

STATE OF NEW HAMPSHIRE

ROCKINGHAM COUNTY, SS.

SUPERIOR COURT  
Docket No. 07-S-2885

STATE OF NEW HAMPSHIRE

v.

JESSE BROOKS

**AFFIDAVIT OF MARIA R. DURANT, ESQ.**

1. I am an attorney licensed to practice law in the Commonwealth of Massachusetts and admitted as counsel *pro hac vice* for the defendant, Jesse Brooks, in the above-captioned matter.
2. On information and belief based upon my review of medical records and related documentation, relevant copies of which are attached hereto, Jesse Brooks underwent the following medical procedures and/or surgeries on the dates listed below:
  - Tab A. January 2004: Hernia surgery at Cedars-Sinai Medical Center, Los Angeles, CA.
  - Tab B. May 2004: Hernia revision surgery at Southern Hills Hospital and Medical Center, Las Vegas, NV
  - Tab C. July 2005: Inguinal hernia nerve repair at Medical District Surgery Center, Las Vegas, NV
  - Tab D. December 2006: Arthroscopic debridement of right elbow entrapment Mayo Clinic, Rochester, MN
3. As early as 2005, Brooks has been prescribed a series of prescription pain medications including most recently, medications prescribed by Dr. Nickolas Karajohn on or about November 25, 2007. *See* Tab E (Affidavit of Nickolas Karajohn).
4. Mr. Brooks was seen at the Portsmouth Regional Hospital Emergency Department on December 27, 2007 for symptoms of narcotic withdrawal associated with the overuse of pain medications. *See* Tab F (Discharge Instructions).
5. At the time of discharge from the Portsmouth Regional Hospital Emergency Department on December 27, 2007, the hospital medical staff applied a Clonidine patch to Mr. Brooks and issued him prescriptions for Lorazepam and Promethazine. *See id.* Further, discharge

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NO  
ROCKINGHAM  
SUPERIOR COURT

instructions provided to Mr. Brooks include instructions to contact a methadone clinic for possible treatment. *See* Tab F.

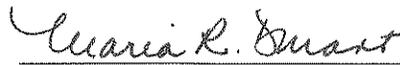
6. On or about January 3, 2008, Mr. Brooks sought admission and was subsequently accepted by Merrimack River Medical Services, Inc. (a/k/a: Community Substance Abuse Centers "CSAC") for purposes of receiving methadone treatment.

7. Based on conversations with representatives of CSAC, Mr. Brooks has been participating in the methadone treatment program on a daily basis since his admission and it is expected that details concerning his program participation will be offered through the testimony of a representative of CSAC at a hearing on the State's Motion to Revoke scheduled for Friday, February 29, 2008 at 10:00 a.m.

8. On information and belief, on or about January 11, 2008, Mr. Brooks was prescribed medications by a licensed physician in the Commonwealth of Massachusetts as set forth more fully in Tab G.

9. On or about February 14, 2008, I provided to the New Hampshire Department of Corrections, Exeter Probation Office, a list of medications that had been prescribed for Mr. Brooks either prior to or during the period of his pre-trial supervision, which began on December 20, 2007, and supporting documentation.

Signed this 28<sup>th</sup> day of February 2008.



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Maria R. Durant

011388948 BROOKS, JESSE

CDR report on file as of: 2/16/04 at 2:15:30 PM

ONGA

CEDARS-SINAI MEDICAL CENTER

PATIENT: BROOKS, JESSE  
MED REC: 011388948  
DICTATOR: GREGG K. NISHI, M.D.

OPERATION REPORT

CC: GREGG K. NISHI, M.D.

DATE OF OPERATION: 01/01/2004

SURGEON: MATTHEW T. WILSON, M.D.

ASSISTANT: GREGG K. NISHI, M.D.

ANESTHESIOLOGIST: AUGUSTA U. IKHISMOJIE, M.D.

PREOPERATIVE DIAGNOSIS: Left inguinal hernia.

POSTOPERATIVE DIAGNOSIS: Left pantaloon hernia with both indirect and direct components.

NAME OF PROCEDURE: Left direct and indirect herniorrhaphy with mesh.

INDICATIONS FOR SURGERY: Left inguinal hernia.

DESCRIPTION OF FINDINGS: Left pantaloon hernia with both direct and indirect components with a large floor defect.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: None.

PHYSICAL PRESENCE STATEMENT: Dr. Matthew Wilson was present for the entire case.

DISPOSITION: The patient tolerated the procedure well and was transferred to the recovery room in stable condition postoperatively.

DESCRIPTION OF PROCEDURE: This patient is a 27-year-old male who presented with a recurrent left inguinal hernia. The patient had a prior left inguinal herniorrhaphy as a child and developed recurrence of this hernia.

The patient was informed of the risks of the operation and informed consent was obtained. The patient was given 1 gm IV Ancef prior to the operation. He was then brought to the operating room, placed on the operating room table in the supine position. The patient was induced under general anesthesia and intubated via endotracheal intubation. The patient's abdomen was then prepped and draped in the usual sterile fashion. The left groin was inspected and a mass could be palpated in the left inguinal region. Local anesthetic was injected, first to provide an inguinal nerve block by injecting just medial to the anterior-superior iliac spine on the left side.

In addition, the skin was infiltrated with local anesthetic as well. An approximately 5 cm linear incision was made through the skin using a 10 blade knife in the direction of the inguinal ligament. The

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subcutaneous tissue and Scarpa fascia were then dissected using Bovie electrocautery at the level of the external abdominal oblique fascia.

The fascia was then incised using a 15 blade knife and then this incision was carried along the direction of its fibers using Metzenbaum's scissors. The spermatic cord was identified using blunt dissection along the pubic tubercle. The ilioinguinal nerve was identified, isolated and protected.

The cord was isolated with a Penrose drain and pulled aside. This allowed us to inspect the floor of the inguinal canal which obviously had a large defect. This is where the patient's direct defect was located. We then inspected the cord and separated the cremasteric fibers and opened up the cord allowing us to visualize the vasa \_\_\_\_\_ as well as the vas deferens. In the cord, multiple cord lipoma were identified which were coming from the internal ring and this obviously was a small indirect inguinal hernia as well.

The cord lipoma were ligated as well as the small hernia sac which was ligated with 2-0 Vicryl suture and then excised. We then placed a Marlex plug into the defect in the internal ring followed by placement of a Marlex onlay mesh over the floor of the inguinal canal to repair the direct inguinal defect. The Marlex mesh was first secured to the pubic tubercle using a single 2-0 Prolene suture.

Following this, the Marlex mesh was then tacked down at three other points. The superior aspect of the mesh was tacked to the internal oblique fascia. The inferior edge of the Marlex mesh was sutured to the shelving edge of the inguinal ligament and finally, the lateral two edges of the Marlex mesh were tacked together using the Prolene suture. This was also secured to the Marlex plug.

Care was taken to place the Marlex mesh around the spermatic cord to create a new external ring. A single finger was placed next to the cord through the new external ring to insure that the external ring was not too tight.

With this in place, the operative field was inspected for bleeding. Small bleeding was controlled using the Bovie electrocautery. We then copiously irrigated with antibiotic solution. The external oblique fascia was then reapproximated using 4-0 Vicryl suture in a running fashion. We then closed the Scarpa fascia again with 4-0 Vicryl suture in a running fashion.

The skin was closed using 4-0 Monocryl suture in a subcuticular running fashion. The wound was then injected again with local anesthetic. The incision was then cleaned, dried and dressed with Steri-Strips. The instrument count was correct. The sponge count was correct.

Dr. Matthew Wilson was present for the entire case.

The right testicle was grasped and pulled downward with ease and without any traction. The patient was then awakened from general anesthesia and extubated without difficulty and transferred to the recovery room in stable condition.

\_\_\_\_\_  
GREGG K. NISHI, M.D.

\_\_\_\_\_  
\*X: MATTHEW T. WILSON, M.D.

GKN:YOG/03471755/ac D: 01/01/2004 T: 01/01/2004 JOB#: 85908

*Confidentiality Warning: The information in this system should only be viewed by patient care personnel with a "need to know" for purposes of diagnosis and treatment. All accesses are logged with your name, the patient's name, the type of data viewed, the date and time. Inappropriate accesses are subject to disciplinary measures and/or legal action, up to and including termination of employment on the first offense. Any printouts from this system should be disposed of properly.*

DATE OF PROCEDURE: 05/05/04

PREOPERATIVE DIAGNOSIS:

Left lower quadrant incisional hernia with periumbilical hernia.

POSTOPERATIVE DIAGNOSIS:

Left lower quadrant incisional hernia with normal diagnostic comprehensive laparoscopy.

OPERATION:

1. Diagnostic comprehensive laparoscopy with finds of no intra-abdominal hernia, no periumbilical hernia, and mesh plug noted at the left groin hernia.
2. Repair of left lower quadrant incisional hernia with reinforcement and removal of scar tissue.

SURGEON(S):

Kevin R. Rayls, M.D.

ASSISTANT SURGEON(S):

Barry Rives, M.D.

ANESTHESIOLOGIST:

Edmond Freis, M.D.

ANESTHESIA:

General.

DESCRIPTION OF PROCEDURE:

After informed consent, the patient was brought back to the Operating Room and placed in the supine position on the Operating Room table. After adequate general anesthesia he was then sterilely prepped and draped of the entire abdominal area.

A small incision was made in the infraumbilical midline down to the fascia. \_\_\_\_\_ was inserted under direct vision. The abdomen was insufflated to 50 mmHg, the two pressure needles were removed and the 5 mm trocar was inserted. The abdomen was inspected. It was noted that there is some small amount of subcutaneous tissue on the undersurface of the fascia, there was no hernia present in the periumbilical or left flank area. We placed an 11 mm port just above the umbilicus in the midline using a 10 mm camera at this point. I dissected down the left groin. There was an old mesh plug in the internal ring area, however, there was no bowel contents or weakness of the floor noted to allow intra-abdominal contents to protrude outward. The right groin was inspected; no

PATIENT NAME: BROOKS, JESSE T  
 ATTENDING PHYSICIAN: Kevin R Rayls, MD ROOM NO:  
 ACCOUNT NO/MRN: H89670028357/000000H000002397  
 DISCHARGE DATE:

OPERATIVE REPORT

Southern Hills Hospital and Medical Center Las Vegas, Nevada

lesions were noted there. There were no other abnormalities in the pelvis. The gallbladder and the remainder of his bowel looked normal.

After this diagnostic comprehensive examination was evaluated, I felt like I needed to evaluate his left lower quadrant, which clinically had weakness before and pain. The scope was removed. The wounds were irrigated with saline and the fascia was closed with an 0 Vicryl suture. The skin incisions were closed with 0000 Monocryl subcuticular stitch.

The old left lower quadrant incision was opened laterally from two-thirds on laterally down to the subcutaneous tissues. Hemostasis was obtained by electrocautery. Upon going down to the fascia there was knotted up scar tissue, which was removed with electrocautery down to the fascia. The fascia was very weak although there is no obvious defect as noted preperitoneally. I had removed the old scar tissue and in going down to the inguinal ligament I found this to be rather weak. I imbricated and strengthened this with a running 0 Vicryl suture. 0.5% Marcaine with epinephrine was used for local, and the subcu was approximated with #3-0 Vicryl suture. The skin was closed with a running 0000 Monocryl subcuticular stitch. Steri-Strips were applied. The patient tolerated the procedure well.

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Kevin R Rayls, MD

KRR:EDix20744 C:  
D: 05/05/04 16:29 T: 05/05/04 17:53 DOCUMENT: 200405052110637500

CC: Kevin R Rayls, MD

PATIENT NAME: BROOKS, JESSE T  
ATTENDING PHYSICIAN: Kevin R Rayls, MD ROOM NO:  
ACCOUNT NO/MRN: H89670028357/000000H000002397  
DISCHARGE DATE:

OPERATIVE REPORT  
Southern Hills Hospital and Medical Center Las Vegas, Nevada  
Page 2 of 2

**GENERAL DISCHARGE INSTRUCTIONS  
FOR THE PATIENT RECEIVING ANESTHESIA**

7/20/05

After your surgery, you may experience:

1. A sore throat - this should go away within a few days.
2. Some nausea - this, too, should go away within 24 - 48 hours.
3. Some vomiting - one or two times is not uncommon. Any more than that, notify your doctor.
4. A slight fever - a slight fever is not unusual. A fever over 101° should be reported to your doctor.
5. Headache, dizziness, drowsiness or muscle aches - these may last 24-48 hours.

For the next 24 hours:

1. Do not drive a car, operate machinery or power tools, or use kitchen appliances.
2. Do not drink alcoholic beverages, including beer.
3. Do not make any important decisions or sign any legal documents.

-Start your diet with clear liquids (water, tea, apple juice, etc.) then try soups, crackers, toast, etc. and then a regular diet.

If you receive a prescription for pain, take your medication with food. Some pain medications can cause nausea.

If you have any questions or problems, call your doctor. If you are unable to contact your doctor, and you feel you have an emergency, go to the nearest Faster Care Center or Emergency Room.

Doctors Special Discharge instructions:

*Take medication as directed*  
*Keep dressing clean and dry*  
*Call Dr. Hoffman's office to schedule followup appt.*

Someone from Medical District Surgery Center will call you in a few days to see how you are doing.

I understand the above instructions and have received a copy of this sheet.

Pt/Family Signature *J. Brooks* MOTHER

Discharge Nurse's Signature *[Signature]* N/A

Date/Time *7/21/05*

**MEDICAL DISTRICT SURGERY CENTER**  
2020 Goldring Ave., Suite 300 • Las Vegas, NV 89106  
(702) 477-7000

**General Discharge Instructions For  
Patient Receiving Anesthesia**

Addressograph

104763 12/11/76  
BROOKS, JESSE M 28YR  
HOFFMAN, STUART M.D.  
MDSC 07/21/05

Report ID: ALI REPORTS &amp; LABS

Terminal ID: W103040 Run Date/Time: 21Feb2007 1:00pm

Reporting period = 7Oct1979 thru 21Feb2007 Requested by: MRA2525

## ECHO

ECHO Reports

No Matching Data Found

## SURGERY

Surgical Reports

6-366-780

29

M

(2006)

Brooks, Mr. Jesse T.

Las Vegas NV

PREOP DIAGNOSIS: POSTTRAUMATIC ARTHROSIS RIGHT ELBOW, LOOSE BODIES.

PREOP INDICATION: PAIN.

Date of Surgery: 5 DEC 2006

Surgeon: B. F. MORREY, MD (77)47397 (+00) ORTS

Assistant: A. CIL, MD (12700899)

Location: Rochester Bldg:RM Floor:01 Room:OR 84

Visit Type: Outpatient

Right Arm Total Tourniquet Time: 0:57

PostOp Diagnosis: Posttraumatic arthrosis, right elbow.

Loose bodies, right radiohumeral joint.

Procedure: &gt; Arthroscopic debridement, right radial humeral joint and anterior compartment right elbow.

Open arthrotomy.

Removal of multiple (five) free bodies adherent to the lateral capsule.

Inspection of the joint.

Cortisone injection.

Under general anesthesia, the patient was placed in the left lateral decubitus position. After the standard prep and drape, the tourniquet was inflated and the arthroscope was introduced through an anteromedial portal after the ulnar nerve had been palpated and felt to be in its groove. Very difficult visualization was obtained. The patient had tremendous scarring in the joint and synovitis. Because of the significant synovium, we were not able to identify the articular surface or the quality of the capsule. We therefore introduced a shaver through an anterolateral portal. Through this portal, we removed the proliferative synovium and were able to identify radial head. The radial head was extremely difficult to accurately discern because it was completely covered by fibrous tissue. With patience and multiple orientations of the shaver, we were ultimately able to free the scar tissue from the radial head. There was a very discrete band over the radial head which was felt was counting for the patient's crepitus and snapping. The adherent fibrous tissue was completely released. The margin of the annular ligament was released, and the anterior capsule of the radial humeral joint was released from the humerus. This resulted in excellent decompression and debridement of the lateral ulnohumeral joint. We then introduced the scope through the lateral portal so that we could address the pathology from the medial portal. Additional clearance of synovium allowed clear visualization of the ulnohumeral joint. The coronoid was roughened, and the ulnohumeral joint showed some roughening, but there was no full-thickness losses that could be appreciated. Debridement of the medial compartment was carried out, but the capsule was left intact. A retractor was used throughout the case from the anterolateral ridge. Because there was no posterior pathology symptomatically or radiographically, the scope was withdrawn. At this juncture, a 6-cm incision was made over the radial head just proximal to Kocher's interval. The dissection was carried through the subcutaneous tissue, and the calcification seen on the x-ray was easily palpated. We opened the capsule and removed one large cm-diameter loose body. Three additional loose bodies measuring from 5 mm in diameter to 8 mm in diameter were removed. Two small additional osseous fragments were removed. This allowed visualization of the joint. The radial humeral joint looked quite well decompressed. The joint remained stable. There were grade 2 changes radial humeral joint but no full thickness loss. The arthrotomy was closed with an 0 Vicryl suture, the subcutaneous tissue

Report ID: ALL REPORTS &amp; LABS

Terminal ID: W101040 Run Date/Time: 21Feb2007 1:00pm

Reporting period = 7Oct1979 thru 21Feb2007 Requested by: MRA2525

6-365-780

29 M

(2006) (Continued)

with 2-0 Vicryl, and stainless steel staples were employed on the skin and the portal sites. A 4:1 ratio of 10 cc, 0.5% Marcaine and Depo-Medrol was injected into the joint. A sterile compressive dressing was applied...Dr. Morrey/jdm.

Wound Type: TYPE I - CLEAN

Transcriptionist: jdm

Electronically Signed:

Dec 11 2006 7:11AM by B. F. MORREY, MD

## TRANSFUSION MEDICINE

Tx Med Reports

No Matching Data Found

## GENETICS

Genetics Reports

No Matching Data Found

## PENDING RESULTS

Pending Results

Description

Status

Service Date / Time

No Pending Data Found

## LEGENDS

MCR = RO, KC, Laboratory Director

Mayo Clinic Rochester, 200 SW First Street, Rochester, MN, 55905

## PERFORMING LEGENDS

RO = Franklin R. Cockerill, III, MD, Laboratory Director

Dept Lab Med Path, 200 1ST ST SW, ROCHESTER, MN, 55905

\*\*\* End of data \*\*\*

I, Nickolas Karajohn, do depose and state as follows:

- 1. I am a medical doctor licensed to practice medicine in the State of Nevada.
- 2. Jesse T. Brooks is one of my patients.
- 3. On or about November 25, 2007, I prescribed the following medications for Mr. Brooks to be taken as indicated:
  - (a) Androgel 1%; applied as needed
  - (b) Oxycontin 80 mg tablet; one tablet by mouth twice a day;
  - (c) Zolpidem Tartrate 10 mg tablet; one tablet by mouth at bedtime;
  - (d) Alprazolam 2 mg tablet; one tablet by mouth every 8 hours.
- 4. On or about December 9, 2007, I prescribed the following medication for Mr. Brooks to be taken as indicated:
  - (a) Oxycodone/Acetaminophen 325 mg; one tablet every 4 to 6 hours as needed.

Signed this 22 day of February 2008.



Nikolas Karajohn, MD

**Nickolas Karajohn, MD**  
**License # NV 10508**  
**Advanced Urgent Care**  
**9975 S. Eastern Ave., Ste. 110**  
**Las Vegas, NV 89123**  
**Ph: (702) 361-2273 Fax: 361-6885**

Discharged 12/27/07 @ 2115 B. Brooks F

General Instructions with ExitWriter

Portsmouth Regional Hospital
Emergency Department
333 Borthwick Avenue, Portsmouth, NH 03801 603.436.5110
12/27/2007 18:19

Patient: BROOKS, JESSE T

MRN: F000301822

Thank you for visiting the Portsmouth Regional Hospital-Emergency Department.
You have been evaluated today by Wetherbee, Karen, A.R.N.P. for the following condition(s):

Substance abuse (oxycodone) (overuse of opiate prescriptions:oxycodone and oxycontin). Narcotic withdrawal.

INSTRUCTIONS

Rest. (METHADONE CLINIC NEWINGTON 436-0448
METHADONE CLINIC SOMERSWORTH 953-0077
Call your PCP to arrange FEDEX of your opiate prescriptions to local CVS in NH as discussed with CVS pharmacist who will then verify prescription with your PCP by phone
REFERRALS PER PARS
CALL LOCAL PAIN CLINICS TO BECOME AN ESTABLISHED PATIENT).

Warnings: Further evaluation is necessary.

Your Current Medications: Continue current medications. Your current home medications have been reviewed (NP). No changes in your current home medications are recommended at this time.

Continue taking the following medications:
Alprazolam Oral 2 mg, EVERY 8 HRS, 2 DOSES TODAY

Zolpidem Tartrate Oral 10 mg, at bedtime, Last dose: NONE IN A WHILE.

Prescription Medications: Ativan 1 mg; take 1 orally every 6 hours as needed for anxiety. Dispense ten (10). No refill. Generic substitute OK.

Phenergan Tablets 25 mg; take 1 tablet orally every 8 hours as needed for nausea. Dispense ten (10). No refill. Generic substitute OK.

\* TAKE OFF CLONIDINE PATCH ONCE YOU HAVE RESTARTED YOUR OXYCODONE AND OXYCONTIN.

Understanding of the discharge instructions verbalized by patient.

ADDITIONAL INFORMATION

NARCOTIC WITHDRAWAL

Narcotic withdrawal occurs in persons who have used narcotics on a daily basis for at least three weeks. Symptoms usually begin about 12 hours after the last dose of narcotic. Withdrawal symptoms last 3-5 days and may include yawning, sweating, runny nose, restlessness, stomach cramping, diarrhea, nausea.

G

Claude A. Curran, M.D. 46547  
198 Hanover Street, Fall River, MA 02720  
TEL: 508-672-1444 FAX: 508-672-6544  LAB TESTS  
DEA # BC 5845358, BUPRENORPHINE # XC 5845358

PHARMACY: JUS - 136 WILLOW ST PORTSMOUTH  
NAME: BROOKS, JOSSE DOB: 1/14  
ADDRESS: \_\_\_\_\_ DATE: 1/14/08

RX: TRAXONE 15  
7 PO BID PR  
14 (FOURTEEN)

- SCRIPT NOT TRANSFERRABLE TO OTHER PHARMACY.
- POSITIVE ID REQUIRED FOR PICKUP. Refill 5 times
- DO NOT DISPENSE TO PT REPRESENTATIVE (602)
- DECREASE DOSE AS TOLERATED.
- REFILLS Q 7  15  30 DAYS, NO EARLY REFILLS.

\_\_\_\_\_  
(Signature) (CUR)

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.

CLAUDE A. CURRAN, M.D.  
199 HANOVER STREET  
FALL RIVER, MA 02720

(508) 672-1444 TEL  
(508) 672-6544 FAX

DEA # BC 5845358  
BUPRENORPHINE # XC-5B45358

NAME: B. B. B. B. B. B. AGE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE 1/1/18

Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

**R**

Doxepin 50

1 - 1/11 PM HS

(Two) 60

Fill 2 times

(Signature)

Interchange is mandated unless the practitioner writes the words 'NO  
SUBSTITUTION' in this space.

7HPS0111183

Claude A. Curran, M.D. 46548  
198 Hanover Street, Fall River, MA 02720  
TEL: 508-672-1444 FAX: 508-672-6544  LAB TESTS  
DEA # BC 5845358, BUPRENORPHINE # XC 5845358

PHARMACY: CVS - BUTNUT ST - PORTSMOUTH NH  
NAME: BROUSS, GREG DOB: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ DATE: 1/11/08

RX:

~~X 10~~ Klonopin 1g (ONE)  
PO TID PRN  
21 (Autofill)

- SCRIPT NOT TRANSFERABLE TO OTHER PHARMACY.  
 POSITIVE ID REQUIRED FOR PICKUP. Refill 5 times  
 DO NOT DISPENSE TO PT REPRESENTATIVE. (P.O.)  
 DECREASE DOSE AS TOLERATED.  
 REFILLS  7  15  30 DAYS, NO EARLY REFILLS.

[Signature]  
(Signature)

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.