July 29, 2001

Beverly Harris, Esq.
Mazanec, Raskin & Ryder CO.,L.P.A.
Attorneys and Councelors at Law
100 Franklin's Row
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Re: Forrest Gregg Stone, a minor, by and through his Mother and Natural Guardian Edna L. Stone, et al v. Corazon O. Go, M.D., et al
Cuyalioga County Court of Common Pleas Case No.: 396873

Dear Beverly Harris, Esq.:

At your request, I have reviewed all of tlie materials you sent me on tlie above referenced case including:

1. Medical Records from Metro Health Medical Center;
2. Medical Records from Deaconess Hospital;
3. Office Records of Dr. Corazon Go, M.D.;
4. Office Calendar of Dr. Go;
5. Visiting Nurse Association records;
6. The Deposition Transcript of Dr Paul Hudock, M.D. and;
7. The Deposition Transcript of Dr. Corazoii Go.

Forrest Gregg Stone was tlie 7 pound 15 ounce product of a Gravida 2 Para 2, O positive, Group B streptococcus negative, Rubella immune, VDRL negative, hepatitis B negative 32 year old mother following an uncomplicated pregnancy labor and delivery. Delivery was vaginal, vertex at 39 weeks gestation on Marcli 25,1999. The infant was born eighteen minutes after clear rupture of membranes with Apgar scores of 8/9. Forrest required brief oxygen by mask, suctioning and tactile stimulation as his only resuscitation. There was no family history of bleeding diathesis and or hemopliilia; and there was a healthy sibling at home.

An initial physical by the nursery nurse revealed a bruise of tlie left tibial area. On admission to the nursery his weight was 7 pounds 10 ounces, head circumference 35 centimeters, length 21 inches. His initial exam by the

pediatrician, Dr. Go, on March 25 was significant for facial bruising and a systolic ejection murmur; otherwise his exam was entirely normal. Forrest was initially bottle fed Enfamil with iron, brit was breast fed during his remaining hospital course; lie did receive vitamin K. On March 26,1999 Dr Hudock performed an uneventful circumcision. Some oozing from his circumcision was noted on the twenty sixth; vaseline guaze was applied. The morning of tlie twenty - seventh there some additional oozing from the circumcision which was controlled with adrenaline and Hemostat, applied by Dr. Hudock. Dr. Go ordered a complete blood count, PT, and PTT however not enough blood was obtained for the clotting studies. A discharge physical was done which included resolution of the heart murmur, mild icterus and facial bruising. Arrangements were made for a Visiting Home Nurse to go to the home after the infant's discharge.

Forrest had a Visiting Nurse Association (VNA) visit scheduled for Tuesday, March 30,1999. The VNA visit did not occur because it was cancelled by Mrs. Stone. Dr. Go had arranged for the VNA visit to evaluate the circumcision site.

Mrs. Stone did speak to the office staff of Dr. Go on March 30,7999 and expressed concern about the child's color being jaundiced. Arrangements were made for the infant to have an outpatient bilirubin drawn; however this was not accomplished as Mrs. Stone opted not to have her baby stuck for the blood draw. She had registered at the outpatient lab, but changed her mind before the specimen was obtained. When Dr. Go learned of the family's decision not to have the blood taken she attempted to call the family, but was unable to get through to anyone who spoke English.

Forrest presented to Cleveland Metro Emergency Room on the morning of March 31,1999 with a twelve hour history of poor feeding and irritability. Additionally lie was also noted to have had twitching of his arms and legs tlie prior evening. A complete evaluation at the hospital disclosed; a possible skull fracture, subdural hematoma and possible hemophilia A (factor VIII deficiency).

I believe the care rendered by Dr. Go to Forrest Stone was appropriate. There was no family history of bleeding problems and the degree of bleeding experienced by this infant in the nursery is not uncommon. Many pediatricians would not have ordered any blood work. Dr. Go had made reasonable follow up care appointment both with the VNA as well as in her

own office. Clearly, there are some issues of noncompliance on the part of Mrs. Stone in choosing not to have tlie blood drawn and not communicating her concerns about the blood draw or the baby's feeding issues to Dr. Go before going to the emergency room. Forrest's subsequent medical problems were not, in my opinion, proximately caused by the care of Dr. Go.

Respectfiilly,

Mary Goessler

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September 08, 2001

John R. Scott
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113 Saint Clair Avenue
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Re: Forrest Gregg Stone versus Go, MD (your file: 4107-10-41659-99)

Dear Mr. Scott:

Thank you for asking me to review the above mentioned case. I have examined and reviewed the binder that you sent to nie which included the medical records of Edna Stone. the delivery of her infant on March 25. and the subsequent records of the infant's hospitalization March 25-March 27, 1999.

Based on my review of these records, I believe the nurses were thorough in tlie assessment of the infant, noting a bnuse on the face, presence of petechiae?and a lump under the vitamin K injection site. Certainly not uncommon items to find in newborns, but parameters which need to be evaluated by the health provider. The pediatrician was aware of the above mentioned parameters of assessment. Once the infant had a circumsion perfornied on the 2nd day of life, the nurses did note some 8 hours later oozing of blood again not uncommon. The following morning March 27, 1999. the infant was assessed as having some oozing of blood from the posterior site of the circumsion. This was immediately brought to tlie attention of the pediatrician who was present in the nursery and to the obstetrician (who actually performed the circumsion) . Both of these physicians evaluated the situation, interventions to assist with hemostasis were employed and follow up blood work was ordered by the pediatrician. The nurses obtained the blood, sent it to the laboratory and upon receiving the results sent them to tlie pediatrician for evaluation and final authority to discharge the infant. Appropriate assessment of the infant was accomplished and a note indicating "no bleeding from the circ, discharge home in satisfactory condition" was written in the chart. It is my opinion the nurses met the acceptable standards of practice in the care of this newborn.

Sincerely,

Linda R. DiPasquale

Linda R. DiPasquale, RNC. MSN
Perinatal Clinical Nurse Specialist