# USA & Capital Punishment: The Oklahoma Way of Death – "Why are some states so willing to spend a great deal to maintain the machinery of death for a few, and so unwilling to make the same in improving the health and lives of so many?"

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**The "botched" execution of Clayton Lockett should shatter the illusion that lethal injection is neither cruel nor unusual.**

The killing of Clayton Lockett by the State of Oklahoma has been widely characterized as a "botched execution." The truth of this description is, on one level, self-evident. At 6:23 pm on April 29, Lockett was administered the sedative midazolam via a catheter inserted into a vein in his groin, an option of last resort, since a fifty-one-minute inspection of his arms, legs and feet by a phlebotomist failed to locate another "viable point of entry." At 6:30, the doctor in attendance found Lockett still conscious; by 6:33, he was seemingly not. The paralyzing agent vecuronium bromide was then pumped into his body to stop his breathing, potassium chloride to stop his heart. What happened next registered as an intolerable agony, even in a society as inured to suffering as ours.

Witnesses said Lockett began twitching and writhing, trying to lift his body off the gurney. He moaned. He mumbled. One observer reported that he said "man." His torture continued for nine minutes before officials drew the shades; eleven more minutes before the doctor reported that his vein had collapsed, that the drugs "had either absorbed into tissue, leaked out or both" and that "a faint heartbeat" was detectable; twenty-three more minutes before the director of corrections called off his execution. Lockett's defense attorney then told reporters that prison officials would try to "save him so they can kill him another day." At 7:06 pm, he was declared dead. The execution of the other prisoner scheduled to be killed that night, Charles Warner, has been stayed while the state conducts an investigation.

Lockett's killing was grotesque and obscene, but it was neither unprecedented nor surprising. In 2006, witnesses observed a Florida inmate, Angel Diaz, "grimacing, blinking, licking his lips, blowing and attempting to mouth words" twenty-four minutes into his execution. Earlier this year, Michael Lee Wilson, an Oklahoma inmate executed by a drug cocktail that included pentobarbital, cried out, "I feel my whole body burning." In January, it took Ohio twenty-five minutes to execute Dennis McGuire using an untried drug combination. According to his daughter, who was present, McGuire made "horrible, horrible noises."

Since the restoration of capital punishment in 1976, the Death Penalty Information Center has recorded at least forty-five such "botched executions," 73 percent of which were by lethal injection.

Only one of those prisoners, Romell Broom, is alive today (Ohio executioners failed for over two hours to find a usable vein; his case is now on appeal). Like Lockett, the remainder have been declared dead. What distinguishes these executions as “botched” is not the outcome, but that somewhere along the line, the highly circumscribed ritual necessary to maintain the illusion that lethal injection is neither cruel nor unusual went terribly awry.

Indeed, the official timeline of Lockett’s execution is an appalling record of state incompetence. It hints at mismanagement, poorly trained staff, and unclear and untested protocols. But woven into that narrative is a perverse and multifarious sort of competence—political, legal and, most disturbing, medical. In order for Oklahoma to subject Lockett to its way of killing, it had to keep him alive and, in some minimal and debased sense of the word, healthy. On the morning of his execution, he was taken to be X-rayed. He refused to be restrained and was tasered. During a medical inspection, a “self-inflicted laceration on his right arm” was discovered, and over the next few hours it was treated or examined at least four times. A physician assistant determined that no sutures were necessary, but had they been, presumably some macabre form of gallows triage would have transpired. At 4:55 pm, he visited with “mental health personnel” for fifteen minutes, as required by protocol. Throughout this entire process, he was under almost constant surveillance.

It is a sickening observation, but Clayton Lockett probably received more government healthcare on the day of his execution than most Oklahomans do in a year. This morbid disparity will only be exacerbated by Governor Mary Fallin’s refusal to expand Medicaid under the Affordable Care Act, even though 150,000 of her constituents would have received coverage. Her indifference to those lives ought to be placed alongside the exertion and haste she marshaled in bringing Lockett to the gurney. Fallin resisted, at every step, efforts by Lockett’s attorneys to force the state to disclose the source of the untested drug mixture used in his execution, including issuing an executive order defying a State Supreme Court–ordered stay of execution. (It should be noted here that each of the drugs used on Lockett—midazolam, vecuronium and potassium chloride—have common therapeutic uses). One of her allies in the Legislature later introduced a bill to impeach the five justices who voted for that stay. Hours later, the court reversed itself. Had Lockett’s execution proceeded without incident, Fallin would have been hailed by many on the right as a can-do kinda guv, the adept leader of what can only be described as a cult of death.

I don’t mean to pick on Oklahoma, even though it does lead the nation in per capita executions. Twenty-two other states have also refused to expand Medicaid, and not so coincidentally, nineteen of them still practice the death penalty. My former *Nation* colleague Liliana Segura has written in harrowing detail about the increasingly secretive and extralegal steps many of those states have taken to procure the drugs used in lethal injection, including using discontinued and illegally obtained drugs and drugs purchased at unregulated “compounding pharmacies.” This is an achievement of anti–death penalty groups like Britain’s Reprieve, which has lobbied pharmaceutical companies to stop making or selling the drugs used in lethal injections.

It’s possible that this strategy of disrupting the supply chain will lead to an abandonment of capital punishment. It’s also possible that, with much effort, states will succeed in pulling the scrim of a “humane and dignified death” over the brutality of lethal injection, at least enough to quiet public outrage. Either way, we should also be asking: Why are some states so willing to spend a great deal of time and effort to maintain the machinery of death for a few, and so unwilling to make the same kind of investment in improving the health and lives of so many?

**Richard Kim**

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