CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF DEBRA JAYNE MORLAND-SHEARER

[2026] SACC 24

Inquest Findings of her Honour Deputy State Coroner Kereru

7 July 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a woman who was detained in her home under a Guardianship Order following a traumatic brain injury. The Inquest explored whether there had been compliance with a Dysphagia Management Plan in respect of the provision of food and whether the Dysphagia Management Plan was clearly set out.

Held:

1. Debra Jayne Morland-Shearer, aged 64 years of Glandore, died at Glandore on 11 January 2023 as a result of choking on food on a background of Alzheimer's disease and antipsychotic therapy.

2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MR G DUDZINSKI
Hearing Date/s: 23/10/2025
Inquest No: 33/2025 **File No/s: 0103/2023**

INQUEST INTO THE DEATH OF DEBRA JAYNE MORLAND-SHEARER [2026] SACC 24

Introduction

1 Debra Jayne Morland-Shearer was born on 4 September 1958. She lived in the Morialta Children's Home with her late brother for a short time as a child during her parents' separation. She completed year 12 and then worked as a school support officer. Ms Morland-Shearer had two sons, Chad and Adam, and maintained a relationship with her mother.

2 Her medical history included bipolar disorder, schizoaffective disorder, borderline personality disorder traits, depression, dependent and histrionic personality disorder, somatic symptom disorder and tardive dyskinesia.

3 In 2007, Ms Morland-Shearer had an incident where she experienced lithium toxicity, resulting in a hypoxic brain injury and she was subsequently placed in full-time care in around 2008.[1]

4 Following the Independent Commission Against Corruption's Oakden enquiry,[2] the '31 Homes Project' was initiated by the state government to provide community-based support to individuals with complex needs, of which Ms Morland-Shearer was a participant. The project involved the transition of 26 patients, who had previously been detained at the Glenside Health Service, into community placements. Through this process, in 2019 Ms Morland-Shearer was gradually moved into a home at Glandore with 24-hour care support.

5 On 14 March 2019, a Guardianship Order was made by the South Australian Civil and Administrative Tribunal (SACAT) which appointed the Public Advocate as her limited guardian.[3] By April 2019, Ms Morland-Shearer was living in the Glandore home permanently, with her care being provided by 'Community Living Options' (CLO), a National Disability Insurance Scheme-affiliated provider that has been operating for more than 40 years.

6 In August 2021, Ms Morland-Shearer's carers raised concerns that she may have been suffering from dementia-type issues. A further application was lodged with SACAT to vary her existing Guardianship Orders, and the Public Advocate was appointed as a full guardian to Ms Morland-Shearer.

7 In November 2021, Ms Morland-Shearer was taken to the Flinders Medical Centre (FMC) following significant weight loss after a period of refusing food. During this admission she continued to refuse food and was subsequently placed on an Inpatient Treatment Order in order to provide her necessary treatment. However, invasive clinical methods were unsuccessful, and Ms Morland-Shearer lost a further 4 kg during her three-week admission to the hospital despite the insertion of a nasogastric tube for feeding. A high-risk strategy was developed between FMC and CLO for Ms Morland-Shearer to be

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1 Exhibit C7 at [3]-[4]

2 The Hon Bruce Lander QC, 'Oakden: A Shameful Chapter in South Australia's History' (Independent Commissioner Against Corruption, 28 February 2018)

3 Exhibit C9 at [9]

returned to her own home for management in the community, with strict criteria for readmission. This method proved successful, and Ms Morland-Shearer managed to gain seven kilograms of body weight with high-calorie swaps for her already self-restricted diet.

8 In May 2022, a review was conducted by SACAT in relation to Ms Morland-Shearer's existing Guardianship Order. The Tribunal was satisfied that there were grounds for Ms Morland-Shearer's existing full guardianship order to remain in force, which included restrictions that she must reside in a place deemed appropriate by her guardian.

Dysphagia

9 In October 2022, Ms Morland-Shearer had a choking incident. I note that, prior to this, there had been no swallowing difficulties observed or reported by her support workers. The Public Advocate authorised her referral to a speech pathologist employed by Hendercare, and she underwent a comprehensive swallowing assessment in November 2022, where a mild pre-oral and oropharyngeal dysphagia was diagnosed.

It was considered that Ms Morland-Shearer's swallowing was impaired due to difficulties coordinating muscles, structures of the face and throat against a background of hypoxic brain injury, tardive dyskinesia and lack of dentition.[4] She was noted to be at an increased risk of choking and aspiration-related illness without modified food and close supervision. Soft, easy to chew food was recommended to be served with moisture. The plan advised that if Ms Morland-Shearer did not follow prompts about safe eating, her food should be cut into small pieces.

11 January 2023

10 In the morning of Wednesday, 11 January 2023, a carer, Hadiza Adedokun, arrived at Ms Morland-Shearer's house at 6 am. This was Ms Adedokun's first time caring for Ms Morland-Shearer, but she had read her file in advance and was aware of her conditions and care requirements.[5]

11 Ms Adedokun had previously worked with clients who had dysphagia and had received dysphagia training through the NDIS Commission.[6] She had a Certificate IV in Disability as well as first aid and CPR certifications.

12 Upon arriving, Ms Adedokun was met by the carer on shift, Stamatoula Hristodoulou, who gave her an orientation and handover.[7] This process took about 75 to 90 minutes. During the handover, Ms Hristodoulou told Ms Adedokun about the food preparation requirements and that Ms Morland-Shearer had to be watched while she swallowed.[8]

13 At about 7:45 am, Ms Adedokun began making pancakes for Ms Morland-Shearer.[9] She cut the pancakes into small pieces and Ms Morland-Shearer took them, added maple syrup and ate two. Ms Adedokun wrapped the leftover pancakes in plastic wrap.

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4 It is noted that Ms Morland-Shearer had dentures, however often refused to wear them.
5 Exhibit C5a at [4]
6 Exhibit C5a at [5] and Exhibit C8 at [49]
7 Exhibit C5a at [5]
8 Exhibit C6 at [9]
9 Exhibit C5 at [5] and Exhibit C5a at [11]. It is noted that pancakes were Ms Morland-Shearer's usual breakfast, and this was not a change in routine for her.

14 At about 8 am, Ms Adedokun commenced giving Ms Morland-Shearer her medications.

15 At about 9 am, Ms Morland-Shearer commenced the process of showering with the assistance of Ms Adedokun. The process took about 30 minutes because they could not get the water to warm up. Ms Morland-Shearer had recorded prior incidents of delaying showering with new care staff by complaining about the water temperature.

16 At about 9:20 am, Ms Morland-Shearer returned to the kitchen and started to eat the leftover pancakes that were still cut up on the plate.

17 While she was eating, Ms Adedokun was about one metre away and maintained observations the whole time.[10] Ms Morland-Shearer said that she liked the pancakes. Just before 9:44 am, Ms Adedokun noticed that Ms Morland-Shearer was becoming uncomfortable and got her to sit down. Ms Morland-Shearer then started choking.

18 Ms Adedokun asked her to cough the food in her mouth out. She spat a small amount into Ms Adedokun's hand. Ms Adedokun then called triple zero as she realised something was wrong.

19 She used the palm of her hand to strike Ms Morland-Shearer's back in an upwards movement four times.[11] As a result a bit more food came out and Ms Adedokun could see that Ms Morland-Shearer's airways were clear. However, she was not improving.

20 Ms Adedokun laid Ms Morland-Shearer on the ground. She then commenced CPR with support from the triple zero operator.

21 The ambulance arrived at 9:53 am and took over the CPR effort. Ms Adedokun then retrieved Ms Morland-Shearer's medical folder and found that she had formally requested that resuscitation not be performed and the paramedics stopped the resuscitation effort.

22 A police officer viewed the food around Ms Morland-Shearer after she died and observed that it appeared to be consistent with Ms Adedokun's description; that is, it was pancake cut into small pieces.[12] There were leftover cut up pancakes found on the kitchen bench as well as the whole pancakes in cling wrap. Another police officer viewed the food in the kitchen and taken from Ms Morland-Shearer's mouth and concluded that it was in line with her dysphagia management plan.[13]

23 A post-mortem examination was conducted by forensic pathologist Dr John Gilbert.[14] Dr Gilbert found small amounts of residual soft food in Ms Morland-Shearer's pharynx with traces on the distal trachea and main bronchi. Dr Gilbert found pulmonary oedema and congestion, as well as mild changes consistent with rheumatic valvular disease in the mitral valve of the heart.

24 A separate examination of Ms Morland-Shearer's heart was conducted by neuropathologist Dr Esther Quick.[15] Dr Quick found no evidence of old or recent

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10 Exhibit C5a at [14]
11 Exhibit C5a at [16]
12 Exhibit C10 at [39]
13 Exhibit C12 at [36]
14 Exhibit C2a
15 Exhibit C4a and Exhibit C4b

ischaemic injury. She found no signs of head trauma and no structural abnormalities. There were numerous amyloid plaques within the cerebral cortex. Signs of Alzheimer's disease were revealed by immunohistochemistry analysis.

25 An examination of a sample of Ms Morland-Shearer's blood revealed therapeutic levels of paracetamol, olanzapine, quetiapine, mirtazapine and lorazepam. Dr Gilbert explained that quetiapine and olanzapine may contribute to swallowing difficulties as they can cause dry mouth and muscular weakness. Her medication interfering with her ability to chew and swallow is also noted in Ms Morland-Shearer's Support Plan.

26 Putting all of these findings together, Dr Gilbert concluded that Ms Morland-Shearer's death was as a result of choking on food on a background of Alzheimer's disease and antipsychotic therapy. I consider that the evidence supports this conclusion and I find that that was Ms Morland-Shearer's cause of death.

Lawfulness of detention

27 An order had been made under s 32 of the *Guardianship & Administration Act 1993* including powers authorising the detention of Ms Morland-Shearer at a place the guardian decided she was to reside. This order was in place, operational, and therefore validly allowed detention at home at the time of Ms Morland-Shearer's death.

Community Living Options

28 CLO provide a range of services with all staff having at least Certificate III in Disability.[16] In addition to mandatory base-level qualifications, they then conduct their own additional in-house training. There are then ongoing supervision meetings and service coordinators monitoring the care provided.[17] Each client is paired with carers that suit their individual requirements rather than operating a pool arrangement where carers may have little familiarity with clients.

29 Orientation for Ms Morland-Shearer's supporting staff included mandatory dysphagia management training.[18] Her Support Plan also included instructions for identifying swallowing difficulties, and what to do in response. This included instructions that incidents that cannot be resolved in 10-15 seconds must be referred to triple zero, as well as what kind of First Aid to perform to resolve these choking incidents.[19]

30 In short, CLO appears to be a well-governed organisation. Ms Morland-Shearer's family emphasised their satisfaction in relation to the care that she was provided.

Assessment of the care provided

31 A recent independent audit by NDIS found that CLO adopts what is best practice specifically in relation to the care of clients with dysphagia.[20]

32 At the time when Ms Morland-Shearer experienced her first choking episode, she was referred for speech therapy assessment with a dysphagia management plan formulated. It

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16 Exhibit C8 at [35] and [38]
17 Exhibit C8 at [40]
18 Exhibit C15 (Support Plan dated 21/12/2022) at 6
19 Ibid at 7
20 Exhibit C8 at [44]

was then implemented. The plan itself mandated Level 7 food textures which were within the International Dysphagia Diet Standardisation Initiative framework. Given that her dysphagia was assessed as mild and based largely on coordination between muscles and structures of the throat, this appears to be the appropriate level. Particularly in light of the fact that mitigatory techniques were also recommended.

33 The meal provided to Ms Morland-Shearer was clearly within the Level 7 classification.

34 In respect of the care provided when the emergency occurred, Ms Adedokun's response appeared to be appropriate. However, as she discovered after the incident, Ms Morland-Shearer had opted against having resuscitative measures.

35 Ms Adedokun was asked about Ms Morland-Shearer's dysphagia management plan immediately following the incident and was reportedly able to articulate it, indicating that she had a solid familiarity with it after her detailed handover that morning.[21] The physical evidence located supports a conclusion that she properly applied the management plan in relation to the size and texture of food.

Improvement

36 Following Ms Morland-Shearer's death, CLO sent all staff a practice alert about dysphagia and now include additional NDIS Commission training on 'Preparing safe and enjoyable meals' in its induction program for new staff.[22]

37 General Managers were also directed to ensure that dysphagia management was discussed at all team meetings, including what to do if carers noticed new issues with swallowing, and ensuring that plans were followed.

38 During the Inquest it was identified that some important features of Ms Morland-Shearer's Dysphagia Management Plan were not expressed as clearly as they potentially could have been. In particular, that Ms Morland-Shearer sometimes had 'impulsive behaviours' which included some relating to food; that she sometimes ate large pieces or took several mouthfuls at once.

39 I consider that those impulsive behaviours in combination with Ms Morland-Shearer's poor insight as a result of her brain injury and her lack of dentition combined to give rise to a higher risk of choking than many people with dysphagia. While these aspects of Ms Morland-Shearer's behaviour were included in the plan, they did not have the prominence one would expect for matters of this significance.

40 Following the hearing of the Inquest, counsel assisting me, Mr Dudzinski, wrote to Hendercare who prepared Ms Morland-Shearer's Dysphagia Management Plan. Hendercare were asked whether the format of Ms Morland-Shearer's Dysphagia Management Plan was standard, and whether other clients might have plans that could also have important features not given sufficient prominence.

41 Hendercare's Chief Executive Officer, Ms Emma Hinchey, responded to Mr Dudzinski by letter, a copy of which was received into evidence. Ms Hinchey advised that while no

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[21] Exhibit C12a at 27
[22] Exhibit C8 at [62]-[63]

fundamental changes have been made to the structure of the Dysphagia Management Plan, an internal review had been conducted by the speech pathology clinical lead which sought to enhance the existing format to improve clarity of key risks and instructions. This included the use of bolded red text for critical safety disclaimers, highlighting of high-risk instructions, and in the inclusion of images to guide alertness and positioning.

42 Hendercare further advised that progress continues into further enhancements to improve visibility of critical information while maintaining clinical integrity of the document. This includes consideration of text boxes to highlight critical information, improved placement of key risk statements, support staff acknowledgement sections, and feedback from participants and stakeholders to improve usability and clarity.

43 I am satisfied that these improvements are meaningful and will work to reduce the risk of adverse incidents involving clients with dysphagia in future.

44 On the basis of that, I have concluded that there are no systemic safety issues identified in light of Ms Morland-Shearer's death and I therefore have no recommendations to make.

Keywords: *Choking; Supported Independent Living; Death in custody; Guardianship Order*