IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

ROSA ESTELLA OLVERA JIMENEZ
Petitioner,

v.

LORIE DAVIS,
Director, Texas Department of Criminal Justice, Correctional Institutions Division,
Respondent.

CIV. ACTION NO. 1:12-CV-00373-LY-AWA

Emergency Motion for Release Pursuant to Rule 23 Due to Health Threat Posed by COVID 19 Pandemic and Request for Immediate Status Conference

Since this case was last before the court, a public health crisis caused by the COVID-19 pandemic has plagued the nation, increasing exponentially in a relatively short period of time with severe and deadly consequences. In Texas alone, there are now over 16,455 confirmed cases and 393 deaths as a result of the virus.[1] Epidemiologists and other public health officials have started ringing the alarm regarding the significant risk posed by prisons and jails, which, during pandemics, become "ticking time bombs" as "[m]any people crowded together, often suffering from diseases that weaken their immune systems, form a potential breeding ground and reservoir for diseases."[2]

[1] Texas Department of State Health Services, *Texas Case Counts COVID-19*, Apr. 16, 2020 *available at* https://txdshs.maps.arcgis.com/apps/opsdashboard/index.html#/ed483ecd702b4298ab01e8b9cafc8b83 (updating regularly).

[2] *See* Saint Louis University, *"Ticking Time Bomb" Prisons Unprepared For Flu Pandemic*, SCIENCE DAILY (2006), https://www.sciencedaily.com/releases/2006/09/060915012301.htm; Zusha Elinson & Deanna Paul, *Jails Release Prisoners, Fearing Coronavirus Outbreak: Experts say virus could spread quickly in crowded correctional facilities, which are also banning visitors and restricting inmates' movements*, WALL STREET JOURNAL (Mar. 22, 2020), https://www.wsj.com/articles/jails-release-prisoners-fearing-coronavirus-outbreak-11584885600; Martin Kaste, *Prisons And Jails Worry About Becoming Coronavirus "Incubators."* NPR (Mar. 13, 2020), https://www.npr.org/2020/03/13/815002735/prisons-and-jails-worry-about-

Ms. Jimenez is at heightened risk for contracting COVID-19, she suffers from serious underlying conditions and is immunocompromised, the consequences for her would be severe, quite possibly fatal, and it is only a matter of time before she is exposed, if she has not been already. As this court is aware, Ms. Jimenez has been diagnosed with Stage IV Chronic Kidney Disease ("CKD"). The attached letter from Nephrologist Dr. Bruce Wall explains: "patients with stage IV CKD are 60% more likely to contract viral illnesses," will likely "be similarly susceptible to COVID-19 and carry a greater risk of complications, including death." He explains, "this class of immunosuppressed patients have a greater risk of serious illness and hospitalization," cautioning that Ms. Jimenez "should not be placed in an environment where there is high risk for contracting COVID-19." (March 23, 2020 Letter of Dr. Bruce Wall, Dallas Nephrology Associates, Attached hereto as Exhibit "A".). Ms. Jimenez also suffers from hypertension. The Texas Department of State Health Services has advised: "Minimizing exposure is especially important for people ... who have an underlying health conditions like …high blood pressure... People in those groups have a higher risk of developing severe disease if they do get COVID-19, and the safest thing for them during an outbreak will be to stay home as much as possible and minimize close contact with other people."[3]

Ms. Jimenez cannot afford to wait any longer: the danger is imminent. As Jeff Formby, executive director of the American Federation of State, County and Municipal Employees Texas Corrections, put it: "There is no social distancing in prison." Ms. Jimenez lives in a dorm with 33 other women; she sleeps within a few feet of them, they all share the same sinks, drink from the

becoming-coronavirus-incubators; *Harris County to release about 1,000 'non-violent' inmates, calling jail a 'ticking time bomb,'* KHOU 11, Mar. 31, 2020, *available at:* https://www.khou.com/article/news/health/coronavirus/harris-county-extends-stay-at-home-order-through-april-30-citing-alarming-accelertion-of-covid-19-cases/285-46fda6df-572e-48e3-930b-92eade3f68ec

[3] Texas Department of State Health Services, News Updates: COVID-19 (new coronavirus), Apr. 11, 2020, available athttps://dshs.texas.gov/news/updates.shtm#coronavirus.

same water fountains, and shower next to each other. As of April 7, 2020, 29 Texas Department of Criminal Justice employees, staff or contractors and 26 inmates had tested positive for COVID-19.[4] In less than ten days, the number of inmates alone who are infected *has increased by 1,000%*. There are now 327 inmates inside Texas prisons with COVID-19, and there are 158 infected TDCJ staff members.[5] The Lane Murray Unit in Gatesville, a woman's prison just down the road from the Mountain View Unit, where Ms. Jimenez is being held, is on complete lockdown, *with twenty-seven confined women testing positive for the virus* (up from eleven cases just last week).

On February 3, 2020, Travis County District Attorney Margaret Moore publicly announced that her office was undertaking a conviction integrity review of Ms. Jimenez's case, and she also "appointed an experienced team to determine whether the case can and should be retried, as was ordered by the federal court."[6]

Counsel for Ms. Jimenez submitted the medical evidence from this case to a panel of several of the nation's leading pediatric otolaryngologists from Cincinnati Children's Hospital Medical Center, UT Southwestern Medical Center and Children's Medical Center, and Stanford University's Lucile Salter Packard Children's Hospital. Unlike the medical experts at Ms. Jimenez's trial (EMTs, pediatric emergency room doctors, intensivists, pediatricians and child abuse experts) the specialty and expertise of the otolaryngologists "involve blocked airways of children and the biological mechanisms at play in pediatric airway blockage situations." The

[4] Julian Gill, *Four Texas Prisons on Complete Lockdown Related to Possible Covid-19 Exposers*, HOUSTON CHRONICLE, April 7, 2020 available at https://www.houstonchronicle.com/news/houston-texas/houston/article/prison-lockdown-texas-coronavirus-covid-19-15184545.php.

[5] Texas Department of Criminal Justice, COVID-19 TDCJ Update, Apr. 16, 2019, available at https://www.tdcj.texas.gov/covid-19/index.html.

[6] KVUE Staff, *State leaders urge for new trial or release of woman previously charged with murder in boy's choking death*, KVUE, Feb. 3, 2020, *available at* https://www.kvue.com/article/news/crime/estela-rosa-jimenez-murder-conviction-letter-travis-county/269-957a7470-e5fb-4428-b50c-4db51dd96186

panel represents "a broad network of pediatric airway specialists" whose "research endeavors and airway management practices exist at the forefront of aerodigestive medicine." (*Consensus Statement of Pediatric Otolaryngologists, State of Texas v. Rosa Estela* Jimenez at ¶ 4, attached hereto as Exhibit B).

These doctors independently reviewed the case and presented their findings to members of the Travis County District Attorney's Office on March 31, 2020.[7] The experts determined that the trial evidence that "accidental ingestion of the paper towels [by BG] was 'impossible'" based on the object's size was wrong, finding: "BG could have readily inserted the paper towels in his mouth, either as a string or as a wad" and "in a matter of seconds" begun "to have trouble swallowing them completely or getting them out of his mouth." The doctors rejected the notion that a single person, Ms. Jimenez, could have intentionally put the paper towels in BG's mouth explaining that: "Inserting a string or wad of paper towels would be exceedingly difficult even with additional adults restraining the child. A single individual attempting this on a 21-month-old boy would find this task nearly impossible." The doctors concluded: "the medical evidence makes it far more likely than not that this was an accidental ingestion by BG. This is a tragic outcome, but an outcome stemming from an accident, not a malicious act on the part of Rosa Estela Jimenez." (*Consensus Statement* at ¶ 6).

[7] The experts include: *Michael Rutter*, BHB MBChB FRACS, Professor of Pediatric Otolaryngology, Cincinnati Children's Hospital; *Ron Mitchell*, Professor and Vice Chairman, Chief of Pediatric Otolaryngology, William Beckner, Distinguished Chair in Otolaryngology, Department of Otolaryngology, Head and Neck Surgery UT Southwestern and Children's Medical Center, Dallas; *Douglas Sidell*, MD, FAAP, FACS, Stanford, University School of Medicine, Assistant Professor of Otolaryngology, Head and Neck Surgery Director, Pediatric Aerodigestive and Airway Reconstruction Center, Department of Otolaryngology-Head and Neck Surgery, Division of Pediatric Otolaryngology; as well as *Karen B. Zur, MD*, who testified in the post-conviction proceedings in this case and is the Interim Chief, Division of Pediatric Otolaryngology, Children's Hospital of Philadelphia, Associate Professor, Otolaryngology: Head & Neck Surgery, and Perelman School of Medicine, University of Pennsylvania.

Fed R. App P 42 provides a mechanism for this case to be immediately resolved. *See also* 5th Cir Rule 42.1 (requiring dismissal "where the appellant or petitioner files an unopposed motion to withdraw" an appeal).

Given the significant risks that COVID-19 poses to Ms. Jimenez and the additional evidence of her factual innocence, counsel requests that she be released on her own recognizance pursuant to Federal Rule of Appellate Procedure 23(c). This mechanism is possible notwithstanding a stay on this court's order release or retry order. *Floyd v. Vannoy*, CV 11-2819, 2017 WL 2688082, at *2 (E.D. La. June 22, 2017) (noting the "the parties agree that the Court's [Release or Retry] Order should be stayed pending the State's appeal, and that [the defendant] should be conditionally released on a personal recognizance bond while the State's appeal is pending," granting the State's motion to stay and defendant's motion for release on a personal recognizance bond.).

The Innocence Project's social work department has secured an apartment in Austin that is available to Ms. Jimenez to move into immediately so that she can safely shelter in place pending final resolution of the case and will work to provide supervision and support services to her upon her release.

Certificate of Conference. Counsel for Respondent has conferred with counsel in the Texas Attorney General's Office, as well as in the Travis County District Attorney's Office, regarding the relief requested in this motion. These conferences are ongoing but in light of the quickly deteriorating circumstances, Ms. Jimenez could not wait any longer to file this motion, and the State is opposed to the relief requested in this motion at this time. The communications between counsel for the petitioner and these offices is continuing and counsel will update this certificate of conference, as necessary.

Date: April 17, 2020

Respectfully submitted,

/s/ Vanessa Potkin

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March 23, 2020

Vanessa Potkin
Director, Post-Conviction Litigation
40 Worth Street, Suite 701
New York, NY 10013

Dear Vanessa Potkin:

I am a Board certified nephrologist, in practice in a large group in Dallas, Texas for more than 34 years. Our practice involves the treatment of Chronic Kidney Disease ("CKD"), which is often progressive in the setting of hypertension or diabetes. Patients with CKD are in at increased risk for viral and bacterial infections, often with an adverse outcome in regards to infection and progression of renal failure. I have spoken with you and Sara Brown regarding your client, Rosa Jimenez, who was diagnosed with Stage IV CKD in 2016. You asked me to provide opinion in regards to the risk of COVID-19 for Ms. Jimenez, in light of her CKD diagnosis. Based on her diagnosis of Stage IV CKD , Ms. Jimenez is immunocompromised. I have not been involved in the treatment of this patient, or reviewed her medical records, but feel very comfortable that she is at increased risk because of her CKD. While there are no studies on the risk of COVID-19 and chronic kidney disease patients, this class of immunosuppressed patients have a greater risk of serious illness and hospitalization. According to UptoDate ®, patients with stage IV CKD are 60% more likely to contract viral illnesses, pneumonia, and bladder infections. Patients with stage IV CKD will likely be similarly susceptible to COVID-19 and carry a risk of greater complications, including death. Accordingly, this patient should not be placed in environment where there is high risk for contracting COVID-19.

If you have any questions regarding, please do not hesitate to contact me at 214-366-6400.

Respectfully,

Bruce R. Wall, MD FACP
Dallas Nephrology Associates

Consensus Statement of Pediatric Otolaryngologists, State of Texas v. Rosa Estela Jimenez

1. **Background of Otolaryngologists.** We are Board-Certified Otolaryngologists whose principle area of practice includes managing pediatric patients with airway problems. Brief additional background is as follows:

   i. **Dr. Michael J. Rutter:** I am a Board-Certified pediatric Otolaryngologist, a Professor of Otolaryngology and the Director of the Aerodigestive Center at Cincinnati Children's Hospital Medical Center. I am also the Director of Clinical Research at the Department of Otolaryngology, University of Cincinnati College of Medicine. My principle area of practice is managing pediatric patients with airway problems. I have a national and international reputation for my expertise in this area. I have extensive experience in the treatment of airway obstruction, including subglottic stenosis and tracheal stenosis, and have lectured and published extensively on this and other topics, having authored or co-authored over 100 peer-reviewed articles and dozens of book chapters, and been an invited speaker at 245 international and 249 national conferences. I have four patents, and have received numerous research grants, including from the National Institute of Health. I have considerable expertise in aerodigestive foreign body management. I provide informal airway advice resource for the pediatric otolaryngology community. I am asked for advice by 40-50 ENT surgeons (pediatric surgeons, pulmonologists, intensivists and cardiothoracic surgeons) annually from around the world about challenging cases.

   ii. **Dr. Ron Mitchell:** I am a Professor and the Vice Chairman of the Department of Otolaryngology at UT Southwestern Medical Center and serve as Chief of Pediatric Otolaryngology. I hold the William Beckner Distinguished Chair in Otolaryngology. I specialize in pediatric otolaryngology and airway conditions. I edit four otolaryngology journals and serve as a peer reviewer for 11 more. I have published over 130 peer-reviewed papers, as well as two dozen book chapters and four books on pediatric otolaryngology. I have delivered over 110 lectures on pediatric otolaryngology and pediatric sleep medicine across the United States as well as in Israel, Panama, Argentina, Brazil, and Mexico. I am actively involved in my profession's national leadership, chairing multiple committees including a recent task force of the American Academy of Otolaryngology-Head and Neck Surgery (AAOHNS), and chaired a committee that published a consensus document about the optimal care of patients with a tracheostomy.

   iii. **Dr. Karen B. Zur:** I am the Interim Chief of Otolaryngology, Associate Director of the Center for Pediatric Airway Disorders, Director of the Pediatric Voice Program and Attending Surgeon at Children's Hospital of Philadelphia. I am also an Associate Professor of Otorhinolaryngology, Head and Neck Surgery, Perelman School of Medicine at the University of Pennsylvania. I am an expert in the field of pediatric otolaryngology, pediatric airway disorders and pediatric voice disorders. My research interests include pediatric laryngotracheal pathology, surgical reconstruction, voicing issues, and airway simulation. I have been invited to deliver over 120 lectures at both national and international conferences. I have written over 45 peer-reviewed research publications

and reviews, more than 55 abstracts and 5 books and have held numerous editorial positions with top-tier pediatric and otolaryngology journals. I currently serve as the President of the American Broncho-Esophagological Association (ABEA).

iv. **Dr. Douglas Sidell:** I am Assistant Professor of Otolaryngology-Head and Neck Surgery at the Stanford University Medical Center, where I am a member of the Division of Pediatric Otolaryngology. My surgical practice focuses on the management of children with complex airway and pulmonary disorders, with a special interest in complex and revision airway reconstruction. I am the Director of the Pediatric Aerodigestive Center and the Center for Pediatric Voice and Swallowing Disorders at Lucile Packard Children's Hospital Stanford. I am the elected otolaryngology representative of the Aerodigestive Society and a founding executive member of the Aerodigestive Research Consortium, both with primary focus on the diagnosis and management of complex airway, pulmonary and esophageal disorders. I have written over 70 peer-reviewed research publications and authored or co-authored 19 book chapters which appear in top-tier medical publications. I have held numerous editorial positions with leading pediatric and Otolaryngology peer-reviewed journals and have presented at over 30 international conference and over 75 national conferences.

2. **Information Reviewed.** We were provided the following records relating to Bryan Gutierrez ("BG"), who was in the care of Rosa "Estela" Jimenez on Jan 30th, 2003:

i. INDEX VOLUME 1, containing: Trial testimony of Suzie Woelfel (911 Dispatcher); Irene Vera (Neighbor Who Administered CPR); William Torres (Police Officer Who Administered CPR); Jordan Rojo (EMS responded to scene); Robert Curr (EMS who Removed Wad of Paper Towel); John Boulet (Pediatric ER Doctor); Dr. Patricia Oehring (Pediatric Critical Care Doctor/Child Abuse); Wilson Young (DNA Expert); Dr. Leigh Fredholm (Pediatric Hospice); Dr. Elizabeth Peacock (Forensic Pathologist); Dr. Ira Kanfer (Defense Expert Forensic Pathologist); Keith Kritselis (Produced Kanfer's Demonstrative Exhibit); Dr. Vladimir Parungao (Forensic Pathologist Who Performed Autopsy); Dr. Randall Alexander (Pediatrician State's Child Abuse Expert); Dr. George Parker (Psychologist Who Evaluated Rosa Jimenez); Fidel Juarez (Rosa Jimenez's Husband).

ii. INDEX VOLUME 2, containing 911 Call Transcript; EMS Records; Children's Hospital Records of Bryan Gutierrez; Photos of Jimenez home, hand, Bryan Gutierrez and paper towel wad; Autopsy Documents; CV of Dr. Randall Alexander; Translated Interview of Rosa Jimenez.

iii. Post-Conviction Hearing Testimony of Drs. Oehring, McCloskey, Eskew, Peacock, Zur, and of Robert Curr.

iv. Affidavits of Drs. Dunham, Ophoven, McCloskey and Zur.

v. Excerpt from the Statement of Facts, Jimenez Amended Petition.

vi. Color Photographs of Wad and of Paper Towels Unfolded.

3. **Factual Summary.** To very briefly summarize the course of events as derived from the information and records provided:

   i. Estela Jimenez was an undocumented Mexican national who had been a care provider for BG, a 21-month-old boy, for approximately 7 months. She was 7 months pregnant at the time of the incident, and was accompanied by her one-year-old daughter. The incident occurred at Estela Jimenez's apartment on January 30th, 2003.

   ii. Around lunchtime, according to Estela Jimenez, she wiped BG's nose with a paper towel, with the roll being left on the couch. BG was later playing with paper he had torn off the roll. Sometime later he walked into the kitchen clutching his throat and choking. She rushed him to the bathroom, patted him on the back, tried to perform a Heimlich, tried to finger sweep his mouth (and was bitten), and then rushed him to a neighbor's house where a phone was available to call emergency services.

   iii. The first to respond was an officer who attempted CPR. EMS subsequently arrived finding BG blue and pulseless. Initial resuscitation attempts failed as they could not move air. They rapidly ascertained that there was an oropharyngeal (throat) foreign body and were able to remove it with difficulty. It was a wadded up wet and slightly bloody mass of 5 paper towels. They then intubated BG, and he was transported to the hospital.

   iv. By this time BG had sustained a severe hypoxic brain injury from lack of oxygen. He was eventually transferred to a hospice having not regained consciousness, had a care withdrawal 3 months later and subsequently died.

   v. At Ms. Jimenez's trial, testimony was presented from an EMS worker, a pediatric emergency room doctor, a pediatric intensivist, and pediatrician with child abuse experience who concluded that it was "impossible" that BG accidentally choked after putting the paper towels in his mouth; that an object of this size would have had to be put in BG's mouth/down BG's throat by another person; that a child of BG's age would not put so many paper towels in his mouth; and the presence blood indicated that the paper towels were forced down BG's throat by another person.

4. We were asked to render an opinion as to whether the oropharyngeal foreign body that resulted in BG sustaining a hypoxic brain injury, and ultimately resulted in a care withdrawal and death some 3 months later, was accidental or non-accidental. Unlike EMTs, pediatric emergency room doctors, intensivists, pediatricians and child abuse experts, our specialty and expertise involve blocked airways of children and the biological mechanisms at play in pediatric airway blockage situations. We represent a broad network of pediatric airway specialists, and our research endeavors and airway management practices exist at the forefront of aerodigestive medicine. Our day to day practice involves the management of airway foreign bodies, we perform and supervise efforts, and advise on cases regarding objects of all kinds stuck in the airways of children and efforts to remove them.

5. Our reviews were conducted independently of each other, and we did not consult or talk with each other prior to reaching and rendering our individual opinions.

6. This case has a tragic outcome. The issue is whether this was a tragic accident, or whether BG was the victim of a deliberate action. The following are relevant questions and our consensus opinions.

   i. **How common are aerodigestive "Foreign Bodies"?**
   Quite common.
   In America the most common aerodigestive (meaning things that enter the mouth) foreign bodies are coins in the upper esophagus, and peanuts in the bronchi. While rare, foreign bodies in the throat or larynx are well-recognized as being potentially lethal – hotdog sausages in young children being the most common.

   ii. **Can "Foreign Bodies" in the aerodigestive tract be life threatening?**
   Yes.
   This is a particular concern to toy manufacturers, and there are guidelines on toy size and composition to minimize the risk of a foreign body in a child.

   iii. **Do children place inappropriate objects in their mouths?**
   Yes.
   It is remarkable the things that are removed from children's aerodigestive tracts both in terms of size and composition. There is nothing inherent about paper towels that would prevent a child from putting them in his or her mouth.

   iv. **Was the paper inserted as a wad?**
   Unclear.
   The appearance of the mass on extraction may be very different than on insertion or ingestion. It would be easier to "feed in" a string of paper towels than to insert as a single mass. Once inserted they would then have a tendency to "wad" together. The appearance of the wad after removal does not necessarily reflect how the paper was inserted.

   v. **Could BG insert such a large object into his own mouth?**
   Yes.
   Whether as a wad (and note that it could have been smaller on insertion before it absorbed saliva), or fed in and then wadded together inside the mouth. In fact the larger the object the less likely it is that another person could have intentionally forced the paper towels inside. A 21-month-old would fight very hard, and you would expect to see injuries on both BG and Ms. Jimenez that were absent. Without being restrained by 1-2 additional adults, an unwilling 21-month-old would prevent it from happening.

   vi. **Would it be easy for an adult to "force" a string or wad of paper towels of this size into a 21-month-old boy's mouth?**
   No.
   Children are surprisingly strong, even at 21 months. Trying to force something in the mouth of an unwilling child, especially if they clamp their teeth shut (which would be expected) would be remarkably difficult, whether feeding in a string of paper towels, or

forcing in a wad of them. There would likely be other physical consequences, whether to the child, or the person trying to force in the paper towels. The best analogy for us as Pediatric Otolaryngologists is to use a tongue depressor to look at a child's tonsils – this is almost impossible to achieve in an uncooperative child without the assistance of a second adult (usually a parent) who has been shown how to hold the child still so that we can examine the child. Even in a cooperative child, viewing the tonsils with a tongue depressor would be much easier than inserting any object, paper towel notwithstanding, into a patient's oropharynx. In an uncooperative child viewing the tonsils can be very difficult as described. Inserting a string or wad of paper towels would be exceedingly difficult even with additional adults restraining the child. A single individual attempting this on a 21-month-old boy would find this task nearly impossible.

vii. **How could BG accidentally choke on the paper towels after putting them in his mouth?**

Children will intentionally put a wide variety of foreign objects in their mouth without thinking of the consequences. This is THE common first step preceding most choking events—the child places something in their mouth that shouldn't be there. The act of placing the foreign object in the mouth is done without any consideration of a possible choking event.

BG could have readily inserted the paper towels in his mouth, either as a string or as a wad. Only after they are in his mouth would he begin to have trouble swallowing them completely or getting them out of his mouth. If the foreign body is present in the back of his mouth one of the natural responses would be for BG to attempt to swallow. During this process, the muscles of the throat will contract, bringing the foreign body further down the throat. At that point, the foreign body will either pass into the esophagus—traveling beyond the airway—or it will get stuck. Smaller foreign bodies, such as coins, are often swallowed and pass to a point immediately behind the voice box where a very established "bottleneck" region exists. Objects here are often trapped due to narrowing formed by a muscular ring at the opening of the esophagus, and further compressed by the voice box in the front, and by the bone of the spine from behind. Smaller foreign bodies occasionally cause airway symptoms when swallowed, but this is less common. Because they are small, they are abler to pass beyond the opening of the airway before they get stuck.

If the foreign object is larger, such as the paper towel wad, it has the potential to become wedged in the throat without any chance of passing very far into the esophagus. If it gets lodged in the location between the back of the throat and the opening of the airway, it will cause either partial or complete obstruction of the airway. As BG's airway is obstructed, the natural response is to forcefully try to pass the object. His body would likely do this by continued attempts at swallowing while struggling to breathe. In doing so, he would be contracting the throat muscles, wedging the paper towel wad further into the throat. In other words, even though the body is trying to swallow the object aggressively, only the tip of the iceberg may enter the esophagus, and the majority will block the airway. All of this could ensue in a matter of seconds after the object is placed in the mouth.

viii. **Was the wad of paper towel the same size when it came out as when it went in?**
Likely no.
The paper may have gone in dry or wet. A wet paper towel can be more malleable. However, any object in the mouth or pharynx (throat) will stimulate saliva production, with the paper then absorbing the saliva and enlarging in size.

ix. **Once the paper towel was in BG's mouth, could any member of the "lay public" have done anything effective to remove it?**
Likely no.
Given that it took a paramedic with McGill forceps using a marked amount of force to remove the foreign body, in an extremely co-operative child (as he was unresponsive at this point), it seems very unlikely that it could have been removed by anyone else prior.

x. **Does the difficulty of removing the object tell us anything about whether it was intentionally ingested by the child or forced there by an adult?**
No.
Once the object is in the mouth it will expand in size and will be difficult to remove. Trying to open the mouth and remove it will be met with a lot of resistance by the child. This would be the case regardless of whether it was ingested by the child or forced by an adult. Moreover, attempts at removal such as finger sweeps, continued contraction of the throat by BG during the choking event, and "bagging" the patient during cardiopulmonary resuscitation have the potential to wedge the foreign body further into the throat. The difficulty of removing the object does not provide useful information about how it got there.

xi. **How long was BG hypoxic?**
Unclear, and not directly relevant.
Whether BG was hypoxic for 5 minutes or 20 minutes, the outcome is that he received a severe hypoxic brain injury. Blood gas levels are unreliable for determining how long someone is hypoxic. Two different patients under very different circumstances may have very similar-appearing blood gasses. Patients may achieve hypoxia on a blood gas over a matter of minutes, and others may achieve the same level of hypoxia slowly—over a matter of hours.

xii. **Could the brain damage have occurred between the time of the 911 call and the time the EMS arrived?**
Yes.
This most likely occurred between the 911 call and the arrival of the paramedics.

xiii. **Is the blood on the wadded-up paper relevant in assessing whether this was an intentional act by a third person or an accidental ingestion by BG?**
No.
The blood on the paper towels is irrelevant. Whether the paper towels were placed there deliberately, or were self-ingested, the attempts at removal easily explain the small amount of blood present on the towels. In our experience this is not a large amount of blood given the way the paper towels were removed.

xiv. **If there had not been a care withdrawal 3 months after the incident, might BG still be alive?**
Yes.
With appropriate nursing and feeding, BG might well still be alive today. This is in no way saying that a care withdrawal was in any way inappropriate.

7. **In conclusion**, we reject as erroneous the opinion that accidental ingestion of the paper towels was "impossible," and that such opinions could be relied upon to prove Rosa guilty beyond a reasonable doubt. On the contrary, in our expert opinions the medical evidence makes it far more likely than not that this was an accidental ingestion by BG. This is a tragic outcome, but an outcome stemming from an accident, not a malicious act on the part of Rosa Estela Jimenez.

8. Our opinions are rendered on the basis of the materials provided to us, and our experience and expertise, and are subject to change should further relevant information be provided.

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