The Genocide of Battered Mothers and their Children

Battered Mothers-A Human Rights Issue

- About
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Dr. Richard Gardner's Complete Autopsy Report

In Parental Alienation (PAS), Parental Alienation (PAS), Parental Alienation (PAS) on **April 1, 2010 at 3:17 pm**

http://www.cincinnatipas.com/dr-richardgardnerautopsy.html

Dr. Richard Gardner, M.D.

born April 28, 1931

Committed Suicide

May 25, 2003

"CAUSE OF DEATH:

Incised wounds of chest and neck."

Allow us to disabuse the pro-abusers. Dr. Richard Gardner's son told the New York Times that his father committed suicide. Contrary to false assertions made by the father's rights movement, Richard Gardner most certainly did not die peacefully in his sleep.

It was far uglier than that.

The Bergen County (New Jersey) Medical Examiner reported that Dr. Richard Gardner died a gory, bloody and violent death – from his own hand. Gardner took an overdose of prescription medication while stabbing himself several times in the neck and chest. Gardner plunged a butcher knife deep into his heart.

The medical examiner removed the knife from Gardner's chest and listed the stabbing wounds as the cause of death.

(Here is Gardner's autopsy report and the NY Times obituary.)

County Of Bergen

Department of Public Safety

Medical Examiner Autopsy Report

May 27, 2003

02030860.aut

GARDNER, Richard A.

COUNTY OF BERGEN
DEPARTMENT OF PUBLIC SAFETY
MEDICAL EXAMINER
351 E. Ridgewood Avenue • Paramus, New Jersey 07652
(201) 599-6097 • Fax (201) 986-1780

Sunandan B. Singh, M.D.
Medical Examiner
Mary Ann B. Clayton, M.D.
Deputy Medical Examiner
Laura S. Carbone, M.D.
Assistant Medical Examiner

02030860.aut
GARDNER, Richard A. May 27, 2003

This is to certify that I, Laura S. Carbone, M.D., Bergen County Medical Examiner, have conducted a postmortem examination and autopsy on the unembalmed and refrigerated body of Richard A. Gardner at the Bergen County Medical Examiner's Office on May 27, 2003, between 1030 and 1235 hours with the assistance of Ms. Coleen McVeigh.

IDENTIFICATION:

The decedent is identified visually at the scene by his girlfriend, Natalie Weiss.

CLOTHING/PERSONAL EFFECTS:

The decedent is received clad in a white with black print ("carpe diem") sweatshirt, white undershirt, navy blue trousers and white boxer shorts. The garments are all intact showing no discrete perforations or tears. The sweatshirt and undershirt show patchy blood stains which are most concentrated on the right shoulder and the back areas of the garments. A white handkerchief is recovered from the right front pocket of the trousers; a similar handkerchief and 2 ½ light orange oval tablets are within the left front pocket. A yellow, metal, nugget-type ring is worn on the right middle finger.

All of the above-described items with the exception of the tablets recovered from a pant pocket (retained) are released to the funeral home (Wien and Wien).

OTHER ITEMS:

Various items are recovered from the scene and are received within labeled paper envelopes as follows:

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Several bottles of prescription medications are recovered, some of which are empty. For specific medications, dosages, quantities, etc., please see the report prepared by the Medical Examiner Investigator.

A bloodied steak knife is recovered from the scene. The knife has a wooden handle measuring 3 ¾ x ½ x ¼ inches with a yellow metal serrated blade measuring 5 inches in length and up to 5/8 inch wide and 1/16 inch in maximum thickness; dried blood is visible smeared on the blade surface and smudged on the handle. The knife is photographed.

All of the above-described items are retained by the Bergen County Medical Examiner's Office.

MARKS OF TREATMENT:

There is no evidence of terminal medical attention.

RADIOLOGY:

No postmortem x-ray studies are performed.

INJURIES, EXTERNAL AND INTERNAL:

There are incised wounds (sharp-force injuries) to the chest and neck. The injuries are listed below for descriptive purposes only. No sequence is implied.

I. CHEST:

There are at least four stab wounds clustered within a 6 x 3 inch area on the anterior left chest. The wounds will be described from inferior to superior designated A-D as follows:

A:
There is a nearly horizontally-oriented elliptical stab wound centered 1" below the top of the left shoulder, 2" left of the midline and 4" medial to the left nipple line. With normal skin tension this is a 1 1/8 x ¼" wound; with release of skin tension this is 1 ¼ x 1/8" wound. The medial edge is blunt and the lateral edge is sharp. The wound extends into the subcutaneous soft tissue of the anterior chest wall up to 3/8" in maximum depth.

B and C:
Wound B is a nearly-horizontally oriented triangular shaped stab wound centered 10 ½" below the top of the left shoulder, 2 ¾" left of the midline and 3 ¾" medial to the left nipple line. With normal skin tension this wound measures 2 x ¼" in greatest dimension;

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with release of skin tension this is a 2 1/8 x ¼" wound. The medial edge is blunt and the lateral edge is sharp showing a dovetail configuration with a ¼ x 1/8" triangular abrasion projecting laterally from the inferior edge of the dovetail at an approximately 5 o'clock position.

Wound C is an irregularly-shaped stab wound centered 10" below the top of the left shoulder, 2" left of the midline and 3 ½" medial to the left nipple line measuring 2 x ¼" in greatest dimension with normal skin tension; with release of skin tension this is a 2 1/8 x ¼" greatest dimension wound. The medial edge is blunt and the lateral edge is sharp. There is a ¾ x 1/8" bridge of skin visible within the wound.

Wounds B and C penetrate the full thickness of skin and soft tissue of the anterior chest wall and underlying ribs resulting in a 2" mostly curvilinear incision involving the medial aspect of the left lower-most ribs associated with focal surrounding soft tissue hemorrhage which involves the medial aspect of the left hemidiaphragm. These wounds terminate at the inner surface of the rib cage and do not extend into the left lung.

D:
The body is received with a knife plunged into wound D. The knife is angled upward and inward with the sharp and dull edges of the blade within the lateral and medial edges of the wound, respectively. The knife handle and 2 ½" of exposed blade project from the wound at angles of approximately 45 degrees and 60 degrees when viewing downward from the top of the head and laterally from the left side of the body, respectively. The knife is removed by the undersigned Medical Examiner (see below).

Once the knife is removed, wound D consists of an elliptical-shaped stab wound measuring 1 ¾ x 1/8" in greatest dimensions with and without skin tension. This wound is centered 7 ¾" below the top of the left shoulder, 3" left of the midline and 2 ¼" medial to the left nipple line. The medial edge is blunt and the lateral edge is sharp. After penetration through the full thickness of the skin and soft tissue of the left anterior chest wall, the knife extended through the intercostal muscle between the left second and third ribs creating a 2" linear incision. The knife then perforated the superior aspect of the pericardial sac resulting in a ¾" incision near the base of the heart; the pericardial sac contains only a small amount of residual bloody fluid. The knife then penetrated the heart; there is a ¾" focal epicardial hemorrhage adjacent to the left auricle associated with in a ½" incision into the epicardium at the base of the heart and the origin of the aorta which transects the left carotid artery resulting in hemorrhage extending along the proximal left anterior descending artery course for approximately 1 ½". The knife then terminated in the lumen of the aorta resulting in a 3/8", mostly linear, transversely oriented incision of the origin of the aorta situated just below the left aortic ostium and just above the annulus of the aortic valve.

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Approximately 2500 ml of bloody fluid is accumulated within the left hemithorax. The pericardial sac contains only a small unquantified amount of blood (as above). The left lung is collapsed but shows no discrete incisions or perforations. However, there is focal hemorrhage accumulated along the hilus of the left lung. No discrete incisions of the pulmonary vessels are found.

The direction of the wound's track is upward and inward, from left to right. The maximum depth of penetration is approximately 5".

II. NECK:

There are three parallel obliquely-oriented incised wounds on the right lateral aspect of the neck situated approximately ½" apart and each at angles along the same line as the angle of the jaw.

The lower-most wound is a linear 1" superficial incised wound measuring up to 1/16" in maximum depth. The wound has a 1" linear or superficial tear extending from the medial/anterior aspect of the wound which courses more horizontally across the neck.

The upper-most wound is a linear, 1 ½" long superficial incised wound measuring up to 1/8" in maximum depth.

The central wound is a 3 ¼ x ¼" linear deep incised wound measuring up to ½" in maximum depth. The would incises underlying skeletal muscle and subcutaneous soft tissue, transects the right jugular vein and cuts into the right lamina of the thyroid cartilage resulting in a ¾" nearly transversely oriented superficial incision into the cartilage associated with focal surrounding soft tissue hemorrhage. Patchy foci of hemorrhage also extend throughout much of the right side of the neck.

Two discrete, v-shaped superficial abraded lacerations measuring ¼" each are on the more posterior aspect of the right side of the neck adjacent to the lateral edge of the upper-most incised wound and vertically along the same lines situated between the middle and lower-most wounds. A few very superficial scratch-like linear abrasions parallel to the aforementioned incised wounds are visible on the intervening skin.

These injuries, having been described, will not be repeated.

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KNIFE:

The knife which is recovered from the subject's chest is a butcher knife having a black and gray metal handle and a gray metal blade measuring 7 ¾" length, 1 ¾" maximum width and up to 1/8" maximum thickness. The sharp edge of the blade shows a pattern of tiny serrations. Much of the blade is bloodied.

The knife is photographed and retained by the Bergen County Medical Examiner's Office.

EXTERNAL EXAMINATION:

The body is that of a well-developed and well-nourished, medium framed and slender elderly man whose appearance is consistent with the reported age of 72 years. The measured height is 71" and the scale weight is 163 pounds. Rigor mortis is very strong and symmetrical in all muscle groups. There is patchy pale-pink-red lividity concentrated on the posterior dependent surfaces of the head and neck, torso and extremities which blanches diffusely on firm pressure.

The face is pale. Dry, superficial abraded lacerations measuring ¼" and ½" are on the top and left side of the forehead, respectively. The scalp is without laceration. The skull is intact to palpation. The fine and wavy dark and light gray scalp hair measures up to 2" in greatest length and shows prominent thinning along the temples. The corneas are clear. The irides are blue-gray and the pupils are round and symmetrical measuring 5 mm each in diameter. The conjunctivae and sclerae are pale without any focal hemorrhages, petechiae or jaundice. There is no periorbital edema or eyelid injury. The nasal bones are intact and the nares are clear. The nasal septal mucosa is without ulceration or perforation. The bones of the face are palpably intact. The lips and oral mucosa are atraumatic. A small amount of pink fluid is accumulated within the mouth; no solid matter is found. The dentition is natural and in good overall condition and repair. The tongue and gingival mucosa are intact. The ears are atraumatic having clear auditory canals.

The neck is slender and symmetrical showing incised wounds (as above). No other external injuries are evident. The trachea is midline. There is no palpable thyromegaly or lymphadenopathy. No abnormal mobility of the neck is detected upon manipulation.

The chest is symmetrical, showing incised wounds clustered over the left chest (as above). There are no palpable fractures. The breasts have the usual male configuration and are without any discrete palpable masses. The nipples are without ulceration. No scars of the chest are apparent. The abdomen is slightly protuberant and soft without any discrete palpable masses, visible injuries or discernable surgical scars. Four transparent

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"duragesic" patches are in place on each quadrant of the abdomen; three of these patches are square and show "25 micrograms" as their dosage. The rectangular shaped patch on the left lower quadrant of the abdomen shows the dosage as "50 micrograms". The back is atraumatic. The perianal region is clean. The external genitalia is that of a normal circumcised adult male. The testes are palpable within the atraumatic scrotal sac which shows patchy pink-red drying artifact of the scrotal skin.

The arms and legs are symmetrical and normally developed without any discrete palpable fractures or visible acute injuries. There are no amputations or deformities. No cutaneous burns are observed. No hyperpigmented linear scars or recent injection marks are seen overlying subcutaneous veins on the forearms, wrist or hands. No other discrete injuries are apparent. The hands show smudgy and/or dry bloodstains. The fingernails are well groomed, clean and intact. There is no appreciable edema of the lower extremities. The lower legs show minimal hair growth and somewhat shiny skin. The feet are clean; the plantar surfaces are slightly yellowed. The toenails are gray-tan and thickened. The toes are unremarkable.

INTERNAL EXAMINATION:

The abdominal panniculus measures 1 ½" in thickness at the level of the umbilicus. No unusual odor is detected in the body cavities. The viscera exhibit their normal anatomic relationships. There are no pleural plaques. The pleural and peritoneal cavities are free of any adhesions. The peritoneal cavity contains no significant fluid accumulation.

CARDIOVASCULAR SYSTEM:

The pericardium and heart show the previously described incised wounds. The pericardium is otherwise thin and without adhesions. The heart is somewhat globular in configuration and weighs 430 grams. The epicardium is smooth and shiny showing a normal amount of epicardial fat and focal hemorrhage and penetrating injury (as above). The coronary arteries are of medium caliber and show moderate-to-severe mildly calcific multifocal atherosclerotic stenosis which measures up to 75% maximum within the mid-to-distal portion of the left anterior descending artery. No discrete thrombi obstruct any of the coronary artery lumens. The foramen ovale is closed and there are no septal defects. The myocardium is sectioned serially and is diffusely dark brown-red and soft showing no discrete foci of fibrosis, pallor or hyperemia. There is mild dilatation of all four heart chambers. The left ventricle wall and interventricular septum each measure 1.8 cm in thickness; the right ventricle measures 0.3 cm thick. The papillary muscles are dark brown-red and soft without central fibrosis. The chordae tendineae are thin and delicate. The tricuspid, pulmonic, mitral and aortic valves are normal in configuration with thin leaflets and cusps; patchy yellow-tan foci of soft atherosclerotic plaque are visible on the mitral valve leaflet and there is patchy plaque deposition on the annulus of

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the aortic valve. There are no discrete valvular vegetations or defects. The endocardial surfaces are smooth and shiny without significant fibrosis or mural thrombi. The aorta shows injury (as above); the major branches are normally distributed. The intima is yellow-tan and remarkable for innumerable scattered plaques which are most concentrated within the aortic arch and infrarenal segments where they show patchy foci of calcification and/or ulceration. The carotid, pulmonary and renal arteries are patent without stenosis or emboli. The inferior vena cava is intact and the lumen is free of thrombi. The renal veins are unobstructed. The jugular veins are intact.

RESPIRATORY SYSTEM:

The anterior strap muscles are dissected in a layer-wise fashion revealing the above-described findings. The thyroid cartilage shows injury (as above). The hyoid bone, cricoid and tracheal cartilages are without fracture. The laryngeal, tracheal and bronchial lumens are of normal caliber. The mucosal surfaces are smooth pink-tan and minimally congested without any focal hemorrhages, ulcerations or exudates. The bronchi contain no secretions or obstructions. The right and left lungs are collapsed/atelectatic and weigh 400 grams and 330 grams, respectively. The pleural surfaces are pink-red to pink-gray showing scattered foci of abundant anthracotic pigment deposition and gray-tan foci of apical plaque bilaterally. The parenchyma is pink-tan showing mild congestion and anthracotic pigment deposition stippled throughout. No discrete consolidated areas are palpable. No abscesses, tumor masses or calcifications are found. The left hemidiaphragm shows focal hemorrhage (as above); the diaphragms have no defects and are located at the usual intercostal levels.

DIGESTIVE SYSTEM:

The supraglottic mucosa is smooth and tan-pink. The oral cavity contains pink fluid (as above). The tongue is normal in configuration without any lacerations or bite marks on the surface; sections do not reveal any deep hemorrhages or scars. The esophageal mucosa is gray-white and smooth. The esophagogastric junction is distinct and unremarkable. The stomach contains approximately 500 ml of watery green-blue fluid having no distinct aroma; no discrete intact tablets, capsules or recognizable solid food matter are discernable. The gastric mucosa is pink-tan and smooth with normal rugae. No tumors, ulcers or areas of wall thickening are noted. The pylorus is somewhat thickened and is otherwise patent. The small bowel contains thick yellow-tan liquid. The appendix is thin and tapering without inflammation or fibrosis. The large bowel is normally positioned and contains abundant soft green-tan fecal matter and shows numerous, hard, stool-filled diverticula throughout nearly the entire length; no discrete foci of perforation and/or surrounding inflammation or fibrosis are apparent. *[initials]*

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The liver weighs 1380 grams and has a normal configuration with a smooth capsular surface and sharp free edge. The parenchyma is uniformly brown-red and soft having a normal lobular pattern without apparent fibrosis and nodularity. The gallbladder is saccular, thin-walled and distended by approximately 50 ml of viscid green bile. There are no gallstones. The extrahepatic biliary ducts are patent. The pancreas is of normal size, shape and position having a diffusely congested and slightly autolyzed tan-pink parenchyma with normal lobulation and diffusely softened texture. There are no discrete foci of fat necrosis, fibrosis or hemorrhage noted.

LYMPHORETICULAR SYSTEM:

The thymus gland is not identified. The spleen has an intact smooth gray capsular surface and weighs 120 grams. The parenchyma is dark purple-red and soft without prominent white pulp. The peribronchial, porta hepatic, peripancreatic and periaortic lymph nodes are normal in size and consistency. Very little dark red fluid blood is within the vessels. The bone marrow is pink-red.

ENDOCRINE SYSTEM:

The pituitary gland is of normal size and configuration. The thyroid is bilobed and symmetrical having a brown-gray, gelatinous and slightly fibrotic parenchyma without any discrete cystic lesions or nodules. The adrenals are normally located and similar in size and shape. The golden yellow cortices are thin and clearly separated from the softened and autolyzed brown-gray medullae. No nodules or hemorrhages are seen.

UROGENITAL SYSTEM:

The right and left kidneys weigh 140 grams each. The capsules are thin and delicate and strip easily. The renal configuration is normal. The cortical surfaces are diffusely pink-tan, pale and granular showing several clear fluid-filled cortical cysts on each kidney ranging from 0.2-0.6 cm maximum dimension each. No masses are found. The cut surfaces show distinct corticomedullary junctions and pale cortices of normal thickness. The medullae and papillae are without abnormality. The calyceal and pelvic urothelium is smooth and intact. The ureters are patent and are of normal caliber and course. The bladder wall is of normal thickness and the mucosa is white-gray and smooth without any focal lesions or masses. The bladder contains approximately 300 ml of light, yellow, clear urine. The prostate gland is not significantly enlarged and is gray-tan to gray-yellow and diffusely firm. No discrete foci of induration are noted. The testes are palpable within the atraumatic scrotal sac.

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CENTRAL NERVOUS SYSTEM:

The scalp is reflected revealing no focal hemorrhages or injuries. The temporalis muscles are of normal configuration without any focal hemorrhages. There are no fractures of the calvarium or base of the skull. The dura mater is thin, delicate and gray-white without any focal discoloration. There are no epidural or subdural hemorrhages or hematomas. The meninges are pale without any focal hemorrhages or exudates. The cerebral hemispheres are symmetrical and the gyral pattern is normal. The brain weighs 1480 grams. There is no apparent cingulate gyrus herniation or uncal grooving. The cerebellar tonsils are not prominent. The blood vessels at the base of the brain are normally distributed without any aneurysms, showing a few patchy foci of non-occlusive soft atherosclerotic plaque. Multiple coronal sections of the brain show normal demarcation of the gray and white matter. No focal discolorations, hemorrhages, masses or injuries are noted. No discrete areas of softening are palpable. The corpus callosum, basal ganglia and mamillary bodies are normal. The ventricles are not dilated and contain no blood. Sections of the mid brain, pons, medulla and cerebellum show no discrete abnormalities. The spinal cord is not removed for further examination.

MUSCULOSKELETAL SYSTEM:

The thoracic and abdominal musculature is red-brown and symmetrical. The thoracic muscles show focal hemorrhage in the area of trauma (as above). There is no palpable or visible ligamentous injury or fracture of the cervical spine which is mostly rigid. The vertebral column is intact showing mild scoliosis of the thoracic segment. The sternum is without deformity or injury. The ribs are symmetrical and atraumatic with the exception of the left lower-most ribs (as above). The pelvic rim is smooth and intact. All of the bones examined are osteoporotic.

TOXICOLOGY:

No premortem samples are obtained. Postmortem blood, urine, liver, brain and gastric contents are submitted for analysis. See Analytic Bio-Chemistries laboratory report.

ADDITIONAL SAMPLES:

A blood sample is retained on an FTA card for DNA.

HISTOLOGY:

No sections are processed for microscopic examination.

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POLICE REPORT:

Police reports from the Tenafly Police Department are pending and will be reviewed upon receipt.

PHOTOGRAPHY:

Autopsy and scene photography is performed by the Bergen County Medical Examiner's Office.

FINDINGS/FINAL DIAGNOSIS:

I. Incised wounds of chest and neck.

   A. Stab wounds (4) of left chest with:
   (a) Incisions of heart, aorta and pericardial sac.
   (b) Hemothorax (1200ml), left.
   (c) Soft tissue hemorrhages.

   B. Incised wounds (3) of right neck with:
   (a) Transection of right jugular vein.
   (b) Incision of right thyroid cartilage lamina.
   (c) Soft tissue hemorrhages.

II. Arteriosclerotic cardiovascular disease.

   A. Cardiomegaly, moderate (heart weight = 430 grams), with concentric left ventricular hypertrophy (left ventricle = 1.8 cm thick) .

   B. Moderate-severe multifocal coronary atherosclerosis.

   C. Moderate grade aortic atherosclerosis.

   D. Severe nephrosclerosis.

III. Renal cortical cysts, multiple, bilateral (0.2-0.6 cm each).

IV. Abraded lacerations (2) on forehead.

V. Diverticulosis coli.

VI. Osteoporosis.

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VII. Mild scoliosis, thoracic spine.

VIII. Toxicology report pending.

CAUSE OF DEATH:

Incised wounds of chest and neck.

MANNER OF DEATH:

Suicide.

Laura S. Carbone, M.D.
Assistant Medical Examiner

DATE DICTATED:	05-27-03
DATE TRANSCRIBED:	06-23-03
DATE FINALIZED:	07-02-03

LSC/gr

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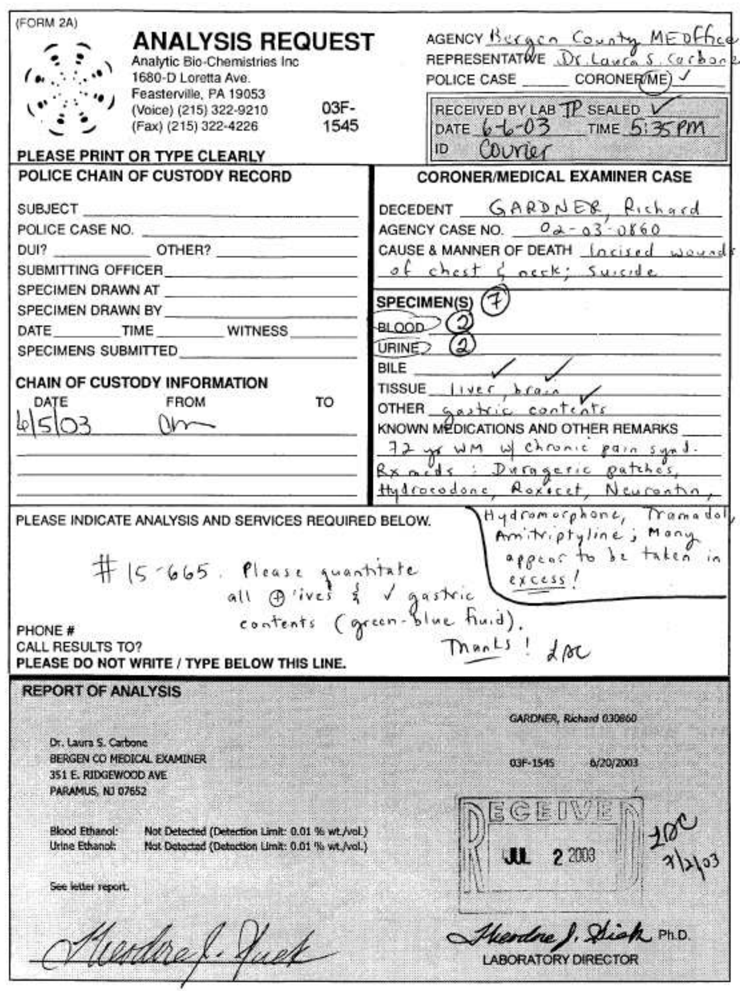

(FORM 2A)

ANALYSIS REQUEST

Analytic Bio-Chemistries Inc
1680-D Loretta Ave.
Feasterville, PA 19053
(Voice) (215) 322-9210
(Fax) (215) 322-4226

03F-1545

AGENCY Bergen County ME Office
REPRESENTATIVE Dr. Laura S. Carbone
POLICE CASE ______ CORONER/ME ✓

RECEIVED BY LAB TP SEALED ✓
DATE 6-6-03 TIME 5:35 PM
ID Courier

PLEASE PRINT OR TYPE CLEARLY

POLICE CHAIN OF CUSTODY RECORD

SUBJECT
POLICE CASE NO.
DUI? OTHER?
SUBMITTING OFFICER
SPECIMEN DRAWN AT
SPECIMEN DRAWN BY
DATE TIME WITNESS
SPECIMENS SUBMITTED

CHAIN OF CUSTODY INFORMATION

DATE	FROM	TO
6/5/03	[illegible]	

CORONER/MEDICAL EXAMINER CASE

DECEDENT GARDNER, Richard
AGENCY CASE NO. 02-03-0860
CAUSE & MANNER OF DEATH Incised wounds of chest & neck; Suicide

SPECIMEN(S) (7)
BLOOD (2)
URINE (2)
BILE
TISSUE liver, brain ✓ ✓
OTHER gastric contents ✓
KNOWN MEDICATIONS AND OTHER REMARKS
72 yr WM w/ chronic pain synd.
Rx meds: Duragesic patches, Hydrocodone, Roxicet, Neurontin, Hydromorphone, Tramadol, Amitriptyline; Many appear to be taken in excess!

PLEASE INDICATE ANALYSIS AND SERVICES REQUIRED BELOW.

#15-665. Please quantitate all ⊕'ives & ✓ gastric contents (green-blue fluid).
Thanks! LSC

PHONE #
CALL RESULTS TO?
PLEASE DO NOT WRITE / TYPE BELOW THIS LINE.

REPORT OF ANALYSIS

GARDNER, Richard 030860

Dr. Laura S. Carbone
BERGEN CO MEDICAL EXAMINER
351 E. RIDGEWOOD AVE
PARAMUS, NJ 07652

03F-1545 6/20/2003

RECEIVED JUL 2 2003

LSC 7/2/03

Blood Ethanol: Not Detected (Detection Limit: 0.01 % wt./vol.)
Urine Ethanol: Not Detected (Detection Limit: 0.01 % wt./vol.)

See letter report.

Theodore J. Siek Ph.D.
LABORATORY DIRECTOR

1680 D Loretta Ave.
Feasterville, PA 19053
(215) 322-9210 (voice)
(215) 322-4226 (fax)

June 20, 2003

Dr. Laura S. Carbone
BERGEN CO MEDICAL EXAMINER
351 E. RIDGEWOOD AVE
PARAMUS, NJ 07652

Subject: GARDNER, Richard 030860
AB-C Lab Number: 03F-1545

The significant toxicology findings on specimens obtained from Richard Gardner are summarized below.Substances tested for are given in the Analysis Summary included with this report.

Ethanol: Blood Ethanol- Not Detected (Detection Limit: 0.01 % wt./vol.), Urine Ethanol- Not Detected (Detection Limit: 0.01 % wt./vol.)

TOXICOLOGY SURVEY FINDINGS:

Urine: Positive for acetaminophen, opiates, and tramadol.

Blood Quantitations:

Blood: Acetaminophen, 140 mg/L (5 -26 mg/L); morphine, 0.008 mg/L (0.01 - 0.18 mg/L); hydrocodone, 0.46 mg/L; oxycodone, 0.084 mg/L (0.01 - 0.06 mg/L for hydrocodone and oxycodone therapeutic range). Fentanyl, 6 nanogrampml; urine fentanyl, 100 nanogram/ml. Fentanyl in blood is in the range for reported overdose deaths.
Gastic Contents: Acetaminophen, approximately 220 mg in 20 mL of gastric; hydrocodone was also detected.

Comments:

Excessive use of acetaminophen, hydrocodone, and probably fentanyl is documented by test results. Gross quantitites of acetaminophen were present in the small volume of gastric fluid submitted.

Respectfully,

Paul R. Marker Supervisor

Theodore J. Siek, Ph. D.
Forensic Toxicologist, DABFT

LBU
7/2/03

Analytic Bio-Chemistries, Inc.
1680-D Loretta Avenue
Feasterville, PA 19053
Phone: (215) 322-9210
FAX: (215) 322-4226

Friday, June 20, 2003

ANALYSIS SUMMARY

Patient Name: GARDNER, Richard 030860
Lab Number: 03F-1545

Dr. Laura S. Carbone
BERGEN CO MEDICAL EXAMINER
351 E. RIDGEWOOD AVE
PARAMUS, NJ 07652

15-665 TOXICOLOGY SURVEY

SUBSTANCES TESTED FOR ARE LISTED BELOW:

Serum, plasma, blood tests:

Acetaminophen
Barbiturates
Benzodiazepines
Butalbital
Caffeine
Carbamazepine
Carisoprodol
Clozapine
Diazepam
Dyphylline
Ethanol
Ethchlorvynol
Glutethimide
Ibuprofen
Lorazepam
Meprobamate
Methyprylon
Methaqualone
Naproxen
Nordiazepam
Oxazepam
Phenobarbital
Phenytoin
Salicylates
Temazepam
Theophylline
Volatiles
Zolpidem

Urine tests:

Acetaminophen
Amiodarone
Amitriptyline
Amlodipine
Amoxapine
Amphetamines
Antihistamines
Barbiturates
Benzodiazepines
Benzoylecgonine (BE)
Caffeine
Cannabinoids
Carbamazepine
Carisoprodol
Chlorpheniramine
Cimetidine
Clomipramine
Clozapine
Cocaine
Codeine
Cyclobenzaprine
Desipramine
Desmethylsertraline
Dextromethorphan
Diltiazem
Diphenhydramine
Dipyridamole
Disopyramide
Doxepin
Doxylamine
Dyphylline
Ephedrine
Erythromycin
Ethanol
Ethchlorvynol
Fenfluramine
Fluoxetine
Guaifenesin
Hydrocodone
Hydromorphone
Hydroxyzine
Ibuprofen
Imipramine
Lidocaine
Loxapine
LSD
Maprotiline
MDA
MDMA
Meperidine
Meprobamate
Mesoridazine
Methadone
Methamphetamine
Methaqualone
Methocarbamol
Methylphenidate
Mirtazapine
Morphine
6-Monoacetylmorphine
N-acetylprocainamide
Naproxen
Nicotine
Norclomipramine
Nordoxepin
Norfluoxetine
Normeperidine
Norpropoxyphene
Nortriptyline
Olanzapine
Opiates
Orphenadrine
Oxycodone
Paroxetine
Pentazocine
Phencyclidine
Pheniramine
Phenmetrazine
Phenothiazines
Phentermine
Phenylpropanolamir
Procainamide
Propoxyphene
Propranolol
Protriptyline
Pseudoephedrine
Quinidine
Quinine
Ranitidine
Salicylates
Sertraline
Spironolactone
Thioridazine
Tramadol
Trazodone
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New York Times

June 9, 2003, Monday

METROPOLITAN DESK

Richard Gardner, 72, Dies;

Cast Doubt on Abuse Claims

By STUART LAVIETES

"Dr. Richard A. Gardner, a psychiatrist and psychoanalyst who developed a theory about parental alienation syndrome, which he said could lead children in high-conflict custody cases to falsely accuse a parent of abuse, died on May 25 at his home in Tenafly, N.J. He was 72.

The cause was suicide, said Dr. Gardner’s son, Andrew, who said his father had been distraught over the advancing symptoms of reflex sympathetic dystrophy, a painful neurological syndrome.

Dr. Gardner, who testified in more than 400 child custody cases, maintained that children who suffered from parental alienation syndrome had been indoctrinated by a vindictive parent and obsessively denigrated the other parent without cause.

In severe cases, he recommended that courts remove children from the homes of the alienating parents and place them in the custody of the parents accused of abuse.

His theory has provoked vehement opposition from some mental health professionals, child abuse experts and lawyers. Critics argue that it lacks a scientific basis, noting that the American Psychiatric Association and the American Medical Association have not recognized it as a syndrome.

They also say that the theory is biased against women, as allegations of abuse are usually directed at fathers, and that it is used as a weapon by lawyers seeking to undermine a mother’s credibility in court." …

… "His marriage to Lee Gardner ended in divorce. In addition to his son, of Cherry Hill, N.J., he is survived by two daughters, Nancy Gardner Rubin of Potomac, Md., and Julie Gardner Mandelcorn, of Newton, Mass.; his mother, Amelia Gardner of Manhattan; eight grandchildren; and his partner, Natalie Weiss.

Correction: June 14, 2003, Saturday An obituary on Monday about Dr. Richard A. Gardner, a psychiatrist and psychoanalyst, misstated his position at Columbia University. He was a clinical professor of psychiatry in the division of child and adolescent psychiatry — an unpaid volunteer — not a professor of child psychiatry."

End of Obituary Excerpt

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A comment about Dr. Richard Gardner's suicide released by the last man to cross examine him, attorney Richard Ducote:

¬Ý¬ÝJune 1, 2003

"Parental Alienation Syndrome is a bogus, pro-pedophillic fraud concocted by Richard Gardner. I was the last attorney to cross examine Gardner. In Paterson, NJ, he admitted that he has not spoken to the Dean of Columbia's medical school for over 15 years, and has not had hospital admitting privileges for over 25 years.

He has not been court appointed to do anything for decades.

The only two appellate courts in the country who have considered the question of whether PAS meets the Frye test, i.e., whether it is generally accepted in the scientific community, said it does not. As Dr. Paul Fink, former president of the American Psychiatric Association has stated, Dr. Gardner and PAS should be only a "pathetic footnote" in psychiatric history. Gardner and his bogus theory have done untold damage to sexually and physically abused children and their protective parents. PAS has been rejected by every reputable organization considering it.

In a Florida case in which I was recently involved, when the judge insisted on a Frye hearing, Gardner simply did not show up. Perhaps because he finally realized that the entire nation was on to his scam, he committed suicide on May 25. Let's pray that his ridiculous, dangerous PAS foolishness died with him."

Richard Ducote

attorney at law

New Orleans, LA

Dr. Richard Gardner, seen here at age 67 in February 1999, authored the money making PAS theory that made him a very rich man. Gardner committed suicide on May 25, 2003, plunging a seven inch butcher knife into his neck and heart. Gardner testified mostly for men, charging $500 per hour, routinely recommending custody to abusers, deprogramming children and threat therapy for mothers. Gardner was against society's overly moralistic and punitive reaction to pedophiles.

To get a better understanding of the damage Dr. Richard Gardner did in his lifetime, go to this link:

Dr. Richard Gardner – Parental Alienation Syndrome

Technorati Tags:
Richard,Gardner,Complete,Autopsy,Report,April,Suicide,CAUSE,DEATH,chest,neck,York,Times,father,Contrary,rights,movement,Bergen,Jersey,Medical,Examiner,prescriptio

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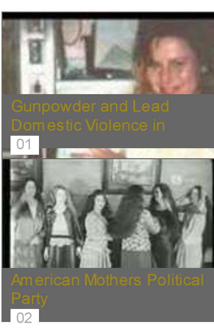

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  - Angelfury
  - Anne Caroline Drake
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  - Baitul Salaam Network
  - Battered Mothers – A Human Right's Issue
  - Battered Mothers, Child Custody, Court Abuse
  - California Protective Parents Association
  - Chaos Theory
  - Claudine Dombrowski
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  - Parenting Abused Children
  - Parenting News Network
  - Randi James
  - Rights For Mothers.com
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  - The Custody Scam
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  - The Liz Library
  - The Majority United
  - The Survivor Manual from Angela Shelton
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