

No. 26-

IN THE
Supreme Court of the United States

BRAD PASSWATER,

Petitioner,

v.

DR. DANIEL RIPPETOE AND
DEPUTY WARDEN TRICIA PRETORIUS,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED
STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

PATRICK A. SHOULDERS
Counsel of Record
ROBERT L. BURKART
ZIEMER, STAYMAN, WEITZEL
& SHOULDERS, LLP
20 NW First Street, 9th Floor
P.O. Box 916
Evansville, IN 47706
(812) 424-7575
pshoulders@zsws.com

Attorneys for Petitioner

QUESTIONS PRESENTED

In *Farmer v. Brennan*, 511 U.S. 825 (1994), this Court held that prison officials violate the Eighth Amendment’s prohibition on cruel and unusual punishment if they exhibit “deliberate indifference” to a substantial risk of serious harm to an inmate. “Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence.” *Id.* at 842.

1. Brad Passwater, a prisoner with paranoid schizophrenia, experienced a psychotic episode while on suicide watch. After determining that Brad was suicidal and posed an imminent and substantial risk of self-harm, Dr. Rippetoe prescribed involuntary psychotropic medication. Dr. Rippetoe admitted, and Brad’s expert agreed, that the standard of care required Dr. Rippetoe to assess the medication’s effectiveness through follow-up care. He provided none as Brad’s psychosis worsened, resulting in Brad gouging out his eyes, causing permanent blindness, and ripping out his testicles with his bare hands. Although the Seventh Circuit assumed no follow-up care occurred, it held that “best practices” and standard of care are words of negligence and cannot, as a matter of law, support an inference of deliberate indifference.¹

Whether, under *Farmer v. Brennan*, a court may reject an inference of deliberate indifference by treating evidence of accepted medical practice as merely evidence of negligence, without giving that evidence its cumulative

1. The video of Brad’s self-harm is included in the appellate Record.

inferential force alongside a psychiatrist's admitted knowledge of a prisoner's substantial and imminent risk of self-harm, the psychiatrist's emergency involuntary-medication order, and the assumed absence of any post-medication follow-up?

2. The prison uses inmates as suicide watch companions. During constant suicide watch with the cell door closed, prison policy limited companion's shifts to two hours because they had to continuously stand and observe through a small window in the cell door. Brad's companion was assigned a four-hour shift. While the companion sat in a chair, Brad spent 52 minutes gouging out his eyes and ripping out his testicles. Despite assuming that Deputy Warden Tricia Pretorius knew of systemic noncompliance with the two-hour policy – a safeguard critical to inmate safety – and failed to ensure compliance, the Seventh Circuit held that the companion's failure to observe Brad was a superseding cause precluding her liability.

In challenging a deputy warden's knowing failure to correct systemic noncompliance with a suicide-watch shift limit, can a companion's failure to maintain observation be deemed a superseding cause as a matter of law because he could have detected self-harm before the required rotation, without resolving foreseeability and whether that failure fell within the risk the safeguard addressed?

PARTIES TO THE PROCEEDINGS

Petitioner Brad Passwater was the Plaintiff in the proceedings before the United States District Court for the Southern District of Indiana, Terre Haute Division; and the Appellant in the proceedings before the United States Court of Appeals for the Seventh Circuit.

Respondents Dr. Daniel Rippetoe and Deputy Warden Tricia Pretorius were the Defendants in the proceedings before the United States District Court for the Southern District of Indiana, Terre Haute Division; and the Appellees in the proceedings before the United States Court of Appeals for the Seventh Circuit.

There are no corporate parties.

CORPORATE DISCLOSURE STATEMENT

Petitioner is an individual. No corporate disclosure is required of him under Sup. Ct. R. 29.6.

STATEMENT OF RELATED PROCEEDINGS

Federal Proceedings (Under Review)

Passwater v. Pretorius, et al., No. 25-1149 (U.S. Ct. App. 7th Cir.) (183 F.4th 531) (July 23, 2026) (opinion affirmed district court's order granting summary judgment to defendants [Dkt. 34] and Final Judgment thereon [Dkt. 35])

Passwater v. Pretorius, et al., No. 2:21-cv-00475-MPB-MG (U.S. District Court, S.D. Indiana, Terre Haute Division Jan. 2, 2025) (2025 WL 411782) (order granted defendants' motions for summary judgment [Dkt. 129] and Final Judgment thereon [Dkt. 130])

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PETITION FOR WRIT OF CERTIORARI

Petitioner Brad Passwater respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit (Pet. App. 1a-18a) is reported at 183 F.4th 531. The United States District Court for the Southern District of Indiana Terre Haute Division's opinion (Pet. App. 21a-40a) is not reported in Fed. Supp., 2025 WL 411782, and is reproduced as Appendix B.

JURISDICTION

This Court's judgment is invoked under 28 U.S.C. § 1254(1). The Seventh Circuit Court of Appeals issued its opinion on July 23, 2026. No rehearing petition was filed. This Petition is timely filed under Supreme Court Rule 13.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Eighth Amendment to the U.S. Constitution provides: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

42 U.S.C. § 1983 provides: Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction

thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

STATEMENT OF THE CASE

A. Factual Background as to Dr. Rippetoe.

Brad has paranoid schizophrenia. As of April 16, 2020, he was incarcerated at Plainfield, Indiana, Correctional Facility, and had been on 24/7 constant suicide watch for several days. At the prison, Brad was being treated by Dr. Rippetoe, a psychiatrist residing in Florida, who provided psychiatric services to inmates via telehealth. On April 16, Brad had a psychotic episode, and Dr. Rippetoe ordered a nurse to give Brad emergency medication. Dr. Rippetoe ordered the medication after determining that Brad met the requirements under the Indiana Department of Correction's medication policy (the "Policy"), including a determination that (i) Brad was acutely or chronically mentally ill, (ii) he was suicidal, and (iii) he had a clear and imminent substantial threat of physical self-harm.

Said Policy required nursing staff to assess Brad for medication effects at 15-minute intervals for two hours and report on behavioral effect to Dr. Rippetoe

after two hours. The nursing staff did not assess Brad or report to Dr. Rippetoe. The electronic medical records contain an entry by a mental health professional within two hours of Brad receiving the medication which noted that Brad's psychosis had worsened. Two hours after the mental health professional's assessment, Brad's self-harm commenced, and he gouged out his eyes, causing permanent blindness, and ripped out his testicle with his bare hands. Dr. Rippetoe admitted the standard of care required him to follow up and assess the medications' effectiveness and whether Brad's behavior had improved.

Brad's expert also opined that "best practices," *i.e.*, the standard of care, required a post-medication assessment by Dr. Rippetoe. For purposes of summary judgment, the Seventh Circuit assumed that Dr. Rippetoe did not provide any post-medication care.

B. Procedural history as to Dr. Rippetoe.

Dr. Rippetoe filed a motion for summary judgment but did not challenge the objective component of Brad's deliberate indifference claim. The District Court granted the motion by holding that the medication regimen met the standard of care. Brad, however, did not challenge the medication regimen. He challenged the lack of post-medication care.

On appeal, the Seventh Circuit affirmed the District Court. The Seventh Circuit noted the parties did not dispute that Brad suffered from an objectively serious medical condition or that he was at a serious risk of committing suicide. The Seventh Circuit stated, the question is whether a reasonable jury could find that

Dr. Rippetoe acted with deliberate indifference when he failed to provide any follow-up care after ordering the emergency medication. The Seventh Circuit held (i) Brad failed to present evidence that “no minimally competent” physician would have behaved as Dr. Rippetoe did, and (ii) it would not have been obvious to a minimally competent physician that a failure to act would have resulted in a serious risk of harm to Brad. The Seventh Circuit determined, as a matter of law, that no reasonable jury could find in Brad’s favor because Dr. Rippetoe’s testimony as to the standard of post-medication care and Brad’s expert’s testimony as to “best practices” “are words of negligence and not deliberate indifference.”

C. Factual Background as to Deputy Warden Pretorius.

Plainfield utilized trained inmates to help prison officials monitor individuals on suicide watch, and their shifts were generally four hours. Plainfield’s suicide policy required constant observation of an inmate where there is an imminent danger of engaging in self-injurious behavior. The inmate suicide watch cells have an exterior door with a small window, and when closed the suicide companion can only keep the required one-to-one, line of sight, direct visual observation by standing and observing through the door window.

Plainfield implemented a two-hour policy for companions observing inmates on constant suicide watch when the cell door is closed because four-hours is a long time to continuously stand, and it wanted to avoid companion complacency and ensure inmate safety (the “Two-Hour Policy”). On April 16, Brad was on constant

suicide watch with the cell door closed. His companion (the “Companion”) was scheduled for a four-hour shift beginning at noon, and he sat in a chair rather than standing and observing Brad. Approximately an hour and one-half into Companion’s shift, Brad’s self-harm began, and it continued unnoticed for 52 minutes before correctional staff intervened.

D. Procedural history as to Deputy Warden Pretorius.

Deputy Warden Pretorius filed a motion for summary judgment denying the existence of the Two-Hour Policy, any systemic noncompliance, or knowledge thereof. While omitting consideration of the Two-Hour Policy, the District Court granted the motion by holding that there was no widespread practice of an unconstitutional nature.

On appeal, the Seventh Circuit affirmed the District Court. The Seventh Circuit assumed that there is evidence from which a reasonable jury could find (i) the existence of the Two-Hour Policy, (ii) the Two-Hour Policy was necessary for the safety of inmates and played a significant role in the prison’s ability to monitor severely suicidal inmates, (iii) systemic noncompliance with the Two-Hour Policy, and (iv) Deputy Warden Pretorius’s failure to correct it. Without assessing foreseeability or risk, the Seventh Circuit held Companion’s failure to observe was a superseding cause that severed any liability of Deputy Warden Pretorius.

REASONS FOR GRANTING THE WRIT

I. The medical evidence must be considered as part of the totality of evidence.

A. Circumstantial proof must remain a meaningful route to a jury.

Farmer v. Brennan, 511 U.S. 825, 837, 842–45 (1994), requires actual awareness and disregard of a substantial risk, while allowing awareness to be inferred from circumstantial evidence, including an obvious danger. It also protects officials who respond reasonably. That framework requires a contextual inquiry; it does not demand an admission of unconstitutional intent. At summary judgment, the question is whether the evidence permits the necessary inference, not whether it compels it.

Here, the evidence established:

- Dr. Rippetoe’s knowledge of Brad’s suicide watch;
- Dr. Rippetoe’s knowledge of Brad’s psychiatric emergency;
- Dr. Rippetoe’s involuntary-medication decision made under a restrictive Policy;
- Dr. Rippetoe’s determinations under the Policy that Brad was acutely or chronically mentally ill, and there existed a clear and imminent substantial threat that Brad was suicidal and will cause serious physical self-harm;

- Dr. Rippetoe’s testimony that the medical standard of care required his post-medication assessment of Brad;
- Dr. Rippetoe’s knowledge of Policy monitoring requirements, including he be apprised of Brad’s post-medication behavior after two hours;
- Dr. Rippetoe’s knowledge of and access to Brad’s electronic medical records;
- The existence of electronic medical records (“EMR”) showing no post-medication nurse monitoring or communication with Dr. Rippetoe, and a mental health professional’s assessment that Brad’s psychosis was worsening;
- Brad’s expert’s testimony that a lack of post-medication assessment by Dr. Rippetoe was inconsistent with “best practices;”
- The Seventh Circuit’s assumption for summary judgment that Dr. Rippetoe did not provide any post-medication care; and
- The Seventh Circuit’s assumption for summary judgment that the parties did not dispute that Brad suffered from an objectively serious medical condition or that he was at a serious risk of committing suicide.

Dr. Rippetoe knew of the imminent risk of self-harm and the need for his follow-up care, but he provided none, *i.e.*, the complete absence of professional judgment during a diagnosed emergency of suicide/self-harm. Each

evidentiary item has a different role. The suicide watch and psychiatric emergency bear on awareness; the Policy and testimony bear on the understood need for his post-medication assessment; the electronic medical records and lack of follow-up bear on the response. The inference of deliberate indifference arises from their combination.

The Seventh Circuit's treatment deprived the standards evidence of that contextual force. It described medical care which is "standard" and "common" as only "words of negligence," then rejected Brad's expert's "best-practices" formulation because failure to follow same is not deliberate indifference. [Pet. App. 12a-14a]. While medical standard evidence may support a negligence inference, it can also support a more culpable inference when combined with other proof. The legal classification of an isolated phrase cannot decide what the whole record shows about a defendant's state of mind.

B. Professional language cannot become an extra evidentiary element.

The formulation concerning what no minimally competent professional would do can help distinguish professional judgment from constitutionally culpable disregard. It should not become a requirement that an expert recite those exact words.

Brad's expert criticized the failure to comply with post-medication "best practices," *i.e.*, standard of care. Dr. Rippetoe's testimony supplied additional evidence about the need for follow-up care. [Pet. App. 12a-14a]. The question is what those opinions and admissions establish in context, not whether a witness states the ultimate legal conclusion.

The Tenth Circuit's decision in *Mata v. Saiz*, 427 F.3d 745, 757–59 (10th Cir. 2005), examines the whole course of care and recognizes the relevance of protocols, expert evidence, a physician's own testimony, and the defendant's knowledge in assessing whether deliberate indifference could be inferred. Its facts differ, and it does not establish that this particular record necessarily suffices. It supports the narrower proposition that medical-standard evidence can contribute to proof of deliberate indifference even though a violation of the standard alone would be inadequate.

Mata permits a jury to evaluate whether a departure from a known treatment requirement, considered with the doctor's knowledge, reflects disregard rather than a permissible medical choice. *Id.* The evidence here must receive the same contextual assessment. An expert's use of ordinary clinical terminology does not strip that evidence of probative value concerning what the defendant understood and failed to do. Such recognizes a totality of circumstances approach which is consistent with this Court's holding in *Farmer* that the Eighth Amendment subjective requirement may be established by "reliance on any relevant evidence." See *supra*, at 848.

Providing some treatment does not necessarily resolve a claim that a separate necessary response was withheld. *Zaya v. Sood*, 836 F.3d 800, 805 (7th Cir. 2016). The initial prescription may have reflected sound judgment while the subsequent absence of judgment remained unjustified. Brad does not ask the Court to decide that every missed assessment is deliberate indifference. He asks that an omission during a known emergency be evaluated on the evidence of awareness and response, with reasonable

inferences drawn in his favor as Fed. R. Civ. P. 56 and *Tolan v. Cotton*, 572 U.S. 650, 656–60 (2014) require.

The conflict asserted is therefore with the restrictive treatment of evidence in this decision, not with an express holding that all standards evidence is inadmissible. The Seventh Circuit did not announce such a categorical rule. Brad seeks review of an application that effectively deprives circumstantial evidence of its combined force. The ground for review is the decision's incompatibility with *Farmer's* treatment of circumstantial proof, reinforced by the method used in *Mata, supra*.

C. The Policy bears on actual knowledge.

1. The order and the known suicide watch supply the starting point.

The Policy matters for two distinct reasons. Its emergency criteria bear on what Dr. Rippetoe understood before he ordered treatment. Its monitoring provisions bear on the protective response contemplated afterward. Brad does not contend that a policy violation itself establishes an Eighth Amendment violation. He contends that the Policy, the doctor's familiarity with it, and his testimony about satisfying its criteria are evidence of actual awareness when read with his knowledge of the suicide watch.

Dr. Rippetoe's medication order establishes a specific finding of imminent suicide and self-harm. But the record also identified suicidal ideation and constant watch. The relevant risk was already present when Dr. Rippetoe acted. Whether he later read the EMR describing Brad's

worsening psychosis cannot be the exclusive route to proving awareness of danger.

2. The absence of new information did not establish that the known danger ended.

The Seventh Circuit held that any failure of Dr. Rippetoe to read the EMR would not have created an awareness of a serious risk of harm to Brad. [Pet. App. 14a]. The EMR is evidence that the psychosis continued; without proof Rippetoe read it, it is not proof that its contents reached him. Brad accepts that distinction. But administering emergency medication did not, as a matter of law, establish resolution of the previously known risk. A factfinder could consider the absence of the expected assessment information in deciding whether the doctor consciously left that risk unaddressed.

The Policy assigned particular observation and reporting tasks to nurses. It should not be rewritten as an express command that the psychiatrist personally examine the patient within two hours. The asserted responsibility for follow-up instead rests on Dr. Rippetoe's prescribing role, his testimony of required follow-up care, the known emergency, and the absence of post-medication judgment. Those facts require an inference of actual disregard, not merely a showing that he ought to have known more.

Farmer does not permit liability based solely on what a reasonable doctor should have perceived. 511 U.S. at 837–38. But it also does not require a new warning of the same substantial danger each time a protective step fails. The additional requirement Brad challenges is proof

of knowledge of the later deterioration as if knowledge of the original, still-unresolved emergency could have no evidentiary significance. Review would clarify that distinction while preserving the defense of a genuinely reasonable response.

II. Foreseeability and concurrent causation require review.

A. The claim concerns Deputy Warden Pretorius's own conduct.

Brad does not rely on respondeat superior. Section 1983 requires a connection between the official's own misconduct and the deprivation. *Ashcroft v. Iqbal*, 556 U.S. 662, 676 (2009). The asserted misconduct is Deputy Warden Pretorius's knowing failure to correct systemic noncompliance with a safety-critical rotation policy. The Seventh Circuit recognized evidence supporting that theory. [Pet. App. 14a-17a].

Companion's role in the institutional watch explains the protective arrangement; it does not automatically impute his liability to Pretorius. The Seventh Circuit held that Companion's failure to stand was a superseding cause, reasoning that, had he stood, he would have observed Brad's self-harm and alerted staff within the first two hours of his shift. [Pet. App. 17a-18a].

But it did not address whether the Companion's failure was independent and unforeseeable—or instead a foreseeable consequence of the Deputy Warden Pretorius's assumed failure to enforce the two-hour safeguard. The Seventh Circuit assumed the purpose of the Two-Hour

Policy was to prevent companion complacency and ensure inmate safety. Companion's ability to avert harm does not by itself establish that the missed rotation could not also have a causal role. *See Staub v. Proctor Hospital*, 562 U.S. 411, 420 (2011) (an injury may have more than one proximate cause).

The causal inquiry must therefore ask whether her assumed disregard helped produce injury within the danger the Two-Hour Policy rotation requirement addressed. *County of Los Angeles v. Mendez*, 581 U.S. 420, 431–32 (2017), directs attention to foreseeability and the scope of risk associated with the particular constitutional violation. *Mendez* did not resolve this case's facts, but its method requires identifying that specific risk before declaring a later act superseding.

B. Failure of observation was within the safeguard's purpose.

The shift limitation was linked to the need to stand continuously to observe through a small window in the cell door to ensure suicidal inmate safety. The Opinion explains why ordinary seating was inadequate and why shifts were shortened. [Pet. App. 15a-16a]. The foreseeable concern was unnoticed inmate self-harm and companion complacency, *i.e.*, the loss of effective observation during that demanding assignment. A companion who remains seated cannot detect the danger constant watch exists to address. That connection supports a jury inference that Companion's lapse fell within the risk of Deputy Warden Pretorius disregarding the Two-Hour Policy safeguard. In fact, the very harm the Two-Hour Policy was designed to prevent occurred.

The Companion's refusal to stand, even after instructions, may support the characterization of an independent act. But it also permits inquiry into whether noncompliance by a suicide companion was a foreseeable failure the rotation arrangement was meant to reduce. Deliberate disobedience does not answer that scope-of-risk inquiry merely by being deliberate. The Seventh Circuit did not establish why this record permits only the conclusion that Companion's conduct was outside the relevant risk.

III. The questions warrant review.

The petition presents recurring questions about how constitutional claims may be proved when the decisive evidence is circumstantial and protective responsibilities are distributed among several actors. If medical standards are discounted because they also describe negligence, the remaining knowledge evidence may be evaluated in an artificial vacuum. If a foreseeable monitoring failure necessarily supersedes an official's knowing failure to maintain the relevant safeguard, the causal analysis may insulate the very omission challenged.

The requested review is grounded principally in the asserted conflict with this Court's decisions, under Sup. Ct. R. 10(c), rather than a claim of a demonstrated circuit split. The Seventh Circuit recited generally correct standards. Brad contends its operative analysis nevertheless imposed evidentiary and causal barriers inconsistent with those standards. Brad recognizes that this Court ordinarily does not grant review merely to reconsider factual applications of settled law. The importance of this case lies in whether the stated legal tests retain their meaning when applied

to omitted care and failed suicide-watch safeguards. The Court can resolve those questions without deciding which witness to believe or whether respondents ultimately are liable.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

PATRICK A. SHOULDERS

Counsel of Record

ROBERT L. BURKART

ZIEMER, STAYMAN, WEITZEL

& SHOULDERS, LLP

20 NW First Street, 9th Floor

P.O. Box 916

Evansville, IN 47706

(812) 424-7575

pshoulders@zsww.com

Attorneys for Petitioner

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**APPENDIX A — OPINION OF THE UNITED
STATES COURT OF APPEALS FOR THE
SEVENTH CIRCUIT, FILED JULY 23, 2026**

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 25-1149

BRAD PASSWATER,

Plaintiff-Appellant,

v.

TRICIA PRETORIUS, *et al.*,

Defendants-Appellees.

Argued November 5, 2025

Decided July 23, 2026

OPINION

Appeal from the United States District Court for the
Southern District of Indiana, Terre Haute Division.
No. 2:21-cv-475 — **Matthew P. Brookman**, *Judge*.

Before RIPPLE, KIRSCH, and LEE, *Circuit Judges*.

LEE, *Circuit Judge*. Brad Passwater, who has been incarcerated at Plainfield Correctional Facility for several years, suffers from paranoid schizophrenia. After

Appendix A

expressing suicidal thoughts, he was placed on constant suicide watch twenty-four hours a day, seven days a week.

At some point, while on suicide watch, Passwater suffered a psychotic episode, and the prison's psychiatrist, Dr. Daniel Rippetoe, who worked remotely, ordered the on-site nurse to give Passwater an emergency dose of psychotropic medication. No one, however, followed up with Passwater to see if he was experiencing any adverse effects from the medication. Unfortunately, the medication exacerbated Passwater's psychosis, and he began harming himself, eventually gouging out his eyes and ripping out his testicles.

To prevent such incidents, Plainfield utilized trained inmates (called "suicide companions") to help prison officials monitor individuals on suicide watch, like Passwater. The suicide companions would typically stand outside of the suicidal prisoner's cell and observe the subject through a small window located towards the top of the cell door. Passwater's suicide companion, however, was sitting down during his shift and did not see Passwater harm himself.

Pursuant to 42 U.S.C. § 1983, Passwater sued Dr. Rippetoe, as well as the prison's Deputy Warden, Tricia Pretorius, for exhibiting deliberate indifference to his medical needs in violation of the Eighth Amendment. Specifically, Passwater claims that Dr. Rippetoe failed to provide any follow-up care following the emergency administration of psychotropic medication. As for Deputy Warden Pretorius, Passwater alleges that she was aware

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that Plainfield's suicide companions were not adequately monitoring suicidal prisoners but took no action. The district court granted summary judgment for the defendants, and Passwater appeals.

This case is unquestionably a tragic one. We have no doubt that Passwater required some medical care following the administration of the psychotropic medication. But the question before us is more limited: whether the record contains evidence from which a rational jury could find that these two defendants violated Passwater's Eighth Amendment rights. Unable to discern an evidentiary basis from which a reasonable jury could find in Passwater's favor, we affirm.

I. Background

Because Passwater challenges the district court's order granting summary judgment to the defendants, we recount the facts in the light most favorable to him. *See Sanders v. Moss*, 153 F.4th 557, 561 (7th Cir. 2025).

A. April 16, 2026 Incident

Passwater was incarcerated at Plainfield Correctional Facility ("Plainfield"), part of the Indiana Department of Corrections ("IDOC"), during the events in question. He has a long history of mental illness, including a diagnosis of paranoid schizophrenia, of which Plainfield was aware.

At the prison, Passwater was being treated by Dr. Rippetoe, a psychiatrist whom Plainfield hired to provide

Appendix A

medical care for its inmates. Dr. Rippetoe resided in Florida and had been providing psychiatric services to Plainfield inmates via telehealth appointments since 2019. Because of his remote services, Dr. Rippetoe relied on a mental health team at Plainfield that included an on-site psychologist and master's-level therapist. He also relied on nurses to administer medications to inmates and to monitor them afterwards.

In the months leading up to April 2020, Passwater saw Dr. Rippetoe to manage his medication, which primarily consisted of Haldol Decanoate injections. Although the injections were involuntary, Passwater believed Haldol Decanoate was effectively controlling his mental illness.

Sometime before April 12, 2020, Dr. Rippetoe decreased Passwater's Haldol dosage over time and added Risperdal. After the first decrease in Haldol, Passwater did not notice any significant change in his mental health. After the second time, however, Passwater began to feel delusional and paranoid, and he ended up in two fights, landing him in restricted housing. Eventually, Passwater expressed suicidal thoughts and tried to find a razor blade to harm himself because, in his mind, he was "starting Armageddon." For that, Passwater was placed on constant suicide watch where he remained for four days until the day of the incident at issue, April 16. During that time, his mental health worsened.

At 7:30 a.m. on April 16, Passwater had a scheduled telepsychiatry appointment with Dr. Rippetoe, but Passwater refused the appointment. In his Electronic

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Medical Record (“EMR”) filed at 8:03 a.m., Dr. Rippetoe reported that Passwater “has become delusional and disorganized” since his Haldol dosage was reduced. Dkt. 119-18 at 21, 23.¹ There were “[n]o current safety issues,” he wrote but observed that Passwater was “[p]aranoid,” had a “[l]oose” thought process, and experienced “[s]evere” impairment in making reasonable decisions. *Id.* at 21–22. Around the same time, Passwater began throwing toilet water at correctional officers and staff as they walked by his cell because, he says, uncontrollable thoughts in his head were directing him to do so.

At 10:29 a.m., Nurse Sara Scott had a verbal telehealth conference with Dr. Rippetoe regarding Passwater’s “psychotic episode.” *Id.* at 25. Dr. Rippetoe directed her to give Passwater an emergency dose of Haldol Decanoate and Haldol Lactate.

Before Nurse Scott had a chance to administer the medications, a correctional officer went into Passwater’s cell and pepper sprayed him to deter him from throwing toilet water on the staff. When this failed, Passwater was sprayed a second time.

After the guards took Passwater to the showers to wash off the pepper spray, Nurse Scott gave Passwater the emergency doses of Haldol Decanoate and Haldol Lactate. He was then returned to his cell, and the exterior door to his cell was closed. As a result, the only way anyone

1. “Dkt.” refers to the docket number in the district court record.

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standing outside of the cell could see in was by looking through a small window located towards the top of the cell door. Once inside his cell, Passwater began to feel worse and felt a burning sensation along his back.

Although IDOC policy required Nurse Scott to assess Passwater after administering the medications, she did not do so. However, between 11:06 a.m. and 11:34 a.m., Passwater was visited by Mark Lincks, a mental health professional at Plainfield. In his EMR (filed at 12:55 p.m.), Lincks reported that Passwater had “just received” the emergency medication and that Passwater told Lincks he was still having suicidal thoughts. Dkt. 119-4 at 118. The report also indicated that Passwater was “continue[ing] to throw urine or water on staff and suicide companions.” *Id.* Lincks ordered that the suicide watch continue.

Although remote, Dr. Rippetoe had access to Passwater’s medical records, including Lincks’s EMR. But, after ordering the emergency dose administration, Dr. Rippetoe did not conduct a post-medication assessment, nor did he follow up with Lincks, Nurse Scott, or anyone else for that matter.²

2. Dr. Rippetoe argues that he did provide post-medication care, citing to his testimony that he had calls with the nurses before and after Passwater’s self-harming incident. But this is disputed; there is no record of such calls as IDOC procedures required. Dr. Rippetoe also could not recall the timing of these calls or whom they were with. Thus, for the purposes of summary judgment, we assume that Dr. Rippetoe did not provide any post-medication care.

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At noon, Antoine Fox, one of Plainfield's suicide companions, began a 4-hour shift monitoring Passwater. Video recordings indicate that, around 1:28 p.m., Passwater began to punch himself in the face. His actions drew no blood, but he began to "get[] very agitated." Dkt. 109-6 at 2. At 1:46 p.m., Passwater began poking and mutilating his eyes, but again he did not appear to be bleeding. Ten minutes later, Passwater can be seen beginning to "forcefully pull on his penis on and off" to the point where blood was plainly visible on his hands and crotch area. *Id.* At 2:04 p.m., he began to rip and tear at his scrotum and penis, drawing large amounts of blood visible on his arms, legs, and torso.

Throughout this time, Fox was seated in a chair outside of Passwater's cell, unable to see inside. Two different correctional officers instructed Fox to stand up at different times, but he did not listen. At 2:17 p.m., an officer looked into Passwater's cell, saw him covered in blood, and reported it to the sergeant "immediately." *Id.* A sergeant then "rushed" to Passwater's cell and "immediately" called for first responders. Dkt. 109-5 at 8.

Passwater was rushed to the hospital where he underwent several operations. He remains blind and without any testicles.

B. The Suicide Companion Policy

Plainfield's supervision of suicidal inmates was governed by IDOC Policy 4.06A*, "Suicide and Self-Injury Prevention." In accordance with the policy, the facility

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provided two levels of “enhanced supervision” for such inmates—close observation and constant observation. Dkt. 109-1 at 2. The latter required “[c]ontinuous, 1:1 observation for an offender who has engaged in an act of self-injury or” who is at “imminent risk of self-injury.” *Id.* “The offender shall be observed continuously without interruption” the policy continued, “with a clear, unobstructed view, until the Constant Observation Suicide Watch is discontinued.” *Id.*

The policy also laid out the requirements for the training and utilization of “Suicide Watch Companions” who can “assist staff in the direct, constant, visual monitoring of an offender who has been placed on Constant Observation.” *Id.* When an inmate agrees to serve as a suicide companion, he attests that he will, among other things, maintain constant and direct visual observation of the inmate on suicide watch and alert staff immediately if the inmate on suicide watch displays signs of self-injurious behavior.

Furthermore, under Policy 4.06A*, an individual could only serve as a suicide companion for four hours in a twenty-four-hour period. It was later decided that shifts be limited to two hours for suicide companions who assisted in a “constant suicide watch,” because they needed to remain standing during the entire shift in order to view the subject through the cell door window. Dkt. 119-8 at 15.

As the Deputy Warden of Plainfield in April 2020, Tricia Pretorius was aware of Policy 4.06A* and the requirements for suicide companions. In fact, she participated in regular

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Suicide Prevention Meetings with Plainfield's Suicide Prevention Committee, which included herself, various medical and mental health providers, custody staff, and chaplains. At these meetings, the committee discussed Plainfield's suicide prevention measures and addressed any problems with the implementation of the prison's suicide prevention policy.

On March 13, 2020, approximately a month before Passwater's incident, Leah Stevenson, a suicide companion coordinator at Plainfield, stated that she "was not aware of" the new two-hour policy. Dkt. 119-8 at 15. She added that she "went around yesterday to [mental health] staff and custody staff and [she] could not find anyone who could verify" the policy. *Id.* In response, Lincks sent the following email to Stevenson adding Deputy Warden Pretorius to the recipient list:

[T]his appears to be something you need to verify and discuss with Ms. Pretorius and maybe Mr. Vanihel as they have both been involved in the discussions of the policy for 2 hr shifts for SW [Suicide Watch] companions that have to stand, so I'll copy them on this email thread. If you're concerned we don't have the staffing to do this then they need to be involved with this discussion.

Id. at 14.

*Appendix A***C. Procedural History**

In January 2024, Passwater filed an amended complaint, alleging that Dr. Rippetoe and Deputy Warden Pretorius violated his Eighth Amendment rights. As to the former, Passwater claimed that Dr. Rippetoe was deliberately indifferent to the significant risk of harm that might befall him following an emergency administration of psychotropic medication by failing to provide any post-administration care. As to the latter, he alleged that Deputy Warden Pretorius was aware that suicide watch companions were not adhering to the two-hour policy but failed to take any action to remedy it. Dr. Rippetoe and Deputy Warden Pretorius moved for summary judgment, and the district court granted summary judgment in their favor. Passwater appeals.

II. Discussion

We review the district court's order granting summary judgment *de novo* after construing all factual disputes in Passwater's favor. *See Sanders*, 153 F.4th at 567. We begin with Passwater's Eighth Amendment claim against Dr. Rippetoe before turning to his claim against Deputy Warden Pretorius.

A. Dr. Rippetoe

Passwater contends that Dr. Rippetoe was deliberately indifferent to his medical needs by failing to provide any care following the emergency administration of psychotropic medication. Section 1983 confers a private

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right of action against government officials who, acting under color of state law, deprive a plaintiff of “any rights, privileges, or immunities secured by the Constitution and laws” of the United States. *Hunter v. Mueske*, 73 F.4th 561, 565 (7th Cir. 2023) (quoting 42 U.S.C. § 1983). And “[t]he Eighth Amendment’s ban on ‘cruel and unusual punishments’ obligates prison officials to provide medical care to prisoners in their custody.” *Dean v. Wexford Health Sources, Inc.*, 18 F.4th 214, 234 (7th Cir. 2021) (quoting *Estelle v. Gamble*, 429 U.S. 97, 102, 97 S.Ct. 285, 50 L.Ed.2d 251 (1976)).

To violate a prisoner’s Eighth Amendment rights in the delivery of medical care, prison officials must exhibit “deliberate indifference to an inmate’s serious medical needs.” *Riley v. Waterman*, 126 F.4th 1287, 1295 (7th Cir. 2025). To prevail on such a claim, the plaintiff must prove “(1) that he had an objectively serious medical condition (2) to which prison officials were deliberately, that is subjectively, indifferent.” *Id.* (citation modified). He must also prove that the defendant’s “deliberate indifference actually caused his injury.” *Hunter*, 73 F.4th at 565 (citing *Roe v. Elyea*, 631 F.3d 843, 864 (7th Cir. 2011)).

As to what “deliberate indifference” means, “[p]rison officials are deliberately indifferent when they know of and disregard a substantial risk to the inmate’s health.” *Riley*, 126 F.4th at 1295. It “entails something more than mere negligence but something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result.” *Peterson v. Wexford Health Sources, Inc.*, 986 F.3d 746, 752 (7th Cir. 2021) (citation modified);

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Farmer v. Brennan, 511 U.S. 825, 835, 114 S.Ct. 1970, 128 L.Ed.2d 811 (1994). “Evidence that the defendant responded reasonably to the risk, even if he was ultimately unsuccessful in preventing the harm, negates an assertion of deliberate indifference.” *Rasho v. Jeffreys*, 22 F.4th 703, 710 (7th Cir. 2022) (citation omitted).

As a result, when the defendant is a medical professional, the plaintiff must show more than medical negligence to prove deliberate indifference. *Riley*, 126 F.4th at 1295. The “chosen treatment plan must represent so significant a departure from accepted professional standards or practices that it calls into question whether the provider actually was exercising professional judgment.” *Id.* (citation modified). Put another way, the medical professional’s care must be “so inadequate that it demonstrated an absence of professional judgment” such that “no minimally competent professional would have so responded under those circumstances.” *Peterson*, 986 F.3d at 752 (citation omitted).

The parties do not dispute that Passwater suffered from an objectively serious medical condition or that he was at serious risk of committing suicide. The question is whether a reasonable jury could find that Dr. Rippetoe acted with deliberate indifference when he failed to provide any follow-up care after the nurses gave Passwater an emergency dose of psychotropic medication.

We conclude that the record lacks evidence from which a reasonable jury could so find. Passwater points to Dr. Rippetoe’s deposition testimony acknowledging that a

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post-medication assessment is “standard,” “common,” and “might even be” required by IDOC policy. Dkt. 119-2 at 13–14, 32–33. But “standard” and “common” are words of negligence not deliberate indifference, which requires that “no minimally competent professional would have so responded under those circumstances.” *Peterson*, 986 F.3d at 752 (citation omitted).

This is not to say that the medical personnels at Plainfield acted satisfactorily. As Passwater notes, Plainfield policy required nurses to observe an inmate for two hours after administering emergency psychotropic medication, record their observations in an EMR, and send the EMR to the prescribing doctor.³ There is no indication that the nurses did any of this, and when he did not receive such a report, Dr. Rippetoe should have reached out to them to check on Passwater.

That said, Passwater failed to present evidence that “no minimally competent” physician would have behaved as Dr. Rippetoe did. Passwater relies on his expert, Dr. Andrew Lampkins, who opines that the failure to comply with the monitoring policy “would be contrary to best practices regarding patient safety and monitoring following the administration of involuntary psychotropic medication.” Dkt. 113-3 at 3. But, again, failure to follow

3. The policy required nurses to take vital signs immediately following the administration of the medication and one hour later. They were also required to assess the inmate continuously at fifteen-minute intervals for the first two hours and report any adverse side effects to the prescribing psychiatrist.

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“best practices” is not deliberate indifference. *See Riley*, 126 F.4th at 1295.

Passwater also points to Lincks’s EMR to argue that Dr. Rippetoe knew (or should have known) that Passwater was having a negative reaction to the emergency medication and should have intervened. Lincks visited Passwater after he had received the medication and approximately two hours before he began to harm himself. In a 12:55 p.m. EMR, Lincks reported that Passwater had “just received” the emergency medication but was still suicidal and “continued to display psychomotor agitation and unintelligible speech.” Dkt. 119-4 at 118. Because Dr. Rippetoe had access to Lincks’s EMR, Passwater posits, the doctor knew that Passwater was experiencing adverse effects from the emergency medication or, alternatively, should have checked the EMRs to make sure nothing was wrong.

The problem is that there is no evidence that Dr. Rippetoe read Lincks’s EMR or deliberately avoided it. Nor is there any evidence that it would have been obvious to any minimally competent physician in Dr. Rippetoe’s situation that failing to read Lincks’s EMR would have resulted in serious risk of harm to Passwater. For these reasons, summary judgment in favor of Dr. Rippetoe was appropriate.

B. Deputy Warden Pretorius

Next, Passwater contends that Deputy Warden Pretorius violated the Eighth Amendment because she

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knew that correctional officers were not following the two-hour suicide companion policy but did nothing to correct it. As an official responsible for setting prison policy, Deputy Warden Pretorius can be held liable for a constitutional violation if she is aware of a systematic lapse in enforcement of a policy critical to ensuring inmate safety and does nothing. *Sinn v. Lemmon*, 911 F.3d 412, 423 (7th Cir. 2018) (citing *Steidl v. Gramley*, 151 F.3d 739, 741 (7th Cir. 1998)).

As Passwater notes, there is evidence that Plainfield had a policy instituting a two-hour shift for suicide companions who assisted with the constant observation of suicidal inmates. For example, in his March 13, 2020, email to Stevenson, Lincks wrote:

Leah, it was brought to my attention you're not aware of a policy regarding SW [suicide watch] companions. Administration decided a year or two ago that if an offender, who is on Constant SW, has to have their door shut, then the companion has to stand at the door and stare thru the window his whole shift. We've tried stools, but none are high enough because that window is so high. So it was decided to cut back their shift from 4hrs to 2 hrs.

Dkt. 119-8 at 15.

Additionally, because IDOC Policy 4.06A* mandated that suicidal inmates like Passwater be monitored constantly, a reasonable jury could find that the two-hour

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policy was necessary for the safety of such inmates. And the record contains evidence from which a jury could find that there was a systematic lapse in the enforcement of the two-hour policy. In fact, in response to Lincks's email, Stevenson replied that she "was not aware of this" and that she "could not find anyone who could verify this." *Id.*

What is more, there is evidence that Deputy Warden Pretorius may have known that the two-hour policy was not being followed. After Lincks received Stevenson's response, he sent another email to her, this time including Pretorius as a recipient:

Ms Stevenson, this appears to be something you need to verify and discuss with Ms. Pretorius and maybe Mr. Vanihel as they have both been involved in the discussions of the policy for 2 hr shifts for SW companions that have to stand, so I'll copy them on this email thread. If you're concerned we don't have the staffing to do this then they need to be involved with this discussion.

Dkt. 119-8 at 14. And there is no evidence that Deputy Warden Pretorius did anything in response.

In short, we agree with Passwater that there is evidence from which a reasonable jury could find the existence of the two-hour suicide companion policy, the significant role the policy played in the prison's ability to monitor severely suicidal inmates, systemic noncompliance with the policy, and Deputy Warden Pretorius's failure to

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correct it. But, despite this, Passwater's claim against her fails for lack of causation.

In addition to establishing that Deputy Warden Pretorius was deliberately indifferent to a serious medical need, Passwater must prove that her "deliberate indifference actually *caused* his injury." *Hunter*, 73 F.4th at 565 (citing *Roe*, 631 F.3d at 864). "In assessing causation in § 1983 cases, we look to general principles of causation from tort law." *Id.* at 567–68 (citing *Whitlock v. Brueggemann*, 682 F.3d 567, 582–83 (7th Cir. 2012)). This includes proximate causation, which limits a defendant's liability to only those harms she foreseeably risked by her wrongful actions. *Id.* at 568 (citations omitted). Furthermore, a "corollary" to proximate cause is the idea of "superseding cause," which is when "the plaintiff's injury is caused not by a risk created by the defendant but by an unforeseeable intervening act" that "sever[s] the defendant's liability." *Id.* (citations omitted). Although causation is "typically a question best left for the jury," "there are cases where proximate causation may be decided as a matter of law." *Id.* (citation omitted). Such is the case here.

In this case, Fox's refusal to stand while serving as Passwater's suicide companion was an intervening act that impeded the correctional officers from preventing Passwater from severely harming himself. Passwater, however, blames the prison's purported noncompliance with the two-hour policy for suicide companions, arguing that, because Fox had started his shift at noon, the policy would have relieved him of duty at 2:00 p.m., allowing a

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new suicide companion to look in on Passwater at that time. But, as the video recording shows, Passwater began punching himself around 1:28 p.m., and by 1:45 p.m., he started to poke and grab at himself. Finally, at 1:56 p.m., Passwater began pulling forcefully on his penis, bloodying his hands and crotch area.

As this undisputed evidence shows, had Fox been standing during his shift outside of Passwater's door—as he was repeatedly instructed to do—he would have been able to observe Passwater's actions and alert the authorities within two hours of commencing his shift. Fox's actions, thus, constituted a superseding cause of Passwater's injuries that severed any liability on the part of Deputy Warden Pretorius, and summary judgment in her favor was appropriate.

* * *

For these reasons, the district court's grant of summary judgment is AFFIRMED.

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**APPENDIX B — JUDGMENT OF THE UNITED
STATES COURT OF APPEALS FOR THE
SEVENTH CIRCUIT, FILED JULY 23, 2026**

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 25-1149

BRAD PASSWATER,

Plaintiff-Appellant,

v.

TRICIA PRETORIUS, *et al.*,

Defendants-Appellees.

Filed July 23, 2026

FINAL JUDGMENT

Before

KENNETH F. RIPPLE, *Circuit Judge*
THOMAS L. KIRSCH II, *Circuit Judge*
JOHN Z. LEE, *Circuit Judge*

Originating Case Information:
District Court No: 2:21-cv-00475-MPB-MG
Southern District of Indiana, Terre Haute Division
District Judge Matthew P. Brookman

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The judgment of the District Court is **AFFIRMED**, with costs, in accordance with the decision of this court entered on this date.

/s/ _____
Clerk of Court

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**APPENDIX C — ORDER OF THE UNITED
STATES DISTRICT COURT FOR THE SOUTHERN
DISTRICT OF INDIANA, TERRE HAUTE
DIVISION, FILED JANUARY 2, 2025**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
TERRE HAUTE DIVISION

No. 2:21-cv-00475-MPB-MG

BRAD PASSWATER,

Plaintiff,

v.

TRICIA PRETORIUS, *et al.*,

Defendants.

Filed January 2, 2025

**ORDER GRANTING DEFENDANTS' MOTIONS
FOR SUMMARY JUDGMENT**

Plaintiff Brad Passwater is an inmate currently incarcerated at the New Castle Correctional Facility (“NCCF” or “New Castle”). He filed a complaint alleging that, while incarcerated at the Plainfield Correctional Facility (“PCF” or “Plainfield”), defendants violated his Eighth Amendment rights while he was on suicide watch on April 16, 2020.

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The correctional and medical defendants have moved for summary judgment. Dkts. 108, 111. For the reasons explained below, the defendants' motions for summary judgment, dkts. [108] and [111] are **GRANTED**.

I. Standard of Review

A motion for summary judgment asks the Court to find that a trial is unnecessary because there is no genuine dispute as to any material fact and, instead, the movant is entitled to judgment as a matter of law. *See* Fed. R. Civ. P. 56(a). When reviewing a motion for summary judgment, the Court views the record and draws all reasonable inferences from it in the light most favorable to the nonmoving party. *Khungar v. Access Cmty. Health Network*, 985 F.3d 565, 572–73 (7th Cir. 2021). It cannot weigh evidence or make credibility determinations on summary judgment because those tasks are left to the fact-finder. *Miller v. Gonzalez*, 761 F.3d 822, 827 (7th Cir. 2014). A court only has to consider the materials cited by the parties, *see* Fed. R. Civ. P. 56(c)(3); it need not “scour the record” for evidence that might be relevant. *Grant v. Trs. of Ind. Univ.*, 870 F.3d 562, 573–74 (7th Cir. 2017) (cleaned up).

A party seeking summary judgment must inform the district court of the basis for its motion and identify the record evidence it contends demonstrates the absence of a genuine issue of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986).

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Whether a party asserts that a fact is undisputed or genuinely disputed, the party must support the asserted fact by citing to particular parts of the record, including depositions, documents, or affidavits. Fed. R. Civ. P. 56(c)(1)(A). Failure to properly support a fact in opposition to a movant's factual assertion can result in the movant's fact being considered undisputed, and potentially in the grant of summary judgment. Fed. R. Civ. P. 56(e).

II. Factual Background

Because Defendants have moved for summary judgment under Rule 56(a), the Court views and recites the evidence in the light most favorable to Mr. Passwater and draws all reasonable inferences in his favor. *Khungar*, 985 F.3d at 572–73.

Plaintiff Brad Passwater has a long history of mental illness, including a diagnosis of paranoid schizophrenia. Dkt. 93 ¶ 22. Mr. Passwater was confined at Plainfield Correctional Facility during the events that gave rise to his complaint in April of 2020. *Id.* ¶ 23.

A. Parties

Defendant Stanley Knight is the former Warden of Plainfield. Dkt. 109-7 at 1 ¶ 2. By the time Mr. Passwater initiated this lawsuit on December 29, 2021, Mr. Knight had already retired from employment from the Indiana Department of Correction (“IDOC”). *Id.* at 3-4 ¶ 9. Mr. Knight testified that, since his retirement, he has very little contact with IDOC, and they generally do not notify

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him of any pending litigation against Plainfield, other facilities, and current or former employees, unless he is specifically named in the litigation. *Id.* He further testified that he does not personally keep track of lawsuits asserted against Plainfield or its employees. *Id.*

Defendant Tricia Pretorius is the current Warden of Plainfield. Dkt. 109-8 at 1 ¶ 2. Warden Pretorius is familiar with the version of the Suicide Prevention Policy (“Policy”), 4.06A, that was in effect during the events that gave rise to the complaint, and which contains the rules regarding the Suicide Companion Program (“Program”). *Id.* at 1 ¶ 3. Warden Pretorius testified that she hosted and participated in regular suicide Prevention Meetings with the Suicide Prevention Committee at Plainfield. *Id.* at 2 ¶ 6. The committee included Warden Pretorius, various medical and mental health providers, custody staff, and chaplains. *Id.* At the meetings, the committee discussed Plainfield’s current suicide prevention methods, and addressed issues with practices and implementation of the suicide prevention policy. *Id.* at 2-3 ¶ 6. In the year leading up to the events on April 16, 2020, Warden Pretorius did not recall receiving any indication that staff or suicide companions were systemically or repeatedly failing to adhere to or enforce the requirements of the Program. *Id.* at 3 ¶ 6. Specifically, she did not recall any reports of recurrent issues with suicide companions failing to adequately monitor their assigned inmate, or of staff neglecting to monitor or require suicide companions to maintain proper observation practices or otherwise uphold their duties. Warden Pretorius was not on the unit on April 16, 2020, when Mr. Passwater was actively

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engaged in self-mutilation while under watch of suicide companion Antoine Fox. *Id.* at 4 ¶ 8. Warden Pretorius was not aware of the incident until the emergency signal was called and Mr. Passwater was in the care of correctional and medical staff. *Id.*

Defendant Daniel Rippetoe is a psychiatrist who was contracted to provide services at Plainfield. Dkt. 114-1 at 2. Dr. Rippetoe provided services over telepsychiatry from Florida. *Id.* at 2-3. Dr. Rippetoe therefore relied on a mental health team at Plainfield that consisted of a psychologist and master level therapist. *Id.* at 3. He also relied on nursing staff to administer medications. *Id.* at 3, 5. Dr. Rippetoe recalled nursing staff had certain responsibilities for monitoring patients after the administration of medication. *Id.* at 5. Dr. Rippetoe was familiar with the IDOC psychotropic medication policy, for which he received yearly department-wide and company-wide trainings. *Id.* at 5. Dr. Rippetoe recalled several phone calls back and forth between him and medical staff on April 16, 2020. *Id.* at 6. After he was contacted by nursing staff, Dr. Rippetoe approved emergency psychotropic medication for Mr. Passwater which consisted of 50 mg of Haldol Decanoate and 5 mg of Haldol Lactate. *Id.* at 7-8.

B. Experts

Mr. Passwater retained pharmacology expert Andrew J. Lampkins. Dkt. 113-1 at 1. Mr. Lampkins' opinion was that the overall medication regimen and dosages as ordered by Dr. Rippetoe were reasonable.

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Id. Medical defendants retained psychiatric expert Dr. Steven Berger. Dkt. 113-2 at 1. Dr. Berger's opinion was that Dr. Rippetoe's orders were the common medications and doses used in similar situations and comply with the standard of care. *Id.*

C. Suicide Companion Program

IDOC Policy 4.06A* "Suicide and Self-Injury Prevention" was the policy that outlined the "Suicide Companion Program" and was the relevant policy related to inmate self-harm. Dkt. 109-1; dkt. 109-2 at 13:7-14. Under the Suicide Companion Program, qualifying inmates were employed to assist staff in preventing self-injury or suicide by serving as "companions." Dkt. 109-1 at 2, 17-21. The companions were specially trained to provide "constant observation" surveillance of inmates on suicide watch. *Id.* Inmates could only serve as suicide companions upon meeting certain educational, disciplinary, physical health, and mental health requirements. *Id.* at 18. Inmates who met the criteria were selected and given training on how to identify and respond to self-harm and self-injury. *Id.* The training also included job duties, reporting protocol, confidentiality, prohibited conduct and corresponding disciplinary action for failure to comply with companion duties. *Id.* at 18-19. Upon completion of training, companions were required to review and sign a copy of the Suicide Companion Agreement Form, to certify that they understood the scope of their duties. *Id.*; See Dkt. 109-3.

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When an inmate signs the Agreement form, he attests that he will, among other things, maintain constant and direct visual observation of the inmate on suicide watch, and alert staff immediately if the offender on suicide watch displays signs of self-injurious behavior. Dkt. 109-3 at 1. When a Suicide Watch Companion is utilized, an assigned correctional staff person shall confirm that the Suicide Watch Companion maintained the visual watch by conducting routine visual checks at staggered intervals not to exceed thirty (30) minutes and noting if any problems occurred. Dkt. 109-1 at 10.

D. Medication History

In the months leading up to April of 2020, Mr. Passwater was under orders to involuntarily receive psychotropic medications, primarily an injection of Haldol. Dkt. 109-4 at 18. Mr. Passwater testified that he believed the Haldol was effective at assisting with his control of mental illness. *Id.* Before April 16, 2020, Mr. Passwater specifically asked Dr. Rippetoe to make a change in his medication. *Id.* at 22. He wanted to switch from injections to pills. *Id.* Mr. Passwater had a discussion with Dr. Rippetoe where they decided to introduce Risperal as an additional medication. *Id.*

Over the course of the next two to three weeks after Mr. Passwater's Haldol injections were decreased and Risperal was introduced, Mr. Passwater felt more delusional. *Id.* at 23-24. During this time, he had incidents with staff that resulted in his move to restricted housing and suicide watch. *Id.*

*Appendix C***E. April 2020 incidents**

On or around April 10, 2020, Mr. Passwater had a psychiatric crisis and was placed on suicide watch, where he would remain for several days. Dkt. 93 ¶¶ 23-25. Over the next few days, Mr. Passwater used recreational and synthetic drugs. Dkt. 109-4 at 42-43. He testified: “I was smoking spice every now and again.” *Id.* Mr. Passwater was on suicide watch consistently with a suicide companion outside his door from April 12 through April 16, 2020. *Id.* at 26-27.

On April 16, inmate Antoine Fox was Mr. Passwater’s suicide companion. Dkt. 93 at ¶¶ 47-48. Despite orders to stand at Mr. Passwater’s cell and observe him, Mr. Fox remained seated in a plastic chair where he could not see Mr. Passwater through the observational window. Dkt. 93 at ¶¶ 47-48; dkt. 109-4 at 30.

That day, Mr. Passwater heard voices his head telling him to throw toilet water on the officers and staff at his cell door. *Id.* at 29-33. Because he was throwing toilet water on prison staff, the guards sprayed him with OC. *Id.* at 28-29.

Due to his outbursts, Mr. Passwater was given an emergency injection of medication. *Id.* at 28-29. After Mr. Passwater was administered Haldol Decanoate and Haldol Lactate, he had an episode where he felt a burning sensation. *Id.* at 36-38. Mr. Passwater had previously received these injections without experiencing any burning sensation. *Id.* Mr. Passwater then pulled on his

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genitals, ripped out his testicles, and popped his eyeballs out. *Id.* at 36-38. He testified that felt like he was being controlled. *Id.*

Mr. Passwater was then found by officers and taken to the hospital. *Id.* at 36-38. He underwent several operations, but after the self-injurious incident on April 16, 2020, Mr. Passwater no longer has testicles and is blind. *Id.* at 38-39.

III. Discussion

A. Legal Standard

The Eighth Amendment’s prohibition against cruel and unusual punishment imposes a duty on the states, through the Fourteenth Amendment, “to provide adequate medical care to incarcerated individuals.” *Boyce v. Moore*, 314 F.3d 884, 889 (7th Cir. 2002) (citing *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)). “Prison officials can be liable for violating the Eighth Amendment when they display deliberate indifference towards an objectively serious medical need.” *Thomas v. Blackard*, 2 F.4th 716, 721–22 (7th Cir. 2021). “Thus, to prevail on a deliberate indifference claim, a plaintiff must show ‘(1) an objectively serious medical condition to which (2) a state official was deliberately, that is subjectively, indifferent.’” *Johnson v. Dominguez*, 5 F.4th 818, 824 (7th Cir. 2021) (quoting *Whiting v. Wexford Health Sources, Inc.*, 839 F.3d 658, 662 (7th Cir. 2016)).

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The Court assumes for purposes of the summary judgment motion that Mr. Passwater’s mental illness was objectively serious. To avoid summary judgment, then, the record must allow a reasonable jury to conclude that defendants acted with deliberate indifference—that is, that they “consciously disregarded a serious risk to [Mr. Passwater]’s health.” *Dean v. Wexford Health Sources, Inc.*, 18 F.4th 214, 241 (7th Cir. 2021) (cleaned up).

Deliberate indifference requires more than negligence or even objective recklessness. *Id.* Rather, Mr. Passwater “must provide evidence that an official actually knew of and disregarded a substantial risk of harm.” *Petties v. Carter*, 836 F.3d 722, 728 (7th Cir. 2016). “Of course, medical professionals rarely admit that they deliberately opted against the best course of treatment. So in many cases, deliberate indifference must be inferred from the propriety of their actions.” *Dean*, 18 F.4th at 241 (internal citations omitted).

A failure to provide protection constitutes an Eighth Amendment violation only if deliberate indifference by prison officials to a prisoner’s welfare effectively condones the harm by allowing it to happen. *Eagan v. Dempsey*, 987 F.3d 667, 693–94 (7th Cir. 2021) (citing *Santiago*, 599 F.3d at 756). Suicide and acts of self-harm may constitute serious risks to an inmate’s health and safety. *See id.*, e.g., *Rice ex rel. Rice v. Corr. Med. Servs.*, 675 F.3d 650, 665 (7th Cir. 2012) (“[P]rison officials have an obligation to intervene when they know a prisoner suffers from self-destructive tendencies.”); *Collins v. Seeman*, 462 F.3d 757, 760–61 (7th Cir. 2006) (considering deliberate

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indifference in prison suicide context); *Hall v. Ryan*, 957 F.2d 402, 406 (7th Cir. 1992) (confirming “prisoner’s right to be protected from self-destructive tendencies”).

B. Analysis**1. Former Warden Stanley Knight**

Defendant Stanley Knight is the former Warden of Plainfield Correctional Facility. Dkt. 109-7 at 1 ¶ 2 In his amended complaint, Mr. Passwater alleges that Warden Knight was responsible for a policy that allowed for inmates on suicide watch to be monitored by untrained inmate suicide watch companions and knew that the suicide watch companions regularly failed to supervise their assigned inmates. But Defendant Knight argues that the claim against him is time barred because the amended complaint does not relate back to the original complaint pursuant to Federal Rule of Civil Procedure 15(c). The Court agrees.

“Rule 15(c) of the Federal Rules of Civil Procedure governs when an amended pleading ‘relates back’ to the date of a timely filed original pleading and is thus itself timely even though it was filed outside an applicable statute of limitations.” *Krupski v. Costa Crociere S. p. A.*, 560 U.S. 538, 541 (2010). Claims brought under § 1983 “borrow the limitations period and tolling rules applicable to personal-injury claims under state law.” *Devbrow v. Kalu*, 705 F.3d 765, 767 (7th Cir. 2013). “The pertinent Indiana statute of limitations is two years.” *Id.* (citing Ind. Code § 34-11-2-4).

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The only two inquiries that the district court is now permitted to make in deciding whether an amended complaint relates back to the date of the original one are, first, whether the defendant who is sought to be added by the amendment knew or should have known that the plaintiff, had it not been for a mistake, would have sued him instead or in addition to suing the named defendant; and second, whether, even if so, the delay in the plaintiff's discovering his mistake impaired the new defendant's ability to defend himself. *Joseph v. Elan Mortorsports Technologies Racing Corp.* 638 F.3d 555, 559-560 (7th Cir. 2011). "A potential defendant who has not been named in a lawsuit by the time the statute of limitations has run is entitled to repose—unless it is or should be apparent to that person that he is the beneficiary of a mere slip of the pen, as it were." *Id.* at 560 (quoting *Rendall–Speranza v. Nassim*, 107 F.3d 913, 918 (D.C. Cir. 1997); see *Wood v. Worachek*, 618 F.2d 1225, 1230 (7th Cir. 1980); *Locklear v. Bergman & Beving AB*, 457 F.3d 363, 366–67 (4th Cir. 2006)).

Mr. Passwater cannot satisfy the first inquiry. Mr. Passwater filed his original complaint on December 29, 2021. Dkt. 1. That complaint did not name Warden Knight as a defendant. *Id.* By the time Mr. Passwater initiated this lawsuit on December 29, 2021, Mr. Knight had already retired from employment from IDOC. Dkt. 109-7 at 3-4 ¶ 9. Mr. Knight testified that, since he has been retired, he has very little contact with IDOC, and they generally do not notify him of any pending litigation against Plainfield, other facilities, and current or former employees, unless he is specifically named in the litigation. *Id.* He further

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testified that he does not personally keep track of lawsuits asserted against Plainfield or its employees. *Id.* Accordingly, Mr. Knight did not know—and would have no reason to know—that Mr. Passwater would have sued him instead or in addition to Warden Pretorius. *Joseph*, 638 F.3d at 559-560.

Mr. Passwater cannot satisfy the second inquiry, either. Warden Knight was subpoenaed to testify on or around September 19, 2023, Dkt. 109-7 at 3-4 ¶ 9, which was more than a year and a half after Mr. Passwater filed his original complaint. *See* Dkt. 1. Mr. Passwater's delay in discovering his mistake impaired Mr. Knight's ability to defend himself. *Joseph*, 638 F.3d at 559-560.

Thus, Mr. Passwater's amendment to add Warden Knight as a defendant does not relate back to the amended complaint. The amended complaint was filed on December 15, 2023. Dkt. 87. The statute of limitations for claims related to Mr. Passwater's April 16, 2020, incident tolled two years later on April 16, 2022. Accordingly, any claim against Warden Knight is barred by the statute of limitations. He is entitled to summary judgment.

2. Warden Tricia Pretorius

Defendant Tricia Pretorius is the current Warden at Plainfield. Dkt. 109-8 at 1 ¶ 2. Mr. Passwater proceeds on an individual capacity Eighth Amendment claims against Warden Pretorius based on allegations that she was responsible for an inadequate system whereby inmate suicide watch companions were assigned to oversee

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inmates on suicide watch, which ultimately resulted in Mr. Passwater's injuries. Dkt. 92 at 14.

As a general principle, prison wardens are “not liable for an isolated failure of his subordinates to carry out prison policies. . .” when they are “not directly involved in the day-to-day operations” of the prison and otherwise lack knowledge of or involvement in the particular instance of policy defiance. *Steidl v. Gramley*, 151 F.3d 739, 741 (7th Cir. 1998) (warden is not liable if they are not involved in everyday oversight and did not direct the misconduct); *Sinn v. Lemmon*, 911 F.3d 412, 423 (7th Cir. 2018) (the warden is not liable if he or she lacks knowledge of the claimant's “individual circumstances”). However, a warden can be held liable for a specific instance of their staff failing to uphold prison policy if the administrator had prior knowledge of a “systematic lapse in enforcement of a policy critical to ensuring inmate safety” and neglected to take action to ensure compliance. *Sinn*, 911 F.3d at 423 (citing *Steidl*, 151 F.3d at 741) (internal quotations omitted).

“[A]n inmate cannot show a widespread practice of an unconstitutional nature, such as a custom of ignoring prison policy, by pointing to isolated incidents. . .” *Sinn*, 911 at 741 (citing *Palmer v. Marion County*, 327 F.3d 588, 597 (7th Cir. 1998)) (internal quotations omitted). Rather, pre-existing knowledge of global policy nonconformity is demonstrated with “evidence of a series of bad acts” that the defendant “was bound to have noticed, like a pervasive pattern of [inmate self-injury]. . .” *Id.* at 741 (quoting *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525, 531 (7th Cir. 2000)) (internal quotations omitted).

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Warden Pretorius is familiar with the version of the Suicide Prevention Policy (“Policy”), 4.06A, that was in effect during the events that gave rise to the complaint, which contains the rules regarding the Suicide Companion Program (“Program”). Dkt. 109-8 at 1 ¶ 3.

Warden Pretorius testified that she hosted and participated in regular suicide Prevention Meetings with the Suicide Prevention Committee at Plainfield. *Id.* at 2 ¶ 6. The committee included Warden Pretorius, various medical and mental health providers, custody staff, and chaplains. *Id.* At the meetings, the committee discussed Plainfield’s current suicide prevention methods, and addressed issues with practices and implementation of the suicide prevention policy. *Id.* at 2-3 ¶ 6.

In the year leading up to the events on April 16, 2020, Warden Pretorius did not recall receiving any indication that staff or suicide companions were systemically or repeatedly failing to adhere to or enforce the requirements of the Program. *Id.* at 3 ¶ 6. Specifically, she did not recall any reports of recurrent issues with suicide companions failing to adequately monitor their assigned inmate, or of staff neglecting to monitor or require suicide companions to maintain proper observation practices or otherwise uphold their duties. *Id.* Mr. Passwater has presented no evidence to rebut her testimony.

It undisputed that Warden Pretorius was not on the unit on April 16, 2020, when Mr. Passwater was actively engaged in self-mutilation while under the watch of a suicide companion Mr. Fox. *Id.* at 4 ¶ 8. Warden Pretorius

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was not aware of the incident until the emergency signal was called and he was in the care of correctional and medical staff. *Id.* Warden Pretorius cannot be held liable for an isolated failure of her subordinates to carry out prison policies because she was not directly involved in the day-to-day operations on the suicide watch unit. *Steidl*, 151 F.3d at 741. Similarly, Warden Pretorius cannot be held liable for this specific instance of failure to uphold the Program, because she had no prior knowledge of “systematic lapse in enforcement of a policy critical to ensuring inmate safety” and therefore could not have neglected to take action to ensure compliance. *Sinn*, 911 F.3d at 423 (citing *Steidl*, 151 F.3d at 741) (internal quotations omitted).

It is clear that Mr. Passwater’s suicide companion, Antoine Fox¹ failed to uphold his duties under the Suicide Companion Agreement Form given that he evidently failed to maintain constant and direct visual observation of Mr. Passwater, and alert staff immediately upon Mr. Passwater’s signs of self-injurious behavior. *See* Dkt. 109-3 at 1. And it is also evident that the correctional officers assigned to ensure that Mr. Fox maintained the visual watch also failed to adhere to policy, since the record does not reflect that routine visual checks were conducted at staggered intervals not to exceed thirty (30) minutes in accordance with the policy. *See* Dkt. 109-1 at 10. But this departure from IDOC policy does not

1. The record contains no evidence of Mr. Fox’s qualifications to be selected as a suicide companion. The record only contains information regarding the policy that governs the criteria and selection process for suicide companions.

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equate to a constitutional violation. *Estate of Simpson v. Gorbett*, 863 F.3d 740, 746 (7th Cir. 2017) (“Section 1983 protects against constitutional violations, not violations of departmental regulation and practices.”).

At most, Mr. Passwater testified of one incident between April 12 and April 16, 2020, when he thought a suicide watch-companion was sleeping. Dkt. 109-4 at 51. But Mr. Passwater did not testify that he told any IDOC staff about the sleeping inmate. *See generally id.* Otherwise, the record shows no other instances where an inmate or staff member deviated from the policy. One instance is not enough to show “evidence of a series of bad acts” that the defendant “was bound to have noticed, like a pervasive pattern of [inmate self-injury]. . .” *Sinn*, 911 at 741 (quoting *Turbin v. County of Wood*, 226 F.3d at 531; *see also Goka v. Bobbitt*, 862 F.2d 646, 652 (7th Cir. 1988)) (suggesting that thirteen (13) prior instances of the alleged policy noncompliance at-issue in the two-year period preceding the claimant’s injuries could evidence prior knowledge of systemic noncompliance). Though the events that gave rise to this action are certainly unfortunate, “. . . [Mr. Passwater] cannot show a widespread practice of an unconstitutional nature, such as a custom of ignoring prison policy, by pointing to isolated incidents. . .” *Sinn*, 911 at 741 (citing *Palmer v. Marion County*, 327 F.3d 588, 597 (7th Cir. 1998)) (internal quotations omitted). Warden Pretorious is entitled to summary judgment in her favor.

*Appendix C***3. Doctor Daniel Rippetoe**

Dr. Rippetoe is entitled to summary judgment on the deliberate indifference claim against him. Mr. Passwater contends that Dr. Rippetoe was deliberately indifferent because he ordered Mr. Passwater to be involuntarily medicated and failed to direct anyone to monitor him afterward. Dkt. 1, *see also* Dkt. 92 at 14.

Dr. Rippetoe admits that Mr. Passwater's mental health condition on April 16, 2020, constitutes a serious medical need. Dkt. 112 at 14. Accordingly, the first prong is satisfied. However, the undisputed record reflects that Dr. Rippetoe was not deliberately indifferent to Mr. Passwater's serious medical need as to satisfy the second prong of his Eighth Amendment claim.

After he was contacted by nursing staff on April 16, Dr. Rippetoe approved emergency psychotropic medication for Mr. Passwater which consisted of 50 mg of Haldol Decanoate and 5 mg of Haldol Lactate. Dkt. 114-1 at 7-8. Dr. Rippetoe had several phone calls back and forth between him and medical staff that day. *Id.* at 6.

Both Mr. Passwater and Medical Defendants retained experts in this case. The expert witnesses retained by Medical Defendants and Mr. Passwater agreed that Dr. Rippetoe acted within the standard of care. Mr. Passwater's pharmacology expert Andrew J. Lampkins' opinion was that the overall medication regimen and dosages as ordered by Dr. Rippetoe were reasonable. Dkt. 113-1 at 1. Medical defendants' psychiatric expert

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Dr. Steven Berger's opinion was that Dr. Rippetoe's orders were the common medications and doses used in similar situations and comply with the standard of care. Dkt. 113-2 at 1.

Further, Dr. Rippetoe acted reasonably in assuring Mr. Passwater was properly monitored after receiving psychotropic medication. Because Dr. Rippetoe provided services over telepsychiatry, dkt. 114-1 at 2-3, he relied on a mental health team at the facility that consisted of a psychologist and master level therapist, as well as nursing staff to administer medications. *Id.* at 3, 5. Further, Dr. Rippetoe knew nursing staff had certain responsibilities for monitoring patients after the administration of medication. *Id.* at 5. Dr. Rippetoe was familiar with the IDOC psychotropic medication policy. *Id.* at 5.

Dr. Rippetoe had every reason to believe that the medical staff who were physically present at the facility would abide by the IDOC psychotropic medication policy. Dr. Rippetoe cannot be held accountable for the actions or inactions of those medical or correctional staff physically present at the facility and interacting with Mr. Passwater the day of the incident. "To recover damages under § 1983, a plaintiff must establish that a defendant was personally responsible for the deprivation of a constitutional right." *Whitfield v. Spiller*, 76 F.4th 698, 706 (7th Cir. 2023) (quoting *Gentry v. Duckworth*, 65 F.3d 555, 561 (7th Cir. 1995)). For this purpose, each defendant is considered independently. *Id.* No reasonable jury could find that Dr. Rippetoe acted with deliberate indifference. Accordingly, summary judgment is appropriate.

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4. Wexford of Indiana, LLC

The Court allowed a *Monell* claim to proceed against Wexford. Dkt. 8 at 6, dkt. 92 at 14. However, Mr. Passwater withdrew this claim against Wexford. Dkt. 121 at 1. Accordingly, the Court need not address any of the briefing as it relates to Defendant Wexford, as the claims against it were voluntarily dismissed.

IV. Conclusion

Defendants' motions for summary judgment, dkts. [108] and [111] are **GRANTED**. Because this matter will not proceed to trial, judgment consistent with this Entry shall now issue.

SO ORDERED.

Dated: January 2, 2025

/s/ Matthew P. Brookman
Matthew P. Brookman, Judge
United States District Court
Southern District of Indiana

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**APPENDIX D — JUDGMENT OF THE UNITED
STATES DISTRICT COURT SOUTHERN DISTRICT
OF INDIANA, TERRE HAUTE DIVISION,
FILED JANUARY 2, 2025**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
TERRE HAUTE DIVISION

No. 2:21-cv-00475-MPB-MG

BRAD PASSWATER,

Plaintiff,

v.

TRICIA PRETORIUS, *et al.*,

Defendants.

Filed January 2, 2025

FINAL JUDGMENT

The court now enters FINAL JUDGMENT.

The action is **dismissed with prejudice.**

Date: January 2, 2025

/s/ Matthew P. Brookman
Matthew P. Brookman, Judge
United States District Court
Southern District of Indiana