ACT Official Visitors

Annual Report 2025/26

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Message from the Chair, Official Visitors Board

> I am pleased to present this report from the Official Visitors Board (the Board) for ACT Official Visitors for the 2025-26 financial year.

As required by section 23DA of the *Official Visitor Act 2012* (the Act), the report covers –

(a) the number of—
  (i) visits by Official Visitors to visitable places
  (ii) complaints received by Official Visitors in relation to visitable places
  (iii) referrals of complaints to investigative entities
(b) the action taken on the complaints received
(c) systemic issues in relation to the operation of the Act identified by the Board
(d) the number and kinds of matters referred by an Official Visitor to an investigative entity
(e) the number of times an Official Visitor inspected records in accordance with section 15(2)(b) of the Act.

This annual report marks my final report as Chair. Reflecting on my tenure as Chair, I am proud of the progress made by the scheme and the Board's ongoing commitment to strengthening oversight, governance and accountability.

During 2025-26, the Board continued to enhance its governance and compliance functions through the development and endorsement of new policies, procedures and governance documentation. We also achieved an important legislative amendment, broadening the range of suitably qualified individuals to be appointed as Official Visitors. This reform, together with improvements to our recruitment, selection and training processes, will help ensure the scheme remains well equipped to meet its important oversight functions into the future.

Despite this progress, there remains further work to be done. The Board continues to advocate for a comprehensive review of the *Official Visitor Act 2012* and associated legislation as well as the implementation of effective feedback mechanisms for matters raised by Official Visitors. We also continue to advocate for greater First Nations representation on the Board. I have raised this issue with the last two Ministers and whilst there has been agreement in principle, the matter is yet to be resolved.



One of the most significant challenges facing the scheme at the moment is funding. There has been a substantial growth in visitable places and the number of people we engage with, and the current level of funding significantly constrains the ability of Official Visitors to fulfill their statutory functions.

This reporting period also brought several changes to our Official Visitor cohort. I extend my thanks to Mr David Healey and Mr Leslie Purcell for their service to the community as Official Visitors. I also welcome Ms Kim Ward, who commenced in July 2025 and has made valuable contributions across both the children and young people and homelessness jurisdictions.

I would also like to acknowledge and thank Ms Danae Lacey for her contributions in her capacity as Acting Public Trustee and Guardian, a role she undertook across three separate periods during 2025-26. Her support for the scheme has been greatly appreciated.

I would like to thank Minister Suzanne Orr for her support as the scheme's Minister throughout 2025-26.

While I am stepping down from my role, I do so with confidence in the future of ACT Official Visitors. I am pleased with the progress achieved during my time with the scheme and grateful for the dedication of my fellow Board members, Official Visitors and Executive Officer. Together, we have strengthened the scheme's foundations and positioned it to continue delivering independent oversight for some of the ACT's most vulnerable people. I look forward to watching the scheme build on these achievements in the years ahead.

Peter Muir

CHAIR, OFFICIAL VISITORS BOARD

Part 1: Board identified systemic issues

> Under section 23DA(1)(c) of the *Official Visitor Act 2012* (the Act), the Annual Report must report on any systemic issues relating to the operation of the Act.

During 2025-26, Official Visitors continued to observe many of the same systemic issues reported in previous years across corrections, disability, mental health, homelessness, and children and young people settings.

While there have been examples of positive reform and local improvement, four persistent challenges continue to shape people's experiences: access to housing, cultural safety, fragmented service systems, and uneven accountability.

These issues do not occur in isolation. Together, they influence whether people can successfully transition from care, recover from crisis, maintain community connections and access the support they need to thrive.

Housing remains a critical barrier to stability

Stable housing is one of the strongest predictors of whether people can successfully transition from crisis, avoid repeated contact with government services, and build independence in the community. Across multiple settings, the Board continues to hear that a lack of suitable housing is preventing people from successfully transitioning into the community, prolonging periods of institutional care, and increasing the likelihood of future crises. When people are unable to transition safely into the community, demand increases across housing, health, justice and community services, placing additional pressure on systems that are already stretched.

Official Visitors observed this challenge consistently across disciplines. People leaving detention can struggle to secure accommodation needed to support release arrangements, while barriers to applying for housing from within custody can further delay transition back into the community. Children and young people leaving Bimberi Youth Justice Centre or Out of Home Care continue to face difficulties accessing suitable accommodation, often with limited transition planning and few age-appropriate housing options.

Housing shortages are also affecting health and disability systems. Mental health patients continue to experience delayed discharge because appropriate accommodation cannot be secured, contributing to pressure on inpatient services and reducing access for others waiting for care. Disability Official Visitors reported ongoing difficulties accessing suitable housing that reflects a person's support needs and long-term circumstances, with lengthy waiting periods when existing arrangements break down.

The challenge is not only housing availability. Official Visitors continue to receive reports of poor housing conditions and lengthy delays in maintenance across several settings. While Housing ACT's maintenance insourcing trial demonstrated encouraging improvements for multi-unit properties in 2024-25, many entitled persons continue to experience long waits for repairs and inconsistent responsiveness.

Taken together, these observations demonstrate that housing is not simply a housing issue. It affects how effectively health, justice, disability and community services operate, and remains one of the most significant barriers to stability, recovery and community participation across the ACT service system.

Trust and cultural safety are essential for effective services

Services work best when people trust the organisations supporting them. When people feel respected, understood and culturally safe, they are more likely to engage with services and achieve positive outcomes. Official Visitors continue to identify opportunities to strengthen cultural capability across Canberra's service delivery settings. The Board is therefore encouraged by reforms arising from the Public Sector (Closing the Gap) *Legislation Amendment Act 2025*, which introduces stronger accountability for ACT Government leaders and provides an opportunity to drive lasting cultural change across services.

In corrections settings, ongoing workforce pressures, including shortages of Indigenous Liaison Officers, continue to limit access to cultural supports. Similar concerns were raised in youth justice settings, where cultural support remains insufficient despite emerging efforts to strengthen programs for Aboriginal and Torres Strait Islander children and young people.

In disability settings, Official Visitors reported concerns about cultural capability among service providers and support coordinators, including perceptions that cultural responsiveness has declined in some areas. These concerns reflect broader challenges in ensuring First Nations people receive support that recognises and responds to their cultural identities, experiences and connections.

There are encouraging signs of progress. Mental Health Official Visitors observed positive steps to strengthen cultural recognition and inclusion in health settings, including actions taken in response to concerns raised by patients and visitors including Acknowledgement of Country signage and some commissioned artwork.

While these developments are welcome, meaningful progress will ultimately be measured by the everyday experiences of Aboriginal and Torres Strait Islander peoples accessing services and we hope that the new legislative framework will translate into concrete changes on the ground level.

Within the scheme, the Board has been advocating for three years with successive Ministers for a First Nations representative on the Board. The Board strongly believes this is necessary to strengthen the cultural capability of the scheme and to better oversight the cultural safety needs of entitled persons. Whilst Ministers have agreed in principle with the Board, proposals to action this agreement have not been actioned.

People continue to navigate systems that were designed separately

People should not have to navigate complex government systems on their own. Many of the people Official Visitors speak with rely on support from several government services at the same time. However, those systems do not always work together effectively. The result is often duplication, delays and confusion, both for the people receiving support and for the services trying to assist them.

Across multiple settings, Official Visitors observed that people can become caught between services, experience delays in support, or be left without clear coordination of their care. These challenges are particularly evident during transitions between institutional settings and the community, when people are often most vulnerable and most reliant on coordinated support.

Official Visitors reported concerns about limited information sharing between agencies, differing expectations across service environments, and uncertainty regarding responsibility for coordinating support. In some cases, service providers were not provided with necessary information to safely deliver services and had to withdraw when more complex behaviours were identified. These examples reinforce a broader observation that services continue to operate largely within organisational boundaries, even when people's needs span across multiple systems.

The impacts are visible across several settings. Mental Health Official Visitors reported ongoing pressures associated with referrals from court custody settings into acute mental health services. Disability Official Visitors highlighted challenges at the intersection of justice and disability systems, including difficulties accessing disability supports and specialist equipment in custodial environments. Official Visitors also noted that people moving between detention, residential care, mental health and community settings can encounter vastly different expectations, supports and service models, often making transitions more difficult than they need to be.

While there are examples of agencies working collaboratively to resolve individual issues, these tend to reflect local relationships and individual initiative rather than a consistently integrated approach across government / services.

Improving coordination, continuity, and integration of supports should be a strong priority for key stakeholders and leadership across directorates to achieving better outcomes for individuals across the ACT service system.

Accountability mechanisms must drive improvement

Effective complaints mechanisms, independent oversight and strong safeguards help identify risks, improve service quality and prevent the same issues from occurring repeatedly.

Across several settings, Official Visitors continue to identify gaps in accountability mechanisms that limits each system's ability to learn, improve and build public confidence.

Disability OVs continued to see deaths in disability care during 2025-26, and the most significant concern remains the absence of a dedicated disability death review mechanism in the ACT. Official Visitors and the Board have not observed any meaningful progress by the ACT Government towards implementing a disability death review scheme, nearly three years after the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability recommended that disability death review schemes be established across Australia (which the ACT Government had accepted in principle). While recent national reforms may strengthen regulatory oversight, they do not address the continued absence of an ACT-based disability death review mechanism. Similarly, some Canberra service providers have introduced measures to improve safety practices and reduce the risk of preventable deaths. Although these initiatives are welcome, they are not a substitute for a formal, independent system that can review deaths, identify systemic issues, and drive broader sector-wide improvements.

Official Visitors also continue to hear concerns about complaints processes in corrections settings. While the completion of an internal review of complaints management and the development of recommendations are encouraging, tangible improvements have not yet been observed by detainees seeking to raise concerns within the system.

A related issue is the continued need for stronger rehabilitation and reintegration supports for people leaving custody. Official Visitors observed some positive developments during the year, including literacy initiatives however, these efforts remain at an early stage and are not yet operating at the scale required to deliver sustained systemic change.

There are positive signs that service systems are becoming more willing to examine areas of risk and pursue reform. However, accountability mechanisms are most effective when concerns raised through oversight are translated into tangible improvements in people's experiences.

The Board's view is that stronger safeguards, greater transparency and sustained attention to system learning will be essential if longstanding issues are to be addressed rather than simply reappearing in future reports.

Summary assessment

There are encouraging signs of efforts to address longstanding systemic issues, including the multi-unit properties insourcing maintenance trial, internal review of the corrections complaints management processes, and the introduction of the Closing the Gap legislation. While these initiatives represent positive developments, their potential to deliver meaningful and lasting change will depend on sustained leadership commitment, strategic direction and adequate resourcing.

The Board's assessment is that the ACT continues to face a number of longstanding systemic challenges that affect people across multiple service settings. Many positive outcomes still depend on select agency and individual commitments / efforts rather than consistent system design. As a result, people can have very different experiences depending on where they receive support.

Part 2: Systemic issues identified by Official Visitors

Mental Health

> This annual report highlights three recurring systemic issues affecting mental health consumers: the condition of the Adult Mental Health Unit (AMHU), barriers to forensic rehabilitation, and concerns about National Disability Insurance Scheme (NDIS) Supported Independent Living (SIL) providers. These issues have persisted throughout the reporting period despite being raised with senior decision-makers.

Adult Mental Health Unit environment

Consumers and visitors continue to raise concerns about the physical environment of the AMHU, particularly the lack of comfortable furnishings and contemporary décor. Between four and six complaints were recorded during each of the quarterly reporting periods. Bathroom upgrades have commenced, and a business case for broader refurbishment is being developed. This matter has been highlighted frequently for over five years.

Impact

A consumer spending an extended period in the AMHU may experience a sterile, institutional environment that does not support recovery, comfort, or wellbeing. While bathroom upgrades are positive, concerns remain about the overall therapeutic environment.

Rehabilitation of forensic consumers

Consumers requiring forensic rehabilitation continue to experience long-term detention in highly restrictive settings following the closure of Gawanggal Mental Health Unit (GMHU). This is considered inconsistent with the *Mental Health Act 2015*'s principle of providing care in the *least restrictive* environment.

Examples of reported barriers include:

- limited access to mobile devices
- security screening requirements
- lack of independent cooking opportunities
- restricted access to recreation
- overnight observations every two hours
- limited opportunities to practice independent living skills, and
- poor access to community facilities and public transport.

Impact

A consumer preparing for community reintegration may be unable to practice everyday tasks such as self-catering, managing appointments independently, or navigating public transport, reducing opportunities to build real-world living skills.

NDIS Supported Independent Living (SIL)

There are ongoing concerns that some SIL providers may be prioritising funding retention over consumer choice, particularly when consumers wish to transfer to another provider. These concerns have reportedly been raised by several support coordinators and escalated to the Minister for Mental Health.

Impact

A consumer wishing to move to a different SIL provider may face resistance from their current provider, potentially limiting their ability to exercise choice and control over their living arrangements.

While some progress is occurring, such as AMHU upgrades and ministerial engagement, each issue reflects a broader concern about whether consumers are receiving care and support that promotes dignity, choice, recovery, and least restrictive practice.

Disability

> Official Visitors for Disability Services (OVDS) continue to raise significant concerns about the operation of the NDIS, which falls primarily under Commonwealth responsibility. Matters raised in this report need to be taken up with the Commonwealth by the relevant Minister.

Information gathered during the reporting period indicates that complaints raised by participants, families, providers, support coordinators and other stakeholders are not isolated. Rather, they reflect persistent systemic issues across the disability sector relating to participant rights, provider accountability, workforce capability, housing, guardianship, funding and oversight.

Misuse of guardianship authority

OVDS continues to identify instances where private guardians appear to exceed their legal authority by overriding participant preferences, restricting relationships, controlling daily activities, or discouraging access to advocacy. Some guardians and financial managers also appear to have limited understanding of their legal obligations and supported decision-making principles, leading in some cases to financial mismanagement or exploitation. Providers may compound these issues by implementing decisions that fall outside a guardian's lawful authority, including unauthorised restrictive practices. These concerns highlight the need for stronger education, oversight and safeguards.

Housing maintenance and repairs

Participants continue to experience lengthy delays in addressing issues such as mould, damaged fixtures, accessibility barriers, heating failures and unsafe living conditions. Poor communication about repair progress often exacerbates these problems, leaving individuals exposed to avoidable risks and reduced wellbeing.

Poor communication and record keeping

Providers frequently fail to maintain accurate, up-to-date and accessible records, including care plans, incident reports and behavioural support information. Information gaps contribute to inconsistent support, poor decision-making and increased risks to participant safety.

Quality, training and supervision of the workforce

OVDS have identified workers lacking essential skills or qualifications, poor attendance, inadequate supervision and failure to provide expected levels of support. Workforce shortcomings can affect participant safety, community participation and the quality of supported accommodation. Stronger training, supervision and provider accountability are required.

Provider practices undermining participant rights and wellbeing

Complaints include poor hygiene, inadequate supervision, barriers to advocacy, pressure to sign service agreements and reprisals when participants seek to challenge decisions or change providers. In some cases, participants report essential supports being reduced or withdrawn when seeking alternative providers.

These concerns are closely linked to reports that some providers prioritise financial interests over participant outcomes. Participants, particularly those with substantial NDIS funding, may be treated as financial assets, with resistance to provider transitions and pressure to increase occupancy in Supported Independent Living (SIL) homes. Such practices risk compromising participant choice, control and wellbeing.

SIL compatibility and overcrowding

Participants and guardians are not always adequately consulted before new residents are placed in shared accommodation. Poorly matched living arrangements can lead to distress, conflict, aggression and reduced quality of life, highlighting the need for meaningful consultation and compatibility assessments.

Coercive control and unauthorised restrictive practices

Restrictive measures can become normalised within service settings, particularly where providers adopt decisions made by guardians beyond the scope of their authority. These issues underscore the need for stronger safeguards and accountability mechanisms to protect participant rights.

Transitioning between providers

Transitions between providers are often poorly managed, with inadequate communication disrupting supports and creating uncertainty for participants and service networks. Concerns that providers may discourage or obstruct participant transitions further undermine genuine choice and control.

NDIS funding shortfalls and inflexible reassessment processes

Participants can exhaust funding due to unexpected costs or changing circumstances, while lengthy reassessments delay access to necessary supports. This can reduce social participation, independence and overall wellbeing.

Worker exploitation and under-reporting of issues

The reporting period also highlighted concerns about worker exploitation and under-reporting of issues, particularly among workers with insecure employment arrangements or limited knowledge of workplace rights. Fear of negative consequences may discourage reporting of concerns affecting participant safety and service quality.

Limited regulatory response and oversight

OVDS has continued to refer concerns to the NDIS Quality and Safeguards Commission but has often observed limited evidence of timely investigation or resolution. Similar concerns arise regarding oversight of private guardians and financial managers. The persistence of similar complaints suggests current mechanisms are not consistently achieving effective intervention.

Advocacy organisations remain under significant pressure

Demand for advocacy organisations are often exceeding available resources. Long wait times and limited service capacity can leave participants without timely access to independent advocacy, increasing vulnerability and reducing their ability to address concerns.

Overall systemic picture

A consistent theme across all issues is the difficulty many participants experience in exercising genuine choice, control, dignity of risk and independence. Whether through guardianship decisions, provider practices, funding constraints, housing arrangements or barriers to advocacy, participants' rights and preferences can become secondary to organisational, financial or administrative considerations.

The recurring nature of these concerns suggests that resolving individual complaints alone will not address the underlying causes. Meaningful improvement will require stronger systemic accountability, clearer responsibilities, improved communication and information systems, a more capable workforce, effective regulatory intervention and greater protection of participant rights.

Corrections

> Many of the systemic issues identified this year remain consistent with previous years, however higher detainee numbers over the period have exacerbated these concerns.

Rehabilitation and reintegration

An overarching concern is about rehabilitation and reintegration. While we acknowledge that there are programs and supports in place, these are inadequate in comparison to the need. Case management support for instance is overstretched and therefore unable to provide and facilitate the level of interventions needed. Likewise, education opportunities are limited. The number of detainees in tertiary distance education appears to have dropped, although it is hard to confirm this as we have been told that records are not kept to compare participant numbers over time. Detainees have told OVs that they have postponed their studies because the support provided is inadequate.

Resources that were already stretched have not been able to cope with the high numbers of detainees this year, which at times have been further exacerbated by staff shortages. At one point when an OV asked about support being provided to someone prior to their release, the staff member had advised a case load of 80 detainees. Health services have also been stretched by high detainee numbers.

We have seen improvements in the Transitional Release Program (TRP) in this period with the Transitional Release Centre (TRC) often full (rather than underutilised as in previous years) or close to full and many in external employment. However, we note that women are unable to access many of the benefits of the TRP as they cannot be housed at the TRC. We remain concerned that not enough is being done in relation to this inequity.

Assaults and use of force

The number and severity of assaults during this period have also been a concern, with high detainee numbers contributing to this and constraining options for placement. Of particular concern are cases where a detainee has raised concerns about their safety in a particular yard but has been placed there anyway and has then been assaulted. We have also received disturbing reports of sexual assaults.

Use of force during some incidents has also been of concern. We note efforts to strengthen the committee

that reviews these incidents but continue to identify that this process would be strengthened by providing a mechanism for the detainee's perspective on an incident to be recorded and considered. We acknowledge the fast-moving nature of many incidents and their complexity and note that in many cases staff have done an exemplary job in dealing with difficult circumstances. However, in other cases we have raised concerns about the communication and de-escalation in advance of the actual use of force, and whether a more trauma-informed approach may have reduced the chance of force being used.

Racism

We are aware of racist incidents at Alexander Maconochie Centre (AMC), with at least some of these having been dealt with through internal disciplines. However, we understand that behaviours that could lead to a criminal charge in the community are not dealt with in the same way in AMC as it is not considered a public place. We are concerned about the impact on the targets of this abuse and that action taken is not equivalent to what could occur in the community, reducing prevention and accountability.

Inconsistent application of policies and procedures

Inconsistent application of policies and procedures or the communication of these has also been an issue. One example is uncertainty about items allowed at the Transitional Release Centre (TRC). A number of items that are banned in the main centre, such as non-transparent bags and scissors, are informally allowed at TRC, reflecting the lower security environment and objective to assist detainees in their transition back to the community. These are still included on the contraband list, however, so what is and is not allowed at the TRC is not universally understood by detainees and staff, putting detainees in an uncertain position.

Supporting complex mental health needs

Lastly, an issue of particular concern that we wish to highlight is the support and management of a small group of detainees with very complex mental health needs. We observe deterioration in some detainees, with increasingly aggressive engagement towards staff perhaps indicating that their complex clinical care needs are unmet. We are deeply concerned about their welfare with members of this cohort experiencing segregation for months and even years. We are also concerned for the safety of staff. While we are not clinicians, our observation is that AMC does not appear to be the appropriate location for this small group of detainees. AMC is not a therapeutic environment, severely limiting the care that they receive and any chances of improved health and rehabilitation. The stresses on AMC are also immense, with considerable resources spent trying to keep detainees and staff safe.

Overall

While noting all these areas of concern, these experiences are not universal and we also note the many staff who continue to operate with respect and empathy, trying to support detainees in often very trying circumstances. During this period detainees have noted the caring attitude of staff in many areas, including at the Crisis Support Unit and particular doctors.

We also note improvements that have occurred in the last year, including:

- computers are now located in common cell block areas, increasing accessibility during the long wait for tablets to be introduced
- increased resources for administrative support leading to reduced waiting times for most simple requests such as phone numbers and emails being added to contact lists
- a mural, now displayed in the visitors' area, painted as a collaboration between detainees and a staff member – a positive example of creative activities that can be undertaken with relatively little resources
- a peer review commissioned by Justice Health, showing a desire to learn and improve. We also note that more detainees appear able to continue their ADHD medication in custody which is positive
- a pilot literacy project with Canberra Institute of Technology (CIT).

Children and Young People

Transition from care

Transition from care planning and after care support is an ongoing concern, particularly when there is a lack of suitable accommodation options and support for young people exiting statutory care.

Much needed after care assistance programs are still not operational and therefore, vulnerable young adults 18 years and over continue to slip through the cracks of the system and face being at significant risk of homelessness.

After-care living arrangements for young people with significant disabilities is also a concern that is emerging. This is further complicated by cuts to NDIS packages.

There are emerging concerns regarding after-care arrangements for young people with significant disabilities which require targeted action. Advocacy for review of NDIS package reductions is essential to ensure adequate support.

Young people leaving care face disproportionate risks of homelessness, unemployment, poor mental health, and social isolation. Early planning, youth-led decision making, and sustained support are critical to improving life outcomes. The ACT Government's Next Steps for Our Kids Strategy 2022–2030 provides a foundation, but implementation gaps still exist.

There are various options available to significantly improving the life outcomes and opportunities for Canberra's most vulnerable young people including earlier transition planning at age 15, co-design and annual review of plans, funding of young person-led services, mandatory after-care assistance up to 21 or 24 years of age depending on case history and ongoing support needs, mandatory practice of providing housing and financial support up to 21 or 24 years of age, Housing ACT policies to better support young people exiting care, expanded housing options by investing in culturally responsive and trauma informed supported accommodation and transitional housing, supporting young people's choice in who they live with, programs / mentors to strengthen life skills and employment pathways, after-care assistance to support navigating adult life, and improved accountability by publishing annual outcomes.

Official Visitor access to Bimberi Youth Justice Centre

Current oversight arrangements at Bimberi Youth Justice Centre do not fully align with the intent of the Official Visitors legislative framework. OVs are still required to be escorted throughout the Centre, which may affect the extent to which young people feel comfortable sharing their experiences.

This coupled with restricted booking times for OVs visiting Bimberi reduces the oversight functions of the OVs who are not always available at the preferred times of Bimberi staff.

The number of times Official Visitors visit Bimberi has also been impacted by budget restraints and the increasing number of Out of Home Care (OOHC) residential houses, requiring increased visits and meetings for children and young people in the community. Bimberi currently has good oversight from other government agencies allowing Official Visitors to liaise with these agencies as needed. However, there still needs to be ongoing collaboration and further legal review of the obligations and responsibilities of Bimberi Youth Justice Centre staff to enable a shared agreement and formalised approach to support OV oversight at the Centre.

Oversight in Community Adolescence Programs

Oversight of young people residing in CAP (Community Adolescence Programs) housing remains significantly constrained, with OVs having no direct or routine visibility of their living conditions or the adequacy of support being provided. This absence of access represents a significant gap of independent oversight limiting the system's ability to assure safety and wellbeing for this cohort.

CAP housing is listed on the visitable places register for children and young people as well as the visitable places register for homelessness and is therefore covered by ACT Official Visitors under two separate disciplines. However, Official Visitors are only provided details for children and young people at CAP housing, as the *Children and Young People Act 2008* and *Legislation Act 2001* defines a young person as over the age of 12 years, and an adult upon turning 18 years old. Accordingly, advice from Health and Community Services Directorate and housing providers such as Barnardos is that they need consent by young persons over 18 years to provide their details to the Official Visitors. They also advise that young people are provided with OV contact information upon entering CAP housing. Unfortunately, this does not constitute as meaningful or

reliable oversight as there is no structured mechanism for engagement or visibility of the quality of accommodation or support young people receive.

There may be pathways for consideration including updating legislation to support those over the age of 18 and better oversight mechanisms for CAP housing.

Placement in the Adult Mental Health Unit

OVs have observed several instances where young people with significant mental health difficulties have required hospital admission and, due to the absence of adequate therapeutic and age-appropriate facilities, have been placed in the Adult Mental Health Unit (AMHU).

OVs often become aware of these situations anecdotally, highlighting gaps in communication and coordinated response pathways. Admission of young people to an adult mental health unit is highly concerning, as these environments are not designed to meet the developmental, therapeutic, or trauma-informed needs of children and young people and may increase their vulnerability.

Better outcomes would be the establishment of age-appropriate, trauma-informed mental health facilities. This would be supported by interagency communication and clear escalation protocols when hospital admissions occur as well as age-appropriate mental health responses for children and young people to ensure children and young people are not placed in adult mental health units.

Family-based care placement availability for children under 10 years of age

The lack of a targeted strategy to address limited availability of family-based care remains a significant concern. The number of children under 10 years of age in residential care highlights broader pressures with limited placement availability in family-based care. An example of this is two siblings aged 3 years and 6 years who have been in residential care for over 18 months. Young children receiving care through continual rotating youth worker rosters are not provided with the relational stability required to support the development of secure attachment with a primary caregiver. This model is not aligned with best practice approaches for meeting the developmental and emotional needs of younger children.

First Nations overrepresentation

The significant overrepresentation of Aboriginal and Torres Strait Islander children and young people in both OOHC and Bimberi highlights the critical importance of culturally responsive service delivery. However, there remains a notable gap in the availability of dedicated resources and support mechanisms necessary to provide reliable cultural oversight and ensure care environments foster cultural identity, connection, and wellbeing.

Understanding of the Official Visitor role

There is lack of visibility and understanding of the Official Visitor role with staff in residential properties. Sector awareness of the Official Visitor role remains inconsistent, limiting opportunities for children and young people to engage effectively with OVs despite promotional materials being available to display in residences.

Homelessness

Housing demand and rising vulnerability

Canberra continues to experience a significant shortage of appropriate housing stock, with demand far exceeding supply. As a result, increasing numbers of individuals and families are experiencing homelessness or living at heightened risk.

This includes families, young people, older people, women, First Nations people, people with disabilities, culturally and linguistically diverse (CALD) communities, LGBTIQA+ and transgender individuals, neurodiverse people, and those with complex needs such as offenders exiting detention, young people leaving care, people with addictions, and victim survivors of family violence.

First Nations homelessness and cultural safety

Aboriginal and Torres Strait Islander people remain disproportionately affected by homelessness and face greater barriers to securing stable housing. A whole of sector uplift in cultural capability, culturally safe leadership, and accountability is required to align with the National Agreement on Closing the Gap and eliminate institutional and systemic racism within the housing and homelessness system.

Tenancy support and service gaps

A lack of outreach support for vulnerable tenants continues to undermine tenancy sustainability. Without adequate assistance, individuals who secure housing often struggle to maintain it, leading to notices to vacate and repeated cycles of homelessness. Additional gaps include the absence of crisis or transitional accommodation for men who are primary caregivers, and limited access to health, employment, and financial supports for people experiencing homelessness.

Oversight, advocacy, and public perception

Oversight and complaint mechanisms for people experiencing homelessness remains minimal, leaving individuals vulnerable within an overstretched system. Community myths and assumptions about homelessness further compound these challenges, despite the reality that homelessness can affect anyone. The Homelessness OV's oversight capacity remains constrained, with limited resourcing restricting visits to only a small proportion of multi occupancy properties and preventing comprehensive system monitoring.

Family and domestic violence systemic issues

Systemic shortcomings within the family and domestic violence (FDV) and homelessness response systems continue to place victim survivors at risk. Inconsistent recognition of coercive control limits access to crisis accommodation for women experiencing non-physical abuse. Structural barriers such as financial dependence, fear of child removal, and limited early intervention pathways further inhibit help seeking. Insufficient dedicated FDV housing options result in homelessness services absorbing emergency accommodation needs, particularly for women with children. Opportunities for early coordinated, trauma informed support—including financial counselling, legal advice, safety planning, and transitional housing are often inaccessible.

Specialist women's services

Specialist women's services such as Toora Women Inc provide essential crisis and transitional accommodation for over 200 women annually. They support women with children in their care (despite receiving no specific funding for children) offering safe housing and wraparound support that enables families to remain together. Toora Women Inc also delivers specialised, much needed assistance for women connected to the justice system, providing safe and supported accommodation.

Specialist men's services and justice interface

Everyman Australia delivers programs for men who have high and complex needs, including individuals exiting prison, perpetrators of FDV, and men with serious mental health conditions. Reduced funding for FDV programs created a significant service gap, leaving a high-risk cohort without adequate support resulting in unintended consequences of increased risk for women and children. The justice system frequently mandates engagement with Everyman Australia without confirming program capacity, creating operational strain and increasing systemic risk.

Youth homelessness and after care gaps

Young people exiting statutory care remain at significantly elevated risk of homelessness, often leaving care at eighteen without stable housing or adequate support. Aboriginal and Torres Strait Islander young people are overrepresented in this cohort and face additional structural barriers to securing and sustaining a tenancy. Current after care support and housing options are insufficient, contributing to high rates of youth homelessness. Broader youth homelessness support services remain

at unacceptable levels and require urgent, coordinated investment in housing, after care services, and sustained support pathways.

Positive changes

During engagement with service providers, the Official Visitor has continued to be overwhelmingly impressed by the commitment and dedication of workers, their passion, determination and importantly their humility in working with disadvantaged people who are or are at risk of homelessness.

Following the most recent budget some vital services across the homelessness sector received longer term funding. This has enabled consistent service delivery and job security across the sector.

Part 3: Other section 23DA reporting

Section 23DA of the Act provides that the Board must give the Minister a written report for the financial year about:

a) The number of -
   i. Visits by Official Visitors to visitable places
   ii. Complaints received by Official Visitors in relation to visitable places
   iii. Referrals of complaints to investigative entities
b) Actions taken on the complaints received
c) Any systemic issues in relation to the operation of the Act identified by the Board
d) The number and kinds of matters referred by an Official Visitor to an investigative entity
e) The number of times an Official Visitor inspected records in accordance with section 15(2)(b).

The following information has been drawn from Official Visitor quarterly summary reports and from consultation with Official Visitors.

Visits, complaints, referrals and inspection of records

Jurisdiction	Visits s. 23DA(1)(a)(i)	Complaints received s. 23DA(1)(a)(ii)	Complaints referred to investigative entities s. 23DA(1)(a)(iii)	Inspected client records under s. 15(2)(b) s. 23DA(1)(e)
Mental Health	205	75	14	26
Disability	175	131	72	50
Corrections	93	1,234	9	0
Children and Young People	156	28	20	0
Homelessness	27	6	1	0
Total	656	1,474	116	76

Mental Health

Active resolution of consumer concerns

A key function of the Official Visitors for Mental Health (OVMH) throughout the year was responding to concerns raised by mental health consumers. Most issues were addressed directly with clinical and operational staff during visits or escalated to senior managers when required. This approach allowed concerns to be dealt with quickly and informally wherever possible. The OVMH also continued to monitor matters after they were raised to ensure appropriate action was taken and that issues were not overlooked.

Strong collaboration across mental health services

The OVMH maintained regular engagement with the Mental Health Advocates at the Human Rights Commission and the Office of the Chief Psychiatrist. These relationships supported information sharing, coordinated responses to consumer concerns, and reduced duplication between oversight and advocacy bodies. Regular communication also helped identify emerging issues and facilitated timely resolution of matters affecting consumers.

Ongoing engagement with community agencies

In addition to formal stakeholder meetings, the OVMH met with community organisations that provide services to mental health consumers when required. This enabled the OVMH to maintain awareness of challenges experienced by consumers outside hospital settings and supported a more coordinated response to issues that crossed multiple service systems.

Participation in key governance and oversight committees

Throughout the reporting period, the OVMH participated in the Canberra Health Service's Restrictive Practices Oversight Committee and the Chief Psychiatrist's Advisory Committee and Restrictive Practice Oversight Committee. Participation in these forums provided an opportunity to contribute an independent consumer-focused perspective to discussions about mental health services, patient safety, restrictive practices, and service quality.

Facilitating access to specialist support services

Where issues could not be addressed through direct intervention, the OVMH assisted consumers by referring them to organisations better placed to provide support, advocacy, legal assistance, complaint resolution, housing assistance, guardianship services, or culturally appropriate support. Referrals were made to:

- Mental Health Advocates
- Health Services Commissioner
- Public Trustee and Guardian
- Housing ACT
- Legal Aid
- ACT Disability, Aged and Carer Advocacy Service (ADACAS)
- Advocacy for Inclusion
- Aboriginal Official Visitor, and
- Official Visitors Program (NSW).

This demonstrates the OVMH's role not only in oversight and monitoring, but also in helping consumers navigate complex service systems and access appropriate supports.

Referral activity reflects a broad range of consumer needs

The referrals made during the reporting period show that consumers experienced a variety of issues extending beyond mental health treatment alone. Matters relating to legal rights, guardianship, service complaints, housing, advocacy, and cultural support required engagement with multiple agencies. The increase in referrals during the April to June 2026 quarter suggests growing complexity in some consumer circumstances and highlights the importance of strong interagency relationships.

Focus on consumer rights and independent oversight

This report demonstrates the OVMH's ongoing role in safeguarding the rights and wellbeing of mental health consumers through independent visits, advocacy, monitoring of concerns, participation in oversight committees, and collaboration with other agencies. By maintaining visibility within mental health services and raising issues directly with providers, the OVMH helps to ensure that consumer experiences and concerns are heard and addressed.

Overall

The OVMH continued to provide independent oversight of mental health services, worked collaboratively with key stakeholders, promoted consumer rights, and assisted consumers to access appropriate support when required. While the number of formal referrals was relatively modest, the activities undertaken demonstrate a consistent focus on early intervention, problem resolution, system collaboration, and protecting the interests of people receiving mental health services.

Disability

During the 2025-26 financial year, Official Visitors for Disability Services (OVDS) received several complaints concerning matters such as:

- Housing repairs and inadequate housing conditions - including significant repair delays, non-functional utilities, unsafe conditions leading to increased risks of injury or illness, and poor communication regarding repairs
- Provider communication issues and poor or inaccessible records - frequent communication failures with stakeholders, poor file notes, and difficulties accessing electronic records
- Guardianship overreach and misuse - including a lack of understanding of legal powers and decision-making authority, restricted control of daily choices, discouraging access to independent advocacy, financial exploitation, and restrictive practices
- Provider control over participants - including instances of coercion, and withdrawal of supports without notice
- Service provider conduct - including poor hygiene practices, leaving participants unattended, inadequate emergency readiness, obstructing advocacy oversight, and the provision of unnecessary supports
- Poor staff quality, training and supervision - including missing qualifications, staff absence, poor or inadequate service quality, and the exploitation of vulnerable workers
- Supported Independent Living (SIL) housemate compatibility consultation issues - including moving people into properties without adequate consultation resulting in distress, fear, conflict, and overcrowding
- Financial pressures within the NDIS system - including encouraging service provider profit motive, inflated prices for services, funding shortfalls, participant commodification, and inaction by NDIS Quality and Safeguards Commission.

Action taken on complaints included –

- Raising the issues with staff or a senior manager on the day or immediately after the visit
- Monitoring concerns raised and ensuring that agreed actions were implemented
- Raising concerns about housing with the relevant housing provider, such as Housing ACT or community housing providers. OVDS have observed that repairs and maintenance requests are more likely to progress once raised by Official Visitors
- Liaising with support coordinators about actions already underway to address issues and to provide information to inform future actions or decisions
- Providing advice about other complaint resolution options, such as mediation or formal complaints processes, and possible outcomes
- Referrals to other bodies, including investigative or decision-making authorities such as the ACT Civil and Administrative Tribunal, the ACT Human Rights Commission, the Office of the Senior Practitioner, and others.

Corrections

Corrections Official Visitors received 1,234 complaints this year. They covered most areas of Corrections' operations and health. Some of the most common complaints were about:

- Calls, visits, mail and email - often about delays adding contacts or visitors not being approved, although we note that improvements in this area have been made during the year
- Health, general healthcare and medications - commonly about pain and mental health medications that were prescribed in the community not being available at the Alexander Maconochie Centre (AMC), access to Opioid Maintenance Treatment and timely access to see a doctor. Access to dentists, allied health and specialists is also an issue
- Programs, activities, employment and education - complaints from people looking for purposeful and productive ways to spend their time. Timely access to court or case plan mandated programs (for example, addressing domestic violence or alcohol and other drug issues) is a common complaint.

Broadly, our approach to handling complaints is:

- Triage to ensure we are responding quickly to the most serious complaints and those from detainees who are less able to advocate for themselves. This has become particularly important this year as our budget has been reduced, requiring greater prioritisation
- Looking into the complaint which may include reviewing case notes or other documentation and viewing closed circuit television (CCTV) footage, as well as speaking to staff in yards or supervisors, aiming to resolve the concern as quickly as possible
- Complaints we receive can also be emailed to the Corrections compliance team or Justice Health operational director; however the compliance team is at times under-resourced to be able to respond to all queries in a timely manner

- At times, individual complaints are escalated to senior staff, and we use regular meetings to share our observations on patterns
- Where possible we seek to report back to detainees quickly, however, have found that this is not always possible due to limited resources and the need to prioritise new issues raised.

We would also note that during this period, Corrections conducted an internal review of complaints management. We understand that discussions are underway about how to respond to those findings and have offered to be part of these to share our observations and ideas for improvement.

Children and Young People

During 2025-26, complaints ranged from mobile phone confiscation, lack of support from Children, Youth and Families (CYF) and service providers, limited choice of food, lack of cutlery and crockery, lack of furniture, not being involved in care team meetings, lack of transition from care planning, not being woken up on school mornings, poor service response when in crisis, concerns about restoration, and worry / concerns about change of placement – no consultation, views and wishes not being obtained.

All complaints were managed through direct interactions with service providers or referrals to CYF or other oversight agencies. Service providers were generally responsive to Official Visitor enquiries and requests regarding young people.

Homelessness

During the 2025-26 financial year, the Homelessness Official Visitor received a number of complaints concerning matters such as –

- Access to suitable accommodation / wait time, overcrowding
- Support received in crisis accommodation, restrictions on visitors, out-of-hours support, rent arrears / proposed repayments not being affordable
- Cleanliness and hygiene conditions, accommodation repairs and poor heating
- Access to basic facilities and amenities while in crisis accommodation
- No provision of crisis accommodation for a man with children in his care
- Access to counselling and advocacy services.

Action taken on complaints included –

- Meeting with service provider, providing advocacy to negotiate affordable payment plan for rent arrears
- Meeting with service provider regarding delays in heating repairs and access to kitchen facilities. Subsequent monitoring to ensure actions were implemented
- Referral to ACT Human Rights Commission (HRC) regarding wait time for allocation of appropriate housing for a family with complex needs
- Support letters provided to entitled persons to assist with Housing ACT applications
- Liaising with support services regarding priority access to counselling services
- Providing updates and outcomes advice to entitled persons.

Number and kinds of matters referred by an Official Visitor to an investigative entity

> Official Visitors will refer complaints or issues from, or on behalf of, entitled persons at the place to relevant investigative entities.

Mental Health

During the 2025-26 financial year, the following kinds of matters were referred to investigative entities -

- 4 referrals to the ACT Public Trustee and Guardian (PTG) for financial management and guardianship matters
- 4 referrals to ACT Public Advocate for consumers requesting / requiring advocacy
- 3 referrals to the ACT Human Rights Commission (HRC) for consideration
- 1 referral to the Aboriginal and Torres Strait Islander Official Visitor to investigate First Nations concerns
- 1 referral to the Official Visitors Program (NSW) to investigate a matter in an alternate Official Visitor jurisdiction
- 1 referral to the Corrections Official Visitors to investigate a corrections matter.

There were also 1 Advocacy for Inclusion, 1 Legal Aid, and 2 Housing ACT referrals to non-investigative entities.

Disability

During the 2025-26 financial year, the following kinds of matters were referred to investigative entities -

- 1 referral to the Mental Health Official Visitors to investigate a mental health matter
- 8 referrals to the Office of the Senior Practitioner in relation to restrictive practices
- 1 referral to the ACT Public Advocate for entitled persons requesting / requiring advocacy
- 18 referrals to the HRC for consideration as complaints
- 20 referrals to the NDIS Quality and Safeguards Commission for formal investigation
- 2 referrals to the ACT Civil and Administrative Tribunal for financial management and guardianship matters
- 12 referrals to the PTG for guardianship concerns
- 2 referrals to the Guardianship Division at the NSW Civil and Administrative Tribunal for guardianship matters
- 2 referrals to Services for Children and Families, Department for Education, Children and Young People (Tasmania) for child safety matters
- 3 referrals to the Social Services Regulation, ACT Health and Community Services Directorate, for investigation
- 1 referral to the Queensland Civil and Administrative Tribunal for guardianship matters
- 1 referral to the Queensland Office of the Public Guardian for guardianship matters
- 1 referral to the Queensland Public Trustee for financial management matters.

There were also 17 Housing ACT, 2 Integrated Services Response Program, 1 Advocacy for Inclusion, 1 CHC Housing, 2 Havelock Housing, and 2 Minister for Disability, Carers and Community Services non-investigative entity referrals.

Corrections

During the 2025-26 financial year, the following kinds of matters were referred to investigative entities -

- 9 referrals to the HRC for consideration of issues.

Additional referrals were made to community organisations, in particular ACT Disability, Aged and Carer Advocacy Services (ADACAS), Care Financial and Prisoners Aid.

Children and Young People

During the 2025-26 financial year, the following kinds of matters were referred to investigative entities -

- 12 referrals to the ACT Public Advocate seeking advocacy for young people due to physical / psychological incidents or issues
- 1 referral to the HRC for consideration of issues
- 7 referrals to Children, Youth and Families to investigate and respond to concerns.

Homelessness

During the 2025-26 financial year, the following kinds of matters were referred to investigative entities -

- 1 referral to the HRC for consideration of issues.

Part 4: Information about ACT Official Visitors and 2025-26 activities

ACT Official Visitors

> ACT Official Visitors play an important role in safeguarding the rights and wellbeing of people who reside in various government and non-government facilities, accommodation, housing, centres, and refuges. These places are known as "visitable places" and the people visited by Official Visitors are known as "entitled persons".

Official Visitors are independent statutory officeholders. They meet with and talk to entitled persons in visitable places to hear their concerns and resolve any complaints. They prepare and send reports to the operational Ministers responsible for the visitable places, including about any systemic issues or concerns that they have. They also prepare summary reports to the Minister with over-arching responsibility for ACT Official Visitors.

Official Visitors seek to identify, monitor and resolve service issues, using early intervention and resolution practices, with a view to improving service quality. They observe the environment and interactions between staff and entitled persons, make enquiries, inspect documents, communicate with entitled persons to ensure they are being supported with dignity and respect, and identify any issues of concern.

ACT Official Visitors cover five jurisdictions under each of the following Operational Acts:

- Children and Young People under the *Children and Young People Act 2008*
- Corrections under the *Corrections Management Act 2007*
- Disability under the *Disability Services Act 1991*
- Housing and Homelessness under the *Housing Assistance Act 2007*
- Mental Health under the *Mental Health Act 2015*.

The Board

> The Board was first established in 2013 in response to concerns about the absence of a centralised, consistent and professional source of support and guidance for Official Visitors.

The Board is a governance board, overseeing and supporting the work of Official Visitors rather than directing or controlling that work. Under section 23C of the *Official Visitor Act 2012* (the Act), its functions are to:

- Oversee the exercise of functions by Official Visitors
- Arrange for the recruitment, induction, training and support of Official Visitors
- Provide support for, and manage, the exercise of functions by Official Visitors
- Consider and try to resolve any complaints about Official Visitors
- Exercise any other function given to the Board under legislation.

Board membership

The Board is established under section 23A of the Act and comprises –

- The Chair as appointed by the Minister
- The Public Trustee and Guardian
- At least one Commissioner under the *Human Rights Commission Act 2005*; nominated by the Commissioners under that Act
- Two Official Visitors elected by the Official Visitors
- Any other member/s appointed by the Minister.

Election of the representatives of Official Visitors is undertaken every three years or when the term of an elected Official Visitor representative comes to an end.

Board members at the end of the reported period were –

- Mr Peter Muir, Chair, Official Visitors Board
- Ms Danae Lacey, Acting Public Trustee and Guardian
- Ms Jodie Griffiths-Cook, Public Advocate and Children and Young People Commissioner and representative of the ACT Human Rights Commission
- Ms Clare Doube, Official Visitor for Corrections and Official Visitor representative
- Mr Geoff Dulhunty, Official Visitor for Mental Health and Official Visitor representative.

Ms Robyn Hakelis substantially held the role of Public Trustee and Guardian as at 30 June 2026. Ms Danae Lacey has served as Public Trustee and Guardian from 2 January to 27 January 2026, 3 April to 19 April 2026, and 1 June to 17 July 2026.

Meetings

A requirement for the Board to meet quarterly was introduced in April 2020.

The Board had four substantive meetings during the reported year on 11 September 2025, 4 December 2025, 12 March 2026 and 22 June 2026.

Attendance at the meetings is as follows:

Meeting	11 September 2025	4 December 2025	12 March 2026	22 June 2026
Peter Muir	Yes	Yes	Yes	Yes
Jodie Griffiths-Cook	Yes	Yes	Yes	Yes
Robyn Hakelis	Yes	Yes	Yes	
Clare Doube	Yes	Yes	Yes	Yes
Geoff Dulhunty	Yes	Yes	Yes	Yes
Danae Lacey				Yes

Disability Official Visitors, Ms Kim Webster, Mr Dwayne Cranfield, and Ms Zoe O'Dwyer, attended the 11 September 2025 Board meeting, the Children and Young People Official Visitor, Ms Kim Ward, attended the 4 December 2025 Board meeting, the Mental Health Official Visitors, Dwayne Cranfield and Geoff Dulhunty, attended the 12 March 2026 Board meeting, and the Corrections Official Visitors, Ms Clare Doube and Mr Tristan Ray, attended the 22 June 2026 Board meeting to highlight points of interest and issues in their respective disciplines / spaces. Dr Louise Bassett also attended the 22 June 2026 Board meeting to discuss private residences in the disability visitable places register.

Prior to meetings, Board members are required to disclose any material interest to be considered at the meeting. No disclosures were made by Board members during the 2025-26 financial year.

Key items discussed in the 2025-26 Board meetings included:

- Official Visitor vacancies and recruitment
- Budget and financial position
- Official Visitor induction, training and development
- Raising scheme awareness
- Risks, controls, security and safety
- Ensuring legislative compliance
- Information sharing with Official Visitors and key stakeholders
- Official Visitor activity and reporting
- Scheme dashboard indicators
- Complaint investigation and feedback
- Development of annual reporting
- Restrictions on Official Visitor access and movement
- Cultural safety and capability
- Open access for scheme governance documents.

Complaints received by the Board

The Board is required to consider and try to resolve any complaints about Official Visitors as per section 23C(1)(d) of the *Official Visitor Act 2012*. The Board received four complaints regarding Official Visitors during the reporting period. One complaint identified the need for further support for Official Visitors, resulting in development and endorsement of the mandatory training policy. Another complaint identified the need to further enhance awareness of ACT Official Visitors with entitled persons and services providers.

Official Visitors

> Official Visitors are appointed under section 10 of the Act by the Minister responsible for the Act, for the purposes of each of the Operational Acts.

Two of the jurisdictions, Corrections and Children and Young People, have a requirement that at least one of the appointed Official Visitors must be an Aboriginal or Torres Strait Islander person.

Current appointments

As at the end of the reporting period the following Official Visitors were in place:



Dwayne Cranfield
Disability Services Act 1991
25.4.2025 to 24.4.2028
Mental Health Act 2015
8.8.2025 to 7.8.2028



Clare Doube
Corrections Management Act 2007
1.9.2023 to 31.8.2026



Geoff Dulhunty
Mental Health Act 2015
29.6.2024 to 28.6.2027



Zoe O'Dwyer
Disability Services Act 1991
25.4.2025 to 24.4.2028



Vickie Quinn
Children and Young People Act 2008
5.10.2024 to 4.10.2027



Tristan Ray
Corrections Management Act 2007
16.12.2023 to 15.12.2026



Kim Ward
Children and Young People Act 2008
18.7.2025 to 17.7.2028



Kim Webster
Disability Services Act 1991
7.5.2024 to 6.5.2027

(NB: Commencement date does not necessarily represent the full term of service, rather the term as provided in the most recent disallowable instrument)

Expiry of term or resignation of appointment

The following Official Visitors' terms expired during the reporting period –

Name	Jurisdiction	Commencement	Expiry / resignation date
David Healey	*Housing Assistance Act 2007*	14 May 2024	30 October 2025
Vickie Quinn	*Corrections Management Act 2007*	11 January 2023	10 January 2026
Leslie Purcell	*Corrections Management Act 2007*	24 February 2026	22 May 2026

Training / professional development

Official Visitor Professional Development Days (PDDs) were held on 8 August 2025, 17 November 2025, 12 February 2026 and 1 May 2026.



Professional Development Day on 1 May 2026

Left to right: Kim Ward, Kim Webster, Geoff Dulhunty, Dwayne Cranfield, Clare Doube, Vickie Quinn, Tristan Ray and Zoe O'Dwyer.

Financial – 2025-26 end of financial year summary

The 2025-26 budget comprised $662,000 for territorial expenses (remuneration and ACT Official Visitors related expenses).

Remuneration and expenses funding	$662,000.00
Total Budget	**$662,000.00**
Less Remuneration and Allowances	$648,124.19
Less Operational Expenses	$20,577.27
Total Expenses	**$668,701.46**
Operating Result	**($6,701.46)**

The allocation of $183,000 in departmental funding to the Human Rights Commission is not included in the financial summary. Departmental funding contributes to the Executive Officer's and the Chair's salary and on-costs.

Executive Officer / Administrative Support



Mr **Stefan Dzwonnik** is the Executive Officer of ACT Official Visitors.

Glossary of Abbreviations and Acronyms

Act, the	*Official Visitor Act 2012*
ADACAS	ACT Disability, Aged and Carer Advocacy Services
ADHD	Attention deficit hyperactivity disorder
AMHU	Adult Mental Health Unit
AMC	Alexander Maconochie Centre
Bimberi	Bimberi Youth Justice Centre
Board, the	Official Visitors Board
CALD	Culturally and Linguistically Diverse
CAP	Community Adolescent Program
CCTV	Closed-circuit television
CIT	Canberra Institute of Technology
CYF	Children, Youth and Families
Disability Royal Commission, the	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
FDV	Family and Domestic Violence
GMHU	Gawanggal Mental Health Unit
HCSD	Health and Community Services Directorate
HRC	ACT Human Rights Commission
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual, Aromantic and Agender
NDIS	National Disability Insurance Scheme
NDISQSC	NDIS Quality and Safeguards Commission
OOHC	Out of Home Care
OV	Official Visitor
OVDS	Official Visitor(s) for Disability Services
OVMH	Official Visitor(s) for Mental Health
PDD	Professional Development Day
PTG	ACT Public Trustee and Guardian
SIL	Supported Independent Living
TRC	Transitional Release Centre
TRP	Transitional Release Program



ACT Official Visitors

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