may well be an effective alternative").

third drugs are administered only after the inmate has been determined to be unconscious. *See* Resp. Br. 17, 32-33; *see also Valle v. Singer*, 655 F.3d 1223, 1233 (11th Cir. 2011) (noting that under Florida's protocol, a consciousness check is required and "the execution cannot proceed until the individual is rendered unconscious"); *Schwab v. State*, 995 So. 2d 922, 930 (Fla. 2008) (detailing the steps of the consciousness check).

Responding to the same concerns Petitioners raise on this point, the Florida Supreme Court addressed Florida's consciousness check explicitly, noting the state's supplementing the eyeball tap and shout with "an additional test to ensure unconsciousness, where the person undertaking the consciousness check added a painful pinch test of the trapezius muscle." *Howell*, 133 So. 3d at 522. This test is the same test physicians have used to test patient consciousness. "In fact, Dr. Lubarsky recognized that before current technology provided other means of testing for unconsciousness, he would similarly use a clamp to pinch a patient's skin to determine whether the patient was able to feel pain." *Id.* Another expert "likewise testified that he would use a painful pinch as the noxious stimuli to ensure that a person was unconscious prior to surgery." *Id.* (citing Dr. Dershwitz's testimony).

The Florida Supreme Court is not the only court to reject claims that midazolam will not sufficiently render inmates unconscious and insensate before the administration of the last two drugs or that the consciousness check is insufficient. *See Muhammad v. Crews*, No. 3:13–cv–1587–J–32JBT, 2013 WL

6844489, at *8 (M.D. Fla. Dec. 27, 2013) (noting that if consciousness check is done correctly after administration of midazolam hydrochloride there is no substantial risk of harm), *aff'd sub nom. Muhammad v. Sec'y, Fla. Dep't of Corrections*, 739 F.3d 683 (11th Cir.) *cert denied sub nom. Muhammad v. Crews*, 134 S. Ct. 894 (2014); *Chavez v. Palmer*, 2014 WL 521067, at *13 (finding expert testimony established that "in the massive dose required by the Florida protocol, [midazolam] will render the individual insensate to noxious stimuli by placing the individual in an anesthetic state, unable to discern pain"). Most importantly, no Florida inmate has failed the tiered consciousness check or required any additional midazolam injections beyond the initial doses.

Finally, Petitioners assert that the possibility of paradoxical reactions make midazolam an inappropriate choice, implying that paradoxical reactions may occur after the inmate is first unconscious. Pet'rs' Br. 14. But the fact-findings rejecting this theory are consistent with the lack of any reported instances of paradoxical reactions (most often manifested by overt consciousness and agitation) in any of the eleven Florida executions using midazolam. *See also Chavez*, 742 F.3d at 1271 ("Dr. Evans testified during the evidentiary hearing that the incidence of paradoxical reactions in normal therapeutic settings was 'less than 1 percent,' and that a massive dose of midazolam would avoid any potential paradoxical reactions and directly render a person unconscious. The district court credited all of that testimony and discredited Dr. Lubarsky's contrary testimony.").

The likelihood that a paradoxical reaction would occur (and none have in any Florida execution), that the inmate would remain conscious, and that the inmate would still pass the graded consciousness check is so remote that it cannot meet the *Baze* standard.

III. STATES ADJUST EXECUTION PROTOCOLS TO REDUCE RISK OF HARM.

Experience from Florida demonstrates that midazolam is effective when properly administered as the first drug in a three-drug protocol, similar to the protocol this Court approved in *Baze*. When there are problems with the administration of the drugs, it should not undermine confidence in the selection of the drug itself, and states can be trusted to quickly assess and reevaluate their overall execution protocols when problems arise. *See* Resp. Br. 14-16 (detailing Oklahoma's changes following the Lockett execution).

For example, when a misplaced intravenous line led to complications with Florida's 2006 execution of Angel Diaz, Florida promptly made substantial changes to its lethal injection protocol. These changes, however, did not require a change in the drugs used. *See generally Lightbourne v. McCollum*, 969 So. 2d 326, 345 (Fla. 2007) ("In reviewing the trial court's order and the facts as developed in the evidentiary hearing, we note that it is undisputed that in the execution of Angel Diaz, the intravenous lines were not functioning properly because the catheters passed through his veins in both arms and thus delivered the lethal chemicals into soft tissue,

rather than into his veins."). The Florida Supreme Court upheld the revised lethal injection protocols against a number of challenges following a thirteen-day evidentiary hearing about the Diaz execution. *See id.* at 331-32.

Problems with administration of drugs in an individual execution do not equate to problems with the selection of the drugs themselves. Indeed, since the *Lightbourne* decision—and the protocol changes it considered—Florida has executed twenty-six inmates by lethal injection without any similar complications. *See* Execution List: 1976-present, *available at www.dc.state.fl.us/oth/deathrow/execlist.html.*

IV. THIS COURT SHOULD REJECT PETITIONERS' ARGUMENT THAT IT SHOULD REWEIGH EVIDENCE.

The litigation in Florida and the litigation below show how factual disputes should be resolved. Each side should present its best evidence, and the trial court should weigh that evidence and make appropriate findings. Then, appellate courts should review the trial court's factual findings for clear error—not substitute their own findings. *See Anderson v. City of Bessemer City, N.C.*, 470 U.S. 564, 573-74 (1985) ("If the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently."); *cf. Chavez*, 742 F.3d at 1272 ("The district court's findings, none of which are clearly

erroneous, negate any contention that Chavez's evidence shows that midazolam is not effective as an anesthetic."). Through that process, trial and appellate courts in Florida and Oklahoma determined that claim that midazolam produces unconstitutional risk cannot succeed.

Yet Petitioners ask this Court to accept their competing facts, disregard the fact-findings below, and announce as a matter of *fact*, that a particular drug in a particular protocol is unsafe and unfit for use in capital punishment. This would constitute a substantial departure from the Court's longstanding view of its role in reviewing lower court decisions. *See Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 123 (1969) ("In applying the clearly erroneous standard to the findings of a district court sitting without a jury, appellate courts must constantly have in mind that their function is not to decide factual issues de novo."). Indeed, in *Baze*, the plurality recited the trial court's finding regarding a minimal risk and, rather than independently reweighing the evidence, noted only that it "cannot say that this finding is clearly erroneous." 553 U.S. at 54 (plurality op.).

This Court should do likewise and refuse to disturb the trial court's factual findings, affirmed on appeal.

CONCLUSION

Petitioners have not met their "heavy burden" to establish that using a three-drug protocol with a 500 milligram dose of midazolam as the first drug constitutes cruel and unusual punishment. *See Baze*,

553 U.S. at 53 (plurality op.). As Florida's experience demonstrates, midazolam has proven safe and effective in rendering an inmate unconscious, just as the previous drugs did in the similar protocol approved in *Baze*. The procedures for carrying out the capital sentences in states like Oklahoma and Florida provide protections well beyond what the Eighth Amendment requires.

This Court should dismiss the petition as improvidently granted. If it reaches the merits, it should affirm.

Respectfully submitted,

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