CITATION: *Inquest into the death of Blake Neil Victor Harvey* [2001] NTMC 56

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A27/2000
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HEARING DATE(s):	7,8,9 March 2001
FINDING OF:	Mr Greg Cavanagh SM

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REPRESENTATION:

Counsel:

Assisting:	Ms Elizabeth Morris
Territory Health Services And Dr Greg Winterflood	Mr Tony Morgan

Solicitors:

Territory Health Services And Dr Greg Winterflood	Morgan Buckley

Number of paragraphs:	42
Number of pages:	17

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0027/2000

In the matter of an Inquest into the death of

BLAKE NEIL VICTOR HARVEY
ON 17 MAY 2000

FINDINGS

(Delivered 17 August 2001)

Mr CAVANAGH:

THE NATURE AND SCOPE OF THE INQUEST

1. Blake Neil Victor Harvey ("the deceased") died at around 0130hrs on 17 May 2000 as the result of burns received in a fire.

2. Section 12(1) of the *Coroners Act* ("the Act") defines a "reportable death" to mean a death that:

> "appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury".

3. For reasons that appear in the body of these Findings, the death fell within the ambit of that definition and this Inquest is held as a matter of discretion pursuant to s15(2) of the Act.

4. Section 34(1) of the Act details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> "(1) A coroner investigating -
>
> (a) a death shall, if possible, find -

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(v) any relevant circumstances concerning the death."

5. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

6. The public Inquest in this matter was heard at the Alice Springs Magistrates Court on 7, 8 and 9 March 2001. Counsel assisting me was Deputy Coroner Ms Elizabeth Morris. Mr Tony Morgan sought leave to appear on behalf of Territory Health and Dr Greg Winterflood. I granted leave pursuant to s40(3) of the Act. The parents of the deceased were in attendance during the Inquest.

7. This evidence enables me to make the following formal findings as required by the Coroner's Act:

FORMAL FINDINGS

(a) The identity of the deceased was Blake Neil Victor Harvey, a Caucasian male born on 11 November 1999 at Cooma in New South Wales.

(b) The time and place of death was on the 17th of May 2000 at 0130hrs on a Royal Flying Doctor Service flight between Kulgera and Alice Springs.

(c) The cause of death was burns.

(d) The particulars required to register the death are:

1. The deceased was a male.

2. The deceased was of Caucasian Australian origin.

3. The death was reported to the Coroner.

4. The cause of death was confirmed by post-mortem examination.

5. The death was caused in the matter described in paragraph (c) above.

6. The pathologist viewed the body after death.

7. The pathologist was Dr Terence Sinton of the Royal Darwin Hospital.

8. The father of the deceased is Neil Roy Harvey and the mother of the deceased is Tara-Clare Swann.

9. The usual address of the deceased was 10 Pinque Court Moulden, in the Northern Territory of Australia.

10. The deceased was an infant.

The deceased

8. The deceased was born in Cooma, and was aged six months at the time of his death. He was travelling with his parents (Tara-Clare Swann and Neil Roy Harvey) and siblings (Zachary (2 years) and Shaquille (5years)), in order to take up residence in Darwin. The family stopped in Kulgera on 13 May 2000, as they had been having car troubles. An agreement was reached with the Kulgera Roadhouse manager, Ms Kathleen Dalwood-Mason, that in return for work at the Roadhouse, Ms Swann and family could have accommodation and meals. The accommodation was a room in a demountable building at the rear of the premises, room number 7. This

particular accommodation was the cheapest offered by the roadhouse, and was commonly referred to as “backpackers” cabins.

9. The room contained only a queen size bed, in which Ms Swann, Mr Harvey and the deceased slept. The two other children had bedding laid on the floor near the foot of the bed. Also in the room was the family’s belongings, including a portable gas primus ring with gas bottle attached.

Relevant Circumstances

10. On Tuesday 16 May Ms Swann did some cleaning in the Backpackers cabins in the afternoon. Mr Harvey was looking after the children. Ms Swann had a few glasses of wine with other staff members after finishing her duties. Mr Harvey then bought the children over to Ms Swann at the Roadhouse, and escorted them all back to their room. He then returned to the Roadhouse and had some drinks with another staff member.

11. Ms Swann prepared the children and herself for bed at around 9.30pm that night. Her recollection is that the children were tired and went directly to sleep. She then got into bed herself and fell asleep. Whilst she does have strong medication for headaches, Ms Swann gave evidence that she did not take any medication herself that night. At about 10.00 pm she was awoken by fire; she grabbed the two older children and pushed them out the door, but could not return due to the heat of the fire for the deceased. She received severe burns to her feet in the process of trying to save her child.

12. The alarm was raised in the Roadhouse. Many people came to assist with fire extinguishers initially, however, there was little inway made into the fire. Mr Harvey tried to get through the front door several times. Eventually he went around to the back of the accommodation and wrenched off a security screen, broke the window and reached into the room to remove the deceased from the bed.

13. First aid to the deceased was given by witnesses and also Mrs Angie Bull, a registered nurse (and wife of the local police officer), who was also in attendance. . The Flying Doctor service was contacted. The Flying Doctor arrived at about 12.30am and treated Ms Swann's feet as well as attending to the deceased.

14. Angela Bull gave evidence at the Inquest. She was the first person to endeavour to diagnose the deceased's condition and I quote her evidence as follows (Transcript P45):-

> "What happened, Dan had – Dan went to the police station to ring the Flying Doctors. I rang St John's Ambulance after hour's number to ask them to get the doctor to ring me. Then I rang the police. This is from the roadhouse. Then I rang the police station and Dan was talking to the doctor on the other line so I said to him, you know, 'Get the doctor to ring me here at the roadhouse'. So I actually spoke to the doctor then.
>
> Can you remember what that conversation was?---I told him what I had. I told him that there'd – had a baby who'd been in a fire, who was six months old. I told him the extent of his burns and - - -
>
> Did you give that as a percentage or did you just - - -?---I didn't give any percentage. I said he had full thickness burns to his hands, his arms, his abdomen, his face, his feet and – and legs, and I just said he was so – you know, his eyes were swollen shut, his hands were absolutely black. He had blistering on his lips and his nose was all burnt around and, you know, you could sort of smell the sooty breath and stuff, so I imagine he had respiratory burns as well. And I said, you know, just the swelling was remarkable and just the age of the baby and everything. I just wanted to know how quick they could get down.
>
> Right. What did the doctor say?---He said about two hours and I can't quite remember what time that was. But that was the first time I spoke to the doctor. Then I went back to the baby and the parents."

15. Both Ms Swann and the deceased were taken to the airstrip, put on the plane which departed at about 1.00pm. The deceased stopped breathing shortly after take-off and died despite attempts to resuscitate him inflight.

How the fire started

16. Present in the room occupied by the deceased and his family was a gas cooker. Ms Swann gave evidence that earlier that night Zachary had switched on the cooker. I quote her evidence as follows (Transcript P10/11):

> "Now in room number 7 how were you living? How did you all fit into that room? ---Well, there was a queen size bed and Neil and I had lots of doonas and that because we'd been camping with a tent on the way up. We had the camping gear, so we made quite a comfortable bed at the end of our bed for the children. Built it up with lots of doonas and things, but that particular night the children were actually in bed with me.
>
> And was that something common, that they'd crawl into bed with you?---Yeah, all the time, yep. Still do.
>
> And the baby slept with you?---Yeah.
>
> And the two older boys slept at the end of your bed on the doonas on the floor? ---Yeah.
>
> What else did you have in the room?---There was clothes. There was a gas camp fire bottle which was put in the cupboard out the way, and we both smoked, so cigarette lighters were usually put on top of the cupboard anyway, so I don't understand how - I'm very aware in my children that they touch things they're not supposed to.
>
> When you say `the cupboard', was the cupboard something that was already in the room?---Yes, it was.
>
> And was that - - -?---It was like a metal - - -
>
> A locker, like a school locker?---Yeah, that's correct.
>
> And you normally kept your gas cooker in the locker. Had any of the kids, while you were at Kulgera, played with the gas cooker?---One tried to that night before I put them to bed. My 2-year old actually switched the switch and I smacked his hand and told him never to touch it again, and made sure it was completely turned off and put it back in the cupboard.

You put it back right inside?---Yes, I did.

And was the cupboard locked or not?---It didn't have any keys to lock them but it was fairly hard for him to get into for a 2-year old.

And you're sure that you put it in the cupboard, you didn't just put it with your other gear?---No, I'm positive."

AND I also quote her (Transcript P16):-

"Do you remember they did a recorded one that was very soon after this happened?---That was – that was first thing in the morning on the – yeah, on the tape.

And do you also remember doing a written statement?---Yes.

I'm just going to read you a little bit from your written statement. You're talking about the cooker: 'had a large silver cooktop on the top and a knob on the side to turn on the gas'.

Your Worship, in the brief there's actually a photo of what we're talking about.

'I think I turned it off tightly' – sorry. 'Zachary turned the knob on the side. I immediately smelt gas and turned it off. I think I turned it off tightly. I then put the cooker in the corner of the room because I couldn't reach up to put it up high. I put a big long black bag, containing clothes, around it so that it was out of sight of the kids'---Between where the locker is is what I was talking about.

Sorry?--- In the corner where I'm talking about is where the locker was.

But you didn't put it in the locker?---I mustn't have done. I though I did. That's what I'm saying. A lot of things are still very blurry to me and it's hard to - - -

So it's possible that you didn't put it in the locker?---It's possible, yeah. Though I remember he definitely did play with the knob that night and I was concerned 'cause I – I've had a gas incident when I was a child and I've always been scared of gas, so."

17. On the balance of probabilities, I find that the gas cooker remained in a place in the room accessible to the children.

18. The father of the deceased, Mr Neil Harvey, also gave evidence at the Inquest and told me as follows (Transcript P21):-

> "And so you went into the room but you couldn't see anything because of the smoke?---No.
>
> Did you get injured at all?---Yeah, I did, but that was – the gas bottle was sitting on the right-hand side – right-hand side of the room and it was still leaking gas out. And like the bottle was near empty as it was.
>
> How do you know it was still leaking gas out?---'Cause I could hear it. It has hissing and carry on and that's when I grabbed it and threw it straight out of the door, and that's where it landed, where it landed.
>
> So can you remember exactly in the room where it was when you saw it, the gas bottle?---Yep, it was – you walk in the demountable. It would've been right there, on the right-hand side – left-hand side, sorry, probably two feet inside the door.
>
> And if you're standing at the door of the demountable, it's quite small. The double bed is back right-hand corner?---Corner.
>
> And the kids' bed was back left-hand corner?---Yeah.
>
> And the gas bottle was on your left-hand side?---Left-hand side, yeah.
>
> Lockers are on your right-hand side?---Yes."

19. Evidence from the fire investigator (which I accept) shows that the source of the fire was near the base of the bed on the left hand side of the room. No other evidence exists to indicate another source of the fire.

20. I find that the fire was started when the child Shaquille attempted to ignite the portable gas cooker with a cigarette lighter. Shaquille was spoken to after the fire. A conversation was also had with Shaquille by police, with Ms Swann being present. A transcript of this conversation was tendered with the brief of evidence. On Wednesday 17 May Shaquille said (unprompted) to Detective's Megget and Funnell that "I light the lighter…it

went on me….Last night when it was dark." And "I was trying to light up that thing, the cooker with the lighter." He later repeated this story in a further conversation with police on 21 May 2000, indicating that he was trying to make a coffee on the cooker.

Medical treatment of the deceased

21. Evidence was given by Dr Greg Winterflood, the Royal Flying Doctor on duty that evening and Nurse Angie Bull. Evidence was also tendered in a statement of expert opinion by Associate Professor Anthony Brown, the Senior Staff Specialist, Department of Emergency Medicine, Royal Brisbane Hospital.

22. Professor Brown's concerns involved the underestimation of the "real time of transfer back to Alice Springs", which must include flying time, as well as loading, transfer, engine start-up etc. In his opinion the real time was always going to be at least one hour or more than that estimated by Dr Winterflood.

23. Professor Brown also states:

> "I accept that this was a critically ill baby, in an emotionally charged environment, with technically difficult vascular and airway access and monitoring problems. I accept that GW (Dr Winterflood) in good faith at the time made a personal judgement to depart without any resuscitation procedures. It was unclear whether these were then to be attempted in-flight, as immediate deterioration in BH's condition occurred."

24. Professor Brown does not suggest in his report or covering letter, that the deceased's life could definitely have been saved by attempts at resuscitation earlier than those attempted by Dr Winterflood.

25. Dr Winterflood gave evidence in person at the Inquest. In his evidence the Doctor recounted attending at a room at Kulgera and observing the deceased's condition, which left him aghast. He saw that the deceased,

although breathing, had full thickness burns affecting 80% of the body surface. That skin had peeled off both hands and ankles and that the deceased's condition was very serious.

26. Dr Winterflood was the attending doctor and a former district medical officer in the Northern Territory, he had been a district medical officer as far back as 1983, he had also been for many years the director of emergency medicine in Alice Springs. He made a judgment on arrival at the scene of the fire, he had very little time to make judgments and decisions in relation to the medical treatment of the child, he was with the Flying Doctor nurse (Mr Steve Jordan). Dr Winterflood's reaction after receiving the telephone call about the baby in Alice Springs was timely and appropriate in terms of getting to the plane and getting to the deceased as soon as possible. A judgment had to made as to whether to treat the deceased at the scene of the fire or endeavour to return him to the Alice Springs hospital as soon as possible. There was also a subsidiary question of inserting an intra-osseous needle for the purpose of infusion of fluids at the scene of the fire or inflight on the way back to Alice Springs. The doctor told me of the deceased's presentation and I quote (Transcript P55):-

> "So the actual physical presentation left you aghast?---Well, he was black around here. There'd obviously been a night bonnet of some kind. I've read the other statements now to know that he had a little hood on. There was no hair. While his – while his scalp wasn't as black as that, you know, there'd be some other colour around here. It – it was heading toward black and his face was – he didn't have any eyelashes left and his eyelids were seared together. His lips were starting to protrude and that's an indication that things are swelling up. There was black smoke in his nose and I had leant down at one stage to listen to his breathing, 'cause you get used to what babies breathing should sound like, and I was listening to hear if he was obstructed at all. And I thought, 'Gee, how am I going to intubate this kid with his lips like that?' No instant way. I mean, normally in an accident there's one arm or one leg that you can get a drip in, but this kid had – are there any relatives here?
>
> MR MORGAN: In terms of your observations, just keep going through your observations?---Yeah. The skin was hanging in tatters

off both hands. It must've blistered up and just fell off. The – the tips of his fingers were charred and his feet were exactly the same. There was skin in tatters off his ankles. There was serum oozing out of the skin."

27. In relation to his judgment that he ought to try and return the baby for full treatment at Alice Springs Hospital he told me as follows (Transcript P58):-

> "MR MORGAN: Did you make some observations and estimates in connection with the extent of the burns?---Yeah, 80%.
>
> 80% of what?---Of the body surface area.
>
> Right. So your decision wasn't to proceed then?---Mm, mm.
>
> And indication from Steve was that he thought scoop and run?---Yeah.
>
> From your observations?---Well, I – I use that word because it's a term in pre-hospital talk. My idea is really scoop and do on the run, because I had that opportunity and I felt I needed to get him to the hospital. There's – there's a lot more complex things to do after you get a line in and start resuscitation, and I wanted help and the baby needed help.
>
> In terms of the application though, did you have a point in time then that you were going to administer the intra-osseous needle?---Well, these are very stable aircraft . . . "

28. Dr Winterflood in frank evidence told me that with the benefit of hindsight he wished that he had endeavoured to insert the intra-osseous needle earlier than was going to be the case and I quote his evidence (Transcript P61):-

> "So in terms of treatment what was your decision then?---Well, I though we would put the needle in, in the air, while moving towards Alice Springs.
>
> Right. On reflection, what do you say now?---Well, when – when the child died, I thought 'Bloody hell'. You know, 'I should've had that needle in before this happened'. Right? That's the clever thing to do, and on thinking about it now. Before we took off I should've reached round, tapped Steve Jordan – Steve Patrick, the pilot, said 'Stop, we're staying here. We're going to get things going on the ground and then take off'. I mean, I could've just put the needle in

on the ground – this is on reflection. Could've put the needle in on the ground and run the fluids in as we were taking off or rumbling down the – rumbling down the airstrip, you know?

THE CORONER: How long had you been in the air before the child died?---It – it wasn't very long. He hadn't reached cruising altitude."

AND (Transcript P64):

"Sorry. I thought you were telling me about some mistake about the time it was going to take to get back to the hospital?---No, no. No, the next day when I arrived at work and spoke to my colleagues, one of the doctor I worked with for many years – and I told him the story. I said, 'I went out last night for a six monther with 80% burns'. He went, 'Huh, did you put in an IO?' That was his first words. I said, 'No'. And he didn't say anything, but I should've put the IO in before the baby had the cardiac arrest.

That was the reference then to what you, in hindsight, regard as an error or mistake, or you wished you had done, in hindsight?---Yeah, yeah. And I expressed that to the mother afterwards too, outside the hospital."

29. In Dr Winterflood's opinion an intra-osseous procedure was appropriate, but he decided to undertake that procedure in the aircraft. This was due to the environment the deceased was in (dirty), lighting, surface, chance of detachment during transport, and the availability of other equipment in the aircraft. He informed Ms Swann that he was not going to insert a cannula. I accept Dr Winterflood's evidence that he did not tell Ms Swann that he did not intend to treat the deceased prior to arrival in Alice Springs.

30. Once on board the aircraft, the Doctor determined to wait until flying altitude was reached prior to undertaking the procedure. In his evidence, Dr Winterflood said that in hindsight, he should have undertaken the intra-osseous procedure on the ground prior to the aircraft disembarking.

31. After take-off the nurse, Steve Jordan, indicated to the Doctor that the deceased had no heartbeat. Dr Winterflood commenced CPR, however his observations indicated that the deceased had gone into an agonal rhythm.

This indicated that the deceased had not been breathing for some three to four minutes. He also observed other degenerative changes, which indicated to him that further resuscitation was futile.

32. I accept the submission of Counsel for Territory Health Services that on all of the evidence on the night of the death "that the procedures in place between Territory Health Services and Royal Flying Doctor Service were, entirely adequate and appropriate and on the night those involved were exemplary in their compliance with established practices and protocols."

Fire Safety

33. The manager of the Kulgera Roadhouse, Kathleen Dalwood-Mason, gave evidence at the Inquest. The manager had only been in residence at the roadhouse for approximately four weeks prior to the time of the fire. She gave evidence in relation to the fact that some of the smoke detector devices in the demountable rooms (one of which was occupied by the deceased) were not working at the time of the fire and I quote her evidence as follows (Transcript P30):-

> "An examination of those smoke detectors after the fire found that while they were hard-wired, which is into the mains system, and had capacity for a battery backup, in fact nearly all of the batteries – all the batteries were missing?---Yeah.
>
> And most of them had been unplugged from the hard wiring. Were you aware at the time of the fire that that was the cause?---No, no.
>
> Do you know, were any regular checks conducted of those smoke detectors?---We had a maintenance – like a man who did maintenance work for us. That was his entire job. The we had a woman who did housekeeping. To the best of my knowledge, they actually checked them once a week. In fact, they said they did. They checked them regularly because they made an issue of it afterwards.
>
> THE CORONER: Yes. Well, I may make an issue of it too?---Yeah, I know.

Why would they want to check them each week?---Just to see if they were working, because the backpackers steal a lot of batteries.

That's what I want to know?---Yeah, they do, steal a lot. They still do.

So is it a regular and known thing that the backpackers would take the batteries for their own purposes?---Yep. Everyone knows.

It's a regular thing, happens all the time?---Yeah, still does now.

Still happens now?---Even with the hard-wiring."

34. Station Commander Paul Herrick of the Northern Territory Fire and Rescue Service gave evidence before me. He had been a member of the service for some 28 years, he was an expert in the field of fire safety and regulation. He told me that the Kulgera Roadhouse had been subject to regular audit in terms of fire safety, unfortunately the demountable building had been in existence prior to new laws which were introduced in 1987 which would of resulted in a greater level of fire safety. I quote his evidence as follows (Transcript P72/73):-

> "MS MORRIS: Why do you think that it took some time for the fire to be contained by that number of fire extinguishers, plus hoses?--- It's my understanding that as soon as the hoses were brought onto the fire that the fire was extinguished. One of the problems with the fire extinguishers, the dry powder fire extinguishers, is that they don't cool the actual fire, the heat. They don't take the heat out of the fire, so heat is one of the main sources of fire. They're designed to smother a very small area. They're definitely not designed to fight structure fires. If a fire extinguisher had of been brought to bear very early, possibly, but because of the gas – the gas would have to be turned off, the seat of the fire, where the seat of the fire was. It was still being fed by gas from the cylinder. The only way you're going to stop that is by either removing the source of heat, and that can be either taking it out of the room or turning the cylinder off. So the fire extinguishers themselves, once the fire took hold of the whole building the fire extinguishers wouldn't have been of not much use."

AND (Transcript P73):-

> "But if it had been the other side it may well have burnt into the next room and the next room and the next room, so the whole demountable might've gone up?---Yeah, exactly. I believe the demountable has been there for quite some time, so it was prior to fire ratings and Building Code of Australia which it required this particular place to be brought up to standard, the same as in a town area. In 1987 the law changed that any building within 500 metres of a main road has to comply to the same standards as in a town. It is my belief that this demountable was there prior to this law coming in"

35. He further went on to tell me (Transcript P76/77):-

> "For this type of accommodation, backpacker accommodation in a remote area, are you aware of what the fire safety requirements are?---Since 1987 the fire safety requirements are the same as in the – in any build-up area and we woke from the Building Code of Australia. This is the Building Code. It's quite large volumes. They refer back to the Australian Standards, which that is, and there's a lot of Australian Standards that the equipment used must comply with in the Australian Standards. And so therefore, yeah, the Kulgera motel/hotel complex must comply to all the fire safety standards.
>
> And so there's no lesser standard for a backpacker, cheap-type accommodation, than there is for a motel room?---In fact – no. In fact, backpacker accommodation, motel accommodation, is classed as a class 3 building and they're much more stringent than most places.
>
> So the governing laws are the Building Code of Australia and the Australian Standards, which are incorporated in that. Is there also other legislation?---Yes, there's the Northern Territory Fire and Rescue Service Act of '96, which is Acts and Regulations. So we refer to that, which is here.
>
> THE CORONER: Was that made mandatory, the fire safety equipment?---Yep."

36. He advised of the fact that the Kulgera roadhouse had invested in extensive new equipment in terms of fire safety since the death of the child. He also confirmed that the fire cart that had been available on the night of the fire and which was not able to be used because the cord that started the motor was broken during attempts to start the motor was, in fact, in good working

order. Apparently in emergency situations it is not uncommon for over zealous operatives to pull the cord too hard and break it.

Conclusions and Recommendations

37. This death was accidental. This death is yet another example of the disaster that all too often occurs when young children play with fire, or are allowed access to lethal objects.

38. Only as recently as the 2nd of August 2001 I had occasion to comment in relation to the accidental death of a child as a result of a gun shot wound (an Alice Springs Inquest finding). (Inquest [2001] NTMC 51 P9):-

> "This case, again, highlights the real and ever present dangers, whether it's in the remotest settlement in the remotest part of Australia or inner city suburbs, of adults keeping firearms in their homes with ready access to ammunition.
>
> How many times over how many decades have we read and heard about children playing with such weapons and death resulting? It's sad."

39. Unfortunately this death once again highlights the needs for carers and parents to be forever vigilant in relation to children. In saying this I do not criticise the parents of the deceased. The mother having put the children to bed, and gone to sleep herself, was simply not in the position to stop what occurred.

40. On all of the evidence I am of the view that no particular criticism can or should be made of anyone in relation to this death.

41. The only recommendation I make is that the Northern Territory Fire and Rescue Service consider mandating the use of hard-wired fire alarms of a type that are not able to be easily interfered with in those premises where fire alarms are necessary.

42. I recommend Counsel for Territory Health Services forward Professor Brown's report (Exhibit No. 5) to his client for their consideration (no doubt in combination with these findings).

Dated this day of 2001.

_____

GREG CAVANAGH

TERRITORY CORONER