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IN THE IOWA DISTRICT COURT FOR JONES COUNTY

SARA MONTAGUE, Individually, and as Parent and Next Friend of C.M., a Minor, and as the Duly Authorized Representative of the ESTATE OF ROBERT MCFARLAND, Deceased, Plaintiffs, vs. BETH SKINNER, WILLIAM SPERFSLAGE, SAMANTHA TUCKER-SIEBERG, SARAH HOLDER, DANIEL CLARK, JEREMY LARSON, MICHAEL HEINRICY, CHAD KERKER, SCOTT ESCHEN, BRIAN TRACY, ROBERT HARTIG, JOSH BALL, TRACY DIETSCH, JEREMY BURDS, JON DAY, LUCAS FOWLER, RONNIE BEEMER, LANCE LAKE, ESTATE OF BRIAN AHLRICHS, MICHAEL KRAY, KURT GILLMORE, LAWRENCE MCMAHON, BRIAN SUTHERS, JOHN CLARK, TODD DINGBAUM, and JEROME GREENFIELD, Defendants.	Case No. LACV007621 **PETITION AT LAW AND JURY DEMAND**

COME NOW Plaintiffs, by their attorneys, and for their Petition at Law and Jury Demand, state the following:

PARTIES, JURISDICTION, AND VENUE

1. The instant case arises out of the murder of Iowa Department of Corrections Correctional Officer Robert McFarland ("Officer McFarland") and Nurse Stephanie Shulte ("Nurse Schulte"), on March 23, 2021, by inmates, Michael Dutcher ("Dutcher") and Thomas Woodard ("Woodard"), at the Anamosa State Penitentiary ("Anamosa"), located in Anamosa, Jones County, Iowa.

2. All facts alleged herein existed or occurred at times material and relevant to the instant cause of action, unless otherwise stated specifically herein.

3. When used herein, reference to the "Iowa Department of Corrections" indicates acts or omissions by and through its directors, officers, and employees, including the Named Defendants.

4. When used herein, reference to "Anamosa" indicates acts or omissions by and through its directors, officers, and employees, including the Named Defendants.

5. Plaintiffs, Sara Montague and C.M., a minor, were residents of Ely, Linn County, Iowa and now reside in Cedar Rapids, Linn County, Iowa.

6. Plaintiff, Sara Montague, was the legal spouse of Officer McFarland.

7. Plaintiff, Sara Montague, was and is the Duly Authorized Representative of the Estate of Robert McFarland in Linn County case number ESPR045568.

8. The Decedent, Officer McFarland, was a resident of Ely, Linn County, Iowa.

9. Plaintiffs Sara Montague and Decedent, Officer McFarland, are the biological parents of C.M., a minor.

10. Officer McFarland was employed by the State of Iowa, Iowa Department of Corrections, as a correctional officer.

11. The State of Iowa is a sovereign governmental entity subject to such rights as may at any time exist in the United States in relation to public lands, or any establishment of the national government.

12. The State of Iowa has waived its sovereign immunity and has consented to being sued for the acts and omissions of its employees, acting within the scope of their employment, pursuant to Iowa Code Chapter 669.

13. The Iowa Department of Corrections is a department and/or agency of the State of Iowa, organized under the laws of the State of Iowa with its headquarters and principal place of business in Des Moines, Polk County, Iowa.

14. The Iowa Department of Corrections' legislatively prescribed duties include overseeing and maintaining institutions within the Iowa Department of Corrections' jurisdiction and the Iowa State Prison Industries program pursuant to Chapter 904 of the Iowa Code.

15. The Iowa Department of Corrections is responsible for the control, supervision, treatment, and rehabilitation of offenders within the correctional system, including those incarcerated at Anamosa, pursuant to Iowa Code Chapter 904.

16. Officer McFarland was a correctional officer with the Iowa Department of Corrections, assigned to the Infirmary and Medical Housing Unit ("Infirmary") of Anamosa.

17. Upon information and belief, Defendant Beth Skinner ("Skinner") was a resident of the State of Iowa.

18. Skinner was employed by the State of Iowa, Iowa Department of Corrections, as the Director of the Iowa Department of Corrections.

19. Skinner was acting within the scope of her employment as the Director of the Iowa Department of Corrections.

20. Upon information and belief, Defendant William Sperfslage ("Sperfslage") was a resident of the State of Iowa.

21. Sperfslage was employed by the State of Iowa, Iowa Department of Corrections as the Deputy Director of Institutions.

22. Sperfslage was acting within the scope of his employment as the Deputy Director of Institutions with the State of Iowa, Iowa Department of Corrections.

23. Upon information and belief, Defendant Samantha Tucker-Sieberg ("Tucker-Sieberg") was a resident of the State of Iowa.

24. Tucker-Sieberg was an employee of the State of Iowa, employed by the Iowa Department of Corrections.

25. Tucker-Sieberg was acting within the scope of her employment as the Safety Director for the Iowa Department of Corrections.

26. Upon information and belief, Defendant Sarah Holder ("Holder") was a resident of the State of Iowa.

27. Holder was employed by the State of Iowa, Iowa Department of Corrections as the Training Director for the Iowa Department of Corrections.

28. Holder was acting within the scope of her employment as the Training Director for the Iowa Department of Corrections.

29. Upon information and belief, Defendant Daniel Clark ("Clark") was a resident of the State of Iowa.

30. Clark was employed by the State of Iowa, Iowa Department of Corrections as a Deputy Director of Iowa Prison Industries.

31. Clark was acting within the scope of his employment as a Deputy Director of the Iowa Prison Industries.

32. Upon information and belief, Defendant Jeremy Larson ("Larson") was a resident of the State of Iowa.

33. Larson was employed by the State of Iowa, Iowa Department of Corrections as the Warden of Anamosa.

34. Larson was acting within the scope of his employment as the Warden of Anamosa.

35. Upon information and belief, Defendant Michael Heinricy ("Heinricy") was a resident of the State of Iowa.

36. Heinricy was employed by the State of Iowa, Iowa Department of Corrections as a Deputy Warden for Anamosa.

37. Heinricy was acting within the scope of his employment as a Deputy Warden at Anamosa.

38. Upon information and belief, Defendant Chad Kerker ("Kerker") was a resident of the State of Iowa.

39. Kerker was employed by the State of Iowa, Iowa Department of Corrections as the Security Director for Anamosa.

40. Kerker was acting within the scope of his employment as the Security Director at Anamosa.

41. Upon information and belief, Defendant Scott Eschen ("Eschen") was a resident of the State of Iowa.

42. Eschen was employed by the State of Iowa, Iowa Department of Corrections as Deputy Warden of Anamosa.

43. Eschen was acting within the scope of his employment as a Deputy Warden at Anamosa.

44. Upon information and belief, Defendant Brian Tracy ("Tracy") was a resident of the State of Iowa.

45. Tracy was employed by the State of Iowa, Iowa Department of Corrections as a Security Officer at Anamosa.

46. Tracy was acting within the scope of his employment as a Security Officer at Anamosa.

47. Upon information and belief, Defendant Robert Hartig ("Hartig") was a resident of the State of Iowa.

48. Hartig was employed by the State of Iowa, Iowa Department of Corrections as the Administration Captain for Anamosa.

49. Hartig was acting within the scope of his employment as the Administration Captain at Anamosa.

50. Upon information and belief, Defendant Josh Ball ("Ball") was a resident of the State of Iowa.

51. Ball was employed by the State of Iowa, Iowa Department of Corrections as a Captain at Anamosa.

52. Ball was acting within the scope of his employment as a Captain at Anamosa.

53. Upon information and belief, Defendant Tracy Dietsch ("Dietsch") was a resident of the State of Iowa.

54. Dietsch was employed by the State of Iowa, Iowa Department of Corrections as a Treatment Director at Anamosa.

55. Dietsch was acting within the scope of her employment as a Treatment Director at Anamosa.

56. Upon information and belief, Defendant Jeremy Burds ("Burds") was a resident of the State of Iowa.

57. Burds was employed by the State of Iowa, Iowa Department of Corrections as a Senior Correctional Officer assigned as the Tool Control Sergeant at Anamosa.

58. Burds was acting within the scope of his employment as a Senior Correctional Officer assigned as Tool Control Sergeant at Anamosa.

59. Upon information and belief, Defendant Jon Day ("Day") was a resident of the State of Iowa.

60. Day was employed by the State of Iowa, Iowa Department of Corrections, as Prison Operations Manager at Anamosa.

61. Day was acting within the scope of his employment as a Prison Operations Manager at Anamosa.

62. Upon information and belief, Defendant Lucas Fowler ("Fowler") was a resident of the State of Iowa.

63. Fowler was employed by the State of Iowa, Iowa Department of Corrections, as Deputy Warden of Iowa Prison Industries at Anamosa.

64. Fowler was acting within the scope of his employment as a Deputy Warden of Iowa Prison Industries at Anamosa.

65. Upon information and belief, Defendant Ronnie Beemer ("Beemer") was a resident of the State of Iowa.

66. Beemer was employed by the State of Iowa, Iowa Department of Corrections, as a Supervisor of Iowa Prison Industries programming at Anamosa.

67. Beemer was acting within the scope of his employment as a Supervisor of Iowa Prison Industries programming at Anamosa.

68. Upon information and belief, Defendant Lance Lake ("Lake") was a resident of the State of Iowa.

69. Lake was employed by the State of Iowa, Iowa Department of Corrections, as Iowa Prison Industries Technician at Anamosa.

70. Lake was acting within the scope of his employment as a Supervisor of Iowa Prison Industries programming at Anamosa.

71. Upon information and belief, Defendant Brian Ahlrichs ("Ahlrichs") was a resident of the State of Iowa and is now deceased as of December 23, 2023.

72. An Estate has been opened for Brian Ahlrichs in Jones County case number ESPR004239 with Roberta Ahlrichs being appointed as Administrator of the Estate on February 13, 2024.

73. Ahlrichs was employed by the State of Iowa, Iowa Department of Corrections as a Correctional Trades Leader at Anamosa.

74. Ahlrichs was acting within the scope of his employment as a Correctional Trades Leader at Anamosa.

75. Upon information and belief, Defendant Michael Kray ("Kray") was a resident of the State of Iowa.

76. Kray was employed by the State of Iowa, Iowa Department of Corrections as a Correctional Trades Leader at Anamosa.

77. Kray was acting within the scope of his employment as a Correctional Trades Leader at Anamosa.

78. Upon information and belief, Defendant Kurt Gillmore ("Gillmore") was a resident of the State of Iowa.

79. Gillmore was employed by the State of Iowa, Iowa Department of Corrections as a Correctional Trades Leader at Anamosa.

80. Gillmore was acting within the scope of his employment as a Correctional Trades Leader at Anamosa.

81. Upon information and belief, Defendant Lawrence McMahon ("McMahon") was a resident of the State of Iowa.

82. McMahon was employed by the State of Iowa, Iowa Department of Corrections as a Correctional Trades Leader at Anamosa.

83. McMahon was acting within the scope of his employment as a Correctional Trades Leader at Anamosa.

84. Upon information and belief, Defendant Brian Suthers ("Suthers") was a resident of the State of Iowa.

85. Suthers was employed by the State of Iowa, Iowa Department of Corrections as Correctional Officer assigned to RE-14 Checkpoint at Anamosa.

86. Suthers was acting within the scope of his employment as a Correctional Officer at RE-14 Checkpoint at Anamosa.

87. Upon information and belief, Defendant John Clark ("J. Clark") was a resident of the State of Iowa.

88. J. Clark was employed by the State of Iowa, Iowa Department of Corrections as Correctional Officer in the Control Center at Anamosa.

89. J. Clark was acting within the scope of his employment as a Correctional Officer at Anamosa.

90. Upon information and belief, Defendant Todd Dingbaum ("Dingbaum") was a resident of the State of Iowa.

91. Dingbaum was employed by the State of Iowa, Iowa Department of Corrections as Correctional Officer in the Control Center at Anamosa.

92. Dingbaum, was acting within the scope of his employment as a Correctional Officer in the Control Center at Anamosa.

93. Upon information and belief, Defendant Jerome Greenfield ("Greenfield") was a resident of the State of Iowa.

94. Greenfield was employed by the State of Iowa, Iowa Department of Corrections as Health Services Administrator in the Control Center at Anamosa.

95. Greenfield was acting within the scope of his employment as a Health Services Administrator at Anamosa.

96. On or about March 14, 2023, each Plaintiff filed State Appeal Board Claim Forms and Affidavits, one on behalf of Sara Montague as Parent and Next Friend of C.M, (Claim # T230468), one on behalf of Sara Montague, individually (Claim # T230469), and one by Sara Montague as Administrator of the Estate of Robert McFarland (Claim # T230470).

97. The State Appeal Board confirmed receipt of all Plaintiffs' claims on March 22, 2023.

98. While the Appeals Board stated that the Attorney General's Office will investigate Plaintiffs' claims and report back to the State Appeal Board who in turn would notify Plaintiffs of a final disposition of the claims, no further correspondence has been received by Plaintiffs' counsel regarding any such investigation as of the time of filing this Petition.

99. The Iowa Attorney General did not make a final disposition of the claims within six months of Plaintiffs' claims being filed and consequently, Plaintiffs, by notice in writing, withdrew their claims from consideration on February 19, 2024.

100. The State Appeals Board has confirmed receipt of all Plaintiffs' withdrawals.

101. Plaintiffs have exhausted all administrative remedies under the Iowa Tort Claims Act as required by Iowa Code Section 669.5.

102. The events giving rise to this cause of action occurred at the Anamosa State Penitentiary, which is a medium/maximum security prison run by the Iowa Department of Corrections, located in Anamosa, Jones County, Iowa.

103. Jurisdiction and Venue are properly laid in Jones County, Iowa pursuant to Iowa Code Section 669.4.

104. The undersigned hereby certifies that this action meets the applicable jurisdictional requirements for the amount in controversy.

FACTS COMMON TO ALL COUNTS

105. Plaintiffs hereby replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

106. The Iowa Department of Corrections is legislatively established pursuant to Iowa Code Chapter 904.

107. The Iowa Department of Corrections is responsible for the control, security, treatment, and rehabilitation of all offenders and inmates committed to the prisons in Iowa, including those incarcerated at Anamosa. *See* Iowa Code Section 904.102.

108. The Iowa Department of Corrections is responsible for the training, supervision, security, and safety of its employees.

109. Anamosa is a State Correctional Facility under the direction and control of the Iowa Department of Corrections.

110. Iowa Prison Industries is a statutorily created division of the Iowa Department of Corrections under Iowa Code Chapter 904.

111. The Iowa Department of Corrections has created certain policies and procedures for facilitating duties and responsibilities to inmates and employees.

112. These policies and procedures are required to be followed by all Iowa Department of Corrections employees.

OVERARCHING FAILURES LEADING UP TO THE ATTACKS

Iowa Department of Corrections and Anamosa Over-Capacity and Understaffing

113. Pursuant to the policies of the Iowa Department of Corrections, Anamosa was designated as a Security Designation 5 (medium/maximum security) institution for adult males.

114. Anamosa had a designated maximum capacity of 911 inmates on March 23, 2021.

115. Anamosa operated overcapacity and housed over 950 offenders on March 23, 2021.

116. Anamosa possessed a funded budget for 201 custody staff positions in 2021.

117. Anamosa only staffed 172 of the available custody staff positions on March 23, 2021.

118. Anamosa operated on a functional staff vacancy rate for correctional officers of over 37% on March 23, 2021.

119. Anamosa was operated over-capacity and under-staffed for at least five months prior to the attack giving rise to this Petition.

120. Prior to the attack giving rise to this Petition, Anamosa was so understaffed that nurses were required to walk through the "Yard" of Anamosa carrying "sharps and totes" without any escort or correctional officer supervision or protection.

121. The over-capacity and under-staffing were not an issue unique to Anamosa.

122. It was a pattern and practice of the entire Iowa Department of Corrections to far exceed institutional capacity limitations without sufficient staff.

123. The Iowa Department of Corrections custodial facilities had a state-wide, cumulative inmate capacity of 6,990 but retained custody of 8,106 inmates in 2021.

124. The Iowa Department of Corrections custodial facilities were understaffed, state-wide, by a total of 366 custodial corrections officers in 2021.

125. As of the filing of this lawsuit, the Iowa Department of Corrections has allowed its over-capacity prison population to increase to 8,175 inmates.

126. All Named Defendants knew that overcrowding and/or understaffing created a serious security risk to both inmates and employees of the Iowa Department of Corrections and Anamosa.

127. All Named Defendants in this action had actual knowledge of the over-capacity and under-staffing deficiencies at the Iowa Department of Corrections and Anamosa.

128. All Named Defendants created and/or failed to remedy the over-capacity and under-staffing deficiencies at the Iowa Department of Corrections and Anamosa, knowing that serious injury and/or death of employees were probable results.

129. All Named Defendants knew the inmates were aware of the aforementioned overcrowding and under-staffing deficiencies and resulting compromised security.

Inadequate Training, Policies, and Compliance Systems

130. The custodial correctional staff with the Iowa Department of Corrections, and specifically, Anamosa, were undertrained.

131. The Iowa Department of Corrections, including Anamosa, failed to hold critical incident drills to train or test the preparedness of staff.

132. The Iowa Department of Corrections, including Anamosa, failed to create, implement, and/or enforce an appropriate Emergency Response Plan.

133. The Iowa Department of Corrections, including Anamosa, did not adequately train employees, including correctional officers, regarding the creation, implementation, and/or enforcement of an appropriate Emergency Response Plan.

134. The Iowa Department of Corrections, including Anamosa, failed to create, implement, and/or enforce an appropriate Workplace Violence Prevention and Response Program.

135. The Iowa Department of Corrections, including Anamosa, did not adequately train employees, including correctional officers, regarding the creation, implementation, and/or enforcement of an appropriate Workplace Violence Prevention Program.

136. The Iowa Department of Corrections, including Anamosa, failed to create, implement, and/or enforce appropriate Tool Control Policies.

137. The Iowa Department of Corrections, including Anamosa, did not adequately train employees, including correctional officers, regarding the creation, implementation, and/or enforcement of appropriate Tool Control Policies.

138. The Iowa Department of Corrections, including Anamosa, did not adequately train employees, including correctional officers, regarding the creation, implementation, and/or enforcement of an appropriate staff response to emergency situations inside the facility.

139. The only "training" received by correctional officers employed by the Iowa Department of Corrections, including Anamosa employees, was by way of E-Learning.

140. The Iowa Department of Corrections online training modules failed to provide employees with the opportunity to ask questions of their trainers and/or supervisors.

141. Pursuant to policies and procedures of the Iowa Department of Corrections, corrections officers, including all officers at Anamosa, were required to participate in E-Learning

training at their actual duty post, while they were on active duty, within Anamosa, thereby preventing officers from adequately supervising inmates.

142. All Named Defendants in this action had actual knowledge of the inadequate training, policies, and compliance systems at the Iowa Department of Corrections and Anamosa.

143. All Named Defendants at the Iowa Department of Corrections and/or Anamosa created and/or failed to remedy the inadequate training, policies, and compliance systems at the Iowa Department of Corrections and Anamosa knowing that serious injury and/or death of employees were probable results.

144. All Named Defendants knew the inmates were aware of the aforementioned training deficiencies and the resulting compromised security.

Inadequate Radio, Engineering Controls, and Emergency Response Systems

145. The Iowa Department of Corrections and/or Anamosa, failed to provide adequate radio, engineering controls, and/or emergency response systems to their employees.

146. The ability of Anamosa staff to communicate via radio was inadequate.

147. The emergency notification buttons on radios that were assigned to Anamosa staff were known to only be intermittently functional.

148. Faulty radio reception and function prevented adequate communication with corrections staff in the Infirmary.

149. There were multiple reported incidents prior to March 23, 2021, where Anamosa staff and correction officer radios were not operational and did not transmit broadcasts at all.

150. The Iowa Department of Corrections, and all Named Defendants, had knowledge of correctional staffs' inability to effectively communicate via radio within Anamosa.

151. The Iowa Department of Corrections and all Named Defendants had knowledge of the inadequate radio reception throughout Anamosa, including but not limited to the lack of radio reception in the Infirmary.

152. Anamosa staff were not provided individual, working radios to ensure adequate communication in Anamosa, including but not limited to the Infirmary.

153. For example, the dental personnel in the Infirmary were required to share one radio between three separate staff members.

154. The Iowa Department of Corrections and Anamosa failed to appropriately utilize the Control Center and Engineering Controls at Anamosa pursuant to their own policies and procedures.

155. Despite surveillance cameras placed throughout Anamosa, the Iowa Department of Corrections and Anamosa, failed to ensure that correctional officers appropriately monitored inmate activity and movement on the cameras.

156. Iowa Department of Corrections would assign Anamosa Correctional Officers to emergency response teams sometimes referred to as "A-Responders" or "CERT teams."

157. Anamosa Correctional Officers on these emergency response teams were assigned to Anamosa control posts which severely limited and/or prevented the assigned officer's effective responses to emergency situations within Anamosa.

158. All Named Defendants in this action had actual knowledge of the inadequate radio, control center, engineering controls, and emergency response systems at the Iowa Department of Corrections and Anamosa.

159. All Named Defendants at the Iowa Department of Corrections and/or Anamosa created and/or intentionally failed to remedy the inadequate radio, engineering controls, and

emergency response systems at the Iowa Department of Corrections and Anamosa knowing that serious injury and/or death of employees were probable results.

160. All Named Defendants knew that the inmates were aware of the aforementioned radio, control center, engineering, control center, and emergency response deficiencies and the resulting compromised security.

Anamosa Inmate Work Program

161. All inmates within the custody of the Iowa Department of Corrections were required to perform hard labor during their term of incarceration per Iowa Department of Corrections and Anamosa policies and procedures. *See* Iowa Code § 904.701(1); *See also* Iowa Code § 904.701(3) (unless the director of the Iowa Department of Corrections finds that an inmate is unsuitable for hard labor).

162. The Iowa Department of Corrections selected Inmate Maintenance Workers at Anamosa to perform maintenance tasks around the correctional penitentiary.

163. Inmates at Anamosa were also selected to participate in programs led by the Iowa Prison Industries.

164. Dutcher and Woodard were both utilized by the Iowa Department of Corrections as workers in Anamosa.

165. Dutcher was utilized through the Iowa Department of Corrections as an Iowa Prison Industries ("IPI") Worker.

166. Woodard was utilized by the Iowa Department of Corrections as an Inmate Maintenance Worker at Anamosa, on the electrical crew.

167. IPI Workers at Anamosa, such as Dutcher, manufactured products that are sold for profit, the proceeds of which are returned to the Iowa Department of Corrections budget.

168. Inmate Maintenance Workers were tasked with assisting Corrections Trade Leaders in the completion of routine maintenance at the Iowa Department of Corrections facilities and IPI facilities.

169. Correctional Trade Leaders and Inmate Maintenance Workers used the Maintenance Shop inside the Maintenance Building to carry out everyday maintenance tasks around the Anamosa facility.

170. Correctional Trade Leaders and Inmate Maintenance Workers were also tasked with completing miscellaneous maintenance tasks in other areas of Anamosa.

171. The Iowa Department of Corrections failed to create, implement, and/or enforce appropriate policies and/or procedures regarding institutional work orders or any other form of communication processes by which staff could schedule, notify, or confirm legitimate maintenance projects undertaken by Inmate Maintenance Workers.

172. Anamosa specifically, did not adequately utilize a work-order procedure, or any other form of communication process by which staff could schedule, notify, or confirm legitimate maintenance projects undertaken by Inmate Maintenance Workers.

173. Inmate Maintenance Workers were permitted to show up at locations within Anamosa and verbally advise correctional staff of their maintenance projects at that time.

174. Neither the Iowa Department of Corrections nor Anamosa had a specific written policy or procedure setting out qualification standards for Inmate Workers to participate in the Inmate Maintenance Worker Programs or IPI.

175. The Iowa Department of Corrections and Anamosa failed to adequately screen inmates for pre-determined qualification standards to participate in the Inmate Maintenance Worker Programs or IPI.

176. All Named Defendants in this action had actual knowledge of the deficiencies and inadequacies of the Inmate Work and IPI Programs at the Iowa Department of Corrections and Anamosa.

177. All Named Defendants at the Iowa Department of Corrections and/or Anamosa created and/or intentionally failed to remedy the deficiencies and inadequacies of the Inmate Work and IPI Programs at the Iowa Department of Corrections and Anamosa knowing that serious injury and/or death of employees were probable results.

178. All Named Defendant knew that inmates were aware of the aforementioned deficiencies in the Inmate Work and IPI Programs and their resulting compromised security.

Absence of Tool Control

179. The Iowa Department of Corrections provided Inmate Maintenance Workers at Anamosa with a variety of tools to facilitate performance of their work-related duties.

180. The Iowa Department of Corrections did not have a Department-wide Tool Control Policy that established classifications of tools. Instead, the Iowa Department of Corrections left the tool classification to the discretion of the individual Institutions, including Anamosa.

181. Similarly, the Iowa Department of Corrections through IPI, provided IPI Workers with a variety of tools to facilitate performance of their work-related duties.

182. Class-A Tools are restricted tools that are specifically categorized as tools that could be used as weapons or for purposes of an escape attempt.

183. Class-A Tools are required by Correctional Standards to be secured behind three locking devices.

184. The Class-A Tools at Anamosa were stored within the perimeter of the institution without the minimum, adequate security restraints and/or devices.

185. Class-A Tools were also stored in the IPI designated areas of Anamosa without the minimum adequate security restraints and/or devices.

186. Under the minimum correctional standards, no inmate is permitted to possess or utilize Class-A Tools unless they are under direct supervision of correctional staff.

187. All hammers used at Anamosa should have been classified as Class-A tools.

188. All grinders used at Anamosa were classified as Class-A tools.

189. Anamosa issued Inmate Workers tool bags to transport tools throughout Anamosa.

190. The tool bags issued by Anamosa were black in color, preventing the viewing of the contents of the bags.

191. In contrast, Anamosa required Correctional Officers and Staff to utilize clear, see-through, lunch bags.

192. Under no circumstances should inmates be permitted to possess or utilize any tools outside of the designated working shop perimeters without direct and constant supervision of a correctional officer.

193. The Iowa Department of Corrections did not have a Department-wide Tool Control Policy that mandated direct supervision of inmates possessing or using Class-A tools.

194. It was the common practice of the Iowa Department of Corrections and Anamosa to permit inmates to possess, use, and transport tools that could inflict serious injury and death upon another person, outside of the designated working shop perimeter, without direct and constant supervision by a correctional officer.

195. Neither the Iowa Department of Corrections nor Anamosa created, implemented, or enforced adequate, specific written policies or procedures mandating appropriate storage and security of tools utilized by Inmate Maintenance Workers and/or IPI Workers.

196. Neither the Iowa Department of Corrections nor Anamosa created, implemented, or enforced adequate, specific written policies or procedures mandating direct supervision of Inmate Maintenance Workers or IPI Workers while possessing or utilizing tools.

197. Neither the Iowa Department of Corrections nor Anamosa created, implemented, or enforced adequate, specific written policies or procedures articulating or limiting under what conditions Inmate Maintenance Workers or IPI Workers were permitted to access, possess, utilize, or transport tools within an Iowa Department of Corrections facility.

198. Insufficient tool control at Anamosa was identified annually as a continued security risk, in Security Audits conducted by the Iowa Department of Corrections and yet the tool control at Anamosa remained deficient on March 23, 2021.

199. Tool control remains an ongoing security issue at Anamosa to this very day as evidenced by Anamosa losing a hammer in 2024, which as of filing this Petition, has yet to be recovered.

200. Corrections Trade Leaders were correctional officers responsible for the control, safety, and supervision of the Inmate Maintenance Workers, and those inmates' use of tools.

201. Iowa Prison Industries Supervisors and Technicians were responsible for the control, safety, and supervision of the IPI Workers, and those inmates' use of tools.

202. Anamosa had ten Correctional Trades Leader positions.

203. One Anamosa Correctional Trades Leader worked outside the institution at a powerplant location.

204. On March 23, 2021, one Anamosa Correctional Trades Leader position was vacant.

205. On March 23, 2021, eight Anamosa Correctional Trades Leaders worked inside Anamosa.

206. Two Anamosa Correctional Trades Leaders that worked inside the institution's Maintenance Shop had the day off on March 23, 2021.

207. On March 23, 2021, only six out of the ten Anamosa Correctional Trades Leaders were working inside Anamosa.

208. On March 23, 2021, there was not a correctional officer or Correctional Trades Leader assigned to the electrical crew at Anamosa leaving those crew members, including Woodard, unsupervised.

209. Upon information and belief, on March 23, 2021, an Iowa Department of Corrections newly hired Maintenance Electrician was working his first shift at Anamosa inside the Iowa Department of Corrections controlled area.

210. Corrections Trade Leaders at Anamosa permitted inmates to utilize tools, including Class-A Tools without adequate supervision by correctional officers.

211. Corrections Trade Leaders at Anamosa permitted inmates to access, possess, use, and transport tools, including Class-A and Class-B Tools, without adequate supervision by correctional officers.

212. Inmate Maintenance Workers were assigned a designated tool kit that they were required to check out every day.

213. The tool kits corresponded with the Inmate Maintenance Workers assigned crew and responsibilities on the assigned crew.

214. Inmate Maintenance Workers checked out their designated tool kits from the Maintenance Tool Crib located inside the Maintenance Machine Shop.

215. Burds was the senior correctional officer assigned to the Maintenance Tool Crib as the Tool Control Sergeant.

216. As the Tool Control Sergeant, Burds was responsible for Tool Control at Anamosa.

217. Burds supervised and operated the Maintenance Tool Crib inside the Maintenance Machine Shop which housed tools classified as "Class-A and Class-B Tools."

218. Burds responsibilities included checking tools in and out of the Maintenance Tool Crib to inmates in the Maintenance Shop.

219. Burds, the assigned Tool Control Sergeant, also held an office in the Maintenance Machine Shop, which contained tool cribs and shadow boards of hammers and other hand tools.

220. Burds was responsible for the appropriate storage and security of all tools contained within the Maintenance Tool Crib

221. Burds inappropriately delegated his duties as Tool Control Sergeant to an Inmate.

222. Specifically, Burds allowed an Inmate to check tools in and out of his assigned Tool Crib in the Maintenance Machine Shop.

223. Burds allowed Inmate Maintenance Workers and Corrections Trade Leaders to routinely remove tools from the tool cribs and shadow boards for use inside and outside of the designated Maintenance Areas without following a check-out, check-in procedure.

224. Burds permitted inmates to access and possess hammers and other hand tools from the tool cribs and shadow boards, independent of their assigned tool kits.

225. Burds did not require inmates to provide any documentation or explanation for the inmate's purported need to access and possess specific tools.

226. All Named Defendants in this action had actual knowledge of the deficiencies and inadequacies of Tool Control at the Iowa Department of Corrections and Anamosa.

227. All Named Defendants at the Iowa Department of Corrections and/or Anamosa created and/or failed to remedy the deficiencies and inadequacies of Tool Control at the Iowa Department of Corrections and Anamosa knowing that serious injury and/or death of employees were probable results.

228. All Named Defendants knew that inmates were aware of the aforementioned deficiencies in Tool Control policies and procedures and their resulting compromised security.

Lack of Inmate Supervision and Restrictions on Movement

229. Inmate access to the Maintenance Shop area of Anamosa was not controlled by a checkpoint staffed by a correctional officer.

230. Inmate access to the IPI areas of Anamosa were not controlled by a checkpoint staffed by a correctional officer.

231. Inmate access to the Maintenance Shop area of Anamosa was not otherwise controlled by correctional officers nor was there any system in place to monitor, regulate, or restrict inmate access to the Maintenance Shop area.

232. Inmate access to the IPI areas of Anamosa were not otherwise controlled by correctional officers nor was there any system in place to monitor, regulate, or restrict inmate access to the IPI areas.

233. Inmate movement during daytime hours, between the Anamosa "Yard," Maintenance Shop, IPI areas, Housing Units, and the Infirmary were not controlled nor restricted.

234. On March 21, 2021, two-days prior to Officer McFarland being murdered, staffing levels were so low at Anamosa that no correctional officers were available to personally supervise the "Yard."

235. The Iowa Department of Corrections and/or Anamosa did not create, implement, or enforce adequate policies or procedures limiting inmate movement and access of services within Iowa Department of Corrections facilities, including Anamosa.

236. The Iowa Department of Corrections and/or Anamosa did not create, implement, or enforce adequate policies or procedures limiting inmate access to Infirmaries within Iowa Department of Corrections facilities, including Anamosa.

237. Anamosa permitted inmates to visit the Infirmary without an appointment.

238. The Infirmary at Anamosa was located on the ground level and contained windows and walls that lead to the exterior parking lot.

239. The Infirmary's location made it an elevated security risk as it was the location that provided inmates with the most direct route of access to the exterior of the facility.

240. Anamosa allowed inmates to self-report to the Infirmary without prior approval from staff or notification to correctional officers or staff providing services at the Infirmary.

241. Anamosa allowed inmates to visit the Infirmary without passing through a staffed security checkpoint.

242. Anamosa did not monitor nor restrict inmate possession or transportation of items to the Infirmary.

243. Inmates at Anamosa were not searched before entering the Infirmary.

244. The correctional officers assigned to the Infirmary were required to supervise all inmates who arrived at the Infirmary seeking evaluation and treatment, while simultaneously supervising the inmates being actively treated, full-time admitted patients, and the mental health inmate patients as well.

245. Correctional officers assigned to the Infirmary were over supervision capacity.

246. Correctional officers assigned to the Infirmary were not responsible for the supervision of Inmate Maintenance Workers or IPI Workers who arrived at the Infirmary for maintenance projects.

247. The correctional officers assigned to the Infirmary were also required to dispense medication to inmate patients.

248. The Infirmary's schedule required three correctional officers to staff it during daytime hours.

249. On March 23, 2021, only two officers staffed the Infirmary during the daytime hours.

250. The two officers staffed at the Infirmary on March 23, 2021, were Officer McFarland and Officer Conden.

251. All Named Defendants in this action had actual knowledge of the inadequate supervision and restrictions on movement of inmates in the custody of the Iowa Department of Corrections and Anamosa.

252. All Named Defendants at the Iowa Department of Corrections and/or Anamosa created and/or intentionally failed to remedy the deficiencies and inadequacies of inadequate supervision and restrictions on movement of inmates in the custody of the Iowa Department of Corrections and Anamosa knowing that serious injury and/or death of employees were probable results.

253. All Named Defendants knew that inmates were aware of the aforementioned deficiencies in the supervision, restriction, control, and movements of inmates throughout Anamosa and their resulting compromised security.

Knowledge of Safety Risk to Corrections Officers

254. The aforementioned deficiencies at the Iowa Department of Corrections and Anamosa, lead to Inmates repeatedly perpetrating physical attacks on staff members of Anamosa in the years leading up to the murder of Officer McFarland.

255. All Named Defendants herein had actual knowledge of the physical attacks on correctional officers at Anamosa set forth below.

256. On October 19, 2016, an escape was attempted from the Infirmary that resulted in a correctional officer being beaten with a metal pipe, suffering serious injuries.

257. Iowa Department of Corrections and Anamosa records document that on January 27, 2019, a dietary worker was assaulted in the kitchen by an inmate of Anamosa.

258. Iowa Department of Corrections and Anamosa records document that on September 20, 2019, a correctional officer was assaulted by an inmate of Anamosa.

259. On December 26, 2019, a female employee of Anamosa was assaulted by an inmate.

260. Iowa Department of Corrections and Anamosa records document that on February 14, 2020, a correctional officer was assaulted by an inmate of Anamosa.

261. On August 18, 2020, the Iowa Department of Corrections was cited and penalized by the Iowa Division of Labor for insufficient radio and “man down” alarms at Anamosa.

262. On August 18, 2020, the Iowa Department of Corrections was cited and penalized by the Iowa Division of Labor for insufficient emergency response plans at Anamosa.

263. On January 1, 2021, a nurse at the Infirmary was attacked by an inmate, locking herself in the Pill Room to avoid the physical attack.

264. Iowa Department of Corrections and Anamosa records document that on March 4, 2021, a correctional officer was injured responding to a staff assault incident by an inmate of Anamosa.

265. Prior to March 23, 2021, employees of Anamosa had made written complaints regarding concerns for employee safety due to Anamosa's insufficient supervision of inmates and specifically, Inmate Maintenance and IPI Workers supervision.

266. All Named Defendants in this action had actual knowledge of their actions and inactions placing correctional officers at risk for their personal safety at the Iowa Department of Corrections and Anamosa.

267. All Named Defendants at the Iowa Department of Corrections and/or Anamosa created and/or intentionally failed to remedy the deficiencies and inadequacies which placed correctional officers at risk for their personal safety at the Iowa Department of Corrections and Anamosa, knowing that serious injury and/or death of employees were probable results.

268. All Named Defendants knew that inmates were aware that the above-mentioned incidents had occurred and were attempted or completed as a result of all or some of the previously identified deficiencies of the Iowa Department of Corrections and/or Anamosa.

Known Dangerous Propensities of Dutcher and Woodard

269. Dutcher and Woodard were inmates incarcerated in Anamosa.

270. Both Dutcher and Woodard had extensive criminal and institutional disciplinary records, demonstrating propensities for violence against staff and others that was known by the Iowa Department of Corrections and administration of Anamosa, including all Named Defendants, prior to their murder of Officer McFarland.

Dutcher Criminal History and History of Known Violence

271. Dutcher's criminal history began when he was twelve-years old in 2004 when he was charged with two counts of Harassment in the First Degree for calling two separate individuals and threatening to kill their family members.

272. On February 11, 2005, Dutcher was adjudicated as a delinquent pursuant to a plea to one count of Harassment in the First Degree, an aggravated misdemeanor. *See* Case No. JVJV000742, Ida County.

273. As a juvenile offender, Dutcher was sent to several facilities within the Iowa Department of Corrections system to control his delinquency.

274. However, Dutcher's criminal tendencies did not subside while he was housed in State facilities, rather his violent and disobedient behavior continued to escalate.

275. In 2009, while Dutcher was housed at the Youth Emergency Services in Cherokee County, Iowa, Dutcher was arrested and eventually convicted of Criminal Mischief in the Third Degree for breaking down a window to a door. *See* Case No. FECR023825, Cherokee County.

276. In 2010, Dutcher was charged and convicted of Burglary in the Third Degree for breaking into a car. *See* Case No. AGCR023874, Cherokee County.

277. On August 26, 2010, Dutcher was imprisoned at the Iowa Department of Corrections facility, Oakdale Correctional Facility, for a period of six years.

278. Dutcher was not granted parole and instead discharged the entirety of his prison sentence.

279. While incarcerated at Oakdale, Dutcher was formally disciplined on fifteen separate occasions that are fully documented in his offender file maintained by the Iowa Department of Corrections.

280. On July 26, 2011, Dutcher was disciplined for: (1) disobeying a lawful order/direction, (2) out of place of assignment; (3) obstructive/disruptive conduct, (4) false statements.

281. On August 31, 2011, Dutcher was disciplined for: (1) disobeying lawful order/direction, (2) false statements, (3) misuse of mail, telephone, or other communications.

282. On May 24, 2012, Dutcher was disciplined for: (1) obstructive/disruptive behavior, and (2) false statements.

283. On July 17, 2012, Dutcher was disciplined for: (1) out of place of assignment.

284. On July 17, 2012, Dutcher was disciplined again for: (1) out of place of assignment.

285. On October 26, 2012, Dutcher was disciplined for: (1) disobeying lawful order/direction, and (2) obstructive/disruptive conduct.

286. On November 26, 2012, Dutcher was disciplined for: (1) obstructive/disruptive conduct.

287. On January 15, 2013, Dutcher was disciplined for: (1) threats/intimidation for threatening to kill a correctional officer, (2) disobeying lawful order/direction, (3) verbal abuse, (4) obstructive/disruptive conduct.

288. On January 15, 2013, Dutcher was also disciplined for: (1) unauthorized possession /exchange.

289. On July 24, 2013, Dutcher was disciplined for: (1) obstructive/disruptive conduct.

290. On August 1, 2013, Dutcher was disciplined for: (1) fighting, (2) damage to property, (3) out of place of assignment.

291. On August 1, 2013, Dutcher was again disciplined for: (1) disobeying lawful order/ direction, (2) constructive/disruptive conduct.

292. On August 1, 2013, Dutcher was also disciplined for: (1) threats/intimidation, (2) disobeying lawful order/direction, (3) verbal abuse, (4) obstructive/disruptive conduct.

293. On August 6, 2013, Dutcher was disciplined for: (1) threats/intimidation, (2) disobeying lawful order/direction, (3) obstructive/disruptive conduct.

294. Dutcher was discharged from Oakdale Correctional Facility on January 2, 2014, at the expiration of the entirety of his sentence.

295. In April of 2014, Dutcher was investigated for Possession with Intent to Deliver Marijuana, Tax Stamp Violation, and Theft in the Second Degree for stealing a safe from a Woodbury County citizen's residence. *See* Case No. FECR088733, Woodbury County.

296. On April 30, 2014, Dutcher was convicted of Disorderly Conduct – Fighting or Violent Behavior. *See* Case No. SMSM489188, Woodbury County.

297. In May of 2014, Dutcher entered a Super 8 Motel and brandished a handgun while threatening the clerk's life if the clerk did not comply with his orders to hand him all the money. *See* Case No. FECR007055, Ida County.

298. On June 1, 2014, Dutcher was charged and eventually convicted of Operating While Intoxicated, First Offense. *See* Case No. OWCR088984, Woodbury County.

299. On June 13, 2014, Dutcher stole and concealed a hunting mask from Scheels for which he was later convicted of Theft in the Fifth Degree. *See* Case No. SMSM489787, Woodbury County.

300. On June 14, 2014, Dutcher entered a Travelodge Motel in Sioux City, Iowa wearing a mask and brandishing a knife, demanding money from the victim. *See* Case No. FECR0890110, Woodbury County.

301. On June 14, 2014, approximately one-and-a-half hours after the robbery at the Travelodge Motel, Dutcher reported that his vehicle had been stolen and subsequently returned to the Sioux City Police Department.

302. On June 18, 2014, Dutcher was arrested and later convicted for Possession with Intent to Deliver a Controlled Substance, Marijuana, as a result of the April 2014 investigation. *See* Case No. FECR088733, Woodbury County.

303. Dutcher was released from jail on bond after the arrest for Possession with Intent to Deliver Marijuana and fled the Sioux City area.

304. After fleeing Sioux City, Dutcher called Troy Hansen of the Sioux City Police Department and informed the officer that he had fled because he did not want to do "that kind of time."

305. Between July 23, 2014, and July 24, 2014, Dutcher stole two firearms, one handgun and one shotgun, from two different girlfriends in Moville, Iowa. *See* Case No. FECR089010, Woodbury County.

306. On July 24, 2014, in Holstein, Ida County, Iowa, Dutcher walked into a United Bank of Iowa displaying a firearm and demanded U.S. currency while pointing the firearm at the bank employee threatening to inflict serious harm if she did not comply with his orders.

307. In August of 2014, law enforcement located Dutcher in Quimby, Iowa.

308. While attempting to arrest Dutcher in August of 2014, Officers had to tase Dutcher in an effort to subdue him and take him into custody.

309. While incarcerated in Woodbury County Jail waiting for his trial, Inmate Dutcher had several disciplinary rule infractions, which led him to maximum administrative segregation.

310. While incarcerated in Woodbury County Jail awaiting trial, Dutcher stabbed himself twice and had to be transported to obtain medical treatment on several occasions for self-inflicted injuries.

311. While segregated in a suicide cell, Inmate Dutcher attempted to "dig a vein out of his arm," and when officers responded, they found a large amount of blood.

312. Dutcher used the blood to write "I didn't do them robberies" on the wall of his segregated cell.

313. Additionally, while incarcerated in Woodbury County Jail, jail personnel found a hole that he had dug inside his cell, SWAT had to be called, as Dutcher had several instances of threatening jail staff and officers.

314. Major Gregg Stallman from the Woodbury County Jail testified at Dutcher's sentencing hearing on May 14, 2015: "That seems to be kind of an ongoing thing that I've had to talk to him about, is the threatening violence towards our officers."

315. Major Stallman further testified that the behavior of Dutcher in the Woodbury County Jail presented him with concerns about the safety of the staff at the jail.

316. While incarcerated at Woodbury County Jail, an inmate informed jail personnel via a written letter called a "kite" that Dutcher was planning an escape with another inmate and that they were intending to kill two federal agents and a witness that testified against Dutcher after they escaped.

317. The inmate reported that Dutcher and another inmate were planning to convince jail staff to open their doors to attempt to violently escape or alternatively, they would fake an injury in an effort to be transported to the hospital in order to carry out their violent escape plan.

318. Woodbury County officials contacted federal law enforcement agents, who conducted an investigation into Dutcher and his alleged escape plan.

319. Jailers at Woodbury County Jail instituted a new policy that only SWAT team members and high-risk team members were allowed to have contact with Dutcher.

320. On April 21, 2015, Dutcher was convicted of Second-Degree Robbery, First-Degree Robbery, and Ongoing Criminal Conduct in Woodbury County for the crimes he committed between May 15, 2014 to July 24, 2014.

321. At the sentencing hearing, James Loomis, Assistant Woodbury County Attorney argued that:

> This particular defendant and the history that he has shown indicates a continued and progressive escalation of violence, a continued and progressive escalation of nonconformity. This defendant wants to do what he wants, when he wants, how he wants to do it. He's not going to listen to anyone tell him what to do, and I think that's clear. He's defiant. He's unwilling to change his behavior… Ultimately, this defendant is dangerous, and he's dangerous to this community…

322. The County Attorney further argued that:

> He's one of the more dangerous defendants that I've seen doing this job, and the only way that we're going to protect this community from this defendant is to incarcerate him for as long as possible. Because as long as he's physically able and capable of committing crimes and hurting people, that's what he's going to do. He's not going to conform to society's norms. He's not going to conform to rules and laws, because they don't apply to him.

323. On May 14, 2015, Dutcher was placed into the custody of the Iowa Department of Corrections to serve a 10-year sentence for the conviction of Second-Degree Robbery, 25-

year sentence for a conviction of First-Degree Robbery, and a 25-year sentence for a conviction of Ongoing Criminal Conduct in Woodbury County, Iowa. *See* Case No. FECR089010, Woodbury County.

324. All the afore-cited facts were included in documentation provided to the Iowa Department of Corrections upon Dutcher's commitment to the custody of the Iowa Department of Corrections.

325. On September 23, 2015, while being housed in an Iowa Department of Corrections institution, Dutcher was disciplined for: (1) obstructive/disruptive conduct.

326. On October 8, 2015, Dutcher was convicted of First-Degree Robbery in Ida County for the armed bank robbery in Holstein, Iowa.

327. On November 3, 2015, Inmate Dutcher was placed into the custody of the Iowa Department of Corrections to serve an additional, consecutive 25-year sentence for a conviction of First-Degree Robbery in Ida County, Iowa. *See* Case No. FECR007055.

328. On December 2, 2015, while in the custody of the Iowa Department of Corrections, Dutcher was disciplined for: (1) disobeying lawful order/direction.

329. On December 2, 2015, Dutcher was again disciplined for (1) disobeying lawful order/direction.

330. On December 2, 2015, Dutcher was also disciplined by the Iowa Department of Corrections for: (1) unauthorized possession/exchange.

331. On February 2, 2016, Dutcher was disciplined by the Iowa Department of Corrections for: (1) obstructive/disruptive conduct.

332. On February 16, 2016, Dutcher was disciplined by the Iowa Department of Corrections for: (1) unauthorized possession/exchange.

333. On March 23, 2016, Dutcher was disciplined by the Iowa Department of Corrections for: (1) unauthorized possession/exchange.

334. On February 1, 2017, Dutcher was disciplined by the Iowa Department of Corrections for: (1) unauthorized possession/exchange.

335. On March 16, 2017, Dutcher was disciplined by the Iowa Department of Corrections for" (1) bartering, selling goods, or services, etc.

336. On April 5, 2017, Dutcher was disciplined by the Iowa Department of Corrections for: (1) threats/intimidation, (2) disobeying a lawful order/direction, (3) verbal abuse, (4) obstructive/disruptive conduct, (5) attempt or complicity.

337. On April 12, 2017, Dutcher was disciplined by the Iowa Department of Corrections for: (1) threats/intimidation, (2) disobeying lawful order/direction, (3) verbal abuse, (4) obstructive/disruptive conduct, (5) false statements, (6) attempt or complicity.

338. On April 12, 2017, Dutcher was disciplined again by the Iowa Department of Corrections for: (1) threats/intimidation, (2) disobeying a lawful order/direction, (3) obstructive/disruptive conduct.

339. On April 19, 2017, Dutcher was disciplined by the Iowa Department of Corrections for: (1) disobeying lawful order/direction, (2) verbal abuse, (3) obstructive/disruptive conduct, (4) attempt or complicity.

340. On April 19, 2017, Dutcher was disciplined again by the Iowa Department of Corrections for: (1) tampering/interfering with locks, security items, computers, or electronic devices, (2) obstructive/disruptive conduct, (3) safety, sanitation, tattooing, and piercing, (3) attempt or complicity.

341. On November 13, 2018, Dutcher was disciplined by the Iowa Department of Corrections for: (1) obstructive/disruptive conduct, (2) false statements, (3) attempt or complicity.

342. On February 8, 2019, Dutcher was disciplined by the Iowa Department of Corrections for: (1) obstructive/disruptive conduct, (2) security threat groups, (3) attempt or complicity.

343. On January 6, 2020, Dutcher was disciplined by the Iowa Department of Corrections for: (1) obstructive/disruptive conduct.

344. On February 27, 2020, Dutcher was disciplined by the Iowa Department of Corrections for: (1) assaulting staff, (2) criminal or unlawful conduct, (3) threats/intimidation, (4) disobeying a lawful order/direction, (5) obstructive/disruptive conduct, (6) attempt or complicity.

345. On April 9, 2020, Dutcher was disciplined by the Iowa Department of Corrections for: (1) disobeying lawful order/direction, (2) obstructive/disruptive conduct.

346. Between September of 2015 and March 23, 2021, Dutcher was formally disciplined by the Iowa Department of Corrections 20 times for at least 45 rule violations.

347. Prior to March 23, 2021, Dutcher spent time in mental health observation rooms in the medical unit of Anamosa.

348. Prior to March 23, 2021, Dutcher made specific statements and threats against the safety of other inmates and staff members as a result of the security deficiencies at Anamosa.

349. Dutchers comments were reported to Anamosa supervisors who failed to take appropriate action.

350. Dutcher was classified as a Maximum-Security prisoner at Anamosa.

351. All Named Defendants had knowledge of Dutcher’s propensity for violence, mental illness, disciplinary records, and history of escalating dangerous behaviors.

Woodard's Criminal History and Known History of Violence

352. On January 28, 2005, Woodard was convicted of Assault – 3rd Degree in the County Court of Sarpy, Nebraska and he was sentenced to 30 days in Sarpy County Jail and 18 months of probation.

353. On October 17, 2011, Woodard was convicted of Attempt of a Class 3 Felony – Statute 28-201(4)(D) in the Sarpy County District Court and was subsequently sentenced to 120 days in the Sarpy County Jail.

354. On January 26, 2012, Woodard was convicted of Domestic Assault – 3rd Degree in the County Court of Sarpy, Nebraska and was subsequently sentenced to 90 days in Sarpy County Jail and 12 months of concurrent probation.

355. On December 7, 2012, Woodard was involved in an armed bank robbery at a SAC Federal Credit Union in Plattsmouth, Nebraska.

356. On May 15, 2014, Thomas Woodard forced entry into a home of a woman who Woodard knew was a manager at a bank in Woodbury County, Iowa.

357. Woodard brandished a knife and requested that the bank manager victim take him to the bank, but, when she refused, Woodard took money out of her purse, duct taped the woman to the ground, and poured bleach all over the woman before exiting the residence.

358. Woodard was incarcerated with the Nebraska Department of Corrections when the criminal complaint was filed in Woodbury County, Iowa on July 5, 2016.

359. On August 22, 2016, Woodard was convicted of Criminal Mischief -- $1,500 or more – Statute 25-519(2) in the Sarpy County District Court, Nebraska, and was subsequently sentenced to a minimum of 20 months in Nebraska Department of Correctional Services.

360. Woodard was discharged from the State Department of Corrections Lincoln on April 6, 2018.

361. On June 18, 2018, Woodard was formally disciplined while in custody of the Iowa Department of Corrections for: (1) assault, (2) fighting, (3) out of place of assignment, and (4) obstructive/disruptive conduct.

362. On November 21, 2018, Woodard was convicted of robbing the SAC Federal Credit Union Bank in the United States District Court of the District of Nebraska and was subsequently sentenced to the custody of the Bureau of Prison for a term of 100 months with 48 months consecutive and 52 months concurrent to the sentence imposed in Woodbury County District Court Case No. FECR095002. *See* USA v. Woodard, 8:17-cr-00347-RFR-MDN-1.

363. All Named Defendants had full knowledge of the specifics of Woodard's prior criminal history and disciplinary actions when they took custody of him on November 21, 2018.

Classification, Selection for Working, and Release from Solitary Confinement for Dutcher and Woodard.

364. All Named Defendants had knowledge of the potential for violence perpetrated by incarcerated individuals in correctional institutions such as Anamosa.

365. Additionally, all Named Defendants had knowledge of the dangerous and violent propensities unique to both Dutcher and Woodard as a result of their criminal and institutional records.

366. Despite the knowledge of the dangerous and violent propensities of Dutcher and Woodard, both Dutcher and Woodard were selected and utilized by the Named Defendants as Inmate Maintenance Workers and/or Iowa Prison Industries Workers.

367. Just prior to the incident giving rise to this Petition, Dutcher was being held in Solitary Confinement due to his violent and dangerous behavior.

368. It is believed that Defendant Kerker asked an inmate whether Dutcher should be released from Solitary Confinement.

369. It is believed that the inmate reported to Kerker that Dutcher was "batshit crazy."

370. Despite the warning from the inmate, it is believed that Defendant Kerker, Defendant Dietsch, and other Named Defendants released Dutcher from Solitary Confinement into General Population allowing him to roam freely and unsupervised throughout the penitentiary.

SPECIFIC FAILURES RESULTING IN ATTACKS ON MARCH 23, 2021

Absence of Supervision of Maintenance Shop, IPI Areas, and Tools on March 23, 2021

371. On March 23, 2021, Burds was assigned to and tasked with Tool Control at the Maintenance Tool Crib at Anamosa.

372. On that same date, Woodard obtained his assigned electrical tool kit from the Maintenance Tool Crib at Anamosa.

373. Woodard was not supervised by a correctional officer or Correctional Trade Leader on March 23, 2021.

374. Woodard's tool kit included an Anamosa issued black tool bag into which tools could be placed, hidden, and transported throughout the facility.

375. That same morning, Burds permitted an Inmate Maintenance Worker to check out Class-A Tool identified as "Grinder 4.5 ATC-13" along with several other tools.

376. Said Inmate was not directly supervised by any correctional officer following checking out the "Grinder 4.5 ATC-13."

377. Inmate Maintenance Workers at Anamosa, assigned to the welding shop, would routinely use Class-A grinders, such as the tool identified as "Grinder 4.5 ATC-13," without direct supervision of a correctional officer.

378. Ahlrichs was the Correctional Trades Leader responsible for the Inmate Maintenance Workers assigned to the welding crew on the morning of March 23, 2021, at Anamosa.

379. Defendants Kray, Gillmore, and McMahon were also Correctional Trades Leaders assigned to the Maintenance Shop on March 23, 2021, at Anamosa.

380. On March 23, 2021, Rod Kinsella was an Electrician hired and employed by the Iowa Department of Corrections, assigned to work at Anamosa.

381. Rod Kinsella's first day of employment at Anamosa was March 23, 2021.

382. Rod Kinsella was not a trained or certified correctional officer but was permitted to be physically located within the secure area of Anamosa.

383. At around 9:30 a.m., on March 23, 2021, a prison-wide count of inmates cleared.

384. After the count cleared, Defendants Gillmore, McMahon, and Kinsella left the Anamosa Maintenance Building area to show Kinsella the "chow" area.

385. Defendants Gillmore, McMahon, and Kinsella exited the Anamosa Maintenance Shop leaving a single Correctional Trade Leader, Ahlrichs, to supervise the entire area.

386. At the same time, Defendant Kray was absent from the area of the Anamosa Machine Shop that he was responsible for supervising.

387. While the sole supervisor of the Anamosa Maintenance Shop, Ahlrichs located himself in the Maintenance Shop Office which prevented him from being able to observe a significant portion of the Maintenance Building, including the welding area and the Machine Shop.

388. During this time several unsupervised, accessible Class-A tools, including "Grinder 4.5 ATC-13" were being used by inmates in the Anamosa Maintenance Building.

389. Additionally, Defendants Gillmore, McMahon, and Kinsella left their assigned positions in the Anamosa Maintenance Machine Shop area unsupervised, which also contained numerous unsupervised dangerous tools for an unknown amount of time.

390. While Defendants Gillmore, McMahon, and Kinsella were away from their post and while Ahlrichs remained in the Anamosa Maintenance Shop Office unable to observe the rest of the Shop, Woodard, in coordination with Dutcher, gained unsupervised access to the welding area of the Maintenance Machine Shop.

391. Ahlrichs left the welding area unattended for approximately 20 to 25 minutes, which allowed Woodard, in coordination with Dutcher, to remove the Grinder 4.5 ATC-13 from the welding booth.

392. Woodard in coordination with Dutcher, also gained access to the unsupervised Anamosa Machine Shop.

393. Within the Anamosa Machine Shop was a shadow board containing two metal hammers, neither of which were secured with any tethers or locks.

394. Woodard, in coordination with Dutcher, gained access to two metal hammers, hiding them in his assigned tool kit bag.

395. The Iowa Department of Corrections and/or Anamosa, through the Named Defendants, failed to create, implement, and/or enforce adequate policies, procedures, or security checkpoints to prevent inmates such as Woodard and Dutcher from removing tools from the Anamosa Maintenance Building.

396. All Named Defendants knew that the inmates were aware of the lack of policies, procedures, and security checkpoints to prevent inmates from removing tools from the designated Maintenance Building.

Unsupervised Transportation of Tools and Inmate Movement on March 23, 2021

397. While unsupervised by any correctional officer, Woodard, in coordination with Dutcher, transported the grinder and hand tools, including two metal hammers, out of the Maintenance Building.

398. Outside of the Maintenance Building, IPI operates a Metal Furniture Shop.

399. Anamosa Inmates involved in programs operated by IPI also had access to Class-A Tools.

400. A Tool Crib located within the Anamosa Metal Furniture Shop was used by IPI Technicians and Workers to distribute tools and consumables to inmates for the use of the tools on the shop floor.

401. Housed in the Anamosa Metal Shop Tool Crib were tools, including but not limited to, cut-off wheels, hand tools, and grinders.

402. Anamosa IPI Inmate Workers routinely distributed abrasive grinding and cutoff wheels to other inmate workers.

403. Anamosa IPI Inmate Workers used the grinders and grinding wheels daily in the Metal Shop.

404. On March 23, 2021, four cutoff disks were issued to welding Anamosa IPI employees and were left unattended and unsupervised.

405. While the area was unsupervised, Woodard, in coordination with Dutcher, entered the Anamosa IPI welding booths and removed the four grinder cutoff disks.

406. Woodard, in coordination with Dutcher, transported the grinder, hammers, and the four disks out of the Anamosa IPI building without detection.

407. Woodard, in coordination with Dutcher, was also able to transport all these tools throughout Anamosa without being searched for contraband or even questioned by any correctional officers.

408. Anamosa, through the Named Defendants, failed to create, implement, and/or enforce adequate policies, procedures, or security checkpoints to prevent inmates such as Woodard and Dutcher from removing tools from Maintenance and IPI buildings.

409. All Named Defendants knew that the inmates were aware of the lack of policies, procedures, and security checkpoints to prevent inmates from removing tools from the Maintenance and IPI buildings.

Attack of Officer McFarland on March 23, 2021 and Insufficient Emergency Response

410. Woodard and Dutcher transported all the tools, including the Class-A grinder and the hammers to the Infirmary.

411. Woodard and Dutcher specifically bypassed RE-14 Checkpoint which was assigned to be supervised by Suthers.

412. Woodard and Dutcher did not have authorization permitting them to access the Infirmary.

413. Upon entry into the Infirmary, Woodard and Dutcher attacked Officer McFarland with the hammers obtained from the Anamosa Maintenance Shop.

414. Due to insufficient emergency procedures and/or adequate communication systems, occupants of the Infirmary were unable to signal or call for needed assistance.

415. Lori Mathes, a member of the dental staff, was not equipped with a radio and was taken hostage by Woodard and Dutcher.

416. Woodard and Dutcher repeatedly struck Officer McFarland with the hammers obtained from the Anamosa Maintenance Shop, fracturing his skull, and causing multiple additional external and internal injuries.

417. During this time, Unit Manager, Lindsay Stupka ("Stupka") was in her office on the Second Floor of Anamosa.

418. Stupka's office was just above the Infirmary, cornered with the visiting area at Anamosa.

419. At approximately 10:13 a.m., Stupka heard glass shatter outside of her office.

420. Stupka observed shattered glass on the windowsill below her near the medical unit break room.

421. Stupka also observed Grinder 4.5 ATC-13, taken by Woodard, protruding from the Infirmary break room window.

422. Stupka identified that there was a dangerous situation unfolding downstairs in the Infirmary break room.

423. Stupka did not have access to an emergency radio to call for assistance.

424. Stupka verbally informed Matt Miller that they needed to go downstairs to intervene in the Infirmary.

425. Once downstairs, Stupka was able to confirm that it was the Infirmary break room where the window had been shattered.

426. As Stupka approached the Infirmary break room, she noticed blood splatter on the door and window of the break room and blood on the floor of the break room.

427. Stupka ran to the nearest phone at the nursing station inside the Infirmary.

428. Stupka notified a security officer that inmates were attempting to escape.

429. After Stupka notified the security office, a Code response was radioed through the building.

430. After the radio announcement, Officer Condon responded to the nursing area from the back area of the Infirmary.

431. Pursuant to Iowa Department of Corrections and Anamosa policy and procedures, Officer Condon, who was stationed in the Infirmary with Officer McFarland, had been completing her E-Learning training while on duty, at her duty post, during the attack on McFarland.

432. Correctional Officer Mike Cooper and Correctional Officer Ray Turano next responded to the area.

433. Immediately after Cooper, Miller, Turano, and Stupka breached the hallway door, Dutcher ran out of the breakroom, with blood on his hands and immediately yelled, "They attacked me. I didn't do it."

Officer McFarland Injuries and Cause of Death

434. As a result of the repeated blows from the hammers, Officer McFarland suffered the following injuries:

a. Blunt Force Injuries of Head, including:

i. Abrasions of face.

ii. Contusion of inferior oral mucosa.

iii. Lacerations (2) of posterior scalp associated with depressed skull fractures.

iv. Fracture laceration and contusions of brain.

v. Subdural hemorrhage and subarachnoid hemorrhage, acute.

b. Blunt force injuries of lower extremities.

435. Officer McFarland was still alive when paramedics responded to the scene on March 23, 2021.

436. Officer McFarland ultimately passed away from the injuries he sustained in the attack.

437. Officer McFarland's death was ruled a Homicide caused by blunt force injuries to his head which were sustained in the attack by Woodard and Dutcher.

Iowa OSHA Investigation after Attack on March 23, 2021

438. As a result of the attacks on Officer McFarland and Nurse Schulte, Iowa OSHA was contacted on March 23, 2021, and a personnel-initiated inspection of Anamosa occurred on March 24, 2021.

439. Iowa OSHA's investigation led to numerous violations, Enforcement Actions, Orders, and Citations to the Iowa Department of Corrections by Iowa OSHA.

440. Iowa OSHA determined that Iowa Department of Corrections, by and through its officers, directors, and employees, did not adequately ensure that Anamosa employees were furnished with a workplace free from recognized hazards that were causing or were likely to cause death or serious injury to their employees.

441. Iowa OSHA determined that Iowa Department of Corrections, by and through its officers, directors, and employees, failed to establish effective means to prevent Anamosa employees from being exposed to workplace violence hazards.

442. Iowa OSHA determined that Iowa Department of Corrections, by and through its officers, directors, and employees, created or permitted conditions and practices at Anamosa which allowed unauthorized inmate possession of dangerous objects, including but not limited to the hammer and grinder used by Dutcher and Woodard, which exposed Anamosa employees to hazardous workplace violence events.

443. Iowa OSHA determined that Iowa Department of Corrections, by and through its officers, directors, and employees, did not establish effective means to supervise Anamosa Inmate Maintenance Workers assignments and operations throughout the facility, which exposed correction staff to workplace violence hazards during violent attacks and escape attempts.

444. Iowa OSHA determined that Iowa Department of Corrections, by and through its officers, directors, and employees, failed to establish effective means to prevent and supervise inmate access to dangerous tools inside the Anamosa Maintenance Shop, which allowed an inmate to remove two hammers from the area without authorization and to use those tools to fatally assault Officer McFarland.

445. Iowa OSHA determined that Iowa Department of Corrections, by and through its officers, directors, and employees, failed to establish a comprehensive workplace violence prevention program to effectively educate and train Anamosa employees on the steps to be taken to prevent and/or eliminate workplace violence.

446. Iowa OSHA determined that Iowa Department of Corrections, by and through its officers, directors, and employees, failed to effectively develop, implement, and utilize a method of supervising and monitoring inmate movement throughout Anamosa.

447. Iowa OSHA determined that Iowa Department of Corrections, by and through its officers, directors, and employees, failed to establish an effective means and policies for searching Anamosa IPI and Maintenance Workers for contraband and potential weapons.

448. According to the Iowa OSHA violation, Iowa Department of Corrections management previously identified lack of Class-A tool supervision in the "2019 Security, Safety, ICS Simulation Audit."

449. The Named Defendants in administrative and/or supervisory roles within the Iowa Department of Corrections and Anamosa, failed to take adequate action upon receipt of the 2019 Security, Safety, ICS Simulation Audit.

LAW COMMON TO ALL NAMED DEFENDANTS AND COUNTS

450. The Iowa Legislature passed Iowa Code Section 669.14A on June 17, 2021, which was after the date of the incident giving rise to this action.

451. Because statues are presumed to be prospective unless expressly stated otherwise, it is the belief of the Plaintiffs, this code section has no application to the instant matter.

452. Nevertheless, out of an abundance of caution and in compliance with Iowa Code Section 669.14A(3), Plaintiffs specifically plead that the law was clearly established at the time of the incident giving rise to this petition and that all Named Defendants violated the clearly established law resulting in the injuries and eventually death of Officer McFarland.

453. Clearly established law at the time of the incident on March 23, 2021, included but is not limited to:

a. The State has consented to permit a cause of action against employees of the state on account of personal injury or death, caused by the negligent or wrongful act or omission of any employee of the state while acting within the scope of the employees office or employment, under circumstances where the state, if a private person, would be liable to the claimant for such damage, loss, injury, or death. Iowa Code § 669.2(3).

b. An injured employee may maintain a common law tort action against a co-employee to recover for injuries when the employee can establish that his injuries were caused by the co-employees gross negligence amounting to such lack of care

as to amount to wanton neglect for the safety of others. *Swanson v. McGraw*, 447 N.W.2d 541, 543 (Iowa 1989); Iowa Code § 85.20.

c. The following code sections were in place, imposing affirmative duties and responsibilities upon the Named Defendants: Iowa Code § 88.4(2), Iowa Code Chapter 904, including but not limited to, Iowa Code § 904.102(2), Iowa Code § 904.103(2), Iowa Code § 904.107, Iowa Code § 904.108, Iowa Code § 904.111, Iowa Code § 904.202, Iowa Code § 904.301, Iowa Code § 904.303, Iowa Code § 904.303A, Iowa Code § 904.305, Iowa Code Section 904.306, Iowa Code § 904.309, Iowa Code § 904.401, Iowa Code § 904.402, Iowa Code § 904.403, Iowa Code 904.404, Iowa Code § 904.501, Iowa Code § 904.502, Iowa Code § 904.503, Iowa Code § 904.701, Iowa Code § 904.703, Iowa Code § 904.707, Iowa Code § 904.802, Iowa Code § 904.806, Iowa Code § 904.809; Iowa Code Chapter 905; Iowa Code Chapter 915; as well as all Administrative Code Sections, Department of Corrections Prison Policies, and/or Anamosa Prison Policies, created pursuant to, and in execution and enforcement of the afore-cited statutes.

COUNT I
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Beth Skinner)

454. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

455. Defendant Skinner was Director of the Iowa Department of Corrections and pursuant to Iowa Code § 904.108, was statutorily mandated to:

a. Supervise the operations of the institutions under the Department of Corrections jurisdiction;

b. Delegate the powers and authorities given to her by statute to officers or employees of the Department of Corrections;

c. Establish and maintain acceptable standards of treatment, training, education, and rehabilitation in the various state penal and corrective institutions;

d. Employ, assign, and reassign personnel as necessary for the performance of duties and responsibilities assigned to the department with employees being selected on the basis of fitness for work to be performed with due regard to training and experience;

e. Establish standards of mental fitness governing the initial recruitment, selection, and appointment of correctional officers and to utilize batteries of psychological tests to determine cognitive skills, personality characteristics, and suitability of all applicants for a correctional career;

f. Examine all state penal institutions to determine their efficiency for adequate care, custody, and training of their inmates;

g. Adopt rules subject to the approval of the board, pertaining to the internal management of institutions and agencies under the director's charge and necessary to carry out the duties and powers outlined in § 904.108; and

h. Establish and maintain a correctional training program.

456. Skinner, as the Director of the Iowa Department of Corrections was statutorily mandated to "determine the number and compensation of subordinate officers and employees for each institution subject to chapter 8A, subchapter IV." Iowa Code § 904.303(1).

457. Skinner, as the Director of Iowa Department of Corrections was statutorily mandated to provide training to all new officers or employees of the Department free of charge and to

offer in-service training including classes for officers and employees in the areas of safety, first aid, emergency preparedness, and any other appropriate classes. Iowa Code § 904.303A.

458. Skinner, as the Director of the Iowa Department of Corrections was required by Iowa Code § 904.401 to "visit and inspect the institutions under the director's control, and investigate the financial condition and management of the institutions at least once in six months."

459. Skinner, as Director of the Iowa Department of Corrections is statutorily mandated to determine inmates who are unsuitable for the performance of hard labor within the Department of Corrections and was required to adopt rules to implement such determination. Iowa Code § 904.701.

460. Skinner failed to comply with occupational safety and health standards and all rules and orders issued pursuant to Chapter 88 which are applicable to her actions and conduct as an employee of the Iowa Department of Corrections.

461. Skinner had a duty to exercise reasonable care toward all employees of the Iowa Department of Corrections, including those at Anamosa, including Officer McFarland.

462. Skinner was grossly negligent, through acts and/or omissions including but not limited to the following particulars:

a. Failing to comply with the statutory obligations set forth in Iowa Code sections 904.108(1)(a), (b), (d), (e) (f), (k) and (o); 904.116, 904.303A, 904.401, 904.701, and 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Director to individuals who were not qualified;

d. Failing to ensure that officers and employees of the Iowa Department of Corrections and Anamosa were adequately trained;

e. Failing to ensure that officers and employees of the Iowa Department of Corrections and Anamosa were adequately supervised;

f. Failing to ensure that inmates of the Iowa Department of Corrections and Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of the Iowa Department of Corrections and Anamosa were adequately equipped with communications and other necessary safety equipment;

h. Failing to provide a safe working environment for employees in the Iowa Department of Corrections and Anamosa;

i. Failing to establish and implement an adequate comprehensive workplace violence prevention program within the Iowa Department of Corrections and Anamosa;

j. Failing to establish and implement adequate emergency response plans within the Iowa Department of Corrections and Anamosa;

k. Ordering, sanctioning, and/or permitting institutions under the Department of Corrections, including Anamosa, to be overcapacity with inmates;

l. Ordering, sanctioning, and/or permitting institutions under the Iowa Department of Corrections, including Anamosa, to be understaffed;

m. Ordering, sanctioning, and/or permitting correctional officers to engage in E-Learning while on duty at the Iowa Department of Corrections, including Anamosa;

n. Failing to ensure adequate staffing and supervision of post areas within the Iowa Department of Corrections and Anamosa;

o. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within the Iowa Department of Corrections and Anamosa;

p. Failure to implement, follow, and enforce sufficient safety protocols within the Iowa Department of Corrections and Anamosa;

q. Failing to implement, follow, and enforce comprehensive reviews of security measures within the Iowa Department of Corrections and Anamosa;

r. Failing to implement, follow, and enforce comprehensive security and safety audits of institutions of the Iowa Department of Corrections and Anamosa;

s. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

t. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

u. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within the Iowa Department of Corrections and Anamosa;

v. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

w. Failing to respond to employee complaints regarding safety within the Iowa Department of Corrections and Anamosa;

x. Failing to prevent inmate attacks of employees within the Iowa Department of Corrections and Anamosa;

y. Failing to ensure enforcement of all policies and procedures in place within the Iowa Department of Corrections and Anamosa;

z. In violating State and Federal laws and regulations;

aa. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by Correctional Department Directors in similar circumstances;

bb. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of the Department of Corrections under similar circumstances; and

cc. Such other acts and omissions as may be developed through the course of discovery.

463. Skinner knew of the danger(s) and/or peril(s) caused by her actions and inactions.

464. Skinner knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

465. Skinner consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

466. Skinner's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and other similarly situated employees and amounted to gross negligence.

467. Skinner's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT II
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant William Sperfslage)

468. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

469. Defendant Sperfslage was the Deputy Director of Institutions of the Iowa Department of Corrections.

470. As the Deputy Director of Institutions, Sperfslage was responsible for all correctional facilities and institutions within the jurisdiction of the Iowa Department of Corrections, including Anamosa. *See* Iowa Admin. Code 201-1.8(1)(a)(2).

471. Pursuant to Iowa Administrative Code section 201-1.8, as the Deputy Director of Institutions, Sperfslage was responsible for the following within the Iowa Department of Corrections, including Anamosa:

a. Classification of inmates;

b. Safety officers; and

c. Security operations.

472. Pursuant to Iowa Department of Corrections Policy IS-CL-01 ("Transitional Incentive Program"), Sperfslage and his designees were responsible for Institution Classification and Transition Incentive Programs at each institution, including Anamosa.

473. Pursuant to Iowa Department of Corrections Policy IO-SC-26 ("Institutional Safety Audits"), Sperfslage was responsible for creating, implementing, and ensuring compliance with institutional security audits of all institutions for the Iowa Department of Corrections and Anamosa.

474. Pursuant to Iowa Department of Corrections Policy IO-SE-03 ("Safety Health and Management Program"), Sperfslage was responsible for "maintaining a workplace free from health and safety hazards while utilizing a proactive approach in all safety programs" for the Iowa Department of Corrections and Anamosa.

475. Pursuant to Iowa Department of Corrections Policy AD-PR-03 ("Review of Staff Requirements"), Sperfslage was responsible for creating, implementing, and enforcing staffing requirements at Iowa Department of Corrections Institutions, including Anamosa.

476. According to Iowa Department of Corrections Policy AD-PR-03 ("Review of Staff Requirements"), "[i]t is the policy of the IDOC to have an orderly system for establishing, reviewing, and revising the staffing requirements of each correctional institution, so as to effectively meet the specific programs, services, and security needs of the incarcerated individual population at each location."

477. Sperfslage had a duty to exercise reasonable care toward all employees of the Iowa Department of Corrections, including those at Anamosa, and specifically, Officer McFarland.

478. Sperfslage was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory obligations set forth in Iowa Code sections 904.108(1)(a), (b), (d), (e) (f), (k) and (o); 904.116, 904.303A, 904.401, 904.701, and 88.4(2);

b. Failing to comply with his legal obligations set forth in Iowa Administrative Code section 201-1.8;

c. Failing to comply with Iowa Department of Corrections Policies and Procedures;

d. Delegating powers and authorities given to the Deputy Director of Institutions to individuals who were not qualified;

e. Failing to ensure that correctional officers and employees of Anamosa were adequately trained;

f. Failing to ensure that correctional officers and employees of Anamosa were adequately supervised;

g. Failing to ensure that inmates at Anamosa were adequately supervised;

h. Failing to ensure that correctional officers and employees at Anamosa were adequately equipped with communications equipment and other necessary safety equipment;

i. Failing to provide a safe working environment for employees at Anamosa;

j. Failing to establish and implement an adequate comprehensive workplace violence prevention program within Anamosa;

k. Failing to establish and implement adequate emergency response plans within Anamosa;

l. Ordering, sanctioning, and/or permitting Anamosa, to be overcapacity with inmates;

m. Ordering, sanctioning, and/or permitting understaffing of Anamosa;

n. Ordering, sanctioning, and/or permitting correctional officers at Anamosa to engage in E-Learning while on duty;

o. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

p. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

q. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

r. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

s. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa;

t. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/ IPI Programs at Anamosa;

u. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate's movements throughout Anamosa;

v. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

w. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls at Anamosa;

x. Failing to respond to employee complaints regarding safety within Anamosa;

y. Failing to prevent inmate attacks of employees within the Iowa Department of Corrections and Anamosa;

z. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

aa. In violating State and Federal laws and regulations;

bb. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by Deputy Director of Institutions in similar circumstances;

cc. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Iowa's Correctional Institutions, including Anamosa, under similar circumstances; and

dd. Such other acts and omissions as may be developed through the course of discovery.

479. Sperfslage knew of the danger(s) and/or peril(s) caused by his actions and inactions.

480. Sperfslage knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

481. Sperfslage consciously failed to remedy and/or avoid the dangers(s) and/or peril(s).

482. Sperfslage's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

483. Sperfslage's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT III
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Samantha Tucker-Sieberg)

484. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

485. On March 23, 2021, Samantha Tucker-Sieberg was the Safety Director of the Iowa Department of Corrections.

486. As the Safety Director of the Iowa Department of Corrections, Tucker-Sieberg was responsible for supervision, training, and leading all correctional institutions, including Anamosa's, safety officers and safety personnel.

487. Tucker-Sieberg's responsibilities as the Safety Director also included developing and enforcing the Department's safety policies and procedures.

488. Pursuant to Iowa Department of Corrections Policy IO-SE-03 ("Safety Health and Management Program"), Tucker-Sieberg was responsible for "maintaining a workplace free from health and safety hazards while utilizing a proactive approach in all safety programs."

489. Additionally, Tucker-Sieberg was responsible for developing, coordinating, and oversight of all safety audits at correctional institutions.

490. Samantha Tucker-Sieberg had a duty to exercise reasonable care toward all employees of the Iowa Department of Corrections, including those at Anamosa, including Officer McFarland.

491. Samantha Tucker-Sieberg was grossly negligent, through acts and omissions including but not limited to the following particulars:

    a. Failing to comply with the statutory obligations set forth in Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Safety Director to individuals who were not qualified;

d. Failing to ensure that officers and employees of the Iowa Department of Corrections and Anamosa were adequately trained;

e. Failing to ensure that officers and employees of the Iowa Department of Corrections and Anamosa were adequately supervised;

f. Failing to ensure that inmates of the Iowa Department of Corrections and Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of the Iowa Department of Corrections were adequately equipped with communication devices and other necessary safety equipment;

h. Failing to provide a safe working environment for employees of the Iowa Department of Corrections and Anamosa;

i. Failing to establish, implement, or enforce a comprehensive workplace violence prevention program within the Iowa Department of Corrections and Anamosa;

j. Failing to establish and implement an adequate emergency response plan within the Iowa Department of Corrections and Anamosa;

k. Ordering, sanctioning, and/or permitting Iowa Department of Corrections and Anamosa, to be overcapacity with inmates;

l. Ordering, sanctioning, and/or permitting understaffing of Iowa Department of Corrections and Anamosa;

m. Ordering, sanctioning, and/or permitting correctional officers at Anamosa to engage in E-Learning while on duty;

n. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

o. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

p. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

q. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

r. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa;

s. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/ IPI Programs at Anamosa;

t. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate's movements throughout Anamosa;

u. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

v. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls at Anamosa;

w. Failing to respond to employee complaints regarding safety within Anamosa;

x. Failing to prevent inmate attacks of employees within Anamosa;

y. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

z. In violating State and Federal laws and regulations;

aa. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Safety Director in similar circumstances;

bb. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Iowa's Correctional Institutions, including Anamosa, under similar circumstances; and

cc. Such other acts and omissions as may be developed through the course of discovery.

492. Tucker-Sieberg knew of the danger(s) and/or peril(s) caused by her actions and inactions.

493. Tucker-Sieberg knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

494. Tucker-Sieberg consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

495. Tucker-Sieberg's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

496. Tucker-Sieberg's acts and/or omissions were a cause of the death of Officer McFarland and the Plaintiffs' damages.

COUNT IV
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Sarah Holder)

497. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

498. On March 23, 2021, Holder was the Training Director for the Iowa Department of Corrections.

499. As the Training Director, Holder was responsible for establishing and implementing training standards, and providing training and instructions to all Department of Corrections employees.

500. Additionally, Holder's responsibilities included overseeing and reviewing all of Iowa Department of Correction's agency-wide training policies and staff development programming.

501. Holder had a duty to exercise reasonable care toward all employees of the Iowa Department of Corrections, including those at Anamosa.

502. Holder was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory obligations set forth in Iowa Code § 88.4(2);

b. Failing to comply with the Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Training Director to individuals who were not qualified;

d. Failing to ensure that officers and employees of the Iowa Department of Corrections and Anamosa were adequately trained;

e. Failing to ensure that officers and employees of the Iowa Department of Corrections and Anamosa were adequately supervised;

f. Failing to ensure that inmates of the Iowa Department of Corrections and Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of the Iowa Department of Corrections were adequately trained on the use of communication devices and other necessary safety equipment;

h. Failing to provide a safe working environment for employees of the Iowa Department of Corrections and Anamosa;

i. Failing to establish, implement, or enforce a comprehensive workplace violence prevention program within the Iowa Department of Corrections and Anamosa;

j. Failing to establish and implement an adequate emergency response plan within the Iowa Department of Corrections and Anamosa;

k. Ordering, sanctioning, and/or permitting correctional officers at Anamosa to engage in E-Learning while on duty;

l. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

m. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

n. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

o. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

p. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa;

q. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/ IPI Programs at Anamosa;

r. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate's movements throughout Anamosa;

s. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

t. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls at Anamosa;

u. Failing to respond to employee complaints regarding safety within Anamosa;

v. Failing to prevent inmate attacks of employees within Anamosa;

w. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

x. In violating State and Federal laws and regulations;

y. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Training Director in similar circumstances;

z. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Iowa's Correctional Institutions, including Anamosa, under similar circumstances; and

aa. Such other acts and omissions as may be developed through the course of discovery.

503. Holder knew of the danger(s) and/or peril(s) caused by her actions and inactions.

504. Holder knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

505. Holder consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

506. Holder's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

507. Holder's acts and/or omissions were a cause of the death of Officer McFarland and the Plaintiffs' damages.

COUNT V
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Daniel Clark)

508. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

509. Defendant Clark was Deputy Director of the Iowa Prison Industries.

510. Clark was responsible for the day-to-day operations of the Iowa Prison Industries, including but not limited to the security of inmates participating in the Iowa Prison Industries programing to protect the safety of the public.

511. Specifically, Clark as the Deputy Director for Iowa Prison Industries was responsible for manufacturing/service/processing operations; the activities and programs of the sales manager and territorial sales staff; budget, income, and expense record keeping and planning for the Iowa Prison Industries; and the private sector employment of inmates. *See* Iowa Admin. Code section 201 -1.8(4)(a)-(g).

512. Clark had a duty to exercise care toward employees working in or with inmates in the Iowa Prison Industries Program.

513. Clark was grossly negligent, through acts and/or omissions including but not limited to the following particulars:

    a. Failing to comply with the statutory obligations set forth in Iowa Code § 88.4(2);

b. Failing to comply with the statutory and administrative regulations applicable to the Deputy Director of IPI;

c. Failing to comply with Iowa Department of Corrections Policies and Procedures;

d. Delegating powers and authorities given to the Deputy Director of IPI to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

e. Failing to ensure that officers and employees of the IPI were adequately trained and supervised;

f. Failing to ensure that inmates of the Iowa Department of Corrections and Anamosa participating in IPI were adequately supervised;

g. Failing to provide a safe working environment for employees in the Iowa Department of Corrections and Anamosa and Iowa Prison Industries;

h. Permitting understaffing of Iowa Prison Industries operations throughout the Iowa Department of Corrections and specifically at Anamosa;

i. Failing to ensure adequate staffing and supervision of post areas within and/or related to IPI;

j. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within the IPI Program;

k. Failure to implement, follow, and enforce sufficient safety protocols within the IPI Program;

l. Failing to implement, follow, and enforce comprehensive reviews of security measures within the IPI Program;

m. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the IPI Program;

n. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within IPI Program;

o. Failing to respond to employee complaints regarding safety concerns regarding inmates participating in the IPI Program;

p. Failing to prevent inmate attacks of employees by inmate participants of the IPI Program;

q. Failing to ensure enforcement of all policies and procedures in place within the IPI Program;

r. In violating State and Federal laws and regulations;

s. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Deputy Director of Prison Industries in similar circumstances;

t. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Department of Corrections Prison Industries under similar circumstances; and

u. Such other acts and omissions as may be developed through the course of discovery.

514. Clark knew of the danger(s) and/or peril(s) caused by his actions and inactions.

515. Clark knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

516. Clark consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

517. Clark's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

518. Clark's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT VI
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Jeremy Larson)

519. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

520. On March 23, 2021, Defendant Jeremy Larson was the Warden of Anamosa.

521. It was common practice for Larson to work from home while on duty as the Warden of Anamosa.

522. Larson's working from home while acting as the Warden of Anamosa was authorized and sanctioned by Defendants Skinner, Sperfslage, and Tucker-Sieberg.

523. As the Warden of Anamosa, Larson was responsible for the operation of Anamosa, the safety of the inmates and staff, and all programs operating within the Penitentiary.

524. Pursuant to Iowa Department of Corrections Policy IO-SC-26 ("Institutional Safety Audits"), Larson was responsible for creating, implementing, ensuring compliance with institutional security audits of all institutions for the Iowa Department of Corrections and Anamosa.

525. Pursuant to Iowa Department of Corrections Policy I0-SC-02 ("Post Orders"), Larson was responsible for creating, implementing, and enforcing Post Orders at Anamosa.

526. According to Iowa Department of Corrections Policy AD-PR-03 ("Review of Staffing Requirements"), Larson was responsible for "a systemic ongoing determination by the

Warden to ensure incarcerated individuals access to staff and availability of support services."

527. Post orders are general instructions for the operation of every correctional post, including security instructions that are to be authored by the Warden.

528. Larson had a duty to exercise reasonable care toward all employees of Anamosa, including Officer McFarland.

529. Larson was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory and administrative regulations applicable to an Iowa Department of Corrections Warden, including but not limited to Iowa Code § 88.4(2);

b. Failing to comply with the Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Warden of Anamosa to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of Anamosa were adequately trained;

e. Failing to ensure that officers and employees of Anamosa were adequately supervised;

f. Failing to ensure that inmates of Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

h. Failing to provide a safe working environment for employees at Anamosa;

i. Failing to establish and implement an adequate comprehensive workplace violence prevention program at Anamosa;

j. Failing to establish and implement an adequate emergency response plan at Anamosa;

k. Permitting Anamosa to be overcapacity with inmates;

l. Ordering, sanctioning, and/or permitting Anamosa to be understaffed;

m. Ordering, sanctioning, and/or permitting correctional officers to engage in E-Learning while on duty at Anamosa;

n. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

o. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

p. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

q. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

r. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa;

s. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

t. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

u. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

v. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

w. Failing to respond to employee complaints regarding safety within Anamosa;

x. Failing to prevent inmate attacks of employees within Anamosa;

y. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

z. In violating State and Federal laws and regulations;

aa. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Warden in similar circumstances;

bb. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

cc. Such other acts and omissions as may be developed through the course of discovery.

530. Larson knew of the danger(s) and/or peril(s) caused by his actions and inactions.

531. Larson knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

532. Larson consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

533. Larson's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

534. Larson's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT VII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Michael Heinricy)

535. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

536. On March 23, 2021, Defendant Michael Heinricy was a Deputy Warden at Anamosa.

537. As the Deputy Warden, Heinricy was responsible for the operation of Anamosa, the safety of the inmates and staff, and all programs operating within the Penitentiary.

538. Heinricy had a duty to exercise reasonable care toward all employees at Anamosa.

539. Heinricy was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory and administrative regulations applicable to an Iowa Department of Corrections Deputy Warden, including but not limited to Iowa Code § 88.4(2);

b. Failing to comply with the Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Deputy Warden of Anamosa to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of Anamosa were adequately trained;

e. Failing to ensure that officers and employees of Anamosa were adequately supervised;

f. Failing to ensure that inmates of Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

h. Failing to provide a safe working environment for employees at Anamosa;

i. Failing to establish and implement an adequate comprehensive workplace violence prevention program at Anamosa;

j. Failing to establish and implement an adequate emergency response plan at Anamosa;

k. Permitting Anamosa to be overcapacity with inmates;

l. Ordering, sanctioning, and/or permitting Anamosa to be understaffed;

m. Ordering, sanctioning, and/or permitting correctional officers to engage in E-Learning while on duty at Anamosa;

n. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

o. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

p. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

q. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

r. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa;

s. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

t. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

u. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

v. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

w. Failing to respond to employee complaints regarding safety within Anamosa;

x. Failing to prevent inmate attacks of employees within Anamosa;

y. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

z. In violating State and Federal laws and regulations;

aa. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Deputy Warden in similar circumstances;

bb. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

cc. Such other acts and omissions as may be developed through the course of discovery.

540. Heinricy knew of the danger(s) and/or peril(s) caused by his actions and inactions.

541. Heinricy knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

542. Heinricy consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

543. Heinricy's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

544. Heinricy's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT VIII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Chad Kerker)

545. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

546. On March 23, 2021, Defendant Chad Kerker was the Security Director at Anamosa.

547. As the Security Director, Kerker was responsible for enforcing the Department of Corrections safety policies and procedures at Anamosa.

548. Pursuant to Iowa Department of Corrections Policy IO-SC-26 ("Institutional Safety Audits"), Kerker was responsible for creating, implementing, ensuring compliance with institutional security audits of all institutions for the Iowa Department of Corrections and Anamosa.

549. Pursuant to Iowa Department of Corrections Policy IO-SC-02 ("Post Orders"), Kerker was responsible for reviewing all post orders at Anamosa.

550. Kerker had a duty to exercise reasonable care toward all employees at Anamosa.

551. Kerker was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory and administrative regulations applicable to a Security Director, including but not limited to Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Security Director to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of Anamosa were adequately trained on security measures;

e. Failing to ensure that officers and employees at Anamosa were adequately supervised;

f. Failing to ensure that inmates of Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

h. Failing to provide a safe working environment for employees at Anamosa;

i. Failing to establish and implement an adequate comprehensive workplace violence prevention program at Anamosa;

j. Failing to establish and implement an adequate emergency response plan within Anamosa;

k. Ordering, sanctioning, and/or permitting institutions, including Anamosa, to be overcapacity with inmates;

l. Ordering, sanctioning, and/or permitting institutions, including Anamosa, to be understaffed;

m. Ordering, sanctioning, and/or permitting correctional officers to engage in E-Learning while on duty at Anamosa;

n. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

o. Failing to review and/or revise insufficient post orders throughout Anamosa;

p. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

q. Failure to implement, follow, and enforce sufficient security protocols at Anamosa;

r. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

s. Failing to implement, follow, and enforce comprehensive security and safety and security audits at Anamosa;

t. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

u. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

v. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

w. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

x. Failing to respond to employee complaints regarding safety and security within Anamosa;

y. Failing to prevent inmate attacks of employees within Anamosa;

z. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

aa. In violating State and Federal laws and regulations;

bb. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Security Director in similar circumstances;

cc. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

dd. Such other acts and omissions as may be developed through the course of discovery.

552. Kerker knew of the danger(s) and/or peril(s) caused by his actions and inactions.

553. Kerker knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

554. Kerker consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

555. Kerker's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

556. Kerker's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT IX
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Scott Eschen)

557. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

558. On March 23, 2021, Defendant Eschen was a Deputy Warden at Anamosa.

559. Eschen was known amongst Iowa Department of Corrections staff, including the Named Defendants, to become friendly with dangerous inmates housed in facilities run by the Iowa Department of Corrections, including Inmate Dutcher.

560. While a member of the correctional staff at the Iowa Department of Corrections, it is believed that Eschen has been reported to the Iowa Department of Corrections and the Named Defendants by several employees for professional negligence and misconduct.

561. It is believed that Eschen had been reported to the Named Defendants for deleting major disciplinary reports and other generic notes associated with dangerous inmates of the Iowa Department of Corrections to make it more likely that the dangerous inmate would obtain a favorable transfer.

562. It is also believed that Eschen had been reported to the Iowa Department of Corrections and the Named Defendants by several employees for unacceptable relationships with dangerous inmates, such as Dutcher.

563. As a Deputy Warden, Defendant Eschen had a duty to exercise care towards employees working at Anamosa.

564. Defendant Eschen was grossly negligent, through acts and/or omissions including but not limited to the following particulars:

a. Failing to comply with the statutory and administrative regulations applicable to an Iowa Department of Corrections Deputy Warden, including but not limited to Iowa Code § 88.4(2);

b. Failing to comply with the Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Deputy Warden of Anamosa to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Modifying and/or manipulating disciplinary records of dangerous inmates including but not limited to Dutcher;

e. Failing to ensure that officers and employees of Anamosa were adequately trained;

f. Failing to ensure that officers and employees of Anamosa were adequately supervised;

g. Failing to ensure that inmates of Anamosa were adequately supervised;

h. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

i. Failing to provide a safe working environment for employees at Anamosa;

j. Failing to establish and implement an adequate comprehensive workplace violence prevention program at Anamosa;

k. Failing to establish and implement an adequate emergency response plan at Anamosa;

l. Permitting Anamosa to be overcapacity with inmates;

m. Ordering, sanctioning, and/or permitting Anamosa to be understaffed;

n. Ordering, sanctioning, and/or permitting correctional officers to engage in E-Learning while on duty at Anamosa;

o. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

p. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

q. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

r. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

s. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa;

t. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

u. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

v. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

w. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

x. Failing to respond to employee complaints regarding safety within Anamosa;

y. Failing to prevent inmate attacks of employees within Anamosa;

z. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

aa. In violating State and Federal laws and regulations;

bb. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Deputy Warden in similar circumstances;

cc. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

dd. Such other acts and omissions as may be developed through the course of discovery.

565. Eschen knew of the danger(s) and/or peril(s) caused by his actions and inactions.

566. Eschen knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

567. Eschen consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

568. Eschen's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

569. Eschen's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT X
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Brian Tracy)

570. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

571. On March 23, 2021, Defendant Brian Tracy was the Safety Officer at Anamosa.

572. As the Safety Officer, Tracy was responsible for enforcing the Department of Corrections safety policies and procedures at Anamosa.

573. Tracy had a duty to exercise reasonable care toward all employees at Anamosa.

574. Tracy was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory and administrative regulations applicable to a Safety Officer, including but not limited to Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Safety Officer to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of Anamosa were adequately trained on safety;

e. Failing to ensure that officers and employees of Anamosa were adequately supervised;

f. Failing to ensure that inmates of Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

h. Failing to provide a safe working environment for employees in Anamosa;

i. Failing to establish and implement an adequate comprehensive workplace violence prevention program at Anamosa;

j. Failing to establish and implement an adequate emergency response plan within Anamosa;

k. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

l. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

m. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

n. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

o. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa;

p. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

q. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

r. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

s. Failing to respond to employee complaints regarding safety within Anamosa;

t. Failing to prevent inmate attacks of employees within Anamosa;

u. Failing to ensure enforcement of all policies and procedures in place within the Department of Corrections and Anamosa;

v. In violating State and Federal laws and regulations;

w. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Safety Officer in similar circumstances;

x. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

y. Such other acts and omissions as may be developed through the course of discovery.

575. Tracy knew of the danger(s) and/or peril(s) caused by his actions and inactions.

576. Tracy knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

577. Tracy consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

578. Tracy's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

579. Tracy's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XI
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Robert Hartig)

580. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

581. On March 23, 2021, Defendant Robert Hartig was the Administration Captain for Anamosa.

582. Pursuant to Iowa Department of Corrections Policy IO-SC-26 ("Institutional Safety Audits"), Hartig was responsible for creating, implementing, and ensuring compliance with institutional security audits at Anamosa.

583. Hartig was also responsible for ensuring Anamosa was in compliance with all safety and security policies and procedures.

584. Pursuant to Iowa Department of Corrections Policy IO-SC-26 ("Institutional Safety Audits"), Hartig was responsible for creating, implementing, and ensuring compliance with institutional security audits of all institutions for the Iowa Department of Corrections and Anamosa.

585. Hartig had a duty to exercise reasonable care toward all employees at Anamosa.

586. Hartig was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory and administrative regulations applicable to an Administration Captain, including but not limited to Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Administration Captain to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of Anamosa were adequately trained;

e. Failing to ensure that officers and employees of Anamosa were adequately supervised;

f. Failing to ensure that inmates of Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

h. Failing to provide a safe working environment for employees in Anamosa;

i. Failing to establish and implement an adequate comprehensive workplace violence prevention program within Anamosa;

j. Failing to establish and implement an adequate emergency response plan within Anamosa;

k. Failing to ensure adequate staffing and supervision of post areas within Anamosa;

l. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;

m. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

n. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

o. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa;

p. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

q. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

r. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

s. Failing to respond to employee complaints regarding safety within Anamosa;

t. Failing to prevent inmate attacks of employees within Anamosa;

u. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

v. In violating State and Federal laws and regulations;

w. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Administration Captain in similar circumstances;

x. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

y. Such other acts and omissions as may be developed through the course of discovery.

587. Hartig knew of the danger(s) and/or peril(s) caused by his actions and inactions.

588. Hartig knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

589. Hartig consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

590. Hartig's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

591. Hartig's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Josh Ball)

592. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

593. On March 23, 2021, Defendant Josh Ball was the Captain for Anamosa.

594. As the Captain, Ball was responsible for setting goals, directing the operations of, monitoring the performance of, and setting and implementing policies at Anamosa.

595. Ball was also responsible for ensuring Anamosa was in compliance with all safety policies and procedures.

596. Ball had a duty to exercise reasonable care toward all employees at Anamosa.

597. Ball was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory and administrative regulations applicable to a Captain within the Iowa Department of Corrections, including but not limited to Iowa Code § 88.4(2);
b. Failing to comply with Iowa Department of Corrections Policies and Procedure;
c. Delegating powers and authorities given to a Captain to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;
d. Failing to ensure that officers and employees of Anamosa were adequately trained;
e. Failing to ensure that officers and employees of Anamosa were adequately supervised;
f. Failing to ensure that inmates of Anamosa were adequately supervised;
g. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;
h. Failing to provide a safe working environment for employees in Anamosa;
i. Failing to establish and implement an adequate comprehensive workplace violence prevention program within Anamosa;
j. Failing to establish and implement an adequate emergency response plan within Anamosa;
k. Failing to ensure adequate staffing and supervision of post areas within Anamosa;
l. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa;
m. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

n. Failure to implement, follow, and enforce sufficient security protocols within Anamosa;

o. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI program;

p. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

q. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

r. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

s. Failing to respond to employee complaints regarding safety within Anamosa;

t. Failing to prevent inmate attacks of employees within Anamosa;

u. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

v. In violating State and Federal laws and regulations;

w. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Captain in similar circumstances;

x. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

y. Such other acts and omissions as may be developed through the course of discovery.

598. Ball knew of the danger(s) and/or peril(s) caused by his actions and inactions.

599. Ball knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

600. Ball consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

601. Ball's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

602. Ball's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XIII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Tracy Dietsch)

603. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

604. On March 23, 2021, Defendant Tracy Dietsch was the Correctional Treatment Director at Anamosa.

605. It is believed that Dietsch was known among Iowa Department of Corrections staff, including all Named Defendants, to become friendly with dangerous inmates housed in facilities ran by the Iowa Department of Corrections, including Inmate Dutcher while at Anamosa.

606. It is believed that Dietsch allowed her personnel feelings and sympathies to compromise her professional decision-making regarding classification of inmates such as Dutcher, with whom she had created an inappropriate and unprofessional emotional bond.

607. Dietsch was responsible for planning, directing, administering, and evaluating various treatment programs within the Iowa Department of Corrections, including but not limited to those at Anamosa.

608. It is believed that it was Dietsch's responsibility to ensure all Iowa Department of Corrections and Anamosa's policies and procedures relating to the treatment of inmates.

609. It is believed that Deitsch was responsible for evaluation and classification of inmates for participation in the Inmate Maintenance Program and/or IPI Worker Program.

610. Dietsch had a duty to exercise care toward employees at Anamosa in performing duties described herein.

611. Dietsch was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with the statutory and administrative regulations applicable to Correctional Treatment Director, including but not limited to Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Correctional Treatment Director to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that inmates of Anamosa were adequately supervised;

e. Failing to provide a safe working environment for employees in Anamosa;

f. Permitting Dutcher and Woodard to be classified in a manner inconsistent with their true classification scores thereby enabling them to participate in IPI and Anamosa Inmate Worker Programs;

g. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or Iowa Prison Industries program;

h. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

i. Failing to prevent dangerous inmates from having access to tools within Anamosa;

j. Failing to respond to employee complaints regarding safety within Anamosa;

k. Failing to prevent inmate attacks of employees within Anamosa;

l. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

m. In violating State and Federal laws and regulations;

n. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Treatment Director in similar circumstances;

o. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

p. Such other acts and omissions as may be developed through the course of discovery.

612. Dietsch knew of the danger(s) and/or peril(s) caused by her actions and inactions.

613. Dietsch knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

614. Dietsch consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

615. Dietsch's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

616. Dietsch's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XIV
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Jeremy Burds)

617. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

618. On March 23, 2021, Defendant Jeremy Burds was a Senior Correctional Guard assigned as the Tool Control Sergeant.

619. As a Senior Correctional Officer assigned as a Tool Control Sergeant, Burds was responsible for tool control within the Maintenance Building at Anamosa.

620. Burds was also responsible for supervising offender's working in the Maintenance Building at Anamosa.

621. Burds had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

622. Burds was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Tool Control Sergeant to individuals, including inmates of Anamosa, who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that inmates were adequately supervised while using tools;

e. Failing to provide a safe working environment for employees in Anamosa;

f. Failing to ensure adequate staffing and supervision of post areas within Anamosa, and specifically, areas of Anamosa which housed tools;

g. Failing to exercise reasonable care in personnel oversight and management within Anamosa as it relates to inmate access, possession, and use of tools;

h. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa relating to tools and tool control;

i. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa relating to tools and tool control;

j. Failing to implement, follow, and enforce comprehensive security and safety audits of Anamosa, including areas of Anamosa which housed tools;

k. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa, including those who had access to tools;

l. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

m. Failing to respond to employee complaints regarding safety within Anamosa relating to tools and tool control;

n. Failing to prevent inmate attacks of employees within Anamosa;

o. Failing to ensure enforcement of all policies and procedures in place within Anamosa relating to tools, tool control, and inmate movement with tools;

p. In violating State and Federal laws and regulations;

q. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Tool Control Sergeant in similar circumstances;

r. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

s. Such other acts and omissions as may be developed through the course of discovery.

623. Burds knew of the danger(s) and/or peril(s) caused by his actions and inactions.

624. Burds knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

625. Burds consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

626. Burds' actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

627. Burds' acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XV
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Jon Day)

628. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

629. On March 23, 2021, Defendant Jon Day was a Prison Operations Manager at Anamosa.

630. As the Prison Operations Manager, Defendant Jon Day was responsible for oversight of the Maintenance Department at Anamosa.

631. Additionally, Defendant Jon Day was responsible for the supervision of all Correctional Trades Leaders at Anamosa.

632. Defendant Jon Day had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

633. Day was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Prison Operations Manager to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and Correctional Trades Leaders of Anamosa were adequately trained;

e. Failing to ensure that Correctional Trades Leaders of Anamosa were adequately supervised;

f. Failing to ensure that inmates of Anamosa were adequately supervised;

g. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

h. Failing to provide a safe working environment for employees in Anamosa;

i. Failing to ensure adequate staffing and supervision of post areas within Anamosa, including those designated to Correctional Trades Leaders;

j. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management with regard to Correctional Trades Leaders at Anamosa;

k. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

l. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

m. Failing to implement, follow, and enforce comprehensive security and safety audits within Anamosa;

n. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

o. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

p. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

q. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

r. Failing to respond to employee complaints regarding safety within Anamosa;

s. Failing to prevent inmate attacks of employees within Anamosa;

t. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

u. In violating State and Federal laws and regulations;

v. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Prison Operations Manager in similar circumstances;

w. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

x. Such other acts and omissions as may be developed through the course of discovery.

634. Day knew of the danger(s) and/or peril(s) caused by his actions and inactions.

635. Day knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

636. Day consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

637. Day's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

638. Day's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XVI
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Lucas Fowler)

639. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

640. On March 23, 2021, Defendant Lucas Fowler was the Associate Warden of IPI at Anamosa.

641. As the Associate Warden of IPI at Anamosa, Defendant Fowler was responsible for the control and supervision of inmates and tools within the IPI designated areas.

642. Defendant Fowler had a duty to exercise reasonable care toward all employees at Anamosa.

643. Fowler was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Associate Warden of IPI to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of IPI were adequately supervised;

e. Failing to ensure that inmates of Anamosa participating in IPI programs were adequately supervised;

f. Failing to provide a safe working environment for employees at Anamosa;

g. Failing to ensure adequate staffing and supervision of post areas within Anamosa IPI areas;

h. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa IPI areas;

i. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa IPI areas;

j. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa IPI areas;

k. Failing to implement, follow, and enforce comprehensive security and safety audits of institutions of Anamosa IPI areas;

l. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

m. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa IPI areas;

n. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools through Anamosa IPI Program;

o. Failing to respond to employee complaints regarding safety within Anamosa IPI Program;

p. Failing to prevent inmate attacks of employees within Anamosa;

q. Failing to ensure enforcement of all policies and procedures in place for the Anamosa IPI Program;

r. In violating State and Federal laws and regulations;

s. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Associate Warden of IPI in similar circumstances;

t. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

u. Such other acts and omissions as may be developed through the course of discovery.

644. Fowler knew of the danger(s) and/or peril(s) caused by his actions and inactions.

645. Fowler knew that serious injury and/or death was probable as opposed to a possible result of those danger(s) and/or peril(s).

646. Fowler consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

647. Fowler's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

648. Fowler's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XVII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Ron Beemer)

649. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

650. On March 23, 2021, Defendant Ron Beemer was a Supervisor of IPI at Anamosa.

651. As the Supervisor for IPI, Defendant Beemer was responsible for the control and supervision of inmates and tools within the IPI designated areas.

652. Defendant Beemer had a duty to exercise reasonable care toward all employees at Anamosa.

653. Beemer was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Supervisor of IPI to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of IPI were adequately supervised;

e. Failing to ensure that inmates of Anamosa participating in IPI Programs were adequately supervised;

f. Failing to provide a safe working environment for employees at Anamosa;

g. Failing to ensure adequate staffing and supervision of post areas within Anamosa IPI areas;

h. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa IPI areas;

i. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa IPI areas;

j. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa IPI areas;

k. Failing to implement, follow, and enforce comprehensive security and safety audits of institutions of Anamosa IPI areas;

l. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

m. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa IPI areas;

n. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools through Anamosa IPI Program;

o. Failing to respond to employee complaints regarding safety within Anamosa IPI Program;

p. Failing to prevent inmate attacks of employees within Anamosa;

q. Failing to ensure enforcement of all policies and procedures in place in the Anamosa IPI Program;

r. In violating State and Federal laws and regulations;

s. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Supervisor of IPI in similar circumstances;

t. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight within Anamosa under similar circumstances; and

u. Such other acts and omissions as may be developed through the course of discovery.

654. Beemer knew of the danger(s) and/or peril(s) caused by his actions and inactions.

655. Beemer knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

656. Beemer consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

657. Beemer's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

658. Beemer's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XVIII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Lance Lake)

659. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

660. On March 23, 2021, Defendant Lance Lake was a Supervisor of IPI at Anamosa.

661. As the Supervisor for IPI, Lake was responsible for the control and supervision of inmates and tools within the IPI designated areas.

662. Defendant Lake had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

663. Lake was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Supervisor of IPI to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of IPI were adequately supervised;

e. Failing to ensure that inmates of Anamosa participating in IPI Programs were adequately supervised;

f. Failing to provide a safe working environment for employees at Anamosa;

g. Failing to ensure adequate staffing and supervision of post areas within Anamosa IPI areas;

h. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa IPI areas;

i. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa IPI areas;

j. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa IPI areas;

k. Failing to implement, follow, and enforce comprehensive security and safety audits of institutions of Anamosa IPI areas;

l. Failing to create, implement, monitor, and enforce adequate policies and procedures for screening and classifying inmates for the Inmate Maintenance Worker and/or IPI Program;

m. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa IPI areas;

n. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools through Anamosa IPI Program;

o. Failing to respond to employee complaints regarding safety within Anamosa IPI Program;

p. Failing to prevent inmate attacks of employees within Anamosa;

q. Failing to ensure enforcement of all policies and procedures in place in the Anamosa IPI Program;

r. In violating State and Federal laws and regulations;

s. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Supervisor of IPI in similar circumstances;

t. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight within Anamosa under similar circumstances; and

u. Such other acts and omissions as may be developed through the course of discovery.

664. Lake knew of the danger(s) and/or peril(s) caused by his actions and inactions.

665. Lake knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

666. Lake consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

667. Lake's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

668. Lake's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XIX
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Estate of Brian Ahlrichs)

669. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

670. On March 23, 2021, Defendant Brian Ahlrichs was a Correctional Trades Leader at Anamosa.

671. As a Correctional Trades Leader, Ahlrichs was responsible for supervising inmates and assigned to work in the Maintenance Building at Anamosa.

672. Ahlrichs was also responsible for working with inmates in completing maintenance at Anamosa.

673. Ahlrichs had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

674. Ahlrichs was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Correctional Trades Leaders to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that the Maintenance Area of Anamosa was adequately supervised;

e. Failing to ensure that inmates of Anamosa were adequately supervised;

f. Failing to provide a safe working environment for employees in Anamosa;

g. Failing to ensure adequate staffing and supervision of post areas within Anamosa's Maintenance Areas;

h. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

i. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

j. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

k. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

l. Failing to prevent inmate attacks of employees within Anamosa;

m. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

n. In violating State and Federal laws and regulations;

o. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by Correctional Trades Leader in similar circumstances;

p. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight within Anamosa, under similar circumstances; and

q. Such other acts and omissions as may be developed through the course of discovery.

675. Ahlrichs knew of the danger(s) and/or peril(s) caused by his actions and inactions.

676. Ahlrichs knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

677. Ahlrichs consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

678. Ahlrichs' actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

679. Ahlrichs' acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XX
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Michael Kray)

680. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

681. On March 23, 2021, Defendant Michael Kray was a Correctional Trades Leader at Anamosa.

682. As a Correctional Trades Leader, Kray was responsible for supervising inmates and assigned to work in the Maintenance Building at Anamosa.

683. Kray was also responsible for working with inmates in completing maintenance at Anamosa.

684. Kray had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

685. Kray was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2).

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Correctional Trades Leaders to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that the Maintenance Area of Anamosa was adequately supervised;

e. Failing to ensure that inmates of Anamosa were adequately supervised;

f. Failing to provide a safe working environment for employees in Anamosa;

g. Failing to ensure adequate staffing and supervision of post areas within Anamosa's Maintenance Areas;

h. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

i. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

j. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

k. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

l. Failing to prevent inmate attacks of employees within Anamosa;

m. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

n. In violating State and Federal laws and regulations;

o. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Trades Leader in similar circumstances;

p. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight within Anamosa, under similar circumstances; and

q. Such other acts and omissions as may be developed through the course of discovery.

686. Kray knew of the danger(s) and/or peril(s) caused by his actions and inactions.

687. Kray knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

688. Kray consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

689. Kray's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

690. Kray's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XXII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Kurt Gillmore)

691. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

692. On March 23, 2021, Defendant Kurt Gillmore was a Correctional Trades Leader at Anamosa.

693. As a Correctional Trades Leader, Gillmore was responsible for supervising inmates and assigned to work in the Maintenance Building at Anamosa.

694. Gillmore was also responsible for working with inmates in completing maintenance at Anamosa.

695. Gillmore had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

696. Gillmore was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Correctional Trades Leaders to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that the Maintenance Area of Anamosa was adequately supervised;

e. Failing to ensure that inmates of Anamosa were adequately supervised;

f. Failing to provide a safe working environment for employees in Anamosa;

g. Failing to ensure adequate staffing and supervision of post areas within Anamosa's Maintenance Areas;

h. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

i. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

j. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

k. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

l. Failing to prevent inmate attacks of employees within Anamosa;

m. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

n. In violating State and Federal laws and regulations;

o. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Trades Leader in similar circumstances;

p. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight within Anamosa, under similar circumstances; and

q. Such other acts and omissions as may be developed through the course of discovery.

697. Gillmore knew of the danger(s) and/or peril(s) caused by his actions and inactions.

698. Gillmore knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

699. Gilmore consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

700. Gillmore's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

701. Gillmore's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XXIII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Lawrence McMahon)

702. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

703. On March 23, 2021, Defendant McMahon was a Correctional Trades Leader at Anamosa.

704. As a Correctional Trades Leader, McMahon was responsible for supervising inmates and assigned to work in the Maintenance Building at Anamosa.

705. McMahon was also responsible for working with inmates in completing maintenance at Anamosa.

706. McMahon had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

707. McMahon was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Correctional Trades Leaders to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that Maintenance Area of Anamosa was adequately supervised;

e. Failing to ensure that inmates of Anamosa were adequately supervised;

f. Failing to provide a safe working environment for employees in Anamosa;

g. Failing to ensure adequate staffing and supervision of post areas within Anamosa's Maintenance Areas;

h. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

i. Failing to implement, follow, and enforce comprehensive reviews of security measures within Anamosa;

j. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

k. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

l. Failing to prevent inmate attacks of employees within Anamosa;

m. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

n. In violating State and Federal laws and regulations;

o. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by Correctional Trades Leader in similar circumstances;

p. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

q. Such other acts and omissions as may be developed through the course of discovery.

708. McMahon knew of the danger(s) and/or peril(s) caused by his actions and inactions.

709. McMahon knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

710. McMahon consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

711. McMahon's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

712. McMahon's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XXIV
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Brian Suthers)

713. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

714. On March 23, 2021, Defendant Brian Suthers was a Correctional Officer at Anamosa assigned to RE-14 Checkpoint.

715. As the Correctional Officer assigned to the RE-14 Checkpoint, Suthers was responsible for supervising inmates and controlling the RE-14 Checkpoint.

716. Suthers had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

717. Suthers was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Correctional Officer at RE-14 checkpoint to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that RE-14 Checkpoint was adequately supervised;

e. Failing to ensure that inmates of Anamosa were adequately supervised;

f. Failing to search inmates of Anamosa passing through the RE-14 Checkpoint;

g. Failing to provide a safe working environment for employees in Anamosa;

h. Failure to implement, follow, and enforce sufficient safety and security protocols within Anamosa;

i. Failing to supervise, monitor, and control inmate movements throughout Anamosa;

j. Failing to prevent inmate attacks of employees within Anamosa;

k. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

l. In violating State and Federal laws and regulations;

m. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by Correctional Officer in similar circumstances; and

n. Such other acts and omissions as may be developed through the course of discovery.

718. Suthers knew of the danger(s) and/or peril(s) caused by his actions and inactions.

719. Suthers knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

720. Suthers consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

721. Suther's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

722. Suther's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XXV
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant John Clark)

723. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

724. On March 23, 2021, Defendant John Clark was a Correctional Officer assigned as the Master Control at Anamosa.

725. As the Master Control, J. Clark was responsible for supervising the Control Center at Anamosa and operating the prison's Engineering Controls.

726. J. Clark had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

727. J. Clark was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Master Control to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that inmates of Anamosa were adequately supervised;

e. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

f. Failing to provide a safe working environment for employees in Anamosa;

g. Failing to establish and implement an adequate emergency response plan within Anamosa;

h. Failing to exercise reasonable care, personnel oversight, and management within Anamosa;

i. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

j. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

k. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

l. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

m. Failing to respond to employee complaints regarding safety within Anamosa;

n. Failing to prevent inmate attacks of employees within Anamosa;

o. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

p. In violating State and Federal laws and regulations;

q. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Master Control in similar circumstances;

r. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Anamosa under similar circumstances; and

s. Such other acts and omissions as may be developed through the course of discovery.

728. J. Clark knew of the danger(s) and/or peril(s) caused by his actions and inactions.

729. J. Clark knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

730. J. Clark consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

731. J. Clark's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

732. J. Clark's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XXVI
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Todd Dingbaum)

733. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

734. On March 23, 2021, Defendant Todd Dingbaum was a Correctional Officer assigned as the Master Control at Anamosa.

735. As the Master Control, Dingbaum was responsible for supervising the Control Center at Anamosa and operating the prison's Engineering Controls.

736. Dingbaum had a duty to exercise reasonable care toward all employees at Anamosa, including Officer McFarland.

737. Dingbaum was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Master Control to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that inmates of Anamosa were adequately supervised;

e. Failing to ensure that officers and employees of Anamosa were adequately equipped with communications and other necessary safety equipment;

f. Failing to provide a safe working environment for employees in Anamosa;

g. Failing to establish and implement an adequate emergency response plan within Anamosa;

h. Failing to exercise reasonable care, personnel oversight, and management within Anamosa;

i. Failure to implement, follow, and enforce sufficient safety protocols within Anamosa;

j. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate movements throughout Anamosa;

k. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa;

l. Failing to create, implement, monitor, and enforce adequate policies and procedures for use and maintenance of adequate Control Centers and/or Engineering Controls within Anamosa;

m. Failing to respond to employee complaints regarding safety within Anamosa;

n. Failing to prevent inmate attacks of employees within Anamosa;

o. Failing to ensure enforcement of all policies and procedures in place at Anamosa;

p. In violating State and Federal laws and regulations;

q. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Master Control in similar circumstances;

r. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight within Anamosa under similar circumstances; and

s. Such other acts and omissions as may be developed through the course of discovery.

738. Dingbaum knew of the danger(s) and/or peril(s) caused by his actions and inactions.

739. Dingbaum knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

740. Dingbaum consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

741. Dingbaum's actions constituted willful and wanton disregard of the health and safety of Officer McFarland, and other similarly situated employees, and amounted to gross negligence.

742. Dingbaum's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

COUNT XXVII
CO-EMPLOYEE GROSS NEGLIGENCE – WRONGFUL DEATH
(Defendant Jerome Greenfield)

743. Plaintiffs replead and incorporate by reference the allegations in the paragraphs above as though fully set forth herein.

744. Defendant Greenfield was the Health Services Administrator for the Iowa Department of Corrections.

745. Greenfield was responsible for overseeing the health of patients at all nine Iowa Correctional Facilities controlled and operated by Anamosa.

746. Greenfield was responsible for the implementation, creation, and enforcement of policies and procedures relating to the Dispensing and Medication Administration (HSP-404).

747. Greenfield was also responsible for ensuring that the Infirmary at Anamosa was appropriately staffed, and for ensuring the safety of inmate patients and employees working in the Infirmary at Anamosa.

748. Greenfield was grossly negligent, through acts and omissions including but not limited to the following particulars:

a. Failing to comply with Iowa Code § 88.4(2);

b. Failing to comply with Iowa Department of Corrections Policies and Procedures;

c. Delegating powers and authorities given to the Health Services Administrator to individuals who were not qualified or competent nor fit for the performance of the assigned duties and responsibilities;

d. Failing to ensure that officers and employees of Anamosa Health Services were adequately trained;

e. Failing to ensure that officers and employees of Anamosa Health Services were adequately supervised;

f. Failing to ensure that inmates of Anamosa Health Services were adequately supervised;

g. Failing to ensure that officers and employees of Anamosa Health Services were adequately equipped with communications equipment and other necessary safety equipment;

h. Failing to provide a safe working environment for employees in Anamosa Health Services;

i. Failing to ensure adequate staffing and supervision of post areas within Anamosa Health Services;

j. Failing to exercise reasonable care in hiring, firing, promoting, demoting, and other personnel oversight and management within Anamosa Health Services;

k. Failing to establish and implement effective methods of supervising, monitoring, and controlling inmate's movements throughout Anamosa Health Services;

l. Failing to create, implement, monitor, and enforce adequate policies and procedures limiting, restricting, and supervising inmate access and/or use of tools within Anamosa Health Services;

m. Failing to respond to employee complaints regarding safety within Anamosa Health Services;

n. Failing to prevent inmate attacks of employees within Anamosa Health Services;

o. Failing to ensure enforcement of all policies and procedures in place within Anamosa Health Services;

p. In violating State and Federal laws and regulations;

q. Failure to use and exercise that degree of skill, care, and learning ordinarily possessed and exercised by a Correctional Department Health Services Administrator in similar circumstances;

r. Failing to act or comply with industry standards related to the operation, training, supervision, and oversight of Department of Corrections Health Services under similar circumstances; and

s. Such other acts and omissions as may be developed through the course of discovery;

749. Greenfield knew of the danger(s) and/or peril(s) caused by his actions and inactions.

750. Greenfield knew that serious injury and/or death was a probable as opposed to a possible result of those danger(s) and/or peril(s).

751. Greenfield consciously failed to remedy and/or avoid the danger(s) and/or peril(s).

752. Greenfield's actions constituted willful and wanton disregard of the health and safety of Officer McFarland and amounted to gross negligence.

753. Greenfield's acts and/or omissions were a cause of the death of Officer McFarland and Plaintiffs' damages.

DAMAGES COMMON TO ALL COUNTS AND ALL NAMED DEFENDANTS

754. The acts and/or omissions of each Named Defendant, acting alone or in concert with one another, were the cause of the death of Officer McFarland and Plaintiffs' Damages, including but not limited to:

a. Pre-death pain and suffering;

b. Past loss of full use of mind and body;

c. Past medical expenses;

d. Past and future loss of earnings;

e. Loss of opportunity for survival;

f. Burial and interests on burial expenses;

g. Loss of spousal consortium of Plaintiff, Sara Montague;

h. Loss of parental consortium of Plaintiff, Sara Montague as Next Friend of C.M., a Minor; and

i. Present value of the loss of accumulation of the Estate of Robert McFarland.

WHEREFORE, Plaintiffs respectfully request that the Court enter judgment against the Defendants in an amount that will fully and fairly compensate them for their injuries and damages; for attorneys' fees as allowed by law; for interest and costs as allowed by law; and for any other such and further relief the Court deems just and necessary.

JURY DEMAND

Plaintiffs hereby demand a jury on all legal claims and issues raised by the Petition.

Respectfully submitted,

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