

EXHIBIT A

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99 PARK AVENUE, PH/26TH FLOOR
NEW YORK, N.Y. 10016

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CYNTHIA ROLLINGS
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PETER S. MATORIN
KAREN L. DIPPOLD
MARJORY D. FIELDS
EMILY JANE GOODMAN
(JUSTICE, NYS SUPREME COURT, RET.)
FRANK HANDELMAN

January 11, 2022

REF:

WRITER'S DIRECT DIAL:
212-277-5825
drankin@blhny.com

VIA EMAIL

FOIA/PA Section
Office of General Counsel, Room 924
Federal Bureau of Prisons
320 First Street, N.W.
Washington, DC 20534
BOP-OGC-EFOIA-S@bop.gov

USP Thomson
U.S. Penitentiary
Federal Bureau of Prisons
1100 One Mile Road
Thomson, IL 61285
TOM-ExecAssistant@bop.gov

**Re: Freedom of Information Act Request for records pertaining to
Decedent Bobby Everson, Reg. No. 14009-052**

Dear FOIA Officer:

My name is David B. Rankin, and I am the attorney for Ms. Sabrina Davis Everson related to the death of her son, Mr. Bobby Everson Register No. 14009-052, DOB [REDACTED]. We request the following:

- All documents concerning Bobby Everson including but not limited to his medical records, mental health records, complete inmate file, records from his entire time in the Federal Bureau of Prison's ("BOP") custody;
- All documents concerning assaults, uses of force, and/or unusual incidents involving Bobby Everson. This request applies equally to assaults and/or batteries by BOP staff or incarcerated individuals; and
- All documents concerning the death of Bobby Everson, and/or any investigation into his death, including medical documents, incident reports, after action reports, documents or communications to external agencies such as the Office of Inspector

BELDOCK LEVINE & HOFFMAN LLP

Everson – FOIA BOP

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General (“OIG”) or the United States Attorney’s Office (“USAO”).

We request these records be produced in electronic format, if they are kept in that form and note that the term “document” applies to records in both hard copy and electronic format.

If this request is denied in whole or part, we ask that you describe the nature of the information withheld and justify all deletions by reference to specific exemptions of the FOIA. We expect you to release all segregable portions of otherwise exempt material. We are open to negotiating a modification to this request where production of all responsive documents would be unreasonably voluminous.

We further ask that all responsive records be produced as they are identified and gathered, rather than delaying production until all responsive records are found. However, we reserve the right to appeal a decision to withhold any information.

If there are any costs incurred with producing copies of the records requested, you have our advance authorization to incur up to \$500, which amount we will promptly reimburse. If the fees exceed \$500, please contact me before incurring the expense.

Enclosed with this letter are an authorization of representation, Form BP - A0301 authorizing the release of confidential information, Form BP-A621 authorizing the release of medical information, and certificates of identity for myself and Ms. Sabrina Everson.

Thank you for your cooperation.

Sincerely,

A handwritten signature in blue ink, appearing to read "David B. Rankin", with a long horizontal flourish extending to the right.

David B. Rankin
Partner

BELDOCK LEVINE & HOFFMAN LLP
99 PARK AVENUE
NEW YORK, N.Y. 10016-1503

To: FOIA/PA Section 1
Office of General Counsel, Room 924
Federal Bureau of Prisons
320 First Street, N.W.
Washington, DC 20534

TEL: (212) 490-0400
FAX: (212) 557-0565
REF: _____

AUTHORIZATION

I MRS. SABRINA D. EVERSON Mother of Decedent Bobby Everson, Reg. No. 14009-052, declare under penalty of perjury that the foregoing is true and correct:

I hereby authorize the below identified attorneys to represent me, for the purposes of obtaining my deceased son's personal records. This includes, but is not limited to: criminal records, medical records, mental health records, records obtained through Freedom of Information Act (FOIA) requests, education records, and employment records.

David B. Rankin, Esq.
Regina Power, Esq.
Beldock Levine & Hoffman LLP
99 Park Avenue, PH/26th Floor
New York, New York 10016
T: 212-277-5825 and 212-277-5892
F: 212-277-5880
drankin@blhny.com
rpowers@blhny.com

I further authorize Mr. Rankin, Ms. Powers, or paralegal Abigail Robinson, working on their behalf, to correspond with any and all relevant records custodians necessary to obtain my deceased son's personal records.

Dated: 1/10/22, New York

Sign Name: Mrs. Sabrina D. Everson

1/10/22, 2022

Print Name: MRS. SABRINA D. EVERSON

BP-A0301

JUN 10

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

TO: David B. Rankin, Esq. and Regina Powers, Esq. of BELDOCK LEVINE & HOFFMAN, LLP
99 Park Avenue, PH/26th Floor, New York, New York 10016

I authorize release to the United States Department of Justice all confidential records and information concerning me.

El abajo firmante autoriza al Funcionario del el Departamento de Justicia de los Estados Unidos a disponer y obtener todos los records e información confidencial referente mi persona.

J'autorise le délégué à U.S. Department of Justice à avoir acces à tous documents et informations de nature confidentielle qui me concernent.

<p>1. Name (Last, First, Middle) NOMBRE (Apellido, Primero & Segundo NOM (de famille, prenom, nom de jeune fille)</p> <p>Everson, Bobby, A.J</p>	<p>2. Date of Birth Fecha de nacimiento DATE DE NAISSANCE</p> <p>[REDACTED]</p>
<p>3. Signature Firma Signature</p> <p>Mrs. Sabrina D. Everson</p>	<p>4. Date signed Fecha de la firma DATE DE SIGNATURE</p> <p>1/10/22</p>

FILE IN SECTION 2 UNLESS APPROPRIATE FOR PRIVACY FOLDER

SECTION 2

BP-A621.060
FEB 05

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Inmate Name <u>Bobby Everson</u>	Register Number 14009-052	Date <u>1/10/22</u>
[REDACTED]		[REDACTED]

I hereby authorize and request the Federal Bureau of Prisons to:

- release information to, or obtain information from

PLEASE CONTACT IF
PAYMENT IS REQUIRED
PRIOR TO FILLING
REQUEST

Name/Facility: David B. Rankin, Esq. of BELDOCK LEVINE & HOFFMAN, LLP

Address: 99 Park Avenue, PH/26th Floor

City, State, Zip: New York, New York 10016

I understand the information is to be used for (specific reason for release of information):

- Continuation of care, or Other: Release to Attorney at Patient's request

Information to be Released/Obtained: Copy of and/or information from my medical file pertaining to my evaluation and treatment received from 01/01/2012 to present

- This is to include:
- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> Complete Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Consultations | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Actual Films** |
| <input checked="" type="checkbox"/> Other: <u>INCLUDING MENTAL HEALTH RECORDS</u> | | <input type="checkbox"/> Actual Slides* |

*will be returned
#duplicates accepted

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that I may revoke this consent at any time by sending a written notice to the Supervisor of Medical Records. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. This authorization will automatically expire three months from the date of the signature.

Signature of Patient	Date (Month, Day, Year)	Staff Witness
<u>FAX SIGNATURE VALID ORIGINAL</u>		

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW.
Must sign below, to Release Protected Information.

I specifically authorize the release of data and information relating to:

1. Substance Abuse 2. Mental Health 3. HIV

x Mrs. Sabrina D. Everson
Signature

x 1/10/22
Date

Deliver Records To: (Institution Address & Fax number)

David B. Rankin, BELDOCK LEVINE & HOFFMAN, 99 Park Avenue PH/26th Floor, New York, NY 10016

Phone: 212-277-5825, Fax: 212-277-5880, Email: drankin@blhny.com

U.S. Department of Justice

Certification of Identity

FORM APPROVED OMB NO. 1103-0016
EXPIRES 05/31/17

Privacy Act Statement. In accordance with 28 CFR Section 16.41(d) personal data sufficient to identify the individuals submitting requests by mail under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. The purpose of this solicitation is to ensure that the records of individuals who are the subject of U.S. Department of Justice systems of records are not wrongfully disclosed by the Department. Requests will not be processed if this information is not furnished. False information on this form may subject the requester to criminal penalties under 18 U.S.C. Section 1001 and/or 5 U.S.C. Section 552a(i)(3).

Public reporting burden for this collection of information is estimated to average 0.50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Suggestions for reducing this burden may be submitted to the Office of Information and Regulatory Affairs, Office of Management and Budget, Public Use Reports Project (1103-0016), Washington, DC 20503.

Full Name of Requester¹ MRS. SABRINA D. EVERSON

Citizenship Status² U.S.A. Citizen Social Security Number³ [REDACTED]

Current Address [REDACTED]

Date of Birth [REDACTED] Place of Birth Portchester Ny

OPTIONAL: Authorization to Release Information to Another Person

This form is also to be completed by a requester who is authorizing information relating to himself or herself to be released to another person.

Further, pursuant to 5 U.S.C. Section 552a(b), I authorize the U.S. Department of Justice to release any and all information relating to me to:
David B. Rankin, BELDOCK LEVINE & HOFFMAN, LLP, 99 Park Avenue, PH/26th Floor, New York, New York 10016

Print or Type Name

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than \$10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than \$5,000.

Signature⁴ Mrs. Sabrina D. Everson Date 1/10/22

¹ Name of individual who is the subject of the record(s) sought.

² Individual submitting a request under the Privacy Act of 1974 must be either "a citizen of the United States or an alien lawfully admitted for permanent residence," pursuant to 5 U.S.C. Section 552a(a)(2). Requests will be processed as Freedom of Information Act requests pursuant to 5 U.S.C. Section 552, rather than Privacy Act requests, for individuals who are not United States citizens or aliens lawfully admitted for permanent residence.

³ Providing your social security number is voluntary. You are asked to provide your social security number only to facilitate the identification of records relating to you. Without your social security number, the Department may be unable to locate any or all records pertaining to you.

⁴ Signature of individual who is the subject of the record sought.

U.S Department of Justice

Certification of Identity

FORM APPROVED OMB NO. 1103-0016
EXPIRES 03/31/17


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Full Name of Requester ¹ David B. Rankin 

Citizenship Status ² Citizen Social Security Number ³ 

Current Address 99 Park Avenue, PH/26th Floor, New York, NY 10016

Date of Birth  Place of Birth Portland, Oregon

OPTIONAL: Authorization to Release Information to Another Person

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David B. Rankin, BELDOCK LEVINE & HOFFMAN, LLP, 99 Park Avenue, PH/26th Floor, New York, New York 10016

Print or Type Name

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than \$10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than \$5,000.

Signature ⁴  Date 1/11/22

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