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**IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA  
FIFTH APPELLATE DISTRICT**

THE PEOPLE,

Plaintiff and Respondent,

v.

BRODERICK JEROME STEELE,

Defendant and Appellant.

F069441

(Super. Ct. No. CF0604028)

**OPINION**

**THE COURT\***

APPEAL from an order of the Superior Court of Fresno County. James Petrucelli, Judge.

Rachel Lederman, under appointment by the Court of Appeal, for Defendant and Appellant.

Kamala D. Harris, Attorney General, Gerald A. Engler, Chief Assistant Attorney General, Michael P. Farrell, Assistant Attorney General, Stephen G. Herndon and Melissa Lipon, Deputy Attorneys General, for Plaintiff and Respondent.

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\* Before Levy, Acting P.J., Poochigian, J. and Peña, J.

Broderick Jerome Steele was recommitted to Atascadero State Hospital (ASH) for another year of involuntary treatment as a mentally disordered offender (MDO). On appeal, he contends there was insufficient evidence that he was currently dangerous and that his severe mental disorder caused serious difficulty in controlling dangerous behavior. We conclude the evidence was sufficient and affirm the trial court's order extending his commitment.

### **FACTS**

On December 4, 2012, the Fresno County District Attorney filed a petition pursuant to Penal Code sections 2962, 2970, and 2972<sup>1</sup> to extend Steele's involuntary commitment as an MDO. On May 8, 2014, Steele waived a jury trial and a court trial was held on the same day. The following evidence was elicited.

Dr. Perry, a forensic psychologist at ASH, testified that he had conducted section 2970 evaluations of Steele in October 2012 and October 2013. Dr. Perry opined that Steele had a severe mental disorder called schizoaffective disorder bipolar type. Based on an incident in 2006, Steele was taken to ASH in 2009 and diagnosed with this disorder. Steele had a history of (1) auditory hallucinations with voices telling him to do things, such as hurt himself or others; (2) persecutory delusions with fixed beliefs not based on reality about others trying to harm or persecute him; (3) grandiose delusions, such as the belief that he worked for the CIA; (4) delusions of reference, such as the belief that the television or radio transmitted messages to him or transmitted his thoughts to others; and (5) mood swings. He was first hospitalized for psychiatric treatment in the early to mid-1980's and he began receiving benefits for mental illness in the late 1980's. Without treatment, his mental disorder substantially impaired his thoughts, emotions, judgment, and perception of reality. Even with treatment, his symptoms were sometimes still quite impairing. When Dr. Perry spoke to Steele's psychologist in April 2014, she

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<sup>1</sup> All further statutory references are to the Penal Code.

said his symptoms had been worsening over the past few months. Steele was placed on an involuntary medication order because he was removing his pills from his mouth. He could not be trusted to comply with treatment on his own and it was likely he would need his medication for the rest of his life. His mental disorder was not currently controlled by medication and it could not be kept in remission without treatment.

Dr. Perry believed Steele represented a substantial danger of physical harm to others because of his severe mental disorder. He had a history of being aggressive toward others when his symptoms were not well controlled in a structured setting. In an unstructured setting, he might reoffend. Recommitment to ASH would be the most effective and the safest way to treat his mental disorder.

On cross-examination, Dr. Perry testified that he was a forensic evaluator and not Steele's treating physician. He evaluated Steele personally for 30 or 40 minutes, and also reviewed his records and history. When he spoke to Steele, Steele was calm, polite, and appropriate, but he did make some statements with a delusional quality. Dr. Perry agreed that Steele had not touched or physically harmed anyone since 2006.

Dr. Perry explained that patients have both good and bad days. Patients often do not want to take antipsychotic medications, which have side effects. Steele frequently reported unpleasant drooling caused by his medication, Haldol.

Risk factors for MDO's include a history of threats or aggression related to the disorder, a lack of insight or compliance with the treatment that could control the symptoms, a history of substance abuse that could make symptoms worse, a lack of appropriate discharge plans to manage symptoms and behaviors in the community, and a general history of violent behavior.

Steele attended his group meetings at a rate of 60 to 70 percent, which was better than most patients. Steele's stated plans upon release included appropriate actions.

On redirect, Dr. Perry testified that he believed Haldol helped control Steele's mental disorder. Without it, he would likely be at a greater risk for psychiatric decompensation and for future threats or aggression.

Steele had attended a discharge planning group meeting, but he had not yet completed a comprehensive detailed plan. Without one, Dr. Perry explained, patients often decompensate and their symptoms worsen.

### ***Defense Evidence***

Steele testified that he had been at ASH since June 12, 2009. He said he received fair treatment there, but thought a lot of staff did not like him and they would write lies in his chart to keep him there longer. He took various medications, including Haldol for hearing voices. He said he started hearing voices in 1992 and Haldol worked for the voices. His rule since 1992 was to ignore the voices that were Satan and pay attention to the voices that were God. He still heard voices, but he only listened to God's voice. The lithium worked really well because he could tell himself to ignore the negative voices and tell himself it was Satan. He would then read his Bible or pray. His medications most definitely had a beneficial effect on him and he would continue to take them if he were released. (He explained that the medication he had removed from his mouth was blood pressure medicine.) If released, he would get his medications at either the Veterans Administration hospital or the local mental health hospital.

Steele said he was an honorably discharged veteran. He had never hurt anyone, even when he was in the military. He was involved with church and had contacted Victory Outreach, a Christian men's home. In fact, he had been an ordained minister since 1998, and he planned to stay involved in the church. His immediate plan was to find shelter for the night, then go to the Social Security office and apply for assistance in the morning. He planned to stay clean and sober. He wanted to see his family, including grandchildren he had never met and parents who were getting old.

Steele testified he was not a danger to anyone. The employees at ASH lied because it was their job to keep patients coming back. He had received awards for his group meeting attendance. He enjoyed some of the groups because they helped him express his feelings, channel his thinking, and speak well. If released, he would find a group through the Veterans Administration.

On cross-examination, Steele explained that he still heard voices on a daily basis even though he was taking medication. But he did not listen to Satan's voice. He said, "If it's God just testing me, if it's God just testing me, I'm not to judge that. But if I hear something negative, I ignore it. And if it's positive, I know it's God." He said he listened to God when God talked to him.

After hearing argument, the court made the following ruling:

"All right. Then the Court has considered the testimony of the doctor and the testimony of Mr. Steele, and the Court hereby finds that there is proof beyond a reasonable doubt that the respondent, Broderick Steele, has a severe mental disorder, that the severe mental disorder is not in remission and cannot be kept in remission if the respondent's treatment is not continued, and that by reason of the severe mental disorder, respondent represents a substantial danger of physical harm to others.

"Therefore it is hereby ordered that respondent, Broderick Steele, continue treatment under the direction of the medical directors at Atascadero State Hospital for an additional one year until [June] 12, 2015, pursuant to Penal Code Section 2970.

"It's further ordered that respondent, Broderick Steele, be transported to the custody of the medical director of Atascadero State Hospital forthwith for an additional year until June 12th of 2015."

### **DISCUSSION**

"The Mentally Disordered Offender Act (MDO Act), enacted in 1985, requires that offenders who have been convicted of violent crimes related to their mental disorders, and who continue to pose a danger to society, receive mental health treatment ... until their mental disorder can be kept in remission." (*Lopez v. Superior Court* (2010))

50 Cal.4th 1055, 1061 (*Lopez*), disapproved on another point in *People v. Harrison* (2013) 57 Cal.4th 1211; § 2962 et seq.) “Commitment as an MDO is not indefinite; instead, ‘[a]n MDO is committed for ... one-year period[s] and thereafter has the right to be released unless the People prove beyond a reasonable doubt that he or she should be recommitted for another year.’” (*Lopez, supra*, at p. 1063.)

To obtain an extension of one year, the People must prove that (1) the person continues to have a severe mental disorder; (2) the person’s mental disorder is not in remission or cannot be kept in remission without treatment; and (3) because of his mental disorder, the person continues to represent a substantial danger of physical harm to others. (§ 2972, subd. (c); *Lopez, supra*, 50 Cal.4th at p. 1063; *People v. Beeson* (2002) 99 Cal.App.4th 1393, 1398-1399.) Furthermore, an involuntary civil commitment requires proof that the person’s mental disorder causes serious difficulty in controlling dangerous behavior (*In re Howard N.* (2005) 35 Cal.4th 117, 122), “in order to distinguish those persons who are subject to civil commitment from those persons more properly dealt with by the criminal law” (*id.* at p. 132). A mental health professional “may and should take into account the prisoner’s entire history in making an MDO evaluation. This includes prior violent offenses as well as the prisoner’s mental health history.” (*People v. Pace* (1994) 27 Cal.App.4th 795, 799.)

“In considering the sufficiency of the evidence to support MDO findings, an appellate court must determine whether, on the whole record, a rational trier of fact could have found that [the person] is an MDO beyond a reasonable doubt, considering all the evidence in the light which is most favorable to the People, and drawing all inferences the trier could reasonably have made to support the finding. [Citation.] ““Although we must ensure the evidence is reasonable, credible, and of solid value, nonetheless it is the exclusive province of the trial judge or jury to determine the credibility of a witness and the truth or falsity of the facts on which that determination depends. [Citation.] Thus, if the [finding] is supported by substantial evidence, we must accord due deference to the

trier of fact and not substitute our evaluation of a witness's credibility for that of the fact finder.””” ( *People v. Clark* (2000) 82 Cal.App.4th 1072, 1082-1083.)

We note that a single opinion by a psychiatric expert that a person is currently dangerous due to a severe mental disorder can constitute substantial evidence to support the extension of a commitment. (See *People v. Bowers* (2006) 145 Cal.App.4th 870, 879; *People v. Zapisek* (2007) 147 Cal.App.4th 1151, 1165 [§ 1026.5 commitment].) “In civil commitment cases, where the trier of fact is required by statute to determine whether a person is dangerous or likely to be dangerous, expert prediction may be the only evidence available.” ( *People v. Ward* (1999) 71 Cal.App.4th 368, 374.) But “[e]xpert opinion testimony constitutes substantial evidence only if based on conclusions or assumptions supported by evidence in the record. Opinion testimony which is conjectural or speculative ‘cannot rise to the dignity of substantial evidence.’” ( *Roddenberry v. Roddenberry* (1996) 44 Cal.App.4th 634, 651.)

Steele contends Dr. Perry's opinion that he was currently dangerous was not based on any current or past physical violence, but was instead based primarily on his 2006 offense of attempted criminal threat and some incidents at the hospital two and three years before the trial in which staff felt his demeanor was aggressive. The MDO Act, however, specifically states that a “‘substantial danger of physical harm’ does not require proof of a recent overt act.” (§ 2962, subd. (f); see *In re Qawi* (2004) 32 Cal.4th 1, 24 (*Qawi*)). Moreover, Steele's lack of recent violence in a controlled institutional setting did not prove he no longer represented a substantial danger to others when placed outside that controlled setting. ( *People v. Sumahit* (2005) 128 Cal.App.4th 347, 353.) Steele had a history of aggression when his symptoms were not controlled in a structured setting, and Dr. Perry believed he might reoffend if he were no longer in a structured setting. Although Steele had plans for his release, they did not qualify as comprehensive detailed plans, without which patients often experience decompensation and worsening of their symptoms upon release. Dr. Perry's prediction constituted substantial evidence of

Steele's dangerousness. (*Qawi, supra*, 32 Cal.4th at p. 24 [“substantial danger of physical harm to others” is without definition; “it appears to mean a prediction of future dangerousness by mental health professionals”].)

Steele argues Dr. Perry's concern that he would not take his medication upon his release and would be physically dangerous was pure speculation. He points out that he had never laid hands on or physically harmed anyone; he had shown no physically dangerous behavior in the past year and had never been physically violent. But Dr. Perry noted Steele had been aggressive in the past when he was not medicated. And Steele had complained about his medication's side effects, had recently refused to take some of his medications, and had been placed on an involuntary order. The possibility that he would not take his medications voluntarily was not speculative at all.

Steele contends there was no proof that his mental disorder caused him difficulty in controlling dangerous behavior. He argues he was able to ignore the negative voices he heard, and he did not have to show that he did not experience delusions. Dr. Perry explained that Steele's mental disorder required medication, and even the medication did not currently control his symptoms, such as his ongoing auditory hallucinations. Dr. Perry opined that without treatment, Steele's mental disorder substantially impaired his thoughts, emotions, judgment, and perception of reality, and that even with treatment, his symptoms were not completely controlled and were sometimes quite impairing. In the recent months, his symptoms had worsened and Dr. Perry believed he could not be trusted to comply with his treatment if released.

From this evidence, we conclude substantial evidence supported a finding that Steele's mental disorder had caused him serious difficulty in controlling his aggression and would likely do so again if he were released, and that his mental disorder continued to represent a substantial danger of physical harm to others. We commend Steele's efforts to attend group meetings and plan for his future, but we cannot say that we find error in the trial court's recommitment order.

**DISPOSITION**

The order is affirmed.