

CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF GARY JAMES NORRIS

[2026] SACC 46

Inquest Findings of his Honour Deputy State Coroner Evans

13 October 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man with an intellectual disability and epilepsy who suffered a choking event while eating.

Held:

1. Gary James Norris, aged 51 years of Mount Gambier, died at the Royal Adelaide Hospital on 20 July 2023 as a result of hypoxic ischaemic brain injury due to cardiac arrest following acute upper airway obstruction on a background of intellectual disability and epilepsy.
2. Circumstances of death as set out in these findings.

No recommendations made.

INQUEST INTO THE DEATH OF GARY JAMES NORRIS [2026] SACC 46

Introduction

- 1 The Court heard an inquest on the papers in relation to the death of a 51-year-old man who lived with intellectual disability who experienced a choking event that led to a hypoxic ischaemic brain injury that caused his death.

Background

- 2 Gary Norris was born on 12 March 1972. He had two older sisters. He lived with his family in Keith until he was four years old, and then in Naracoorte. At six years old Mr Norris moved to Mount Gambier to attend live-in schooling at the Cooina Hostel where he received 24-hour care. He returned home each weekend.
- 3 When Mr Norris was 17 years old, he moved into his own house in Mount Gambier, again with 24-hour care supporting him.¹ He continued to return to the family home on the weekends. His care was managed by the Department for Human Services in addition to the National Disability Insurance Scheme.²
- 4 Mr Norris' intellectual disability was diagnosed in his first year of life.³ He required physiotherapy which assisted him to learn to walk. As he developed, he continued to have a mental age of between six to ten years old.⁴ A carer described that Mr Norris had autistic traits in addition to his intellectual disability.⁵
- 5 At the age of about 16 years old, it became apparent that Mr Norris had significant hearing difficulties.⁶ Over time, his hearing got even worse. He used hearing aids to assist him.
- 6 When Mr Norris was about 25 years old, he was diagnosed with epilepsy, experiencing absence seizures which brought about episodes where he would completely 'zone out' for up to a minute. He was medicated with clonazepam and sodium valproate.⁷
- 7 When it came to food and nutrition, Mr Norris was known to eat any food he could obtain, including occasions of consuming raw food. He would also eat food quickly.⁸ For this reason, locks were installed on the food cupboards in his home to ensure that he did not have access to food without supervision.
- 8 Mr Norris was able to maintain employment at Bedford Industries on-and-off for about six years until it became too much for him and he gave up work.⁹ After he stopped working, he started to put on more weight and he began to struggle with the physical aspect of daily activities.

¹ Exhibit C3 at [17]

² Exhibit C4 at [3]

³ Exhibit C3 at [8]

⁴ Exhibit C3 at [10]

⁵ Exhibit C4 at [3]

⁶ Exhibit C3 at [13]

⁷ Exhibit C4 at [5]

⁸ Exhibit C3 at [24] and [29]

⁹ Exhibit C3 at [22]

- 9 At Christmas time in 2021, Mr Norris was with his family. He swallowed an entire roast potato without chewing it and began to choke.¹⁰ His family were able to get him to spit up the food in his airway and he recovered.¹¹ On 8 January 2023 Mr Norris was observed to choke while eating his breakfast. His face went bright red and then he sneezed, expelling phlegm and returning to normal breathing.
- 10 On 14 June 2023, Mr Norris' general practitioner, Dr Lydia Twining, discussed Mr Norris with his carer who had attended a checkup with him. The incident in January was discussed. It was reported that Mr Norris appeared to have no issues with the swallowing process, but that he did not chew much. Dr Twining made a referral for a formal speech and swallowing assessment to determine whether any modifications to his care might assist him to avoid further incident.¹² This process was still in progress at the time of his death.

Circumstances leading to death

- 11 On 15 July 2023, Mr Norris' carer, Tony Papageorgios, attended in the morning. Mr Papageorgios did some housework and Mr Norris ate some rice crackers and biscuits. He then took Mr Norris to Hungry Jacks as he had done regularly over the preceding two years. Mr Norris had a grilled chicken burger, chips and a drink. Mr Papageorgios watched Mr Norris eat. He was observed to swallow his chips one at a time, but without chewing. He then took his burger and took two large bites without chewing, before becoming quiet.¹³ Mr Norris wiped his face with a napkin, and then sat still, staring, with his eyes watering. Mr Papageorgios thought that he was having a seizure or choking. He administered back blows and chest blows.¹⁴ As a result, Mr Norris vomited and then fell forward onto the table.
- 12 Mr Papageorgios yelled for someone to call an ambulance and a staff member approached to assist with the triple zero call underway, commencing at about 12.47 pm.¹⁵ Mr Norris was moved to the ground and CPR was commenced with the guidance of emergency services over the phone.
- 13 Paramedics arrived at 12.51 pm.¹⁶ Mr Norris was still under CPR. Forceps were used to remove food from his mouth and airway. This included some reasonably-sized pieces of chicken and some bread.¹⁷ Those pieces were relatively intact and had not been greatly chewed. Paramedics connected a monitor and found that Mr Norris was in a non-shockable rhythm; pulseless electrical activity.
- 14 After a period of CPR, a weak pulse was detected, however an airway was not able to be established. Multiple attempts at suctioning were made, with further food being removed. At 12.55 pm, an airway device, known as an iGel, was then able to be inserted so that air could be delivered into Mr Norris' lungs.¹⁸ Adrenaline and saline were administered at 1.05 pm. These efforts were able to achieve a return of spontaneous circulation at

¹⁰ Exhibit C4 at [10]

¹¹ Exhibit C3 at [28]

¹² Exhibit C7

¹³ Exhibit C4 at [12]

¹⁴ Exhibit C4 at [13]

¹⁵ Exhibit C13, Background Event Chronology at 1

¹⁶ Exhibit C6 at [6]

¹⁷ Exhibit C6 at [10]

¹⁸ Exhibit C6 at [13]

1.10 pm with a weak pulse improving over time.¹⁹ Mr Norris was then taken to the Mount Gambier Hospital and handed over to the care of the Emergency Department.

- 15 Dr Fiona Leaker was in charge of the Emergency Department at that time. Mr Norris was brought directly into the resuscitation room at 2.06 pm, with a medical team assembled to assist.²⁰ Dr Leaker examined Mr Norris' airway after he was sedated and found further food matter in the lower airway, with the upper airway being clear. Mr Norris' iGel airway was substituted for an endotracheal tube uneventfully and with haemodynamic stability maintained. A transfer to the Royal Adelaide Hospital was then arranged through MedSTAR, leaving at about 10 pm.²¹
- 16 On 16 July 2023 Mr Norris' sedation was weaned and he demonstrated twitching movements. Anti-seizure medication was administered without reduction in the movements. A CT scan was then conducted which showed no brain bleed, but right lower lobe collapse of the lung, attributable to the strong and successful resuscitation efforts. An EEG was conducted which showed features consistent with severe anoxic brain injury.²² Discussions were had with Mr Norris' family about the expected lack of recovery from this condition and Mr Norris was then transitioned to end-of-life care. A declaration of life extinct was then made at 1.30 pm on 20 July 2023. Mr Norris was 51 years old.

Investigation into the cause of death

- 17 It seems likely that Mr Norris experienced an episode of absence seizure while eating his lunch at Hungry Jacks. I make this finding on the basis of Mr Papageorgios' description of Mr Norris becoming quiet and sitting still while staring. It is therefore likely that a combination of a seizure and Mr Norris' habit of not sufficiently chewing food has brought about his choking episode.
- 18 A pathology review of the medical records was conducted by Dr Erin O'Connor through Forensic Science SA. Dr O'Connor explained that intellectual disability can generally increase the risk of upper-airway obstruction by food. This was clearly applicable given that Mr Norris had a previous episode of obstruction. Dr O'Connor's opinion is that Mr Norris' death was as a result of brain injury due to cardiac arrest after the airway obstruction occurred. I accept Dr O'Connor's advice and enter a finding that Mr Norris died as a result of hypoxic ischaemic brain injury due to cardiac arrest following acute upper airway obstruction on a background of intellectual disability and epilepsy.

Assessment of the issues

Detention

- 19 On 25 October 2021, the South Australian Civil and Administrative Tribunal (SACAT) heard an application for a Guardianship Order in relation to Mr Norris. The application had been made by his parents and was supported by a doctor.²³ Safety concerns were raised in the application, including the need to lock food cupboards and that locks on the gas stove were required after incidents of Mr Norris turning the gas on and walking

¹⁹ Exhibit C13, Treatment Summary Report

²⁰ Exhibit C8 at [9]

²¹ Exhibit C8 at [23]

²² Exhibit C1 at [2]

²³ Exhibit C5 at [14] and Annexure DA5

away.²⁴ SACAT granted the application, formally appointing Mr Norris' parents as his guardians and authorising his detention at home.²⁵

- 20 This order was reviewed in May 2022, with further medical advice provided to SACAT, resulting in SACAT confirming the continuation of the orders.²⁶ The process for another review was commenced on 22 July 2023, but not completed before Mr Norris' death.²⁷
- 21 A Guardianship Order, and in particular the power to detain Mr Norris if necessary, was clearly required to deal with the behaviours that his conditions made him exhibit. In particular, safety issues arising from his inability to hear, his lack of impulse control and difficulty appreciating issues affecting his own safety. There was ample basis to seek the orders that were then properly made by SACAT. I therefore find that Mr Norris was lawfully subject to a power of detention at the time of his death.

Care provided

- 22 In relation to Mr Norris' epilepsy, I observe that post-mortem toxicological analysis demonstrated that Mr Norris was medicated with his anti-seizure medications at the time of his death. The risk of seizure was therefore guarded against.
- 23 Mr Norris' eating was known to be an issue, in particular that he would consume an unhealthy quantum and also items that should not be eaten. This was addressed in a reasonable way, by installing locks on the cupboards that contained food and seeking a Guardianship Order to allow restrictive practices to be used when necessary.
- 24 Mr Norris' episode of choking in January 2023 was formally documented in an incident report. It was unclear whether it actually related to the food he was eating. The issue was then raised with his doctor when he was next seen for a regular checkup. This resulted in a referral for a speech pathology assessment, but was determined not to be urgent, given that there had been no incidents for a number of months. This referral was not able to be completed by the time Mr Norris had died.
- 25 While a more urgent speech pathology assessment could have been attempted, Mr Norris' eating habits did not constitute an acute threat to his life at the time it was being pursued, and in my view it was not unreasonable that this one known instance of choking did not raise more serious concerns that would require an urgent referral. I exclude the operation of hindsight bias in that assessment. It may also be that Mr Norris' eating behaviours had also developed following the first incident, and that he was taking larger and larger mouthfuls over time without chewing. I allow a role for that potential progression. In those circumstances, I am satisfied that the approach of documenting a single choking episode and raising it for the GP's attention at the next checkup was a reasonable response to this particular incident. In relation to Dr Twining's non-urgent referral for speech pathology assessment, I also consider that this was reasonable in light of the extent of the issue known at that time and that there had been no repeat of any choking incident, which would have appeared as a one-off on the information known to Dr Twining.

²⁴ Exhibit C5 at Annexure DA4

²⁵ Exhibit C5 at Annexure DA8

²⁶ Exhibit C5 at Annexure DA10

²⁷ Exhibit C5 at [18]

- 26 In relation to the CPR performed by staff at Hungry Jacks and then paramedics, this was, quite obviously, exemplary in that it achieved a return of spontaneous circulation in very difficult circumstances. The inability to clear deeply lodged food in the lower airways while in the field is a limiting factor that is unfortunate, but does not represent a failure to provide the best care that can be provided in the circumstances. I recognise the incredible effort of the staff member who performed CPR and I also recognise the good work of paramedics in restoring circulation.
- 27 The care provided by the Mount Gambier Hospital and then the Royal Adelaide Hospital also appears to have been of a high standard, although treatment was not able to assist Mr Norris to recover.

Recommendations

- 28 Given my findings, I have no recommendations to make.

Condolences

- 29 I express my condolences to Mr Norris' family.