# CORONERS COURT OF SOUTH AUSTRALIA



# INQUEST INTO THE DEATH OF NAHUEL SEBASTIAN LOWERY

**[2026] SACC 2**

**Inquest Findings of her Honour Deputy State Coroner Kereru**

**26 February 2026**

## CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man subject to home detention conditions. The Inquest explored the events leading up to his death including the adequacy of his medical treatment in custody.

Held:

1. Nahuel Sebastian Lowery, aged 41 years of Brompton, died at the Royal Adelaide Hospital on 24 January 2022 as a result of acute liver failure with contributing Castleman's disease.

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

No recommendations made.

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**Counsel Assisting: MR G DUDZINSKI**
**Hearing Date/s: 19/01/2026**
**Inquest No: 32/2025** **File No/s: 0208/2022**

# INQUEST INTO THE DEATH OF NAHUEL SEBASTIAN LOWERY [2026] SACC 2

## Introduction

1 Nahuel Sebatian Lowery was a 41-year-old Aboriginal man who lived at Brompton. During his early years, he was the victim of neglect and of sexual abuse. Later in life, he became involved with drugs and the criminal justice system. His death was brought about by circumstances that commenced while he was in custody. Accordingly, I heard an Inquest on the Papers to establish the cause and circumstances of his death.

## Mr Lowery's upbringing and young adulthood

2 Mr Lowery was born Leslie George Lowery, to Michael and Elizabeth Lowery. He spent his early life in Merbein, a rural town in the city of Mildura in Victoria. It was in adulthood that Mr Lowery legally changed his name to Nahuel Sebastian Lowery as he did not like his birth name.[1]

3 Mr Lowery's early life involved exposure to squalor, neglect and sexual abuse.[2] At 15 years old, he put himself on a bus and came to Adelaide. He secured accommodation at an Aboriginal Hostel and enrolled in Adelaide High School.[3] It was there that Mr Lowery met a fellow student by the name of Nikki Candy. This meeting had a profound impact on the trajectory Mr Lowery's life.

4 Mr Lowery was invited to Ms Candy's house for Christmas Day, around when he was 15 or 16 years old. From that day forward, he never returned to the hostel and effectively became part of the Candy family.[4]

5 Judith Candy, Ms Candy's mother, became in every practical sense, Mr Lowery's mother and Mrs Candy's daughters, India, Nikki and Rebecca, effectively became his sisters, although not formally.[5]

6 Mr Lowery blossomed in the care of the Candy family. As with any family, life was not always harmonious, but the Candy family saw him as passionate, adventurous and brave. He commenced studying psychology at the University of Adelaide.[6]

7 Mr Lowery was a caring person who volunteered through Lifeline and sponsored a child through The Smith Family charity. Notwithstanding his traumatic upbringing, he was a man who seemed to genuinely care for the wellbeing of others.

8 He secured employment as an Executive Officer assisting the Dean of Aboriginal Studies at the University of Adelaide. This was something of a dream position for Mr Lowery and he was incredibly involved in the work. The job was not limited to administrative duties and allowed Mr Lowery to be involved with other Aboriginal

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[1] Exhibit C1a at [2]
[2] Exhibit C1a at [3]
[3] Exhibit C1a at [5]
[4] Exhibit C1a at [6]
[5] Exhibit C1a, at [3]
[6] Exhibit C1a at [6]

students by accompanying them on trips. This included a trip to California for the World Indigenous Law Conference Study Tour, and sharing his own personal experiences with them as an indigenous man.

9 However, after a change in senior management, Mr Lowery began experiencing some conflict in the workplace which precipitated a period of illness. Mr Lowery ceased employment with the University and subsequently received a settlement in recognition of the manner in which he had been treated.[7]

10 Following the loss of his employment and, in particular, the work that he found so rewarding, Mr Lowery entered a period of instability. He began using methylamphetamine and his health significantly suffered as a result.[8]

## Medical history and therapy compliance

11 Dr Jennifer Catford, an infectious diseases consultant, provided a letter to the Court detailing Mr Lowery's medical history.[9] I will briefly detail the significant events that he experienced from a medical perspective.

12 In 2003, Mr Lowery contracted HIV. He reported that this was because of a sexual assault in Sydney. Following that diagnosis, his compliance with his antiretroviral medication was variable, and Mr Lowery was reluctant to engage in therapy even at the time of his original diagnosis.

13 In 2006, Mr Lowery travelled to Argentina and spent most of the year there. On his return he was found to have had a significant drop in his CD4 count[10] and he was commenced on a highly active antiretroviral therapy.

14 Between January 2007 and October 2008, Mr Lowery was recorded as being '*mostly compliant with HIV therapy*' apart from a period where there was an increase in his HIV viral load. His compliance improved after he received counselling about the importance of his therapy regime.

15 In June 2015, Mr Lowery was admitted to the Royal Adelaide Hospital which was in the context of him disclosing that '*he had not been very complaint with his HIV therapy'*. On this occasion, he presented with enlarged lymph nodes, an enlarged liver and spleen, anaemia and a platelet count below the normal threshold. Mr Lowery's CD4 count was at 217 cells/mm$^3$ and his viral load was over 7 million IU/mL. A biopsy of his lymph nodes revealed Multicentric Castleman's Disease.[11] He received treatment and was discharged on some days later.

16 In 2016, Mr Lowery travelled to South Africa. He returned to Australia in May 2016 and was next seen in a clinic in November 2017. Mr Lowery again reported that there were periods where he had not been very compliant with his HIV therapy.

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7 Exhibit C1a at [13]
8 Exhibit C1a at [14]
9 Exhibit C4
10 A CD4 count is a blood test measuring CD4 cells (a type of white blood cell crucial for fighting infections) which acts as a check on the immune system strength of people with HIV
11 Is a rare, non-cancerous (but cancer-like) disorder involving the overgrowth of cells in the lymph nodes

17 Mr Lowery did not attend scheduled consultations for review in March and June 2018 and he was next seen at the Royal Adelaide Hospital in July 2018. He reported that he had not been taking his antiretroviral medications since January 2018, and that this was due to problems at work. At this stage, Mr Lowery had a recurrence of leg swelling, abdominal distention and swelling of his lymph nodes.

18 Dr Catford noted that Mr Lowery had been '*commenced on antiretroviral therapy ... but was not entirely compliant with it*.'[12] Mr Lowery's compliance levels on this occasion meant that there was a delay in the ability to perform a biopsy of his neck node, which did not occur until December 2018. When it did occur, the results again showed multicentric Castleman's disease.

19 Following this, Dr Catford recorded that Mr Lowery was '*lost to follow up'* until January 2020.[13] At this point, he again stated that he had not been compliant with his HIV therapy. Dr Catford reported a low CD4 count of 100 cells/$mm^3$ and a viral load of 115,700 IU/mL. There was also evidence of CMV viremia without end-organ disease, leg oedema and hyperkeratosis as well as recurrent Kaposi's sarcoma on the left leg. Consequently, Mr Lowery was recommenced on antiretroviral therapy but again compliance with these therapies proved to be variable with his CD4 count remaining low and his viral load elevated.

## Mental health history

20 Mr Lowery engaged with a psychiatrist, Dr Ian Jennings, in 2002 for psychotherapy related to past trauma and relationship difficulties. He returned in 2003 and 2005 when he encountered a period of major depression.[14]

21 In 2011, Dr Jennings diagnosed Mr Lowery with having Attention Deficit Hyperactivity Disorder (ADHD) and Mr Lowery continued some level of engagement with Dr Jennings until June 2016.[15]

22 From 19 March 2020 to 23 November 2021, Mr Lowery was engaged with Dr Andrew Beckwith, a specialist psychiatrist, consulting with him on seven occasions. Dr Beckwith produced a report for the purposes of sentencing.[16] Dr Beckwith assessed Mr Lowery as having amphetamine use disorder, ADHD and distress and anxiety relating to his court proceedings.[17]

23 In relation to the amphetamine use disorder, Dr Beckwith recorded Mr Lowery as engaging in daily use prior to 19 March 2020 which reduced to more sporadic use after treatment. Dr Beckwith also noted that Mr Lowery had variable adherence to his HIV medication, which Dr Beckwith considered appeared to be related to his amphetamine use.[18]

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[12] Exhibit C4 page 2
[13] I understood this to mean that Mr Lowery had not attended a number of appointments and was uncontactable
[14] Exhibit C5 at [16]
[15] Exhibit C5 at [18]
[16] Exhibit C5 at [10]
[17] Exhibit C5 at [13]
[18] Ibid

## Detention

24 On 30 October 2020, Mr Lowery was sentenced in the District Court to imprisonment for three years, with a non-parole period of 12 months, in relation to charges of manufacturing a controlled drug and trafficking in a controlled drug. The sentence was ordered to be served on home detention.[19]

25 On 12 August 2021, Mr Lowery was taken into custody in relation to an application for enforcement of a breached home detention order.[20] This related to allegations that Mr Lowery had failed drug tests during the period of his home detention which contravened a condition of the order. He was subjected to a bail agreement in relation to the enforcement application the following day, with his bail conditions mirroring his home detention conditions. In particular, Mr Lowery was not permitted to leave his residence and was subject to electronic monitoring.[21] That is, he was effectively detained at home.

26 On 4 November 2021, Mr Lowery was granted parole in relation to the drug manufacturing and trafficking offences. The effect of that process is usually to release the parolee from their home-detention obligations and onto a parole regime without a detention component. However, in Mr Lowery's case, his bail conditions in relation to the pending enforcement application remained operative and he remained effectively detained.[22]

## Events leading to death

27 The evidence established that Mr Lowery turned his mind to his own death on 7 January 2022 when he completed paperwork setting out his desire not to receive any treatment for complications resulting from HIV.[23]

28 On 17 January 2022 at about 1:09 pm, Mr Lowery phoned emergency services, complaining of abdominal pain and difficulty moving as well as trouble retaining fluids. An ambulance arrived at 1:23 pm.

29 Mr Lowery reported to paramedics that he had been '*lying on the floor for two days unable to move*' and that he was unsure whether he had hit his head. The paramedics observed that none of Mr Lowery's medication appeared to have been taken for five days.[24]

30 At 1:42 pm while in the presence of paramedics, Mr Lowery's heart rate significantly slowed and he went into cardiac arrest. CPR was administered and after about 30 seconds there was a return to spontaneous circulation. Mr Lowery again went into cardiac arrest at 1:52 pm but achieved another return of spontaneous circulation after about 10 seconds of further CPR.

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[19] Exhibit C6 at [7] – [8].
[20] Exhibit C9, page 4.
[21] Exhibit C9a.
[22] Exhibit C9, page 4.
[23] Exhibit C6 at [21]
[24] Exhibit C12

31 Paramedics took Mr Lowery to the Royal Adelaide Hospital. He was admitted to the Intensive Care Unit at 2:37 pm. On admission he was found to be severely anaemic with abnormally low levels of platelets and high levels of bilirubin.

32 Mr Lowery required intravenous vasopressors to maintain blood pressure and was treated for septic shock. No clear focus of secondary infection was able to be identified and no treatable cause for the anaemia was established.

33 A CT scan and ultrasound of his abdomen showed enlargement of the liver and spleen as well as changes consistent with steatosis cirrhosis and portal hypertension. Gallstones were also noted, but without signs of obstruction.

34 A chest x-ray showed background changes of chronic obstructive pulmonary disease, with large bullae in the apices. New diffuse bilateral airspace opacities were noted. Bilateral leg x-rays did not show any bony injury.

35 Infectious diseases, gastroenterology and haematology specialists were consulted. Although Mr Lowery's prognosis was considered guarded, he was treated with broad spectrum intravenous antibiotics, antivirals for HIV, he was given irradiated blood transfusions, dexamethasone, and was generally provided supportive intensive care. Despite these interventions he continued to deteriorate.

36 On 18 January 2022, Mr Lowery disclosed to his treating team that he had not been compliant with his HIV medication and that he did not want to be resuscitated in the event of significant deterioration.[25] He continued with regular treatments.

37 On 20 January 2022, Mr Lowery had an episode of acute shortness of breath and became unconscious, with no detectable pulse. He was placed on a non-rebreather mask and quickly recovered. A discussion was had with Mr Lowery and his family about his poor prognosis. He told the infection diseases specialist that he knew he was terminal and that he wanted to be palliated.[26] The focus of care was then changed to comfort care.

38 Mr Lowery died on 24 January 2022, surrounded by his family.[27] Mr Lowery was noted to stop breathing at 8:15 pm and he was formally pronounced life extinct at 9:10 pm.[28]

## Cause of death

39 A pathology review is a review of relevant medical history and case notes, including ambulance records. The pathology review is a tool available to coroners where the circumstances of a person's death can be established on the papers without the need for an autopsy procedure.

40 A pathology review was conducted in Mr Lowery's case by Dr Jane Alderman of Forensic Science SA and the case was discussed with senior forensic pathologist, Dr John Gilbert.

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[25] Exhibit C9 at 10
[26] Ibid
[27] Exhibit C3 at [10]
[28] Exhibit C10

41 Dr Alderman provided her opinion that Mr Lowery's death was as a result of:

> *Acute liver failure, likely multi-factorial, contributed to by progressive Castleman's disease in the context of undertreated HIV infection due to variable compliance with medication*.[29]

42 I accept Dr Alderman's opinion and enter a finding that Mr Lowery's death was as a result of acute liver failure with contributing Castleman's disease.

## Assessment of the issues arising

*Supervision by Department for Correctional Services (DCS)*

43 It is clear from the DCS case notes that Mr Lowery had face-to-face meetings with DCS staff on numerous occasions during his supervision, notwithstanding the issues that COVID-19 presented at the time. DCS were aware, and Mr Lowery kept them informed about his poor health.[30]

44 The DCS records reveal that Mr Lowery was routinely provided passouts, enabling him to attend to his various medical appointments.[31]

45 Mr Lowery's compliance with his release conditions became more infrequent towards the end of his life with an increasing number of breaches recorded. This generally related to not answering phone calls and not maintaining charge on his device. The records reflect that DCS staff approached these breaches by noting Mr Lowery's poor health and concluding that the compliance issues were not serious enough to warrant breach proceedings.[32] In my view, this was an entirely appropriate approach to dealing with minor breaches by a quite unwell man who was not detained due to any violent offences.

46 The evidence establishes that the state of Mr Lowery's home at the time of his admission to hospital was far from optimal. In particular, I note India Candy's affidavit, where she describes the home as being in unpleasant and squalid conditions.[33]

47 While understandably distressing for any family to think of their loved one living in unpleasant conditions, it was evident that Mr Lowery valued his privacy and had refused help from family members to assist with cleaning.[34] I am unable to reach a conclusion that DCS staff ought to have done more to address the state of the house, given that their role was one of monitoring detention and ensuring Mr Lowery was safe. If the situation continued for longer, it may have presented a risk to his health which required action, but those circumstances did not arise. This is an issue that DCS should be mindful of in future to ensure that conditions of squalor do not reach unsafe levels before action is taken. As I said, those levels were not reached here.

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[29] Exhibit C2a and Exhibit C1a at [2]
[30] Exhibit C9 at 14
[31] Exhibit C6 at [17]
[32] Exhibit C6 at [20]
[33] Exhibit C3 at [13]-[15]
[34] Exhibit C3 at [13]

48 I am able to safely reach the conclusion that Mr Lowery's house had not reached a condition that was unreasonable for DCS not to address because the medical evidence does not draw any connection between it and his illness. I am satisfied that Mr Lowery's health struggles were predominantly brought about by his lack of compliance with his HIV therapy rather than any environmental factor.

49 Taking into account all of the circumstances and considering the events carefully, I find that the supervision provided by DCS was adequate. His health was monitored and he was given appropriate opportunities for the provision of care.

### *Care by paramedics and hospital staff*

50 I turn now to Mr Lowery's care by the health system from 17 January 2022.

51 Mr Lowery was gravely unwell following repeated incidents of Castleman's disease in the context of undertreatment of the HIV virus. His prognosis was poor and Mr Lowery was aware of this. As I have observed, even before his admission he commenced the process of recording his wish to be palliated if he experienced a medical episode.

52 Upon a review of the medical file, it is clear that relevant investigations were undertaken and comprehensive treatments were provided. While no cause for the underlying infection was able to be found, this was not for a lack of effort.

53 I consider that there is no criticism to be made of the paramedics and hospital staff that provided care to Mr Lowery during this time.

### *Delay in providing palliative care*

54 The affidavits received into evidence raised a concern that there was a delay between the decision to transition to comfort care on 20 January 2022 and the actual provision of end-of-life medications.[35]

55 A review of the case notes makes it clear to me that appropriate palliative care did start on 20 January 2022 and continued over the weekend. In particular, consistent with the proposed palliative care plan, Mr Lowery was administered hydromorphone and clonazepam on 20 January 2022 around 2:56 pm,[36] which is recorded has having the desired effect of calming Mr Lowery. Further hydromorphone was also administered at 8:35 pm.[37]

56 This medication regime continued through 21 January[38], 22 January[39] and 23 January 2022,[40] with modifications to the regime recorded when Mr Lowery displayed signs of agitation.[41] While it is quite obviously distressing to see a loved one experience episodes of agitation while under comfort care, that is not an unexpected event when medications are being titrated against a changing and developing condition. I

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[35] Exhibit C1a at [41]
[36] Exhibit C10 at 111
[37] Exhibit C10 at 115
[38] Exhibit C10 at 116, 121 and 123
[39] Exhibit C10 at 124-125
[40] Exhibit C10 at 128
[41] Exhibit C10 at 125 and 127

understand the concerns raised but I do not consider that the episodes reflect a standard of care that was inadequate.

### *Police investigation into bruising*

57 Another concern raised was the lack of police investigation in relation to bruising that Mr Lowery had around his left eye.[42]

58 There were no obvious defence marks or wounds observed on Mr Lowery's body, which was consistent with there being no physical altercation,[43] and during his phone call to emergency services, Mr Lowery had not alleged any physical altercation. He described difficulty with moving but at no stage attributed this to any physical violence. Importantly, he was unable to recall whether he had hit his head that day. If he had, facial bruising might be expected. He was also in a state of acute liver failure which increases susceptibility to bruising.

59 Given that Mr Lowery reported no incident, that there were no independent signs of any incident, and that there was an explanation for his bruising, I do not consider that there is any criticism to be made of police for not launching a criminal investigation into the bruising.

60 It is very important to note that there was no evidence to suggest that this bruising had any causal relationship to Mr Lowery's death.

## Recommendations

61 Given my assessment of the care provided to Mr Lowery, I consider that there are no recommendations that need to be considered that might improve the safety for those detained at home or that might prevent a recurrence of similar events.

## Acknowledgements and condolences

62 I wish to acknowledge the presence of the Candy family at the Inquest. Their unwavering support and love for Mr Lowery was very apparent in both their attendance and the fond memories they shared through their affidavits. It was also evident across the medical records and their presence during his final days. Despite Mr Lowery's difficult upbringing, he was a remarkable, caring and determined young man who accomplished many admirable achievements.

63 I convey my sincere condolences to the Candy family and to all those who were affected by the loss of Mr Lowery.

*Keywords:* *Death in custody; Home detention; HIV-AIDS*

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[42] Exhibit C8 at [9] and Exhibit C7 at 3
[43] Ibid