Commonwealth
National
Preventive
Mechanism

Post Visit Summary

Villawood Immigration Detention Centre and Miowera Village (APOD)

August 2026

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Summary

Our visit

The Commonwealth National Preventive Mechanism (NPM) conducted an announced visit to Villawood Immigration Detention Centre (VIDC), including Miowera Village, from Tuesday 10 to Thursday 12 March 2026. A concluding meeting was held with onsite operational Australian Border Force (ABF) personnel, and a letter was sent to the Secretary of Home Affairs escalating immediate concerns following the visit.

The visit was conducted by five OPCAT Monitors from the Commonwealth NPM.

During this visit, we focussed on areas we identified may pose the greatest risks for ill treatment during this visiting cycle. These areas were:

- safety and security within the facility
- detention of children in Miowera Village
- staffing levels
- hygiene and facilities maintenance
- disability access and inclusion.

The time devoted to each focus area was dynamic and the Monitors allowed for flexibility in the schedule to address other areas of concern.

Methodology

The Commonwealth NPM visits places of detention to:

- monitor the treatment of people in detention and the conditions of their detention
- identify any systemic issues where there is a risk of torture or ill-treatment
- make recommendations, suggestions, or comments promoting systemic improvement.

Humane treatment in detention is a central safeguard that helps ensure accountability, lawful behaviour and protection of human rights. Safe, lawful and humane conditions help prevent abuse, neglect, and exploitation, while also reducing the risk of torture or other cruel, inhuman and degrading treatment.

The Commonwealth NPM conducts three types of visits: announced, unannounced, and semi-announced. The type, location and timing of each visit is determined by the Commonwealth NPM alone.

Each place of detention is observed in terms of its performance based on treatment and conditions for people in detention. We assess these against the 5 indicators of a healthy detention facility, adapted from those used by other international and domestic visiting bodies.

The five indicators of a healthy centre are[1]:

Safety	people in detention are held in safety and that consideration is given to the use of force and disciplinary procedures as a last resort
Respect	people in detention are treated with respect for their human dignity and the circumstances of their detention

[1] These indicators have been adapted from expectations used by international and domestic inspectorates.

Purposeful activity	the detention facility encourages activities and provides facilities to preserve and promote the mental and physical wellbeing of people in detention
Wellbeing and social care	people in detention are able to maintain contact with family and friends, support groups, and legal representatives, and have a right to make a request or complaint
Physical and mental health	people in detention have access to appropriate medical care equivalent to that available within the community. Stakeholders work collaboratively to improve general and individual health conditions for people in detention

What we found

During the visit, Monitors identified serious and systemic concerns about the safety, security, maintenance and overall operation of the facility. Key concerns identified include:

- the prolonged detention of a family at Miowera Village
- ineffective management of the security situation at the facility, with both staff and people in detention reporting concerns about their safety
- insufficient staffing and limited interaction between staff and people in detention to mitigate security risks and reduce the likelihood of incidents occurring
- the hazardous deterioration and disrepair of the built environment and material conditions across almost all compounds
- people in detention sleeping outside sleeping areas, which it appeared could have been due to a range of reasons including the heat inside sleeping areas due to the broken air conditioners, intimidation by other people in detention, and concerns about safety (noting that sleeping areas typically are not monitored by CCTV)
- seemingly free movement of illicit substances within the facility, with people in detention alleging that substance use is commonplace and illicit substances are being traded relatively openly, despite an increase in search and seizure activities by staff
- inappropriate placements and/or inadequate supports for people with complex physical and mental health needs and behavioural concerns, including an inability to gain approval to apply to move people into Tier 4 placements in a timely manner (or at all).

These issues seemed to intersect with, and exacerbate, one another, and their combined impact presents risks of inhuman and degrading conditions and treatment. The conditions observed by Monitors were indicative of a system under considerable pressure; a lack of effective control and oversight of the security situation; and a failure to provide a level of service provision that is adequate to meet minimum standards of safety, care and support.

I consider that the matters observed by Monitors at the VIDC require urgent consideration and, to the extent possible, remedial action, to ensure the safety of both people in detention and staff and to maintain the good order of the facility. If left unaddressed, there is a risk of further deterioration in conditions and increased harm to people in detention and staff, potentially including serious injury and loss of life.

Recommendations

I recommend the following:

Recommendation 1

As a matter of urgency, the Department should ensure that all children of compulsory school age detained at Miowera Village have access to education commensurate with their age and ability level.

Recommendation 2

The Department should consider engaging an early childhood educator to provide educational support to children below school age detained at Miowera Village.

Recommendation 3

Noting the risks to the wellbeing and development of children posed by prolonged detention, the Department should engage a qualified external child psychologist and a child learning and development expert to assess the children detained at Miowera Village and provide recommendations on measures to safeguard their wellbeing and development.

Recommendation 4

As a matter of urgency, the Department should work with the detention service provider at VIDC to:

- increase staffing levels to enable more effective management of the current security situation
- introduce measures to support effective dynamic security practices, including but not limited to reviewing rostering arrangements, increasing oversight and performance monitoring of staff, and providing additional training to staff as needed.

Recommendation 5

As a matter of urgency, the Department should work with facility staff to undertake a comprehensive review of safety hazards at VIDC and implement strategies to mitigate or eliminate any identified risks.

Recommendation 6

As soon as possible and within three months at the latest, the Department should develop and introduce a structured maintenance regime to address outstanding maintenance items at VIDC.

This regime should include measures to prevent deterioration of material conditions in the future, such as a regular infrastructure audit with mandatory remediation timeframes and escalation pathways.

Recommendation 7

The Department should review internal procurement process to determine whether current approval thresholds provide sufficient flexibility to address routine maintenance in immigration detention facilities without undue delay.

Recommendation 8

Within three months, the Department should require that all vehicles used in transport and escort activities for people in immigration detention comply with contractual requirements for safety and security features, including adequate monitoring and communication capabilities.

Recommendation 9

Within three months, the Department should work with facility staff to ensure that:

- hard copies of the induction booklet are readily available in the initial processing area
- the induction booklet is translated into the most commonly-spoken languages among people in immigration detention.

Recommendation 10

Within six months, the Department should work with facility staff to strengthen policies and procedures for handling complaints and requests, to ensure consistency in handling and outcomes. These policies and procedures should include:

- clear guidance for staff on handling complaints that have already been resolved by the time the complaint is processed, with recommended practice being that such complaints are recorded as being resolved rather than withdrawn
- processes to ensure that all requests are acknowledged and progress updates are provided to the person making the request, similar to the process currently used for complaints
- regular audits of the availability of complaint and request forms and the condition of locked letterboxes in compounds, to ensure that people in detention can obtain and submit forms confidentially or anonymously.

Recommendation 11

Within three months, the Department should work with facility staff to introduce rostered access to the “community” area to all people detained at VIDC, to improve access to facilities for purposeful activity.

Recommendation 12

Within three months, the Department should review the programs, activities and recreational facilities and equipment currently provided at VIDC to ensure that adequate purposeful activity is being provided to people in detention, including those detained for prolonged periods.

Recommendation 13

Within six months, the Department work with facility staff to:

- undertake an accessibility audit of exercise and outdoor recreation facilities at VIDC
- based on the outcomes of this audit, develop a refurbishment plan to remedy any identified deficiencies.

Recommendation 14

The Department should revise its policies and procedures for Tier 4 placements to ensure that facility staff are not required to exhaust all internal placement options before making a Tier 4 referral, in cases where internal placement options are clearly inappropriate.

Recommendation 15

Noting barriers to progressing external Tier 4 placements in a timely manner, within three months the Department should undertake a review to determine:

- whether any existing facilities within the immigration detention network could be utilised or modified to provide appropriate accommodation for people requiring Tier 4 placements
- in conjunction with the above, whether additional contracting arrangements with external care providers may be required to ensure appropriate support for people requiring Tier 4 placements.

Iain Anderson
Commonwealth National Preventive Mechanism

Facility & demographics

VIDC is a high-security immigration detention facility located in south-west Sydney, originally established in 1949 as a migrant hostel and converted into a detention centre in 1976. The facility consists of multiple compounds and buildings across a large site and includes both the main detention centre and an adjacent residential housing precinct (Miowera Village) typically used for people deemed to be lower risk, including children and families.

VIDC consists of several accommodation compounds, which vary in capacity, style and function, and has an operational capacity of 572 people.

On 9 March 2026 there were 428 people detained within VIDC with 78 beds offline due to fire damage from an incident in July 2023. There were a further 20 people detained in Alternative Places of Detention (APODs) in NSW (inclusive of Miowera Village) making a total of 448 people held in detention in the state overall.

The current population of people detained at the VIDC is diverse and complex. It includes asylum seekers, visa overstayers and individuals detained following visa cancellation due to character concerns (often criminal convictions). The cohort is predominantly male, with smaller numbers of females and children, some of whom are accommodated at Miowera Village (as the main facility is not used to detain children). A significant number of people detained at VIDC have been held in closed detention for a prolonged period of time, which contributes to a complex risk profile and heightened mental health needs.

VIDC is one of the most secure and high-risk facilities within the Australian immigration detention network due to the composition of its population and the length of time for which many of the people detained at the facility have been held in detention.

The length of time spent in detention ranged from 2 to 4,017 days (approx. 11.00 years). Of the 465 people in detention on 01 March 2026, 268 (57.63%) had been in detention for up to one year. 145 people (31.18%) had been in detention for one to 5 years, and 49 (10.53%) had been in for between 5 and 10 years. Three individuals had been in detention at VIDC for more than 10 years.

Observations

Miowera Village

Miowera Village is a low-security compound adjacent to the main high-security detention facility at VIDC. The Village consists of several semi-detached 2- and 3-bedroom residential-style dwellings with a kitchen, bathroom and living room. The compound has a central building used as a common area for programs and activities, social interaction and meetings.

There are also outdoor garden and grassed areas shared by all people accommodated at the Village. Family groups and children are accommodated at this facility rather than in the main high-security facility, along with other people in detention for whom a lower-security detention environment may be more appropriate.

At the time of the Commonwealth NPM's visit, there was a family group at the Village who had been detained there for around two months. The children in the family ranged in age from preschoolers to teenagers, with the majority being of compulsory school age.

Monitors observed that the compound was clean, well-maintained and free of obvious hazards. Accommodation units were observed to provide sufficient space and facilities for short periods of detention.

The residential style of the compound and absence of obtrusive security infrastructure (such as internal fencing) provides a far more appropriate environment for children, families and other vulnerable groups than higher-security facilities such as the main VIDC complex. Monitors also observed respectful interactions and consideration by staff for the circumstance of the people accommodated at the Village.

Monitors were advised by people accommodated at the Miowera Village that all health and medical needs were being attended to promptly and access to external hospitals is available when needed. Access to visits was accommodated but limited. However, at the time of the visit, children detained at the Village were unable to attend excursions or interact with peers outside detention, reportedly due to operational and staffing constraints.

Monitors also observed a lack of purposeful activities for the people detained at the Village. Despite provision of some activities and materials for children, there were insufficient meaningful and engaging activities for children of different ages.

Monitors also observed that some basic items, such as computers with functional speakers, appropriate reading material, play equipment or sports equipment were limited or not available. Monitors were advised that there had been significant challenges in providing a basic level of formal education to school-aged children detained at the Village (with distance education options being considered at the time of the visit). No access to early childhood education was apparent to Monitors at the time of the visit. After the visit, the Department of Home Affairs advised that the children had been enrolled in (but had not yet commenced, distance education). They also advised they had approved educational supplies to assist the children with their education.

While noting that conditions at Miowera Village are preferable to those in a higher-security facility for families and children, Monitors were nonetheless concerned about the length of time for which children had been detained at the Village at the time of the visit.

A substantial body of research demonstrates that immigration detention settings are profoundly harmful to children, with a recent systematic review finding high rates of depression (over 40%) and Post Traumatic Stress Disorder (around 32%) among detained children, with severity increasing over time of detention.[2] Studies consistently show that such environments contribute to developmental regression, anxiety, behavioural issues, and long term emotional harm, particularly where children are exposed to prolonged uncertainty, restricted movement, and a lack of normalising social experiences.

In this context, there is a high risk that the continued detention of children at Miowera Village will be detrimental to their mental health, wellbeing and social and emotional development and may result in enduring negative developmental outcomes. The absence of peer engagement and meaningful activities further compounds these risks, depriving children of critical opportunities for social, cognitive and emotional growth.

[2] The impact of immigration detention on children's mental health: systematic review. The British Journal of Psychiatry: The Journal of Mental Science.

The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has previously found that the detention of children based on their migration status may contravene states' obligations under the Convention Against Torture:

> *Within the context of administrative immigration enforcement, it is now clear that the deprivation of liberty of children based on their or their parents' migration status is never in the best interests of the child, exceeds the requirement of necessity, becomes grossly disproportionate and may constitute cruel, inhuman or degrading treatment of migrant children.*[3]

The *Migration Act 1958* affirms as a principle that children shall only be detained in immigration detention facilities as a measure of last resort.[4] The Act also provides the Minister for Immigration with discretionary powers to grant a person a visa, or make a determination that a person in detention is to reside at a location other than an immigration detention facility, if they consider it is the public interest to do so.

While acknowledging that these powers are non-compellable and non-delegable, we note that significant powers are available to the Minister to enable consideration of alternatives to closed immigration detention for children and families. Prompt consideration of these alternatives would significantly mitigate the risk of harm inherent in closed detention environments where children are concerned.

Recommendation 1

As a matter of urgency, the Department should ensure that all children of compulsory school age detained at Miowera Village have access to education commensurate with their age and ability level.

[3] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, 5 March 2015, A/HRC/28/68.
[4] *Migration Act 1958,* s4AA

Recommendation 2

The Department should consider engaging an early childhood educator to provide educational support to children below school age detained at Miowera Village.

Recommendation 3

Noting the risks to the wellbeing and development of children posed by prolonged detention, the Department should engage a qualified external child psychologist and a child learning and development expert to assess the children detained at Miowera Village and provide recommendations on measures to safeguard their wellbeing and development.

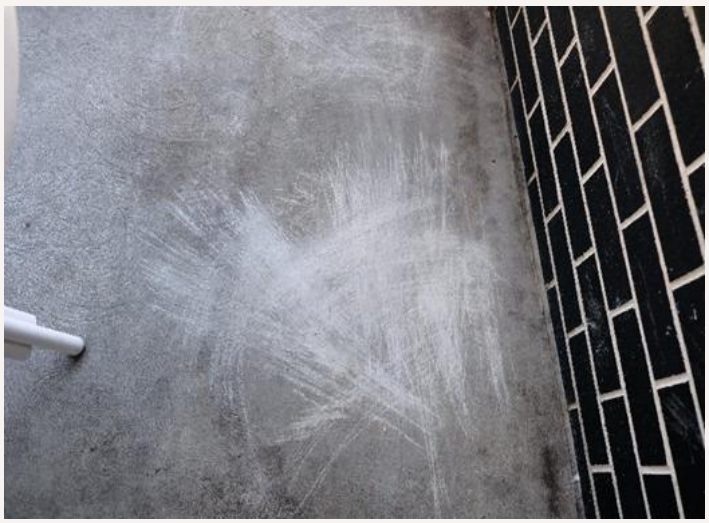
Villawood IDC

Safety

Physical safety and security

Monitors were deeply concerned by the security situation they observed at VIDC at the time of the visit. Monitors considered that the security environment presented a very high risk to the safety of people in detention as well as staff, and this risk was not being effectively managed. Most of the people in detention who engaged with Monitors during the visit raised concerns about their safety and security, with people reporting incidents of bullying, aggression and physical assault (either directed towards them personally, or that they had witnessed), and expressing distress and fear that they may be at risk of physical harm from other people in detention. Incidents of alleged sexual harassment and sexual assault perpetrated by people in detention, some of which were directed towards staff, were reported in operational meetings during the visit.

Monitors heard that concerns for personal safety influenced where people in detention spent their time. Some reported isolating themselves in their rooms during the day to avoid other people in detention who may be violent or unpredictable due to the trade in or use of illicit drugs. Others indicated that they chose to sleep in common areas rather than their assigned rooms, as they perceived these areas to be safer due to the presence of CCTV monitoring (noting that bedrooms are not monitored by CCTV in most accommodation compounds at VIDC). Monitors also observed damage to concrete and brickwork that was consistent with sharpening of metal objects, suggesting that some people in detention may be attempting to produce makeshift weapons.



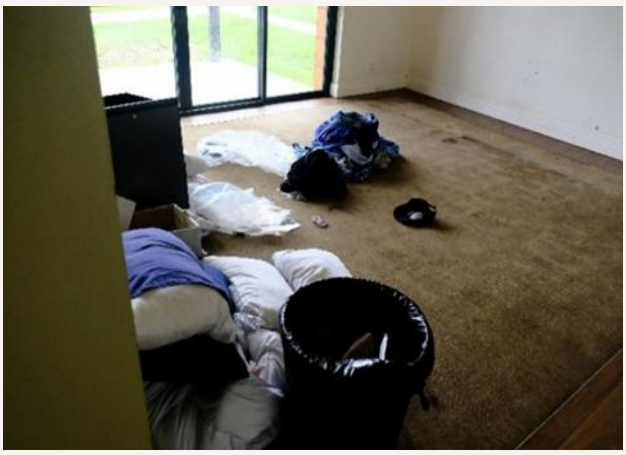
Damage to concrete consistent with sharpening of metal objects

At the same time, however, staff indicated that the number of recorded incidents at VIDC had been decreasing over time, which suggested that the security situation was improving. There appeared to be a disconnect between these records and the experiences reported to Monitors by people in detention and staff 'on the ground'.

People in detention also alleged to Monitors that some staff appeared reluctant to intervene to prevent escalation of incidents or protect the safety of people in detention. While Monitors were not in a position to substantiate all of these allegations, other observations made during the visit indicated that the security situation was not being managed effectively.

For example, Monitors noted a number of factors that appeared to undermine the development of rapport and trust between staff and people in detention, which forms the foundation of effective dynamic security.[5] Monitors observed a low staffing presence across compounds relatively to the size and security profile of VIDC, and limited interaction between staff and people in detention. Some staff also raised concerns that the current rostering approach at VIDC, whereby staff regularly rotate between compounds, limited their ability to 'get to know' people in detention and understand security risks posed by particular individuals.

[5] The United Nations Standard Minimum Rules for the Treatment of Prisoners, rule 76.



Person sleeping outside (L) and bedding in a common area (R)

Monitors also directly witnessed an example of staff failing to intervene to prevent escalation of a serious physical altercation. While acknowledging that this example may not necessarily be reflective of the management of incidents across VIDC generally, it was consistent with other evidence received by Monitors indicating ineffective management of the security situation.

For example, Monitors were advised that the detention services provider had insufficient staffing reserves to manage unplanned absences, such as in cases where several staff were on sick leave at the same time. Monitors were advised that in these circumstances, Incident Response Team staff are routinely redeployed to cover general duties, undermining their primary function and reducing the centre's ability to respond to incidents. Some staff expressed concerns about their own safety and appeared reluctant to engage in dynamic security practices due to the lack of adequate personnel support.

Monitors also observed that key risk areas within the facility, such as visiting areas and sallyports, appeared to be understaffed. For example, Monitors were advised by staff that visiting areas were considered a high-risk site for entry of contraband (such as illicit substances) into the facility, yet at the same time, Monitors were advised that visiting areas may at times be staffed by a smaller number of officers than recommended under internal procedures.

Overall, Monitors were left with the impression that the security situation at VIDC was not being effectively controlled, with the result that both people in detention and staff were being exposed to significant risks to their physical safety.

Recommendation 4

As a matter of urgency, the Department should work with the detention service provider at VIDC to:

- increase staffing levels to enable more effective management of the current security situation
- introduce measures to support effective dynamic security practices, including but not limited to reviewing rostering arrangements, increasing oversight and performance monitoring of staff, and providing additional training to staff as needed.

Security infrastructure

Monitors received evidence from staff and directly observed that a significant number of CCTV cameras were not operational, substantially undermining the effectiveness of the surveillance system. Coverage was also insufficient in some areas, and some cameras appeared to be dirty and hazy, making it difficult to clearly identify individuals. These deficiencies in CCTV infrastructure limited the ability of staff to monitor safety, respond to incidents, and maintain accountability.

Responses to major incidents

In January 2026, a person in detention at VIDC died after allegedly being attacked by another person in detention, who was subsequently charged with their murder. Monitors sought information from staff and people in detention about the support provided following a major incident such as a death in detention. Information provided by staff indicated that staff were aware of the need to provide additional and targeted support in these situations, and that adequate support had been made available directly after the death in detention in the form of debriefs, onsite clinical support provided by Health Care Australia and (for staff) access to the Employee Assistant Program. However, some people in detention raised concerns that this support was limited to the immediate aftermath, and there was a lack of ongoing support in the weeks and months following the incident.

Material conditions and safety hazards

Monitors observed that the material conditions of detention at VIDC appeared to have declined significantly since the Commonwealth NPM's last visit. Evidence of damage, disrepair and poor maintenance was apparent across almost all compounds. Examples observed by Monitors included:

- missing or damaged doors and windows
- significant damage to property – for example, Monitors were informed by staff in one compound that all of the computers had been removed due to being damaged by a person in detention, and had not yet been replaced
- damage to infrastructure (such as walls, phone boxes and bins), some resulting from 'wear and tear', and some from intentional damage by people in detention
- inoperative air conditioners in sleeping areas that reportedly had not been repaired for some months, coinciding with the summer period, with the result

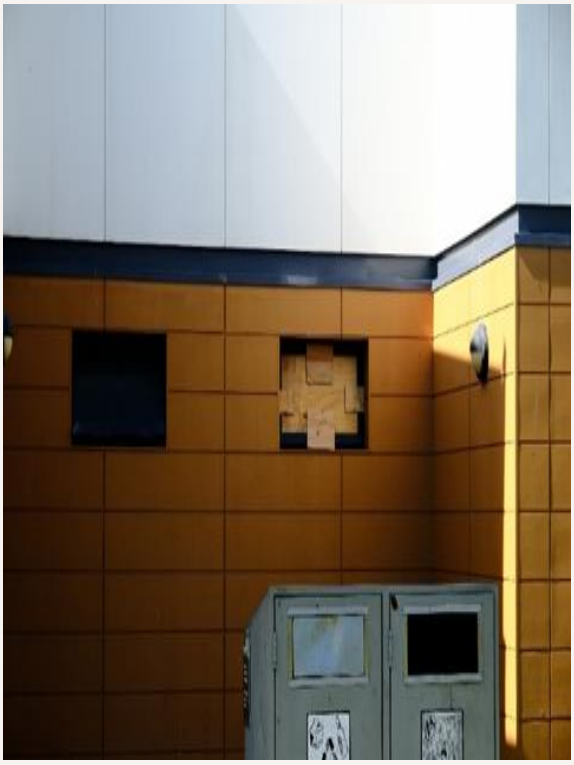
that some people in detention had resorted to sleeping in common areas (such as classrooms) that did have working air conditioning

- poor standards of cleanliness, including dirty carpets and visible rubbish in common and outdoor areas
- damage to an accommodation building caused by a fire in July 2023, which still had not been repaired
- overgrown grass and vegetation, which Monitors acknowledged was in part due to recent weather conditions, but which further contributed to the overall impression of poor maintenance.

Staff and people in detention both expressed frustration about intentional damage to property and infrastructure caused by people in detention, and its impact on material conditions (such as reduced access to computers). Information provided to Monitors suggested that the consequences for intentional damage were relatively minimal, often involving a reduction in 'points'[6] or movement to a different compound, with more serious penalties or investigation by police only occurring in cases of major damage (such as a fire). While acknowledging that intentional damage may in some cases be linked to significant mental health or behavioural concerns, Monitors noted with concern that the perception of limited consequences could itself play a role in driving further incidents of intentional damage.

[6] 'Points' refer to a reward provided as part of an incentive scheme for participation in purposeful activity in detention. Points can be used to purchase items (such as snacks, cigarettes and toiletries) within detention. They cannot be exchanged for money.

Damaged Doors – board replacing door and missing handle



Damaged window with temporary boarding and damaged door handle with internal metal components removed from common area door in accommodation compound

Damaged rubbish bins and overgrown grassed area in front of accommodation building

Monitors were advised by facility staff that recent changes to procurement processes within the Department of Home Affairs had contributed to a significant backlog in maintenance items at the time of the visit. Staff indicated that the threshold for items requiring central approval had been lowered, with the result that some routine maintenance items that would previously have been approved by staff at a facility level now required central approval. While acknowledging this challenge, Monitors noted that the level of disrepair across the facility (some of it long-standing) suggested a need for improvement in maintenance procedures at both a facility and departmental level.

Monitors also observed a number of significant safety hazards that could present a risk of serious injury or loss of life to staff and people in detention, including:

- smoke detectors within accommodation areas that had been deliberately covered with plastic bags taped to the ceiling, rendering them inoperable and potentially delaying evacuation and emergency response in the event of a fire
- makeshift modifications to electrical cords by people in detention, such as cords being spliced to extend their length, with joins secured only by sticky tape
- several light bollards in various states of disrepair, some with exposed electrical wiring, presenting a significant hazard in high foot-traffic areas and during wet weather conditions
- large shards of glass (which were a hazard in themselves but could also be used as weapons) from a broken window that had not been cleared.

Monitors observed that these hazards were generally clearly visible, and in many cases immediate action could have been taken to mitigate or eliminate the identified safety risk. It was unclear why this had not occurred, particularly given that procurement

would not have been required to reduce immediate risks. For example, the hazard posed by makeshift modifications to electrical cords could have been addressed by simply removing the affected appliances from compounds.

Modified lengthen wiring from fan and electric cable holding door open

Pathway lighting with exposed wires

Shard of glass found on ground in common area with business card to demonstrate size

Taken together, the material conditions documented by Monitors at VIDC were inadequate to ensure the safety, dignity and wellbeing of people in detention.

Recommendation 5

As a matter of urgency, the Department should work with facility staff to undertake a comprehensive review of safety hazards at VIDC and implement strategies to mitigate or eliminate any identified risks.

Recommendation 6

As soon as possible and within three months at the latest, the Department should develop and introduce a structured maintenance regime to address outstanding maintenance items at VIDC.

This regime should include measures to prevent deterioration of material conditions in the future, such as a regular infrastructure audit with mandatory remediation timeframes and escalation pathways.

Recommendation 7

The Department should review internal procurement process to determine whether current approval thresholds provide sufficient flexibility to address routine maintenance in immigration detention facilities without undue delay.

Transport and escort

During the visit, Monitors inspected examples of vehicles used for transport and escort activities. Monitors observed that the vehicles are now equipped with several positive safety features, including physical screens separating the driver from the rear compartment, fire extinguishers, blankets and first aid kits. Noting that inadequate safety features in vehicles was identified in the Commonwealth NPM's recent report on the change in detention service providers, Monitors were pleased to observe an improvement in this area.

However, Monitors identified significant deficiencies in vehicle safety features, particularly security, monitoring and communication systems. For example, staff were relying entirely on mobile phones, creating risks during rural or remote escorts where network coverage may be unreliable or unavailable. In addition, video monitoring consisted of body-worn cameras mounted within the vehicle rather than an inbuilt monitoring system, which has limitations in terms of battery life, the need for manual activation, the ability to disable recording, and the absence of continuous recording. Monitors considered that these issues significantly undermine the reliability, integrity and accountability of monitoring during escort operations and could present serious safety and security risks.

Monitors also observed that vehicles lacked secure locking systems, relying instead on standard child locks. Monitors noted that the lack of autolocking features had been a contributing factor in a previous escape incident during a transport operation from VIDC.[7]

[7] See the case study on p. 20 of the Commonwealth NPM's OPCAT in Action report on risks arising from the change of detention service providers.

Recommendation 8

Within three months, the Department should require that all vehicles used in transport and escort activities for people in immigration detention comply with contractual requirements for safety and security features, including adequate monitoring and communication capabilities.

Respect

Induction booklet

All people entering an immigration detention facility are meant to receive a copy of an induction booklet containing key information about how the facility operates and the rights and responsibilities of people in detention. The booklet typically includes information about expected standards of behaviour in detention, what is and is not allowed in the facility, how to make complaints and requests, and processes for external visits.

During the visit to VIDC, Monitors observed that the induction booklet was not readily available in the initial processing area for new arrivals, with staff instead locating and printing copies on an ad hoc basis. A number of people who had recently arrived at the facility advised Monitors that they had not been provided with a copy of the induction booklet.

The booklet is also only available in English, with staff advising that tools such as Google Translate may be used to provide translated versions. In the view of Monitors, this is not an appropriate approach given the importance of the information set out in the induction booklet. The absence of a standardised, readily accessible supply of induction materials in multiple languages undermines the ability of people in detention to understand their rights and responsibilities, available services and internal processes (including complaints processes), and may impact their ability to navigate the detention environment safely and effectively.[8]

[8] The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), Rule 54.

Recommendation 9

Within three months, the Department should work with facility staff to ensure that:

- hard copies of the induction booklet are readily available in the initial processing area
- the induction booklet is translated into the most commonly-spoken languages among people in immigration detention.

Communications and complaints

While many people in detention have access to their own mobile phones, those who do not rely on landline telephones provided within common areas, compounds and dedicated interview rooms. Monitors observed that landline phones within compounds at VIDC were largely non-operational, potentially impacting the ability of people in detention to seek legal advice, maintain social and familial connections and access external support – critical components of wellbeing and procedural fairness.

Monitors received detailed information from facility staff about the complaints-handling process at VIDC. Monitors noted a need for improvement in internal documentation of policies and procedures. For example, when asked by Monitors how staff determine to whom complaints should be allocated, staff responded to the effect of 'we just know'. This suggests a lack of adequate written guidance and an overreliance on corporate knowledge, potentially leading to inconsistent processes and outcomes for people making complaints.

Staff also indicated that, when an issue has already been resolved by the time a complaint is processed, staff may approach the complainant to ask if they wish to withdraw their complaint. Monitors observed that this is likely done with the intention of resolving complaints more expeditiously, rather than to pressure or coerce people in detention to withdraw complaints. However, Monitors were concerned by the perception of coercion this may create among people in detention, even if this is not the intention. Recording such complaints as withdrawn also obscures the fact than an issue warranting complaint had arisen in the first place (and been successfully resolved), limiting the ability of staff to monitor and track patterns in complaints data and identify systemic or recurring issues.

Monitors observed that the processes for people in detention to make requests of facility staff or management (such as to advise of maintenance issues, request access to their property, make appointments with particular people or speak to a manager) appeared to be unclear and inconsistent. The requests process involves completing and submitting a paper Detainee Request Form. Monitors were told by people in detention that there was no acknowledgement of receipt given at the time requests were submitted, and that many requests went unanswered, leaving people with no assurance that their request is progressing or has even been received.

Monitors observed that paper complaints and request forms were not always readily available, with document boxes intended for these forms being completely empty in several compounds at the time of the visit. Monitors also observed that some locked letterboxes designed for submitting forms were broken or unusable. Monitors were advised that people in detention could request forms from staff, or hand completed forms directly to staff. However, this approach would impede people in detention from making complaints confidentially or anonymously, and would be of particular concern if a person wished to make a complaint about staff.

Recommendation 10

Within six months, the Department should work with facility staff to strengthen policies and procedures for handling complaints and requests, to ensure consistency in handling and outcomes. These policies and procedures should include:

- clear guidance for staff on handling complaints that have already been resolved by the time the complaint is processed, with recommended practice being that such complaints are recorded as being resolved rather than withdrawn
- processes to ensure that all requests are acknowledged and progress updates are provided to the person making the request, similar to the process currently used for complaints
- regular audits of the availability of complaint and request forms and the condition of locked letterboxes in compounds, to ensure that people in detention can obtain and submit forms confidentially or anonymously.

Purposeful Activity

Programs and activities

VIDC has extensive, purpose-built facilities for providing access to programs, activities, exercise and recreation. This includes a "community" area with a gym, indoor basketball court, library, music room and other recreational facilities. At the time of the visit, however, access to the "community" area was restricted to people in the lower-security compounds, and some facilities in this area were open only during certain hours of the day rather than being generally accessible.

The higher-security compounds at VIDC contain a range of inbuilt recreational and exercise facilities, including gyms and small sports fields; however, the facilities are far more limited than in the "community" area. A number of people detained in higher-security compounds raised concerns with Monitors about limited facilities for purposeful activity and the inability to access the more extensive facilities in the "community" area.

Monitors considered this limited access to the "community" area to be of particular concern given that the higher-security compounds at VIDC are not used exclusively for higher-risk cohorts. For example, at the time of the visit, one of the higher-security compounds was being used to accommodate women, due to this compound being at a more suitable distance from the compounds accommodating men. As a result, all women in detention at VIDC – regardless of their individual risk rating or record of behaviour in detention – did not have access to the "community" area.

People in detention also raised concerns with Monitors about the number and quality of programs and activities offered at VIDC. Some indicated that the programs and activities on offer were insufficient to fill their time, and those that were offered were not particularly meaningful or engaging. For example, one person claimed that activities largely comprised 'cards and colouring'. This feedback is of particular concern given the prolonged periods of time for which many people are detained at VIDC.

Monitors observed that some compounds had limited or no televisions or computers, with people in detention reporting that some televisions and computers had not been replaced after being damaged. Monitors also observed that existing televisions and computers were not fitted with protective security casings, and were thus susceptible to further damage. While television access may be considered a relatively minor shortcoming in conditions, in the context of limited availability of purposeful activity at

VIDC, it can contribute further to boredom, frustration and heightened tension within the facility, which may negatively impact the wellbeing of people in detention and increase the risk of behavioural issues and incidents.

Recommendation 11

Within three months, the Department should work with facility staff to introduce rostered access to the "community" area to all people detained at VIDC, to improve access to facilities for purposeful activity.

Recommendation 12

Within three months, the Department should review the programs, activities and recreational facilities and equipment currently provided at VIDC to ensure that adequate purposeful activity is being provided to people in detention, including those detained for prolonged periods.

Accessibility

At the time of the visit, there were a number of people detained at VIDC who had mobility-related disability and were using mobility aids such as walkers and wheelchairs. Monitors observed several shortcomings in accessibility features for people with mobility-related disability, including a lack of appropriately modified exercise equipment and uneven ground in outdoor areas and sports fields resulting from overgrown vegetation. Noting the important role of exercise and outdoor recreation in supporting the health and wellbeing of people in detention, these facilities should be accessible to people with disability.

Recommendation 13

Within six months, the Department work with facility staff to:

- undertake an accessibility audit of exercise and outdoor recreation facilities at VIDC
- based on the outcomes of this audit, develop a refurbishment plan to remedy any identified deficiencies.

Wellbeing and social care

Illicit substances

Monitors continued to hear concerns about the availability, movement and use of illicit substances at VIDC. Monitors observed that there is seemingly free movement of illicit substances within the facility, with people in detention alleging that substance use is commonplace and illicit substances are being traded relatively openly, despite an increase in search and seizure activities by staff.

People in detention expressed concern and fear about the use and trade of illicit substances within the facility and the effect this was having on their sense of safety. They described incidents of aggressive behaviour, intimidation and standover tactics associated with the illicit drug market, which they perceived as contributing to a culture of fear within the centre. Concerningly, it was alleged to Monitors that some people in detention who were currently using illicit substances had not used them prior to being detained, with the implication that they had become users for the first time within detention.

Monitors recognised the challenges faced by staff in controlling the entry, trade and use of illicit substances within VIDC, and acknowledged that it is a complex problem without a simple solution. However, Monitors also observed that the extent of illicit substance use was also significantly influenced by factors that could be more easily addressed. For example, the low staffing presence and limited interaction between staff and people in detention limits the capacity of staff to observe and disrupt the trade in illicit substances, and receive intelligence that could inform targeted search activities. As such, recommendations made elsewhere in this report regarding staffing and dynamic security practices would likely also assist with combatting illicit drug use.

Monitors also noted that the strategies used to facilitate the trade in illicit substances at VIDC, as described by both staff and people in detention, were indicative of considerable knowledge of the detention environment and significant networks within and outside detention. Noting that lengthier periods in detention would amplify opportunities to develop such knowledge and networks, the prolonged nature of detention for many people detained at VIDC is likely a contributing factor to the complexity of the illicit substances problem. While acknowledging that the length of detention is beyond the control of facility staff, Monitors noted that current efforts of staff to combat the entry of illicit substances into VIDC are unlikely to be fully effective without concurrent efforts to address this broader contributing factor.

Physical and mental health

People with complex needs

At the time of the visit, there were several individuals detained at VIDC who had significant and complex health and behavioural concerns and significant care needs. Both staff and people in detention raised concerns with Monitors about challenges in meeting the needs of these individuals within the detention environment.

People in detention reported incidents of abuse, threats, aggressive behaviour and damage to common property involving people with significant mental health or behavioural concerns. In some compounds, people reported that these incidents occurred on an almost daily basis, leading to significant tension and conflict. Monitors directly witnessed several examples of these kinds of incidents during the visit.

At the time of the visit, there were also a number of people detained at VIDC who had very significant care needs, necessitating the employment of dedicated full-time carers. Some people in detention raised concerns about the adequacy of these arrangements, alleging that they had themselves been providing significant assistance with personal care and support to a person with high care needs.

In one of the high-security compounds at VIDC, which was typically used for people with complex needs, Monitors observed that people with significant vulnerabilities resulting from physical health and/or mobility issues were being accommodated alongside people displaying abusive and aggressive behaviour. While staff had made efforts to manage this situation – such as through placing people with behavioural concerns in separate, self-contained accommodation within the compound – it

exemplified the limited capacity within VIDC to appropriately manage a diverse range of complex needs.

In cases where a person has needs that cannot be met or managed appropriately within a closed immigration detention facility, a referral may be made by staff for a Tier 4 placement. This is a form of specialised detention for people who pose a significant risk to themselves or others, but who require specialised services or management that other entities would be better equipped to provide. A Tier 4 placement is distinct from community detention in that it is intended for people who are considered to pose a high risk and will remain in a secure environment while receiving additional support. Examples of facilities that may be used for Tier 4 placements include correctional facilities, specialised medical facilities and aged care facilities.

Staff advised Monitors that Tier 4 placements had been considered for a number of individuals at VIDC, but referrals could not progress until staff had demonstrated that all placement options within the facility had been exhausted. In practice, this had resulted in some placement options being attempted even when it was clear from the outset that they were inappropriate or would negatively impact other people in detention. Staff also advised that, even in cases where internal options had been exhausted and a Tier 4 placement had been approved, there may be lengthy delays in progressing a placement due to challenges in identifying an appropriate facility.

The inability to secure timely alternative placements for individuals with complex needs raises a significant risk of ill-treatment, both for the individuals themselves and others in detention who may be impacted by challenging behaviour. Monitors observed that staff at VIDC were aware of this risk and had made significant efforts to support individuals with complex needs, but there was a limit to what they could reasonably achieve at a facility level. In the view of Monitors, there is a need for further consideration at a systemic level of processes for managing people with complex needs in immigration detention, to ensure that these individuals are appropriately supported while also ensuring a safe environment for other people in detention.

Recommendation 14

The Department should revise its policies and procedures for Tier 4 placements to ensure that facility staff are not required to exhaust all internal placement options before making a Tier 4 referral, in cases where internal placement options are clearly inappropriate.

Recommendation 15

Noting barriers to progressing external Tier 4 placements in a timely manner, within three months the Department should undertake a review to determine:

- whether any existing facilities within the immigration detention network could be utilised or modified to provide appropriate accommodation for people requiring Tier 4 placements
- in conjunction with the above, whether additional contracting arrangements with external care providers may be required to ensure appropriate support for people requiring Tier 4 placements.

Progress against previous recommendations

The Commonwealth NPM conducted a visit to VIDC in November 2024. We made 9 recommendations and one suggestion to improve the operations and conditions of the VIDC and Miowera Village. The Department accepted 6 recommendations and 1 suggestion, partially agreed with 1 recommendation, noted 1 recommendation and did not agree to 1 recommendation.

The Commonwealth NPM also visited VIDC as part of its OPCAT in Action investigation into risks arising from the detention service provider transition. The report of that investigation made 4 recommendations, some of which were related to issues highlighted in this report.

Recommendation	Progress
1. The Department implement across the network a process for the routine, formalised review of all unplanned use of force incidents independent of the Facilities and Detainee Services Provider by 30 June 2025, as agreed to in the Melbourne IDC Post Visit Summary.	The Department accepted this recommendation and has indicated that it intends to complete implementation by the end of 2026. 
2. The Department work with the service provider(s) to identify and, if necessary, construct appropriate infrastructure to support the respite program /" low stimulus" placements, removing the reliance on HCA units for this purpose.	The Department accepted this recommendation and has indicated that it intends to complete implementation by the end of 2026. 

3. As a priority, and reiterating our previous recommendation, individuals in immigration detention who are suspected of having complex psychiatric, neurological, or developmental disorders, organic brain damage, and/or behaviours of concern, are comprehensively assessed at the earliest opportunity to ensure that they can receive the most appropriate placement and care.	The Department accepted this recommendation and has indicated that implementation is complete. We will follow this recommendation up at the next visit. 
4. The Department should allow the Health Services Provider to maintain a small stockpile of regularly used medical aids and equipment in each centre, for immediate use, or while waiting for procurement of specialist equipment.	The Department partially agreed with this recommendation and has indicated that it intends to complete implementation by the end of 2026. 
5. The new Detention Health Service Provider should provide medical services to the Miowera Village.	The Department accepted this recommendation and has indicated that it intends to complete implementation by the end of 2026. 

6. The Department and service provider(s) cease routine pat searches for residents of the Miowera village.	The Department did not agree with this recommendation. 
7. When undertaken, pat searches must be performed by a staff member of the same gender as the detained person identifies, unless otherwise consented to by the detainee.	The Department noted this recommendation. 
8. The Department and service provider(s) should deliver training to staff on the management of, and interactions with, a range of uniquely vulnerable cohorts including but not limited to cultural, religious, transgender persons, and those with complex mental health needs.	The Department accepted this recommendation and has indicated that it intends to complete implementation by the end of 2026. 
9. The Department should develop a nationally consistent and clear policy on the management and placement of transgender and gender non-conforming persons in the Immigration Detention Network.	The Department accepted this recommendation and has indicated that it intends to complete implementation by the end of 2026. 

The Commonwealth National Preventive Mechanism Mandate

The *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT) is an international human rights treaty designed to strengthen the protections for people deprived of their liberty and potentially vulnerable to mistreatment and abuse.

OPCAT does not create new rights for people who are detained, rather it seeks to reduce the likelihood of mistreatment. OPCAT combines monitoring at an international level (by the Subcommittee for the Prevention of Torture) and by National Preventive Mechanisms (NPMs) at a domestic level.

NPMs are independent visiting bodies, established in accordance with OPCAT, to examine the treatment of persons deprived of their liberty, with a view to strengthening their protection against torture and other cruel, inhuman, or degrading treatment or punishment.

An NPM is not an investigative body. The mandate of an NPM differs from other bodies in its preventive approach: it seeks to identify patterns and detect systemic risks of torture and ill-treatment, rather than investigating or adjudicating complaints.

In July 2018, the Australian Government announced the Commonwealth Ombudsman as the visiting body for Commonwealth places of detention (the Commonwealth NPM). At present, the Commonwealth NPM visits places of detention operated by:

- the Department of Home Affairs
- the Australian Federal Police
- the Australian Defence Force.

Australian Government
Department of Home Affairs

SECRETARY

Our ref: EC26-004082
Your ref: A2600489

Mr Iain Anderson
Commonwealth Ombudsman
GPO Box 442
Canberra ACT 2601

Dear Mr Anderson,

Thank you for your letter of 16 July 2026 enclosing the draft Post Visit Summary Report on the Commonwealth National Preventive Mechanism's visit to Villawood Immigration Detention Centre and Miowera Village Alternative Place of Detention in March 2026.

The Department of Home Affairs values its ongoing engagement with the Commonwealth NPM and appreciates the observations and recommendations contained in the report. The report provides a useful opportunity to reflect on our practices and identify areas for continued improvement across immigration detention operations.

The Department has carefully considered the findings and recommendations and welcomes the constructive approach taken by the NPM team. We recognise the importance of ensuring people in immigration detention are treated with dignity and respect, and of maintaining immigration detention arrangements that are safe, appropriate and consistent with Australia's obligations.

The Department's detailed response to the recommendations is at **Attachment A.** The Department agrees with eight recommendations and partially agrees with seven recommendations. The Department acknowledges that in a number of instances, matters raised have already been addressed or are currently in progress.

Should your office have further questions in relation to this matter, [redacted], is best placed to assist. Alternatively, you are welcome to contact me directly if that is helpful.

Yours sincerely,

[redacted]

Hamish Hansford
A/g Secretary

7 August 2026

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Attachment A

Department of Home Affairs response to Commonwealth National Preventive Mechanism's Post Visit Summary – Villawood Immigration Detention Centre (VIDC) and Miowera Village (APOD) in March

Recommendation 1: As a matter of urgency, the Department should ensure that all children of compulsory school age detained at Miowera Village have access to education commensurate with their age and ability level.

The Department **agrees** with this recommendation and has already implemented it. As of 1 May 2026, all children of compulsory school age detained at Miowera Village are enrolled in NSW Distance Education.

The education program is tailored to each child's age, educational attainment and learning needs, and is adjusted as required to support ongoing educational development. The Department considers that the arrangements in place provide children of compulsory school age detained at Miowera Village with access to education commensurate with their age and ability level.

The Department acknowledges the benefits of mainstream schooling, including access to structured learning, social interaction and developmental opportunities, and will continue to explore options to support these outcomes for the children.

Recommendation 2: The Department should consider engaging an early childhood educator to provide educational support to children below school age detained at Miowera Village.

The Department **partially agrees** with this recommendation. The Department agrees with the intent of ensuring children below compulsory school age at Miowera Village have access to age-appropriate educational and developmental support. However, the Department does not agree that engaging an early childhood educator is the only way to meet this objective in the current circumstances.

To meet the objective of this recommendation the Facilities Detainee Service Provider (FDSP), at the request of the Department, has engaged a Teacher's Aide to provide educational support for children detained at Miowera Village, including those below compulsory school age. The Teacher's Aide attends Villawood Immigration Detention Centre (VIDC) three days per week and delivers age-appropriate educational and developmental activities to support early learning, social development and school readiness.

On that basis, the Department considers the current arrangements provide an appropriate level of support for children below compulsory school age, while remaining proportionate to the needs of the current cohort.

Recommendation 3: Noting the risks to the wellbeing and development of children posed by prolonged detention, the Department should engage a qualified external child psychologist and a child learning and development expert to assess the children detained at Miowera Village and provide recommendations on measures to safeguard their wellbeing and development.

The Department **partially agrees** with this recommendation.

The Department supports access to external specialist assessment where clinically appropriate, including referral to an external child psychologist. However, rather than committing to the engagement of specific experts for all children detained at Miowera Village, the Department considers that referrals and assessments should be guided by clinical need and undertaken through appropriate specialist services.

The Detention Health Service Provider (DHSP) has confirmed that it supports referrals to an external child psychologist and is currently exploring referral pathways through the NSW Child and Adolescent Mental Health Service (CAMHS) via the Westmead Hospital Refugee Health Service.

On 24 July 2026, the DHSP contacted the service to discuss referral options and to seek advice regarding access to specialist assessment services, including psychosocial, educational and developmental assessments, where clinically appropriate.

The Department will continue to work with the DHSP to facilitate appropriate external assessment and specialist referral pathways. Any recommendations arising from those assessments will be considered in consultation with relevant clinical providers, with the wellbeing and developmental needs of the children remaining a primary consideration.

Recommendation 4: As a matter of urgency, the Department should work with the detention service provider at Villawood IDC to:

- **Increase staffing levels to enable more effective management of the current security situation**
- **Introduce measures to support effective dynamic security practices, including but not limited to reviewing rostering arrangements, increasing oversight and performance monitoring of staff, and providing additional training to staff as needed.**

The Department **partially agrees** with this recommendation. The Department agrees with the need to ensure workforce arrangements, supervision, staff capability and dynamic security practices at VIDC are effective and responsive to the current operational environment. However, the Department does not agree that the recommendation should be implemented through a prescribed increase in staffing levels.

The Facilities and Detainee Services Contract is outcomes-based and does not prescribe minimum staffing levels. Under the contract, the FDSP is responsible for maintaining workforce arrangements that are appropriate to support safe, secure and effective service delivery, and for ensuring workforce resources remain responsive to operational requirements.

The Department has discussed the staffing component of the recommendation with the FDSP. The FDSP has advised that current workforce arrangements at VIDC are appropriate to support the management of safety, security and operational requirements at the facility. The Department will continue to test and monitor that advice through established contract management, assurance and performance monitoring mechanisms.

The Department agrees with the second aspect of the recommendation: introducing measures to support effective dynamic security practices. This includes reviewing rostering arrangements, strengthening oversight and performance monitoring where required, and ensuring staff have appropriate training and support to perform their roles effectively.

The FDSP has advised that workforce arrangements are currently the subject of Enterprise Agreement negotiations and that proposed roster reforms are intended to strengthen dynamic security practices across the Immigration Detention Network, including by supporting workforce sustainability, continuity of engagement with detainees and the reduction of staff fatigue. The FDSP also maintains mandatory and role-specific training programs for operational staff, which are reviewed and updated as required to support workforce capability, effective dynamic security practices, and the safe and secure management of people in detention.

In addition, the FDSP has recently introduced a Senior Operations Manager role at VIDC to strengthen operational leadership, workforce supervision, performance oversight and assurance activities at the facility.

The Department will continue to assess workforce arrangements through routine contract management activities, operational assurance processes and performance monitoring to ensure staffing resources remain aligned to operational risks and service delivery requirements.

Recommendation 5: As a matter of urgency, the Department should work with facility staff to undertake a comprehensive review of safety hazards at Villawood IDC and implement strategies to mitigate or eliminate any identified risks.

The Department **agrees** with this recommendation and recognises the importance of proactively identifying, assessing and managing safety hazards within the detention environment.

The Department works closely with service providers through monthly Work Health and Safety (WHS) Committee meetings to review emerging risks, discuss safety concerns and coordinate actions to address identified hazards and improve safety outcomes across the facility.

Additionally, The Australian Border Force (ABF) VIDC Health and Safety Representative (HSR) has commenced engagement with the FDSP HSR, with an initial meeting held on 30 July 2026 to discuss a coordinated approach to reviewing workplace health and safety hazards across the facility and identifying opportunities for further risk mitigation.

Furthermore, the FDSP has advised that it is undertaking a comprehensive uplift of its WHS framework, including the introduction of a Systemic Hazards Register, updated WHS plans and procedures, and enhanced processes for the identification, assessment and management of workplace hazards and risks.

The Department will continue to work closely with the FDSP and relevant facility stakeholders to ensure safety hazards are systematically identified, assessed and appropriately managed. This will include ongoing oversight through established contract management, assurance and WHS governance arrangements to ensure identified risks are mitigated, controlled or eliminated, where reasonably practicable.

Through these measures, the Department considers that appropriate mechanisms are in place to support the ongoing identification, assessment and management of safety hazards at VIDC and to promote a safe environment for staff, detainees and visitors.

Recommendation 6: As soon as possible and within three months at the latest, the Department should develop and introduce a structured maintenance regime to address outstanding maintenance items at Villawood IDC.

This regime should include measures to prevent deterioration of material conditions in the future, such as a regular infrastructure audit with mandatory remediation timeframes and escalation pathways.

The Department **agrees** with this recommendation and recognises the importance of maintaining infrastructure at VIDC to support a safe, secure and appropriate environment for detainees, staff and visitors.

The FDSP maintains planned preventative and reactive maintenance programs for facility assets, supported by facility asset management and maintenance plans. Maintenance activities and asset condition are routinely monitored through established contract management and governance arrangements between the Department and the FDSP.

The Department acknowledges that a number of outstanding maintenance issues have been identified at VIDC. These matters have been raised directly with the FDSP and continue to be actively monitored through established contract management, assurance and governance mechanisms.

The Department has sought assurance from the FDSP that maintenance planning, asset condition monitoring and remediation activities remain appropriate to address both existing and emerging infrastructure issues. Preventive maintenance, asset condition, remediation priorities and escalation pathways continue to be standing agenda items within governance forums to ensure maintenance risks are identified, prioritised and addressed in a timely manner.

In addition, the FDSP has advised that it is reviewing maintenance planning and asset management arrangements to ensure maintenance activities remain responsive to operational requirements and facility conditions, including through the ongoing monitoring of asset condition and the prioritisation of remediation works where required.

The Department has requested targeted assurance from the FDSP regarding progress in addressing identified maintenance backlogs at VIDC. The Department will continue to work closely with the FDSP to monitor infrastructure condition, oversee remediation activities and identify opportunities to strengthen maintenance planning and oversight. Through these arrangements, the Department considers that appropriate mechanisms are in place to support the ongoing identification, prioritisation and remediation of maintenance issues at VIDC and to reduce the risk of future deterioration in facility conditions.

Recommendation 7: The Department should review internal procurement process to determine whether current approval thresholds provide sufficient flexibility to address routine maintenance in immigration detention facilities without undue delay.

The Department **agrees** with this recommendation.

The Department considers that existing contractual and governance arrangements provide sufficient flexibility to address urgent maintenance issues without undue delay while maintaining appropriate financial oversight and assurance. However, in response to the Ombudsman's observation the Department will undertake review these arrangements to make sure that they remain fit for purpose.

The Department notes routine preventive maintenance is not subject to additional Departmental approval processes and forms part of the Facilities and Detainee Services Contract (the Contract) service requirements.

Under the Contract, labour and non-labour costs associated with reactive maintenance are managed through established Pass-Through Cost arrangements, which require appropriate approval and assurance processes to ensure compliance with the Commonwealth Procurement Rules and the *Public Governance, Performance and Accountability Act 2013*.

The Department recognises that urgent maintenance issues may arise where delays could present work health and safety, security or operational risks. To address these circumstances, the Department has implemented a Notification of Urgent Works (NUW) process under the current contractual arrangements.

Under the NUW process, urgent make-safe works can proceed immediately without waiting for standard financial approval processes. The initial response is required to focus on addressing any immediate risk to the facility, assets, detainees, staff or visitors. Once immediate risks have been addressed, the Service Provider is required to submit supporting documentation and known costs for assessment through established contractual arrangements.

Recommendation 8 – Within three months, the Department should require that all vehicles used in transport and escort activities for people in immigration detention comply with contractual requirements for safety and security features, including adequate monitoring and communication capabilities.

The Department **agrees** with this recommendation and has already implemented it.

Audits have been conducted on all vehicles used for detainee transport and escort activities following the transition to the current Facilities and Detainee Services Contract.

These audits assessed compliance with contractual requirements relating to safety and security features, including monitoring and communication capabilities, and confirmed that the vehicles meet the required contractual standards.

Based on the outcomes of these assurance activities, the Department is satisfied that vehicles currently used for detainee transport and escort activities comply with contractual requirements. The Department will continue to monitor compliance through routine assurance activities, contract management processes and established governance arrangements to ensure these standards are maintained.

Recommendation 9: Within three months, the Department should work with facility staff to ensure that:

- **Hard copies of the induction booklet are readily available in the initial processing area**
- **The induction booklet is translated into the most commonly-spoken languages among people in immigration detention.**

The Department **partially agrees** with this recommendation. The Department agrees with the intent of ensuring people in immigration detention have timely access to clear and accessible induction information about their rights, responsibilities, obligations and available services. The Department also agrees that hard-copy versions of the induction booklet should be readily available in initial processing areas once the revised booklet has been approved.

The Department does not agree that the full recommendation can be implemented within three months. This is because the induction booklet is currently being updated by the FDSP following Departmental feedback to ensure the information is accurate, comprehensive and fit for purpose, and translated into the most commonly spoken languages will require additional time to complete once the revised booklet is approved.

In practical terms, the Department agrees to the first component of the recommendation: ensuring hard-copy versions of the approved induction booklet are readily available within initial processing areas and across relevant detention facilities to support access for newly arrived detainees.

The Department also agrees to progress the second component of the recommendation by requiring the FDSP to arrange translation of the induction booklet into the most commonly spoken languages across the Immigration Detention Network. However, the Department does not agree that this translation work can be completed within the recommended three-month timeframe, given the need to finalise the booklet content before translation and allow sufficient time for translation and quality assurance.

The Department expects to complete implementation within six months, subject to translation timeframes, and will monitor progress through established contract management and assurance mechanisms.

Recommendation 10: Within six months, the Department should work with facility staff to strengthen policies and procedures for handling complaints and requests, to ensure consistency in handling and outcomes. These policies and procedures should include:

- **Clear guidance for staff on handling complaints that have already been resolved by the time the complaint is processed, with recommended practice being that such complaints are recorded as being resolved rather than withdrawn**
- **Processes to ensure that all requests are acknowledged and progress updates are provided to the person making the request, similar to the process currently used for complaints**
- **Regular audits of the availability of complaint and request forms and the condition of locked letterboxes in compounds, to ensure that people in detention can obtain and submit forms confidentially or anonymously.**

The Department **agrees** with this recommendation. The Department has commenced working with the FDSP to review complaints and requests management policies, procedures and supporting guidance to ensure consistency in handling and outcomes across the Immigration Detention Network.

As part of this review, the Department will ensure specific consideration is given to:

- the appropriate recording and management of complaints that have been resolved before processing, including ensuring such complaints are not recorded as withdrawn unless requested by the complainant;
- processes for acknowledging requests and providing progress updates to detainees; and
- the ongoing availability, accessibility and integrity of complaints and requests mechanisms, including complaint forms and locked letterboxes.

The Department notes that contractual requirements are already in place to support accessible and timely complaints management, including requirements for complaints to be acknowledged, recorded, tracked and reported. The FDSP has also been reminded that complaints resolved prior to processing are not to be recorded as withdrawn unless withdrawal has been requested by the complainant.

In addition, NSW Detention Operations undertakes regular oversight of detainee complaints and requests and conducts routine compliance and assurance activities to verify that detainees have access to complaints and requests mechanisms, information and support services, including the ability to raise matters confidentially and receive appropriate responses. This includes inspections of complaint and request forms and locked letterboxes within detention facilities.

The Department will continue to work with the FDSP to strengthen complaints and requests management processes where appropriate and will finalise its review within the timeframe recommended by the Ombudsman.

Recommendation 11: Within three months, the Department should work with facility staff to introduce rostered access to the "community" area to all people detained at Villawood IDC, to improve access to facilities for purposeful activity.

The Department **partially agrees** with this recommendation. The Department agrees with the intent of improving access to facilities that support purposeful activity, social engagement and wellbeing for people detained at VIDC. The Department also agrees to work with the FDSP and facility staff to review current access arrangements for the community area and identify opportunities to increase access where it is safe and operationally appropriate to do so.

The Department does not agree that rostered access to the community area can be introduced for **all** detainees as an automatic or universal arrangement. Access to the community area must remain subject to individual risk assessments, cohort management requirements, operational considerations, and safety and security risks.

In practical terms, the Department agrees to review existing access arrangements over the next three months, with a view to increasing opportunities for detainees to access community facilities and participate in purposeful activities. This review will consider whether rostered access arrangements can be introduced or expanded for additional detainee cohorts where this is consistent with operational requirements and does not compromise safety or security.

Any changes will be implemented in a way that appropriately balances detainee wellbeing and access to purposeful activity with the need to maintain the safety and security of detainees, staff, visitors and the broader facility environment.

The Department will continue to monitor access arrangements through established operational, contract management and assurance mechanisms to ensure they remain appropriate, equitable and responsive to the needs of the detainee population.

Recommendation 12: Within three months, the Department should review the programs, activities and recreational facilities and equipment currently provided at Villawood IDC to ensure that adequate purposeful activity is being provided to people in detention, including those detained for prolonged periods.

The Department **agrees** with this recommendation and recognises the importance of ensuring detainees have access to meaningful and purposeful activities, particularly those detained for extended periods.

In May 2026, NSW Detention Operations and the FDSP Welfare team reviewed the Winter Programs and Activities Schedule for VIDC. As part of this review, the Department recommended a number of enhancements, including the introduction of additional educational programs and activities to better support the needs of the detainee cohort.

The Department and FDSP will continue to review programs, activities, recreational facilities and equipment at VIDC to ensure detainees have access to purposeful activities that are appropriate to their circumstances and responsive to the needs of the population, including those detained for prolonged periods.

Detainee feedback will continue to inform the development and refinement of programs and activities, alongside operational and welfare considerations, to support ongoing participation and engagement.

While access to some activities may be subject to individual safety, security and cohort management considerations, the Department will continue to work with the FDSP to identify opportunities to enhance access to meaningful activities and recreational facilities across the centre.

Recommendation 13: Within six months, the Department work with facility staff to:

- **Undertake an accessibility audit of exercise and outdoor recreation facilities at Villawood IDC**
- **Based on the outcomes of this audit, develop a refurbishment plan to remedy any identified deficiencies.**

The Department **agrees** with this recommendation and recognises the importance of ensuring that exercise and outdoor recreation facilities are accessible to all people detained at VIDC.

The Department has commenced engagement with the FDSP to undertake an accessibility audit of exercise and outdoor recreation facilities across the centre. Existing inspection, maintenance and asset management processes will inform this review and assist in identifying any barriers to accessibility or areas requiring improvement.

Following completion of the audit, the Department will work with the FDSP over the subsequent 6 months to develop a refurbishment plan to address any identified deficiencies. Any required remediation works will be prioritised based on risk, operational requirements, accessibility outcomes and available funding.

The Department will continue to monitor progress through established contract management, assurance and governance arrangements to ensure identified issues are appropriately addressed and to support ongoing accessibility improvements across the facility.

Recommendation 14 – The Department should revise its policies and procedures for Tier 4 placements to ensure that facility staff are not required to exhaust all internal placement options before making a Tier 4 referral, in cases where internal placement options are clearly inappropriate.

The Department **partially agrees** with this recommendation. The Department agrees with the intent of ensuring Tier 4 referrals can be progressed promptly where internal placement options are clearly inappropriate. The Department also agrees that facility staff should have a clear understanding of the circumstances in which a Tier 4 referral can be made.

The Department does not agree that the policy requires revision to remove a requirement to exhaust all internal placement options before making a Tier 4 referral, because the current policy does not impose such a requirement. The current policy, *DSM – Detainee Placement – Specialised Detention – Tier 4 – Procedural Instruction* (DM-7176), allows a referral for specialised detention be considered where a detainee's health, welfare, safety or security needs cannot be appropriately managed within the Immigration Detention Network (IDN).

In practical terms, the Department agrees to ensure the policy is clearly understood and consistently applied by operational staff. This includes reinforcing that, while alternative placement and management options within the IDN should be considered as part of the decision-making process, every available option does not need to be trialled or exhausted before a Tier 4 referral can proceed. Where an internal placement option is assessed as clearly unsuitable or incapable of safely managing a detainee's identified needs, risks or behaviours, decision-makers are not required to pursue that option solely to satisfy referral requirements.

The Department will ensure facility staff are aware of the existing policy requirements so Tier 4 referrals can be progressed appropriately and in a timely way where internal placement options are clearly inappropriate.

Recommendation 15 – Noting barriers to progressing external Tier 4 placements in a timely manner, within three months the Department should undertake a review to determine:

- **Whether any existing facilities within the immigration detention network could be utilised or modified to provide appropriate accommodation for people requiring Tier 4 placements**
- **In conjunction with the above, whether additional contracting arrangements with external care providers may be required to ensure appropriate support for people requiring Tier 4 placements.**

The Department **partially agrees** with this recommendation. The Department agrees with the intent of ensuring appropriate accommodation and support arrangements are available for people who require Specialised Detention Placements, previously referred to as Tier 4 placements. The Department also agrees to continue considering whether existing facilities within the Immigration Detention Network (IDN) can safely and appropriately support people with higher health, welfare, safety or security needs.

The Department does not agree that it is currently feasible to establish a fit-for-purpose Specialised Detention Placement capability within the IDN through the use or modification of existing facilities. The Department has previously examined options to utilise or adapt existing immigration detention infrastructure for this purpose. Based on current funding allocations, infrastructure limitations and operational requirements, those options are not presently viable.

In practical terms, the Department agrees to continue assessing available placement and support options on a case-by-case basis where a Specialised Detention Placement is required. This includes considering whether a person's needs can be safely and appropriately managed within the IDN with additional supports, or whether an external placement is required to manage health, welfare, safety or security risks.

The Department agrees with the second aspect of the recommendation: considering whether additional or alternative external care arrangements may be required for people who cannot be appropriately supported within an immigration detention facility. For health-related placements, referrals are generally considered where clinical advice indicates that a detainee's health or support needs cannot be appropriately managed within an immigration detention facility. In these circumstances, the Department works with the Detention Health Service Provider (DHSP) and external providers to identify appropriate care pathways, which may include hospitals, rehabilitation facilities, aged care providers or other specialised healthcare services.

The Department also agrees to continue using existing FDSP arrangements with external providers where these can deliver additional support services and allow a detainee to be safely accommodated within the detention environment with enhanced care arrangements. Where those arrangements are not sufficient, the Department will consider external placement options consistent with clinical advice, operational requirements and available provider capability.

For corrective services placements, decisions will continue to be informed by a detainee's behavioural, safety and security risks and whether those risks can be safely managed within the IDN. In some circumstances, external facilities are better equipped to provide the level of security, supervision and specialised support required.

The Department will continue to work with the DHSP, FDSP and relevant service providers to ensure appropriate care pathways, accommodation options and support arrangements remain available for detainees requiring specialised detention placements and higher levels of care.

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