FIRST EDITION

A SYSTEM THAT CANNOT SEE ITSELF

Domestic and family violence in the Australian Capital Territory, 2016–2026, and how to fix it

JULIAN TALBOT

Foreword by Dr Gavriel Schneider

A System That Cannot See Itself

The technical volume

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The evidence, a rewritten risk framework,
and the legislation to fix it

Domestic and family violence in the Australian Capital Territory, 2016–2026

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Book 2 of *The ACT Domestic and Family Violence Review*
Book 1 is the public edition



A System That Cannot See Itself

The Technical Volume: The Evidence, a Rewritten Risk Framework, and the Legislation to Fix It

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Book 2 of *The ACT Domestic and Family Violence Review*. Book 1 is the public edition, *A System That Cannot See Itself: The Public Edition* (ISBN 9798172055058), which states the same argument in fifteen minutes and is free to download at dfvrisk.com.au. A third volume, on preventing violence before it begins, is in preparation.

First edition.

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Evidence cut-off: 2 September 2026. Every figure in this edition has been checked against its primary source; Appendix N sets out what was checked and what cannot be verified.

This work is a risk analysis of public administration. It is not legal advice, and no part of it should be relied on as advice about any person's circumstances. Nothing in it is intended to identify any person who is not already named in the public record.

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Foreword

I have spent much of my professional life working in environments where getting risk wrong can have serious consequences. My work has taken me across risk, security, safety, emergency management, organisational resilience and leadership, working with governments, major corporations and organisations operating in complex and high-consequence environments. A consistent theme throughout that work has been the gap between what organisations believe they are doing and what they can actually demonstrate.

What drew me to this book was not simply its subject matter, but the risk-management question sitting underneath it: how does a system know whether it is actually working?

That experience has shaped the way I read *A System That Cannot See Itself*. Identifying a risk is not the same as managing it, and having a framework is not the same as knowing that the framework works. That distinction is at the heart of Julian Talbot's work.

Julian is approaching this subject as a risk practitioner, not simply as a commentator on public policy. He has spent approximately 35 years working in security and risk management across Australia and internationally, including senior leadership roles across government, resources, commercial and not-for-profit environments. He has worked at Director and C-suite level and has spent much of his career dealing with the practical reality of making decisions where information is incomplete, consequences matter and accountability cannot be avoided.

His professional credentials are directly relevant to the work presented here. Julian holds a Master of Risk Management, is a Fellow of both the Risk Management Institution of Australasia and the Institute of Strategic Risk Management, and has been recognised with the Australian Security Medal. He is also the author of *Control Effectiveness Assessment* and lead author of the *Security Risk Management Body of Knowledge*.

That background matters. The book is fundamentally about risk management. It examines how a system identifies risk, how information is gathered and interpreted, how decisions are made, how controls are selected, how resources are allocated, how accountability is established and, critically, how anyone knows whether those controls and decisions are actually working. These are not abstract questions for a risk practitioner. They are the foundations of effective risk management.

The integrity of the research

Before considering what Julian finds, it is worth considering how he gets there. This is not a book built around a preferred political narrative, or an argument that asks the reader to accept its conclusions because of the author's personal experience. The research is deliberately anchored in the public record and draws on legislation, government reviews, budgets, administrative material, audits, freedom of information material, strategies, evaluations and other publicly obtainable evidence.

Just as importantly, Julian makes a clear distinction between what the evidence demonstrates and what it does not.
Funding announced is not automatically funding allocated.
Funding allocated is not automatically funding spent.
Funding spent is not automatically an outcome.

Where the available evidence does not support a conclusion, he uses the term "not proven". That is an important discipline in risk analysis. It is also one that can be difficult to maintain when the subject matter is politically sensitive and emotionally charged.

The book repeatedly demonstrates an understanding of the difference between evidence, interpretation and assumption. It also acknowledges the limitations of the available data and, importantly, does not turn an absence of evidence into evidence of wrongdoing. That is good research practice. It is also good risk practice.

There is another aspect of Julian's methodology worth acknowledging. His own experience of the domestic and family violence system gives him a perspective that a researcher who had never encountered that system would not have. In that sense, there is a participatory dimension to the work that was not simply a methodological choice: his circumstances placed him, to some extent, within the system he was seeking to understand.

That creates both opportunity and risk. Lived experience can expose questions that an external observer may not think to ask. It can also create the risk of confirmation bias, or of personal interpretation influencing conclusions.

Julian deals with that risk in the most important way available to a researcher: he makes his position visible and then anchors the conclusions in evidence that exists independently of his experience. He does not ask the reader to accept his experience as proof. He uses it to ask questions, and then tests those questions against the record.

He also makes the work open to correction. Where an agency, practitioner or reader believes a statement is wrong, the invitation is to provide the evidence. If the evidence demonstrates that the book is wrong, the correction can be made. For me, this is one of the strongest indicators of research integrity. A credible researcher does not need to be infallible. They need to be correctable.

What the research reveals

The findings are challenging, but importantly, they are not principally an argument about whether people within the system are trying hard enough. The ACT has invested substantially in responding to domestic and family violence. It has established new structures, funding arrangements, coordination mechanisms, legislation, services, strategies and review processes. There are clearly people across the system working extraordinarily hard to support people experiencing violence and to reduce harm. Julian does not deny this.

His question is different. Can the system demonstrate that all of that activity is producing the outcomes it is intended to produce? That distinction between activity and effectiveness is fundamental to good risk management. A system can have more funding, more programmes, more staff, more policies and more reporting while still being unable to demonstrate whether the underlying risk is changing.

The importance of this book is amplified by the subject it examines. Domestic and family violence is one of the areas of public policy where getting risk management right matters most. The consequences are not theoretical. Decisions made by police, courts, government agencies, service providers and practitioners can affect personal safety, family relationships, children, liberty, housing, employment and, in the most serious cases, whether someone lives or dies.

That makes fairness particularly important. Fairness in this context does not mean treating every circumstance as though it were the same. Nor does it mean avoiding difficult decisions because the consequences of getting them wrong are uncomfortable. It means having a system in which risk is assessed consistently, evidence is considered properly, uncertainty is acknowledged and decisions can be explained, challenged and improved.

This is where risk management and fairness intersect. A system designed to protect people must be capable of identifying genuine risk and responding decisively to it. But it must also be capable of recognising when the available evidence is uncertain, when a judgement may be wrong and when the system itself may be creating unintended harm. Both sides matter. If genuine risk is underestimated, people can be left exposed to serious harm. If risk is incorrectly attributed, the consequences can also be profound.

That is why I believe Julian's examination of the system is so important. In an area as sensitive and consequential as domestic and family violence, we should demand more than good intentions, more than activity and more than the existence of policies and frameworks. We should demand that the system can demonstrate that its decisions are fair, its risk judgements are defensible, its interventions are effective and its mistakes can be identified and corrected. The people working within these systems deserve that standard. Most importantly, so do the people whose lives depend upon them.

The book repeatedly returns to this problem, and perhaps the most important example is the risk framework itself. A risk framework should allow people dealing with the same information to reach sufficiently consistent and defensible conclusions. That does not mean every practitioner will reach exactly the same judgement;

risk involves uncertainty and professional judgement. But there need to be defined criteria, thresholds, decision rules and mechanisms for testing whether those judgements are reliable.
Without that, consistency cannot properly be assessed.
Without consistency, validation becomes difficult.
Without validation, errors are difficult to identify.
And if errors cannot be identified, they cannot reliably be corrected.

That is not simply a domestic and family violence problem. It is a fundamental risk-management problem.

The title matters

The title of this book is provocative, but I think it is accurate. A system that cannot see itself cannot properly learn from itself. If an organisation cannot identify what decisions it is making, why it is making them, what assumptions underpin those decisions, what outcomes follow and where those decisions fail, then it has limited capacity to improve.
That is true in cyber security.
It is true in critical infrastructure.
It is true in emergency management.
It is true in corporate governance.
It is true in national security.
And it is true in domestic and family violence.

This is why I believe the value of Julian's work extends beyond the specific system he examines.

A risk practitioner's perspective

I should also be clear about my own position. I am not a domestic and family violence specialist, and I do not approach this book as one. My professional expertise is in risk, security, human behaviour, organisational decision-making, resilience and leadership.

That distinction matters. I have spent my career examining what happens when organisations have to make consequential decisions with imperfect information. I have seen sophisticated frameworks fail because the people using them did not understand them, because information did not flow between the right people, because assumptions were never tested, or because nobody had established how success would actually be measured.

I have also seen the opposite. Good systems do not eliminate uncertainty. They make uncertainty visible. They create feedback loops. They test assumptions. They identify error. They learn. And they change.

That is the lens through which I read *A System That Cannot See Itself*. The book is not asking us to conclude that every decision made within the ACT system is wrong, nor is it arguing that every person working within the system has failed. It is asking a more difficult and ultimately more useful question: does the system have the architecture necessary to know when it is getting things wrong?

That is a question every serious risk professional should be prepared to ask of their own organisation.

Julian has done something that is difficult to do in any politically and emotionally charged environment. He has taken a complex system, separated the available evidence from the assumptions surrounding it, tested the architecture against established risk-management principles and then identified where the evidence runs out.

He has also done the harder thing that usually follows. Julian does not confine himself to criticism, and he does not leave the questions hanging. He offers practical solutions: a rewritten domestic and family violence risk assessment and management framework, drafted policy and legislative change, and a set of well-considered recommendations that directly address the problems he has identified. It is comparatively straightforward to demonstrate that a system cannot see itself. It is considerably harder to set out, in operational detail, what seeing itself would actually require, and then to put that on the record where it can be tested, costed and argued with.

The result is not comfortable reading. Nor should it be. Good risk management is rarely about making people comfortable. It is about making reality visible early enough that something can still be done about it.

This book does not pretend to have every answer, and it does not claim that its proposals are the only ones available. Its contribution is that it asks better questions, shows its working, offers a considered way forward, and gives the reader enough information to test all three.

That is what I look for in serious risk analysis. Not certainty. Not ideology. Not activity for activity's sake. But evidence, accountability, feedback and the capacity to learn.

Ultimately, the question raised by this book is one that should sit with every leader responsible for a complex system: can we see ourselves clearly enough to know when we are getting things wrong, and can we change before the consequences become irreversible?

That is a question worth asking. And it is a question worth answering.

Dr Gavriel Schneider

Dr Gavriel Schneider is a risk and security practitioner, author, educator and entrepreneur. He is the Founder and Chair of Risk 2 Solution and the creator of the Presilience® approach, a framework integrating risk intelligence, resilience, human behaviour, leadership and organisational agility.

He is Director and Senior Researcher at the Australian Security Research Centre and has held senior leadership responsibilities within the Institute of Strategic Risk Management, including President of ISRM ANZ and leadership responsibilities within the APAC community. He is a Fellow of the Institute of Strategic Risk Management, Governance Institute of Australia and Australian Risk Policy Institute.

Dr Schneider has spent almost a decade as a postgraduate educator and programme director in the Psychology of Risk and is the author and co-author of books and professional publications on risk, security, resilience and human behaviour. His work has been applied across government, critical infrastructure, resources, aviation, corporate security and other high-consequence environments.

His contribution to the risk profession has been recognised through awards including RMIA Risk Consultant of the Year (2019) and RMIA Risk Leader of the Year (2022), as well as recognition in international security and risk thought-leadership and innovation programmes. His work developing the Presilience approach has also received recognition for innovation within the risk and security profession.

Preface to the first edition

This is the first edition of a work that has been two years in the research and was finished quickly. The reason for the speed is stated plainly, because it shapes what follows.

Two bills were before the Legislative Assembly of the Australian Capital Territory when the evidence was frozen on 2 September 2026. The *Family, Personal and Sexual Violence Legislation Amendment Bill 2025* would repeal the after-hours orders that a judicial officer now makes and replace them with fourteen-day safety notices issued by police. The *Crimes (Coercive Control) Amendment Bill 2026* would create an offence of coercive control carrying seven years' imprisonment. Both bills are well-intentioned. Both respond to failures that are real and documented. Both also build serious consequences for a person on a decision — who is at risk, and from whom — that the Territory has never assessed against written criteria, never recorded in a form a court can read, and never counted. That is the gap this work was written to describe, and the two bills would widen it. A book held back for its own final polish would have arrived after the Assembly had voted.

So this edition is published to meet the bills. Chapter 19 assesses both, credits what they get right, identifies what they get wrong, and drafts the amendments that would fix it. The public edition carries the short version; this is the technical volume behind it. The rest of the work is the analysis of the existing system that the bills would amend: how it was built between 2016 and 2026, what it cost, what the deaths show, how orders are made, how the risk framework works and does not, who is counted and who is not, and what would have to change.

The limits should be stated with the same plainness. This is a study of the system as it now exists for responding to domestic and family violence once it has occurred or been alleged: the orders, the assessments, the services, the courts, the money and the records. It is not a study of prevention. Reducing the rate at which violence begins runs through education, child development, housing, income, health, alcohol and the norms that make control seem ordinary, and it is a larger task with a different evidence base. The ACT's 2026–2036 Strategy is the first Territory document to put that task on the page; what it has not yet done is build it. Prevention deserves its own book, and it will get one. This one is about how domestic and family violence is currently funded and managed, and whether anyone can tell if it is working.

Every figure here comes from a document that anyone can obtain. Where the record does not support a conclusion, the finding is "not proven" — used as a verdict, not as a polite way of avoiding one. Comments on this edition, including from the government and agencies whose work it describes, will be carried into a second edition, and corrections will be printed at the same prominence as the statements they correct. The author is willing to contribute to the revision of the bills that this work argues for.

It is my sincere hope that this contributes to keeping all Australians safer — in the Australian Capital Territory first, because that is where the evidence is, and elsewhere as the same questions are asked.

Julian Talbot
September 2026

Executive summary

Figure 0.1, which follows this summary, states the same argument in a single page. What follows states it in prose, and Chapter 1 states it at length. Every sentence in all three is established later in this work, with its source.

The finding

Between 2016 and 2026 the Australian Capital Territory built most of the components of a serious domestic and family violence system, paid for partly through a levy on every household. The architecture is far stronger than it was. What was never built is the other half: the part that measures whether any of it works. The Territory's own Auditor-General found in 2024 that the responsible office had not developed a performance monitoring strategy or an evaluation framework. Its own death review examined 13 deceased victims in 2025 and found that 8 of the 13 had, while alive, been wrongly recorded by police or another agency as the person causing the violence. Underneath sits one technical failure: the ACT requires every part of its operation to manage risk to a recognised standard, AS ISO 31000:2018, and it did not apply that standard to the process that can remove a person from their home without notice.

The result is a system that cannot demonstrate what it achieved, and cannot tell whether it has caused harm.

Four numbers, each checkable in an afternoon

- **No performance monitoring strategy or evaluation framework** for the levy — ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024, 22 November 2024.
- **8 of 13** deceased victims had been wrongly recorded as the aggressor while alive — misidentified, in the review's word — ACT Domestic and Family Violence Review Biennial Report 2025.
- **0 of 17** requirements of AS ISO 31000:2018 are fully met by the July 2022 family violence risk framework. Eight are not met; nine are partly met.
- **2019–20** — the last year in which the ACT Magistrates Court published protection-order application statistics, in a period in which the Supreme Court has published five annual reviews.

Why it is published now

Two bills were before the Legislative Assembly when the evidence was frozen on 2 September 2026. One would repeal the after-hours orders a judicial officer now makes and replace them with fourteen-day safety notices issued by police. The other would create an offence of coercive control carrying seven years' imprisonment. Both are well-intentioned, and both respond to failures that are real and documented. Both also attach serious consequences for a person to a single decision — who is at risk, and from whom — that the Territory has never assessed against written criteria,

never recorded in a form a court can read, and never counted. That is the gap described here, and the bills would widen it: they warrant revision before passage rather than amendment at the margin. Chapter 19 assesses both and Appendix G9 drafts the amendments, none of which raises a threshold or shortens the protection either instrument gives.

What was built, and what cannot be shown

The construction is real, and a criticism that ignores it is not credible: a statutory scheme, a levy, a Coordinator-General, a Family Safety Hub, a statutory death review, funded crisis and behaviour change services, five Aboriginal community-controlled organisations, a ten-year Strategy, and indexed ongoing base funding from 2029–30 after a decade of four-year packages. What is examined here is the response to violence that has occurred or been alleged, because that is the side the Territory built; prevention deserves its own volume.

None of it answers the question a household paying the levy is entitled to ask: what changed? Cost per victim made safe, cost per death or serious injury averted, the rate at which the wrong person is recorded as the aggressor, change in reoffending, comparative outcomes between groups, the cost of unmet demand — none can be established from any public source. These are not things nobody has bothered to calculate. They cannot be calculated, because the data is not collected in a form that permits it. The verdict on value for money is therefore **not proven**: not poor, since several programs show promising results and there is no evidence of waste in the ordinary sense; and not good either, since nothing exists that would support that.

The root cause

Procurement is assessed against the risk standard. So are public events, and staff travel. One decision is not: the one that can remove a person from a home without notice, suspend the licence they need to work and interrupt their contact with their children, taken in minutes on material from one side. Risk criteria — the written rules saying how likely and how serious a risk is being called, and what level is acceptable — are what make two assessors of the same facts reach the same answer. The 2022 framework has none, and without criteria decisions cannot be consistent, cannot be validated, and their errors cannot be detected or corrected. Two errors are possible at every such decision and only one is counted: failing to protect someone who is then harmed produces a coronial process and a review, while restricting someone who was not a danger produces criminal charges, lost work, lost housing and removed children, and is counted nowhere. That asymmetry is why the reforms below are structural rather than exhortations.

What the deaths show

Since 2000 the Territory has recorded 168 fatal incidents in a domestic and family violence context, and it cannot say what any of them tell it. Of the 12 homicides the 2023 review examined closely, coercive control was present in almost all, and in about three-quarters there had been no significant physical violence beforehand: the signal the system watches for was absent in three of every four killings it looked at hardest. Between 2020 and 2024 the register recorded 49 deaths — 11 homicides and 38 that were not, 29 of them suicides. Almost everything in the system is built around the homicides.

The Territory found the misidentification of victims because it went looking for it. It has never published a rate for it, and it has never looked for the same error in the other direction: of the 25 people the 2025 review recorded as having used violence, 21 died by suicide and 20 had been named as respondents to a civil order, and no published check exists of whether any of those records was ever tested or wrong. That is not a claim that men are more often misidentified; the ACT holds no data that could support such a claim or refute it. The point is narrower — the error was searched for in one direction only. Orders are made where danger already exists, which remains the leading explanation and may be the whole of it; it has simply never been tested, because the Suicide Register has no field recording order status at death. These are also small numbers: 13 and 25 are not rates in any wider population.

What would fix it

Seven things could start this week. None requires legislation or significant money, and each produces a public document that does not exist now: an order-status field in the Suicide Register; a queryable flag in the police records system, set when an order is served; a published implementation tracker for every death review and audit recommendation; quarterly court statistics; inter-rater reliability testing of the current risk instrument, with the pass mark published before anyone knows the result; a named accountable position for each Strategy outcome; and an operational plan for coercive control and systems abuse. The fifth matters most, because the only outcome with no value is continuing not to know.

Five reforms sit behind them. Rewrite the risk framework so that it actually functions as one. Require a structured risk assessment before an interim order is made without the respondent present, commencing only once the registry time to do it is funded — a form added to an unchanged workload produces worse decisions and better documentation. Give the respondent a fast way back into court, and give the reasons the Act already requires some content. Require a safety and support step when an order is served. Publish one annual ledger of what was spent and what changed.

The cost is about $1.7 million one-off and $0.7 to $1.2 million a year: roughly $4.4 to $6.3 million over four years, or 3 to 4 per cent of the $151.4 million of direct investment announced over the same period. Adopting the package without funding it would be worse than rejecting it.

What is not argued

That the money was wasted; that anyone is biased against men or against women; that the gendered design is wrong, when 24 of the 25 people the 2025 review recorded as using violence were male and every male among them targeted a female victim; that orders cause deaths; that false allegations are common; or that anyone has acted in bad faith. The framework proposed in Part III is itself unvalidated by its own standard, and must not be used on anyone until its reliability has been measured and published, with the trigger that would withdraw it stated in advance.

> **Promising architecture. Incomplete implementation. Unproven aggregate impact. And a system that, by its own records, cannot yet tell whether it has caused harm.**

That is not a conclusion about anyone's intentions. It is a description of what the Territory can and cannot demonstrate. It is also entirely fixable, and seven of the fixes could begin this week.

FIGURE 0.1

A system that cannot see itself: the argument on one page

What the Territory can and cannot show for ten years of reform, and what is proposed instead. Each claim names where it is established.

THE BOTTOM LINE

The error it found, and never counted



wrongly recorded

8 of the 13 deceased people the 2025 death review assessed as victims had been wrongly recorded as the aggressor while alive. Eleven of the 13 were women.

It has never been counted, or looked for in the other direction.

Thirteen is not a rate in any wider population.

No scoreboard was ever built

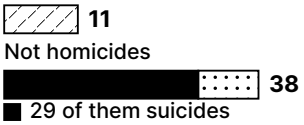


No performance monitoring strategy and no evaluation framework for what the Safer Families Levy funds.
ACT Auditor-General, 2024.

The levy raised more than $46 million to 30 June 2024. Direct investment announced for 2026–30 is $151.4 million.

No decade total exists: the packages overlap and cannot be added.

Most deaths here are not homicides



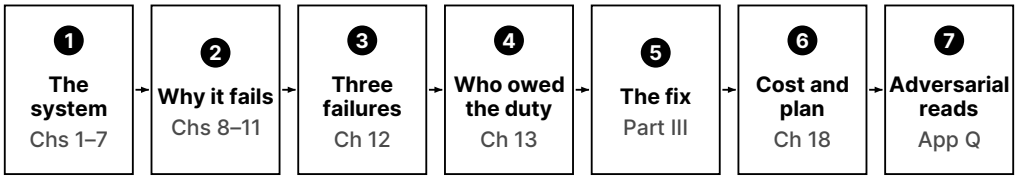
ACT, 2020–2024

Forty-nine deaths in five years: 11 homicides, 38 that were not, 29 of them suicides.

Almost everything in the system is built around the 31 homicides recorded since 2000.

Ten of the 11 homicides could not be analysed: proceedings were on foot.

THE ROADMAP



THREE KEY FINDINGS

1. It cannot count the harm it deals with, or the harm it causes.
2. Its most coercive decision sits outside AS ISO 31000:2018 — 0 of 17 requirements fully met, eight not met at all.
3. Value for money is not proven — the data is not collected.

WHY READ IT NOW

- Two bills are before the Assembly, resting on a decision never assessed or counted.
- Both warrant revision before passage; amendments are drafted at Appendix G9.
- Seven fixes need no legislation and little money. The full package costs $4.4–6.3m over four years.

WHAT IS IN IT

- ☑ A rewritten risk framework
- ☑ A pre-listing assessment instrument
- ☑ Drafted legislative amendments
- ☑ A costed, sequenced plan
- ☑ Two critiques, answered
- ☑ An account of what was verified, and what is not

The argument compressed to a page; each panel names where the claim is established and its source given.

ACT Auditor-General Report 10 of 2024; ACT DFV Review Biennial Report 2025; ACT 2026–27 Budget. Counts drawn from 13 deaths are not rates in any wider population.

Prologue — What the record cannot say

Since 2000 the Australian Capital Territory has recorded 168 fatal incidents in a domestic and family violence context.

It cannot say what any of them tell it.

That is not a figure of speech. The Territory reviews a portion of these deaths, publishes what it finds, and makes recommendations. It does not measure whether anything it does changes the number, the pattern, or the classification errors its own reviews identify. There is no baseline, no indicator and no published test of whether the system's central judgment — who is at risk, and from whom — is made consistently.

What follows is a record of that gap, and a proposal for closing it. It begins with the deaths because the deaths are the only part of the record that is written down reliably.

What the homicide reviews found

The Territory's first biennial death review was published in 2023. It examined 12 homicides in depth, drawn from a register of 134 incidents recorded between 2000 and 2022 — 106 of them identified as domestic and family violence deaths and 28 suspected.

Twelve deep reviews out of 134 incidents is about nine per cent of the register. Homicide files are the most complete files the system holds, and in-depth review is expensive, so starting there was reasonable. It also means the themes came from a small and deliberately selected slice.

Within that slice the review found coercive control present in almost all of the 12 homicides examined. In about three-quarters of them there was no significant physical violence before the killing.

Read those two findings together and they describe a detection problem. Coercive control is a pattern of domination exercised over time. Much of it is not itself criminal, and none of it produces an injury to photograph. The signal the system is built to detect — a reported incident of physical violence — was absent in roughly three of every four killings the Territory examined closely.

The 2023 review made 12 recommendations. Recommendation 4 asked for a tool that could tell which party in a relationship is the perpetrator and which is using violent resistance to ongoing abuse. As at September 2026 the updated tool was still described as being developed or embedded, and no validation results had been published. On the public record, none of the 12 recommendations can be shown to be fully implemented.

That much the sector already accepts. What follows is the part that has not been examined.

The deaths that are not homicides

Between 2020 and 2024 the Territory recorded 49 deaths in a domestic and family violence context.

Eleven were homicides. Thirty-eight were not. Twenty-nine of the 38 were suicides.

Deaths that were not homicides outnumbered homicides by more than three to one. Suicides alone outnumbered homicides by more than two and a half to one.

Over 25 years the shape is the same. The register holds 168 fatal incidents, of which 31 are homicides and 137 are not. For every homicide the Territory recorded, it recorded more than four other deaths.

Almost everything in the system is built around those 31 homicides.

Two groups, one measurement failure

The 2025 review divides the 38 non-homicide deaths into two groups and reports the cause of death for each. The two groups are worth setting out together, because the same failure runs through both: the Territory could not reliably establish who was at risk, and from whom.

Thirteen were people the review assessed as victims. Eleven of the 13 were women. Eight of the 13 died by suicide. Separately, 8 of the 13 had been wrongly recorded by police or another agency as the predominant aggressor while alive — two of them within three months of death. The review lists the consequences it observed: criminal charges, loss of employment, removal of children, incarceration. The review does not report whether the 8 who were misidentified are the same 8 who died by suicide.

Twenty-five were people who had been accused of using domestic or family violence. Twenty-four of the 25 were men. Twenty-one of the 25 died by suicide. Twenty of the 25 had been named as the respondent to a family violence order, which is a civil order. Nine of the 25 held a current order when they died.

The first group records a finding the Territory made about itself. It looked for a specific error — people it had classified as victims having earlier been recorded as aggressors — and it found that error in 8 of the 13 cases it examined. That finding is the government's own, it is serious, and nothing here diminishes it.

For the second group, the same question was never asked. Of the 25 people the review recorded as perpetrators, there is no published check of whether that record was ever tested, contested or wrong.

So the Territory knows this classification error occurs. It knows the consequences are severe. It has looked for it in one direction and not the other, and it has never measured the rate in either.

That is not a claim that men are more often misidentified than women. The ACT holds no data that could support such a claim, and none that could refute it. The documented misidentification in the Territory's record runs against women. The point is narrower and harder to answer: the error was searched for in one direction only.

Why the deaths are the floor and not the measure

A death is the only outcome in this system that is recorded reliably. Nothing counts the harm short of it. Not the people who lost work, housing or contact with their children after an allegation. Not the people who were in acute distress and did not die.

That is why the deaths matter beyond their own number. They are the part of the record that is binary and unequivocal. A person is dead or they are not — there is no classification decision, no threshold and no discretion in the fact itself, which is more than can be said for anything else the system records.

Using deaths that way is ordinary statistical practice rather than an inference invented here. Homicide is the benchmark measure in international crime statistics because it is the offence most completely recorded, and mortality is used the same way in health services research, where deaths are treated as the visible fraction of a much larger volume of adverse events. That convention — reading recorded deaths as the visible part of a larger volume of unrecorded harm — has limits, and those limits are debated in both fields.

So the 29 are not the extent of the damage. They are the part of it the Territory is obliged to write down.

What can be said safely about the twenty-one

The review calls the 25 perpetrators. In ordinary speech that word implies proven guilt, which is more than the record behind it establishes.

The classification is the review's own. It read the available records, looked for a pattern of violence over time, and where it found one it recorded that person as a perpetrator. That is a defensible method for a death review. It is not an adjudication, and the review does not present it as one.

Underneath that label, the legal material is civil. A family violence order is made on the balance of probabilities. The court need not comply with the rules of evidence, and it may inform itself in any way it considers appropriate. An interim order is made before the case is heard, on the applicant's material, and often before the respondent knows the application exists. An order is a finding that protection is necessary. It is not a finding that the respondent did what was alleged.

Five of the 25 had contravened an order. Contravention is a criminal offence, and that is the only subgroup where the record points to something a criminal court would have had to prove. The review does not report how many of the 25 had ever been convicted of a domestic or family violence offence.

So the safe statement is this. **Twenty-one people took their own lives after being accused of using family violence. Most of them had been named as respondents to a civil order. For most of them, no court ever determined whether the accusation was true.** Some of them may well have used violence. Some plainly did. The point is that the record does not say, and nobody has ever asked it to.

How close the system was, and what that does not prove

Start with the explanation that is most likely to be right.

Orders are made where danger already exists. A high rate of orders among people who later die is exactly what would be expected if orders are working as intended and are being made where they are needed. That is the leading explanation for everything in this section, and it may be the whole of it. Nothing in the figures below establishes that an order, a service event or a court process contributed to any death, and nothing here should be read as making that claim.

With that caution stated, 9 of the 25 were subject to a current order when they died. Twenty-two of the 25 had been involved with police at some point, and 6 of the 25 had police involvement in the week before their death. The review defines police involvement in this dataset to include responding to a domestic and family violence incident, being served an interim family violence order, arrest, a welfare check, or a response to a mental health crisis.

In six cases out of 25, the system was at the door within seven days of the death. That is a fact about proximity. It is not a fact about cause, and on 25 cases it could not be.

The question nobody has asked

Whether the leading explanation is the whole explanation has never been tested. Between November 2025 and April 2026 the basic data was sought, by freedom of information application and by correspondence. The answers are themselves the finding.

The ACT Suicide Register has no field recording whether a deceased person was subject to a family violence order at the time of death. The Coroners Court confirmed that no review, audit, thematic analysis, research project or annual summary has ever examined correlations between domestic violence proceedings and suicide outcomes. ACT Policing advised that producing the figures would require an officer to read every recorded suicide case. Court statistics on interim orders were refused on the ground that outcomes are not administrative in nature.

None of those answers is evidence that such a relationship exists, or that anything has been suppressed. A refused request is a refused request, and a missing field is a missing field. What the four answers establish is narrower, and it is enough: the Territory has held 25 years of mortality data in this field and has never built the means to ask this question of it.

What the household pays for this

Every rates notice in the Territory carries the Safer Families Levy. It began on 1 July 2016 at $30 a household, it is $70 in 2026–27, and it had raised more than $46 million by 30 June 2024.

In November 2024 the Auditor-General reported that the responsible office "has not developed a performance monitoring strategy or evaluation framework to measure the outcomes and impacts of domestic and family violence initiatives funded through the Safer Families Levy".

On 27 May 2026 the Territory released a ten-year strategy and a first action plan. Neither uses the word "baseline". Neither uses the word "indicator". Neither sets a numeric target for any of its six outcomes, and neither names an agency accountable for any of them. The action plan promises to build a monitoring and evaluation framework over 2026 to 2028. A promise to build something is also a statement about what does not yet exist.

Seven things that could start this week

None requires legislation. None requires significant money. Each produces a public document that does not exist now.

1. Add a field to the ACT Suicide Register recording whether the deceased was subject to a family violence order, and publish the death review's existing cohort data cross-tabulated by sex, cause of death and order status.
2. Add a queryable flag to the police records system, set when an order is served.
3. Publish an implementation tracker for every death review and audit recommendation: owner, due date, status, evidence.
4. Publish quarterly court statistics on applications, interim orders, orders made without notice, conditions, outcomes and timeliness.
5. **Commission a test of the current risk instrument on standardised vignettes, register the protocol and the pass mark publicly, and publish the result whatever it shows.** It uses no client data, so no privacy approval is required. The fieldwork takes weeks and the whole study takes about five months; what happens in the hundred days is the commissioning and the public registration of the threshold. If agreement is high, the framework's authors are vindicated and a central criticism in these pages is wrong. If it is low, the Territory has learned something it needs to know before it prosecutes offences that turn on the same judgment. The replacement framework proposed in Part III is subject to the same test, on the same terms, before it is used on anyone.
6. Name an accountable position for each Strategy outcome, with the measures it will be assessed against.
7. Publish an operational plan for coercive control and systems abuse: the tools, the training, the charging guidance, and a protocol to stop a victim being recorded as the aggressor.

Behind those seven sit five larger reforms: rewrite the risk framework so that it actually functions as one; require a structured assessment before an order is made

without notice; give the respondent a fast way back into court and make the reasons the Act already requires actually say something, so that the moment the system classifies two people having heard from one leaves a record that can be checked; require a welfare and referral step when an order is served; and publish one annual ledger of what was spent and what changed. A sixth question — whether the blanket rule that a protected person commits no offence by helping to breach the order made for their protection should remain — is put separately, in the annex to Chapter 16, because it is a question and not yet a proposal.

Twenty-nine people died by their own hand inside this system in five years. The 2025 review can say that 9 of the 25 it recorded as perpetrators held a current order when they died, and that 21 of those 25 died by suicide. It has never published whether those are the same people. Nor has it published whether the 8 victims it found had been misidentified are the 8 who died by suicide. In both directions the Territory holds the records and has not run the cross-tabulation.

That is where the rest of the work starts.

How to use this work

Most readers should read only the public edition. This is the technical volume: the evidence and the instruments behind the short text. The two are the same argument at two lengths — the public edition is Book 1 of *The ACT Domestic and Family Violence Review* and this is Book 2. Where they differ in emphasis, quote the public edition: its sequence is the intended one, and Chapter 1 here is written to the same sequence for the same reason. Nothing in this volume goes further than the short text; it is only more detailed.

First pass. Chapters 1, 4, 6, 11, 16, 18 and 19. With the preface and prologue you have just read, that is the argument, the remedy, and the two bills. Chapter 1 stands alone and is written to be photocopied. A reader who has come for the bills can go straight to Chapter 19; it is written to be read on its own, and its drafted amendments are at Appendix G9.

Evidence pass. The rest of Parts I and II, in any order. Every chapter opens with a page that stands alone and closes with its sources.

Tools. Appendices A to H are working documents meant to be lifted out and used, not read. Appendix B Part 1 is a form, not a chapter. Appendix O is a study design, written at the level of detail a research office would need to run it.

Checking. Appendix I lists the principal sources and what each establishes. Appendix J defines the terms. Appendix K sets out the method. Appendix L assesses the 2026 Strategy and First Action Plan against what a strategy has to contain. Appendix M is the register of every finding in the work, with the identifier used to cite it. Appendix N sets out how the figures were verified, and which classes of statement cannot be verified in that sense. Appendix R sets out what the ACT and five other jurisdictions publish, and what reliability figures exist for the risk instruments they use. The author's standing and a full disclosure are at the back, under "About the author".

Arguing with it. Appendix Q contains two constructed critiques of this work — one from a specialist practitioner, one from a defence or human rights lawyer — each written as strongly as it can be written, each answered. Several are conceded, and one caused the third reform to be substantially narrowed. The critiques are printed as they were written, against the package as first proposed, rather than rewritten to fit the answer. Read that appendix before deciding whether the rest is fair.

Costing it. Appendix P costs every reform proposed here, with the volume assumption, the unit assumption and the result separated in every table, so that a reader who disagrees can identify which assumption they disagree with.

. . .

The standard applied. Everything here comes from the public record, frozen at 2 September 2026. Announced money, allocated money and spent money are kept apart, and none of the three is treated as a result. Where the record does not support

a conclusion, the finding is “not proven”, and that is used as a verdict rather than as a euphemism. People are named only where a public record already attributes a finding, a statement or a decision to them.

Part I — The system as it is

Chapter 1 — What the evidence shows

This chapter stands alone. Every statement in it is established later, with its source. Nothing here requires the reader to have read anything else. It is written to be photocopied.

The finding, in one paragraph

Between 2016 and 2026 the Australian Capital Territory built most of the components of a serious domestic and family violence system, paid for partly through a levy on every household. The architecture is far stronger than it was. What was never built is the other half: the part that measures whether any of it works. The Territory's own Auditor-General found in 2024 that the responsible office had not developed a performance monitoring strategy or an evaluation framework. Its own death review examined 13 deceased victims in 2025 and found that 8 of the 13 had, while alive, been wrongly recorded by police or another agency as the person causing the violence. Its own records cannot answer basic questions about who the system reaches, what happens to them, or who dies while inside it. Underneath all of it sits one technical failure. The ACT requires every part of its operation to manage risk to a recognised standard, and did not apply that standard to the process that can remove a person from their home without notice. The result is a system that cannot demonstrate what it achieved, and cannot tell whether it has caused harm.

Four numbers, each checkable in an afternoon

- **No performance monitoring strategy or evaluation framework** for the levy — ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024, 22 November 2024.
- **8 of 13** deceased victims had been wrongly recorded as the aggressor while alive — misidentified, in the review's word — ACT Domestic and Family Violence Review Biennial Report 2025.
- **0 of 17** requirements of AS ISO 31000:2018 are fully met by the July 2022 family violence risk framework. Eight are not met; nine are partly met.
- **2019–20** — the last year in which the ACT Magistrates Court published protection-order application statistics, in a period in which the Supreme Court has published five annual reviews.

What this work covers, and what it does not

The scope is deliberate, and stating it prevents a misreading that would otherwise be reasonable.

Risk management divides a hazard at the point where the unwanted event occurs. On one side sits **likelihood management**: everything that makes the event less likely to happen at all. On the other sits **consequence management**: everything that limits the harm once the event has occurred or is imminent, stops it escalating, and prevents the next one. Practitioners draw it as a bow tie, with the event as the knot.

This is a study of consequence management: the right-hand side of the risk bow tie. It examines what the Territory does once domestic or family violence has occurred or been alleged: how risk is assessed, how orders are made and served, how classification decisions are reached, what happens to the people on either side of them, and whether any of it is measured. That is what the *Family Violence Act 2016* is, what the 2022 risk framework governs, and where the great majority of the Safer Families Levy has been spent.

Likelihood management is not treated here, and its absence is not a judgment about its importance. Reducing the rate at which violence begins is a broader public policy question than this one. It runs through education, health, housing, welfare, child development, alcohol policy and the norms that shape behaviour long before any agency in this system meets anybody. It has its own evidence base, its own lead indicators and its own measurement problems, and it deserves its own volume. Chapter 2 section 8 sets out what the Territory has and has not built on that side, because the two sides have to be described together even when only one is being examined.

A note on why the material that follows concerns respondents so often. It is not a statement about who deserves attention. It is a consequence of where this system's own operations produce harm, and the record shows that harm running in both directions: 8 of the 13 deceased victims the death review examined had been wrongly recorded as the aggressor while alive, and 21 of the 25 people it recorded as having used violence died by suicide. Those are the same failure — a classification made without criteria and never checked — seen from opposite ends. A study of the right-hand side of the bow tie is necessarily a study of what the system does to the people it has already reached.

Two bills before the Assembly

Two bills were before the Legislative Assembly at the evidence cut-off, and this edition was published to meet them. Chapter 19 assesses both in full; Appendix G9 drafts the amendments. The short form is here because a reader who has come for the bills should not have to find it.

The *Family, Personal and Sexual Violence Legislation Amendment Bill 2025* repairs several things and replaces one. The repairs — good character in child-sex sentencing, protected confidences, remote presence in court, a dead cross-reference in section 113(e) — are improvements and should pass. The replacement is Part 2A: the after-hours orders a judicial officer now makes would be repealed (cl 47) and replaced by fourteen-day family violence safety notices issued by a police officer of or above the rank of sergeant, with two years' imprisonment for breach.

> **Three best.** The respondent's views must be considered before a notice issues, as far as reasonably practicable (ss 13D(2)(b), 13H(2)(b)) — nothing requires that before an interim court order. The notice served must state how each ground is satisfied and be explained in person (ss 13I(d), 13U), and cross-notices are barred because police "may be unable to identify the primary aggressor" (s 13B(d); Explanatory Statement p 30). Firearms may be seized at the moment of service (s 13ZD), section 113(e) is fixed (cl 39), and a written record is required at every branch of the decision (ss 13E, 13F, 13H(3), 13N).

Three worst. The applicant and the decision-maker are the same organisation, the standard is a belief on reasonable grounds that there is "a risk", and the judicial scheme is repealed rather than supplemented (ss 13B, 13H(1); cl 47). Reasons with content are prescribed for a refusal (s 13N(1)(e)) but a decision to issue produces only "a written record of the matters considered", kept in police records (s 13H(3)); only the notice reaches the court (s 13M); the respondent's return is "as soon as practicable" and must be dismissed if no date is available (s 13Y(3)). Nothing measures the scheme: the substituted section 156 names no data and no indicator, the government could give the Committee one number about the scheme being repealed — 45 orders in 2024–25 — and national recognition, later court history, working-with-vulnerable-people disclosure and tenancy consequences attach to a notice no court has seen.

The *Crimes (Coercive Control) Amendment Bill 2026* creates an offence of coercive control of a family member, punishable by seven years' imprisonment, commencing two years after notification, with an advisory committee from day one and a ministerial review three years after the offence commences.

Three best. The course-of-conduct provisions solve the particularisation problem that has defeated pattern prosecutions elsewhere, while still requiring the prosecution to plead the nature of the conduct and the period (s 72J(2), (4)–(7)). Oversight is established first and the offence is held for two years (s 2). One definition of family violence serves civil and criminal law (*Family Violence Act* ss 8, 9), the fault element is explained as a misidentification safeguard, and the strict liability of the 2024 bill is gone.

Three worst. The review examines "the operation of the amendments" and nothing else — no baseline, no measure of wrongful charging, no independent reviewer (s 72K). The committee's one function is to advise the Minister, its members are the Minister's choice, and it expires one year after the offence commences and at least two years before the review can begin (ss 433, 434). Nothing operates before charge: intent, the definition, the objective test and the reasonableness exception are all matters for trial; commencement is a date rather than a readiness test (s 2(2)); and a seven-year maximum without a prosecution election lets the accused choose the Supreme Court (*Crimes Act* ss 374, 375).

Both bills are well-intentioned, as the preface says. Both build a consequence on a police classification of who is at risk from whom, and neither requires that classification to be assessed against criteria, written in a form a court can read, or counted. The concerns are significant enough to warrant revision before passage rather than amendment at the margin: Part 2A of the first Bill should be rebuilt, and the second Bill should commence on demonstrated readiness rather than on a date. Every amendment needed is drafted at Appendix G9, and none of them raises a threshold or shortens the protection either instrument gives. Comments will be carried into a second edition.

What was built, and what it cost

This must be stated fairly. It is real, and a criticism that ignores it is not credible.

Since 2016 the ACT has:

- passed the *Family Violence Act 2016*;
- introduced the Safer Families Levy on 1 July 2016, at $30 per household, rising to $70 in 2026–27;
- announced a foundation package of $21.42 million over four years, and successively larger packages since;
- created a Coordinator-General for Family Safety, a Family Safety Hub, a multi-agency high-risk coordination program and a statutory death review;
- funded specialist crisis services, perpetrator behaviour change programs, health-justice partnerships, programs for children, and five Aboriginal community-controlled organisations;
- published a risk assessment framework in 2022 and information-sharing legislation in 2024;
- released a ten-year Strategy and First Action Plan on 27 May 2026; and
- committed, in the 2026–27 Budget, $47.8 million in additional funding and $151.4 million of total direct investment over four years, plus $13.2 million a year, indexed and ongoing, from 2029–30.

Three of those deserve specific credit. Indexed, ongoing base funding is what allows a service to plan, retain staff and invest in its systems, and it is a structural improvement on a decade of four-year packages. The 2026–27 Budget factsheet is the most transparent allocation document the Territory has produced, identifying recipients, funding sources and component amounts. The 2026 Strategy is the best strategic document in the archive: it covers prevention through to recovery, recognises children as victims in their own right, includes perpetrator accountability, and commits to Aboriginal and Torres Strait Islander leadership.

What cannot be shown

None of that answers the question a household paying the levy is entitled to ask: **what changed?**

The following cannot be established from any public source:

- cost per victim made safe;
- cost per repeat assault, serious injury, suicide or homicide averted;
- the rate at which the wrong person is identified as the aggressor, or whether it has changed;
- change in reoffending attributable to behaviour change programs;
- comparative outcomes for people of different sexes, genders or communities;
- the cost of unmet demand — waitlists, unanswered calls, people turned away;
- whether the mix of crisis, prevention, early intervention and recovery spending is the right one; or

- whether raising the money through a levy produces better outcomes than raising it through general revenue.

This is not a list of things nobody has bothered to calculate. It is a list of things that **cannot** be calculated. The underlying data is not collected in a form that permits it.

The correct verdict on value for money is therefore **not proven**. Not poor — several programs show promising results, and there is no evidence of waste in the ordinary sense. Not good either — no evidence exists that would support that conclusion.

"Not proven" is the finding, and it carries an obligation. A government that cannot show what a levy achieved, ten years after introducing it, owes the households paying it an explanation and a timetable.

This is the government's own conclusion

The First Action Plan of May 2026 commits the Territory to deliver, over 2026 to 2028: a monitoring and evaluation framework with annual progress reporting; updated system and client journey mapping; and analysis of the true cost of delivering safe, effective and integrated services. It also commits to a commissioning roadmap and revised cross-directorate governance.

Every item on that list is a core system management function.

A plan is also a statement about the present. Read plainly, the First Action Plan is an official statement of what the system lacked as at May 2026. As at that date the ACT did not have a monitoring and evaluation framework, a current system map, an understanding of what its services cost, or a commissioning approach.

The root cause, in plain terms

The ACT Government requires risk to be managed to a recognised standard across all of its functions. Its own policy says so, and says the requirement includes health and safety activities, policy development and planning. The standard is AS ISO 31000:2018.

Procurement is assessed that way. Public events are assessed that way. Staff travel is assessed that way. Information security is assessed that way.

One decision is not. It can remove a person from their home without notice. It can suspend the licence they need to work. It can interrupt their contact with their children. It is taken in minutes, on material from one side.

What the standard says

AS ISO 31000:2018, the risk management standard, defines risk as the effect of uncertainty on objectives. Six words, and three of them carry the meaning.

- **Objectives** — what the decision is trying to achieve.
- **Uncertainty** — what is not known at the time it is taken.
- **Effect** — the consequence or impact on those objectives, either positive or negative.

Take a police officer at a front door at two in the morning. Two people, two accounts, no history to hand. The objective is that nobody is hurt tonight or in future, and that

nobody is wrongly accused or removed from their home. The uncertainty is almost everything: which account is accurate, what happened before tonight, what either person will do once the car leaves. The possible effects run both ways — a person left in danger, or a person charged or put out of their house who was not a danger to anyone. Every part of that is risk in the standard's sense, and the standard's answer is not to wait for certainty. It is to reduce the uncertainty as far as the time allows, act on the best information available, and write down what remained unknown, so that the next person to touch the matter can see what the decision rested on.

The standard sets out three core elements:

- **Principles** — what good risk management does.
- **Framework** — how an organisation supports it.
- **Process** — the sequence an assessor follows.

That is as much as this chapter needs; Chapter 8 sets out all three in full and tests the ACT's framework against each of them in turn. A practitioner handbook covering the process in working detail is at dfvrisk.com.au, and the standard itself is available from Standards Australia.

The *Family Violence Act* requires a number of decisions at that point. Section 68 requires the court to record its reasons for making the order, and the Dictionary brings interim orders inside that duty — so the ACT is, on the face of its statute, ahead of several comparable jurisdictions. But section 68 does not say what the reasons must contain, does not require that they be given to the respondent, and provides for no publication; nothing in the public record indicates that any reasons recorded under it have ever been counted or read by anyone outside the file. Beyond that empty duty there is no published form, checklist, criteria set or content requirement structuring any of these decisions. Risk criteria — the written rules that say how likely and how serious a risk is being called, and what level is acceptable — are what makes two assessors of the same facts reach the same answer. The framework that would have supplied them has none.

The consequence runs through everything that follows. Without criteria, decisions cannot be consistent. Without consistency, they cannot be validated. Without validation, errors cannot be detected. Without detection, they cannot be corrected. The ACT's own death review has documented the most consequential of those errors, in 8 of a group of 13 people who later died.

The Territory left its most coercive process outside the risk standard it wrote for itself, and as a result cannot tell when it gets that process wrong.

Why exhortation has not worked

The missing measurement is the root cause. It is not the whole cause, and a reform that treats it as the whole cause will fail. Chapter 13 section 5 sets out the rest of it; the part that matters here is the incentive.

Two errors are possible at every decision in this system. Failing to protect a person who is then harmed produces a coronial process, a review, media attention, and a decision traceable to an individual. Restricting a person who was not a danger produces criminal charges, lost employment, removal of children and lost housing — and is entirely uncounted, because nothing counts it.

A decision-maker with no written criteria, under time pressure, facing one error that is visible and attributable and another that is invisible, will rationally maximise protection in every case that is not clear. That is not timidity. It is the correct individual response to the incentive structure, and any careful person would produce it.

Training tells a decision-maker to consider the less restrictive option. The incentive tells them that choosing it exposes them and choosing the other does not. That is why the reforms below are structural, and why none of them is an instruction to try harder.

What the deaths require

Two death reviews, read together, tell the system what it has to be able to do.

See patterns, not incidents. In about 9 of the 12 homicides reviewed in depth in 2023 there was "a clear absence of significant physical violence prior to the homicide". Coercive control was present in almost all 12. The signal this system is built to detect — a reported incident of physical violence — was absent in three of every four killings the review examined closely. A screening approach built around counting assaults will miss most lethal cases.

Measure misidentification. Eight of the 13 deceased victims had been wrongly recorded by police or another agency as the predominant aggressor while alive, two of them within three months of death. Eleven of the 13 were women. Four of the 13 had been the respondent to a family violence order where, on the review's own reading of the files, the evidence indicates the applicant was the aggressor — a classification made in the same way, and carrying the same limits, as the perpetrator label at finding 6. The consequences recorded include being criminally charged, losing employment, having children removed, and being incarcerated. This is the error the risk framework exists to prevent, documented in the Territory's own record. It was found because somebody looked for it. No rate has ever been published for it, and the same question has never been asked in the other direction.

Stop equating fatality prevention with homicide prevention. Over 25 years the register records 137 non-homicide deaths against 31 homicides. In the most recent five years, suicides outnumbered homicides by more than two and a half to one. The 2026 Strategy cites both death reviews and adopts two of their findings, and uses the word "suicide" once, inside the title of a different document; the First Action Plan does not use it at all.

A caution about the twenty-one, and what it is for

The 2025 review also recorded 25 people it classified as having used violence. Twenty-one of them died by suicide, and 20 had been named as respondents to a civil order. That classification is the review's reading of files, not a conviction, and five of the 25 are recorded as having contravened an order, which is the only subgroup in which a criminal standard was engaged.

Orders are made where danger already exists. That is the leading explanation for the association, it may be the whole of it, and nothing here establishes that an order or a court process contributed to any death. It has also never been tested, because the Suicide Register has no order-status field and no agency has ever run the analysis.

The point is the missing test, not a cause. Chapter 11 sets out what can and cannot be said about this cohort at length, and does not go further than this.

Treat the deaths as a floor, not a measure. A death is the only outcome this system records reliably, and the only one that is binary: a person is dead or they are not, with no classification threshold and no assessor judgment in the fact itself. Suicide attempts are not typically recorded. No agency records psychological harm, loss of work, loss of housing or loss of contact with children as an outcome of an allegation or an order. Treating recorded deaths as an indicator of a much larger unmeasured volume of harm is standard practice in crime statistics, where homicide is the benchmark offence because it is the most completely recorded, and in health services research, where mortality is read as the visible fraction of adverse events.

Treat housing and income as safety issues. Among deceased victims, 62 per cent were unemployed and 54 per cent had experienced homelessness or housing instability, against 36 per cent and 20 per cent among deceased perpetrators.

Connect the responses. Of the 25 deceased perpetrators, 24 had a history of problematic substance use and 19 had a mental health condition. Both reviews found those systems poorly integrated with the family violence response.

Count the children. Sixty-seven children were affected by the 38 non-homicide deaths. Some of them discovered the body.

The question nobody has asked

Start with the explanation most likely to be right. Orders are made where danger already exists, so a high rate of orders among people who later die is exactly what would be expected. That is the leading explanation, it may be the whole of it, and nothing in these pages establishes that an order or a court process contributed to any death.

Whether the leading explanation is the whole explanation has never been tested. Between November 2025 and April 2026 the data that would test it was sought, by freedom of information application and by correspondence. The four answers are the finding.

- The ACT Suicide Register has **no field** recording whether a deceased person was subject to a family violence order at the time of death.

- The Coroners Court confirmed that **no review, audit, thematic analysis, research project or annual summary** has ever examined correlations between domestic violence proceedings and suicide outcomes.
- ACT Policing advised that producing the figures would require an officer to review every case in which a suicide is recorded.
- Court statistics on interim orders were **refused**, on the ground that they concern court outcomes rather than the management of court resources.

None of that is evidence of concealment and none of it is treated as such here. Each answer has an ordinary administrative explanation, and the sources are set out at Chapter 11. What the four together establish is narrower, and it is enough: the Territory has held 25 years of mortality data in this field and has never built the means to ask a question of it.

The ACT death review does record family violence order status at the time of death, and reports it: nine of the 25 deceased people it identified as perpetrators were respondents to a current order when they died. The mortality register does not hold the same variable, and no agency has joined the two. Item 1 of the hundred-day list is that join.

Seven things that could be done in a hundred days

None requires legislation. None requires significant funding. Each produces a published artefact that does not currently exist.

#	Action	Who	Cost
1	Add a field to the ACT Suicide Register recording family violence order status at the time of death, and publish the death review's existing cohort data cross-tabulated by sex, cause of death and order status	ACT Coroners Court; death review	A schema change and a query against data already held
2	Add a queryable status flag to the police records system, set when an order is served	ACT Policing	A routine system change request
3	Publish an implementation tracker for every death review and audit recommendation: owner, due date, status, evidence	Responsible directorate	Assembly of existing information
4	Publish quarterly court administrative statistics on applications, interim orders, orders made without notice, conditions, outcomes and timeliness	ACT Courts and Tribunal	A report from an existing system. The court published an annual version of part of this series until 2019–20
5	Commission inter-rater reliability testing on the current risk instrument using standardised vignettes; publicly register the protocol, the thresholds and the withdrawal trigger before recruitment	Framework owner, with an independent analyst	About $147,000; no client data required. Fieldwork six weeks; whole study about five months. Protocol at Appendix O
6	Name an accountable position for each Strategy outcome, with the measures it will be assessed against	Government	A governance decision
7	Publish an operational plan for coercive control and systems abuse: frontline tools, training, charging guidance, and a protocol against recording a victim as the aggressor	Responsible directorate and ACT Policing	Existing policy capacity

Item 5 is the most important. It is a vignette study using no client data, which is what removes the privacy approvals that would otherwise dominate the timeline. It answers the question the public record leaves open: how consistently is the Territory's risk instrument actually applied? If agreement is high, a central criticism here is wrong and the framework's authors are vindicated. If it is low, the Territory has learned something it needs to know, and needs to know it before commencing offences that turn on the same judgment. The only outcome with no value is continuing not to know.

The design is specified in full at **Appendix O**: twenty vignettes built only from published material, about 150 assessors across five role groups, the statistic and the reason for choosing it, the agreement threshold that counts as adequate, matched pairs that vary the sex of the parties on otherwise identical facts, and a pre-registered result that would require the instrument to be withdrawn from classification decisions. The fieldwork is six weeks. The whole study is about five months and costs about $147,000, which is roughly 4 per cent of the new system-building money announced with the 2026 Strategy. What belongs inside a hundred days is the decision to proceed, the public registration of the protocol, and the publication of the thresholds before anyone knows the result. Registering the pass mark in advance is the part that cannot be done afterwards.

The five reforms

1. Rewrite the risk framework so that it actually functions as one. Keep structured professional judgment, the evidence-based risk factors, coercive control as a pattern, and the person's own assessment. Add defined likelihood and consequence scales, a stated risk tolerance, and a full comparison of the treatment options. Add a residual risk statement — what is left after the protections are actually in place — with a named person who accepts it, named risk owners, framework-level monitoring and framework-level reporting. Replace the sex-specific primary aggressor indicators with an evidence and pattern method that applies to any person and permits the answer "unresolved". Do not deploy it until inter-rater reliability has been measured and published. State in advance the result that would cause it to be withdrawn. *(Chapter 15; Appendices A, C, D and E)*

2. Require a structured risk assessment before an interim order is made without the respondent present. A new Division 4.1B of the *Family Violence Act* (numbered 4.1B because the Bill before the Assembly inserts a Division 4.1A of its own). It does not change the threshold in section 21, does not delay urgent action, and does not invalidate orders. It requires the decision to proceed without notice to rest on a documented analysis rather than on practice — an assessment and a risk management plan prepared at the registry, in accordance with the approved framework and consistent with AS ISO 31000:2018, the standard the government applies to itself, inside the two-day window the court already works to.

> **The duty does not commence until the registry and judicial time it consumes has been funded, and the clause says so.** The Minister may not fix a commencement day until a statement has been presented to the Legislative Assembly identifying the re-

sourcing provided, the volume assumed and the assessment time assumed. A structured assessment added to an unchanged workload becomes a form to be signed rather than an analysis to be done: worse decisions, better documentation. That is a risk to be managed in the drafting, not a caveat to be noted in a costing. *(Chapter 16 sections 3.2 and 3.2b; Appendix G1, s 47B)*

3. Give the respondent a fast way back into court, and make the reasons the Act already requires say something. At the ex parte stage the court classifies two people having heard from one, and the Territory's own record shows that classification going wrong: 8 of the 13 deceased victims had been wrongly recorded as the predominant aggressor, and 4 of the 13 had been the respondent to an order where the evidence indicates the applicant was the aggressor. Two things follow, and both can be defended from Chapter 7 alone.

The expedited return. Section 91B of the Act gives an applicant refused by a Registrar a same-day request for review, a rehearing anew, and a return within two days — and provides that the registrar need not tell the respondent about it. A respondent restrained by a granted order has no equivalent. Section 82(c) lets them apply to amend the order, but that application routes through a preliminary conference listed "as soon as practicable"; and the Act's urgent limb, section 82B, is open only to the protected person or the applicant. The reform gives the respondent one request and the same two-business-day period, with the protective conditions continuing until the listing, and gives the magistrate power to confirm, amend or revoke. The protected person is written into it: notice as soon as practicable, appearance by audiovisual link, one adjournment of up to seven days for representation with the order continuing, and a power in the court to decline the expedited listing where they could not be fairly heard in the time. It is an entitlement to be heard, not to a discharge.

Content for the reasons. Section 68 of the *Family Violence Act* already requires a court to record the reasons for making a protection order, and the Dictionary defines *protection order* to include an interim order. What section 68 does not do is say what those reasons must contain, require that they be given to the respondent, or provide for their publication or aggregation — and nothing in the public record indicates that reasons recorded under it have ever been counted, sampled or reported. A new section 68A would require the reasons, in a without-notice case, to state the material relied on and whether any of it came from a source independent of the applicant's account, why the matter could not wait for a notified listing, which less restrictive conditions were considered and why they were insufficient, and whether the court could identify which party is the person most in need of protection. A copy goes to the respondent with the order. The last of those is what makes the classification capable of being measured: at present nothing on the file distinguishes a case in which the court was confident from one in which it was not. A third element makes the first two enforceable: section 92 confines appeals to final orders and section 87 confines review to special interim orders, so a general interim order made without notice attracts neither. A new section 47D extends the section 87 review to such an order, with non-compliance with the assessment or reasons duties as a ground. The three elements are proposed together and are not severable, because reasons nobody reads

within the window that matters become boilerplate, and a duty with no remedy is a request. *(Chapter 16 section 4; Appendix G1, G1A)*

And one question put to the Assembly, not a recommendation. This is not a proposal that an interim order made without notice be mutual by default. It is narrower: where a **magistrate** is satisfied that the material does not permit the court to identify which party is the person most in need of protection, they **may** include equivalent conditions binding both until the first contested listing. Conduct by both parties does not of itself engage it, and resistive or protective conduct must be disregarded, so an applicant's candid account of hitting back is not the trigger. Reasons are required for making reciprocal conditions and not for declining to. Not a default, and not a finding — the reciprocal limb would not suspend a firearms licence, would not be a finding of family violence, and would not be disclosable. It would carry an offence, but only because an express provision deems the protected person into section 43 for that purpose; the existing section does not do that work by itself, because section 43 applies to a person *against whom* an order is made. An express amendment to section 21 is also required. No jurisdiction has run the design, so it cannot commence before its baseline is published, carries an expiry keyed to any fall in applications concentrated in a cohort vulnerable to misclassification, and ends after 24 months unless the Assembly resolves otherwise. The strongest objection — that it may deter people from applying at all — cannot be answered from any existing record and is not answered here. *(Chapter 16 section 4; Appendix G1A and G8)*

4. Require a safety and support step when an order is served. A new Division 3.8. The legislated minimum is a scripted welfare question set, written information about support, and a recorded offer of referral, with a defined escalation pathway where the answers indicate acute risk. Regulation enables stronger versions: accompanied service in defined high-risk categories, and clinical support for both parties. This is the control that is now absent at the moment of highest risk. *(Chapter 16; Appendix G)*

5. Publish the money and the results. One annual ledger covering every initiative, showing original and revised budget, actual expenditure, funding source, recipient, cohort served, targets, achieved outputs and outcomes, reprofiled and lapsed amounts, evaluation status, and cost per result. A flag identifies which figures may be added together and which may not. With it: published quarterly court statistics, a published implementation tracker, and published validation results for every instrument in use. With it also: where an order is discharged, withdrawn or dismissed, the discharge is corrected through every system that recorded it, a firearms licence suspended under section 44 is reinstated administratively rather than on fresh application, and the number of orders ending that way at first contested hearing is published. *(Chapters 16 and 17; Appendices F and P)*

A question put, not a reform proposed

Section 43(4) of the *Family Violence Act* removes complicity liability from a protected person absolutely. A protected person who deliberately induces a respondent to contravene the order made for their protection commits no complicity offence, whatever their intention. A replacement offence is not proposed as a reform. It is set out instead as a question in the annex to Chapter 16, with the draft provision at Appendix G3 marked accordingly.

The reason is evidentiary, not political. The other five reforms each answer a gap documented in the ACT record. This one does not. No ACT data establishes how often deliberate inducement occurs, and the comparative charging data from jurisdictions without a blanket exemption has not been assembled here. Until that evidence exists, it is a question about the design of a criminal exemption, and it is put as one. Nothing in the five reforms depends on how it is answered.

A sixth measure is a Cabinet process change rather than a reform of this system. No material justice or service reform should be funded without a published whole-of-system demand and capacity model that names the agency expected to absorb any unfunded demand. *(Chapters 6 and 16)*

What the five reforms would cost. About $1.68 million one-off and between about $720,000 and $1.20 million a year: about $4.4 to $6.3 million over four years for the legislated minimum, with an illustrative central case of about $5.1 million. The range is wide because two of the quantities that drive it — the annual number of determinations made in the absence of a respondent, and the proportion in which the court cannot identify the person most in need of protection — are not published anywhere, which is the same missing data the rest of these pages describe. The recurrent cost is about 1.9 to 3.2 per cent of the Territory's direct annual investment, and the four-year figure exceeds the $3.6 million allocated in 2026–27 to building the system rather than running it. Adopting the package without funding it would be worse than rejecting it. *(Chapter 18 section 7; Appendix P)*

FIGURE 1.1

The five reforms

Each reform names the failure it addresses and the provision that would carry it. The sixth measure is a Cabinet process change, not a reform of this system.

1	**Rewrite the risk framework so that it actually functions as one.**	Chapter 15; Appendices A, C, D, E. No legislative element.
2	**Require a structured risk assessment before an interim order is made without the respondent present.**	New Division 4.1B: s 47A, with commencement at s 47B. Section 21 threshold unchanged.
3	**Give the respondent a fast way back into court, and make the reasons the Act already requires say something.**	New s 47C (expedited return), s 68A (reasons content), s 47D (review ground, extending s 87).
4	**Require a safety and support step when an order is served.**	New Division 3.8, ss 44H–44M.
5	**Publish the money and the results.**	Reporting, not legislation. Appendix G5; s 44 on reinstatement.

A sixth measure, outside this system
No material justice or service reform funded without a published whole-of-system demand and capacity model that names the agency expected to absorb any unfunded demand.

Cost of the legislated minimum
About $1.68m one-off and $720,000 to $1.20m a year: about $4.4–$6.3m over four years, with an illustrative central case of about $5.1m.

The five reforms, with the legislative element each requires. Adopting the package without funding it would be worse than rejecting it.

Chapter 1. Costs are the package total; per-reform costs at Appendix P.

The replacement framework proposed here is unvalidated, by its own standard. No inter-rater reliability figure exists for it, because it has never been used. That is the same objection made in these pages against the instrument now in force, and it applies with full force to the replacement. The framework must not be deployed on any person before agreement between assessors has been measured on standardised vignettes and the result published, whatever the result shows. The protocol is specified in full at Appendix O, including the analysis plan, the threshold that counts as adequate agreement, and the pre-registered result that would require the framework to be withdrawn. Publishing that trigger before the data is collected is the point. A framework that cannot survive its own test should not survive it. *(Chapters 15 and 18; Appendix O)*

Eighteen findings

Each is stated in one sentence, with its figure and its source. Each is established in the chapter identified.

1. The government's own auditor found there was no way to measure whether the money worked. "The DFSVO has not developed a performance monitoring strategy or evaluation framework to measure the outcomes and impacts of domestic and family violence initiatives funded through the Safer Families Levy." — ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024, 22 November 2024. *(Chapter 3)*

2. A household levy operated for nine years without a Territory strategy. The ACT's previous strategy expired in 2017. In March 2018 the government identified a national plan as its overarching strategy. No ACT-specific strategy operated until 27 May 2026 — nine years and ten months after the levy commenced. — Auditor-General Report 10 of 2024; ACT DFSV Strategy 2026–2036. *(Chapters 2 and 3)*

3. Eight of the 13 deceased victims the ACT reviewed had been wrongly recorded as the aggressor. "Of the non-homicide deaths reviewed for this report more than half (8 out of 13) of the victims appeared to have been misidentified as the predominant aggressor by police or another agency prior to their death." The recorded consequences included criminal charges, loss of employment, removal of children and incarceration. Eleven of the thirteen were women. — ACT Domestic and Family Violence Review Biennial Report 2025. *(Chapters 4 and 9)*

4. The Territory has never measured how often it gets that decision wrong. No sensitivity, specificity, inter-rater reliability or error analysis has ever been published for any ACT family violence risk or classification instrument. *(Chapters 8 and 9)*

5. Deaths in this system are overwhelmingly not homicides, and the system is designed around homicides. Between 2000 and 2024 the ACT register recorded 168 fatal incidents in a domestic and family violence context: 31 homicides and 137 non-homicide deaths. Between 2020 and 2024 there were 11 homicides and 38 non-homicide deaths, 29 of them suicides — more than three non-homicide deaths for every homicide, and more than two and a half suicides for every homicide. The 29 divide into 21 of the 25 people accused of using violence and eight of the 13 assessed as victims. So the largest category among the deaths this review was able to examine is people who had been accused of using violence and who then took their own lives — a statement about the 38, not about the 49, since 10 of the 11 homicides could not be analysed. Twenty-four of those 25 were men, and 20 of the 25 had been named

as respondents to a family violence order. The disproportion is not new and is not unpublished: the 2023 report recorded 17 homicides among 106 identified incidents from 2000 to 2022. The 2026 Strategy cites both reviews, adopts their coercive control and patterns findings, and uses the word "suicide" once, inside the title of a different document. The First Action Plan does not use it at all. Neither document states which deaths this system is responsible for preventing, publishes a count of the deaths that are not homicides, or names an agency that holds them. — ACT DFV Review Biennial Reports 2023 and 2025; ACT DFSV Strategy 2026–2036 and First Action Plan 2026–28. *(Chapter 4 sections 3 and 7)*

What the 2020–24 cohort is, and is not

Every figure drawn from the 2025 death review's 38 non-homicide deaths comes from a group assembled in a particular way, and the way it was assembled shapes what is in it.

Who gets onto the register. A death enters the register when an agency identifies it as occurring in a domestic and family violence context and shares that identification. It is not a census. The register grew from 134 incidents to 2022 (106 identified and 28 suspected) to 168 incidents to 2024. The two totals are not built the same way, but the growth exceeds what two further years of deaths would add, which indicates the earlier count was incomplete. A death no agency identifies is not in the record at all, and there is no way to estimate how many those are.

"Perpetrator" and "victim" are the review's classifications. They are the review's reading of the available records, made for the purpose of the review. They are not court findings, and the review does not present them as such. Where a person was misclassified while alive, the review's classification can inherit that error. That is what Theme 1 of the review is about.

The homicides are missing. Of the 11 homicides in the period, 10 were before the courts or the coroner and could not be analysed. The 38 are therefore what remains after the most serious and most fully investigated deaths have been set aside. Any contrast drawn between the non-homicide deaths and the homicides is a contrast with a group this review could not examine.

What that does to the numbers. Thirteen and 25 are small, they are not random samples of anything, and the proportions within them are not rates in any wider population. Every figure taken from them describes these people. None of them is an estimate of prevalence.

6. The label on the second cohort was never tested by a court. The perpetrator label in the fatality record is the death review's own reading of the records, not a court finding. Underneath it the legal material is civil: 20 of the 25 had been named as the respondent to a family violence order and nine held a current one when they died. A family violence order is made on the balance of probabilities, in a court that need not comply with the rules of evidence, and an interim order is made before the case is heard and often before the respondent knows of it. It is a finding that protection is necessary, not a finding that the respondent did what was alleged. Five of the 25 are recorded as having contravened an order, which is the only subgroup where a criminal standard was engaged, and the review does not report how many of the 25 had ever been convicted of a domestic or family violence offence. What can be said

is that 21 people took their own lives after being accused of using family violence, that most of them had been named as respondents to a civil order, and that for most of them no court determined whether the accusation was true. — ACT DFV Review Biennial Report 2025; *Family Violence Act 2016* (ACT), ss 13, 13A, 21, 65. *(Chapters 4 and 7)*

7. Nine people died while subject to a current family violence order, and no agency has ever examined why. Of 25 deceased people identified as perpetrators between 2020 and 2024, 20 had been the respondent to an order at some point. Nine were respondents to a current order when they died. Six had police involvement within a week of death, and the review records that police involvement in this dataset includes being served an interim order. The review has never published whether those nine are among the 21 who died by suicide. — ACT DFV Review Biennial Report 2025. *(Chapters 4 and 11)*

8. The coroner does not record it, the police cannot query it, and nobody has looked. "The ACT Suicide register does not have a field identifying whether a deceased person was subject to a Family Violence Order at the time of death... There has been no internal review, audit, thematic analysis, research project, or annual summary has examined correlations between domestic violence proceedings and suicide outcomes." — ACT Coroners Court advice, provided through the Justice and Community Safety Directorate, 26 March 2026. ACT Policing separately advised that producing the figures would require "an AFP Officer to review every case where a suicide is recorded" — AFP freedom of information decision LEX 5220, 19 February 2026. *(Chapter 11)*

9. Basic court statistics about the order system are not published and cannot be obtained. A request was refused. It asked for the number of interim orders made without the respondent present, the recorded gender of those respondents, and how many were confirmed at final hearing. The reason given was: "It requests information regarding material Court outcomes, not information regarding the management of Court resources." The ACT Magistrates Court had published application and interim application counts in its annual reviews until 2019–20 — 1,249 applications and 1,152 interim applications in that year — and has published no annual review since, in a period in which the Supreme Court has published five. — JACS freedom of information decision 2026/496, 2 February 2026; ACT Magistrates Court Annual Review 2019–20; ACT Courts annual reviews page as at 2 September 2026. *(Chapter 11)*

10. The framework that governs family violence risk decisions is not a risk framework by the government's own standard. The ACT requires risk management aligned to AS ISO 31000:2018 across all its functions, expressly including health and safety activities. The July 2022 family violence risk framework contains no risk criteria, no likelihood or consequence scales, no tolerance threshold, no treatment option comparison, no residual risk step, no named risk owners, no framework-level monitoring and no framework-level reporting. Tested clause by clause, eight requirements are not met, nine are partly met, and none is fully met. — CMTEDD Risk Management Framework and Policy v7.0; AS ISO 31000:2018; ACT DFV Risk Assessment and Management Framework, July 2022. *(Chapter 8)*

11. Two years after the framework was published, agencies were still reaching different conclusions about the same case. An independent review found agencies across the system using different risk processes, and found them capable of reaching different conclusions about the same case. — *Review of Sexual Violence and Domestic and Family Violence Crisis Response Services in the ACT*, May 2024. *(Chapters 5 and 8)*

12. The framework tells practitioners that a man who is calm, or critical of the system, or focused on his rights, is more likely to be the aggressor. Fact Sheet 10 lists, among indicators that a man claiming to be a victim is more likely to be the primary aggressor, that he "seems overly calm and confident", "presents as overly charming or charismatic", is "forthright, critical and opinionated about the ways that 'the system'... responds to domestic and family violence", "focuses on his rights and how he feels they are being violated", and "appears to have a second motive for the allegations, such as a Family Court matter". The same fact sheet states that "there is no definitive set of indicators", and no validation has ever been published. — ACT DFV Risk Assessment and Management Framework, Fact Sheet 10, July 2022. *(Chapter 9)*

13. The Territory's high-risk coordination program recorded four male victims in 258 referrals. Across three financial years the Family Violence Safety Action Program recorded 4, 5 and 6 male victim-survivors out of 258, 258 and 211 referrals, and one non-binary victim-survivor across all three years. National data records men as roughly 24 per cent of people experiencing physical or sexual violence by a cohabiting partner since the age of 15, and roughly 36 per cent of those experiencing any partner violence or abuse. The ACT has never examined the difference. — ACT Human Rights Commission freedom of information decision, 4 November 2025; ABS Personal Safety Survey 2021–22. *(Chapter 10)*

14. The prosecution service says it does not have time to prepare matters properly. Over four years, family violence prosecutions rose about 50 per cent and sexual violence prosecutions rose about 170 per cent. The Director of Public Prosecutions told Assembly hearings that "when you put additional police on the street, it results in increased charges which come into my office, and there has been no commensurate increase to my funding", and that "the real-life effect... is that my staff simply do not have time to prepare the matters properly". — ACT Legislative Assembly Hansard, 16 September 2025. *(Chapter 6)*

15. Sexual violence prosecutions grew about four and a half times faster than reported sexual offending. The Director of Public Prosecutions reported a 170 per cent increase in sexual violence prosecutions over four years. Over roughly the same period the ACT's recorded sexual assault victimisation rate rose from 65.0 to 89.4 per 100,000 — about 37 per cent. Family violence prosecutions rose about 50 per cent against a 33 per cent rise in recorded incidents. Those are different measures over slightly different periods, but the divergence is specific to the sexual violence stream. Over the same period the share of matters that ended without being proved rose sharply: family violence matters discontinued went from 2.4 per cent of completed matters in 2017–18 to 12.7 per cent in 2023–24, and sexual offence matters from 2.5 per cent to 17.3 per cent. No agency publishes the reasons for discontinuance, or whether the material that ended a prosecution was already held. — ACT DPP annual

reports 2017–18, 2023–24 and 2024–25; ABS *Recorded Crime — Victims* 2024; ACT Policing Annual Report 2024–25; Hansard, 16 September 2025. *(Chapter 6)*

16. The crisis line cannot answer every call, and the Minister could not say how many are missed. The 2024 review found the 24-hour domestic violence crisis line "is unable to answer all calls… with many diverted to voicemail, especially overnight and on weekends". On 10 June 2026 the responsible Minister was asked in the Assembly for the current rate of unanswered calls, and said the member would have to speak directly to the service. The Minister also said the acceptable rate was a question for the service. — Crisis services review, May 2024; ACT Legislative Assembly Hansard, 10 June 2026. *(Chapter 5)*

17. Three years on, not one recommendation from the ACT's first death review can be shown to be fully implemented. The 2023 review made 12 recommendations and warned that unactioned recommendations perpetuate a cycle of inaction. The 2025 review made no new recommendations, stating that the 2023 recommendations remained relevant. The Auditor-General recommended in 2024 that implementation be monitored and reported. No implementation tracker has been published. — ACT DFV Review Biennial Reports 2023 and 2025; Auditor-General Report 10 of 2024. *(Chapters 4 and 13)*

18. The strategy that ended the nine-year gap contains no baseline, no target and no named indicator. The ACT Domestic, Family and Sexual Violence Strategy 2026–2036 sets six outcomes. Neither it nor the First Action Plan 2026–28 uses the word "baseline" or the word "indicator" once. Neither sets a numeric target for any outcome. Neither names a lead agency for any outcome. The monitoring and evaluation framework that would supply those things is described in the future tense, and governance arrangements are described as "being developed". Of the funding announced with the Strategy, $3.6 million over four years is directed to new foundational system infrastructure; the remainder of the package is largely continuity for frontline services. — ACT DFSV Strategy 2026–2036 and First Action Plan 2026–28, 27 May 2026; joint media release, 27 May 2026. *(Chapter 2; Appendix L)*

The limits of these findings

Six limits are stated here, once, and are not restated elsewhere. Anything attributed to these findings beyond them is not in them.

It does not say the money was wasted. That would require actual expenditure data, outcome data and a comparison. None of the three exists for most of the portfolio.

It does not say anyone is biased against men or against women. The evidence shows differences in service reach and in framework design. It does not show intent, and the data that would permit a proper analysis of differential treatment has never been collected. What the evidence does establish is *measurement* bias: the data architecture makes some groups invisible. That is a property of a data system, not of a person.

It does not say the gendered design of the system is wrong. In the deaths reviewed for 2025, 24 of 25 people identified as perpetrators were male, 11 of 13 iden-

tified as victims were female, and every male perpetrator targeted a female victim. A system that concentrates resources on violence against women and children, and on the behaviour of men who use violence, is responding to what its own evidence shows. The argument in Chapter 10 is not that this focus is wrong. It is that a system built around the modal case still has to be able to see the others, and this one cannot.

It does not say that orders cause deaths. Orders are made in situations that are already dangerous, so a high rate of orders among people who later die is what would be expected. That is the leading hypothesis. It has never been tested, because the data required to test it has never been collected.

It does not generalise from single cases. Chapter 12 examines three ACT matters in detail: two in which an allegation was accepted and did not survive examination — one ending in the complainant's conviction for perjury, one in charges discontinued after the investigating officer's admissions in cross-examination — and one in which reports of danger to a child were made repeatedly and not assembled. Cases establish a mechanism. They do not establish a rate, and no rate is claimed from them. The research consensus that deliberately false allegations are a small minority of reports, and that under-reporting is the larger problem, is accepted here and is not disturbed by anything in that chapter. The three matters are in the chapter because the same structural failure — a verification step with no owner — is documented running in both directions.

It does not allege bad faith by any person or agency. Systems of this kind fail through accumulated design decisions, missing feedback loops and unfunded interfaces. Naming a person for a system failure obscures the cause and makes it harder to fix. Functions are named throughout; individuals are named only where a public record already attributes a finding, statement or decision to them.

How to check anything in this chapter

Twenty-four documents carry the argument. All are public.

#	Document	Date
1	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024	22 Nov 2024
2	ACT Domestic and Family Violence Review Biennial Report 2025	2025
3	ACT Domestic and Family Violence Review Biennial Report 2023	2023
4	ACT DFV Risk Assessment and Management Framework, with Fact Sheets 1–10	July 2022
5	AS ISO 31000:2018 Risk Management — Guidelines	2018
6	CMTEDD Risk Management Framework and Policy, v7.0	July 2023
7	*Family Violence Act 2016* (ACT)	to 1 July 2025
8	*Human Rights Act 2004* (ACT)	to 17 Mar 2025
9	Magistrates Court Practice Direction 1 of 2026	10 Mar 2026
10	Crisis specialist services review, Social Ventures Australia	May 2024
11	ACT DFSV Strategy 2026–2036	27 May 2026
12	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026
13	2026–27 Budget DFSV factsheet	2026
14	2025–26 Budget Outlook, Appendix H	2025
15	Safer Families Levy Principles	2025
16	Glanfield, *Review into the system level responses to family violence in the ACT*	May 2016
17	ACT Legislative Assembly Hansard, 16 September 2025	16 Sep 2025

#	Document	Date
18	ACT Legislative Assembly Hansard, 10 June 2026	10 Jun 2026
19	ABS, *Personal Safety, Australia*, 2021–22	2023
20	Mathews and others, *Medical Journal of Australia*	2025
21	ACT Human Rights Commission FOI decision and 2024–25 annual report	4 Nov 2025
22	ACT Director of Public Prosecutions annual reports, 2017–18, 2023–24 and 2024–25	2018–2025
23	ABS, *Recorded Crime — Victims*, 2024	2025
24	ACT Policing Annual Report 2024–25	2025

Appendix I lists these documents with what each establishes, together with the freedom of information decisions cited in Chapter 11 and the full source list.

The verdict

Promising architecture. Incomplete implementation. Unproven aggregate impact. And a system that, by its own records, cannot yet tell whether it has caused harm.

That is not a conclusion about anyone's intentions. It is a description of what the Territory can and cannot demonstrate.

It is also entirely fixable, and seven of the fixes could begin this week.

Chapter 2 — Building the system, 2016–2026

In one page

In 2016 the ACT restarted its response to domestic and family violence. The trigger was the death of a nine-year-old boy, Bradyn Dillon, killed by his father in February 2016. A system-level inquiry led by Laurie Glanfield AM reported in May 2016, with three other reviews alongside it. They said the same thing in different words: the system was fragmented, agencies did not share information, children were being missed, and nobody was accountable for the whole.

The response was substantial: a new *Family Violence Act 2016*, a household levy from 1 July 2016, a four-year $21.42 million Safer Families package, and new institutions built around a Coordinator-General for Family Safety. Perpetrator programs, a risk assessment framework, information-sharing legislation and much more money followed.

Two things did not happen. The Territory's previous domestic violence strategy expired in 2017 and was not replaced for nine years. And no framework was built to tell anyone whether any of it was working.

The Domestic, Family and Sexual Violence Strategy 2026–2036 and its First Action Plan, released on 27 May 2026, are the strongest strategic documents the Territory has produced. They also commit to future work: a monitoring and evaluation framework, a system map, a costing of services and a commissioning roadmap. Those are the tools used to run a system. Committing to build them in 2026 states what did not exist for the ten years before.

One number, one quote, one action

Number: Nine years. The ACT's domestic violence strategy expired in 2017 and was not replaced until 27 May 2026. The Safer Families Levy collected money for the whole of that gap.

Quote: A monitoring and evaluation framework "will be used to establish a consistent approach" to monitoring, reporting and evaluation, including of Safer Families Levy expenditure. — ACT Domestic, Family and Sexual Violence Strategy 2026–2036, 27 May 2026

This week: An Assembly member can lodge questions on notice asking, for each of the six Strategy outcomes, what the 2026 baseline value is, what the 2028 target is, which data source will be used, how often it will be reported, and which position is accountable. A government can answer by publishing those six lines on one page.

1. The lag between commitment and delivery

Ten years of official record show a consistent pattern. It is not neglect. Money, legislation and institutions arrived. What arrived late, or not at all, are the parts that let a government tell whether any of it worked.

Component	First recommended	Delivered
Information sharing authority	2016 (Glanfield)	Legislation 2024; implementation continuing 2026
Common risk framework	2016–2018	Published July 2022; update still in progress 2026
Territory strategy	Previous strategy expired 2017	Released 27 May 2026
Monitoring and evaluation framework	2024 (audit)	Committed as future work in 2026
System-wide needs assessment	2024 (audit)	Committed as future work in 2026
Levy allocation principles	2024 (audit)	Effective from 2025–26
Pattern-based primary aggressor tool	2023 (death review)	In development at September 2026

The lag is six to ten years for the components that make the separate parts work as a system. Five of the seven rows were still open at the evidence cut-off.

The constraint was not a lack of diagnosis. Between 2016 and 2026 the Territory produced or received about a dozen substantial pieces of analysis. They ran from the Glanfield inquiry to an Auditor-General audit of the levy. They included two biennial death reviews, an independent review of crisis specialist services and an Aboriginal and Torres Strait Islander expert reference group report. Many identified the same problems.

What was missing was the feedback loop. A functioning system identifies need, funds a response and delivers it. It then measures what changed, sets that against what it cost, and feeds the answer into the next funding decision. The ACT built the first steps and not the last. A system that cannot measure its results cannot detect its errors. Chapters 9, 10 and 11 show what that looks like from the inside.

2. The starting point, 2016

On 15 February 2016, nine-year-old Bradyn Dillon died in Canberra. His father was later convicted of his murder. The case had been known to child protection services.

On 22 April 2016 the ACT Government commissioned an inquiry into the system-level responses to family violence, led by Laurie Glanfield AM, a former New South Wales director-general of justice. He reported the following month. The inquiry was explicit that it was not investigating the death itself; criminal proceedings and any coronial inquest would deal with responsibility.

The report described a system with good parts and no working joints. Staff did not believe they had authority to share information, and had no culture of sharing it. The Child and Youth Protection Service faced rising child concern reports, progressed very few, and rarely referred the rest on. Mandatory reporters got little feedback,

which drove them to report again. No single position was accountable for making services work together.

The recommendations grouped into four outcomes: an information-sharing culture focused on the safety of the whole family; better assessment, referral and case management for vulnerable families and children; better quality and transparency in child protection decisions; and better oversight, including a mechanism to ensure recommendations are actually implemented. The fourth is worth marking. In May 2016 the Territory's foundational inquiry identified a distinct problem needing its own solution: recommendations in this field tend not to be implemented. That problem recurs throughout the record.

The report also recommended a Coordinator-General for Family Safety, and a Family Safety Hub to assess lower-level child concern reports and self-referrals and connect families to services. Three further pieces of diagnostic work followed: a service system gap analysis, a review of the family violence legislation, and the death review function that became the biennial reports examined in Chapter 4. The ACT entered 2016–17 knowing what was wrong, which rules out one standard explanation for slow reform: that nobody knew.

3. The legislative and funding response, 2016–17

3.1 The Family Violence Act 2016

The *Family Violence Act 2016* replaced the previous protection order regime for family violence. Its preamble does two things at once. It recognises that **anyone can be a victim of family violence**, regardless of gender or sexual identity. It also states that family violence is **predominantly committed by men against women and children**. Both are supported: the Act applies to any person in a family relationship, and the Territory's fatality evidence supports the statement about the pattern. The difficulty is that the operational documents built underneath the Act lean on the second statement — the pattern of men's violence against women and children — while the legal framework rests on the first, that the Act applies to any person. Chapters 8 and 9 examine what that produces.

The Act also created the framework for family violence orders, including interim orders, which may be made in the absence of the respondent. Chapter 7 examines that pathway.

3.2 The Safer Families Levy

The Safer Families Levy commenced on 1 July 2016. It is a flat charge on ACT households, collected with rates. Its stated purpose was to support people affected by domestic and family violence and to raise community awareness. The government later described it as "a partial offset" to broader investment, never intended to fund the whole response.

Year	Levy per household
2016–17	$30
2021–22 to 2024–25	Rising by $5 a year to $50

Year	Levy per household
2025–26	$60
2026–27	$70

From the 2024–25 Budget, the levy no longer funded any non-frontline ACT Government position, matching a commitment that levy money would go to frontline services. The levy is expected to raise around $49.401 million over the four years to 2027–28, and by 30 June 2024 had raised more than $46 million since commencement. The $63.0 million levy figure in the 2026–27 Budget, set out in section 6 below, covers a later four-year window, 2026–27 to 2029–30, at the higher rate. The two figures are not in conflict.

A dedicated charge on every household creates a durable funding base, and creates with it an obligation to account for what the money bought. Chapter 3 examines whether households have been given an account of what the money achieved.

3.3 The Safer Families package

The 2016–17 Budget announced a four-year Safer Families package of **$21.42 million**. It funded system leadership through the Coordinator-General, case coordination, specialist services, family violence liaison officers, and Room4Change, a residential and non-residential behaviour change program for men who use violence. Every later announcement builds on it, and several include parts of it. Those overlapping announcements are the origin of the counting problem described in Chapter 3.

4. Building out, 2017–2024

4.1 The institutional layer

The **Coordinator-General for Family Safety** and the **Family Safety Hub** were established as Glanfield recommended. The **Family Violence Safety Action Program** became the multi-agency mechanism for high-risk cases. The **Domestic Violence Prevention Council** continued as an advisory body, producing a review of domestic and family violence deaths and a discussion paper on criminalising coercive control. The **death review function** was established in statute.

The 2018–19 Budget added **$6 million** for Family Safety Hub pilots and **$6.5 million** for accommodation, expressly including women's refuges. It added **$1.7 million** for counsellors at the Canberra Rape Crisis Centre and the Domestic Violence Crisis Service. In 2017 the Standing Committee on Justice and Community Safety began an inquiry into domestic and family violence policy; the government responded in December 2019, adding recommendations to those already outstanding from 2016.

4.2 The strategy gap opens

The ACT's previous domestic violence strategy ran from 2011 to 2017. When it expired, it was not replaced. For the following nine years the Territory relied mainly on national plans: first the National Plan to Reduce Violence against Women and their Children, then the National Plan to End Violence against Women and Children 2022–2032. National plans set national priorities. They do not identify what is needed in a jurisdiction of 470,000 people, or tell a government how to allocate its budget.

The Auditor-General later found that for much of the levy period there was no Territory-specific strategy in operation, and no current system-wide assessment of need. A levy was collecting money, packages were announced and programs funded, with nothing current to prioritise or judge them against.

4.3 2021: sexual violence and the Listen. Take Action report

In 2021 the *Listen. Take Action to Prevent, Believe and Heal* report was published, following consultation about sexual violence responses in the ACT. It drove reviews of specialist services and of police processes for sexual assault, the appointment of an adviser, and work towards a multidisciplinary centre.

The 2021–22 Women's Budget Statement reported **$35.9 million over four years** for domestic, family and sexual violence work, and forecast **$30.3 million** of levy revenue over four years. Presenting that spending in a Women's Budget Statement is consistent with the population evidence. It also means the record of that year's spending sits inside a document organised around gender. Chapter 10 returns to what that does to the data.

4.4 The risk framework and the information-sharing scheme

In July 2022 the ACT published its **Domestic and Family Violence Risk Assessment and Management Framework**, usually shortened to the DFV-RAMF. Before it, agencies had no common language for family violence risk. It sets out a structured professional judgment model, covers generalist as well as specialist services, and addresses coercive control, children and perpetrator accountability. The framework is candid about its limits: its tools are built on evidence about heterosexual intimate partner violence, and it says it should be updated as evidence about other groups develops.

Part II examines the framework in detail. For the chronology, one fact matters beyond the dates in the table above: it was not consistently implemented across the system in the years that followed.

Information sharing was Glanfield's first recommended outcome in 2016. Legislation to authorise it passed in 2024, eight years later, with commencement delayed while the supporting framework, protocols and training were developed. The First Action Plan of 2026 lists implementation as continuing work.

4.5 The 2024 audit

On 22 November 2024 the ACT Auditor-General published Report 10 of 2024, a performance audit of the Safer Families Levy. It is the only independent, whole-of-portfolio assessment in the decade. Chapter 3 sets out its findings; in summary:

- no Territory-specific strategy operating for much of the period;
- no current system-wide assessment of need;
- weak linkage between identified need, strategy, budget allocation and levy allocation;
- incomplete performance measures; and
- public reporting that did not allow anyone to assess the levy's contribution to system outcomes.

It also found, in words the government has not disputed, that the responsible office had not developed a performance monitoring strategy or an evaluation framework. The government response accepted the substance and committed to a published set of principles governing the use of the levy, improved budget disclosure, evaluation and annual reporting. The principles took effect from 2025–26, nine years after the levy began.

5. Coercive control, 2024–2026

Coercive control is a pattern of behaviour used to dominate and control another person. It may include isolation, surveillance, financial control, threats and micromanagement of daily life, with little or no physical violence. Its legislative history shows how the Territory handles a reform where the destination is agreed and the route is not.

Date	Event
14 May 2024	Assembly considers coercive control education and system readiness
25 June 2024	Leanne Castley MLA presents a private member's Crimes (Coercive Control) Amendment Bill 2024
27 August 2024	The bill is negatived. The government's published position is that it does not support the bill at that time, favouring further implementation work, education and consultation
October 2024	Criminalising coercive control is a commitment at the ACT election
20 March 2025	Further Assembly motion and debate; the government amends the motion, committing to a pathway to criminalisation and system readiness
25 September 2025	The government commits publicly to legislate a standalone coercive control offence by mid-2026
28 May 2026	Minister Marisa Paterson MLA presents the government's Crimes (Coercive Control) Amendment Bill 2026
2 September 2026	The legislation page records the bill as before the Assembly

Just under two years separate the first private member's bill from the government bill. The stated reason was system readiness: training, risk tools, information sharing and public education had to be in place before a new offence could be enforced safely. That is reasonable in principle.

The 2023 death review recommended a pattern-based primary aggressor tool for police and courts. At the evidence cut-off the updated tool was still described as being developed or embedded, and no validation results had been published. A new offence turning on a pattern of control would be enforced using assessment tools whose accuracy has never been measured. Chapter 9 examines that combination, and whether the readiness work has been done.

6. 2026: the Strategy, the Action Plan and the Budget

On 27 May 2026 the ACT released the **Domestic, Family and Sexual Violence Strategy 2026–2036** and the **First Action Plan 2026–28**. The Strategy is direct on gender: the ACT will take a gendered, intersectional approach that includes tailored responses for men and boys. Section 7 assesses both documents.

The First Action Plan commits the Territory to deliver, over 2026 to 2028:

- a Monitoring and Evaluation Framework, with annual progress reporting;
- updated system mapping and client journey mapping;
- analysis of the true cost of delivering safe, effective and integrated services;
- a commissioning roadmap;
- revised cross-directorate governance;
- implementation of the information-sharing scheme and an updated risk framework; and
- a primary prevention infrastructure model.

Every item is a core system management function that a government running a dedicated levy for ten years would normally have already. Read plainly, the plan is an official acknowledgement: as at May 2026 the ACT had not published a monitoring and evaluation framework, a current system map, a costing of its services, or a commissioning approach.

The 2026–27 Budget accompanied the Strategy with the largest and most transparent package of the decade:

- **$47.8 million additional over four years**, of which **$44.2 million** was described as frontline investment;
- **$151.4 million total direct investment over four years**, combining new and continuing commitments;
- funded from about **$77.2 million** ACT consolidated revenue, **$63.0 million** levy, **$11.0 million** Commonwealth agreement funding and a small reprofiled amount;
- a further **$37.9 million** in adjacent initiatives supporting strategy outcomes; and
- **$13.2 million a year**, indexed and ongoing, from 2029–30.

The last is the most significant and least reported. Indexed, ongoing base funding lets a service plan, retain staff and invest in systems — a structural improvement on a decade of four-year packages.

7. The 2026 Strategy: direction without a scoreboard

The Strategy 2026–2036 is the strongest strategic document in the ACT archive. It runs from prevention through to recovery, rather than stopping at crisis. It recognises children as victims in their own right, not as witnesses to harm done to someone else. It carries a whole outcome for Aboriginal and Torres Strait Islander self-determination. It names disability, LGBTIQA+ people, migrant and refugee communities and older people. Ten years earlier none of that was on the page. Nothing below argues that the Strategy should not have been written, or that its direction is wrong.

The Strategy sets six outcomes. Four are described as human-focused: changes in people's lives. Two are described as enabling: changes in the system meant to produce the other four.

A full-text examination of both documents establishes what is not there. Across the Strategy and the First Action Plan, the word "baseline" does not appear. The word "indicator" does not appear. No numeric target is set for any outcome, for 2028, 2032 or 2036. No data source is nominated. No reporting frequency is stated. No lead agency is named for any outcome.

That gap has a practical consequence. In 2036 no one will be able to say whether the Strategy succeeded, because no state of affairs has been described against which the six outcomes could be tested. The Auditor-General's 2024 criticism was of reporting that describes activity instead of measuring impact. Outcomes without indicators carry that same risk up to the level of the Strategy itself.

The instrument that would supply the numbers is described in the future tense. The Strategy states that a monitoring and evaluation framework "will be used to establish a consistent approach" to monitoring, reporting and evaluation, including of Safer Families Levy expenditure. That is the instrument the Auditor-General found missing in November 2024. Eighteen months later it is a commitment rather than a document, and governance arrangements are described as "being developed". A commitment to build a measurement system is welcome. It is not a measurement system.

Delivery is phased in a way that matters to anyone waiting for a service. The Strategy's own delivery figure places 2026 to 2028 as a period of sustaining services while longer-term reform begins: mapping the system, redesigning governance and preparing for the next stage of commissioning. The substantive redesign, and the commissioning that follows it, sit in the 2028–32 action plan. That work is necessary. But a person on a waiting list in 2026 is waiting for a redesign that starts to be commissioned in 2028.

Accountability in the Strategy is written as "we" and "our", with responsibility shared across government, the sector and the community. Shared responsibility is a fair description of the social task. It is not a governance arrangement. A commitment with no named owner cannot be tracked, escalated, or seen to fail, which means it cannot be corrected. The same pattern appears with priority groups: disability, LGBTIQA+ people, migrant and refugee women and older people are

described in the Strategy's analysis, but none carries dedicated outcome machinery, a funding principle or an access measure.

Set against the ten-year record, the position is straightforward. The Territory has closed the strategy gap it opened in 2017. It has not closed the measurement gap the Auditor-General identified in 2024. The 2026 documents supply direction, the thing most obviously missing for nine years. They do not supply a scoreboard, so the Assembly, the sector and households paying the levy can judge progress only against the government's own account of its activity.

The Strategy's account of the current state rests on consultation. A consultant led an engagement process across Aboriginal community-controlled organisations, the specialist sector, broader human services and government, and Women's Health Matters ran a separate consultation with adult victim-survivors through the peer-led Victim Survivors Voices pilot. That work produced two Listening Reports and a published consultation report, and the Strategy sets out what it heard from each group. The material is necessary: it is the only available account of what the system is like for the people inside it.

It is used, however, where a measurement should be. The Strategy describes rising reports, unmet demand and piecemeal funding qualitatively, drawing on the Listening Reports, and it does not publish a current demand and gap analysis. Consultation tells a government what people experienced. It does not tell it how many, how often, at what cost, or whether anything changed. **Consultation is not measurement, in the same way that outputs are not outcomes.** In each case something real — what people said, or what was delivered — is counted as evidence of something else: whether anything changed.

The same substitution appears twice in the Strategy. The Strategy's priority-groups analysis is also drawn from consultation, and it does not carry through into outcome machinery, funding principles or access measures. Consultation identified the groups. Nothing measures whether they are reached.

That is a governance finding rather than an objection to listening, and the remedy is not less consultation. It is to publish the two things beside each other: what people said, and what the numbers show. Chapter 14 sets out the same rule at the level of the individual assessment — a person's account is a primary input and is not by itself a rating.

A second omission runs the other way. The Strategy cites both biennial death reviews and takes two findings from them: coercive control in almost all deaths examined, and patterns rather than single incidents. The composition of the deaths does not appear. On a full-text check of both published documents, the word "suicide" occurs once in the Strategy, inside the title of another plan listed among related strategies, and not at all in the First Action Plan. Neither uses "self-harm", "homicide", "fatality" or "death review". Chapter 4 section 7 examines what follows from that.

Appendix L sets out the full assessment: fourteen findings tested against what a strategy must contain if anyone is later to say whether it worked, fourteen remedies, and a one-page scoreboard the Territory could publish without new legislation. Chapter 17 sets out the governance instruments that would give the six outcomes owners.

8. The bow tie: which side the Territory built

Sections 1 to 7 describe what was built in the order it was built. This section describes it a second way, because the shape matters more than the sequence and because it sets the boundary of what the rest of this work examines.

8.1 The two sides

Risk management divides a hazard at the point where the unwanted event occurs. Draw the event as a knot and the controls fan out on either side of it, which is why the picture is called a bow tie.

The left side is likelihood management. It contains everything that makes the event less likely to happen at all: changing the conditions, the norms and the trajectories that produce it. In this field that means education, the development of children, housing and economic security, alcohol policy, health and mental health services, and the attitudes that make control seem ordinary. Most of it operates years before anybody meets an agency in this system.

The right side is consequence management. It contains everything that limits harm once violence has occurred or is imminent: identifying who is at risk, protecting them, stopping escalation, holding the person using violence in view, and preventing the next incident.

Both sides are necessary and they are not substitutes. A system that manages only consequences becomes efficient at responding to a problem it has not reduced. A system that funds only prevention leaves the people already in danger to manage on their own. The question is never which side to build. It is whether either side can show that it works.

8.2 What the ACT built, side by side

Read against that division, the record in this chapter is lopsided in a way that is easy to miss when it is read chronologically.

	Left side — likelihood	Right side — consequence
Legislation	—	*Family Violence Act 2016*: protection orders, conditions, contravention offences, service
Risk instruments	—	2022 Risk Assessment and Management Framework: screening, current-risk assessment, safety planning
Coordination	—	Family Safety Hub; the multi-agency high-risk coordination program; information sharing
Services	Prevention programs, at a share of levy-supported initiatives that did not materially rise across the audited period	Crisis line, crisis accommodation, counselling, behaviour change programs, court support
Measurement	None published	None published

The *Family Violence Act 2016* is, in operation, a protection-order and enforcement instrument. The 2022 framework assesses risk as it stands at the moment of assessment. The coordination architecture convenes agencies around people already identified. Chapter 3 records the spending shape that follows: crisis response took 34 to 46 per cent of levy-supported initiatives annually, and prevention 12 to 20 per cent,

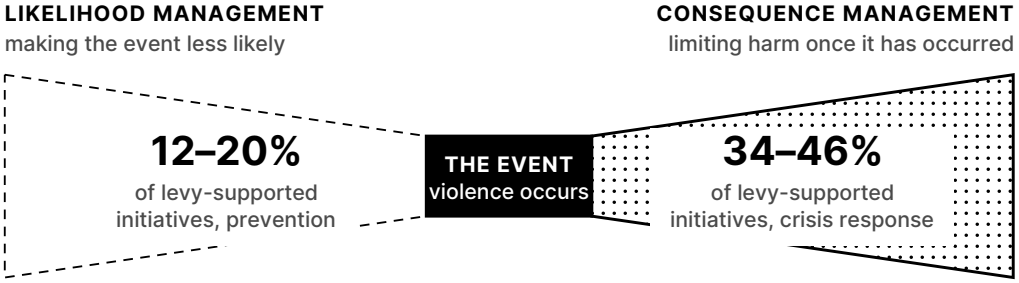
with the prevention and recovery shares not materially rising across the period the Auditor-General examined, despite repeated strategic commitments that they would.

That is not a criticism of any of those components. It is a description of where a decade of effort went.

FIGURE 2.1

The bow tie: which side the Territory built

Draw the event as a knot and the controls fan out on either side of it. Both sides are necessary and they are not substitutes.



THE FOUR STAGES THE AUDIT COUNTED

Prevention	Early intervention	Crisis response	Recovery
12–20%	**25–33%**	**34–46%**	**13–17%**

The wings above show the one stage the chapter places on each side. Initiatives can be counted in more than one stage, so the four shares do not sum to 100 per cent, and early intervention and recovery are not assigned to a side here.

	Left side — likelihood	Right side — consequence
Legislation	—	Family Violence Act 2016: protection orders, conditions, contravention offences, service
Risk instruments	—	2022 Risk Framework: screening, current-risk assessment, safety planning
Coordination	—	Family Safety Hub; high-risk coordination; information sharing
Services	Prevention programs, at a share that did not materially rise	Crisis line, crisis accommodation, counselling, behaviour change, court support
Measurement	**None published**	**None published**

Each side has a measurable claim attached to it. Neither has been tested here.

The likelihood claim
fewer first incidents, fewer people beginning to use violence, changed norms

not measured as a system

The consequence claim
serious harm, lethality, repeat victimisation and system failure fall

not measured as a system

A system that manages only consequences becomes efficient at responding to a problem it has not reduced. What follows examines the right-hand side, because that is where the Act, the framework and the great majority of the expenditure sit.

Chapter 2, section 8; Chapter 3, section 2.3. ACT Auditor-General, Safer Families Levy, Report 10 of 2024. Wing proportions are schematic; the shares are annual, across the audited period, and given at their range.

8.3 What the 2026 Strategy changes

The Strategy is a different document in this respect, and the difference should be credited plainly.

It puts the left side on the page. It states that violence "is preventable, not inevitable". It adopts a four-stage continuum — prevention, early intervention, response, recovery and healing — and defines prevention as "stopping violence before it starts by addressing the underlying drivers among the whole community". It carries a dedicated social-change outcome, Outcome 4, that all people "actively model safe and respectful behaviours and are empowered to embody and enact social change". It commits to build "effective primary prevention infrastructure to drive down rates of violence over time", and states that people using or at risk of using violence will be "recognised early, held accountable and supported to change their behaviour before violence occurs or escalates".

Read as a map, the Strategy is a full-continuum document rather than a consequence-management one. That is a real shift, and it is the strongest thing in it.

What follows the map is where the difficulty starts. The funding announced alongside it for new foundational system infrastructure is $3.6 million over four years, and its prevention component funds Women's Health Matters to **develop a model** for primary prevention infrastructure. A model is a design. The Strategy's own phasing places the substantive redesign and commissioning in the 2028 to 2032 window. So the left side is named, partially funded, and scheduled — and not yet operating at population scale.

8.4 The test that applies to both sides

The point of the bow tie is not that one side is neglected. It is that each side has a measurable claim attached to it, and neither claim has been tested here.

The likelihood claim is that violence becomes less common: fewer first incidents, fewer people beginning to use violence, changed attitudes and norms. **The consequence claim** is that when violence does occur, serious harm, lethality, repeat victimisation and system failure fall, that victim-survivors are safer sooner, and that intervention with people using violence stops recurrence.

Neither is being measured as a system. The Auditor-General found in November 2024 that the responsible office had developed no performance monitoring strategy and no evaluation framework, that monitoring was ad hoc, that indicators often lacked targets, and that only some programs had been evaluated. The Strategy promises a monitoring and evaluation framework, which is an acknowledgement of the gap rather than a closing of it.

What is visible instead is architecture. A levy, an office, a framework, a hub, a sector network, an information-sharing coordinator, and a training program. Those are inputs and system capabilities. **Counting them is not the same as showing that either likelihood or consequence changed**, and that substitution — controls implemented and reported, residual risk assumed to have fallen, and nobody able to demonstrate it — is the standard failure mode in risk management. Chapter 8 shows

it operating at the level of the individual assessment. This section shows the same thing at the level of the portfolio.

8.5 One consequence for how the Strategy states its own problem

There is a small illustration of the measurement discipline this section is about, and it is on the face of the Strategy.

The Strategy states, in its opening pages, that "approximately 1 in 5 women in the ACT report having experienced physical violence and/or sexual violence since the age of 15". Six pages later it states that "42% of women – or an estimated 73,200 women – in the ACT reported having experienced physical and/or sexual violence since the age of 15", sourced to the Australian Bureau of Statistics.

Those two sentences describe the same measure — ACT women, physical and/or sexual violence, since the age of 15 — and differ by a factor of about two.

The likely explanation is benign: one of the two sentences has probably lost a qualifier in drafting, and the 42 per cent figure is internally consistent with the count of 73,200 that accompanies it. Nothing here suggests otherwise, and the discrepancy is not treated as evidence of anything beyond itself.

It is included because of what it illustrates. This is the headline prevalence figure of a ten-year strategy, stated twice, at two values, in a document that sets no baseline and no target for any of its six outcomes. A strategy that had to publish a 2026 baseline and measure against it in 2036 would have reconciled those two sentences before it went to print, because one of them would have become the number everything else was judged against. Appendix L records this as finding L14.

8.6 What this means for the rest of this work

The chapters that follow examine the right-hand side, because that is the side the *Family Violence Act*, the risk framework and the great majority of the expenditure occupy, and because it is the side on which the Territory's own records document harm.

That is a scope decision and not a claim about relative importance. Prevention is not a slogan attached to the edge of the real work; it is the only thing that changes the base rate, and a right-hand side that works perfectly still processes whatever the left-hand side sends it. A second study, of likelihood management in the ACT, would be at least as valuable as this one and would require a different evidence base to write.

What can be said from here is narrower. On the right-hand side, the Territory has built a great deal and measured almost none of it. That is the subject of Parts I and II, and the reason Part III begins with measurement rather than with services.

What this chapter established

Five findings that this chapter establishes and nothing else in these pages does. This chapter's complete set of 15 is at Appendix M, where it can be read against every other chapter's.

- **F2.5** — The previous strategy expired in 2017 and was not replaced until 27 May 2026. For that nine-year gap the levy operated with no Territory-specific strategy and no current needs assessment.

- **F2.9** — Structural components lagged their first recommendation by six to ten years. The 2026 Strategy and First Action Plan commit as future work to the monitoring and evaluation framework, system map, true-cost analysis and commissioning roadmap a system of this age would normally hold.
- **F2.10** — The Strategy 2026–2036 is the strongest strategic document in the ACT archive. It sets six outcomes: four described as human-focused, two as enabling. Full-text examination of the Strategy and the First Action Plan finds no use of the words "baseline" or "indicator", no numeric target for any outcome for 2028, 2032 or 2036, no nominated data source, no stated reporting frequency and no named lead agency.
- **F2.13** — The ACT's system is, in bow-tie terms, predominantly consequence management: the *Family Violence Act 2016* is a protection-order and enforcement instrument, the 2022 framework assesses current risk, and crisis response took 34 to 46 per cent of levy-supported initiatives annually against 12 to 20 per cent for prevention. The 2026 Strategy is the first ACT document to put likelihood management on the page, with a four-stage continuum, a dedicated social-change outcome and a commitment to primary prevention infrastructure — funded, in its first tranche, to develop a model.
- **F2.10b** — The Strategy cites both biennial death reviews and adopts two of their findings. The composition of the deaths does not appear: "suicide" occurs once in the Strategy, within the title of another plan, and not at all in the First Action Plan.

Sources for this chapter

Claim	Source	Date
Inquiry commissioned 22 April 2016; findings and recommendations	*Report of the Inquiry: Review into the system level responses to family violence in the ACT* (Glanfield)	May 2016
Act preamble: universal coverage and gendered pattern	*Family Violence Act 2016* (ACT)	2016
Levy start and rates to $70 in 2026–27; $49.401m to 2027–28; non-frontline positions removed 2024–25	Safer Families Levy Principles	2025
Levy raised more than $46 million to 30 June 2024	ACT Auditor-General, Report 10 of 2024	22 November 2024
$21.42m Safer Families package and components	2016–17 Budget, Safer Families material	2016
2018–19 package: $6m Hub, $6.5m accommodation, $1.7m counsellors	2018–19 Budget material	2018
$35.9m over four years; $30.3m forecast levy revenue	2021–22 Women's Budget Statement	2021
Audit findings: no Territory strategy or current needs assessment; weak need-to-allocation linkage; incomplete performance measures; no monitoring or evaluation framework	ACT Auditor-General, Report 10 of 2024	22 November 2024

Claim	Source	Date
Risk framework published; built on heterosexual intimate partner violence evidence	ACT DFV Risk Assessment and Management Framework	July 2022
Coercive control chronology	Assembly bill pages, Hansard, government responses	2024–2026
Commitment to legislate by mid-2026	Ministerial media release	25 September 2025
Strategy and Action Plan commitments	ACT DFSV Strategy 2026–2036; First Action Plan 2026–28	27 May 2026
Gendered, intersectional approach, including tailored responses for men and boys	ACT DFSV Strategy 2026–2036	2026
Six outcomes, four human-focused and two enabling; prevention to recovery; children as victims in their own right; Aboriginal and Torres Strait Islander self-determination outcome; priority groups named	ACT DFSV Strategy 2026–2036	27 May 2026
No “baseline” or “indicator”; no numeric target for 2028, 2032 or 2036; no data source, reporting frequency or lead agency (full-text examination)	ACT DFSV Strategy 2026–2036; First Action Plan 2026–2028	27 May 2026
“is preventable, not inevitable”; the prevention / early intervention / response / recovery continuum and its definitions; Outcome 4; “effective primary prevention infrastructure to drive down rates of violence over time”; people using or at risk of using violence “recognised early… before violence occurs or escalates”	ACT DFSV Strategy 2026–2036	27 May 2026
“approximately 1 in 5 women in the ACT report having experienced physical violence and/or sexual violence since the age of 15” (p 5) against “42% of women – or an estimated 73,200 women – in the ACT reported having experienced physical and/or sexual violence since the age of 15” (p 11, ABS 2023)	ACT DFSV Strategy 2026–2036	27 May 2026
Consultant-led engagement; separate Women’s Health Matters consultation with adult victim-survivors under the peer-led Victim Survivors Voices pilot; two Listening Reports; published consultation report	ACT DFSV Strategy 2026–2036, “Victim Survivor Voices” and “Strategy Consultation”	27 May 2026
Word occurrence check: “suicide” once in the Strategy, within the title of the ACT Mental Health and Suicide Prevention Regional Plan 2025–2030, and zero times in the First Action Plan; “self-harm”, “homicide”, “fatality” and “death review” zero in both	Full-text search of the published PDFs of both documents	Checked 3 September 2026
Monitoring and evaluation framework “will be used to establish a consistent approach”; governance “being developed”; phasing 2026–28 and 2028–32	ACT DFSV Strategy 2026–2036; First Action Plan 2026–2028	27 May 2026
Release of the Strategy and First Action Plan	Joint media release, Chief Minister and Minister for the Prevention of Domestic, Family and Sexual Violence	27 May 2026
2026–27 funding figures and sources	2026–27 Budget DFSV factsheet	2026

Chapter 3 — The money: announced, allocated, spent, proven

In one page

Between 2016 and 2026 the ACT announced at least eight major domestic and family violence funding packages. The headline figures range from $12 million to $151.4 million. They cannot be added together. Each covers a rolling four-year window that overlaps the last. Each mixes new money with money already committed. Each draws on different sources: ACT revenue, the Safer Families Levy, and Commonwealth funding.

The levy raised more than $46 million from 1 July 2016 to 30 June 2024. Across levy-supported initiatives in that period, $33.323 million from all sources went to government activity and $25.628 million went to community-sector activity. The balance shifted markedly. In the first four years, government activity received $17.334 million against $5.222 million for the community sector. In the second four years, the community sector received $20.406 million against $15.989 million for government.

The spending mix stayed weighted towards crisis. Across the audited years, crisis response accounted for 34 to 46 per cent of levy-supported initiatives each year. Prevention accounted for 12 to 20 per cent, early intervention for 25 to 33 per cent, and recovery for 13 to 17 per cent. Prevention and recovery shares did not materially rise. The policy commitment to shift upstream was by then a decade old.

The 2024 Auditor-General's report is the only independent assessment of the whole portfolio in the decade. It found three things. Planning was undermined by the absence of a Territory strategy and of a current understanding of need. The responsible office had not developed a performance monitoring strategy or evaluation framework. Public reporting was not transparent or effective in showing how the levy was used or what it achieved.

The 2026–27 Budget is the most transparent allocation document the Territory has produced. It is still an allocation document. It shows where money is intended to go. It does not show what was achieved.

The verdict on value for money is **not proven**. That is not the same as "wasted", and it is not the same as "fine".

> **One number, one quote, one action**
>
> **Number:** $302.7 million. That is the total produced by adding five separately published, individually true statements about the 2026–27 Budget. The real figure for direct investment is $151.4 million, and $47.8 million of that is additional. The remainder is named components counted a second time, plus $37.9 million of adjacent spending on a different set of things.
>
> **Quote:** "The DFSVO has not developed a performance monitoring strategy or evaluation framework to measure the outcomes and impacts of domestic and family violence initiatives funded through the Safer Families Levy." — ACT Auditor-General, *Safer Families*

Levy, Report 10 of 2024, 22 November 2024. The DFSVO is the ACT's Domestic, Family and Sexual Violence Office.

This week: Write to the Community Services Directorate asking for the most recent completed year's budget and actual expenditure for every Safer Families initiative, set out in the format of Appendix F. The directorate already holds every element. What does not yet exist is the requirement to publish them in one table.

1. Why the headline numbers cannot be added

A counting problem confuses public debate about this spending. It is worth setting out carefully. It is the reason the same money can be reported three times without anyone saying anything untrue.

Australian budget announcements in this field are usually given as four-year totals. Each budget announces a package covering the coming four years. The next budget announces a package covering its own four years. That window overlaps the previous one by three years.

Add to that four further complications:

1. **New versus continuing.** A package total often includes money already committed in an earlier package. That money is now being confirmed or extended.
2. **Multiple sources.** A single package may draw on ACT consolidated revenue, the Safer Families Levy and Commonwealth agreement funding. The levy is a funding source, not an additional package.
3. **Direct versus adjacent.** Some packages separately identify "adjacent" initiatives. These are justice system or housing measures that support the strategy without being domestic violence services.
4. **Package versus component.** A headline figure usually contains named components. Reports often give the headline and the components together without saying that one contains the other. That doubles the money.

The table below sets out the principal announcements. Each row gives the reason that figure cannot be summed with its neighbours.

Budget	Headline	Basis	Why it cannot be added
2016–17	$21.42m	Four-year Safer Families package	Contains named sub-programs listed separately
2018–19	$24.1m	Four-year family support investment	Contains the $6m hub, $6.5m accommodation and $1.7m counsellor lines
2021–22	$35.9m	Four-year expanded response	Overlaps 2018–19 window; includes levy-supported and gender-budget measures
2022–23	$71.6m	Four-year total	Explicitly includes $24m new plus existing commitments
2023–24	$20m	Four-year further package	Overlaps 2022–23 window; contains named components
2024–25	More than $12m	Public announcement	Period and grouping differ across documents

Budget	Headline	Basis	Why it cannot be added
2025–26	$66.158m	Four-year initiative total, 2025–26 Budget Outlook Appendix H	Mixed levy, Commonwealth, reprofiled, existing and revenue sources
2026–27	$47.8m additional / $151.4m total direct	Four-year Strategy package	The $151.4m includes prior commitments and several sources; the $47.8m is a component of it

1.1 A worked example of the problem

Take the 2026–27 Budget. Reported without qualification, the following are all true statements:

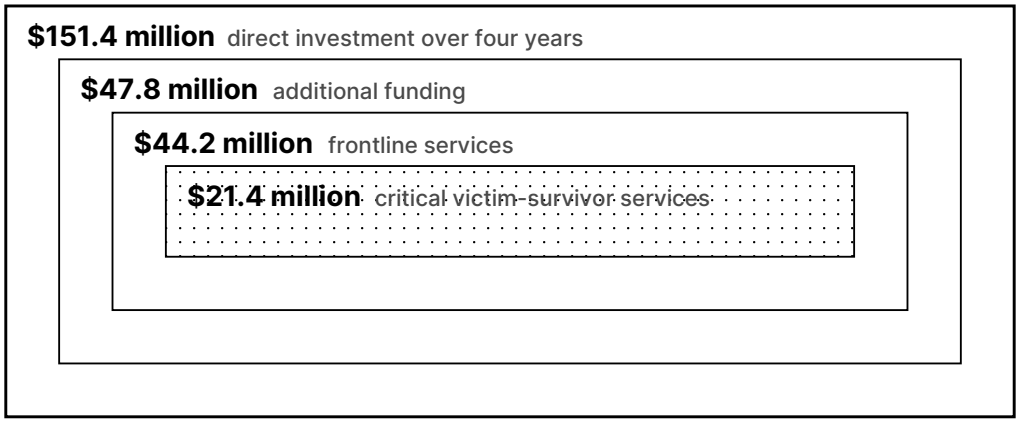
- The ACT announced $47.8 million in additional domestic, family and sexual violence funding over four years.
- The ACT is investing $151.4 million directly in domestic, family and sexual violence over four years.
- The ACT is investing $44.2 million in frontline services.
- The ACT is investing $21.4 million in critical victim-survivor services.
- The ACT is investing a further $37.9 million in adjacent initiatives.

Added together these produce $302.7 million. The real figure for direct investment is $151.4 million. Of that, $47.8 million is additional. The $44.2 million sits inside the $47.8 million. The $21.4 million sits inside the $44.2 million. The $37.9 million is a different category of spending on a different set of things.

FIGURE 3.1

The overlapping reality of the 2026–27 budget announcements

Five statements, each reported without qualification, each true. Four of them are the same money.



Each figure sits wholly inside the one above it.

$37.9 million adjacent initiatives

A different category of spending, on a different set of things. It does not sit inside any of the four above.

Added together these produce **$302.7 million**

None of the individual statements is false. The sum is meaningless.

The real figure for direct investment is $151.4 million. Of that, $47.8 million is additional; the $44.2 million sits inside the $47.8 million and the $21.4 million sits inside the $44.2 million.

Chapter 3, section 1.1. 2026–27 Budget. Box sizes show containment, not scale.

None of the individual statements is false. The sum is meaningless. This is not unique to the ACT, and there is no evidence it is deliberate. But a reader cannot form an accurate picture of the Territory's investment from the announcements alone. It is one reason the Auditor-General found public reporting was not effective.

1.2 What can be said accurately

Three statements about the trajectory are defensible:

- **Funding has grown substantially.** The 2016–17 foundation package was $21.42 million over four years. The 2026–27 direct commitment is $151.4 million over four years. Even allowing for definitional differences, the order of magnitude has changed.
- **The funding base has become more durable.** The 2026–27 Budget commits $13.2 million a year, indexed and ongoing, from 2029–30. That is a structural change from a decade of time-limited packages.
- **Transparency has improved after audit.** The 2026–27 factsheet identifies recipients, funding sources and component amounts. Earlier years did not give that level of detail.

2. The levy: what it raised and where it went

2.1 The revenue

The Safer Families Levy is a flat charge collected with household rates. It started on 1 July 2016 at $30 per household. It rises to $70 in 2026–27.

By 30 June 2024, the levy had raised **more than $46 million** since it started. It is expected to raise about **$49.401 million** in the four years to 2027–28.

For the 2026–27 package, the levy supplies $63.0 million of the $151.4 million direct commitment. ACT consolidated revenue supplies $77.2 million, Commonwealth agreement funding supplies $11.0 million, and a small reprofiled amount makes up the balance. The components are rounded and do not sum exactly to the published total.

The levy is therefore a substantial but minority source. The government describes it as "a partial offset" to broader investment. That is accurate and worth repeating. Public debate sometimes proceeds as though the levy funds the response.

2.2 The split between government and community

The Auditor-General's report contains the only reconciled account of where levy-supported money went across the period.

Across levy-supported initiatives from 2016–17 to 2023–24, from all funding sources:

- **$33.323 million** supported government activity;
- **$25.628 million** supported non-government, community-sector activity.

The trend within that total moved substantially:

Period	Government activity	Community activity
First four years (2016–17 to 2019–20)	$17.334m	$5.222m
Second four years (2020–21 to 2023–24)	$15.989m	$20.406m

In the first four years, government activity received more than three times what the community sector received. In the second four years, that reversed.

This is a real and positive shift. Community-sector organisations deliver most direct service in this field. The funding model was weighted towards internal government activity in the establishment phase, then rebalanced towards delivery. That is a defensible sequence.

The shift is also relevant to how the levy was described to the community. A household charge introduced to "fund reforms that will address family violence" spent its first four years mainly on government activity. That may have been the right choice. It was not clearly communicated at the time. The Auditor-General found that communication about how initiatives were designed, funded and intended to work was poor.

2.3 The crisis-to-prevention question

The most policy-significant number in the audit is the breakdown of levy-supported initiatives by stage of response.

Stage	Annual share across the audited period
Crisis response	34–46%
Early intervention	25–33%
Prevention	12–20%
Recovery	13–17%

Initiatives can be counted in more than one category, so the figures do not sum cleanly. The shape is still clear. Crisis was the largest category every year. Prevention was the smallest or second smallest.

Two readings are possible and both are partly right.

The defensive reading: crisis demand is not optional. When a person calls a crisis line at two in the morning, that call must be answered. Prevention work can be delayed without an immediate visible consequence. Crisis work cannot. A system under demand pressure will always weight towards crisis. The ACT was under demand pressure throughout.

The critical reading: the national plans the ACT adopted, and the Territory's own policy statements across the decade, committed to shifting investment upstream towards prevention and early intervention. Over eight audited years, the prevention share did not materially rise. A commitment that appears in every plan and never appears in the allocation is not a commitment; it is an aspiration.

The honest position combines them. The record does not show a decision not to shift upstream. It shows that the mechanism that would have made a shift defensible was never built. That mechanism has three parts. The first is a current needs assessment. The second is a prioritisation method across portfolios. The third is an

evaluation framework able to show that a dollar spent on prevention returns more than a dollar spent on crisis.

Without that evidence, no responsible government moves money away from crisis. The missing measurement system is therefore not a separate problem from the allocation pattern. It is one of its causes.

3. What the Auditor-General found

Report 10 of 2024 examined the Safer Families Levy. It is the only independent, whole-of-portfolio assessment in the ten-year period. Its conclusions are set out here in the audit's own terms.

3.1 On planning

The audit found that initiatives were planned and developed mainly through Cabinet business cases in the annual budget process. It found that this planning had been undermined by the lack of:

- a Territory-specific strategy for responding to domestic and family violence; and
- an up-to-date understanding of what the ACT's needs were.

It also found that poor communication with the community and stakeholders undermined planning. The gaps covered how initiatives were designed to respond to community needs, how they were funded, and what benefits they were intended to produce.

The audit set out the history precisely. The ACT had a specific strategy at the time the levy was announced: the *ACT Prevention of Violence against Women and Children Strategy 2011–2017*. That strategy nominally ended. In March 2018 the ACT Government identified the National Plan to Reduce Violence against Women and their Children 2010–2022 as its overarching strategy. No other ACT-specific strategy was implemented after that point.

The consequence is worth stating plainly. The levy was a household charge raised specifically for ACT domestic and family violence reform. From March 2018 until 27 May 2026, the framework governing its intent and purpose was a national plan. That plan predated the levy and was not written for the Territory.

3.2 On performance monitoring

The audit's central finding, in its own words:

> The DFSVO has not developed a performance monitoring strategy or evaluation framework to measure the outcomes and impacts of domestic and family violence initiatives funded through the Safer Families Levy.

It qualified this in two directions. There was an established practice of commissioning external evaluations for individual Safer Families initiatives. The ACT does evaluate programs, and section 5 below examines several. But not all initiatives had effective performance monitoring arrangements. The responsible office also did not

make effective use of the monitoring and reporting arrangements that did exist. It did not use them to assess how initiatives were performing.

The distinction is important. The problem was not an absence of evaluation activity. It was the absence of a framework. No framework could combine individual evaluations into a portfolio view, compare initiatives against one another, or say whether the whole was working.

3.3 On public reporting

The audit found public reporting of the levy and its use was not transparent or effective. It did not inform the community about how the levy was being used. Nor did it show how initiatives were performing, individually or as a whole.

It described the reporting that did exist as not comparable or consistent over time. Performance was often reported as a series of highlights. A reader could not easily tell which activities were new and which were ongoing.

3.4 The four recommendations

The audit made four recommendations, directed to the Community Services Directorate.

Recommendation 1 — Strategy and plan. As part of designing and implementing the ACT Domestic, Family and Sexual Violence Strategy and Plan: establish clear and accessible communication products updating the community on levy-funded initiatives, their purpose and intended outcomes. Develop principles for funding initiatives under the levy and communicate how they are implemented. Establish documented feedback mechanisms for the sector and the community.

Recommendation 2 — Performance monitoring. Establish a common evaluation framework for levy-funded initiatives. It should evaluate both the impact of each initiative and its impact across the suite of initiatives. Establish practices for regularly reporting performance to the Coordinator-General.

Recommendation 3 — Death review reporting. As part of future biennial reports, establish processes to monitor and report on the implementation of the recommendations of past reports.

Recommendation 4 — Public reporting. Review financial reporting of levy-funded initiatives to ensure comparable and informative reporting of how levy funds are used. Establish public performance reporting showing planned and actual performance, with analysis and explanation of significant variations.

3.5 What has happened since

The government accepted the substance and has acted on parts of it.

- **Levy principles** were published and took effect from 2025–26. They address Recommendation 1(b).
- **Budget transparency** improved markedly in the 2026–27 factsheet. It identifies recipients, sources and component amounts. That is progress against Recommendation 4(a).

- **The Strategy and First Action Plan** were released on 27 May 2026. The Action Plan commits to a Monitoring and Evaluation Framework with annual progress reporting. That is a commitment against Recommendation 2, not yet a delivery.
- **Recommendation 3** — a published implementation tracker for death review recommendations — had not been delivered as at the evidence cut-off. The 2025 biennial report stated that measurable progress had occurred on most 2023 recommendations and that further work was required. It did not provide a formal, independently verified status matrix. Chapter 4 examines this.

Nearly two years after the audit, the recommendations that required publishing a document have largely been met. The recommendations that required building a measurement capability are in progress.

4. Budget to actual: what the record shows

4.1 The one year that can be traced

For 2024–25, the Budget Outlook reports both a budget figure and an estimated outcome for Safer Families initiatives.

TABLE 3.1

Budget to estimated outcome, 2024–25

Where money was allocated to deliver services, it was largely spent. Where money was allocated to build the system's ability to see itself, it moved to next year.

Initiative	Budget	Estimated outcome	Difference	
Safer Families initiatives, total	$15.696m	$14.117m	$1.579m	
Community-led Aboriginal responses	$0.988m	$0.666m	$0.322m	
Health Justice Partnership	$0.912m	$0.877m	$0.035m	
Further frontline DFSV services	$3.073m	$2.873m	$0.200m	
Continuation of the DFV Review	$0.020m	**nil**	$0.020m	**reprofiled**
Coercive control response	$0.375m	**nil**	$0.375m	**reprofiled**
DFV Information Sharing Scheme	$0.350m	**nil**	$0.350m	**reprofiled**
Integrated information sharing and risk assessment	$0.277m	**nil**	$0.277m	**reprofiled**

The four initiatives with a nil outcome are the system-capability lines: the death review, the coercive control response, the information sharing scheme, and integrated information sharing and risk assessment. Each was reprofiled to a later year.

Reprofiling is a normal and legitimate budget mechanism, and this is not an accusation. The figures are an estimated outcome, not audited final expenditure, and the manuscript records no target year for any reprofiled line.

Chapter 3, section 4.1. 2025–26 Budget Outlook, Appendix H, Tables H.1 and H.2.

Four initiatives recorded a zero estimated outcome for the year. Each was reprofiled to a later year.

Reprofiling is a normal and legitimate budget mechanism. Money that could not be spent in the year it was appropriated is moved to the year in which it can be. It is not cancellation and it is not loss.

But look at which four initiatives did not spend anything in 2024–25:

- the continuation of the domestic and family violence death review;
- the coercive control response;
- the information sharing scheme; and
- integrated information sharing and risk assessment work.

These are the four system-capability initiatives in the list. The frontline service lines spent most of their allocation. The lines that would have built the measurement, information and risk infrastructure spent none of it.

That is not an accusation. There are ordinary reasons a capability project does not start on schedule. Staff cannot be recruited. A supporting instrument is not ready. A design decision is unresolved. But the pattern is consistent with what later chapters document. Where money was allocated to deliver services, it was largely spent. Where money was allocated to build the system's ability to see itself, it moved to next year.

4.2 What cannot be traced

The 2024–25 figures above are an **estimated outcome**, not audited final expenditure. For most of the decade, even estimated outcomes are not available at initiative level in a comparable form.

The public record does not contain, for any year, a single ledger showing for every initiative:

- the original budget and any revised budget;
- cash paid and accrued expenditure;
- the recipient and the funding source;
- amounts reprofiled, returned or lapsed;
- the cohort served;
- output and outcome targets;
- achieved outputs and outcomes;
- evaluation status; and
- cost per result.

Appendix F sets out a template for exactly that ledger. It is not complicated. Every element in it already exists somewhere in government. What does not exist is the requirement to bring them together in one public document each year.

5. What individual programs show

The absence of portfolio-level evidence does not mean there is no evidence at all. Several ACT programs have been independently evaluated, and the results are useful. They are set out here with their limitations attached. The limitations are as important as the findings.

5.1 Programs with published evaluation results

Solid Ground — a program for young people. Evaluated in 2025. The evaluation found it met a genuine service gap and reported positive participant experience. It calculated a weekly cost of about **$328 to $416 per completed participant**. The evaluator recommended continuation.

Limitation: the evaluation described the program as cost-effective without a conventional cost-benefit analysis. Its own discussion noted that many of the benefits were intangible and were not monetised.

Heartfelt — a program for children affected by family violence. Reported an estimated cost of about **$12,808 per child**, operated within its funding, and showed promising outcomes for children and caregivers.

Limitation: the evidence came from small samples and included staff-reported material.

Beryl Safe and Strong Van — a mobile therapeutic service. Reduced transport barriers, delivered **353 sessions to 47 clients**, at about **$5,272 per participant** in its pilot phase.

Limitation: pilot phase; per-participant cost in a pilot is not a guide to cost at scale.

Community Justice Partnership — a legal service co-located with the crisis service. Performed better when a lawyer was physically co-located with the Domestic Violence Crisis Service. The funded model was about **$141,000 a year**. The intended full-time model was estimated at **$563,000**.

Limitation and finding: the archive contains no clearer instance of this pattern. A service model was funded at roughly a quarter of the cost of the model the evidence supported. The evaluation identified co-location as the active ingredient. The funding did not buy the full version of it.

Financial Stability for women at the Alexander Maconochie Centre — recorded about **$83,000 of debt waived** for participants.

Limitation: outcome data were weak. The provider also contributed resources beyond the grant, so the reported cost understates the true cost of the model.

5.2 What the evaluations have in common

Read together, these evaluations share a set of features that limit what can be concluded from them.

- Several **created a theory of change retrospectively**. The logic explaining how the program was supposed to work was written during or after the evaluation, not before the program started.
- Most rely on **small samples**.

- Several rely substantially on **staff perceptions** rather than independently measured outcomes.
- Almost none have a **comparator group** — people with similar needs who did not receive the program.
- None follow participants over a long enough period to measure durable change.

This is not a criticism of the evaluators. They generally state these limitations clearly. It is a criticism of the commissioning arrangements.

An evaluation designed at the same time as the program, with a baseline and a comparison, costs more at the start. It also produces evidence that can be acted on. An evaluation commissioned at the end of a pilot produces a report that says the program is promising. That is the answer that leads to another pilot.

5.3 What the crisis services review found

The 2024 independent review of crisis specialist services examined the Domestic Violence Crisis Service and the Canberra Rape Crisis Centre. It found both service models broadly evidence-informed and highly valued by the victim-survivors who could access them.

That last clause carries the weight. The same review found the service was unable to answer all calls to the crisis line. Chapter 5 sets out the operational findings in full.

6. What can and cannot be said about value

6.1 What cannot be stated on the public record

The following cannot be established from the available evidence:

- cost per victim made safe;
- cost per repeat assault, serious injury, suicide or homicide averted;
- change in the rate at which the wrong person is identified as the predominant aggressor;
- change in reoffending attributable to behaviour change programs;
- comparative outcomes for people of different sexes, genders or communities;
- the cost of unmet demand — waitlists, unanswered calls, people turned away;
- whether the crisis, prevention, early intervention and recovery mix is the right one; or
- whether raising the money through a levy produces better outcomes than raising the same money through general revenue.

That is not a list of things nobody has bothered to calculate. It is a list of things that cannot be calculated. The underlying data is not collected in a form that permits it.

6.2 The verdict

The correct finding on value for money is **not proven**.

This is a specific verdict and it should not be rounded in either direction.

It is **not** "poor value". Several programs are promising and the service models are evidence-informed. There is no evidence of waste in the ordinary sense: money missing, services not delivered, or contracts not performed.

It is **not** "good value". No evidence exists that would support that conclusion. The government's own auditor found the framework needed to produce that evidence did not exist.

"Not proven" is the finding, and it carries an obligation. Ten years after introducing the levy, the government cannot show what it achieved. It owes the households paying it an explanation and a timetable. The First Action Plan supplies a partial timetable. The explanation has not been given.

7. What drove the funding decisions

The archive supports identifying the visible drivers of funding decisions across the decade. It does not support the claim that funding was allocated for publicity or electoral advantage. That claim is not made here.

The drivers visible in the record are:

1. **The 2016 reviews and policy reset.** The Glanfield inquiry, gap analysis, legislation review and death review supplied a diagnostic base for the first package and the levy.
2. **National policy architecture and Commonwealth money.** National plans and Commonwealth funding agreements shaped local grants and programs.
3. **Sexual violence reviews and public testimony.** The 2021 *Listen. Take Action* report drove service reviews, police process review and adviser work.
4. **Frontline demand and cost pressure.** Government and providers repeatedly cited higher call volumes, longer crisis stays, workforce costs and service demand.
5. **National political urgency.** The 2024–25 Budget speech explicitly linked funding to the May 2024 National Cabinet discussion of a national crisis of gender-based violence.
6. **Election commitments.** Criminalising coercive control was a 2024 election commitment. The large 2026 package followed the first full budget cycle after that election.
7. **Independent scrutiny.** The 2024 levy audit directly drove the levy principles, improved budget disclosure and commitments to evaluation and annual reporting.
8. **Aboriginal community-led advocacy.** *The Long Yarn* report led to multi-year funding for community-controlled responses.

7.1 The narrower, supportable critique

The record does support a more precise criticism than "funding was political".

Before the 2024 audit, individual Cabinet business cases generally described objectives, evidence and expected benefits. What was missing was a level above the individual business case. That level would hold a current system-wide needs assessment, an implemented method for prioritising across portfolios, and adequate analysis of duplication and collective impact.

Individual decisions could be reasonable while the portfolio as a whole lacked an investment framework. That is a governance finding, not a motive finding. It is the one the evidence supports.

8. The money announced with the 2026 Strategy

The ACT Domestic, Family and Sexual Violence Strategy 2026–2036 was released on 27 May 2026. It sets a ten-year direction for rebuilding the Territory's response to domestic, family and sexual violence. The Strategy document itself is uncosted. It contains no costings. It does not attach a dollar figure to any outcome, action or reform it describes.

The money was announced separately, in the 2026–27 Budget. Those figures are set out in section 1 above: $47.8 million in additional funding and $151.4 million of total direct investment, each over four years. They are not re-derived here. What section 1 does not ask is what the additional money buys.

The joint media release of 27 May 2026 answers part of that question. It identifies $3.6 million over four years, from 2026–27, "to progress foundational system infrastructure". The release lists four components:

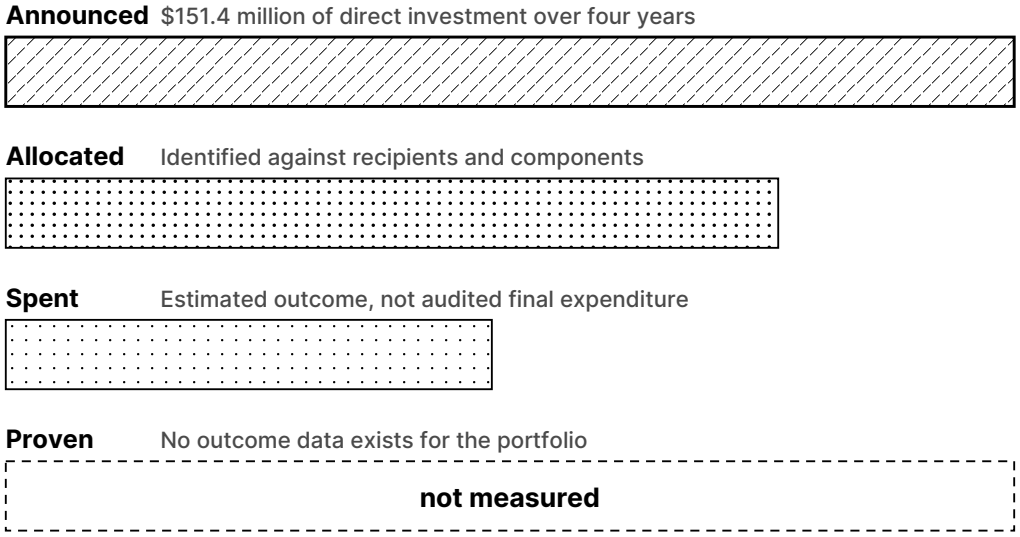
- resourcing over three years to establish a domestic, family and sexual violence sector network providing advocacy, coordination and workforce development, including for Aboriginal community-controlled organisations;
- a dedicated Information Sharing Coordinator role to oversee the Information Sharing Scheme;
- two years of funding to operationalise the updated Risk Assessment and Management Framework through targeted training; and
- support for Women's Health Matters to develop a model for primary prevention infrastructure.

The balance of the package is substantially continuity funding for frontline services. Continuity funding is valuable. A service that loses its funding stops, and a service that has stopped helps nobody. The shift to indexed, ongoing base funding of $13.2 million a year from 2029–30 is a structural improvement on a decade of time-limited packages. That improvement is credited in section 1.2 above and at F3.2 in Appendix M.

FIGURE 3.2

Announced, allocated, spent, proven

ACT domestic, family and sexual violence investment, 2026–27 Budget



Bar width shows how much of the announced sum can be traced at each stage. The final bar is empty because nothing exists to measure.

Money can be traced from announcement to estimated expenditure. It cannot be traced to a result, because no outcome data is collected.

2026–27 Budget DFSV factsheet; ACT Auditor-General, Safer Families Levy, Report 10 of 2024. Widths after the first bar illustrate traceability, not dollars.

The observation here is one of proportion. A ten-year rebuild of a system is being commenced with about $3.6 million of new system-building money over four years, against about $47.8 million of additional funding. That is about 7.5 per cent of the additional funding, and about 2.4 per cent of the $151.4 million total direct investment. Whether the sum is the right one is a separate question, and the record does not settle it.

The chapter's counting rules apply here as they apply to every other package. This is announced money. It is not allocated money, and it is not spent money. Section 4 above records what happened to the last set of system-capability allocations: in 2024–25 the death review continuation, the coercive control response, the information sharing scheme and integrated information sharing and risk assessment work each recorded a zero estimated outcome and were reprofiled to a later year. None of the $3.6 million is a result. It is an intention with a dollar figure attached, and the intention will be testable only when expenditure and outputs are published against it.

What the four components buy is also worth stating plainly. Three of them build foundations rather than deliver services: a sector network, a coordinator position, and training on a risk framework. Each is a precondition for something else. The fourth funds the development of a model for primary prevention infrastructure. Developing a model for prevention is not the same as operating prevention. Section 2.3 above shows the prevention share of levy-supported initiatives did not materially rise across the audited period.

Appendix L sets out the full assessment of the Strategy, including its treatment of costing, sequencing and prevention. Chapter 2 examines what the Strategy and the First Action Plan commit to, and what they defer to the second action plan window from 2028.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. This chapter's complete set of 14 is at Appendix M, where it can be read against every other chapter's.

- **F3.5** — Crisis response accounted for 34–46 per cent of levy-supported initiatives annually; prevention for 12–20 per cent. Prevention and recovery shares did not materially rise across the audited period, despite repeated strategic commitments to shift upstream.
- **F3.6** — The Auditor-General found in 2024 that planning was undermined by the absence of a Territory strategy and of a current understanding of need; that the responsible office had not developed a performance monitoring strategy or evaluation framework; and that public reporting was not transparent or effective.
- **F3.9** — No public ledger exists, for any year, showing budget, actual expenditure, recipient, source, cohort, targets, achieved outcomes, evaluation status and cost per result by initiative.

- **F3.12** — The verdict on portfolio value for money is not proven — neither poor nor good, because the evidence required to decide does not exist.

Sources for this chapter

Claim	Source	Date
Levy raised more than $46m to 30 June 2024; government/community split; first and second four-year figures; stage-of-response percentages; planning, monitoring and reporting conclusions; four recommendations; 2011–2017 strategy and March 2018 adoption of the National Plan	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024	22 November 2024
Levy rates, purposes and principles; $49.401m over four years to 2027–28; non-frontline positions removed 2024–25	Safer Families Levy Principles	2025
Package headline figures and components 2016–17 to 2026–27	Archive funding ledger, compiled from ACT Budget papers, factsheets and media releases	2016–2026
2024–25 budget and estimated outcome by initiative; reprofiling	2025–26 Budget Outlook, Appendix H, Tables H.1 and H.2	2025
2026–27 totals, sources, components and ongoing indexed funding	2026–27 Budget DFSV factsheet	2026
Solid Ground evaluation results and cost per participant	Solid Ground Evaluation Report	2025
Heartfelt, Beryl Van, Community Justice Partnership and Financial Stability results	*Evaluation of four Domestic and Family Violence programs*	ACT Government
DVCS unable to answer all crisis line calls; service models evidence-informed	ACT DFSV Crisis Specialist Services Review Summary	2024
Budget speech link to May 2024 National Cabinet	2024–25 Budget speech	2024
Commitment to a Monitoring and Evaluation Framework and annual progress reporting	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026
$3.6 million over four years for foundational system infrastructure, its four listed components, and the quoted purpose	Joint media release, Chief Minister and Minister for the Prevention of Domestic, Family and Sexual Violence	27 May 2026
The Strategy contains no costings; ten-year direction and action plan windows	ACT DFSV Strategy 2026–2036	27 May 2026
$47.8 million additional and $151.4 million total direct investment over four years, as used in section 8	2026–27 Budget DFSV factsheet	2026

Chapter 4 — What the deaths show

In one page

The ACT maintains a register of deaths that occurred in the context of domestic and family violence. Between 2000 and 2024 it recorded 168 fatal incidents: 31 homicide incidents and 137 non-homicide incidents.

That ratio is the most important fact in the fatality record. For every homicide the Territory recorded in the context of domestic and family violence over 25 years, it recorded more than four other deaths. In the most recent five years the ratio is more than three to one, and suicides alone outnumber homicides by more than two and a half to one.

The 2025 biennial review examined 38 non-homicide deaths from 2020 to 2024. Twenty-nine of the 38 were suicides. Thirteen of the deceased were assessed as victims of domestic and family violence; 25 were assessed as perpetrators. Twenty-four of the 25 perpetrators were male; 11 of the 13 victims were female. Every male perpetrator had targeted a female victim, and every female victim had been harmed by a male perpetrator.

The suicides divide the same way. Of the 25 assessed as perpetrators, 21 died by suicide. Of the 13 assessed as victims, eight did. So, among the deaths this review was able to examine, the largest single category is people who had been accused of using violence, almost all of them men, who took their own lives. Section 3.6 sets out what that accusation does and does not amount to: the classification is the review's own reading of the records, it rests largely on civil orders made on the balance of probabilities, and only five of the 25 are recorded as having contravened an order.

Two findings from that review should change how the system works.

First, more than half of the deceased victims — 8 of 13 — had been misidentified as the predominant aggressor by police or another agency before they died. The consequences recorded include criminal charges, loss of employment, removal of children and incarceration. Four of the 13 had been the respondent to a family violence order where the evidence indicates the applicant was the predominant aggressor.

Second, family violence orders appear on both sides of the fatality record. Among the 25 deceased perpetrators, 20 had been the respondent to at least one order in their life, and nine were respondents to a current order when they died. Among the 13 deceased victims, three were the protected person on a current order and nine had previously been a protected person.

The 2023 review examined 12 homicides in depth. It found coercive control present in almost all of the 12. In about 9 of the 12 there was no significant physical violence before the killing.

Neither review has been followed by a published, independently verified matrix showing which of the 2023 recommendations have been implemented.

One number, one quote, one action

Number: Over 25 years the ACT register recorded 168 fatal incidents in the context of domestic and family violence: 31 homicide incidents and 137 non-homicide incidents. For every homicide the Territory recorded, it recorded more than four other deaths.

Quote: "Of the non-homicide deaths reviewed for this report more than half (8 out of 13) of the victims appeared to have been misidentified as the predominant aggressor by police or another agency prior to their death." — ACT Domestic and Family Violence Review Biennial Report 2025, Theme 1

This week: The Community Services Directorate publishes a status line for each of the 12 recommendations of the 2023 death review: complete, partially complete, or not started, with the responsible agency named against each. The Auditor-General recommended that tracker in November 2024. No such matrix has been published.

1. What the register is, and what it is not

1.1 The statutory basis

The Domestic and Family Violence Review was established under the *Domestic Violence Agencies Act 1986* in 2021. A Review Coordinator maintains a register of domestic and family violence deaths and conducts a review every two years. A report goes to the Minister.

The register records deaths that occurred in the context of domestic and family violence. It includes:

- **homicides** — where a person was killed by another; and
- **non-homicide deaths** — suicides, unintentional deaths such as accidental overdose, deaths where the coroner could not determine intent, and deaths by legal intervention.

A death is recorded on the register where there is evidence the deceased person had been a victim of domestic and family violence, or had perpetrated it.

1.2 What the register cannot do

The reviews are candid about their limits. Those limits should be carried alongside every figure quoted from them.

The numbers are small. The ACT has a population of roughly 470,000. Over five years, the review had 38 non-homicide deaths to analyse. Percentages calculated on 13 people are not stable. Where a proportion from the review is quoted here, the count is quoted with it.

Cells under five are suppressed. Ethical de-identification requirements mean the reports cannot publish numbers below five. This obscures findings for smaller groups, including Aboriginal and Torres Strait Islander people, people with disability and LGBTIQA+ people. The 2025 report says so expressly.

Information access is uneven. The Review Coordinator gathers information from agencies that operate separate data systems. The 2025 report notes limited access to mental health and community service information. That limits what can be said about whether people were engaged with support.

It is a desktop review. The reviews analyse records. They do not interview surviving family members, and they are not inquests.

Open proceedings block analysis. Of the 11 homicides in the 2020–2024 period, 10 were the subject of ongoing criminal or coronial proceedings. In-depth analysis of the homicides was therefore not possible for the 2025 review.

That last constraint is worth pausing on. In its second cycle, the Territory's own fatality review could not examine the deaths that receive the most public attention. The courts had not finished with them. This is a structural feature of biennial thematic review, not a fault of the Coordinator. Chapter 17 proposes a different design.

1.3 The register grew between reports

The 2023 report recorded 134 domestic and family violence incidents from 2000 to 2022: 106 of them identified and 28 suspected. Within the 106 identified incidents it recorded 17 homicides. Where these pages cite the 2023 register, the figure is 134 incidents unless the identified subset of 106 is stated; the two numbers describe the same register.

The 2025 report records 168 fatal incidents from 2000 to 2024, comprising 31 homicide incidents and 137 non-homicide incidents.

The two are not directly comparable. The periods differ, and the classification of suspected cases differs. The register is also a living record that improves as information arrives. The increase does not indicate that homicides doubled in two years.

It does indicate something else, and it matters for public reporting. The Territory's count of past domestic and family violence deaths is not fixed. It depends on what agencies have identified and shared. A register that grows by that much between reports is a register that was previously incomplete.

2. The 2023 review: what killing looks like

2.1 What was examined

The first biennial review was published in 2023. It covered deaths from 2000 to 2022 and analysed 12 homicides in depth.

Twelve deep reviews out of 134 registered incidents is about nine per cent. That was a reasonable place to start. Homicide files are the most complete, and in-depth review is resource-intensive. It also means the themes in the 2023 report came from a small and deliberately selected slice of the fatality picture.

2.2 What it found

The 2023 review found:

- **coercive control was present in almost all the cases reviewed**;
- in **approximately 75 per cent** of the cases there was a clear absence of significant physical violence before the homicide;
- **separation was a period of heightened risk**;
- **incident-based responses missed cumulative patterns** of behaviour;
- victims often had **little or no engagement with specialist services**;
- **perpetrator accountability was limited**;

- **children were often not visible** as victims in their own right;
- **mental health and alcohol and other drug services were poorly integrated** with domestic and family violence responses;
- victims from **culturally and linguistically diverse backgrounds faced distinct barriers**; and
- victims' **defensive or resistive violence could be misread** as perpetration.

2.3 Why the 75 per cent finding matters most

Of all the findings in either review, this one has the widest operational consequences:

> in approximately 75% of these cases there was a clear absence of significant physical violence prior to the homicide

Consider what most risk screening actually asks about. Has there been an assault? Were there injuries? Was there a previous incident? Has an order been breached? Has the person been charged?

Those questions all look for physical violence. They look for it as discrete events. In about 9 of the 12 homicides the ACT reviewed in depth, that search would have returned little or nothing.

This is not an argument that physical violence is unimportant. Non-fatal strangulation, threats to kill and previous serious assault remain among the strongest known indicators of lethal risk. They appear in the ACT's own data. The argument is narrower: in the 12 homicides the ACT examined closely, a screening approach built mainly around counting physical incidents would have returned little or nothing in about 9 of them.

What was present in almost all of them was coercive control. It is a pattern of domination exercised over time. Much of it is not itself criminal, and none of it produces an injury to photograph.

Detecting a pattern requires three things a single-incident system does not have. It needs information from more than one point in time. It needs information from more than one agency. And it needs a method for weighing accumulation rather than severity. Chapters 8 and 15 are largely about how to build that.

2.4 The warning about recommendations

The 2023 report contained an observation about its own genre. It noted that unactioned recommendations perpetuate a cycle of inaction. Research shows the same unactioned recommendations resurface in later reviews.

The report conducted a desktop scan of recommendations from previous reports, inquests and reviews. It organised them into ten focus areas. It found that many called for multi-agency, multi-stage responses. Those are the kind hardest to implement and easiest to leave partially done.

That is the second occasion recorded here on which an official ACT document has identified non-implementation of recommendations as a distinct problem requiring its own solution. The first was the Glanfield inquiry in 2016.

2.5 The twelve recommendations

The 2023 review made 12 recommendations, directed to all government agencies, ACT Policing, the courts and the community.

#	Recommendation
1	Explore revising the definition of domestic and family violence to recognise coercive control as an overarching strategy or context, rather than a separate tactic or example of behaviour
2	Ongoing education and training for the community and frontline services about the dynamics of domestic and family violence, including coercive control and victim resistive behaviour
3	All frontline agencies, ACT Policing and the courts to review policies and procedures to recognise the differences between intimate partner violence and other family violence
4	Introduce a tool for ACT Policing and the courts to assess patterns of coercive control that would detect which party is the perpetrator and which party is using violent resistance to ongoing abuse
5	Support frontline agencies to share and analyse data sets to understand patterns of perpetrator behaviour
6	Support prevention initiatives focused on all aspects of domestic and family violence
7	Specialist services supporting culturally and linguistically diverse communities to design and implement a community-based education campaign in partnership with government
8	Design and apply risk assessment and management tools that address both the immediate safety of the victim and interventions to disrupt perpetrator behaviour
9	Ongoing community education and frontline training about the heightened risk of lethality at separation, and the imperative of safety planning
10	Continue to fund appropriate responses supporting children and young people as victims of domestic and family violence
11	Continue work to identify the intersections between domestic and family violence, mental illness and substance abuse, to tailor multi-agency supports including perpetrator identification and responses
12	Support cross-service and cross-sector integration through infrastructure that enables an integrated system and builds skills

Recommendation 4 is the one later chapters return to repeatedly. It asks for a tool that identifies which party is the perpetrator and which is using violent resistance. It was made in 2023. As at September 2026 the updated tool was still described as being developed or embedded. No validation results had been published.

3. The 2025 review: what the wider fatality picture looks like

3.1 The headline numbers

For 1 January 2020 to 31 December 2024, the register recorded **49 fatal incidents**: **11 homicides** and **38 non-homicide deaths**.

Because 10 of the 11 homicides were still before the courts or the coroner, the review analysed the 38 non-homicide deaths.

What the 2020–24 cohort is, and is not

Every figure drawn from the 2025 death review's 38 non-homicide deaths comes from a group assembled in a particular way, and the way it was assembled shapes what is in it.

Who gets onto the register. A death enters the register when an agency identifies it as occurring in a domestic and family violence context and shares that identification. It is not a census. The register grew from 134 incidents to 2022 to 168 incidents to 2024. The two totals are not built the same way, but the growth exceeds what two further years of

deaths would add, which indicates the earlier count was incomplete. A death no agency identifies is not in the record at all, and there is no way to estimate how many those are.

"Perpetrator" and "victim" are the review's classifications. They are the review's reading of the available records, made for the purpose of the review. They are not court findings, and the review does not present them as such. Where a person was misclassified while alive, the review's classification can inherit that error. That is what Theme 1 of the review is about.

The homicides are missing. Of the 11 homicides in the period, 10 were before the courts or the coroner and could not be analysed. The 38 are therefore what remains after the most serious and most fully investigated deaths have been set aside. Any contrast drawn between the non-homicide deaths and the homicides is a contrast with a group this review could not examine.

What that does to the numbers. Thirteen and 25 are small, they are not random samples of anything, and the proportions within them are not rates in any wider population. Every figure taken from them describes these people. None of them is an estimate of prevalence.

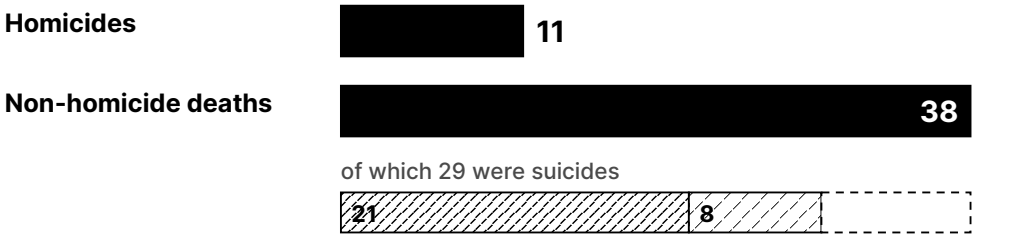
Of the 38:

- **13** were people assessed as victims of domestic and family violence;
- **25** were people assessed as perpetrators;
- **29** died by suicide;
- the remainder were unintentional deaths or deaths where intent could not be determined.

FIGURE 4.1

The deaths the Territory counts, and the harm it does not

ACT domestic and family violence context, 2020–2024



Of the 29 suicides: 21 of the 25 people accused of using violence, and 8 of the 13 assessed as victims. The remaining 9 deaths were other or undetermined.

Everything above this line is recorded. Everything below it is not.

Suicide attempts. Psychological harm. Lost work.
Lost housing. Lost contact with children.

No field exists

Non-homicide deaths outnumbered homicides by more than three to one, and no agency records any outcome short of death.

ACT Domestic and Family Violence Review Biennial Report 2025. Thirteen and 25 are small numbers and the proportions within them are not rates in any wider population. Bars are to scale; the dashed area has no size.

Reading the figures. Four elements carry meaning throughout. **Solid black** is recorded and verified. **Grey** is partial, or an output reported in place of an outcome. **Hatching** is announced but not delivered. **A dashed hollow outline** is never measured: no field exists, and the shape has no size because there is nothing to size it by.

The review reports the cause of death separately for each of those two groups, and the split matters. Of the 25 assessed as perpetrators, **21** died by suicide. Of the 13 assessed as victims, **8** did. Twenty-one plus eight is the 29.

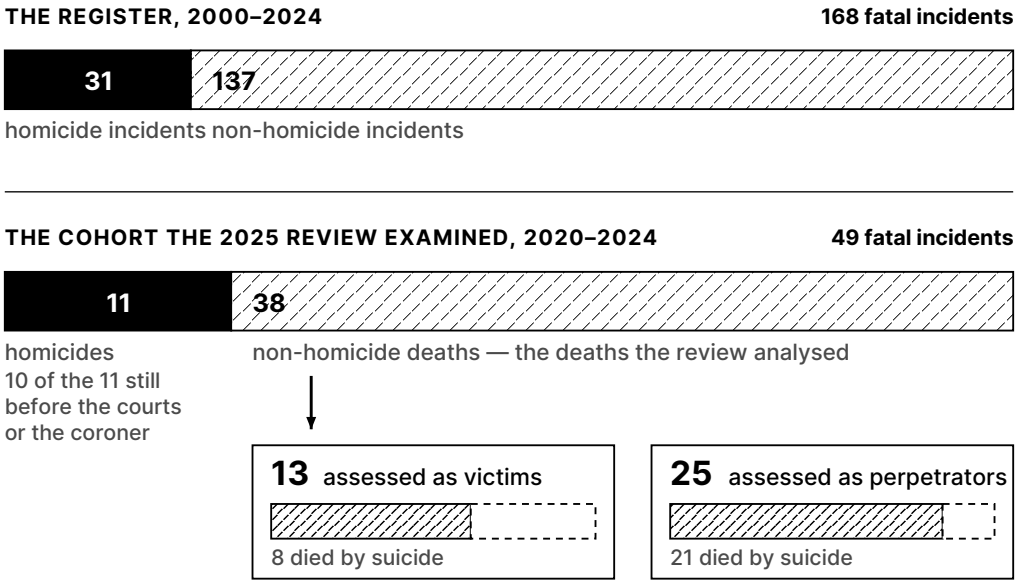
So, among the deaths this review was able to examine, the largest single category is people who had been accused of using violence and who then took their own lives: 21 deaths, against 11 homicides in the same five years that the review could not examine in depth. Twenty-four of the 25 were men, and 20 of the 25 had been named as respondents to a family violence order.

The review does not publish the sex of the 29 suicides directly. It can be bounded from the two cohorts. The perpetrator group was 24 men and one woman, and the victim group was 11 women and two men, so between 20 and 23 of the 29 were men and between six and nine were women. The exact figures would require the review to cross-tabulate two columns it already holds.

FIGURE 4.2

Where the fatality record goes

From the register as a whole to the deaths the 2025 review was able to examine



21 suicides among people assessed as perpetrators, against 11 homicides in the same five years that the review could not examine in depth.

These are the review's own classifications, not court findings. Thirteen and 25 are small numbers; the proportions within them are not rates in any wider population, and none is an estimate of prevalence.

ACT Domestic and Family Violence Review Biennial Report 2025. Chapter 4, sections 3.1 and 5. Bars are drawn to scale within each tier.

3.2 The gender pattern

The 2025 review states the pattern without ambiguity.

- **24 of the 25** deceased perpetrators were male.
- **11 of the 13** deceased victims were female.
- **Every** male perpetrator had targeted a female victim.
- **Every** female victim had been harmed by a male perpetrator.
- Of the 38 people who died, **24 were males who had perpetrated intimate partner violence** and **11 were females who were victims of intimate partner violence**.

Earlier chapters said that the Territory's gendered policy orientation is supported by its own evidence. This is that evidence. It is not equivocal and nothing in the chapters that follow qualifies it.

What follows in Chapters 9 and 10 is a different proposition. A system can be correct about the population pattern and still be wrong about the individual in front of it. The ACT's own fatality data shows this happening. The rate has never been measured.

3.3 The victims

Of the 13 deceased victims:

- **11** had experienced intimate partner violence;
- age ranged from **16 to 62**, with a median of **31**;
- **6** were from culturally and linguistically diverse backgrounds;
- fewer than five were Aboriginal or Torres Strait Islander;
- none were recorded as a person with disability;
- **12** had experienced coercive control;
- **10** had reported a mental health condition;
- **10** had documented histories of adverse childhood experiences;
- **8** had experienced violence from at least two intimate partners, and **7** from three or more;
- **62 per cent** were unemployed, **54 per cent** had experienced homelessness or housing instability, and **46 per cent** had documented financial stressors.

By comparison, among the 25 deceased perpetrators, 36 per cent were unemployed, 20 per cent had experienced homelessness or housing instability and 44 per cent had financial stressors.

On this evidence, deceased victims were in materially worse economic and housing circumstances than deceased perpetrators. That has direct implications for what a safety response has to include. A safety plan that does not address income and housing leaves the two largest stressors untouched.

3.4 The perpetrators

Of the 25 deceased perpetrators:

- **24** had used coercive control;
- 96 per cent had used emotional violence, 68 per cent physical threats or assault, and 48 per cent threats to kill;
- **24** had a history of problematic substance use;
- **19** had reported a mental health condition;
- **16** had documented histories of adverse childhood experiences;
- **16** had criminal histories;
- **15** had criminal records indicating violence outside the domestic and family violence context — for example, assault of a stranger or neighbour;
- **21** died by suicide, as determined by the ACT Coroner; the remainder were unintentional deaths or deaths of undetermined intent;
- **22** had been involved with police at some point in their life, and **6** had police involvement within a week of their death;
- **7** had perpetrated violence against at least two intimate partners, and **11** against multiple victims including partners, children and siblings;
- **8** died in the context of a pending or recent separation from an intimate partner, within three months.

The review noted that most of the deceased perpetrators — 15 of the 25 — had criminal records indicating violence outside the domestic and family violence context. That factor is **not currently captured in the national risk assessment principles**.

That is a specific, actionable gap. A person with a record of violence against strangers who is also using violence at home presents a risk profile that the standard tool does not ask about. Adding the question costs nothing.

3.5 Family violence orders in the fatality record

This is set out in full because it is the least-reported material in either review.

Among the 25 deceased perpetrators:

- **20** had been the respondent to one or more family violence orders at some time in their life;
- **9** were respondents to a **current** family violence order at the time of their death;
- **5** had previously contravened an order;
- **9** had been the respondent to one or more personal protection orders;
- **4** had been the respondent to an order three or more times.

Among the 13 deceased victims:

- **3** were the protected person on a **current** family violence order at the time of death;
- **9** had previously been the protected person on at least one order;
- **2** had been the protected person on an order more than once;

- **4** had been the **respondent** to an order where there is evidence the applicant was the predominant aggressor.

Read those two lists together. Orders appear throughout the fatality record, on both sides of it. Twenty of 25 deceased perpetrators had been respondents. Nine were under a current order when they died. Four of 13 deceased victims had themselves been made respondents to orders where the evidence indicates the applicant was the predominant aggressor.

This does not establish that orders cause deaths. No claim of that kind is made here. Orders are made in situations that are already dangerous. A high rate of orders among people who later die is exactly what you would expect. That is the correct starting hypothesis.

But it is a hypothesis, and it has never been tested. Chapter 11 sets out what the ACT would need to do to test it, what it was told when asked, and why no agency has ever looked.

3.6 What "perpetrator" means in the fatality record

The word carries more weight in ordinary speech than it carries in this dataset, and the difference matters for every conclusion drawn from it.

The classification is the review's own. It analysed the available records for a pattern of domestic and family violence over time. Where the pattern showed a deceased person using violence, it recorded that person as a perpetrator and predominant aggressor. Where the pattern showed a deceased person subjected to violence, it recorded them as a victim. That is a defensible method for a death review, and it is more careful than relying on a single agency's record. It is not an adjudication, and the review does not present it as one.

The legal material underneath the classification is largely civil. Twenty of the 25 had been the respondent to a family violence order at some point; nine were respondents to a current order when they died. A family violence order is a civil order. Chapter 7 sets out the statutory position in full: the court must be satisfied only on the balance of probabilities, it need not comply with the rules of evidence, and it may inform itself in any way it considers appropriate. An interim order is made before the case is heard, on the applicant's material, and often before the respondent knows the application exists. An order is a finding that protection is necessary. It is not a finding that the respondent did what was alleged.

Five of the 25 had contravened an order. Contravention is a criminal offence, and that is the only subgroup in the fatality record where the material points to something a criminal court would have had to prove. The review does not report convictions for the remainder.

Sixteen of the 25 had criminal histories of some kind, and 15 had records indicating violence outside the domestic and family violence context. Those are findings about criminal records generally, not findings that the domestic and family violence attributed to them was proved anywhere.

Three consequences follow.

Accuracy of language. The accurate description of most of this cohort is that they were assessed as perpetrators on the civil record and on the review's reading of the pattern. These chapters use the review's terms because those are the terms the record is kept in. They are not treated as proof about any individual.

The direction of the error check. The review examined whether people it had classified as victims had been wrongly recorded as aggressors, and found that eight of 13 had been. Section 4 sets that out. It does not report the reciprocal examination: whether anyone it classified as a perpetrator was classified wrongly. That check has never been published, for this cohort or any other, and section 4.3 explains why the rate is unknown in either direction.

What the number can carry. The safe statement is that 21 people took their own lives after being accused of using family violence, that 20 of the 25 had been named as respondents to a civil order, and that for most of them no court determined whether the accusation was true. Some of them may well have used violence. That is a finding about a blind spot in the record, not a finding that any of those people was innocent, and not a finding that the accusation or the order caused the death. Chapter 11 sets out what would have to be collected before either question could be answered.

3.7 The children

The review identified **67 children affected** by the deaths of the victims and perpetrators.

Some children had experienced significant violence, including physical and sexual violence. In some cases a child discovered the body of the deceased, often a parent.

Sixty-seven children in five years, in a jurisdiction of 470,000 people, from 38 deaths.

The review concludes that children must be treated as victims in their own right. That means a child-centred, trauma-informed approach. It must prioritise their safety, their healing and their relationship with the non-violent parent. It must also be embedded into risk assessment and management practice, information-sharing protocols and system responses.

That word — *embedded* — is doing a great deal of work. Chapter 15 sets out what embedding it in an assessment instrument actually requires.

4. Theme 1: misidentification

4.1 What the review found

The 2025 review's first theme is that victims are misidentified as perpetrators and perceived as "problematic".

Its central finding:

> Of the non-homicide deaths reviewed for this report more than half (8 out of 13) of the victims appeared to have been misidentified as the predominant aggressor by police or another agency prior to their death.

Of those eight, two were misidentified within the three months before death. The other six occurred a year or more before.

The review recorded that misidentification contributed to negative outcomes including **loss of employment, statutory intervention leading to removal of children, and incarceration**.

It gave examples:

- a victim was charged after a perpetrator broke into her home and attacked her;
- a victim was identified as the predominant aggressor during a police-attended incident, despite a documented history of violence perpetrated by the other party.

It also recorded the case of at least one victim. There was clear evidence that the father of her children had perpetrated intimate partner violence against her. Authorities accused her of manipulating systems by claiming to be a victim in order to gain custody of her children.

4.2 How misidentification happens

The review sets out the mechanism. Police respond to an incident. They are unsure which person is the victim — the person most in need of protection — and which is the predominant aggressor. They charge, or apply for an order against, the person most in need of protection.

Once that happens, the error spreads. The review notes it can trigger misidentification across other systems: child protection, immigration, housing.

The contributing factors it identifies are:

- **defensive or resistive acts by the victim** — a person who fights back at the point of an assault presents, at that moment, as someone using violence;
- **manipulation of the system by the perpetrator** — a person who applies first, presents calmly and gives a coherent account can be more persuasive than a person who is frightened, angry or intoxicated;
- **a focus on single incidents rather than patterns** — the same failure mode identified in the 2023 review.

It also notes that Aboriginal and Torres Strait Islander women are particularly vulnerable to misidentification and its consequences.

4.3 What the finding does and does not prove

What it establishes: in a group of 13 people who died, full records were later reconstructed across agencies. Eight had at some point been recorded as the person causing the violence when the reconstructed record indicates they were the person experiencing it.

The review put two of the eight into words, in its own de-identified vignettes. “Kelly was twice misidentified by police as the predominant aggressor when she was acting to protect herself and her children. The misidentification resulted in her being charged and taken into custody.” And: “Jodie was misidentified by police as the predominant aggressor. Acting on this information, child protection services intervened, removing her children from her care.” The names are the review’s

pseudonyms. Both women are among the 13. Neither error was visible in any data the Territory holds while it could still have been corrected, because no dataset records the classification as a decision that can be wrong.

How the review knew: by cross-referencing information from a range of sources, so that patterns of behaviour over time could be compared. That is the point. The correct classification became visible only when someone assembled the whole record. At the moment of the original decision, the person deciding had one incident and two accounts.

What it does not establish: the rate of misidentification in the general population of family violence matters. Thirteen deceased people are not a sample of everyone the system deals with. It is plausible that misidentification is more common among people who go on to die. Misidentification is itself a risk factor: it destroys trust and it forecloses help-seeking. The review says so.

The honest statement is therefore this. The ACT knows that misidentification occurs and knows some of its consequences. It does not know how often it occurs. It has never measured the rate.

That is the finding carried into Part II. It is not that the system is biased. It is that the system makes a decision of enormous consequence. It uses an instrument whose error rate has never been measured. The Territory's own death review has documented that error in 8 of a group of 13 people who later died.

Measuring the error rate is one of the hundred-day actions in Chapter 18, and is set out in operational detail in Chapter 15.

5. Theme 4: suicide and the lethality profile

The 2025 review's fourth theme is that perpetrators who die by suicide show similar risk factors to perpetrators who commit homicide.

It found that many of those who died by self-inflicted means displayed the lethality risk factors identified in the ANROWS National Risk Assessment Principles. Those factors are partner sexual violence, coercive control, non-fatal strangulation, stalking and threats to kill.

The review states that 8 of the 25 perpetrator deaths occurred in the context of a pending or recent separation from an intimate partner, within three months. The denominator is the perpetrator cohort of 25, not the 21 suicides within it. The 2023 review had already identified separation as a period of heightened risk for intimate partner violence.

The review recorded that in several cases, suicide appeared to be used to punish victims or to avoid accountability.

5.1 What this means for how the system thinks about risk

Three consequences follow, and they are not the ones usually drawn.

First, the same risk profile predicts two different outcomes. A person showing the classic lethality indicators may kill their partner, or may kill themselves, or may do neither. The indicators do not distinguish. This means the risk assessment that identifies a dangerous person is also identifying a person at elevated risk of suicide. The system currently acts on only one of those.

Second, the perpetrator's death does not end the victim's risk. Where a suicide is used to punish, the harm to the surviving partner and children continues. A system that closes the file when the respondent dies has not finished its work.

Third, separation is the hinge for both. The 2023 review found separation was the high-risk period for homicide. The 2025 review found that eight of the 25 deceased perpetrators died during or shortly after separation from a partner. Separation is also, very often, the moment the legal system becomes involved — an application is made, an order is served, proceedings begin.

That convergence is the subject of Chapter 11.

6. What the reviews recommended, and what happened

6.1 The 2025 review made no new recommendations

The 2025 review made no new recommendations. It stated that the 2023 recommendations remained relevant.

It said measurable progress had occurred on most of them. Further work was required for full implementation.

It did not provide a formal, independently verified matrix showing, recommendation by recommendation, what was complete, what was partially complete and what had not started.

This matters because the Auditor-General had specifically recommended that one be created. Recommendation 3 of Report 10 of 2024 asked the Community Services Directorate to establish processes to monitor and report on the implementation of recommendations from past reports. Those processes were to form part of future biennial reports.

The 2025 report followed the audit. It did not contain the matrix.

6.2 An assessment of implementation status

The table below assesses the public status of each 2023 recommendation as at 2 September 2026. It is an analytical assessment based on public evidence only. It is not an official status report. It is offered to show what the Territory should be publishing, not as a substitute for it.

TABLE 4.1

The 2023 death review's twelve recommendations, three years on

An analytical assessment based on public evidence only, as at 2 September 2026. It is not an official status report.

#	Recommendation, in short	Assessed public status
1	Coercive control as overarching context	● Substantial but incomplete
2	Ongoing training on coercive control and resistive behaviour	◔ Partial
3	Distinguish intimate partner violence from other family violence	○ Not demonstrated
4	Pattern and primary aggressor tool for police and courts	◑ In progress
5	Cross-agency data sharing and analysis of perpetrator patterns	◑ In progress
6	Prevention across all forms of family violence	◔ Partial
7	CALD community education co-designed with specialist services	◔ Partial
8	Tools addressing immediate safety and disruption of perpetrator behaviour	◑ In progress
9	Education and safety planning for separation risk	◔ Partial
10	Support children and young people	● Substantial but incomplete
11	Family violence, mental health and substance use intersections	◔ Limited to partial
12	Integrated cross-service infrastructure and workforce capability	◑ In progress

None is complete.

1 not demonstrated · 5 partial or limited · 4 in progress
2 substantial but incomplete · 0 complete

On the public record, no recommendation from the ACT's first domestic and family violence death review can be shown to be fully implemented. The assessment is the author's, because the implementation tracker the Auditor-General recommended in November 2024 has not been published.

Chapter 4, section 6.2; Appendix H. Dial fill is a reading aid only, not a measured score.

Read down the status column. One recommendation is “not demonstrated”. Five are “partial” or “limited to partial”. Four are “in progress”. Two are “substantial but incomplete”. None is complete.

Three years have passed since the recommendations were made, and nearly two years since the Auditor-General asked for an implementation tracker. On the public record, no recommendation from the ACT’s first domestic and family violence death review can be shown to be fully implemented.

6.3 Why this is the pattern the 2023 report predicted

The 2023 report warned that unactioned recommendations perpetuate a cycle of inaction, and that the same recommendations resurface in later reviews.

That is what happened. The 2025 review made no new recommendations because the 2023 recommendations were still live. The next review, due in 2027, will face the same choice.

A recommendation without an owner, a due date and a published status is not a plan. It is a statement of intent. Appendix H sets out a tracker template that would fix this in a single page per recommendation.

7. The defence, stated at its strongest

There is an answer available at this point, and it is not a weak one. It should be put in its best form before it is examined.

The defence. The Territory’s system was built to prevent intimate partner homicide and to protect women and children from men who use violence. That is what the evidence base supported, it is what the national plan directs, and it is what the ACT’s own fatality data shows when the question is who kills whom. Of the 25 people the 2025 review identified as perpetrators, 24 were male. Of the 13 it identified as victims, 11 were female. Every male perpetrator targeted a female victim. Suicide is a different problem. It has its own strategy, its own portfolio and its own clinical response. A domestic and family violence system is not a suicide prevention system, and asking it to become one would dilute a focus its evidence supports. On that account the composition of the death register is not a failure. It is a description of a boundary the system drew deliberately.

That account is coherent, and none of what follows requires it to be wrong. Four things follow anyway.

7.1 The shape of the record was published before the current Strategy was written

The register did not exist in 2016. The first biennial report was published in 2023, so the original design cannot be faulted for not using a document that had not been written.

By 2023 the shape was public. The 2023 report recorded 106 identified domestic and family violence incidents from 2000 to 2022, and 17 homicides among them. That is 89 non-homicide incidents against 17 homicides, a ratio of about five to one, published three years before the current Strategy.

The 2025 report’s own totals point the same way for the earlier period. It records 168 fatal incidents from 2000 to 2024, of which 31 are homicides, and 49 incidents for

2020 to 2024, of which 11 are homicides. Subtracting one from the other leaves 119 fatal incidents recorded for 2000 to 2019, of which 20 are homicides and 99 are not. That is arithmetic on published totals rather than a published figure, and it carries two qualifications. The register is a living record, so the earlier years are the least complete. And the review does not publish the cause of death for those years, so how many of the 99 were suicides is not known.

Neither qualification helps the defence. Homicide is the most completely recorded death in any register, although the ACT's own homicide count also rose between the two reports. Even so, an undercount in the earlier years is likelier to fall on the non-homicide side, and the true ratio is more likely to be wider than five to one than narrower.

So the proposition is not that the Territory should have known something unknowable. It is narrower. The disproportion between homicide and non-homicide deaths in this context was in the Territory's own published record from 2023, and the current Strategy was written in 2026.

7.2 The 2025 review put the composition beyond doubt

The 2025 report does not leave the reader to derive anything. It reports 38 non-homicide deaths against 11 homicides for 2020 to 2024, reports that 29 of the 38 were suicides, and reports the split: 21 of the 25 assessed as perpetrators and 8 of the 13 assessed as victims. It is a government document, published before the Strategy.

7.3 The Strategy read that review and took two findings from it

This is the part that decides the question, and it can be checked by anyone with the two documents.

The Strategy cites both biennial death reviews by name. It says the 2023 and 2025 reports "documented the prevalence and significance of coercive control, identifying this form of violence in almost all deaths examined", and that they "emphasised the importance of recognising victim resistive behaviours and responding to patterns of violence, rather than focusing on single incidents".

Both statements are accurate. Both are findings from the reviews. Neither is the finding about what the deaths are.

The word "suicide" appears once in the ACT Domestic, Family and Sexual Violence Strategy 2026–2036. It appears in the title of a different document listed among related strategies: the ACT Mental Health and Suicide Prevention Regional Plan 2025–2030. The Strategy does not use the word in its own voice at any point. In the First Action Plan 2026–28 the word does not appear at all. Neither document uses "self-harm". Neither uses "homicide", "fatality" or "death review". The single use of the word "deaths" in the Strategy is in the sentence quoted above, about coercive control.

So the Strategy is not unaware of the reviews. It cites them, quotes their themes, and lists them among the evidence guiding its design. It carried two findings across and left the third where it found it.

7.4 What the defence would require in order to succeed

A boundary drawn deliberately is a legitimate act of government. Four things would show that this one was drawn deliberately rather than left undrawn.

1. **It is stated.** A sentence saying which deaths this system is responsible for preventing and which it is not.
2. **The deaths on the other side of it are counted.** A published figure, updated, for deaths in a domestic and family violence context that are not homicides.
3. **An agency is named.** If those deaths are the responsibility of the mental health and suicide prevention portfolio, that portfolio's plan says so and holds the number.
4. **Something measures the arrangement.** An indicator that would show whether the boundary is working, and a review point at which it is reconsidered.

None of the four exists in either document. The ACT Mental Health and Suicide Prevention Regional Plan is listed as a related strategy; no handover of this cohort to it is described in the Strategy, and no shared indicator is stated. A boundary that is nowhere stated, whose other side is nowhere counted, and which nobody is named as owning, is not a boundary that has been drawn. It is a subject that has not been raised.

7.5 The defence and the finding are the same sentence

There is a further difficulty, and it is the one that runs through the rest of these chapters.

"The system is working as intended" is a claim about results. Establishing it requires a statement of the intended result, a measure of the actual result, and a comparison. The Auditor-General found in November 2024 that the responsible office had developed neither a performance monitoring strategy nor an evaluation framework. The Strategy published in May 2026 sets six outcomes and states no baseline, no indicator and no numeric target for any of them, and names no accountable agency for any of them.

So the defence cannot be made out on the record, and neither can its opposite. A system that publishes no baseline cannot demonstrate that it is achieving its intention, and cannot be shown to be failing to. That is not a rhetorical point scored against the defence. It is the same finding read from the other end, and it is the reason the verdict in Chapter 1 is *not proven* rather than *poor*.

The remedy is identical either way. Publish the composition of the deaths, name who is responsible for each part of it, and state what would count as improvement. If the boundary is the right one, that record will show it.

8. What the fatality evidence requires of the system

Six requirements follow directly from the two reviews. Each is stated here and picked up in Part III.

1. Stop equating fatality prevention with homicide prevention. Non-homicide deaths outnumber homicides four to one over 25 years and three to one in the most recent period. A system designed around homicide prevention is designed around less than a quarter of the deaths.

2. Assess patterns, not incidents. In about 9 of the 12 homicides reviewed in depth there was no significant prior physical violence, and coercive control was present in almost all 12. An incident-counting system would not have seen most of those 12 cases.

3. Measure misidentification. Eight of 13 deceased victims had been recorded as the aggressor. The rate in the general population is unknown and has never been measured.

4. Treat economic and housing insecurity as safety issues. Deceased victims had markedly higher unemployment and housing instability than deceased perpetrators.

5. Connect the responses. Of the 25 deceased perpetrators, 24 had a history of problematic substance use and 19 had reported a mental health condition. Both reviews found these systems poorly integrated with family violence responses.

6. Count the children and act on the count. Sixty-seven children were affected by 38 deaths. Some found the body.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. This chapter's complete set of 19 is at Appendix M, where it can be read against every other chapter's.

- **F4.2** — For 2020 to 2024 the register recorded 49 incidents: 11 homicides and 38 non-homicide deaths. Twenty-nine of the 38 were suicides: 21 of the 25 people assessed as perpetrators, and 8 of the 13 assessed as victims. Among the deaths this review was able to examine, people assessed as perpetrators who died by suicide are the largest single category.
- **F4.6** — Eight of the 13 deceased victims had been misidentified as the predominant aggressor by police or another agency before death, with recorded consequences including criminal charges, loss of employment, removal of children and incarceration.
- **F4.14** — The 2023 review found coercive control in almost all of the 12 homicides examined and no significant prior physical violence in about 9 of the 12.
- **F4.14b** — The ACT Domestic, Family and Sexual Violence Strategy 2026–2036 cites both biennial death reviews and adopts two of their findings, being coercive control and patterns rather than incidents. The word "suicide" appears once in the Strategy, in the title of a different document, and does not appear at all in the First Action Plan 2026–28. Neither document uses "self-harm", "homicide", "fatality" or "death review".

Sources for this chapter

Claim	Source	Date
Cause of death by cohort: 21 of 25 perpetrators and 8 of 13 victims died by suicide; 22 perpetrators with police involvement, 6 within a week of death; police involvement defined to include being served an interim order; 5 perpetrators had contravened an order	ACT DFV Review Biennial Report 2025	2025
Classification method: patterns of perpetration and victimisation analysed from records to identify perpetrators and victims	ACT DFV Review Biennial Report 2025, Misidentification	2025
“Kelly” and “Jodie” vignettes: twice misidentified, charged and taken into custody; misidentified, children removed by child protection	ACT DFV Review Biennial Report 2025, Theme 1, Victims are misidentified as perpetrators (side boxes)	2025
A family violence order is a civil court order	ACT DFV Review Biennial Report 2025, glossary; *Family Violence Act 2016* (ACT), ss 13, 13A, 21, 65	2025
Register 2000–2024: 168 incidents, 31 homicide, 137 non-homicide; 2020–2024: 49 incidents, 11 homicide, 38 non-homicide; 10 of 11 homicides subject to proceedings	ACT Domestic and Family Violence Review Biennial Report 2025	2025
29 of 38 deaths were suicides; 13 victims and 25 perpetrators; sex breakdown; victim and perpetrator characteristics; economic and housing comparison; children affected	ACT DFV Review Biennial Report 2025	2025
8 of 13 victims misidentified; timing; consequences; examples; contributing factors	ACT DFV Review Biennial Report 2025, Theme 1	2025
Family violence order histories of deceased victims and perpetrators	ACT DFV Review Biennial Report 2025	2025
Lethality factors among perpetrators who died by suicide; 8 of 25 at separation; violence outside DFV context not captured in national principles	ACT DFV Review Biennial Report 2025, Theme 4	2025
Register established under the *Domestic Violence Agencies Act 1986* in 2021	ACT DFV Review Biennial Report 2025	2025
2023 register of 134 incidents; 12 homicides analysed; coercive control in almost all; ~75% no significant prior physical violence; cycle of inaction warning; 12 recommendations	ACT Domestic and Family Violence Review Biennial Report 2023	2023
Recommendation 3: establish processes to monitor and report on implementation of past recommendations	ACT Auditor-General, Report 10 of 2024	22 November 2024
Implementation status assessment	Analytical assessment from public sources, ACT DFV 2023 recommendation status ledger	2 September 2026
2023 report: 106 identified incidents from 2000 to 2022, of which 17 were homicides	ACT Domestic and Family Violence Review Biennial Report 2023	2023
Derived: 119 fatal incidents recorded for 2000–2019, 20 homicides and 99 non-homicide, by subtraction of the 2020–2024 figures from the 2000–2024 totals. Arithmetic on published totals, not a published figure. Cause of death for those years is not published.	ACT DFV Review Biennial Report 2025, totals for 2000–2024 and 2020–2024	Derived 3 September 2026
Strategy cites the 2023 and 2025 biennial reports for coercive control “in almost all deaths examined” and for patterns rather than single incidents	ACT Domestic, Family and Sexual Violence Strategy 2026–2036, p 16	27 May 2026

Claim	Source	Date
Word occurrence check: “suicide” appears once in the Strategy, within the title *ACT Mental Health and Suicide Prevention Regional Plan 2025–2030*, and zero times in the First Action Plan; “self-harm”, “homicide”, “fatality” and “death review” appear zero times in both	Full-text search of the published PDFs of the ACT DFSV Strategy 2026–2036 and First Action Plan 2026–28	Checked 3 September 2026

Chapter 5 — The service system: capacity, waits and housing

In one page

In May 2024 an independent review of the ACT's crisis specialist services reported. It examined the two organisations the Territory funds to provide crisis response: the Domestic Violence Crisis Service and the Canberra Rape Crisis Centre.

Its overall finding was positive. Both service models are informed by evidence and best practice. Victim-survivors who could access them described the support in strong terms. Counselling was called "life changing".

The qualifier — *who could access them* — is where the chapter's substance lies.

The domestic violence crisis line operates 24 hours a day. The review found it could not answer all calls. Many were diverted to voicemail, particularly overnight and at weekends when staffing is reduced. The service could not resource attendance at every police callout. Counselling waits at the rape crisis centre could extend to several months.

It found a specific and avoidable cause for part of this. Crisis workers were spending a substantially increased share of their time finding accommodation. The causes were a housing shortage and difficulties with the centralised allocation process. Time spent searching for a bed is time not spent answering the crisis line.

It found that funding was provided through legacy programs not aligned to demand or to the true cost of operations. Contract arrangements were managed under historical arrangements described as not fit for purpose.

It found that agencies across the system used different risk processes and could reach different conclusions about the same case.

The 2026–27 Budget responds to parts of this with increased and indexed provider funding. It does not yet establish that unanswered calls, waits, housing bottlenecks or inconsistent risk decisions have been resolved. No published measure tracks any of them.

One number, one quote, one action

Number: The 2026–27 ACT Budget adds $47.8 million for domestic, family and sexual violence services. No published measure tracks the proportion of crisis line calls answered, so the effect of the increase cannot be assessed.

Quote: "DVCS is unable to answer all calls to the crisis line, with many diverted to voicemail, especially overnight and on weekends when DVCS has reduced staffing." — *Review of Sexual Violence and Domestic and Family Violence Crisis Response Services in the ACT*, Social Ventures Australia, May 2024

This week: The Minister for the Prevention of Domestic, Family and Sexual Violence tables in the Assembly the crisis line's call statistics for the past 12 months, showing the monthly proportion of calls answered by a person and the proportion diverted to

voicemail, by time of day. The phone system generates the figure already. On 10 June 2026 the Minister told the Assembly the number would have to come from the service.

1. The demand context

1.1 What the population data shows

The Australian Bureau of Statistics Personal Safety Survey provides the best available population estimate for the ACT.

- An estimated **73,200 women in the ACT — 42 per cent** — have experienced physical or sexual violence since the age of 15.
- An estimated **44,900 women — 26 per cent** — have experienced violence or other abuse by a cohabiting partner since the age of 15.
- **11 per cent of women and 5 per cent of men** reported being sexually abused before the age of 15.
- People who experienced childhood sexual abuse were at increased risk of sexual assault later in life.

Research cited in the review puts the co-occurrence of sexual violence with domestic and family violence in Australia at about 30 per cent. The ACT's review was originally scoped to sexual violence services. That is why it was expanded to include domestic and family violence crisis services.

1.2 What this means for service planning

Population prevalence is not service demand. Most people who have experienced violence do not contact a crisis service. Not all who do need crisis response.

But the figures set the scale of the possible demand pool. They show why demand pressure is structural rather than cyclical. A service system sized against reported incidents is sized against a fraction of the underlying need.

The ACT has never published a current system-wide assessment of need or of unmet demand. The Auditor-General identified the absence in 2024. The First Action Plan commits to system and client-journey mapping as future work. Until that exists, service capacity is set by history and by budget cycles rather than by measured need.

2. What the 2024 review examined and how

The review was commissioned in late 2022. It followed a recommendation in the 2021 *Listen. Take Action to Prevent, Believe and Heal* report that specialist support services be independently reviewed. Social Ventures Australia conducted it, with support from the Sexual Assault and Family Violence Centre. It reported in May 2024, after more than 12 months of research, consultation and analysis.

Its method included:

- research into best, leading and emerging practice in crisis response;
- interviews with victim-survivors in the ACT, under a process approved by a human research ethics committee;

- extensive stakeholder consultation;
- review of reports, data and documentation; and
- interviews with sector experts in the ACT and nationally.

Its scope was deliberately limited. It did **not** review prevention services, recovery services, legislative and regulatory frameworks, perpetrator programs, or police responses. Police processes were being examined separately.

That scope matters for how the findings should be read. The review looked at two organisations and the system conditions around them. It did not look at the rest of the system. Its silence on other components is not endorsement.

3. What the review found about the domestic violence crisis service

3.1 The model

The review found the crisis response model is informed by evidence and best practice frameworks. It delivers positive outcomes for victim-survivors.

The service maintains many community partnerships and access points. It works closely with ACT Policing to encourage referrals when victim-survivors contact police. It has staff present at the Magistrates Court and at Child and Youth Protection Services. It also has partnerships with refuges and other community organisations.

The crisis team is responsible for the crisis line and online enquiries. It attends police callouts where required, conducts crisis visits, arranges supports and liaises with other agencies. Staff are described as highly dedicated. They receive in-depth training on continually assessing risk.

3.2 The crisis line could not answer all calls

The crisis line operates 24 hours a day, seven days a week. It is the main entry point to the service. Victim-survivors use it, and so do referring organisations including police, hospitals and refuges.

The review found:

> DVCS is unable to answer all calls to the crisis line, with many diverted to voicemail, especially overnight and on weekends when DVCS has reduced staffing.

It stated the consequence directly: this can have serious implications for victim-survivors' safety and wellbeing, and for their trust in the service.

Victim-survivors described what it meant in practice. For some, being unable to get through was a minor frustration. For others, it represented a missed opportunity to improve their safety.

3.3 The service could not attend all police callouts

The review found the service was unable to resource attendance at all callouts with police. It observed there was potential to increase clarity between police and the service about when attendance should be prioritised.

This is a coordination and capacity issue combined. Attending a police callout puts a specialist worker at the scene at the moment of highest risk and highest opportunity. When the service does not attend, police deliver the response alone.

3.4 The action backlog

The crisis team operates a "diary" of actions: responding to voicemails, arranging crisis visits, completing referrals and responding to email requests for crisis support. Actions are triaged by priority and by implications for client risk and safety.

The review observed that rostering changes had recently been made to address a backlog in the diary. But the service still experienced challenges providing swift responses on priority actions.

3.5 Continuity of care

Victim-survivors commented on the care and compassion of the crisis team. Many also noted the difficulty of speaking to a different team member each time they called.

The review recommended adding individualised crisis case management to the crisis response model. That would provide greater continuity and align with best practice.

This is a design finding rather than a resourcing complaint. Some people in crisis must re-explain their situation to a new worker at each contact. They are being asked to do the system's information management for it. They are asked at the point when they have least capacity to do it.

4. Housing: how a shortage in one system consumed capacity in another

The archive contains no clearer example of a failure at the interface between two systems. It deserves to be set out precisely.

4.1 What the review found

The crisis team spends a substantial amount of its attention finding and securing crisis accommodation. The people who need it have become homeless, or need temporary safe accommodation, because of domestic and family violence.

The proportion of time spent managing crisis accommodation had **increased substantially** in recent years. The review found two causes:

1. the ongoing shortage of suitable housing; and
2. challenges with crisis accommodation allocation through the centralised intake service for crisis accommodation and homelessness services.

Then the review made the connection explicit:

> These issues compound the abovementioned challenges with crisis line responsiveness, as crisis team members who are tied up dealing with accommodation issues may be unable to answer the crisis line or respond to victim survivors' enquiries.

4.2 Why this matters for how the system is funded

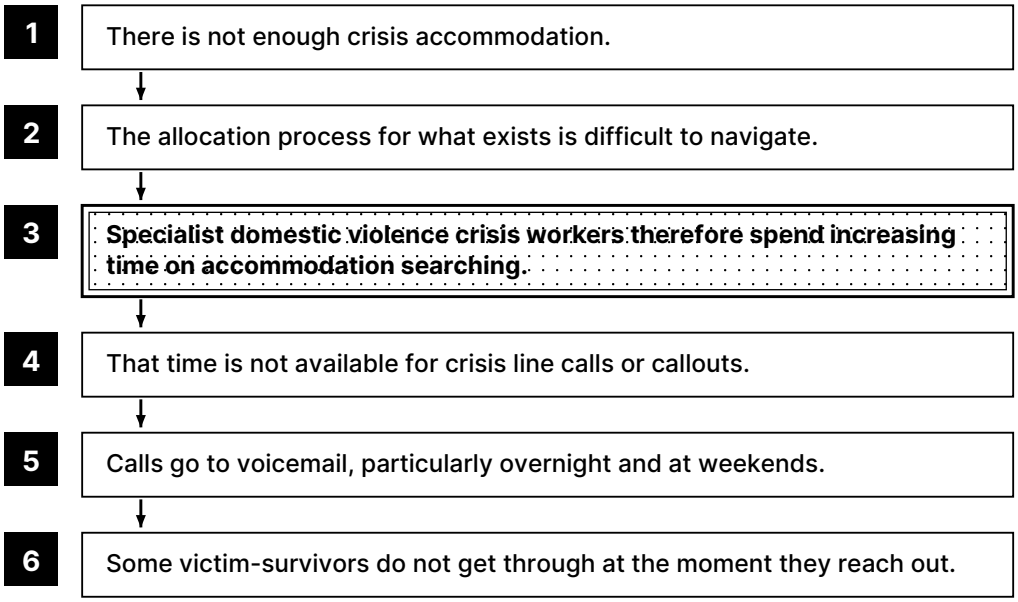
Read as a chain of consequence:

- There is not enough crisis accommodation.
- The allocation process for what exists is difficult to navigate.
- Specialist domestic violence crisis workers therefore spend increasing time on accommodation searching.
- That time is not available for crisis line calls or callouts.
- Calls go to voicemail, particularly overnight and at weekends.
- Some victim-survivors do not get through at the moment they reach out.

FIGURE 5.1

The accommodation bottleneck

How a shortage in one system consumes capacity in another. Read as a chain of consequence.



At no point in that chain is there a failure by the crisis service.
Every link is a rational response to the previous one.

None of it is counted. Not published in the ACT:

- proportion of crisis line calls answered
- proportion of police callouts attended
- average time from first contact to a safe bed
- proportion of crisis worker time spent on accommodation searching
- number of people who could not be accommodated

The crisis service budget is, in effect, subsidising the housing system's shortfall. It does so invisibly, because nobody counts the hours.

Chapter 5, section 4. The steps are findings of the May 2024 crisis services review; the chain is the author's reading.

At no point in that chain is there a failure by the crisis service. Every link is a rational response to the previous one.

This is what an unfunded interface looks like. The housing shortage converts part of the money spent on the crisis service into accommodation-searching labour. The crisis service budget is, in effect, subsidising the housing system's shortfall. It does so invisibly, because nobody counts the hours.

Chapter 6 shows the same pattern in the justice system. There, reforms in one agency generated demand in another without corresponding funding. Chapter 16 section 7 proposes the control. Any material reform would have to model its flow-on demand across all affected systems before it is funded.

4.3 What has not been established

The 2026–27 Budget increases funding to providers and indexes it. Increased funding may reduce the pressure. It does not, by itself, resolve either underlying cause: the housing shortage or the allocation process.

More importantly, nothing published allows anyone to check. There is no public measure of:

- the proportion of crisis line calls answered;
- the proportion of police callouts attended;
- the average time from first contact to a safe bed;
- the proportion of crisis worker time spent on accommodation searching; or
- the number of people who could not be accommodated.

Each is a standard operating measure for a telephone crisis service. None is published in the ACT.

4.4 What the Assembly was told in 2026

On 10 June 2026 the crisis line was raised in the Legislative Assembly. That was two years after the review reported.

A member asked the Minister for the Prevention of Domestic, Family and Sexual Violence what the current rate of unanswered calls to the crisis line was. The member said the service had reported in the previous year that only half of all calls were answered. Some victims waited days to hear back.

The Minister answered that the member would have to speak directly to the service for the exact number. She described the pressure on services and the year-on-year funding increases. She described the uplift for call services in the previous year. She also described the extension, expansion and ongoing core funding provided in the current budget.

A second member asked why the Minister did not know the number of unanswered calls from a body receiving government funding. The member also asked what the acceptable rate of unanswered calls was. The Minister replied that this was really a question for the service. She described the core contract, the funding increases and her engagement with the service's board and chief executives.

This exchange is recorded here without characterising anyone's conduct. It illustrates a structural point that recurs throughout these chapters. It does so more clearly than any analysis could.

The number of unanswered calls to a 24-hour crisis line is the single most direct measure of whether a crisis service is meeting demand. The phone system generates it automatically. The Territory funds the service under a core contract. Yet the responsible Minister, asked in the Assembly, could not state the figure. She identified the service rather than the government as the place to obtain it.

That is not a failure of preparation. It is a description of the reporting architecture. Suppose a funding agreement does not require a provider to report a measure to government, and government does not publish it. Then no one in government holds it. The Minister's answer was accurate.

The remedy is not to ask ministers harder questions. It is to write the measure into the contract and publish it. Section 8.3 below lists the six measures that would do this for crisis services.

5. What the review found about the sexual assault crisis service

5.1 The model

The review found the Canberra Rape Crisis Centre provides high quality, evidence-based support to victim-survivors who are able to access its services. National best practice standards inform that support.

It provides good access to on-demand crisis support through its crisis phone line, online and text-based services, and a 24-hour callout service. The crisis team attends police stations, hospitals and other services to support victim-survivors making statements or undergoing forensic examinations.

Two embedded services provide tailored support:

- **SAMSSA** — Services Assisting Male Survivors of Sexual Assault — provides crisis support and counselling to male victim-survivors.
- **Nguru** — one of the first Aboriginal-managed sexual violence support services in Australia — provides holistic, culturally appropriate services for Aboriginal and Torres Strait Islander people.

SAMSSA is relevant to Chapter 10. It establishes that the ACT does fund a dedicated service for male victim-survivors of sexual violence. Chapter 10 examines what is and is not visible for male victims of domestic and family violence specifically.

5.2 The counselling model and its cost

The centre provides counselling with no charge and no limit on the number of sessions a person can attend. It regards this as crucial, because trauma recovery is not linear or predictable.

Victim-survivors valued this highly, particularly those who had previously used services with strict session limits.

The review observed the tension this creates. Maintaining an uncapped service while minimising waiting times is challenging. It requires constant attention and agility in resource allocation.

5.3 The waits

Victim-survivors raised waiting times for counselling as their key concern. Waits **could extend up to several months**.

The review found a need for greater attention to managing the counselling waitlist. It also found a need for greater collaboration between the centre and other agencies. Support should then be provided as quickly as possible once someone reaches out — whether by the centre or another appropriate provider.

Two things are true simultaneously. An uncapped, free counselling model is better clinical practice than a capped one. An uncapped model without matching capacity produces a queue. The queue falls on people who have just disclosed sexual violence, at the point the review itself identifies as the one where support should come quickest.

5.4 Workforce

Victim-survivors spoke highly of counsellor skills. Their main improvement request was for more counsellors, so waits could be reduced.

Some noted staff turnover as a concern. It takes time to rebuild rapport and trust with a new counsellor. They were still understanding of counsellors' decisions to leave. They expressed empathy for people doing an important and difficult job.

The centre had experienced periods of high turnover and had taken steps, including an internal cultural review. Retention had significantly improved by the time of the review. The review noted that workforce challenges are common across sexual violence services in Australia. It found ongoing focus is needed on workforce development and support, including stress, burnout and vicarious trauma.

5.5 Governance and infrastructure

The review found the organisation is managed by a dedicated senior leadership team and board. Like most community sector organisations, it relies on an all-volunteer board. The board had experienced periods of high turnover. The review found it would benefit from support to review its structures, membership, governance processes and operations.

It also found the organisation would benefit from support to improve data collection and reporting. That work would build on previous investment in client record management and case tracking systems.

Operating costs had increased in response to rising demand, straining financial sustainability. The review noted a funding increase of about $1.5 million over three years for crisis support. It called that an important commitment bringing funding back into line with operating costs.

6. The system conditions

The review examined the conditions in which both organisations operate. Four findings apply across the sector.

6.1 Legacy contracts not aligned to demand or true cost

The review found that funding was provided through legacy programs and was **not well aligned with changes in demand or the true costs of operations**. Contracts were managed under historical arrangements described as **not fit for purpose**. That created a lack of clarity in communications and reporting.

The government had started commissioning reform for funded services. But the process had not yet reached all providers. There was uncertainty about what it would involve or when it would occur. The review noted a commitment to start reform of these arrangements from 1 July 2024.

Two years later, the First Action Plan committed to developing a commissioning roadmap. It also committed to analysing the true cost of delivering safe, effective and integrated services. Both are future work.

The significance of "true cost" is easy to miss. Some grants fund direct service hours but not supervision, data systems, evaluation, insurance, premises or management. The organisation must then fund those from somewhere else. Small organisations meet the gap by under-investing in the invisible functions: data, evaluation and workforce support. Those are precisely the functions whose absence the following chapters document.

Under-costed contracts are therefore not only a fairness problem for providers. They are one of the mechanisms by which the system loses the ability to measure itself.

6.2 Inconsistent risk processes across agencies

Agencies across the system include police, courts, the crisis service and others. The review found they used different risk processes. They could reach different conclusions about the same case.

This finding is examined fully in Chapter 8. It is recorded here because it came from a service review, not a risk review. The inconsistency was visible from the service floor, two years after the common framework was published.

6.3 Gaps in coverage for specific groups

Stakeholders named gaps in tailored service coverage for:

- children and young people, including young people experiencing intimate partner violence;
- older people;

- people with disability, particularly intellectual disability;
- LGBTIQA+ people, especially people who identify as trans; and
- people from culturally and linguistically diverse communities, including recent migrants, people with limited English and people on limited-stay visas.

The review noted that the ACT Government had increased funding for services supporting some of these groups. It had also funded five Aboriginal community-controlled organisations to deliver culturally appropriate, holistic support.

6.4 Variable response from universal services

Victim-survivors reported mixed experiences when disclosing to universal services — health, community services and others. Some described services going above and beyond. Others felt let down, or unsafe.

A published submission to the 2026 coercive control inquiry supplies one account of what the second category can look like. Elisabeth Yar describes seeking help from health providers during the relationship, and writes that they failed to identify the patterns that turn an apparently reasonable act into coercive control. She gives an example: a counsellor at a publicly funded ACT health provider agreed that her husband should remove her car keys "for my own safety", which removed, at a point of high risk, a means of escape from physical violence.

One account is not a rate, and none is claimed from it. It is included because it identifies a mechanism precisely: a control tactic endorsed as a safety measure by a service with no method for telling the two apart. That is what a framework covering generalist services exists to prevent, and Chapter 8 sets out why the current one cannot.

The review concluded there are gaps in knowledge and skills across the broader services sector about how to respond appropriately to disclosures.

This is the practical test of a whole-of-system risk framework. A framework that covers generalist services is meant to produce a consistent minimum standard of response wherever someone discloses. Two years after publication, the response was still variable enough for victim-survivors to notice.

7. What people using the system said, in their own words

Sections 1 to 6 are drawn from a commissioned review, budget papers and Assembly transcripts. Those establish capacity, cost and timing. They do not establish what the system is like from inside it, and no administrative dataset does.

Two published documents supply that, and both are on the public record because their authors put them there. In 2026 the Legislative Assembly's Standing Committee on Legal Affairs received submissions to its inquiry into the Crimes (Coercive Control) Amendment Bill 2026 and authorised them for publication. The accounts below are quoted from two of them. Nothing here is drawn from any matter that is not already public.

7.1 On whether help was available at the scale required

Elisabeth Yar made a submission as an individual victim-survivor. She describes leaving, after two decades, a relationship defined by emotional and financial control and physical violence against her and three children.

> "I know that the level of support my family and I needed to leave a situation of violence and re-establish a sense of safety and security, before even thinking about court processes, far exceeded anything available to us. While I appreciated the support of services such as the Domestic Violence Crisis Service (DVCS) and Victims Support ACT, it was a drop in the bucket compared with the huge need we faced."

That is the same finding as sections 3 and 5 of this chapter, arrived at from the other side of the counter. The review measured unanswered calls and counselling waits. This describes what those measurements are measurements of.

She also describes what filled the gap:

> "In my experience, having support, particularly peer and lived-experience support, in navigating services and systems was absolutely essential to escaping domestic violence. However, this role was performed almost entirely in an ad hoc and informal way by friends and proved unsustainable in the long term and damaging to an already fragile support network."

Unfunded navigation carried by a person's friends is not a service model. It is what happens where there is no service model, and it has a failure point.

7.2 On the response from services when people did come forward

A joint submission by Sisters in Spirit Aboriginal Corporation and Women's Health Matters reports consultations with Aboriginal and Torres Strait Islander women in the ACT. Participants described why they do not use services:

> "I don't use a lot of services in Canberra, because there's just, you feel like you're just not being heard ... It's just 'deal with it, move on'."

> "They don't take it serious. Judged before you've even walked in the door."

Section 6.4 records the 2024 review's finding that responses from universal services were variable enough for victim-survivors to notice. This is what that variability sounds like when it is described by the person who encountered it.

The same submission records a further theme, which is not about capacity at all. Participants described institutions — police, child protection, courts, corrections and funding bodies — as operating in ways that removed autonomy, punished attempts to get needs met, and isolated people from support. The submission's word for the pattern is that participants experienced the system itself as a perpetrator of coercive control.

That is a claim about a mechanism, not a measurement of how often it occurs, and it is used here as the former. It matters because it is not a claim the service data could ever produce. A dataset that counts contacts cannot record what a contact did to the person who made it.

7.3 What this evidence does and does not establish

These accounts establish meaning, mechanism and barrier. They do not establish prevalence. A handful of people saying a thing is a handful of people saying it, and the submissions do not claim otherwise.

They belong here for a reason that is specific rather than decorative. Every finding in sections 1 to 6 is a statement about a system, and the question a system exists to answer is what happens to a person who comes to it. On that question these are primary sources and the budget papers are not. Chapter 14 section 13 sets out the full position: an account of experience is a necessary and insufficient form of evidence, and the correct response to insufficiency is triangulation rather than exclusion.

There is also a fact worth recording about the second submission. It reports what Aboriginal and Torres Strait Islander women said in a consultation run by two community organisations. The equivalent finding does not appear in any ACT administrative dataset, because the Territory does not collect it. Where a cohort is below five in the published data, it is suppressed entirely, as Chapter 10 records. So for that group, the consultation is not one source among several. It is the only one.

8. What the 2026 package changes, and what it does not

8.1 What it does

The 2026–27 Budget provides, within the $47.8 million additional package:

- **$21.4 million** for critical victim-survivor services, including about **$9.9 million** to the Domestic Violence Crisis Service, **$8.7 million** to the Canberra Rape Crisis Centre and **$2.8 million** to YWCA Canberra;
- **$4.1 million** for children and young people, including a therapeutic program, a mobile therapeutic service and a specialist children's worker at a refuge;
- **$7.5 million** for marginalised groups, including $2.1 million for multicultural women, children and young people, $2.1 million for Aboriginal community-controlled sexual violence responses and $1 million for an LGBTIQA+ program;
- **$6.7 million** for men's behaviour change work, comprising $3.5 million and $3.2 million to two providers; and
- **$3.6 million** for system foundations, including a sector network, information-sharing coordination, risk framework implementation and prevention infrastructure work.

Beyond the package, **$13.2 million a year indexed and ongoing from 2029–30** provides the base funding stability the review found missing.

This is a direct and substantial response to several of the review's findings. Provider funding increases. Indexation addresses the mismatch between costs and grants. Gaps identified for specific groups receive targeted funding. System foundations are separately funded.

8.2 What it does not do

Money addresses capacity. It does not, by itself, address the four structural findings.

The housing interface is unchanged. Increased crisis service funding buys more worker hours. If the accommodation shortage and allocation difficulty persist, a proportion of those additional hours will also be spent searching for beds. Nothing in the package changes the housing supply or the allocation process.

Nothing is measured. No published measure tracks calls answered, callouts attended, wait times, time to safe accommodation or the proportion of worker time spent on accommodation. Without a baseline from before the funding increase, the effect of the increase cannot be assessed. This is not a hypothetical concern: it is exactly what the Auditor-General found in 2024 about the previous decade of spending.

Commissioning reform is still ahead. The true-cost analysis and commissioning roadmap are future actions in the First Action Plan. Until they are done, funding increases are applied to a contracting model the review described as not fit for purpose.

Risk process inconsistency is still ahead. The framework update was still in progress at September 2026.

8.3 The measurement that would settle it

Six measures, published quarterly, would allow anyone to see whether the 2026 investment worked:

1. Proportion of crisis line calls answered by a person, by time of day and day of week.
2. Proportion of police callouts attended by a specialist worker where attendance was requested.
3. Median and 90th percentile wait from first contact to first counselling session.
4. Median and 90th percentile time from crisis presentation to safe accommodation.
5. Proportion of crisis worker time spent on accommodation search and allocation.
6. Number of people seeking crisis accommodation who could not be accommodated.

Five of the six are generated by normal operations. The fifth requires a simple time-coding of worker activity. What is missing is the requirement to publish them.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. This chapter's complete set of 12 is at Appendix M, where it can be read against every other chapter's.

- **F5.2** — The 24-hour domestic violence crisis line could not answer all calls; many were diverted to voicemail, particularly overnight and at weekends when staffing is reduced.

- **F5.5** — Crisis workers were spending a substantially increased share of their time on accommodation searching because of a housing shortage and difficulties with centralised allocation, and the review found this directly compounded crisis line responsiveness problems.
- **F5.7** — Agencies across the system used different risk processes and could reach different conclusions about the same case — a finding made from the service floor two years after the common framework was published.
- **F5.10** — On 10 June 2026 the responsible Minister, asked in the Legislative Assembly for the current rate of unanswered crisis line calls, said the member would need to ask the service directly, and identified the acceptable rate as a question for the service.

Sources for this chapter

Claim	Source	Date
ACT prevalence estimates: 73,200 women (42%); 44,900 women (26%); 11% of women and 5% of men sexually abused before 15	ABS Personal Safety Survey 2021–22, ACT statistics, as cited in the review	2021–22
Co-occurrence of sexual with domestic and family violence approximately 30%	AIHW, cited in the review	2019
Review commissioning, method, scope and exclusions	*Review of Sexual Violence and Domestic and Family Violence Crisis Response Services in the ACT*, Social Ventures Australia, Final Summary Report	May 2024
Crisis line unable to answer all calls; voicemail diversion overnight and weekends; safety and trust implications	Same review	May 2024
Unable to resource attendance at all police callouts	Same review	May 2024
Diary backlog and rostering changes	Same review	May 2024
Accommodation time increase; housing shortage and allocation difficulties; compounding effect on crisis line	Same review	May 2024
Counselling waits up to several months; uncapped free model	Same review	May 2024
SAMSSA and Nguru embedded services	Same review	May 2024
Workforce turnover, board governance, data and reporting findings; ~$1.5m over three years for crisis support	Same review	May 2024
Legacy funding not aligned to demand or true cost; contracts not fit for purpose; commissioning reform from 1 July 2024	Same review	May 2024
Service coverage gaps by cohort; five Aboriginal community-controlled organisations funded	Same review	May 2024
Variable response from universal services	Same review	May 2024
2026–27 package components and recipients; indexed ongoing funding	2026–27 Budget DFSV factsheet	2026
Assembly exchange on unanswered crisis line calls, 10 June 2026	ACT Legislative Assembly Hansard, 10 June 2026 (proof), pages P2115–P2116	10 June 2026

Claim	Source	Date
True-cost analysis and commissioning roadmap as future actions	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026
Victim-survivor account: support needed far exceeded what was available; informal peer navigation carried by friends; health provider endorsed removal of car keys as a safety measure	Submission 002, Elisabeth Yar, Inquiry into the Crimes (Coercive Control) Amendment Bill 2026, ACT Legislative Assembly Standing Committee on Legal Affairs	Authorised for publication 1 July 2026
Participant accounts of not being heard, of being judged before entry, and of institutions experienced as reproducing coercive dynamics	Submission 022, Sisters in Spirit Aboriginal Corporation and Women's Health Matters, same inquiry	Authorised for publication 5 August 2026

Chapter 6 — The justice system: demand without capacity

In one page

Between about 2021 and 2025 the ACT increased police numbers and appointed additional Supreme Court judges. Both were reasonable responses to demand.

Neither was matched by a corresponding increase to the agency that receives the resulting work. The Director of Public Prosecutions told the Assembly that putting additional police on the street results in increased charges coming into the office. The Director said there had been no commensurate increase to funding.

The numbers the office reported are these. Over four years, family violence prosecutions rose by about 50 per cent. Sexual violence prosecutions rose by about 170 per cent. In one financial year the office prosecuted 5,231 matters across ACT courts. That included completing more than 800 family violence files and commencing more than 200 sexual assault files.

The Director's description of the consequence was direct: staff simply do not have time to prepare matters properly.

The same pressure appears at the other end of the justice chain. Legal Aid ACT told an Assembly committee that it was prioritising criminal and domestic and family violence matters. It said civil, employment and discrimination matters were "not getting much preference". Its funding threshold reached only 120 per cent of the poverty line, against an aspiration of 180 per cent. The baseline review it had requested was not occurring.

This is the pattern the chapter documents. Domestic and family violence reform is not costless outside the domestic and family violence budget. It generates work in police, prosecution, defence, courts, corrections, housing, health and community services. When that flow-on demand is not modelled and funded, the cost does not disappear.

It is transferred to the parts of the system that were not consulted. Ultimately it is transferred to people who go unrepresented or whose matters are not properly prepared.

One number, one quote, one action

Number: Sexual violence prosecutions in the ACT rose about 170 per cent over four years. Recorded sexual assault victimisation rose about 37 per cent over roughly the same window. That is a divergence of about four and a half times.

Quote: "The real-life effect, going back to your question, is that my staff simply do not have time to prepare the matters properly." — Director of Public Prosecutions, ACT Legislative Assembly Hansard, 16 September 2025

This week: The Director of Public Prosecutions publishes, for the last two reporting years, the number of family violence and sexual offence matters discontinued, broken

down by the stage at which the decision was made and the reason recorded. The office holds the files. The annual reports publish the totals and nothing about why.

1. Why this chapter belongs in a study of domestic violence

A reader might reasonably ask why a study of the domestic and family violence system spends a chapter on prosecution funding and legal aid.

The justice system is where a great deal of domestic and family violence policy is actually delivered. It is not funded as part of the domestic and family violence portfolio.

Consider what happens when the Territory decides to take family violence more seriously. It puts more police on the street. Police attend more incidents and lay more charges. Those charges go to the Director of Public Prosecutions. Matters are listed in the Magistrates Court, and the more serious ones in the Supreme Court. Defendants who cannot afford a lawyer seek legal aid.

Some are remanded, which is a corrections cost. Some are convicted and supervised, which is another. Protection order applications are made, listed, contested and enforced. Breaches generate further charges.

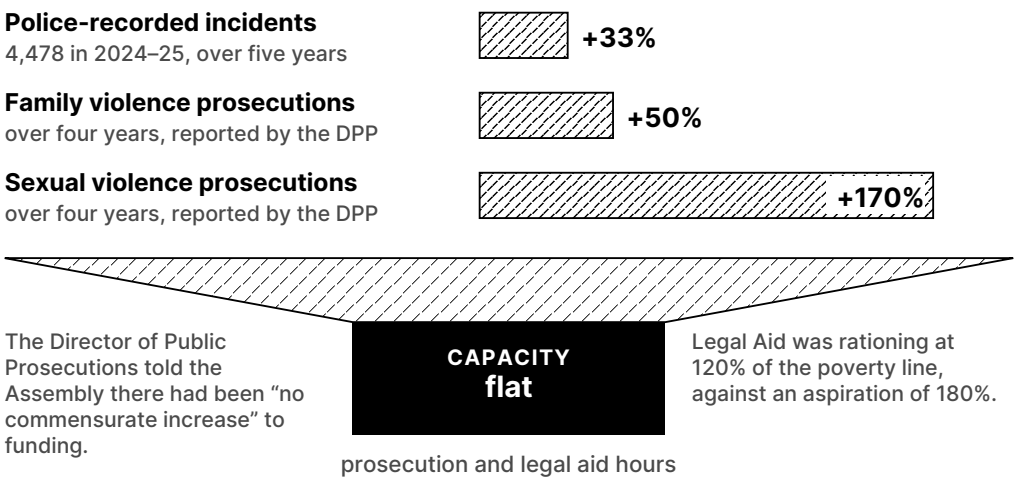
None of that appears in the domestic and family violence budget factsheet. It appears — if it appears at all — as pressure in the annual reports of other agencies.

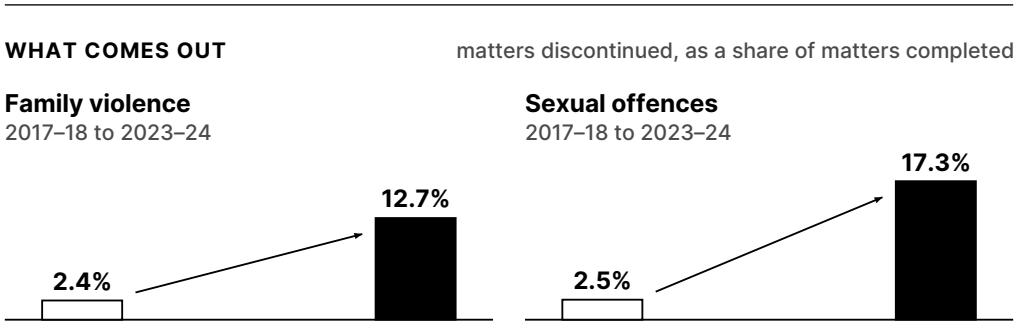
The 2026–27 Budget does identify about **$37.9 million** of "adjacent" justice system initiatives supporting strategy outcomes. That is an improvement: it acknowledges the connection. It is not the same as a demand model.

FIGURE 6.1

The justice interface: demand without capacity

Front-end volume rose. The capacity to absorb it was not matched.





Adding police at the front end produces charges. The prosecution service, legal aid and the courts absorb them from existing hours.

Chapter 6, sections 2 to 3. Growth figures cover different periods and different measures and are not directly comparable; the manuscript states each separately.

2. What the prosecution service reported

2.1 The volume increase

The Director of Public Prosecutions made an opening statement submission to the 2025–26 Assembly hearings. The submission reported that over four years the office had seen:

- a **50 per cent increase** in prosecution numbers in family violence; and
- a **170 per cent increase** for sexual violence.

In hearings, the office stated:

> Last financial year, my office prosecuted 5,231 matters across ACT courts, including completing more than 800 family violence files and commencing more than 200 sexual assault files.

The 5,231 figure is the one in the office's 2023–24 annual report. The 2024–25 annual report gives 7,299 matters. The two reports may not count matters on the same basis, and the difference is not relied on here.

2.2 The mechanism

The Director described the causal chain plainly:

> ...when you put additional police on the street, it results in increased charges which come into my office, and there has been no commensurate increase to my funding.

This is not a complaint about police. Increasing police numbers in response to rising family and sexual violence reporting is a defensible policy choice. It was made openly. The point is narrower. The decision produced a predictable downstream cost in a different agency, and that agency's budget was not adjusted.

2.3 The stated consequence

Asked about the real-life effect, the Director said:

> The real-life effect, going back to your question, is that my staff simply do not have time to prepare the matters properly.

And, on the office's position relative to other jurisdictions:

> ...we are asked to deliver the impossible, with a budget that has fallen significantly behind and has left us out of step with the service prosecuting agencies are able to provide in other states and territories.

2.4 Why this matters for victims specifically

Under-preparation in a prosecution service does not fall evenly. In family and sexual violence matters it falls in particular ways:

- **Delay.** Matters take longer to reach hearing. In family violence matters, delay extends the period in which a complainant is a witness in a live proceeding. The complainant is often sharing children, a lease or a suburb with the accused.
- **Attrition.** Complainants withdraw. Delay is one of the best-documented predictors of withdrawal in sexual and family violence prosecutions.
- **Weaker preparation.** Proper preparation in these matters means conferencing with the complainant, and obtaining and analysing digital evidence. It also means dealing with protected confidences applications, and preparing for cross-examination that is often about credibility. All of it is time-intensive.
- **Wrong outcomes in both directions.** Under-prepared prosecutions can fail when they should succeed. They can also proceed when a properly resourced review of the brief would have discontinued them.

The second half of that last point receives less attention than it deserves. A prosecution service without time to prepare properly is also without time to identify the cases that should not be run.

2.5 Other reported constraints

Beyond volume and funding, the office also reported:

- inadequate training; and
- obsolete case management technology.

Case management technology is not an administrative detail in this context. Chapter 11 examines what happens when justice system record systems cannot answer basic questions about the people who pass through them.

2.6 The workload transfer that did not work

The Director's office transferred regulatory prosecutions to the Solicitor-General to relieve pressure.

The Solicitor-General later reported that the transferred workload had been **significantly underestimated**.

This is a small but instructive example. Faced with unfunded demand, an agency moved work to another agency. The receiving agency then found the work larger than expected. No new capacity entered the system; the pressure changed address.

2A. Did reported offending rise as fast?

This is the question the volume figures raise and do not answer. Prosecutions grew. Did the underlying reported offending grow at the same rate?

The answer is different for the two streams, and the difference matters.

2A.1 What was reported to police

Family and domestic violence. ACT Policing recorded **4,478** domestic and family violence related incidents in 2024–25, an average of about 12 a day. That was a **33 per cent increase over five years**. In the same year, 44.9 per cent of all recorded assault offences were domestic and family violence related, and total assault offences fell by 3.3 per cent on the previous year.

Sexual assault. The Australian Bureau of Statistics records sexual assault victims by jurisdiction. The ACT rate per 100,000 people ran:

Year	ACT sexual assault victims per 100,000	Victims
2019	75.0	—
2020	65.0	—
2021	75.4	—
2022	71.2	—
2023	79.7	372
2024	89.4	428

From 2020 to 2024 the ACT rate rose by about 37 per cent. From 2019 to 2024 it rose by about 19 per cent. In 2024, about 37 per cent of ACT sexual assaults were family and domestic violence related — 160 victims.

2A.2 What was prosecuted

The DPP publishes matter counts in its annual reports.

Reporting year	Family violence matters commenced	Sexual offence matters commenced
2017–18	678	93
2023–24	799	201
2024–25	933	248

The Director's "four years" comparison runs from a base year the statement does not name. The table above gives the published annual report figures; over the seven years from 2017–18 the increases are about 38 per cent for family violence and about 167 per cent for sexual offences.

2A.3 The comparison

Family violence. Prosecutions commenced rose about 50 per cent over four years, on the DPP's own figure. Recorded incidents rose about 33 per cent over five years. Those are different measures over different periods, but they are the same order of magnitude. The prosecution growth is broadly consistent with the growth in reporting.

Sexual violence. Prosecutions commenced rose about 170 per cent over four years, on the DPP's own figure. Recorded sexual assault victimisation in the ACT rose about 37 per cent over roughly the same window.

That is a divergence of about four and a half times. Even allowing generously for the differences in measure and period, prosecution volume in the sexual violence stream grew several times faster than reported offending.

2A.4 What that means, and what it does not

It does not mean the additional prosecutions were wrong. There is a well-documented history in every Australian jurisdiction of sexual offences being reported and not prosecuted. Prosecuting a higher share of what is reported is a legitimate policy objective, and improving the justice response to sexual violence was a stated aim of the reforms that followed the 2021 *Listen. Take Action* report. If the ACT previously prosecuted too few of the sexual offences reported to it, then prosecutions rising faster than reports is the reform working.

It does mean the growth was not simply demand. The volume did not arrive on its own. Something changed in the proportion of reported matters that were charged and taken forward. That change reflects decisions by police and the prosecution service about which reported matters to take forward, or changes in how matters are recorded. Either can be evaluated.

It makes the funding question sharper, not softer. Section 2.3 above has recorded that the prosecution service says it does not have time to prepare matters properly. If the growth in its workload were driven by rising crime, that would be an argument for more money and nothing else. Where the growth is substantially driven by a decision to charge a higher proportion of what is reported, the question is not only whether the office has enough money. It is whether the decision to increase the flow was accompanied by a decision to fund it.

2B. What happened to the matters

Volume is only half of it. The other half is what happened to the matters once they were brought.

2B.1 The outcome figures

The DPP publishes, for each reporting year, matters commenced, completed, proved and discontinued.

Family violence

	2017–18	2023–24
Commenced	678	799
Completed	715	814
Proved	581	615
Discontinued	17	103
Proved, as a share of completed	81.3%	75.6%
Discontinued, as a share of completed	2.4%	12.7%

Sexual offences

	2017–18	2023–24
Commenced	93	201
Completed	122	75
Proved	70	48
Discontinued	3	13

	2017–18	2023–24
Proved, as a share of completed	57.4%	64.0%
Discontinued, as a share of completed	2.5%	17.3%

Supreme Court sexual offence trials

	2017–18	2023–24
Trials	19	13
Trial days	117	89
Guilty verdicts	9	5
Not guilty verdicts	8	5
Other	2	3

2B.2 The pattern

Two things moved in the same direction in both streams.

Discontinuance rose sharply. In family violence, from 2.4 per cent of completed matters to 12.7 per cent — more than five times. In sexual offences, from 2.5 per cent to 17.3 per cent — nearly seven times.

Proved rates fell in the larger stream and rose only on a much smaller base in the other. In family violence the proved share of completed matters fell, from 81.3 to 75.6 per cent. In sexual offences it rose, from 57.4 to 64.0 per cent, but on 75 completed matters against 122.

At trial in the Supreme Court, sexual offence matters produced roughly as many not guilty verdicts as guilty verdicts in both years.

2B.3 The four explanations

A rising discontinuance rate has at least four possible causes. All are plausible. None has been tested.

One — more marginal matters are being charged. If police and prosecutors take forward a higher proportion of reported matters, the average strength of the matters taken forward falls, and more of them are later discontinued. This is the explanation the volume divergence in section 2A points towards, and it is the one that would concern a court.

Two — complainants withdraw more often. Discontinuance frequently follows a complainant deciding not to proceed. Longer preparation times make that more likely, and section 2.3 above records the prosecution service's own account of the time available to it.

Three — the office has less time to filter. The prosecution policy requires every matter to be assessed for reasonable prospects of conviction and public interest. A service that says its staff do not have time to prepare matters properly is also a service with less time to identify, early, the matters that should not be run.

Four — recording practice changed. A rise in a recorded category can reflect a change in how the category is recorded rather than a change in what happened.

2B.4 What the ACT publishes about which explanation is right

Nothing.

The DPP annual reports publish the counts. They do not publish the reasons for discontinuance, the stage at which matters were discontinued, or the time from charge to discontinuance. No agency publishes the proportion of matters discontinued after the prosecution obtained material that was available earlier.

That last measure is the one that would matter most. Chapter 12 sets out a documented ACT case in which a prosecution continued for months after exculpatory evidence existed, in which a magistrate described the conduct of both police and prosecutors as "egregious", and in which a seized phone was not delivered for forensic examination for seven months. That is one case. Whether it is an outlier or an example cannot be established, because the measure that would show it is not collected.

2B.5 The finding

The defensible finding is narrower than "cases without merit are being prosecuted", and harder to dismiss.

> Prosecution volume in the sexual violence stream grew several times faster than reported offending. The share of matters discontinued rose sharply in both streams. The ACT publishes nothing that would show why, and no agency measures whether matters are being brought that should not be.

That is the same shape as every other finding recorded here. A decision was made, it had a measurable effect, and nobody built the measurement.

2B.6 What would settle it

Four measures, published annually, from data the DPP and the courts already hold:

1. **Discontinuance rate by stream and by stage** — before first mention, before hearing, at hearing.
2. **Reason for discontinuance**, in defined categories: complainant withdrawal, evidentiary insufficiency identified after charge, public interest, other.
3. **Time from charge to discontinuance**, median and 90th percentile.
4. **Proportion of discontinued matters in which the material that led to discontinuance was in the possession of police or the prosecution more than 60 days before the decision.**

The fourth is the accountability measure. It distinguishes a matter that collapsed because new information arrived from a matter that continued while the information sat unexamined.

3. What Legal Aid reported

3.1 The rationing

Legal Aid ACT gave evidence to an Assembly committee that it was prioritising criminal and domestic and family violence matters. In the committee's report, civil, employment and discrimination matters were **"not getting much preference"**.

That is a rationing decision, and it is a defensible one. If an agency must choose, the right priorities are criminal matters, where liberty is at stake, and family violence matters, where safety is at stake.

But the choice has a cost that lands on people who are not in either category. A person facing unlawful dismissal, a discrimination complaint or a civil dispute does not receive assistance. That is a transfer of harm from one group to another. It happened because domestic and family violence demand grew faster than the legal assistance budget.

3.2 The threshold

Legal Aid ACT reported that its means test threshold reached only **120 per cent of the poverty line**, against an aspiration of **180 per cent**.

In plain terms: a person must be very close to the poverty line to qualify for legal aid in the ACT. A person earning modestly above it does not qualify, and generally cannot afford a private lawyer.

3.3 The review that was not occurring

Legal Aid ACT also reported that the **baseline funding review it had requested was not occurring**.

A baseline review reassesses an agency's core funding against its actual workload. Without one, an agency whose demand has structurally increased keeps operating on a base set for a smaller workload. It manages the gap by rationing.

3.4 What this means for family violence matters specifically

The rationing decision favours family violence matters, so at first glance family violence proceedings are protected.

The picture is more complicated when you consider who appears in family violence proceedings.

- The applicant for a protection order may qualify for assistance, and specialist legal services exist.
- The respondent may or may not qualify. A respondent earning modestly above the threshold does not.
- In matters where both parties allege violence, the question of who is represented can determine which account the court hears in an organised form. As Chapter 9 shows, the ACT does not know what proportion of matters these are.

A system in which one party is represented and the other is not does not produce reliably better outcomes for the represented party. It produces less reliable fact-finding for everyone. The process depends on both sides being able to test the other's evidence.

4. The courts

4.1 Volume

Supreme Court listings rose by nearly 50 per cent over the period in which prosecutions grew. Judge numbers were increased. That is the correct response to listing growth, and it was made.

But adding a judge adds capacity only if the matters arriving are ready to be heard. A court with more judges and a prosecution service without time to prepare produces adjournments rather than throughput.

4.2 The Magistrates Court

The Magistrates Court carries the family violence order workload — applications, interim orders, contested hearings, variations and breach proceedings. Chapter 7 examines that pathway in detail.

Two structural features are recorded here.

Publication. Magistrates Court reasons are published far less consistently than Supreme Court reasons. Family violence proceedings are frequently private, restricted, pseudonymised or unpublished. This is largely for good reasons — safety and privacy. But it has a consequence for accountability: the busiest court in the family violence system is the least visible.

Volume against resources. The ACT Courts and Tribunal business plan for 2025–26 records a budget of $93.239 million and identifies key risks. Registry capacity for the family violence order workload sits inside that envelope.

4.3 What the archive could not establish

The public record does not show how long family violence order matters take. It does not show how many interim orders are made, how many are contested, how many are confirmed at final hearing, or how many are dismissed. It does not show how those figures have changed over time.

Those figures are administrative metadata generated by the court's own case management system. They are the kind of figures published routinely in other Australian jurisdictions; Appendix R sets out what each publishes.

Chapter 11 sets out what happened when they were sought.

5. Corrections, housing and health

The archive is thinner on these interfaces. Three connections are documented well enough to record.

5.1 Corrections

Remand and sentenced custody are the end point of a proportion of family violence prosecutions. Increased charging produces increased remand. The 2025 death review found that misidentification of victims as aggressors contributed to outcomes including incarceration.

A person wrongly identified as the aggressor and remanded loses employment, housing and, frequently, contact with children — before any finding is made.

5.2 Housing

Chapter 5 documented the crisis accommodation shortage and its effect on crisis service capacity.

The justice system multiplies that demand. An exclusion condition on an order requires one party to leave a residence. That person needs somewhere to live. So, often, does the protected person, if remaining in the home is unsafe. A single order can generate two housing needs in a market with no spare capacity.

5.3 Health and mental health

The 2025 death review found that 19 of 25 deceased perpetrators had a reported mental health condition, and 24 of 25 had a history of problematic substance use. Among deceased victims, 10 of 13 had reported a mental health condition.

Both death reviews found mental health and alcohol and other drug services poorly integrated with family violence responses.

Justice processes are a significant source of acute psychological stress. Chapter 11 examines what the Territory knows about the intersection of orders, proceedings and death. It also sets out what the Territory has never examined.

6. The structural finding: reform without a demand model

6.1 What happened

Over the decade, the ACT made a series of reasonable decisions:

- increase police numbers;
- encourage reporting of family and sexual violence;
- improve police response to family violence;
- increase Supreme Court judicial capacity;
- create new processes and, prospectively, a new criminal offence.

Each was defensible. Together they increased the flow of matters into prosecution, courts, legal assistance, corrections and housing.

The corresponding capacity decisions were made separately, later, or not at all. The prosecution service reported no commensurate funding increase. Legal Aid reported rationing and an unmet request for a baseline review. Crisis accommodation was already short.

6.2 Why this is a governance failure rather than a funding failure

It would be easy to read this chapter as an argument that the ACT should spend more on prosecution and legal aid. That may be true, but it is not the finding.

The finding is that decisions were made without modelling their consequences elsewhere.

Before the police increase was funded, a whole-of-system business case would have asked some questions. How many additional charges will this generate, and in which offence categories? What does that cost in prosecution, defence, court and corrections time? That is an arithmetic exercise. It is done routinely for infrastructure. It was not done here, or if it was, it did not change the allocations.

The consequence is that the true cost of a family violence reform is systematically understated at the point of decision. The shortfall is discovered later as "pressure" in agencies that had no say.

6.3 The coercive control test case

The ACT is about to run this experiment again, in public, with a well-documented before state.

A standalone coercive control offence will require police to investigate patterns of behaviour over time rather than discrete incidents. Pattern investigations are substantially more resource-intensive than incident investigations: more witnesses, more digital evidence, longer briefs.

Those briefs go to a prosecution service that has already said its staff do not have time to prepare matters properly. Defendants will seek legal aid from an agency already rationing at 120 per cent of the poverty line. Contested matters will be listed in courts already carrying increased volume.

The government's stated reason for the two-year interval between the defeated private member's bill and its own bill was system readiness. Readiness has been discussed in terms of training, risk tools, information sharing and public education. The public record does not show a published demand and capacity model covering police, prosecution, defence, courts and corrections.

If that model exists, publishing it would answer the question. If it does not, the offence will commence into the same unfunded interface that this chapter documents.

Chapter 16 proposes that no material justice reform proceed without one, and Appendix G contains the drafting.

7. What a whole-of-system model would contain

The proposal in Part III is not complicated. Before a material police, offence, court or service reform is funded, the business case should state:

1. **Expected volume change** — additional incidents attended, charges laid, applications made, by category, with the assumptions stated.
2. **Flow-through** — the proportion of those matters expected to reach prosecution, contested hearing, conviction, custody and supervision.
3. **Time cost per matter** — in prosecution hours, defence hours, court sitting time, registry time and corrections days.
4. **Consequent funding requirement** — for each affected agency, by year.
5. **Housing and health demand** — additional accommodation needs generated by exclusion conditions and separations; additional mental health and substance use service demand.
6. **The unfunded remainder** — where the model shows demand that will not be funded, the business case should say so explicitly and identify who will absorb it.

The Cabinet measure is the one that changes behaviour. A business case that must name the agency expected to absorb unfunded demand gets read by that agency before the decision is made.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. This chapter's complete set of 18 is at Appendix M, where it can be read against every other chapter's.

- **F6.1** — The Director of Public Prosecutions reported a 50 per cent increase in family violence prosecutions and a 170 per cent increase in sexual violence prosecutions over four years, and stated there had been no commensurate increase to funding.
- **F6.9** — Sexual offence matters discontinued rose from 2.5 per cent of completed matters in 2017–18 to 17.3 per cent in 2023–24.
- **F6.11** — No agency publishes the reasons for discontinuance, the stage at which matters are discontinued, or whether the material that ended a prosecution was already held.
- **F6.18** — No published whole-of-system demand and capacity model exists for any ACT family violence reform, including the proposed coercive control offence.

Sources for this chapter

Claim	Source	Date
50 per cent family violence and 170 per cent sexual violence prosecution increases over four years; 5,231 matters; more than 800 family violence files completed; more than 200 sexual assault files commenced; "no commensurate increase to my funding"; "do not have time to prepare the matters properly"; "asked to deliver the impossible"	ACT Legislative Assembly Hansard, 16 September 2025 (proof), pages P2551–P2553, quoting the Director of Public Prosecutions' opening statement submission and evidence to the 2025–26 hearings	16 September 2025
4,478 DFV related incidents in 2024–25; 33 per cent increase over five years; 44.9 per cent of assaults DFV related; assaults down 3.3 per cent	ACT Policing Annual Report 2024–25	2025
ACT sexual assault victims per 100,000, 2019 to 2024; 428 victims in 2024; 37 per cent of ACT sexual assaults FDV related (160 victims)	ABS, *Recorded Crime — Victims*, 2024	Released 2025
Family violence and sexual offence matters commenced, completed, proved and discontinued; Supreme Court sexual offence trial outcomes, 2017–18	ACT Director of Public Prosecutions Annual Report 2017–18, Tables 3 and 4	2018
Family violence and sexual offence matters commenced, completed, proved and discontinued; Supreme Court sexual offence trial outcomes; 5,231 matters; 24.8 per cent increase in sexual offence matters commenced, 2023–24	ACT Director of Public Prosecutions Annual Report 2023–24, Tables 2, 3 and 4	2024
Family violence matters commenced 933 and sexual offence matters commenced 248, 2024–25; 7,299 matters; 23,149 charges; 4,583 victims	ACT Director of Public Prosecutions Annual Report 2024–25	2025
DPP pipeline growth in family and sexual violence (a second appearance; the quotations in sections 2.1 to 2.3 are from the 16 September 2025 hearing)	Opening statement of the Director of Public Prosecutions to an Assembly committee	12 November 2025

Claim	Source	Date
Legal Aid ACT prioritisation; "not getting much preference"; 120 per cent of the poverty line against a 180 per cent aspiration; baseline review not occurring	Standing Committee on Justice and Community Safety, *Inquiry into Annual and Financial Reports 2024–25*	2026
Supreme Court listing growth and judicial numbers; transfer of regulatory prosecutions to the Solicitor-General and subsequent underestimation	Select Committee on Estimates, *Inquiry into the Appropriation Bill 2025–2026*	2025
Courts and Tribunal budget $93.239m and identified risks	ACT Courts and Tribunal Business Plan 2025–26	2025
Mental health and substance use prevalence among deceased perpetrators and victims; misidentification contributing to incarceration	ACT DFV Review Biennial Report 2025	2025
Poor integration of mental health and alcohol and other drug services with family violence responses	ACT DFV Review Biennial Reports 2023 and 2025	2023, 2025
Approximately $37.9m of adjacent justice initiatives	2026–27 Budget DFSV factsheet	2026

Chapter 7 — The order pipeline: interim orders, notice and fairness

In one page

A family violence order is a civil court order. It can prohibit a person from being at their own home, from being near their children's school, from contacting their partner, and from possessing firearms. Contravening it is a criminal offence. The maximum penalty is five years' imprisonment.

An **interim** order is made before the case has been heard. Under the *Family Violence Act 2016*, a court may make one if satisfied the order is necessary. It must be necessary to ensure the safety of an affected person, or to prevent substantial property damage, until the final application is decided. The standard of proof is the balance of probabilities. The Magistrates Court need not comply with the rules of evidence.

Interim applications are listed before the Registrar no later than two business days after filing. Where the Registrar refuses, the applicant may seek review. The matter is then listed before a Magistrate within two business days. A respondent has no matching review pathway. At that stage the respondent is usually not a participant.

The Act contains a careful balance. Section 36 makes the safety of the affected person and any child the paramount consideration in setting conditions. Section 37 requires the conditions to be the least restrictive of the respondent's rights and liberties. They must still achieve the Act's objects and give effect to section 36. Section 39 requires the court to consider accommodation needs before it imposes an exclusion condition. Those are the needs of the protected people, the respondent and any child.

Those provisions describe a structured weighing of two things at once. The public record shows no instrument that performs that weighing in a documented, consistent, reviewable way. No published form, checklist, criteria set or record requirement sets out the section 37 and section 39 analysis in writing.

This chapter describes the pipeline as the law and the practice directions establish it. It identifies where discretion sits, and what is not recorded. Appendix B sets out an instrument that would record it.

One number, one quote, one action

Number: Contravening a family violence order carries a maximum penalty of five years' imprisonment. The interim order that creates that liability is listed before a Registrar within two business days of filing, usually on material from one side only.

Quote: "A court must ensure the conditions included in a family violence order are the least restrictive of the personal rights and liberties of the respondent as possible that still achieve the objects of this Act and give effect to section 36." — *Family Violence Act 2016* (ACT), section 37, effective 1 July 2025

This week: The Magistrates Court publishes the forms, checklists and guidance notes used by Registrars when deciding interim family violence order applications. If none exist, it states that. Either answer puts on the public record a fact that is not there now.

1. What an order does

1.1 The conditions available

Section 38 allows a court to include the conditions it considers necessary, having regard to sections 36 and 37. The Act then lists, without limiting that power, conditions that may prohibit the respondent from:

- being on premises where the protected person lives;
- being on premises where the protected person works;
- being on premises where the protected person is likely to be;
- being in a particular place;
- being within a particular distance of the protected person;

and other conditions of the same kind.

1.2 The firearms consequence

Section 44 is automatic and immediate. If an **interim** order or an after-hours order is made against a firearms licence holder, the licence is **suspended** until the order ends. If a **final** order is made, the licence is **cancelled**.

The court or judicial officer **may** also order seizure of the licence, and of any firearm or ammunition in the respondent's possession.

The distinction between suspension and seizure matters in both directions. Section 6 below examines it.

The Bill before the Assembly at the evidence cut-off would remove the after-hours reference from section 44 and add a police-issued family violence safety notice as a further trigger: the licence would be suspended automatically and police could seize it, and any firearm, at the moment the notice is served (new section 13ZD). Chapter 19 §2.2 records this as an improvement.

1.3 The criminal consequence

Section 43 makes it an offence to engage in conduct contravening the order. It applies where the person was present when the order was made, or has been personally served. The maximum penalty is 500 penalty units, five years' imprisonment, or both. The Bill before the Assembly would extend the offence to a respondent served by substituted service under a court order (clause 34; Chapter 19 §2.1).

The offence applies to conduct inside and outside the ACT.

1.4 What follows in practice

Beyond the terms of the order, the practical consequences of an interim order commonly include:

- leaving a residence, sometimes immediately, if an exclusion condition applies;
- loss or suspension of a firearms licence, which for some occupations and for primary producers affects employment;
- interruption to contact with children living at the excluded premises;
- disclosure to employers where the person's work involves licensing, security clearance or working with vulnerable people;
- restriction on movement in defined areas; and
- the ordinary consequences of being a party to litigation.

These consequences begin when the interim order takes effect. They do not wait for the final hearing.

2. The statutory framework

The Act sets out a small number of provisions that govern how these decisions are made. They are quoted or paraphrased here because the rest of the chapter turns on them.

2.1 Section 12 — the procedural principle

> Procedures for this Act are to be as simple, quick and inexpensive as is consistent with achieving justice.

This is a genuine balancing instruction, and both halves are operative. Speed matters because delay is dangerous. The qualifier — *consistent with achieving justice* — matters too. Speed bought at the cost of accuracy is not a saving.

2.2 Section 13 and 13A — proof and evidence

Section 13 requires the court to be satisfied on the **balance of probabilities**. Section 13A removes doubt on a second point. The Magistrates Court **need not comply with the rules of evidence** in a proceeding under the Act. Section 65 allows the court to inform itself in any way it considers appropriate.

These provisions are appropriate for the subject matter. Family violence often occurs without witnesses and without documentation. A strict evidentiary approach would make many genuine applications unprovable.

But they also shift where the decision rests. It rests heavily on the quality of the assessment rather than the quality of the evidence, because the evidence may be thin by design. Where the rules of evidence are relaxed, the method used to weigh what is presented becomes more important, not less. That is the argument made throughout these chapters: relaxed evidentiary rules increase the need for a documented and consistent assessment method. They do not reduce it.

2.2a What the balance of probabilities requires when the allegation is serious

There is a further point about section 13 that is often left out, and it is settled law rather than an argument advanced here.

The balance of probabilities is not a fixed quantity of persuasion applied identically to every question. In *Briginshaw v Briginshaw*, Dixon J said that reasonable satisfaction "is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved", and that "the seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal".

Three things about that are frequently misstated, and each matters here.

It is not a third standard of proof. There is nothing between the balance of probabilities and beyond reasonable doubt. *Briginshaw* governs the degree of satisfaction required within the civil standard. It does not require an applicant to prove more. It requires the decision-maker to be more careful before saying they are satisfied.

Section 13A does not displace it. Section 13A provides that the court need not comply with the rules of evidence. *Briginshaw* is not a rule of evidence; it is a proposition about when a tribunal may say it is satisfied. A court that may inform itself as it considers appropriate still has to reach reasonable satisfaction. Where fewer evidentiary filters operate before material reaches the decision-maker, the principle does more work, not less.

The gravity of the consequences runs in both directions. An application for a family violence order carries grave consequences whichever way it is decided. Refusing protection to a person in danger is one. Removing a person from their home, suspending the licence they work under, and interrupting their contact with their children, on one party's material and before they know an application exists, is another. Chapter 4 records that 8 of the 13 people the death review assessed as victims had been wrongly recorded as the aggressor by police or another agency, and that 4 of the 13 had been made respondents to orders where the evidence indicates the applicant was the aggressor. Chapter 11 records that no agency counts either error.

So the principle does not point towards making orders harder to obtain, and nothing here argues that it should. It points towards a decision-maker being able to state what they were satisfied of, on what material, and why the more restrictive course was necessary rather than a less restrictive one. That is a record. The current process does not produce one, which is the finding of section 4 below.

Appendix D4 sets out how the replacement framework operates this: independent evidence layers are counted rather than assumed, the number required rises with the consequence being rated, and where the material is a single layer and the option would remove a person from a home before they know an application exists, four specific things are recorded. None of them defeats an application. They are the record of a decision that is currently made without one.

2.3 Section 21 — the test for an interim order

> A court may make an interim order if satisfied that the order is necessary to do either or both of the following until the application for the final order is decided: (a) ensure the safety of an affected person from family violence; (b) prevent substantial damage to an affected person's property.

The word is **necessary**. Not desirable, not prudent, not reasonable — necessary.

An "affected person" includes any child who hears, witnesses or is otherwise exposed to family violence committed against another person.

2.4 Sections 36 and 37 — paramountcy and least restriction

Section 36:

> In deciding the conditions to be included in a family violence order, a court must give paramount consideration to the safety and protection of the affected person and any child directly or indirectly affected by the respondent's alleged conduct.

Section 37:

> A court must ensure the conditions included in a family violence order are the least restrictive of the personal rights and liberties of the respondent as possible that still achieve the objects of this Act and give effect to section 36.

Read together, these are not in conflict. Section 36 sets the objective. Section 37 sets the method: achieve the objective with the least restriction that achieves it.

That is precisely the structure of a risk treatment decision. Identify the risk. Identify the options. Choose the option that reduces the risk to an acceptable level with the least collateral cost. It is what a risk framework does.

2.5 Section 39 — exclusion conditions

Before including an exclusion condition — the condition that removes a person from a residence — the court must consider:

Primary factors - the physical, emotional and psychological needs of the protected people; - any disability the protected people have.

Secondary factors - the accommodation needs of, and accommodation options available to, the protected people, **the respondent**, and any child of either; - the length of time required for those people to find alternative accommodation.

An applicant may seek an exclusion condition. If the court decides to make the order without it, the court must give reasons.

Note the asymmetry in the last requirement. Reasons are required when an exclusion condition is **refused**. The Act does not impose an equivalent express reasons requirement when one is **imposed**.

Note also what section 39(1)(b) requires. The court must consider the respondent's accommodation needs and options, and how long it would take them to find somewhere else. That is a direct statutory instruction to consider the respondent's housing situation. Chapter 5 established that the ACT has a crisis accommodation shortage. The Act requires the court to consider accommodation options that, for many people, do not exist.

2.5a Section 68 — the reasons requirement, and what it does not require

Section 68 (1) provides that if a court makes a protection order, the court **must record the reasons for making the order**. The Dictionary defines *protection order* to mean an interim order or a final order. So the duty applies to an interim order made in the absence of the respondent, and it has applied since the Act commenced.

That matters in two directions, and the second is the one this chapter is about.

The duty exists. Any account of the ACT process that says a court is not required to record reasons for an interim order is wrong, and nothing in these pages should be read that way. On the face of the statute the ACT is ahead of several comparable jurisdictions on this point. Appendix R sets out what could be established about the others.

The duty is empty. Section 68 says that reasons must be recorded. It does not say what they must contain, to what standard, or in what form. It does not require the court to identify the material relied on, to state whether that material came from more than one independent source, to state why the matter could not wait for a listing at which both parties were present, or to record which less restrictive option was considered and rejected. It does not require the reasons to be given to the respondent, and there is no provision for their publication or aggregation. Nothing in the public record indicates that reasons recorded under section 68 have ever been counted, sampled, audited or reported.

Read with the Act's other reasons provisions, a pattern appears. It has to be stated carefully, because the Act does require reasons on both sides of some decisions, and an overstatement here would be easy to refute.

The Act contains five reasons provisions.

- **Section 39 (3)** — reasons where an applicant seeks an exclusion condition and the court makes the order **without** it. No equivalent where the court imposes one. No content prescribed.
- **Section 110 (2)** — a police officer satisfied there are grounds for an after-hours order who **decides not to apply** must record the decision and "a brief note of the reasons". No equivalent where the officer does apply. No content prescribed.
- **Section 103** — a judicial officer **refusing** an after-hours order must record four stated matters, including the reasons for the refusal. This is the **only** provision in the Act that prescribes what a reasons record must contain, and it attaches to a refusal to restrain.
- **Section 104 (a)** — a judicial officer who **makes** an after-hours order must record the reasons for making it. So the Act does require reasons for a decision to restrain, and any claim that it never does is wrong.
- **Section 68** — reasons for making a protection order, in terms that prescribe nothing.

Two things follow, and the second is sharper than the first.

Where the Act prescribes content, it does so once, for a refusal. Section 103 is the only content-bearing reasons provision in the Act. Every provision governing a

decision to restrain — sections 68 and 104 (a) — requires that reasons be recorded and says nothing about what they must say.

And where the Act puts a reasons record on the court record, it does so for the refusal and not for the order. Section 104 (b) requires the judicial officer to ensure that every record made under section 102 or section **103** — the refusal record — becomes part of the record of the Magistrates Court. The section 104 (a) record of reasons for **making** an after-hours order is given no such destination. That is the pattern in its most precise form: the Act is more careful about documenting the decision not to restrain than the decision to restrain, and more careful about where that document ends up.

Appendix R records a comparable asymmetry in the drafting of two other jurisdictions, which suggests a design habit rather than an ACT oversight. A habit is not a justification, and the effect here is that the more coercive of the two decisions leaves the thinner record.

The pattern survives the Bill that would repeal Part 7. The Family, Personal and Sexual Violence Legislation Amendment Bill 2025, before the Assembly at the evidence cut-off, omits Part 7 and with it sections 103, 104 and 110 (clause 47). The analysis above is retained as the origin of the pattern. In the replacement scheme a senior police officer refusing a notice must record reasons "including each ground in section 13B that was not satisfied" (new section 13N (1)(e)); an officer issuing one must make "a written record of the matters considered" (new section 13H (3)); both stay in police records; and only the notice itself reaches the court (new section 13M). Chapter 19 §2.4 sets this out.

None of these produces a document anyone outside the file will ever see. Section 149 makes it an offence to publish an account of a proceeding identifying a party, so the position is not merely that publication is not required but that it is restricted — a point that matters for the statistics proposed at Appendix G5, which are drafted to be de-identified for that reason. And the freedom of information decision recorded at Chapter 11 refused the aggregate statistics that would have shown how the discretion is exercised across cases.

One further absence, and it is the one a respondent's lawyer would reach for first. Sections 48 (3), 66 (4), 67 (4) and 109 (2) each provide that a failure to comply does not affect validity. Section 68 contains no such provision. On the ordinary contrast principle that omission is at least deliberate-looking. What does **not** follow is that a breach invalidates the order: section 68 (1) is triggered *by* the making of the order, so compliance cannot be a condition precedent to it, and invalidating protection orders on a documentation ground would defeat the objects in sections 6 and 7. The honest statement is narrower and still useful — the Act supplies no answer for section 68, and nobody has had to find one, because no reasons recorded under it have ever been reviewed.

The consequence for this analysis is precise. The absence identified in section 4 of this chapter is not the absence of a reasons requirement. It is the absence of any specified content for one that already exists, and of any mechanism by which what is recorded under it could ever be reviewed. A duty to record reasons that prescribes

nothing and is never read is a duty that cannot detect an error. That is the gap the reform at Chapter 16 section 4 closes, and it closes it by giving an existing obligation content rather than by creating a new one.

2.6 Section 43(4) — the protected person exemption

Section 43(4) provides that a person does not commit an offence of complicity under the Criminal Code if the person:

- is a protected person under the order; and
- aids, abets, counsels, procures, or is knowingly concerned in or a party to, conduct that contravenes the order.

The purpose is protective and sound. A person who is being controlled should not face prosecution over the contravention of an order made for their own protection. Coerced or induced contact is common. A protected person who invites contact may be doing so under pressure.

The provision as drafted is nonetheless absolute. It admits no exception for a case where a protected person deliberately induces a contravention. Section 5 below examines the consequence.

2.7 Section 47 — timing

Where an interim order is sought, the court must set a return date for the hearing of the interim order. That date must be **not later than two days** after the application is received.

Read that carefully, because it is easy to misread and the misreading flatters the process. The two-day period in section 47 (1) runs to the hearing **of the interim order** — the hearing at which the order is made, and the hearing the respondent frequently does not attend and does not know about. It is not a period within which the respondent is brought before the court. It is a period within which an order can be made against them.

After that hearing, a preliminary conference must be held, unless the court is satisfied that holding one would create an unacceptable risk to a person's safety or would be unlikely to achieve its objects. The registrar must then serve on the respondent a copy of the application, a copy of any interim order made, and a timing notice or notice of the return date.

The date of that next listing is governed by the words "as soon as practicable". Section 47 (3)(a) requires a return date for a preliminary conference "as soon as practicable after the hearing". Section 47 (4)(a), where no conference is held, requires the registrar to set a return date for the application, with service and notice again "as soon as practicable". No provision of the Act fixes a maximum period between the making of an ex parte interim order and the first occasion on which the respondent may be heard.

The applicant's expedited pathway is in the Act, and it is more generous than the practice direction alone would suggest. Section 91B provides that where a registrar refuses to make an interim order, adjourns under section 54, or refuses a condition

sought, the registrar **must tell the applicant** about the section; the applicant may request review before the close of registry that day; the return date must be "as soon as reasonably practicable, but not later than 2 days after the day the request is received"; the review is "a rehearing of the matter anew"; and section 91B (6) provides that the registrar **need not tell the respondent** about the return date, time and place of the hearing.

Practice Direction 1 of 2026 restates that scheme. It does not create it.

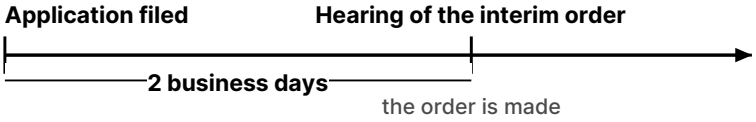
So the timing asymmetry in this chapter is not an artefact of listing practice. It is in the statute, expressly, and the Assembly turned its mind to it in enough detail to specify that the respondent need not be told. An applicant who is **refused** has a statutory same-day request, a rehearing anew, and a two-day return. An applicant who **succeeds** has an order made within two days of filing — and by section 154, where a period of less than five days is prescribed under the Act, it is worked out ignoring days on which the court is not open, so the Act's "2 days" is two business days and reconciles with the practice direction. The respondent restrained by that order has no statutory period at all: only "as soon as practicable", which is a standard of diligence rather than a deadline. Nothing here suggests the courts are dilatory, and no such claim is made. The point is that the Act sets no outer limit for one party and a precise one for the other, and the ACT publishes nothing from which the actual interval could be known. That absence is the same one Chapter 11 records.

FIGURE 7.1

Section 47: two clocks

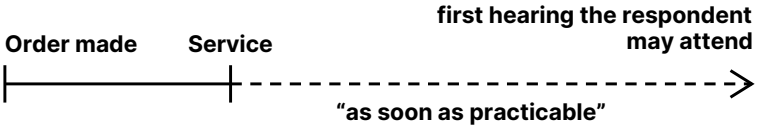
The Act fixes a precise period for one party and no outer limit for the other.

The applicant
s 47(1), read with s 154



The respondent frequently does not attend this hearing and does not know about it. It is not a period within which the respondent is brought before the court.

The respondent
ss 47(3)(a) and 47(4)(a)



No provision of the Act fixes a maximum period between the making of an ex parte interim order and the first occasion on which the respondent may be heard.

For comparison: the refused applicant

Under s 91B a refused applicant may request review before the registry closes, and the return date must be not later than 2 days. Section 91B(6): the registrar need not tell the respondent about that hearing.

No ACT statistic measures the actual interval.

Nothing here suggests the courts are dilatory, and no such claim is made. "As soon as practicable" is a standard of diligence rather than a deadline, and the ACT publishes nothing from which the actual interval could be known.

Chapter 7, section 2.7. Family Violence Act 2016 (ACT).

The respondent is not entirely without a route, and the route proves the point. Section 82 (c) permits the respondent to apply to amend a protection order, and section 83 (3) gives as an example an original order that "restricts the respondent's rights unnecessarily". But that application routes through a preliminary conference under section 82A listed "as soon as practicable", and section 82B — provisional amendment, the urgent limb that operates without a conference — is available only to "the protected person, or the applicant, for the protection order". The Act therefore provides an urgent amendment pathway and confines it to one side.

And one provision that does not work at all. Section 113 (e) applies "section 47 (1)(b)" to a court-initiated interim order. Section 47 (1) has no paragraph (b); the section was substituted in 2017 and again in 2024 and the cross-reference was not carried through. The single provision that would have applied a timing rule to court-initiated interim orders is inoperative.

Two things the Bill before the Assembly would change here, in opposite directions. Clause 39 of the Family, Personal and Sexual Violence Legislation Amendment Bill 2025 replaces the dead cross-reference with "section 47 (2) to (5)"; the Explanatory Statement confirms the reference was not updated after the 2024 amendments. If enacted, the sentence above is overtaken and the correction is recorded at Chapter 19 §2.2. Clause 37 of the same Bill adds section 91B (6A), which stays a registrar's refusal until the applicant's review is heard. That deepens the applicant's pathway. Nothing is added on the respondent's side, so the asymmetry described in this section is left as it is and restated (Chapter 19 §2.6).

3. The pipeline in practice

Practice Direction 1 of 2026 establishes the listing arrangements. It commenced on 10 March 2026 and revoked the previous direction.

3.1 The steps

Stage	What happens	Timing
Filing	Application filed at the registry, in person or by post. Email filing requires leave, granted only in exceptional circumstances	—
Interim listing	Application for an interim order listed **before the Registrar**	No later than 2 business days after filing
Interim decision	Registrar decides whether to make an interim order and on what conditions	At that listing
Review of refusal	If the Registrar refuses an order or a condition, the **applicant** may request review, by notifying the Registrar in court immediately, at the counter, or by email, before 4.30pm the same day	Listed before a Magistrate no later than 2 business days after the request
Service	Registrar serves the application, any interim order and the notice on the respondent	As soon as practicable
Preliminary conference	Both parties attend and attempt resolution before any contested hearing	As soon as practicable
Directions list	Unresolved matters listed in the Registrar's Family and Personal Violence Directions List, each Wednesday at 9.00am	—

Stage	What happens	Timing
Contested hearing	Block listing following a callover	As directed

3.2 Where the decisions sit

Three features of this structure are worth stating plainly, because they are often misunderstood in public discussion.

Interim orders are made by a Registrar, not a Magistrate. The practice direction lists interim applications before the Registrar. It provides for a Magistrate to review a Registrar's refusal. This is a normal and efficient allocation of judicial and quasi-judicial work. It also means a registrar typically makes the first substantive decision affecting a person's home, children and licence.

The review pathway runs one way. If the Registrar **refuses**, the applicant has a same-day review right. A hearing before a Magistrate follows within two business days. If the Registrar **grants**, there is no equivalent expedited pathway for the respondent, who is not usually present and has not usually been served. The respondent's opportunity arrives at the preliminary conference or the return date.

This is not an oversight in the practice direction. It follows from the nature of an interim application. The point of an interim order is to protect someone before the other side has been heard. But it does mean the expedited safeguards in the pipeline are built around the risk of *under*-protection. Sections 37, 39 and 82 speak to the risk of *over*-restriction, but no expedited mechanism does.

In-person attendance is the default. Proceedings require in-person attendance unless the Court grants leave to appear remotely. Remote appearance is available, through an existing leave process, but it is not a standard selectable listing option. The Bill before the Assembly would put appearance "by audiovisual link or telephone" on a statutory footing, still "with the court's leave" (new section 44B, clause 35; Chapter 19 §2.2).

That matters because remote appearance is one of the most effective protective measures available. In a remote hearing both parties take part, but from different places. That removes the physical proximity that makes an attended hearing risky. It also preserves the respondent's opportunity to be heard. Chapter 14 and Appendix B treat it as a first-class listing option rather than an exception requiring leave.

4. What is not recorded

This is the core of the chapter.

4.1 The decisions that must be made

Read together, the Act requires a decision-maker in an interim application to determine:

1. whether an order is **necessary** for safety or to prevent substantial property damage (s 21);

2. what conditions give **paramount consideration** to the safety of the affected person and any child (s 36);
3. which of the available conditions is the **least restrictive** that still achieves that (s 37);
4. if an exclusion condition is proposed, the primary and secondary factors in s 39, including the respondent's accommodation needs and options and how long it would take them to find alternatives;
5. whether a preliminary conference would create an unacceptable risk to safety (s 47(2)); and
6. whether to order seizure of a firearms licence, firearms and ammunition (s 44(3)).

These are substantial judgments, made quickly, usually on material from one side only.

4.2 What the public record shows about how they are recorded

Section 68 requires the court to record its reasons for making the order, and that duty covers an interim order. Beyond it, there is no published form, checklist, criteria set, guidance note or content requirement that structures any of these six decisions, and no requirement that says what a section 68 record must contain.

Specifically, the public record does not disclose:

- a documented method for assessing how likely the alleged harm is, and how serious it would be;
- defined scales for likelihood or consequence;
- a stated threshold at which an order becomes "necessary" for the purposes of s 21;
- any structured method for identifying and comparing the available options — for example, an order with a non-contact condition against an order with an exclusion condition, or an attended listing against a listing without notice;
- a record in which the s 37 least-restriction analysis is written down;
- a record in which the s 39 accommodation factors are recorded as considered;
- a method for recording what is **unknown** at the time of the decision, as distinct from what is known to be absent; or
- any requirement to record what protective measures were assumed to be in place, who was responsible for them, and how their operation would be confirmed.

4.3 Why the absence matters

A decision that is not recorded cannot be reviewed, audited, compared or improved.

Consider what would be needed to answer any of the following questions about the ACT's interim order practice:

- How often is an exclusion condition imposed?

- In what proportion of matters is the least restrictive alternative considered and rejected, and on what basis?
- Are interim orders made on the same facts by different decision-makers with the same conditions?
- What proportion of interim orders are confirmed at final hearing, and what proportion are dismissed or withdrawn?
- Has the introduction of a new tool, training program or practice direction changed any of these?

None of these can be answered without a structured record. None of them is currently produced.

This is not a criticism of any decision-maker. A registrar applies sections 21, 36, 37 and 39 in a short listing, on material from one side. That is difficult work, done with no instrument designed to support it. The absence of the instrument is a system design question. It is answerable at system level.

4.4 The comparison that makes the point

The ACT Government requires structured risk assessment before it enters a procurement, holds a public event or approves staff travel. Those processes have documented criteria, defined likelihood and consequence scales, named risk owners, recorded treatment options and residual risk acceptance. Chapter 8 sets out the requirements and their sources.

An interim family violence order can remove a person from their home, suspend their licence to work, and interrupt their contact with their children. That decision is taken in a short listing, on untested material. There is no equivalent documented structure for it.

The comparison is not rhetorical. It is a compliance question, and it is put in full in Chapter 8.

5. Section 43(4): the accountability gap

5.1 What the provision does

Section 43(4) removes complicity liability from a protected person who aids, abets, counsels, procures, or is knowingly concerned in a contravention of the order made for their protection.

5.2 Why it exists

The reason is sound and should not be disturbed lightly. Protected people often face continuing pressure. A person who agrees to meet, invites contact, or resumes a relationship may be acting under coercion, under financial necessity, or out of fear.

Prosecuting that person would be both unjust and dangerous. It would deter people from seeking orders in the first place. It would also give a person using violence a further lever of control — the threat of exposing the protected person to prosecution.

5.3 The gap

The provision is absolute. It contains no exception, no threshold and no discretion.

That produces a category of conduct in which nobody bears responsibility. Take a case in which a protected person deliberately induces a contravention, by inviting contact and then reporting it. The respondent faces a criminal charge carrying up to five years' imprisonment.

There is no public ACT data on how often this occurs, and no claim is made here that it is common. The 2025 death review does record two related points, in a different context. In the review's finding, people using violence manipulate systems to exert control. Systems can fail by not recognising when they are being used to commit violence. That finding is about people using violence operating systems against victims.

The structural point is the same in either direction. A legal process that can be operated by one party against another raises the question whether a mechanism is needed to address deliberate misuse.

5.4 A possible answer, put as a question

One answer to that is drafted in the annex to Chapter 16 and at Appendix G3. It is put there as a question rather than proposed as a reform, because the ACT frequency of deliberate inducement is unmeasured and the comparative charging evidence has not been assembled. The drafted provision does not remove the protection. It would replace a blanket exemption with a complicity offence that:

- applies to any person, including a protected person or applicant;
- requires intention or recklessness as to the contravention;
- and is subject to an express statutory list of matters to which regard may be had in deciding whether to prosecute, including the seriousness of the contravention, the extent of the person's involvement, whether the conduct was intentional, reckless or inadvertent, and the safety of the protected person and any affected child.

The prosecutorial discretion provision is what would have to prevent such an offence being used against genuine victims, by protecting those who act inadvertently or under coercion. Whether it would be sufficient is not settled here.

6. Firearms: suspension is not seizure

Section 44 creates an automatic suspension on an interim order and a discretionary power to order seizure.

The gap between the two is operationally important in both directions.

In the direction of safety: a suspended licence does not remove a firearm from a house. A respondent may have firearms at home and learn of an application before any seizure has occurred. The period between notice and seizure is then a period of elevated risk. The national risk assessment principles the ACT's death review applies include access to weapons among the high-risk factors. Sequencing matters:

if seizure is going to happen, it should happen before the respondent learns of the application, not after.

In the direction of proportionality: licences are held for different reasons. A licence may be held for recreational shooting, for primary production, or as a condition of employment, and an authority may be held through a sporting club. Each has different consequences when suspended. The Act does not distinguish them. There is no published workflow for notifying employers, agencies or clubs, or for recording which occurred.

Appendix B keeps home, occupational and club firearms access as separate items. It requires confirmation of any seizure action to be recorded before the respondent is notified. It also requires the occupational and sporting consequences to be recorded as part of the least-restriction analysis.

For the police-issued notice proposed in the Bill before the Assembly, the sequencing this section asks for is supplied: new section 13ZD suspends the licence automatically and lets a police officer seize the licence and any firearm at the moment of service (Chapter 19 §2.2).

7. The human rights framework

7.1 The rights engaged

The *Human Rights Act 2004* (ACT) protects, among others:

- **section 8** — recognition and equality before the law;
- **section 12** — privacy and reputation;
- **section 21** — fair trial;
- **section 27B** — the right to work and other work-related rights.

An interim order made without notice engages each of these to some degree. So does the failure to make an order that was necessary, for the person left unprotected.

7.2 How limits are assessed

Section 28 provides that rights may be subject only to reasonable limits. Those limits must be set by laws that can be demonstrably justified in a free and democratic society. In deciding whether a limit is reasonable, all relevant factors must be considered, including:

- the nature of the right affected;
- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relationship between the limitation and its purpose; and
- **any less restrictive means reasonably available** to achieve the purpose.

The last of these is the same test as section 37 of the *Family Violence Act*, expressed in human rights terms.

7.3 Who is bound

Section 40B makes it unlawful for a public authority to act incompatibly with a human right. It is also unlawful for a public authority, in making a decision, to fail to give proper consideration to a relevant human right.

Section 40(2)(b) excludes a court from the definition of public authority **except when acting in an administrative capacity**.

That exception is significant for this chapter. Listing practices, service arrangements, form design and registry procedure are administrative functions. The judicial decision to make or refuse an order is not.

So the Act draws a line. The decision is judicial and sits outside section 40B. The administrative machinery around it sits inside: how matters are listed, what forms are used, how service is sequenced, what is recorded.

7.4 What this implies

A public authority must give proper consideration to relevant human rights when making a decision. Public authorities make the administrative arrangements around interim orders. Those arrangements should therefore be capable of showing that consideration.

That is a documentation question. A process that records what less restrictive means were available, and why they were not adopted, can show the section 28 analysis. A process that records nothing cannot.

No assertion is made here that any ACT process is unlawful. The observation is narrower: the public record does not contain the relevant documentation. That documentation would show the section 28(2)(e) question — less restrictive means reasonably available — being asked and answered in the administrative arrangements around interim orders.

8. What would change

Appendix B contains a complete pre-listing instrument. Its design is summarised here so the reader can see the shape of the proposal before the detail.

The instrument does four things.

1. It separates two risks and never averages them. - **R1** is the risk that a person who has used or may use family violence commits family violence, causing physical, sexual, psychological, emotional or economic harm to the protected person, any child or any other affected person, within a stated period. - **R2** is the risk that the process or the measures selected restrict housing, work, a licence, contact with children or liberty, causing hardship or a rights limitation beyond what is necessary to hold R1 within tolerance, to the respondent or to a child in their care, over the same period.

Both are rated. Neither is allowed to cancel the other out. R1 governs whether protection is needed and how much. R2 governs which of the protective options is chosen, and the return date. R2 can never defeat protection where R1 is properly assessed at the highest level.

2. It rates listing options, not people. The instrument does not produce a score for a person. It compares four listing packages: an order without notice, an attended listing with both parties present, a listing with the parties separated or appearing remotely, and a short no-notice step with a prompt review. It then asks which achieves the required protection with the least restriction.

3. It records what is unknown. Every screening item is marked *established*, *reasonably open*, or *unknown*. There is no "no" box, because "we did not check" and "we checked and there is nothing" are different states and must not be recorded identically. A check that was not run stays unknown. A check that was run and returned nothing is recorded as a nil result. A nil result is not proof of safety.

4. It records controls, owners and failure responses. Every protective measure has a named owner, a time by which it must be in place, a statement of what would count as proof it worked, and a stated response if it fails. A protective measure nobody has confirmed is recorded as failed, not assumed.

Appendix B section B5 lists every reform the instrument assumes, item by item. For each, it gives the current legal position, why the change is proposed, the principle that must remain intact, and the instrument that would have to be amended. Nothing in the model is presented as current law.

What this chapter established

Five findings that this chapter establishes and nothing else in these pages does. This chapter's complete set of 11 is at Appendix M, where it can be read against every other chapter's.

- **F7.1** — An interim family violence order can exclude a person from their home, suspend their firearms licence, restrict their movement and interrupt contact with their children, and its contravention is an offence carrying up to five years' imprisonment.
- **F7.4** — The *Family Violence Act 2016* contains five reasons provisions. Section 103, the only one that prescribes what a reasons record must contain, applies to a judicial officer **refusing** an after-hours order; section 104 (b) places that refusal record on the record of the Magistrates Court, and gives no destination to the section 104 (a) record of reasons for **making** one. Sections 39 (3) and 110 (2) likewise attach to decisions not to restrain and prescribe no content. Section 68 requires a court to record its reasons for making a protection order, and the Dictionary definition of *protection order* brings interim orders within that duty. The section prescribes no content for those reasons, no form, no requirement that they identify the material relied on or the less restrictive option considered, no entitlement in the respondent to receive them, and no publication or aggregation; nothing in the public record indicates that reasons recorded under section 68 have ever been counted, sampled or reported. Section 39 separately requires reasons where an exclusion condition is **refused**, with no equivalent express requirement where one is imposed.
- **F7.5** — Section 47 (1) fixes a maximum of two days between receipt of an application and the hearing of the interim order — the hearing at which the order is

made, not one at which the respondent is heard. Sections 47 (3)(a) and 47 (4)(a) govern the next listing by the words "as soon as practicable", and no provision of the Act fixes any maximum period between the making of an ex parte interim order and the first occasion on which the respondent may be heard. Section 91B gives an applicant refused by a registrar a statutory same-day request, a rehearing anew, a return not later than two days after the request, and provides that the registrar need not tell the respondent about it. The respondent restrained by a granted order has no equivalent expedited pathway and no outer limit: section 82 (c) permits an application to amend, but it routes through a section 82A preliminary conference listed "as soon as practicable", and the urgent limb at section 82B is confined to the protected person or the applicant. Section 113 (e), which would have applied a timing rule to court-initiated interim orders, cross-refers to a section 47 (1)(b) that does not exist. No ACT statistic measures the interval.

- **F7.7** — Beyond the general duty in section 68 to record reasons, the public record does not disclose any published form, checklist, criteria set or content requirement structuring the section 21, 36, 37, 39, 44 or 47 decisions, and no defined likelihood or consequence scales exist for them.
- **F7.8** — As a result, basic administrative questions about interim order practice — how often exclusion conditions are imposed, how often orders are confirmed at final hearing, whether decisions are consistent — cannot be answered from any published source.

These findings describe the Act as in force on 1 July 2025. The Bill before the Assembly at the evidence cut-off would alter three of them if enacted: section 43 (1)(b) would reach substituted service and section 44 would be joined by a notice suspension with seizure at service (F7.1); sections 103, 104 and 110 would be repealed with Part 7 and the pattern in F7.4 would continue in new sections 13H (3), 13I (d) and 13N; and the section 113 (e) cross-reference in F7.5 would be corrected while section 91B gained a stay for the applicant only. Chapter 19 §§2.2, 2.4 and 2.6 record each.

Sources for this chapter

Claim	Source	Date
Procedures to be simple, quick and inexpensive consistent with achieving justice (s 12); balance of probabilities (s 13); rules of evidence need not be complied with (s 13A); court may inform itself (s 65)	*Family Violence Act 2016* (ACT), R17	Effective 1 July 2025
Interim order test — necessity for safety or to prevent substantial property damage (s 21)	*Family Violence Act 2016* (ACT)	Effective 1 July 2025
Paramount consideration (s 36); least restrictive principle (s 37); conditions available (s 38); exclusion condition factors and reasons requirement (s 39)	*Family Violence Act 2016* (ACT)	Effective 1 July 2025
Duty to record reasons for making a protection order (s 68); definition of *protection order* as an interim order or a final order (Dictionary)	*Family Violence Act 2016* (ACT), republication 17	Effective 1 July 2025

Claim	Source	Date
Contravention offence and penalty (s 43(1)–(3)); protected person complicity exemption (s 43(4))	*Family Violence Act 2016* (ACT)	Effective 1 July 2025
Reasonable satisfaction is affected by the seriousness of the allegation, the inherent unlikelihood of the occurrence and the gravity of the consequences	*Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336 at 361–362 (Dixon J)	1938
Firearms licence suspension on interim order, cancellation on final order, discretionary seizure (s 44)	*Family Violence Act 2016* (ACT)	Effective 1 July 2025
Two-day return date; preliminary conference; service requirements (s 47)	*Family Violence Act 2016* (ACT)	Effective 1 July 2025
Listing before the Registrar within two business days; applicant review of refusal; preliminary conferences; directions list; in-person attendance default	Magistrates Court of the ACT, Practice Direction 1 of 2026, Family and Personal Violence Matters	Commenced 10 March 2026
Rights engaged: recognition and equality (s 8), privacy and reputation (s 12), fair trial (s 21), work (s 27B)	*Human Rights Act 2004* (ACT), R17	Effective 17 March 2025
Reasonable limits test including less restrictive means (s 28(2))	*Human Rights Act 2004* (ACT)	Effective 17 March 2025
Public authority duty (s 40B); court excluded except when acting administratively (s 40(2)(b))	*Human Rights Act 2004* (ACT)	Effective 17 March 2025
Perpetrators manipulate systems; systems fail by not recognising manipulation	ACT DFV Review Biennial Report 2025, Theme 1	2025
Substituted service (cl 34); s 44B (cl 35); s 91B (6A) (cl 37); s 113 (e) corrected (cl 39); new Part 2A ss 13H (3), 13I (d), 13M, 13N, 13ZD (cl 46); Part 7 repealed (cl 47)	Family, Personal and Sexual Violence Legislation Amendment Bill 2025 (ACT), as presented; Explanatory Statement p 50	Presented 3 December 2025

Part II — Why it fails

Chapter 8 — What a risk framework is, and what the ACT framework is not

In one page

The hour.

What follows is a constructed illustration, not a real matter, and nobody in it is named or quoted. Its features come from the published process described in Chapter 7.

An application for an interim family violence order is listed before a registrar within two business days. The applicant's material is the only material. The other party is not present, and has usually not yet been served. The decision is made at that listing, in minutes.

The order can remove a person from their home, suspend a licence they need in order to work, and interrupt contact with their children. It is then served, or it is not.

A control is something already in place that reduces a risk, and a control nobody has checked is an assumption. Nothing requires a record of which controls are in place afterwards. No published requirement obliges anyone to ask either party a welfare question when the order is served.

That hour is what a risk standard exists for. Part II begins there, not with the number of the standard.

Principle one: rate the option, not the person.

A risk score attached to a human being travels into police, child protection, housing, corrections and employment systems. There it hardens into a fact about a person. The date, the context and the uncertainty do not travel with it.

Rating the available courses of action produces a decision instead of a label, and a decision can be revisited when new information arrives. The principle is developed in Chapter 14. It is built into the replacement instrument in Chapter 15 and Appendix B.

The two-risk rule.

Two risks are rated separately and never averaged, and each is written as one sentence naming its source, its event, its consequence, the person affected and the period.

The first, R1, is the risk that a person who has used or may use family violence commits family violence, causing physical, sexual, psychological, emotional or economic harm to the person needing protection, any child or any other affected person, within a stated period.

The second, R2, is the risk that the process or the measures selected restrict housing, work, a licence, contact with children or liberty, causing hardship or a rights limitation beyond what is necessary to hold R1 within tolerance, to the person being restricted or to a child in their care, over the same period.

The first sets the floor for how much protection is required. The second chooses between the options that meet that floor. It never lowers the floor. Averaging destroys information: an option with the first risk extreme and the second low, and an option with the reverse, can average to the same number and are completely different decisions.

Section 37 of the *Family Violence Act* already requires the least restrictive conditions that still achieve the Act's objects, and section 39 requires accommodation needs to be considered before an exclusion condition, so recording this analysis records something the law already requires.

Then the standard.

The ACT Government requires risk to be managed to a recognised standard across all of its functions, expressly including health and safety activities, policy development and planning. Its own framework says so. The standard is AS ISO 31000:2018.

That standard is not complicated. A risk framework needs six things at minimum. Risk criteria — the written rules that say how likely and how serious a risk is being called, and what level is acceptable. Treatment options, with a reason for choosing between them.

Residual risk, which is what is left after the protections are actually in place, stated with who accepted it. Named people accountable for particular risks. A monitoring and review schedule. And reporting that lets someone above the case level see how the system is performing.

The ACT Domestic and Family Violence Risk Assessment and Management Framework was published in July 2022. It contains none of those six things.

It does contain valuable things: a common language, structured professional judgment, coverage of generalist as well as specialist services, coercive control, children, intersectionality, "perpetrator accountability" — the framework's own term — and candour about its own evidence base. It is better than no framework.

But it cannot produce consistent, comparable, auditable decisions. It has no criteria to be consistent with or audited against. It uses words like "at risk", "elevated" and "high" without defining what separates them. It asks a victim to rate their own risk on a scale of nought to ten, and gives no rule for what a given number means or does.

Two years after publication, an independent review of ACT crisis services found agencies using different risk processes, capable of reaching different conclusions about the same case. Tested clause by clause, eight requirements are not met, nine are partly met, and none is fully met. Chapter 15 and Appendix A set out a replacement: everything the framework does well, plus the six missing components.

One number, one quote, one action

Number: Six — the components a defensible risk decision requires. The July 2022 ACT domestic and family violence risk framework contains none of them.

Quote: "if you had to rate the risk of something happening again from 1 to 10, where might you rate that risk?" — ACT Domestic and Family Violence Risk Assessment and Management Framework, Practice Guide 2, July 2022. No rule is stated for what the number means or does.

This week: Run inter-rater reliability testing on the current risk instrument. Give standardised case vignettes to police, registry, crisis service, health and child protection assessors, measure how often they reach the same rating, and publish the agreement statistic. It uses no client data. The protocol is at Appendix O.

1. What a risk framework has to contain

The opening set out the decision the standard has to serve. This section sets out the standard itself, in plain English. A reader who already knows ISO 31000 can skip to section 3.

1.1 The three parts

AS ISO 31000:2018 divides risk management into three parts.

Principles — the qualities good risk management has. It should be integrated into how the organisation works. It should be structured, and customised to the situation. It should include the people affected. It should rest on the best available information. And it should be improved continually.

Framework — the organisational machinery. Leadership commitment, a policy, assigned roles and accountabilities, resources, and arrangements for evaluating and improving how risk is managed.

Process — the steps you actually follow. Establish the scope, context and criteria. Identify risks. Analyse them. Evaluate them. Treat them. Monitor and review. Record and report.

1.2 The six things a decision needs

Strip that down further. For any individual risk decision to be defensible, six things have to exist.

One: risk criteria. Written rules state how likelihood is scored and how consequence is scored. They state how the two combine into a risk level. They also state what level of risk is acceptable.

Without criteria, "high risk" means whatever the person writing it thinks it means. Two practitioners can look at identical facts and reach different conclusions. There is no way to establish which of them is right. No standard exists to compare them to.

Two: a full set of treatment options. The standard requires the whole range to be considered. The range is: avoid the risk, remove its source, change how likely it is, change how bad it would be, share it with another party, or knowingly accept it. The chosen option has to be justified against the others.

Without this, the response is whatever the practitioner's service usually does. Nobody asks "was there a less restrictive option that would have worked?" in a form that produces an answer.

Three: residual risk and who accepted it. After the treatments are in place, some risk remains. The standard requires that remaining risk to be stated. It requires a named person to accept it.

Without this, nobody is ever recorded as having decided that the remaining level of danger was acceptable. Everyone in the chain can believe someone else made that call.

Four: named risk owners. A specific person accountable for a specific risk.

Without this, a risk assessment is a document rather than an allocation of responsibility.

Five: monitoring and review at framework level, not just case level. Planned, ongoing review with defined responsibilities, feeding into performance reporting.

Without this, an organisation cannot tell whether its risk management is working.

Six: recording and reporting. Documented process and outcomes, with reporting designed for the people who need to oversee it.

Without this, there is no oversight and no learning.

FIGURE 8.1

The six things a risk decision needs

For any individual risk decision to be defensible, six things have to exist.



The ACT Domestic and Family Violence Risk Assessment and Management Framework, published in July 2022, contains none of them.

The framework does contain valuable things: a common language, structured professional judgment, coverage of generalist as well as specialist services, and candour about its own evidence base. It is better than no framework. These six are what it is missing.

Chapter 8, sections 1.2 and 5. Broken borders mark components that are absent.

1.3 Why this is not bureaucratic overhead

Every one of the six exists to answer a question that will eventually be asked.

- Criteria answer: *why did you rate it that way, and would someone else have rated it the same?*
- Treatment options answer: *what else could you have done?*
- Residual risk answers: *what danger did you knowingly leave in place, and who agreed to that?*
- Risk owners answer: *who was responsible?*
- Monitoring answers: *has anything changed since?*
- Reporting answers: *is the system as a whole working?*

Those are the questions asked at an inquest, in a review, at a committee hearing and in a court. A framework that cannot answer them has not made anyone safer. It has made the process harder to examine.

2. The standard the ACT set for itself

2.1 The whole-of-government requirement

The Chief Minister, Treasury and Economic Development Directorate maintains the ACT Government's risk management framework and policy. That framework is aligned to AS ISO 31000:2018.

It requires risk management to be embedded across all ACT Government functions. It states expressly that this includes health and safety activities, policy development and planning.

Whole-of-government risk management attributes support it. Those attributes are cultivating a positive risk culture, establishing a robust risk assessment process, defining responsibility and accountability, and embedding risk management into operations. These are compliance obligations, not aspirations.

2.2 What that means for this chapter

This chapter tests the domestic and family violence framework against ISO 31000. That is not an external benchmark chosen for effect. The ACT has adopted the standard. The question is whether one of its frameworks meets it.

2.3 The obvious objection, answered

There is a fair objection to this whole chapter. It should be dealt with before the analysis rather than after.

The objection: the DFV-RAMF is a practice framework for frontline workers, not an enterprise risk management framework for an organisation. It is unfair to test a practitioner's guide against a corporate governance standard. Practitioners need practical guidance, not consequence matrices.

The answer has four parts.

First, the document is titled a *Risk Assessment and Management Framework*. The Territory uses it to identify, assess and manage this category of risk. What it is called by the standard is what it does.

Second, the ACT's own policy does not carve out an exception for practice frameworks. It applies risk management to all functions, including health and safety activities.

Third — and this is the substantive point — the objection assumes criteria are a corporate formality. It assumes they would get in a practitioner's way. The opposite is true. Criteria are what allow two practitioners to reach the same conclusion about the same facts. One may work in a health service and the other in a police station. Structured professional judgment without criteria is professional judgment with a checklist attached.

Fourth, the comparison jurisdiction shows it can be done. Victoria's multi-agency framework is also a practice framework. It is embedded in law. It assigns responsibilities to prescribed organisations. It requires those organisations to align their policies, procedures and tools. It connects the framework to information sharing, workforce capability and continuous improvement. It carries accountability architecture without ceasing to be practical.

3. What the ACT framework contains

The framework should be described accurately before it is critiqued.

3.1 What it does well

The July 2022 framework:

- **creates a common language** across services that previously had none;
- **adopts structured professional judgment**, which combines evidence-based risk factors, professional judgment, the victim-survivor's own assessment and information from other agencies;
- **covers generalist, statutory and specialist services**, not only specialists;
- **addresses coercive control** as a pattern rather than a list of separate acts;
- **addresses children**, including risk factors specific to them;
- **addresses intersectionality**;
- **includes perpetrator accountability**;
- **recognises that risk changes over time** and requires reassessment;
- **is candid about its evidence base**, stating that its tools are built on evidence about heterosexual intimate partner violence and should be updated as evidence for diverse groups develops; and
- **provides practical tools** — screening questions, an example risk assessment, a safety plan template, an e-safety checklist, a risk management planning template and a summary template.

None of that is trivial. A jurisdiction with this framework is better placed than a jurisdiction without one.

3.2 The tools it provides

Screening uses three agreed ACT screening questions:

- Has your partner or ex-partner ever put you down, humiliated you, called you bad names or tried to control what you can or cannot do?
- Have you been hit, slapped or hurt in other ways by your partner or ex-partner?
- Are you ever frightened by your partner or ex-partner?

Risk assessment uses a list of 14 risk factor questions. They cover separation, pregnancy, escalation, pressure to the neck or throat, controlling behaviour, threats to kill, past assault, sexual coercion, stalking, weapons access, breach of orders, harm to pets, drug and alcohol issues, and mental illness with suicide threats.

A fifteenth item asks for the victim-survivor's own assessment, including: *if you had to rate the risk of something happening again from 1 to 10, where might you rate that risk?*

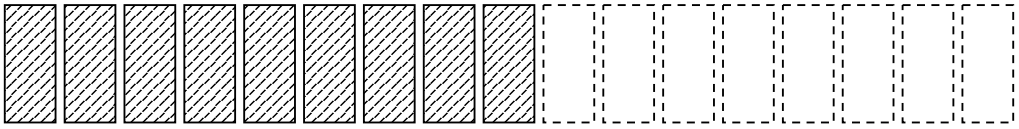
Fact sheets cover several topics. They are coercive control, intersectionality, impacts on women, impacts on children, ACT key risk factors, structured professional judgment, a risk management conversation guide, risk factors for children, men labelled as victims, and determining the primary aggressor.

FIGURE 8.2

Seventeen requirements. None fully met.

AS ISO 31000:2018 tested clause by clause against the ACT family violence risk framework

Each block is one requirement of AS ISO 31000:2018, tested against the July 2022 ACT family violence risk framework.



0 fully met 9 partly met 8 not met

No block is filled. The ACT requires risk to be managed to this standard across all of its functions.

The Territory requires every part of its operation to manage risk to this standard, and did not apply it to the process that can remove a person from their home without notice.

Chapter 8, section 4. The clause-by-clause scoring is the author's; the full assessment is at Table 8.1.

4. The test, clause by clause

The table below sets out what the standard requires, what the framework does, and whether they match.

TABLE 8.1

AS ISO 31000:2018, clause by clause

The July 2022 ACT domestic and family violence risk framework tested against the standard the ACT Government requires across all of its functions.

Clause	What the standard requires	What the framework does	
P1	Integrated	a practice guide, not in agency governance	●
P2	Structured, comprehensive	narratives and templates, no method	●
P3	Customised	one model; updates named as future work	◐
P4	Inclusive	engagement centred on women victims	◐
P5	Best available information	limits noted, assumptions still applied	◐
P6	Continual improvement	a working document, no improvement cycle	◐
5.2	Leadership and commitment	no policy, appetite or accountability map	●
5.3	Integration	not embedded in agency decision gates	◐
5.4	Understand context	no organisational context step	●
5.4	Roles and resources	roles and resources not assigned	●
5.4	Communication and consultation	practice tips, no governance model	◐
5.6–5.7	Evaluation and improvement	no indicators, no evaluation cadence	●
6.3	**Scope, context and criteria**	no scales, thresholds or risk appetite	●
6.4	Risk assessment	assumptions and effectiveness not recorded	◐
6.5	Risk treatment	no full option set, no choosing criteria	●
6.6	Monitoring and review	case level only; no owners or cycle	◐
6.7	Recording and reporting	case templates, no reporting standard	◐

● not met at all ◐ partly met

Eight requirements are not met at all. Nine are partially met. None is fully met.

The entry that matters most is clause 6.3. Everything else in a risk process depends on criteria: without them, analysis cannot be evaluated, treatments cannot be compared, and residual risk cannot be stated.

Chapter 8, section 4. The assessment is the author's, clause by clause.

Eight requirements are not met at all. Nine are partially met. None is fully met.

The entry that matters most is clause 6.3. Everything else in a risk process depends on criteria. Without them, analysis cannot be evaluated. Treatments cannot be compared. Residual risk cannot be stated.

5. The six missing components, in detail

5.1 No risk criteria

The framework uses broad qualitative language about levels of risk. It does not define:

- a likelihood scale, or what period it refers to;
- a consequence scale;
- rules for combining the two;
- thresholds at which a risk level changes; or
- a statement of what level of risk is acceptable, and to whom.

Why it matters. Consider two practitioners in different agencies. Both are given the same facts: a recent separation, one previous incident of pressure to the throat, no order history, no weapons, and a victim-survivor who rates her own risk at 7 out of 10.

Practitioner A weighs the strangulation heavily and records high risk. Practitioner B weighs the absence of prior orders and weapons and records moderate risk. Both have applied the framework. Neither has departed from it. There is no rule that makes either wrong.

That is not a hypothetical. The 2024 crisis services review found that agencies used different risk processes. Those agencies could reach different conclusions about the same case.

The self-rating problem. The fifteenth assessment item asks the victim-survivor to rate the risk from 1 to 10. The victim's own assessment is genuinely important. The research base supports treating it as a significant indicator.

But the framework provides no rule for what to do with the number. A 7 does not correspond to any defined risk level. Two 7s from two people do not mean the same thing. Two 3s are recorded identically. One may come from a person who has been minimising for years. The other may come from a person in a genuinely low-risk situation.

Collecting a number and providing no rule for interpreting it is worse than not collecting it. It gives the appearance of measurement.

5.2 No treatment option set

The framework moves from assessment to safety planning and referral. It does not require the practitioner to identify the available options. Nor does it require the practitioner to compare them and record why one was chosen over the others.

Why it matters. Section 37 of the *Family Violence Act* requires a court to perform exactly this analysis. It is the analysis of the least restrictive condition that still achieves protection. A framework that never asks "what else could achieve this?" cannot support that finding.

It also matters in the other direction. A framework that does not compare options cannot show that the option chosen was strong enough. Consider safety planning with a person who is about to be exposed to a highly dangerous person. That is not treatment if it does not change the exposure.

5.3 No residual risk or acceptance

Nowhere does the framework require a practitioner to state: *after everything we are doing, this much risk remains, and I am accepting it.*

Why it matters. Risk is never eliminated. A safety plan reduces risk. It does not remove it. Someone must decide the remaining level is acceptable. That decision should be visible.

Without that step, everyone in a multi-agency response can reasonably assume someone else is holding the remaining danger. That is the structural condition in which cases fall between agencies. Both death reviews describe it.

5.4 No named risk owners

The framework does not assign ownership of risks, or accountability for accepting residual risk, to named roles.

Why it matters. The 2016 Glanfield inquiry found that no single position was accountable for making the system work as a whole. This framework was published six years later and assigns no ownership. It has not addressed that finding at the case level.

5.5 No framework-level monitoring

The framework requires reassessment of individual cases as circumstances change. That is correct practice.

It specifies nothing at the level above. There are no indicators, no owners, no reporting cycle, and no method for detecting whether the framework is producing good decisions.

Why it matters. This is why nobody knows the misidentification rate. It is why nobody knows whether the framework changed any decision. It is also why the Auditor-General's finding applies as much to risk practice as to program funding. That finding was about the absence of a performance monitoring strategy.

5.6 No framework-level reporting

Case templates exist. There is no standard specifying what is reported above the case, how often, or to whom.

Why it matters. Without aggregate reporting, patterns are invisible. Consider a run of cases in which the same factor was present and the same response failed. Nobody can detect it.

6. Internal tensions in the framework

Beyond the missing components, the framework contains tensions between its own parts. These are recorded because they affect what a practitioner actually does.

6.1 Autonomy against mandated action

The framework states that a victim-survivor's autonomy and agency are respected, and that they decide.

It also states that practitioners must take responsibility and act. They may notify child protection without consent where immediate protection is required.

Both positions are defensible. Together they leave unresolved who decides. They also leave unresolved when the practitioner's judgment overrides the victim-survivor's. A framework should state the rule. This one leaves it to the practitioner.

6.2 "The victim knows best" against a guided conversation

The structured professional judgment model treats the victim-survivor's own assessment as a key component. It treats that assessment as among the most accurate available indicators.

The same framework supplies scripted prompts, screening questions and a conversation guide that shape how the account is elicited. The conversation guide is written to a female client and uses "he" for the person using violence throughout.

Guided conversation is normal and often necessary. People often cannot name what has happened to them without prompting. But this framework treats the victim's assessment as the most accurate indicator. It also structures how that assessment is arrived at. It should therefore say how the practitioner is to distinguish between eliciting an account and shaping one. This framework does not.

6.3 The mental illness item

Assessment question 14 asks whether the person using violence has ever been diagnosed with a mental illness. It also asks whether that person has ever threatened suicide.

These are two different things joined into one question. Threatening suicide is a well-evidenced risk factor and belongs on the list. A past diagnosis of mental illness, by itself, is not a reliable indicator of risk to another person. The great majority of people with a mental illness are not violent.

Combining them means a "yes" cannot be interpreted. It also means a diagnosis contributes to a risk picture. Nothing states what weight it should carry.

6.4 Unweighted and unranked factors

The framework lists a substantial number of risk factors without weighting or ranking them. It mixes factors of very different evidential strength.

Non-fatal strangulation is among the strongest known predictors of subsequent homicide. "Does he try to control what you do?" is a screening question for coercive control. The ACT's own death review found coercive control present in almost all fatal cases. A recorded issue with drug or alcohol use is a contextual factor.

All three are items on the same undifferentiated list. A practitioner counting "yes" answers has no guidance about which answers matter more.

7. The screening asymmetry

The framework describes screening as follows:

> Screening is the systematic routine of asking every woman who uses the service the same key questions.

And the suggested introduction for a practitioner:

> Services across the ACT have begun to routinely ask all women the same questions about violence at home.

This is a design decision with a defensible rationale. The framework cites an evidence base for it. Women tend not to disclose domestic violence unless directly asked. Women who receive a positive initial response are more likely to seek further help. Universal screening of women in health and community settings is established practice in several jurisdictions.

It is also a decision with a measurable consequence. Consider a service that routinely screens all women but does not routinely screen all clients. It will identify domestic and family violence among women at a higher rate than among other clients. That holds independent of the underlying prevalence. The screening design partly determines who is found.

That does not make the design wrong. It does mean that service data produced under it cannot describe the distribution of victimisation in the population. The detection method is not applied evenly.

This becomes important in Chapter 10. That chapter compares the ACT's service reach figures to national victimisation surveys. Part of the gap comes from how the screening is designed. How much cannot be calculated. The framework does not require services to record which clients were screened.

8. Structured professional judgment: what it is and what it is not

The framework adopts structured professional judgment, and that choice is right. It is the mainstream approach in violence risk assessment internationally. It suits family violence better than either unstructured clinical judgment or a purely actuarial score.

Structured professional judgment means combining:

- a defined set of evidence-based risk factors;
- the practitioner's professional judgment;
- the subject's own assessment; and
- information from other sources.

It is sometimes taken to mean that the checklist alone supplies the structure. That is not what it means.

In its established forms, structured professional judgment includes the following. Defined factors with coding rules, stating what counts as present, partially present or absent. A requirement to formulate the case, not merely tally the factors. Defined risk scenarios. Explicit management recommendations linked to the formulation. And, critically, published validation — how well the instrument performs, tested against outcomes.

The ACT framework has the factors and the professional judgment. It does not have coding rules, defined scenarios, a formulation requirement, or any published validation.

The consequence is that "structured professional judgment" in ACT practice means a list of questions and a practitioner's conclusion. That is professional judgment with a prompt sheet. It is not what the method requires. It does not produce the consistency the method is supposed to deliver.

9. What the government's own evidence shows about the effect

The argument to this point is analytical. Three pieces of official evidence bear on whether it matters in practice.

The 2024 crisis services review found agencies across the system using different risk processes. Those agencies were capable of reaching different conclusions about the same case. The review was conducted two years after the framework was published. Its purpose was to review services, not risk practice. The inconsistency was visible anyway.

The 2023 death review recommended introducing a tool for police and courts. The tool would assess patterns of coercive control. It would also determine which party is the "perpetrator", the review's word, and which is using violent resistance. A recommendation to introduce such a tool in 2023 is a statement. It says the 2022 framework did not provide one.

The 2026 First Action Plan commits to implementing an updated framework as future work. As at 2 September 2026, the government's public coercive control page still described the framework as being updated. Four years after publication, the framework was still being revised. It had not been consistently implemented.

None of these is an opinion offered here. They are the government's own record.

10. The comparison jurisdiction

Victoria's multi-agency risk assessment and management framework is the closest Australian comparator. It is often cited as a model. Two points about it are relevant here.

What it does better. It is established in law. Prescribed organisations must progressively align their policies, procedures, practice guidance and tools to it. It assigns ten defined responsibilities. It links information sharing to risk management. It requires organisational governance and consistent data. It has public implementation architecture and updated practice guides.

That is accountability architecture. It answers the questions "who must do what", "how do we know they did it", and "what happens if they did not".

What it does not prove. Victoria's framework is not evidence that Victorian outcomes are better. Its evidence base shares many of the same limitations as the ACT's. That includes reliance on research about heterosexual intimate partner violence. Adopting it wholesale would import those limitations.

The correct conclusion is narrow. Victoria's model is a stronger **implementation** design. The ACT should adopt implementation architecture of that kind. It is not a reason to skip the validation work that neither jurisdiction has published.

11. What is proposed

Chapter 15 and Appendix A set out a replacement framework in full. Its design brief is stated here.

Keep: structured professional judgment. The evidence-based risk factors. The recognition of coercive control as a pattern. The attention to children, to intersectionality and to perpetrator accountability. The victim-survivor's own assessment as a significant input. The coverage of generalist as well as specialist services. The honesty about the evidence base.

Add: defined likelihood and consequence scales. A stated risk tolerance. Coding rules for every factor. A full treatment option set, with a requirement to justify the choice. A residual risk statement with a named acceptor. Named risk owners. Control effectiveness testing. A monitoring and review cycle with indicators and owners. And a framework-level reporting standard.

Change: screening applied to all clients rather than to one group, with the screening design recorded so that service data can be interpreted. The mental illness item separated into its two components. Factors weighted according to evidential strength. And the primary aggressor material replaced, for the reasons set out in Chapter 9.

Test: publish validation results before full deployment. Show how often the instrument gets it right. Show how often two assessors agree. Show how the error rate varies by sex, gender, relationship type and cohort.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. The complete set of 15 is at Appendix M, where it can be read against every other chapter's.

- **F8.3** — The July 2022 ACT domestic and family violence risk framework contains none of the six.
- **F8.4** — Tested against ISO 31000 clause by clause, eight requirements are not met, nine are partially met, and none is fully met.
- **F8.5** — The framework defines no likelihood scale, no consequence scale, no combination rule, no thresholds and no statement of acceptable risk, so two practitioners applying it to identical facts can reach different conclusions with no rule making either wrong.
- **F8.6** — The framework collects a victim-survivor self-rating from 1 to 10 and provides no rule for interpreting or applying the number.

Sources for this chapter

Claim	Source	Date
Principles, framework and process requirements; clauses 5.2–5.7 and 6.3–6.7	AS ISO 31000:2018 Risk Management — Guidelines	2018
Risk management required across all ACT Government functions including health and safety activities, policy development and planning; whole-of-government risk attributes	CMTEDD Risk Management Framework and Policy, v7.0	July 2023
Framework content, structured professional judgment, coverage, coercive control, children, intersectionality, perpetrator accountability, candour about evidence base	ACT Domestic and Family Violence Risk Assessment and Management Framework	July 2022
Three ACT screening questions; "asking every woman who uses the service"; "routinely ask all women"	Same framework, Practice Guide 1	July 2022
14 risk factor questions; victim-survivor self-rating 1 to 10	Same framework, Practice Guide 2	July 2022
Conversation guide written to a female client	Same framework, Fact Sheet 7	July 2022
Agencies used different risk processes and could reach different conclusions	ACT DFSV Crisis Specialist Services Review Summary	May 2024
Recommendation 4: tool for police and courts to assess patterns and determine which party is the perpetrator	ACT DFV Review Biennial Report 2023	2023
Updated framework implementation as future work	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026
Framework described as being updated	ACT Government coercive control web page	Accessed 2 September 2026
Victorian framework established in law; prescribed organisations must align; ten responsibilities	Victorian Government MARAM framework material	2026
No performance monitoring strategy or evaluation framework	ACT Auditor-General, Report 10 of 2024	22 November 2024

Chapter 9 — Deciding who did what

In one page

Police attend an incident. Both people say the other started it. Someone has to decide which of them is the person most in need of protection. That decision determines who is charged, who is named as respondent on an order, and who leaves the house. It often determines what child protection does next.

The ACT framework provides two fact sheets to help. Fact Sheet 9 deals with men labelled as victims. Fact Sheet 10 deals with determining the primary aggressor.

Both contain useful material. They correctly explain that victims use force defensively. They explain that people who use violence can present as calm and credible. They also explain that a decision based on a single incident can get the pattern backwards.

They also contain a list of indicators that a man claiming to be a victim is more likely to be the primary aggressor. The list mixes two very different kinds of item. Some are evidential: injuries inconsistent with his account, a history of orders, facts inconsistent with the known record. Those are proper investigative material.

Others are about how he presents. The list includes these items: he seems overly calm and confident, presents as overly charming, is forthright in criticising his partner, is critical of how "the system" responds to domestic and family violence, focuses on his rights and how he feels they are being violated, tries to convince the assessor that he is the injured party, or appears to have a second motive such as a Family Court matter.

The framework itself says there is no definitive set of indicators. It provides no coding rules, no weighting, no threshold, and no published evidence on how accurate the list is.

The ACT's own death review found that 8 of the 13 deceased victims — eleven of whom were women — had been misidentified as the predominant aggressor. So the documented errors in the ACT run in the direction the fact sheets are designed to prevent. That is the central finding of this chapter. Neither critic nor defender of the framework usually expects it.

An unvalidated classification instrument produces errors in every direction at once. Nobody can say how many, because nobody has measured.

One number, one quote, one action

Number: Eight of the thirteen deceased victims examined in the ACT's 2025 death review — eleven of whom were women — had been misidentified as the predominant aggressor.

Quote: "While there is no definitive set of indicators that can be used to determine the primary aggressor, a man who claims to be the victim-survivor of domestic and family violence is more likely to be the primary aggressor if he:" — ACT DFV Risk Assessment and Management Framework, Fact Sheet 10, July 2022

This week: Publish the evidence base for the Fact Sheet 10 indicator list. For each of the roughly twenty indicators, record the study or source that reports how often it is right and how often it is wrong. Where there is none, record that there is none. No such list exists.

1. What the decision is

1.1 The situation

Two people. One incident, or a history of incidents. Both allege violence by the other. There may be injuries on both. There may be no independent witness.

Someone must decide who is the **predominant aggressor** — the person who poses the most serious and ongoing threat to safety and wellbeing. That decision therefore also decides who is the person most in need of protection.

1.2 Why it is genuinely hard

Four features of family violence make this decision harder than it looks.

Victims use force. A person subjected to sustained violence may fight back, may pre-empt an attack, may act to protect children, or may act to restore some sense of dignity. At the moment of the incident, that person has used violence.

Injuries can mislead. A person defending themselves may inflict scratches or bites. A person attacking may have bruised hands. The physical evidence is not self-interpreting.

Presentation is not evidence. A person who has been controlled for years may present as distressed, disorganised, angry or intoxicated. A person who has been controlling may present as calm, organised and cooperative. Presentation reflects state and personality as much as conduct.

Systems can be used as weapons. The 2025 death review found that people it identified as perpetrators manipulate systems to exert control, and that systems fail when they do not recognise it. Applying first, and giving a coherent account first, is an advantage.

1.3 What turns on it

The consequences of getting it wrong are documented in the ACT's own record. The 2025 death review found misidentification contributed to:

- criminal charges;
- loss of employment;
- statutory intervention leading to removal of children; and
- incarceration.

It also found that the experience makes future help-seeking less likely. It damages the person's belief that the system is safe or trustworthy. It contributes to poor mental health outcomes, substance use problems and damage to self-worth.

And it noted that Aboriginal and Torres Strait Islander women are particularly vulnerable to misidentification and its consequences.

2. What the framework says

2.1 Fact Sheet 10 — the general material

Fact Sheet 10 is adapted from the Western Australian common risk assessment framework. It defines the primary aggressor as the person who poses the most serious and ongoing threat to safety and wellbeing. It notes that the word "primary" may imply two aggressors. But in most situations, it says, violence is used solely by one person.

It sets out issues to explore:

- **Context, intent and effect** — what happened before and after, why the violence was used (to pre-empt worse violence, or to punish), and its effect, including whether the victim is frightened.
- **Fear** — behaviours become controlling when they instil fear; explore the extent and impact of a person's fear.
- **Agency** — the ability to make decisions for oneself; victims are more likely to report not being involved in decisions or having their views disregarded.
- **Assertion of will** — what happens when wants differ, and whether compromise occurs.
- **Empathy** — victims are likely to make excuses for and empathise with the person using violence; people using violence are often unable to empathise.
- **Entitlement** — an attitude created by lack of empathy that allows a person to assert their will over another.

Much of this is sound. Context, intent and effect is the correct frame. Fear is a well-evidenced marker. Examining the pattern rather than the incident is the central lesson of both death reviews.

It also warns, correctly, about the dangers of incorrectly identifying the primary aggressor. Those dangers include inadvertently colluding with the person using violence, and exposing the adult victim and children to increased risk. It identifies how a perpetrator can be incorrectly identified as a victim. That can happen when a victim uses force in self-defence, to prevent an impending attack, to defend children or others, or as resistance or retaliation.

2.2 The sex-specific indicator list

Fact Sheet 10 then states:

> While there is no definitive set of indicators that can be used to determine the primary aggressor, a man who claims to be the victim-survivor of domestic and family violence is more likely to be the primary aggressor if he:

There follows a list of approximately twenty indicators. They are reproduced faithfully here in two groups. The distinction between the groups is the substance of this chapter.

Group A — evidential indicators

- has or had injuries more consistent with him being the aggressor, for example scratches around arms and hands, bruised hands or feet, different from the injuries sustained by his partner;

- has a history of one or more intervention orders against him for violence or stalking, has a current order, or has previous arrests or convictions for domestic and family violence or other violence-related crimes;
- describes events or circumstances inconsistent with the known facts;
- reports facts inconsistent with his size or that of his partner;
- discusses the incident in vague and general terms rather than providing specifics.

Group B — demeanour and attitude indicators

- refers to his partner in aggressively critical or demeaning terms, as a character attack out of righteous anger rather than fear-based anger;
- seems overly calm and confident, and has no fear or apprehension about the incident or any civil or criminal court process that might result;
- presents as overly charming or charismatic;
- conveys a sense of ownership, entitlement, privilege, jealousy or obsession about his partner;
- is forthright, critical and opinionated about the ways that "the system" — for example courts, police — responds to domestic and family violence;
- focuses on his rights and how he feels they are being violated — victims will generally not feel sufficiently empowered to talk about their rights or how these rights are being violated;
- appears to regard children as his property, believes his children need to show respect and be "taught lessons", appears unable to focus on children's needs;
- tries to convince the assessor that he is the injured party;
- tries to ally with the assessor and subtly or grossly invites the assessor to collude with his story;
- evades questions, attempts to control the conversation, or diverts the assessor from asking pertinent questions — victims are more likely to be feeling disempowered, unsure of themselves and hesitant;
- leaves the assessor feeling manipulated through verbal tactics of persuasion;
- appears to have power and control over his partner;
- appears to have a second motive for the allegations, such as a Family Court matter or an affair, and appears smug about getting his partner into trouble;
- denies any wrongdoing and takes no responsibility — victims often wrongly take some or most responsibility for the violence they are experiencing;
- has trouble empathising with his partner's emotional experiences;
- appears to assert his will over his partner without empathising or considering the consequences to her.

2.3 Fact Sheet 9 — men labelled as victims

Fact Sheet 9 is an extract from Victorian practice guidance. It states that men can genuinely be victim-survivors of domestic and family violence, often from other males' behaviour. It states that approximately 40 to 50 per cent of male victims experience violence from a male perpetrator, such as a son, father, brother or male intimate partner.

It states that men can be victims of women's use of violence too. It then states:

> However, studies in several jurisdictions show that approximately 15–50% of men assessed by police to be the victim of a female intimate partner's use of violence, are actually the perpetrator in the relationship.

It attributes this to a "nice guy" effect. That effect combines with the use of force by some women against the perpetrator. They use force to defend themselves and their children, or to attempt to restore dignity lost through being entrapped by his coercive control.

It explains, correctly, what can follow when a person using violence is incorrectly identified as a victim. That person can use the status to further harm and control the true victim. They can hide behaviour from authorities, gain unsafe access to children, and isolate the victim from police and support services.

It then instructs:

> It is therefore important to be cautious and to keep an open mind when a male client claims to be a victim of a woman's use of family violence, even if police or other services have identified him as such.

It also provides a shorter list of signs "that might indicate he is not the true victim". Those signs include injuries consistent with his partner acting in self-defence, a history of orders, controlling tactics, making most or all important decisions, **not appearing to be afraid**, being forthright in criticising her, showing little empathy, conveying a sense of ownership or entitlement, and denying wrongdoing.

3. The problem with the demeanour indicators

3.1 What Group A does and what Group B does

Group A indicators point to facts. An injury pattern, an order history, an inconsistency with the known record: these can be checked, corroborated or refuted. They are proper investigative material. They belong in an assessment.

Group B indicators point to how a person appears to the assessor. Calm. Charming. Critical. Rights-focused. Persuasive. Unafraid.

Group B has three properties that Group A does not.

It is not falsifiable by the subject. A person cannot show that they are not "overly charming". There is no evidence a person can produce to rebut an impression.

It is bidirectional in application but not in the framework. Being calm is a listed indicator. Being evasive and hesitant is described as characteristic of victims. But hesitancy can equally reflect deception. Calm can equally reflect a person who has

prepared, because they were told to bring their evidence. The framework does not say what distinguishes the two.

It has no threshold. The list contains around twenty items. The framework does not say how many are needed, whether some count more than others, or what to do when items point in different directions.

3.2 The double bind

The clearest way to state the problem is to work through the possible presentations of a man who is in fact a victim.

If he is **calm** — that is a listed indicator ("seems overly calm and confident", "no fear or apprehension").

If he is **pleasant and cooperative** — that is a listed indicator ("presents as overly charming or charismatic").

If he **criticises his partner's conduct**, which is the substance of his complaint — that is a listed indicator ("forthright in criticising her").

If he says the process is unfair to him — that is a listed indicator ("forthright, critical and opinionated about the ways that 'the system' responds").

If he raises his rights — that is a listed indicator ("focuses on his rights and how he feels they are being violated"). The explanatory clause reinforces it: victims will generally not feel sufficiently empowered to do so.

If he **argues his case persuasively** — that is a listed indicator ("tries to convince the assessor that he is the injured party", "leaves the assessor feeling manipulated through verbal tactics of persuasion").

If there is a **family law matter on foot** — that is a listed indicator ("appears to have a second motive for the allegations, such as a Family Court matter").

If he **denies the allegation** — that is a listed indicator ("denies any wrongdoing and takes no responsibility"). The clause that victims often wrongly take responsibility reinforces it.

If he is **evasive, unsure or hesitant** — Fact Sheet 10 characterises that presentation as more typical of victims, so it points the other way. But Fact Sheet 10's own evidential list includes discussing the incident in vague and general terms. Hesitancy points both ways within the same document.

Set out that way, the difficulty is visible. The presentations available to a person in this situation are largely covered. A man who is composed reads as a perpetrator. A man who is aggrieved reads as a perpetrator. A man who argues his case reads as a perpetrator. A man who is in family law proceedings reads as having a second motive. That is a very common circumstance for someone in a family violence matter.

This is not an argument that the underlying observations are wrong. People who use coercive control frequently do present as calm, charming and plausible. They frequently do use the system against their partner. Those observations come from experienced practitioners. There is a real research base for them.

It is an argument about what happens next. True-but-non-specific observations are converted into a checklist with no coding rules, no weighting, no threshold and no measured accuracy. Some characteristics are common among people who use

violence, but also common among people who do not. Those have low diagnostic value, however true the underlying observation is.

FIGURE 9.1

Two kinds of indicator, and the bind they create

Fact Sheet 10, ACT Domestic and Family Violence Risk Assessment and Management Framework, July 2022

Group A — evidential facts that can be checked, corroborated or refuted **5**

- injuries consistent with him as aggressor
- an account inconsistent with known facts
- discusses the incident only vaguely
- a history of orders, arrests or convictions
- reports facts inconsistent with size

Group B — demeanour and attitude how a person appears to the assessor **16**

- refers to his partner in demeaning terms
- presents as overly charming
- critical of how "the system" responds
- regards children as his property
- tries to ally with the assessor
- leaves the assessor feeling manipulated
- appears to have a second motive
- has trouble empathising
- seems overly calm and confident
- conveys ownership or entitlement
- focuses on his rights being violated
- says he is the injured party
- evades questions, controls the talk
- appears to have power and control
- denies wrongdoing, takes no responsibility
- asserts his will over his partner

Group B is not falsifiable by the subject; it is bidirectional in application but not in the framework; and it has no threshold.

The double bind

A person who has in fact been assaulted, presenting to an assessor, may reasonably:

- be calm
- criticise his partner's conduct
- raise his rights
- have a family law matter on foot
- be pleasant and cooperative
- say the process is unfair to him
- argue his case persuasively
- deny the allegation

Each one is a listed indicator.

Hesitancy points both ways: appearing evasive, unsure or hesitant is also listed.

Eight of the 13 people assessed as victims had been wrongly recorded as the predominant aggressor by police or another agency before their death.

Group A points to facts that can be checked. Group B points to how a person appears to the assessor, with no coding rules, no weighting, no threshold and no measured accuracy.

Chapter 9, sections 2.2 and 3. Thirteen and 25 are small numbers, and the proportions within them are not rates in any wider population.

3.3 The asymmetry

Fact Sheet 10 supplies a detailed, sex-specific list for identifying a man falsely claiming victim status.

It does not supply an equivalent detailed list for identifying a woman falsely claiming victim status, or a woman who is the predominant aggressor.

The framework's treatment of women's violence is directed almost entirely at explaining it as defensive or resistive. As the ACT's own death review establishes, it very often is.

The result is a framework that provides structured assistance for one error direction. For the other, the assistance is largely narrative. That is a design asymmetry, and it should be recorded as one. It is not, by itself, evidence that decisions are wrong.

4. The evidential basis

4.1 Where the material comes from

The provenance of the two fact sheets is stated on their face.

Fact Sheet 9 is an extract from Vlais (2018), *Guidelines for identifying and responding to people who cause family violence harm*, produced for the North West Metropolitan Region Primary Care Partnerships in Victoria, at pages 10 to 11. Its indicator list is adapted from a more comprehensive list at pages 194 to 197 of *Towards Safer Families: A Practice Guide for Men's Domestic Violence Behaviour Change Programs*.

Fact Sheet 10 is adapted from the Western Australian *Family and Domestic Violence Common Risk Assessment and Risk Management Framework*, second edition, at page 69.

These are credible practitioner sources. They are practice guidance developed by people with direct experience. There is no reason to doubt their good faith, or their usefulness as prompts for a skilled assessor.

They are not validation studies. Guidance adapted from a behaviour change program practice guide describes what experienced practitioners have observed. Those observations come from a population of men already identified as using violence. A different question is how well those observations discriminate between a man who is using violence and a man who is not. That question arises in a population where both are present.

4.2 The 15 to 50 per cent figure

Fact Sheet 9 states that studies in several jurisdictions show a figure for this. Approximately 15 to 50 per cent of men assessed by police to be the victim of a female intimate partner's violence are actually the perpetrator. The source is described as two large-sample studies in the United Kingdom, two in New South Wales and one in Victoria.

Three observations.

The range is very wide. A figure that varies by a factor of more than three across five studies is describing different populations, different definitions or different methods. A range that wide does not support a precise operational inference.

It is a statement about a population, not a person. Even taking the upper end, if half of police-identified male victims are actually perpetrators, the other half are

not. A practitioner meeting an individual man has no way to know which group he is in. That is precisely what an assessment instrument is supposed to help with. It is precisely what an unweighted list of demeanour cues does not do.

It is not ACT data. No equivalent ACT figure has been published. The ACT does not know what proportion of men it identifies as victims are in fact using violence, because it has not measured it.

4.3 What the framework does not provide

For the primary aggressor material specifically, the framework provides no:

- **coding rules** — what counts as "overly calm", "overly charming", "forthright";
- **weighting** — whether an inconsistent account counts more than a demeanour impression;
- **threshold** — how many indicators, or which combination, supports a conclusion;
- **decision rule** — what to do when indicators conflict;
- **required record** — what the assessor must write down about how the conclusion was reached;
- **sensitivity** — how often the instrument correctly identifies the actual aggressor;
- **specificity** — how often it correctly clears someone who is not;
- **inter-rater reliability** — how often two assessors agree on the same facts;
- **error analysis by cohort** — how performance differs for women, men, same-sex relationships, transgender and non-binary people, Aboriginal and Torres Strait Islander people, people with disability, and people from culturally and linguistically diverse backgrounds; or
- **validation of any kind**.

The framework acknowledges the first part of this, in the sentence quoted at section 2.2, and the acknowledgement is honest. Read alongside the operational instruction it precedes, it is also an acknowledgement that the instruction is not evidence-based in the sense the word usually carries.

5. What the ACT's own data shows

This is where the analysis turns, and where it departs from what a reader might expect.

5.1 The documented errors fell on women

The 2025 death review examined 13 people who died. Each was assessed, on the full reconstructed record, as a victim of domestic and family violence. Eleven of the 13 were female.

Eight of the 13 had been misidentified as the predominant aggressor by police or another agency before their death.

Two were misidentified within the three months before death. Six were misidentified a year or more before.

The examples given include a victim charged after a perpetrator broke into her home and attacked her. They also include a victim identified as the predominant

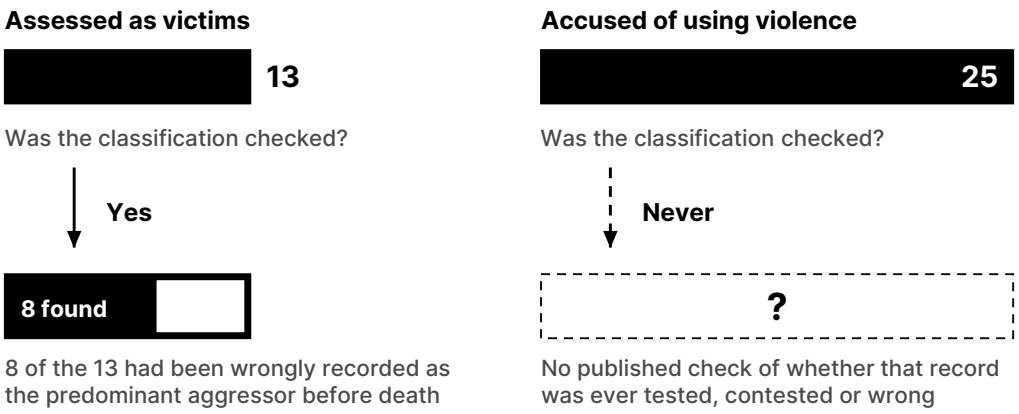
aggressor at a police-attended incident, despite a documented history of violence by the other party.

The review also recorded the case of at least one victim. There was clear evidence of intimate partner violence perpetrated against her by the father of her children. Authorities accused her of manipulating systems by claiming to be a victim in order to gain custody.

FIGURE 9.2

The error that was counted, and the error that was not

Classification of 38 non-homicide deaths, ACT, 2020–2024



The Territory searched for misclassification in one direction, found it in 8 of 13 cases, and has never measured the rate in either direction.

ACT Domestic and Family Violence Review Biennial Report 2025. This is not a claim that men are more often misidentified. No ACT data could support or refute one.

5.2 What follows from that

The fact sheets exist to prevent exactly this error. Their entire orientation is towards ensuring that a woman who used defensive force is not mistaken for the aggressor. It is also towards ensuring that a man presenting persuasively is not mistaken for the victim.

In the group the ACT reviewed, that error occurred anyway, in 8 of the 13 cases.

> **What the 2020–24 cohort is, and is not.** The 38 non-homicide deaths are not a census and not a sample. A death enters the register only when an agency identifies it as occurring in a domestic and family violence context. "Perpetrator" and "victim" are the review's own classifications from records, not court findings, and where a person was misclassified while alive the classification can inherit the error. Of the 11 homicides in the period, 10 were before the courts or the coroner, so in-depth analysis of the homicides was not possible and the 38 are what remains after the most fully investigated deaths were set aside. Thirteen and 25 are small numbers, and the proportions within them are not rates in any wider population. Chapter 4 section 1.2 sets this out in full.

Three conclusions follow. All three should be stated.

First, the framework's protective intent is well-founded. Misidentification of women as aggressors is real, documented in the ACT, and has severe consequences. Anyone arguing that this concern is overstated is arguing against the Territory's own fatality evidence.

Second, the framework did not prevent it. The deaths reviewed occurred between 2020 and 2024. That span covers the framework's publication in July 2022 and the years before it. The review does not break its misidentification findings down by date relative to publication. So the record does not show whether the framework reduced the rate. It shows that the error continued to occur.

Third, an instrument that fails to prevent the error it is designed for provides no assurance about errors in the other direction. If the guidance were highly accurate, it would produce few errors of either kind. The documented error rate in the ACT's reviewed group is not low. There is no basis for assuming that the errors are confined to one direction. No data exists that would show it either way.

5.2a What the people most exposed to the error say about it

The death review establishes that the error occurred. It does not describe what it is like to be on the receiving end of it, and it cannot, because the people it examined had died.

One published joint submission to the Legislative Assembly's 2026 inquiry into the Crimes (Coercive Control) Amendment Bill supplies that. It was authorised for publication.

The joint submission by Sisters in Spirit Aboriginal Corporation and Women's Health Matters identifies the mechanism directly. It records that Aboriginal and Torres Strait Islander women experience what it calls a dual injustice: over-policed as potential offenders and under-protected as victim-survivors. It records the specific pathway by which that produces a wrong classification — that trauma responses and reluctance to engage with police are read as non-cooperation. A participant describes the consequence of that reading:

> "This one woman who was murdered by her partner had called police 47 times, and they said that she was being vexatious."

That account is a single case reported at second hand in a consultation, and it establishes no rate. It describes a mechanism the 2025 death review documents independently: among the 13 deceased victims, at least one had been accused of manipulating systems by claiming to be a victim in order to gain custody. The word used in the submission and the finding in the review are the same phenomenon described from two directions.

The submission also draws the operational conclusion that this chapter reaches from the framework's own text. A new offence turning on the identification of who is exercising control, applied by a workforce whose accuracy at that task has never been measured, may increase the number of misidentifications rather than reduce it.

It was not alone. Of the 22 submissions with text to that inquiry, 16 named misidentification in terms, the government's among them, and five asked for a legislated step to identify the person most in need of protection before a charge is laid. Chapter 19 §§3.3 and 3.4 set out what each said and what the Bill does about it.

There is a point about evidence here that should be made explicitly, because it runs against the general direction of this work. Misidentification is in the ACT record because people said so. The death review found it by reading files against a pattern that survivor accounts and the research built on them had already described. An administrative dataset that records a classification cannot report that the classification was wrong; that error is invisible to it by construction. On this particular question, first-person accounts are not a supplement to the data. They are the reason anybody knew to look.

That is also the limit of what they establish. They locate the error and describe how it happens. They cannot say how often, in which direction, or whether the rate has changed. Only measurement does that, and section 7 sets out what measurement would require.

5.3 The honest position

The honest position on this evidence is narrow and can be stated in four sentences.

The ACT makes a classification decision of very high consequence, frequently on incomplete information, using guidance that contains a substantial component of subjective demeanour assessment, with no coding rules, no weighting, no threshold and no measured accuracy.

Its own death review has documented that decision being made incorrectly in 8 of a group of 13 people who later died, in the direction of misidentifying victims — 11 of the 13 were women — as aggressors.

It has never measured how often the decision is wrong in the general population, in either direction.

Until it does, no claim about bias in either direction can be established, and no claim of accuracy can be either.

6. Why "believe the victim" and structured judgment sit uneasily together

The framework treats the victim-survivor's own assessment as a key component of structured professional judgment. The national principles it draws on state that a survivor's knowledge of their own risk is central to any risk assessment.

That principle is well-supported. In the research literature, survivors' own predictions of future violence perform comparably to structured instruments. They often perform better on imminent risk.

The difficulty is what happens when two people both claim victim status.

If a survivor's self-assessment is treated as centrally important, and both parties self-assess as victims, the principle cannot resolve the question. Something else must. In the ACT framework, that something else is Fact Sheets 9 and 10. They resolve it by treating one party's self-assessment as presumptively less reliable on the basis of sex.

This is a structural tension, not an accusation. It is what happens when a principle designed for the single-victim case is applied to the contested case without a rule for the transition.

The replacement framework in Appendix A handles it differently. The victim-survivor's self-assessment remains a primary input, and is recorded in full for **both** parties. Where the two accounts conflict, the instrument does not resolve the conflict by reference to sex. It resolves it, so far as the available information allows, by pattern over time and by source reliability. It records what is established, what is reasonably open and what is unknown, and requires the assessor to record which it is.

Where the pattern cannot be established, the instrument requires the assessor to record that the classification is unresolved. The assessor must then select protective measures that do not depend on having resolved it.

That last provision is the practical answer. In a genuinely unresolved case, some protective options work regardless of who is the aggressor. They include separation of the parties at court, remote appearance, expedited listing, and firearms action. Whether reciprocal conditions belong on that list is the question Chapter 16 sections 4.4 to 4.6 put to a 24-month trial; it is not a recommendation. Choosing an option that does not require the classification to be correct is better practice than forcing a classification on inadequate information.

7. What a validated instrument would require

Chapter 15 sets out the replacement. The validation requirement is stated here for a reason. It is the recommendation with the shortest path to implementation and the largest effect.

Before full deployment, the ACT should publish:

1. Inter-rater reliability. Give a set of standardised case vignettes to a sample of police, court and service assessors. Measure how often they reach the same classification. Publish the agreement statistic.

It requires no client data. The fieldwork takes six weeks and the full study about five months; Appendix O specifies it.

2. Predictive performance against outcomes. Link classification decisions to later outcomes — further violence, further orders, charges, reversals of classification. Report how often the initial classification was later contradicted by the accumulated record.

3. Error analysis by cohort. Report performance separately for women, men, same-sex relationships, transgender and non-binary people, Aboriginal and Torres Strait Islander people, people with disability, and culturally and linguistically diverse people.

4. Indicator-level contribution. Report which indicators actually distinguish between groups and which do not. Indicators that do not discriminate should be removed, not retained on the basis that experienced practitioners find them useful. If they are useful, the data will show it.

5. A misidentification rate and a correction pathway. Report the proportion of classifications later reversed, the average time to reversal, and what happens to the consequences that flowed from the original decision — charges, orders, employment, child arrangements.

The fifth is the one that would change the most. At present, a person misidentified has no defined pathway to have the record corrected. The consequences that followed do not automatically unwind. Neither of the two bills before the Assembly at the evidence cut-off supplies one; a correction provision for the police-issued notice is drafted at Appendix G9.6 (Chapter 19 §2.9).

8. What should replace the fact sheets

The replacement is set out in Appendix A. Its design is summarised here.

Retain: context, intent and effect as the primary frame; pattern over incident; the recognition that victims use defensive and resistive force; the warning about system manipulation; fear as a marker; the requirement to seek information from other sources and time points.

Retain and strengthen: the evidential indicators — injury patterns inconsistent with an account, order and charge history, accounts inconsistent with the known record, accounts inconsistent with physical facts. These should be coded with explicit rules and recorded with their source.

Remove from the classification decision: demeanour and attitude cues used as indicators of who is the aggressor. Calm, charm, criticism of the system, focus on rights, persuasiveness, and the presence of family law proceedings should not appear as indicators of perpetration for any person of any sex.

They may remain as **contextual observations to be recorded**, because an experienced assessor's impression is information. But an observation that cannot be tested must be recorded as an observation. It must not be counted towards a classification. It must be visible to anyone reviewing the decision.

Make symmetric: whatever indicators survive should apply to any person, of any sex, in any relationship configuration. Where a sex-specific base rate is relevant, it should be stated as a base rate, with its source and its confidence interval. It belongs

in the section of the instrument that deals with base rates, not embedded in an indicator list.

Add an unresolved category. The instrument must permit the answer "cannot be determined on the available information", and must specify what to do in that case.

Add a correction pathway. Where a classification is later shown to be wrong, there must be a defined process for correcting the record across agencies and for reviewing the consequences that followed.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. The complete set of 12 is at Appendix M, where it can be read against every other chapter's.

- **F9.4** — The demeanour indicators include seeming overly calm and confident, presenting as overly charming, being forthright in criticising his partner, being critical of how "the system" responds, focusing on his rights, trying to convince the assessor he is the injured party, and appearing to have a second motive such as a Family Court matter.
- **F9.5** — Taken together, the listed presentations cover most of the ways a person in this situation can present, so a man's demeanour is capable of supporting the same conclusion whether he is composed or aggrieved, articulate or evasive.
- **F9.7** — The framework states there is no definitive set of indicators and provides no coding rules, weighting, threshold, decision rule, required record, sensitivity, specificity, inter-rater reliability, error analysis by cohort, or validation of any kind.
- **F9.10** — The ACT's own death review found 8 of the 13 deceased victims — 11 of the 13 were female — had been misidentified as the predominant aggressor, so the documented errors in the ACT run in the direction the fact sheets exist to prevent.

Sources for this chapter

Claim	Source	Date
Primary aggressor definition; context, intent and effect; fear; agency; assertion of will; empathy; entitlement; the sex-specific indicator list; "no definitive set of indicators"; dangers of incorrect identification	ACT DFV Risk Assessment and Management Framework, Fact Sheet 10, adapted from the Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework, 2nd ed, p 69	July 2022
Men can genuinely be victims; 40–50% of male victims experience violence from a male perpetrator; 15–50% figure and its sources; "nice guy" effect; instruction to be cautious and keep an open mind; indicator list	ACT DFV Risk Assessment and Management Framework, Fact Sheet 9, extract from Vlais (2018) *Guidelines for identifying and responding to people who cause family violence harm*, North West Metropolitan Region Primary Care Partnerships, pp 10–11; list adapted from *Towards Safer Families*, pp 194–197	July 2022

Claim	Source	Date
Eight of 13 deceased victims misidentified; timing; examples; consequences including charges, employment loss, child removal and incarceration; effect on help-seeking; Aboriginal and Torres Strait Islander vulnerability; perpetrator manipulation of systems	ACT DFV Review Biennial Report 2025, Theme 1	2025
11 of 13 deceased victims female	ACT DFV Review Biennial Report 2025	2025
A survivor's knowledge of their own risk is central to any risk assessment	ANROWS National Risk Assessment Principles	2018
Dual injustice of over-policing and under-protection; trauma responses read as non-cooperation; the "called police 47 times… vexatious" account; risk that a new offence increases misidentification	Submission 022, Sisters in Spirit Aboriginal Corporation and Women's Health Matters, Inquiry into the Crimes (Coercive Control) Amendment Bill 2026, ACT Legislative Assembly Standing Committee on Legal Affairs	Authorised for publication 5 August 2026

Chapter 10 — The measurement gap: who the system cannot count

In one page

The ACT's domestic and family violence system cannot say who it reaches. It cannot say what happens to them.

It cannot report service access, unmet demand or outcomes in any consistent way. It cannot break those figures down by sex or gender identity. It cannot break them down by victim or perpetrator status, relationship type, disability, Aboriginal and Torres Strait Islander identity or cultural background. No public dataset exists that would allow it.

That is the finding of this chapter. It is a governance finding before it is anything else. A system that cannot disaggregate cannot detect unequal treatment. It cannot show equal treatment. It cannot allocate according to measured need.

One concrete example runs through the chapter. The Family Violence Safety Action Program is the Territory's multi-agency mechanism for coordinating responses in high-risk cases. Across three financial years, its referrals recorded 4, 5 and 6 male victim-survivors. Those years had 258, 258 and 211 referrals respectively. In the same three years it recorded 254, 252 and 210 male people using violence.

National population data does not look like that. The Australian Bureau of Statistics measured violence or emotional or economic abuse by a cohabiting partner since the age of 15. It found that 27 per cent of women and 15 per cent of men have experienced it. A national survey published in the *Medical Journal of Australia* measured lifetime intimate partner violence. It found that violence was reported by 48.4 per cent of women and 40.4 per cent of men.

That is a very large difference between the population data and the program data. It has several possible explanations. Some of them are entirely legitimate. This chapter sets out all of them. It does not assert bias. The data that would establish or refute bias has not been collected.

Which is the point. The ACT has operated this system for a decade without the information needed to answer the question.

The chapter also examines who the system is designed for. The 2026 Strategy adopts one causal account — violence driven by gender inequality, on the four gendered drivers set out by Our Watch — and treats other well-evidenced contributors as reinforcing factors. The prevalence evidence supporting a gendered focus is accepted here, and the finding is narrower: male victim-survivors, women who use violence, and same-sex and bidirectional violence have no dedicated pathway or operational model, and the ACT cannot tell what difference that makes because it does not collect the data.

One number, one quote, one action

Number: Across three financial years the Family Violence Safety Action Program recorded 4, 5 and 6 male victim-survivors, in 258, 258 and 211 referrals.

Quote: "people who use violence" — ACT DFSV Strategy 2026–2036, 27 May 2026, the term the Strategy prefers to "men"

This week: Ask every funded service for one figure: the number of clients recorded in 2025–26 as male victim-survivors, counted separately from men seeking help about their own use of violence. Publish the answers as a single table, with the counting rule each service used. The 2021 answer to the Assembly could not separate those two groups.

1. What the ACT can and cannot report

1.1 The test

A mature service system should be able to answer, for any year:

- how many people sought help, by sex, gender identity, age, disability, Aboriginal and Torres Strait Islander identity, cultural background and relationship type;
- how many received a service, and which service;
- how many did not, and why;
- how long they waited;
- what changed for them;
- what it cost;
- and how each of those figures compares to the previous year.

1.2 What the ACT can answer

Some of the first item, for some services, for some years.

The ACT publishes service volumes in annual reports. Individual programs publish participant numbers in evaluations. The Human Rights Commission publishes referral numbers for the multi-agency program. They appear in its annual report.

1.3 What the ACT cannot answer

Everything else.

The public record contains no dataset showing service access and outcomes. No dataset breaks them down by sex, gender identity and victim or perpetrator status. The Auditor-General found that public reporting did not allow the levy's contribution to system outcomes to be assessed. It found that reporting was not comparable or consistent over time. It found that performance was often reported as a series of highlights.

The First Action Plan commits to system mapping, client journey mapping and a monitoring and evaluation framework as future work. Those commitments are an accurate description of what does not currently exist.

2. The one place with figures: the multi-agency program

2.1 What the program is

The Family Violence Safety Action Program is the ACT's multi-agency response to high-risk family violence cases. It brings agencies together around individual cases. They share information and agree actions. It began operating in the 2022–23 financial year.

It is important to be precise about what it is. That determines what its data means. It is **not** a general help service that people walk into. It is a coordination mechanism. Police and other agencies refer cases to it, once those cases have been identified as high risk.

Its composition therefore reflects the referral pipeline, not the population.

2.2 The figures

The ACT Human Rights Commission released referral data in a freedom of information decision dated 4 November 2025. That decision was marked for release on the Commission's open access register. Referral totals also appear in the Commission's 2024–25 annual report.

Referrals received, by financial year

Year	Referrals
2024–25	258
2023–24	258
2022–23	211

Victim-survivor gender identity of referrals

Year	Female	Male	Unknown	Non-binary
2024–25	254	4	0	0
2023–24	248	5	4	1
2022–23	205	6	0	0

Gender identity of the person using violence

Year	Female	Male	Unknown	Non-binary
2024–25	4	254	0	0
2023–24	3	252	3	0
2022–23	1	210	0	0

Across three years, 727 referrals recorded 15 male victim-survivors and one non-binary victim-survivor.

2.3 What this data is good for

Three things should be said in the program's favour before anything else.

It records gender identity at all, including a non-binary category. Most ACT service data does not.

It was released. The figures are public and on an open access register. That is more than can be said for most ACT service data.

It is internally consistent. The victim and perpetrator tables are close to mirror images. That is what you would expect. The program codes each case with one victim and one person using violence.

3. The benchmarks

3.1 Australian Bureau of Statistics, Personal Safety Survey 2021–22

The ABS survey is the standard national measure. Its cohabiting partner figures, for experience since the age of 15, are:

Measure	Women	Men
Violence (physical and/or sexual) by a cohabiting partner	17% (1.7 million)	5.5% (526,600)
Violence by an intimate partner	23% (2.3 million)	7.3% (692,600)
Emotional abuse by a cohabiting partner	23% (2.3 million)	14% (1.3 million)
Economic abuse by a cohabiting partner	16% (1.6 million)	7.8% (745,000)
Any violence or emotional or economic abuse by a cohabiting partner	27% (2.7 million)	15% (1.5 million)

Expressed as men's share of the people counted:

- physical and/or sexual violence by a cohabiting partner: about **24 per cent**;
- any violence or emotional or economic abuse by a cohabiting partner: about **36 per cent**;
- emotional abuse: about **36 per cent**;
- economic abuse: about **32 per cent**.

3.2 Mathews and others, *Medical Journal of Australia*, 2025

A national survey covered 8,503 people aged 16 and over. Of those, 7,022 had been in an intimate relationship. Using a validated abuse scale, it found lifetime prevalence of any intimate partner violence:

- **women: 48.4 per cent** (95% confidence interval 46.3–50.4);
- **men: 40.4 per cent** (95% CI 38.3–42.5);
- **overall: 44.8 per cent**;
- **people of diverse genders: 69 per cent** (62 of 88 participants);
- **non-heterosexual people: 70.2 per cent**, against **43.1 per cent** for heterosexual people.

Multitype intimate partner violence means experiencing more than one form. On that measure, the figures were **33.7 per cent of women** and **22.7 per cent of men**.

3.3 What the benchmarks do and do not establish

This is where care is required. These figures are routinely over-read in both directions.

What they establish. A substantial proportion of Australian men experience intimate partner violence. On the broader measures, men are roughly a third of the people counted. On the narrower physical and sexual violence measures, roughly a quarter. Non-heterosexual people and people of diverse genders report much higher rates than the general population.

What they do not establish.

They are not measures of severity. Both sources show women reporting more severe patterns. The ABS gap is much wider for physical and sexual violence than for emotional abuse. Mathews and others found significantly more women than men reporting each type of violence. They also found significantly more women than men reporting multitype violence.

They are not measures of fear, injury or coercive control. The ABS separately measures fear and injury. Those gaps are wider still. Lifetime prevalence of an experience is not the same as a pattern of domination.

They are not measures of who needs a crisis service. Prevalence over a lifetime and current need for an emergency response are different quantities.

They are not lethality. The ACT's own fatality data is overwhelmingly gendered. In the 2025 death review, 24 of 25 people identified as perpetrators were male. Of those identified as victims, 11 of 13 were female. Every male perpetrator targeted a female victim.

The correct statement is therefore this. Population surveys show a substantial male share of people experiencing intimate partner violence on broad measures. They show a smaller share on narrower and more severe measures. They show a very small share among people who die.

That is a real distribution. It is neither "domestic violence is gender-symmetric" nor "domestic violence happens to women".

4. The gap, and the five explanations

4.1 The gap

The multi-agency program recorded male victim-survivors at roughly 2 per cent of referrals. The population benchmarks put the male share of people experiencing partner violence or abuse somewhere between about 24 and 45 per cent. That range depends on the measure.

Even taking the narrowest population measure and the most conservative reading, the difference is an order of magnitude.

4.2 Five explanations

There are at least five explanations for a gap of that size. Several are legitimate. All of them are testable. None has been tested.

Explanation 1 — the program is a high-risk program, and high risk is more gendered than prevalence.

This is the strongest explanation and it should be stated first. The program deals with the most dangerous cases. The ACT's fatality data is overwhelmingly gendered. Suppose the program is correctly identifying the highest-risk cases. A heavily female victim profile is then what you would expect.

How to test it: compare the program's profile against the profile of all matters at the point of police attendance. Compare it also against the profile of cases assessed at each risk level. If the gendering increases as risk increases, the explanation holds.

Explanation 2 — differential help-seeking.

Men are less likely to disclose intimate partner violence. They are less likely to identify it as violence. They are less likely to contact services. This is well established internationally.

How to test it: survey non-attenders. Or compare two services: one that screens all clients uniformly, and one that does not. Compare their disclosure rates.

Explanation 3 — referral pipeline composition.

The program receives referrals largely from police and other agencies. The upstream identification may itself be gendered. Chapters 8 and 9 discuss the reasons. They include screening designed around asking all women, and primary aggressor guidance with sex-specific indicators. If the upstream identification is gendered, the program's composition reflects that upstream design.

How to test it: measure the sex composition at each stage of the pipeline. The stages are these. Incidents attended. People identified as the person most in need of protection. Risk assessments completed. Referrals made. Referrals accepted.

Explanation 4 — eligibility, awareness and service fit.

Male victim-survivors may be less aware of the program. They may be less likely to be told about it. They may be less likely to be referred, because a suitable service placement is not available. If any of that holds, the referral rate falls independently of need.

How to test it: audit referral decisions. And measure awareness.

Explanation 5 — misclassification.

Sometimes a man experiencing violence is classified as the person using violence. He then appears in the perpetrator column rather than the victim column. Chapter 9 established that misidentification occurs in the ACT. It also established that its rate has never been measured, in either direction.

How to test it: the validation study set out in Chapter 9 and Chapter 15.

4.3 What follows

Every one of those five is testable with data the ACT could collect. None has been tested.

A responsible reader cannot conclude from the referral figures that the ACT discriminates against male victims. A responsible government cannot conclude from them that it does not.

That is the finding. **The ACT has operated a high-risk coordination program for four years. It has done so without the information required to know whether it reaches the people who need it.**

5. Funding visibility by cohort

5.1 What the budget record shows

The 2026–27 package identifies:

- **$21.4 million** for critical victim-survivor services across three named providers;
- **$4.1 million** for children and young people;
- **$7.5 million** for marginalised groups, including **$2.1 million** for multicultural women, children and young people, **$2.1 million** for Aboriginal community-controlled sexual violence responses, and **$1 million** for an LGBTIQA+ program;
- **$6.7 million** for men's behaviour change work, split between two providers.

5.2 The pattern

The budget record's explicitly male-targeted funding goes to **men who use or are at risk of using violence**. Those are behaviour change programs.

The collected budget documents do not disclose a clearly labelled, separately costed **male victim** domestic and family violence service line.

5.3 What that does and does not mean

It does **not** mean no man receives a service. Three things are established on the record:

- the crisis service is described as gender-inclusive;
- the sexual assault service operates an embedded service specifically for male survivors of sexual assault;
- universal services and generalist services see male clients and spend money on them.

An official answer in 2021 stated that the crisis service was gender-inclusive. It had supported 326 male-identified clients in 2020–21.

But the same answer disclosed a measurement problem. Within that figure, the government could not separate two groups. One group was people receiving support as victims. The other was men seeking help about their own use of violence. And it did not hold the requested historical male-victim service data.

So the position is this. A service line exists in practice, delivered through inclusive general services. It is not separately identified, separately costed, or separately reported. And the one figure that was produced could not distinguish victims from people seeking help about their own behaviour.

5.4 Why separate visibility matters

There is a reasonable argument against creating a separately costed male victim line. Universal, inclusive services are often better than parallel systems. Separating funding by cohort can fragment services and create thresholds.

That argument is about service design. The visibility question is different, and that argument does not answer it.

Without separate identification, four things are unknowable:

- how much is spent;
- how many people are reached;
- whether demand is met; and
- what outcomes are achieved.

Compare the treatment of the LGBTIQA+ cohort. A $1 million program is separately identified and separately costed. That makes the investment visible and, in principle, evaluable. The same is true of the Aboriginal community-controlled and multicultural lines.

The point is not that men should have a program because other groups do. It is that the ACT has shown it can identify and cost cohort-specific investment when it chooses to. Where it does not, the information disappears.

6. The cohorts the system cannot see

The measurement gap is not confined to sex. It applies to every group for which disaggregated data would matter.

6.1 Gender-diverse people

The multi-agency program recorded one non-binary victim-survivor across three years and 727 referrals.

The national survey found 69 per cent of people of diverse genders reported intimate partner violence. That was the highest rate of any group measured. It came from a small sample of 88 participants, so the estimate is imprecise.

The ACT now funds a $1 million LGBTIQA+ program. Routine service data still does not consistently identify transgender, non-binary or diverse-sex clients.

6.2 Aboriginal and Torres Strait Islander people

The 2025 death review could not report the number of Aboriginal or Torres Strait Islander victims among the 13. The number was below five, and suppression rules applied.

The review stated expressly that legislative and system constraints result in particularly limited information. That applies to Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, people with disability and LGBTIQA+ populations.

The review also found that Aboriginal and Torres Strait Islander women are particularly vulnerable to misidentification. They are particularly vulnerable to its consequences.

So one group is identified as most vulnerable to the system's most consequential error. It is also one of the groups about which the least can be reported.

6.3 People with disability

The 2025 death review recorded **none** of the 13 deceased victims as a person with disability.

That should be read carefully. It may be accurate. It may also reflect the review's stated constraint on information about people with disability. A zero in a dataset with acknowledged information limitations is not a measurement of zero.

Section 39 of the *Family Violence Act* requires a court to consider any disability the protected people have. It must consider that as a primary factor before imposing an exclusion condition. If disability is not reliably recorded, that consideration cannot be evidenced.

6.4 Culturally and linguistically diverse communities

Six of 13 deceased victims in the 2025 review were from culturally and linguistically diverse backgrounds. That is a high proportion in a group that small.

The 2023 review found that these victims face distinct barriers. It recommended community education designed with specialist services. The 2024 crisis services review identified service coverage gaps. They affect recent migrants, people with limited English and people on limited-stay visas.

No public data reports reach, waiting times or outcomes by language or community.

6.5 Children

Sixty-seven children were affected by the 38 deaths reviewed in 2025.

The Strategy recognises children as victims in their own right. Programs are funded. There is no population-level series showing outcomes for children affected by family violence in the ACT.

7. Three kinds of possible bias

This territory is contested. It is worth separating the three things that "bias" can mean here. Each is a different claim requiring different evidence.

7.1 Allocative bias

The claim: money is not distributed in proportion to need.

What would establish it: measured need by cohort. Measured spend by cohort. And a comparison.

What exists: partial spend data, no need data by cohort.

Status: cannot be tested.

7.2 Measurement bias

The claim: some groups become invisible because of how data is collected and reported.

What would establish it: an examination of the data architecture.

What exists: enough to reach a conclusion.

Status: established. Male victims disappear inside universal service totals. Male-specific budget lines are visible mainly as perpetrator programs. Gender-diverse people are not consistently recorded. Cohorts below five are suppressed. Screening is designed around one group. The 2021 official answer could not separate male victims from men seeking help about their own violence.

This is the one finding of the three that the evidence supports. It does not require anyone to have intended it. Measurement bias is a property of a data system, not of a person.

7.3 Assessment bias

The claim: the instruments used to classify people produce systematically different error rates for different groups.

What would establish it: validation results with error analysis by cohort.

What exists: none.

Status: cannot be tested. Chapter 9 sets out what would be required.

7.4 The formulation the evidence supports

> The ACT system has a justified gender-responsive core, supported by its own fatality evidence. Its funding transparency, its routine data and some of its risk assessment guidance nonetheless create a systemic possibility of unequal treatment that has never been measured and has not been ruled out.

That formulation is defensible on the record. Anything stronger is not.

8. Who the system is designed for

The preceding sections are about data. This one is about design. The two are connected: a system collects the data its model of the problem tells it to collect.

8.1 What the prevalence evidence shows

Intimate partner and sexual violence in Australia are not evenly distributed by sex, and nothing in this chapter suggests otherwise.

Measured since the age of 15, the Australian Bureau of Statistics found physical or sexual violence by a cohabiting partner reported by 17 per cent of women and 5.5 per cent of men. Violence or emotional or economic abuse by a cohabiting partner was reported by 27 per cent of women and 15 per cent of men. Sexual violence by any perpetrator was reported by 22 per cent of women and 6.1 per cent of men. Sexual violence against women is overwhelmingly male-perpetrated: 22 per cent of women reported sexual violence by a male perpetrator, against 0.7 per cent by a female perpetrator.

Police and homicide data point the same way. Recorded family and domestic violence offenders are predominantly male. Intimate partner homicide of women is substantially more common than of men, although men are a large share of family homicide victims, more often killed by a son or another family member than by a female partner.

The ACT's own fatality record is consistent with all of that: 24 of 25 people identified as perpetrators were male, and 11 of 13 identified as victims were female.

So the Territory is not inventing a pattern when it says that violence against women is the dominant form of partner and sexual violence, and that most of it is used by men. That much is settled, and is accepted here.

8.2 The causal model the Strategy adopts

What is less settled is why.

The 2026 Strategy adopts one causal account. It states that domestic, family and sexual violence is driven by gender inequality, and reproduces the four gendered drivers set out by Our Watch: condoning of violence against women; men's control of decision-making; rigid gender stereotypes and dominant masculinities; and male peer cultures of aggression and control. Prevention is defined accordingly, as work to change gender inequality. The Strategy sits under the National Plan to End Violence against Women and Children.

Other well-evidenced contributors — childhood trauma, alcohol and other drug use, mental illness, poverty and financial stress, jealousy, situational conflict, and bidirectional abuse in some relationships — appear in the Strategy as reinforcing factors rather than as co-equal causes.

That is a theory of change. It is a defensible one and it is the national orthodoxy. The observation here is narrower: it is held as settled rather than as the leading hypothesis, and a system that treats its causal model as settled does not build the data that could test it. Chapter 8 makes the same criticism of the risk framework in different terms. An instrument that cannot be wrong cannot be improved.

8.3 Inclusion is in the language; the architecture is elsewhere

The Strategy is more careful in its language than earlier documents of this kind. It defines "victim-survivor" as including all genders and including children. It prefers "people who use violence" to "men". Outcome 3 is written in gender-neutral terms. Outcome 4 includes work with men and boys on healthy masculinities. Services for men are listed. Intimate partner violence among LGBTIQA+ people is named, with a lifetime rate of 61 per cent cited in the release accompanying the Strategy.

The test is not the language. It is which groups receive an outcome of their own, a service logic and a pathway through the justice system.

Group	In the problem analysis	In the outcomes machinery
Women victim-survivors	Central	Outcome 1 is built around them
Children	Strong	Explicit within Outcome 1
Aboriginal and Torres Strait Islander women and communities	Strong	The whole of Outcome 2
Men who use violence	Strong	The whole of Outcome 3
Men and boys as a prevention audience	Moderate	Outcome 4
Male victim-survivors	Almost absent	No dedicated pathway
Women who use violence	Almost absent	Folded into "people who use violence"
Same-sex and other LGBTIQA+ partner violence	Named	No operational model

Male victims are not a rounding error in the same national dataset the Strategy relies on. Since the age of 15, about 1.5 million Australian men have experienced violence or emotional or economic abuse by a cohabiting partner, and about 582,400 have experienced sexual violence. Men are also a substantial minority of family and domestic violence hospitalisations.

This matters operationally rather than rhetorically. A male victim-survivor already faces higher stigma and fewer specialist services. He may also be recorded as the person using violence. That is the same failure the death review documents for the women it examined, and identifies as a particular risk for Aboriginal and Torres Strait Islander women. The Strategy does not use the word misidentification at all. Whether it happens more often to men, less often, or at the same rate is not known, because the rate has never been measured in any direction. The failure has one mechanism. The system is built to guard against it in one direction.

8.4 Two honest readings

Reading A — gendered, not biased. A strategy should follow where serious harm concentrates. Partner sexual violence, coercive control and intimate partner homicide of women are heavily male-perpetrated. Building the system around women, with particular attention to Aboriginal and Torres Strait Islander women, children, people with disability and LGBTIQA+ people, is a rationing decision under finite resources. It is not a denial that men can be victims.

Reading B — biased in the policy sense. If the Territory's police, court, housing and child protection settings operate on an assumption that the woman is the victim and the man is the person using violence, then male victims will be under-served, use

of violence by women will be under-detected, bidirectional and same-sex violence will be forced into a heterosexual template, and prevention aimed only at dominant masculinity will miss other pathways into harm.

Both readings are available on the same evidence. The Strategy's own language — "all genders", "people who use violence" — concedes that Reading B describes a real risk. Its outcomes and its national alignment operationalise Reading A.

The ACT cannot currently tell which reading is closer to the truth in its own jurisdiction, because the disaggregated data described in section 1 of this chapter does not exist. That is the finding. It is not a claim that the Territory has chosen wrongly.

8.5 What follows

The remedy is not to weaken the gendered analysis. The sex difference in serious partner and sexual violence is real, and a system that ignored it would be worse.

The remedy is to add what is missing beside it: an explicit workstream covering male victim-survivors, women who use violence, and bidirectional and same-sex violence, with three components.

A service pathway. A defined route to specialist support for a victim-survivor of any sex, stated in the same terms as the pathway for the modal case, so that a service can be held to it.

A classification safeguard that runs in both directions. The evidence and pattern method in Chapter 15 and Appendix A applies to any person and permits the answer "unresolved". The misidentification measure recommended at section 9 below is reported by sex, so that error in either direction becomes visible.

Data that can see these cases. Service, police and court records that record sex, gender identity, relationship type and the direction of violence, so that the question in section 8.4 can be answered in five years rather than argued about.

None of the three requires the Strategy's central commitment to be diluted. Each of them is a condition of knowing whether that commitment is working.

9. What would need to be collected

The recommendation in Part III is a privacy-preserving linked data asset. Its content is specified here so the proposal is concrete.

For every person who has contact with the system, recorded at each contact:

Field	Why
Sex and gender identity, recorded separately	The two are different variables and are currently conflated
Victim, person using violence, or dual status	Dual status is common and currently forced into one of two boxes
Whether the classification was later changed, and when	The only way to measure misidentification
Relationship type	Intimate partner, parent, adult child, sibling, other family — the 2023 review recommended distinguishing these
Aboriginal and Torres Strait Islander identity	Self-identified, with community governance over use
Disability	Required by section 39 of the Act

Field	Why
Cultural and linguistic background, and language	Required to measure the barriers both reviews identified
Service sought, service received, service declined and reason	The only way to measure unmet demand
Wait time from first contact	The measure absent from every ACT report
Risk level assessed, by whom, using which instrument	Required for any validation
Decisions made: charge, order, condition, referral	Required to link assessment to consequence
Outcomes at 3, 12 and 24 months	Required for any statement about effectiveness
Cost of the service provided	Required for any statement about value

9.1 The governance conditions

This dataset would be sensitive. Four conditions should apply.

Community governance. Aboriginal and Torres Strait Islander data should be governed under Indigenous data sovereignty arrangements. Communities should control access and use.

Strict access control. Access by named role, purpose-limited, audited, with penalties for misuse.

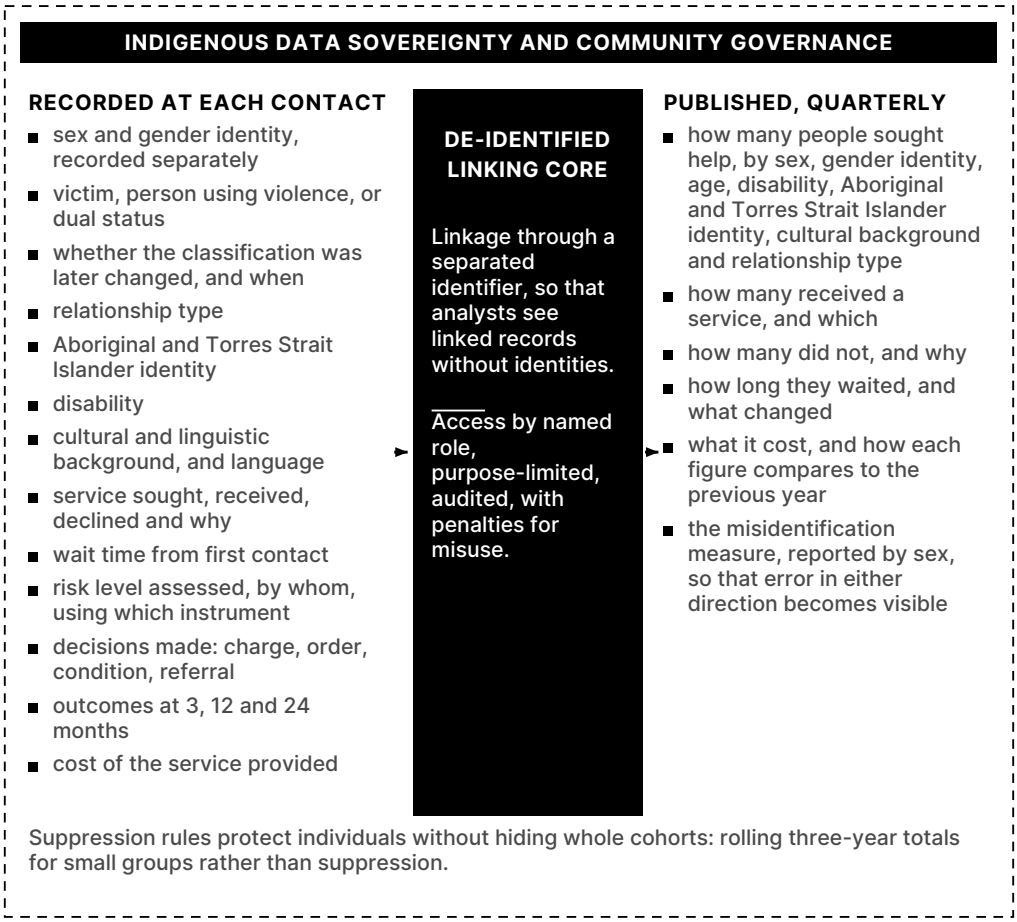
Privacy-preserving linkage. Linkage through a separated identifier, so that analysts see linked records without identities.

Published aggregate reporting. The purpose of collecting it is to publish it. Aggregate reporting should be quarterly. Suppression rules should protect individuals without hiding whole cohorts. For example, they could report rolling three-year totals for small groups rather than suppressing them entirely.

FIGURE 10.1

What would need to be collected

A privacy-preserving linked data asset: the fields, the controls that would have to sit around them, and what it would let the Territory publish.



The alternative is what the Territory has now: $151.4 million of direct investment over four years, with no capacity to say who it reached or what changed.

Four conditions apply: community governance of Aboriginal and Torres Strait Islander data; strict, audited, purpose-limited access; privacy-preserving linkage through a separated identifier; and published aggregate reporting.

Chapter 10, section 9. Section 39 of the Act reaches the disability field only.

9.2 The cost objection

The obvious objection is cost. Three responses.

First, most of these fields are already collected somewhere. The work is linkage and definition, not new collection.

Second, the First Action Plan already commits to system mapping, client journey mapping and a monitoring and evaluation framework. This is the data layer those commitments require.

Third, the alternative is what the Territory has now. That is $151.4 million of direct investment over four years. It comes with no capacity to say who it reached or what changed.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. The complete set of 16 is at Appendix M, where it can be read against every other chapter's.

- **F10.1** — The ACT has no public dataset showing service access, unmet demand or outcomes by sex, gender identity, victim or perpetrator status, relationship type, disability, Aboriginal and Torres Strait Islander identity or cultural background.
- **F10.2** — The Family Violence Safety Action Program recorded 4, 5 and 6 male victim-survivors across 258, 258 and 211 referrals in 2024–25, 2023–24 and 2022–23, and one non-binary victim-survivor across all three years.
- **F10.12** — Of the three kinds of possible bias, only measurement bias is established on the evidence. Allocative bias and assessment bias cannot be tested, because the required data does not exist.
- **F10.15** — Women victim-survivors, children, Aboriginal and Torres Strait Islander women and communities, men who use violence, and men and boys as a prevention audience each hold a place in the outcomes machinery, while male victim-survivors have no dedicated pathway, women who use violence are folded into "people who use violence", and same-sex and other LGBTIQA+ partner violence is named without an operational model.

Sources for this chapter

Claim	Source	Date
Referral totals and victim and perpetrator gender identity by year; program commenced 2022–23	ACT Human Rights Commission freedom of information decision, marked for release on the open access register; referral totals also at page 60 of the Commission's 2024–25 annual report	4 November 2025

Claim	Source	Date
ABS partner violence and abuse figures since age 15, by sex, with estimated numbers	ABS, *Personal Safety, Australia*, 2021–22, "Partner violence" and "Partner emotional abuse" summary tables	Released 15 March 2023; verified against the ABS release 3 September 2026
Lifetime intimate partner violence 48.4% of women and 40.4% of men; 44.8% overall; 69% of people of diverse genders; 70.2% of non-heterosexual people; multitype 33.7% and 22.7%; n=8,503 with 7,022 ever in a relationship	Mathews B and others, "The prevalence of intimate partner violence in Australia: a national survey", *Medical Journal of Australia*	2025
ACT prevalence: 42% of women experienced violence since 15; 26% by a cohabiting partner	ABS Personal Safety Survey 2021–22, ACT statistics, as cited in the ACT crisis services review	2024
No performance monitoring strategy or evaluation framework; reporting not comparable or consistent; performance reported as highlights	ACT Auditor-General, Report 10 of 2024	22 November 2024
Crisis service gender-inclusive; 326 male-identified clients in 2020–21; victims not separable from men seeking help about their own violence; historical male-victim data not held	ACT Government answer to a Legislative Assembly question	2021
2026–27 cohort funding lines	2026–27 Budget DFSV factsheet	2026
Limited information for Aboriginal and Torres Strait Islander peoples, CALD communities, people with disability and LGBTIQA+ populations; suppression below five; no deceased victim recorded as a person with disability; 6 of 13 victims CALD; Aboriginal and Torres Strait Islander women particularly vulnerable to misidentification; 67 children affected; 24 of 25 perpetrators male and 11 of 13 victims female; every male perpetrator had a female victim	ACT DFV Review Biennial Report 2025	2025
Service coverage gaps for recent migrants, people with limited English and people on limited-stay visas; embedded male survivor sexual assault service	ACT DFSV Crisis Specialist Services Review Summary	May 2024
Section 39 requires disability of protected people to be considered as a primary factor	*Family Violence Act 2016* (ACT)	Effective 1 July 2025
System mapping, client journey mapping and monitoring and evaluation framework as future work	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026
Prevalence since age 15: physical or sexual violence by a cohabiting partner 17% of women (1.7 million) and 5.5% of men (526,600); violence or emotional or economic abuse by a cohabiting partner 27% (2.7 million) and 15% (1.5 million); sexual violence 22% of women (2.2 million) and 6.1% of men (582,400); sexual violence against women 22% (2.2 million) by a male perpetrator against 0.7% (67,700) by a female perpetrator	ABS, *Personal Safety, Australia*, 2021–22, and ABS, *Sexual Violence*, 2021–22	Verified against both ABS releases, 3 September 2026. The ABS does not publish a perpetrator-sex breakdown for men's experience of sexual violence, on the ground that the estimates are not sufficiently reliable.

Claim	Source	Date
Four gendered drivers of violence against women; prevention defined as changing gender inequality; alignment to the National Plan; “victim-survivor” defined as including all genders and children; “people who use violence” preferred to “men”; Outcomes 1 to 4	ACT DFSV Strategy 2026–2036	27 May 2026
Lifetime intimate partner violence of 61 per cent cited for LGBTIQA+ people	Joint media release accompanying the ACT DFSV Strategy 2026–2036 and First Action Plan	27 May 2026

Chapter 11 — The blind spot: orders, suicide and the data never collected

> **A note on this chapter.** It discusses suicide in a statistical and policy context. Readers who find the subject difficult may prefer to read the summary and the findings list. Anyone affected by the issues in this chapter can contact Lifeline on 13 11 14, the Suicide Call Back Service on 1300 659 467, the ACT Domestic Violence Crisis Service on (02) 6280 0900, or 1800RESPECT on 1800 737 732.

In one page

Begin with the explanation that is most likely to be right. Orders are made in situations that are already dangerous. A high rate of orders among people who later die is exactly what would be expected if orders are being made where they are needed. That is the leading explanation for every figure in this chapter, and it may be the whole of it. Nothing in this chapter establishes that an order, a service event or a court process contributed to any death, and nothing in it should be read as making that claim.

With that stated, here is what the record holds. The ACT's own death review covers the years 2020 to 2024. It records that 9 of the 25 deceased people identified as perpetrators died by non-homicide means while they were the respondent to a **current** family violence order. Twenty of the 25 had been the respondent to an order at some point in their life. Twenty-nine of the 38 non-homicide deaths were suicides — 21 of the 25 accused of using violence, and 8 of the 13 assessed as victims. Twenty-four of the 25 were men. All 25 are within the 38 non-homicide deaths, so the nine necessarily died by non-homicide means. What the review has never published is whether those nine are among the 21 suicides or among the four other non-homicide deaths.

The word "perpetrator" is the review's classification from records, not a court finding, and Chapter 4 section 3.6 sets out what it rests on. What can be said safely is that 21 people took their own lives after being accused of using family violence, that most had been named as respondents to a civil order made on the balance of probabilities, and that for most of them no court determined whether the accusation was true.

Over 25 years, the register records 137 non-homicide deaths against 31 homicides.

The association may be explained entirely by the underlying danger. It may be partly explained by the acute stress of legal proceedings, which is well documented. It may be a mixture. Nobody knows.

Nobody knows because nobody has looked. Between November 2025 and April 2026, freedom of information applications sought the basic data needed to examine the question. Taken together, the answers are the finding of this chapter.

The **ACT Coroners Court** gave three confirmations. The ACT Suicide Register **does not have a field** identifying whether a deceased person was subject to a family violence order at the time of death. Order status may appear in the narrative of an

individual police report. And **there has been no internal review, audit, thematic analysis, research project or annual summary examining correlations between domestic violence proceedings and suicide outcomes**.

ACT Policing advised that it does not hold the requested figures in any document. Producing them would require an officer to review **every case where a suicide is recorded**. The officer would then have to note separately whether the person was a respondent to an interim or final order. ACT Policing refused on the basis that creating the document would substantially and unreasonably divert resources.

Requests were also made for the corresponding **court** data. Four items were sought: how many interim orders are made without the respondent present, the recorded gender of those respondents, how many are confirmed at final hearing, and how long an application to amend or revoke an interim order waits for its first listing. Those requests were refused. The stated basis was that court information is taken to be contrary to the public interest to disclose unless it is administrative in nature. Outcome data, on that view, is not administrative in nature.

So: the coroner does not record it, the police cannot query it, the court data was refused, and no agency has ever analysed it.

None of that is evidence of concealment, and none of it is treated as evidence of concealment here. A refused request is a refused request. A missing field is a missing field. Each of the three agencies' answers has an ordinary administrative explanation, and the freedom of information decisions are not said here to be legally wrong. What the answers together establish is narrower, and it is enough: the Territory has never built the means to ask this question of its own records.

The Territory holds 25 years of mortality data in this field. It has never asked this question of it.

One number, one quote, one action

Number: Nine people died by non-homicide means while they were the respondent to a current family violence order in the ACT between 2020 and 2024. Twenty-nine of the 38 non-homicide deaths in that period were suicides. No agency has ever examined the relationship.

Quote: "The ACT Suicide register does not have a field identifying whether a deceased person was subject to a Family Violence Order at the time of death... There has been no internal review, audit, thematic analysis, research project, or annual summary has examined correlations between domestic violence proceedings and suicide outcomes." — ACT Coroners Court advice, provided through the Justice and Community Safety Directorate, 26 March 2026

This week: The ACT Coroners Court adds one field to the Suicide Register recording whether the deceased was subject to a family violence order at the time of death, and states the date from which it will be populated. It is a schema change and a data entry step.

1. What the record shows

1.1 The figures

From the 2025 biennial death review, for 1 January 2020 to 31 December 2024:

Of the 25 deceased people identified as perpetrators:

- **20** had been the respondent to one or more family violence orders at some time in their life;
- **9** were respondents to a **current** family violence order at the time of their death;
- **5** had previously contravened an order;
- **9** had been the respondent to one or more personal protection orders;
- **4** had been the respondent to an order three or more times;
- **8** died in the context of a pending or recent separation from an intimate partner, within three months;
- **22** had been involved with police at some point in their life, and **6** had police involvement **within a week** of their death.

Of the 13 deceased people identified as victims:

- **3** were the protected person on a current order at the time of death;
- **9** had previously been the protected person on at least one order;
- **4** had been the **respondent** to an order where there is evidence the applicant was the predominant aggressor.

> **What the 2020–24 cohort is, and is not.** The 38 non-homicide deaths are not a census and not a sample. A death enters the register only when an agency identifies it as occurring in a domestic and family violence context. "Perpetrator" and "victim" are the review's own classifications from records, not court findings, and where a person was misclassified while alive the classification can inherit the error. Of the 11 homicides in the period, 10 were before the courts or the coroner, so in-depth analysis of the homicides was not possible and the 38 are what remains after the most fully investigated deaths were set aside. Thirteen and 25 are small numbers, and the proportions within them are not rates in any wider population. Chapter 4 section 1.2 sets this out in full.

Overall: 29 of the 38 non-homicide deaths were suicides: 21 of the 25 accused of using violence and eight of the 13 assessed as victims. Over 2000 to 2024 the register records 168 fatal incidents: 31 homicides and 137 non-homicide deaths.

1.2 The obvious question

Orders appear throughout the fatality record. Nine of the 25 died while under a current order over five years, in a jurisdiction of roughly 470,000 people. On 25 cases, no rate can be calculated and none is offered.

The question that follows is not "do orders cause deaths". It is the ordinary question any system asks about its own operations:

What is the relationship between our most coercive civil process and the deaths of the people it is applied to, and is there anything in how we run it that could reduce harm without reducing protection?

That question has four possible answers, and they are not mutually exclusive:

1. **Confounding.** Orders are made because danger is present. The danger, not the order, explains the deaths. This is the default hypothesis and is likely to explain a substantial share.
2. **Acute stress.** Legal proceedings, sudden loss of home, separation from children, and the arrival of police at the door are acute stressors. The research literature consistently links justice system contact with deterioration in mental health.
3. **Missed opportunity.** Police had contact with 6 of the 25 people recorded as perpetrators within a week of death. Order service is a scheduled, known point of contact with a person in acute crisis, at which nothing is currently required to happen.
4. **Process design.** Some features of how orders are made and served may affect outcomes on their own. These include whether the person is notified, how much time they have, and what support is offered. Any such effect would be separate from the danger that prompted the order.

Answers 3 and 4 are the ones a government can act on. Answering any of them requires data.

2. What was asked, and what was answered

Between November 2025 and April 2026, a series of freedom of information applications sought the data needed to examine this question. The applications asked for de-identified, aggregated statistics. They expressly did not seek personal information or individual coronial files.

The responses are set out below in the order the agencies gave them.

2.1 ACT Policing

An application dated 20 January 2026 sought, for the three most recent complete years:

- the number of completed suicides where the deceased was, at the time of death, a respondent to an interim or a final family violence order;
- the number of attempted suicides or suicide-related incidents attended where the person was such a respondent;
- any internal statistical reports, briefing notes, dashboards or summaries analysing correlations between orders and suicide or attempted suicide outcomes; and
- confirmation of whether ACT Policing records, flags or tracks order status in any system, and if so the name of the system and the general nature of the data fields.

The decision was dated **19 February 2026** (reference LEX 5220). It recorded that the Family and Sexual Violence Criminal Investigations Team carried out the searches. It advised:

- ACT Policing **does not typically record suicide attempts** in its records management system and in many cases would not hold the information; it does not routinely attend suicide attempts unless exceptional circumstances exist;
- **no information exists** within ACT Policing in relation to the internal analysis request or the system-and-fields request;
- the AFP **does not hold a discrete document** containing the completed-suicide figures; and
- while the information is located in the records management system, **collating it would require an officer to review every case where a suicide is recorded and separately record whether the person was the respondent to an interim or final family violence order**.

The decision concluded that this would be time-consuming and prone to human error, requiring second and third checks. It found that creating the document would substantially and unreasonably divert AFP resources, and refused on that basis under section 24A, there being no existing document to release.

It recorded that the FOI team had spent approximately three hours processing the request. It recommended enquiries with the ACT Coroners Court.

2.2 The ACT Coroners Court and the Justice and Community Safety Directorate

An application dated 19 February 2026 sought from the Coroners Court:

- the number of completed suicides where the deceased was a respondent to an interim or final order;
- confirmation of whether the coronial case management system contains any structured data field, flag or recorded attribute identifying order status at the time of death;
- if not recorded in structured form, whether order involvement is commonly noted in investigative briefs or narrative summaries, and whether any internal review, audit, thematic analysis, research project or annual summary has examined correlations between domestic violence proceedings and suicide outcomes; and
- confirmation of whether the information is held elsewhere in ACT Government, or whether any cross-agency analysis has ever been undertaken.

The request was transferred to the Justice and Community Safety Directorate. Its response, dated **26 March 2026**, provided information from the Coroners Court in these terms:

> The ACT Suicide register does not have a field identifying whether a deceased person was subject to a Family Violence Order at the time of death.
>
> Where relevant to the circumstances of the death, the existence of a current or expired FVO may be disclosed in the individual narrative of a police report.
>
> There has been no internal review, audit, thematic analysis, research project, or annual summary has examined correlations between domestic violence proceedings and suicide outcomes.

It advised that the Coroners Court did not hold the statistical data sought. ACT Policing might hold additional information. The AFP is a federal agency, so the applicant would need to approach it directly.

The formal decision notice, reference JACS2026/3443, later refused to deal with two points of the request. Those points related to information in the possession of a court. Under Schedule 1 of the *Freedom of Information Act 2016* (ACT), such information is taken to be contrary to the public interest to disclose unless it is administrative in nature.

2.3 The court statistics

A separate application received on **27 November 2025** sought statistical information held by ACT Courts and Tribunal about interim family violence orders from 1 January 2023, specifically:

1. the total number of interim orders made in the absence of the respondent;
2. the recorded gender of those respondents;
3. for those orders, how many were confirmed as final orders at the conclusion of proceedings and how many were not confirmed — dismissed, withdrawn, revoked, lapsed or otherwise not made final; and
4. for applications under section 83 of the *Family Violence Act* to amend or revoke an interim order, the average number of days between filing and first listing, by calendar year.

The decision, reference JACS2026/496 and dated **2 February 2026**, refused to deal with the request. It relied on section 43(1)(e) of the *Freedom of Information Act 2016* (ACT). The stated basis was that the request sought court information taken by Schedule 1 to be contrary to the public interest to disclose.

The decision explained the meaning of "administrative in nature". The ACT Ombudsman's guidelines take it to mean documents relating to the management and administration of registry and office resources. The decision cited the High Court's interpretation in *Kline v Official Secretary to the Governor General*. It concluded:

> It requests information regarding material Court outcomes, not information regarding the management of Court resources.

2.4 Review

Applications for external review of several of these decisions went to the ACT Ombudsman. The Commonwealth decisions went to the Office of the Australian Information Commissioner. Several Ombudsman applications resulted in decisions not to review.

3. What those answers establish

Read together, the answers establish seven things. Each is a statement about what is recorded and what has been examined. None of them is a statement about why.

1. The information required to answer the question is not held in structured form anywhere.

The coronial register has no field. The police system has no queryable flag. The court data is not released.

2. The information exists in narrative form.

The Coroners Court confirmed that order status "may be disclosed in the individual narrative of a police report" where relevant. ACT Policing confirmed the information "is located in" its records management system, but only case by case.

So the facts are recorded. They are simply not recorded in a form anyone can count.

3. No agency has ever analysed the relationship.

The Coroners Court's answer is unqualified: no internal review, audit, thematic analysis, research project or annual summary has examined correlations between domestic violence proceedings and suicide outcomes.

That is a statement about 25 years of records.

4. The reason given for not producing the police figures is the absence of a field.

The refusal was not that the question is improper, or that the data is sensitive, or that the analysis would be misleading. It was that answering would require reviewing every recorded suicide case one at a time.

That is precisely the consequence of not having a field. The refusal describes the problem.

4a. The court used to publish some of this, and stopped.

The refusal of the court statistics is not the whole picture, and the rest of it is on the public record.

The ACT Magistrates Court published Protection Unit statistics in its annual reviews: applications for final family violence orders, and the number of applications that included an application for an interim order, year by year. The 2019–20 review reports 1,249 family violence order applications, of which 1,152 included an interim application.

The ACT Courts annual reviews page, as at 2 September 2026, lists Supreme Court annual reviews for every year to 2024–25. It lists Magistrates Court annual reviews to 2019–20 and no later. Five Supreme Court reviews have been published in a period in which no Magistrates Court review has.

So the court that determines family violence order applications produced and published these counts annually, in a settled format, until 2019–20. The figures were not novel, and generating them was not burdensome enough to prevent five consecutive years of publication.

What that establishes is narrow and it is not an allegation. A publication practice lapsed. Nothing in the record explains why, and nothing here infers a reason. But it changes what Chapter 16 Reform 5 is asking for. It is not a request to build a capability. It is a request to resume a practice the court itself maintained for five years.

5. Court outcome data is treated as outside the freedom of information regime.

The refusal of the court statistics rests on a construction of "administrative in nature". That construction confines the term to the management of registry and office resources. On that construction, three things fall outside the Act: the number of interim orders made without notice, the gender of respondents, and the proportion confirmed at final hearing.

No argument is made here that the decision was legally wrong. The construction follows the Ombudsman's guidelines and High Court authority.

It observes the consequence. Several Australian jurisdictions publish aggregate, de-identified administrative counts of what a court does as a matter of course. On this construction, that data is not obtainable under the ACT's freedom of information legislation. If it is to be published here, the courts must publish it voluntarily, or another instrument must require it.

6. The Territory has the raw material.

Twenty-five years of records. A register of 168 fatal incidents. A death review function with statutory access. A records management system that contains the information case by case. Coronial files that contain police narratives.

Everything needed to answer the question exists. What is missing is a field, a query and a decision to look.

4. The duty framework

The absence is not merely an information management failure. It sits inside an existing legal duty.

4.1 The primary duty of care

The *Work Health and Safety Act 2011* (ACT) applies to a person conducting a business or undertaking. It requires that person to ensure, so far as is reasonably practicable, that the health and safety of **other persons** is not put at risk from work carried out as part of the undertaking.

"Health" is defined in the Act to include **psychological** health.

The administration of the family violence order system is work carried out as part of an undertaking. The people to whom orders are applied are other persons.

4.2 What "reasonably practicable" means

The test weighs several matters. They are the likelihood of the hazard occurring, the degree of harm, what the person knows or ought reasonably to know about the hazard and about ways of eliminating or minimising it, the availability and suitability of those ways, and the cost. Cost is relevant only where it is grossly disproportionate to the risk.

4.3 The five absent controls

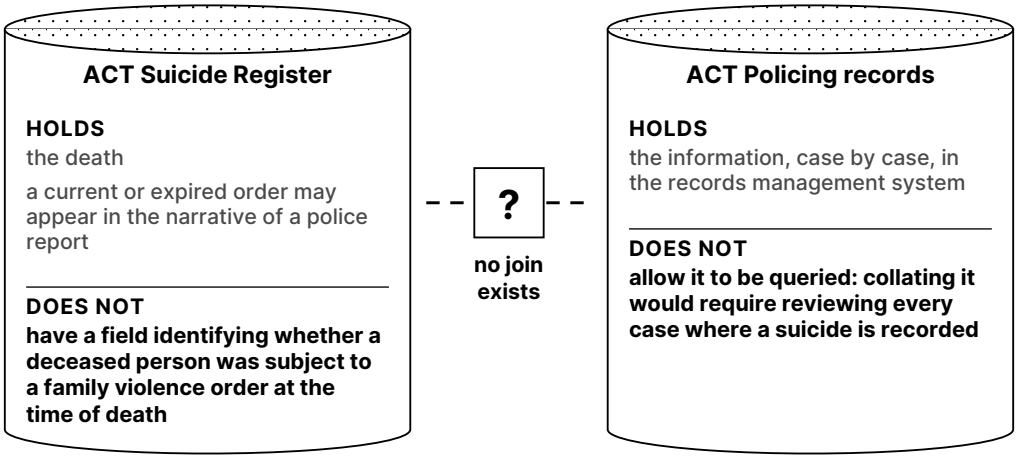
Applying that test to the present state of the system, five controls are absent. Each is identifiable, each is achievable, and none is expensive.

Absent control 1 — no field in the ACT Suicide Register. The Coroners Court has confirmed there is no structured field recording whether a deceased person was subject to an order. Adding a field to a register is routine.

FIGURE 11.1

Two records, no join

The coroner does not record it. The police cannot query it. The court data was refused.



And the third record

The court data was refused under section 43(1)(e): the request was for material Court outcomes, not for information about the management of Court resources.

Everything needed to answer the question exists. What is missing is a field, a query and a decision to look.

None of this is evidence of concealment, and none of it is treated as evidence of concealment here. Nothing in the chapter establishes that an order, a service event or a court process contributed to any death.

Chapter 11, sections 2 and 3. Freedom of information responses LEX 5220 (19 February 2026), JACS (26 March 2026) and JACS2026/496 (2 February 2026).

Absent control 2 — no queryable flag in the police records system. ACT Policing has confirmed the information cannot be cross-referenced without manual file-by-file review. A queryable status flag is a standard system change.

Absent control 3 — no mental health screening or referral at the point of service. There is no published requirement for a welfare check, mental health screening or referral triggered when an order is served on a respondent. Nine people died while under a current order in five years. Service is the moment at which the system knows exactly where a person is, at the point of maximum shock.

Absent control 4 — no safety audit of respondent outcomes. No agency has conducted any review of the relationship between proceedings and death, in 25 years of records.

Absent control 5 — no risk-differentiated listing procedure. Chapter 7 established that no published instrument structures the choice between listing options. The framework contains no criteria against which such a choice could be made consistently.

4.4 What this section does and does not say

This section does **not** assert that any agency has breached the Act. That is a question for a regulator and a court, on evidence not available here.

It says something narrower and harder to dispute. A duty exists. It covers psychological health, and it covers people affected by an undertaking's work. The hazard is documented in the government's own reports. Five controls that would allow the hazard to be monitored are absent, for reasons the agencies have themselves recorded in writing.

5. What is known about the mechanism

The association between orders and death has an obvious first explanation: orders are made where danger exists. That is treated here as the leading hypothesis. But a second body of evidence bears on the question. It should be set out, because it is what makes the absence of analysis matter.

5.1 Relationship breakdown and suicide

Deaths are also the wrong unit for measuring this harm, and the only one available. A death is recorded. Distress short of death is not: ACT Policing advised that it does not typically record suicide attempts, no agency records psychological harm following an allegation or an order, and no agency records loss of work, housing or contact with children as an outcome of the process.

That asymmetry is why the death count carries weight it would not otherwise carry. Among everything this system records, a death is the one datum that is binary and unequivocal. A person is dead or they are not. There is no classification threshold in the fact itself, no assessor judgment and no discretion — unlike a risk rating, a predominant aggressor decision or a referral outcome. The attribution of a death to a domestic and family violence context is still a judgment, and the register's own limitations section says so. The death is not.

Using deaths in that way is standard method rather than an inference constructed for this argument. In crime statistics, homicide is treated as the benchmark indicator because it is the offence most completely recorded and least affected by reporting behaviour; the United Nations Office on Drugs and Crime uses it for that reason. In health services research, mortality is used the same way — as the visible fraction of a much larger volume of adverse events, on the understanding that recorded deaths sit at the top of a distribution whose base is not recorded at all. The convention has limits. Recent criminological work questions how well homicide proxies other violent crime, and the same caution applies here.

The 29 suicides are therefore best read as a floor and as an indicator, not as the size of the problem. What sits beneath them is unmeasured, and the reason it is unmeasured is that no field exists to hold it.

The Australian Bureau of Statistics records psychosocial risk factors for suicide deaths. In 2024, people who died by suicide had an average of four factors mentioned. The most commonly reported factors across all ages were:

Factor	Share
Mood disorders including depression	34.8%
Suicide ideation shared with others	30.5%
Problems in spousal relationship circumstances	**25.0%**
Anxiety and stress related disorders	20.5%
Personal history of self-harm	20.4%

Problems in spousal relationships are the third most commonly recorded factor, present in a quarter of suicide deaths nationally.

5.2 Justice system contact and psychological harm

Research across Australia and comparable jurisdictions consistently links justice system involvement with measurable deterioration in mental health. That involvement includes litigation, police contact, arrest and custody. The deterioration shows as elevated anxiety, depression, post-traumatic symptoms and reduced coping capacity. The effects are most severe among defendants and people in prolonged proceedings. Entry into custody and the period immediately after release are associated with substantially elevated suicide risk.

The consistent finding is not that justice system contact causes suicide. It is that it operates as a **risk amplifier and acute stressor** within an already complex situation.

The ACT has one recent public account of that experience from a person who went through the process and was cleared. Thomas Zaja, the man in the 2025–26 matter examined in Chapter 12, spent two weeks in custody, was released on strict bail conditions, was separated from his young son, and borrowed heavily to meet legal costs. Asked why the case had taken so long, he was quoted in *The Australian* on 31 March 2026 saying that it was "obvious why so many fathers kill themselves", and describing recurrent thoughts, on the drive to work, of steering into a truck.

One account is not a rate, and it establishes nothing about cause. It matters here for a narrower reason. It describes, from inside, the amplifier this section is about, in

a jurisdiction where 29 of 38 non-homicide deaths over five years were suicides and where nine people identified as perpetrators died while subject to a current order. A statement of that kind, made publicly, is the sort of signal that ordinarily prompts an organisation to check its own data. The ACT cannot check, for the reasons set out in section 2.

5.3 Separation

Both ACT death reviews identify separation as a period of heightened risk. The 2023 review found it was a high-risk period for homicide. The 2025 review found that for eight of the 25 people recorded as perpetrators, death occurred in the context of a pending or recent separation from an intimate partner.

Separation is also, very often, the moment at which the legal system becomes involved. An application is filed. An order is served. Proceedings begin.

5.4 What this adds up to

Three independently documented facts converge:

- separation is a high-risk period for both homicide and suicide;
- relationship problems are recorded in a quarter of national suicide deaths; and
- justice system contact is consistently associated with acute psychological deterioration.

The family violence order process happens at the intersection of all three. It is applied to people at separation, in relationship crisis, through a justice process.

That does not establish causation, and no such claim is made. It establishes that the intersection is exactly where a competent system would look. The ACT has never looked.

6. The counterarguments

Four objections can be made to this chapter. Each deserves an answer.

6.1 “The association is entirely explained by the danger that prompted the order”

This may be right, and it is the most likely single explanation for a substantial part of the pattern.

But there are three reasons it does not dispose of the question.

First, it is a hypothesis, not a finding. Nobody has tested it.

Second, even if it is wholly true, it does not explain why the system does nothing at the point of service. Suppose a person is dangerous enough to require an order, and the population of order respondents carries a materially elevated suicide risk. Order service is then a moment at which a known population meets a known risk. Whether the order caused the risk or merely identified it, the opportunity to act is the same.

Third, the 2025 review found that in several cases suicide appeared to be used to punish victims or avoid accountability. That is not a risk to the respondent alone. Where the suicide of a person who has used violence is directed at the surviving partner and children, preventing it is victim protection.

6.2 "Suggesting orders contribute to deaths will discourage victims from seeking them"

This is a serious objection and it should be taken seriously.

Three responses.

First, the recommendation in this chapter is not to make orders harder to get. Nothing proposed here changes the threshold in section 21, or the paramountcy of safety in section 36. Chapter 16 sets out reforms that add process, not obstacles.

Second, the argument proves too much. Suppose the system may not examine whether one of its interventions has adverse effects, because examining it might discourage use. Then no intervention can ever be examined. That is not a standard applied anywhere else in public administration.

Third, the absence of analysis does not protect victims. Four of 13 deceased victims in the 2025 review had themselves been made respondents to orders. In those cases the evidence indicates the applicant was the predominant aggressor. Better data about order respondents would identify that pattern. Refusing to look protects nobody.

6.3 "The numbers are too small to analyse"

Nine deaths under a current order in five years is a small number, and the ACT's population makes small-number problems endemic.

But three points follow.

The register is not small. It holds 168 fatal incidents over 25 years, of which 137 are non-homicide.

Small numbers make analysis harder, not impossible. They require longer time series, careful statistical treatment and appropriate suppression rules. They do not justify never collecting the data.

And the operational conclusions do not require statistical significance. A finding that six of the 25 people recorded as perpetrators had police contact within a week of death is actionable on its face, whatever its confidence interval.

6.4 "This is a matter for the coroner, not for policy"

Coronial inquests examine individual deaths and can make recommendations. They are essential and they are not a substitute for population-level analysis.

A coroner sees one death. Only a register-level analysis can identify that a pattern exists across many. And only a data field allows the register to be analysed.

The 2025 review shows the point. It could state that nine people died under a current order. That is a population-level finding, and it was possible because the death review function had assembled a register. What it could not do is compare that group to a denominator. The denominator is the court data that is not released.

7. What should be done

Five changes. None of them, in the minimum form set out here, requires legislation; Chapter 16 sets out the statutory version of item 4. Together they would allow the question to be answered within two years.

1. Add a field to the ACT Suicide Register. A structured field recording whether the deceased was subject to an interim or final family violence order at the time of death, as protected person or respondent. The field would also record whether they had been subject to one within the preceding 12 months. Cost: a schema change and a data entry step.

2. Add a queryable status flag to the police records management system. A flag set at the point an order is served, queryable against mortality and incident data. This removes the stated reason the figures could not be produced.

3. Publish court administrative statistics. Quarterly publication by ACT Courts and Tribunal of: interim applications filed; interim orders made; interim orders made in the absence of the respondent; recorded gender of respondents; final outcomes by category; and median time from filing to first listing and to final determination.

If Schedule 1 of the *Freedom of Information Act* places these outside the access regime, they should be published voluntarily or required by practice direction or regulation. The construction that makes them exempt from an access application does not prevent the court from publishing them.

4. Require a welfare and support step at the point of service. At minimum: a documented welfare check, a screening question set, and a referral offer, recorded, at the point an order is served on a respondent. Chapter 16 sets out a stronger version.

5. Commission and publish an annual analysis. An annual report examining the relationship between family violence proceedings and deaths, covering both respondents and protected persons. The death review function would produce it, with access to the linked data, and the report would be published.

7.1 The cost

Item 1 is a database field. Item 2 is a routine system change request. Item 3 is a report generated from an existing case management system. Item 4 is a process step at an existing point of contact. Item 5 is an analyst's time against an existing statutory function.

Against a portfolio of $151.4 million of direct investment over four years, the total cost is negligible.

7.2 Why it has not happened

There is no evidence in the public record of any agency deciding not to collect this data. There is no evidence of a decision at all.

What the record shows is an absence: no field, no flag, no analysis, no requirement, and no agency that regards the question as its own. The coroner records deaths. The police record incidents. The court records orders. The death review reports every two years on what it can assemble. Nobody owns the intersection.

That is the ordinary way a blind spot forms in a system with no risk owner and no framework-level monitoring. It is the same failure Chapter 8 describes in the risk framework, appearing at a different scale.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. The complete set of 15 is at Appendix M, where it can be read against every other chapter's.

- **F11.1** — Between 2020 and 2024, nine people died by non-homicide means while subject to a current family violence order; 20 of the 25 people recorded as perpetrators had been respondents to an order at some point; 29 of 38 non-homicide deaths were suicides; and eight of the 25 deaths occurred in the context of a pending or recent separation from an intimate partner.
- **F11.4** — The ACT Coroners Court confirmed in writing, on 26 March 2026, that the ACT Suicide Register has no field identifying whether a deceased person was subject to a family violence order at the time of death.
- **F11.6** — The Coroners Court confirmed that there has been no internal review, audit, thematic analysis, research project or annual summary examining correlations between domestic violence proceedings and suicide outcomes.
- **F11.15** — The ACT Magistrates Court published family violence order application counts and interim application counts in its annual reviews to 2019–20, reporting 1,249 applications and 1,152 interim applications in that year, and has published no annual review since, in a period in which the Supreme Court has published five.

Claim	Source	Date

Sources for this chapter

Claim	Source	Date
Homicide used as the benchmark indicator in crime statistics because it is the most completely recorded offence	UNODC, *Global Study on Homicide 2019*	2019
Validity and limits of using homicide as an indicator of other violent crime	van Breen J, Rabolini A and Liem M, "Old habits die hard: assessing the validity of using homicide as an indicator of other violent crimes", *European Journal of Criminology*	2024
Recorded deaths as the visible fraction of a larger volume of unrecorded adverse events	Patient safety and morbidity literature, including "Tip of the iceberg: patient safety incidents in primary care" and the iceberg model in maternal morbidity and mortality research	2015; 2022
Order histories of the people recorded as perpetrators and as victims; 29 of 38 deaths by suicide; 8 of 25 deaths in the context of a pending or recent separation; police contact within a week for 6 of the 25; 168 incidents 2000–2024 comprising 31 homicide and 137 non-homicide; suicide used to punish victims or avoid accountability	ACT Domestic and Family Violence Review Biennial Report 2025	2025
Separation as a high-risk period for homicide	ACT DFV Review Biennial Report 2023	2023
Reported statement on suicide by the man cleared in the 2025–26 matter; custody, bail conditions, separation from his son and legal costs	*The Australian*, "Canberra man Thomas Zaja cleared of bikie claims after former partner faked threatening texts", by Janet Albrechtsen and Stephen Rice	31 March 2026
No field in the ACT Suicide Register; order status may appear in police report narrative; no internal review, audit, thematic analysis, research project or annual summary of correlations	ACT Coroners Court advice, provided through the Justice and Community Safety Directorate freedom of information team	26 March 2026
Formal refusal to deal with court-held points under s 43(1)(e) and Schedule 1 s 1.1A	JACS freedom of information decision notice, reference JACS2026/3443	2026
No discrete document; collation would require reviewing every recorded suicide case; suicide attempts not typically recorded; no internal analysis; refusal under s 24A	Australian Federal Police freedom of information decision, reference LEX 5220	19 February 2026
Refusal of court statistics on interim orders; construction of "administrative in nature"; *Kline v Official Secretary to the Governor General*	JACS freedom of information decision notice, reference JACS2026/496	2 February 2026
Primary duty of care to other persons; health includes psychological health	*Work Health and Safety Act 2011* (ACT)	—
Psychosocial risk factors in suicide deaths; problems in spousal relationship circumstances at 25.0 per cent; average of four factors	ABS, *Causes of Death, Australia* / *Intentional self-harm (suicide) deaths*, 2024	Released 2025
2026–27 direct investment of $151.4m over four years	2026–27 Budget DFSV factsheet	2026

Claim	Source	Date
Protection Unit statistics: 1,249 family violence order applications and 1,152 interim applications in 2019–20, with the series from 2015–16	ACT Magistrates Court Annual Review 2019–20	2020
Supreme Court annual reviews listed to 2024–25; Magistrates Court annual reviews listed to 2019–20 and no later	ACT Courts, annual reviews page, as archived 2 September 2026	Checked 2 September 2026

Chapter 12 — Three documented failures

A note on this chapter. Section 3.8 quotes a public statement about suicide. Anyone affected can contact Lifeline on 13 11 14, the Suicide Call Back Service on 1300 659 467, the ACT Domestic Violence Crisis Service on (02) 6280 0900, or 1800RESPECT on 1800 737 732.

How this chapter may be quoted.

These three cases establish a verification-chain failure. They do not estimate how often allegations are false.

Under-reporting remains the larger problem. The research consensus that deliberately false allegations are a small minority of reports is accepted here.

The failure runs in both directions, and the third case is the other direction.

The two matters in which an allegation did not survive examination are two cases in a jurisdiction that processed thousands of family violence matters in the same period. The third is one death in a register of 168 fatal incidents.

Anyone quoting this chapter without the sentence "Under-reporting remains the larger problem" is misquoting it.

In one page

Read this paragraph first. This chapter examines three ACT matters. In the first two, allegations of domestic and sexual violence were made and acted on. In the first the accuser was later convicted; in the second the charges were discontinued after the investigating officer accepted in court that material had been fabricated. In the third, reports of danger to a child were made repeatedly and were never assembled into a decision. Three cases show a mechanism, not a rate. The box above states the limits, and they apply to every sentence that follows. These matters appear because each was dealt with in public: two in open court and reported nationally, the third in the published report of a Board of Inquiry. No confidential material is used.

In the first, a man was arrested in 2014 on allegations of rape and domestic violence made by his former fiancée. He spent nearly four months in a maximum security prison in another state before the charges were dropped. The allegations were disproved by evidence establishing he was elsewhere. In January 2019 his accuser was sentenced in the ACT Magistrates Court to three years and one month in prison, with a two-year non-parole period, for making a false rape allegation and staging a crime scene. The magistrate found she had exploited the seriousness with which domestic violence and rape claims are treated. In December 2021 a serving New South Wales police officer was found guilty of perjury in the ACT Supreme Court for evidence he gave supporting her account.

In the second, a Canberra man was arrested on 17 October 2025 in a tactical police operation at his home at 3am, on his former partner's claim that he was an armed and

violent outlaw motorcycle gang member. No record of any such membership was produced. He spent two weeks in custody. Digital forensic analysis was reported to have indicated that threatening messages the complainant said she had received had been sent by her to herself through anonymous texting services. On 20 March 2026 the investigating officer accepted in cross-examination that the complainant had fabricated evidence and had lied to police. The magistrate described the conduct of both police and prosecutors as "egregious" and the months of inaction as "unbelievable". The charges were discontinued on 27 March 2026, costs were awarded, and the magistrate directed that a transcript be provided to the Chief Police Officer and to AFP Professional Standards. Three mastheads reported the matter; two did not name the accused.

In the third, a Board of Inquiry was appointed on 22 February 2016, one week after the death of Bradyn Dillon, to review the system level responses to family violence in the ACT. It recorded that in cases such as that one there are multiple reports from education officers; that concern reports could be received, closed and received again in what an earlier review called a "churning" of cases; that the intake decision making process showed a lack of understanding of thresholds and no consideration of cumulative harm; and that decisions and the reasons for decisions were not always clearly recorded. The error there ran the other way. The information that would have established the danger existed, and it was not assembled.

Taken together, the three cases show four common features: information that would have changed the decision existed at the time the decision was made, no named person owned the step of examining it, the consequences arrived before the examination, and no record distinguishes a check that found nothing from a check that was never made. That is what the three matters are used for here: to show how the failures described in Chapters 7 to 11 operate in a real sequence. The remedy this chapter supports is a published reasons field for discontinuance and a recorded decision trail. It is not a change to the threshold for protection.

One number, one quote, one action

Number: Seven months — the reported time between the seizure of the accused's mobile phone in the 2025–26 matter and its delivery to Digital Forensics, accepted by the officer responsible in cross-examination.

Quote: "I find the entire conduct of both the police and the DPP to be egregious." — Magistrate Jane Campbell, ACT Magistrates Court, reported in *The Australian*, 31 March 2026.

This week: Ask the ACT Courts and Tribunal and the Director of Public Prosecutions to record and publish, for every discontinued family violence or sexual offence matter, the reason for discontinuance and whether the material that ended the prosecution was already held by police or the prosecution.

1. How this chapter uses these cases

1.1 The methodological problem with case studies

Individual cases are the weakest form of evidence about how often something happens. They are the strongest form of evidence about how it happens.

Three cases cannot tell anyone what proportion of allegations are false. They cannot tell anyone whether the ACT has a problem with false allegations. This chapter makes no such claim.

What cases can do is show a sequence. A statistical finding tells you a failure occurred. A case tells you where in the process it occurred. It tells you what information was available at each step, and what the system did or did not do with it.

1.2 Why these three

Six reasons.

All are fully public. The first two were dealt with in open court and received detailed national reporting. The third was examined by a Board of Inquiry under the *Inquiries Act 1991*, whose report was published. No confidential material is used. No non-public matter appears in this chapter.

Two are resolved, and the second is discontinued, which is not the same thing. In the first, the accuser was convicted, and there is a conviction to point at. In the third, the Inquiry's findings about what information was held and what was shared are on the public record. In the second, charges were discontinued after the investigating officer accepted in cross-examination that the complainant had fabricated material — but no charge was ever laid against her, no court made a finding against her, and section 3.5 says so. A discontinuance is the absence of a finding, not a finding of absence. That distinction is the whole of Chapter 6's argument about discontinuance rates and it applies to this chapter's own material.

The evidence rule for the second matter, stated because this work would state it about anybody else's evidence. Appendix D4.1 sets out the counting rule this work applies throughout: one account repeated to several people is one source, not several. The second matter rests on three secondary sources. They are journalists' reports of the hearing: *The Australian* (Janet Albrechtsen and Stephen Rice, 31 March 2026), ABC News (Elizabeth Byrne, 28 March 2026) and Region Canberra (Albert McKnight, 2 April 2026). All three are openly published. No published judgment, transcript or other court record of the matter has been located. Under D4.1, therefore, the three reports corroborate one another as independent accounts of the same public hearing; they are not primary records, and none of them can be. Two of the three did not name the accused or the complainant. The three accounts agree on the sequence, the officer's admissions and the magistrate's words, and none has been contradicted. But all three report a hearing at which the complainant was not a party and was not heard. Accordingly, every factual proposition drawn from the matter is stated in this chapter as reported, and the forensic propositions about the messages are stated as what was reported to have been accepted in court. What is established is that the investigating officer accepted them in cross-examination and the prosecution was discontinued. That is a different and weaker proposition than that they are true. The

accused's name is used because one national masthead published it and he spoke on the record; that two mastheads withheld it is recorded here.

All are ACT matters. The first two involve ACT Policing, the ACT courts and, in the second, the ACT Director of Public Prosecutions. The third involves ACT directorates and the service providers that respond to family violence.

They are separated by a decade. The first began in 2014, before the *Family Violence Act 2016*, before the Safer Families package, before the risk framework. The third arose in 2016, at the beginning of that period. The second concluded in 2026, after all of it. That interval is itself evidence.

There is a further reason for the third. A chapter that showed the error running in one direction only would be usable as an argument it does not make. The third matter is the same failure, running the other way, recorded in the Territory's own inquiry.

1.3 What is not claimed

This chapter does not claim these cases are typical. It does not claim false allegations are common. It does not claim that anyone involved acted maliciously. It does not draw conclusions about anyone who has not been convicted of an offence.

2. The first case: 2014 to 2021

2.1 What happened

In 2014, a man employed as a corrections officer was accused by his former fiancée of rape and of domestic violence over a two-year relationship. The accuser was a former police employee.

He was arrested by Australian Federal Police officers and remanded in custody. Because he worked at the ACT's own correctional centre, he was held instead at Goulburn Correctional Centre in New South Wales, in isolation for his own protection.

He spent **nearly four months** in custody before the charges were dropped.

The allegations were disproved by evidence establishing that he was at his parents' house with other people at the time of the alleged incident.

2.2 The conviction

In **January 2019**, the accuser — Sarah-Jane Parkinson, then aged 28 — was sentenced in the ACT Magistrates Court to **three years and one month** imprisonment with a **two-year non-parole period**, for making a false rape allegation in 2014 and for staging a crime scene.

Magistrate Beth Campbell found that Parkinson's false accusations had exploited the seriousness with which domestic violence and rape claims are treated. The magistrate noted the absence of remorse, in that Parkinson had chosen not to apologise to the man or his family. That finding concerns this case; it establishes a mechanism, not a rate, and says nothing about how often allegations are false.

2.3 The perjury conviction

On **2 December 2021**, Scott John White, a New South Wales police officer, was found guilty of one count of perjury in the ACT Supreme Court.

The perjury concerned evidence he gave under oath that he and Parkinson, then his girlfriend, had never used condoms during their relationship. That evidence was material because Parkinson had claimed her former partner used a condom during the alleged rape in March 2014.

White and Parkinson subsequently married.

2.4 The police conduct

Reporting by the ABC in September 2015 recorded that internal Australian Federal Police investigations found that a former acting sergeant had pressured another officer to alter her statement regarding one of the alleged incidents, and that he later resigned after being found to have become too personally involved with the complainant.

2.5 What the sequence shows

Set out as a sequence, the case has six identifiable decision points.

Point	What happened	What was available
Allegation	Serious allegations made by a former partner with a policing background	The account
Arrest and remand	Arrested and remanded to a maximum security prison interstate	The account
Custody	Held in isolation for nearly four months	Evidence of his whereabouts existed throughout
Investigation	Internal findings later established a serving officer had pressured a colleague to alter a statement and had become too personally involved with the complainant	—
Charges dropped	Charges withdrawn after evidence established he was elsewhere	Evidence that had existed from the outset
Correction	Conviction of the accuser in 2019; perjury conviction of the supporting officer in 2021	Five and seven years after the arrest

The critical column is the third. The evidence that ended the prosecution existed at the time of the arrest. It was not created later. What changed was that someone examined it.

3. The second case: 2025 to 2026

3.1 What happened

At about 3am on 17 October 2025, a police tactical response team entered a Canberra property using explosive charges. The occupant, a 34-year-old earthworks contractor named Thomas Zaja, was removed from his bed in his underwear at gunpoint and taken into the street, where he remained for over an hour. His mother, who also lived on the property, was present.

He was arrested on his estranged former partner's claim that he was an outlaw motorcycle gang member hoarding weapons and drugs. No record of any such membership was produced in the proceedings, and none has been reported.

He was charged with a number of offences including assault, choking, suffocating or strangling, and threatening to kill, following allegations of serious domestic violence.

He spent **two weeks** at the Alexander Maconochie Centre before being released on bail, after a barrister told the court there was "not a scintilla of evidence" to support the charges. He was released on strict bail conditions and separated from his young son.

3.2 The exculpatory evidence

From the morning of the raid, his solicitor told investigating officers that the allegations were fabricated. At every stage his lawyers informed police, prosecutors and the court that the complainant was, in their submission, lying to gain advantage in a contested parenting dispute.

On the reported account of the hearing, digital forensic analysis of the complainant's phone indicated that threatening and obscene messages she said she had received had been sent through anonymous texting services, paid for from her own digital wallet, and that on one occasion — 12 September 2025, on the ABC's account — she sent a demeaning message to herself and then deleted it, on the date she claimed she had been harassed. Police received the phone information on 3 December 2025. On 24 January 2026 prosecutors told the defence the evidence suggested the messages were self-sent. What is established for the purposes of this chapter is that the investigating officer accepted that material in cross-examination on 20 March 2026 and that the prosecution was discontinued on 27 March 2026; the underlying forensic conclusions were never tested by a court, because no charge was laid against her.

3.3 The delays

Two delays and one absence are recorded in the reporting.

The complainant's phone. Investigating police accepted that no meaningful action was taken to verify the accused's claims of innocence for months.

The accused's phone. His mobile phone was reported to have been seized by police in August 2025, two months before the raid. The officer compiling the brief of evidence did not attend court on the listed day. Reached by telephone, he said the reason was that he had that morning delivered the phone to Digital Forensics — **seven months after it was seized**. Asked in cross-examination whether he had failed in that responsibility, he answered: "Yes, that is correct."

Body-worn camera. When the defence asked for body-worn camera footage of the raid, they were told none existed until after a search of the house had begun.

3.4 What was said in court

In cross-examination, the investigating officer was asked whether he accepted that the complainant had fabricated evidence to support the allegations. He replied: "It appears that way, yes." Asked whether the evidence established that she had lied to police, he answered: "Correct."

Magistrate Jane Campbell — a different magistrate from the one who sentenced in the first case — said from the bench:

> I find the entire conduct of both the police and the DPP to be egregious.
>
> The police officer, the informant, today has expressed a belief that this complainant has fabricated evidence. The DPP presumably have that knowledge, and they have had that knowledge since January and no one has done anything about it.
>
> It is unbelievable.
>
> And this matter stands out, in my mind, in a serious way and reflects very poorly on your office.

The ABC's account of the same hearing records her saying that the delay had "put significant prejudice upon a defendant" and that she was "so surprised that the DPP has not made a determination about this matter, even by March 20". The words "presumably have that knowledge" matter. They are a remark from the bench about what the prosecution is likely to have known, not a finding of fact after hearing the prosecution's evidence on the point, and they are treated in that way throughout this chapter.

Those remarks concern this matter; they establish a mechanism, not a rate, and say nothing about how often allegations are false.

3.5 The outcome

The Director of Public Prosecutions discontinued all charges on 27 March 2026. The magistrate awarded costs and directed the registrar to provide a transcript of the proceedings to the Chief Police Officer and to AFP Professional Standards.

The accused's solicitor, Peter Woodhouse, called for an apology and compensation, and asked that the complainant be investigated and charged. As at the time of reporting, no charge had been laid against the complainant, and nothing in this chapter should be read as a finding against her.

3.6 The agencies' responses

Both agencies responded to the reporting, and their positions are recorded here in full for fairness.

A spokesperson for the Director of Public Prosecutions said that, contrary to the criticisms made, the complete relevant material was not received by the office until 18 March 2026, less than two days before the administrative listing, and that within seven business days of receiving the necessary material a determination was made about whether the matter should proceed. The spokesperson said it was not correct that the office did nothing, that the office had "promptly advised" the defence of the concern in January, and that it had "proactively sought" the complete material.

An ACT Policing spokesperson said that concerns about potential exculpatory material arose in January but could not be confirmed until an electronic device was forensically examined in March, and that the circumstances would be considered to seek to identify any learnings that might arise.

Neither agency responded to questions about whether they intended to apologise.

3.7 The DPP's response and Chapter 6

The prosecution service's answer is that it acted within seven business days of receiving the complete material.

That may well be right, and it is consistent with what Chapter 6 documents. A prosecution service that has told the Assembly its staff do not have time to prepare matters properly is a service that will depend heavily on the completeness of the brief it receives.

The delay in this case was substantially upstream: a seized phone not delivered to digital forensics for seven months.

That is the point Chapter 6 makes about unfunded interfaces, appearing in an individual case. Increasing police numbers increases arrests. Arrests generate briefs. Briefs require forensic examination. If forensic capacity and brief preparation do not increase in step, matters sit. Each agency can be doing its best within its resources while the overall system produces a seven-month delay.

3.8 What the process cost, in the respondent's own words

The consequences of the second case did not end when the charges did. The respondent had spent two weeks in custody. He was released on strict bail conditions and separated from his young son. He borrowed a large sum to pay legal fees and keep his business operating. Those are the same categories of consequence the 2025 death review records for the people it examined: charges, incarceration, loss of contact with children, and loss of livelihood.

Asked why it had taken so long, he was quoted in the reporting of the case as saying:

> "Why did it take so long? Why didn't the police investigate or the DPP? What were they doing?... It's obvious why so many fathers kill themselves. Every morning driving to work, I think, if I just pull the steering wheel right straight into a truck, finish at all. But I can't do that to my son."
>
> — Thomas Zaja, quoted in *The Australian*, 31 March 2026

That statement is quoted for one reason. It is a first-hand account of the kind of effect Chapter 11 shows the Territory has never measured.

Chapter 11 sets out what is known and what is not. Between 2020 and 2024 the ACT register recorded 38 non-homicide deaths in a domestic and family violence context, 29 of them suicides. Nine people identified as perpetrators died while subject to a current family violence order. Six had contact with police in the week before death. The ACT Suicide Register has no field recording whether a deceased person was subject to an order. ACT Policing advised that producing the figures would require an officer to

review every recorded suicide case individually. No internal review, audit, thematic analysis, research project or annual summary has ever examined the relationship.

The limits apply here as everywhere in this chapter. One person's account of his own distress is not evidence of a rate, and nothing in it establishes that the process caused any death. It is also not nothing. Where a system produces a documented pattern of severe consequences, and a person who has been through it describes its effect on him in those terms, the ordinary response of a risk-managed organisation is to check whether the effect is happening at scale. The Territory cannot check, because it does not collect the field. That is the finding, and it is the reason the first item on the hundred-day list in Chapter 18 is a change to a database schema.

4. The third case: a death, and the reports that preceded it

This matter runs in the opposite direction to the first two. It is not an allegation of violence accepted without checking. It is an allegation of danger made repeatedly, by people employed to make it, and never assembled into a decision.

Bradyn Dillon died in February 2016. On 22 February 2016, one week after the death, a Board of Inquiry was appointed under the *Inquiries Act 1991*. It was conducted by Laurie Glanfield AM and reported in May 2016 as *Review into the system level responses to family violence in the ACT*.

The Inquiry expressly did not examine individual responsibility. That was left to the criminal proceedings and to the coronial inquest. What it examined was "the information that was held by various ACT directorates and service providers in relation to the case and what information was shared". This section keeps to the same limit: not the death, the injuries or the proceedings, but what the system held.

4.1 What the Inquiry was asked to examine

The terms of reference were to review the legislative framework, policy, practices and operations of ACT directorates and service providers who respond to family violence, focused on systemic issues. Three matters were specified: the effectiveness of interactions and responses in relation to mandatory reporting; responses to family violence, particularly where children are involved; and the extent to which ACT authorities are legally able to, and do actually, share and receive information on at-risk families.

The third is the verification question in another form: not whether a claim was tested, but whether the material that would have tested it was ever brought together.

4.2 The reports were made

The Inquiry recorded that in cases such as this one "there are multiple reports from education officers". Education officers are high-level mandatory reporters generally.

The information reached the system. Quoting the earlier Camilleri Review, the Inquiry recorded that Child and Youth Protection Services focus on separate incidents, and that there can be a "churning" of cases:

> where a concern report is received, no further action is taken or an appraisal is undertaken and substantiated but then the case is closed. Another concern report can result in the same process.

The same passage records the consequence. "Neither education nor CYPS will have taken responsibility for ensuring the family is linked to appropriate services and that they access them."

That is a step with no owner. Each report is received, each is disposed of, and nobody holds the sequence.

4.3 Cumulative harm

The internal review conducted by the Community Services Directorate after the death "found that the intake decision making process demonstrated a lack of understanding of thresholds and that there was no consideration of the impact of cumulative harm".

Cumulative harm is the case where individual child concern reports that do not in themselves meet the threshold may collectively mean harm is occurring and should be looked into further.

That is the inverse of the failure in the first two matters. There, a single account was treated as sufficient without being tested. Here, a series of reports was treated as separate insufficiencies.

4.4 The record of decisions

Peter Muir's independent review of how Child and Youth Protection Services responded to the Dillon children found that "decisions and the reasons for decisions are not always clearly recorded in accordance with the Directorate's procedures". A similar finding had been made by the Auditor-General in 2013.

The 2013 Auditor-General *Performance Audit into the Care and Protection System* had found there were no scheduled or regular quality assurance activities conducted on case files by experienced and qualified care and protection staff. The branch attributed the absence to increased demand and workforce shortage.

There are no formal provisions for internal merits review of decisions relating to intake and assessment, other than sign-off by a team leader. The Inquiry noted that the current sign-off processes had occurred in this case. A Decision Review Panel exists, but is convened only in rare circumstances: four matters had been reviewed by it since 1 July 2012.

The sign-off occurred and the reasons were not always recorded. Whether a particular report was assessed and found not to meet the threshold, or was not assessed at all, is not established on that record.

4.5 The police threshold

The Inquiry recorded that "SACAT advised CYPS that ACT Policing would not undertake an investigation without a specific disclosure from the children".

ACT Policing told the Inquiry that while there is a recognised role for police in managing welfare issues, the primary responsibility falls with Child and Youth Protection Services, and that the first objective on receiving a referral is obtaining disclosure from the child, because a key difficulty is determining whether an injury is accidental or the result of abuse.

Following the matter, additional oversight processes were adopted when allegations of child abuse are received. A dedicated Child Protection Services Referral Offi-

cer within SACAT became responsible for the receipt and evaluation of all child protection referrals. Where a referral does not proceed to investigation, child protection services is advised that there will be no further police action, and the reason for the rejection is recorded.

That last change is the control the first two matters never had: a negative decision written down, with its reason, and the other agency told.

4.6 Two further observations

In late October 2015 the father unenrolled his children from their school, telling the school that he and the children were moving interstate. The Inquiry recorded: "It does not appear that any inquiries were undertaken by the school to confirm this was the case."

The Inquiry also observed that "in the Dillon matter … many agencies involved with the family treated the domestic violence order in place as if it was a parenting order made by the Family Court".

4.7 What the sequence shows

The information existed. It was generated by the officers the legislation appoints to generate it, and delivered to the agency the legislation appoints to receive it. It was not concealed, and it did not have to be discovered.

What was missing was what was missing in 2014 and in 2025. No named person owned the step of assembling the reports into a single view of the family. No record distinguishes a report that was assessed and found not to meet the threshold from a report that was not assessed. A stated intention to move interstate was accepted without inquiry, in the same way an account was accepted without inquiry in the first two matters.

Individual responsibility is not established here, and the Inquiry did not examine it. What these pages take from it is the shape of the chain.

5. What the three cases have in common

Six features appear in all three matters. In the first two they appear directly. In the third, which runs the other way, four appear directly and two in altered form. Each feature is set out below for all three cases. The structure common to them follows at section 5.7.

5.1 The account was accepted, or disposed of, without independent verification

In the first, the arrest and remand proceeded on the account. In the second, a tactical entry proceeded on the claim that the man was an armed gang member. That claim could have been checked against police intelligence holdings before the entry, rather than after it.

The defence submission in the second case was that police "blindly accepted the word of the complainant … without question and without independent investigation".

In the third, the direction reverses and the mechanism does not. A father's statement that the family was moving interstate was accepted by the school without inquiry. Each concern report was disposed of on its own terms, without the earlier

reports being brought alongside it. An account was taken at face value in all three; in the third, the account that was taken at face value was the reassuring one.

Independent verification is not scepticism about victims. It is the ordinary standard applied before any coercive state action, and the ordinary standard before a decision not to act. A claim that a person is armed and dangerous is precisely that kind of claim. So is a claim that a child is safe.

5.2 The consequences arrived before the assessment

In the first, four months in custody. In the second, two weeks in custody, a tactical entry, charges, strict bail conditions, and separation from a young child.

In both, those consequences were complete before anyone examined the evidence that ended the matter.

In the third, the consequence was a death, and the assessment that would have assembled the reports into one view of the family was made afterwards, by an inquiry.

This is the same structure Chapter 7 identifies in the interim order pathway. Consequences are applied at the front of a process, on untested material. The testing comes later.

5.3 The evidence existed from the start

In the first, evidence of the man's whereabouts existed at the time of the alleged incident.

In the second, on the reported account accepted in court, the messages had already been sent from the complainant's own account by the time the allegations were made. The forensic analysis did not create that evidence. It read what was already on the device.

In the third, the reports had been made by the officers the legislation appoints to make them, and received by the agency appointed to receive them, before the death.

In none of the three did the system fail because the truth was unknowable. It failed because nobody looked at what was already there.

5.4 Nobody owned the verification step

In the second case this is documented precisely. Investigating police accepted taking no meaningful action for months. The accused's phone sat for seven months before delivery to digital forensics. The prosecution says it acted within seven business days of receiving complete material.

In the third it is documented in the Inquiry's words: neither education nor child protection "will have taken responsibility for ensuring the family is linked to appropriate services".

Each account may be true. What is missing in all three is a person accountable for the whole chain. That is the risk owner Chapter 8 identifies as absent from the framework.

5.5 The family law connection

In the first two, a contested parenting dispute was in the background. In the second it was the defence's stated explanation for the allegations.

Chapter 9 recorded that the ACT framework lists "appears to have a second motive for the allegations, such as a Family Court matter" as an indicator that a **man** claiming victim status is more likely to be the primary aggressor.

The point is not that the indicator is wrong. Family law disputes genuinely do produce strategic conduct. The point is that the indicator runs in one direction only. Where a family law matter is on foot, the possibility of strategic use exists on both sides. The framework structures the assessor's attention towards only one of them.

In the third, the connection appears in altered form. The Inquiry recorded that many agencies treated the domestic violence order in place as if it were a parenting order made by the Family Court. The two systems were confused, and the confusion narrowed what anyone thought they were required to do.

5.6 The correction came late, and did not unwind the consequences

In the first, the accuser was sentenced five years after the arrest, and the perjury conviction came seven years after.

In the second, the accused had borrowed a large sum to pay legal fees and keep his business operating, and had not seen his son since the morning of the raid.

In the third, the correction arrived after a death, in the form of an inquiry and a rule that a police decision not to investigate must be recorded with its reason.

Costs were awarded in the second case. Costs are not restoration. There is no mechanism in any of the three matters by which the employment, the reputation, the parenting time, the money or the life is returned.

Chapter 9 identified the absence of a correction pathway as a gap in the framework. The three cases show what the gap looks like from inside.

5.7 The direction of the error is the only difference

The direction of the error is the only thing that changes across the three.

In the first two, information that would have contradicted an allegation existed, and no one owned the step of checking it. In the third, information that would have confirmed a danger existed, was reported repeatedly, and no one owned the step of assembling it. The material was inside the system in all three. In none of the three did a named person hold the task of examining it and recording what was found.

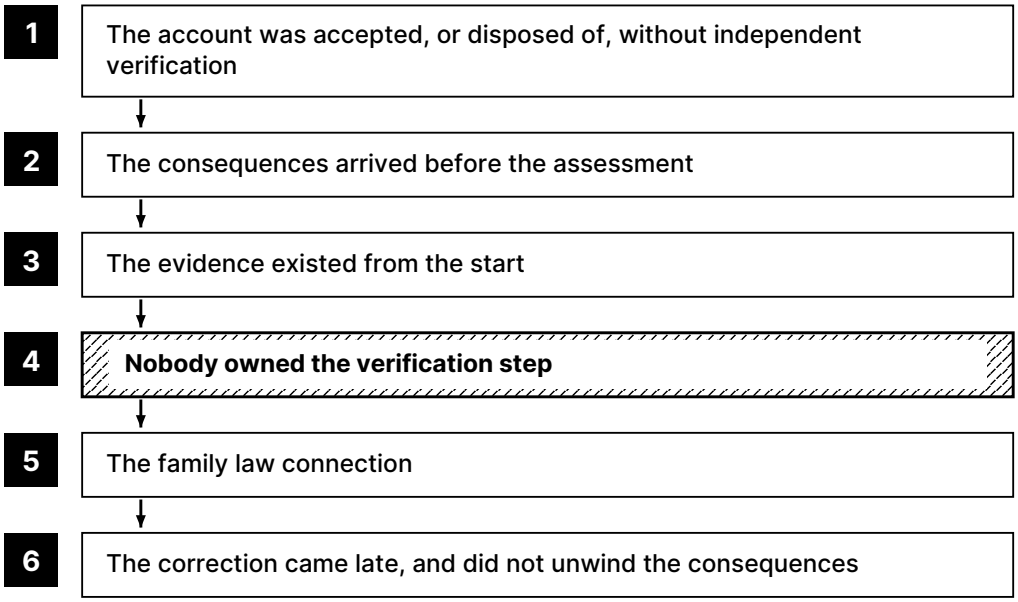
In every case the missing thing is the same: a named owner for the verification step, a record of what was checked and what was found, and a distinction between "checked and found nothing" and "not checked". **A system that cannot show which of those two it did cannot detect either error.**

That is why the reforms in Part III are not addressed to one direction of error. A register of checks does not favour the person accused or the person at risk. It records what was done, and where nothing was done it shows that too.

FIGURE 12.1

The verification chain with no owner

Six features appear in all three matters examined. In the first two they appear directly; in the third, which runs the other way, four appear directly and two in altered form.



What would close it

- a named owner for the verification step
- a record of what was checked and what was found
- a distinction between “checked and found nothing” and “not checked”

A register of checks does not favour the person accused or the person at risk. A system that cannot show which of the two it did cannot detect either error.

These matters do not show that false allegations are common; under-reporting is the far larger problem. They do not show bias against men either — Chapter 10 sets out what would be required to establish that, and it has not been collected. What they show is a step that no one owns.

Chapter 12, sections 5 and 6.

5.8 What the statistics can and cannot add

Chapter 6 records that the share of prosecutions ending without a finding rose sharply over the same period. Family violence matters discontinued went from 2.4 per cent of completed matters in 2017–18 to 12.7 per cent in 2023–24. Sexual offence matters went from 2.5 per cent to 17.3 per cent.

That does not show that the cases in this chapter are typical. Discontinuance has several causes, and a complainant withdrawing is among the most common.

What it does show is that the number of matters ending without a finding grew, and that the ACT does not publish the information that would explain why. In particular, no agency publishes the proportion of discontinued matters in which the material that ended the prosecution was already held by police or the prosecution.

The second case in this chapter is a documented instance of exactly that: the magistrate said from the bench that the prosecution presumably had held the relevant knowledge since January and that nothing had been done about it, the prosecution itself says it told the defence of the concern on 24 January, and a seized phone was not delivered for forensic examination for seven months. One case establishes that it can happen. Only a published measure would establish how often.

6. What the cases do not show

Four things should be stated plainly. Case studies of this kind are frequently overread.

They do not show that false allegations are common. Two of these matters concern allegations that did not survive examination: one ended in the accuser's conviction, the other in a discontinuance after the investigating officer's admissions. Two cases across a decade are not a rate. The jurisdiction processes thousands of family violence matters. The research consensus remains that deliberately false allegations are a small minority of reports, and that under-reporting is the far larger problem.

They do not show that the system is biased against men. Chapter 10 explains what would be required to establish that. It has not been collected. Chapter 4 records that the documented misidentification errors in the ACT's own fatality review ran against women.

They do not show that police or prosecutors acted in bad faith. In the second case, both agencies gave explanations that are consistent with resource constraint rather than intent. In the first, the disciplinary findings concerned specific individuals, not an institution.

They do not show that protective action should be slower. Nothing in the first two cases would have been improved by delaying a genuine protective response. The failures were failures of verification and of ownership, not of speed.

7. What a system with Part III's reforms would have done differently

This is the useful question. It can be answered against specific proposals.

A documented risk assessment at the front (Appendix B). In the first two cases, the material relied on came from a single interested source — in the first case buttressed by evidence later found to be perjured. The proposed instrument requires each claim to be recorded. The record shows its source, its status — established, reasonably open or unknown — and the checks run against it. On its face, that record would have shown that the central claims were uncorroborated at the moment the coercive action was taken.

In the second case, the claim that the man was an armed outlaw motorcycle gang member would have been recorded as a claim from an interested single source. A check against intelligence holdings would have been required. The result of that check would have been recorded before the entry was planned.

Nil results recorded as results (Appendix B). The instrument distinguishes "checked, nothing found" from "not checked". In the second case, the absence of any gang membership record would have been a recorded nil result. It would have been visible to every later decision-maker.

Named owners and proof of completion (Appendix A, Appendix E). Every control has a named owner, a due time, and a statement of what counts as proof it was done. A phone seized for forensic examination is a control with an owner and a deadline. Seven months without delivery would have been an overdue item on a tracked register, not an unnoticed gap.

Both risks rated, never averaged (Appendix B). The instrument rates two risks separately: the risk of harm to the protected person, and the risk of avoidable hardship to the respondent. Neither cancels the other. A tactical entry at 3am into a home containing an older woman would have been rated for its own consequences. That rating would have been made against the alternatives, and on the record.

A correction pathway (Chapter 15). Where a classification is later shown to be wrong, a defined process corrects the record across agencies. It also reviews the consequences that followed — the charge, the order, the employment consequence, the child arrangements.

Published administrative statistics (Chapter 17). None of this is detectable at system level without published data on outcomes. That means how many matters are discontinued, at what stage, and after what delay. Chapter 11 records that this data is not published.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. This chapter's complete set of 14 is at Appendix M, where it can be read against every other chapter's.

- **F12.8** — In the third matter, the 2016 Board of Inquiry recorded multiple reports from mandatory reporters, a "churning" of concern reports received and closed, an intake process with no consideration of cumulative harm, and decisions whose reasons were not always recorded; on that record it cannot be

established whether any given report was assessed and found not to meet the threshold or was not assessed at all, and the one control adopted afterwards — a police decision not to investigate recorded with its reason and notified to child protection — is the control the first two matters never had.

- **F12.11** — The two matters in which an allegation did not survive examination share six features: acceptance of an account without independent verification, severe consequences applied before assessment, exculpatory material that existed from the outset, no single person accountable for the verification chain, a contested parenting dispute in the background, and a correction that arrived too late to unwind the consequences; four of those features — information that existed at the time of the decision, no named owner for the step of examining it, consequences or harm arriving before the examination, and acceptance of an account without independent verification — are present directly in the third matter, the other two are present in altered form, and only the direction of the error differs.
- **F12.12** — The man cleared in the second case described the effect of the process in terms of suicide, saying in reported comments that it was obvious why so many fathers kill themselves and describing recurrent thoughts of driving into a truck; the categories of consequence he described — custody, bail conditions, separation from a child, and large legal debt — are the same categories the 2025 death review records for the people it examined.
- **F12.13** — Three cases establish a mechanism, not a rate; the mechanism is a verification chain with no owner; the error is documented running in both directions, in allegations accepted without checking and in reported danger never assembled; and nothing in this chapter supports a claim that false allegations are common or that the system is biased against any group.

Claim	Source	Date

Sources for this chapter

Claim	Source	Date
Conviction and sentence of Sarah-Jane Parkinson; three years and one month with two-year non-parole; ACT Magistrates Court; Magistrate Beth Campbell; findings on exploitation of the seriousness of domestic violence and rape claims and absence of remorse; nearly four months in Goulburn jail; evidence of the man's whereabouts	ABC News, "Canberra woman Sarah-Jane Parkinson jailed for making false rape claim against ex-partner"	17 January 2019
Perjury conviction of Scott John White in the ACT Supreme Court; subject matter of the perjury; materiality	ABC News, "NSW Police officer who lied to support fake rape claim found guilty of perjury"	2 December 2021
AFP internal disciplinary findings; pressure on an officer to alter a statement; resignation	ABC News investigative reporting, "Police officers investigated over rape, domestic violence vendetta"	16 September 2015
The 2025–26 case: 3am tactical entry; arrest; charges; two weeks in custody; "not a scintilla of evidence"; anonymous texting services and self-sent message; seven-month delay in delivering the seized phone; officer admissions in cross-examination by the investigating officer, Constable David Edwards, and the brief-compiling officer, Constable Vincent Killeen; Magistrate Jane Campbell's remarks; discontinuance of charges; costs; referral of transcript to the Chief Police Officer and AFP Professional Standards; DPP and ACT Policing responses; the accused's name	*The Australian*, "ACT man spent two weeks in jail over fabricated allegations by ex-partner", by Janet Albrechtsen and Stephen Rice. Secondary source: journalists' report of the hearing; no judgment, transcript or court record located	31 March 2026
Magistrate's findings that "the entire conduct of both the police and the DPP" was "egregious", that the delay "put significant prejudice upon a defendant" and that she was "so surprised that the DPP has not made a determination about this matter, even by March 20"; two weeks in custody in October; DPP aware in late January; complainant's phone indicating self-sent anonymous texts on 12 September; DPP statement that the underlying brief was not received until 18 March. Accused and complainant not named	ABC News, by Elizabeth Byrne. Secondary source: journalist's report of the hearing; no judgment, transcript or court record located	28 March 2026, updated 30 March 2026
Arrest 17 October 2025; two weeks' custody; hearing 20 March 2026; discontinuance 27 March 2026; police received phone information 3 December 2025; prosecutors told the defence on 24 January 2026 that the evidence suggested self-sent messages; DPP received complete material 18 March; ACT Policing statement that concerns arose in January but could not be confirmed until forensic examination in March; DPP statement that it "promptly advised" the defence and "proactively sought" complete material. Accused and complainant not named	Region Canberra, by Albert McKnight. Secondary source: journalist's report of the hearing; no judgment, transcript or court record located	2 April 2026

Claim	Source	Date
Quoted statement on suicide and on the effect of the process; two weeks in custody; strict bail conditions; separation from his son; borrowing to meet legal costs	*The Australian*, "Canberra man Thomas Zaja cleared of bikie claims after former partner faked threatening texts", by Janet Albrechtsen and Stephen Rice. Secondary source: journalists' report, including a direct interview	31 March 2026
38 non-homicide deaths 2020–2024, 29 of them suicides; nine deceased people identified as perpetrators subject to a current order; six with police contact within a week of death	ACT DFV Review Biennial Report 2025	2025
No family violence order field in the ACT Suicide Register; no review, audit or analysis ever conducted	ACT Coroners Court advice provided through the Justice and Community Safety Directorate	26 March 2026
Producing suicide and order figures would require review of every recorded suicide case	AFP freedom of information decision LEX 5220	19 February 2026
Eight of 13 deceased victims misidentified as predominant aggressor	ACT DFV Review Biennial Report 2025	2025
"Appears to have a second motive for the allegations, such as a Family Court matter" listed as an indicator	ACT DFV Risk Assessment and Management Framework, Fact Sheet 10	July 2022
Board of Inquiry appointed 22 February 2016, one week after the death of Bradyn Dillon; terms of reference and the exclusion of individual responsibility; multiple reports from education officers; the Camilleri Review "churning" passage and the absence of responsibility for linking the family to services; the internal Community Services Directorate finding on thresholds and cumulative harm; the Muir review finding on recording of decisions and the similar 2013 Auditor-General finding; absence of quality assurance activities on case files; absence of internal merits review other than team leader sign-off and four Decision Review Panel matters since 1 July 2012; SACAT and ACT Policing evidence on disclosure and the subsequent referral and recording changes; the school unenrolment in late October 2015; agencies treating the domestic violence order as a Family Court parenting order	*Review into the system level responses to family violence in the ACT*, Board of Inquiry under the *Inquiries Act 1991*, Laurie Glanfield AM	May 2016

Chapter 13 — Accountability: who owed which duty

In one page

Accountability in a system like this is usually discussed as though it were a question about people. It is more usefully treated as a question about duties. The questions are who was required to do what, whether it was done, and what happened when it was not.

This chapter identifies twelve functions where the official record shows a duty, a gap, and a documented consequence. It names roles, not individuals, except where a public record already attributes a finding, a statement or a decision to a named person.

The pattern across the twelve is consistent. In almost every case the duty existed, was known, and was capable of being performed. What was missing was not capability or intent. It was ownership. Ownership means a named person or body accountable for the specific outcome, with a reporting obligation attached.

That is not an accident of this policy area. It is what happens when a system is built through successive funding packages without a governance layer above them. Each package has an owner. The system has none.

The Glanfield inquiry identified this in 2016 and recommended a coordinating position. The position was created. The gap persisted. Coordination is not the same as accountability.

The chapter also records the other side of the ledger. Much of the diagnosis set out in these chapters exists because people did their jobs well.

An Auditor-General published findings a government did not want. A Director of Public Prosecutions told a committee her office could not prepare matters properly. A legal aid chief executive put rationing on the record. A death review coordinator reported that 8 of 13 deceased victims had been misidentified. A magistrate directed a transcript to professional standards.

An accountable system is not one in which nothing goes wrong. It is one in which what goes wrong becomes visible. Most of what is visible here became visible because someone made it so.

One number, one quote, one action

Number: As at 2 September 2026 no 2023 death review recommendation can be shown on the public record to be fully implemented, and no implementation tracker has been published for any death review or audit recommendation.

Quote: “not getting much preference” — Dr John Boersig, Chief Executive Officer of Legal Aid ACT, on civil, employment and discrimination matters, ACT Legislative Assembly Hansard, 16 September 2025

This week: Publish a status table for the 2023 death review recommendations and the 2024 audit recommendations. One row each: recommendation, named owner, due

date, current status, and the evidence for that status. The information sits inside the directorates. The published table does not exist.

1. How this chapter assigns accountability

1.1 The three-part test

For each entry, the chapter asks:

1. **Was there a duty?** A statutory obligation, a policy requirement, a published commitment, or a recommendation accepted by government.
2. **What does the record show?** Documented evidence of what was and was not done.
3. **What followed?** A documented consequence.

Where all three are present, the entry is included. Where any is missing, it is not.

1.2 Roles, not people

Except where a public record already attributes something to a named person, this chapter names functions.

There are three reasons, and only one of them is legal.

Accuracy. Systems of this kind fail through accumulated design decisions, missing feedback loops and unfunded interfaces. Attributing that to an individual is usually wrong on the facts.

Usefulness. A named function can be fixed. A named person can only be replaced. The successor inherits the same design.

Fairness. Many of the people who held these roles were operating with the information, budget and authority they had. Several of them are the reason the problems are documented at all.

1.3 What is not alleged

Nothing in this chapter alleges bad faith, dishonesty, personal hostility or legal wrongdoing by any person or agency.

2. The duties that existed

Before the individual entries, it is worth listing the obligations that were already in place across the period. None of them is new. None was created by this analysis.

Duty	Source
Manage risk in accordance with AS ISO 31000:2018 across all functions, including health and safety activities, policy development and planning	ACT Government risk management framework and policy
Ensure, so far as reasonably practicable, that the health and safety, including psychological health, of other persons is not put at risk by work carried out as part of an undertaking	*Work Health and Safety Act 2011* (ACT), s 19
Act compatibly with human rights and give proper consideration to relevant human rights when making decisions	*Human Rights Act 2004* (ACT), s 40B

Duty	Source
Make an interim order only where necessary for safety or to prevent substantial property damage	*Family Violence Act 2016* (ACT), s 21
Give paramount consideration to the safety of the affected person and any child	*Family Violence Act 2016* (ACT), s 36
Ensure conditions are the least restrictive that still achieve the Act's objects and give effect to s 36	*Family Violence Act 2016* (ACT), s 37
Consider accommodation needs and options of protected people, the respondent and any child before imposing an exclusion condition	*Family Violence Act 2016* (ACT), s 39
Maintain a register of domestic and family violence deaths and review circumstances biennially	*Domestic Violence Agencies Act 1986* (ACT)
Establish a common evaluation framework and regular performance reporting for levy-funded initiatives	Auditor-General Report 10 of 2024, Recommendation 2, accepted
Monitor and report on implementation of past death review recommendations	Auditor-General Report 10 of 2024, Recommendation 3, accepted
Publish comparable financial and performance reporting of levy-funded initiatives showing planned and actual performance with explanation of variations	Auditor-General Report 10 of 2024, Recommendation 4, accepted

Every entry in the next section concerns one or more of these.

3. Twelve accountability loci

3.1 The central budget and Cabinet process, 2016 to 2024

Duty. To allocate a dedicated levy against identified need, with a strategy and a prioritisation method.

Record. The Auditor-General found that planning and development of levy-funded initiatives was undermined. Two things were absent: a Territory-specific strategy, and an up-to-date understanding of ACT need. From March 2018 the overarching strategy was a national plan that predated the levy. No ACT-specific strategy operated until 27 May 2026.

Consequence. Eight years of allocation without a current statement of need or a cross-portfolio prioritisation method. Crisis response remained 34 to 46 per cent of levy-supported initiatives annually. Prevention remained 12 to 20 per cent. Both figures held despite a repeated commitment to shift upstream.

3.2 The portfolio performance and evaluation function

Duty. To measure whether funded initiatives achieve their intended outcomes, individually and collectively.

Record. The Auditor-General found the responsible office had not developed a performance monitoring strategy or evaluation framework. It also found the office did not effectively use existing monitoring and reporting arrangements to assess performance.

Consequence. No portfolio-level statement of impact exists for the decade. The verdict on value for money is not proven. This is the single finding from which most of the others follow.

3.3 The risk framework owner

Duty. To provide a common framework producing consistent, comparable risk decisions across agencies, compliant with the government's own risk management policy.

Record. The framework published in July 2022 contains no risk criteria and no likelihood or consequence scales. It sets no tolerance thresholds, no treatment option set and no residual risk step. It names no risk owners, and has no framework-level monitoring and no framework-level reporting. Two years after publication, an independent review found agencies using different risk processes and capable of reaching different conclusions about the same case. Four years after publication it was still described as being updated.

Consequence. Risk decisions across the system are not comparable, not auditable, and not capable of being validated. No error rate exists for any of them.

3.4 The primary aggressor decision

Duty. To identify correctly the person most in need of protection.

Record. The available guidance combines evidential indicators with subjective demeanour and attitude cues, and applies a sex-specific list. It provides no coding rules, weighting, thresholds or decision rules, and has no published validation. The 2023 death review recommended a pattern and primary aggressor tool for police and courts. As at 2 September 2026 it was still described as being developed.

Consequence. Eight of 13 deceased victims examined in the 2025 death review had been misidentified as the predominant aggressor. The documented consequences included criminal charges, loss of employment, removal of children and incarceration.

3.5 Whole-of-justice funding and reform governance

Duty. To fund the consequences of reform across the agencies that receive the resulting work.

Record. Police numbers and Supreme Court judicial capacity increased. The Director of Public Prosecutions reported a 50 per cent increase in family violence prosecutions and a 170 per cent increase in sexual violence prosecutions over four years. There was no matching funding increase. Legal Aid ACT reported rationing, and a threshold at 120 per cent of the poverty line against an aspiration of 180 per cent. It also reported that its requested baseline review was not occurring. A transfer of regulatory prosecutions to the Solicitor-General was later reported to have been significantly underestimated.

Consequence. A prosecution service told the Assembly its staff do not have time to prepare matters properly. In the legal assistance service, civil, employment and discrimination matters were "not getting much preference".

3.6 The crisis accommodation and allocation system

Duty. To provide safe accommodation for people leaving violence, and an allocation process that does not consume specialist capacity.

Record. The 2024 review found crisis workers spending a substantially increased share of their time on accommodation searching. The causes were a housing shortage and allocation difficulties. The review found this directly compounded crisis line responsiveness.

Consequence. A 24-hour crisis line that could not answer all calls, with diversion to voicemail overnight and at weekends. In June 2026 the responsible Minister was asked in the Assembly for the current rate of unanswered calls. She said the member would need to ask the service directly.

3.7 Information sharing implementation governance

Duty. To enable lawful, safe information sharing between agencies, first recommended in 2016.

Record. Legislation passed in 2024. Commencement was delayed while framework, protocols and training were developed. Implementation remained continuing work in the 2026 First Action Plan. In 2024–25 the information sharing scheme line recorded a zero estimated outcome and was reprofiled.

Consequence. Ten years after the recommendation, operational implementation was still listed as continuing work. Throughout that period, agencies continued to assess risk on partial information. Both death reviews identify that condition as central to missed patterns.

3.8 Child protection and family service practice

Duty. To keep children visible as victims in their own right. To keep the person using violence visible, rather than transferring responsibility to the non-violent parent.

Record. The Glanfield inquiry found child concern reports rising, few progressing to appraisal or intervention, and referrals rarely followed up. The 2023 death review found children were often not visible as victims. The 2025 review found 67 children affected by 38 deaths, evidence of significant violence against children, and cases where a child discovered the body.

Consequence. Recorded in the 2025 review's second theme: children require a child-centred, trauma-informed approach embedded into risk assessment, information sharing and system responses. That embedding remains an action item.

3.9 Mental health and alcohol and other drug service interfaces

Duty. To recognise and jointly manage family violence risk where it co-occurs with mental illness and substance use.

Record. Both death reviews found these services poorly integrated with family violence responses. Among the 25 people recorded as perpetrators, 24 had a history of problematic substance use and 19 had a mental health condition. Among the 13 recorded as victims, 10 had a reported mental health condition at the time of death. Recommendation 11 of the 2023 review addressed this. The 2025 review found the same picture.

Consequence. The co-occurring conditions are present in almost every fatality. They remain the responsibility of systems that do not routinely share information with the family violence response.

3.10 Community service contracting and grant design

Duty. To fund services at the cost of delivering them.

Record. The 2024 review found funding provided through legacy programs not aligned to demand or true operating costs. It found contracts managed under historical arrangements described as not fit for purpose. A legal service was evaluated as more effective when co-located. It was funded at about $141,000 a year, against an estimated $563,000 for the model the evidence supported. True-cost analysis and a commissioning roadmap remain future actions.

Consequence. Providers meet the gap by under-investing in the functions that are invisible in a grant: data, evaluation, supervision and workforce support. Those are the functions whose absence produces the measurement failures documented in Chapter 10.

3.11 Records and data architecture

Duty. To hold information in a form that allows the system's effects to be monitored.

Record. The ACT Suicide Register has no field recording family violence order status. The police records management system cannot cross-reference order status against mortality data without manual file-by-file review. Court administrative outcome statistics are treated as outside the freedom of information access regime and are not published. No agency has ever examined the relationship between domestic violence proceedings and suicide outcomes. No public dataset shows service access or outcomes by sex, gender identity or victim or perpetrator status.

Consequence. The system cannot detect its own errors. The misidentification rate is unknown. The relationship between its most coercive process and the deaths of the people subject to it is unexamined after 25 years of records.

3.12 Recommendation implementation

Duty. To implement accepted recommendations, and to report on implementation.

Record. The Glanfield inquiry in 2016 identified non-implementation of recommendations as a distinct problem requiring its own solution. The 2023 death review warned that unactioned recommendations perpetuate a cycle of inaction. It warned that the same recommendations resurface in later reviews. The Auditor-General recommended in 2024 that implementation of past death review recommendations be monitored and reported. The 2025 death review made no new recommendations, said the 2023 recommendations remained relevant, and did not publish a status matrix.

Consequence. On the public record as at 2 September 2026, no 2023 death review recommendation can be shown to be fully implemented.

4. What the pattern shows

4.1 The common element

Read the twelve entries together and one element is present in every one: **no named owner for the outcome**. That is the root cause. Section 5 sets out three further forces — the asymmetry between the two kinds of error, time, and the missing less-restrictive option — that explain why it has proved so resistant to correction.

- Nobody owned the question of whether the levy achieved anything.
- Nobody owned the accuracy of the primary aggressor decision.
- Nobody owned the total demand created by justice reform.
- Nobody owned the interface between housing and crisis response.
- Nobody owned the relationship between orders and deaths.
- Nobody owned implementation of the death review recommendations.

In each case the component agencies were doing their work. The prosecution service prosecuted. The police attended. The registry listed. The coroner recorded deaths. The crisis service answered the calls it could. The death review reviewed. None of them was responsible for the outcome that spans them.

4.2 Why coordination did not fix it

The 2016 inquiry saw this and recommended a Coordinator-General for Family Safety to drive coordination, cultural change and oversight. The position was created.

Coordination and accountability are different things. A coordinator convenes, aligns and encourages. An accountable owner is required to produce a result. That owner reports on whether it was produced, and is answerable when it is not.

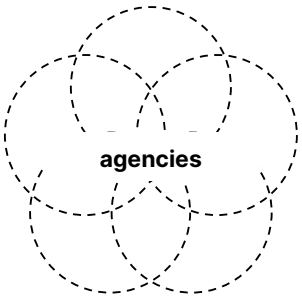
The ACT built the coordination layer and did not build the accountability layer. That is the structural finding of this chapter. Chapter 17 sets out what the accountability layer would contain.

FIGURE 13.1

Coordination and accountability are different things

A coordinator convenes, aligns and encourages. An accountable owner is required to produce a result, reports on whether it was produced, and is answerable when it is not.

THE COORDINATION LAYER



convenes · aligns · encourages

The 2016 inquiry recommended a Coordinator-General for Family Safety to drive coordination, cultural change and oversight. The position was created.

THE ACCOUNTABILITY CHAIN

- A named owner for every outcome — a position, not an agency
- An annual investment and results ledger, planned against actual
- Published court statistics, quarterly
- A published implementation tracker for every accepted recommendation
- Published validation results before full deployment
- Whole-of-system business cases naming who absorbs unfunded demand

Nobody owned the outcome

- the levy achieving anything
- the accuracy of the primary aggressor decision
- the total demand created by justice reform
- the interface between housing and crisis response
- the relationship between orders and deaths
- implementation of the death review recommendations

Each component of the accountability chain converts an internal process into a published artefact. That is what makes failure visible early enough to fix.

A name is not an allocation of blame. It is the address to which a question is sent.

Chapter 13, sections 4 and 7.

4.3 What the Strategy changes

The 2026 Strategy and First Action Plan commit to revised cross-directorate governance, a monitoring and evaluation framework with annual progress reporting, system mapping, true-cost analysis and a commissioning roadmap.

Those are the right components. Whether they produce accountability depends on details not yet published. Three details matter. Does the framework name owners for specific outcomes? Is the annual report published in a form that shows planned against actual? Does anything happen when a target is missed?

Chapter 18 sets out what to look for in the first published report.

5. Why the system looks the way it does

The account so far is that nobody owned the outcome. That is the root cause, and the twelve entries above establish it. It is not the whole cause, and a reform proposal that treats it as the whole cause will fail.

Three further forces are documented in earlier chapters, scattered across them. Read together they explain something the missing-owner finding does not: why exhortation, training and coordination have been tried repeatedly and have not changed the result.

None of what follows is an excuse. It is an explanation of what a competent, well-intentioned decision-maker will do when placed in this structure, and therefore of why the structure has to change rather than the people in it.

5.1 The two errors have wildly different consequences

Every decision in this system can go wrong in two directions.

The first error is failing to protect someone who is then harmed. Where that ends in a death, what follows is a coronial process, a death review, media attention, an internal review, and a decision that can be traced to a person who made it.

The second error is restricting someone who was not a danger. What follows is set out in Chapter 4 and Chapter 7: criminal charges, loss of employment, removal of children, incarceration, loss of housing, a suspended licence, interrupted contact with children. Those are severe. They are also, on the Territory's record, entirely uncounted.

Chapter 11 establishes exactly how uncounted. There is no field in the ACT Suicide Register for order status. There is no queryable flag in the police records system. No review, audit, thematic analysis or annual summary has examined the relationship. No agency records psychological harm, lost work, lost housing or lost contact with children as an outcome of an allegation or an order.

So one error produces an inquiry with a name attached to it. The other produces nothing, because nothing counts it.

5.2 What a rational decision-maker does with that

Put the two together with the third fact this work establishes: the decision-maker has no criteria. Chapter 8 finds no risk criteria, no likelihood or consequence scales, no tolerance threshold and no treatment option comparison in the framework governing the decision.

A person in that position is being asked to make a judgment they cannot justify by reference to any written rule, under time pressure, where one kind of mistake is visible and attributable and the other is invisible.

The rational response is to maximise protection in every case that is not clear.

That is not timidity, and it is not a failure of professionalism. It is the correct individual response to the incentive structure, and it would be produced by any careful person placed in it. A registry officer who grants a marginal application has taken the safe course for themselves and, on the information available, arguably for the applicant. A registry officer who refuses one, and is wrong, will be the subject of the inquiry.

The same logic runs through police attendance decisions, child protection notifications and prosecution decisions. In each, the option that is defensible afterwards is the more restrictive one, because the harm from the alternative leaves no trace in any system that anybody reviews.

Nothing here suggests any person has performed that calculation. No document in the record does, and none is needed. Incentive structures do not require anyone to reason about them. They operate by making one course of action reliably easier to defend than another, and by doing so consistently over years.

5.3 Time is the binding constraint on quality

A structured assessment that is done properly takes time that the system does not have.

Chapter 5 records a crisis line that could not answer all calls, with many diverted to voicemail overnight and at weekends, and crisis workers spending a substantially increased share of their time searching for accommodation. Chapter 6 records the Director of Public Prosecutions telling the Assembly that "my staff simply do not have time to prepare the matters properly", after family violence prosecutions rose about 50 per cent and sexual violence prosecutions about 170 per cent with no commensurate funding increase. Chapter 7 records the statutory two-day timetable for interim orders and the listing of applications before a Registrar within two business days of filing.

A decision that takes twenty minutes to do well and two minutes to do defensively will be done in two when the list is long enough. That is not a training problem and it is not a culture problem. It is arithmetic.

The consequence for the reform proposals in Part III is direct. Reform 2 requires a structured assessment before an order is made without notice. If that assessment is added to the existing workload without the time to complete it, it becomes a form to be signed rather than an analysis to be done, and it will produce worse decisions with better documentation. That is why Chapter 18 costs the workforce implication

and why the Cabinet measure at Chapter 16 section 7 requires a demand and capacity model before any material reform is funded.

5.4 The less restrictive option often does not exist

Section 37 of the *Family Violence Act* requires the least restrictive conditions that still achieve the Act's objects. Section 39 requires the court, before an exclusion condition, to consider the accommodation needs of and options available to the protected people, the respondent and any child, and the time required to find alternative accommodation.

Those provisions assume that an alternative exists.

Chapter 5 documents what happens where it does not. A shortage in the housing system consumed capacity in the crisis system. Where there is nowhere for either party to go, the range of available options narrows to those the court can impose without anyone's cooperation, and the exclusion condition is one of the few.

A least-restrictive rule cannot operate where the less restrictive option has not been funded into existence. The rule is then satisfied formally and defeated practically, and the record will show compliance either way.

5.5 The same asymmetry operates at portfolio level

At the level of a directorate or a Cabinet, the two errors are asymmetric in the same direction and for the same reason.

The cost of a preventable death is large, public and attributable to a portfolio. The cost of a system that restricts people unnecessarily is diffuse, borne by individuals, and attributed to nobody, because no instrument in the Territory counts it. Chapter 3 records the resulting shape of the spending: crisis-weighted, with the measurement and prevention infrastructure repeatedly deferred. Appendix L records that the Strategy places substantive system redesign in the 2028 to 2032 window.

There is a further feature of the same structure, and it should be stated carefully because it is the point at which explanation could slide into allegation. **Building a measurement system creates the possibility of an attributable failure that does not currently exist.** A portfolio with no baseline cannot be shown to have missed a target. That is a property of the arrangement, and it holds whatever anyone intends. It is not a claim that any person or government has declined to measure for that reason, and no document in the record supports such a claim.

It is, however, the reason a commitment to measure has to be structural rather than voluntary. Chapter 17 sets out the instruments.

5.6 Why this matters for the fix

Every one of these forces makes exhortation useless.

Training tells a decision-maker to consider the less restrictive option. The incentive tells them that choosing it exposes them and choosing the other does not. Coordination convenes the agencies. It does not change what any of them is rewarded for. A framework published in 2022 asked for consistent practice, and Chapter 5 records agencies still using different risk processes, capable of reaching different conclusions about the same case, two years later. That is what happens when a document is issued into a structure that rewards something else.

So the fixes in Part III are structural by necessity rather than by preference, and each of them attacks one of the forces above.

- **Criteria** give a decision-maker a written basis on which to justify the less restrictive option. Without them, the only defensible answer is the most protective one.
- **Recorded reasons** make the second error visible for the first time, which is the precondition for it being weighed at all.
- **Measurement in both directions** ends the asymmetry at its source. An error that is counted can be weighed against an error that is counted.
- **A demand and capacity model** funds the time without which a structured assessment becomes a signature.
- **Housing and income treated as safety measures** create the less restrictive option that section 37 assumes.
- **A named owner for each outcome** converts a diffuse, unattributed cost into one somebody is answerable for.

None of that removes the underlying tension. Protecting people from violence and avoiding unnecessary restriction will sometimes conflict, and no framework dissolves that. What a framework can do is make both sides of the conflict visible, so that the trade-off is made deliberately and recorded, rather than settled in advance by which mistake is more dangerous to the person making it.

A note on how this section should be read. It is not a defence of the outcomes documented in Part I and Part II, and it does not reduce anyone's responsibility for them. Its purpose is to explain why a decade of good-faith effort by capable people produced this result, and therefore why the remedy has to change the structure rather than ask harder. A reform proposal that assumes the frontline simply needs to be told again has not understood what it is looking at.

6. The other side of the ledger

Almost everything documented here is known because someone in the system made it known. That should be recorded with the same precision as the failures.

The following individuals are named because a public record attributes the finding, statement or decision to them.

Laurie Glanfield AM. His 2016 inquiry supplied the foundational diagnosis: fragmentation, an absence of information-sharing culture, children falling out of view,

and the failure to implement recommendations. Every substantive problem examined in these chapters was named in that report.

The ACT Auditor-General. Report 10 of 2024 is the only independent, whole-of-portfolio assessment in the decade. Its findings — no Territory strategy, no current needs assessment, no performance monitoring strategy or evaluation framework, and public reporting that did not allow performance to be assessed — are the backbone of Chapters 2 and 3. The levy principles, the improved 2026–27 budget disclosure and the evaluation commitments in the First Action Plan all follow from it.

Victoria Engel SC, Director of Public Prosecutions. In evidence to Assembly hearings she documented the volume increase in family and sexual violence prosecutions, stated that there had been no commensurate funding increase, and said plainly that her staff do not have time to prepare matters properly. That is the clearest available account of how family violence reform transfers cost into the justice system.

Dr John Boersig, Chief Executive Officer of Legal Aid ACT. He put on the parliamentary record that civil, employment and discrimination matters were not getting much preference, that the funding threshold reached 120 per cent of the poverty line against an aspiration of 180 per cent, and that the requested baseline review was not occurring. Without that evidence, the downstream cost of family violence prioritisation would be invisible.

The Domestic and Family Violence Review Coordinator and team. The 2025 report published the finding that 8 of the 13 deceased victims examined had been misidentified as the predominant aggressor. That is the most uncomfortable finding in the Territory's record, and it was published by the Territory itself. Both reports also record their own methodological limits candidly, which is what makes them usable as evidence.

Dr Kate Fitz-Gibbon and Dr Hayley Boxall. Independent advisers to the 2025 review, contributing to its development of the non-homicide fatality themes.

Yvette Berry MLA. As the responsible minister through much of the formative period, she advanced the Safer Families package, the levy, dedicated system leadership, the risk framework and multiple service reforms. The delayed strategy and weak performance reporting also fall within that period. Both statements belong in the same entry. The Auditor-General's findings are about the portfolio, not the office-holder.

Dr Marisa Paterson MLA. As responsible minister she led the release of the 2026 Strategy and First Action Plan, the government's coercive control bill, and the largest and most transparent single funding package in the public record for this portfolio.

Leanne Castley MLA. She introduced the 2024 private member's coercive control bill and sustained parliamentary pressure for education, readiness and criminalisation across two Assemblies.

Sue Webeck, Chief Executive Officer, Domestic Violence Crisis Service. She contributed to major reviews and legislative inquiries and pressed publicly for practical coercive control readiness.

Magistrate Jane Campbell. In March 2026 she described the conduct of police and prosecutors in a matter before her as egregious, awarded costs and directed that the

transcript be provided to the Chief Police Officer and to AFP Professional Standards. That is accountability functioning as designed.

Others. Victim-survivors who gave evidence to reviews and inquiries. Aboriginal Community Controlled Organisations and the authors of *The Long Yarn*. The Canberra Rape Crisis Centre's leadership and staff. Frontline workers in both crisis services. Women's Health Matters, the Women's Legal Centre and Legal Aid practitioners. ACT Policing family and sexual violence specialists. Committee members across parties who asked the questions that produced the Hansard record relied on throughout.

7. What accountability would look like

Six changes would convert the current coordination layer into an accountability layer. Each is developed in Chapters 15 to 17.

1. A named owner for every outcome in the Strategy. Not an agency — a named position, published, with the outcome it is accountable for.

2. An annual investment and results ledger. Planned against actual, by initiative, published. Appendix F.

3. Published administrative statistics from the courts. Applications, interim orders, orders made without notice, outcomes and timeliness, quarterly.

4. A published implementation tracker for every accepted recommendation. Owner, due date, status, evidence. Appendix H.

5. Published validation results for every risk and classification instrument before full deployment. Chapter 15.

6. Whole-of-system business cases. No material justice or service reform funded without a published demand and capacity model naming who absorbs unfunded demand. Chapter 16.

The common feature is that each converts an internal process into a published artefact. A system that publishes planned against actual makes failure visible early enough to fix.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. The complete set of 12 is at Appendix M, where it can be read against every other chapter's.

- **F13.1** — Across twelve functions, the record shows a duty, a documented gap and a documented consequence, and in every case the missing element is a named owner accountable for the outcome.
- **F13.5** — The primary aggressor decision is made using guidance with no coding rules, weighting, thresholds or validation, and eight of 13 deceased victims examined in 2025 had been misidentified.
- **F13.11** — Coordination was established in 2016 and accountability was not; the two are different, and the distinction explains the pattern across all twelve entries.
- **F13.12** — Most of what is documented here is known because an Auditor-General, a Director of Public Prosecutions, a legal aid chief executive, a death

review coordinator, a magistrate and a series of committee members put it on the public record.

Sources for this chapter

Claim	Source	Date
Risk management required across all functions	CMTEDD Risk Management Framework and Policy v7.0	July 2023
Primary duty of care including psychological health of other persons	*Work Health and Safety Act 2011* (ACT), s 19	—
Public authority duty to act compatibly with human rights	*Human Rights Act 2004* (ACT), s 40B	Effective 17 March 2025
Interim order test, paramountcy, least restriction, exclusion factors	*Family Violence Act 2016* (ACT), ss 21, 36, 37, 39	Effective 1 July 2025
Death review register and biennial review function	*Domestic Violence Agencies Act 1986* (ACT)	Function established 2021
No Territory strategy; no current needs assessment; no performance monitoring strategy or evaluation framework; reporting not transparent or effective; Recommendations 1 to 4; crisis and prevention shares	ACT Auditor-General, Report 10 of 2024	22 November 2024
Framework content and absence of criteria, treatment options, residual risk, owners, monitoring and reporting	ACT DFV Risk Assessment and Management Framework	July 2022
Agencies using different risk processes and reaching different conclusions; accommodation time consuming crisis capacity; legacy contracts not fit for purpose; co-located legal service funding	ACT DFSV Crisis Specialist Services Review Summary	May 2024
Prosecution volume increases; no commensurate funding; staff do not have time to prepare matters properly; Legal Aid rationing, threshold and baseline review	ACT Legislative Assembly Hansard, 16 September 2025; Standing Committee inquiry into Annual and Financial Reports 2024–25	2025–2026
Minister's answer on unanswered crisis line calls	ACT Legislative Assembly Hansard (proof), 10 June 2026	10 June 2026
Misidentification of 8 of 13 deceased victims; 67 children affected; 24 of 25 perpetrators with problematic substance use and 19 of 25 with a mental health condition; 10 of 13 victims with a reported mental health condition at the time of death; children not visible as victims	ACT DFV Review Biennial Reports 2023 and 2025	2023, 2025
No field in the Suicide Register; police system cannot cross-reference; no analysis ever undertaken; court statistics refused	ACT Coroners Court advice through JACS FOI, 26 March 2026; AFP FOI decision LEX 5220, 19 February 2026; JACS FOI decision 2026/496, 2 February 2026	2026
Fragmentation, information sharing culture, child concern reports, non-implementation of recommendations	Glanfield, *Review into the system level responses to family violence in the ACT*	May 2016
Magistrate's remarks, costs award and referral of transcript	*The Australian*, 31 March 2026	31 March 2026
Strategy governance, monitoring and evaluation framework, system mapping, true-cost analysis, commissioning roadmap	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026

Part III — How to fix it

Chapter 14 — Design principles for a framework that works

In one page

Part II identified what is missing. This chapter states the twelve principles that should govern the replacement. They are stated as rules, because a principle that cannot be applied to a decision is not a principle.

The first two already open Part II. Chapter 8 states and argues them: the instrument rates the option, not the person; and two risks are rated separately and never averaged. They are restated below in short form.

None of this is novel. All of it is ordinary risk practice. The novelty is applying it here.

One number, one quote, one action

Number: Nine. Between 2020 and 2024, nine people in the ACT died by non-homicide means while subject to a current family violence order. Principle 2 exists because R2 is also a safety risk.

Quote: "A court must ensure the conditions included in a family violence order are the least restrictive of the personal rights and liberties of the respondent as possible that still achieve the objects of this Act and give effect to section 36." — *Family Violence Act 2016* (ACT), s 37, in force 1 July 2025

This week: Score the risk assessment form an agency uses now against the twelve rules below. Count how many it satisfies. It takes an hour, uses no client data, and the count is the agenda for the next review.

The twelve principles

#	The rule	Where it is implemented
1	The instrument rates courses of action. It does not score a person.	Chapter 8; Chapter 15 §2.3; Appendix B
2	Two risks — R1 harm, R2 hardship and rights limitation — are each written as one sentence naming source, event, consequence, person affected and period, and are rated separately and never averaged.	Chapter 8; Chapter 15 §3.1; Appendix C
3	Every item is established, reasonably open or unknown. There is no blank.	Chapter 15 §4.2–4.3; Appendix B
4	A protective measure counts only if someone has verified it is operating.	Appendix E; Chapter 15 §4.5
5	Each person's own account of their risk is a primary input, for every person.	Chapter 15 §5.2; Appendix A §4.2.2; Appendix B
6	Classification may be recorded as unresolved, with a defined response.	Chapter 15 §5.2 and §5.6

#	The rule	Where it is implemented
7	A check that was run and returned nothing is recorded as run, nil.	Chapter 15 §4.3; Appendix B
8	Every rating carries a confidence level, and source is rated separately from claim.	Chapter 15 §3.6; Appendix D
9	Consequence scales distinguish harm that can be repaired from harm that cannot.	Appendix C; Chapter 15 §3.4
10	Completing the instrument generates the monitoring data as a by-product.	Chapter 15 §4.8 and §8.1
11	Every element must be testable. Untestable observations are recorded, not rated.	Chapter 15 §5.3
12	Nothing is deployed before its performance is measured and published.	Chapter 15 §9.1; Chapter 18

Two further principles, about implementation rather than content, are at section 14. Section 13 sets out what a person's own account of their risk can and cannot carry, which is the reasoning behind Principle 5.

1. Principle 1 — Rate the option, not the person

The rule. The instrument assesses courses of action. It does not produce a risk score attached to an individual.

Chapter 8 sets out why. One further point belongs here: rating options changes the error mode. A wrong person-score produces a mislabelled person, and nothing invites anyone to look again. A wrong option comparison produces a choice, and a choice can be revisited.

The instrument rates each available option against the two risks. Appendix B is the worked form.

2. Principle 2 — Two risks, assessed separately, never averaged

The rule. R1 is the risk of harm to the person needing protection, any child and any other affected person. R2 is the risk of avoidable hardship and rights limitation to the person restricted, or a child in their care. R1 sets the floor; R2 chooses among the options that meet it and never lowers it. The two are never combined into one figure.

Chapter 8 sets out the reasoning, including why recording R2 cannot reduce safety. One further point belongs here: R2 is itself a safety matter. Chapter 11 records nine deaths under a current order in five years, with suicide in several cases appearing to punish victims. Where a restriction produces a catastrophic response aimed at the protected person, ignoring R2 was not the safe choice. Appendix C sets out the scoring.

3. Principle 3 — Unknown is a recorded state

The rule. Every item is recorded as **established**, **reasonably open**, or **unknown**. There is no blank and there is no "no" box.

"We checked and found nothing" and "we did not check" are different states. A system that records them identically will read the second as the first. That matters most under the time pressure in which these assessments are made. Any assessment done in twenty minutes will have unknowns. Making them visible is the difference between a fast assessment and an inaccurate one.

An unknown that blocks a decision is closed or worked around: the fact is obtained, or a reversible safeguard is applied and reviewed quickly. The unknown is never scored as low.

Of the two bills before the Assembly at the evidence cut-off, the first requires an officer to consider a list of matters "as far as is reasonably practicable" and requires no record of which were unknown; the second requires no record before charge at all. The assessment forms drafted at Appendix G9.1 and G9.8 apply this principle to both (Chapter 19 §§2.9, 3.6).

4. Principle 4 — An unverified control is not a control

The rule. A protective measure counts only if someone has confirmed it is operating. Every control has a named owner, a time, a proof standard, and a response if it fails. An unverified control is recorded as **failed**, not assumed.

This is the most common failure in risk practice, and it recurs throughout Part II. An order is not a control until it is served. A firearms suspension is not a control until the firearms are removed. Chapter 12 gives the illustration: a phone seized for examination had an owner and a deadline, and seven months without delivery was a control assumed.

Appendix E sets out the seven tests: relevant, authorised, deliverable in time, owned, verified, effective, and fail-safe.

5. Principle 5 — The person's own account is a primary input, for every person

The rule. Each person's own assessment of their risk is recorded, in their own terms, as a primary input. This applies to every person the instrument concerns, not one of them.

The evidence base for treating a survivor's own assessment as a strong indicator is good, and the national principles state it directly. Applying it to one party only turns that evidential principle into a rule about who is believed. Chapter 9 sets out the problem.

Where the accounts conflict, the instrument does not resolve it by reference to sex. It records both accounts with their sources and looks for pattern and corroboration. Where no pattern is established, Principle 6 applies.

The second half of the rule is that an account is a primary input and is not by itself a rating. Section 13 sets out the reasoning, the literature and the failure mode already present in the Territory's current instrument.

6. Principle 6 — Classification may be left unresolved

The rule. The instrument permits the answer **cannot be determined on the available information**, and specifies what to do in that case.

Forcing a classification on inadequate information does not make it correct. It produces a recorded classification, which is worse, because it looks like a finding.

The decision-maker then selects measures that do not depend on the classification being correct: separation at court, remote appearance (which the Bill before the Assembly would put on a statutory footing, with leave, at new section 44B — Chapter 19 §2.2), expedited listing, firearms action, and address protection for both parties. Reciprocal non-contact conditions belong on that list only if a magistrate is given the power to make them, and Chapter 16 §4.4 puts that power as a question rather than a recommendation. Chapter 15 §5.6 sets out the safeguards.

7. Principle 7 — Nil results are results, and are recorded as such

Restated from Principle 3 because it is routinely lost in practice. A check that was run and returned nothing is recorded as **run, nil**. A criminal history check returning nothing means no recorded history. It does not mean no history, and it is not silence.

8. Principle 8 — Every rating carries a confidence level

The rule. Every risk rating carries a confidence level — low, medium or high — and a one-line reason.

A rating of "high" drawn from an official record and one drawn from a single uncorroborated account are different states of knowledge, and justify different responses. A high rating with low confidence is an instruction to obtain more information quickly, not a settled conclusion.

Source and claim are rated separately, using the register at Appendix D. A reliable source can report something implausible, and an unreliable source something true and independently corroborated.

9. Principle 9 — Consequences that cannot be undone are weighted accordingly

The rule. The consequence scales distinguish harm that can be repaired from harm that cannot. For harm to a protected person, the highest level is death. For hardship to a restricted person, it is **loss that cannot be unwound before the matter is heard**: a tenancy lost, a job ended, an occupational authority not quickly restored.

The two scales are not equivalent, and nothing on the second is death. But reversibility is a real property of a decision. A restriction lifted in three days at a return hearing differs from one that has already cost a tenancy. Where two options give the same protection, the reversible one is preferred. Where an irreversible consequence is unavoidable, the decision is made at a higher level of authority, with reasons recorded and the shortest review interval. Appendix C sets out both scales.

10. Principle 10 — The instrument must produce data

The rule. Every instrument is designed so that completing it generates the data required to monitor and validate it, as a by-product of ordinary use.

Chapter 10 documented that the ACT cannot report on its own system: the data does not exist in usable form, because the forms in use were never designed to produce it. An instrument with defined fields, coded values and structured options produces a dataset. Free-text boxes produce paper.

Each completed assessment yields date, setting and assessor role; the options selected and rejected; both risk ratings before and after controls, with confidence; every item's status; every control, with owner and verification status; the residual risk accepted and by whom; and a case identifier permitting linkage to outcomes. Chapter 15 §8.1 sets out what is reported above case level.

11. Principle 11 — Every element must be testable

The rule. Every item in the instrument must be capable of being tested for whether it improves accuracy. Items that cannot be tested do not count towards a rating.

Chapter 9 set out the problem with untestable indicators. An impression cannot be falsified, reviewed or validated. It is not discarded, because an experienced assessor's impression is information. It is recorded in a designated section, visible to any reviewer, and excluded from the rating. Chapter 15 §5.3 lists the exclusions.

12. Principle 12 — Nothing is deployed before it is validated

The rule. No instrument goes into general use before its performance is measured and published.

Four things are required first. **Inter-rater reliability**, measured on standardised vignettes across the roles that will use it. **A validation plan** for predictive performance, with a date. **Published error analysis by cohort** within a stated period. And **a review trigger**: the level of measured error that would withdraw or revise the instrument.

The last is usually left out. An instrument with no withdrawal trigger cannot fail. It can only be criticised. Chapter 15 §9.1 sets out the pre-deployment tests.

13. What a person's own account can and cannot carry

Principle 5 says that each person's own account of their risk is a primary input, for every person. This section supplies the reasoning, because the principle has two halves and only the first is uncontroversial.

The position taken here can be stated in one line. **An account of lived experience is necessary and insufficient.** Necessary, because it is the only source for some of what a system needs to know. Insufficient, because it cannot by itself establish how often something happens, what caused it, or whether a classification was correct.

Nothing in this section is an argument that survivors should be listened to less. The argument is about what a given kind of evidence can carry, and it applies with the same force to the documentary evidence these chapters are built on. A freedom of information decision establishes what an agency holds. It does not establish what happened in anyone's kitchen.

13.1 Why the account is necessary

Start with what only a first-person account can supply.

It supplies meaning. Two people can experience the same set of recorded events and be in entirely different danger, and the difference lives in the pattern, the history and the intention behind it, none of which is in an incident record.

It supplies barriers. No administrative dataset records why a person did not call, did not leave, or withdrew a statement. In the ACT record those reasons are on the page only because people said them. A joint submission to the 2026 coercive control inquiry by Sisters in Spirit Aboriginal Corporation and Women's Health Matters records participants describing exactly that: "A lot of people are scared like to go into the police and child safety, because once [you say] domestic violence is involved, it's straight to boom, like, you know, 'your kids are unsafe'." And: "A lot of women share the fear of, like, what the system will do to their partners as well... when a woman comes forward to report violence, and then she'll retract the statement."

It supplies the system's own effects on the people inside it. The same submission records participants describing institutions as reproducing the dynamics of the relationships they had left: removing autonomy, punishing attempts to get needs met, isolating people from support. That is a finding about the system. No agency dataset contains it, because no agency collects it.

And it supplies the error that this work is largely about. Misidentification is documented in the ACT because people said so, and because researchers listened. The national work the Territory's own Strategy cites for this point is built on accounts of what happened to people who were recorded as the aggressor. The death review found the error in 8 of the 13 deceased victims it examined by reading records against the pattern those accounts describe. Standpoint evidence located an error that the administrative data was, by construction, incapable of reporting: a dataset that records a classification cannot record that the classification was wrong.

13.2 Why the account is insufficient

Five limits apply. Each is stated neutrally, and each has a source.

Epistemic over-reach. The strong version of the claim is that a person who has experienced something has privileged and unchallengeable knowledge about it. The scholarship most sympathetic to standpoint epistemology does not support that version. Friesen and Goldstein argue that a marginalised social location does not by itself confer an epistemic advantage; the advantage arises where that location is combined with critical engagement, meaning reflection on how power shapes what counts as knowledge. They also warn expressly against tokenisation and against essentialising the category. So the case for standpoint evidence is conditional, and the conditions are stated by its own proponents.

Recall is reconstructive, and this cuts the other way. The evidence here is frequently misused, so it is worth stating precisely. A review of 11 studies by Mattsson, Sonne and Carlsson found that the memory of trauma is as accurate in people with post-traumatic stress disorder as in people without it. The only consistent difference across the studies was that recollection of a trauma shifts over time. That is

a finding about ordinary human memory, which is reconstructive for everyone. Its operational implication is the opposite of the one usually drawn: variation between a person's account today and their account six months ago is the expected behaviour of memory, and is not evidence that either account is false. A system that treats inconsistency as a credibility test is misreading the research. What the finding does establish is that an account is a recollection rather than a recording, which is a reason to corroborate it where corroboration exists, not a reason to discount it where corroboration does not.

Methodological limits. Accounts gathered for research or consultation are gathered from people who came forward, which is not a random sample of the people concerned. They are produced in a social setting: Priestley and Mazzoli-Smith argue that an interview is a social practice in which the researcher participates, and that experience data should not be treated as a transparent representation of reality. People also describe their experience in the language available to them, which is shaped by the same policy discourse the account is being used to evaluate. And "lived experience" is not one category. The experience of an Aboriginal woman in Canberra, a man who is a victim of partner violence, and a person misidentified as an aggressor are not interchangeable, and a single representative cannot speak for all of them.

Policy misuse. Two failure modes recur. The first is the account used as a conclusion rather than as evidence, where "we heard from victim-survivors" ends an argument instead of opening one. The second is circular citation, where a policy document cites a consultation, a later document cites the policy, and the chain is mistaken for accumulating evidence. Smith-Merry's analysis of experiential knowledge in evidence-based policy makes the underlying point: validity is context-dependent, and knowledge that is valid in one setting does not transfer to another without a translation step. Appendix L finding L11 records what happens when the translation step is skipped: the ACT Strategy uses consultation in the place a demand and gap analysis would occupy.

Normative risks. Who is in the room shapes what is heard. Unpaid or single-seat lived-experience positions select for people who can afford to attend and can survive the role, which is why the submission by Elisabeth Yar to the same inquiry asks for representation that is "paid, trauma-informed, supported and plural rather than tokenistic". And an account can be shaped by the scripts a person has been offered. A system that recognises one story about who is a victim will hear that story back.

13.3 The operational conclusion

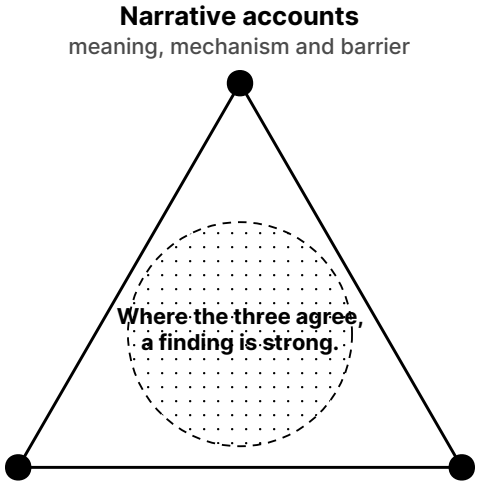
Two conclusions follow, one for research and one for the instrument.

For evidence: triangulate. No single stream answers the question on its own. Narrative accounts establish meaning, mechanism and barrier. Administrative data establishes frequency, distribution and change over time. Quasi-experimental evaluation establishes whether an intervention did anything. Where the three agree, a finding is strong. Where they disagree, the disagreement is the finding, and it is published rather than resolved by preference. That is the standard applied to the documentary record throughout these chapters, and it is the standard applied here.

FIGURE 14.1

Three streams, and what each can carry

No single stream answers the question on its own. An account of lived experience is necessary and insufficient.



Where they disagree, the disagreement is the finding, and it is published rather than resolved by preference.

Two failure modes recur

- the account used as a conclusion rather than as evidence, where “we heard from victim-survivors” ends an argument instead of opening one
- circular citation, where a policy document cites a consultation, a later document cites the policy, and the chain is mistaken for accumulating evidence

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A narrative account cannot establish how often something happens, what caused it, or whether a classification was correct. A dataset that records a classification cannot record that the classification was wrong.

Chapter 14, section 13.

For the instrument: a primary input is not a rating. A person's own account of their risk is recorded, in their own terms, for every person the instrument concerns. It then enters the analysis as one input among several, with its source and its confidence recorded under Principle 8. It does not become the risk rating by itself, in either direction. A person who rates their own risk as low does not thereby produce a low rating, and a person who rates it high does not thereby produce a high one. The rating is the output of the analysis, and the analysis has to be able to say what the account contributed to it.

13.4 The failure mode is already in the Territory's instrument

This is not a hypothetical problem raised against a system that does not have it.

The July 2022 ACT framework asks a person to rate their own risk on a scale of one to ten. It states no rule for what any number on that scale means, and no rule for what it does. A seven does not raise a rating, trigger a response, or require anything to be recorded. The number is collected and then nothing happens to it.

That is the exact failure this section describes, in both directions at once. The account is solicited, which is right. It is then given no defined weight, which means its influence on the outcome is whatever the individual assessor decides it is, and is not recorded, not auditable and not comparable between assessors. Collecting an account and giving it no stated function is not respect for the account. It is the absence of a method.

Appendix A section 4.2.2 supplies the missing rule: what a rating at each level does to R1, what a large gap between the person's rating and the assessed rating requires, and what must be recorded when the two diverge. That rule is what makes the account count for something specific rather than for whatever the reader wishes.

14. Two principles about implementation

The twelve above concern the instrument. Two more concern how it is put into use, and both come from Part II.

14.1 Alignment must be required, not encouraged

The 2022 framework was published and agencies were encouraged to use it. Two years later they were using different processes and reaching different conclusions.

The comparison jurisdiction instead requires prescribed organisations to progressively align their policies, procedures, practice guidance and tools, with public implementation architecture. That is the difference between publication and implementation. The mechanism can be statutory or contractual, but it must name the organisations, define alignment, set a timetable and require reporting.

14.2 The workforce must be funded to do it

An instrument that takes twenty minutes to complete properly, applied to a workload sized for a five-minute process, will be completed badly. Chapter 5 documented crisis workers losing time to accommodation searching, and Chapter 6 a prosecution service without time to prepare matters. Chapter 18 introduces the instrument with a funded time allocation.

15. What these principles rule out

Stating the exclusions stops the proposal being read as compatible with everything. They rule out:

- a single risk score attached to a person;
- averaging protection against restriction;
- treating an unchecked item as absent;
- counting an unverified protective measure;
- demeanour cues contributing to a classification;
- sex-specific indicator lists applied to individuals;
- forcing a classification where the information does not support one;
- deploying an instrument without published inter-rater reliability;
- free-text forms that generate no data; and
- publishing a framework without a mechanism requiring alignment.

What this chapter established

Five findings, which are the chapter. The chapter's findings are registered at Appendix M under the numbers below.

- **F14.1** — Twelve rules govern the replacement instrument. The table states each one and where it is implemented.
- **F14.2** — Principles 1 and 2 are argued in Chapter 8. Rating options changes the error mode, and R2 is itself a safety risk.
- **F14.3** — The recording rules: established, reasonably open or unknown for every item; run, nil for a completed check; a confidence level on every rating; untestable observations recorded but excluded; unresolved classification permitted, with options that do not depend on it.
- **F14.4** — The decision rules: a control counts only if verified against the seven tests; each person's own account is a primary input; conflicts are resolved by pattern and source, not by sex; and reversible consequences are preferred where protection is equal.
- **F14.5** — Nothing is deployed before measured performance and a withdrawal trigger are published, alignment is required rather than encouraged, and the workforce is funded for the time the instrument takes.

Sources for this chapter

Claim	Source	Date
Paramountcy, least restrictive conditions, accommodation needs	*Family Violence Act 2016* (ACT), ss 36, 37, 39	Effective 1 July 2025
Nine non-homicide deaths under a current order, 2020–2024; suicide used to punish victims	ACT DFV Review Biennial Report 2025	2025

Claim	Source	Date
Framework published and use encouraged, without criteria, treatment options, residual risk, owners or reporting	ACT DFV Risk Assessment and Management Framework	July 2022
Agencies using different risk processes; accommodation searching consuming crisis capacity; no time to prepare prosecution matters; system data not in usable form	ACT DFSV Crisis Specialist Services Review Summary; ACT Hansard, 16 September 2025; Auditor-General Report 10 of 2024	2024–2025
Prescribed organisations must progressively align policies, procedures, guidance and tools; survivor's own knowledge of risk central to assessment	Victorian multi-agency framework (the comparison jurisdiction's framework); national principles and ANROWS update project	Current; 2025–2026
Standpoint requires marginalised location combined with critical engagement; warning against tokenisation and essentialisation	Phoebe Friesen and Jordan Goldstein, "Standpoint Theory and the Psy Sciences: Can Marginalization and Critical Engagement Lead to an Epistemic Advantage?", *Hypatia* 37(4), 659–687	2022
Memory of trauma is as accurate in people with PTSD as in those without; the one consistent difference across studies is that recollection shifts over time	A M Mattsson, C Sonne and J Carlsson, "The Accuracy of Traumatic Memories in Posttraumatic Stress Disorder: A Review", *Journal of Nervous and Mental Disease* 209(3), 218–227	2021
An interview is a social practice; experience data should not be treated as a transparent representation of reality	Michael Priestley and Laura Mazzoli-Smith, "The Epistemology and Ethics of Analysing Lived Experience Data", *International Journal of Qualitative Methods* 22	2023
Validity is context-dependent; experiential knowledge requires a translation step to function as policy evidence	Jennifer Smith-Merry, "Evidence-based policy, knowledge from experience and validity", *Evidence & Policy* 16(2), 305–316	2020
Participant accounts of fear of child removal, retraction of statements, and institutions reproducing coercive dynamics	Submission 022, Sisters in Spirit Aboriginal Corporation and Women's Health Matters, Inquiry into the Crimes (Coercive Control) Amendment Bill 2026, ACT Legislative Assembly Standing Committee on Legal Affairs	Authorised for publication 5 August 2026
Lived-experience representation should be paid, trauma-informed, supported and plural rather than tokenistic	Submission 002, Elisabeth Yar, Inquiry into the Crimes (Coercive Control) Amendment Bill 2026, ACT Legislative Assembly Standing Committee on Legal Affairs	Authorised for publication 1 July 2026
Current framework asks the person to rate their own risk from 1 to 10 and states no interpretation rule	ACT DFV Risk Assessment and Management Framework	July 2022

Chapter 15 — A rewritten risk assessment and management framework

In one page

This chapter describes a replacement for the ACT Domestic and Family Violence Risk Assessment and Management Framework. The complete instrument is at Appendix A. The risk criteria are at Appendix C, the source register at Appendix D, and the control test at Appendix E.

The replacement keeps most of what the current framework does. It keeps structured professional judgment, the evidence-based risk factors, and coercive control as a pattern. It keeps the focus on children, intersectionality, perpetrator accountability, and coverage of generalist as well as specialist services. And it keeps the person's own assessment as a primary input.

It adds the six components the current framework lacks: defined risk criteria; a full treatment option set; a residual risk statement with a named acceptor; named risk owners; framework-level monitoring; and framework-level reporting.

It changes five things. Screening is applied to all clients rather than to one group. The screening design is recorded, so the resulting data can be interpreted. Risk factors are weighted according to evidential strength and coded with explicit rules. The mental illness item is separated into its two components. And the primary aggressor material is replaced with a new classification method. That method uses evidence and pattern rather than demeanour. It applies to any person, and it permits the answer "unresolved".

It requires two things the current framework does not. First, prescribed organisations must align to it on a published timetable and report on alignment. Second, no version is deployed in general use until inter-rater reliability has been measured and published. The framework must also state the result that would trigger withdrawal.

None of this reduces protection. Every element that determines how much protection is required remains unchanged.

One number, one quote, one action

Number: Zero validation results have been published for the current framework; the replacement permits no version to enter general use until inter-rater reliability has been measured and published, with a stated withdrawal trigger.

Quote: "there is no definitive set of indicators that can be used to determine the primary aggressor" — ACT DFV Risk Assessment and Management Framework, Fact Sheet 10, July 2022

This week: Run the vignette test. Send one standardised case to every role that assesses risk — police, registry, crisis service, health, child protection — ask each assessor to rate it and to say who is using violence, and publish the level of agreement. It uses no client data, and would be the first published measurement of consistency in ACT family violence risk practice. Appendix O specifies the study.

This framework is unvalidated, by its own standard, and must not be deployed until that is fixed.

The preceding chapters criticise the Territory for using an instrument whose reliability has never been measured. The replacement described here has never been used, so no reliability figure exists for it either. That is not a smaller version of the same problem. It is the same problem, and the criticism applies with full force.

Three things follow, and they are stated here rather than in a concluding section because a reader is entitled to know them before reading the proposal.

One. No version of this framework is used on any person until inter-rater reliability has been measured on standardised vignettes and the result published, whatever it shows. Appendix O specifies the study: the vignettes, the assessor sample, the statistic and the reason for choosing it, and the analysis plan.

Two. The result that would require withdrawal is stated in advance, publicly, before the data is collected. For the classification decision it is a kappa below 0.40, or a lower confidence bound below 0.40. On that result the framework is not deployed for classification, whatever else is true of it and whatever has been invested in it.

Three. If it performs no better than the instrument it replaces, the reliability case for replacement fails. The remaining case would rest on the ISO 31000 conformance findings in Chapter 8. That is a separate argument, and it would have to be made on its own rather than carried by this one.

This is the whole point rather than a caveat attached to it. An instrument that publishes the result that would condemn it, before it knows what the result will be, is doing the thing the current arrangement does not do. If the replacement fails its own test and is withdrawn on that basis, the method will have worked.

1. What changes, in summary

	Current framework	Replacement
Structured professional judgment	Yes, without coding rules or formulation	Yes, with coding rules, formulation and defined scenarios
Risk criteria	None	Defined likelihood and consequence scales, combination rule, tolerance statement
Risk factors	Listed, unweighted, mixed evidential strength	Weighted into three tiers, each with a coding rule
Screening	All women	All clients, with the screening design recorded
Person's own assessment	Collected as 1 to 10, no interpretation rule	Recorded in the person's own terms plus a scaled item, with a defined interpretation rule, for every person
Mental illness item	Combined with suicide threats	Separated; suicide threat retained as a risk factor, diagnosis recorded as context only
Two risks	Not distinguished	R1 and R2 rated separately, never averaged
Treatment options	Safety planning and referral	Full option set with a requirement to compare and justify
Controls	Not tested	Seven-part effectiveness test, named owner, verification, failure response
Residual risk	Not stated	Stated, with a named acceptor
Risk owners	None	Named for each risk

	Current framework	Replacement
Classification of who is using violence	Sex-specific demeanour indicators	Evidence and pattern method, sex-neutral, with an unresolved option
Unknown information	Not distinguished from absent	Recorded as a distinct state
Monitoring	Case level only	Case level plus framework level, with indicators and owners
Reporting	Case templates only	Framework-level reporting standard with content, frequency and audience
Alignment	Encouraged	Required, with a published timetable and reporting
Validation	None	Required before deployment, published, with a withdrawal trigger
Correction	No pathway	Defined pathway across agencies

2. The architecture

The replacement has three layers. The current framework has only the third.

2.1 The governance layer

This layer answers: who is accountable, for what, and how do we know.

It contains:

- a **policy statement** issued at Director-General level, stating that the framework is the Territory's method for managing family violence risk and that alignment is required;
- a **role and accountability map** naming, for each prescribed organisation, the position accountable for alignment, the position accountable for practice quality, and the position that may accept residual risk at each level;
- a **resourcing statement** specifying the time allocation the instrument requires and confirming it is funded;
- an **alignment timetable** with dates by which each organisation must have aligned policies, procedures, practice guidance and tools;
- an **assurance program** — internal review, periodic external audit, and published annual reporting on alignment; and
- a **review cycle** stating when the framework itself is reviewed, on what triggers, and by whom.

2.2 The process layer

This layer answers: what steps are followed, in what order.

It mirrors the standard process: establish scope, context and criteria; identify; analyse; evaluate; treat; monitor and review; record and report. Section 4 sets it out.

2.3 The instrument layer

This layer is the tools a practitioner actually uses: screening, assessment, classification, option comparison, control register, safety plan, and reassessment.

The current framework sits entirely at this layer. It is missing the components that layers one and two would have supplied.

3. The risk criteria

This is the single most important addition. It is summarised here and set out in full at Appendix C.

3.1 The two risks defined

R1 — Harm. The risk that **a person who has used or may use family violence** *(source)* **commits family violence in any of the forms defined by section 8 of the *Family Violence Act 2016*** *(event)*, **causing physical, sexual, psychological, emotional or economic harm** *(consequence)* **to a protected person, a child or another affected person** *(person affected)*, **within the stated period**.

R2 — Hardship and rights limitation. The risk that **the order process, or the protective measures selected** *(source)*, **restricts housing, work, a licence, contact with children, liberty or reputation** *(event)*, **causing hardship or a limitation of rights beyond what is necessary to hold R1 within tolerance** *(consequence)*, **to the person being restricted or to a child in their care** *(person affected)*, **within the same period**.

Each is one sentence, and each names five elements: the **source**, the **event**, the **consequence**, the **person affected**, and the **period**. In general risk practice the fourth element is called the asset. Here it is a person, and it is named as one.

Writing the risk this way prevents the most common error in practice, which is rating a topic rather than a risk. “Firearms” is not a risk. “Separation” is not a risk. Neither can be rated, because neither states what happens to whom. A source without an event is a fact about a case. An event without a consequence is a description. A consequence without a person affected cannot be weighed against any other consequence, which is the whole purpose of a consequence scale.

The two statements above are the general form. In an individual assessment each is rewritten with the particulars of the case substituted into the same five slots, and it is the rewritten sentence that is rated. Appendix C sets out the substitution rule and worked examples.

3.1a Intent and capability are rated for each form of violence, not once

Section 8 of the *Family Violence Act 2016* defines family violence as a set of behaviours: physical, sexual, emotional or psychological, economic, threatening, and coercive or controlling. It expressly includes stalking, deprivation of liberty, damaging property, harming an animal, and harmful use of or interference with technology.

An assessor asked to rate "intent" and "capability" without being told intent to do what will rate physical violence by default. The framework then becomes blind to most of the Act it exists to serve.

So each form in issue is rated separately, and the R1 threat level is the highest reached across them, with the record showing which form produced it. That is not a refinement. It is what makes the rating select the right control. Capability for economic abuse is control over the other person's money — a joint account, a business, an employment relationship, a debt in their name. Capability for technology-facilitated abuse is access to their accounts and devices. Capability for physical violence is access to the person. A firearms seizure does nothing about a joint account, and a bank arrangement does nothing about a person at the door.

The same applies to intent. Whether a person intends economic abuse is answered by their prior conduct with money and by what they have said about it, not by anything in a physical violence indicator list.

And the evidence runs both ways. The 2022 framework lists indicators of risk and lists nothing that would count against a rating. An instrument built that way can reach a low rating only by finding nothing, never by finding the opposite. Those are different states, and Principle 7 requires the difference to be recorded. Continued voluntary financial support with no condition attached bears against intent for economic abuse. Sustained compliance with earlier conditions bears against intent for physical violence. Returning credentials and devices bears against capability for technology-facilitated abuse. Each is recorded against the form it concerns and carried no further, and support given on conditions is recorded as economic abuse rather than as evidence against it. Appendix C3.0 sets out the full mapping and the three limits on its use.

3.2 The period

Every rating states the period it covers. In an interim court context, the period is the **notice window**: from the earliest time the respondent may learn of the application until the selected protections are operating and verified.

Defining the period is what makes likelihood ratings comparable. "Likely" over a week and "likely" over two years are different statements.

3.3 Intent and capability, rated separately

For R1, the assessment rates two dimensions separately and combines them.

Intent — what the person's observable conduct indicates about their intention, on a five-level scale from none through implied, expressed and committed to dedicated, plus an unknown state.

Capability — the present means and opportunity to carry out the harm, on a five-level scale from undeveloped through emerging, moderate and developed to advanced, plus an unknown state.

Rating them separately prevents two frequent errors. The first is treating a person with strong intent and no means as equivalent to a person with means and no expressed intent. The second is inferring intent from capability. Holding a firearms licence is capability. It is not intent.

Both scales are defined by observable conduct and present means, not by diagnosis, occupation, training, identity, distress or substance use. That prohibition is written into the instrument as an anti-profiling rule.

3.4 Likelihood and consequence

For each risk, likelihood is rated on a five-point scale from rare to almost certain. Each level is defined by what would have to be true.

Consequence is rated on separate five-point scales for R1 and R2.

- The **R1 scale** runs from transient fear and distress at level 1 to one or more deaths at level 5.
- The **R2 scale** runs from no material change at level 1 to loss that cannot be unwound before the matter is heard at level 5, assessed across seven domains: housing, work and income, occupational authorities, sporting authorities, child contact, movement, and standing and privacy.

The R2 scale takes the **highest domain**, never an average. A person who loses their home has lost their home. The fact that their movement is unaffected does not reduce it.

3.5 Combination and tolerance

A published matrix combines likelihood and consequence into a band. A published tolerance statement says what happens at each band:

- **Extreme or very high R1** — outside tolerance. The lowest-R1 lawful option is selected, treated immediately, with the shortest available review and the residual recorded.
- **High R1** — inside tolerance only with a named protective package. R2 selects among adequate packages.
- **Medium or low R1** — the participatory option is the default, with proportionate precautions.

3.6 Confidence

Every rating carries low, medium or high confidence with a one-line reason. Confidence is not part of the rating. It is a statement about the rating.

4. The process

4.1 Scope, context and criteria

Before assessment, the practitioner records: who is involved, the setting, the period being assessed, the options actually available in this setting, and any constraint that limits them.

Recording available options at the start is what makes the later comparison honest. Some options cannot be delivered, because a remote appearance room is unavailable or no accommodation exists. Those are recorded as unavailable rather than silently omitted.

4.2 Identification

Screening for all clients, using a short question set. Where a disclosure is made, or where any indicator is present, the assessment layer is entered.

The screening design is recorded: which clients are screened, by whom, using what questions. This is what allows service data to be interpreted later.

4.3 Analysis

The risk factor set, coded. Three tiers:

Tier 1 — strongest evidence for lethal or serious harm. Non-fatal strangulation or pressure to the neck; threats to kill; access to firearms; sexual violence; recent separation; stalking or persistent unwanted contact; escalation in frequency or severity; violence during pregnancy or to an infant; threats of or attempted suicide by the person using violence; previous serious assault.

Tier 2 — established pattern indicators. Coercive control and isolation; monitoring or surveillance; financial control; threats to children or pets; system abuse; breach of a previous order; jealousy or obsessive behaviour; violence outside the family context.

Tier 3 — contextual factors. Problematic substance use; housing instability; unemployment or financial stress; recent significant loss; and other situational stressors.

Each factor has a coding rule. The rule states what counts as established, what counts as reasonably open, and what leaves it unknown.

On the mental illness item. The current framework's question 14 is separated. A threat of suicide or an attempt by the person using violence is a Tier 1 factor. The evidence supports it, and the ACT's own death review found lethality factors present among the people it recorded as perpetrators who died. A diagnosed mental illness is recorded as **context**. It sits in the section that records health, disability and support needs. It does not contribute to a risk rating, because it does not predict violence towards another person.

On violence outside the family context. This is added as a Tier 2 factor. The 2025 death review found that 15 of the 25 deceased people it recorded as perpetrators had criminal records indicating violence outside the family violence context. It noted expressly that the current national principles do not capture this factor.

4.4 Evaluation

Rate R1 and R2 as currently standing, before option-specific controls. Compare to the tolerance statement. Determine whether the current position is inside or outside tolerance.

4.5 Treatment

List the options actually available. Rate each option's R1 and R2 **after** the controls that option carries. Compare. Select the option that brings R1 inside tolerance with the lowest R2.

Record why the selected option was preferred and why each rejected option was rejected.

Every control carries a named owner, a time, a proof standard and a failure response.

4.6 Residual risk

State what R1 and R2 remain after the selected controls are operating. Name the person accepting the residual. Record the review date.

If residual R1 is outside tolerance and no available option brings it inside, the matter is escalated to a higher decision-maker. The instrument does not permit an out-of-tolerance residual to be accepted at practitioner level.

FIGURE 15.1

How a risk decision is made under the rewritten framework

R1 sets the floor. R2 chooses among the options that meet it. They are never combined into a single number.

R1 Harm

THE RISK

that a person who has used or may use family violence commits family violence in any of the forms defined by section 8, causing harm to a protected person, a child or another affected person, within the stated period

R2 Hardship

THE RISK

that the order process, or the measures selected, restricts housing, work, a licence, contact with children, liberty or reputation beyond what is necessary to hold R1 within tolerance, to the person restricted or a child in their care, in the same period

Each is written as one sentence naming five things: source, event, consequence, person affected, period.

1. **Rate R1 and R2 as they currently stand**
   before option-specific controls; record confidence
2. **Compare to the tolerance statement**
   Extreme and Very high are outside tolerance
3. **List the options actually available**
   options that cannot be delivered are recorded as unavailable, not omitted
4. **Rate each option after the controls it carries**
   each control has a T-ID, an owner, a time, a proof and a failure response
5. **Select the option that brings R1 inside tolerance with the lowest R2**
   record why it was selected and why each alternative was rejected
6. **State the residual R1 and R2, and name the person accepting it**
   an out-of-tolerance residual may not be accepted at practitioner level
7. **Set the review date and the triggers**
   new threat, breach, weapon, control failure, separation, court event



Rated separately for R1 and R2, never combined. Extreme and Very high are outside tolerance; accept-and-monitor is available only at Low.

The generic sentence is never rated. It is rewritten with the particulars of the case in each slot, and it is the rewritten sentence that is rated.

Chapter 15, section 4; Appendices A, C and E.

4.7 Monitoring and review

Defined triggers require immediate reassessment:

- a new threat;
- a breach;
- the appearance of a weapon or firearm;
- a failure of service, disclosure or a control;
- separation, or a change in separation status;
- a court event or a change in orders;
- a change in living arrangements or child arrangements;
- a significant change in health, substance use or financial circumstances;
- and the passage of the stated review interval.

Reassessment preserves the previous record rather than overwriting it. It also records who was informed.

4.8 Recording and reporting

At case level, the completed instrument.

At framework level, a defined reporting standard: what is reported, how often, to whom. Section 8 below sets out the indicators.

5. Classification: the replacement for the primary aggressor fact sheets

5.1 The question restated

Chapter 9 establishes the position in the current framework: a statement that no definitive set of indicators exists, followed by a sex-specific list of indicators and no validation. The replacement supplies a method and requires the validation.

The question is not "who is more likely to be an aggressor". It is: **on the available information, whose conduct forms a pattern of coercion or violence directed at the other?**

5.2 The method

Four steps.

Step 1 — Record both accounts in full. Each person's own description of what has happened and their own assessment of their risk, recorded in their own terms.

Step 2 — Build a claim register. Every material claim is entered with: what is claimed, the source, the date, the status of the source, the credibility of the claim, what supports it, what contradicts it, and what check would resolve it. Appendix D sets out the rating system. Source reliability and claim credibility are rated separately.

Step 3 — Test for pattern. The classification rests on pattern over time, not on a single incident. The instrument asks a defined set of pattern questions. The same questions are put about each person: is there a documented history of controlling behaviour; who has restricted whose access to money, transport, communication or people; whose conduct has produced fear, and what is the evidence; who has previ-

ously been the subject of substantiated findings; what does the sequence of events show about context, intent and effect.

Step 4 — Classify or record unresolved. Where the pattern is established, record the classification with the evidence supporting it. Where it is not, record **unresolved**. Then apply Principle 6 from Chapter 14: select protective options that do not depend on the classification being correct.

5.3 What is excluded from the classification

The following do not contribute to classification for any person:

- how calm, confident, charming or composed a person appears;
- how critical a person is of the other party;
- how critical a person is of the police, the courts or the system;
- whether a person raises their legal rights;
- how persuasive a person is;
- whether a person denies the allegation;
- whether a family law matter is on foot;
- and any inference drawn from sex alone.

Each of these may be **recorded as an observation** in a designated section, where it is visible to any reviewer. None counts towards the rating.

5.4 Why family law proceedings are excluded

This item is singled out because it is the most consequential exclusion.

A very large proportion of family violence matters involve people who are separating and who have children. Family law proceedings are therefore present in a substantial share of cases, on both sides.

Treat their presence as an indicator of perpetration by one party, and that indicator is present in most cases and points in one direction. An indicator that is almost always present has no discriminating power. One that points in a single direction imports the conclusion.

The presence of family law proceedings is recorded as context. It informs what protective measures are appropriate. The ACT death review documented system abuse as real, in both directions. But their presence does not determine who is the aggressor.

5.5 What is retained

The evidential indicators are retained and strengthened:

- injury patterns and their consistency with each account, recorded with the source of the observation;
- order and charge history, recorded with dates and outcomes, distinguishing allegations from findings;
- accounts inconsistent with the independently established record;
- accounts inconsistent with physical facts;
- documented history of controlling conduct;

- documented history of defensive or resistive force, and its context.

Each has a coding rule.

5.6 The safeguards

Three safeguards apply to the classification.

A classification is not a finding. It is an assessment made to select protective measures. It does not bind any court, and the instrument says so on its face.

A classification made on unresolved information is recorded as such. It is then subject to mandatory review when the resolving information arrives.

A classification carries a correction pathway. Section 9 sets it out.

6. Children

The current framework addresses children. The replacement changes three things.

Children are assessed as persons at risk in their own right, with their own R1 rating. They are not treated as a dependent factor in an adult's assessment.

Where a child is affected, the instrument requires a named person accountable for the child's safety plan, distinct from the adult's.

The instrument records the child's own account where the child's age and circumstances allow it. It uses the age-appropriate method the framework specifies.

The 2025 death review found that 67 children were affected by 38 deaths. Some experienced significant violence, and some discovered the body. That is the reason for the first of these changes.

7. The screening layer

7.1 The change

Screening is applied to **all clients** of a service, using the same question set, rather than to all women.

7.2 Why

Three reasons, and the first is the strongest.

It produces interpretable data. A service that screens one group and not another cannot report on prevalence in its client population. The detection method is not applied evenly. Chapter 10 documented the consequence.

It removes an assumption from the front of the process. A screening design that selects by sex embeds a conclusion about who is likely to be a victim. It does so before any information is gathered.

It finds people the current design does not. Male victims, people in same-sex relationships, transgender and non-binary people, and older people experiencing violence from adult children are all under-identified in the current data.

7.3 The objections, answered

"It will take more time." Universal screening costs time in services with large client volumes. The screening set is three questions. The evidence on universal screening in health settings shows it is feasible. Some services cannot screen all clients. Where that happens, the framework requires the service to record which clients it screens and why, so the data can be interpreted.

"It will dilute the focus on women." It does not change what happens after a disclosure. It does not change how resources are allocated. It changes who is asked.

"The evidence base for screening is about women." That is true of the studies cited in the current framework. It is an argument for extending the evidence base, not for restricting the screening.

8. Framework-level monitoring and reporting

8.1 The indicators

The framework specifies what is reported above the case level. At minimum, quarterly:

Indicator	Why
Number of screens conducted, and proportion of clients screened	Makes the screening design visible
Disclosure rate, by client characteristics	Detects changes in identification
Assessments completed, by setting and assessor role	Volume and coverage
Distribution of R1 and R2 ratings	Detects drift and inconsistency between agencies
Proportion of assessments with unresolved classification	An honest system will have some
Proportion of controls verified as operating	Tests Principle 4
Proportion of residual risks accepted at each authority level	Detects escalation avoidance
Reassessments triggered, by trigger	Tests whether the review triggers work
Classifications later changed, with time to change	The misidentification measure
Inter-rater reliability, from periodic vignette testing	The accuracy measure

8.2 Who receives it

The framework names the recipient of each report and the action required on each. A report with no named recipient and no required action is not monitoring.

9. Validation, fairness testing and correction

9.1 Before deployment

Inter-rater reliability measured on a set of standardised case vignettes, administered across every role that will use the instrument — police, registry, crisis service, health, child protection — with the agreement statistic published.

It requires no client data, which is what keeps it fast. It would be the first published measurement of consistency in ACT family violence risk practice. Appendix O specifies the design, the thresholds and the withdrawal trigger.

A stated withdrawal trigger, published before the data exists. For the classification decision the pre-registered trigger is a kappa below 0.40, or a lower 95 per

cent confidence bound below 0.40. For the R1 rating it is an intraclass correlation below 0.50. On either result the instrument is not deployed for that decision until it has been redesigned and retested. The trigger is lodged on a public research registry before assessors are recruited, which is what prevents it moving to meet the result. Appendix O sections 5.2 and 7 set this out.

9.2 After deployment

Predictive performance. Classification and risk decisions linked to later outcomes: further violence, further orders, charges, reversals of classification.

Error analysis by cohort. Performance reported separately for women, men, same-sex relationships, transgender and non-binary people, Aboriginal and Torres Strait Islander people, people with disability, and culturally and linguistically diverse people. Where a cohort is too small for annual reporting, rolling multi-year totals are used rather than suppression.

Indicator-level contribution. Which items actually discriminate. Items that do not are removed.

9.3 The correction pathway

Where a classification is later shown to be wrong, the framework requires:

1. **Correction of the record** in every system that holds it, within a defined period;
2. **Notification** to the person, and to every agency that acted on the original classification;
3. **Review of the consequences** — charges, orders, conditions, employment notifications, child arrangements, housing — with a named person accountable for that review;
4. **Recording** of the correction in the monitoring dataset, so the rate is measurable; and
5. **A stated remedy pathway** where the consequences cannot be reversed.

The fifth item is deliberately open. What remedy is appropriate is a policy question not resolved here. What is not defensible is the current position. The record is not corrected, the consequences do not unwind, and the error is not counted.

10. What this does not change

Stated plainly, because the proposal will be read as a weakening of protection and it is not.

The threshold for an interim order is unchanged. Section 21 of the *Family Violence Act* is not amended by anything in this chapter.

The paramountcy of safety is unchanged. Section 36 stands.

Emergency action is unchanged. Where imminent harm is possible, the instrument's first instruction is to use the emergency process and record it afterwards. Nothing in the framework delays urgent action.

The gendered evidence base is unchanged. The Tier 1 factors are the factors the evidence supports. The ACT's fatality profile is what it is.

Specialist services remain specialist. Nothing here requires any service to change who it serves.

What changes is that decisions become consistent, comparable, reviewable and measurable. And when they are wrong, the system can tell.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. The chapter's full set of 15 findings is at Appendix M, where it can be read against every other chapter's.

- **F15.3** — It adds defined risk criteria: separate intent and capability scales, likelihood and consequence scales for two distinct risks, a combination matrix, a tolerance statement and a confidence rating.
- **F15.4** — It rates two risks — harm and hardship — separately and never averages them; the first sets the required protection, the second chooses among adequate options.
- **F15.7** — It replaces the sex-specific primary aggressor indicators with an evidence and pattern method that applies identically to any person and permits the answer "unresolved".
- **F15.13** — It requires published inter-rater reliability and a stated withdrawal trigger before deployment, and published error analysis by cohort after it.

Sources for this chapter

Claim	Source	Date
Current framework content and its omissions: no risk criteria, no full treatment option set, no residual risk statement, no named risk owners, no framework-level monitoring or reporting, no validation; screening of women; the person's own assessment collected as a 1 to 10 scale; question 14 combining mental illness with suicide threats	ACT DFV Risk Assessment and Management Framework	July 2022
"there is no definitive set of indicators that can be used to determine the primary aggressor"; the sex-specific indicator list replaced by the classification method in section 5	ACT DFV Risk Assessment and Management Framework, Fact Sheet 10	July 2022
15 of the 25 deceased people recorded as perpetrators had criminal records indicating violence outside the family violence context, and the national principles do not capture this factor; 67 children affected by 38 deaths; system abuse documented in both directions; lethality factors present among people recorded as perpetrators who died	ACT DFV Review Biennial Report 2025	2025
Threshold for an interim order, section 21; paramountcy of safety, section 36	*Family Violence Act 2016* (ACT)	Effective 1 July 2025
Evidence-based risk factors, and the person's own assessment of their risk as a primary input	ANROWS National Risk Assessment Principles	2018
Full instrument, risk criteria, source and claim rating system, and control effectiveness test	Appendices A, C, D and E	—

Chapter 16 — Legislative reform

In one page

Most of what is proposed in Part III can be done administratively. Five things cannot, or would be materially stronger in legislation. They are set out here, with drafting at Appendix G. The numbering follows the five reforms in Chapter 1; this chapter deals with the legislative element of each.

One — the legislative element of Reform 1: a statutory alignment obligation for the risk framework, with a validation condition. Publication has not produced consistent practice. Prescribed organisations should be required to align their policies, procedures, practice guidance and tools to the framework on a published timetable, and to report on alignment. Approval for general use should be prohibited until validation results, including inter-rater reliability, have been published.

Two — a structured risk assessment before an interim order is made without the respondent present. A new Division 4.1B of the *Family Violence Act 2016* would apply before a court proceeds in the absence of the respondent. It would require that a structured risk assessment and a corresponding risk management plan have been prepared, both in accordance with the approved framework and consistent with AS ISO 31000:2018 (new section 47A). The provision does not change the threshold in section 21. It requires the decision to proceed without notice to be grounded in a documented analysis rather than in practice. **It does not commence until the registry and judicial time it consumes has been funded, and the draft clause says so (new section 47B).**

Three — an expedited return for the respondent, content for the reasons the Act already requires, and a review ground. Where an order is made in the respondent's absence, the respondent would be entitled on request to a listing before a Magistrate within two business days — the pathway the applicant already has on a refusal — with the protective conditions continuing until then (new section 47C). Section 68 of the Act already requires a court to record reasons for making a protection order, and the Dictionary brings interim orders within that duty; what the section does not do is say what the reasons must contain, and none has ever been published or counted. The reform gives that duty content in the without-notice case (new section 68A). Because the Act at present allows neither review nor appeal of a general interim order, a consequential amendment extends the review in section 87 to such orders (new section 47D). Separately, and put as a question for the Assembly rather than as a recommendation, reciprocal conditions would be available only where a magistrate records that the material does not permit the court to identify the person most in need of protection — not as a default, and only as a time-limited trial that cannot commence before a baseline exists (new section 21A).

Four — a safety and support obligation at the point of service. A new Division 3.8 would apply when an order is served. It would require a documented welfare

and support step for the respondent. It would also require that support is available to both parties. Chapter 11 sets out why. This chapter presents three versions at different cost levels. The strongest version is expensive, and a proposal that offers only the expensive version will achieve nothing.

Five — the legislative element of Reform 5: a publication obligation for administrative statistics, and correction of record. Chapter 11 established that court outcome data is treated as outside the freedom of information regime. If it is not obtainable on application, it should be published as a matter of course. Where an order ends, the ending should follow it through every system that recorded it. The ledger, the tracker and the published validation results that complete Reform 5 are administrative and are at Chapter 17.

A sixth item is not a legislative amendment. It is a Cabinet requirement: no material justice or service reform to be funded without a published whole-of-system demand and capacity model.

A seventh matter — whether the blanket rule in section 43(4) removing complicity liability from a protected person should be replaced — is put as a question in the annex to this chapter, with the draft provision at Appendix G3. It is not part of the package, and none of the five reforms depends on it.

One number, one quote, one action

Number: Nine — people who died by non-homicide means while subject to a current family violence order in the ACT between 2020 and 2024, with no published requirement for any welfare check, screening or referral at the point an order is served.

Quote: "The real-life effect, going back to your question, is that my staff simply do not have time to prepare the matters properly." — Director of Public Prosecutions, ACT Legislative Assembly Hansard, 16 September 2025.

This week: Ask a member of the Legislative Assembly to support Version A of the service obligation — a scripted welfare question set, written information about support, and a recorded offer of referral at the point an order is served — as a legislated duty, with the data field that makes the question in Chapter 11 answerable.

1. How these proposals were tested

Each proposal was tested against four questions, set out in the method note (Appendix K).

1. Does it fix a documented failure identified in Part I or Part II?
2. Can it be done administratively, or does it need legislation?
3. Does it reduce protection for anyone at risk?
4. Can compliance be checked from outside?

Any proposal that reduced protection was rejected. Where a proposal changes a process, this chapter identifies the safeguard that preserves the existing level of protection.

The drafting at Appendix G shows intended effect and placement. It would need to be settled by parliamentary counsel.

2. Reform 1 — the legislative element: statutory alignment and a validation condition

2.1 The failure it addresses

The framework was published in July 2022. Two years later an independent review found agencies using different risk processes. They reached different conclusions about the same case. Four years later it was still being updated.

Publication produced a document. It did not produce consistent practice.

2.2 The comparison

Victoria's framework is established in law. Prescribed organisations must progressively align their policies, procedures, practice guidance and tools. Responsibilities are assigned. Information sharing is linked to risk management. Implementation architecture is public.

Nothing recorded here treats Victoria's framework as proof of better outcomes. It is a stronger implementation design. That is what is proposed for adoption: the architecture, not the content.

2.3 The proposal

An amendment establishing that:

- the Minister may approve a family violence risk assessment and management framework;
- prescribed entities must align their policies, procedures, practice guidance and tools to the approved framework;
- alignment must occur progressively, in accordance with a published timetable;
- prescribed entities must report annually on alignment, and the reports must be published;
- the framework must specify the responsibilities of prescribed entities; and
- the framework must not be approved for general use unless validation results have been published, including inter-rater reliability.

2.4 The last item

The final requirement is the one that distinguishes this proposal from simply legislating the current framework.

A statutory alignment obligation attached to an unvalidated instrument would mandate consistency without accuracy. Requiring publication of validation results before approval changes that. The framework must be capable of producing consistent decisions before organisations are required to adopt it.

3. Reform 2 — Risk assessment before proceeding without notice (new sections 47A and 47B)

3.1 The failure it addresses

Chapter 7 established that, beyond the general duty in section 68 to record reasons for making an order, no published form, checklist, criteria set or content requirement structures the decisions required by sections 21, 36, 37, 39, 44 and 47 of the *Family Violence Act*. Section 68 requires that reasons be recorded and says nothing about what they must contain; Chapter 7 section 2.5a sets out why a duty in that form cannot detect an error.

Chapter 8 established that the framework that would have supplied criteria contains none.

So basic administrative questions about interim order practice cannot be answered. And a decision-maker performing the section 37 least-restriction analysis has no instrument designed to support it.

3.2 The proposal

A new Division 4.1B, containing a section 47A, applying where the Magistrates Court proposes to hear or determine an application for an interim order, or make an interim order, in the absence of the respondent.

The division is numbered 4.1B rather than 4.1A because the Bill before the Assembly inserts a Division 4.1A of its own — a definition of presence in court, new section 44B, allowing appearance by audiovisual link or telephone with leave — so the division proposed here sits alongside it, and its section numbers are unaffected (Chapter 19 §2.2; Appendix G1).

New section 47A(1A) places a duty on the registrar to have the structured assessment and the risk management plan prepared before the application is listed, confined to applications proposed to be heard without the respondent.

The court must not proceed in the absence of the respondent unless satisfied that:

- a structured risk assessment has been undertaken in relation to the alleged conduct; and
- a corresponding risk management plan has been developed addressing the risks identified.

The assessment and plan must:

- be prepared in accordance with the approved framework under Reform 1 and be consistent with AS ISO 31000:2018;
- identify, analyse and evaluate risks having regard to the likelihood and consequences of the alleged conduct, the reliability and sufficiency of the information relied on, the alternative procedural pathways available, and the potential adverse impacts on the respondent including hardship and restriction of rights.

On the second of those — the reliability and sufficiency of the information — the assessment records the number of **independent** sources supporting the alleged conduct, applying the counting rule at Appendix D4.1. The rule that matters is that one

account repeated to several people is one source, not several. A file containing a police narrative, a service intake note and a case summary, each recording what the same person said on the same occasion, contains one source, and the appearance of consistency across such a file is the appearance of a single source copied forward.

Where the material is a single source and the court proposes to proceed without notice, the assessment records what check would produce a second, who would perform it, how long it would take, and why the protection sought cannot wait for a notified listing.

This is not a corroboration requirement and does not operate as one. Nothing in the provision prevents an order being made on a single uncorroborated account, and nothing should. Family violence characteristically occurs in private and without documentation, which is why sections 13 and 13A are drawn as they are, and a corroboration threshold would make many genuine applications unprovable. What the provision requires is that the evidentiary shape of the matter be written down before the most restrictive procedural course is chosen. Chapter 7 section 2.2a sets out why that follows from the standard of satisfaction the civil standard already imports, and Appendix B example B3.3 shows what it looks like applied to a matter that cannot yet be assessed.

The plan must include proposed control measures, consideration of the least restrictive means of achieving protection, and arrangements for ongoing monitoring and reassessment.

The court must record its satisfaction that the assessment and the plan exist and have been considered. What the court's **reasons** must contain is dealt with under Reform 3, because that is where the existing section 68 duty is given content, and the two provisions are drafted to work together: Division 4.1B produces the analysis, and the amended reasons obligation requires the court to say what it made of it.

A failure to comply does not of itself invalidate an interim order, but is a ground on which the respondent may seek review under section 87 as extended by new section 47D. Without that extension the saving would point at a remedy that does not exist: section 92 confines appeals to final orders, and section 87 as it stands permits review only of a special interim order, by leave, on three grounds. A general interim order made in the respondent's absence attracts neither. Section 47D is dealt with under Reform 3, at section 4.3a.

3.2b The commencement condition

Appendix P estimates that this reform consumes about 1,150 hours a year of registry and judicial time, or roughly 0.7 of a full-time position, and it is the reform most likely to fail if it is funded at nothing. A structured assessment added to an unchanged workload does not produce a better decision. It produces the same decision with a form attached to it: worse decisions, better documentation.

That is a risk to be managed in the drafting, not a caveat to be noted in a costing appendix. The provision at Appendix G1 therefore does not commence on notification. New section 47B expressly displaces the automatic commencement in the *Legislation Act 2001*, section 79. Section 47A commences on a day fixed by the Minister, and the Minister may not fix that day until a statement has been presented to the Legislative

Assembly identifying the registry and judicial resourcing provided for the purpose and the volume assumption on which it was calculated.

The effect is that a government may decline this reform, or fund it, but may not adopt it and leave the courts to absorb it. That is the same discipline the Cabinet measure at section 7 would apply to every other reform, applied here to one of these.

3.3 What it does not do

It does not raise the threshold. Section 21 is untouched. The test remains necessity for safety or to prevent substantial property damage, on the balance of probabilities.

It does not delay urgent action. The instrument at Appendix B opens with an emergency instruction. Where imminent harm is possible, the emergency process is used and the record is completed afterwards. The provision should be read subject to that. Appendix G contains an express saving.

It does not invalidate an order that was correctly made. The final subsection makes non-compliance a ground of review under section 87, as extended by section 47D, and not a ground of invalidity. That is deliberate: the purpose is to change practice, not to generate collateral litigation about orders that were correctly made.

It does not require a judicial officer to do the assessment. The assessment is prepared at the registry, before listing, in the twenty-minute process at Appendix B. The court's task is to be satisfied it was done.

It does not create a reasons obligation. Section 68 already does that. What the reasons must say in a without-notice case is dealt with at section 4.3, and the two provisions are drafted to operate together.

3.4 The safeguard that preserves protection

The provision's own terms require the risk analysis to have regard to the likelihood and consequences of the alleged conduct. That is the protective half of the analysis, and it is stated first.

An assessment that identifies extreme risk of harm supports proceeding without notice. It supports it with a documented reason rather than a default. On the current arrangements, two applications receive the same procedural treatment. One is in a genuinely dangerous case. The other is in a case with no risk history. The provision distinguishes them.

3.5 The objection: this will slow things down

The instrument at Appendix B is designed for twenty minutes at the point of filing, and it runs in parallel with checks already conducted. Two qualifications, because the numbers in this work have to reconcile with each other.

Appendix P costs the assessment at **thirty** minutes rather than twenty, on the basis that a new process is slower than a mature one, and applies that rate to the whole four-year projection rather than to the first year alone — which overstates years two to four by construction and is noted there. And the reform as a whole consumes about **fifty minutes** per matter, not twenty: the assessment, the time a registrar or magistrate spends reading it, the additional content in the reasons under section 68A, and a quality assurance sample. The twenty-minute figure answers the question "how

long does the person filling in the instrument spend on it". It does not answer "how much time does this reform consume", and the objection in this section is about the second.

The statutory return date under section 47(1) is not later than two days after the application is received. Practice Direction 1 of 2026 lists interim applications before the Registrar no later than two business days after filing. The assessment fits inside that window.

Sometimes it cannot, because information is unavailable or the matter is urgent. In those cases the emergency route and the escalation route both remain open, and both are recorded.

4. Reform 3 — An expedited return, content for the reasons the Act already requires, and a review ground (new sections 47C, 68A and 47D)

4.0 Why Reform 3 is drawn this way

An interim order made in the absence of the respondent is **not** proposed to be mutual by default, rebuttable on recorded reasons. That is not what is proposed here.

Two things shaped it. The first is the constructed critique at Appendix Q1, which is right that a default carries a risk that falls hardest on the group the Territory's own record shows is most often misclassified, and that the risk cannot be quantified from anything in the ACT record. The second is that the strongest objection to the default — that it may deter people from applying at all — was never answerable, and a package whose most visible element rests on an unanswerable objection invites the whole package to be dismissed with it.

So the design is narrowed. What remains of Reform 3 is three elements that can be defended from Chapter 7 alone, and a fourth that is put to the Assembly as a question rather than a recommendation:

1. an expedited return for the respondent, as of right (new section 47C);
2. content for the reasons obligation that already exists in section 68 (new section 68A);
3. a review ground, because the Act at present allows neither review nor appeal of a general interim order made in the respondent's absence (new section 47D); and
4. as a question, and only as a time-limited trial, reciprocal conditions in the narrow class of case where a magistrate records that the material does not permit the court to identify which party is the person most in need of protection (new section 21A).

The narrowing is a concession and is recorded as one. It is not a retreat from the finding underneath it, which is unchanged: at the moment an interim order is made without notice, the court classifies two people having heard from one, and the accuracy of that classification has never been measured in either direction.

4.1 The failure it addresses

Chapter 7 sets out what happens at the ex parte moment. A court makes an interim order on one party's material, on the balance of probabilities, without the rules of evidence, and often before the respondent knows an application exists. Section 47 (1) requires a return date for the hearing **of the interim order** within two days of receipt, and Practice Direction 1 of 2026 lists interim applications before the Registrar within two business days of filing. That period runs to the hearing at which the order is made, not to any hearing the respondent attends: as Chapter 7 section 2.7 establishes, the Act fixes **no** maximum period between the making of an ex parte interim order and the first occasion on which the respondent may be heard, which sections 47 (3)(a) and 47 (4)(a) govern by the words "as soon as practicable".

The order that results is asymmetric. One person is protected. The other is restrained.

That asymmetry is not only a protective measure. It is a classification, and it is made at the point of least information in the whole process.

It is worth being exact about what the court has in front of it, because the point is often stated loosely in both directions. Section 21 is a real threshold: the court must be satisfied the order is necessary, and nothing proposed here weakens it. But section 13 sets the balance of probabilities, section 13A provides that the Magistrates Court need not comply with the rules of evidence, section 65 permits the court to inform itself in any way it considers appropriate, and section 62A, where a police officer applies on behalf of an affected person, allows evidence by affidavit sworn before a sergeant.

So the material is routinely one party's account, untested, at a hearing the other party does not attend and frequently does not know about. **The court has no tested evidence about either party at that moment.** That is not a criticism of the design — Chapter 7 explains why the provisions are drawn this way and why they are appropriate to the subject matter, since family violence characteristically occurs without witnesses and without documentation.

The Territory's own record shows the classification going wrong. Of the 13 deceased people the 2025 review assessed as victims, 8 had been recorded by police or another agency as the predominant aggressor before they died. Four of the 13 had been the **respondent** to a family violence order where the evidence indicates the applicant was the predominant aggressor.

Those four are this failure in its concrete form. A court made an asymmetric order. The asymmetry pointed the wrong way. Nothing in the process was designed to find that out.

Two specific gaps follow, and they are what this reform addresses.

The first is procedural, and it is in the statute rather than in listing practice. Section 91B gives an applicant refused by a registrar a same-day request for review, a rehearing of the matter anew, and a return not later than two days after the request — and section 91B (6) provides that the registrar need not tell the respondent about that hearing. The respondent restrained by a granted order has no equivalent. Section 82 (c) lets them apply to amend, but that routes through a preliminary conference

listed “as soon as practicable”, and section 82B, the urgent limb that operates without a conference, is open only to the protected person or the applicant. The person refused has a deadline written into the Act. The person restrained has “as soon as practicable”, and no published statistic records what that has meant.

The second is evidentiary. Section 68 requires the court to record reasons for making a protection order, and the Dictionary definition brings interim orders inside that duty. But the section prescribes no content. It does not require the court to identify the material relied on, to state whether any of it came from a second independent source, to state why the matter could not wait for a notified listing, or to record which less restrictive option was considered and rejected. Nothing in the public record indicates that reasons recorded under section 68 have ever been counted, sampled or reported, and the aggregate statistics that would have shown how the discretion is exercised were refused under freedom of information. A duty in that form cannot detect an error, because nothing it produces is ever read by anyone who could.

FIGURE 16.1

The order pathway where the respondent has not been heard

What the Act does now, and what the reform would insert. Section 21 and the threshold for making an order are unchanged.

	NOW	PROPOSED
Application and material	s 13 balance of probabilities; s 13A rules of evidence need not apply; s 62A police affidavit. No tested evidence about either party.	s 47A: a structured risk assessment and a risk management plan prepared before the application is listed, consistent with AS ISO 31000:2018. Saving for imminent risk.
Listing	s 47(1): a return date not later than 2 days — for the hearing at which the order is made.	Unchanged. s 47B: commencement fixed by the Minister only after a resourcing statement to the Assembly, 3 months ahead.
Interim order made ex parte	s 68 requires reasons to be recorded and prescribes no content.	s 68A: reasons must state the material relied on and whether any is independent of the applicant's account; why protection could not await a listing at which the respondent was heard; which less restrictive conditions were considered; and whether the person most in need of protection can be identified.
Service	No published requirement for any welfare check, screening or referral at the point an order is served.	New Division 3.8, ss 44H–44M: plain-language information, protocol questions, recorded responses, an offered referral, and action where responses indicate acute risk. Validity unaffected.
First opportunity to be heard	ss 47(3)(a) and 47(4)(a): "as soon as practicable". No maximum period fixed anywhere in the Act.	s 47C: on one request, listed before a magistrate not later than 2 business days. The order continues in force. The protected person may appear remotely and may have one adjournment of not more than 7 days.
Review	s 92 confines appeals to final orders; s 87 permits review of a special interim order only, by leave, on three grounds.	s 47D: extends s 87 so a respondent may seek review of an interim order made in a proceeding in which they were not heard, including for failure to comply with s 47A or s 68A.

The point of the provision is not that it is fast. It is that it is a period. At present the interval is governed by "as soon as practicable" and is not measured.

Reforms 2, 3 and 4 in one view. Non-compliance with the new provisions does not invalidate an order; it grounds review.

Chapter 16; Appendix G. Family Violence Act 2016 (ACT).

4.2 The proposal — element one: an expedited return, as of right (new section 47C)

Where an interim order is made in the absence of the respondent, the respondent is entitled, on one request, to a listing before a Magistrate within two business days — the same period section 91B gives the applicant on a refusal. The magistrate may confirm, amend or revoke the order, applying section 21; an entitlement to a listing with no power attached would be a hearing about nothing.

And the protected person is written into the provision, not left out of it. The drafting at Appendix G1A requires notice to them as soon as practicable, gives them an entitlement to appear by audiovisual link — an entitlement the Bill before the Assembly would support, since new section 44B makes appearance by audiovisual link or telephone, with leave, presence in court (Chapter 19 §2.2) — and to one adjournment of up to seven days to obtain representation with the order continuing in force, allows one request only, and permits the court to decline the expedited listing where the protected person could not be given a fair opportunity to be heard in the period. Without those, this provision would produce a hearing four days after an incident at which one party has a solicitor because they asked for the listing and the other has neither a Legal Aid grant nor a support worker. That is not a symmetry, and drafting attention spent only on the respondent's side of a provision like this is the strongest evidence a critic could want that a package is what its critics say it is.

The point of the provision is not that it is fast. It is that it is a **period**. At present the interval is governed by "as soon as practicable" and is not measured, so no reader of the Act, and no respondent, can say what it is.

Three limits on that entitlement, which are what make it safe.

- **It is an entitlement to a listing, not to a discharge.** The court applies the same test on the same material, with the respondent now heard.
- **The protective conditions continue until the return.** Nothing is suspended by the making of a request.
- **It does not displace anything the Act already requires**, and where the preliminary conference or the return of the application is listed sooner, that listing applies. The entitlement operates only where "as soon as practicable" would otherwise be longer than two business days from the request.

This element is adopted following the constructed critique at Appendix Q2, which is right that recorded reasons are a mechanism for review, and that where no expedited review exists they are read by nobody in the window in which they would matter. An unreviewed reasons obligation produces boilerplate. The expedited return and the reasons content are therefore proposed together and are not severable: the reasons exist to be read at the return, and the return exists so that the reasons are read.

The resource implication is real and is costed at Appendix P4.

4.3 The proposal — element two: content for the section 68 reasons (new section 68A)

Section 68 is not repealed or replaced. A new section 68A is inserted, applying only where the court makes an interim order in the absence of the respondent. In that case the reasons recorded under section 68 must state:

- the material the court relied on, and whether any of it came from a source independent of the applicant's account, applying the counting rule at Appendix D4.1 — one account repeated to several people being one source, not several;
- why the protection sought could not wait for a listing at which the respondent was present, whether in person or by audiovisual link;
- which less restrictive conditions were considered and why they were not sufficient, which is the section 37 analysis written down; and
- whether the court is able, on the material before it, to identify which party is the person most in need of protection, and if it is not able to do so, that fact.

A copy is given to the respondent with the order — and this is the element that most needed a safeguard, because reasons that identify the material relied on can identify an address, a refuge, a service or a person who reported. Section 69 restricts the protected person's address in the *order* and is silent about reasons. The drafting at Appendix G1A therefore withholds from the respondent's copy the protected person's home, work or accommodation address, and anything the court considers would be likely to endanger a person or identify an informant, while requiring the copy to state that something has been withheld and under which paragraph. Withholding has to be visible, or a reasons document can be emptied without anyone being able to say so.

The withholding scheme sits alongside a right the respondent already has, and does not cut it down. Under the *Court Procedures Rules 2006*, rule 3802(1) disapplies most of chapter 2 to family violence proceedings, but rule 3802(2)(s) keeps rule 2903 in force to the extent that it allows a party to inspect and copy a document filed in the proceeding, provided the copy does not include the affected person's home or work address or other locating information. A respondent, as a party, can therefore already inspect and copy the filed material minus address information; the restriction in rule 2903(2)(m) on documents filed in support of an application made in a party's absence applies to non-parties. Section 68A adds a document that does not now exist — reasons with content — and the withholding in its subsections (4) and (5) operates on the copy given to the respondent and on any publication. It does not override the party's inspection right under rule 3802(2)(s), and subsection (5A) of the drafting at Appendix G1A says so expressly.

This is not a corroboration requirement and does not operate as one. Nothing in it prevents an order being made on a single uncorroborated account, and nothing should. Family violence characteristically occurs in private and without documentation, which is why sections 13 and 13A are drawn as they are, and a corroboration threshold would make many genuine applications unprovable. What the provision requires is that the evidentiary shape of the matter be written down at the moment

the most restrictive procedural course is chosen. Chapter 7 section 2.2a sets out why that follows from the standard of satisfaction the civil standard already imports.

Two consequences follow that no amount of training produces. The reasons become capable of being reviewed at the return two days later, by the person they most affect. And the last item makes the classification **falsifiable**: a court that has recorded "the material does not permit me to identify the person most in need of protection" has created a record that can later be checked against what the case turned out to be. At present nothing in the file distinguishes a case in which the court was confident from one in which it was not, which is why the misidentification rate cannot be measured in either direction.

4.3a The proposal — element three: a review ground (new section 47D)

Each of the new provisions carries a saving: a failure to comply does not of itself invalidate the order. A saving of that kind has to point at a remedy. At present there is none for the order these provisions address. Section 92 confines appeals to final orders. Section 87 permits review only of a **special** interim order, by leave, on three grounds: the identity of the respondent, an administrative defect or error, and outstanding related charges. A general interim order made in the absence of the respondent attracts neither review nor appeal.

New section 47D therefore amends section 87 so that a respondent may seek review of an interim order, general or special, made in a proceeding in which the respondent has not been heard, and extends the grounds to include a failure to comply with section 47A, section 68A or section 21A. It creates no ground of invalidity. It gives the expedited return something to review against and the recorded reasons somewhere to be read. The drafting is at Appendix G1A.

4.4 The question put to the Assembly — reciprocal conditions, narrowed, and only as a trial

This is put as a question, in the same way as the section 43(4) matter in the annex, and for the same reason: the evidence for it does not reach the standard the rest of the package is held to.

The narrowed proposal. Where a magistrate proposes to make an interim order in a proceeding in which the respondent has not been heard, and is satisfied that the material does not permit the court to identify which party is the person most in need of protection, the magistrate **may** include conditions applying to the protected person equivalent to the non-contact and non-violence conditions applying to the respondent, until the first listing at which both parties have had the opportunity to be heard.

Six things distinguish this from a mutual order made as a default.

- **The one-way order remains the default.** In every case where the court can identify the person most in need of protection, nothing changes.
- **The trigger is inability to classify, and nothing else.** There is deliberately no second limb turning on the material identifying conduct by each party. Such a limb would require no uncertainty at all, and would be engaged by an applicant's own candid account of resistive force — making honest disclosure the

trigger for conditions against the person disclosing. Appendix G8 now provides expressly that conduct by both parties does not of itself mean the court cannot classify, and that the court must disregard conduct that appears resistive or protective.

- **Only a magistrate may do it**, not a registrar. The provision asks for a judgment about the limits of the material, made under time pressure, in a jurisdiction where the reasons have never been read by anyone.
- **Reasons are required for making reciprocal conditions and not for declining to.** Requiring reasons either way would make the one-way order the more onerous entry to complete, and would invert the default in practice within a year, whatever the section said.
- **It is discretionary, not mandatory.**
- **It is time-limited.** It expires 24 months after commencement unless the Assembly resolves otherwise, and cannot commence until the baseline at subsection (7) is published.

4.5 Why the question cannot be put without an amendment to section 21

Section 21 provides that a court may make an interim order if satisfied the order is necessary to ensure the safety of an affected person from family violence, or to prevent substantial damage to their property.

Even in the narrowed form, the court could not include the reciprocal conditions on the current section, because it has no tested material about the applicant and so cannot be satisfied that an order is necessary as against them. Any amendment would therefore have to be express. The draft at Appendix G8 provides that, in the narrow case to which it applies, the court is not required to be satisfied of the matters in section 21 in relation to the protected person, on the basis that the reciprocal limb is a response to the court's own recorded uncertainty and is not a finding about either party.

Anything less than an express provision leaves the reciprocal limb open to challenge on the ground the court was not satisfied of what section 21 requires. That is the correct outcome under the section as it stands, which is why the question cannot be put without changing it.

4.6 The collateral consequences, and why they must be carved out

This is the part of the proposal that determines whether it protects people or harms them, and it should not be glossed.

An interim order carries consequences beyond its conditions. Under section 44, an interim order made against the holder of a firearms licence suspends that licence. Chapter 7 and Appendix B record the further consequences that follow in practice: effects on employment where a security or occupational authority is involved, effects on housing, and the appearance of an adverse record.

Those are the R2 harms this work counts. Applying them to a person who has sought protection would not be a symmetry. It would be a penalty for making an application.

The draft provision therefore provides that the reciprocal limb, of itself:

- does not suspend or cancel a firearms licence under section 44;
- does not constitute a finding that the person against whom it runs has committed family violence;
- is not a family violence order made against that person for the purposes of any other Territory law, employment screening or licensing scheme; and
- is not disclosable as an adverse record.

Nothing in the carve-out prevents a separate application being made against the protected person on proper material.

What the reciprocal limb does carry is the ordinary consequence of an order: contravening it is an offence under section 43, by virtue of the express deeming provision at section 21A(6A) explained at 4.6a. That is what makes it a protection rather than a request, and it is the point of making it an order at all.

4.6a A consequence that was not the object, and how far it reaches

The starting point. Section 43(4) provides that a protected person commits no complicity offence under the Criminal Code by aiding, abetting, counselling, procuring or being knowingly concerned in a contravention of the order made for their protection. The annex to this chapter sets out that gap and explains why no new offence is proposed to fill it.

Where reciprocal conditions are made, it is tempting to think the arithmetic changes by itself: each party being both protected and bound, an applicant who initiated prohibited contact would commit a **primary** contravention under section 43(2) rather than complicity in another's breach, and section 43(4), which immunises complicity in another's contravention and not a person's own, would not assist. That does not follow from the Act as it stands.

Why it does not. Section 43(1) does not apply to everyone bound by a condition. It applies to "**a person against whom a family violence order is made**" who was present when it was made or has been personally served. Presence is the second half of a two-part test, and the first half is the part that fails. The order is made against the respondent. A protected person to whom reciprocal conditions apply is not a person against whom the order is made — and section 21A(6) says so expressly, deeming the conditions not to be a finding and not to be a family violence order made against that person for the purposes of any other Territory law. Those carve-outs, which exist to stop the reciprocal limb operating as a penalty, cut directly against the chapeau that any enforceability argument would need. Without an express provision the reciprocal limb would carry no offence at all, and would be exactly the "request rather than a protection" that this chapter says it is not.

What follows. The provision at Appendix G8 therefore contains subsection (6A), which deems a protected person bound by reciprocal conditions to be, **for section 43 only**, a person against whom the order is made and a person present when it was made; and subsection (6B), which confines that deeming so that it does not make them a respondent for any other provision, and in particular does not engage section

44, section 47(3)(b) or (4)(b), section 66, section 70C or Part 9. Without (6A) the section does not work. With it, the enforceability follows from an express provision that a Parliament would be voting on with its eyes open, which is the right place for it to come from.

How far it reaches, stated so that it cannot be overread. Three limits apply.

- It depends on an express deeming provision, and is not a consequence of the Act as it stands.
- It reaches only conduct breaching a condition that binds the person who engaged in it — the symmetrical conditions: contact, approach, communication, and third-party or social media contact. It does not reach the inducement of a breach of an **asymmetric** condition such as an exclusion from premises, which binds one party only.
- And it operates only in the narrow class of case to which section 21A applies at all: where a magistrate has been satisfied that the material does not permit the court to identify the person most in need of protection. In every ordinary one-way matter, section 43(4) operates exactly as it does today.

This is therefore not an answer to the section 43(4) question, and should not be presented as one. It is a narrow observation about one class of case, obtained at the cost of an express deeming provision, in a trial that expires after two years. The annex question stands very largely as it did.

And one thing that has not changed. Deeming the protected person into section 43 means that a person who obtained protection can be charged with contravening conditions attached to their own order. That falls, on any realistic view, on the applicants whose accounts were hardest to read — which is the same population the Territory's record already shows being misidentified. Section 21A(5) limits the exposure by ending the conditions at the first return, and nothing in the provision unwinds a charge laid in the interval. That is a cost of this design, it is not mitigated anywhere in the drafting, and it is one of the reasons the reform is put as a question.

4.7 The objections, and what can and cannot be answered

These are the objections a specialist service would make. They are not weak, and the narrowing does not dispose of all of them.

One. Mutual orders are a documented tactic of systems abuse. A person using violence who seeks a cross-order gains a lever: contact the other person initiates becomes a potential offence, and the existence of an order against them can be used in parenting proceedings.

Partly answered, and better than before. The lever exists wherever reciprocal conditions exist, and the carve-out does not remove it. What the narrowing does is remove the lever from every case in which the court could identify the person most in need of protection, which is the great majority. It survives only where the court has recorded that it could not tell — and in that case the lever is available to whichever of the two is using it, which is the same position both parties are in now.

Two. It may deter applications. A person deciding whether to seek protection would be deciding whether to accept the possibility of conditions against themselves.

Those most likely to be deterred are those with the most to lose — people in insecure housing, people with insecure immigration status, people already in contact with child protection, and Aboriginal and Torres Strait Islander women, whom the death review identifies as particularly exposed to misclassification.

Cannot be answered from the record, and is not answered here. No Australian jurisdiction has run this design, so no data exists. Narrowing the trigger reduces the number of cases in which it could operate and therefore reduces the exposure, but it does not establish that the deterrent effect is small, and nothing in these pages should be read as establishing that. This objection is the reason the proposal is put as a question, the reason it cannot commence before a baseline exists, and the reason it carries an expiry trigger keyed to exactly this effect.

Three. It equates two people the evidence may not equate. The Territory's documented misidentification runs against women, and a rule that makes ex parte applicants respondents risks adding to the record of women recorded as respondents.

Answered. The carve-out means the reciprocal limb is expressly not a finding, is not disclosable, and does not enter any record as an adverse classification. And the trigger is the court's recorded inability to classify, so the provision cannot operate in a case where the court has said it can identify the person most in need of protection. It is the opposite of a classification.

Four. It cuts across the person-most-in-need-of-protection approach. The national risk assessment principles, and recommendation 4 of the 2023 ACT death review, are built on identifying which party is the person most in need of protection.

Answered, and more directly than before. The narrowed provision requires the court to attempt that identification and to record the result, including the result "cannot yet be determined". A framework that requires the identification to be made but supplies no criteria for making it, and no record of whether it was made, is not better protected by leaving the question unrecorded. Where the identification can be made, the one-way order follows.

Five. It may not be least restrictive. Section 37 requires conditions least restrictive of the respondent's rights consistent with the Act's objects.

Answered on its own terms, with a residue. Section 37 concerns conditions in an order made against a respondent, and the reciprocal limb is not made on a finding against the applicant. The point retains force as a matter of principle rather than construction, and the honest response is that the provision is discretionary: where reciprocal conditions would be disproportionate, the court does not make them and records why.

Six. "Cannot determine" is the cheapest entry on the form, and this chapter supplies the theory that predicts it. Chapter 1, under the heading "Why exhortation has not worked", argues that a decision-maker with no written criteria, under time pressure, facing one error that is visible and attributable and another that is invisible, will rationally take the course whose error cannot be traced back to them. Section 68A(2)(d) offers three entries: *I can identify her*, *I can identify him*, *I cannot tell*. Only the first two can ever be shown to have been wrong. The theory this work relies on predicts that the third will be over-used, and it predicts that it will be over-used most

in the long lists — which is to say, in exactly the conditions where classification is hardest and the entry matters most.

Partly answered, and the remainder is a reason to measure rather than an answer. Four things are in the drafting because of this objection. Only a magistrate may attach reciprocal conditions, so the entry and the consequence are not made by the same officer under counter pressure. Reasons are required for making reciprocal conditions and not for declining to, so the paperwork does not slope towards the reciprocal order. The rate of each entry is a published measure under section 21A(8)(c), so a rising "cannot determine" rate is visible rather than invisible — which is the whole difference between this and the present arrangement, where nothing about the classification is recorded at all. And the entry is served on the respondent and reviewable at the return two business days later, so it is no longer unfalsifiable. What none of that establishes is the rate itself. If the objection is right, the published measure will say so, and this is one of the few propositions in these pages that will be settled rather than argued.

Seven. The package manufactures its own trigger. Reform 1 replaces the sex-specific primary aggressor indicators with a method that permits the answer "unresolved". Section 68A(2)(d) makes the equivalent question a mandatory field. Section 21A attaches a consequence to one of the answers. Read together, the reforms increase the production of "unresolved", make it recordable, and then make it operative.

Conceded, and not answered. This chapter asserts elsewhere that the trigger class will be small because most cases are clear. There is no basis in the ACT record for that estimate, and Reform 1 pushes in the opposite direction. Appendix P4.3 accordingly costs the class over a range from 5 to 40 per cent of matters and marks the central assumption illustrative. The interaction is a reason to commence the framework rewrite, the reasons obligation and the reciprocal-conditions trial in sequence rather than together, and Chapter 18 section 4.1 sequences them accordingly.

A note on the objection that is not made here. No claim is made that this reform would have prevented any death, or that it would reduce misidentification by any amount. Nothing in the ACT record would support either claim. What it does is create a record of the moment the classification is made, which is the precondition for ever measuring it.

4.8 The condition on which the question is put

The rest of this work argues that an untested instrument should not be deployed until its performance is measured and published. That standard applies here, and it applies first.

The provision at Appendix G8 therefore carries, on its face:

1. **A pre-registered evaluation, published before commencement.** The measures: application volumes; withdrawal rates before first listing; the proportion of interim orders in which the court recorded that it could identify the person most in need of protection and the proportion in which it recorded that it could not; the proportion in which reciprocal conditions were made; contravention

charges by limb; and the composition of applicants by sex and by Aboriginal and Torres Strait Islander status — in each case against a baseline drawn from the two years before commencement.

2. **A stated withdrawal trigger, published in advance.** A sustained fall in ex parte applications, or a fall concentrated in any cohort the death review identifies as vulnerable to misclassification, means the deterrent effect at objection two has occurred. On that result the provision expires by force of its own terms when the report is tabled. The threshold and the measurement period are stated before commencement, not after.
3. **A hard sunset.** The provision expires 24 months after commencement unless the Legislative Assembly extends it on a report against the pre-registered measures. Expiry is the default outcome; extension requires a decision.

A reform that cannot survive its own measurement should not survive it. This one is put on terms that make its survival conditional in the drafting rather than in the argument.

5. Reform 4 — Safety and support at the point of service

5.1 The failure it addresses

Chapter 11 established:

- nine people died by non-homicide means while subject to a current family violence order between 2020 and 2024;
- six of the 25 deceased people recorded as perpetrators had police involvement within a week of death;
- the ACT Suicide Register has no field recording order status;
- the police records system cannot cross-reference order status against deaths without manual review;
- no agency has ever examined the relationship;
- and there is no published requirement for any welfare check, screening or referral at the point an order is served.

Service is a scheduled contact, at a known location. The person served has just received notice of a legal restriction affecting their home, their children and their standing. It is the single most predictable moment of acute stress the system creates. Nothing is required to happen at it.

5.2 Three versions

The strongest version of this reform is expensive. Presenting only the strongest version guarantees it is not adopted. Three versions are therefore set out. Each shows what it requires and what it would cost.

Version A — the minimum. A documented welfare and referral step.
At the point of service, the serving officer:

- provides a written information sheet identifying support services, in plain language;

- asks a short, scripted set of welfare questions;
- records the answers and the person's apparent state;
- offers a referral, and records whether it was accepted; and
- where the responses indicate acute risk, follows a defined escalation pathway.

What it requires: a script, a form, a training module, a referral pathway and a data field.

Cost: not minimal. It adds a few minutes to an existing task for the serving officer, but the referral pathway behind it consumes specialist-service time. Appendix P5 costs the legislated minimum, and it is the largest recurrent line in the package (Appendix P7).

What it achieves: a record exists at the moment of highest risk. Referral is offered universally rather than at officer discretion. And the data field is created, which is what makes the question in Chapter 11 answerable.

Version B — the intermediate. Accompanied service in defined categories.

In defined high-risk categories, a trained support worker or health practitioner accompanies service. That person conducts the welfare step and can make an immediate warm referral. The categories are: where the assessment recorded suicidality, where firearms are involved, where the order includes an exclusion condition, or where the respondent has recorded mental health or substance use factors.

What it requires: a funded roster, defined trigger categories, and a coordination arrangement between police and a health or community provider.

Cost: additional to Version A and proportional to the number of triggered matters; at Appendix P5 it is smaller than Version A's recurrent cost.

What it achieves: a clinical response at the point of service in the cases where the assessment has identified elevated risk.

Version C — the strongest. Service by a qualified psychologist, with ongoing support for both parties.

An order is delivered to the respondent by a qualified psychologist, incorporating an initial psychological safety intervention. A police officer is present where the court considers it necessary. A psychological safety plan is prepared. It addresses mental health status, suicide risk, psychosocial stressors arising from the order, family, social and financial circumstances, and risks to the protected person or others. It sets out mitigation strategies, escalation pathways and monitoring. Support services are available free of charge to both parties for the duration of the order, with periodic reporting to the court or a prescribed authority.

What it requires: a workforce of registered psychologists available for service delivery at short notice, and an ongoing support program for both parties.

Cost: substantial, and the workforce may not exist in the ACT at the required scale.

What it achieves: the most complete version of the control. It is the version that would most reduce the hazard. It is also the version least likely to be funded.

5.3 The recommendation

Legislate Version A now, as a duty. Legislate the power to prescribe Versions B and C by regulation, and commit to Version B in the defined categories within two years.

Under that structure the minimum control begins immediately, and so does the data field. The stronger versions can then be phased in without further primary legislation.

Appendix G contains drafting on that basis.

5.4 Both parties

The obligation runs to both parties. For the protected person, the period after an order is made is also one of elevated risk. The crisis services review documented that support at that point is not consistently available.

5.5 The safeguard

The division includes an express provision. It does not limit the paramountcy of safety under section 36 or the least restrictive principle under section 37. In case of inconsistency, it applies in a way that does not compromise the safety of the protected person.

6. Reform 5 — the legislative element: publication of administrative statistics and correction of record

6.1 The failure it addresses

Chapter 11 established that requests for court administrative statistics were refused. The stated basis was that court information is taken to be contrary to the public interest to disclose unless it is administrative in nature. Outcome data, on that view, is not administrative in nature.

This chapter does not argue the decision was legally wrong. It observes that the construction places aggregate, de-identified counts of what the court does outside the access regime.

6.2 The proposal

A publication obligation, by regulation or practice direction, requiring quarterly publication of de-identified aggregate statistics including:

- applications for protection orders filed;
- interim orders sought and made;
- interim orders made in the absence of the respondent;
- recorded gender and age band of applicants and respondents;
- conditions imposed, by type, including exclusion conditions;
- outcomes at final determination, by category — final order made, dismissed, withdrawn, consent without admission, lapsed;
- median and 90th percentile time from filing to first listing, and to final determination;

- applications to amend, revoke or extend, and time to first listing; and
- contravention charges laid and outcomes.

6.3 Why publication rather than access

An access regime produces information one applicant at a time, after a delay, subject to refusal. A publication obligation produces the same information for everyone, on a schedule, with no application required.

It also removes the burden the access regime places on agencies. Chapter 11 recorded an FOI team spending three hours on a request. A published dataset would have answered it in seconds.

6.3a Correction of record where an order ends

Also adopted following the constructed critique at Appendix Q2, which identified the more serious of the two gaps it found: a work whose central finding is that the Territory cannot tell whether it has caused harm should not be silent about what happens when it can.

At present the making of an order propagates through the systems that hold it. The ending of one does not reliably follow it.

Three requirements follow, and all three are deliberately minimal.

Correction of record. Where an interim order is discharged, or an application is withdrawn or dismissed, the discharge is recorded in every system that recorded the order — including the police records system and any firearms registry entry — within a stated period.

Automatic reinstatement of a suspended authority. Where a firearms licence was suspended under section 44 and the order is discharged, reinstatement is administrative and follows the discharge, rather than requiring a fresh application by the person whose licence it is.

A published count. The number of interim orders discharged, withdrawn or dismissed at the first contested hearing is published quarterly with the other statistics under this reform. It is one of the few measures that would begin to show the rate at which the second kind of error occurs.

Drafting. The three requirements above are drafted at Appendix G5: the published count at G5(1)(j), and correction of record and administrative reinstatement at G5(4) to (7).

What is not proposed, and why. No compensation pathway is proposed. Not because the case for one is weak, but because designing it would require knowing the rate and the severity of the harm, and Chapter 11 establishes that nobody does. The published count is the step that would make that question answerable. A remedy scheme sized to an unknown quantity would be the same error this work criticises elsewhere.

6.4 Two accompanying data changes

Neither requires legislation, and both are recorded here because they belong with this reform.

A field in the ACT Suicide Register recording whether the deceased was, at the time of death or within the preceding 12 months, subject to a family violence order, as protected person or respondent.

A queryable status flag in the police records management system, set at the point an order is served.

7. The Cabinet measure — whole-of-system business cases

7.1 The failure it addresses

Chapter 6 established that police numbers and judicial capacity increased without corresponding funding for the prosecution service or legal assistance. Both agencies stated the consequences on the record.

7.2 The proposal

This is a Cabinet process requirement rather than an amendment. Before any material police, offence, court or service reform is funded, the business case must state:

1. expected volume change, by category, with assumptions;
2. flow-through to prosecution, contested hearing, conviction, custody and supervision;
3. time cost per matter in prosecution, defence, court, registry and corrections terms;
4. consequent funding requirement for each affected agency, by year;
5. additional housing and health service demand generated; and
6. **the unfunded remainder** — where the model shows demand that will not be funded, the business case must say so and identify who will absorb it.

7.3 Why this one changes behaviour

Suppose a business case must name the agency expected to absorb unfunded demand. That agency then reads it before the decision is made.

8. The coercive control offence

8.1 Where it stands

The government presented the Crimes (Coercive Control) Amendment Bill 2026 on 28 May 2026. It was before the Assembly at the evidence cut-off, and the Legal Affairs Committee's report on it was due on 11 September 2026. This chapter takes no position on whether the offence should exist. That is a matter for the Assembly. Chapter 19 §3 examines the Bill as presented, clause by clause, with the 23 submissions to the inquiry.

8.2 What the evidence bears on

Two things, both of which Chapter 19 confirms against the text of the Bill.

The stated reason for the two-year interval was system readiness. The Bill commences the offence two years after notification whether or not readiness has been achieved (section 2 (2)). The 2023 death review recommended a pattern and primary aggressor tool for police and courts. At the evidence cut-off the framework was still being updated and no validation results had been published.

A pattern offence increases the consequences of classification error. The offence in new section 72J turns on a course of conduct of family violence *by* one person *against* another, *intended* to coerce or control. That is the judgment Chapter 9 examined, applied to a criminal charge rather than a civil order; Chapter 4 recorded that eight of 13 deceased victims examined in 2025 had been misidentified as the predominant aggressor, and Chapter 9 that the accuracy of that judgment has never been measured. Every safeguard the Bill contains operates at trial; none operates before charge (Chapter 19 §3.3).

8.3 What follows

Two readiness conditions follow from the evidence recorded in Parts I and II, and neither is an argument against the offence:

Condition 1 — published inter-rater reliability for the classification method, before commencement. The measurement is specified at Appendix O: six weeks of fieldwork, about five months end to end. Chapter 19 §3.7 gives it a legal hook, as a readiness statement on which commencement depends, drafted at Appendix G9.11.

Condition 2 — a published demand and capacity model, before commencement. Chapter 6 sets out why. This condition remains administrative and is the Cabinet measure at section 7 applied to the offence.

Chapter 19 §3.6 adds what the Bill's own machinery needs to make either condition checkable: content for the review in section 72K, a committee that lasts until the review reports, a recorded pre-charge assessment, and a prosecution election for summary disposal. Both conditions are consistent with the government's own stated approach of legislating after readiness. They make readiness measurable.

9. What is not proposed

Four things a reader might expect are not proposed, and the reasons are given.

Raising the threshold for a protection order. Section 21 is appropriate. Nothing in the record supports making orders harder to obtain.

Mutual orders as a default, at any stage. Reciprocal conditions are not proposed as the default where the court proceeds without hearing the respondent, for the reasons at section 4.0. What is put to the Assembly, as a question and as a 24-month trial, is a discretionary power available only where the court has recorded that it cannot identify the person most in need of protection. In every case where the court can make that identification, the one-way order remains the default and nothing changes. Mutual orders at a contested final hearing are not proposed at all: at that stage the court has the material to classify, and a mutual order made on that material can be and has been used against the person most in need of protection.

A costs regime against unsuccessful applicants. This would deter applications, including meritorious ones, and would fall hardest on people with the least money.

A general offence of making a false allegation. Existing offences already cover fabricating evidence, perverting the course of justice and making false reports. The first case in Chapter 12 shows they can be prosecuted. A new specific offence would risk deterring genuine reporting for no additional protection. The Bill before the Assembly likewise creates none for the police-issued notice; the word "false" does not appear in it (Chapter 19 §2.4, item 5).

What this chapter established

Five findings that this chapter establishes and nothing else in these pages does. The chapter's full set of 12 findings is at Appendix M, where it can be read against every other chapter's. F16.6a states the expedited return on its own; F16.9 states Reform 3 as a whole. F16.2 now refers to Division 4.1B, for the reason at section 3.2; F16.8's two readiness conditions are tested against the Bill as presented at F19.4.

- **F16.1** — Five reforms require legislation or are materially stronger in it, and one further measure is a Cabinet process requirement.
- **F16.5** — Section 43(4), which removes complicity liability from a protected person absolutely, is examined in the annex to this chapter as a question rather than a proposal, because the ACT frequency of deliberate inducement is unmeasured and the comparative charging evidence has not been assembled.
- **F16.6a** — Where an interim order is made in the absence of the respondent, the respondent would be entitled on request to a listing before a Magistrate within two business days, matching the expedited pathway the applicant already has on a refusal, with the protective conditions continuing until the return.
- **F16.11** — Section 43(1) applies to a person **against whom** a family violence order is made, so reciprocal conditions attached to a protected person carry no offence unless a provision expressly deems that person into the section. With the express deeming at section 21A(6A), conduct by the protected person breaching a reciprocal condition is a primary contravention under section 43(2) rather

than complicity, because section 43(4) immunises complicity in another person's breach and not a person's own. That operates only where a magistrate was satisfied the person most in need of protection could not be identified, never reaches the inducement of a breach of an asymmetric condition, and creates criminal exposure for a person who sought protection. It is not an answer to the section 43(4) question.

- **F16.9** — Where a court proceeds in the absence of the respondent, the respondent would be entitled on request to a listing before a Magistrate within two business days, with the protective conditions continuing until then (new section 47C); the reasons the court already has to record under section 68 would have to state the material relied on, whether any of it came from an independent source, why the matter could not wait for a notified listing, which less restrictive conditions were considered, and whether the court could identify the person most in need of protection (new section 68A); and, because section 92 confines appeals to final orders and section 87 permits review only of a special interim order, the review in section 87 would be extended to an interim order made in the respondent's absence, with non-compliance with sections 47A, 68A or 21A as a ground (new section 47D). Separately, and put as a question rather than a recommendation, reciprocal conditions would be available at the court's discretion only where it recorded that it could not make that identification, expiring at the first contested listing, with an express amendment to section 21, a carve-out from the automatic consequences, a pre-registered evaluation, a published withdrawal trigger and a 24-month sunset.

Annex to Chapter 16 — The complicity question

This annex is not part of the reform package. It sets out a question, the evidence that would be needed to answer it, and the draft provision that would follow if the answer were yes. Nothing in Chapters 15 to 19 depends on it.

Why this is an annex and not a reform. A replacement complicity offence is not one of the five reforms. The five reforms each answer a failure documented in the ACT record: an unaligned framework, an unstructured ex parte decision, a respondent with no fixed route back to court, an unattended service event, an unpublished ledger. This one does not. The gap it addresses is real as a matter of statutory construction, but its frequency in the ACT is unknown and unmeasured, and the comparative evidence that would settle whether removing a blanket exemption produces retaliatory prosecutions has not been assembled here.

Reform 3 barely touches this gap. Section 4.6a sets it out in full. In short: section 43(1) applies to a person **against whom** an order is made, so reciprocal conditions carry no offence at all without the express deeming provision now at section 21A(6A); with it, a protected person who initiates prohibited contact commits a primary contravention rather than complicity — but only where a magistrate was satisfied the person most in need of protection could not be identified, never for an asymmetric condition, and only for the 24 months the trial runs. The question below therefore stands as it did.

What would be required to move it into the package. Three things, none of which exists in this work. First, comparative law: which Australian and comparable jurisdictions

have no blanket protected-person exemption, and what their provisions say. Second, charging data from those jurisdictions: how many protected people have in fact been prosecuted for complicity in contravention of an order made for their protection, over what period, with what outcomes. Third, a worked analysis of retaliatory-prosecution risk, including how a respondent facing a contravention charge might use the availability of a counter-charge as leverage, and what procedural filters would prevent it. Until those three exist, the honest form of this item is a question.

The strongest objection, stated fairly. A protected person who is themselves being coerced could be exposed to prosecution. The prospect could also deter a person from reporting a contravention at all. Two safeguards are drafted against that — an express statutory list of matters governing the decision to prosecute, including coercion and the safety of the protected person, and a three-year statutory review reporting how many prosecutions were brought against protected persons. Whether those safeguards are sufficient is a legitimate question. It is not settled here, and it is not answered here.

A.1 The current position

Section 43(4) provides that a protected person does not commit a complicity offence under the Criminal Code by aiding, abetting, counselling, procuring, or being knowingly concerned in conduct that contravenes the order.

A.2 Why the protection must be preserved

Chapter 7 set this out. Protected people are frequently subject to continuing pressure. A person who agrees to meet or resumes contact may be acting under coercion, financial necessity or fear. Prosecuting them would be unjust. It would deter people from seeking orders. And it would give a person using violence a further lever of control.

Nothing proposed here disturbs that.

A.3 The gap

The provision is absolute. It admits no exception for deliberate inducement of a contravention. The respondent in such a matter faces a charge carrying up to five years' imprisonment.

The question now has two targets. The Bill before the Assembly reproduces section 43(4) for police-issued family violence safety notices at new section 13ZC(3), in the same terms, so the Assembly has affirmed the design for a second instrument (Chapter 19 §2.4, item 8).

A.4 The provision that would follow

If the question were answered yes, the amendment would repeal section 43(4) and replace it with a complicity offence that:

- applies to any person, including a protected person, an applicant, or any other person;
- requires that the person aids, abets, counsels, procures, or is knowingly concerned in conduct contravening the order; **and**
- requires that the person **intends**, or is **reckless** as to whether, the conduct would result in a contravention.

Both elements must be present. Inadvertence is not caught. Neither is a person who resumes contact without directing themselves to the order.

The provision is accompanied by an express statutory list of matters to which regard may be had in deciding whether to prosecute:

- the nature and seriousness of the contravention;
- the extent of the person's involvement;
- whether the conduct was intentional, reckless or inadvertent;
- whether the person was subject to coercion, control, intimidation or duress; and
- the safety and protection of the protected person and any affected child.

A.5 Why the prosecutorial discretion provision would matter

It is the safeguard that would have to make such a provision acceptable.

A statutory list directs the decision-maker to the safety of the protected person as a relevant consideration in deciding whether to prosecute. That is unusual drafting and it is deliberate. It means that where prosecuting a protected person would itself endanger them, the statute says so.

A.6 What would need to be monitored

If enacted, this provision should be monitored closely and reported on annually. The report should state how many prosecutions are commenced under it, against whom, and with what outcome. It should also state how many are commenced against a person who is the protected person on the order.

A pattern of prosecutions against protected people would indicate the provision is operating as its critics fear. That should trigger review. Appendix G includes a statutory review after three years.

Sources for this chapter

Claim	Source	Date
Sections 13, 13A, 21, 36, 37, 39, 43, 44, 47, 62A, 65, 68, 69, 70C, 82, 82A, 82B, 87, 91B and 92	*Family Violence Act 2016* (ACT), R17	Effective 1 July 2025
Rule 3802(1) and (2)(s); rule 2903, including subrule (2)(m)	*Court Procedures Rules 2006* (ACT)	Current
Interim applications listed before the Registrar within two business days	Magistrates Court Practice Direction 1 of 2026	Commenced 10 March 2026
Risk management framework alignment requirement	CMTEDD Risk Management Framework and Policy v7.0; AS ISO 31000:2018	2018, 2023
Agencies using different risk processes and reaching different conclusions	ACT DFSV Crisis Specialist Services Review Summary	May 2024
Nine deaths under a current order; six people recorded as perpetrators with police contact within a week of death	ACT DFV Review Biennial Report 2025	2025

Claim	Source	Date
No field in the Suicide Register; police system cannot cross-reference; no analysis undertaken; court statistics refused; FOI processing time	ACT Coroners Court advice through JACS FOI, 26 March 2026; AFP FOI decision LEX 5220, 19 February 2026; JACS FOI decision 2026/496, 2 February 2026	2026
Prosecution volume increases and preparation constraint; Legal Aid rationing	ACT Legislative Assembly Hansard, 16 September 2025; Standing Committee inquiry into Annual and Financial Reports 2024–25	2025–2026
Recommendation 4: pattern and primary aggressor tool	ACT DFV Review Biennial Report 2023	2023
Eight of 13 deceased victims misidentified	ACT DFV Review Biennial Report 2025	2025
Coercive control bill presented and before the Assembly; s 2 (2) commencement; s 72J; committee report due 11 September 2026	Crimes (Coercive Control) Amendment Bill 2026 (ACT), as presented; Standing Committee on Legal Affairs inquiry page	28 May 2026
New Division 4.1A and s 44B (cl 35); s 13ZC (3) (cl 46); word “false” absent	Family, Personal and Sexual Violence Legislation Amendment Bill 2025 (ACT), as presented	Presented 3 December 2025
Victorian framework established in law with prescribed organisation alignment	Victorian Government MARAM framework material	2026

Chapter 17 — Governance, data and assurance

In one page

The ACT has a coordination layer. It does not have an accountability layer. Chapter 13 set out why those are different things. It also set out why the difference explains most of what Part II documents.

This chapter specifies the accountability layer. It has five components.

An annual investment and results ledger. One document, published each year. For every initiative it shows: original and revised budget, actual expenditure, funding source, recipient, cohort served, targets, achieved outputs and outcomes, amounts reprofiled or lapsed, evaluation status, and cost per result. The template is at Appendix F.

A monitoring and evaluation framework with baselines and targets that measure harm, not activity. The First Action Plan commits to building one. This chapter specifies what it must contain to be worth building. The ten domains are serious harm, repeat violence, fatality, misidentification, timeliness, unmet demand, housing stability, economic security, children, and outcomes for people who have used violence. They are not awareness and impressions.

A linked, privacy-preserving data asset. Specified in Chapter 10 and developed here. It comes with the governance conditions that make it safe.

A rapid fatality and near-fatality review process. The biennial thematic report is retained. Alongside it, a multidisciplinary panel reviews every eligible incident quickly. That includes suicide and unintentional death. An implementation tracker is published.

Published assurance. Named owners for outcomes. An implementation tracker for every accepted recommendation. Published validation results for every instrument. And an annual external audit against the risk management standard.

The common feature is that each converts an internal process into a published artefact. That is what makes failure visible early enough to fix.

Section 9 turns the same instruments on the Strategy released on 27 May 2026: an outcomes dashboard published with it, the monitoring framework released for independent review, a name and a dollar figure against every outcome, and paid lived-experience positions in oversight.

One number, one quote, one action

Number: Zero. Of the Strategy's six outcomes, none carries a 2026 baseline, a numeric target for 2028, 2032 or 2036, a nominated data source, a stated reporting frequency, or a named accountable position.

Quote: Governance arrangements for the Strategy are described as "being developed". — ACT Domestic, Family and Sexual Violence Strategy 2026–2036, 27 May 2026

This week: Ask the directorate responsible for the Strategy to publish the implementation tracker for the 2023 death review recommendations and for Auditor-General Report

10 of 2024 — recommendation, owner, accepted or not, due date, status, evidence for the status, and date of last update. The information already sits in agencies. Appendix H is the template, and the build is a week's work.

1. Why the accountability layer is the binding constraint

Almost every recommendation in Part III depends on one of five things. Knowing what was spent. Knowing what happened. Knowing whether a decision was right. Knowing whether a control worked. And someone being answerable for the result.

None of the five currently exists in a usable form.

That means the accountability layer is not one recommendation among several. It is the precondition for the others. Consider a rewritten risk framework that nobody is required to align to, and whose performance is never measured. It reproduces the position the Territory is already in.

2. The annual investment and results ledger

2.1 What it replaces

At present, information about this expenditure is distributed across budget papers, factsheets, media releases, annual reports and evaluation documents. Chapter 3 showed that the same money appears in several of them. It showed that headline figures cannot be added. It showed that no document brings budget, actual expenditure, recipient, cohort, outputs and outcomes together.

In 2024 the Auditor-General recommended that financial reporting be reviewed, to ensure comparable and informative reporting of how levy funds are used. The Auditor-General also recommended that public performance reporting show planned against actual performance, with explanation of significant variations.

The ledger is that recommendation, implemented.

2.2 What it contains

One row per initiative, per year. For each:

Field	Content
Initiative	Name, and the package it belongs to
Original budget	As appropriated
Revised budget	After any in-year change
Actual expenditure	Audited, with the estimated outcome shown separately in the year before audit
Variance	With an explanation
Reprofiled	Amount, and the year moved to
Lapsed or returned	Amount, and the reason
Funding source	ACT revenue, levy, Commonwealth, other, with amounts
Recipient	Organisation or internal business unit
Cohort	Who the initiative is intended to serve
Output targets	What was planned
Outputs achieved	What was delivered
Outcome targets	What change was intended
Outcomes achieved	What change was measured, or "not yet measurable" with a date
Evaluation status	Not scheduled, scheduled with a date, in progress, complete with a link

Field	Content
Unit cost	Cost per participant, per service event, or per result, with the denominator stated
Double-count flag	Whether the amount is also reported within another line

2.3 The double-count flag

This single field would fix most of the confusion Chapter 3 documents.

Where a component is reported inside a package total, both rows carry a flag identifying the relationship. Anyone reading the ledger can see immediately which figures may be added. They can also see which may not.

2.4 The "not yet measurable" convention

Outcomes take time. A ledger that requires an outcome figure in the first year will produce invented ones.

The convention is that "not yet measurable" is a permitted entry. It is permitted only with a date by which it will be measurable, and an identified measurement method. An entry that has said "not yet measurable" for three consecutive years with no method is a finding in itself.

2.5 Where it is published

As a single document, in machine-readable form as well as a readable report. At a stable location. On the same date each year.

3. The monitoring and evaluation framework

3.1 The commitment already made

The First Action Plan commits to developing a Monitoring and Evaluation Framework with annual progress reporting. That is the right commitment. This section specifies what would make it worth having.

3.2 The test for an indicator

Every indicator should pass four tests:

1. **Does it measure a change for people, rather than an activity by the system?**
2. **Is there a baseline?**
3. **Is there a target, and a date?**
4. **Would a deterioration in it be visible, and would something happen?**

An indicator that fails the fourth test is reporting, not monitoring.

3.3 What must be measured

Ten domains. For each, the primary measure and the reason it belongs.

Domain	Primary measure	Why
Serious harm	Rate of family violence incidents involving serious injury, strangulation or weapon use	The outcome the system exists to reduce
Repeat violence	Proportion of people with a further recorded incident within 12 and 24 months	Tests whether interventions change trajectories
Fatality	All family violence context deaths, homicide and non-homicide, with order status	Chapter 11
Misidentification	Proportion of classifications later changed, and time to change	Chapter 9; currently unmeasured
Timeliness	Median and 90th percentile times: first contact to service, filing to first listing, filing to final determination, crisis presentation to safe accommodation	Delay is itself a harm
Unmet demand	Crisis calls not answered; people turned away; waitlist length and clearance rate; accommodation requests not met	The measure absent from every ACT report
Housing stability	Proportion of people in stable housing at 3, 12 and 24 months after crisis contact	Chapter 4: 54 per cent of deceased victims had housing instability
Economic security	Employment and income status at the same intervals	Chapter 4: 62 per cent of deceased victims were unemployed
Children	School attendance and engagement, health service contact, and out-of-home care entry for children in affected households	Chapter 4: 67 children affected by 38 deaths
Outcomes for people who have used violence	Program completion; recorded further violence at 12 and 24 months post-completion	The only way to know whether behaviour change programs work

3.4 What must not be the primary measure

Campaign impressions. Website visits. Training sessions delivered. Staff trained. Referrals made. Dollars allocated. Attendance at forums. Satisfaction with a service among people who received it.

Each of these is worth collecting. None is an outcome. None should appear as a headline measure of whether the system works.

The last one deserves a note. Satisfaction among people who received a service tells you nothing about the people who could not access it. On the evidence in Chapter 5, those people are a significant group.

3.5 Baselines

Most of these measures have no ACT baseline. That is not a reason to defer.

The baseline is established by measuring once. The correct sequence is to define the measures. Measure them. Publish the result as the baseline. Set targets against it. Report annually.

A framework published without baselines, with targets to be determined later, will not produce accountability.

4. The linked data asset

4.1 What it is

A privacy-preserving linkage of records already held across police, courts, prosecution, corrections, health, housing, child protection and funded services. It permits analysis at population level without analysts seeing identities.

4.2 The fields

Set out in Chapter 10. The essential additions to what is currently held are:

- sex and gender identity recorded as separate variables;
- victim, person using violence, or dual status, with a field recording any later change and its date;
- relationship type;
- disability;
- cultural and linguistic background and language;
- service sought, received, declined, and the reason;
- wait time from first contact;
- risk level assessed, by whom, using which instrument;
- decisions made, and their dates; and
- outcomes at 3, 12 and 24 months.

4.3 The governance conditions

Indigenous data sovereignty. Aboriginal and Torres Strait Islander data governed under arrangements agreed with Aboriginal community-controlled organisations. Communities control access, use and interpretation.

Purpose limitation. Access for defined analytical purposes only. Not for operational decisions about individuals, and not for compliance or enforcement.

Separated identifiers. Linkage performed by a separate function. Analysts receive linked records without identities.

Access by named role, audited. Every access logged, with periodic published audit of who accessed what and why.

Statutory penalties for misuse.

A published data dictionary, so that anyone can see what is collected and how it is defined.

4.4 The suppression rule

Small cohorts are the problem the ACT's size creates. The current approach is suppressing counts below five. It protects individuals and makes whole cohorts invisible. Chapter 10 documented the consequence.

The alternative is rolling multi-year totals for small cohorts, with the period stated. A three-year or five-year total for a small group is disclosive of far less than an annual count. It permits reporting rather than silence.

4.5 What it would answer

Within two years of operation, the asset would answer questions that currently cannot be answered at all:

- What proportion of people classified as the predominant aggressor are later reclassified, and how does that vary by sex, cohort and setting?
- What is the relationship between orders and subsequent deaths, controlling for the risk factors that prompted the order?
- What proportion of people who seek crisis help receive it, and how long do they wait?
- Does a behaviour change program reduce recorded further violence relative to comparable people who did not attend?
- What is the cost per person for each service, and how does it compare to the outcome achieved?

5. Rapid fatality and near-fatality review

5.1 The limitation in the current design

Chapter 4 established two structural limits on the biennial review.

It is too slow to change practice. A death in early 2020 was reported on in 2025.

Open proceedings block analysis. Ten of 11 homicides in the most recent period could not be analysed. Criminal or coronial proceedings were ongoing.

Neither is a criticism of the review function. That function has produced the most valuable findings in the Territory's record. Both are consequences of a design that combines thematic analysis with a two-year cycle.

5.2 The proposal

Retain the biennial thematic report. It provides the depth and the cross-case analysis.

Add a rapid multidisciplinary review of every eligible incident, conducted within a defined period of the death. A standing panel would conduct it. Its representatives would come from police, health, mental health, alcohol and other drug services, child protection, housing, courts administration and specialist services.

The rapid review has a different purpose from the thematic report. It is not looking for themes. It is asking one question: **was there a point at which this system could have done something different, and is that point still open in other cases now?**

Its output is short. It is a list of system points, each with an owner and a required action, circulated to the agencies concerned.

5.3 Near-fatalities

The design should include near-fatal incidents — attempted homicides, serious strangulation, serious self-harm in a family violence context.

Near-fatalities are more numerous than deaths. The person is available to inform the review. In a jurisdiction with small numbers, they roughly double the learning available.

5.4 Handling open proceedings

The rapid review's purpose is system learning, not attribution of responsibility. That distinction is what allows it to operate alongside criminal and coronial proceedings.

The design requires the following. A statutory basis for the panel's access to information. A prohibition on the panel's findings being used in proceedings. Anonymised outputs. And a protocol agreed with the courts and the coroner about what may be examined while proceedings are on foot.

Other Australian jurisdictions operate death review functions alongside open proceedings on a statutory basis of this kind; Appendix R records the comparison. The design questions are known.

5.5 The implementation tracker

Every recommendation from either the rapid review or the biennial report enters a published tracker. The tracker records the recommendation, owner, accepted or not, due date, current status, evidence for the status, and date of last update.

Appendix H contains the template. It is one page per recommendation.

The Auditor-General recommended this in 2024. It has not been published. It would take a week to build.

6. Assurance

6.1 Named owners

Every outcome in the Strategy has a named accountable position. Not an agency, a position. It is published, with the outcome it is accountable for and the measures by which it will be assessed.

An agency cannot be accountable. An agency is a collection of people. A duty distributed across all of them is held by none of them. That is the mechanism Chapter 13 describes.

FIGURE 17.1

Who would own what

Five instruments, each converting an internal process into a published artefact — and the column the Territory has not filled.

INSTRUMENT	REPORTING PRODUCT	FREQUENCY
An annual investment and results ledger	one row per initiative, planned against actual, machine-readable, at a stable location	Annual, on the same date
A monitoring and evaluation framework	ten domains, each with a primary measure, from serious harm to outcomes for people who have used violence	Annual, against a baseline set by measuring once
A linked, privacy-preserving data asset	a published data dictionary and an access audit of who accessed what and why	Periodic published audit
A rapid fatality and near-fatality review	a list of system points, each with an owner and a required action	Within a defined period of the death
Published assurance	an annual report explaining every measure that moved the wrong way; an implementation tracker; published validation results	Annual report and annual external audit

The column that is empty

Neither the Strategy nor the First Action Plan names a lead agency for any of the six outcomes. Governance arrangements are described as being developed.

OWNER ----------

An empty cell with a date is a governance instrument. Publish the row empty, with the date by which it will be filled and the action that will fill it.

Every outcome has a named accountable position. Not an agency, a position. A name is not an allocation of blame; it is the address to which a question is sent.

Chapter 17, sections 2 to 6 and 9.3. Owners are what the chapter requires and what the record does not supply.

6.2 The annual report

One published annual report covering:

- progress against every outcome, planned against actual;
- the investment and results ledger;
- the monitoring framework measures with baselines and targets;
- the implementation tracker;
- alignment reporting from prescribed entities;
- validation results for every instrument in use; and
- an explanation for every measure that moved in the wrong direction.

The last item is the one that distinguishes a report from a promotional document.

6.3 External audit

An annual external audit of the domestic and family violence risk framework against the ACT's own risk management framework and AS ISO 31000:2018.

This is not a performance audit of the portfolio. The Auditor-General has done that and will presumably do it again. It is a narrower compliance check. Does the framework contain what the standard requires? Are prescribed entities aligned to it?

Chapter 8 conducted this exercise once, from public documents. It took a table. Doing it annually, with access to internal material, is not a large undertaking.

6.4 Validation as a standing obligation

Every instrument in use publishes:

- inter-rater reliability, refreshed periodically;
- predictive performance where outcomes permit;
- error analysis by cohort;
- indicator-level contribution; and
- the withdrawal trigger, and whether it has been approached.

6.5 Independent review of the accountability layer itself

At five years, an independent review of whether the accountability layer is working. Is the ledger published and accurate? Do the measures have baselines and targets? Is the tracker current? Is validation occurring? And did anything change as a result of any of it?

7. What this would cost

The components divide into three cost classes.

Negligible. The double-count flag. The implementation tracker. The Suicide Register field. The police system status flag. Named owners, which is a governance decision.

Modest. The investment and results ledger, which is assembly of information already held. Publication of court administrative statistics from an existing case management system. Inter-rater reliability testing on vignettes, which Appendix O costs. The monitoring framework, which is definition work plus a baseline measurement exercise. The annual external audit.

Substantial. The linked data asset, which requires linkage infrastructure, governance arrangements and analytical capacity. The rapid fatality review, which requires a standing panel, a statutory basis and secretariat support.

The figures are not repeated here. Chapter 18 section 7 states the cost of the five reforms and Appendix P sets out the arithmetic, including where each cost falls if it is not funded. Appendix P9 records that the linked data asset is not costed there; the rapid review is not costed there either. The First Action Plan has already committed to several of the modest items.

The comparison that matters is not cost against zero. It is cost against the alternative. That alternative is another decade in which the Territory cannot say whether the money worked.

8. How to tell whether this is being done

A reader who wants to check progress without reading a budget paper can look for six things.

1. **Is there a single annual document showing budget against actual expenditure by initiative?** If the figures are still distributed across factsheets and annual reports, the ledger does not exist.
2. **Does the monitoring framework have baselines and numeric targets with dates?** If the measures are listed without baselines, it is a list of intentions.
3. **Is there a published implementation tracker for death review and audit recommendations?** If the annual report says "progress has been made on most recommendations", there is no tracker.
4. **Are court administrative statistics published quarterly?** If the answer to "how many interim orders were made last year" requires a freedom of information application, they are not.
5. **Have inter-rater reliability results been published for the risk instrument?** If not, the framework has been deployed unvalidated.
6. **Does the annual report explain measures that moved in the wrong direction?** If every measure in the report improved, the report is selecting measures.

9. The Strategy scoreboard

The Strategy and the First Action Plan were released on 27 May 2026. Appendix L assesses both in detail. Four of its findings are governance findings rather than delivery findings. They belong here, because in each case the remedy is an instrument this chapter has already described, turned on the Strategy itself. None of the four requires a service to change.

9.1 A one-page outcomes dashboard, published with the Strategy

The Strategy sets six outcomes. Across both documents the word "baseline" does not appear. Nor does the word "indicator". No numeric target is set for any outcome, for 2028, 2032 or 2036. No data source is nominated. No reporting frequency is stated.

The remedy is one page. For each of the six outcomes it carries a 2026 baseline, targets for 2028, 2032 and 2036, the data source, the reporting frequency and the accountable position. It is published with the Strategy, not after it. A dashboard that arrives two years later cannot measure the two years it missed.

Not every row is a system measure. Victim-survivor reported safety and dignity belongs alongside the others. A system can improve every measure it holds while the people passing through it feel no safer. Only they can report that.

Appendix L, Part 3 contains a worked version of the table, built from measures that already exist. It is not reproduced here.

9.2 The framework released now, and independently reviewed

Section 3 sets out what the framework must contain. This section is about when it appears.

Finding F3.6 records what the Auditor-General found in November 2024. Eighteen months later the framework is still described in the future tense. The remedy is release now, in draft if necessary, subject to independent review before it is settled. It should tie Safer Families Levy expenditure to outcome indicators. It should report annually in a form a non-specialist can read.

The framework and the annual ledger at section 2 are not competing instruments. They sit at different levels and share one set of definitions.

- The ledger is initiative-level. For each funded line it shows budget, actual expenditure, recipient, cohort, outputs and outcomes. Appendix F is the template.
- The framework is system-level. It defines the measures, baselines and targets set out at section 3.3.
- The dashboard at 9.1 is the one-page summary of both, arranged by Strategy outcome.

The join between them is the ledger's two outcome fields. "Outcome targets" and "outcomes achieved" take their definitions from the framework. A reader can then move from a dollar figure to a population measure without translating between two vocabularies. One set of definitions prevents two reporting systems that cannot be reconciled.

9.3 A name, a dollar figure and a date against every outcome statement

Neither document names a lead agency for any of the six outcomes. Governance arrangements are described in the Strategy as "being developed".

Every outcome statement should carry four things. The lead directorate. The partner services delivering it, including Aboriginal community-controlled organisations. The budget line funding it. The action plan identifier.

The governance principle is plain. A commitment with no named owner cannot be tracked. It cannot be escalated. It cannot be seen to fail. What cannot be seen to fail cannot be corrected. That is the mechanism at section 6.1, applied to the Strategy.

A name is not an allocation of blame. It is the address to which a question is sent.

9.4 Paid, independent lived-experience positions

The oversight body should include paid, independent lived-experience positions.

Payment matters. Unpaid membership selects for people who can afford to attend, which excludes most of the people the Strategy is about. A seat held at the discretion of a funded provider is not independent of it.

Young people should hold positions, with safeguards appropriate to age. That means trained support, control over what is disclosed, and no requirement to recount personal history. Programs that affect a group should carry co-design rights for that group.

The fourth element is a published record of what consultation changed. The Strategy's own consultation record makes this straightforward. The Listening Reports are already published, so what was said is on the record. What is not on the record is which decision each point changed, which points were considered and not adopted, and why. That second document is short. It is the one that tells a participant whether the exercise was real.

9.5 The two rows that cannot be filled today

Two rows of an honest scoreboard cannot be completed now, because the data does not exist.

The first is the misidentification rate: the proportion of classifications later changed, and the time taken to change them. Chapter 9 established that the ACT does not collect it.

The second is reoffending after a behaviour change program. Section 3.3 lists it as the only way to know whether those programs work. It is not measured.

The recommendation is to publish both rows empty, with the date by which each will be filled and the action that will fill it. An empty cell with a date is a governance instrument. It names a gap, assigns a deadline, and can be reported as overdue. A row that is simply absent is not an instrument at all. Nobody can be late for something that is not on the page.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. The chapter's full set of 18 findings is at Appendix M, where it can be read against every other chapter's.

- **F17.1** — The ACT has a coordination layer and not an accountability layer, and the accountability layer is the precondition for every other reform proposed in Part III.
- **F17.2** — An annual investment and results ledger would show, for every initiative, budget against actual expenditure, source, recipient, cohort, targets, achieved outputs and outcomes, reprofiled and lapsed amounts, evaluation status and unit cost, with a double-count flag identifying which figures may be added.
- **F17.9** — Every Strategy outcome should have a named accountable position rather than an accountable agency, because a duty distributed across an agency is held by nobody.
- **F17.18** — Two rows of any honest scoreboard cannot be filled today — the misidentification rate and reoffending after behaviour change programs — and both should be published empty with a date, because an empty cell with a date is a governance instrument and a missing row is not.

Sources for this chapter

Claim	Source	Date
Recommendations on evaluation framework, performance reporting, financial reporting and monitoring of past recommendations	ACT Auditor-General, Report 10 of 2024, Recommendations 2, 3 and 4	22 November 2024
Commitment to a Monitoring and Evaluation Framework with annual progress reporting; system and client journey mapping; true-cost analysis; commissioning roadmap; revised cross-directorate governance	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026
2024–25 budget, estimated outcome and reprofiling by initiative	2025–26 Budget Outlook, Appendix H	2025
Ten of 11 homicides not analysable due to ongoing proceedings; 38 non-homicide deaths analysed; 67 children affected; 54 per cent housing instability and 62 per cent unemployment among deceased victims; suppression below five	ACT DFV Review Biennial Report 2025	2025
Cycle of inaction from unactioned recommendations	ACT DFV Review Biennial Report 2023	2023
Court administrative statistics refused as not administrative in nature; no field in the Suicide Register; police system cannot cross-reference	JACS FOI decision 2026/496, 2 February 2026; ACT Coroners Court advice through JACS FOI, 26 March 2026; AFP FOI decision LEX 5220, 19 February 2026	2026
Risk management standard and whole-of-government framework	AS ISO 31000:2018; CMTEDD Risk Management Framework and Policy v7.0	2018, 2023

Claim	Source	Date
Six outcomes with no baseline, numeric target, data source, reporting frequency or named lead agency; governance arrangements “being developed”	ACT DFSV Strategy 2026–2036; First Action Plan 2026–2028	27 May 2026
Listening Reports as the published consultation record informing the Strategy	ACT DFSV Strategy 2026–2036	27 May 2026
“Has not developed a performance monitoring strategy or evaluation framework” for levy-funded initiatives; needs analysis dated	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024	22 November 2024

Chapter 18 — Implementation

In one page

A reform program that requires everything to happen at once will not happen. This chapter sequences the proposals into what can be done in the first hundred days, the first year, and the first term.

The sequencing rule is simple: **do the cheap, visible things first, because they create the measurement that everything else depends on.**

In the **first hundred days**, seven things can be done. None requires legislation or the agreement of any external body, and all but one can be started within existing budgets; the reliability study is costed at Appendix O. Add a field to the ACT Suicide Register. Add a status flag to the police records system. Publish the implementation tracker for death review and audit recommendations. Publish quarterly court administrative statistics. Run inter-rater reliability testing on the existing risk instrument and publish the result. Name an accountable position for each Strategy outcome. Publish an operational plan for coercive control and systems abuse.

In the **first year**, eight larger pieces. Publish the first investment and results ledger. Publish the monitoring framework with baselines. Introduce the documented welfare and referral step at service. Complete and publish the framework rewrite, with validation. Commission a 2026 system demand and workforce study. Front-load Aboriginal community-controlled funding and data sovereignty into the 2026–28 window. Establish a sexual violence implementation stream with its own measures. Make housing and economic security first-order actions with targets.

In the **first term**, the substantial items: the legislation, the linked data asset, the rapid fatality and near-fatality review, commissioning reform on true costs, prevention infrastructure built to run rather than to model, and the whole-of-system business case requirement.

Each item below states who does it, what it costs, what it produces, and how anyone can check.

> **One number, one quote, one action**
>
> **Number:** Ten years. The last whole-of-system demand and gap analysis for the ACT is the Glanfield review of May 2016, which the Auditor-General found dated in 2024. Commissioning in 2026 is still being planned against it.
>
> **Quote:** "The DFSVO has not developed a performance monitoring strategy or evaluation framework to measure the outcomes and impacts of domestic and family violence initiatives funded through the Safer Families Levy." — ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024, 22 November 2024. The DFSVO is the ACT's Domestic, Family and Sexual Violence Office.
>
> **This week:** Ask the directorate responsible for the Strategy for two dates: the date a 2026 system demand and workforce study will be commissioned, and the date its findings

will be available to the second action plan's commissioning decisions. If neither date exists, the 2016 analysis is still the current one.

1. The sequencing rule

Three considerations drive the order.

Measurement first. Almost every other reform requires knowing something the Territory does not currently know. Measurement items therefore come first, even where they are less visible than service changes.

Cheap before expensive. Items requiring no new money can begin immediately and demonstrate that the program is real.

Publication creates its own pressure. A published tracker with overdue items generates action without any further intervention. A published measure that moves in the wrong direction generates a question. Publication is the cheapest enforcement mechanism available.

2. The first hundred days

2.1 Add a field to the ACT Suicide Register

What. A structured field recording whether the deceased was, at the time of death or within the preceding 12 months, subject to a family violence order, as protected person or respondent, and whether the order was interim or final.

Who. The ACT Coroners Court, with the Justice and Community Safety Directorate.

Cost. A schema change and a data entry step in an existing process.

Produces. From the date of implementation, the Territory can count. It does not fix the historical record, which requires a separate back-capture exercise, but it stops the gap widening.

How to check. The field is either in the register or it is not.

2.2 Add a status flag to the police records system

What. A queryable flag, set when an order is served, recording that the person is a respondent to an interim or final order, with the date and the order's end date.

Who. ACT Policing.

Cost. A routine system change request.

Produces. Removes the stated reason the figures could not be produced. Once the flag exists, the question in Chapter 11 becomes a query rather than a file-by-file review.

How to check. Ask for the count. If the answer is a number, it exists.

2.3 Publish the implementation tracker

What. One page per recommendation from the 2023 death review and from Auditor-General Report 10 of 2024: recommendation, owner, accepted or not, due date, status, evidence for the status, date of last update. Appendix H is the template.

Who. The directorate responsible for the Strategy.

Cost. Assembly of information that already exists in agencies, and a page on a website.

Produces. The first accurate public statement of what has and has not been implemented. Chapter 4's status table is an outside estimate; this replaces it with the real thing.

How to check. It is published, or it is not. If the published statement is "progress has been made on most recommendations", it has not been done.

2.4 Publish quarterly court administrative statistics

What. The list in Chapter 16: applications filed, interim orders sought and made, orders made in the absence of the respondent, recorded gender and age band, conditions by type including exclusion conditions, outcomes at final determination by category, and timeliness measures.

Who. ACT Courts and Tribunal Administration.

Cost. A report from an existing case management system, run quarterly.

Produces. The denominator. Almost every question in the preceding chapters about how the order system operates is unanswerable because these counts are not published.

How to check. Look for the publication. If the only route to the numbers is a freedom of information application, it has not been done.

Note. Chapter 11 established that these statistics are treated as outside the freedom of information access regime. That construction does not prevent publication. It means publication is a choice.

2.5 Run and publish inter-rater reliability testing

What. A set of twenty standardised case vignettes, administered to a sample of assessors across every role that applies the current risk instrument — police, registry, crisis service, health, child protection. Measure how often they reach the same risk rating and the same classification. Publish the agreement statistic and the distribution.

Who. The framework owner, with an independent evaluator.

Cost. About $147,000 if assessor time is absorbed within agencies, or about $185,000 if that time is separately funded. No client data is used, so there are no privacy approvals to obtain. Fieldwork is six weeks; the full study is about twenty-one to twenty-two weeks.

What falls inside a hundred days. The decision to proceed, the engagement of an independent analyst, and the public registration of the protocol, the agreement threshold and the withdrawal trigger. Registering the pass mark before the data exists is the part that has to happen first and cannot be done later. Appendix O specifies the whole study.

Produces. The first published measurement of consistency in ACT family violence risk practice, and a baseline against which the rewritten framework can be compared.

How to check. The result is published, with the method.

Why this one matters most. If agreement is high, an important criticism in the preceding chapters is answered and the framework's authors are vindicated. If it is low, the Territory learns something it urgently needs to know. Either result is worth having, and the test costs about $147,000 against a $151.4 million program.

2.6 Name an accountable position for each Strategy outcome

What. For each of the Strategy's six outcomes, publish the position accountable, the measures against which it will be assessed, and the date of the first report.

Who. Government.

Cost. A governance decision.

Produces. The end of distributed accountability described in Chapter 13.

How to check. The names are published, or they are not.

2.7 Publish an operational plan for coercive control and systems abuse

What. One plan covering four things. The tools frontline workers use to recognise coercive control and systems abuse. The training that goes with them. Charging guidance for police and prosecutors. And a protocol to prevent misidentification of victim-survivors. Systems abuse is the use of legal, financial and administrative processes — applications, complaints, contact arrangements, debt — as a way of continuing control. The misidentification protocol needs particular attention to Aboriginal and Torres Strait Islander women. Chapter 9 records the finding that they are particularly vulnerable to misidentification and its consequences.

Why the first hundred days and not the first year. The offence was before the Assembly at the evidence cut-off, so practice changes at commencement rather than when a plan is ready. The plan requires no legislation, no new money and no external agreement, which is the test applied to every other item in this section. Criminalisation is not implementation. Creating an offence changes what can be charged. It does not change what a worker can recognise at three in the morning, or which of two people is recorded as the aggressor.

Who. The framework owner, with ACT Policing, the Director of Public Prosecutions, specialist services and Aboriginal community-controlled organisations.

Cost. Drafting effort and training design. A funded delivery vehicle already exists: two years of training to operationalise the updated risk assessment and management framework was one of the four components of the $3.6 million announced on 27 May 2026.

Produces. A published document naming the tools, the training, the charging guidance and the misidentification protocol, each with a date and an owner. The charging guidance and the protocol are the administrative form of the pre-charge assessment drafted as new section 72JA at Appendix G9.8 (Chapter 19 §3.6); the plan can be published before the Assembly decides whether to legislate it.

How to check. The plan is published, or it is not. If the misidentification protocol does not require a changed classification to be recorded with its date, the protocol cannot be tested. Chapter 17, section 9.5 sets out why that field matters.

3. The first year

3.1 Publish the first investment and results ledger

What. Appendix F, populated for the current and preceding financial year.

Who. The directorate responsible for the Strategy, with Treasury.

Cost. Assembly of information already held, plus the definitional work of agreeing the double-count relationships.

Produces. The document the Auditor-General's Recommendation 4 asked for.

Realistic expectation. The first ledger will be incomplete. Several outcome fields will read "not yet measurable". That is acceptable and expected. What matters is that the structure exists and the gaps are visible.

How to check. One document, one location, machine-readable, published annually on the same date.

3.2 Publish the monitoring framework with baselines

What. The ten domains in Chapter 17, each with a defined measure, a measured baseline, a numeric target and a date.

Who. The directorate responsible for the Strategy.

Cost. Definition work plus a baseline measurement exercise.

Sequencing note. Baselines require the data. Several measures depend on the linked data asset, which is a first-term item. The correct approach is to publish the framework with the measures that can be baselined now, and to state explicitly which measures await the data asset and when they will be added.

How to check. Every measure has a number next to it and a target with a date. Measures without baselines are identified as such, with the date they will have one.

3.3 Introduce the welfare and referral step at service

What. Version A from Chapter 16: a scripted welfare question set, an information sheet, a recorded referral offer, and a defined escalation pathway where responses indicate acute risk.

Who. ACT Policing, with the health and community sector for the referral pathway.

Cost. Not minimal. The script, form and training are small; the referral pathway behind them is not. Appendix P5 costs the legislated minimum, and it is the largest recurrent line in the package (Appendix P7).

Sequencing note. This can be introduced administratively before the legislation in Chapter 16 is passed. The legislation converts it into a duty; the practice does not have to wait.

How to check. The proportion of served orders with a completed welfare record is a published measure.

3.4 Complete and publish the framework rewrite

What. Chapter 15 and Appendix A.

Who. The framework owner, with the sector, Aboriginal community-controlled organisations and specialist services.

Sequencing note. The First Action Plan already commits to implementing an updated framework, so this work is funded and under way. The proposal is about what the update contains, not whether it happens.

The condition. It is not deployed in general use until inter-rater reliability has been measured on the new instrument and published, with a stated withdrawal trigger.

How to check. The published framework contains defined likelihood and consequence scales, a tolerance statement, named risk owners, a residual risk step, a treatment option set and framework-level reporting requirements. If it does not, the rewrite has not addressed the findings in Chapter 8.

3.5 Commission a 2026 system demand and workforce study

What. A whole-of-system demand and gap analysis. It covers known demand, hidden demand, the specialist workforce shortage, vicarious trauma and retention, and access across the Territory. Vicarious trauma is the cumulative effect on a worker of repeated exposure to other people's trauma.

Who. The directorate responsible for the Strategy, commissioned to an independent body, with the specialist sector and Aboriginal community-controlled organisations.

Cost. A commissioned study. Moderate, and small against the commissioning decisions it informs.

Why now. The last whole-of-system analysis is the Glanfield review of May 2016. The Auditor-General found in 2024 that the needs analysis underpinning levy investment was dated. The First Action Plan places system mapping in the 2026–28 window. The demand study is what turns a map into a number.

Produces. The denominator for commissioning. Without it, a sustainable sector cannot be costed, commissioned or tested.

How to check. The study is published, and the second action plan's commissioning decisions cite its figures.

3.6 Front-load Aboriginal community-controlled funding and data sovereignty

What. Move three items from the 2028–32 window into 2026–28. Multi-year funding agreements with Aboriginal community-controlled organisations. Workforce pay parity. And Indigenous data governance arrangements for the data asset in Chapter 17.

Who. Government, with Aboriginal community-controlled organisations, on terms those organisations set.

Cost. Multi-year agreements are largely a re-phasing of money already committed, plus the parity gap. The data governance work is negotiation and drafting.

Sequencing note. The Indigenous data sovereignty agreement is the first step of the linked data asset at section 4.2. It is a first-term item that has to start in the first

year. Single-year contracts also cannot fund the workforce that the study at 3.5 is likely to show is missing.

Produces. Funding agreements longer than the planning horizon of the organisations holding them, and a data governance agreement in force before any linkage begins.

How to check. Contract terms and the published agreement. Both are documents with dates on them.

3.7 Establish a sexual violence implementation stream

What. A separate implementation stream with its own measures: time from disclosure to service, forensic and counselling wait times, investigation quality, charge and conviction rates, discontinuance with published reasons, and victim-survivor experience of court.

Who. The directorate responsible for the Strategy, with ACT Policing, the Director of Public Prosecutions, health services and specialist sexual violence services.

Why separate. Chapter 6 documented a divergence specific to this stream. Sexual offence prosecutions commenced rose about 170 per cent over four years while recorded sexual assault victimisation rose about 37 per cent. Discontinuance rose from 2.5 per cent of completed matters in 2017–18 to 17.3 per cent in 2023–24. Movements of that size disappear inside a combined family violence measure. A stream reported only within a larger one cannot be managed.

Cost. Measurement and reporting. Discontinuance reasons already exist in prosecution files; publishing them in categories is a reporting change.

Produces. A published series for each measure, separate from the family violence series, so a change in one is visible.

How to check. Look for the sexual violence measures as their own table. If they appear only as a subset of family violence reporting, the stream does not exist.

3.8 Make housing and economic security first-order actions

What. Four targets in place of four intentions. A crisis-to-stable-housing pathway, with the proportion in stable housing at 3, 12 and 24 months stated as a target. Safe at Home capacity, stated as the number of households it can hold in place safely each year. Financial abuse remedies, including a defined route to relief from coerced debt. And employment support attached to the recovery pathway.

Who. The housing and community services directorates, with the directorate responsible for the Strategy.

Cost. Substantial, and unavoidable. This is service delivery rather than measurement, and it is the largest first-year item.

Why first-order. Chapter 4 records that among deceased victims 62 per cent were unemployed and 54 per cent had experienced homelessness or housing instability. Housing and income are safety variables in the Territory's own fatality data. Treating them as recovery items that follow safety inverts what the evidence shows.

Produces. Four published targets with dates, in place of four commitments that cannot be tested.

How to check. The housing stability and economic security domains in Chapter 17, section 3.3 carry a number and a target date rather than a description.

4. The first term

4.1 The legislation

The legislative elements of the five reforms in Chapter 16 and Appendix G.

Sequencing within the term. The alignment obligation and the publication obligation are self-contained and can proceed early. The expedited return, the reasons obligation and the review ground at sections 47C, 68A and 47D can commence together and early; they are self-contained and depend on nothing being built first. The order after that matters. The reasons obligation, the framework rewrite and the reciprocal conditions trial should commence in sequence rather than together: the rewrite permits the answer "unresolved", section 68A(2)(d) makes the equivalent question a recorded field, and section 21A attaches a consequence to one of the answers. Running the reasons obligation for a period before the trial is what produces the rate at which courts record that they cannot identify the person most in need of protection, which is the baseline the trial needs and which nobody now holds (Chapter 16 section 4.7, objection seven). The reciprocal conditions trial must not commence until that baseline has been measured and its evaluation and withdrawal trigger have been published, because the measures that would show whether it deters applications have to exist before it starts. The structured assessment provision must not commence until the registry and judicial resourcing has been provided and a statement to that effect presented to the Assembly, which is a condition on the face of the clause at Appendix G1 and not a matter of good intentions. The risk assessment provision should follow the framework rewrite, because it references a standard the framework must be capable of meeting. The safety and support division can be introduced with Version A as the legislated duty and the stronger versions enabled by regulation.

If the Family, Personal and Sexual Violence Bill passes with Part 2A, the structured assessment for police notices at new sections 13H(2A) and 13HA (Appendix G9.1) should commence with section 47A, because both depend on the same approved form and the same resourcing statement; the expedited review at section 13YA (G9.3) can commence with section 47C on the same footing; and the six-monthly data at section 156(1A) (G9.4) belongs with the publication obligation. Chapter 19 §2.9 sets out the amendments and §5 the order in which the Assembly could take them.

4.2 The linked data asset

Sequencing. Governance arrangements first, including the Indigenous data sovereignty agreement, then the data dictionary, then linkage infrastructure, then the first analytical outputs.

Realistic timeframe. Three to four years to first useful output. This is the longest item in the program and should start earliest.

4.3 The rapid fatality and near-fatality review

Sequencing. Statutory basis, then panel establishment, then protocol with the courts and coroner, then operation.

Note. The near-fatality component can begin earlier than the fatality component, because it does not intersect with coronial jurisdiction.

4.4 Commissioning reform on true costs

The First Action Plan commits to a true-cost analysis and a commissioning roadmap. Chapter 5 documented why this matters: contracts that do not fund data, evaluation, supervision and workforce support produce organisations that cannot measure themselves.

The test of whether it worked. Do funded organisations have the data and evaluation capacity to report against the monitoring framework? If the monitoring framework is published and providers cannot supply the measures, commissioning reform has not delivered.

4.5 Prevention infrastructure built to run rather than to model

The First Action Plan funds the development of a model for primary prevention infrastructure, delivered with Women's Health Matters as one of the four components of the $3.6 million announced on 27 May 2026. Developing a model is a necessary step. It is not the same as operating prevention.

What. Funded settings work in schools, workplaces, sport, faith settings and online, with shared standards, bystander capability and evaluation built in from the start. Bystander capability is the ability of people who are present to interrupt behaviour safely.

Who. The directorate responsible for the Strategy, with the education, sport, workplace and faith settings that deliver it, and the prevention sector.

Sequencing. In parallel with the design contract, not after it. Settings work that waits for the model to be finished begins in the 2028–32 window at the earliest. Reviews since 2016 have found the same crisis-heavy imbalance. A further cycle of design before delivery reproduces it.

The test of whether it worked. Coverage with evaluation attached, not reach. The measure is the proportion of schools, workplaces and sporting clubs running a program to the shared standard and evaluated against it. It is not the number of people who saw a campaign. Chapter 17, section 3.4 sets out why impressions are not an outcome.

4.6 The whole-of-system business case requirement

A Cabinet process change. It can be made at any point, and should be made before the next material justice reform.

5. What to do about the coercive control offence

The bill was before the Assembly at the evidence cut-off, so its status will have changed by the time this is read. Chapter 19 §3 examines it as presented; §3.6 and §3.7 set out the amendments and the five conditions for safe commencement, each drafted at Appendix G9.

Two conditions from Chapter 16 apply regardless of where it has reached:

Before commencement, publish inter-rater reliability for the classification method. This is a first-hundred-days item in any event, and it is directly relevant to an offence that turns on identifying who is exercising control. The Bill fixes commencement at two years after notification whether or not this has been done; Appendix G9.11 makes it a condition of the commencement notice.

Before commencement, publish a demand and capacity model covering police investigation, prosecution, defence, court and corrections.

A third follows from the Bill's own text: **a recorded pre-charge assessment of the person most in need of protection**, disclosed to the accused, with specialist review where each party alleges coercive control by the other (new section 72JA, Appendix G9.8). Every safeguard the Bill contains operates at trial; this is the one that would operate before charge.

If the offence has already commenced, all three should be produced within the first year and the results used to determine what additional resourcing and what practice guidance are required. The two statutory reviews — section 156 of the *Family Violence Act* as the first Bill would substitute it, and section 72K — should be aligned to report the same misidentification measures against the same baseline (Chapter 19 §4).

The operational plan at section 2.7 is the administrative form of the third condition. It is listed in the first hundred days because it applies whether or not the offence has commenced.

6. What success looks like at each stage

6.1 At one hundred days

Seven published artefacts exist that did not exist before: a register field, a system flag, an implementation tracker, a quarterly court statistics release, an inter-rater reliability result, a list of named accountable positions, and an operational plan for coercive control and systems abuse.

Six of them change no service. All of them make the system visible. The seventh changes frontline practice before the offence commences rather than after it.

6.2 At one year

A person outside government can answer, from published documents:

- how much was budgeted and spent on each initiative;
- what the Territory is measuring and what the current value is;
- how many interim orders were made, how many without the respondent present, and how many were confirmed;

- how consistently the risk instrument is applied;
- which recommendations have been implemented and which have not;
- who is accountable for each outcome;
- what current demand is, where it is unmet, and how large the specialist workforce shortage is, from a 2026 study rather than a 2016 one;
- how the sexual violence stream is performing on its own measures, reported separately from family violence;
- what proportion of people leaving crisis are in stable housing at 3, 12 and 24 months, against a target; and
- which Aboriginal community-controlled organisations hold multi-year agreements, and on what data governance terms.

None of that is currently answerable.

6.3 At the end of a term

The Territory can state, with evidence:

- whether serious family violence harm has fallen;
- whether repeat violence has fallen;
- how often classification is wrong and in which direction;
- how long people wait, and how many do not get through at all;
- whether behaviour change programs reduce further violence;
- what the relationship is between orders and subsequent deaths;
- whether prevention is operating in schools, workplaces, sport, faith settings and online to a shared standard, with evaluation attached;
- whether charge, conviction and discontinuance rates in the sexual violence stream moved, and in which direction; and
- what each of those outcomes cost.

That is the loop Chapter 2 identified as never having been closed.

7. What this costs

Appendix P sets out a sketch cost model for the five reforms, with the volume, unit and result separated in every table so that a reader who disagrees can identify which assumption they disagree with.

The headline figures at Appendix P7 are a one-off cost of about **$1.68 million** and a recurrent cost of between about **$720,000 and $1.20 million a year** for the legislated minimum, which is about 1.9 to 3.2 per cent of direct annual investment of about $38 million. Over four years that is about **$4.4 to $6.3 million**, with an illustrative central case of about $5.1 million, or about $5.7 to $8.3 million if the stronger accompanied-service and clinical-support versions of Reform 4 are commenced. Against the $151.4 million of direct investment over the same period the legislated minimum is about 2.9 to 4.1 per cent, and against the $47.8 million of additional funding about 9.2 to 13.1 per cent. The band is wide because two of the quantities that drive it — the annual number of determinations made in the absence of a respondent, and the proportion

in which the court cannot identify the person most in need of protection — are not published anywhere.

FIGURE 18.1

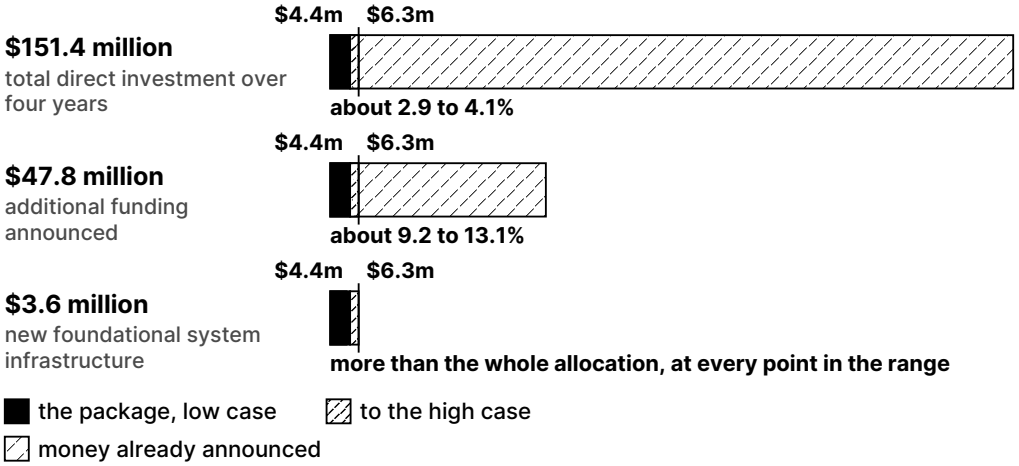
What the reform costs, against what is already committed

The legislated minimum over four years, read as a band rather than as a number.

About $4.4 to $6.3 million over four years

about $1.68m one-off, plus about $720,000 to $1.20m a year; illustrative central case about $5.1m

AGAINST WHAT IS ALREADY ANNOUNCED



The recurrent cost is about 1.9 to 3.2 per cent of the Territory's direct annual investment of about $38 million a year.

The package costs more than the money allocated to building the system. A government could reasonably say it would consume that allocation entirely. That is a fair objection.

Read as a band, not as a number. The central case is not an estimate in the ordinary sense; it is one path through two unknowns.

Chapter 18, section 7; Appendix P, section 7.

Three things about those numbers should be said here rather than left in the appendix.

They are estimates built on a projection, and the projection is the weakest part. The ACT Magistrates Court last published family violence order application counts for 2019–20. Everything since is projected forward at an assumed growth rate. One published number would replace the whole exercise, and hundred-day item 4 produces it.

The package costs more than the money allocated to building the system. The 2026–27 Budget provides $3.6 million over four years for new foundational system infrastructure. This package, at its legislated minimum, is more than that at every point in its range. A government could reasonably say it would consume that allocation entirely. That is a fair objection and it is stated in the appendix rather than buried.

Adopting the package without funding it would be worse than rejecting it. Appendix P section 8 traces where every cost falls and who absorbs it if it is not funded, and the answer in every row is the same: time is taken from the decisions the reform exists to improve. A structured assessment added to an unchanged workload becomes a form to be signed. A welfare step added to unchanged patrol time is completed nominally. A referral pathway added to unchanged service capacity comes directly out of crisis line answer rates, which is the substitution Chapter 5 documents already happening with accommodation searching.

The same objection applies to the two bills before the Assembly. Neither the Family, Personal and Sexual Violence Bill nor its Explanatory Statement carries a resourcing or cost statement for Part 2A, and ACT Policing told the Committee it "would welcome additional funding" for the training that is the government's principal safeguard; Women with Disabilities ACT recorded that the 2026–27 Budget contains no dedicated implementation funding for the coercive control offence. Appendix G9.1 and G9.11 import the section 47B discipline into each (Chapter 19 §§2.9, 3.6).

8. What would cause this to fail

Four failure modes are foreseeable, and naming them is part of the design.

Publication without action. The most likely failure. Documents are published, measures move in the wrong direction, and nothing follows. The control is the requirement in Chapter 17 that the annual report explain every measure moving in the wrong direction, and that each outcome has a named accountable position.

Validation deferred indefinitely. Inter-rater reliability testing is postponed because the framework is being updated, and then postponed again because the update is being implemented. The control is to run the test on the current instrument now, before the rewrite, so there is a baseline and no reason to wait.

The ledger becoming a promotional document. An investment ledger that reports only what went well is worse than none, because it looks like accountability. The controls are the double-count flag, the "not yet measurable" convention with a date, and the requirement to explain variances.

Instrument compliance without capacity. A twenty-minute instrument applied in a five-minute workload produces ticked boxes. The control is the resourcing statement in the governance layer: the instrument specifies the time it requires, and the time is funded.

What this chapter established

Four findings that this chapter establishes and nothing else in these pages does. The chapter's full set of 15 findings is at Appendix M, where it can be read against every other chapter's.

- **F18.1** — Seven actions can be completed within a hundred days, none requiring legislation and all but one within existing budgets, the exception being the reliability study costed at Appendix O: a field in the ACT Suicide Register, a status flag in the police records system, a published implementation tracker, quarterly published court administrative statistics, published inter-rater reliability testing of the existing risk instrument, named accountable positions for each Strategy outcome, and a published operational plan for coercive control and systems abuse.
- **F18.4** — The sequencing rule is measurement first, cheap before expensive, and publication as the enforcement mechanism.
- **F18.7** — The linked data asset has the longest lead time — three to four years to first useful output — and should therefore start earliest.
- **F18.9** — Four foreseeable failure modes — publication without action, deferred validation, a promotional ledger, and instrument compliance without capacity — each have a specified control.

Sources for this chapter

Claim	Source	Date
Six outcomes with no baseline, numeric target, data source, reporting frequency or named lead agency; monitoring and evaluation framework in the future tense; governance arrangements "being developed"; 2026–28 sustainment and mapping, 2028–32 commissioning a re-designed system	ACT DFSV Strategy 2026–2036; First Action Plan 2026–2028	27 May 2026
Commitment to a Monitoring and Evaluation Framework, system and client journey mapping, true-cost analysis, commissioning roadmap and an updated risk assessment and management framework	ACT DFSV Strategy First Action Plan 2026–2028	27 May 2026
$3.6 million over four years for foundational system infrastructure: sector network, Information Sharing Coordinator role, two years of training to operationalise the updated risk assessment and management framework, and support for Women's Health Matters to develop a model for primary prevention infrastructure	Joint media release, Chief Minister and Minister for the Prevention of Domestic, Family and Sexual Violence	27 May 2026
"Has not developed a performance monitoring strategy or evaluation framework" for levy-funded initiatives; recommendations on evaluation, performance reporting, financial reporting and monitoring of past recommendations; needs analysis dated	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024	22 November 2024
Last whole-of-system demand and gap analysis for the ACT	Glanfield, *Report of the Inquiry: Review into the system level responses to family violence in the ACT*	May 2016
62 per cent of deceased victims unemployed; 54 per cent had experienced homelessness or housing instability	ACT DFV Review Biennial Report 2025	2025
170 per cent increase in sexual violence prosecutions over four years; 37 per cent rise in recorded sexual assault victimisation; discontinuance 2.5 per cent to 17.3 per cent	Chapter 6, drawing on ACT Director of Public Prosecutions Annual Reports 2017–18 and 2023–24 and ABS *Recorded Crime — Victims*	2018–2025
Aboriginal and Torres Strait Islander women particularly vulnerable to misidentification	ACT DFV Review Biennial Report 2025, Theme 1	2025
s 2 (2) fixed commencement; s 72K; ss 433–434; no funding statement; ACT Policing "would welcome additional funding" [2.73]; no dedicated implementation funding in 2026–27 Budget (Sub 21)	Crimes (Coercive Control) Amendment Bill 2026; Family, Personal and Sexual Violence Legislation Amendment Bill 2025 and Explanatory Statement; LAC Report 7; Women with Disabilities ACT, Submission 21; Chapter 19	2025–2026

Chapter 19 — The two bills before the Assembly

In one page

Two bills were before the Legislative Assembly at the evidence cut-off of 2 September 2026. Both touch the decisions this work examines, and this chapter was written to meet them.

The Family, Personal and Sexual Violence Legislation Amendment Bill 2025 does two kinds of thing. Its Chapter 2 repairs existing law — good character in sentencing, protected confidences, intimate image abuse, remote presence in court, a dead cross-reference in section 113(e) — and commences seven days after notification. Its Chapter 3 repeals the after-hours order scheme in Part 7 of the *Family Violence Act 2016* and replaces it with family violence safety notices issued by a police officer of or above the rank of sergeant, in force for 14 days, with breach carrying two years' imprisonment. That commences six months after notification. The Standing Committee on Legal Affairs recommended passage with amendments on 24 April 2026; its Chair dissented. The government responded on 28 August 2026, agreeing to eight recommendations, agreeing in principle to two and noting one (recorded from a summary; the response document was not on file).

The Crimes (Coercive Control) Amendment Bill 2026 creates an offence of coercive control of a family member, punishable by seven years' imprisonment. The offence commences two years after notification. An advisory committee is established the day after notification and expires three years later. A ministerial review begins three years after the offence commences. The Committee took 23 submissions and held a hearing on 20 August 2026. Its report was due on 11 September 2026 and had not been presented at the cut-off.

The verdict on the first Bill, in two sentences. The repairs in Chapter 2 are improvements and should pass. Part 2A moves a coercive decision from a judicial officer to a police officer without a structured assessment, without reasons that reach the court or the respondent, without a fixed period to be heard, and without any measure of whether the decision was right; it should be rebuilt before it is passed, not amended at the margin.

The verdict on the second Bill, in two sentences. The offence is coherently drafted and the order of operations — committee first, offence two years later — is the right one. But the offence turns on the classification the Territory has never measured, every safeguard operates at trial rather than before charge, the review has no content, and the committee expires before the review can begin; commencement should depend on readiness that can be shown, not on a date.

Three best and three worst — the Family, Personal and Sexual Violence Bill

Best. (1) The respondent's views must be considered before a notice issues, as far as reasonably practicable (ss 13D(2)(b), 13H(2)(b)); nothing requires that before an interim court order. (2) The notice served must state how each ground is satisfied and must be

explained in person (ss 13I(d), 13U); cross-notices are barred because police "may be unable to identify the primary aggressor" (s 13B(d); ES p 30). (3) Four repairs this work asked for: firearms seizure at the moment of service (s 13ZD(b)), section 113(e) fixed (cl 39), remote presence on a statutory footing (s 44B), and a written record at every branch of the decision (ss 13E, 13F, 13H(3), 13N).

Worst. (1) The applicant and the decision-maker are the same organisation, the standard is a belief on reasonable grounds that there is "a risk", and the judicial after-hours scheme is repealed rather than supplemented (ss 13B, 13H(1); cl 47). (2) Reasons with content are prescribed for a refusal (s 13N(1)(e)) but a decision to issue produces only "a written record of the matters considered", kept in police records (s 13H(3)); only the notice reaches the court (s 13M); the respondent's return is "as soon as practicable" and must be dismissed if no date is available (s 13Y(3)). (3) Nothing measures the scheme: the substituted section 156 names no data and no indicator, the government could produce one number about the scheme being replaced, and collateral consequences — national recognition, later court history, working-with-vulnerable-people disclosure, tenancy — attach to a notice no court has looked at.

Three best and three worst — the Crimes (Coercive Control) Bill

Best. (1) The course-of-conduct provisions solve the particularisation problem that has defeated pattern prosecutions elsewhere, while still requiring the prosecution to plead the nature of the conduct and the period (s 72J(2), (4)–(7)). (2) Oversight is established on day one and the offence is held for two years (s 2). (3) One definition of family violence across civil and criminal law (*Family Violence Act* ss 8, 9); a fault element the government has explained as a misidentification safeguard; the strict liability of the 2024 bill removed.

Worst. (1) The review examines "the operation of the amendments" and nothing else — no baseline, no measure of wrongful charging, no independence (s 72K). (2) The committee's one function is to advise the Minister, its members are the Minister's choice, and it expires one year after the offence commences and at least two years before the review can begin (ss 433, 434). (3) Nothing operates before charge: intent, the definition, the objective test and the reasonableness exception are all matters for trial; commencement is a date rather than a readiness test; and a seven-year maximum without a prosecution election lets the accused choose the Supreme Court (*Crimes Act* ss 374, 375).

One number, one quote, one action

Number: 45 — after-hours orders granted in the ACT in 2024–25, the only figure the government could give the Committee about the scheme the Bill repeals. It could not say how many applications were refused or how many calls to the on-call magistrate went unanswered.

Quote: "In circumstances where police cannot identify the primary aggressor or are concerned of mutual violence, it is likely preferable for a Court to consider these matters, given the greater level of oversight for these decisions." — Explanatory Statement, Family, Personal and Sexual Violence Legislation Amendment Bill 2025, p 30

This week: Ask a member of the Assembly to move that the record an issuing officer must make under new section 13H(3) be given to the registrar and to the respondent with the notice. The Bill already requires the record to exist. The amendment changes where it goes.

1. Why the bills are examined here, and how

1.1 Published to meet them

Chapters 7, 9 and 16 were written against the *Family Violence Act 2016* as it stood in July 2025. Two bills now propose to change it and to raise the stakes of the classification decision Chapter 9 examines. A work that argues for a documented ex parte decision, a fixed route back to court and a published count cannot ignore a bill that redesigns the ex parte decision, or one that attaches seven years' imprisonment to a classification the work says is unmeasured.

Both bills are tested against the four questions at Chapter 16 §1 — does it fix a documented failure; does it need legislation; does it reduce protection for anyone at risk; can compliance be checked from outside — and a fifth for a bill: what does it say about whether it works, and who will ever know.

1.2 What is and is not on file

For the first Bill: the Bill as presented; its Explanatory Statement; the Standing Committee on Legal Affairs Report 7 of April 2026, including the dissenting report. The government response of 28 August 2026 is inside the cut-off; its positions on the eleven recommendations are recorded from a summary, and the response document itself was not on file.

For the second Bill: the Bill as presented; the presentation speech of 28 May 2026; the government's web page "Making coercive control a crime", last updated 1 September 2026; the government's response of September 2025 to the Assembly's resolution of 20 March 2025; and the 23 submissions published by the Committee, of which 22 have text; and the Explanatory Statement and Human Rights Act compatibility statement presented with the Bill on 28 May 2026 (cited as "CC ES p N"). Every statement about the second Bill has been verified against the Explanatory Statement. **Submission 3, from Legal Aid ACT, is a cover sheet only on the file**, and nothing is attributed to it. The *Family Violence Act 2016* is described from the Bills, the Explanatory Statement and the sources already used in Chapters 7 and 16.

The Committee's report on the second Bill was due on 11 September 2026. Nothing about it is assumed.

1.3 The stance

Credit is given where it is due, and a good deal is due. Issues are identified by reference to the text, and each is paired with a drafted solution at Appendix G9. No motive is inferred. Both bills may fairly be described as well-intentioned, as the preface says; nothing here infers otherwise.

One conclusion goes further than the rest, and it is stated here so that it is not mistaken for a drafting quibble. The concerns about Part 2A of the first Bill, and about the review and commencement machinery of the second, are significant enough to warrant revision before passage rather than amendment at the margin. The reason is structural. Each Bill builds a consequence on a police classification of who is at risk from whom, and neither requires that classification to be assessed against criteria, written down in a form a court can read, or counted. Those are not omissions a single amendment fixes. They are the design.

Comments on this chapter will be carried into a second edition. Where a comment shows a claim here is wrong, the correction will be published at the same prominence as the statement it corrects.

2. The Family, Personal and Sexual Violence Legislation Amendment Bill 2025

2.1 What it does

The Bill amends sixteen Acts and one regulation. It is best read as two bills in one cover.

Chapter 2 — general amendments, seven days after notification (cl 2(1)). In sentencing for a sexual offence against a child, a court must not reduce the sentence for good character at all (cl 4–5). Intimate image abuse proceedings attract the closed-court and non-publication protections of sexual offence proceedings (cl 8, 23). The protected confidences immunity is moved so it clearly applies in civil as well as criminal proceedings, with waiver permitted on informed consent in civil proceedings and never in criminal ones (cl 9–18, 24–33). The contravention offence in s 43 extends to a respondent served by substituted service (cl 34). A new Division 4.1A inserts s 44B: "a reference to a person being present in the Magistrates Court or present in court includes the person appearing in the court, with the court's leave, by audiovisual link or telephone" (cl 35). Where an applicant seeks review of a registrar's refusal, the refusal is stayed until the review is heard (new s 91B(6A), cl 37); nothing is added on the respondent's side. The cross-reference in s 113(e) to a non-existent "section 47 (1) (b)" is replaced with "section 47 (2) to (5)" (cl 39). The review clause, s 156, is replaced (cl 40; §2.4, item 10).

Chapter 3 — family violence safety notices, six months after notification (cl 2(2)). Clause 46 inserts a new Part 2A into the *Family Violence Act*. Clause 47 reads, in full: "After-hours orders Part 7 omit". Clauses 49 to 193 make consequential changes across the statute book.

Replacement is the right word. It is not a supplement. Once Chapter 3 commences, no judicial officer will make an after-hours order in the ACT, because the Part that let them do so will no longer exist. Existing orders run out under transitional provisions that themselves expire after a year (cl 48).

Part 2A works like this. A police officer who "considers that the grounds in section 13B … are satisfied" may apply to a senior police officer — a sergeant or above — for a notice (s 13D(1)). The senior officer may issue it if they "believe on reasonable grounds" that the grounds are satisfied (s 13H(1)(b)). The grounds are that "there is a risk to an affected person of family violence by the respondent" and that a notice "is immediately necessary" to ensure the affected person's safety or prevent substantial property damage; the respondent is an adult; no notice is already in force between the two people either way; and the notice is not inconsistent with a court order other than a bail order (s 13B). The notice "comes into force when it is served" and "remains in force for 14 days after the day the notice is served" (s 13L(1)); it "cannot be renewed or extended" (s 13L(3)). It can exclude a person from premises, bar contact and approach, and impose most of the conditions a court can impose under s 38 (s 13Q). A firearms licence is suspended automatically and police may seize the licence and any firearm at service (s 13ZD). Contravention carries 200 penalty units or two years' imprisonment (s 13ZC(1)). The applicant officer may detain the person for up to four hours to complete the process (s 13C). A copy of the notice goes to the registrar (s 13M). Any party may apply to the court to amend or revoke (s 13Y).

The Explanatory Statement gives the reason. ACT Policing pointed to "the short duration of AHFVOs, the restriction of AHFVOs to outside business hours, the limitation on the issuance of an AHFVO alongside the arrest of the respondent, and the additional barriers and practical limitations imposed by the requirement to apply to a judicial officer" (ES p 23). The Domestic Violence Crisis Service found the scheme "piecemeal" and "difficult to access and inconsistently utilised" (ES p 23). And: "Other than the ACT, all states and territories allow for police officers to issue short-term protection notices or orders" (ES p 24).

The Explanatory Statement also records the contrary evidence: "There is some evidence that a judicial officer is better placed to issue immediate protection orders in family violence circumstances, including outside of court hours, and that police should only be able to issue protection notices where it is not reasonable or practicable for the matter to be considered by a judicial officer" (ES p 24). The Bill does not adopt that limit. A notice may issue at any hour, whether or not a judicial officer could be reached, and alongside arrest (ES p 52).

2.2 What deserves credit

Five things in the Bill are better than the Act it amends, and this work asked for several of them.

The respondent's views must be considered before a notice issues. Both officers "must consider … as far as is reasonably practicable in the circumstances … (b) the respondent's views about the proposed family violence safety notice" (ss 13D(2)(b), 13H(2)(b)). No provision of the Act requires anyone to ask the respondent anything before an interim order is made in their absence. The duty is soft, but it exists.

The notice states its grounds and is handed to the person restrained, with an explanation. The notice must contain "a brief statement about how each ground in section 13B for issuing the family violence safety notice is satisfied" (s 13I(d)). It must be "personally served on the respondent as soon as practicable by a police officer" (s

13T(1)). The serving officer "must, as far as practicable in the circumstances, personally explain to the respondent in language likely to be readily understood by the respondent" its purpose, conditions, effect and duration, the consequences of contravention, and how to apply to the court to amend or revoke it (s 13U(1)). A person restrained by an interim court order receives the order; the s 68 reasons stay on the court file. On this point the police scheme gives more paper to the person restrained than the court scheme does.

Cross-notices are barred, and the reason given is misidentification. Section 13B(d) forbids a notice where one is already in force "between the respondent and the affected person", and the note confirms this "includes a family violence safety notice between the parties naming the current respondent as the affected person, and the current affected person as the respondent". The Explanatory Statement explains why: the prohibition "reduces the risk of the victim-survivor being issued a FVSN in circumstances where police may be unable to identify the primary aggressor" (ES p 30). That is an official statement of the classification problem Chapter 9 describes. It is also a design choice with a second face (§2.4, item 6).

Firearms can be seized at the moment of service. Chapter 7 §6 records that under s 44 a suspension does not remove a firearm from a house. New s 13ZD suspends the licence and provides that "a police officer may seize— (i) the firearms licence; and (ii) any firearm or ammunition in the respondent's possession". Clause 113 extends the *Crimes Act* s 192 seizure machinery to notices. That is the sequencing this work asked for.

The record architecture is complete in outline, and repairs are made. Every branch of the decision tree produces a written record: the application (s 13E), a decision not to apply (s 13F), the issue (s 13H(3)), a refusal (s 13N). That is the precondition for the counting Chapter 11 says has never been done. Section 113(e), which Chapter 7 §2.7 describes as a provision that "does not work at all", is fixed (cl 39; ES p 50). Section 44B supports the remote-appearance entitlement in this work's own s 47C. The protected-confidence and good-character amendments respond to published judgments and were supported by submitters and the Committee (Recs 1 and 2).

Three smaller points also count in the Bill's favour and are recorded so that §2.4 is read against them. Section 13F requires a police officer who considers the grounds satisfied but decides not to apply to record "the reasons for deciding not to apply" (s 13F(2)(d)); the current Act has no equivalent record. A court's later order does touch a notice in two places: a notice "is automatically revoked if a family violence order is made against the respondent in relation to the protected person and the order is served" (s 13L(2)(b)), and where a notice condition is inconsistent with a court order "the court order prevails to the extent of the inconsistency" (s 13S(1)(b)). And the substituted s 156 requires the Minister to "review the operation and effectiveness of this Act" (cl 40); effectiveness is named, although no measure of it is.

None of those five is undone by what follows.

2.3 The after-hours order it replaces, side by side

The current Part 7 is described from republication 17 of the Act (ss 100, 103–106, verified 4 September 2026) and from the Explanatory Statement.

Feature	After-hours order — Part 7 (repealed by cl 47)	Safety notice — Part 2A (cl 46)
Decision-maker	Judicial officer, on a police application	Sergeant or above, on a police application (ss 13D, 13H)
Independence from applicant	Yes	No; the ES calls two police officers "two levels of decision-making" (ES p 32)
Standard	A judicial officer "satisfied that" there is a risk and an order is immediately necessary (s 100(a)–(b))	A sergeant or above who "believe[s] on reasonable grounds" (s 13H(1)(b))
Arrest gate	Only where it is not practicable, or there are no grounds, to arrest (s 100(c))	None; a notice may issue alongside arrest (ES p 52)
Duration	To close of business on the second business day (ES p 23)	14 days from service; no renewal or extension (s 13L)
Respondent's views	Not required	Required "as far as is reasonably practicable" (ss 13D(2)(b), 13H(2)(b))
Reasons for making	Required (s 104(a)); no content; no destination on the court record (Ch 7 §2.5a)	"a written record of the matters considered", police records (s 13H(3)); "a brief statement" of grounds on the notice (s 13I(d))
Reasons for refusing	Four stated matters (s 103); on the Magistrates Court record (s 104(b))	Reasons "including each ground in section 13B that was not satisfied", police records (s 13N)
Record reaching the court	Refusal record and the order	The notice only (s 13M)
Detention	Up to four hours, "until (i) if the order is made—a copy of the order is given to the person; or (ii) if the application … is refused—the police officer is notified by the judicial officer of the refusal" (s 105)	Up to four hours, on the applicant officer's own belief, before any senior officer has decided (s 13C)
Breach penalty	Five years (s 43)	Two years (s 13ZC), "due to the comparatively lower level of oversight and checks and balances" (ES p 36)
Route to court	Made by a judicial officer; expires within two business days	Application to amend or revoke (s 13Y); return "as soon as practicable" before expiry; dismissed if no date (s 13Y(3))

On some rows the notice respondent is better placed: views considered, grounds handed over, cross-notices barred, a lower penalty. On the rows this work treats as decisive — an independent decision-maker, a structured record, reasons with content that reach the person restrained and the court, and a fixed period to be heard — the notice scheme is at or below the baseline of the scheme it repeals.

A scheme that describes its own oversight as "comparatively lower" and prices the breach offence accordingly (ES p 36) has accepted the premise of what follows.

2.4 Ten accountability defects in Part 2A

The accountability problem is not that police will sometimes get a scene wrong. It is that the Bill builds a 14-day restraint, a criminal offence and a lasting prior on a classification that no independent body has to check, and that no published measure will ever count. Each item is stated against the text.

1. The decision-maker is the same organisation that will later defend the decision. Applied for by a police officer (s 13D(1)); issued by a sergeant or above (s 13H(1)). No judicial officer unless a party applies. The test is a belief "on reasonable grounds" that there is "a risk" and that a notice is "immediately necessary" (ss 13B, 13H(1)(b)) — an operational belief, not a finding on the balance of probabilities. The after-hours order was made by a judicial officer, and Part 7 is repealed (cl 47).

2. The original decision is almost unreviewable on its merits. The court may amend a notice "only if satisfied that— (a) amending the notice will not adversely affect the safety of the protected person" (s 13Z(a)), and may revoke it on the same test (s 13ZB(1)(a)). Those are prospective safety tests. Neither asks whether the grounds were satisfied at issue, whether the account was reliable, or whether the wrong person was named.

3. The only court door can be shut by the listing calendar. A respondent's application is listed "as soon as practicable" at a date "before the family violence safety notice expires" — "if a return date for the application is available" (s 13Y(3)(a)). Otherwise "the registrar or the court must dismiss the application" (s 13Y(3)(b)). The Attorney-General told the Committee a respondent could "go to the court the next working day" [2.43]. The Bill contains no period.

4. The record of why the power was used is a police file, not a court file. The decision not to apply (s 13F), the record of matters considered (s 13H(3)) and the refusal record (s 13N) are each kept "in the police records". Only the notice goes to the registrar (s 13M). Under Part 7, a refusal record with four stated contents went onto the record of the Magistrates Court (ss 103, 104(b)). Under Part 2A no decision record reaches the court at all.

5. No scheme-specific duty to test the account, and no stated consequence for a false or reckless basis. The word "false" does not appear in the Bill; that was checked by search of the whole text. The general-law offences for false reports remain, and Chapter 16 §9 explains why no new offence is proposed. The point is narrower. Part 2A creates no duty to record what was done to test the affected person's account, whether any information came from another source, or whether the respondent was invited to answer. Section 13H(3) requires a record of "the matters considered", not of what was found.

6. First classification wins. Section 13B(d) bars a notice where one is in force between the same two people in either direction; s 13J confines each notice to one respondent and one affected person (with that person's children). The Explanatory Statement presents the bar as a misidentification safeguard (ES p 30), and §2.2 credits it. But once a notice is served, the other party cannot obtain one for 14 days, whatever the officers later learn. The Explanatory Statement's own answer — that "it is likely

preferable for a Court to consider these matters" — points to a court listing the Bill does not provide.

7. Other systems then treat the notice much as they would a court order. This must be stated precisely. The Dictionary definition of "family violence order" does **not** include a safety notice (ES p 67). But under Part 9 a notice is an "interim FVO" and a "local FVO" for national recognition (cl 69, 70); s 14(1)(g)–(h) as amended requires a court deciding any later application to consider any notice "in force at any time against the respondent" and "any contravention" of one (cl 51); an applicant for NDIS registration under the *Working with Vulnerable People (Background Checking) Act 2011* must disclose a notice "made against them" (cl 191); and a notice supports a family violence tenancy termination and new-tenancy orders in ACAT (cl 173–189). None of those requires a court to have looked at the notice.

8. Criminal liability attaches before any independent finding. A respondent who "has been served" and "engages in conduct that contravenes a condition" commits an offence carrying 200 penalty units or two years (s 13ZC(1)). There is no element that the notice was correctly issued. The protected person is immune from complicity liability (s 13ZC(3)), reproducing s 43(4); the question at the annex to Chapter 16 now has two targets.

9. Detention completes a police-to-police process. Section 13C lets the applicant officer — alone, on their own view that the grounds are satisfied, before any senior officer has decided — remove and detain the person for up to four hours (s 13C(1)(a), (3)). The officer must also believe on reasonable grounds that detention is necessary for safety or for immediate service and is "the least restrictive option reasonably available" (s 13C(1)(c)); that belief is the officer's own, and no one else tests it. Under s 105 of the current Act, detention existed so that a judicial officer could decide: the officer may detain "until (i) if the order is made—a copy of the order is given to the person; or (ii) if the application … is refused—the police officer is notified by the judicial officer of the refusal", for the same four hours. The power is kept; the independent decision it was there to await is removed.

10. No one is accountable for whether any of this achieved the Act's objects. New s 7(aa) adds "giving the police power to issue family violence safety notices to protect people from family violence" (cl 49). The substituted s 156 requires one review beginning "as soon as practicable after the end of 2 years after the day part 2A … commences", a report "within 12 months after the day the review is started", and "expires 5 years after the day it commences" (cl 40). No indicator, no pass mark, no data duty. The Committee recorded that the existing review was due to report before 17 August 2026 [1.12]; the dissent records that it "is now not expected until 2028" (Report p 29).

Items 1, 4 and 8 are structural. Items 2, 3, 5, 7, 9 and 10 are each answerable by a short amendment (§2.9). Item 6 has a benefit and a cost; the fixed return under item 3 addresses the cost.

2.5 How a reversed allegation would travel through Part 2A

This is an illustration constructed from the Bill's text. It uses no real matter. It shows what the provisions do where the person who gives the first coherent account is the person who has been using violence.

One — the account. Police attend. One party gives a clear account naming the other. The other is distressed, injured, intoxicated or silent. The applicant officer "considers that the grounds in section 13B … are satisfied" (s 13D(1)). The officer must consider the respondent's views "as far as is reasonably practicable" (s 13D(2)(b)). Nothing requires a record of whether the respondent was asked, or what they said.

Two — detention and application. On the officer's own belief, the respondent may be detained for up to four hours (s 13C). The application goes to a sergeant, in writing or orally (s 13E(1)), with "a description of the conduct" and "a statement about how each ground in section 13B … is satisfied" (s 13E(2)(a)–(b)).

Three — issue and service. The sergeant, who need not have attended, believes on reasonable grounds that the grounds are satisfied (s 13H(1)(b)). The record of matters considered stays in police records (s 13H(3)). The notice, with "a brief statement" of grounds (s 13I(d)), is served (s 13T). It may exclude the respondent from the home (s 13Q). The firearms licence, if any, is suspended (s 13ZD). The notice runs 14 days from that moment (s 13L(1)).

Four — the lock-in. The next day the respondent's account is corroborated: a neighbour, a message thread, an injury the first account did not explain. No second notice can issue the other way (s 13B(d)). Once served, no police officer can amend or revoke the notice (s 13X). The court may reduce the period or revoke, and cannot extend — "amend" expressly "does not include extending the period" (s 13W(b)) — but only at a hearing the calendar permits. The respondent's application is listed "as soon as practicable" before day 14 if a date exists, and dismissed if none does (s 13Y(3)). At the hearing the court must be satisfied that revocation "will not adversely affect the safety of the protected person" (s 13ZB(1)(a)) — a question about the future, not about who did what.

Five — the consequences that do not wait. While the notice runs it is an "interim FVO" for national recognition (cl 69). It must be disclosed on an NDIS registration application (cl 191). It supports a tenancy termination (cl 173–189). Any breach — a text message, a return to collect belongings — is an offence carrying two years (s 13ZC). The firearms suspension ends with the notice (s 13ZD(a)); the *Firearms Act* suitability criteria as amended do not list notices (cl 139–151), which is a real limit on the consequence and is recorded as one.

Six — the history. Whether or not the notice is revoked, it was "in force at any time against the respondent". Section 14(1)(g) requires a court deciding any later application to consider it (cl 51), and s 13D(2)(f)(i) requires a police officer deciding any later notice to consider "any previous family violence safety notice … against the respondent". No provision deems a revoked notice never to have been made. No provision requires the police records to be corrected. The correction of record at Chapter 16 §6.3a has no counterpart in Part 2A.

Seven — the count. Nothing in this sequence is counted. Section 156 names no measure. The number of notices revoked on the respondent's application, the number in which the first classification was later reversed, the number dismissed for want of a date — none is required to be recorded, and none will be published unless the Minister chooses.

That is not a claim that most notices will be false. It is a claim that the Bill is indifferent to whether they are. Indifference is the accountability finding.

2.6 Tested against the five reforms

Reform	What the Bill does	Aligns or conflicts
1 — a risk framework that is one	No reference to the framework, to any tool, or to any criteria; the ES describes the s 13D(2)/13H(2) list as "assessing the nature and extent of family violence risk" (ES p 25).	**Conflicts by silence.** A new class of ex parte coercive decision is created outside any risk standard.
2 — structured assessment before an ex parte step, funding-conditional	Mandatory considerations mirroring s 14 (ES p 54); a complete record architecture (ss 13E, 13F, 13H(3), 13N). No instrument, no criteria, no record of what was unknown. Commences at six months with no resourcing statement; ACT Policing "would welcome additional funding" [2.73].	**Scaffolding without the instrument.** Aligns on records; conflicts on assessment and commencement.
3 — expedited return; reasons content; review ground	s 13I(d) puts grounds in the respondent's hands; s 13Y gives standing, with "restricts the respondent's rights unnecessarily" as a statutory example; s 44B allows remote presence. But the return is "as soon as practicable" with dismissal for want of a date (s 13Y(3)); the issue record has no content (s 13H(3)); s 91B(6A) deepens the applicant-only pathway.	**Aligns on standing; conflicts on period and content.** Reproduces the F7.4 and F7.5 asymmetries in the new Part.
4 — safety and support at service	s 13U requires an explanation to both parties, saved by s 13U(3). Rec 8 (information materials) agreed. No welfare question, referral or record.	**Partial.** An explanation duty is not a welfare or referral duty.
5 — publish the results; correction of record	s 13M sends every notice to the court; s 156 creates a review; Rec 10 agreed but not in the Bill; ss 13ZA(1)(b), 13ZB(2) notify the firearms registrar and police of amendment or revocation. No published series, no measure, no correction of the police record or of s 14 history.	**Conflicts.** The review is a review of nothing in particular; correction is partial.
The s 43(4) question	Reproduced for notices at s 13ZC(3).	**Unchanged.** Two targets.

2.7 What the Committee and the government said

The Committee reported on 24 April 2026 with eleven recommendations. The government responded on 28 August 2026.

Rec	Substance (abridged)	Response
1	Consider extending the good-character exclusion to all sexual violence offences	Agreed in principle

Rec	Substance (abridged)	Response
2	Consider five protected-confidence matters as future reform	Agreed in principle
3	Let police correct clerical errors in a notice	Agreed
4	Clarify the interaction of notices with bail and other court orders	Noted
5	Police to make reasonably practicable enquiries whether a court order is in force	Agreed
6	As implementation: culturally safe training on misidentification and coercive control; police access to history and specialist services	Agreed
7	Seek further information on a stalking aggravation	Agreed
8	Information materials for respondents	Agreed
9	Consider body-worn camera recording of consent to substituted service	Agreed
10	"ensure collection of appropriate data on the use of the family violence safety notice scheme in order to inform the statutory review to be conducted after two years of operation"	Agreed
11	Pass the Bill subject to the amendments proposed	Agreed

Nothing agreed to changes the decision. Recommendations 3, 5, 8 and 9 are procedural and welcome. Recommendation 6 addresses misidentification through training, outside the statute. Recommendation 10 commits to data, outside the statute, to feed a review whose clause names no measure. None of the eleven adds a structured assessment, content to the issue record, a fixed period to be heard, or a statutory data duty. The majority accepted the architecture and adjusted its fittings.

The Chair dissented. The Committee's Chair presented a dissenting report. Its recommendation: "The Bill not be passed in its current form" (Report p 37). The alternative put was to keep a judicial decision-maker and remove the barriers to reaching one — expanded delegation to judicial registrars, more on-call personnel, dedicated phone lines and court-record access, a business-hours "Urgent Safety Order" equivalent, mandatory police training on the existing scheme, and recording of all after-hours order data (Report pp 36–38). The dissent describes the Bar Association's concern as being that the scheme is "directed at suiting the convenience of police at the expense of ensuring adequate safeguards" (p 34). Those are the dissent's words about a submission, not a quotation from it.

The data the government could not produce. The Victims of Crime Commissioner told the Committee there was "no publicly available administrative data" on the after-hours scheme [2.85] and that "It is difficult for this Committee to make recommendations in relation to this scheme when that data is not available" [2.89]. The government gave one figure: 45 after-hours orders granted in 2024–25 [2.92]. Asked how many applications had been refused, it "did not have that data immediately available, and later suggested that it was unsure it had that data at all" [2.94]. Asked how many attempts to reach the after-hours magistrate had failed, the Minister later advised that ACT Policing did not have "extractable records" [2.95]. ACT Policing described the scheme as "underutilised" [2.93]; the Australian Federal Police Association said officers had "seldom" been unable to obtain an order when required [2.36]. No data on file distinguishes those statements. The Explanatory Statement contains no ACT count of any kind for the scheme it repeals. The baseline against which the replacement could ever be judged does not exist and, on the government's evidence, may not be capable of reconstruction.

2.8 SWOT

Strengths	Respondent's views mandatory (ss 13D(2)(b), 13H(2)(b)). Grounds on the notice, explained in person (ss 13I(d), 13U). Cross-notices barred with misidentification reasoning (s 13B(d); ES p 30). Paramountcy, least restriction and exclusion factors carried across (ss 13O, 13P, 13R). Hard 14-day cap (s 13L). Records at every branch. Firearms seizure at service (s 13ZD). Court sees every notice; any party may apply (ss 13M, 13Y). s 113(e) fixed; s 44B. Lower penalty tied to lower oversight (ES p 36).
Weaknesses	No structured assessment or criteria. Content-bearing reasons for refusal only (s 13N v s 13H(3)). Issue record stays in police records (s 13M). No automatic listing; dismissal for want of a date (s 13Y(3)). No lapse of an unserved notice (s 13L(1)(a)). Detention on the applicant officer's own view (s 13C). No data duty; review deferred and contentless (cl 40). No training, resourcing or cost statement. Collateral consequences without a court finding (cl 51, 69–70, 173–189, 191). Bail interplay read by ACT Policing in a way the Committee found uncertain [2.54]; Rec 4 only noted. s 91B(6A) deepens the one-way pathway.
Opportunities	The record architecture exists; content and routing can be added by short amendment. s 13M already sends every notice to the registrar; a listing duty makes a filing step a return. Rec 10 is agreed; a statutory schedule can carry it. s 44B supports remote hearings for both parties. A natural pilot for a structured tool: defined population, mandatory records, short clock, two-year review already legislated.
Threats	Misidentification at the scene becomes a 14-day notice with collateral consequences and no independent check unless the respondent applies; specialist submitters named the cohorts exposed [2.59]–[2.66]. Volume shifts from court to police, uncounted; 4,495 incidents in 2024–25 [2.96]. Displacement of the criminal response, unmeasured [2.39]. Notices conflicting with Family Law Act orders police cannot see [2.56]. Breach exposure of respondents who did not understand the notice — the Human Rights Commission's "significant inherent risk" [2.76]. Emergency accommodation cannot support 14-day exclusions at scale [2.41]. Review at 2.5 to 3.5 years with no baseline.

2.9 What would have to change

Chapter 2 of the Bill should pass as it stands. For Part 2A, six amendments follow from §2.4, and one alternative the dissent put. Each is drafted at Appendix G9. **None raises the s 13B threshold, and none shortens the protection a notice gives.** Each applies to the police notice the discipline this work asks for the court order: assess against criteria, write down what was relied on and what was unknown, give the person restrained a fixed route back, and count the results.

One — a structured assessment, with a resourcing condition (new ss 13H(2A), 13HA; G9.1). Before issuing, the sergeant completes, or is satisfied the applicant officer has completed, a one-page assessment in a form approved by the Minister and consistent with the approved framework. For each s 13H(2) matter it records whether the information was established, reasonably open, or could not be obtained; and whether the officer could identify the person most in need of protection — and if not, that fact. The Minister may not approve the form until a statement of the training and resourcing for it has been tabled, for the reason at Chapter 16 §3.2b: an assessment added to an unchanged workload becomes a form to be signed.

Two — reasons with content, routed to the court and the respondent (s 13H(3) substituted; ss 13M, 13T(1) amended; G9.2). The issue record states the information relied on and whether any came from a source other than the affected person's

account; why a notice was immediately necessary rather than a court application; each less restrictive condition considered under s 13P and why it was not sufficient; and the s 13R factors where an exclusion condition is included. The record and the application go to the registrar within one business day of service. A copy goes to the respondent with the notice, with the protected person's address and anything that would endanger a person withheld and marked as withheld. A validity saving applies. The court then reviews a decision rather than a form.

Three — an expedited review within two business days (new s 13YA; G9.3). A respondent may, once, request in writing that a magistrate review the notice. The registrar lists it within two business days. The protected person is notified, may appear by audiovisual link or telephone under s 44B, and may have one adjournment of up to seven days to obtain representation, the notice continuing. The magistrate may confirm, amend or revoke; s 13Y(3)(b) does not apply. This matches the period s 91B already gives an applicant, and puts into the Bill what the Attorney-General told the Committee already happens.

Four — statutory six-monthly data (new s 156(1A)–(1B); G9.4). Within three months after each six-month period the Minister tables, de-identified: applications, issues, refusals and decisions not to apply; exclusion conditions; applications to amend or revoke by class of applicant and outcome, including dismissals for want of a date; s 13YA requests and time to hearing; assessments recording that the person most in need of protection could not be identified; notices followed within 14 days by a family violence order application; breach charges and outcomes; arrests and charges for family violence offences against the two years before commencement; and sex, age band and Aboriginal and Torres Strait Islander status of the parties. The s 156 review must address each. This is built on the Victims of Crime Commissioner's three items [2.87]–[2.88] and the Reform 5 list, attached to the review the Bill already creates.

Five — lapse of an unserved notice (new s 13L(4); G9.5). A notice not served within 72 hours of issue lapses and a fresh application must be made. At present s 13T(1) requires service "as soon as practicable" but fixes no outer limit, so a notice issued on the facts of one night can be served weeks later on those facts.

Six — correction of record (new s 13ZF; cl 191 amended; G9.6). A notice revoked by the court, or found on review not to have met the s 13B grounds, is taken never to have been made for the *Firearms Act*, the working-with-vulnerable-people disclosure, and the later-history provisions in s 14(1)(g) and *Personal Violence Act* s 11(1)(d); the registrar notifies the registrar of firearms and the Chief Police Officer. The NDIS disclosure is confined to a notice that was not revoked and either ran its term or was followed by a court order. This is the correction-of-record element of Reform 5 (Chapter 16 §6.3a) applied to the new instrument.

Seven — the alternative the dissent put (G9.7). If the Assembly is not persuaded that a police notice should stand 14 days on police authority, two structural options remain. The first is the dissent's: keep the judicial decision-maker and remove the barriers — delegation to judicial registrars, resourced on-call arrangements, a business-hours equivalent, training, and recording of data (Report pp 36–38). The second

keeps the police notice but deems every notice, on service, to be an application for a family violence order listed before the notice expires, so that no notice ends without a judicial officer having looked at it. Either restores the decision-maker the Explanatory Statement itself records "some evidence" is "better placed" (ES p 24). G9.7 drafts the second in outline; the first needs no new drafting, because Part 7 already exists.

The bottom line for this Bill is short. Pass the evidence and process repairs. Do not repeal Part 7 in exchange for Part 2A as drafted. If Part 2A is to pass, the six amendments above are the minimum that lets the Territory know, two years on, whether it was right.

3. The Crimes (Coercive Control) Amendment Bill 2026

3.1 What it does

The Bill was presented on 28 May 2026 by the Minister for the Prevention of Domestic, Family and Sexual Violence, with an Explanatory Statement that describes it as "a Significant Bill" — one "assessed as likely to have significant engagement of human rights" (CC ES p 1). Debate was adjourned. It has eight sections and a schedule.

The offence. New s 72J(1) of the *Crimes Act 1900*:

> "(1) A person commits an offence if— (a) the person is an adult; and (b) the person engages in a course of conduct consisting of family violence against a family member of the person; and (c) the person intends the course of conduct to coerce or control the family member; and (d) a reasonable person would, in all the circumstances, consider the course of conduct likely to result in harm to, or fear of harm in, the family member or someone else. Maximum penalty: 700 penalty units, imprisonment for 7 years or both."

Four elements. The accused is an adult (CC ES p 22: "only an adult, being a person aged over 18 years old, can be charged"). The conduct is a course of conduct of *family violence* against a *family member* — both terms taken from the *Family Violence Act 2016*, ss 8 and 9, the first through the *Crimes Act* dictionary (CC ES p 22), so the criminal offence and the civil order share one definition. The accused intends the course of conduct to coerce or control; "coerce or control" are undefined and carry their ordinary meaning, and intention has its *Criminal Code* s 18(2) meaning — a person intends a result "if they mean to bring it about or are aware it will happen in the ordinary course of events" (CC ES pp 22–23). And a reasonable person would consider it likely to result in harm or fear of harm; no actual harm need be proved (CC ES p 23).

The machinery. A course of conduct "includes … conduct that is repeated or continuous or both" and "a series of incidents … that do not occur in immediate succession" (s 72I). Whether one exists "must be assessed by considering the totality of the conduct" (s 72J(2)(b)). The trier of fact must be satisfied beyond reasonable doubt that there was a course of conduct (s 72J(4)), but "is not required to be satisfied of the particulars of any specific incident" (s 72J(5)). The prosecution "is required to allege— (i) the nature and description of the conduct alleged to form part of the course of conduct; and (ii) particulars of the period of time over which the course of conduct took

place" (s 72J(6)(b)). Intent attaches to the course, not each incident (s 72J(7)). "Subsection (1) does not apply if the course of conduct was reasonable in all the circumstances" (s 72J(3)); the defendant carries an evidential burden only, and no factors are stated.

Commencement and oversight. Sections 3 and 6 commence the day after notification; s 6 establishes the Coercive Control Advisory Committee (new Part 21). "The remaining provisions commence 2 years after this Act's notification day" (s 2(2)) — the offence and the review clause. The committee's function is "to advise the responsible Minister about the offence … including the implementation of the offence" (s 433(2)); its members are "appointed by the responsible Minister who the Minister considers have relevant skills and experience" (s 433(3)); "This part expires 3 years after the day it commences" (s 434). The Minister "must review the operation of the amendments … as soon as practicable after the end of 3 years after this section commences", report "within 1 year after the day the review is started", and the section "expires 6 years after the day it commences" (s 72K). The Explanatory Statement's note on clause 2 states the two-year commencement and gives no reason for it; the reason — that "systems, services and workforces are ready" — appears only on the government's web page and in the presentation speech. The note also says the provisions commencing the day after notification are "clauses 6, 7 and 10" (CC ES p 21); the Bill has eight clauses and s 2(1) names sections 3 and 6. The Explanatory Statement explains the choice of reviewing Minister — the Minister administering the *Domestic Violence Agencies Act 1986* rather than the Attorney-General, "to better enable the review to consider the broader impacts of the offence, beyond the legal and justice sector" (CC ES p 25) — and describes the review as "an embedded opportunity to review the impact of the offence to ensure it is operating as intended without unduly restricting rights" (CC ES p 12). It gives no reason for the committee's three-year expiry: "This means the advisory committee is to cease at this time" (CC ES p 25).

The timing, computed. Let N be the notification day.

Event	Provision	When
Committee established	s 2(1), s 6	N + 1 day
Offence and s 72K commence	s 2(2)	N + 2 years
Committee expires	s 434	N + 3 years
Review may begin	s 72K(1)	after N + 5 years
Report due	s 72K(2)	about N + 6 years

The committee ceases to exist one year after the offence commences and at least two years before the review can begin. That is design. The government's web page says the committee will advise "on what needs to be done before the proposed crime becomes law" and "during the first year after coercive control is made a crime". Three submissions identified the gap (Sub 17, para 33; Sub 19, Rec 8; Sub 22).

Consequentials. The offence becomes "reportable conduct" under the *Ombudsman Act 1989* and an eligible offence under the *Victims of Crime (Financial Assistance) Act 2016* (Sch 1). The *Bail Act*, the *Crimes (Sentencing) Act*, *Crimes Act* ss 374–375 on summary disposal, the jury-direction provisions and the *Family Violence Act* are not

amended. The Explanatory Statement points out that none of the first two needs to be: because the conduct is family violence, the offence "is a family violence offence" and the provisions of the *Bail Act*, the *Crimes (Sentencing) Act* and other Acts that attach to that term "also apply to the coercive control offence, as relevant" (CC ES p 22).

3.2 What deserves credit

The course-of-conduct provisions are coherent and tested. Sections 72J(2) and (4)–(7) solve the particularisation problem that has defeated pattern prosecutions elsewhere, while s 72J(6)(b) keeps a pleading duty that protects the accused's right to know the case. The government says the model follows New South Wales s 54H, Queensland s 334C and the ACT's own s 56 (Sub 4; CC ES pp 16, 24). The Explanatory Statement adds the reasons an incident-based approach fails — repeated conduct "in similar circumstances", normalisation and gaslighting, and trauma that affects recall (CC ES p 14) — and records that the prosecution's disclosure duty and the court's power to stay proceedings are preserved (CC ES p 16). No submission asked for these provisions to be removed.

Oversight first, offence later. Establishing the committee on day one and holding the offence for two years is the right order of operations. It is what makes every other improvement in this chapter possible. Sub 19 calls it "a genuine strength"; Sub 22 treats the period "not … as a delay, but rather an opportunity".

One definition of family violence. Borrowing ss 8 and 9 avoids a second definition in the same statute book. Four submissions want the broad *family member* kept (Subs 10, 21, 22, 23). The government reports that stakeholders feared a bespoke definition "could create confusion and uncertainty in the community" (Sub 4).

Intent, explained as a safeguard, and strict liability removed. Whatever the Assembly decides about recklessness — seven submissions asked for it — the government has been explicit about why it chose intent: it "is particularly relevant for victim-survivors at greater risk of misidentification and over-criminalisation, including people from Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, LGBTIQA+ communities and people with a disability" (Sub 4). The Law Society records that the Bill "represents a material improvement" on the 2024 Opposition bill by removing strict liability. The Explanatory Statement puts the same point as proportionality: the broad scope of relationships "could heighten risks of over-criminalisation or misidentification by potentially capturing behaviours which are intended to be protective", and intent "appropriately limits the offence from applying to legitimate protective behaviours" (CC ES pp 10–11). That is a reasoned, rights-based position, and the government has said it will monitor the question through the review.

The consequential amendments. Recognition in the Reportable Conduct Scheme and the financial assistance scheme gives a conviction practical effect without further legislation (Subs 15, 19).

3.3 The judgment the offence turns on

Chapter 16 §8 said a coercive control offence turns on a course of conduct of family violence by one person against another, intended to coerce or control — the judgment Chapter 9 examined. The Bill confirms it. Section 72J(1)(b)–(c) requires a course of conduct of family violence *by* this person *against* that family member, *intended* to coerce or control. That is the classification Fact Sheet 10 asks for, the classification the 2023 death review's Recommendation 4 asked to be supported by a tool, and the classification the 2025 review found had been made wrongly for 8 of the 13 deceased victims it examined.

What strengthens the claim. The offence borrows its definitions from an Act that has recognised coercive and controlling behaviour as a ground for a civil order since 2016 (Government Response 2025, para 5). The 2023 and 2025 misidentification findings arose under that regime. The Bill adds criminal consequences to the classification; it does not change how it is made. Sub 22 draws the same link: the offence "requires police to assess patterns of behaviour over time rather than isolated incidents" and "may heighten this risk". Neither the government nor any submission cites Recommendation 4, inter-rater reliability, or validation of any classification method; that was confirmed by search of every file, including the Explanatory Statement, which cites the 2023 death review for the finding that coercive control was present in "almost all" homicides reviewed and the Jumbunna Review for the misidentification of First Nations victim-survivors (CC ES pp 4, 9), and does not cite Recommendation 4.

What limits it. The claim is strongest at the charging stage, not the jury stage. A jury does not apply Fact Sheet 10. It applies s 72J(1)(b)–(d) and s 72J(3) to evidence, and the totality provisions are intended to let a jury see resistive violence for what it is: "a complainant's use of retaliatory violence in self-defence, can be properly identified" (Sub 4). The ANU Law Students for Gender Equity argue the opposite of the same provisions — "by reducing scrutiny of individual incidents, subsections 72J(5)–(7) also reduces the opportunity to notice that a specific act, such as resistance, or self-protective conduct, may indicate the accused is in fact the victim" (Sub 14). That disagreement is about trials. This work's point is aimed earlier: at the unmeasured decision made before any court sees the matter, which decides who becomes the accused and who the complainant. The 8-of-13 finding is a finding about that stage, and the amendments at §3.6 are directed at it.

Every safeguard the government names — intent, the s 8 gate, the objective harm test, the reasonableness exception — is a matter for trial. The Explanatory Statement was read for this point specifically. It says the offence was formulated to address "risks of exacerbating the consequences of victim-survivors being misidentified as the primary aggressor" (CC ES p 3), and its proportionality analysis lists the safeguards "intended to reduce the risk of misidentification": the course-of-conduct structure, the definition of family violence, the fault element of intent and the defence of reasonableness (CC ES pp 8–11), with the s 72K review and the accused's right to consent to summary hearing as "other safeguards" (CC ES p 12). The less restrictive alternatives it records considering are confining the conduct to existing offences, a lower penalty and fuller particulars (CC ES pp 10, 12, 15). Each is an

element, a defence, a sentence or a review. None operates before charge, and the Explanatory Statement does not discuss the investigation or charging stage, police practice, the risk framework, training, data or evaluation. The ANU Centre for Social Policy Research: "the Bill as drafted contains no mechanism directed at reducing misidentification. The only safeguard available to a wrongly-charged defendant is the defence … which operates only after charges have been laid, not as a threshold safeguard in the investigation or charging process" (Sub 13). The same submission records that the updated risk framework "will include guidance on avoiding misidentification" but that the guidance "operates at the level of practice guidance, rather than a statutory requirement".

3.4 What the submissions said

Twenty-three submissions were published; 22 have text. "S" is support or support in principle, "S/A" support with amendments, "NP" no position, "O" opposition maintained.

#	Submitter	Position	Principal points
1	Australian Multicultural Action Network	S	Cultural abuse guidance; annual public reporting
2	Elisabeth Yar (victim-survivor)	S	Funded implementation phase; s 72K to require "an evaluation framework before commencement, annual public reporting and measurable outcomes" including "baseline data" — the only submission to ask for a baseline in those terms
3	Legal Aid ACT	Not on file	Cover sheet only
4	ACT Government	Proponent	Intent retained; broad scope; s 8 definition; 7 years; two years; committee and review as "oversight mechanisms"
5	Aboriginal and Torres Strait Islander Elected Body	S (design recs)	Misidentification of Aboriginal women; child removal; "mandatory culturally informed assessment frameworks"
6	ACT Policing	S, subject to funding	Had considered intimate partners first, citing the NSW rationale of reducing "the risk of misidentification"; "will require new investment"; NSW: 473 incidents, 22 charges in 18 months, median 188 days
7	YWCA Canberra	S/A	Recklessness; DPP summary election; committee data remit, without which "the risk of misidentification will be unmeasurable"
8	Centre for Excellence in Child and Family Welfare	NP	Offence "without a clear evidence-informed framework for identifying the person most in need of protection"
9	Canberra Rape Crisis Centre	S/A	Recklessness; training against "misidentification of the predominant aggressor during police call outs"; summary election
10	Domestic Violence Crisis Service	S (scope); "a band aid on a structural and systems breakage"	"does not address the underlying root causes of misidentification"; "accountability frameworks" for identifying the person most in need of protection
11	Carers ACT	S (intent), amendments	Carers misidentified; statutory factors for "reasonable"

#	Submitter	Position	Principal points
12	Mental Health Community Coalition ACT	S	Recognition, services
13	ANU Centre for Social Policy Research	S (objective), concerns	"no safeguard against misidentification"; NSW police data: 48% of women recorded as perpetrators were misidentified victims, 57% for Aboriginal women; identification of the person most in need of protection "before proceeding with a charge"
14	ANU Law Students for Gender Equity	S/A	Factors for s 72J(1)(d) and (3); police to "interview all parties … separately"; existing guidance "carrying no legislative force"; 5 years to allow DPP election
15	ACT Ombudsman	S (consequential)	Conduct "would likely already be captured"
16	Our Watch	Cautionary	"limited evidence" as a standalone intervention; course-of-conduct approach "may increase risk of misidentification and incarceration of Aboriginal and Torres Strait Islander women"
17	Victims of Crime Commissioner	S in principle	Recklessness; NSW first nine months: 224 reports, 5 prosecutions, 1 conviction; keep 7 years but extend DPP s 374 election — the forum choice "allows the defendant to exercise further control"; committee to run "until at least the finalisation of the statutory review"
18	Victims of Crime Assistance League	S	Fears "unsupported accusations"
19	Zonta, Soroptimists, CWA Canberra	S/A	Awareness standard; "Committee access to implementation data"; fix s 434; public implementation plan
20	ACT Law Society	O (historical)	Supports intent and delay; 7 years removes DPP election — proceedings "weaponised by one party against another"
21	Women with Disabilities ACT	S in principle; "does not support the … Bill proceeding in its current form"	No implementation funding in 2026–27 Budget; s 72K to cover "allegations and instances of misidentification"; annual reporting
22	Sisters in Spirit Aboriginal Corporation and Women's Health Matters	NP	"Require predominant aggressor assessments as standard practice"; "Collect and publish misidentification data"; independent 12-month review led by Aboriginal researchers; committee five years
23	Women's Legal Centre ACT	S in principle	Keep *family member*; mixed fault element; summary-hearing exception; review at two years; data on "misidentification, disproportionate enforcement"

Tallies. Misidentification is named in terms by 16 of the 22, including the government, which names it as a risk it has mitigated. A legislated pre-charge step is sought or implied by five (Subs 5, 10, 13, 14, 22), three of them in terms (Subs 13, 14, 22). Measurement of misidentification by six (Subs 7, 16, 17, 21, 22, 23). The committee's expiry by three (Subs 17, 19, 22); its composition or independence by twelve (Subs 1, 2, 5, 7, 10, 11, 16, 19, 20, 21, 22, 23), one of which (Sub 10) says membership need not be fixed in the statute. Recklessness or an objective standard by seven; intent supported by four. Eight submissions, from opposed standpoints, identify the same

forum consequence of a seven-year maximum: matters go to the Supreme Court unless the defendant consents to summary disposal (Subs 7, 9, 10, 14, 17, 20, 21, 23). The Law Society and the Women's Legal Centre disagree on most things in this Bill; both identify the accused's control of forum as a problem. New South Wales pairs seven years with a prosecution election (Sub 17, para 17).

3.5 SWOT

Strengths	Coherent pattern architecture with a pleading duty (s 72J(2), (4)–(7)). One definition of family violence (FVA ss 8, 9). Intent as an explained, nationally consistent safeguard; strict liability removed. Committee from day one; offence delayed (s 2). Reasonableness attaches to the whole course of conduct (s 72J(3)). Practical consequentials.
Weaknesses	s 72K has no content. Committee advisory only, appointed at discretion, no data or reporting function, expires before the review (ss 433–434). No pre-charge safeguard. Commencement by calendar, not readiness (s 2(2)); no implementation funding in the 2026–27 Budget (Sub 21). Seven years without a DPP election. No factors for "reasonable" — the ES says only that what is reasonable "will differ in each individual case based on the facts" (CC ES p 11). The ES gives no reason for the two-year commencement, the three-year expiry or the content of the review.
Opportunities	The two-year window is long enough for the inter-rater study at Appendix O (about five months) and a published baseline. The NSW review, begun July 2026 (Sub 6), reports inside the lead time. The s 156 and safety-notice reviews can be aligned with s 72K (Sub 17, para 30). A committee with a data function could close the ACT's data gap, including the ABS exclusion of ACT Indigenous-status family violence data (Sub 22). Cross-camp consensus on forum can be adopted without touching contested elements.
Threats	The offence turns on a classification the ACT has never measured; 8 of 13 deceased victims recorded as the predominant aggressor (Chapter 9 §5.1). Low charge conversion — NSW 473 incidents, 22 charges (Sub 6); 224 reports, 1 conviction in nine months (Sub 17) — undermines the denunciatory purpose. Demand without funding (Subs 6, 23). Systems abuse through the offence itself — trivial parenting reports, cross-allegations, forum election. Deterrence of reporting by Aboriginal women who fear child removal (Sub 22). Jury misconceptions where recognition of non-physical abuse is 66–75 per cent (Subs 17, 23).

3.6 Five worst things, and the fixes

Each fix is drafted at Appendix G9. None changes the offence's elements, penalty or scope, on which this work takes no position.

One — the review reviews nothing in particular (s 72K). A Minister reviewing "the operation of the amendments" can satisfy the section with a narrative. No baseline, no indicator of wrongful charging, no disaggregation, and the reviewer is the Minister. The Explanatory Statement describes the review as "an embedded opportunity to review the impact of the offence to ensure it is operating as intended without unduly restricting rights" (CC ES p 12) and says nothing about what it will measure. Seven submissions asked for content. *Fix (G9.9):* list what the review must examine — charges, prosecutions, convictions and time to charge; withdrawals; rates against other family violence offences; people charged who had previously been recorded as a victim in relation to the same family member; cross-allegation matters; disaggregation by cohort; the reliability of the method used to identify the person most in need of protection; unintended consequences including misidentification. Require three

years of pre-commencement data as a published baseline. Require a reviewer who is not a public servant.

Two — the committee dissolves before it can inform the review, and has no data or reporting power (ss 433–434). A body that advises one Minister in private, with a membership chosen by that Minister, and that ends one year after the offence starts, cannot do the monitoring the presentation speech and the Explanatory Statement attribute to it. The Explanatory Statement says the committee "will be able to monitor implementation of the offence, identify any areas of concern (including emerging risks of unintended consequences), and provide advice" (CC ES p 18); the statute gives it the third of those and no power, information right or reporting duty to do the first two. *Fix (G9.10):* monitoring, data-advice and annual public reporting functions, with the Minister to table and respond; at least one independent member with evaluation expertise, lived-experience members, an Aboriginal community-controlled nominee, disability expertise, a defence and a prosecution practitioner, and a police nominee; agencies to supply de-identified data; expiry the day after the s 72K report is tabled.

Three — nothing operates before charge (new s 72JA). A person wrongly charged must raise the protections at trial. The ANU Centre asks for an "explicit, auditable mechanism for identifying the person most in need of protection"; the Law Students for separate interviews and recording; Sub 22 for "predominant aggressor assessments as standard practice". *Fix (G9.8):* no charge without a recorded assessment by a sergeant or above, in an approved form, of which party is the person most in need of protection — the information relied on, whether each party was interviewed separately, prior reports, orders, notices and charges, and whether the person charged was previously recorded as a victim in relation to the same family member. Specialist review before charge where each party alleges coercive control by the other. The record disclosed with the brief. A published DPP guideline on cross-allegations. Noncompliance does not invalidate a charge but may be considered under s 72J(3) and on an application to stay.

Four — commencement is a date, not a readiness test (s 2(2)). The stated purpose of the two years is to "make sure systems, services and workforces are ready" (web page). The Explanatory Statement does not state a purpose (CC ES p 21). The Bill commences the offence whether or not they are. The 2025 response said the updated framework was "expected to be finalised by the end of 2025"; at 1 September 2026 the web page still said it was being updated. *Fix (G9.11):* keep the two-year floor; commence on a day fixed by the Minister; the Minister may not fix the day until a readiness statement has been tabled that publishes a measure of agreement between assessors applying the classification method and the threshold set for it, publishes the baseline, confirms the s 72JA form and DPP guideline are published, reports the proportion of police, prosecutors and judicial officers trained, and identifies the funding appropriated. Expressly displace *Legislation Act 2001* s 79, with a four-year backstop requiring a statement of reasons. Fallback: keep s 2(2) and require the readiness statement not less than six months before commencement.

Five — a seven-year maximum without a prosecution election (*Crimes Act* ss 374–375). Eight submissions from opposite standpoints say the same thing: matters will go to the Supreme Court unless the defendant consents, delay will follow, and the choice sits with the accused. The Explanatory Statement confirms the mechanism and presents it as a safeguard for the accused: "the accused can also consent for a proceeding for the offence to be heard summarily", in which case the maximum is "5 years imprisonment or a fine of $15,000" (CC ES p 12, citing s 375(1)(b)(ii) and (13)). It does not mention a prosecution election. *Fix (G9.13):* keep seven years; add s 374(1A) so the DPP may elect summary disposal for s 72J as if the offence were punishable by more than two but not more than five years. The Women's Legal Centre's "interests of justice" mechanism, or the Law Students' five-year option, reach the same outcome by other routes.

A sixth, just below the five — factors for "reasonable in all the circumstances" (new s 72J(3A); G9.12). Four submissions asked for factors. Drafted from Sub 14 and Sub 23: the totality of the conduct; the relative power and dependency between the parties, including any caring relationship; whether the conduct was a necessary and proportionate response to a legitimate need of the family member, as distinct from control of them; whether it occurred during or after separation; any cultural or kinship context; any other relevant matter.

3.7 Five conditions for safe commencement, each already asked for

This work takes no position on whether the offence should exist (Chapter 16 §8.1). The Bill's own logic — legislate now, commence when ready — is sound, and the five conditions below make "ready" something that can be shown. Each was asked for, in substance, by at least one submitter. None is an outlier.

Condition	What it requires	Who asked	Drafted at
A — a published reliability measure for the classification method, before commencement	Standardised vignettes to police, registry, crisis-service and child-protection assessors; agreement statistic published; threshold set in advance (Appendix O)	Sub 13 ("auditable"); Sub 22; Sub 2	s 2(2A)(a)
B — a published baseline, before commencement	Three years of pre-commencement data on the s 72K(1A)(a)–(f) matters, including how many people charged with a family violence offence had previously been recorded as an affected or protected person in relation to the same family member	Sub 2; Subs 7, 21, 22, 23	s 72K(1B)
C — a misidentification measure in the review	Reversals of classification, cross-allegation matters, charges against persons previously recorded as victims, disaggregation; an independent reviewer	Sub 21; Sub 22; Sub 23; Sub 17; Sub 13	s 72K(1A), (1C)
D — a committee that can measure and outlasts the review's start	Independent member with measurement expertise, data function, public reporting, expiry tied to the s 72K report	Subs 19, 17, 16, 2, 5, 11, 20, 21, 22	ss 433(2)–(3A), 434
E — a recorded pre-charge assessment and charging guidance	Person-most-in-need-of-protection assessment before charge, disclosed; specialist review where both allege; DPP guideline	Subs 13, 14, 22, 5, 10	s 72JA

Condition A is the one this work adds. It is the inter-rater study Chapter 9 §7 specifies and Appendix O designs. It uses vignettes and no client data and takes about five months. The window is 24 months and the committee exists from day one. What it lacks is a legal hook. The readiness statement at G9.11 supplies one.

4. Reading the two bills together

The two bills were presented within six months of each other. Neither refers to the other. Read together, they describe one officer, at one incident, making one classification that feeds two instruments.

The same officer, the same incident, the same classification. Under the first Bill, the attending officer decides whether "there is a risk to an affected person of family violence by the respondent" (s 13B(a)) — which of the two is the respondent. Under the second, the same officer, or a colleague reading the same file, decides whether to charge one of them with a course of conduct of family violence *against* the other, *intended* to coerce or control (s 72J(1)(b)–(c)). That is one judgment about who is exercising control over whom. No document on file for either Bill proposes to test how consistently it is made.

The civil instrument legislates a modest pre-decision consideration. The criminal instrument legislates none. The first Bill requires both officers to consider the respondent's views and the parties' history (ss 13D(2), 13H(2)) and bars a notice the other way (s 13B(d)); its Explanatory Statement says these are "designed to reduce the risk of misidentification" (ES p 54). The second Bill contains nothing before charge. The difference is not explained on the record, and the second Bill's Explanatory Statement, which discusses misidentification at length as a design risk (CC ES pp 3, 8–11), does not mention the first Bill or the notice scheme. A single pre-charge standard for both instruments would be simpler for the officer at the door than two, and the proposed s 72JA and s 13H(2A) are drafted to the same form for that reason.

Error in one feeds the other's history. A notice issued to the wrong party becomes "any previous family violence safety notice … against the respondent", which s 13D(2)(f)(i) requires an officer to consider next time and s 14(1)(g) requires a court to consider. It is also part of the history a prosecutor may plead as "the nature and description of the conduct alleged to form part of the course of conduct" under s 72J(6)(b). Neither Bill provides a correction pathway. A notice issued on a reversed account on a Friday night is, from that moment, a datum a coercive control investigation will read.

The reviews are not aligned. The first Bill's review begins about two and a half years after notification; the second's after five. The committee that could inform both expires at three. The Victims of Crime Commissioner asked that they be aligned (Sub 17, para 30). Two reviews of one classification, years apart, with no shared measure, will describe the same decision twice and count it neither time.

What follows. One classification standard, tested for reliability before either instrument relies on it. One pre-charge and pre-notice record, in the same form, disclosed to the person it names. One correction pathway. Reviews that share a measure and a date. None of that requires a position on whether police should issue notices

or whether coercive control should be a crime. It requires only that the Territory be able to tell, afterwards, whether the decision both bills depend on was right.

FIGURE 19.1

The two bills against the failures this work identifies

Credit is given where it is due, and a good deal is due. This is what each Bill does not reach.

Credit first

The FPSV Bill gives the person restrained more paper than the court scheme does, bars cross-notices, and sends every notice to the court. The Coercive Control Bill holds the offence for two years and stands the oversight committee up first.

WHAT THE BOOK ASKS FOR	FPSV BILL 2025	COERCIVE CONTROL BILL
Structured assessment before an order or notice fix drafted at G9.1, G9.8	● no reference to any framework, tool or criteria	● nothing operates before charge
Reasons with content fix drafted at G9.2	◐ notice states how each ground is satisfied; the issue record stays with police	— not engaged
Expedited return or review fix drafted at G9.3	◐ any party may apply, but the Bill contains no period	— not engaged
Misidentification safeguard at the charging stage fix drafted at G9.6, G9.8	◐ cross-notices barred; first classification wins, with no correction pathway	● no mechanism directed at it
Safety step at service	◐ an explanation duty only: no welfare question, referral or record	— not engaged
Data and reporting fix drafted at G9.4, G9.9, G9.10	● the substituted s 156 names no data and no indicator	● s 72K has no content; the committee expires first
Training fix drafted at G9.11	● agreed as a recommendation, outside the statute	● the statement does not address it
Cost	● commences at six months, with no resourcing statement	● no implementation funding in the Budget

● not addressed ◐ partly addressed — not engaged by this Bill

The two bills describe one officer, at one incident, making one classification that feeds two instruments. No document on file for either Bill proposes to test how consistently it is made.

The stance is revision before passage rather than amendment at the margin, and a drafted solution is offered for each issue rather than an objection.

Chapter 19; Appendix G9. Evidence cut-off 2 September 2026: the Legal Affairs Committee report on the Coercive Control Bill was due 11 September 2026.

5. What the Assembly could do now

One. Pass the evidence and process repairs in Chapter 2 of the Family, Personal and Sexual Violence Bill. Nothing in this chapter qualifies them.

Two. Rebuild Part 2A before passing it. At minimum: a structured assessment on an approved form with a resourcing condition (ss 13H(2A), 13HA); reasons with content, routed to the registrar and the respondent (ss 13H(3), 13M, 13T); an expedited review within two business days with the protected person written in (s 13YA); six-monthly statutory data (s 156(1A)–(1B)); lapse of an unserved notice (s 13L(4)); correction of record (s 13ZF). If the Assembly is not persuaded a police notice should run 14 days on police authority, keep the judicial pathway on the dissent's terms, or deem every notice an application listed before day 14. Do not repeal Part 7 in exchange for Part 2A as drafted.

Three. Enact the coercive control offence, if the Assembly is minded to, with a commencement that depends on readiness shown to the Assembly rather than on a date, and with a review that names what it measures and is conducted by someone outside the public service.

Four. Align the two reviews. Give the advisory committee a data function and a life that lasts until the s 72K report is tabled. Require the s 156 and s 72K reviews to report the same misidentification measures against the same baseline.

Five. Adopt one classification standard for both instruments and test it for reliability before either relies on it. The two-year window is long enough. The committee exists from day one. The study is specified at Appendix O.

6. Limits of this chapter

Some material is secondary. The government response of 28 August 2026 is recorded from a summary. The current Part 7 provisions of the *Family Violence Act 2016* (ss 100, 103–106) were verified against republication 17 on 4 September 2026 — two days after the evidence cut-off. That is verification of statutory text already relied on in Chapter 7, not new evidence; nothing in this chapter depends on a document that came to hand after 2 September 2026. Part 7 is otherwise described from Chapter 7, the Explanatory Statement and the Committee report.

The Explanatory Statement for the coercive control Bill has been read in full. Where this chapter says the second Bill is silent on a matter, that is a statement about the Bill, its Explanatory Statement, the speech, the web page, the 2025 response and the government's submission. The Explanatory Statement does not address the reason for the two-year commencement, the reason for the committee's expiry, the content of the review, the investigation or charging stage, training, data, evaluation or cost; where the chapter relies on those silences it says so.

The Committee had not reported on the coercive control Bill. Its report was due on 11 September 2026. Where it later recommends what this chapter recommends, that will be recorded as convergence, not influence.

There is no ACT data on the after-hours scheme beyond one number. No claim is made about how often that scheme failed, or succeeded.

Every statement about how either Bill would operate is a projection from its text. No notice has been issued and no charge laid. The seven steps at §2.5 are an illustration, not an observation. The findings are about what the Bills require and do not require, not about what police, registrars or prosecutors will do.

One submission is unread. Submission 3 is a cover sheet. Nothing here describes Legal Aid ACT's position on the second Bill.

What this chapter established

Five findings that this chapter establishes and nothing else in these pages does. This chapter's complete set of 14 is at Appendix M, where it can be read against every other chapter's.

- **F19.1** — The Family, Personal and Sexual Violence Legislation Amendment Bill 2025 repeals Part 7 of the *Family Violence Act 2016* (cl 47) and replaces judicial after-hours orders with safety notices issued by a police officer of or above the rank of sergeant who "believe[s] on reasonable grounds" that "there is a risk" and that a notice "is immediately necessary" (ss 13B, 13H(1)), in force for 14 days from service without renewal (s 13L), with two years' imprisonment on breach (s 13ZC) and up to four hours' detention to effect service (s 13C); replacement, not supplement, is the correct description.
- **F19.2** — Part 2A prescribes content-bearing reasons for a refusal — "including each ground in section 13B that was not satisfied" (s 13N(1)(e)) — but for a decision to issue requires only "a written record of the matters considered" kept in police records (s 13H(3)); only the notice reaches the registrar (s 13M); a respondent's application is listed "as soon as practicable" before expiry and "must" be dismissed if no return date is available (s 13Y(3)); the Attorney-General's "next working day" [2.43] appears nowhere in the Bill.
- **F19.3** — The substituted s 156 requires one review beginning two years after Part 2A commences, reporting within twelve months, and names no measure or data duty (cl 40); the government could give the Committee one figure about the scheme being repealed — 45 after-hours orders granted in 2024–25 — and had no extractable data on refusals or unanswered calls to the after-hours magistrate [2.92]–[2.95]; the Explanatory Statement cites no ACT count of any kind.
- **F19.4** — The Crimes (Coercive Control) Amendment Bill 2026 commences the offence two years after notification (s 2(2)), establishes an advisory committee that expires three years after notification (s 434), and requires a ministerial review beginning three years after the offence commences (s 72K(1)), so the committee ceases one year after the offence commences and at least two years before the review can begin, which the government's web page confirms is design; every safeguard the government names — in the Explanatory Statement's proportionality analysis, the course-of-conduct structure, the s 8 definition, intent and the reasonableness exception, with the s 72K review and the accused's consent to summary hearing as "other safeguards" (CC ES pp 8–12) — operates at trial or after it, and none before charge; the Explanatory Statement does not discuss the investigation or charging stage.

- **F19.5** — Read together, the bills require the same officer at the same incident to make the same classification of who is exercising control over whom for a civil notice (s 13B(a)) and a criminal charge (s 72J(1)(b)–(c)); the first legislates consideration of both parties' views and a cross-notice bar before that decision (ss 13B(d), 13D(2)) and the second legislates nothing before charge; a notice issued to the wrong party becomes history under ss 13D(2)(f)(i), 14(1)(g) and 72J(6)(b) with no correction pathway in either Bill; and the two reviews share no measure and no date.

Sources for this chapter

Claim	Source	Date
cl 2 commencement; Part 2A ss 13B–13ZE (cl 46); Part 7 repeal (cl 47); cl 48; s 7(aa) (cl 49); s 14(1)(g)–(h) (cl 51–53); s 44B (cl 35); s 91B(6A) (cl 37); s 113(e) (cl 39); s 156 (cl 40); Part 9 definitions (cl 69–70); *Crimes Act* s 192(1A) (cl 113); tenancy (cl 173–189); WWVP s 18A (cl 191)	Family, Personal and Sexual Violence Legislation Amendment Bill 2025 (ACT), as presented	Presented 3 December 2025
Problem statement (pp 22–24); "better placed" (p 24); risk assessment language (p 25); cross-notice bar (p 30); "two levels of decision-making" (p 32); penalty and oversight (p 36); s 113(e) (p 50); arrest (p 52); misidentification (p 54); FVO definition (p 67)	Explanatory Statement, Family, Personal and Sexual Violence Legislation Amendment Bill 2025	December 2025
Recommendations 1–11; [1.12]; [2.36]; [2.43]; [2.54]; [2.59]–[2.76]; [2.85]–[2.96]; dissenting report (pp 29–38)	Standing Committee on Legal Affairs, *Inquiry into the Family, Personal and Sexual Violence Legislation Amendment Bill 2025*, Report 7, 11th Assembly	24 April 2026
Recs 1–2 agreed in principle; 3, 5–11 agreed; 4 noted	ACT Government response to Report 7 (summarised; not on file)	28 August 2026
s 105 detention text; ss 103, 104, 110; s 44; s 91B	*Family Violence Act 2016* (ACT), R17, as verified for Chapter 7	Effective 1 July 2025
s 2; s 72I; s 72J; s 72K; ss 433–434; Sch 1	Crimes (Coercive Control) Amendment Bill 2026 (ACT), as presented	Presented 28 May 2026
"Significant Bill" (p 1); misidentification as a design risk (pp 3, 8–11); safeguards and less restrictive alternatives (pp 8–12, 15); summary hearing on the accused's consent (p 12); s 72K purpose (p 12) and reviewing Minister (p 25); committee "will be able to monitor" (p 18); clause 2 note (p 21); adult, s 8 via the dictionary, family violence offence, s 18(2) intent (pp 22–23); s 434 (p 25)	Explanatory Statement and Human Rights Act compatibility statement, Crimes (Coercive Control) Amendment Bill 2026	Presented 28 May 2026
Presentation speech; debate adjourned	ACT Legislative Assembly Hansard (proof), pp P1963–P1968	28 May 2026
Committee role "before the proposed crime becomes law" and "during the first year after"; "systems, services and workforces are ready"; framework still being updated	ACT Government, "Making coercive control a crime" (web page)	Updated 1 September 2026

Claim	Source	Date
Coercive control in the civil framework since 2016; framework "expected to be finalised by the end of 2025"	ACT Government response to the Assembly resolution of 20 March 2025	September 2025
Submissions 1–23 (Sub 3 cover sheet only); quotations as cited by submission number. Submission 14 is listed on the Committee's cover sheet as "ANU Law Students for Gender Equity"; the submission's own letterhead reads "Gender Equality". The cover-sheet form is used	Standing Committee on Legal Affairs, *Inquiry into the Crimes (Coercive Control) Amendment Bill 2026*, published submissions; hearing 20 August 2026	June–August 2026
Report due date	Standing Committee on Legal Affairs, inquiry page	11 September 2026
8 of 13 deceased victims misidentified; Recommendation 4	ACT DFV Review Biennial Reports 2025 and 2023; Chapter 9 §5.1	2025; 2023
Five reforms, the s 43(4) question, Division 4.1B, s 47B, s 47C, s 68A; inter-rater study	Chapters 7, 9, 16; Appendices G, O	2026

Chapter 20 — Conclusion

Two files the review counted

The 2025 death review holds two groups of records, and the argument in the preceding chapters is contained in the distance between them.

In the first group are 13 deceased people the review assessed as victims. Of those 13, 8 had been recorded by police or another agency as the person causing the violence before they died. The circumstances the review gives for one of them are short. A man forced his way into her home and assaulted her. The charge was laid against her. The review does not name her, does not say how she died, and nothing further about her is known or assumed here. What is on the record is that she was counted twice: once as a person the system had classified wrongly, and once among the dead.

In the second group are 25 deceased people the review recorded as having used violence. Of those 25, 21 died by suicide, 24 were men, and 20 had been named as respondents to a civil order. For that group there is no equivalent paragraph, because the review did not run the equivalent check. Whether any of those 25 records was wrong is not known, in either direction, because it has not been examined.

The preceding chapters explain how a system arrives at both of those without anyone deciding to.

Chapter 8 established the first step. The ACT requires risk to be managed to a recognised standard across its operations. It did not apply that standard to the process that can remove a person from their home, on material from one side, in minutes. That process was left outside the rule the Territory wrote for itself.

Chapter 8 established the second step. The framework governing family violence risk contains no risk criteria. Criteria are the written rules that say how likely and how serious a risk is being called, and what level is acceptable. They are what makes two assessors of the same facts reach the same answer. The framework has none, so the answer depends on who is asked.

Chapter 9 established the third, and it is the one that reaches the files. Without criteria there is no consistency. Without consistency there is nothing to validate. Without validation, a wrong answer leaves no trace that anybody can find afterwards. No sensitivity, specificity or reliability figure has ever been published for any ACT family violence risk or classification tool. The error in her file was therefore not a thing an individual failed to notice. It was outside the reach of anything built to catch it. So was any error in the other 25.

That is a statement about detection, not about intent. No document in the record suggests that any officer wanted the wrong name on any file. Chapter 1 states the limits of these findings on a single page, and nothing here goes past them. The point is narrower and harder to answer. A system that leaves its most coercive process outside its own risk standard, and never writes the criteria that would make its decisions comparable, cannot find its own mistakes in either direction.

What is decided

Four things are settled, because the Territory's own documents settle them.

The money was raised and spent. The levy has appeared on every ACT rates notice since 1 July 2016. It had raised more than $46 million by 30 June 2024, and the 2026–27 Budget records $151.4 million of direct investment over four years. Chapter 3 traces it.

The architecture was built. Legislation, a minister, an office, a statutory death review, crisis services, perpetrator programs, Aboriginal community-controlled responses, a risk framework, information-sharing law and a ten-year strategy. That work is real, and Chapter 2 sets out what each part of it is.

The measuring half was not built. In November 2024 the Auditor-General found that the responsible office had no performance monitoring strategy and no evaluation framework for the levy. No public document located for this work disputes the finding.

The government now says so itself. The First Action Plan of May 2026 commits the Territory to deliver, over 2026 to 2028, a monitoring and evaluation framework, updated system and client journey mapping, and analysis of what its services actually cost. Those are not enhancements. They are the instruments a functioning system already has. A commitment to build them is a statement about what is missing. Chapter 2 and Appendix L set out the assessment.

What is still open

Three questions are open. Each could be closed with work already described.

Whether the framework is applied consistently. The evidence shows agencies using different processes and reaching different conclusions about the same case. It does not show how often. A vignette study would settle it: twenty standardised cases, a sample of assessors from every role that uses the instrument, and a published agreement statistic. It uses no client data. Chapter 18 puts the fieldwork at six weeks and the whole study at about five months.

Whether the pattern of deaths under orders means anything. Of 25 deceased people the review identified as perpetrators, 9 were subject to a current order when they died. Orders are made in situations that are already dangerous, so a high rate among people who later die is what would be expected. That remains the leading explanation. It has never been tested. A field in the ACT Suicide Register would begin to test it, and a flag in the police records system would let the question be asked as a query rather than a file-by-file review. Chapter 11 sets out both.

Whether the prosecution divergence has an innocent explanation. Over four years, sexual violence prosecutions rose about 170 per cent while the recorded rate of sexual assault victimisation rose about 37 per cent. Over the same period, sexual offence matters discontinued went from 2.5 per cent of completed matters to 17.3 per cent. There are ordinary explanations available: changed reporting, changed charging practice, a resourcing gap the Director of Public Prosecutions has described on the record. Any of them may be right. None can be checked, because no agency pub-

lishes why a prosecution was discontinued. Chapters 6 and 12 set out what a reasons field would show.

Each question is open for the same reason. Not because the answer is unknowable. Not because it is costly. Not because privacy prevents it. Each is open because nobody has looked.

Who owes the answer

A government that cannot say what a ten-year levy achieved owes the households paying it an explanation and a timetable.

Three of the steps towards that are cheaper than the meeting that would decide against them.

A field in the ACT Suicide Register recording whether the deceased was subject to a family violence order. Chapter 18 costs it at a schema change and a data entry step inside a process that already runs.

A queryable flag in the police records system, set when an order is served. A routine system change request.

A published inter-rater reliability result for the risk instrument in use. A vignette study using no client data, and therefore requiring no privacy approvals: six weeks of fieldwork, about five months end to end, and about $147,000. What can be done immediately is to commission it and publish the pass mark before the data exists. Appendix O specifies it.

None of the three requires legislation. None requires money on the scale of any line in the portfolio. None requires the agreement of anyone outside the Territory. Each produces a public document that does not exist now, and each can be checked by asking whether the document is there. Chapter 18 lists the rest of the hundred-day set on the same terms, with the test for each.

The results are not guaranteed to be uncomfortable. If agreement on the vignettes is high, the framework's authors are vindicated and a central criticism here is wrong. If the register field shows no pattern, the leading explanation is confirmed and the question can be closed. The only outcome with no value is the current one.

The Territory does not have to accept a single criticism in these pages to do the seven things on the hundred-day list. If it does them, the next person in her position will at least be counted.

The two bills

Two bills before the Assembly would change the system these pages describe before any of that counting has begun. One would move the decision to restrain a person without notice from a judicial officer to a police sergeant, for fourteen days, with reasons kept in a police file and no fixed day in court. The other would attach seven years' imprisonment to the judgment about who is coercing whom — the judgment the Territory's own death review has shown going wrong in 8 of 13 cases, and has never measured. Chapter 19 credits what each gets right, and a good deal is right. It also shows that both build a consequence on a classification that nothing requires to be assessed against criteria, written where a court can read it, or counted. The amendments that

would change that are drafted at Appendix G9. None of them raises a threshold or shortens anyone's protection. Each of them asks of the new instruments only what these pages ask of the old ones: decide against written criteria, write down what was relied on and what was not known, give the person restrained a fixed way back, and count the results.

Sources for this chapter

Claim	Source	Date
13 deceased victims, 8 recorded as the predominant aggressor before death; 25 deceased people recorded as perpetrators, 21 by suicide, 24 men, 20 ever respondents to an order, 9 respondents to a current order at death; case circumstances quoted	ACT DFV Review Biennial Report 2025	2025
Levy on every rates notice since 1 July 2016; more than $46 million raised to 30 June 2024	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024; ACT Budget papers 2016–17 to 2024–25	2016–2024
$151.4 million direct investment over four years	2026–27 Budget DFSV factsheet	2026
No performance monitoring strategy or evaluation framework for levy-funded initiatives	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024	22 November 2024
First Action Plan commitments: monitoring and evaluation framework, system and client journey mapping, true-cost analysis	ACT DFSV Strategy First Action Plan 2026–2028	27 May 2026
Agencies using different risk processes and reaching different conclusions	ACT DFSV Crisis Specialist Services Review Summary	May 2024
Sexual violence prosecutions up about 170 per cent; recorded victimisation up about 37 per cent; discontinuance 2.5 per cent to 17.3 per cent	Chapter 6, drawing on ACT DPP Annual Reports 2017–18 and 2023–24 and ABS *Recorded Crime — Victims*	2018–2025
Vignette study: twenty vignettes, six weeks of fieldwork, about five months end to end, about $147,000	Appendix O	—
Family violence safety notices: sergeant or above, 14 days, police records, "as soon as practicable" return; coercive control offence: seven years, commencement two years after notification, review with no measures	*Family, Personal and Sexual Violence Legislation Amendment Bill 2025*; *Crimes (Coercive Control) Amendment Bill 2026*; Chapter 19	3 Dec 2025; 28 May 2026

Appendices — The instruments and the evidence

These are the instruments and the evidence behind Parts I to III, and they are four different kinds of thing. **A, B, C and E are meant to be used rather than read** — the rewritten risk framework, the pre-listing instrument, the risk criteria and the control effectiveness test — and **G** drafts the legislation that would carry them. **D, I, K, M and N are the apparatus**: where every source is, how the method works, the register of every finding, and what was verified. **F, H, L, O, P, Q and R are assessments and answers** — the annual ledger, the recommendation tracker, the assessment of the 2026 Strategy, the reliability study design, the costing, two constructed critiques with responses, and what other jurisdictions publish. **J is the glossary.** None of this is needed to follow the argument. All of it is needed to check it.

Appendix A — ACT Family Violence Risk Assessment and Management Framework (rewritten)

Status. Working model prepared as part of the analysis. It is **not** approved, endorsed or issued by the ACT Government or any ACT agency. It is offered as a drafting basis for the framework update the First Action Plan commits to delivering.

Relationship to other appendices. Risk criteria are at Appendix C. The source and claim register is at Appendix D. The control test and treatment schedule are at Appendix E. The court pre-listing instrument is at Appendix B.

What this replaces. The ACT Domestic and Family Violence Risk Assessment and Management Framework of July 2022, including its practice guides and fact sheets. Part 10 sets out, item by item, what is retained, added, changed and removed.

Verification note. Every statutory reference in this appendix was checked against the *Family Violence Act 2016* (ACT) republication 17, effective 1 July 2025, and the *Human Rights Act 2004* (ACT) republication 17, effective 17 March 2025, on 3 September 2026. Section numbers and operative wording are as at those republication dates. Practice Direction 1 of 2026 references are to the direction as published. Check the ACT legislation register for later amendment before use.

Appendix A, Part 1 — Governance

This part does not exist in the 2022 framework. Chapter 8 sets out why, without it, the framework cannot be shown to produce consistent practice.

1.1 Policy statement

The framework is issued under a policy statement made at Director-General level, which states:

- that this framework is the method by which the Territory identifies, assesses and manages family violence risk;
- that it is aligned to AS ISO 31000:2018 and to the ACT Government risk management framework;
- that prescribed entities must align their policies, procedures, practice guidance and tools to it;
- that alignment is reported annually and the reports are published; and
- that the framework is not approved for general use until validation results, including inter-rater reliability, have been published.

1.2 Roles and accountabilities

For each prescribed entity, the framework records three named positions.

Role	Accountable for
Alignment owner	That the entity's policies, procedures, guidance and tools conform to this framework, on the published timetable; and for the entity's annual alignment report
Practice quality owner	The quality and consistency of assessments made within the entity; supervision arrangements; participation in inter-rater reliability testing
Residual risk acceptor	Accepting residual risk at the levels the tolerance statement assigns to that entity; and for escalating residuals above that level

Positions are named. An agency cannot hold a duty; a duty distributed across an agency is held by nobody.

1.3 Risk ownership within an assessment

Every assessment names:

- a **risk owner** for R1 — the person accountable for the protective measures selected;
- a **risk owner** for R2 — the person accountable for ensuring the restriction chosen is the least restrictive adequate option;
- a **control owner** for each control, with a time by which it must be operating; and
- a **child safety owner**, where a child is affected, distinct from the adult risk owners.

1.4 Alignment timetable

The framework publishes, for each prescribed entity, the dates by which it must have:

1. mapped its existing tools against this framework;
2. amended its policies and procedures;
3. amended its forms and systems to produce the required data;
4. trained its workforce to the required competency; and
5. reported alignment.

1.5 Resourcing statement

The framework states the time each instrument requires when completed properly:

Instrument	Time
Screening	3 to 5 minutes
Full assessment, first occasion	30 to 45 minutes
Reassessment	10 to 20 minutes
Court pre-listing instrument (Appendix B)	20 minutes

An entity may not be required to apply an instrument without a corresponding allocation of time. Where an entity's workload does not permit the stated time, the alignment owner records this in the annual alignment report as a constraint, and it is published.

1.6 Assurance

Assurance activity	Frequency	Published
Internal practice review by each prescribed entity	Annual	Summary published in the entity's alignment report
Inter-rater reliability testing across entities	Every two years, and before any material change to the instruments	Yes, in full
External audit against AS ISO 31000:2018 and the ACT risk management framework	Annual	Yes
Framework-level indicator report (Part 9)	Quarterly	Yes
Independent review of the framework	Every three years, and on any trigger in 1.7	Yes

1.7 Review triggers

The framework is reviewed, outside its scheduled cycle, on any of:

- inter-rater reliability falling below the published withdrawal trigger;
- a fatality review finding that the framework contributed to a missed risk;
- a validation result showing materially different error rates between cohorts;
- a change in the national risk assessment principles;
- a material amendment to the *Family Violence Act 2016* or related legislation;
- a court decision bearing on the framework's operation.

1.8 Withdrawal trigger

The framework states, before deployment, the level of inter-rater agreement below which the instruments are not fit for general use, and what happens if that level is not met.

An instrument that cannot fail cannot be validated.

Appendix A, Part 2 — The process

The process follows AS ISO 31000:2018. Each step states what must be recorded.

2.1 Scope, context and criteria

Record: who is involved; the setting; the period being assessed; the options actually available in this setting; and any constraint limiting them.

Rule. An option that cannot be delivered — because a facility is unavailable, a service has no capacity, or no accommodation exists — is recorded as **unavailable**, not silently omitted. The record of what was unavailable is what allows system-level gaps to be seen.

2.2 Communication and consultation

Record: who has been spoken to; who has consented to what; what has been shared and with whom; and what the person has been told about what will happen next.

2.3 Risk identification

Screening (Part 3), followed by the assessment (Part 4) where any indicator is present or a disclosure is made.

2.4 Risk analysis

Rate intent and capability separately for R1. Rate likelihood and consequence for R1 and R2 separately. Apply the critical flag floors. Record confidence.

2.5 Risk evaluation

Compare the current ratings to the tolerance statement at Appendix C8. Determine whether the current position is inside or outside tolerance.

2.6 Risk treatment

Identify the available options. Rate each after its controls. Compare. Select. Record why the selected option was preferred and why each rejected option was rejected. Apply the control test at Appendix E1 to every control.

2.7 Residual risk

State residual R1 and R2. Name the acceptor. Record the review date or trigger.

2.8 Monitoring and review

Apply the triggers at Appendix E7. Preserve the prior record. Record who was informed.

2.9 Recording and reporting

Case level: the completed instrument. Framework level: the indicators at Part 9.

Appendix A, Part 3 — Screening

3.1 Who is screened

All clients of a prescribed service, using the same question set.

This is a change from the 2022 framework, which screens all women. Chapter 15 sets out the three reasons: interpretable data, removal of an assumption from the front of the process, and identification of people the current design misses.

3.2 Recording the screening design

Each entity records, and reports annually:

- which clients it screens;
- at what point in the service contact;
- by whom;
- using which question set; and
- where it does not screen all clients, which clients it does not screen and why.

Without this record, service data cannot be interpreted. Chapter 10 sets out the consequence.

3.3 The screening questions

Asked of every client, in these terms or in an equivalent form recorded by the entity:

1. Has a partner, former partner or family member ever put you down, humiliated you, or tried to control what you can or cannot do?
2. Have you been hit, slapped or hurt in any other way by a partner, former partner or family member?
3. Are you ever frightened of a partner, former partner or family member?

Note on wording. The questions do not use gendered pronouns. The 2022 conversation guide is written to a female client and uses "he" for the person using violence throughout. That wording tells a male client, a person in a same-sex relationship, and a person experiencing violence from an adult child that the question is not about them.

3.4 When screening is not possible or safe

Screening is not conducted where another person is present who may be the person using violence, where an interpreter is not available and the client cannot be understood, or where the client's immediate safety would be affected.

Record: that screening was not conducted, why, and when it will be attempted.

Rule. "Not screened" is recorded as **Unknown**. It is never recorded as a negative result.

3.5 What happens after a disclosure

The framework does not change the response to a disclosure. It changes who is asked.

On disclosure: proceed to assessment (Part 4); provide information about services; make a referral where the client agrees; record the client's own account and their own assessment of their risk.

3.6 What happens after a nil result

Record **run, nil**, with the date. Provide information about services. Advise the client they may raise it at any time.

A nil result is a result. It is not proof that no violence is occurring, and a subsequent disclosure is not treated as inconsistent with it.

Appendix A, Part 4 — Assessment

4.1 Structure

The assessment has five components:

1. the person's own account and their own assessment of their risk;
2. the risk factor set, coded;
3. the source and claim register (Appendix D);
4. the risk ratings (Appendix C); and
5. context: health, disability, housing, income, children, culture, language and supports.

4.2 The person's own account

Recorded in the person's own words, at reasonable length, before the factor list is applied.

Recorded for **every** person the assessment concerns, not one of them.

4.2.1 The person's own risk assessment

Four questions, and one scaled item.

- How frightened do you feel, given what has happened?
- Do you think it will happen again, or continue?
- Is it getting worse?
- What are you most worried might happen?
- On a scale from 0 to 10, where 0 is no risk and 10 is the highest risk you can imagine, where would you put the risk of something happening in the next month?

The 2022 framework collects this as a 1 to 10 scale. The scale here starts at 0 so that a person can record that they see no risk at all. Part 10.3 records the change.

4.2.2 The interpretation rule

This is the rule the 2022 framework omits. The number is collected and then applied. It does not set a floor. Appendix C9 states that there is no likelihood floor, and this rule keeps to that. What it requires is a review and a written reason.

Person's rating	Effect on R1
8 to 10	Where R1 likelihood is rated below 4, the assessor reviews the rating and records the reason for the difference.
5 to 7	Where R1 likelihood is rated below 3, the assessor reviews the rating and records the reason for the difference.
0 to 4	Recorded, and taken into account. No review is triggered.

Additional rules.

- A low self-rating **never** reduces a rating that the factor set or the critical flags support. Minimisation is common and well documented, and the framework must not convert it into a lower risk level.

- Where the self-rating and the factor set point in different directions, that difference is recorded explicitly, with the assessor's reasoning.
- The self-rating is a review trigger, not a score. It cannot by itself set a likelihood or a consequence rating.

4.3 The risk factor set

Factors are grouped into three tiers by evidential strength. Each factor has a coding rule stating what counts as **established (E)**, **reasonably open (O)** and **unknown (U)**.

4.3.1 Tier 1 — strongest evidence for lethal or serious harm

Factor	Established when	Reasonably open when
Non-fatal strangulation or pressure to the neck or throat	Medical record, admission, conviction, or first-hand account with corroborating injury or contemporaneous report	First-hand account without corroboration
Threat to kill	Recorded threat in writing or recording, admission, conviction, or first-hand account with a witness	First-hand account without corroboration
Firearms access — home	Licence and registration confirmed, or firearms confirmed present at a residence the person can access	Licence confirmed but access not established; or account of firearms present, not confirmed
Sexual violence within the relationship	Conviction, admission, medical record, or first-hand account with corroboration	First-hand account without corroboration
Separation within three months, or in progress	Established from any reliable source	—
Stalking or persistent unwanted contact	Records, messages, or a first-hand account with supporting material	First-hand account without supporting material
Escalation in frequency or severity	A documented sequence showing change over time	A first-hand account of change without documentation
Violence during pregnancy, or to an infant	Medical record, admission, conviction, or corroborated account	Uncorroborated first-hand account
Suicidality of the person using violence — threats or attempts	Records, admission, or corroborated account	Uncorroborated account
Previous serious assault	Conviction, court finding, or medical record	Allegation without finding

4.3.2 Tier 2 — established pattern indicators

Factor	Notes
Coercive control and isolation	Assessed as a pattern over time, not as a single act. See 4.4.
Monitoring, tracking or surveillance	Includes device tracking, shared accounts, location monitoring
Financial control	Includes control of income, debt in the other person's name, restriction of access to money
Threats to children	Including threats to remove, harm or report
Threats to or harm of pets	
System abuse	Use of legal, immigration, child protection or other processes to control. Recorded for **any** party, and never used by itself to classify.

Factor	Notes
Breach of a previous order	Distinguish proven breach from alleged breach
Jealousy, obsessive behaviour or a sense of ownership	Assessed on conduct, not on impression
Violence outside the family context	Recorded criminal history indicating violence towards people outside the family. Added because the 2025 death review found that 15 of the 25 deceased people it recorded as perpetrators had such records, and noted the factor is not captured in the national principles.

4.3.3 Tier 3 — contextual factors

Recorded, and relevant to the response. They do not set floors and they are not treated as predictors of violence towards another person.

Factor	Note
Problematic substance use	Highly prevalent in the ACT fatality data and relevant to the response required
Housing instability or homelessness	54 per cent of deceased victims in the 2025 review
Unemployment or financial stress	62 per cent of deceased victims unemployed
Recent significant loss	Bereavement, job loss, relationship breakdown
Isolation from support	Geographic, social, linguistic or imposed
Pregnancy or a new baby	Where not already recorded under Tier 1

4.3.4 Recorded as context only

The following are recorded in the context section. They **do not** contribute to any risk rating.

- A diagnosed mental illness. This is separated from the 2022 framework's question 14, which combines diagnosis with suicide threats. A threat of suicide by the person using violence is a Tier 1 factor. A diagnosis is not, because it does not predict violence towards another person, and the great majority of people with a mental illness are not violent.
- A disability, of any person.
- Cultural background, language, religion, immigration status.
- Sexuality or gender identity.
- Occupation, training, or qualifications.
- The person's demeanour or manner (see Appendix D7).

4.4 Assessing coercive control as a pattern

The 2023 death review found coercive control present in almost all of the 12 homicides examined in depth, and found no significant physical violence beforehand in about 9 of the 12. An assessment that counts physical incidents would not have seen most of those 12 cases.

Coercive control is assessed by asking, of the relationship as a whole:

- **Freedom.** What can this person not do, that they would otherwise be able to do? Who decides?

- **Money.** Who controls income, spending, debt and accounts?
- **Movement.** Who decides where the person goes, when, and with whom?
- **People.** Who has the person stopped seeing, and why?
- **Communication.** Who has access to the person's phone, messages, accounts and location?
- **Fear.** What does the person do differently in order to avoid a reaction?
- **Children.** How are the children used in the pattern?
- **Change over time.** What has changed in the last three months, six months, year?

The answers are recorded as narrative and coded against the Tier 2 factors. The pattern questions are asked of each party.

4.5 Rating

Apply Appendix C. Record intent, capability, likelihood, consequence, band and confidence, for R1 and R2 separately, with the critical flag floors applied and any departure reasoned.

The critical flags are those listed at Appendix C9, and only those. The tiers at 4.3 group factors by evidential strength. They do not themselves set floors. A factor sets a floor only if it appears in the C9 list. Appendix C9 is the single source for that list, and Appendix B Section G reproduces it without change.

Appendix A, Part 5 — Classification: who is exercising coercion or violence

This part replaces Fact Sheet 9 and Fact Sheet 10 of the 2022 framework. Chapter 9 sets out why.

5.1 The question

Not: *who is more likely to be an aggressor?*

But: **on the available information, whose conduct forms a pattern of coercion or violence directed at the other?**

5.2 When this part is used

Only where more than one person is alleged to have used violence, or where a classification is required for a decision.

Where one person is alleged to have used violence and there is no competing allegation, this part is not applied.

5.3 The method

Step 1 — Record both accounts in full

Each person's own description of what has happened, in their own words, and their own assessment of their risk, under Part 4.2, applied identically.

Where one person has not been able to give an account — because they have not been contacted, or have declined — record that. **The absence of an account is not adverse to that person.**

Step 2 — Build the claim register

Every material claim entered in the register at Appendix D, with source grade, claim grade, supporting material, contradicting material, and the check that would resolve the gap.

Grades are applied identically to both parties.

Step 3 — Test for pattern

The following questions are asked of **each** person, in the same terms, and answered from the register.

#	Question
1	Is there a documented history of controlling conduct by this person towards the other? What is the evidence, and what grade is it?
2	Who has restricted whose access to money, transport, communication, documents or other people? What is the evidence?
3	Whose conduct has produced fear in the other, and what is the evidence of that fear — behaviour changed, precautions taken, disclosures made?
4	Has either person previously been the subject of a substantiated finding, conviction or admission in relation to violence towards the other, or towards another person?
5	Where force has been used, what does the sequence show about context, intent and effect — what happened before, what happened after, what was the apparent purpose, what was the effect?

#	Question
6	Is there evidence of defensive or resistive force by either person, and what is its context?
7	Is there evidence of either person using a legal, administrative or child protection process against the other, and what is the evidence?
8	What does information from other agencies and other time points show?
9	Has either person previously been recorded as the person most in need of protection, or as the person using violence, and was that record later changed?

Step 4 — Classify, or record unresolved

Classify where the pattern is established on material of adequate grade. Record the classification, the evidence supporting it, and the confidence.

Record unresolved where it is not. Then apply 5.6.

5.4 What does not contribute to classification

None of the following counts towards a classification, for any person, of any sex, in any relationship configuration:

- how calm, confident, charming, charismatic or composed a person appears;
- how critical a person is of the other party;
- how critical a person is of the police, the courts, or the system;
- whether a person raises their legal rights or asserts that their rights have been affected;
- how persuasive a person is, or whether the assessor feels persuaded;
- whether a person denies the allegation;
- whether a person appears afraid, or does not appear afraid;
- whether a person is vague, hesitant, forthright or specific;
- whether family law proceedings are on foot;
- whether a person has engaged a lawyer;
- any inference drawn from sex, gender, sexuality, culture, occupation or training.

Each of these may be **recorded as an observation** under Appendix D7, where it is visible to any reviewer and available for later corroboration. None contributes to the rating.

5.4.1 Why family law proceedings are excluded

A very large proportion of family violence matters involve people who are separating and who have children. Family law proceedings are therefore present in a substantial share of cases, on both sides.

An indicator that is present in most cases has no power to discriminate between cases. An indicator that is applied to one party only imports its conclusion.

The presence of family law proceedings is recorded as **context**. It informs what protective measures are appropriate, because system abuse is real and is documented in the ACT record in both directions. It does not determine who is exercising coercion or violence.

5.5 What does contribute

The evidential indicators, each with a coding rule and each recorded with its source grade:

Indicator	Coding note
Injury pattern and its consistency with each account	Record who observed it, when, and what was documented. Record whether a medical opinion was obtained.
Order and charge history	Record dates and outcomes. Distinguish allegation, withdrawal, consent without admission, finding and conviction.
Account inconsistent with the independently established record	Identify the record and the inconsistency.
Account inconsistent with physical facts	Identify the fact and the inconsistency.
Documented history of controlling conduct	Coded against the Tier 2 factors.
Documented history of defensive or resistive force, with context	Recorded for either party.
Pattern across time and across sources	The primary indicator. A classification resting on a single incident is recorded as low confidence.

5.6 Where classification is unresolved

Where the classification cannot be made on the available information, the assessor records **unresolved**, records what would resolve it, and selects protective measures that do not depend on the classification being correct.

Options that operate regardless of classification include:

- separation of the parties at court: separate entry, separate waiting, staggered departure, screens;
- remote appearance for one or both parties;
- expedited listing, to shorten the period of uncertainty;
- firearms action, which reduces the consequence of the worst outcome whoever causes it;
- protection of address and contact details, for both parties; and
- the safety plan, welfare check and referral steps, offered to both parties.

Reciprocal conditions on an interim order are **not** an option this framework lists. Under the Act as it stands, conditions bind the respondent only. Whether a magistrate — and only a magistrate — should have a discretionary power to impose reciprocal conditions where the material does not permit the court to identify the person most in need of protection is put in Chapter 16 section 4.4 as a question for a time-limited trial, with a published evaluation and withdrawal trigger. Until the Assembly answers it, an assessor recording an unresolved classification selects from the measures above and refers the classification question to the court.

Rule. A protective measure that requires the classification to be correct — for example, an exclusion condition against one party — should not be selected on an unresolved classification unless the R1 rating independently supports it and the reasons are recorded.

5.7 Safeguards

A classification is not a finding. It is an assessment made to select protective measures. It does not bind any court, and every instrument states this on its face.

A classification made on unresolved or low-grade information is recorded as such, with a mandatory review when resolving information arrives.

Every classification carries a correction pathway. See Part 9.4.

Appendix A, Part 6 — Children

6.1 Children are assessed in their own right

A child affected by family violence is assessed as a person at risk, with their own R1 rating, not as a factor within an adult's assessment.

The 2025 death review identified 67 children affected by the deaths of the 38 people it examined — 13 recorded as victims and 25 recorded as perpetrators — found evidence of significant violence against children, and found that in some cases a child discovered the body of a parent.

6.2 The child's own account

Recorded where the child's age and circumstances allow, using an age-appropriate method, by a person with the relevant training.

Where it is not recorded, record why, and who will do it.

6.3 Child risk factors

In addition to the adult factor set:

- exposure to violence between adults, including hearing it or seeing its aftermath;
- direct physical, sexual or emotional violence towards the child;
- the child being used in the pattern — as a messenger, as leverage, as a means of monitoring;
- threats to remove the child, or to report the non-violent parent;
- disruption to schooling, care arrangements or health care;
- the child's own fear and its behavioural expression;
- the capacity of the non-violent parent to protect, and what support they need to do so; and
- the child's relationship with the non-violent parent, and what would preserve it.

6.4 The child safety owner

Where a child is affected, a named person is accountable for the child's safety plan, distinct from the adult risk owners.

6.5 The rule against transferring responsibility

Both death reviews and the 2016 inquiry found that children and the conduct of the person using violence can disappear from view while responsibility shifts to the non-violent parent.

The framework requires, in every assessment involving a child:

- that the conduct of the person using violence is recorded as the source of the risk;
- that any requirement placed on the non-violent parent is recorded together with the support provided to meet it; and
- that where a requirement is placed on the non-violent parent without corresponding support, that is recorded as an unmitigated risk.

Appendix A, Part 7 — The risk management plan

7.1 Contents

Every assessment that produces a risk above Low results in a plan. A Medium risk produces a plan with proportionate precautions. Treatment is required above Medium (Appendix C8.1). The plan contains:

Section	Content
Risk statements	R1, R2 and any R3, written as sentences
Current ratings	Before option-specific controls, with confidence
Options considered	Every option available in this setting, including those recorded as unavailable
Option comparison	Ratings after controls for each option (Appendix E4)
Selected option	With reasons for selection and for rejecting each alternative
Controls	T-ID, owner, time, proof, failure response (Appendix E2)
Residual risk	R1 and R2, with the named acceptor
Key unknowns	With the action to close each, its owner and its time
Review	Date and triggers
Communication	What the person has been told; who else has been informed; what was shared
Handover	Where responsibility passes, the extract at Appendix E6

FIGURE A.1

The risk management plan

Every assessment that produces a risk above Low results in a plan. Treatment is required above Medium.

RISK MANAGEMENT PLAN		case reference
1	**Risk statements**	R1, R2 and any R3, written as sentences
2	**Current ratings**	before option-specific controls, with confidence
3	**Options considered**	every option available here, including those recorded as unavailable
4	**Option comparison**	ratings after controls, for each option
5	**Selected option**	with reasons for selection and for rejecting each alternative
6	**Controls**	T-ID, owner, time, proof, failure response
7	**Residual risk**	R1 and R2, with the named acceptor
8	**Key unknowns**	with the action to close each, its owner and its time
9	**Review**	date and triggers
10	**Communication**	what the person has been told; who else has been informed; what was shared
11	**Handover**	where responsibility passes

Section 4 in full

Opt	T-IDs and owners	R1 after	R2 after	In tol.
A				
B				
C				
D				

Section 7 in full

Residual R1	band, likelihood and consequence
Residual R2	band, highest domain named
Confidence	high, medium or low, with reason
Key unknown	and the action to close it

ACCEPTED BY

name and position

Choose the option that brings residual R1 inside tolerance with the lowest residual R2. Where no option brings R1 inside tolerance, escalate: do not select the least-bad option at practitioner level. The acceptor must hold authority at the level the tolerance statement requires.

What the plan must not do

- place a requirement on the person at risk without recording the support provided to meet it
- rely on a control that has not been verified
- record a residual risk as accepted by a person who does not hold authority to accept it

A safety plan is a control. It counts only when the person has it and can use it. A plan drafted and not provided is recorded as failed.

Appendix A, Part 7; Appendix E, sections 2 to 6. Every control carries a T-ID that is copied into the option comparison and into the handover.

7.2 The safety plan

The safety plan is the part of the risk management plan held by the person at risk. It is written with them, in their language, in terms they can use.

It covers: what to do if it happens again; where to go; who to call; what to take; device and account security; children's arrangements; work and school; transport; money; and what to do if a control fails.

Rule. A safety plan is a control. It counts only when the person has it and can use it. A plan drafted and not provided is recorded as failed.

7.3 What the plan must not do

- It must not place a requirement on the person at risk without recording the support provided to meet it.
- It must not rely on a control that has not been verified.
- It must not record a residual risk as accepted by a person who does not hold authority to accept it.

Appendix A, Part 8 — Reassessment

8.1 Triggers

Appendix E7.

8.2 What reassessment records

- what changed;
- the revised ratings, with the previous ratings preserved;
- whether the selected option remains appropriate;
- whether any control has failed;
- who was informed, and when.

8.3 The prohibition on overwriting

The prior record is preserved. A reassessment adds to the record; it does not replace it.

This is what makes it possible, later, to see how an assessment developed — and to measure how often a classification changed.

Appendix A, Part 9 — Records, reporting, validation and correction

9.1 What each assessment must generate

Completing the instrument produces, as a by-product:

- date, setting, assessor role, entity;
- whether screening was conducted, and the screening design applied;
- the option selected and the options rejected;
- R1 and R2 before and after controls, with confidence;
- every factor's status: established, reasonably open, or unknown;
- every control, with owner and verification status;
- residual risk and the acceptor;
- classification, or unresolved, with confidence;
- any later change to a classification, with the date; and
- a case identifier permitting linkage to outcomes.

9.2 Framework-level indicators

Reported quarterly, to a named recipient, with a required action on each.

Indicator	Recipient	Required action
Screens conducted; proportion of clients screened, by entity	Practice quality owners	Explain any entity below the published threshold
Disclosure rate, by client characteristics	Framework owner	Investigate material change
Assessments completed, by setting and role	Framework owner	Compare to expected volumes
Distribution of R1 and R2 bands, by entity	Framework owner	Investigate divergence between entities on comparable caseloads
Proportion of assessments with unresolved classification	Framework owner	A rate of zero is a finding: it indicates classification is being forced
Proportion of controls verified as operating	Alignment owners	Explain any entity below the published threshold
Residual risks accepted, by authority level	Residual risk acceptors	Investigate escalation avoidance
Reassessments triggered, by trigger	Framework owner	Test whether triggers are operating
Classifications later changed, and time to change	Framework owner	The misidentification measure. Published.
Inter-rater reliability	Framework owner and Minister	Compare to the withdrawal trigger

9.3 Validation

9.3.1 Before general deployment

- **Inter-rater reliability** measured on standardised case vignettes across every role that will use the instruments, with the agreement statistic and its distribution published.
- **The withdrawal trigger** published: the level of agreement below which the instruments are not fit for general use.
- **A validation plan** for predictive performance, with a date.

9.3.2 After deployment

- **Predictive performance**: risk ratings and classifications linked to subsequent outcomes — further violence, further orders, charges, and reversals of classification.
- **Error analysis by cohort**: performance reported separately for women; men; people in same-sex relationships; transgender and non-binary people; Aboriginal and Torres Strait Islander people; people with disability; and people from culturally and linguistically diverse backgrounds. Where a cohort is too small for annual reporting, rolling multi-year totals are used rather than suppression.
- **Indicator-level contribution**: which factors actually discriminate. Factors that do not are removed at the next review, not retained on the basis that practitioners find them useful.

9.4 The correction pathway

Where a classification, or a material element of an assessment, is later shown to be wrong:

Step	Requirement	Timeframe
1	Correct the record in every system holding it	Within 10 working days of the error being established
2	Notify the person, and every agency that acted on the original	Within 10 working days
3	Review the consequences that followed — charges, orders, conditions, employment notifications, child arrangements, housing — with a named person accountable	Within 20 working days
4	Record the correction in the monitoring dataset	At the time of correction
5	Apply the remedy pathway where consequences cannot be reversed	As determined by policy

Step 5 is deliberately left to policy. What remedy is appropriate is a question this framework does not resolve. What is not defensible is the current position, in which the record is not corrected, the consequences do not unwind, and the error is not counted.

Appendix A, Part 10 — Schedule of changes from the 2022 framework

10.1 Retained without change

- Structured professional judgment as the underlying method.
- Recognition of coercive control as a pattern rather than a list of separate acts.
- Recognition that risk changes over time and requires reassessment.
- The evidence-based risk factors, subject to the tiering in 4.3.
- The victim-survivor's own assessment as a primary input.
- Coverage of generalist, statutory and specialist services.
- Attention to children, intersectionality and perpetrator accountability.
- The candid statement about the limits of the evidence base.
- The safety plan, e-safety checklist and risk management planning templates, as a starting point for the revised versions.

10.2 Added

- The governance layer at Part 1: policy statement, named roles, alignment timetable, resourcing statement, assurance program, review and withdrawal triggers.
- Defined risk criteria: intent and capability scales, likelihood and consequence scales for two risks, matrix, tolerance statement, critical flag floors, confidence ratings (Appendix C).
- The source and claim register (Appendix D).
- The control effectiveness test, treatment register and option comparison (Appendix E).
- Residual risk with a named acceptor.
- Named risk owners, control owners and a child safety owner.
- The unknown state, and the rule that a nil result is a result.
- An interpretation rule for the person's own risk rating.
- Violence outside the family context as a Tier 2 factor.
- Framework-level indicators, reporting and validation.
- The correction pathway.

10.3 Changed

- **Screening**: applied to all clients rather than all women; screening design recorded and reported.
- **Pronouns and framing**: all instruments written without gendered pronouns.
- **Risk factors**: tiered by evidential strength, each with a coding rule.
- **Mental illness**: separated. Suicide threats by the person using violence remain a Tier 1 factor. A diagnosis is recorded as context and does not contribute to a rating.
- **Children**: assessed in their own right with their own rating and their own named owner.
- **The person's own rating**: retained, with the scale changed from 1 to 10 to 0 to 10, a defined interpretation rule that triggers review and a written reason rather than a floor, and an express prohibition on a low self-rating reducing a supported rating.

10.4 Removed

- The sex-specific indicator list in Fact Sheet 10 identifying when a man claiming victim status is more likely to be the primary aggressor.
- The instruction in Fact Sheet 9 to be cautious and keep an open mind specifically when a male client claims to be a victim.
- Demeanour and attitude cues as contributors to classification: calm, confident, charming, critical of the partner, critical of the system, rights-focused, persuasive, denying, unafraid, vague, hesitant.
- The presence of family law proceedings as an indicator of perpetration.
- The combined mental illness and suicide threat item.
- The undifferentiated risk factor list.

10.5 What is not changed

- The statutory threshold for a protection order.
- The paramountcy of the safety of the affected person and any child.
- The availability and priority of emergency action.
- The gendered evidence base for the Tier 1 factors.
- The scope, eligibility or focus of any specialist service.

Appendix B — Interim order pre-listing risk assessment instrument

Status. Working model prepared as part of the analysis. It is **not** approved, endorsed or issued by the ACT Magistrates Court, and it is not a description of current ACT listing practice. Ratings produced using it are not findings and bind nothing at any hearing.

Verification. Every statutory reference in this instrument was checked against the *Family Violence Act 2016* (ACT) republication 17, effective 1 July 2025, and the *Human Rights Act 2004* (ACT) republication 17, effective 17 March 2025, on 3 September 2026. Practice Direction 1 of 2026 references are to the direction as published. Check the ACT legislation register for later amendment before use.

What it is for. To structure, in twenty minutes at the point of filing, the judgment the *Family Violence Act 2016* already requires: whether protection is necessary, what conditions give paramount consideration to safety, and which of the available conditions and listing arrangements is the least restrictive that still achieves that.

What it is not for. It does not decide whether an order is made. That decision remains with the judicial officer under sections 21 and 36 to 39. This instrument creates no power and records no finding.

Related appendices. Risk criteria at Appendix C. Source register at Appendix D. Control test and treatment schedule at Appendix E. The framework it sits within is at Appendix A.

B0. Instructions before anything else

B0.1 Emergency first

If an attack, self-harm, a weapon at court, or an unsafe disclosure may be imminent, use the police or court emergency process now. Do not complete this form first. Record the action afterwards.

Nothing in this instrument delays urgent action.

B0.2 Protected information

Home, work, school and service addresses and contact details are recorded **only** on the confidential forms. They are never written on this instrument, and this instrument never enters a served document pack.

B0.3 What this instrument does and does not do

Use it to	Do not use it to
Structure protective triage	Treat a risk band as a fact
Rate the **option**, not the person	Replace the balance of probabilities under s 13
Keep R1 and R2 separate	Assume an order enforces itself
Record evidence status, unknowns, owners, proof and failure responses	Profile a person by occupation, licence, diagnosis, identity or distress
Make the least-restriction analysis visible	Expose a protected address
—	Delay urgent action

B0.4 Who does what

Who drafts	Who verifies	Who decides
The applicant, a support person, a duty lawyer, a police family violence officer, a registry officer, or a Deputy Registrar in a structured interview	A Deputy Registrar checks completeness, unknowns, protected-address handling, the emergency override, authority, and referral, before any listing date is issued	The statutory interim order and condition decisions remain with the judicial officer under ss 21 and 36 to 39

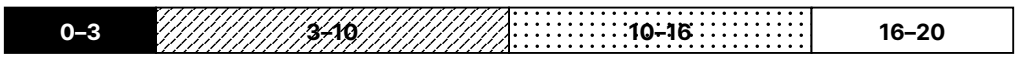
B0.5 The twenty minutes

Minutes	Drafter	Deputy Registrar	Output
0–3	Ask the emergency question. Confirm names and matter details. Keep protected contact details on the confidential forms. Record service, notification and awareness separately. Define the notice window.	Launch available checks in parallel. Identify any immediate judicial or police referral.	An emergency path, or a safe start; protected-address boundary set; deadline identified
3–10	Draft the R1 and R2 risk sentences at Section H. Enter the four strongest decision-relevant claims. Mark every screen row E, O or U. Mark critical flags.	Watch for missing data, profiling shortcuts, and any critical flag floor. Ask only questions that could change the mode, the service arrangements, firearms action, or the conditions.	Sections A to G complete enough to use. Unknowns visible, not guessed.
10–16	Clarify housing, child, work and service facts if asked.	Complete the ratings at Section H first. Rate every available option after named controls. Apply the matrix and the tolerance rule. Check authority, deliverability, proof and failure response.	A preferred listing package; residual R1 and R2; owners; a real return date
16–20	Confirm what the applicant may safely take away.	Verify completeness, privacy, authority and referral. Sign. Issue or obtain the listing package. Advise the applicant of notice status, attendance mode, date, and precinct or service protections. Send the handover extract only.	A signed record; applicant advice; handover; review triggers

FIGURE B.1

The twenty minutes

To structure, at the point of filing, the judgment the Family Violence Act 2016 already requires.



	0–3	3–10	10–15	16–20
DRAFTER	Ask the emergency question. Confirm names and matter details. Keep protected contact details on the confidential forms. Define the notice window.	Draft the R1 and R2 risk sentences at Section H. Enter the four strongest claims. Mark every screen row E, O or U. Mark critical flags.	Clarify housing, child, work and service facts if asked.	Confirm what the applicant may safely take away.
DEPUTY REGISTRAR	Launch available checks in parallel. Identify any immediate judicial or police referral.	Watch for missing data, profiling shortcuts and critical flag floors. Ask only questions that could change the mode, the service arrangements, firearms action or the conditions.	Complete the ratings at Section H first. Rate every available option after named controls. Apply the matrix and the tolerance rule. Check authority, deliverability and proof.	Verify completeness, privacy, authority and referral. Sign. Issue the listing package. Advise the applicant of notice status, attendance mode, date and protections. Send the handover extract only.
OUTPUT	An emergency path, or a safe start; protected-address boundary set; deadline identified	Sections A to G complete enough to use. Unknowns visible, not guessed.	A preferred listing package; residual R1 and R2; owners; a real return date	A signed record; applicant advice; handover; review triggers

Who does what

Who drafts	the applicant, a support person, a duty lawyer, a police family violence officer, a registry officer, or a Deputy Registrar in a structured interview
Who verifies	a Deputy Registrar checks completeness, unknowns, protected-address handling, the emergency override, authority and referral, before any listing date is issued
Who decides	the statutory interim order and condition decisions remain with the judicial officer under sections 21 and 36 to 39

Twenty minutes at the point of filing, split four ways: a safe start; the two risk sentences with unknowns visible rather than guessed; every available option rated after its named controls; and a signed record handed over with review triggers.

Appendix B, sections B0.4 and B0.5. Segment widths are proportional to the minutes.

B1. Part 1 — The live form

Section A — Matter, privacy and the notice window

Emergency check. Imminent attack, self-harm, weapon at court, or unsafe disclosure? ☐ No ☐ Yes → use the emergency process now.

Field	Entry
Matter number	
Date and time	
Drafter and role	
Deputy Registrar verifier	

Party	Entry
Applicant	
Protected person or persons	
Affected child or children	
Respondent	
Judicial officer or referral	

The three notice events, recorded separately.

Event	No / Yes / Unknown	When and how
Formal service under the Act		
Operational notification — phone, email, agency contact		
Actual awareness, however it arose, including a third party or a leak		

Notice window: from [earliest of the three above] to [the time the selected protections are operating and verified].

Registry deadline / first listing advice due: _____

Protected address boundary. Home, work, school and service details go only on the Private and Confidential form and the Notice of Address for Service. They are not written here and not on any served page. The full form is a court file document and is not served.

Section B — Material, checks and unknowns

Check	Result — write NIL if run and nothing found	Not run = Unknown	Owner and by when
Criminal history and prior violence		☐	
Firearms: licence / registration / actual access		☐	
Prior orders, and any proven breach		☐	
Bail or corrections status		☐	
Child protection flag		☐	
Related criminal charges before the court		☐	

Rule. A check run and returned nil is information. A check not run stays **Unknown**. Nil history, or nothing on a registry, does not prove low capability or low likelihood.

Material relied on: ☐ application form ☐ affidavit ☐ police family violence material ☐ medical ☐ prior orders ☐ other: _____

Section C — Options in scope

Available	Listing package to be rated at Section J	Earliest lawful and realistic time	Safety or participation limitation
☐	**A** — Order without notice now; respondent heard at a short return		
☐	**B** — Respondent notified or aware and expected; both parties in court, with named precinct arrangements		
☐	**C** — Respondent notified or aware and expected; remote appearance or physical separation		
☐	**D** — Short step without notice, followed by a prompt attended or remote review		

Rule. An option that cannot be delivered — no remote room, no security, no capacity — is marked unavailable and the reason recorded. An unavailable option is not silently omitted, because the record of unavailability is what makes system gaps visible.

Legal frame. A judicial officer may make an interim order only if satisfied it is necessary to ensure the safety of an affected person from family violence, or to prevent substantial damage to an affected person's property (s 21). Safety of the affected person and any affected child is the paramount consideration for conditions (s 36). Conditions must be the least restrictive of the respondent's personal rights and liberties as possible that still achieve the Act's objects and give effect to s 36 (s 37). Section 39 factors apply before an exclusion condition. Rights limits are justified under *Human Rights Act 2004* s 28(2)(a)–(e) and laws interpreted compatibly under s 30. A court is outside s 40B except when acting administratively (s 40(2)(b)). **An option is not lawful merely because it is printed on this form.**

Section D — The two risks: what each governs

The risk sentences themselves are written once, at Section H. This section states what each risk decides, so the drafter knows what the sentence must be able to answer.

Risk	Elements the sentence at Section H must name	What it governs
R1 Harm	Source; event within the notice window; consequence; the protected person, child or other affected person	Whether protection is necessary; the listing mode; service arrangements; conditions
R2 Hardship and rights	The court process or the proposed conditions; the avoidable consequence; the respondent, or a child in their care	Which of the adequate options is chosen; the conditions; the return date

R3 — any further distinct risk: _____
Key unknown, safeguard, and owner-by: _____

Section E — Source and claim register

Four rows minimum. Attach a continuation sheet as needed. Grades from Appendix D.

ID	Claim and date	Source, date and status	Source A–F	Claim 1–6	Supports / contradicts / gap and check
E1					
E2					
E3					
E4					

Overall protective triage: predominant source grade ____ / predominant claim grade ____. *Not a finding. Does not bind the final hearing.*

Section F — Short threat and history screen

Mark every row E, O or U. There is no "no" box.

Factor that may change mode, service, firearms action or conditions	E	O	U	Evidence ID, and any contrary or protective fact
Firearms — home: licence held	☐	☐	☐	
Firearms — home: registered to the respondent	☐	☐	☐	
Firearms — home: arms actually accessible at any residence; storage and keys	☐	☐	☐	
Firearms — work: current occupational access (keep separate)	☐	☐	☐	
Firearms — club: sporting or club authority (keep separate)	☐	☐	☐	
Reach: home, work or school; keys; vehicle; tracker or shared account	☐	☐	☐	
Relevant force training, or prior use of or threat with a named weapon, or harm to an animal	☐	☐	☐	
Threat to kill, murder-suicide threat, or a threat conditioned on the court process	☐	☐	☐	
Prior strangulation; sexual violence; violence in pregnancy or to an infant	☐	☐	☐	
Separation within three months; escalation; stalking; persistent unwanted contact	☐	☐	☐	
Coercive control or isolation; threats to a child or pet; suicidality used as leverage	☐	☐	☐	
Stated intent to defy an order, or to confront about the application or the court	☐	☐	☐	
Prior violence, order, or proven breach; bail or corrections status; recent reports	☐	☐	☐	
Recorded violence towards people outside the family	☐	☐	☐	

Section G — Critical flags and floors

The twelve flags, as listed at Appendix C9. That list is the single source; nothing is added here.

☐ 1 threat to kill ☐ 2 non-fatal strangulation or pressure to the neck ☐ 3 firearms access ☐ 4 separation within three months ☐ 5 stalking or persistent unwanted contact ☐ 6 sexual violence ☐ 7 escalation in frequency or severity ☐ 8 pregnancy or an infant in the household ☐ 9 suicidality of the person using violence ☐ 10 a proven breach of a previous order ☐ 11 coercive control ☐ 12 threats to children

Recorded violence towards people outside the family is screened at Section F and bears on capability and history. It is not a flag and sets no floor (Appendix C9).

Floor rules (Appendix C9).

- Separation alone: review and a written reason. No automatic floor.
- Any one of {threat to kill, strangulation, firearms access}: R1 consequence ≥ 4 and intent ≥ Expressed, unless reasons recorded.
- Two or more flags, or separation plus another: R1 consequence ≥ 4; consider 5 where a threat to kill, strangulation or firearms access is present; intent ≥ Expressed, and ≥ Committed where a threat to kill or strangulation is present, unless reasons recorded.
- **No likelihood floor.**

Departure reason: _____

Section H — Write the two risks, then rate them

Write each risk as one sentence before rating it. Substitute this case into every slot. A rating entered against a blank or generic sentence is not a rating. The generic forms and worked examples are at Appendix C1.

	Source	Event	Consequence	Person affected	Period
R1					
R2					

R1, written out: *The risk that* _____ *within* _____.

R2, written out: *The risk that* _____ *within* _____.

If either sentence names a topic rather than an event and a consequence — "firearms", "separation", "mental health" — it is not yet a risk. Rewrite it before continuing.

Which forms of family violence are in issue? Tick every form the facts raise. Intent and capability are rated for each ticked form, never once in the abstract. Appendix C3.0 states what bears on each.

☐ Physical violence or abuse ☐ Sexual violence or abuse ☐ Emotional or psychological abuse ☐ Economic abuse ☐ Threatening behaviour ☐ Coercion or controlling behaviour ☐ Stalking ☐ Deprivation of liberty ☐ Harmful use of, or interference with, technology ☐ Systems abuse ☐ Damaging property ☐ Harming an animal ☐ A child hears, witnesses or is exposed

Intent and capability, by form

Form in issue	Intent 1–5 / U	Evidence for	Evidence against	Capability 1–5 / U	Evidence for	Evidence against	Threat level

Evidence against is recorded, not omitted. A blank in that column means the check was not run. "Nil" means it was run and returned nothing. Support given on conditions is evidence of economic abuse, not against it: record it in the "evidence for" column and say why.

Highest threat level reached: _____ Form that produced it: _____

Current ratings, before option-specific controls

Risk	Threat level (highest form)	Likelihood 1–5 / U	Consequence 1–5 / U	Band	Confidence and reason
R1 harm					
R2 hardship and rights	—				

Section I — Respondent impact worksheet (R2)

Take the highest domain. Never average.

Domain and question	Yes / No / Unknown	Effect within the notice window, and evidence
Housing: who leaves? Is there safe housing for both, and for children? (ss 14, 39)		
Work and income: affected?		
Occupational firearms or security authority affected? (*HRA* s 27B; FVA s 44)		
Sporting or club firearms authority affected?		
Does a child live with the respondent, or is contact due?		
Movement or residence restriction?		
Standing, privacy or loss of hearing opportunity not cured by a short return? (*HRA* s 21)		

Section J — Controlled option comparison

Option	Controls and owners (T-IDs)	R1 after: L / C / band	R2 after: L / C / band	Inside R1 tolerance?	Limiting factor or unknown
A — without notice now					
B — notified; both in court					
C — notified; remote or separated					
D — brief step without notice + prompt review					

Two-key rule. The higher band sets the response. Every risk above Medium is treated. An unverified control is rated as failed unless its assumption is recorded.

R2 rule. R2 may defeat a no-notice option at residual R1 of High or below. It never defeats a properly made-out Catastrophic R1 — an R1 rated at consequence 5 that no notified option brings inside tolerance (Appendix C8). "Catastrophic" is a consequence label, not a band; the bands are read from the matrix.

Section K — Treatments

☐ T1 no notice + shortest return ☐ T2 rights preserved at return ☐ T3 respondent remote ☐ T4 protected person remote ☐ T5 security or sheriff ☐ T6 safe room or separate wait ☐ T7 separate or staggered entry ☐ T8 screen or no sightline ☐ T9 escort or transport ☐ T10 no personal cross-examination ☐ T11 address protection ☐ T12 redacted service pack ☐ T13 police service ☐ T14 home firearms action, confirmed ☐ T15 work or club firearms action ☐ T16 narrow conditions; s 39 ☐ T17 no third-party or social media contact ☐ T18 lawyer or support person ☐ T19 police or specialist safety plan ☐ T20 expedited listing ☐ T21 accept and monitor — only at Low R1 ☐ T22 welfare and referral at service ☐ T23 accompanied service

Section L — Least restriction, human rights record, decision and residuals

Required record	Answer and reason
FVA s 37 — are these the least restrictive conditions that still achieve the Act's objects and give effect to s 36?	☐ Yes ☐ No — reason: _____
HRA s 28(2)(a)–(e) — nature of the right; importance of the purpose; nature and extent of the limitation; relationship between limitation and purpose; **less restrictive means reasonably available**	Rights engaged and reasoning: _____
FVA s 39 — exclusion condition factors recorded, including the respondent's accommodation needs, options and time to find alternatives?	☐ Yes ☐ No ☐ Not applicable — _____

Field	Entry
Recommended package	☐ A ☐ B ☐ C ☐ D
Residual R1	
Residual R2	
Return or listing date	
Judicial referral required?	☐ Yes ☐ No
Why this package, and why the others were rejected	
Residual accepted by (name and position)	

Section M — Handover

T-ID and risk	Owner and by when	Proof it worked	If it fails

Field	Entry
Drafter, role, time	
Deputy Registrar verifier, signature, time	
Referral or decision owner	

Field	Entry
Applicant advised of:	☐ notice status ☐ attendance mode ☐ date ☐ protections

Review and re-rate on: a new threat; a breach; a weapon or firearm; a failure of service, disclosure or any control; delay; or any material change of circumstances. Preserve the prior record. Record who was told.

Appendix B, Part 2 — Counter card, worked examples and assumed reforms

B2. Counter card

A single laminated card kept at the registry counter. It carries the definitions and the rules, so the live form carries only the decisions.

B2.1 Evidence — source is not the same as claim

Source	Reliability	Claim	Credibility
A	Completely reliable: independently verified record	1	Confirmed by independent evidence
B	Usually reliable: contemporaneous official record	2	Probably true; consistent with other material
C	Fairly reliable: sworn first-hand, internally consistent	3	Plausible; not corroborated or contradicted
D	Not usually reliable: material inconsistency or demonstrated interest	4	Doubtful; contradicted by other material
E	Unreliable: uncorroborated hearsay or known unreliability	5	Improbable on the available material
F	Cannot be judged	6	Cannot be judged

Never multiply the labels. Use them as an audit trail. D-to-F or 4-to-6 material is not discarded, but cannot by itself carry a Committed or Dedicated intent rating, a Catastrophic consequence rating, or a classification. Consent without admission is not proof. Sections 13 and 13A still govern the standard and the flexibility of evidence.

B2.2 Intent and capability — rate separately, within the notice window

Level	Intent — observable conduct	Capability — present means and opportunity
Unknown	Missing, conflicting or too weak to judge. Unscored.	Access, opportunity, skill or barriers cannot be judged. Unscored.
1 None / Undeveloped	Adequate current checks identify no target, threat, preparation, approach or attempt. Not a prediction.	No practical means to reach the person in the window; strong verified barriers.
2 Implied / Emerging	Control, jealousy, monitoring, distress at separation; no explicit threat.	Some ability or opportunity; distance, custody or other barriers materially limit it.
3 Expressed / Moderate	Direct, indirect or conditional threat; anger at the application; wants to confront.	Physically capable; knows whereabouts; transport; weapons of opportunity; barriers partial.
4 Committed / Developed	Repeated threats; obsessive pursuit; planning or locating; refusal to accept separation.	Direct access to the person or to relevant means; advanced skill; few effective barriers.

Level	Intent — observable conduct	Capability — present means and opportunity
5 Dedicated / Advanced	Recent serious attack or attempt, or explicit threat to kill with consequences accepted; the order treated as irrelevant.	Ready access to lethal means and to the person, including firearms at home or work; can defeat barriers.

Capability ↓ / Intent →	1	2	3	4	5
5 Advanced	Low	Medium	High	Extreme	Extreme
4 Developed	Low	Medium	High	High	Extreme
3 Moderate	Negligible	Low	Medium	High	High
2 Emerging	Negligible	Negligible	Low	Medium	High
1 Undeveloped	Negligible	Negligible	Negligible	Low	Medium

Hygiene. If either axis is Unknown, do not invent a cell. Close the gap, or use a reversible safeguard and a fast review. **Capability is not intent.** Keep licence, registration and actual access separate, and keep home, work and club access separate. Diagnosis, distress, substance use, identity, occupation and training are **not** intent. A condition is only as good as the willingness to obey it.

B2.3 R1 consequence

1 Limited	2 Minor	3 Major	4 Severe	5 Catastrophic
Fear or transient distress; no physical contact; no disclosure	Minor unwanted contact; distress not needing treatment; a supporter frightened	Treated injury without admission; significant psychological harm; a child exposed; forced relocation; address or school disclosed	Serious injury, strangulation, weapon injury, fracture, sexual assault, child abduction; lifelong trauma; disclosure forcing a move	One or more deaths, including homicide-suicide or a child death; disclosure enabling a fatal or near-fatal attack

B2.4 R2 consequence — highest domain, never an average

Domain	1	2	3	4	5 Hard to unwind
Housing	No change	Ready alternative	Leave at short notice; disruptive alternative	No identified housing; homelessness likely before return	Tenancy lost, not recoverable before hearing; dependent child affected
Work and income	No effect	Leave; no income loss	Duties or income reduced	Stand-down or dismissal likely	Irreversible job or sole-income loss
Occupational authority	None held	Held; no work nexus	Suspension; duties adjustable	Role ends or discipline triggered	Occupation or primary-production business not restorable quickly
Sporting or club authority	None held	No imminent event	Competition or season missed	Membership or authority terminated	Lengthy restoration unrelated to the merits

Domain	1	2	3	4	5 Hard to unwind
Child contact	None due	One occasion missed	Contact suspended for the interim	Child must move, or all contact stops	Stacked schooling, care and contact loss
Movement	No restriction	Minor route limit	Daily area excluded	Suburb, or only residence, excluded	No practical place to live before hearing
Standing and privacy	Private	Known in family	Employer, school or body informed	Serious interim damage, no chance to answer	Correction at return cannot repair the damage

B2.5 Likelihood and the matrix

Likelihood	Meaning	C1	C2	C3	C4	C5
5 Almost certain	Expected without prompt control, or already occurring; a court-conditioned threat, or escalation in train	M	H	VH	E	E
4 Likely	Clear path and indicators; controls weak	L	M	H	VH	E
3 Possible	Plausible supported path; a key fact or control unclear	L	L	M	H	H
2 Unlikely	Credible path but not expected; material barriers with some doubt	L	L	L	M	M
1 Rare	Unusual conditions required; strong verified barriers	L	L	L	L	L

B2.6 Tolerance

Residual R1	Default
Extreme / Very high	Outside tolerance. Take the lowest-R1 lawful route; immediate judicial attention; shortest real review; firearms and address action; record the residual and the acceptor.
High	Inside tolerance only with a named protective package, verified. R2 may defeat a no-notice route; choose the least restrictive adequate package.
Medium / Low	Attended, both-parties listing is the default, with proportionate precautions and address protection. T21 accept-and-monitor only at Low. Re-run on any trigger.

B2.7 Control quality — all seven, or it is not a control

Relevant · Authorised · Deliverable before the event · Specific owner and time · Verified · Effective · Fail-safe response.

B2.8 Treatment effects

ID	Effect
T1	Removes the notice event as a trigger within the window
T2	Bounds the period during which the respondent is unheard
T3 / T4	Removes proximity at the precinct for the respondent / the protected person
T5	Deters and interrupts
T6	Removes contact while waiting
T7	Removes contact on arrival and departure
T8	Removes sightline and intimidation

ID	Effect
T9	Covers the precinct boundary
T10	Protects the person and the quality of the evidence
T11	Removes a locating means
T12	Prevents disclosure through the served pack
T13	Controls the timing of the trigger event
T14	Lowers capability and consequence — **only when confirmed**
T15	Lowers capability and consequence; rate the R2 effect separately
T16	Reduces opportunity while limiting R2; test against ss 36–39
T17	Closes third-party and social media routes
T18	Improves participation and information quality
T19	Covers exposure outside the court process
T20	Shortens the window
T21	Accept and monitor — only where residual R1 is Low
T22	Addresses acute risk at the point of notification
T23	Provides an accompanied response at service, and a clinical one where the category prescribed requires it

B3. Worked examples

These are constructed illustrations. No real matter is described. No file numbers, no parties, no findings. Each is built to show the criteria applied to a different evidentiary shape, and the four together are the calibration set.

How to read the rating strips. Every rated dimension is shown twice: as the label and number the instrument records, and as a five-box strip where filled boxes equal the rating. The strip carries no information the number does not. It is there so that a reader can see the shape of an assessment at a glance, and so that these tables can be rendered as figures without redrawing the analysis. A box marked **U** is an unknown, which is never scored as low.

Strip	Rating
■□□□□	1
■■□□□	2
■■■□□	3
■■■■□	4
■■■■■	5
□□□□□ **U**	Unknown — not scored

B3.1 Example class 1 — an acute, corroborated, lethal path

Facts. Recent strangulation. A threat to kill conditioned on the applicant going to court. Two firearms accessible at the home address. A history of proven breach of a previous order.

Evidence layers, under Appendix D4.1

#	Layer	Source grade	Claim grade	Goes to
1	Applicant's sworn first-hand account	C	2	Strangulation (graded on the corroborated strangulation; the threat to kill rests on this layer alone and would be a 3 — see Appendix D6)

#	Layer	Source grade	Claim grade	Goes to
2	Emergency department record with photographs	A	1	Strangulation
3	Firearms registry and licence check, positive	A	1	Capability
4	Court record of a proven breach of a previous order	A	1	Intent, control effectiveness

Layer count: four independent layers on the path as a whole, three of them graded A. Two independent layers on the strangulation, one graded A. Consequence 5 is supportable under D4.2.

Ratings

Dimension	Rating	Strip	Basis
Intent	Dedicated (5)	■■■■■	Explicit threat to kill with consequences accepted, conditioned on the court process
Capability	Advanced (5)	■■■■■	Ready access to lethal means and to the person; verified by check
Threat level	**Extreme**		Matrix cell 5 × 5
R1 likelihood	5	■■■■■	Within the notice window
R1 consequence	5	■■■■■	Two layers, one graded A
R1	**Extreme**		
R2 consequence	4	■■■■□	Exclusion condition and firearms licence effect, rated separately
R2 likelihood	5	■■■■■	Certain if the option is selected
R2	**Extreme**		Matrix cell L5 × C4. Recorded in full; does not reduce R1
Classification	Resolved	■■■■■	Established on three A-graded layers, not on demeanour

Options after controls

Option	Treatments applied	Residual R1	Inside tolerance?
B or C	Notice event open; home firearms in place through the window	Extreme	No
A or D	T11 address protection, T12 redacted service, T13 police service, T14 confirmed home firearms action, T16 narrow conditions	Very high until firearms action confirmed, then High	Only once T14 is confirmed

Decision. Order without notice, or a short step without notice with a prompt review. The parties are not brought together before confirmed firearms action and a verified protective package.

Where R2 operates. On the conditions and the return date, not on the mode. R2 is Extreme on the matrix, and it is recorded as Extreme. It still does not change the mode, because R2 never defeats a properly made-out Catastrophic R1 (Section J, R2 rule). The occupational firearms consequence is recorded and the return date is set as short as the court can list.

What the record shows. That R2 was rated at its true level, was considered, and was correctly not permitted to defeat a properly made-out Catastrophic R1.

B3.2 Example class 2 — a thin, uncorroborated path

Facts. Alleged shouting and a blocked doorway. No injury. No weapon. No threat to kill. The parties share a home. Criminal history and firearms checks run and returned nil. Recent separation.

Evidence layers

#	Layer	Source grade	Claim grade	Goes to
1	Applicant's account	C	3	The alleged conduct
2	Criminal history check, run, **nil**	A	1	Capability, history
3	Firearms check, run, **nil**	A	1	Capability

Layer count: one layer on the alleged conduct. Two nil results, recorded as run and nil rather than blank. Under D4.2, a consequence rating above 3 would require a recorded gap and check.

Ratings

Dimension	Rating	Strip	Basis
Intent	Implied (2)	■■□□□	Distress at separation; no threat
Capability	Moderate (3)	■■■□□	Shared home, physically capable, no weapons established
Threat level	**Low**		Matrix cell 3 × 2
R1 likelihood	3	■■■□□	
R1 consequence	3	■■■□□	Single layer; ceiling applies
R1	**Medium**		
R2 consequence	5	■■■■■	No identified alternative housing; shared tenancy
R2 likelihood	4	■■■■□	If an exclusion condition without notice were imposed
R2	**Extreme**		

Options after controls

Option	Treatments applied	Residual R1	Residual R2	Selected
B	T6 safe room, T7 staggered entry, T8 screen, T11, T12, T13, narrow T16 without exclusion, T18 support, T20 expedited listing	Low	Low	**Yes**
C	As above, separated appearance	Low	Medium	Available, more restrictive than the assessed risk requires
A or D	Without notice, exclusion	Low	Extreme	No — adds nothing to R1 that B does not achieve

Decision. Respondent notified and expected. Attended listing is the default. The applicant leaves the registry knowing the attendance mode, the date, and the precinct protections in place.

Where R2 operates. R2 defeats the no-notice exclusion, because B brings residual R1 inside tolerance without it.

B3.3 Example class 3 — retrospective, single-layer, internally inconsistent

Facts. An application filed shortly after the other party commenced parenting proceedings. It alleges a course of conduct said to have occurred over the preceding two years. No contemporaneous record of any of it is produced. The account given to police differs from the account in the application as to the dates and the location of the two most serious incidents. No injury is alleged. No medical record, message record, photograph or witness is identified. Criminal history, firearms and prior police attendance checks are run and return nil.

Evidence layers

#	Layer	Source grade	Claim grade	Goes to
1	Applicant's account, in two versions that materially differ	D	4	The alleged conduct
2	Criminal history check, run, **nil**	A	1	History
3	Firearms check, run, **nil**	A	1	Capability
4	Police attendance history at the address, run, **nil**	A	1	Corroboration of a two-year course of conduct

Layer count: one, on the alleged conduct. The source is graded D because of the material inconsistency, under D1. The claim is graded 4 because it is contradicted by other material from the same source, under D2. Under D3, D-to-F source material or a 4-to-6 claim cannot by itself support an intent rating of Committed or Dedicated, an R1 consequence of Catastrophic, or a classification of who is exercising coercion or violence.

Ratings

Dimension	Rating	Strip	Basis
Intent	Implied (2)	■■□□□	Ceiling applied under D3; the account alone cannot carry more
Capability	Moderate (3)	■■■□□	Physically capable; no weapons established; parties live apart
Threat level	**Low**		Matrix cell 3 × 2
R1 likelihood	2	■■□□□	
R1 consequence	3	■■■□□	Ceiling applied; gap recorded
R1	**Low**		Matrix cell L2 × C3. Confidence Low: the gaps recorded below could change the band
R2 consequence	5	■■■■■	The parties live apart, so housing is unaffected; no-notice conditions would suspend contact with a child and, through a workplace condition, affect employment — highest domain, child contact, Hard to unwind
R2 likelihood	4	■■■■□	If no-notice conditions restricting contact were imposed
R2	**Extreme**		
Classification	**Unresolved**	□□□□□ **U**	Principle 6. The material does not establish who, if either, is the person most in need of protection

Gaps recorded, with the check that would resolve each

Gap	Check that would produce a second layer	Owner	By when
No contemporaneous record of any incident	Produce message, email or call records for the stated dates	Applicant	Before first listing

Gap	Check that would produce a second layer	Owner	By when
Date and location inconsistency	Invite the applicant to address the difference; record the answer	Registry, at listing	First listing
No witness identified	Identify any person told at the time	Applicant	Before first listing
No medical evidence	Produce any medical or counselling record for the period	Applicant	Before first listing

Decision. Notified listing, option B. No condition restricting contact is imposed without notice. Expedited return date. The four gaps and their checks are on the face of the assessment, so the first listing has an agenda.

What this example is not. It is **not** a finding that the account is untrue, and the instrument does not make one. Many true accounts have exactly this evidentiary shape, because family violence characteristically occurs in private, without witnesses and without documentation, and because recollection of a traumatic event shifts over time in people with and without post-traumatic stress disorder alike. Delay in disclosure is common, well documented, and is not evidence of fabrication.

A fabricated account can also have this shape. **The instrument cannot tell the two apart, and its correct behaviour is to say so rather than to guess.** That is what the unresolved classification records. What it does instead of guessing is identify, in writing, the four checks that would move the matter in one direction or the other, and decline to impose the most restrictive option before they are run.

The contrast with example 1 is the point of including this one. There, four independent layers supported the most restrictive option available. Here, one contested layer supports a protective step at a notified listing and nothing more, and the reason is recorded. The current process, which has no criteria, produces no visible difference between these two matters at all.

B3.4 Example class 4 — unequivocal and multiply corroborated

Facts. An assault causing visible injury. The applicant made an audio recording during the incident which captures a threat to kill. Photographs of the injury were taken at hospital, and a hospital record was made the same night. A neighbour attended, saw part of the incident, and gave a statement to police that night. A police incident record was made. The respondent has no firearms licence. The respondent has identified alternative accommodation at a parent's address.

Evidence layers

#	Layer	Source grade	Claim grade	Goes to
1	Applicant's sworn first-hand account	C	2	The assault and the threat
2	Audio recording of the incident	A	1	The threat to kill, in the respondent's own words
3	Hospital record and photographs, same night	A	1	Injury, timing
4	Independent eyewitness statement to police	B	2	The assault
5	Police incident record made at the time	B	1	The whole account
6	Firearms check, run, **nil**	A	1	Capability

Layer count: five independent layers on the conduct, four of them graded A or B, from three sources that do not depend on one another. Under D4.2 the material supports the top

of the consequence scale. Under D4.3, an allegation of this seriousness with consequences of this gravity is exactly the case in which reasonable satisfaction is most readily reached, because the material does not rest on a single account.

Ratings

Dimension	Rating	Strip	Basis
Intent	Committed (4)	■■■■□	Recorded threat to kill; conduct carried through to injury
Capability	Developed (4)	■■■■□	Direct access to the person; no lethal means established
Threat level	**High**		Matrix cell 4 × 4
R1 likelihood	4	■■■■□	Within the notice window
R1 consequence	5	■■■■■	Threat to kill, corroborated; injury documented
R1	**Extreme**		Matrix cell L4 × C5
R2 consequence	2	■■□□□	Alternative accommodation identified; no licence effect; no dependent care disrupted
R2 likelihood	4	■■■■□	If exclusion imposed
R2	**Medium**		Matrix cell L4 × C2
Classification	Resolved	■■■■■	Established on multiple independent layers, not on demeanour

Options after controls

Option	Treatments applied	Residual R1	Residual R2	Selected
B	Notified listing, narrow conditions; no protective package can be verified before the respondent learns of the application	Extreme	Low	No — the notice window stays open with a recorded threat to kill and no verified package, so R1 remains outside tolerance
A or D	Without notice, exclusion, T11, T12, T13, T16, T19 safety plan, T20 expedited listing	Medium	Medium	**Yes**

Decision. Order without notice, with an exclusion condition and an expedited return. The respondent's identified alternative accommodation is recorded, which is what keeps R2 at Medium rather than Extreme.

Why option B fails the tolerance test. Under Appendix C8, High is inside tolerance only with a named protective package in place and verified. Under option B nothing can be verified before the notice event, because the notice event is the listing itself. The residual under B is therefore unchanged at Extreme — an unverified control is rated as failed (Appendix E1) — and Extreme is outside tolerance. Had a package been verifiable under B — a confirmed remote appearance and a confirmed safety plan before notice — the residual would have been High, B would have been inside tolerance, and R2 would then have selected between B and A.

What the record shows. That the most restrictive option was selected on five independent layers rather than on one, that the least restrictive alternative was tested and rejected on stated grounds, and that the R2 finding rests on a verified fact — the alternative address — rather than an assumption. Under Appendix E, if that address is not verified before service, the R2 rating is revised upward and the option is reconsidered.

B3.5 The calibration set, side by side

This is the table to read across. It is the reason the four examples exist.

	Ex 1 — acute, corroborated	Ex 2 — thin, uncorroborated	Ex 3 — retrospective, inconsistent	Ex 4 — unequivocal, corroborated
Independent layers on the conduct	2–4	1	1, internally contradicted	5
Best source grade	A	C	D	A
Intent	■■■■■ (5)	■■□□□ (2)	■■□□□ (2)	■■■■□ (4)
Capability	■■■■■ (5)	■■■□□ (3)	■■■□□ (3)	■■■■□ (4)
R1	Extreme	Medium	Low	Extreme
R2 if the most restrictive no-notice option	Extreme	Extreme	Extreme	Medium
Classification	Resolved	Not required	**Unresolved**	Resolved
Mode selected	Without notice	Notified	Notified	Without notice
What decided it	R1 Extreme, corroborated; R2 Extreme recorded but cannot defeat a Catastrophic R1	R2 Extreme, R1 controllable at B	One contested layer; gaps recorded	R1 Extreme, corroborated, **and** R2 Medium because an alternative exists

Examples 1 and 4 both carry an Extreme R1 and both proceed without notice. They differ on R2. In example 1 the no-notice exclusion produces an Extreme R2, and the record shows it was rated and set aside under the rule that R2 never defeats a properly made-out Catastrophic R1. In example 4 the same option produces a Medium R2, because an alternative address exists and is verified. The instrument records both, so a reviewer can see that the two orders were made on the same mode for different reasons.

Read the bottom row across. In each of the four, a different element decided the outcome, and in each the instrument records which one it was. That is the whole difference between this and a process with no criteria: not that it reaches different answers, but that it can say why.

A note on examples 3 and 4 together. They are included as a pair and should be read as one. Example 4 shows what the criteria do with a strong case: they make it obviously strong, quickly, on the record, and they do not let an R2 argument defeat it. Example 3 shows what they do with a case that cannot yet be assessed: they say so, name the checks, and decline the most restrictive option in the meantime. An instrument that could only do one of those two things would be worse than useless, because the two failures it would produce — under-protecting in case 4, over-restricting in case 3 — are the two failures the Territory's own fatality record contains.

Rule	Ex 1	Ex 2	Ex 3	Ex 4

B3.6 Calibration check

All four examples are checked against seven rules.

Rule	Ex 1	Ex 2	Ex 3	Ex 4
R1 and R2 were never averaged	✓	✓	✓	✓
Unknown was never scored as Low	✓	✓ Checks run and returned nil, recorded as nil	✓ Classification recorded as unresolved	✓
Layer count recorded before the consequence rating	✓	✓	✓	✓
A single or D-graded layer was not permitted to carry the top of a scale	Not applicable	✓	✓	Not applicable
Only **confirmed** controls were allowed to reduce consequence	✓	Not applicable	Not applicable	✓ Alternative address must be verified
The less restrictive package won once residual R1 was inside tolerance	Not applicable — no option brought R1 inside tolerance before firearms action was confirmed	✓	✓	Not applicable — B left R1 at Extreme, outside tolerance, because no package could be verified before notice
Every band was read from the matrix at Appendix C7, not assigned	✓ L5 × C5; L5 × C4	✓ L3 × C3; L4 × C5	✓ L2 × C3; L4 × C5	✓ L4 × C5; L4 × C2

B4. Stop and refer up

Do not improvise power.

Trigger	Required response
Imminent attack, self-harm, weapon at court, or unsafe disclosure	Use the emergency process now; record afterwards
Extreme, or unresolved Very high, residual R1, and no lawful option inside tolerance	Immediate judicial attention; lowest-R1 lawful option; shortest real review; record the residual acceptance
Home firearms established or reasonably open, and firearms action cannot be confirmed before notice or service	Refer to a judicial officer and to police. Do not rate T14 as working.
A protected address appears on any page that may be served	Stop release. Remove or redact. Verify the correct confidential form and service pack.
An unknown blocks intent, capability, consequence or service sequencing	Do not invent a cell. Obtain the fact, or apply a reversible safeguard with a fast review.
The package exceeds the Deputy Registrar's authority; a control has no owner or no proof; or remote or security capacity is unavailable	Refer to the authorised decision-maker. Rate the unavailable control as failed.

Trigger	Required response
Child care, exclusion, disability, housing, occupational firearms, or a family law interaction is unresolved	Obtain legal or judicial direction before finalising the package.

B5. Schedule of reforms this model assumes

Every item below is an assumption made for this working model. None is a statement of current law. Nothing here is hidden inside the form as though it were already the position.

#	Item	Current position	Why change	Principle preserved	Instrument to change
1	**A pre-listing structured assessment**	Section 47(1) fixes not later than two days between receipt of the application and the hearing of the interim order — the hearing at which the order is made, not one at which the respondent is heard. Practice Direction 1 of 2026 [3] lists interim applications before the Registrar no later than two business days after filing. Neither establishes this assessment or makes its completion a condition of issuing a date.	Create a filing-to-listing step that launches checks and records R1 and R2 without delaying urgent action or the statutory timetable	Sections 12, 21 and 47 unchanged. Emergency and after-hours routes remain open. The judicial officer still applies the statutory test.	Family Violence Act or Court Procedures Rules; PD 1/2026; registry standard operating procedure; approved forms
2	**Deputy Registrar listing-package authority**	Current law and PD 1/2026 do not confer an express authority to select options A to D at filing. The interim order and condition decisions remain judicial (ss 21, 36–39).	Authorise an administrative listing and safety package within defined limits, and require referral to a Magistrate for options A and D, novel conditions, out-of-tolerance residuals, and disputed authority	No new order-making power. Natural justice, ss 21 and 36–39, the balance of probabilities and judicial reasons remain controlling.	Court Procedures Rules; PD 1/2026; delegation or listing instrument; registry SOP
3	**Risk-based notification, service and attendance at first listing**	Section 47(3)–(4) requires post-hearing service steps but does not preclude earlier service. Service, operational notification and actual awareness are distinct. PD 1/2026 does not establish a consistent risk-based choice among these routes.	Standardise when options B or C may use formal service, operational notification or confirmed awareness; record the method and time; state whether the respondent is expected; and coordinate the route with firearms, address and precinct controls where residual R1 is High or below	Natural justice improves. No-notice remains available where necessary. Section 21 and safety paramountcy are not diluted.	PD 1/2026; registry and listings SOP; notification and service protocol; forms. Amend Part 4 or the Rules only if the chosen formal-service route requires it.
4	**Remote or separated appearance as a listed protective option**	PD 1/2026 [30]–[31] requires in-person attendance unless leave is granted. A remote witness room is operationally available but is not a default selectable package.	Make option C a standard risk-based listing option at filing, with capacity confirmed and a fail-safe if the link, the room or staffing fails	Fair participation and open justice remain. The Court retains control. HRA ss 21 and 28 proportionality is recorded.	PD 1/2026; remote appearance practice; Court Procedures Rules; registry SOP; facilities plan

#	Item	Current position	Why change	Principle preserved	Instrument to change
5	**Confirmed firearms action before service**	An interim order automatically suspends a firearms licence; the court or judicial officer **may** order seizure of the licence, firearms and ammunition (s 44). The Act does not make seizure before service automatic, and listing procedure does not guarantee the sequence.	Where home firearms access is established or reasonably open, require judicial direction and operational confirmation of registry or police action **before** the notice or service event, unless a Magistrate records another lawful course	The distinction between automatic suspension and discretionary seizure remains exact. Police powers, warrant requirements, reasons and work and sport consequences remain governed by law.	Section 44 if clarification is needed; judicial checklist or order; ACT Policing SOP; firearms registry protocol; PD 1/2026
6	**Occupational and club firearms workflow**	Current law suspends a licence on an interim order and permits seizure. It does not supply an employer, agency or club notification workflow. Occupational and sporting consequences differ.	Create a directed, need-to-know workflow keeping home, occupational and club access separate; record R2 before notice; verify who acted	No profiling from occupation or licence. Privacy and work rights limited only as lawfully justified. Only necessary recipients informed.	Information-sharing protocol; ACT Policing, registry, employer and club SOPs; judicial directions; HRA practice
7	**Redacted service sequencing**	The approved application form states it will be served, and directs contact details to a Notice of Address for Service and a Private and Confidential form that are not given to the respondent. Sections 17, 69 and 70D protect address handling; s 70E permits police service when the court directs.	Generate a verified redacted service pack; sequence police service after any required firearms action; and prohibit this risk instrument from entering the served pack	Personal service and fair notice remain. The respondent receives the allegations and the lawful order material, not protected addresses, operational intelligence or third-party check data.	Approved forms; registry SOP; service protocol; PD 1/2026; Court Procedures Rules
8	**Access, disclosure, retention and destruction of this instrument**	The approved forms state confidentiality boundaries for contact details. There is no settled rule for this instrument's criminal history, firearms, employment, child and risk-analysis content, because the instrument does not currently exist.	Define who may see the full instrument; what parties receive or may apply to inspect; the redaction and natural justice procedure; access audit; retention period; review copy; and secure destruction	Open justice, procedural fairness, privacy and section 69 address protection are balanced by a documented process. The instrument is neither automatically secret nor automatically served.	Court Procedures Rules; practice direction; registry records policy; information-sharing protocol; privacy impact assessment
9	**Parallel checks and the meaning of a nil result**	The current application form gathers history information from the applicant. This model assumes parallel criminal history, firearms, prior order, child protection and bail or corrections checks landing before listing. Authority, access and turnaround are not uniform.	Create lawful data connections, minimum necessary fields, audit trails and service levels. Define "not run" as Unknown, and "run, nil" as a recorded result and never as proof of safety.	Privacy, purpose limitation, accuracy, correction, natural justice, and the distinction between records and findings remain intact.	Information-sharing instrument; data-sharing agreements; registry and agency SOPs; privacy impact assessment
10	**A welfare and referral step at service**	No published requirement for welfare screening, a check or a referral at the point an order is served.	Create a documented step at the point of service (Chapter 16, Version A), with the stronger versions enabled by regulation	Does not limit s 36 paramountcy or s 37 least restriction.	Family Violence Act new Division 3.8; ACT Policing SOP; referral protocol

#	Item	Current position	Why change	Principle preserved	Instrument to change
11	**Published administrative statistics**	Court outcome data is treated as outside the freedom of information access regime because it is not administrative in nature.	Publish quarterly de-identified aggregate statistics on applications, interim orders including those made without notice, conditions, outcomes and timeliness	Privacy is protected by aggregation and suppression rules. Open justice is advanced.	Practice direction or regulation; courts publication policy
12	**Validation before deployment**	No published validation exists for any current ACT family violence risk instrument.	Measure and publish inter-rater reliability across roles, with a stated withdrawal trigger, before this instrument is used in general practice	An instrument that cannot fail cannot be validated.	Framework governance layer (Appendix A, Part 1)

Appendix C — Risk criteria

Status. Working model prepared as part of the analysis. Not approved, endorsed or issued by any ACT agency. Ratings produced using these criteria are assessments made to select protective measures. They are not findings and they do not bind any court.

Purpose. These are the written rules that Chapter 8 found missing from the current framework. They state how likelihood is scored, how consequence is scored, how the two combine, and what level of risk is acceptable. Without them, two people assessing the same facts can reach different conclusions and neither can be shown to be wrong.

C1. The two risks

Every assessment rates two risks separately. They are never averaged.

R1 — Harm. The risk that **a person who has used or may use family violence** *(source)* **commits family violence in any of the forms defined by section 8 of the *Family Violence Act 2016*** *(event)*, **causing physical, sexual, psychological, emotional or economic harm** *(consequence)* **to a protected person, a child or another affected person** *(person affected)*, **within the stated period**.

R2 — Hardship and rights limitation. The risk that **the order process, or the protective measures selected** *(source)*, **restricts housing, work, a licence, contact with children, liberty or reputation** *(event)*, **causing hardship or a limitation of rights beyond what is necessary to hold R1 within tolerance** *(consequence)*, **to the person being restricted or to a child in their care** *(person affected)*, **within the same period**.

R3 — Optional. A further distinct risk may be recorded where one exists — for example, a risk to a third party, to a worker, or to a person in the same household who is neither party. It is written in the same form.

C1.1 Writing the risk as a sentence

Every risk is written as one sentence naming five elements.

Element	What it names	R1	R2
Source	What could give rise to the event	The person who has used or may use family violence	The order process, or the protective measures selected
Event	What could happen	Family violence in any form defined by section 8	A restriction on housing, work, a licence, contact with children, liberty or reputation
Consequence	The harm that would follow	Physical, sexual, psychological, emotional or economic harm	Hardship or a rights limitation beyond what is necessary to hold R1 within tolerance
Person affected	Who bears it. In general risk practice this element is called the asset; here it is a person and is named as one	The protected person, a child, or another affected person	The person being restricted, or a child in their care
Period	The window the rating covers	The stated period, usually the notice window	The same period

The substitution rule. In an individual assessment the general sentence is rewritten with the particulars of the case in each slot, and it is the rewritten sentence that is rated. The generic form is never rated directly.

Worked examples, in the form that would appear on the instrument:

> **R1:** The risk that the respondent, who has a recorded history of non-fatal strangulation and threats to kill, commits further physical violence against the protected person, causing serious injury or death, in the period from service of the order until the exclusion condition and firearms seizure are confirmed operating.
>
> **R2:** The risk that the exclusion condition selected, applied to a respondent with no alternative accommodation and a licence condition affecting the respondent's employment, causes loss of housing and loss of work beyond what is necessary to hold R1 within tolerance, to the respondent and to the child in the respondent's care three nights a week, over the same period.

Both sentences can be rated. Neither could be rated if it were written as "strangulation" or "exclusion".

What this prevents. The most common error in practice is rating a topic rather than a risk. "Firearms", "separation", "mental health" and "substance use" are not risks. They are sources, or facts about a case. None of them states what could happen, to whom, or with what result, so none of them can carry a likelihood or a consequence rating. An assessor asked to rate "firearms" is being asked to rate a word.

C1.2 The decision rule

- **R1 sets the floor.** It determines how much protection is required.
- **R2 chooses among the options that meet the floor.** It never lowers the floor.
- **They are never combined into a single number.**

C2. The period

Every rating states the period it covers. A likelihood rating without a period is meaningless.

In a court listing context the period is the **notice window**: from the earliest time the respondent may learn of the application — by service, by operational notification, by a third party, or by any other means — until the selected protections are operating and verified.

In a service context the period is stated explicitly, and defaults to **the next 30 days** unless a different period is recorded.

C2.1 Service, notification and awareness are distinct

Three different events, recorded separately:

- **Formal service** — service in accordance with the Act.
- **Operational notification** — a telephone call, an email, or a message from an agency.
- **Actual awareness** — the person knows, however they came to know, including through a third party or a leak.

The notice window opens at the **earliest** of the three, not at formal service.

C3. Intent and capability

For R1, two dimensions are rated separately and then combined. Rating them separately prevents two frequent errors: treating strong intent with no means as equivalent to means with no expressed intent, and inferring intent from capability.

C3.0 Rate both for each form of violence in issue, not once in the abstract

This rule comes first because getting it wrong makes everything after it wrong.

Family violence under section 8 of the *Family Violence Act 2016* is not one behaviour. It is physical violence or abuse, sexual violence or abuse, emotional or psychological abuse, economic abuse, threatening behaviour, and coercion or other behaviour that controls or dominates a family member and causes them to fear for someone's safety or wellbeing. It expressly includes sexually coercive behaviour, damaging property, harming an animal, stalking, deprivation of liberty, and harmful use of or interference with technology. It includes causing a child to hear, witness or otherwise be exposed to any of it.

An assessor asked to rate "intent" and "capability" without being told intent to do what will rate physical violence, because that is what the words suggest in ordinary use. The result is an instrument that is blind to most of the Act it serves.

The rule. Identify which forms in section 8 are in issue on the facts. Rate intent and capability **separately for each form identified**. The R1 threat level is the **highest** level across the forms rated, and the record states which form produced it. Never average across forms.

Why the highest and not the average. A person may have advanced capability and committed intent in relation to economic abuse and undeveloped capability in relation to physical violence, or the reverse. Averaging returns a moderate rating that describes neither, and it selects the wrong control. Seizing a firearm does nothing about a joint account. Freezing a joint account does nothing about a person at the door. The control follows the form, so the form has to be visible in the rating.

What this looks like in practice. The table below is not a checklist of indicators. It states, for each group of forms, what kind of fact bears on intent, what kind of fact bears on capability, and what would count as evidence in the other direction.

Form in issue	What bears on **intent**	What bears on **capability**	Evidence pointing the other way
Physical or sexual violence	Prior use of force; threats; escalation on separation; statements about consequences; refusal to accept the relationship has ended	Physical access to the person; knowledge of whereabouts; transport; access to weapons, including firearms at home, at work or at a club, rated separately	Verified distance or barriers; compliance with earlier conditions over a sustained period
Economic abuse	Prior control of money, accounts, debt, documents or employment; statements about cutting someone off; use of money to secure compliance; conduct in property or child support proceedings	Present or prospective control of the other person's finances: joint or sole account signatory, control of a business or trust, employer of the other person, guarantor, holder of documents or credentials, ability to incur debt in their name, control of a benefit or payment	Continued voluntary financial support with no condition attached; separation of accounts already completed; transfer of documents or credentials back

Form in issue	What bears on **intent**	What bears on **capability**	Evidence pointing the other way
Emotional or psychological abuse; coercion and control	Pattern of degradation, isolation, monitoring or rule-setting over time; response to the other person exercising independence	Continuing channels of influence: contact with the person, with children, with family or community; standing in a shared community or faith setting; ability to affect the person's housing, work or immigration status	Sustained absence of contact by choice; verified respect for boundaries previously set
Threatening behaviour; stalking; deprivation of liberty	Content, frequency and specificity of threats; pursuit or locating behaviour; attempts to prevent departure	Knowledge of movements and routine; access to vehicles, keys, premises; proximity; time available	Verified relocation unknown to the person; no attempt to locate over a sustained period
Harmful use of, or interference with, technology	Prior monitoring, publication of images, impersonation, or use of devices to track or intimidate; statements about what is held	Access to accounts, devices, cloud storage, shared subscriptions, family plans, vehicle telematics or home automation; possession of images or credentials; technical skill; ability to reach the person's contacts	Verified credential resets and device handovers, confirmed by someone other than the person who held them
Systems abuse (a form of coercion, exercised through processes)	Pattern of applications, complaints, notifications or proceedings used to exhaust or punish; statements of that purpose; timing relative to the other party's steps	Standing to bring proceedings; resources, including legal representation and time; access to institutions willing to act; the other party's inability to respond	Withdrawal of unmeritorious steps; proportionate and timely conduct across a sustained period
Damaging property; harming an animal	Prior destruction or harm; threats directed at possessions or an animal; targeting of items of significance	Access to the property or the animal; opportunity	Care arrangements verified; property returned intact
Exposure of a child	Any of the above conducted where a child hears, witnesses or is exposed, or is used as a channel	Contact with or access to the child; ability to route conduct through handover, schooling or a parenting arrangement	Verified arrangements that separate the child from the conduct

C3.0.1 Evidence in the other direction is recorded, and it counts

The right-hand column above is not decoration. It exists because a scale that can only be pushed upward is not a scale.

The current ACT framework lists indicators of risk. It lists nothing that would count against a rating. An instrument built that way can produce a low rating only by finding nothing, never by finding the opposite, and those are different states. Principle 7 requires the difference to be visible: a check that was run and returned nothing is recorded as run, nil, and is not the same as a check that returned contrary evidence.

So where conduct in the period bears against intent for a given form, it is recorded against that form and taken into account in the rating. Continued voluntary financial support with no condition attached bears against intent for economic abuse. Sustained compliance with earlier conditions bears against intent for physical violence. Returning documents, credentials or devices bears against capability for technology-facilitated abuse.

Three limits on that, stated because the point is open to misuse.

First, support given on conditions is not evidence against economic abuse. It is economic abuse. Money used to secure compliance belongs in the intent column, not the counter-evidence column, and the assessor records which of the two it is and why.

Second, a form-specific finding is form-specific. Voluntary financial support says nothing about intent to commit physical violence, and must not be carried across. This is the same error as averaging, made one column at a time.

Third, a single instance is not a pattern in either direction. The Act is concerned with patterns over time, and so is this instrument. One payment is not a period of support, and one calm interaction is not sustained compliance.

C3.1 Intent

Rated on observable conduct within the period, **for each form of violence in issue** under C3.0. The labels below are generic; the facts that satisfy them differ by form, and the table at C3.0 states how.

Level	Label	Definition
U	Unknown	Information is missing, conflicting or too weak to judge. Unscored.
1	None	Adequate current checks identify no target, threat, preparation, approach or attempt. This is a statement about the checks, not a prediction.
2	Implied	Control, jealousy, monitoring, or distress at separation, without an explicit threat.
3	Expressed	A direct, indirect or conditional threat; anger at the application; a stated wish to confront.
4	Committed	Repeated threats; obsessive pursuit; planning or locating; refusal to accept separation.
5	Dedicated	A recent serious attack or attempt, or an explicit threat to kill with consequences accepted; the order or process treated as irrelevant.

C3.2 Capability

Rated on present or reasonably prospective means and opportunity within the period, **for each form of violence in issue** under C3.0. Capability for economic abuse is control over the other person's money; capability for technology-facilitated abuse is access to their accounts and devices; capability for physical violence is access to the person. They are rated separately and are not interchangeable.

Level	Label	Definition
U	Unknown	Access, opportunity, skill or barriers cannot be judged. Unscored.
1	Undeveloped	No practical means to reach the person in the period; strong verified barriers.
2	Emerging	Some ability or opportunity; distance, custody or other barriers materially limit it.
3	Moderate	Physically capable; knows whereabouts; has transport; weapons of opportunity available; barriers partial.
4	Developed	Direct access to the person or to relevant means; advanced relevant skill; few effective barriers.
5	Advanced	Ready access to lethal means and to the person, including firearms at home or at work; able to defeat barriers.

C3.3 The anti-profiling rule

The following are **not** intent and must not be rated as intent:

- a licence, occupation, qualification or training;
- a diagnosis, a disability, or a mental health history;
- distress, anger, agitation or crying;
- substance use;
- identity, culture, religion, sexuality or gender;
- the absence of an account from the person, where they have not been asked or have not been able to respond.

An ordinary household item is not a weapon capability. A firearms licence is capability, and only where access is established or reasonably open.

Capability is judged by the form. Being the other person's employer is capability for economic abuse and is not capability for physical violence. Holding the password to a shared account is capability for technology-facilitated abuse. Neither is evidence of intent to do anything, and neither may be rated as intent.

Occupational firearms access, home firearms access and sporting or club access are recorded and rated **separately**, because their consequences differ.

C3.4 The threat matrix

Intent and capability combine into a threat level.

Capability ↓ / Intent →	1 None	2 Implied	3 Expressed	4 Committed	5 Dedicated
5 Advanced	Low	Medium	High	Extreme	Extreme
4 Developed	Low	Medium	High	High	Extreme
3 Moderate	Negligible	Low	Medium	High	High
2 Emerging	Negligible	Negligible	Low	Medium	High
1 Undeveloped	Negligible	Negligible	Negligible	Low	Medium

One matrix per form. The matrix is applied once for each form of violence in issue. The R1 threat level is the highest cell reached across the forms, and the instrument records which form produced it, because that is what determines which control is required.

Hygiene rule. If either axis is unknown, do not select a cell. Either obtain the fact, or apply a reversible safeguard and set a short review. An unknown is never scored as low.

C4. Likelihood

Applies to both R1 and R2, over the stated period.

Level	Label	Meaning
U	Unknown	Cannot be judged on available information. Unscored.
1	Rare	Would require unusual conditions; strong verified barriers in place.
2	Unlikely	A credible path exists but is not expected; material barriers, with some doubt.
3	Possible	A plausible, supported path exists; a key fact or a key control is unclear.
4	Likely	A clear path and indicators are present; controls are weak.
5	Almost certain	Expected without prompt control, or already occurring; a threat conditioned on the court process, or escalation already in train.

C5. Consequence — R1

Harm to a protected person, a child, or another affected person.

Level	Label	Definition
1	Limited	Fear or transient distress; no physical contact; no disclosure of protected information.
2	Minor	Minor unwanted contact; distress not requiring treatment; a supporter frightened.
3	Major	Treated injury without admission to hospital; significant psychological harm; a child exposed; forced relocation; an address or school disclosed.
4	Severe	Serious injury, strangulation, injury by weapon, fracture, sexual assault, or abduction of a child; lifelong trauma; disclosure forcing a move.
5	Catastrophic	One or more deaths, including homicide-suicide or the death of a child; disclosure enabling a fatal or near-fatal attack.

C6. Consequence — R2

Avoidable hardship and rights limitation to the person being restricted, or a child in their care.

Rule: take the highest domain. Never average across domains.

Domain	1 Limited	2 Minor	3 Major	4 Severe	5 Hard to unwind
Housing	No change	A ready alternative exists	Must leave at short notice; alternative is disruptive	No identified housing; homelessness likely before the return date	Tenancy lost and not recoverable before the matter is heard; a dependent child affected
Work and income	No effect	Leave taken; no income lost	Duties or income reduced	Stand-down or dismissal likely	Irreversible loss of a job or sole income
Occupational authority	None held	Held, no work connection	Suspension; duties can be adjusted	Role ends, or disciplinary process triggered	Occupation or primary-production business cannot be restored quickly
Sporting or club authority	None held	No imminent event	A competition or season missed	Membership or authority terminated	Lengthy restoration process unrelated to the merits
Child contact	None due	One occasion missed	Contact suspended for the interim period	Child must move, or all contact stops	Stacked loss of schooling, care and contact
Movement	No restriction	Minor route limitation	A daily area excluded	A suburb, or the only residence, excluded	No practical place to live before the matter is heard
Standing and privacy	Private	Known within the family	Employer, school or professional body informed	Serious interim damage with no opportunity to answer	Correction at the return hearing cannot repair the damage

C6.1 Why level 5 is defined as irreversibility

Nothing on the R2 scale is death. The scales measure different things and must not be read as equivalent.

Level 5 on the R2 scale is defined as loss that cannot be unwound before the matter is heard. Reversibility is the property that matters for choosing between options: where two options provide the same protection, the one whose consequences can be undone should be preferred.

C7. The risk matrix

Applies separately to R1 and to R2.

Likelihood ↓ / Consequence →	1	2	3	4	5
5 Almost certain	Medium	High	Very high	Extreme	Extreme
4 Likely	Low	Medium	High	Very high	Extreme
3 Possible	Low	Low	Medium	High	High
2 Unlikely	Low	Low	Low	Medium	Medium
1 Rare	Low	Low	Low	Low	Low

C8. Tolerance

The tolerance statement is what makes a risk level mean something.

Residual R1	Default response
Extreme or Very high	Outside tolerance. Select the lawful option with the lowest residual R1. Refer immediately to the authorised decision-maker. Set the shortest available review. Take firearms and address action. Record the residual and who accepted it.
High	Inside tolerance only with a named protective package in place and verified. Where two or more packages bring R1 to High or below, R2 selects between them.
Medium or Low	The participatory option — both parties notified and heard — is the default, with proportionate precautions and address protection. Accept-and-monitor is available only at Low.

C8.1 The two-key rule

Where more than one risk is rated, the **higher band sets the response**, and **every risk above Medium is treated**. A high R2 does not reduce the response required by a high R1, and a low R2 does not excuse leaving a high R1 untreated.

C8.2 Escalation

An out-of-tolerance residual R1 may not be accepted at practitioner level. It is referred to the authorised decision-maker named in the governance layer.

C9. Critical flags

Certain factors set a floor. They are not predictors and they do not determine the outcome; they prevent a rating being set below a level the evidence does not support.

This list is the single source. Appendix A applies it (Part 4.5) and Appendix B Section G reproduces it without change. A factor that is not on this list does not set a floor, whatever tier it sits in at Appendix A.

Flags (12):

1. threat to kill;
2. non-fatal strangulation or pressure to the neck;
3. firearms access;
4. separation within three months;
5. stalking or persistent unwanted contact;
6. sexual violence;
7. escalation in frequency or severity;
8. pregnancy or an infant in the household;
9. suicidality of the person using violence;
10. a proven breach of a previous order;
11. coercive control;
12. threats to children.

Recorded violence towards people outside the family is a Tier 2 factor at Appendix A 4.3.2. It is recorded and it bears on capability and history. It is not a flag and sets no floor.

Floor rules:

- **Separation alone** triggers a review and a written reason. It does not set an automatic consequence or intent floor.
- **Any one of {threat to kill, strangulation, firearms access}**: R1 consequence is rated at 4 or above and intent at Expressed or above, unless reasons are recorded.
- **Two or more flags, or separation plus any other flag**: R1 consequence is rated at 4 or above; consider 5 where a threat to kill, strangulation or firearms access is among them; intent at Expressed or above, and at Committed or above where a threat to kill or strangulation is present, unless reasons are recorded.
- **There is no likelihood floor.** Likelihood remains a judgment on the evidence. The person's own risk rating at Appendix A 4.2.2 triggers a review and a written reason; it does not set a floor either.
- Any departure from a floor requires a recorded reason.

C10. Confidence

Every rating carries a confidence level and a one-line reason.

Level	When
High	Based on official records or independently corroborated material; the key facts are established; few material unknowns.
Medium	Based on a first-hand account that is internally consistent and partly corroborated; some material unknowns, none of which would change the band.
Low	Based on uncorroborated material, or material unknowns exist that could change the band.

Rule. A rating with low confidence requires either an action to obtain the missing information, with an owner and a time, or a reversible safeguard and a short review. It is not a settled conclusion.

C11. Recording unknowns

Every screening and assessment item is marked:

- **E — Established** on the material available;
- **O — Reasonably open** on the material available;
- **U — Unknown**.

There is no "no" box.

- A check that was not run is **Unknown**.
- A check that was run and returned nothing is recorded as **run, nil** — a result, not proof of safety.
- Absence of a record is not evidence of absence of conduct.
- The absence of an account from a person who has not been asked is not adverse to that person.

C12. What these criteria are not

They are not an actuarial instrument. They do not produce a probability.

They are decision criteria: written rules that make two assessors more likely to reach the same answer on the same facts, and that make any answer capable of being reviewed.

Their accuracy is an empirical question, and Chapter 15 sets out the validation program that would answer it. Until inter-rater reliability has been measured and published, these criteria — like the ones they replace — are untested.

Appendix D — Source reliability and claim credibility register

Status. Working model prepared as part of the analysis. Not approved, endorsed or issued by any ACT agency.

Purpose. To record, for every material claim, where it came from, how reliable that source is, how credible the claim is, what supports it, what contradicts it, and what check would resolve it.

The central rule. The reliability of a **source** and the credibility of a **claim** are separate judgments and are always recorded separately. A completely reliable source can report something implausible. An unreliable source can report something true and independently corroborated. Collapsing the two loses information that matters.

D1. Source reliability

Grade	Label	What it means
A	Completely reliable	An independently verified record. A court order, a conviction, a medical record, a forensic result, a system record with an audit trail.
B	Usually reliable	A contemporaneous official record. A police incident record, a case note made at the time, an agency file entry.
C	Fairly reliable	A sworn, first-hand, internally consistent account by a person with direct knowledge.
D	Not usually reliable	A source with a material inconsistency, or a demonstrated interest in the outcome.
E	Unreliable	Uncorroborated hearsay, or a source with known unreliability.
F	Cannot be judged	Insufficient information to grade the source.

D2. Claim credibility

Grade	Label	What it means
1	Confirmed	Confirmed by independent evidence.
2	Probably true	Consistent with other material from a separate source.
3	Plausible	Neither corroborated nor contradicted.
4	Doubtful	Contradicted by material from another source.
5	Improbable	Improbable on the material available.
6	Cannot be judged	Insufficient information to grade the claim.

D3. Rules of use

Never multiply the two grades. A "B2" is not a score. It is a pair of separate judgments recorded together. Combining them into a number destroys the distinction the register exists to preserve.

Both parties' accounts are graded on the same scale. The identity, sex, gender or role of a person does not affect the grade applied to their account.

Grade the claim, not the person. A person may make one claim graded 1 and another graded 4 in the same matter.

A D-to-F source, or a 4-to-6 claim, is not discarded. It is recorded, and it is available for later corroboration. But material of that grade cannot, by itself, support:

- an intent rating of Committed or Dedicated;
- an R1 consequence rating of Catastrophic; or
- a classification of who is exercising coercion or violence.

Consent without admission is not proof. An order made by consent without admission establishes that an order was made. It does not establish that the alleged conduct occurred.

An allegation is not a finding. The register records the status of every item: allegation, admission, conviction, court finding, direct observation, official record, or consent without admission.

Relaxed rules of evidence do not change the grading. Where a court may inform itself as it considers appropriate, the grading becomes more important, not less, because the grading is what preserves the difference between kinds of information.

D4. Corroboration layers, and the standard of satisfaction

The grades at D1 and D2 describe one item at a time. This section describes what happens when several items are put together, which is where most of the error in practice occurs.

D4.0 What this rule is not

This is not a corroboration requirement for making a family violence order, and nothing here should be read as one.

Family violence characteristically occurs in private, without witnesses and without documentation. That is why sections 13 and 13A of the *Family Violence Act 2016* set the balance of probabilities and provide that the Magistrates Court need not comply with the rules of evidence. Those provisions are appropriate to the subject matter, and a rule requiring corroboration would make a large proportion of genuine applications unprovable. Chapter 7 says so and this appendix does not disturb it.

What follows governs two narrower things:

1. what the **risk instrument** may rate at the top of its scales, and
2. what **reasons must be recorded** before the most restrictive options are selected, and in particular before a court proceeds without notice.

An order can be made on a single uncorroborated account. That is the law and it should remain the law. Whether the assessment supporting it may be rated Catastrophic, and whether the person may be removed from their home before they know an application exists, are different questions, and they are the questions this section answers.

D4.1 What counts as a layer

An **independent evidence layer** is a source of information that is not derived from, and does not depend on, another layer already counted.

Counts as a separate layer	Does not count as a separate layer
The person's own account	The same account repeated to a second, third or fourth person
A contemporaneous message, email or call record	A later summary of that record by someone who read it
A photograph of an injury, with metadata	A description of the photograph
A medical or hospital record made at the time	A referral letter reciting what the person said
An audio or video recording of the conduct	A transcript of that recording
An independent eyewitness with direct knowledge	A person repeating what the applicant told them, unless the fact of the complaint at that time is itself the point
A police incident record made at the time	A later police summary drawing on the same record
A system record — door access, vehicle telematics, banking, phone location	A party's assertion about what such a record would show
An admission by the other party	An inference from silence

The rule that is most often broken. One account repeated to three people is **one layer, not three**. A file that contains a police narrative, a service intake note and a case summary, each recording what the same person said on the same occasion, contains one layer. The appearance of consistency across a file is frequently the appearance of a single source copied forward.

A note about recent complaint. The fact that a person told someone at the time is real evidence and belongs in the register. It goes to the consistency of the account over time. It is not a second layer as to whether the conduct occurred, because its content is the same account.

D4.2 How many layers the rating requires

The number of independent layers required rises with what the rating will be used to do. This is a rule about the assessment, not about proof.

R1 consequence to be rated	Layers required	If not available
1–2	One layer, graded and recorded	—
3	One layer, plus the standard checks run and recorded, including nil results	—
4	Two independent layers, **or** one layer with recorded reasons why the second is not available and what check would produce it	Rate at 3 and record the gap, with the check and its owner
5 (catastrophic)	Two independent layers, at least one graded **A or B**	Rate at 4 and record the gap, with the check, its owner and a shortened return date

Proceeding without notice. Where the material consists of a single layer, and the option under consideration would remove a person from their home, suspend a licence they need to work, or interrupt their contact with a child before they know an application exists, the assessment records:

- that the material is a single layer, and its grades;

- what check would produce a second layer, who would do it, and how long it would take;
- why the protection sought cannot wait for a listing at which the respondent is notified; and
- the shortest return date the court can list.

None of those four defeats an application. They are the record of a decision for which the Act currently prescribes no content.

D4.3 Why: the standard of satisfaction

The reasoning is not invented here. It is the long-settled Australian position on what "the balance of probabilities" requires when the allegation is serious and the consequences are grave.

In *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362, Dixon J said:

> "Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal."

Three points about that passage matter here, and all three are frequently misstated.

It is not a third standard of proof. There is no standard between the balance of probabilities and beyond reasonable doubt. *Briginshaw* governs the **degree of satisfaction** required within the civil standard. An applicant is not required to prove more; the decision-maker is required to be more careful before being satisfied.

Section 13A does not displace it. Section 13A provides that the Magistrates Court need not comply with the rules of evidence. *Briginshaw* is not a rule of evidence. It is a proposition about when a tribunal may say it is satisfied. A court that may inform itself as it considers appropriate still has to reach reasonable satisfaction, and the seriousness of the allegation and the gravity of the consequences still bear on when it has done so. If anything the principle does more work where the rules of evidence are relaxed, not less, because fewer filters have operated before the material reaches the decision-maker.

It cuts both ways, and the second way is usually forgotten. The gravity of the consequences flowing from a finding is a consideration. In an application for a family violence order the consequences are grave in both directions. Refusing protection to a person in danger is a grave consequence. Removing a person from their home, suspending the licence they work under, and interrupting their contact with their children, on one side's material and before they know the application exists, is also a grave consequence. Chapter 4 records that 8 of the 13 deceased victims in the Territory's own fatality record had earlier been wrongly recorded as the predominant aggressor, and Chapters 9 and 10 record that the rate of that error has never been measured in either direction.

So the principle does not point towards making orders harder to obtain. It points towards the decision-maker being able to say what they were satisfied of, on what material, and why the more restrictive course was necessary. That is a record, not a threshold. Section 68 requires reasons to be recorded, but prescribes no content for them, and none has been published or counted.

D4.4 What the register does with a contradiction

Where two items from the same person conflict, both are recorded as separate rows and the conflict is recorded in the "what contradicts it" column of each.

An internal contradiction affects the **source** grade, under D1, because a material inconsistency is what grade D describes. It does not by itself make either claim false, and neither claim is deleted. A person may be mistaken about a date and correct about an assault, and a person under sustained fear frequently is: the research at Chapter 14 section 13.2 finds that recollection of a trauma shifts over time, in people with and without post-traumatic stress disorder alike, and that variation is the expected behaviour of memory rather than evidence of fabrication.

What the contradiction does require is that it be recorded and that the check which would resolve it be identified. A contradiction that nobody wrote down is the failure this register exists to prevent.

D5. The register

One row per material claim. Attach continuation sheets as needed. Four rows is the working minimum for a short assessment; there is no maximum.

ID	Claim and date	Source, date and status	Source grade (A–F)	Claim grade (1–6)	What supports it	What contradicts it	Gap, and the check that would resolve it	Check owner and by when
E1								
E2								
E3								
E4								

D5.1 The status field

Every source entry records one of:

- **allegation** — asserted, not tested;
- **admission** — accepted by the person it concerns;
- **conviction** — a criminal conviction, with the offence and date;
- **court finding** — a finding of fact by a court, with the proceeding;
- **direct observation** — observed by the person recording it;
- **official record** — a record made by an agency in the ordinary course;
- **consent without admission** — an order or agreement made without any admission of the alleged conduct.

D5.2 The overall protective triage line

At the foot of the register, a single line records the **predominant source grade** and the **predominant claim grade** relied on for the assessment.

This is a triage aid, not a finding. It exists so that anyone reviewing the assessment can see at a glance whether it rests on official records or on an untested account. It does not bind any hearing.

D6. Worked illustration

Constructed for illustration. No real matter is described.

ID	Claim	Source and status	Source	Claim	Supports	Contradicts	Gap and check
E1	Applicant was strangled on a stated date	Emergency department record with photographs, official record	A	1	Medical findings consistent with the account	—	None
E2	Respondent threatened to kill the applicant if the applicant attended court	Applicant's sworn account, first-hand, internally consistent, allegation	C	3	Consistent with E1 in timing	No independent record	Check phone records; owner and time recorded
E3	Respondent has firearms at the home address	Applicant's account, allegation	C	3	—	—	Firearms registry and licence check; owner and time recorded
E4	Respondent has no criminal history	Criminal history check, run, nil, official record	A	1	—	—	None. Recorded as run, nil. Not proof of no conduct.

Reading the illustration.

E1 is an A1 and can carry weight on its own.

E2 is a C3 — a first-hand sworn account, plausible, not corroborated. It is sufficient to trigger a check and to inform a protective decision, but it cannot by itself carry a Dedicated intent rating.

The claim grade attaches to the claim, not to the person (D3). Had the applicant's account of the strangulation been entered as its own row, it would be graded 2, because it is consistent with E1, a separate source. The threat has no second source yet, so it is a 3. Appendix B example B3.1, built on the same facts, records the account as a C2 because that table grades the account on the strangulation.

E3 is a C3 that is capable of being resolved by a check that takes minutes. Until the check is run, firearms access is recorded as **Unknown**, not as present and not as absent.

E4 is a nil result, correctly recorded as a result rather than as a blank, and correctly not treated as proof of safety.

Counting the layers, under D4.1. There are two independent layers on the strangulation allegation: the applicant's account, and the emergency department record with photographs, which is not derived from that account. One of the two is graded A. Under D4.2 that supports rating the R1 consequence at 5 if the other criteria are met.

There is **one** layer on the threat to kill: the applicant's account. E1 corroborates the strangulation, not the threat. Under D4.2 the threat alone would support a consequence rating of 4, with the gap recorded and the phone record check identified, its owner named and its time stated. A phone record, if produced, would be the second layer.

There is **one** layer on firearms access, and it is a claim the register itself shows can be resolved in minutes. Until it is, firearms access is Unknown and is not scored.

D7. Observations recorded but not rated

A designated section of the register records observations that cannot be tested — impressions of demeanour, manner, plausibility, or affect.

These are recorded because an experienced assessor's impression is information and suppressing it would lose something real.

They are subject to three rules:

1. They are recorded in the observations section, never in the claim register.
2. They do not contribute to any rating or classification.
3. They are visible to any person reviewing the assessment, so that a later reviewer can see what impression was formed and test it against what was subsequently established.

Chapter 9 sets out why demeanour must not contribute to a classification.

Appendix E — Control effectiveness test and treatment schedule

Status. Working model prepared as part of the analysis. Not approved, endorsed or issued by any ACT agency.

The rule this appendix implements. A protective measure counts only if someone has confirmed it is in place and operating. An unverified control is recorded as **failed**, not assumed.

E1. The seven-part control test

A control counts towards a residual risk rating only if all seven are satisfied.

#	Test	Question	If the answer is no
1	**Relevant**	Does it address the specific risk as written in the risk sentence?	Rate as not applicable; find a control that does.
2	**Authorised**	Does the person applying it have the power to do so?	Refer to the person who does. Do not improvise authority.
3	**Deliverable in time**	Will it be operating before the risk event, within the stated period?	Rate as failed. Select a control that can be delivered.
4	**Owned**	Is a named person responsible, with a time by which it must be operating?	Rate as failed until an owner is recorded.
5	**Verified**	Has someone confirmed it is operating?	Rate as failed. An assumption is not a control.
6	**Effective**	Is there a stated basis for believing it reduces this risk?	Record the assumption explicitly and reduce the confidence rating.
7	**Fail-safe**	Is there a stated response if it does not work?	Record one before relying on the control.

E1.1 The verification rule in practice

- An order is not a control until it has been served.
- A firearms licence suspension is not a control until the firearms have actually been removed.
- A referral is not a control until the person has been seen.
- A safety plan is not a control until the person has it and can use it.
- A remote appearance is not a control until the room, the link and the staffing are confirmed available on the day.
- A security presence is not a control until it is rostered.

Where verification is pending, the control is recorded as **assumed, unverified** and rated as failed for the purposes of the residual risk calculation. It is upgraded when verification is received, and the rating is revised.

E2. The treatment register

One row per control.

T-ID	Control	Risk addressed (R1 / R2 / R3)	Owner and role	Operating by (date and time)	Proof it is working	Verified?	Response if it fails

Rules.

- Every control has a T-ID that is copied into the option comparison and into the handover.
- "Proof it is working" must be something that can be checked — a confirmation received, a document sighted, a person spoken to — not a statement of intent.
- "Response if it fails" must name what happens and who does it.

E3. Standard treatment set

A defined list produces consistency. Where a treatment is not on the list, it is recorded with a description and added at the next framework review.

E3.1 Process and listing treatments

ID	Treatment	Main effect
T1	Proceed without notice, with the shortest available return	Removes the notice event as a trigger within the period
T2	Preserve rights at the return hearing	Bounds the period during which the person is unheard
T3	Respondent appears remotely	Removes proximity at the precinct
T4	Protected person appears remotely	Removes proximity at the precinct
T20	Expedited listing	Shortens the period of uncertainty for both parties

E3.2 Physical safety treatments

ID	Treatment	Main effect
T5	Security or sheriff presence	Deters and interrupts
T6	Safe room or separate waiting area	Removes contact while waiting
T7	Separate or staggered entry and departure	Removes contact on arrival and departure
T8	Screen or removal of sightline	Removes visual intimidation
T9	Escort or transport assistance	Covers the precinct boundary, where risk is highest

E3.3 Evidence and privacy treatments

ID	Treatment	Main effect
T10	No personal cross-examination by a party	Protects the person and the quality of the evidence
T11	Protection of address and contact details	Removes a locating means
T12	Redacted service pack	Prevents disclosure of protected information through the served documents
T13	Service by police, where directed	Controls the timing of the trigger event

E3.4 Capability reduction treatments

ID	Treatment	Main effect
T14	Home firearms action, confirmed	Lowers capability and consequence. Counts only when confirmed.
T15	Occupational or club firearms action	Lowers capability and consequence. Rate the R2 effect separately.

E3.5 Condition and support treatments

ID	Treatment	Main effect
T16	Narrowly drawn conditions	Reduces opportunity while limiting R2
T17	Prohibition on third-party and social media contact	Closes indirect routes
T18	Lawyer or support person	Improves participation and the quality of information
T19	Police or specialist service safety plan	Covers exposure outside the court process
T22	Welfare and referral step at service	Addresses acute risk at the point of notification
T23	Accompanied service in defined categories	Provides an accompanied response at service, and a clinical one where the category prescribed requires it

E3.6 Acceptance

ID	Treatment	When it may be used
T21	Accept and monitor	Only where residual R1 is Low. Requires a named acceptor and a review trigger.

Option	Controls applied (T-IDs) and owners	R1 after controls: L / C / band	R2 after controls: L / C / band	Inside R1 tolerance?	Limiting factor or unknown

E4. Option comparison

Options are rated after the controls each option carries. This is the analysis that section 37 of the *Family Violence Act* requires and that Chapter 8 found no instrument records.

Option	Controls applied (T-IDs) and owners	R1 after controls: L / C / band	R2 after controls: L / C / band	Inside R1 tolerance?	Limiting factor or unknown
A					
B					
C					
D					

The selection rule. Choose the option that brings residual R1 inside tolerance with the lowest residual R2. Record why the selected option was preferred and why each rejected option was rejected.

Where no option brings R1 inside tolerance, escalate to the authorised decision-maker. Do not select the least-bad option at practitioner level.

E5. Residual risk and acceptance

Field	Entry
Residual R1 after selected controls	Band, with likelihood and consequence
Residual R2 after selected controls	Band, with the highest domain named
Confidence	High / medium / low, with reason
Key remaining unknown	And the action to close it, with owner and time
Accepted by	Name and position
Review date or trigger	

Rules.

- Residual risk is stated in every assessment, including where it is Low.
- The acceptor must hold authority at the level the tolerance statement requires.
- An out-of-tolerance residual R1 may not be accepted at practitioner level.

E6. Handover

Where responsibility passes to another person or agency, a handover extract is produced containing only:

Field	Entry
T-ID and the risk it addresses	
Owner and the time by which it must be operating	
Proof that it is working	
Response if it fails	
Who has been told	

Field	Entry
Review trigger	

The full assessment is not transmitted with the handover. The handover extract contains what the receiving person needs to act, and no protected address or third-party check data.

E7. Review and re-rating triggers

Immediate reassessment is required on any of:

- a new threat;
- a breach, alleged or established;
- the appearance of a weapon or firearm, or new information about access;
- a failure of service, of disclosure, or of any control;
- separation, or a change in separation status;
- a court event, or a change in orders or conditions;
- a change in living arrangements or child arrangements;
- a material change in health, substance use or financial circumstances;
- new information that would change any grade in the source register;
- delay beyond the recorded review date.

On reassessment: preserve the prior record rather than overwriting it; record what changed; record who was informed and when.

Appendix F — Annual investment and results ledger

Status. Working template prepared as part of the analysis.

Purpose. To implement Recommendation 4 of Auditor-General Report 10 of 2024: comparable and informative reporting of how funds are used, and public performance reporting showing planned against actual performance with explanation of significant variations.

Publication. One document, at a stable location, on the same date each year, in both a readable report and a machine-readable file.

F1. The ledger table

One row per initiative, per financial year.

#	Field	Definition
1	Initiative name	As used in budget papers
2	Package	The announced package this initiative belongs to
3	Financial year	
4	Original budget	As appropriated
5	Revised budget	After any in-year adjustment
6	Estimated outcome	Where the year is not yet audited. Labelled as an estimate.
7	Actual expenditure	Audited. Blank until audited.
8	Variance	Revised budget less actual
9	Variance explanation	Required where variance exceeds 5 per cent or $100,000
10	Reprofiled	Amount, and the year it moved to
11	Lapsed or returned	Amount, and the reason
12	Funding source	ACT revenue / Safer Families Levy / Commonwealth / other, with amounts
13	Recipient	Named organisation, or the internal business unit
14	Cohort	Who the initiative is intended to serve
15	Output target	What was planned, with a number
16	Output achieved	What was delivered, with a number
17	Outcome target	What change was intended, with a measure and a number
18	Outcome achieved	What change was measured; or “not yet measurable” with a date and a method
19	Evaluation status	Not scheduled / scheduled with date / in progress / complete with link
20	Unit cost	Cost per participant, service event or result, with the denominator stated
21	**Double-count flag**	Whether this amount is also reported inside another row, and which row

F2. The double-count flag

This single field resolves most of the confusion described in Chapter 3.

Every row records one of:

- **Standalone** — not reported inside any other row.
- **Component of [row ID]** — this amount is included within the named package total.
- **Package total containing [row IDs]** — this row contains the named components.
- **Adjacent** — this amount is not part of the direct investment total and must not be added to it.

A reader can then see immediately which figures may be added.

F3. The “not yet measurable” convention

Outcomes take time. A ledger that requires an outcome figure in the first year will produce invented ones.

Rule. “Not yet measurable” is permitted, but only with:

- a date by which it will be measurable; and
- the method by which it will be measured.

An entry that has read “not yet measurable” for three consecutive years without a method is itself a reportable finding, and must be flagged in the summary.

F4. Summary tables published with the ledger

F4.1 Reconciliation of announcements

For every package announced in the year, and every package still running:

Package	Announced total	Period	New money	Continuing commitments	Components listed separately	May this be added to other packages?

F4.2 Source reconciliation

Source	Budgeted	Actual	Variance
ACT consolidated revenue			
Safer Families Levy			
Commonwealth agreement funding			
Other			
Total			

F4.3 Stage-of-response allocation

Replicating the classification the Auditor-General used, so the shift upstream can be tracked over time.

Stage	Amount	Share	Change on previous year	Five-year trend
Prevention				
Early intervention				
Crisis response				
Recovery				

Note. Initiatives may be counted in more than one category. The method used must be published, and must not change between years without an explanation and a restated prior year.

F4.4 Government and community sector split

	Amount	Share
Government activity		
Non-government and community sector activity		

F4.5 Cohort allocation

Where an initiative is directed at an identified cohort, the amount is reported by cohort. Where it is universal, it is reported as universal.

Cohort	Amount	Share	Reach (people served)	Unit cost
Universal				
Women and children				
Children and young people specifically				
Aboriginal and Torres Strait Islander people				
Culturally and linguistically diverse communities				
LGBTIQA+ people				
Men — victim support				
Men — behaviour change				
People with disability				
Older people				

Note on the male victim support row. Chapter 10 established that no separately costed male victim service line appears in the budget record, and that a 2021 official answer could not separate male victims from men seeking help about their own use of violence. Where the amount cannot be separately identified, the row records "not separately identified", which is itself the reportable finding.

F5. Worked illustration

Constructed for illustration. Figures are indicative only.

Field	Row 1	Row 2
Initiative	Frontline specialist services package	Crisis service core funding
Package	2026–27 Strategy package	2026–27 Strategy package
Year	2026–27	2026–27
Original budget	$10,400,000 (2026–27 appropriation; four-year announced total $44,200,000 recorded at F4.1)	$2,300,000 (2026–27 appropriation; four-year announced total $9,900,000 recorded at F4.1)
Revised budget		
Estimated outcome		
Actual expenditure		
Variance and explanation		
Reprofiled		
Funding source	ACT revenue and levy, amounts stated	As above
Recipient	Multiple, listed	Named provider

Field	Row 1	Row 2
Cohort	Victim-survivors	Victim-survivors
Output target		Crisis line staffed 24/7; target proportion of calls answered
Output achieved		Proportion of calls answered, by time of day
Outcome target		Reduction in time from first contact to safe accommodation
Outcome achieved		
Evaluation status		
Unit cost		Cost per crisis contact
Double-count flag	**Package total containing Row 2 and others**	**Component of Row 1**

The illustration makes the point of the flag. Reported without it, $44.2 million and $9.9 million appear as separate investments. With it, the relationship is visible on the face of the document.

It also makes the point of F6 rule 1. A row covers one financial year, so the original budget field carries that year's appropriation. The four-year announced total belongs in the reconciliation of announcements at F4.1, where its period is stated beside it. A four-year figure in a one-year row is the confusion the ledger exists to remove. The single-year figures above are illustrative splits of the announced totals, not published appropriations.

F6. Quality rules

1. **No figure is published without its period.**
2. **No package total is published in the same table as its components without the double-count flag.**
3. **An estimated outcome is always labelled as an estimate.**
4. **Where a measure changes definition between years, the prior year is restated and both are shown.**
5. **Every variance above the threshold carries an explanation, in plain language.**
6. **Every measure that moved in the wrong direction is listed in a single summary section, with an explanation.**

Rule 6 is what distinguishes an accountability document from a promotional one.

Appendix G — Draft legislative amendments

Status. Drafting proposals prepared as part of the analysis. They show intended effect and placement. They are **not** parliamentary drafting and would need to be settled by parliamentary counsel.

Verification. Section numbers and cross-references were checked on 3 September 2026 against the *Family Violence Act 2016* (ACT), republication 17, effective 1 July 2025. Check the ACT legislation register for later amendment before use.

Bracketed periods. Where a period appears in square brackets, the number is a placeholder: the drafting takes a position on whether a period should exist and on what it governs, and leaves its length to be settled with the agencies that would have to meet it. Nothing else in this appendix is provisional in that way.

G1. Family Violence Act 2016 — new Division 4.1B: Applications heard where the respondent has not been heard

Inserted in Part 4, after Division 4.1.

Drafting note on the division number: this division is numbered 4.1B because the Bill before the Assembly inserts a Division 4.1A of its own (clause 35 of the Family, Personal and Sexual Violence Legislation Amendment Bill 2025: a definition of presence in court, new section 44B); the division proposed here sits alongside it, and its section numbers 47A to 47D are unaffected. Chapter 19 §2.2; G9.

Drafting note: the lettered subsection numbers used in this appendix — (1A), (2A), (5A), (6A) and the like — are provisional. They preserve the numbering that Chapter 16 and the drafting notes cross-refer to, and would be regularised by Parliamentary Counsel in a Bill.

. . .

Division 4.1B — Applications heard where the respondent has not been heard

47A Structured risk assessment required before proceeding where respondent has not been heard

(1) This section applies if the Magistrates Court proposes to hear or determine an application for an interim order, or to make an interim order, in a proceeding in which the respondent has not been heard.

Note "Has not been heard" is used throughout this Division, and in sections 21A and 68A, rather than "in the absence of the respondent", because a respondent may be present and not heard, or absent and have filed material. The Act's own vocabulary of presence (see ss 25 (d), 29 (1)(b), 30 (c), 43 (1)(a), 66 (1)(b)) is directed at a different question.

(1A) If an application for an interim order is proposed to be heard or determined in a proceeding in which the respondent has not been heard, the registrar must ensure that a structured risk assessment and a corresponding risk management plan are prepared in relation to the application before it is listed.

Note Subsection (1A) is confined to applications proposed to be heard without the respondent having been heard. That is the volume on which the resourcing statement under section 47B (2)(b) and the cost estimate at Appendix P3 are calculated. An application listed for a hearing at which the respondent is expected to be heard is outside this section, though the registry may apply the instrument at Appendix B to it as a matter of practice.

(2) The court must not proceed in a proceeding in which the respondent has not been heard unless satisfied that —

(a) a structured risk assessment has been undertaken in relation to the conduct alleged in the application; and

(b) a corresponding risk management plan has been developed addressing the risks identified in the assessment.

(3) The risk assessment and the risk management plan must —

(a) be prepared in accordance with the approved framework, and be consistent with AS ISO 31000:2018 Risk management — Guidelines as in force from time to time; and

(b) identify, analyse and evaluate the risks having regard to —

(i) the likelihood and the consequences of the conduct alleged;

(ii) the reliability and the sufficiency of the information relied upon;

(iii) the procedural alternatives reasonably available, including hearing the application with the respondent present, whether in person or by audiovisual link; and

(iv) the potential adverse effects on the respondent, and on any child in the respondent's care, including hardship and limitation of rights.

(4) The risk management plan must include —

(a) the control measures proposed;

(b) consideration of the least restrictive means reasonably available of achieving the protection required; and

(c) arrangements for ongoing monitoring and reassessment.

(5) The court must record its satisfaction under subsection (2).

Note Section 68 requires the court to record the reasons for making the order. Section 68A states what those reasons must contain where the order is made in a proceeding in which the respondent has not been heard, including reference to the risk assessment and the risk management plan.

(6) This section does not apply so as to prevent or delay any action the court considers necessary to address a risk to the safety of a person that is **imminent**, in the sense that it cannot await completion of the assessment.

Note After-hours orders need no exception: an after-hours order is made under part 7 by a judicial officer and not by the Magistrates Court hearing an application for an interim order, so this section does not apply to one. The word "imminent" is doing the work here, and it is narrower than the section 21 test of necessity for safety; a provision excepting everything necessary for safety would except every case.

(7) If the court proceeds under subsection (6), the assessment and the plan must be completed as soon as practicable afterwards, and the reasons recorded under subsection (5) at that time.

(8) A failure to comply with this section does not of itself invalidate an interim order, but is a ground on which the respondent may seek review under section 87 as amended (see the amendment set out at 47D below).

. . .

Dictionary — new definitions

Inserted in the Dictionary to the Act, so that each term has one meaning wherever it is used. Placing them in section 47A as "In this section" definitions would not reach sections 21A and 68A, where both terms are also used.

approved framework means the family violence risk assessment and management framework approved under section [see G4].

person most in need of protection, of 2 people, means the person who is most in need of protection from family violence committed by the other, having regard to the pattern of behaviour between them rather than to any single incident, and to whether conduct by a person was resistive or protective or a response to violence used against them or a child.

Note The term is used at ss 21A, 47A and 68A. It is not currently defined in this Act and is imported from other jurisdictions, so it is defined here rather than left to practice.

. . .

47B Commencement of section 47A

Drafting note: in a Bill this provision belongs in the amending Act's commencement section, not in the principal Act. It is set out here so that the condition can be read with the section it conditions. It must expressly displace the Legislation Act 2001 *section 79 automatic commencement, or inaction will commence section 47A six months after notification and defeat the whole point of it. Section 79 is a determinative provision (*Legislation Act 2001*, ss 5 and 6), so it can be displaced only by express words; a provision that is merely inconsistent with it is not enough. The same applies to section 21A (7).*

(1) Section 47A commences on a day fixed by the Minister by written notice, and the *Legislation Act 2001*, section 79 is expressly displaced.

(2) The Minister must not fix a day under subsection (1) unless the Minister has presented to the Legislative Assembly a statement identifying —

(a) the registry and judicial resourcing provided for the purpose of section 47A;

(b) the annual volume of applications for interim orders proposed to be heard or determined in a proceeding in which the respondent has not been heard, on which that resourcing was calculated; and

(c) the assessment time per matter assumed in that calculation.

(3) The statement must be presented not less than 3 months before the day fixed.

. . .

Note on drafting. Subsections 47A (6) and (7) are the emergency saving. Subsection 47A (8) is deliberate: the purpose is to change practice, not to create a collateral ground for challenging orders that were correctly made. Subsection 47A (3)(b)(i) states the protective analysis first, so that the section cannot be read as directed only at the respondent's interests.

Section 47B is the reason this provision is safe to enact. Appendix P estimates that section 47A consumes about 1,150 hours a year of registry and judicial time. Chapter 13 section 5.3 and Appendix P8 establish what happens to a documentation obligation imposed on an unchanged workload: it is complied with formally and not substantively, producing worse decisions with better records. A commencement condition expressed in the Act, rather than an assurance recorded in a costing, is what prevents that outcome. It is drafted so that a government may decline this reform or fund it, and may not adopt it and leave the courts to absorb it.

G1A. Family Violence Act 2016 — new section 68A, new section 47C and amendment of section 87: reasons, expedited return and review where the respondent has not been heard

Section 47C is inserted in Division 4.1B after section 47A, so that Division 4.1B reads 47A, 47C. Section 68A is inserted after section 68. The amendment of section 87, set out at 47D below, belongs in the amending Act. Section 13YA at G9.3 is the counterpart of section 47C for the police-issued notice proposed in the Bill before the Assembly, and is drafted to the same form; the Bill's own section 44B would supply the audiovisual-link presence relied on in subsection (2B)(a).

Chapter 16 sections 4.2 and 4.3 set out the reasoning. Section 68 already requires a court to record the reasons for making a protection order, and the Dictionary defines protection order *to mean an interim order or a final order. Section 68A does not create the duty. It states what the duty requires in the one class of case where nobody is present to test the answer.*

. . .

68A Reasons — interim order made where respondent has not been heard

(1) This section applies if a court makes an interim order in a proceeding in which the respondent has not been heard.

(2) The reasons recorded under section 68 must state —

(a) the material the court relied on, and whether any of that material is from a source independent of the applicant's account;

(b) why the protection sought could not await a listing at which the respondent had an opportunity to be heard, whether in person or by audiovisual link;

(c) which less restrictive conditions were considered and why they were not sufficient to achieve the protection required; and

(d) whether the court is able, on the material before it, to identify which party is the person most in need of protection, and if it is not able to do so, that fact.

Note 1 For paragraph (a), an account given by one person and recorded by several people is one source (see the approved framework).

Note 2 Paragraph (a) does not require the court to be satisfied that the alleged conduct is corroborated, and does not prevent an order being made on a single uncorroborated account.

(2A) The reasons must be recorded before the order is served.

(3) The registrar must give the respondent a copy of the reasons recorded under section 68 when serving the order under section 70C.

(4) However, the copy given under subsection (3) must not include —

(a) the protected person's home or work address, or the address of a service, refuge or accommodation used by the protected person or a child, except to the extent that the address is included in the order under section 69 (1); or

(b) any other information that the court, on its own initiative or on application, considers would be likely to endanger the safety of the protected person, an affected child or any other person, or to identify a person who gave information to an agency.

Note Section 69 restricts the inclusion of the protected person's address in a family violence order. Subsection (4) applies the same protection, and a wider one, to the reasons.

(5) Where information is withheld under subsection (4), the copy given to the respondent must state that information has been withheld and the paragraph relied on, and the full reasons remain on the court record.

(5A) Subsections (4) and (5) —

(a) apply to the copy given to the respondent under subsection (3), and to any publication, extract or aggregation of the reasons; and

(b) do not limit a party's entitlement under the *Court Procedures Rules 2006*, rule 2903 as applied by rule 3802 (2)(s), to inspect or take a copy of a document filed in the registry in relation to the proceeding, other than a document or part of a document containing the affected person's home or work address or other information that could locate the affected person.

Note Rule 3802 (1) disapplies chapter 2 of the Rules to family violence proceedings. Rule 3802 (2)(s) then applies rule 2903, but only so far as it allows a party to inspect or copy a filed document, and only where the document does not include the affected person's home or work address or other locating information. A respondent can therefore already inspect and copy the filed material, minus address information. Subsection (5A) makes clear that this section operates on the copy of the reasons the registrar gives and on publication. It does not cut down the party's inspection right.

(6) A failure to comply with this section does not of itself invalidate an interim order, but is a ground of review under section 87 as amended (see 47D below).

Note Section 68 itself contains no provision about the effect of non-compliance, although sections 48 (3), 66 (4), 67 (4) and 109 (2) each contain one. That omission is left as it stands: section 68 (1) is triggered by the making of the order, so compliance cannot be a condition precedent to validity, and invalidating protection orders on a documentation ground would defeat the objects in sections 6 and 7.

. . .

Note on drafting — subsection (5A) and the Court Procedures Rules. The withholding scheme in subsections (4) and (5) was drafted against section 69, which protects the protected person's address in the order. It also has to be read against the *Court Procedures Rules 2006*. Rule 3802 (2)(s) already lets a party inspect and copy documents filed in the proceeding, other than the affected person's address or locating information, and rule 2903 (2)(m) restricts only **non-parties** from a document filed in support of an application made in the absence of a party. Two consequences follow. First, the material the court relied on is, in large part, already open to the respondent as a party; what subsection (4)(b) withholds from the **reasons** — matter that would endanger a person or identify an informant — is the narrower class the Rules do not already protect, and a court that withholds it from the reasons should consider whether a direction about the filed document is also needed. Second, subsection (5A) is expressed so that this section sits alongside rule 3802 (2)(s) rather than overriding it. A reasons provision that purported to narrow a party's inspection right would raise a fairness question this package has no reason to raise.

. . .

47C Expedited return where interim order made where respondent has not been heard

(1) This section applies if a court makes an interim order in a proceeding in which the respondent has not been heard.

(2) The respondent is entitled, on **one** request, to have the interim order listed before a magistrate not later than 2 business days after the request is made.

(2A) On a listing under subsection (2) the magistrate may, having heard both parties, confirm, amend or revoke the interim order, applying section 21.

(2B) The registrar must give the protected person notice of a listing under subsection (2) as soon as practicable, and the protected person is entitled —

(a) to appear by audiovisual link; and

(b) to one adjournment of not more than 7 days to obtain legal representation, during which the interim order continues in force.

(2C) The court may decline to list a matter under subsection (2) if satisfied that the protected person cannot reasonably be given a fair opportunity to be heard within the period, in which case the court must fix the earliest date on which they can.

(3) A request under subsection (2) does not suspend, vary or otherwise affect the operation of the interim order or any condition of it.

(4) This section does not displace anything required by section 47, and if a preliminary conference under section 47 (3), or a return of the application under section 47 (4), is listed for a day earlier than a listing under subsection (2), that day applies.

(4A) Nothing in this section permits the court to decide the application for a final order, and section 31 (Applications not to be decided until related charges finalised) is not affected.

Note 1 Section 47 (1) fixes the time for the hearing of the interim order. Sections 47 (3)(a) and 47 (4)(a) require the next listing to be set as soon as practicable and fix no maximum period.

Note 2 Section 91B gives an applicant whose interim order is refused by a registrar a review before a magistrate on request made the same day, with a return date not later than 2 days after the request is received, at which the matter is reheard anew, and s 91B (6) provides that the registrar need not tell the respondent about the hearing. Section 47C gives the respondent an equivalent period. It does not give the respondent a rehearing anew, and it does not dispense with notice to the protected person.

. . .

47D Amendment of section 87 (Review of special interim orders)

Drafting note: this is an amendment of an existing section and belongs in the amending Act, not as a section of the principal Act. It is set out here, with the number 47D, so that the references in sections 47A (8) and 68A (6) can be followed. In a Bill those references would read "section 87" and the amendment would appear in the schedule of amendments. Section 87 is amended, not replaced.

(1) Section 87 is amended so that a respondent may seek review of an **interim order** (whether a general interim order or a special interim order) made in a proceeding in which the respondent has not been heard.

(2) The grounds in section 87 are extended, for an order to which subsection (1) applies, to include a failure to comply with section 47A, section 68A or section 21A.

Note Without this amendment the non-invalidation provisions in sections 47A (8) and 68A (6) would point at remedies that do not exist. Section 92 confines appeals to final orders, and section 87 as it stands permits review only of a **special** interim order, by leave, on three grounds — the identity of the respondent, an administrative defect or error, and outstanding related charges. A general interim order made in a proceeding in which the respondent has not been heard, which is the case every provision in this Division addresses, attracts neither review nor appeal. Section 21A is included in subsection (2) because a failure to observe subsections 21A (3) or (3A) should be reviewable on the same footing, although section 21A carries no non-invalidation provision of its own.

. . .

Note on drafting — the safety provision is not optional. Section 68A (2)(a) requires the reasons to identify the material relied on, and section 68A (3) gives the respondent a copy. Without subsections (4) and (5) that combination would hand a respondent the applicant's address, the identity of a service that provided information, or the identity of a third party who reported. Section 69 protects the address in the *order* and says nothing about reasons, so the protection has to be written here. Subsection (5) exists so that withholding is visible on the face of the document rather than silent: a respondent who cannot see that something was removed cannot argue about whether it should have been, and a reasons document that can be silently emptied is worth no more than the section 68 duty it replaces.

Note on drafting — where section 47C sits in the Act's own scheme. The asymmetry this section addresses is Parliament's and is express. Section 91B gives the applicant a same-day request, a rehearing anew, a two-day return, and no obligation to notify the respondent. The respondent has section 82 (c), which permits an application to amend a protection order, but that application routes through a preliminary conference under section 82A listed "as soon as practicable" — and section 82B, the provisional amendment available without a conference, is open only to "the protected person, or the applicant". The urgent limb is one-way on the face of the Act. Section 47C supplies the missing limb. Subsections (2B) and (2C) exist because an expedited listing that the protected person attends unrepresented, without notice and four days after the incident is not a symmetry either, and drafting attention spent only on the respondent's side would be the strongest available evidence that this package is what its critics say it is.

Note on drafting. These two provisions are proposed together and are not severable. Recorded reasons are a mechanism for review; where no expedited review exists they are read by nobody in the window in which they would matter, and what an unreviewed reasons obligation produces is boilerplate. Section 68A (2)(d) is the provision that makes the classification capable of being measured: a court that has recorded that it cannot identify the person most in need of protection has created a record that can be checked against the outcome of the matter, and at present nothing on the file distinguishes a case in which the court was confident from one in which it was not. Section 68A (6) mirrors section 47A (8) for the same reason: the object is to change practice, not to generate collateral litigation about orders that were correctly made. Both point at section 87 as amended by the provision set out at 47D, which is the third element of Reform 3: without it neither provision has a remedy attached.

G2. Family Violence Act 2016 — new Division 3.8: Safety and support obligations

Inserted in Part 3, after Division 3.7. Drafting note on section numbers: the Bill before the Assembly inserts its own section 44B (clause 35, presence in court by audiovisual link or telephone), so these sections are numbered 44H to 44M to avoid the collision.

. . .

Division 3.8 — Safety and support obligations
44H Safety and support step on service of an order

(1) This section applies if an interim order, a final order or an after-hours order is served on a respondent.

(2) The person serving the order must, at the time of service —

(a) give the respondent written information, in plain language, about support services available to the respondent;

(b) ask the respondent the questions set out in the approved safety and support protocol;

(c) record the respondent's responses, and the person's observations of the respondent's apparent state;

(d) offer the respondent a referral to a support service, and record whether the offer was accepted; and

(e) if the responses or observations indicate an acute risk to the respondent's health or safety, take the action required by the approved safety and support protocol.

(3) The Territory must ensure that written information of the kind mentioned in subsection (2)(a) is also given to the protected person, and that a referral to a support service is offered to the protected person.

(4) A respondent or protected person may decline any support offered under this section.

(5) A failure to comply with this section does not affect the validity or the enforceability of an order.

44I Approved safety and support protocol

(1) The Minister may approve a safety and support protocol for this division.

(2) The protocol must specify —

(a) the questions to be asked under section 44H(2)(b);

(b) the action required under section 44H(2)(e);

(c) the information to be recorded, and the system in which it is to be recorded; and

(d) the training required of a person performing a function under this division.

44J Prescribed enhanced service arrangements

(1) A regulation may prescribe circumstances in which service of an order must be accompanied by a person with prescribed qualifications or training.

(2) Without limiting subsection (1), the circumstances that may be prescribed include circumstances in which —

(a) a risk assessment has identified a risk of self-harm by the respondent;

(b) the order includes a condition prohibiting the respondent from being at premises where the respondent lives;

(c) firearms are involved; or

(d) a risk assessment has identified prescribed health, disability or substance use factors.

44K Prescribed continuing support

A regulation may prescribe —

(a) support services to be made available, without charge, to a respondent or a protected person for the duration of an order;

(b) the preparation of a safety and support plan by a person with prescribed qualifications; and

(c) reporting arrangements in relation to a plan prescribed under paragraph (b).

44L Recording and reporting

(1) Information recorded under section 44H must be recorded in a form that permits aggregate reporting.

(2) The Minister must publish, at least annually, aggregate de-identified information about the operation of this division, including —

(a) the number of orders served;
(b) the proportion for which a record under section 44H was completed;
(c) the number of referrals offered and accepted; and
(d) the number of occasions on which action was taken under section 44H(2)(e).

44M Relationship with other provisions

(1) This division does not limit section 36 or section 37.

(2) If a provision of this division is inconsistent with the safety of a protected person or an affected child, the provision applies only to the extent that it is not inconsistent.

. . .

Note on drafting. Section 44H is the legislated minimum — Version A in Chapter 16. Sections 44J and 44K are enabling provisions, so that the stronger versions can be commenced by regulation without further primary legislation. Section 44L creates the data field that Chapter 11 shows does not currently exist.

G3. ANNEX — Family Violence Act 2016, amendment of section 43

This provision is not part of the reform package. It is drafted to show what an answer to the question in the annex to Chapter 16 would look like, not to propose that the answer be given. The evidence that would be required before it could be proposed — comparative law, charging data from jurisdictions without a blanket exemption, and a worked analysis of retaliatory-prosecution risk — has not been assembled here. Read it as a drafting exercise attached to an open question. Nothing in G1, G1A, G2, G4 to G8 or G9 depends on it. The question now has a second target: the Bill before the Assembly reproduces section 43(4) for police-issued family violence safety notices at new section 13ZC(3), in the same terms (Chapter 19 §2.4, item 8). Any answer given here would have to be given there too.

Existing subsections 43(1) to (3) would be retained. Subsection 43(4) would be repealed and replaced.

. . .

43 Offence — contravention of family violence order

(1)–(3) *[Existing provisions retained.]*

(4) Procuring a contravention

A person commits an offence if —

(a) the person aids, abets, counsels or procures, or is knowingly concerned in or a party to, conduct that contravenes a family violence order, including a condition of the order; and

(b) the person intends that the conduct will contravene the order, or is reckless as to whether the conduct will contravene the order.

Maximum penalty: 500 penalty units, imprisonment for 5 years or both.

(5) Subsection (4) applies to any person, including a protected person under the order and the applicant for the order.

(6) In deciding whether to prosecute a person for an offence against subsection (4), regard may be had to —

(a) the nature and seriousness of the contravention;
(b) the extent of the person's involvement;
(c) whether the person's conduct was intentional, reckless or inadvertent;
(d) whether the person was subject to coercion, control, intimidation or duress; and
(e) the safety and protection of the protected person and of any affected child.

(7) The Minister must review the operation of subsections (4) to (6) as soon as practicable after the end of 3 years from the day this section commences, and present a report of the review to the Legislative Assembly.

(8) The review under subsection (7) must include —

(a) the number of prosecutions commenced under subsection (4);
(b) the number of those prosecutions in which the defendant was a protected person under the order; and
(c) the outcome of each prosecution.

. . .

Note on drafting. The mental element in subsection (4)(b) is what protects a person who resumes contact without directing themselves to the order. Subsection (6)(d) is the express coercion consideration. Subsections (7) and (8) create the monitoring that would show, within three years, whether the provision is operating as its critics fear.

G4. Approval and alignment of the risk framework

Placement to be settled: either in the Family Violence Act 2016 *or in the* Domestic Violence Agencies Act 1986.

. . .

Approval of a family violence risk assessment and management framework

(1) The Minister may approve a family violence risk assessment and management framework.

(2) The framework must specify —

(a) the entities to which it applies;
(b) the responsibilities of each of those entities;
(c) the risk criteria to be applied, including the scales by which likelihood and consequence are assessed and the level of risk that is to be treated as acceptable;
(d) the arrangements for recording, monitoring, reviewing and reporting on risk; and
(e) the arrangements for evaluating the framework's operation.

(3) The Minister must not approve a framework for general application unless the results of validation of the instruments contained in the framework have been published, including —

(a) a measure of the consistency with which the instruments are applied by different assessors; and
(b) the level of consistency below which the instruments are not to be used.

Alignment by prescribed entities

(4) A prescribed entity must align its policies, procedures, practice guidance and tools to the approved framework.

(5) Alignment under subsection (4) must be achieved progressively, in accordance with the timetable published in the approved framework.

(6) A prescribed entity must report annually to the Minister on its alignment, and the Minister must present the reports to the Legislative Assembly.

Publication

(7) The approved framework, each validation result, and each annual alignment report must be published.

. . .

Note on drafting. Subsection (3) is the provision that distinguishes this proposal from legislating the current framework. A statutory alignment obligation attached to an unvalidated instrument would mandate consistency without accuracy.

G5. Publication of administrative statistics

By regulation, or by practice direction, whichever is the appropriate instrument.

. . .

Publication of statistics relating to protection orders

(1) The registrar must publish, at least quarterly, de-identified aggregate statistics in relation to protection orders, including —

(a) applications filed;
(b) interim orders sought, and interim orders made;
(c) interim orders made in a proceeding in which the respondent has not been heard;
(d) the recorded gender and age band of applicants and respondents;
(e) conditions imposed, by type, including conditions prohibiting a respondent from being at premises where the respondent lives;
(f) outcomes at final determination, by category;
(g) the median and 90th percentile time from filing to first listing, and from filing to final determination;
(h) applications to amend, revoke or extend an order, and the time from filing to first listing;
(i) charges for contravention of an order, and their outcomes; and
(j) the number of interim orders that ended at the first contested hearing because the order was discharged or revoked, or the application was withdrawn or dismissed, shown separately for each of those outcomes.

(2) Statistics published under subsection (1) must be published in a form that does not permit the identification of any person.

(3) Where a count is small enough that publication could permit identification, the registrar must publish a rolling multi-year total rather than suppressing the count.

. . .

Correction of the record where an order ends

(4) This subsection applies if an interim order is discharged or revoked, or the application on which it was made is withdrawn or dismissed.

(5) The registrar must, within [5] business days, give notice of the ending of the order to every agency that was notified of the making of the order, including the chief police officer and the registrar of firearms, and each agency must record the ending of the order in every system in which it recorded the order within [5] business days of receiving the notice.

(6) If a firearms licence was suspended under section 44 because of the order, the suspension ends when the order ends, and the registrar of firearms must record the licence as reinstated on receiving the notice under subsection (5), without an application by the licensee.

(7) Subsection (6) does not affect any other ground on which a licence may be suspended or cancelled under the *Firearms Act 1996*, and does not require the return of a firearm that is held on another lawful basis.

Note Subsections (4) to (7) are the correction-of-record and reinstatement requirements described at Chapter 16 section 6.3a. Whether they sit in the Act, a regulation or an administrative instrument is a placement question for parliamentary counsel; they are set out here because they belong with the publication obligation, and because subsection (1)(j) is the count that shows how often they operate.

. . .

Note on drafting. Subsection (3) addresses the problem identified in Chapter 10: suppression of counts below five protects individuals and makes whole cohorts invisible. A rolling multi-year total discloses less and reports more.

Note on drafting — subsections (1)(j) and (4) to (7). Chapter 16 section 6.3a describes three requirements: correction of the record through every system when an order is discharged, withdrawn or dismissed; administrative reinstatement of a firearms licence suspended under section 44; and publication of the count of orders ending that way at the first contested hearing. All three are drafted here. The bracketed periods in subsection (5) are placeholders for a period to be settled with the agencies concerned; the point is that a period exists and is stated. Subsection (6) is confined to a suspension that arose **because of the order**; it does not touch any other basis for a suspension. No compensation pathway is drafted, for the reason given at Chapter 16 section 6.3a: the rate and severity of the harm are unknown, and subsection (1)(j) is the measure that would begin to make them known. Section 13ZF at G9.6 applies subsections (4) to (7) to the police-issued notice proposed in the Bill before the Assembly, which carries no correction provision of its own; the two are drafted to the same bracketed period.

G6. Coronial and police data fields

Neither requires legislation. They are recorded here because they belong with these reforms.

ACT Suicide Register. A structured field recording whether the deceased was, at the time of death or within the preceding 12 months, subject to a family violence order or a personal protection order, whether as protected person or as respondent, and whether the order was interim or final.

Police records management system. A queryable status flag, set at the point an order is served, recording that the person is a respondent to an interim or final order, with the commencement date and the end date, and queryable against mortality and incident data.

G7. Cabinet requirement — whole-of-system business cases

Not a legislative amendment. A change to the Cabinet handbook requirement for business cases.

Before a material police, offence, court or service reform is approved, the business case must state:

1. the expected change in volume, by category, with the assumptions stated;
2. the expected flow-through to prosecution, contested hearing, conviction, custody and supervision;
3. the time cost per matter, in prosecution, defence, court sitting, registry and corrections terms;
4. the consequent funding requirement for each affected agency, by year;
5. the additional housing, health and community service demand generated; and
6. **the unfunded remainder** — where the model shows demand that will not be funded, the business case must state so and identify the agency or agencies expected to absorb it.

A business case that does not contain item 6, or that states the unfunded remainder as nil without a supporting model, is not to be considered.

G8. Family Violence Act 2016 — new section 21A: Reciprocal conditions where the court cannot identify the person most in need of protection

This provision is put as a question, not as a recommendation. Chapter 16 section 4.4 explains why it sits at a lower level of confidence than the other drafting in this appendix. Reciprocal conditions are not drafted as the **default** wherever a court proceeds in the absence of a respondent. The trigger is the court's own recorded inability to identify the person most in need of protection, the power is discretionary, the section cannot commence before its baseline is published, and it expires after 24 months unless the Legislative Assembly extends it.

. . .

21A Reciprocal conditions — court unable to identify person most in need of protection

(1) This section applies if a court proposes to make an interim order under section 21 in a proceeding in which the respondent has not been heard and the court is satisfied that it is **not able, on the material before it, to identify which party is the person most in need of protection**.

(1A) For subsection (1) —

(a) the fact that the material identifies conduct by each party that would, if established, constitute family violence does not of itself mean that the court is not able to identify the person most in need of protection; and

(b) the court must disregard conduct that appears to have been resistive or protective, or a response to violence used against the person or a child.

Note 1 The matter in subsection (1) must in any event be recorded in the reasons for the order (see s 68A (2)(d)). This section is engaged by the court's satisfaction of the matter and not by the recording of it, so that it can operate at the time the order is made.

Note 2 Subsection (1A) exists because a protected person's own candid account of resistive force would otherwise engage this section. That would make honest disclosure the trigger for conditions against the person disclosing.

(1B) This section does not impose a condition on an applicant who is not the protected person.

Note Compare s 69 (2). A police officer may apply for a protection order for an affected person (s 16B), and under pt 8 the applicant may be a stated police officer (s 113 (c)). Without this subsection, this section would purport to impose conditions on the investigating officer. The operative subsections of this section therefore refer to the **protected person** throughout, and the word "applicant" is used only in subsection (8), where it means the applicant on the order.

(2) The court **may** include in the order conditions that apply to the protected person that are equivalent, so far as practicable, to the non-contact and non-violence conditions that apply to the respondent.

Note The structured risk assessment and risk management plan under division 4.1A are material to which the court may have regard.

(3) If the court includes conditions under subsection (2), it must record its reasons for doing so, and those reasons form part of the reasons recorded under section 68. **No reasons are required for not including conditions under subsection (2).**

Note Requiring reasons for either course would make the one-way order the more onerous entry to complete, which would make the reciprocal order the path of least resistance and invert the default this section is intended to preserve.

(3A) Conditions may be included under subsection (2) only by a magistrate.

(4) For subsection (2), the court is **not required to be satisfied** of the matters in section 21 in relation to the protected person. Conditions included under subsection (2) are included because the court is satisfied of the matter mentioned in subsection (1), and are not a finding about either party.

(5) Conditions included under subsection (2) end at the earlier of —

(a) the first return of the application at which both parties have had the opportunity to be heard; and

(b) the day the interim order ends.

(6) Conditions included under subsection (2), of themselves —

(a) do not suspend or cancel a firearms licence held by the protected person, and section 44 does not apply to the protected person because of them;

(b) are not a finding that the protected person has committed family violence;

(c) are not a family violence order made against the protected person for the purposes of any other Territory law, or of any employment screening, licensing, registration or working-with-children scheme; and

(d) are not disclosable as an adverse record in relation to the protected person.

(6A) For section 43 only, a protected person to whom conditions included under subsection (2) apply is taken to be a person against whom the family violence order is made, and is taken to have been present when the order was made.

Note Subsection (6A) is required and cannot be omitted. Section 43 (1) applies to "a person against whom a family violence order is made" who was present when it was made or has been personally served; presence is the second half of a two-part test, not the operative element. Subsection (6) deems the conditions **not** to be an order made against the protected person for other purposes, so without subsection (6A) the conditions would carry no offence at all and would be a request rather than a protection.

(6B) Subsection (6A) does not make the protected person a respondent for any other provision of this Act, and in particular does not engage sections 44, 47 (3)(b), 47 (4)(b), 66, 70C or part 9.

(7) This section commences on a day fixed by the Minister by written notice, the *Legislation Act 2001*, section 79 is expressly displaced, and the Minister must not fix a day unless the Minister has published —

(a) a baseline of the measures in subsection (8), for the 2 years before commencement;

(b) the method by which those measures will be reported, including the characteristics of applicants by which the measure in subsection (8)(f) will be reported; and

(c) the percentage fall that is to be the threshold for subsection (9), and the period over which it is to be assessed.

Note Subsection (7) is a commencement provision and, like section 47B, belongs in the amending Act. It is set out here so that the condition can be read with the section it conditions. Section 79 of the *Legislation Act 2001* is a determinative provision (ss 5 and 6) and must be displaced by express words; see the drafting note to section 47B.

(8) The measures are —

(a) the number of applications for interim orders, and the number heard or determined in a proceeding in which the respondent has not been heard;

(b) the number of applications withdrawn before the first return;

(c) the proportion of interim orders made in a proceeding in which the respondent has not been heard in which the court recorded under section 68A (2)(d) that it was able to identify the person most in need of protection, and the proportion in which it recorded that it was not;

(d) of the orders in the second of those proportions, the proportion in which conditions were included under subsection (2);

(e) charges under section 43 for contravention, identifying whether the defendant was the protected person or the respondent on the order; and

(f) the composition of applicants by sex, by Aboriginal and Torres Strait Islander status, and by the other characteristics stated in the method published under paragraph (7)(b).

(9) This section expires at the end of the day on which a report under subsection (10) is presented to the Legislative Assembly, if the report finds either —

(a) a fall in applications for interim orders against the published baseline that equals or exceeds the threshold published under subsection (7)(c); or

(b) a fall equalling or exceeding that threshold in applications by a cohort identified in the most recent report under the *Domestic Violence Agencies Act 1986* as vulnerable to being misidentified as a person using violence.

(9A) The threshold published under subsection (7)(c) must be expressed as a percentage fall, must state the period over which it is measured, and must be accompanied by a statement of the smallest fall the published measures are capable of detecting in each cohort.

Note Expiry operates by force of the section on a finding in a tabled report, rather than by giving the Minister power to repeal a section of an Act by notifiable instrument. The threshold is published under subsection (7)(c) and subsection (9) refers back to it; neither subsection now points at the other for something it does not contain. Subsection (9A) exists because a cohort of a few dozen applicants a year cannot support the detection of a modest deterrent effect over 18 months, and a safeguard that cannot see the harm it exists to detect is not a safeguard.

(10) The Minister must review the operation of this section as soon as practicable after the end of 18 months from the day it commences, report against each measure in subsection (8), and present the report to the Legislative Assembly.

(11) This section expires 24 months after the day it commences, unless before that day the Legislative Assembly resolves, on a report under subsection (10), that it continue in force.

. . .

Note on drafting — what changed, and why.

Subsection (1) is a discretion, not a default. Reciprocal conditions are not drafted as a mandatory default in every matter heard in the absence of a respondent, rebuttable on recorded reasons, because two objections at Chapter 16 section 4.7 could not be answered from anything in the ACT record, and one of them — that a default may deter people from applying at all — falls hardest on the cohorts the Territory's own death review identifies as most exposed to misclassification. A default that carries an unquantifiable risk to those people is not defensible merely because it is rebuttable, because the rebuttal happens after the person has decided whether to apply. Tying the power to the court's own recorded uncertainty confines it to the class of case in which a symmetrical response is coherent, and leaves every other case exactly as it is now.

Subsection (1) is drafted to avoid a circularity. An earlier formulation triggered this section on a record made under section 68A (2)(d). Reasons are recorded for an order that has been made, and reciprocal conditions are conditions *of* that order, so a trigger expressed that way could not operate at the moment it needs to. The trigger is therefore the court's satisfaction of the matter, and the recording obligation runs alongside it.

Subsection (4) is what makes the provision possible at all. Without it a court could not include the conditions, because section 21 requires satisfaction that an order is necessary and the court has no tested material about the applicant.

Subsection (6) determines whether this provision protects people or penalises them. Without the carve-out, a protected person caught by it would acquire a suspended firearms licence and a disclosable adverse record. What is deliberately **not** carved out is section 43: contravening a reciprocal condition is an offence, and that is what makes it a protection rather than a request. **Subsection (6A) is what delivers that, and it cannot be dropped as surplusage** — see the note below.

Subsections (7), (9), (10) and (11) are the terms on which the question is put. Subsection (7) makes commencement impossible until the baseline exists, so that the deterrence objection can be measured rather than argued. Subsection (9) is a withdrawal trigger of the same

kind proposed for the risk framework at Appendix O. Subsection (11) makes expiry the default outcome: continuation requires an affirmative decision of the Assembly on a published report, which is the opposite of the position a novel provision usually occupies.

A consequence for section 43(4), its source, and its limits. It might be thought that no amendment to section 43 is needed, because a protected person bound by a reciprocal condition would commit a primary contravention under section 43(2) and be caught by section 43(1)(a) as a person present when the order was made. **That does not work.** Section 43(1) applies to "a person against whom a family violence order is made" who was present or was served; presence is the second limb of the test, and the first fails, because the order is made against the respondent — a point subsection (6) reinforces by deeming the conditions not to be an order made against the protected person for other purposes. Without subsection (6A) the reciprocal limb would carry no offence at all.

With subsection (6A), conduct by the protected person that breaches a reciprocal condition is a primary contravention under section 43(2), and section 43(4) is not engaged because it immunises complicity in another person's contravention rather than a person's own. That operates only in the cases to which subsection (1) applies, never reaches the inducement of a breach of an asymmetric condition such as an exclusion, and lasts only for the 24 months of the trial. The mischief at G3 is not substantially answered by this route, and the annex question at Chapter 16 stands very largely as it did. See Chapter 16 section 4.6a.

G9. Amendments proposed to the two bills before the Assembly

Status. Drafted against the bills as presented — the Family, Personal and Sexual Violence Legislation Amendment Bill 2025 (J2025-163) and the Crimes (Coercive Control) Amendment Bill 2026 (J2025-1308) — not against any amendments the government may move. Section numbers for the first Bill are the new sections of the *Family Violence Act 2016* inserted by clause 46 of that Bill; section numbers for the second are the new sections of the *Crimes Act 1900* inserted by sections 5 and 6 of that Bill. Chapter 19 sets out the reasoning. The Explanatory Statement for the second Bill (presented 28 May 2026, cited as "CC ES") was read in full; it does not address the investigation or charging stage, the reason for the two-year commencement, the reason for the committee's expiry, or the content of the review, so nothing in Part B is inconsistent with it and nothing in it answers Part B. Like G1 to G8, these are drafting proposals showing intended effect and placement, and would need to be settled by parliamentary counsel.

Drafting note on numbering: the first Bill inserts its own Division 4.1A into Part 4 of the Family Violence Act (clause 35, new section 44B). The division proposed at G1 is therefore renumbered Division 4.1B; its section numbers 47A to 47D are unaffected, and the Bill's section 44B is relied on at G9.3 (3)(a). "Has not been heard" is used below, as throughout this appendix, for the position of a party who has not had an opportunity to answer.

Part A — Family, Personal and Sexual Violence Legislation Amendment Bill 2025, new Part 2A

G9.1 Structured assessment before issue — new sections 13H (2A) and 13HA

Inserted after section 13H (2). Section 13E (2)(c) is amended so that the application carries the assessment as far as the applicant police officer has completed it. Chapter 19 §2.9, item one. This is the police-notice counterpart of section 47A at G1, and section 13HA (2) is the counterpart of the commencement condition at section 47B.

13H Senior police officer may issue family violence safety notice

(2A) In deciding whether to issue a family violence safety notice, the issuing police officer must complete, or be satisfied that the applicant police officer has completed, a structured

assessment of the risk of family violence in the form approved under section 13HA, and must record in the assessment —

(a) for each matter in subsection (2), whether the matter was considered and whether the information relied on was established, reasonably open, or not able to be obtained in the circumstances; and

(b) whether the officer was able, on the information available, to identify which of the parties is the person most in need of protection, and if not, that fact.

Note 1 "Person most in need of protection" has the meaning given in the Dictionary (see G1). "Not able to be obtained" is a recorded state, not an absence: see Chapter 14, Principle 3.

Note 2 Subsection (2A) does not alter the grounds in section 13B or the standard in subsection (1)(b). It requires the matters the Bill already lists to be recorded in a form that states what was known, what was not, and whether the classification could be made.

13HA Approved assessment form

(1) The Minister must approve a form for section 13H (2A) that is consistent with the family violence risk assessment and management framework approved under this Act.

Note If G4 is not enacted, the reference is to the framework published by the Territory from time to time.

(2) The Minister must not approve a form under subsection (1) unless the Minister has presented to the Legislative Assembly a statement identifying the training and resourcing provided to police officers for its use and the annual volume of applications on which that resourcing was calculated.

(3) Section 13H (2A) does not apply until a form has been approved under subsection (1).

13E Application for family violence safety notice — subsection (2)(c) substituted:

(c) information about the matters in section 13D (2), and the assessment under section 13H (2A) so far as it has been completed by the applicant police officer, as far as is reasonably practicable; and

Note on drafting. Subsection 13HA (2) is the resourcing condition. It is expressed as a condition on approval of the form rather than on commencement of the Part, because the Bill commences Part 2A at six months by clause 2 (2) and the form is the only instrument the Minister must make. The effect is the same as section 47B: the government may decline the assessment or fund it, and may not adopt it and leave police to absorb it. Subsection (3) means that until the form exists the Bill operates as drafted.

G9.2 Content of the issue record, and where it goes — section 13H (3) substituted; sections 13M and 13T (1) amended

Chapter 19 §2.4, items 2, 4 and 5; §2.9, item two. Section 13N (1)(e) already prescribes content for a refusal. This gives the decision to issue the same discipline and routes the record to the court and the respondent.

13H (3) substituted:

(3) The issuing police officer must make a written record of —

(a) the matters considered under subsection (2) and the assessment under subsection (2A); and

(b) the information relied on in deciding that each ground in section 13B is satisfied, and whether any of that information came from a source other than the affected person's account; and

(c) why a family violence safety notice was immediately necessary rather than an application to the Magistrates Court for an interim order; and

(d) each less restrictive condition considered under section 13P and why it was not sufficient; and

(e) if an exclusion condition is included — the matters considered under section 13R.

Note For paragraph (b), an account given by one person and recorded by several people is one source (see G1A, section 68A, Note 1, and Appendix D4.1).

13M Family violence safety notice to be given to Magistrates Court — paragraph (a) substituted:

(a) give a copy of the family violence safety notice, the application under section 13E and the record under section 13H (3) to the registrar of the Magistrates Court within 1 business day after the notice is served on the respondent; and

13T Service of family violence safety notice — subsection (1) substituted:

(1) A family violence safety notice must be personally served on the respondent as soon as practicable by a police officer, together with a copy of the record under section 13H (3).

(1A) The copy given under subsection (1) must not include the protected person's home, work or accommodation address, or any information the issuing police officer is satisfied would be likely to endanger a person or identify a person who provided information, but must state that information has been withheld and under which limb of this subsection.

(1B) A failure to comply with subsection (1) so far as it relates to the record under section 13H (3), or with subsection (1A), does not affect the validity of the family violence safety notice, but may be taken into account by the Magistrates Court on an application under section 13Y or a review under section 13YA.

Note on drafting. Subsection (1A) follows section 68A (4) and (5) at G1A: withholding must be visible on the face of the document. Subsection (1B) is the validity saving the Bill already uses at sections 13T (5) and 13U (3), extended to the new material, for the reason given at Chapter 16 §3.3 — the object is to change what the court and the respondent can read, not to create a ground for setting aside notices that were correctly issued.

G9.3 Expedited review on the respondent's request — new section 13YA; section 13U (1)(c) amended

Inserted after section 13Y. Chapter 19 §2.4, item 3; §2.9, item three. This is the police-notice counterpart of section 47C at G1A and matches the period section 91B gives an applicant. The protected person is written in.

13YA Expedited review of family violence safety notice on request of respondent

(1) A respondent who has been served with a family violence safety notice may, once, request in writing that the notice be reviewed by a magistrate.

(2) A request may be given to the registrar of the Magistrates Court, or to a police officer, who must forward it to the registrar on the day it is received.

(3) On receiving a request the registrar must —

(a) list the review before a magistrate not later than 2 business days after the day the request is received, at which the protected person and the issuing police officer may appear in person or, under section 44B, by audiovisual link or telephone; and

(b) give the protected person and the issuing police officer notice of the listing as soon as practicable.

(4) The protected person is entitled, on request, to one adjournment of not more than 7 days to obtain legal representation, during which the family violence safety notice continues in force.

(5) On the review the magistrate may confirm the notice, or amend or revoke it under section 13Z or 13ZB, and must record whether, on the material before the court, the grounds in section 13B were satisfied when the notice was issued.

(6) Section 13Y (3)(b) does not apply to a review under this section.

(7) A request under this section does not suspend, vary or otherwise affect the operation of the family violence safety notice, which continues in force until the review is decided or the notice expires.

(8) The court may decline to list a review within the period in subsection (3)(a) if satisfied that the protected person cannot reasonably be given a fair opportunity to be heard within it, in which case the court must fix the earliest day on which they can.

Note Section 13Y (3)(a) requires a return "as soon as practicable" before the notice expires and section 13Y (3)(b) requires dismissal where no return date is available. This section gives the respondent one fixed period and disapplies the dismissal rule for that one listing. Section 13Y is otherwise unaffected.

13U (1)(c) substituted:

(c) how the respondent may apply to the Magistrates Court to have the family violence safety notice amended or revoked, including the right to request an expedited review under section 13YA.

Note on drafting. Subsection (5) records the answer to the question sections 13Z and 13ZB do not ask — whether the grounds were satisfied at issue. That record is what section 13ZF at G9.6 and the data series at G9.4 depend on. Subsections (4) and (8) follow section 47C (2B) and (2C): a review the protected person attends unrepresented and without notice is not a symmetry either.

G9.4 Six-monthly data and content for the review — new section 156 (1A) and (1B)

Inserted into section 156 as substituted by clause 40. Chapter 19 §2.4, item 10; §2.9, item four. The list is built on the Victims of Crime Commissioner's three items [2.87]–[2.88] and the Reform 5 list at G5, applied to the notice scheme; paragraphs (a), (h) and (i) are the Commissioner's, the rest are this appendix's. Committee Recommendation 10, which the government agreed to, commits to data collection outside the statute; this puts it inside.

156 Review of Act

(1A) The Minister must, within 3 months after the end of each 6-month period after part 2A commences, present to the Legislative Assembly a report of the following for that period, de-identified and aggregated —

(a) the number of applications for family violence safety notices made, and the number issued, refused under section 13N, and not applied for after the grounds were considered satisfied under section 13F;

(b) the number of notices that included an exclusion condition;

(c) the number of applications under section 13Y by each class of applicant, and the number of notices amended, revoked, confirmed, or dismissed under section 13Y (3)(b);

(d) the number of requests under section 13YA, the median and 90th percentile period between request and hearing, and the number of reviews at which the magistrate recorded under section 13YA (5) that the grounds in section 13B were not satisfied when the notice was issued;

(e) the number of assessments under section 13H (2A) recording that the person most in need of protection could not be identified;

(f) the number of notices followed within 14 days by an application for a family violence order, and by which party;

(g) the number of charges for an offence against section 13ZC and their outcomes;

(h) arrests and charges for family violence offences, for comparison with the 2 years before part 2A commenced;

(i) the recorded sex, age band and, where recorded, Aboriginal and Torres Strait Islander status of respondents and protected persons.

(1B) The review under subsection (1) must address each matter in subsection (1A), the rate at which notices were amended or revoked on the respondent's application, and the rate at which the grounds were found not to have been satisfied at issue.

Note The suppression rule at G5 (3) applies: a count small enough to permit identification is reported as a rolling multi-year total rather than suppressed.

G9.5 Lapse of an unserved notice — new section 13L (4)

Chapter 19 §2.9, item five. Section 13L (1)(a) brings a notice into force on service; section 13T (1) requires service "as soon as practicable" but fixes no outer limit within which service must occur.

13L Duration of family violence safety notice

(4) A family violence safety notice that has not been served on the respondent within 72 hours after it is issued lapses, and a further notice may be issued only on a fresh application under section 13D.

Note A notice issued on the grounds existing on one night should not be served weeks later on those grounds. The period is a placeholder to be settled with ACT Policing; the point is that a period exists.

G9.6 Correction of record — new section 13ZF; clause 191 amended

Inserted after section 13ZE. Chapter 19 §2.4, item 7; §2.5, step six; §2.9, item six. This is the correction-of-record element of Reform 5 (Chapter 16 §6.3a; G5 (4) to (7)) applied to the notice.

13ZF Effect of revocation or adverse review finding on other laws

(1) This section applies to a family violence safety notice that —

(a) has been revoked by the Magistrates Court under section 13ZB; or

(b) a magistrate has recorded under section 13YA (5) was issued when the grounds in section 13B were not satisfied.

(2) The notice is taken never to have been made for the purposes of —

(a) the *Firearms Act 1996*;

(b) the *Working with Vulnerable People (Background Checking) Act 2011*, section 18A;

(c) section 14 (1)(g) and (h) of this Act, and section 13D (2)(f) so far as it refers to a previous family violence safety notice;

(d) the *Personal Violence Act 2016*, section 11 (1)(d) and (e); and

(e) part 9 (National recognition of family violence orders).

(3) The registrar must, within 2 business days, notify the registrar of firearms, the chief police officer and the entity responsible for registration under the *Working with Vulnerable People (Background Checking) Act 2011*, and each must correct any record held under a law in subsection (2) within [14] days after the notification.

(4) Nothing in this section affects the liability of a person for an offence against section 13ZC committed while the notice was in force, or prevents an application being made against any person on proper material.

Clause 191 — *Working with Vulnerable People (Background Checking) Act 2011*, section 18A (1)(b)(iii)(A) as substituted — after "family violence safety notice" (first occurring) insert "that was not revoked and that either remained in force for 14 days or was followed by a family violence order".

Note on drafting. Subsection (2)(e) is included because clauses 69 and 70 make a notice an "interim FVO" and a "local FVO" for national recognition; a notice found not to have met its own grounds should not remain recognised interstate. Subsection (4) preserves the breach offence for the period the notice ran, on the same reasoning as section 21A (6A) at G8: the correction is of the record, not of history. The bracketed period is a placeholder, as at G5 (5).

G9.7 Alternative — every notice a listed application (outline)

Chapter 19 §2.9, item seven. This is drafted only in outline, as an alternative to G9.3 rather than an addition to it, for an Assembly not persuaded that a police notice should run 14 days on police authority. The other alternative, keeping Part 7 with the improvements the dissenting report proposed, requires no new drafting.

13MA Family violence safety notice taken to be application for family violence order

(1) On service of a family violence safety notice, the notice is taken to be an application by the issuing police officer, on behalf of the protected person, for a family violence order against the respondent.

(2) The registrar must list the application before the Magistrates Court on a day before the notice expires, and must give the parties notice of the listing.

(3) Sections 47 (2) to (5) apply to the application, and the family violence safety notice is taken to be an interim order for section 47 (3)(b) and (4)(b) only.

(4) If the protected person notifies the registrar in writing before the listing that they do not seek a family violence order, the application is taken to be withdrawn and the notice expires under section 13L.

Note on drafting. Subsection (4) preserves the protected person's choice: nobody is made an applicant against their will. Subsection (3) confines the deeming so that the notice does not acquire the consequences of an interim order under any other provision. The effect is that no notice ends without a judicial officer having listed it.

Part B — Crimes (Coercive Control) Amendment Bill 2026

G9.8 Identification of the person most in need of protection before charge — new section 72JA

Inserted in Part 3B after section 72J. Chapter 19 §3.3; §3.6, item three; §3.7, Condition E. Drafted to the same form as section 13H (2A) at G9.1, so that one record serves both instruments (Chapter 19 §4).

72JA Identification of person most in need of protection before charge

(1) A police officer must not charge a person with an offence against section 72J unless a police officer of or above the rank of sergeant has recorded, in the form approved by the Chief Police Officer, an assessment of which party to the relationship is the person most in need of protection, including —

(a) the information relied on and its source, and whether any of it came from a source other than the complainant's account;

(b) whether each party was interviewed separately;

(c) any previous report, family violence order, family violence safety notice or charge involving either party; and

(d) whether the person to be charged has previously been recorded by a police officer, a court or a Territory agency as a person experiencing family violence in relation to the same family member.

(2) If each party alleges coercive control by the other, the assessment must be reviewed and confirmed by an officer of the unit of ACT Policing responsible for domestic and family violence investigation (however named) before a charge is laid.

(3) The record under subsection (1) must be disclosed to the accused with the brief of evidence.

(4) The Director of Public Prosecutions must publish a guideline about prosecuting an offence against section 72J where each party alleges coercive control by the other.

(5) A failure to comply with this section does not invalidate a charge, but may be taken into account by the court in deciding whether the course of conduct was reasonable in all the circumstances under section 72J (3) and on any application to stay or dismiss the proceeding.

Note "Person most in need of protection" has the meaning given in the *Family Violence Act 2016*, Dictionary (see G1). The form under subsection (1) and the form under section 13H (2A) of that Act may be one form.

Note on drafting. Every safeguard the Bill contains — intent, the section 8 definition, the objective harm test and the exception in section 72J (3), the four the Explanatory Statement names as reducing "the risk of misidentification" (CC ES pp 8–11) — operates at trial. This is the only provision in this appendix that operates before charge. Subsection (5) follows the pattern of sections 47A (8) and 68A (6): a documentation duty attached to a remedy, not a ground of invalidity.

G9.9 Content, baseline and independence for the review — new section 72K (1A) to (1C)

Chapter 19 §3.6, item one; §3.7, Conditions B and C.

72K Review of provisions about coercive control

(1) [as drafted]

(1A) The review must examine at least the following —

(a) the number of reports, investigations, charges, prosecutions, convictions and sentences for an offence against section 72J, and the time between report and charge;

(b) the number of charges withdrawn or discontinued, and the reasons;

(c) charge and prosecution rates for section 72J compared with other family violence offences;

(d) the number of people charged with an offence against section 72J who, in the 5 years before the charge, had been recorded by a police officer, a court or a Territory agency as an affected person, protected person or victim of family violence in relation to the same family member;

(e) the number of matters in which each party alleged coercive control by the other, and how each was resolved;

(f) each matter in paragraphs (a) to (e) disaggregated by sex, gender, Aboriginal and Torres Strait Islander status, disability, cultural and linguistic background and relationship type;

(g) the reliability of the method used by police to identify the person most in need of protection, including any published measure of agreement between assessors;

(h) the effectiveness of training delivered to police, prosecutors, judicial officers and services;

(i) the experience of complainants and accused persons; and

(j) any unintended consequences, including the misidentification of a person experiencing family violence as a person using it.

(1B) The responsible Minister must, before section 72J commences, publish the data mentioned in subsection (1A)(a) to (f) for the 3 years before commencement, so far as it exists, to serve as a baseline for the review.

(1C) The review must be conducted by a person who is not a public servant, appointed by the Minister, and who must consult the advisory committee under section 433.

(2) [as drafted]

Note Paragraph (d) is the closest administrative proxy for misidentification available without a linked data asset. Paragraph (g) is the measure Chapter 9 §7 and Appendix O specify. Subsection (1B) uses "so far as it exists" because Chapter 11 establishes that some of this data is not now collected; the baseline records that fact rather than inventing a figure.

G9.10 Functions, membership and life of the advisory committee — sections 433 (2), (3), new (3A) and 434 substituted

Chapter 19 §3.1 (timing); §3.6, item two; §3.7, Condition D.

433 Advisory committee

(2) The functions of the advisory committee are —

(a) to advise the responsible Minister about the offence relating to coercive control mentioned in the *Crimes (Coercive Control) Amendment Act 2026*, section 5, including the implementation of the offence;

(b) to monitor the preparation for, and the operation of, the offence;

(c) to advise on the data to be collected and published about the offence, including the matters in section 72K (1A); and

(d) to report to the Legislative Assembly on its work at least once each year.

(2A) The responsible Minister must present a report under subsection (2)(d) to the Legislative Assembly within 6 sitting days after receiving it, and must respond to it in writing within 3 months.

(3) The advisory committee is made up of members appointed by the responsible Minister, and must include —

(a) at least 1 member who is not employed by the Territory, or by an entity funded by the Territory to deliver family violence or legal services, and who has expertise in evaluation or measurement;

(b) at least 2 members with lived experience of family violence;

(c) at least 1 member nominated by an Aboriginal or Torres Strait Islander community-controlled organisation;

(d) at least 1 member with expertise in disability;

(e) 1 legal practitioner experienced in criminal defence and 1 experienced in prosecution; and

(f) 1 member nominated by the Chief Police Officer.

(3A) A Territory agency must give the advisory committee de-identified data that it reasonably requests for the exercise of its functions.

434 Expiry — pt 21

This part expires on the day after the report under section 72K (2) is presented to the Legislative Assembly.

Note on drafting. As presented, the committee expires three years after notification (section 434) and the review cannot begin until five years after notification (sections 2 (2) and 72K (1)): the committee ceases one year after the offence commences and at least two years before the review can begin. The government's web page confirms that timing is intended; the Explanatory Statement records the expiry without a reason (CC ES p 25) and says the committee "will be able to monitor implementation" (CC ES p 18), a function section 433 (2) does not confer. Substituted section 434 ties the committee's life to the report it exists to inform. Paragraph (3)(a) is the independence requirement; without it the committee is a consultation mechanism, as Submission 19 to the inquiry describes it.

G9.11 Readiness-conditional commencement — section 2 (2) substituted; new (2A) and (2B)

Chapter 19 §3.6, item four; §3.7, Condition A. Keeps the two-year floor in the Bill and adds a readiness test to it. The Legislation Act 2001 *section 79 must be expressly displaced: it is a determinative provision (sections 5 and 6 of that Act), and a provision merely inconsistent with it is not enough. See the drafting note to section 47B at G1.*

2 Commencement

(1) [as drafted]

(2) The remaining provisions commence on a day fixed by the Minister by written notice, which must not be earlier than 2 years after this Act's notification day.

(2A) The Minister must not fix a day under subsection (2) unless the Minister has presented to the Legislative Assembly a readiness statement that —

(a) publishes a measure of agreement between assessors applying the method by which police identify the person most in need of protection in a family violence matter, and states the threshold the Territory has set for that measure;

(b) publishes the baseline required by section 72K (1B) of the *Crimes Act 1900*;

(c) states that the form under section 72JA (1) and the guideline under section 72JA (4) of that Act have been published;

(d) reports the proportion of sworn police officers, prosecutors and judicial officers who have completed training on the offence; and

(e) identifies the funding appropriated for implementation.

(2B) The *Legislation Act 2001*, section 79 (Automatic commencement of postponed law) is expressly displaced; however, if the remaining provisions have not commenced 4 years after this Act's notification day, the Minister must present to the Legislative Assembly a statement of the reasons.

Fallback. If conditional commencement is not accepted: retain section 2 (2) as drafted, insert paragraphs (2A)(a) to (e) as a description of the contents of a readiness statement (omitting the opening words of subsection (2A)), and insert —

(3) The Minister must present to the Legislative Assembly, not less than 6 months before the day the remaining provisions commence, a readiness statement addressing each matter in subsection (2A)(a) to (e).

Note on drafting. Paragraph (2A)(a) is Chapter 16 §8.3, Condition 1, given a legal hook. The study is specified at Appendix O and takes about five months; the window is 24 months. Subsection (2B) supplies a backstop so that conditional commencement cannot become indefinite postponement without an account to the Assembly.

G9.12 Factors for "reasonable in all the circumstances" — new section 72J (3A)

Chapter 19 §3.6, sixth item. Adapted from Submissions 14 (Recommendation C) and 23. Non-exhaustive.

72J Coercive control of family member

(3A) In deciding whether a course of conduct was reasonable in all the circumstances for subsection (3), regard must be had to —

(a) the totality of the conduct, and not any single incident considered in isolation;

(b) the relative power and dependency between the parties, including any caring relationship;

(c) whether the conduct was a necessary and proportionate response to a legitimate need of the family member, as distinct from control of the family member;

(d) whether the conduct occurred during or after separation;

(e) any cultural or kinship context; and

(f) any other relevant matter.

G9.13 Prosecution election for summary disposal — Schedule 1, new Part 1.0

Chapter 19 §3.4 (the forum tally); §3.6, item five. The Bill's Schedule 1 amends two Acts and does not touch the Crimes Act 1900 *provisions on summary disposal. A seven-year maximum exceeds the five-year ceiling in section 374, so the Director of Public Prosecutions cannot elect summary disposal and the defendant's consent governs under section 375. Eight submissions from opposed standpoints identified the consequence. This keeps the penalty and restores the election.*

Schedule 1, Part 1.0 — Crimes Act 1900

[1.0] Section 374, new subsection (1A) — insert:

(1A) This section also applies to an offence against section 72J (Coercive control of family member) as if the offence were punishable by imprisonment for longer than 2 years but not longer than 5 years.

Note The Magistrates Court's jurisdictional limit on sentence applies to a matter dealt with summarily under this subsection; the Explanatory Statement puts it at "5 years imprisonment or a fine of $15,000" for a summary hearing on the accused's consent (CC ES p 12), and does not mention a prosecution election. New South Wales pairs a seven-year maximum for its coercive control offence with a prosecution election (Submission 17, para 17).

Note on drafting. Two alternatives reach the same outcome: a standalone "interests of justice" summary-hearing mechanism (Submission 23, Recommendations 4–5), or a five-year maximum (Submission 14, Recommendation E). This appendix drafts the election because it changes neither the penalty nor the elements, which are the Assembly's to decide.

. . .

Note on G9 as a whole. Nothing in Part A raises the threshold in section 13B or shortens the protection a notice gives; nothing in Part B changes the elements, penalty or scope of the offence. Each provision applies to the new instrument the discipline this appendix applies to the court order at G1 to G5: assess against criteria, record what was relied on and what was unknown, give the person restrained or charged a fixed route to an independent decision, and count the results. Sections 13H (2A) and 72JA are drafted to the same form so that the officer at the door has one standard, not two (Chapter 19 §4).

Appendix H — Recommendation implementation tracker

Status. Working template prepared as part of the analysis.

Purpose. To implement Recommendation 3 of Auditor-General Report 10 of 2024, which asked that processes be established to monitor and report on the implementation of recommendations from past reports.

Scope. Every recommendation accepted by government from: domestic and family violence death reviews; Auditor-General performance audits; Assembly committee inquiries; coronial inquests; commissioned reviews; and this framework's own review cycle.

Publication. One page per recommendation, published, updated quarterly, at a stable location.

H1. The record

Field	Content
Reference	Source document, year, recommendation number
Recommendation	Full text, quoted
Government response	Accepted / accepted in principle / noted / not accepted, with the date and the document
Owner	Named position accountable for implementation
Sponsor	The Director-General or equivalent to whom the owner reports on this item
Due date	Original
Revised due date	With the reason for each revision, and the date of each revision
Status	Not started / in progress / substantially complete / complete / superseded / not proceeding
Evidence for the status	A document, a published artefact, a dataset, or a system change — not a description of activity
What remains	In plain language
Last updated	Date

H2. Status definitions

The definitions matter more than the categories, because ambiguous definitions are what allow "progress has been made" to substitute for a status.

Status	Definition
Not started	No work has commenced.
In progress	Work has commenced. The deliverable does not yet exist.
Substantially complete	The deliverable exists but is not yet operating, published, or applied across all entities to which it applies.
Complete	The deliverable exists, is operating, and where the recommendation required publication, it is published. Evidence is identified.
Superseded	A later recommendation or a change of circumstances has replaced it. The replacement is identified.
Not proceeding	Government has decided not to implement. The decision and its reasons are recorded.

Rule. "Complete" requires evidence that a person outside government can check. A statement that a program is under way is not evidence of completion.

H3. The summary table

Published on the front page of the tracker.

Source	Total recommendations	Not started	In progress	Substantially complete	Complete	Superseded	Not proceeding	Oldest outstanding
DFV Death Review 2023	12							
Auditor-General Report 10 of 2024	4							
[Other sources]								
Total								

The "oldest outstanding" column is the one that produces action. A recommendation from 2023 still showing "in progress" in 2027 is visible on the front page.

H4. Worked illustration

Constructed from the public record, to show the format.

Field	Entry
Reference	ACT Domestic and Family Violence Review Biennial Report 2023, Recommendation 4
Recommendation	"Introduce a tool for ACT Policing and the Courts to assess patterns of coercive control that would detect which party is the perpetrator and which party is using violent resistance to ongoing abuse."
Government response	[To be recorded from the government response document]
Owner	[Named position]
Sponsor	[Director-General]
Due date	[Original]
Revised due date	[With reasons]
Status	In progress
Evidence for the status	Updated framework described as under development in public material as at September 2026. No published tool. No published validation results.
What remains	The tool must be published; it must be adopted by ACT Policing and the courts; inter-rater reliability must be measured and published; and a withdrawal trigger must be stated.
Last updated	[Date]

H5. Why this is the cheapest reform proposed

Every field in the tracker is information that already exists inside an agency. The tracker assembles it and publishes it.

The Auditor-General recommended it in November 2024. As at 2 September 2026 it had not been published, and the 2025 death review — which followed the audit — did not contain a status matrix.

Chapter 4 contains an outside estimate of implementation status, produced from public documents. It should not have been necessary to make one.

Appendix I — Principal sources

Evidence cut-off: 2 September 2026.

This appendix lists the documents that carry the argument. It is not a complete bibliography of the archive, which holds 6,246 official source files. It lists the sources a reader would need in order to check any substantive claim in the analysis.

Every source is public. Web addresses were current at the evidence cut-off and should be re-checked.

I1. The twenty-four documents that carry the argument

A reader who obtained only these twenty-four documents could verify almost every substantive finding. The same twenty-four are listed, in short form, at the end of Chapter 1.

#	Document	Date	What it establishes
1	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024	22 Nov 2024	No Territory strategy; no current needs assessment; no performance monitoring strategy or evaluation framework; reporting not transparent or effective; levy revenue and allocation; crisis and prevention shares; four recommendations
2	ACT Domestic and Family Violence Review Biennial Report 2025	2025	Register totals; 38 non-homicide deaths; 29 suicides; misidentification of 8 of 13 victims; order histories; 67 children; economic and housing comparison; themes
3	ACT Domestic and Family Violence Review Biennial Report 2023	2023	12 homicides reviewed; coercive control in almost all; ~75% no significant prior physical violence; cycle of inaction warning; 12 recommendations
4	ACT Domestic and Family Violence Risk Assessment and Management Framework	July 2022	The framework tested in Chapters 8 and 9, including the screening design, the 14-factor assessment, the self-rating item, and Fact Sheets 9 and 10
5	AS ISO 31000:2018 Risk Management — Guidelines	2018	The standard against which the framework is tested
6	CMTEDD Risk Management Framework and Policy, v7.0	July 2023	The ACT's own requirement that risk be managed to that standard across all functions
7	*Family Violence Act 2016* (ACT)	republication 17, in force to 1 July 2025	Sections 12, 13, 13A, 21, 36, 37, 38, 39, 43, 44, 47, 62A, 65, 68, 70C, 82, 82A, 82B, 91B, 103, 104, 113, 149, 154, and the Dictionary
8	*Human Rights Act 2004* (ACT)	in force to 17 Mar 2025	Sections 8, 12, 21, 27B, 28, 30, 40, 40B
9	Magistrates Court Practice Direction 1 of 2026, Family and Personal Violence Matters	commenced 10 Mar 2026	The listing pathway; Registrar decisions; applicant review of refusal; in-person attendance default
10	*Review of Sexual Violence and Domestic and Family Violence Crisis Response Services in the ACT*, Social Ventures Australia	May 2024	Crisis line calls unanswered; callouts not attended; counselling waits; accommodation consuming capacity; legacy contracts; inconsistent risk processes

#	Document	Date	What it establishes
11	ACT DFSV Strategy 2026–2036	27 May 2026	The strategic framework; six outcomes; the absence of baselines, indicators, targets and lead agencies; the consultation basis for the current state; the citation of both death reviews
12	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026	The commitments to build monitoring and evaluation, system mapping, true-cost analysis and a commissioning roadmap as future work; the 2026–28 phasing
13	2026–27 Budget, Domestic, Family and Sexual Violence factsheet	2026	$47.8m additional; $151.4m direct; funding sources; component allocations; $13.2m ongoing indexed from 2029–30
14	2025–26 Budget Outlook, Appendix H	2025	2024–25 budget against estimated outcome by initiative; reprofiling
15	Safer Families Levy Principles	2025	Levy history, rates, purposes and principles
16	Glanfield, *Review into the system level responses to family violence in the ACT*	May 2016	The foundational diagnosis, including non-implementation of recommendations as a distinct problem
17	ACT Legislative Assembly Hansard, 16 September 2025 (proof), P2551–P2553	16 Sep 2025	DPP prosecution volume increases; no commensurate funding; staff without time to prepare matters properly
18	ACT Legislative Assembly Hansard, 10 June 2026 (proof), P2115–P2116	10 Jun 2026	The exchange on unanswered crisis line calls
19	ABS, *Personal Safety, Australia*, 2021–22	2023	Partner violence and abuse prevalence by sex
20	Mathews B and others, “The prevalence of intimate partner violence in Australia: a national survey”, *Medical Journal of Australia*	2025	Lifetime IPV 48.4% of women and 40.4% of men; diverse gender and non-heterosexual rates; multitype violence
21	ACT Human Rights Commission FOI decision and 2024–25 annual report	4 Nov 2025 / 2025	Multi-agency program referral totals and gender identity of victims and people using violence, 2022–23 to 2024–25
22	ACT DPP annual reports 2017–18, 2023–24 and 2024–25	2018–2025	Matters commenced, completed, proved and discontinued for family violence and sexual offences; Supreme Court trial outcomes
23	ABS, *Recorded Crime — Victims*, 2024	2025	ACT sexual assault victimisation rates 2019–2024
24	ACT Policing Annual Report 2024–25	2025	4,478 DFV incidents; 33 per cent five-year increase; 44.9 per cent of assaults DFV related

Document	Date	What it establishes

I1a. Further sources that carry specific claims

These are not among the twenty-four, but a reader would need them to check the particular claims listed against each.

Document	Date	What it establishes
ABS, *Sexual Violence*, 2021–22	2023	Sexual violence by perpetrator sex: 22% (2.2 million) of women by a male, 0.7% (67,700) by a female; and the ABS statement that men's figures are not sufficiently reliable to publish at that level of detail
ACT Magistrates Court Annual Review 2019–20, Protection Unit Statistics	2020	Family violence order applications 2015–16 to 2019–20; 1,249 applications and 1,152 including an interim application in 2019–20; the last published series
ACT Courts, annual reviews page	as archived 2 Sep 2026	Supreme Court annual reviews listed to 2024–25; Magistrates Court annual reviews listed to 2019–20 and no later
Submission 002, Elisabeth Yar, Inquiry into the Crimes (Coercive Control) Amendment Bill 2026	authorised for publication 1 Jul 2026	First-person victim-survivor account of support falling short of need, informal navigation carried by friends, and a health provider endorsing a control tactic as a safety measure; the request for paid and plural lived-experience representation
Submission 022, Sisters in Spirit Aboriginal Corporation and Women's Health Matters, same inquiry	authorised for publication 5 Aug 2026	Consultation accounts of fear of child removal, statements retracted, services experienced as dismissive, institutions reproducing coercive dynamics, and the dual injustice of over-policing and under-protection
Family, Personal and Sexual Violence Legislation Amendment Bill 2025 (ACT), as presented	presented 3 Dec 2025	New Part 2A (family violence safety notices, ss 13B–13ZE); repeal of Part 7 (cl 47); s 44B (cl 35); s 91B (6A) (cl 37); s 113 (e) corrected (cl 39); s 156 substituted (cl 40); consequential amendments to sixteen other Acts and one regulation — Chapter 19 §2
Explanatory Statement, Family, Personal and Sexual Violence Legislation Amendment Bill 2025	Dec 2025	The stated problem and the evidence relied on (pp 22–24); the human rights analysis; the cross-notice bar tied to misidentification (p 30); "two levels of decision-making" (p 32); the lower breach penalty tied to lower oversight (p 36); no ACT administrative data on the after-hours scheme
Standing Committee on Legal Affairs, *Inquiry into the Family, Personal and Sexual Violence Legislation Amendment Bill 2025*, Report 7, 11th Assembly, with dissenting report	24 Apr 2026	Eleven recommendations; 45 after-hours orders granted in 2024–25 and no extractable refusal or unanswered-call data [2.92]–[2.95]; the Attorney-General's "next working day" [2.43]; the Chair's dissent recommending the Bill not be passed in its current form
ACT Government response to Report 7	28 Aug 2026	Recommendations 1 and 2 agreed in principle; 3, 5–11 agreed; 4 noted. **Summarised only; the response document was not on file at the cut-off**
Crimes (Coercive Control) Amendment Bill 2026 (ACT), as presented	presented 28 May 2026	s 2 commencement; s 72I definitions; s 72J offence and course-of-conduct machinery; s 72K review; Part 21 advisory committee (ss 433–434); Schedule 1 consequentials — Chapter 19 §3

Document	Date	What it establishes
Explanatory Statement and Human Rights Act compatibility statement, Crimes (Coercive Control) Amendment Bill 2026, presented 28 May 2026	May 2026	On file; cited as "CC ES p N". A "Significant Bill" (p 1); misidentification treated as a design risk answered by the course-of-conduct structure, the s 8 definition, intent and the reasonableness defence (pp 3, 8–11); summary hearing on the accused's consent (p 12); no reason given for the two-year commencement (p 21) or the committee's expiry (p 25); no discussion of the charging stage, training, data or evaluation
ACT Legislative Assembly Hansard, 28 May 2026 (proof), P1963–P1967	28 May 2026	Presentation speech for the coercive control Bill; the death review evidence relied on; the steering committee; the committee and review as "embedded opportunities to monitor"; debate adjourned
ACT Government, "Making coercive control a crime" (web page)	last updated 1 Sep 2026	The advisory committee to advise "before the proposed crime becomes law" and "during the first year after"; the two-year period for readiness; the framework still being updated
ACT Government response to the Legislative Assembly resolution of 20 March 2025 on coercive control	Sep 2025	Coercive control recognised in the civil framework since 2016; commitment to legislate by mid-2026; the updated framework "expected to be finalised by the end of 2025"
Submissions 001–023, Inquiry into the Crimes (Coercive Control) Amendment Bill 2026, and hearing schedule for 20 August 2026	Jun–Aug 2026	The 22 submissions with text tallied at Chapter 19 §3.4. **Submission 003 (Legal Aid ACT) is a cover sheet only; no position is attributed to it.** Submissions 002 and 022 are listed separately above
Briginshaw v Briginshaw [1938] HCA 34; (1938) 60 CLR 336	1938	The degree of satisfaction required within the balance of probabilities, given the seriousness of an allegation and the gravity of the consequences
Friesen P and Goldstein J, "Standpoint Theory and the Psy Sciences", *Hypatia* 37(4)	2022	Marginalisation alone does not confer epistemic advantage; critical engagement is also required; the warning against tokenisation and essentialisation
Mattsson A M, Sonne C and Carlsson J, "The Accuracy of Traumatic Memories in Posttraumatic Stress Disorder: A Review", *Journal of Nervous and Mental Disease* 209(3)	2021	Trauma memory is as accurate in people with PTSD as in those without; the one consistent difference is that recollection shifts over time
Priestley M and Mazzoli-Smith L, "The Epistemology and Ethics of Analysing Lived Experience Data", *International Journal of Qualitative Methods* 22	2023	An interview is a social practice; experience data is not a transparent representation of reality
Smith-Merry J, "Evidence-based policy, knowledge from experience and validity", *Evidence & Policy* 16(2)	2020	Validity is context-dependent; experiential knowledge requires a translation step to function as policy evidence

I2. ACT Government policy and reports

- ACT Domestic, Family and Sexual Violence Strategy 2026–2036
- ACT DFSV Strategy First Action Plan 2026–28
- Joint media release of the Chief Minister and the Minister for the Prevention of Domestic, Family and Sexual Violence, 27 May 2026 — $3.6 million over four years for foundational system infrastructure
- ACT Domestic and Family Violence Risk Assessment and Management Framework, July 2022, with Fact Sheets 1 to 10 and Practice Guides 1 to 6
- ACT Domestic and Family Violence Review Biennial Report 2023, and plain English summary
- ACT Domestic and Family Violence Review Biennial Report 2025, and plain English summary
- *Review of Sexual Violence and Domestic and Family Violence Crisis Response Services in the ACT*, Final Summary Report, Social Ventures Australia, May 2024
- *Listen. Take Action to Prevent, Believe and Heal*, Sexual Assault Prevention and Response Steering Committee, 2021, and the government response
- *The Long Yarn*, Domestic Violence Prevention Council Aboriginal and Torres Strait Islander Expert Reference Group, 2024, and the government response, 2025
- Domestic Violence Prevention Council, *Review of Domestic and Family Violence Deaths*
- Domestic Violence Prevention Council, joint discussion paper on criminalising coercive control
- ACT Domestic Violence Service System Final Gap Analysis Report
- Review of the *Family Violence Act*, Report, 14 December 2020
- *Evaluation of four Domestic and Family Violence programs*
- Solid Ground Evaluation Report, 2025
- ACT Practice Standards, Men's Behaviour Change Programs
- Safer Families Levy Principles
- Government response to the Auditor-General's report on the Safer Families Levy

I3. Budget and funding

- ACT Budget papers, 2016–17 through 2026–27, including Budget Outlook and Budget Statements
- Safer Families budget material, 2016–17 and 2018–19
- Women's Budget Statements, 2021–22 and 2025–26
- Domestic, family and sexual violence budget factsheets, 2024–25, 2025–26 and 2026–27
- Budget speeches, 2022–23 through 2026–27

I4. Legislative Assembly, Hansard and committee material

- Daily Hansard, 2024 to 2026
- Standing Committee on Justice and Community Safety, *Inquiry into Domestic and Family Violence: Policy Approaches and Responses*, and the government response, December 2019
- Select Committee on Estimates, *Inquiry into the Appropriation Bill 2025–2026*
- Standing Committee, *Inquiry into Annual and Financial Reports 2024–25*
- Inquiry into the Family Violence Legislation Amendment Bill 2022, and related material
- Inquiry into the Sexual, Family and Personal Violence Amendment Bill 2023, final report
- Crimes (Coercive Control) Amendment Bill 2024, with explanatory statement and presentation speech

- Crimes (Coercive Control) Amendment Bill 2026, its explanatory statement and Human Rights Act compatibility statement, and the presentation speech, all of 28 May 2026
- Family, Personal and Sexual Violence Legislation Amendment Bill 2025, explanatory statement, Standing Committee on Legal Affairs Report 7 (April 2026) with dissenting report, and the government response of 28 August 2026 (summarised only)
- Domestic Violence Agencies (Information Sharing) Amendment Bill 2024
- Coercive control inquiry submissions 001–023 and hearing schedule, 2026 (Submission 003 cover sheet only)
- Safer Families Levy inquiry material, 2025–2026

I4A. Prosecution and recorded crime data

- ACT Director of Public Prosecutions Annual Report 2017–18 — family violence and sexual offence matters commenced, completed, proved and discontinued; Supreme Court sexual offence trial outcomes
- ACT Director of Public Prosecutions Annual Report 2023–24 — the same tables, plus 5,231 matters across all courts and the 24.8 per cent increase in sexual offence matters commenced
- ACT Director of Public Prosecutions Annual Report 2024–25 — 933 family violence and 248 sexual offence matters commenced; 7,299 matters; 23,149 charges; 4,583 victims
- ACT Policing Annual Report 2024–25 — 4,478 domestic and family violence related incidents; 33 per cent increase over five years; 44.9 per cent of assaults DFV related
- ABS, *Recorded Crime — Victims*, 2024 — ACT sexual assault victims and rates, 2019 to 2024

I5. Audit and oversight

- ACT Auditor-General, Report 10 of 2024, *Safer Families Levy*
- ACT Auditor-General, Report 5 of 2024, *Management and Oversight of ACT Policing Services*
- ACT Human Rights Commission annual reports, 2020–21 to 2024–25
- Justice and Community Safety Directorate annual reports
- Community Services Directorate annual reports
- ACT Policing annual reports

I6. Courts

- Magistrates Court Practice Direction 4 of 2024, revoked 10 March 2026
- Magistrates Court Practice Direction 1 of 2026, Family and Personal Violence Matters
- Practice Direction 3 of 2024, Remote Appearances
- Practice Direction 6 of 2024, protected confidences material
- Magistrates Court family violence and protection order information, forms and guidance
- ACT Courts and Tribunal Business Plan 2025–26
- ACT Courts and Tribunal annual reviews
- Protocol for the release of data relating to the operations of the ACT Courts, 16 July 2021
- Coronial Practice Direction CPD-2 of 2019, Release of Information

I7. Legislation

- *Family Violence Act 2016* (ACT)
- *Personal Violence Act 2016* (ACT)
- *Human Rights Act 2004* (ACT)
- *Domestic Violence Agencies Act 1986* (ACT)
- *Work Health and Safety Act 2011* (ACT)
- *Freedom of Information Act 2016* (ACT)
- *Crimes Act 1900* (ACT)
- *Criminal Code 2002* (ACT)
- *Court Procedures Rules 2006* (ACT), including rr 2903 and 3802
- *Legislation Act 2001* (ACT), including ss 5, 6 and 79
- *Firearms Act 1996* (ACT)
- Sexual, Family and Personal Violence Legislation Amendment Act 2024

I8. Freedom of information decisions and agency correspondence

Cited by reference and date. Applicant identities are not recorded.

- Australian Federal Police FOI decision LEX 5220, 19 February 2026 — no discrete document; collation would require reviewing every recorded suicide case; suicide attempts not typically recorded
- Australian Federal Police FOI decisions LEX 4648, LEX 4735, LEX 4805, LEX 4806, LEX 4986, LEX 4987, LEX 5436
- Justice and Community Safety Directorate FOI decision 2026/496, 2 February 2026 — refusal of court statistics as not administrative in nature
- Justice and Community Safety Directorate FOI decision 2026/3443 — refusal in relation to coronial data
- ACT Coroners Court advice provided through the Justice and Community Safety Directorate, 26 March 2026 — no field in the ACT Suicide Register; order status may appear in police report narrative; no review, audit, thematic analysis, research project or annual summary of correlations
- ACT Human Rights Commission FOI decision, 4 November 2025 — multi-agency program referral data
- ACT Ombudsman decisions FOI-RR_25_80072, FOI-RR_25_80075, FOI-RR_26_80005
- Office of the Australian Information Commissioner review MR25-02624

I9. National research and comparison jurisdiction

- ANROWS, *National Risk Assessment Principles for domestic and family violence*, Insights 07/2018, with the Quick Reference Guide and the Companion Resource
- ANROWS, national principles update project, 2025–2026
- Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, and implementation material
- Victorian Royal Commission into Family Violence, Report and Recommendations, 2016
- Australian Institute of Criminology, *Predicting repeat domestic violence*, Trends and Issues 581
- Australian Institute of Criminology, *Improving police risk assessment of domestic violence*, Trends and Issues 674
- Australian Institute of Criminology, *Homicide in Australia 2023–24*, Statistical Report 52
- ABS, *Personal Safety, Australia*, 2021–22

- ABS, *Causes of Death, Australia*, 2024, and *Intentional self-harm (suicide) deaths*, 2024
- Mathews B and others, "The prevalence of intimate partner violence in Australia: a national survey", *Medical Journal of Australia*, 2025
- National Plan to End Violence against Women and Children 2022–2032

I10. Media reporting used for the case studies in Chapter 12

- ABC News, "Police officers investigated over rape, domestic violence vendetta", 16 September 2015
- ABC News, "Canberra woman Sarah-Jane Parkinson jailed for making false rape claim against ex-partner", 17 January 2019
- ABC News, "NSW Police officer who lied to support fake rape claim found guilty of perjury", 2 December 2021
- *The Australian*, "ACT man spent two weeks in jail over fabricated allegations by ex-partner", Janet Albrechtsen and Stephen Rice, 31 March 2026
- ABC News, Elizabeth Byrne, 28 March 2026 (updated 30 March 2026) — the same matter; the accused and the complainant are not named
- Region Canberra, Albert McKnight, 2 April 2026 — the same matter; the accused and the complainant are not named
- The third case in Chapter 12 rests on the Glanfield Board of Inquiry report, *Review into the system level responses to family violence in the ACT*, May 2016 (item 16 above), not on media reporting

I11. Known gaps in the evidence base

Stated here so that the limits of the evidence base are visible in the same place as its sources.

1. **Audited program-level actual expenditure** for the most recent years.
2. **A published monitoring and evaluation framework** with baselines and targets.
3. **A current system-wide needs and unmet demand assessment.**
4. **Linked outcome data** across police, courts, prosecution, legal assistance, health, housing, child protection and funded services.
5. **Service access and outcomes by sex, gender identity and victim or perpetrator status.**
6. **Validation and fairness results** for any current ACT family violence risk instrument.
7. **A formal, published implementation status matrix** for the 2023 death review recommendations.
8. **Current rates of predominant aggressor misidentification**, and the effect of training on them.
9. **Longitudinal outcome and reoffending evidence** for behaviour change programs.
10. **Cost-effectiveness comparisons** across prevention, crisis, recovery and perpetrator interventions.
11. **Complete case law coverage.** Automated collection from the national legal database was blocked by security verification.
12. **Unpublished Magistrates Court files**, restricted judgments and protection order material.
13. **Cabinet submissions, business cases, grant acquittals and internal evaluations.**
14. **Court administrative statistics**, which were sought and refused.
15. **Any analysis linking family violence proceedings to deaths**, which no agency has undertaken.

Items 5, 6, 8, 14 and 15 are not merely gaps in this research. They are gaps in what the Territory itself holds, and each is a finding in its own right.

Appendix J — Glossary

Terms are defined as they are used in the analysis. Where a term has a statutory meaning, that meaning is given and the section is identified.

Risk terms

Risk — the effect of uncertainty on something you are trying to achieve. Not the same as "danger", and not the same as "a bad thing that happened".

Hazard — a source of potential harm.

Likelihood — how likely something is to happen, within a stated period. A likelihood rating without a period is meaningless.

Consequence — how bad it would be if it did happen.

Risk criteria — the written rules stating how likelihood and consequence are scored, how they combine, and what level of risk is acceptable. Without criteria, two people assessing the same facts can reach different conclusions and neither can be shown to be wrong.

Risk appetite / risk tolerance — the level of risk an organisation is prepared to accept, stated in advance.

Control — something already in place that reduces a risk. A control that nobody has confirmed is operating is an assumption, not a control.

Treatment — something done to change a risk. The full option set is: avoid the activity; remove the source; change the likelihood; change the consequence; share the risk; or knowingly retain it.

Residual risk — what remains after the treatments are operating.

Risk owner — the named person accountable for a particular risk.

Intent — what a person's observable conduct indicates about their intention within the stated period. Rated separately from capability.

Capability — present means and opportunity to carry out the harm within the stated period. Capability is not intent.

Confidence — a statement about how well-founded a rating is, distinct from the rating itself.

Structured professional judgment — an approach combining a defined set of evidence-based risk factors, the practitioner's judgment, the subject's own assessment, and information from other sources. In its established forms it also includes coding rules, a case formulation, defined risk scenarios and published validation.

Inter-rater reliability — a measure of how often two assessors reach the same conclusion on the same facts.

Sensitivity — how often an instrument correctly identifies the thing it is looking for.

Specificity — how often an instrument correctly clears a case that does not have the thing it is looking for.

Validation — measuring how well an instrument performs, and publishing the result.

Withdrawal trigger — the result, stated in advance, that would cause an instrument to be withdrawn or revised. An instrument that cannot fail cannot be validated.

R1 — the risk that a person who has used or may use family violence commits family violence, causing physical, sexual, psychological, emotional or economic harm to a protected person, a child or another affected person, within a stated period. Written in full at Appendix C1.

R2 — the risk that the order process or the measures selected restrict housing, work, a licence, contact with children, liberty or reputation, causing hardship or a rights limitation beyond what is necessary to hold R1 within tolerance, to the person being restricted or a child in their care, over the same period. Written in full at Appendix C1.

Legal terms

Family violence order (FVO) — a civil order made under the *Family Violence Act 2016* (ACT). The court must be satisfied only on the balance of probabilities, need not comply with the rules of evidence, and may inform itself as it considers appropriate. An order is a finding that protection is necessary. It is not a finding that the respondent did what was alleged.

Perpetrator (as used in the fatality record) — a classification applied by the ACT death review to a deceased person whose records showed a pattern of using domestic or family violence. It is the review's own reading of the records, not a court finding, and it does not imply a conviction. Where these pages describe the 25 people in that group, the safe description is that they had been accused of using family violence, and that 20 of the 25 had been named as respondents to a civil order.

Personal protection order (PPO) — a civil order made under the *Personal Violence Act 2016* (ACT), for people not in a family relationship.

Interim order — an order made before the final application is decided. The court may make one if satisfied it is necessary to ensure the safety of an affected person from family violence, or to prevent substantial damage to an affected person's property (s 21).

Final order — an order made after the application is decided.

After-hours order — an order made outside court hours under the procedures the Act provides.

Ex parte — a hearing at which only one party is present. Usually, a hearing the respondent did not know about.

Applicant — the person who applies for an order. May be the affected person, or a police officer on their behalf.

Respondent — the person against whom an order is sought or made. Being a respondent is not a finding of guilt.

Protected person — the person for whose protection an order is made.

Affected person — includes any child who hears, witnesses or is otherwise exposed to family violence committed against another person.

Exclusion condition — a condition prohibiting a respondent from being at premises where the respondent lives.

Balance of probabilities — the civil standard of proof: more likely than not. Applied under s 13.

Least restrictive principle — the requirement in s 37 that conditions be the least restrictive of the respondent's personal rights and liberties as possible that still achieve the Act's objects and give effect to s 36.

Paramount consideration — the requirement in s 36 that the safety and protection of the affected person and any affected child be given paramount consideration when deciding conditions.

Preliminary conference — a conference held after the interim hearing, at which parties attempt to resolve the application before it is listed for contested hearing.

Return date — the date on which a matter comes back before the court.

Contravention — conduct that breaches an order. An offence under s 43, carrying up to 500 penalty units, five years' imprisonment, or both.

Complicity — aiding, abetting, counselling, procuring, or being knowingly concerned in another person's offence.

Assessment and classification terms

Predominant aggressor — the person assessed as posing the most serious and ongoing threat to safety and wellbeing, where more than one person is alleged to have used violence. Also called "primary aggressor".

Person most in need of protection — the other side of the same assessment.

Misidentification — recording the wrong person as the predominant aggressor.

Defensive or resistive force — force used by a person experiencing violence, to protect themselves or others, to pre-empt an attack, or as resistance.

Coercive control — a pattern of behaviour used to dominate and control another person. May include isolation, surveillance, financial control, threats, and micromanagement of daily life, and may involve little or no physical violence.

System abuse — the use of legal, administrative, immigration or child protection processes to control or harm another person.

Screening — a short, routine set of questions asked to identify whether family violence may be present.

Assessment — the fuller process undertaken where screening indicates family violence may be present, or where a disclosure is made.

Classification — the determination of whose conduct forms a pattern of coercion or violence directed at the other.

System and institutional terms

DFV — domestic and family violence.

DFSV — domestic, family and sexual violence. The term the ACT Government now uses.

FVSAP — the Family Violence Safety Action Program, the ACT's multi-agency mechanism for coordinating responses in high-risk cases.

DVCS — the Domestic Violence Crisis Service.

CRCC — the Canberra Rape Crisis Centre.

SAMSSA — Services Assisting Male Survivors of Sexual Assault, an embedded service of the Canberra Rape Crisis Centre.

Nguru — an Aboriginal-managed sexual violence support service embedded within the Canberra Rape Crisis Centre.

Safer Families Levy — a flat charge on ACT households, collected with rates, introduced on 1 July 2016 to fund domestic and family violence reform.

Death review — the function established under the *Domestic Violence Agencies Act 1986*, which maintains a register of domestic and family violence deaths and reports biennially.

Coordinator-General for Family Safety — the position recommended by the 2016 Glanfield review to drive coordination, cultural change and oversight.

ANROWS — Australia's National Research Organisation for Women's Safety.

MARAM — the Victorian multi-agency risk assessment and management framework, referred to throughout as "the comparison jurisdiction's framework".

ACCO — Aboriginal Community Controlled Organisation.

Budget and accountability terms

Budget — the amount appropriated for an initiative.

Revised budget — the amount after any in-year adjustment.

Estimated outcome — an estimate of what will be spent in the current year, made before the books close. It is not audited final expenditure.

Actual expenditure — audited final spending.

Reprofiling — moving an appropriation from one year to a later year. It is not cancellation, but it means the announced delivery timetable has moved.

Lapsed — an appropriation not spent and not carried forward.

Output — something the system did: money allocated, a service funded, staff trained, clients seen, referrals made, campaign impressions.

Outcome — something that changed for people: fewer serious assaults, shorter waits, fewer wrong decisions, lower reoffending.

Unit cost — cost per participant, per service event, or per result. Meaningless without the denominator stated.

Double counting — reporting the same money in more than one figure without identifying the relationship. The most common source of confusion in this policy area.

Baseline — the measured starting value of an indicator, against which change is assessed. Established by measuring once.

Not proven — a verdict that neither confirms nor denies effectiveness, returned where the evidence required to decide does not exist. Distinct from "poor" and from "good".

Evidence terms

Source reliability — how reliable the source of a claim is, graded A to F.

Claim credibility — how credible the claim itself is, graded 1 to 6. Rated separately from source reliability.

Established (E) — supported on the material available.

Reasonably open (O) — a conclusion the material could support, without establishing it.

Unknown (U) — not known, including because a check was not run.

Run, nil — a check was conducted and returned nothing. A result, and not proof of safety.

Consent without admission — an order or agreement made without any admission that the alleged conduct occurred.

Candidate figure — a figure taken from an automated register that has not been separately verified against the primary source.

Briginshaw principle — the rule, from *Briginshaw v Briginshaw* (1938) 60 CLR 336, that the degree of satisfaction required within the balance of probabilities is affected by the seriousness of the allegation, the inherent unlikelihood of the occurrence, and the gravity of the consequences of a finding. It is not a third standard of proof, and it is not a rule of evidence, so a provision removing the rules of evidence does not displace it. See Chapter 7 section 2.2a and Appendix D4.3.

Independent evidence layer — a source of information about a claim that is not derived from, and does not depend on, another source already counted. One account repeated to three people is one layer. See Appendix D4.1.

Bow tie — a way of drawing a hazard that puts the unwanted event in the middle, the controls that make it less likely on the left, and the controls that limit harm once it has happened on the right. Used in Chapter 1 and Chapter 2 section 8 to state the scope of this work, which examines the right-hand side.

Likelihood management — the left-hand side of the bow tie: everything that reduces the rate at which the event occurs at all. In this field it runs through education, child development, housing, economic security, health and mental health services, alcohol policy and social norms. Not examined here.

Consequence management — the right-hand side of the bow tie: everything that limits harm once violence has occurred or is imminent, stops it escalating, and prevents the next incident. Protection orders, risk assessment, crisis services, behaviour change programs and the justice interface all sit here. This is the subject of this work.

Appendix K — Method: how the evidence was assembled and tested

Where the short version is. A four-sentence statement of the standard applied appears in "How to use this work" at the front. This appendix is the full account, written for a reader who wants to test the method rather than take it on trust.

In one page

The evidence base is the public record. It comprises ACT Government publications, budget papers, Legislative Assembly Hansard, committee reports and transcripts, Auditor-General reports, court records and practice directions, freedom of information decisions, and published national research. The core archive holds 6,246 official source files, assembled on 1 and 2 September 2026 and covering the ten years from the Glanfield review of May 2016 to the evidence cut-off of 2 September 2026, with a searchable text copy of 6,219 of them.

One test is applied to every claim the government makes, and the same test to every claim made in the analysis. The test has five steps: is the need established, is the design sound, was the money actually spent, did anything change, and was the change worth the cost. A program that clears the first three steps and fails the last two is not a failure. It is unproven. That word is used often, and it is meant precisely.

The analysis separates three things that are routinely mixed together in public debate: what was announced, what was allocated, and what was spent. It separates outputs from outcomes. It does not add rolling four-year funding packages together, because they overlap.

The method also states its own limits. Cabinet submissions, business cases, grant acquittals, internal evaluations, unpublished court files and restricted judgments were not available. Where those absences matter, the text says so rather than guessing.

A professional standard is applied to the ACT's risk framework: AS ISO 31000:2018, the Australian and international standard for risk management, and the ACT Government's own risk management framework, which is aligned to it. That is not an outside benchmark imposed for effect. It is the standard the ACT Government requires of itself.

1. What the evidence base is

1.1 The archive

The primary archive was assembled between 1 and 2 September 2026 and frozen at that date. It contains 6,246 official source files published by the ACT Government, the Legislative Assembly, the ACT Courts and Commonwealth bodies: 697 PDFs, 5,508 HTML pages, and a balance of 41 files in other formats. Searchable text copies exist for 6,219 of them, amounting to roughly 105 million characters. A full-text search index covers the set.

The collection rule was deliberately over-inclusive: where there was doubt about relevance, the document was kept. That produces noise. It also means the absence of a document from the archive is meaningful. If a category of record is not there, it is generally because it was not published, not because it was overlooked.

The archive breaks down as follows.

Category	Files	What it contains
Legislative Assembly, Hansard, bills and inquiries	4,512	Complete available daily Hansard for 2024–2026, both current inquiry transcripts, all 23 coercive control submissions, committee reports and government responses
ACT Courts	1,410	Judgment catalogue, practice directions, forms, annual reviews, 165 saved judgment pages and 96 linked judgment PDFs
Audit, oversight and inquiry	238	Auditor-General reports, annual report inquiry material
Budget, funding and grants	40	Every ACT budget year in the period, including full Budget Outlook and Budget Statement sets
ACT Government policy and reports	36	Strategy, action plan, death reviews, risk framework, service reviews, program evaluations
Media and people records	9	Separately captured statements and releases

The six categories sum to 6,245 against a total of 6,246. The one-file difference has not been traced to a category, and it is recorded here rather than adjusted away.

Alongside the archive sit a set of derived registers: a funding ledger that separates package totals from components and flags where they overlap; a reconciliation of 2024–2026 budget lines; a register of 2,010 candidate statement excerpts attributed to 126 apparent speakers; a curated register of verified quotations; and a crosswalk of 167 court records.

1.2 The difference between a register and a finding

Two of those registers are discovery tools, not evidence. The statement register was built by automated keyword extraction. It shows where in the record a particular person appears to have said something about a particular topic. It has not been checked line by line against the transcripts, and attribution in an automated extract can be wrong.

Nothing is therefore quoted from the statement register. Quotations come only from the curated register, in which each quotation has been checked against the original document, or from the primary document itself. Where a figure comes from an automated source and has not been separately verified, it is labelled a candidate figure, with a note of what would be needed to confirm it.

1.3 What is not in the archive

The following categories of record could not be obtained, and their absence shapes what the analysis can conclude.

- **Cabinet submissions and business cases.** The reasoning behind individual funding decisions is not public. The Auditor-General has seen some of it. The archive does not hold it.
- **Grant acquittals and contract-level payments.** The record shows what was budgeted and, for recent years, an estimated outcome. It does not show what was actually paid to whom.
- **Internal evaluations.** Some programs have been evaluated internally without publication.
- **Complete court files.** Family violence proceedings are frequently private, restricted, unpublished or pseudonymised. Magistrates Court reasons are published far less consistently than Supreme Court reasons. Protection order applications and transcripts are not public web records.
- **A complete case law set.** Automated collection from the national legal database was blocked by security verification. The official ACT court copies cover many of the same superior court decisions, but the set is not complete.

- **Service-level client data.** No public dataset was located showing service use and outcomes broken down by sex, gender identity, victim or perpetrator status, and service type.

The last of these matters most. It is discussed in Chapter 10, because the absence is itself one of the central findings.

2. The five-step test

The same five questions are applied to every program, package and reform.

Step 1 — Need. Is the problem defined? Is the target group identified? Is there current local evidence about the size and shape of the need, or is the need assumed?

Step 2 — Design. Is the intervention plausibly connected to the need? Is there evidence, from anywhere, that this kind of intervention works? Is there a written theory of how the money is supposed to produce the result?

Step 3 — Delivery. Was the money actually spent? Was the service actually delivered, to the number of people intended, in the way intended?

Step 4 — Outcome. Did anything measurably change? Is there a baseline? Is there a comparison group, or a before-and-after measure, or a plausible counterfactual?

Step 5 — Value. Was the change worth the cost? How does it compare to the next best use of the same money?

Most ACT domestic and family violence spending clears Steps 1 and 2. A good deal of it clears Step 3, at least to the level of an estimated outcome in a budget table. Very little of it clears Steps 4 and 5, and in most cases the information needed to attempt Step 4 does not exist.

That is the finding. It is not the same as saying the money was wasted.

2.1 Why "not proven" is the correct verdict

There are three possible verdicts on the value of the ACT's spending: it worked, it did not work, or nobody can tell.

The third verdict is returned on the portfolio as a whole. That is a real finding with real consequences, and it should not be softened into either of the others.

It is not the same as "the money was wasted". Several programs show promising results, and Chapter 3 sets them out with their costs per participant. It is not the same as "the money worked, we just have not written it up". A system that has operated a dedicated levy for ten years and cannot report what changed has a governance failure, not a paperwork backlog.

The Auditor-General reached the same conclusion in 2024, in the words of the Territory's own auditor: the responsible office had not developed a performance monitoring strategy or an evaluation framework. The 2026 First Action Plan effectively confirms it, because it commits to building a monitoring and evaluation framework, a system map, a true-cost analysis and a commissioning roadmap as future actions. Those are the tools used to run a system. Committing to build them in 2026 is an accurate statement about what did not exist before 2026.

2.2 Outputs are not outcomes

This distinction does more work than any other in the analysis, so it is worth stating carefully.

An **output** is something the system did. Money was allocated. A service was funded. Staff were trained. Clients were seen. A campaign was viewed a certain number of times. Referrals were made.

An **outcome** is something that changed for people. Fewer serious assaults. Fewer repeat incidents. Shorter waits. More victims safely housed. Fewer wrong decisions about who caused the violence. Lower reoffending after a behaviour change program.

Public reporting in this field is heavily weighted towards outputs. That is not unique to the ACT and it is not evidence of bad faith. Outputs are easy to count and available quickly. Outcomes are hard to measure, take years to appear, and often require linking data across agencies that do not share systems.

But the difference is not cosmetic. A service that answers more calls has produced an output. Whether the people who called are safer is an outcome, and it is the only thing that justifies the expenditure. Where a number is reported, the text says which kind of number it is.

2.3 An estimated outcome is not an audited figure

Budget papers report an "estimated outcome" for the current year alongside the budget figure. This is an estimate made before the books close. It is not audited final expenditure.

The distinction matters because the gap between the two is where reprofiling shows up. In 2024–25, ACT Safer Families initiatives were budgeted at $15.696 million with an estimated outcome of $14.117 million — a difference of $1.579 million. Much of that difference was explicitly moved to later years rather than cancelled. Reprofiling is a normal budget mechanism and is not evidence of failure. But a package described publicly as delivered in a given year, which is in fact partly delivered in a later year, has not delivered on the announced timetable. Chapter 3 traces this in detail.

3. How funding is counted

Funding announcements in this field are usually expressed as four-year totals. Each new announcement covers a rolling four-year window that overlaps the previous one. The packages mix new money with continuing commitments, ACT revenue with Commonwealth funding and levy revenue, recurrent funding with time-limited grants, and direct spending with adjacent initiatives.

The consequence is simple and important: **the headline announcements cannot be added together.** Doing so produces a number that has no meaning. Chapter 3 sets out each package with its basis and the specific reason it cannot be summed with its neighbours.

Where a total is given, it identifies:

- the period the total covers;
- whether the money is new, continuing or a mix;
- the funding source or sources;
- whether the figure is a budget, an estimated outcome or an audited actual;
- and whether the figure includes any component listed separately elsewhere.

That is a five-line qualification on every number. It is tedious. It is also the only way to say anything true about the spending.

4. The professional standard applied to the risk framework

Part II tests the ACT's domestic and family violence risk assessment and management framework against two documents.

The first is **AS ISO 31000:2018 Risk Management — Guidelines**. This is the Australian adoption of the international standard for managing risk. It is not a domestic violence document. It is a general standard that applies to any organisation managing any kind of risk, and it sets out what a risk framework must contain: principles, a governance structure, and a process running from scope and context, through risk criteria, identification, analysis and evaluation, to treatment, monitoring, review, recording and reporting.

The second is the **ACT Government's own risk management framework and policy**, maintained by the Chief Minister, Treasury and Economic Development Directorate. It is aligned

to ISO 31000. It requires risk management to be embedded across all ACT Government functions, and it says expressly that this includes health and safety activities, policy development and planning.

Testing the domestic and family violence framework against these two documents is not an act of external criticism. It is a compliance question. The ACT Government has told itself, in writing, that this is how it manages risk. Chapter 8 asks whether one particular framework does what the government's own policy requires, and answers the question clause by clause.

A reader who is not a risk professional does not need to know ISO 31000 to follow that chapter. It is explained in plain English before it is applied, and the test is set out as a table with three columns: what the standard requires, what the framework does, and whether they match.

4.1 Why the standard matters more here than elsewhere

The ACT applies this standard to procurement decisions, to public events, to staff travel and to information security. Those activities can cause loss and inconvenience.

The decisions examined in Part II can remove a person from their home without notice, separate them from their children, suspend a licence they need to work, and attach a lasting record to their name. On the other side, a decision made badly in the opposite direction can leave a person at risk of serious injury or death.

Both errors are severe. Both are exactly what a risk framework exists to weigh against one another. A process that carries consequences of this size, in both directions, has a stronger claim on rigorous risk management than a procurement, not a weaker one.

5. How people are named

An individual is named only where a public record already attributes a finding, a statement or a decision to that person. That includes:

- statements recorded in Hansard or in a published committee transcript;
- published opening statements to Assembly committees;
- findings in an Auditor-General's report;
- decisions announced in a government media release;
- judgments published by a court;
- and, for the three case studies in Chapter 12, detailed reporting in national and local media about matters dealt with in open court, and a published Board of Inquiry report.

Everywhere else, the role, the agency or the function is named. Chapter 13, which deals with accountability, is written almost entirely in these terms. It identifies functions where the official record shows adverse effects or governance gaps. It does not allege that any individual holding that function caused harm, acted in bad faith or committed any wrongdoing.

This is a deliberate choice, and it is not only a legal one. Systems of this kind fail through accumulated design decisions, missing feedback loops and unfunded interfaces, not through individual malice. Naming a person for a system failure obscures the cause and makes the failure harder to fix. Naming the function makes it fixable.

6. What cannot be concluded

Five conclusions are unavailable on the public record. None of them is reached.

First, it cannot be concluded that the spending was wasted. That would require actual expenditure data, outcome data and a comparison. None of the three is available for most of the portfolio.

Second, it cannot be concluded that any individual or agency is biased against men or against women. Bias in the legal and everyday sense requires evidence about intent or about differential treatment of like cases. The available evidence shows differences in service reach and in framework design. It does not show intent, and the data that would allow a proper differential-treatment analysis has not been collected. Chapter 10 sets out precisely what would need to be measured.

Third, it cannot be concluded that the risk framework causes specific wrong decisions. The record can show that the framework lacks the components that would make its decisions consistent, testable and reviewable. It can show that misidentification occurs at a documented rate. Connecting the two requires a validation study that has never been done. Recommending that study is one of the principal proposals.

Fourth, no causal link can be established between the making of a family violence order and any individual death. Chapter 11 sets out what the record does show: the number of deaths, the number of deceased people who were subject to an order, and the fact that no agency has ever examined the relationship. The absence of the analysis is the finding. No guess is substituted for the analysis that was not done.

Fifth, nothing can be said about the content of documents that could not be obtained. Where a freedom of information request was refused, the text records the request, the refusal and the stated reason. It does not speculate about the content.

7. How the recommendations were developed

Part III does not simply reverse the findings of Part II. Each recommendation was tested against four questions.

1. **Does it fix a documented failure?** Each recommendation is traced back to a specific finding in Part I or Part II.
2. **Can it be implemented with existing powers, or does it need legislation?** Recommendations are separated into administrative changes and legislative amendments, and the required instrument is named.
3. **Does it reduce protection for anyone at risk?** Any recommendation that would has been rejected. Where a proposal changes a process, the text states which safeguard preserves the existing level of protection.
4. **Can compliance be checked from outside?** A recommendation that cannot be independently verified reproduces the problem it is meant to solve. Each proposal therefore specifies what would be published, how often, and by whom.

The drafted legislative amendments in Chapter 16 and Appendix G are drafting proposals, not parliamentary drafting. They show the intended effect and the section they would sit in. They would need to be settled by parliamentary counsel.

8. Verification and error

This work was assembled from a large archive in a short period. Three categories of error are possible and the reader should treat them accordingly.

Transcription and extraction error. Some source documents were read by optical character recognition from scanned images. OCR introduces errors, particularly in tables and figures. Any figure taken from an OCR source is marked and should be checked against the image before it is quoted publicly.

Attribution error. Statements attributed to individuals have been checked against the source document for every quotation used. Any statement attributed to a named person should nonetheless be checked against the full transcript before republication, because context can change meaning.

Currency error. The evidence cut-off is 2 September 2026. Legislation before the Assembly at that date may since have passed, been amended or lapsed. The status of the coercive control bill, the information sharing scheme and the risk framework update should be re-checked before any statement about them is repeated.

Where a claim depends on a document that could not be independently verified, the text says so at that point rather than in a footnote.

What this appendix establishes

1. The evidence base is 6,246 official source files, assembled on 1 and 2 September 2026 and covering the period from May 2016 to the evidence cut-off of 2 September 2026, with searchable text for 6,219 of them.
2. Every claim is tested against five questions: need, design, delivery, outcome and value.
3. Outputs and outcomes are counted separately. An estimated outcome in a budget paper is not audited expenditure.
4. Rolling four-year funding announcements overlap and are never added together.
5. The ACT's risk framework is tested against AS ISO 31000:2018 and the ACT Government's own risk management framework, because those are the standards the government has adopted for itself.
6. Individuals are named only where a public record already attributes the finding, statement or decision to them.
7. Five conclusions are unavailable on the public record and are not reached: that spending was wasted, that any person or agency is biased, that the framework causes specific wrong decisions, that any order caused any death, or what refused documents contain.

Sources for this appendix

Claim	Source	Date
Archive composition and file counts	Archive research report, `README_RESEARCH_REPORT.md`	2 September 2026
Statement register is a discovery tool, not verified attribution	Archive research report, section on people statement register	2 September 2026
No performance monitoring strategy or evaluation framework	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024	22 November 2024
Monitoring and evaluation framework committed as a future action	ACT DFSV Strategy First Action Plan 2026–28	27 May 2026
2024–25 budget $15.696m, estimated outcome $14.117m	2025–26 Budget Outlook, Appendix H, Table H.1	2025

Claim	Source	Date
Risk management required across all ACT Government functions	CMTEDD Risk Management Framework and Policy, v7.0	July 2023
Risk management standard	AS ISO 31000:2018 Risk Management — Guidelines	2018

Appendix L — Assessment of the ACT DFSV Strategy 2026–2036 and First Action Plan 2026–28

Documents assessed: *ACT Domestic, Family and Sexual Violence Strategy 2026–2036* and *First Action Plan 2026–2028*, both released 27 May 2026, together with the joint media release of the same date.

Purpose of this appendix. Chapter 2 sets out what the Strategy is and where it sits in the ten-year sequence. This appendix does the detailed work: it tests the two documents against the things a strategy has to contain if anyone is later to say whether it worked, records what is present and what is absent, and sets out fourteen changes that would close the gap. It is written to be used as a checklist by a committee, an auditor or a directorate, not read as narrative.

The test applied. A strategy is assessable if it states where things stand now, where they are to be by stated dates, how that will be measured, who is accountable, and what it costs. Three of those five were the subject of adverse findings by the Auditor-General in Report 10 of 2024: no current Territory strategy, no current needs analysis, and no performance monitoring strategy or evaluation framework. The five are applied here to the document that replaced the strategy gap that report identified.

Stated fairly first. The 2026 Strategy is the strongest strategic document in the ACT archive. It covers prevention through to recovery. It recognises children as victims in their own right. It carries a whole outcome for Aboriginal and Torres Strait Islander self-determination. It names disability, LGBTIQA+ people, migrant and refugee communities and older people. It commits to a monitoring and evaluation framework. None of the findings below is an argument that the Strategy should not have been written, or that its direction is wrong.

Part 1 — Fourteen findings

L1. It is a strategy without a scoreboard

The Strategy sets six outcomes: four described as human-focused and two as enabling. Each is a desirable end state expressed in words.

Across the Strategy and the First Action Plan, the word "baseline" does not appear. The word "indicator" does not appear. No numeric target is set for any outcome, for 2028, 2032 or 2036. No data source is nominated for any outcome. No reporting frequency is stated.

The consequence is that in 2036 no one will be able to say whether the Strategy succeeded, because there is no state of affairs against which the six outcomes could be tested. The Auditor-General's 2024 criticism was of reporting that describes activity rather than measuring impact. A document with outcomes but no indicators reproduces that risk at the strategic level.

Measures that exist and are not used include hospitalisations for assault by a family member, charging and conviction rates, discontinuance rates, crisis line answer rates, service wait times, exits from crisis to stable housing, behaviour change program completion and subsequent reoffending, and victim-survivor reported safety.

L2. The monitoring and evaluation framework is promised, not delivered

The Strategy states that a monitoring and evaluation framework "will be used to establish a consistent approach" to monitoring, reporting and evaluation, including of Safer Families Levy expenditure. The framework itself is not in the document. Neither document contains a data dictionary, a reporting cadence, an evaluation schedule, or a commitment to an independent public dashboard.

This is the same instrument the Auditor-General found missing in November 2024. Eighteen months later it is described in the future tense. A commitment to build a measurement system is welcome; it is not a measurement system.

L3. Accountability is expressed as "we"

The Strategy is written in the first person plural. Responsibility is shared across government, sector and community.

Neither document names a lead agency for any of the six outcomes. Neither assigns decision rights. Governance arrangements are described as "being developed".

Shared responsibility is a reasonable description of the social task. It is not a governance arrangement. A commitment with no named owner cannot be tracked, cannot be escalated, and cannot fail visibly, which means it cannot be corrected.

L4. Delivery is back-loaded

The First Action Plan window, 2026 to 2028, is described in the Strategy as sustaining effective services while commencing longer-term reform through whole-of-system mapping, governance redesign and preparation for the next stage of commissioning.

The substantive system redesign — commissioning a re-designed system and building workforce capacity — is placed in the second action plan window, 2028 to 2032.

Mapping, governance design and commissioning preparation are necessary. Placing all of them in the first two years means that a person on a waiting list in 2026 is waiting for a redesign that starts to be commissioned in 2028.

L5. The Strategy itself is uncosted

The Strategy contains no costings. The funding announced alongside it, in the 2026–27 Budget, was reported as $47.8 million in additional funding and $151.4 million of total direct investment over four years.

Of that, the joint media release identifies $3.6 million over four years for foundational system infrastructure: a sector network, an information sharing coordinator role, two years of training to operationalise the updated risk assessment and management framework, and support for Women's Health Matters to develop a model for primary prevention infrastructure. The balance is substantially continuity funding for frontline services, which is itself valuable and is credited in Chapter 3.

The observation is one of proportion. A ten-year rebuild of a system is being started with about $3.6 million of new system-building money. That is not an argument that the sum is wrong. It is an argument that the sum and the ambition should be reconciled in public, in the same document.

L6. Prevention is design work, not delivery

Outcome 4 and the prevention infrastructure language are well founded, and match a decade of reviews finding the ACT response crisis-heavy.

The funded next step is the development of a model. Successive reviews since 2016 have found the same imbalance. Commissioning another model is not the same as operating prevention at population scale in schools, workplaces, sport, faith settings and online, with shared standards and evaluation.

L7. Priority groups appear in the analysis and thin out in the outcomes

Disability, LGBTIQA+ people, migrant and refugee women, and older people are described in the problem chapters of the Strategy. Intersectionality is stated as a principle.

None of those groups has dedicated outcome machinery, a funding principle, or an access measure attached to it. A principle that is not attached to a measure or a budget line is not yet a delivery plan.

L8. Housing, income and child protection are named, then left thin

Outcome 1 identifies housing, workforce participation and healthcare as long-term recovery needs.

Neither document contains a housing-first pathway, a Safe at Home scale-up commitment, a child protection misidentification protocol, or a defined interface with the Youth Justice Strategy still in development. Neither document uses the word misidentification at all, although the Territory's own death review made it the first theme of its 2025 report. Chapter 4 records that among the 13 deceased victims, 62 per cent (8 of 13) were unemployed and 54 per cent (7 of 13) had experienced homelessness or housing instability. Housing and income are safety variables in the Territory's own fatality data.

L9. Accountability for people who use violence is under-specified

Outcome 3 is correctly framed: early identification, legal consequences, keeping people in view, and support to change.

The delivery language is about building the evidence base for men's behaviour change programs. It does not set program standards, funded capacity, completion and safety measures, partner-contact requirements, or consequences for non-compliance. Chapter 10 records that the Territory cannot report reoffending or program outcomes for any cohort.

L10. It does not confront the current state with numbers

The Strategy describes rising reports, unmet demand and piecemeal funding qualitatively, drawing on consultation.

It does not publish a current demand and gap analysis. The 2016 Glanfield review supplied the last whole-of-system analysis, and the Auditor-General found in 2024 that the needs analysis underpinning levy investment was dated. Without a current gap analysis, "a sustainable sector" cannot be costed, commissioned or tested.

L11. Consultation is treated as evidence of the current state

The Strategy's account of where things stand rests on what people said.

The consultation itself was substantial and was properly done. A consultant led an engagement process across Aboriginal community-controlled organisations, the specialist sector, broader human services and government. Women's Health Matters ran a separate consultation with adult victim-survivors through the peer-led Victim Survivors Voices pilot. The process produced two Listening Reports and a published consultation report. The Strategy summarises what it heard from victim-survivors under six headings, among them accountability, lived experience advice, intersectionality, trauma-informed approaches and justice system reform, and what it heard from services and government under six more.

That material is necessary. It is the only available account of what the system is like for the people inside it, of why people do not report, and for which barriers are real rather than theoretical. Nothing here argues for less of it.

It is also not a measurement of the current state, and the Strategy uses it as one. Consultation tells a government what people experienced. It does not tell it how many, how often, at what cost, or whether anything changed. The Strategy describes rising reports, unmet de-

mand and piecemeal funding in qualitative terms drawn from that process, and publishes no current demand and gap analysis alongside it (finding L10).

The parallel is exact to the rule this work applies to the rest of the portfolio. **Outputs are not outcomes, and consultation is not measurement.** Both are cases of a real thing being counted as evidence of a different thing. A list of what people told a government they need is a statement of priorities. The number of people who need it, the number who receive it, and the difference it makes are three separate quantities, and none of them can be derived from the list.

The same pattern appears a second time in the same document. The priority-groups analysis at finding L7 is drawn from consultation, and does not carry through into outcome machinery, funding principles or access measures. Consultation identified the groups. Nothing measures whether they are reached.

This is a governance finding, not a philosophical objection to listening. The remedy is not less consultation. It is to publish the two things side by side: what people said, and what the numbers show. Chapter 14 sets out why an account of experience is a primary input and not by itself a rating, and the same logic operates at system level.

L12. The composition of the deaths does not appear

The Strategy cites both biennial death reviews. It draws two findings from them: that coercive control was present in almost all deaths examined, and that responses should address patterns rather than single incidents. Both statements are accurate.

The third finding in the same reports does not appear. Neither document records that non-homicide deaths outnumber homicides in the ACT register by more than four to one over 25 years, that 29 of the 38 non-homicide deaths in 2020–24 were suicides, or that 8 of the 13 deceased victims had been misidentified as the aggressor before they died.

On a full-text check of both published documents, the word "suicide" appears once in the Strategy, inside the title of the *ACT Mental Health and Suicide Prevention Regional Plan 2025–2030* in a list of related strategies. It appears nowhere in the First Action Plan. Neither document uses "self-harm", "homicide", "fatality" or "death review". The Strategy's only use of the word "deaths" is in the coercive control sentence quoted above.

A government may decide that deaths other than homicides are the responsibility of another portfolio. Four things would show that decision had been made: a statement of which deaths this system is responsible for preventing; a published count of the deaths on the other side of that line; a named agency that holds them; and an indicator by which the arrangement could be assessed. None of the four appears in either document, and no handover to the mental health and suicide prevention plan is described. Chapter 4 section 7 sets this out in full.

L13. The left side is named and not yet proven; the right side is built and not yet measured

This finding is a credit and a criticism in the same paragraph, and the credit comes first.

The Strategy is the first ACT document in this field to put likelihood management on the page as a funded intention rather than an aspiration. It states that violence "is preventable, not inevitable". It adopts a four-stage continuum — prevention, early intervention, response, recovery and healing. It carries a dedicated social-change outcome. It commits to building "effective primary prevention infrastructure to drive down rates of violence over time", and to recognising people using or at risk of using violence "before violence occurs or escalates". Measured against a decade in which the ACT built a protection-order system, a current-risk framework and a coordination layer, that is a genuine widening of scope.

The difficulty is what sits under each side of the map.

On the left side, the commitment is to design. The prevention component of the $3.6 million announced with the Strategy funds Women's Health Matters to develop a *model* for

primary prevention infrastructure. The Strategy's phasing places substantive redesign and commissioning in 2028–32. So the left side exists as a named intention with a design contract attached. Whether it changes prevalence, first use of violence or community norms cannot be assessed, because it has not yet operated and no baseline has been published against which it could later be assessed.

On the right side, the commitment is to continue. The great majority of the package is continuity funding for services that already exist, which is valuable and is credited at finding L5 and in Chapter 3. But there is no published account of whether consequence management has reduced lethality, repeat harm or system failure relative to what was spent on it. Chapter 3 records that the verdict on that question is *not proven*.

The result is symmetrical and it is the finding: **one side of the bow tie is described but not yet operating, and the other is operating but not measured.** Neither can be shown to be working, and the Strategy does not propose a measure that would show it for either. Chapter 2 section 8 sets out the analysis in full.

L14. The Strategy states its headline prevalence figure at two different values

The Strategy states, at page 5, that "approximately 1 in 5 women in the ACT report having experienced physical violence and/or sexual violence since the age of 15".

At page 11 it states that "42% of women – or an estimated 73,200 women – in the ACT reported having experienced physical and/or sexual violence since the age of 15", sourced to the Australian Bureau of Statistics.

The two sentences describe the same measure and differ by a factor of about two.

The likely explanation is a drafting error rather than anything else, and it is recorded as such. One of the two sentences has probably lost a qualifier, and the 42 per cent figure is internally consistent with the count of 73,200 that accompanies it. No inference beyond that is drawn.

It is recorded because of the position the figure occupies. This is the prevalence statement of a ten-year strategy, in a document that publishes no baseline and no numeric target for any of its six outcomes. Where a strategy is required to state a 2026 baseline and report against it, a figure of this kind becomes the number every later claim is judged against, and an inconsistency in it is caught before publication because somebody has to use it. Where no baseline is required, the figure is decoration, and nothing in the document depends on which of the two values is right.

That is the mechanism this appendix documents everywhere else, appearing here in its smallest form.

Part 2 — Fourteen changes that would close the gap

#	Change	What it produces	When
1	Publish a one-page outcomes dashboard with the Strategy	2026 baseline, 2028 / 2032 / 2036 targets, data source, reporting frequency and accountable position for each of the six outcomes, including victim-survivor reported safety and dignity	Immediate
2	Release the monitoring and evaluation framework, with independent review	Levy expenditure tied to outcome indicators, reported annually in a form a non-specialist can read	Within the first year
3	Attach a name, a dollar figure and a date to every "this means" statement	Lead directorate, partner services including ACCOs, budget line and action ID for each outcome statement	First Action Plan revision

#	Change	What it produces	When
4	Front-load Aboriginal community-controlled funding and data sovereignty	Multi-year funding agreements, workforce pay parity and Indigenous data governance moved into 2026–28 rather than 2028–32	2026–28
5	Create a dedicated sexual violence implementation stream	Separate measures for disclosure, forensic and counselling wait times, investigation quality, charge and conviction rates, discontinuance with reasons, and court experience	2026–28
6	Write an operational plan for coercive control and systems abuse	Frontline tools, training, charging guidance, and a protocol to prevent misidentification of victim-survivors, with particular attention to Aboriginal women	Before and alongside commencement
7	Make housing and economic security first-order actions	Targets for crisis-to-stable housing pathways, Safe at Home capacity, financial abuse remedies and employment support	2026–28
8	Build prevention infrastructure to run, not to model	Funded settings work with shared standards, bystander capability and evaluation, delivered in parallel with the design contract rather than after it	2026–28
9	Commission a 2026 system demand and workforce study	Replacement for the 2016 gap analysis: known and hidden demand, specialist workforce shortage, vicarious trauma and retention, and access across the Territory	Within the first year
10	Hard-wire lived experience and children's voices into governance	Paid, independent victim-survivor positions on the oversight body, including young people with appropriate safeguards; co-design rights; and a published record of what consultation changed	With the governance design
11	Publish the numbers beside the Listening Reports	For each qualitative theme drawn from consultation, the corresponding count: how many people, how often, at what cost, and the change since the last measurement. Where no number exists, the cell is published empty with the date it will be filled	With the monitoring and evaluation framework
12	State the fatality boundary and publish the count on both sides of it	A sentence identifying which deaths in a domestic and family violence context this system is responsible for preventing; a published, updated count of deaths in that context that are not homicides; the agency accountable for them; and an indicator against which the arrangement is assessed	Immediate
13	Publish one likelihood indicator and one consequence indicator, with 2026 baselines	For likelihood: a population measure capable of showing whether violence is becoming less common. For consequence: a measure capable of showing whether serious harm, repeat victimisation and lethality are falling among people the system has reached. Two numbers, published annually, against which the whole Strategy can be judged in 2036	With the monitoring and evaluation framework
14	Reconcile the prevalence statement	One figure for ACT women's experience of physical and/or sexual violence since the age of 15, stated once, with its source and its qualifier, and used as the published 2026 baseline	Immediate

Part 3 — The scoreboard the Strategy needs

This is the artefact recommended by change 1. It is one page. Every cell is either a published number or a nominated owner. Nothing in it requires new legislation or new data collection beyond what Chapter 17 already recommends.

Outcome	Baseline measure (2026)	Target	Data source	Frequency	Accountable position
1. Victim-survivors have access to support at all stages	Crisis line answer rate; median wait to specialist counselling; crisis accommodation turn-aways	To be set for 2028 / 2032 / 2036	Service data; crisis line reporting	Quarterly	Named
2. Aboriginal and Torres Strait Islander communities determine and deliver responses	Share of DFSV funding held by ACCOs; ACCO workforce pay parity gap; Closing the Gap Target 13 measure	To be set	Funding ledger; Closing the Gap reporting	Annual	Named
3. People using violence are held accountable and supported to change	Program capacity against referrals; completion rate; reoffending within 24 months; partner-contact rate	To be set	Program data; reoffending requires a link to police and court data that does not yet exist	Annual	Named
4. All people model safe and respectful behaviours	Population attitude measures; settings coverage in schools, workplaces and sport	To be set	National attitude survey; program reporting	Biennial	Named
5. A coordinated, sustainable, integrated and capable system	Specialist workforce vacancy and turnover; unmet demand; misidentification rate and time to correction	To be set	Workforce survey; service data; misidentification is not currently recorded anywhere	Annual	Named
6. Systems, institutions and communities play an active role	Institutions with a published response policy; information sharing scheme use	To be set	Scheme reporting; directorate reporting	Annual	Named

Two measures in that table have no data source today, because the data is not collected: the misidentification rate in Outcome 5, and reoffending after behaviour change programs in Outcome 3. Both are addressed by the hundred-day and first-year actions in Chapter 18. Until the data exists, those two cells should be published empty, with the date by which they will be filled. An empty cell with a date is a governance instrument. An outcome with no cell at all is not.

What this appendix established

Four findings that this appendix establishes and nothing else in these pages does. The complete set of 11 registered findings, FL.1 to FL.11, is at Appendix M, where it can be read against every other chapter's. Part 1 has fourteen sections; the bow-tie finding at L13 is registered from Chapter 2 as F2.13, and the prevalence inconsistency at L14 is carried as change 14 in Part 2 rather than as a registered finding.

- **FL.1** — Neither the Strategy nor the First Action Plan uses the word "baseline" or "indicator", sets a numeric target, or names a lead agency for any of its six outcomes.
- **FL.2** — The monitoring and evaluation framework identified as missing by the Auditor-General in November 2024 is described in the future tense in both May 2026 documents, and governance arrangements are described as being developed.

- **FL.8** — The Strategy's account of the current state rests on consultation, which produced two Listening Reports and a published victim-survivor consultation report, and is used in place of a current demand and gap analysis. Consultation records what people experienced; it does not establish how many, how often, at what cost, or whether anything changed.
- **FL.10** — The Strategy cites both biennial death reviews and adopts two of their findings. The composition of the deaths does not appear. On a full-text check, "suicide" appears once in the Strategy, within the title of another plan, and not at all in the First Action Plan; "self-harm", "homicide", "fatality" and "death review" appear in neither.

Sources for this appendix

Claim	Document	Date
Six outcomes; four human-focused and two enabling; outcome statements	ACT DFSV Strategy 2026–2036, "Our outcomes"	27 May 2026
Monitoring and evaluation framework in the future tense; governance "being developed"	ACT DFSV Strategy 2026–2036	27 May 2026
Absence of the words "baseline", "indicator" and "misidentification"; absence of numeric targets and named lead agencies	Full-text examination of both documents	27 May 2026
Action plan phasing: 2026–28 sustainment and mapping; 2028–32 commissioning a re-designed system	ACT DFSV Strategy 2026–2036, Figure 3	27 May 2026
$3.6 million over four years for foundational system infrastructure, and its four components	Joint media release, Chief Minister and Minister for the Prevention of Domestic, Family and Sexual Violence	27 May 2026
$47.8 million additional and $151.4 million direct over four years	2026–27 Budget DFSV factsheet	2026
Consultation process: consultant-led engagement; separate Women's Health Matters consultation with adult victim-survivors through the peer-led Victim Survivors Voices pilot; two Listening Reports; published consultation report; the "what we heard" headings	ACT DFSV Strategy 2026–2036, "Victim Survivor Voices" and "Strategy Consultation"	27 May 2026
Strategy cites the 2023 and 2025 biennial reports for coercive control in almost all deaths examined and for patterns rather than single incidents	ACT DFSV Strategy 2026–2036, p 16	27 May 2026
Word occurrence check: "suicide" once in the Strategy, within the title *ACT Mental Health and Suicide Prevention Regional Plan 2025–2030*, and zero times in the First Action Plan; "self-harm", "homicide", "fatality" and "death review" zero in both	Full-text search of the published PDFs of both documents	Checked 3 September 2026
"is preventable, not inevitable"; the four-stage continuum and its definition of prevention; Outcome 4; "effective primary prevention infrastructure to drive down rates of violence over time"; "before violence occurs or escalates"	ACT DFSV Strategy 2026–2036	27 May 2026
"approximately 1 in 5 women in the ACT report having experienced physical violence and/or sexual violence since the age of 15"	ACT DFSV Strategy 2026–2036, p 5	27 May 2026
"42% of women – or an estimated 73,200 women – in the ACT reported having experienced physical and/or sexual violence since the age of 15", sourced to ABS 2023	ACT DFSV Strategy 2026–2036, p 11 and footnote 16	27 May 2026

Claim	Document	Date
No performance monitoring strategy or evaluation framework; dated needs analysis	ACT Auditor-General, *Safer Families Levy*, Report 10 of 2024	22 Nov 2024
Employment and housing status of deceased victims	ACT DFV Review Biennial Report 2025	2025

Appendix M — The findings register

What this is. Every numbered finding made anywhere in this work, in one table, with the identifier used to cite it and the chapter that establishes it.

Why it exists. Each chapter previously carried its own full list of findings, and a reader going through the work in sequence met the same material three times: in Chapter 1, in the chapter body, and in the chapter's closing list. Those closing lists are now cut to four or five items each. This register carries the rest.

How to cite a finding. Findings are numbered by chapter. **F4.6** is the sixth finding of Chapter 4. Where a finding was added after the original numbering, it carries a letter — **F4.14a** — so that existing references remain valid.

Where the source is. Every chapter ends with a sources table giving the document, page and date for each claim in it. This register gives the finding and the chapter; the chapter gives the source. Appendix N sets out how the figures were verified.

What is not in it. Recommendations are not findings and are not listed here. The reforms are at Chapter 1 and Chapter 16, the hundred-day list at Chapter 18, and the changes proposed to the 2026 Strategy at Appendix L Part 2.

Chapter 2 — Building the system, 2016–2026

ID	Finding
F2.1	The ACT's current system began with a reset in 2016, triggered by a child's death and diagnosed by the Glanfield inquiry, which reported in May 2016.
F2.2	That inquiry identified, as a distinct problem, the failure to implement recommendations in this field.
F2.3	The *Family Violence Act 2016* is universal in coverage and gendered in its statement of the pattern. Both are supported; the operational documents built underneath it lean on the second.
F2.4	The Safer Families Levy commenced on 1 July 2016 at $30 per household and rises to $70 in 2026–27. It had raised more than $46 million by 30 June 2024, and is expected to raise about $49.401 million in the four years to 2027–28. The foundational Safer Families package was $21.42 million over four years from 2016–17.
F2.5	The previous strategy expired in 2017 and was not replaced until 27 May 2026. For that nine-year gap the levy operated with no Territory-specific strategy and no current needs assessment.
F2.6	Information sharing, first recommended in 2016, was legislated in 2024 and was still being implemented in 2026. The risk assessment framework was published in July 2022 and was still being updated in September 2026.
F2.7	Criminalising coercive control moved from a defeated private member's bill in August 2024 to a government bill on 28 May 2026, on the stated basis that system readiness was required first.
F2.8	The 2026–27 Budget provides $47.8 million additional and $151.4 million total direct investment over four years, and $13.2 million a year indexed and ongoing from 2029–30.
F2.9	Structural components lagged their first recommendation by six to ten years. The 2026 Strategy and First Action Plan commit as future work to the monitoring and evaluation framework, system map, true-cost analysis and commissioning roadmap a system of this age would normally hold.
F2.10	The Strategy 2026–2036 is the strongest strategic document in the ACT archive. It sets six outcomes: four described as human-focused, two as enabling. Full-text examination of the Strategy and the First Action Plan finds no use of the words "baseline" or "indicator", no numeric target for any outcome for 2028, 2032 or 2036, no nominated data source, no stated reporting frequency and no named lead agency.

ID	Finding
F2.10a	The Strategy's account of the current state rests on consultation, which produced two Listening Reports and a published victim-survivor consultation report, and stands in the place of the current demand and gap analysis it does not publish. Consultation is not measurement, in the same way that outputs are not outcomes.
F2.10b	The Strategy cites both biennial death reviews and adopts two of their findings. The composition of the deaths does not appear: "suicide" occurs once in the Strategy, within the title of another plan, and not at all in the First Action Plan.
F2.11	The Strategy describes its monitoring and evaluation framework, including of levy expenditure, in the future tense, and governance arrangements as "being developed" — eighteen months after the Auditor-General found those instruments missing.
F2.12	The Strategy's own phasing places 2026–28 as sustaining services while the system is mapped, governance redesigned and commissioning prepared. The substantive redesign and commissioning sit in the 2028–32 action plan.
F2.13	The ACT's system is, in bow-tie terms, predominantly consequence management: the *Family Violence Act 2016* is a protection-order and enforcement instrument, the 2022 framework assesses current risk, and crisis response took 34 to 46 per cent of levy-supported initiatives annually against 12 to 20 per cent for prevention. The 2026 Strategy is the first ACT document to put likelihood management on the page, with a four-stage continuum, a dedicated social-change outcome and a commitment to primary prevention infrastructure — funded, in its first tranche, to develop a model.

Chapter 3 — The money

ID	Finding
F3.1	The eight major funding announcements between 2016–17 and 2026–27 cannot be added together. They overlap in period, mix new with continuing money, draw on different sources, and contain components that are also reported separately.
F3.2	Funding has grown substantially in real terms, and the 2026–27 commitment of $13.2 million a year indexed and ongoing from 2029–30 is a structural improvement on time-limited packages.
F3.3	The Safer Families Levy raised more than $46 million from 1 July 2016 to 30 June 2024 and supplies $63.0 million of the $151.4 million 2026–27 direct commitment. It is a partial offset, not the funding base.
F3.4	Across levy-supported initiatives from 2016–17 to 2023–24, $33.323 million went to government activity and $25.628 million to community-sector activity, with the balance shifting from government-weighted in the first four years to community-weighted in the second four.
F3.5	Crisis response accounted for 34–46 per cent of levy-supported initiatives annually; prevention for 12–20 per cent. Prevention and recovery shares did not materially rise across the audited period, despite repeated strategic commitments to shift upstream.
F3.6	The Auditor-General found in 2024 that planning was undermined by the absence of a Territory strategy and of a current understanding of need; that the responsible office had not developed a performance monitoring strategy or evaluation framework; and that public reporting was not transparent or effective.
F3.7	From March 2018 to 27 May 2026, the ACT's overarching strategy for the purposes of the levy was a national plan that predated the levy and was not written for the Territory.
F3.8	In 2024–25, four initiatives recorded a zero estimated outcome and were reprofiled. All four were system-capability initiatives: the death review continuation, the coercive control response, the information sharing scheme, and integrated information sharing and risk assessment.
F3.9	No public ledger exists, for any year, showing budget, actual expenditure, recipient, source, cohort, targets, achieved outcomes, evaluation status and cost per result by initiative.
F3.10	Individual program evaluations show promising results with recurring methodological limits: retrospective theories of change, small samples, staff-reported data and no comparison groups.

ID	Finding
F3.11	The Community Justice Partnership was funded at approximately $141,000 a year against an estimated $563,000 for the model the evaluation supported.
F3.12	The verdict on portfolio value for money is not proven — neither poor nor good, because the evidence required to decide does not exist.
F3.13	The ACT Domestic, Family and Sexual Violence Strategy 2026–2036 is uncosted and contains no costings. The funding announced alongside it, in the 2026–27 Budget, was $47.8 million in additional funding and $151.4 million of total direct investment over four years.
F3.14	Of that, the joint media release of 27 May 2026 identifies $3.6 million over four years for foundational system infrastructure, in four components. Three build foundations rather than deliver services, and the fourth funds the development of a prevention model rather than the operation of prevention. The balance of the package is substantially continuity funding. On the chapter's counting rules this is announced money, not spent money, and none of it is a result.

Chapter 4 — The deaths

ID	Finding
F4.1	The ACT register recorded 168 fatal incidents in the context of domestic and family violence from 2000 to 2024: 31 homicide and 137 non-homicide incidents.
F4.2	For 2020 to 2024 the register recorded 49 incidents: 11 homicides and 38 non-homicide deaths. Twenty-nine of the 38 were suicides: 21 of the 25 people assessed as perpetrators, and 8 of the 13 assessed as victims. Among the deaths this review was able to examine, people assessed as perpetrators who died by suicide are the largest single category.
F4.3	The review does not publish the sex of the 29 suicides. It can be bounded from the cohorts, which were 24 men and one woman among perpetrators and 11 women and two men among victims: between 20 and 23 of the 29 were men.
F4.4	Ten of the 11 homicides could not be analysed because proceedings were ongoing, so the 2025 review examined only non-homicide deaths.
F4.5	Of the 38 non-homicide deaths, 13 were assessed by the review as victims and 25 as perpetrators; 24 of the 25 perpetrators were male and 11 of 13 victims were female; every male perpetrator targeted a female victim and every female victim was harmed by a male perpetrator.
F4.6	Eight of the 13 deceased victims had been misidentified as the predominant aggressor by police or another agency before death, with recorded consequences including criminal charges, loss of employment, removal of children and incarceration.
F4.7	Four of the 13 deceased victims had been the respondent to a family violence order where the evidence indicates the applicant was the predominant aggressor.
F4.8	Of the 25 deceased people the review recorded as perpetrators, 20 had been the respondent to one or more family violence orders, nine were respondents to a current order at the time of death, and five had contravened an order. Twenty-two had been involved with police at some point and six within a week of their death; the review records that police involvement in this dataset includes being served an interim order.
F4.9	Of the 13 deceased victims, three were the protected person on a current order and nine had previously been a protected person.
F4.10	Deceased victims had markedly worse economic and housing circumstances than deceased perpetrators: 62 per cent (8 of 13) unemployed against 36 per cent (9 of 25), and 54 per cent (7 of 13) with housing instability against 20 per cent (5 of 25).
F4.11	Fifteen of the 25 people the review recorded as perpetrators had criminal records indicating violence outside the family violence context — a factor the review notes is not captured in the national risk assessment principles.
F4.12	Sixty-seven children were affected by the 38 deaths.

ID	Finding
F4.13	The perpetrator classification in this record is the review's own assessment from records, not a court finding. A family violence order is a civil order made on the balance of probabilities, and only five of the 25 are recorded as having contravened one. The review examined misidentification only among the people it had classified as victims; it publishes no reciprocal check on the 25.
F4.14	The 2023 review found coercive control in almost all of the 12 homicides examined and no significant prior physical violence in about 9 of the 12.
F4.14a	The disproportion between homicide and non-homicide deaths was in the Territory's published record from 2023, when the first biennial report recorded 17 homicides among 106 identified incidents from 2000 to 2022.
F4.14b	The ACT Domestic, Family and Sexual Violence Strategy 2026–2036 cites both biennial death reviews and adopts two of their findings, being coercive control and patterns rather than incidents. The word "suicide" appears once in the Strategy, in the title of a different document, and does not appear at all in the First Action Plan 2026–28. Neither document uses "self-harm", "homicide", "fatality" or "death review".
F4.14c	Neither document states which deaths the system is responsible for preventing, publishes a count of deaths in this context that are not homicides, names an agency responsible for them, or states an indicator by which the arrangement could be assessed.
F4.15	The 2023 review made 12 recommendations. The 2025 review made no new recommendations, stating that the 2023 recommendations remained relevant, and did not publish an implementation status matrix despite the Auditor-General having recommended one.
F4.16	On the public record as at 2 September 2026, no 2023 recommendation can be shown to be fully implemented.

Chapter 5 — The service system

ID	Finding
F5.1	The 2024 independent review found both ACT crisis specialist service models are evidence-informed and highly valued by victim-survivors who could access them.
F5.2	The 24-hour domestic violence crisis line could not answer all calls; many were diverted to voicemail, particularly overnight and at weekends when staffing is reduced.
F5.3	The service could not resource attendance at all police callouts, and clarity was needed with police about when attendance should be prioritised.
F5.4	Counselling waits at the sexual assault service could extend to several months, in a model that is deliberately free and session-unlimited.
F5.5	Crisis workers were spending a substantially increased share of their time on accommodation searching because of a housing shortage and difficulties with centralised allocation, and the review found this directly compounded crisis line responsiveness problems.
F5.6	Funding was provided through legacy programs not aligned to demand or true operating costs, and contract arrangements were described as not fit for purpose.
F5.7	Agencies across the system used different risk processes and could reach different conclusions about the same case — a finding made from the service floor two years after the common framework was published.
F5.8	Stakeholders identified service coverage gaps for children and young people, older people, people with disability, LGBTIQA+ people and culturally and linguistically diverse communities.
F5.9	Victim-survivors reported variable responses from universal services, indicating gaps in knowledge and skills across the broader sector about responding to disclosures.
F5.9a	Published submissions to the 2026 coercive control inquiry record victim-survivor accounts that the support available fell far short of what was needed, that navigation was carried informally by friends, that services were experienced as dismissive, and, in one account, that a publicly funded health provider endorsed a control tactic as a safety measure. These establish meaning, mechanism and barrier; they do not establish prevalence, and none is claimed.

ID	Finding
F5.10	On 10 June 2026 the responsible Minister, asked in the Legislative Assembly for the current rate of unanswered crisis line calls, said the member would need to ask the service directly, and identified the acceptable rate as a question for the service.
F5.11	The 2026–27 package increases and indexes provider funding and funds several identified gaps, but does not change the housing interface, the contracting model or the risk process inconsistency, and introduces no published measure by which its effect could be assessed.

Chapter 6 — The justice interface

ID	Finding
F6.1	The Director of Public Prosecutions reported a 50 per cent increase in family violence prosecutions and a 170 per cent increase in sexual violence prosecutions over four years, and stated there had been no commensurate increase to funding.
F6.2	In one financial year the office prosecuted 5,231 matters across ACT courts, including completing more than 800 family violence files and commencing more than 200 sexual assault files.
F6.3	The Director stated that the real-life effect was that staff do not have time to prepare matters properly, and that the office was asked to deliver the impossible with a budget that had fallen significantly behind other jurisdictions.
F6.4	The office also reported inadequate training and obsolete case management technology.
F6.5	ACT Policing recorded 4,478 domestic and family violence related incidents in 2024–25, a 33 per cent increase over five years, while total assault offences fell 3.3 per cent on the previous year.
F6.6	The ACT sexual assault victimisation rate rose from 65.0 per 100,000 in 2020 to 89.4 in 2024, about 37 per cent, while sexual offence prosecutions commenced rose about 170 per cent over four years — a divergence of roughly four and a half times.
F6.7	Family violence prosecution growth of about 50 per cent over four years is broadly consistent with the 33 per cent growth in recorded incidents; the divergence is specific to the sexual violence stream.
F6.8	Family violence matters discontinued rose from 2.4 per cent of completed matters in 2017–18 to 12.7 per cent in 2023–24, and the proved share fell from 81.3 to 75.6 per cent.
F6.9	Sexual offence matters discontinued rose from 2.5 per cent of completed matters in 2017–18 to 17.3 per cent in 2023–24.
F6.10	In Supreme Court sexual offence trials, not guilty verdicts roughly equalled guilty verdicts in both 2017–18 (8 against 9) and 2023–24 (5 against 5).
F6.11	No agency publishes the reasons for discontinuance, the stage at which matters are discontinued, or whether the material that ended a prosecution was already held.
F6.12	Regulatory prosecutions were transferred to the Solicitor-General to relieve pressure; the Solicitor-General later reported that the transferred workload had been significantly underestimated.
F6.13	Legal Aid ACT reported prioritising criminal and domestic and family violence matters, with civil, employment and discrimination matters “not getting much preference”.
F6.14	Legal Aid ACT reported a means threshold reaching only 120 per cent of the poverty line against an aspiration of 180 per cent, and that its requested baseline review was not occurring.
F6.15	Supreme Court listings rose by nearly 50 per cent and judicial numbers were increased, but added judicial capacity does not increase throughput where matters arrive unprepared.
F6.16	Magistrates Court family violence reasons are published far less consistently than Supreme Court reasons, making the busiest part of the family violence system the least visible.
F6.17	The 2026–27 Budget identifies approximately $37.9 million of adjacent justice initiatives, which acknowledges the connection between reform and downstream demand but is not a demand model.
F6.18	No published whole-of-system demand and capacity model exists for any ACT family violence reform, including the proposed coercive control offence.

Chapter 7 — Family violence orders

ID	Finding
F7.1	An interim family violence order can exclude a person from their home, suspend their firearms licence, restrict their movement and interrupt contact with their children, and its contravention is an offence carrying up to five years' imprisonment.
F7.2	The statutory test is necessity for safety or to prevent substantial property damage, on the balance of probabilities, in a court that need not comply with the rules of evidence and may inform itself as it considers appropriate.
F7.3	Sections 36, 37 and 39 require a structured weighing of protection against restriction, including express consideration of the respondent's accommodation needs and options.
F7.4	The *Family Violence Act 2016* contains five reasons provisions. Section 103, the only one that prescribes what a reasons record must contain, applies to a judicial officer **refusing** an after-hours order; section 104 (b) places that refusal record on the record of the Magistrates Court, and gives no destination to the section 104 (a) record of reasons for **making** one. Sections 39 (3) and 110 (2) likewise attach to decisions not to restrain and prescribe no content. Section 68 requires a court to record its reasons for making a protection order, and the Dictionary definition of *protection order* brings interim orders within that duty. The section prescribes no content for those reasons, no form, no requirement that they identify the material relied on or the less restrictive option considered, no entitlement in the respondent to receive them, and no publication or aggregation; nothing in the public record indicates that reasons recorded under section 68 have ever been counted, sampled or reported. Section 39 separately requires reasons where an exclusion condition is **refused**, with no equivalent express requirement where one is imposed.
F7.5	Section 47 (1) fixes a maximum of two days between receipt of an application and the hearing of the interim order — the hearing at which the order is made, not one at which the respondent is heard. Sections 47 (3)(a) and 47 (4)(a) govern the next listing by the words "as soon as practicable", and no provision of the Act fixes any maximum period between the making of an ex parte interim order and the first occasion on which the respondent may be heard. Section 91B gives an applicant refused by a registrar a statutory same-day request, a rehearing anew, a return not later than two days after the request, and provides that the registrar need not tell the respondent about it. The respondent restrained by a granted order has no equivalent expedited pathway and no outer limit: section 82 (c) permits an application to amend, but it routes through a section 82A preliminary conference listed "as soon as practicable", and the urgent limb at section 82B is confined to the protected person or the applicant. Section 113 (e), which would have applied a timing rule to court-initiated interim orders, cross-refers to a section 47 (1)(b) that does not exist. No ACT statistic measures the interval.
F7.6	In-person attendance is the default; remote appearance requires leave and is not a standard selectable listing option.
F7.7	Beyond the general duty in section 68 to record reasons, the public record does not disclose any published form, checklist, criteria set or content requirement structuring the section 21, 36, 37, 39, 44 or 47 decisions, and no defined likelihood or consequence scales exist for them.
F7.8	As a result, basic administrative questions about interim order practice — how often exclusion conditions are imposed, how often orders are confirmed at final hearing, whether decisions are consistent — cannot be answered from any published source.
F7.9	Section 44 suspends a firearms licence automatically on an interim order but makes seizure discretionary, and no published workflow governs the sequencing of seizure relative to notice, or the separate treatment of home, occupational and club access.
F7.10	Section 43(4) removes complicity liability from a protected person absolutely, leaving no mechanism to address deliberate inducement of a contravention.
F7.11	The *Human Rights Act 2004* requires public authorities to give proper consideration to relevant rights, and excludes courts only when acting judicially, not administratively; the administrative arrangements around interim orders do not produce documentation capable of demonstrating that the less-restrictive-means question was asked.

Chapter 8 — The risk framework against the standard

ID	Finding
F8.1	The ACT Government requires risk management aligned to AS ISO 31000:2018 across all its functions, expressly including health and safety activities, policy development and planning.
F8.2	A defensible risk decision requires six components: risk criteria, a full treatment option set, a residual risk statement with a named acceptor, named risk owners, framework-level monitoring, and framework-level reporting.
F8.3	The July 2022 ACT domestic and family violence risk framework contains none of the six.
F8.4	Tested against ISO 31000 clause by clause, eight requirements are not met, nine are partially met, and none is fully met.
F8.5	The framework defines no likelihood scale, no consequence scale, no combination rule, no thresholds and no statement of acceptable risk, so two practitioners applying it to identical facts can reach different conclusions with no rule making either wrong.
F8.6	The framework collects a victim-survivor self-rating from 1 to 10 and provides no rule for interpreting or applying the number.
F8.7	The framework does not require options to be identified, compared or justified, which is the analysis section 37 of the *Family Violence Act* requires a court to perform.
F8.8	The framework contains unresolved internal tensions: victim autonomy against mandated action, and treating the victim's assessment as the most accurate indicator while structuring how it is elicited.
F8.9	Assessment question 14 combines a past mental illness diagnosis with suicide threats into a single item, so a positive answer cannot be interpreted.
F8.10	Risk factors are listed without weighting, mixing factors of very different evidential strength.
F8.11	Screening is designed as the routine asking of every woman who uses a service, which partly determines who is identified and means service data cannot be read as a measure of population distribution.
F8.12	The framework adopts structured professional judgment but lacks the coding rules, formulation requirement, defined scenarios and published validation that the method requires.
F8.13	An independent review two years after publication found agencies using different risk processes and reaching different conclusions about the same case.
F8.14	The 2023 death review recommended a pattern and primary aggressor tool for police and courts, which is a statement that the 2022 framework did not provide one.
F8.15	Four years after publication the framework was still described as being updated and had not been consistently implemented.

ID	Finding

Chapter 9 — The predominant aggressor decision

ID	Finding
F9.1	The predominant aggressor decision determines who is charged, who is named as respondent, who leaves the home and what child protection does, and the ACT's own death review documents its consequences as including criminal charges, loss of employment, child removal and incarceration.
F9.2	The ACT framework's Fact Sheet 10 contains sound general material on context, intent, effect, fear, agency, empathy and entitlement, and correctly warns about the dangers of misidentifying in either direction.
F9.3	Fact Sheet 10 also contains a sex-specific list of approximately twenty indicators that a man claiming victim status is more likely to be the primary aggressor, mixing evidential indicators with demeanour and attitude indicators.
F9.4	The demeanour indicators include seeming overly calm and confident, presenting as overly charming, being forthright in criticising his partner, being critical of how "the system" responds, focusing on his rights, trying to convince the assessor he is the injured party, and appearing to have a second motive such as a Family Court matter.
F9.5	Taken together, the listed presentations cover most of the ways a person in this situation can present, so a man's demeanour is capable of supporting the same conclusion whether he is composed or aggrieved, articulate or evasive.
F9.6	Fact Sheet 9 instructs practitioners to be cautious and keep an open mind when a male client claims to be a victim, even where police or other services have identified him as such.
F9.7	The framework states there is no definitive set of indicators and provides no coding rules, weighting, threshold, decision rule, required record, sensitivity, specificity, inter-rater reliability, error analysis by cohort, or validation of any kind.
F9.8	The material is adapted from Victorian and Western Australian practitioner guidance, including a behaviour change program practice guide. Those are credible practice sources; they are not validation studies.
F9.9	The cited figure that 15 to 50 per cent of police-identified male victims are actually perpetrators spans a factor of more than three, is a population statement rather than an individual one, and has no ACT equivalent.
F9.10	The ACT's own death review found 8 of the 13 deceased victims — 11 of the 13 were female — had been misidentified as the predominant aggressor, so the documented errors in the ACT run in the direction the fact sheets exist to prevent.
F9.11	An instrument that does not prevent the error it is designed for provides no assurance about errors in the other direction, and no ACT data exists that would measure either.
F9.12	The framework treats the victim-survivor's self-assessment as centrally important but provides no rule for the contested case in which both parties self-assess as victims, resolving it instead by reference to sex.

Chapter 10 — What is measured, and who disappears

ID	Finding
F10.1	The ACT has no public dataset showing service access, unmet demand or outcomes by sex, gender identity, victim or perpetrator status, relationship type, disability, Aboriginal and Torres Strait Islander identity or cultural background.

ID	Finding
F10.2	The Family Violence Safety Action Program recorded 4, 5 and 6 male victim-survivors across 258, 258 and 211 referrals in 2024–25, 2023–24 and 2022–23, and one non-binary victim-survivor across all three years.
F10.3	In the same period it recorded 254, 252 and 210 male people using violence.
F10.4	ABS data shows men as roughly 24 per cent of people experiencing physical or sexual violence by a cohabiting partner since age 15, and roughly 36 per cent of people experiencing any violence or emotional or economic abuse by a cohabiting partner.
F10.5	A national survey published in 2025 found lifetime intimate partner violence reported by 48.4 per cent of women and 40.4 per cent of men, with women reporting substantially more multitype violence.
F10.6	The gap between program composition and population prevalence has at least five testable explanations — high-risk case profile, differential help-seeking, referral pipeline composition, awareness and service fit, and misclassification — and none has been tested.
F10.7	The budget record contains no clearly labelled, separately costed male victim service line, while male-specific budget lines appear as behaviour change programs for men who use violence.
F10.8	A 2021 official answer reported 326 male-identified clients of the crisis service in 2020–21 but could not separate victims from men seeking help about their own use of violence, and the requested historical male-victim data was not held.
F10.9	The ACT has demonstrated it can separately identify and cost cohort-specific investment, including a $1 million LGBTIQA+ program, $2.1 million for multicultural women, children and young people, and $2.1 million for Aboriginal community-controlled sexual violence responses.
F10.10	The 2025 death review recorded no deceased victim as a person with disability, in a review that states its information about people with disability was particularly limited.
F10.11	Suppression of counts below five prevents reporting for Aboriginal and Torres Strait Islander people and other small cohorts, including the group the review identifies as most vulnerable to misidentification.
F10.12	Of the three kinds of possible bias, only measurement bias is established on the evidence. Allocative bias and assessment bias cannot be tested, because the required data does not exist.
F10.13	The prevalence evidence accepted here is that, since the age of 15, 17 per cent of women and 5.5 per cent of men report physical or sexual violence by a cohabiting partner, and 27 per cent of women and 15 per cent of men report violence or emotional or economic abuse by a cohabiting partner; 22 per cent of women and 6.1 per cent of men report sexual violence, and 22 per cent of women report sexual violence by a male perpetrator against 0.7 per cent by a female perpetrator.
F10.14	The 2026 Strategy adopts gender inequality as its causal account of domestic, family and sexual violence, reproducing the four gendered drivers set out by Our Watch — condoning of violence against women, men's control of decision-making, rigid gender stereotypes and dominant masculinities, and male peer cultures of aggression and control — and places childhood trauma, alcohol and other drug use, mental illness, poverty, jealousy, situational conflict and bidirectional abuse among reinforcing factors rather than co-equal causes.
F10.15	Women victim-survivors, children, Aboriginal and Torres Strait Islander women and communities, men who use violence, and men and boys as a prevention audience each hold a place in the outcomes machinery, while male victim-survivors have no dedicated pathway, women who use violence are folded into "people who use violence", and same-sex and other LGBTIQA+ partner violence is named without an operational model.
F10.16	The chapter recommends adding a workstream covering male victim-survivors, women who use violence, and bidirectional and same-sex violence, with three components: a defined service pathway stated in the same terms as the pathway for the modal case; a classification safeguard that runs in both directions, permitting the answer "unresolved" and reporting misidentification by sex; and data recording sex, gender identity, relationship type and the direction of violence.

Chapter 11 — Orders, suicide and the data never collected

ID	Finding
F11.1	Between 2020 and 2024, nine people died by non-homicide means while subject to a current family violence order; 20 of the 25 people recorded as perpetrators had been respondents to an order at some point; 29 of 38 non-homicide deaths were suicides; and eight of the 25 deaths occurred in the context of a pending or recent separation from an intimate partner.
F11.2	Six of the 25 deceased people recorded as perpetrators had police involvement within a week of their death.
F11.3	Four of 13 deceased victims had been respondents to an order where the evidence indicates the applicant was the predominant aggressor.
F11.4	The ACT Coroners Court confirmed in writing, on 26 March 2026, that the ACT Suicide Register has no field identifying whether a deceased person was subject to a family violence order at the time of death.
F11.5	The Coroners Court confirmed that order status may appear in the narrative of an individual police report, so the information exists but is not structured.
F11.6	The Coroners Court confirmed that there has been no internal review, audit, thematic analysis, research project or annual summary examining correlations between domestic violence proceedings and suicide outcomes.
F11.7	ACT Policing decided on 19 February 2026 that it holds no discrete document with the requested figures, and that producing them would require reviewing every recorded suicide case individually to note order status; access was refused on resource grounds.
F11.8	ACT Policing confirmed it does not typically record suicide attempts and holds no internal analysis of the relationship.
F11.9	Requests for court administrative statistics on interim orders made without the respondent present, respondent gender, and confirmation rates at final hearing were refused on 2 February 2026 on the basis that court information is taken to be contrary to the public interest to disclose unless administrative in nature, and that outcome data is not administrative in nature.
F11.10	The *Work Health and Safety Act 2011* (ACT) primary duty of care extends to the psychological health of other persons affected by an undertaking's work, and five reasonably practicable controls relevant to this hazard are absent.
F11.11	The ABS records problems in spousal relationship circumstances as the third most common psychosocial risk factor in Australian suicide deaths, present in 25.0 per cent of deaths in 2024.
F11.12	Deaths are the only outcome recorded reliably in this field, and the only recorded datum that is binary rather than the product of an assessor's judgment. Suicide attempts are not typically recorded by ACT Policing, and no agency records psychological harm, loss of work, loss of housing or loss of contact with children as outcomes of an allegation or an order. Treating deaths as an indicator of a larger unmeasured volume of harm is standard practice in crime statistics and in health services research, subject to known limits, so the 29 suicides are best read as a floor and an indicator rather than as a measure of the harm.
F11.13	Research consistently associates justice system contact with acute psychological deterioration, and both ACT death reviews identify separation as a period of heightened risk for both homicide and suicide.
F11.14	Five changes — a register field, a police system flag, published court statistics, a welfare step at service, and an annual published analysis — would allow the question to be answered, and none requires legislation.
F11.15	The ACT Magistrates Court published family violence order application counts and interim application counts in its annual reviews to 2019–20, reporting 1,249 applications and 1,152 interim applications in that year, and has published no annual review since, in a period in which the Supreme Court has published five.

Chapter 12 — Three cases

ID	Finding
F12.1	In 2014 a man was arrested and remanded on allegations of rape and domestic violence, and spent nearly four months in a maximum security prison interstate before charges were dropped on evidence establishing he was elsewhere at the time.
F12.2	In January 2019 his accuser was sentenced in the ACT Magistrates Court to three years and one month imprisonment with a two-year non-parole period for making a false rape allegation and staging a crime scene, the magistrate finding she had exploited the seriousness with which domestic violence and rape claims are treated.
F12.3	In December 2021 a New South Wales police officer was found guilty of perjury in the ACT Supreme Court over evidence he gave supporting her account.
F12.4	ABC reporting in 2015 recorded internal AFP findings that a former acting sergeant had pressured another officer to alter a statement and had become too personally involved with the complainant, and later resigned.
F12.5	In October 2025 a Canberra man was arrested at 3am in a tactical police operation on his former partner's claim that he was an armed outlaw motorcycle gang member, a claim for which no supporting record was produced in the proceedings, and spent two weeks in custody.
F12.6	On the account reported from the hearing and accepted by the investigating officer in cross-examination, digital forensic analysis of the complainant's phone indicated that threatening messages she said she had received had been sent by her to herself through anonymous texting services paid for from her own digital wallet; the forensic conclusions were not tested by a court and no charge was laid against her.
F12.7	In March 2026 the investigating officer accepted in cross-examination that the complainant had fabricated evidence and had lied to police.
F12.8	In the third matter, the 2016 Board of Inquiry recorded multiple reports from mandatory reporters, a "churning" of concern reports received and closed, an intake process with no consideration of cumulative harm, and decisions whose reasons were not always recorded; on that record it cannot be established whether any given report was assessed and found not to meet the threshold or was not assessed at all, and the one control adopted afterwards — a police decision not to investigate recorded with its reason and notified to child protection — is the control the first two matters never had.
F12.8a	The magistrate described the conduct of both police and prosecutors as egregious, said from the bench that the prosecution presumably had held the relevant knowledge since January without acting, called the situation unbelievable; the charges were discontinued, costs were awarded, and the magistrate directed that a transcript be provided to the Chief Police Officer and to AFP Professional Standards.
F12.9	The accused's mobile phone, seized in August, was not delivered to digital forensics until seven months later; the officer responsible accepted in cross-examination that he had failed in that responsibility.
F12.10	The Director of Public Prosecutions said the complete relevant material was not received until 18 March 2026 and that a determination was made within seven business days; ACT Policing said exculpatory concerns could not be confirmed until an electronic device was forensically examined and that it would consider the circumstances for learnings.
F12.11	The two matters in which an allegation did not survive examination share six features: acceptance of an account without independent verification, severe consequences applied before assessment, exculpatory material that existed from the outset, no single person accountable for the verification chain, a contested parenting dispute in the background, and a correction that arrived too late to unwind the consequences; four of those features — information that existed at the time of the decision, no named owner for the step of examining it, consequences or harm arriving before the examination, and acceptance of an account without independent verification — are present directly in the third matter, the other two are present in altered form, and only the direction of the error differs.

ID	Finding
F12.12	The man cleared in the second case described the effect of the process in terms of suicide, saying in reported comments that it was obvious why so many fathers kill themselves and describing recurrent thoughts of driving into a truck; the categories of consequence he described — custody, bail conditions, separation from a child, and large legal debt — are the same categories the 2025 death review records for the people it examined.
F12.13	Three cases establish a mechanism, not a rate; the mechanism is a verification chain with no owner; the error is documented running in both directions, in allegations accepted without checking and in reported danger never assembled; and nothing in this chapter supports a claim that false allegations are common or that the system is biased against any group.

Chapter 13 — Accountability

ID	Finding
F13.1	Across twelve functions, the record shows a duty, a documented gap and a documented consequence, and in every case the missing element is a named owner accountable for the outcome.
F13.2	The central budget process operated a dedicated levy for more than eight years (from March 2018, when a national plan was identified as the overarching strategy, to May 2026) without a Territory strategy or a current needs assessment.
F13.3	The portfolio performance function did not develop a performance monitoring strategy or evaluation framework, which is why no statement of impact exists for the decade.
F13.4	The risk framework owner published a framework containing none of the six components required for consistent, auditable risk decisions, and it remained under revision four years later.
F13.5	The primary aggressor decision is made using guidance with no coding rules, weighting, thresholds or validation, and eight of 13 deceased victims examined in 2025 had been misidentified.
F13.6	Justice reform increased demand on prosecution and legal assistance without corresponding funding, with consequences stated on the record by both agencies.
F13.7	A housing shortage and allocation difficulties consumed specialist crisis capacity, contributing to unanswered crisis line calls.
F13.8	Information sharing, recommended in 2016, was legislated in 2024, reprofiled in 2024–25 and still being implemented in 2026.
F13.9	No agency holds structured data linking family violence orders to deaths, and none has ever analysed the relationship.
F13.10	Non-implementation of recommendations was identified as a distinct problem in 2016 and again in 2023, an implementation tracker was recommended by the Auditor-General in 2024, and none has been published.
F13.11	Coordination was established in 2016 and accountability was not; the two are different, and the distinction explains the pattern across all twelve entries.
F13.12	Most of what is documented here is known because an Auditor-General, a Director of Public Prosecutions, a legal aid chief executive, a death review coordinator, a magistrate and a series of committee members put it on the public record.

Chapter 14 — Design principles

ID	Finding
F14.1	Twelve rules govern the replacement instrument. The table states each one and where it is implemented.
F14.2	Principles 1 and 2 are argued in Chapter 8. Rating options changes the error mode, and R2 is itself a safety risk.
F14.3	The recording rules: established, reasonably open or unknown for every item; run, nil for a completed check; a confidence level on every rating; untestable observations recorded but excluded; unresolved classification permitted, with options that do not depend on it.
F14.4	The decision rules: a control counts only if verified against the seven tests; each person's own account is a primary input; conflicts are resolved by pattern and source, not by sex; and reversible consequences are preferred where protection is equal.
F14.5	Nothing is deployed before measured performance and a withdrawal trigger are published, alignment is required rather than encouraged, and the workforce is funded for the time the instrument takes.

Chapter 15 — The rewritten framework

ID	Finding
F15.1	The replacement retains structured professional judgment, the evidence-based risk factors, coercive control as a pattern, the focus on children, intersectionality, perpetrator accountability, and the person's own assessment.
F15.2	It adds three layers where the current framework has one: governance, process and instrument.
F15.3	It adds defined risk criteria: separate intent and capability scales, likelihood and consequence scales for two distinct risks, a combination matrix, a tolerance statement and a confidence rating.
F15.4	It rates two risks — harm and hardship — separately and never averages them; the first sets the required protection, the second chooses among adequate options.
F15.5	It weights risk factors into three tiers by evidential strength, each with a coding rule, and adds violence outside the family context as a factor the national principles do not capture.
F15.6	It separates diagnosed mental illness, which is recorded as context and does not contribute to a rating, from suicide threats by the person using violence, which remain a Tier 1 factor.
F15.7	It replaces the sex-specific primary aggressor indicators with an evidence and pattern method that applies identically to any person and permits the answer "unresolved".
F15.8	It excludes demeanour, criticism of the system, assertion of rights, persuasiveness, denial and the presence of family law proceedings from classification, while recording them as visible observations.
F15.9	It applies screening to all clients and records the screening design so the resulting data can be interpreted.
F15.10	It requires every control to have a named owner, a time, a proof standard and a failure response, and records unverified controls as failed.
F15.11	It requires a residual risk statement with a named acceptor, and prohibits acceptance of an out-of-tolerance residual at practitioner level.
F15.12	It specifies framework-level indicators, reporting frequency, named recipients and required actions.
F15.13	It requires published inter-rater reliability and a stated withdrawal trigger before deployment, and published error analysis by cohort after it.
F15.14	It establishes a correction pathway requiring record correction, notification, consequence review, measurement and a stated remedy pathway.
F15.15	It changes nothing about the statutory threshold for an order, the paramountcy of safety, emergency action, the evidence base for the Tier 1 factors, or the scope of specialist services.

Chapter 16 — Legislative reform

ID	Finding
F16.1	Five reforms require legislation or are materially stronger in it, and one further measure is a Cabinet process requirement.
F16.2	A new Division 4.1B (the Bill before the Assembly inserts a Division 4.1A of its own) would require a structured, standard-compliant risk assessment and risk management plan before a court proceeds in the absence of the respondent, with the court recording its satisfaction and reasons, without changing the section 21 threshold and without invalidating orders for non-compliance.
F16.3	A new Division 3.8 would create a safety and support obligation at the point of service, with a minimum documented welfare and referral step legislated as a duty, and stronger accompanied and clinical versions enabled by regulation.
F16.4	A statutory alignment obligation would require prescribed entities to align policies, procedures, practice guidance and tools to an approved framework on a published timetable and report annually, and would prohibit approval for general use until validation results including inter-rater reliability have been published.
F16.5	Section 43(4), which removes complicity liability from a protected person absolutely, is examined in the annex to this chapter as a question rather than a proposal, because the ACT frequency of deliberate inducement is unmeasured and the comparative charging evidence has not been assembled.
F16.6	A publication obligation would require quarterly de-identified aggregate court statistics on applications, interim orders including those made without the respondent present, conditions, outcomes and timeliness, accompanied by a field in the ACT Suicide Register and a queryable flag in the police records system, and would require the discharge of an order to be corrected through every system that recorded it, a suspended firearms licence to be reinstated administratively on discharge, and the number of orders discharged, withdrawn or dismissed at first contested hearing to be published.
F16.6a	Where an interim order is made in the absence of the respondent, the respondent would be entitled on request to a listing before a Magistrate within two business days, matching the expedited pathway the applicant already has on a refusal, with the protective conditions continuing until the return.
F16.7	A Cabinet requirement would prohibit funding of material justice or service reform without a published whole-of-system demand and capacity model that names who absorbs any unfunded remainder.
F16.8	Two readiness conditions follow from the evidence for any coercive control offence: published inter-rater reliability for the classification method, and a published demand and capacity model, both before commencement. (Tested against the Bill as presented at F19.4.)
F16.9	Where a court proceeds in the absence of the respondent, the respondent would be entitled on request to a listing before a Magistrate within two business days, with the protective conditions continuing until then (new section 47C); the reasons the court already has to record under section 68 would have to state the material relied on, whether any of it came from an independent source, why the matter could not wait for a notified listing, which less restrictive conditions were considered, and whether the court could identify the person most in need of protection (new section 68A); and, because section 92 confines appeals to final orders and section 87 permits review only of a special interim order, the review in section 87 would be extended to an interim order made in the respondent's absence, with non-compliance with sections 47A, 68A or 21A as a ground (new section 47D). Separately, and put as a question rather than a recommendation, reciprocal conditions would be available at the court's discretion only where it recorded that it could not make that identification, expiring at the first contested listing, with an express amendment to section 21, a carve-out from the automatic consequences, a pre-registered evaluation, a published withdrawal trigger and a 24-month sunset.
F16.10	Three measures are expressly not proposed: raising the order threshold, a costs regime against unsuccessful applicants, and a new offence of making a false allegation.

ID	Finding
F16.11	Section 43(1) applies to a person **against whom** a family violence order is made, so reciprocal conditions attached to a protected person carry no offence unless a provision expressly deems that person into the section. With the express deeming at section 21A(6A), conduct by the protected person breaching a reciprocal condition is a primary contravention under section 43(2) rather than complicity, because section 43(4) immunises complicity in another person's breach and not a person's own. That operates only where a magistrate was satisfied the person most in need of protection could not be identified, never reaches the inducement of a breach of an asymmetric condition, and creates criminal exposure for a person who sought protection. It is not an answer to the section 43(4) question.

Chapter 17 — Governance and measurement

ID	Finding
F17.1	The ACT has a coordination layer and not an accountability layer, and the accountability layer is the precondition for every other reform proposed in Part III.
F17.2	An annual investment and results ledger would show, for every initiative, budget against actual expenditure, source, recipient, cohort, targets, achieved outputs and outcomes, reprofiled and lapsed amounts, evaluation status and unit cost, with a double-count flag identifying which figures may be added.
F17.3	A monitoring and evaluation framework must measure serious harm, repeat violence, fatality, misidentification, timeliness, unmet demand, housing stability, economic security, child outcomes and perpetrator outcomes — with baselines, numeric targets and dates — rather than activity measures.
F17.4	Most of these measures have no ACT baseline, and a baseline is established by measuring once.
F17.5	A privacy-preserving linked data asset would answer questions that currently cannot be answered at all, under governance conditions including Indigenous data sovereignty, purpose limitation, separated identifiers, audited role-based access, statutory penalties and a published data dictionary.
F17.6	Rolling multi-year totals should replace suppression for small cohorts, so that small groups are reported rather than made invisible.
F17.7	A rapid multidisciplinary review of every eligible fatality and near-fatality should operate alongside the retained biennial thematic report, with a statutory basis, a prohibition on use in proceedings and a protocol for open matters.
F17.8	Every recommendation should enter a published implementation tracker with owner, due date, status and evidence — recommended by the Auditor-General in 2024 and not yet delivered.
F17.9	Every Strategy outcome should have a named accountable position rather than an accountable agency, because a duty distributed across an agency is held by nobody.
F17.10	The annual report must explain every measure that moved in the wrong direction.
F17.11	Every instrument in use must publish inter-rater reliability, predictive performance, error analysis by cohort, indicator-level contribution and its withdrawal trigger.
F17.12	The cost divides into negligible, modest and substantial components. The package is costed at Appendix P7 at about 2.9 to 4.1 per cent of the $151.4 million direct investment over four years, and at more than the $3.6 million foundational system allocation at every point in the range; it is not marginal.
F17.13	The Strategy sets six outcomes, and neither it nor the First Action Plan supplies a baseline, a numeric target, a data source, a reporting frequency or a named lead agency for any of them.
F17.14	A one-page outcomes dashboard published with the Strategy would supply those five things for each outcome, including victim-survivor reported safety and dignity; a worked version is at Appendix L, Part 3.

ID	Finding
F17.15	The monitoring and evaluation framework should be released now for independent review, tying Safer Families Levy expenditure to outcome indicators and reported annually in plain language; it defines the measures that the annual ledger's outcome fields report against, so the two are one system rather than two.
F17.16	Every outcome statement should carry a lead directorate, partner services including Aboriginal community-controlled organisations, a budget line and an action plan identifier, because a commitment with no named owner cannot be tracked, escalated or seen to fail, and therefore cannot be corrected.
F17.17	Oversight should include paid, independent lived-experience positions, young people with age-appropriate safeguards, co-design rights over programs that affect them, and a published record of what consultation changed.
F17.18	Two rows of any honest scoreboard cannot be filled today — the misidentification rate and reoffending after behaviour change programs — and both should be published empty with a date, because an empty cell with a date is a governance instrument and a missing row is not.

Chapter 18 — Implementation

ID	Finding
F18.1	Seven actions can be completed within a hundred days, none requiring legislation and all but one within existing budgets, the exception being the reliability study costed at Appendix O: a field in the ACT Suicide Register, a status flag in the police records system, a published implementation tracker, quarterly published court administrative statistics, published inter-rater reliability testing of the existing risk instrument, named accountable positions for each Strategy outcome, and a published operational plan for coercive control and systems abuse.
F18.2	Eight larger items belong in the first year: the first investment and results ledger, the monitoring framework with baselines, the documented welfare and referral step at service, the completed framework rewrite with published validation, a 2026 system demand and workforce study, front-loaded Aboriginal community-controlled funding and data sovereignty, a sexual violence implementation stream with its own measures, and housing and economic security actions carrying targets.
F18.3	The substantial items belong in the first term: the legislation, the linked data asset, the rapid fatality and near-fatality review, commissioning reform on true costs, prevention infrastructure built to run rather than to model, and the whole-of-system business case requirement.
F18.4	The sequencing rule is measurement first, cheap before expensive, and publication as the enforcement mechanism.
F18.5	Inter-rater reliability testing should be run on the current instrument before the rewrite, so that a baseline exists and validation cannot be deferred pending the update.
F18.6	The welfare and referral step can be introduced administratively before the legislation converting it into a duty.
F18.7	The linked data asset has the longest lead time — three to four years to first useful output — and should therefore start earliest.
F18.8	At one year, a person outside government should be able to answer six questions from published documents that are currently unanswerable.
F18.9	Four foreseeable failure modes — publication without action, deferred validation, a promotional ledger, and instrument compliance without capacity — each have a specified control.
F18.10	An operational plan for coercive control and systems abuse belongs in the first hundred days rather than the first year, because practice changes at commencement and criminalisation is not implementation.
F18.11	The last whole-of-system demand and gap analysis is the Glanfield review of May 2016, found dated by the Auditor-General in 2024; a 2026 demand and workforce study is what allows the second action plan to commission against numbers.

ID	Finding
F18.12	Aboriginal community-controlled multi-year funding, workforce pay parity and Indigenous data governance should move from the 2028–32 window into 2026–28, because the data sovereignty agreement is the first step of the linked data asset and single-year contracts cannot fund a workforce.
F18.13	Sexual violence needs its own implementation stream and its own published measures, because the prosecution divergence documented in Chapter 6 is invisible inside a combined family violence measure.
F18.14	Housing and economic security are first-order safety actions rather than recovery extras, because 62 per cent of the 13 deceased victims (8 of 13) were unemployed and 54 per cent (7 of 13) had experienced homelessness or housing instability.
F18.15	Prevention should be funded to run in schools, workplaces, sport, faith settings and online in parallel with the design contract, and measured by evaluated coverage rather than by reach.

Chapter 19 — The two bills before the Assembly

ID	Finding
F19.1	The Family, Personal and Sexual Violence Legislation Amendment Bill 2025 repeals Part 7 of the *Family Violence Act 2016* (cl 47) and replaces judicial after-hours orders with safety notices issued by a police officer of or above the rank of sergeant who "believe[s] on reasonable grounds" that "there is a risk" and that a notice "is immediately necessary" (ss 13B, 13H(1)), in force for 14 days from service without renewal (s 13L), with two years' imprisonment on breach (s 13ZC) and up to four hours' detention to effect service (s 13C); replacement, not supplement, is the correct description.
F19.2	Part 2A prescribes content-bearing reasons for a refusal — "including each ground in section 13B that was not satisfied" (s 13N(1)(e)) — but for a decision to issue requires only "a written record of the matters considered" kept in police records (s 13H(3)); only the notice reaches the registrar (s 13M); a respondent's application is listed "as soon as practicable" before expiry and "must" be dismissed if no return date is available (s 13Y(3)); the Attorney-General's "next working day" [2.43] appears nowhere in the Bill.
F19.3	The substituted s 156 requires one review beginning two years after Part 2A commences, reporting within twelve months, and names no measure or data duty (cl 40); the government could give the Committee one figure about the scheme being repealed — 45 after-hours orders granted in 2024–25 — and had no extractable data on refusals or unanswered calls to the after-hours magistrate [2.92]–[2.95]; the Explanatory Statement cites no ACT count of any kind.
F19.4	The Crimes (Coercive Control) Amendment Bill 2026 commences the offence two years after notification (s 2(2)), establishes an advisory committee that expires three years after notification (s 434), and requires a ministerial review beginning three years after the offence commences (s 72K(1)), so the committee ceases one year after the offence commences and at least two years before the review can begin, which the government's web page confirms is design; every safeguard the government names — in the Explanatory Statement's proportionality analysis, the course-of-conduct structure, the s 8 definition, intent and the reasonableness exception, with the s 72K review and the accused's consent to summary hearing as "other safeguards" (CC ES pp 8–12) — operates at trial or after it, and none before charge; the Explanatory Statement does not discuss the investigation or charging stage.
F19.5	Read together, the bills require the same officer at the same incident to make the same classification of who is exercising control over whom for a civil notice (s 13B(a)) and a criminal charge (s 72J(1)(b)–(c)); the first legislates consideration of both parties' views and a cross-notice bar before that decision (ss 13B(d), 13D(2)) and the second legislates nothing before charge; a notice issued to the wrong party becomes history under ss 13D(2)(f)(i), 14(1)(g) and 72J(6)(b) with no correction pathway in either Bill; and the two reviews share no measure and no date.

ID	Finding
F19.6	Five features of the first Bill improve on the current Act: the respondent's views are a mandatory consideration before issue "as far as is reasonably practicable" (ss 13D(2)(b), 13H(2)(b)); the notice served states how each s 13B ground is satisfied and is explained in person (ss 13I(d), 13T, 13U); cross-notices are barred and the Explanatory Statement ties the bar to police being "unable to identify the primary aggressor" (s 13B(d); ES p 30); firearms may be seized at the moment of service (s 13ZD(b); *Crimes Act* s 192(1A)); and a written record is required at every branch of the decision (ss 13E, 13F, 13H(3), 13N), with s 113(e) repaired (cl 39) and remote presence put on a statutory footing (s 44B).
F19.7	The word "false" does not appear in the first Bill; Part 2A creates no duty to record what was done to test the affected person's account, whether any information came from another source, or whether the respondent was invited to answer; the contravention offence (s 13ZC) contains no element that the notice was correctly issued; and the court's power to amend or revoke turns on prospective safety tests (ss 13Z(1)(a), 13ZB(1)(a)), not on whether the grounds were satisfied at issue.
F19.8	The Dictionary definition of "family violence order" excludes a safety notice (ES p 67), but a notice is an "interim FVO" and "local FVO" for national recognition (cl 69–70), must be considered by a court in any later application as a notice "in force at any time" (s 14(1)(g)–(h), cl 51–52), must be disclosed on an NDIS registration application (cl 191, WWVP Act s 18A(1)(b)(iii)(A)), and supports a tenancy termination and ACAT orders (cl 173–189); none of these consequences requires a court to have looked at the notice, and no provision deems a revoked notice never to have been made or requires correction of police records.
F19.9	The Standing Committee on Legal Affairs made eleven recommendations on 24 April 2026 and recommended passage; the government on 28 August 2026 agreed to eight, agreed in principle to two and noted one; none of the eleven adds a structured assessment, content to the issue record, a fixed period for the respondent to be heard, or a statutory data duty; the Chair's dissenting report recommended that "The Bill not be passed in its current form" and proposed retaining a judicial decision-maker with expanded registrar delegation, resourced on-call arrangements and recorded data.
F19.10	The coercive control offence in s 72J(1) requires an adult, a course of conduct of family violence against a family member (*Family Violence Act* ss 8, 9), intent to coerce or control, and objective likelihood of harm or fear of harm, with a maximum of 700 penalty units or seven years; because seven years exceeds the five-year ceiling in *Crimes Act* s 374, the Director of Public Prosecutions cannot elect summary disposal and the defendant's consent governs under s 375, a consequence identified by eight submissions from opposed standpoints, while New South Wales pairs seven years with a prosecution election.
F19.11	Of the 22 submissions with text to the coercive control inquiry, 16 name misidentification in terms, including the government's, which names it as a risk it has mitigated through intent, the s 8 definition, the objective test and the reasonableness exception; five ask for a legislated pre-charge step to identify the person most in need of protection; six ask for misidentification to be measured; and no government document or submission cites the 2023 death review's Recommendation 4, inter-rater reliability, or validation of any classification method.
F19.12	The Coercive Control Advisory Committee has one function, "to advise the responsible Minister" (s 433(2)); its members are appointed by the Minister on the Minister's view of "relevant skills and experience" (s 433(3)); it has no monitoring, data, reporting or publication function, no independence requirement and no right to information; three submissions identified that it expires before the s 72K review can begin and twelve addressed its composition or independence.
F19.13	The first Bill inserts its own Division 4.1A into Part 4 of the *Family Violence Act* (cl 35, s 44B), so the division proposed at Appendix G1 is renumbered Division 4.1B with its section numbers unchanged; and s 13ZC(3) reproduces s 43(4) for notices, so the complicity question at the annex to Chapter 16 now has two targets.

ID	Finding
F19.14	The first Bill and its Explanatory Statement contain no ACT administrative data on the after-hours scheme, no reference to the ACT Family Violence Risk Assessment and Management Framework or any assessment tool, and no training, resourcing or cost statement for Part 2A; the Explanatory Statement's case rests on stakeholder consultation and on the statement that "Other than the ACT, all states and territories allow for police officers to issue short-term protection notices or orders" (ES p 24), while itself recording "some evidence that a judicial officer is better placed" to make such orders (ES p 24).

Appendix L — Assessment of the 2026 Strategy

ID	Finding
FL.1	Neither the Strategy nor the First Action Plan uses the word "baseline" or "indicator", sets a numeric target, or names a lead agency for any of its six outcomes.
FL.2	The monitoring and evaluation framework identified as missing by the Auditor-General in November 2024 is described in the future tense in both May 2026 documents, and governance arrangements are described as being developed.
FL.3	The substantive system redesign is scheduled for the 2028–32 action plan window; the 2026–28 window is sustainment, mapping, governance design and commissioning preparation.
FL.4	The Strategy is uncosted; $3.6 million over four years was announced for new foundational system infrastructure alongside it.
FL.5	Priority groups described in the analysis do not carry dedicated outcome machinery, funding principles or access measures.
FL.6	The last whole-of-system demand and gap analysis is the 2016 Glanfield review, which the Auditor-General found dated in 2024.
FL.7	Neither document uses the word misidentification, which was the first theme of the ACT's 2025 death review.
FL.8	The Strategy's account of the current state rests on consultation, which produced two Listening Reports and a published victim-survivor consultation report, and is used in place of a current demand and gap analysis. Consultation records what people experienced; it does not establish how many, how often, at what cost, or whether anything changed.
FL.9	The priority-groups analysis is drawn from consultation and does not carry through into outcome machinery, funding principles or access measures, which is the same pattern a second time.
FL.10	The Strategy cites both biennial death reviews and adopts two of their findings. The composition of the deaths does not appear. On a full-text check, "suicide" appears once in the Strategy, within the title of another plan, and not at all in the First Action Plan; "self-harm", "homicide", "fatality" and "death review" appear in neither.
FL.11	Neither document states which deaths the system is responsible for preventing, publishes a count of the deaths that are not homicides, names an agency accountable for them, or states an indicator by which that arrangement could be assessed.

How the register is used

In Chapter 1. The eighteen findings in Chapter 1 are the load-bearing ones, stated in full with their quotations and sources. They are a selection from this register, not a separate set.

In each chapter. Each chapter closes with the four or five findings that chapter establishes which nothing else in the work establishes. The rest are here.

Counting. This register contains **263** findings across eighteen chapters and one appendix. No finding is created here that its chapter does not already make. That number is not a claim about the seriousness of anything. A count of findings measures how much was written down, not how much is wrong, and a system that published more would generate more.

The test to apply to any of them. Each finding in this register is either a quotation from a public document, a figure from one, an arithmetic operation on figures from one, or a statement that a document does not contain something. The fourth kind is the most common in this work and the easiest to check: open the document and search it. Where a finding is an inference rather than one of those four, it is marked as such in the chapter that makes it.

Appendix N — Verification

What was checked. Every figure, statutory reference and quoted phrase in this work was read against its primary source: the *Family Violence Act 2016* (ACT) and the other Acts as in force at the evidence cut-off of 2 September 2026; the budget papers; the Auditor-General's reports; the domestic and family violence death review reports; the court annual reviews; and the freedom of information responses. Those sources are listed at Appendix I, and each chapter closes with a table giving the document, page and date for the claims made in it. Where a document could not be obtained, the claim it would have supported is not made.

What that establishes, and what it does not. It establishes that the figures here are the figures in the sources, and that the statutory references point where they say they point. It does not establish that the reading of them is right. That is an argument, and the reader is free to reject it. Where the record does not support a conclusion, the finding is "not proven" — a verdict, not a polite way of avoiding one.

Four classes of statement cannot be verified in that sense, and each is marked where it appears.

Projections. The volumes in Appendix P after 2019–20 are projected forward from the last published figures at an assumed growth rate. They are labelled as projections, the assumption is stated, and the range is given. One published number would replace them.

Derived arithmetic. Figures obtained by subtracting one published total from another are labelled as derived rather than published, with the qualifications that attach to them.

Statements that a document does not contain something. These are the most common form of finding in this work, and the easiest for a reader to check independently: open the document and search it. Every such finding names the document and the word or thing searched for, so that the check can be repeated. Where a search was run across two documents, both are named.

Two documents obtained only at second hand. The government response of 28 August 2026 to Legal Affairs Committee Report 7 is recorded from a summary — recommendations 1 and 2 agreed in principle, 3 and 5 to 11 agreed, 4 noted — and should be verified against the tabled response. Submission 003 (Legal Aid ACT) to the coercive control inquiry is a cover sheet only on the file, and no position is attributed to it anywhere in this work.

Errors. Best efforts have been made to verify everything in this volume. In a work of this length, drawing on this many documents, it is likely that some error remains. Where one is found it will be corrected rather than defended, and the correction will be published at the same prominence as the statement it corrects. See *Corrections*, at the end of this volume.

Appendix O — Inter-rater reliability protocol for ACT family violence risk instruments

Status. A study design prepared as part of the analysis. It is not approved, endorsed or commissioned by any ACT agency. It is written at the level of detail a research office would need to run it, because a proposal at any lower level of detail is a slogan.

Why it is here. Item 5 of the hundred-day list in Chapters 1 and 18 asks the Territory to measure how consistently its risk instrument is applied and to publish the result. Chapter 15 states that the replacement framework proposed here must not be deployed until the same measurement has been made of it. Neither commitment means anything without a specified design, a threshold stated before the data exists, and a pre-registered result that would cause the instrument to be withdrawn.

The one-sentence version. Give a representative sample of the people who actually use the instrument the same set of standardised cases, measure how often they reach the same answer, publish the number with its confidence interval, and state in advance what number would be bad enough to stop.

O1. What is being measured, and what is not

Three distinct properties are often confused. This study measures the first only.

Property	The question it answers	Measured here
Reliability	Do different assessors, given the same facts, reach the same answer?	**Yes**
Accuracy	Is the answer correct?	Partly — see O6
Predictive validity	Does a high rating predict subsequent harm?	**No.** This requires linked outcome data over years, and the data asset described in Chapter 17

Reliability is measured first because it bounds the other two. An instrument that produces different answers from the same facts cannot be accurate, and cannot be validated, because there is no stable quantity to validate. A low reliability result therefore forecloses the other two questions. A high reliability result does not answer them; it makes them answerable.

This ordering is why the study is worth doing before anything more expensive.

O2. The vignettes

O2.1 Number

Twenty vignettes in the full set, each 600 to 900 words, presented in the format the assessor's own workflow uses. Five of the twenty are second versions of matched pairs (O2.4), and each assessor sees one version of each pair, so **each assessor completes fifteen**.

Twenty is chosen for three reasons. It is enough that the reliability estimate for a nominal outcome has a usable confidence interval at fifteen vignettes per assessor and the assessor numbers in O3. Fifteen is few enough to be completed in a single sitting of about three hours, which is what makes recruitment feasible. And it permits the balanced design in O2.3, which requires the number to be divisible by four.

O2.2 Source material — no client files

Every vignette is constructed from material that is already public. No file belonging to any living or deceased person is used, and no agency record is accessed. This is the design feature that removes the privacy approvals which would otherwise dominate the timeline.

Permitted sources:

- published judgments of the ACT Magistrates Court, Supreme Court and Court of Appeal, and of comparable courts in other jurisdictions;
- the de-identified case descriptions published in the ACT Domestic and Family Violence Review biennial reports;
- published coronial findings;
- published submissions and transcripts of Assembly committee inquiries;
- published research case studies; and
- constructed composites assembled from the above.

Every vignette is labelled with its provenance, and the labels are published with the results. A composite is labelled as constructed. Nothing is presented as a real matter unless it is drawn from a matter dealt with in open court.

O2.3 Composition

The set is balanced by design rather than sampled, because a random sample of cases would be dominated by the modal case and would say nothing about the decisions that are hard.

Group	Number	What it tests
A. Clear	5	Floor effect. Facts on which competent assessors should agree. Disagreement here is a serious result on its own
B. Bidirectional or resistive	5	The primary aggressor decision where both parties have used force and one is resisting ongoing abuse. This is the decision the 2023 review's recommendation 4 was written about
C. Genuinely ambiguous	5	Cases where the correct answer is arguably "unresolved". Tests whether assessors can reach that answer at all, and whether the instrument lets them record it
D. Matched pairs	5 second versions of vignettes drawn from A to C	Sensitivity to a single varied factor. See O2.4

O2.4 The matched pairs

Five vignettes appear twice in the full set, in two versions differing in exactly one respect. Each assessor sees only one version of each pair; assignment is randomised at the assessor level, balanced across role groups.

Pair	Held constant	Varied
1	All conduct, history and evidence	The sex of each party is reversed
2	All conduct and evidence	The respondent's demeanour on contact: composed and articulate, against agitated and aggrieved
3	All conduct and evidence	Whether a Family Court parenting matter is on foot
4	All conduct and evidence	Whether the person seeking help is Aboriginal or Torres Strait Islander

Pair	Held constant	Varied
5	All conduct and evidence	Whether the respondent has a recorded mental health diagnosis, with no suicide threat in either version

Pairs 1, 2, 3 and 5 correspond directly to material in the current framework's Fact Sheet 10, which Chapter 9 examines. Fact Sheet 10 lists demeanour, a concurrent Family Court matter, and calmness among indicators bearing on which party is the primary aggressor. Whether those indicators change the answer on otherwise identical facts is an empirical question, and it has never been asked. Pair 4 exists because the death review identifies Aboriginal and Torres Strait Islander women as particularly exposed to misidentification, and because a difference here would be a finding of a different order.

Matched-pair analysis is a **pre-registered secondary outcome**, not a bolt-on. Its thresholds are at O5.3.

O2.5 Construction and quality control

Vignettes are drafted by a two-person team, one with practice experience and one without, and are reviewed by a panel of five: a specialist service practitioner, a police family violence officer, a court registry officer, an Aboriginal community-controlled service practitioner, and a defence or human rights lawyer. The panel's role is to confirm that each vignette is realistic, contains the information the instrument asks for, and does not signal a preferred answer. Panel members do not participate as assessors.

The full vignette set is published after data collection closes.

O3. Who is assessed

O3.1 The sampling frame

The unit is the person who applies the instrument to a real decision, not the person who owns it. Assessors are sampled from every role that does.

Group	Target	Minimum	Why included
ACT Policing — frontline responders and Family Violence Coordination Unit	40	15	Makes the predominant aggressor determination at the incident, which is the decision the death review found wrong in 8 of 13 cases
Specialist domestic and family violence services, including Aboriginal community-controlled organisations	40	15	Primary framework users; the ACCO sub-sample is reported separately where numbers permit
Generalist and universal services — health, housing, community services	30	12	The framework covers them, and the 2024 crisis services review found their responses variable
Court registry — Deputy Registrars and registry officers	15	8	Chapter 7 establishes that a registry officer typically makes the first substantive interim decision
Child protection	25	10	Applies the classification with consequences for the removal of children
Total	**150**	**60**	

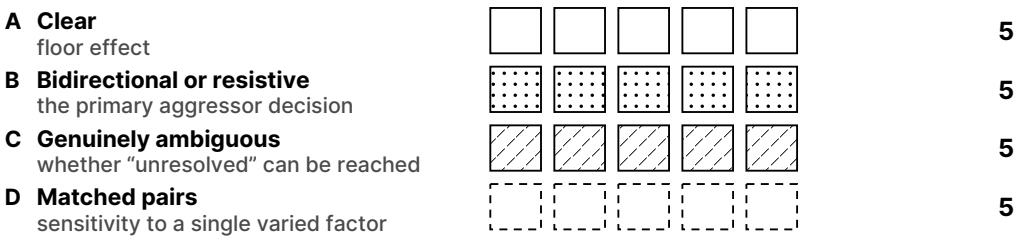
Both figures are stated because a study that reaches only the minimum is still worth running and publishing, with wider intervals, provided the minimum was stated in advance rather than reached and then declared adequate.

FIGURE O.1

The vignette reliability study

Twenty vignettes, balanced by design rather than sampled: a random sample of cases would be dominated by the modal case and would say nothing about the decisions that are hard.

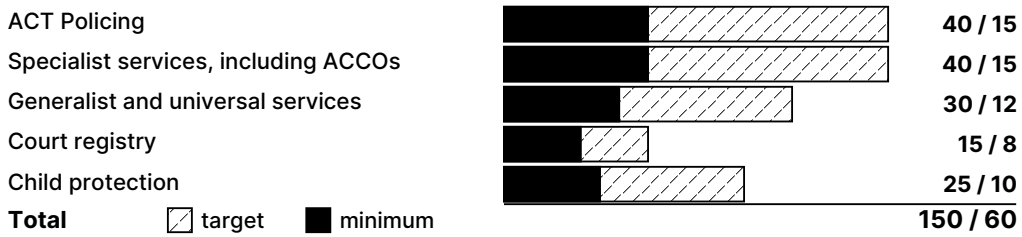
THE VIGNETTE SET — each assessor completes 15, in one sitting of about three hours



In each matched pair, everything is held constant except one factor

the sex of each party · the respondent's demeanour, composed against agitated · whether a Family Court matter is on foot · Aboriginal or Torres Strait Islander identity · a recorded mental health diagnosis, with no suicide threat in either version

THE ASSESSORS — target / minimum; vignette order randomised per assessor



THE THRESHOLDS, LODGED BEFORE RECRUITMENT OPENS

Decision	Statistic	Threshold
Risk rating (R1 band)	ICC(2,1) and ICC(2,k), two-way random effects, absolute agreement	adequate at ICC(2,k) 0.75 and above; withdrawal trigger below 0.50
Classification	Fleiss' kappa: party A, party B, both, unresolved	adequate at 0.60 with lower CI 0.50; withdrawal trigger below 0.40
Action selected	Fleiss' kappa	as for classification

What is not conventional, and is the point of the exercise, is publishing the consequence attached to each band before anyone knows which one will occur.

A difference of 15 percentage points or more between the two versions of a matched pair, with a confidence interval excluding zero, is a finding that the varied factor is driving the classification.

Appendix O, sections O2, O3 and O5. Confidence intervals bootstrapped, 10,000 resamples.

O3.2 What is recorded about each assessor

Role group, years in the role, whether they have completed the framework training and when, and organisation type. Nothing that identifies an individual. Individual results are never reported to an employer, and this is stated to participants in writing before consent. An assessor is a research participant, not an examinee.

O3.3 Administration

Online, in one sitting, with vignette order randomised per assessor. Assessors use the instrument they use in their work, with its published guidance available, exactly as in practice. No training is delivered before the exercise, because the object is to measure practice as it currently is.

O4. What each assessor produces

For every vignette, three outputs and one free-text field.

1. **Risk rating** for R1, on the ordinal band scale the instrument uses.
2. **Classification**: which party, if either, is the person most in need of protection. Response options are party A, party B, both, and **unresolved**. The presence of "unresolved" is itself under test, because Chapter 14 Principle 6 argues it must be available and the current framework does not offer it.
3. **Action selected** from a fixed list of protective and procedural options.
4. **Free text**: the two or three facts that most influenced the answer. Coded afterwards, blind to the rating, and used to interpret disagreement rather than to measure it.

O5. The statistics, and the thresholds, stated before the data exists

O5.1 Which statistic, and why

Three outcomes, three statistics, chosen by the measurement level of each. Percentage agreement is reported alongside each but is never the headline, because it does not correct for agreement that would occur by chance.

Outcome	Level	Statistic	Reason for the choice
Risk rating (R1 band)	Ordinal	**Intraclass correlation, ICC(2,1) and ICC(2,k), two-way random effects, absolute agreement**	Assessors are a random sample of a larger population, the bands are ordered, and absolute agreement rather than consistency is the property that matters: two assessors calling the same case "high" and "moderate" have not agreed, even if their rankings correlate perfectly. Quadratic-weighted kappa is reported as a secondary measure
Classification	Nominal, four categories	**Fleiss' kappa**	More than two raters, nominal categories, no natural ordering. Cohen's kappa is not applicable because it is defined for two raters
Action selected	Nominal	**Fleiss' kappa**	As above

Confidence intervals are bootstrapped, 95 per cent, 10,000 resamples, with assessors as the resampling unit. The interval is reported in every case. A point estimate published without an interval is not a result.

O5.2 The primary thresholds

These are the numbers that must be lodged publicly before recruitment opens. They are stated here so that the design cannot later be adjusted to the data.

Result on the classification outcome	Reading	What follows
κ ≥ 0.60 and the lower bound of the 95% CI ≥ 0.50	Adequate	The instrument supports the decisions made with it. The criticism in Chapter 9 is answered on this measure. Retest at three years
κ 0.40 to 0.59, or a lower CI bound below 0.50	Marginal	The instrument may continue in use, with mandatory second-assessor review for any decision that removes a person from a home, changes the care of a child, or founds a charge. Redesign and retest within twelve months
κ below 0.40, or a lower CI bound below 0.40	**Withdrawal trigger**	The instrument does not produce a stable answer to the question it asks. It must not be used to determine the primary aggressor for any decision with a criminal, custodial or housing consequence until it has been redesigned and retested. The rating fields may continue as a structured record; the classification output may not be relied upon

Where a result meets the condition of two rows — for example a point estimate in the marginal band with a lower confidence bound below 0.40 — the lower row governs.

For the R1 rating outcome, the equivalent bands are ICC(2,k) ≥ 0.75 adequate, 0.50 to 0.74 marginal, below 0.50 withdrawal trigger, with the same rule where two rows are met.

The bands are conventional. What is not conventional, and is the point of the exercise, is publishing the consequence attached to each band before anyone knows which one will occur.

O5.3 The pre-registered secondary thresholds

For each matched pair, the outcome is the difference in the proportion of assessors selecting each classification between the two versions, with a 95 per cent confidence interval.

- A difference of **15 percentage points or more**, with a confidence interval excluding zero, is recorded as a finding that the varied factor is driving the classification on otherwise identical facts.
- A finding on pair 1 (sex reversed) or pair 4 (Aboriginal or Torres Strait Islander status) requires the indicator set to be revised before the instrument is used further for classification, and requires the finding to be reported to the Assembly.
- A finding on pairs 2, 3 or 5 requires the corresponding Fact Sheet 10 indicator to be withdrawn or restated with evidence, within six months.

O5.4 What is reported regardless of the result

Overall and by role group. Agreement on the "clear" vignettes reported separately, because disagreement there is a more serious result than disagreement on the ambiguous set. The proportion of assessors who selected "unresolved" where it was available. The full distribution of ratings per vignette, not only the summary statistic. The coded free-text reasons. And the number of assessors who did not complete, with the reasons given.

O6. The accuracy sub-study

Reliability without accuracy is insufficient: assessors could agree consistently and be consistently wrong.

Five of the 20 vignettes are drawn from matters where a subsequent authoritative determination is on the public record — a contested final hearing, a coronial finding, or a death review case description that records what was later established. For those five, and only those five, assessor answers are compared against that determination.

This is a weak accuracy test and is labelled as one. The subsequent determination is itself a judgment made on more information than the assessor had, and the five cases are not a sample of anything. It is reported as a descriptive comparison with that limitation stated, never as a sensitivity or specificity figure. A proper accuracy study requires the linked data asset in Chapter 17 and is a separate, later, more expensive piece of work.

O7. Pre-registration

The protocol, the analysis plan, the thresholds at O5.2 and O5.3, and the withdrawal trigger are lodged on a public research registry before any assessor is recruited. The registration record includes the vignette composition, the sampling targets and minimums, the statistics, the confidence interval method, and the exact wording of the consequence attached to each result band.

The registration number is published at lodgement, not at completion.

What pre-registration prevents. It prevents the threshold moving to meet the result. It prevents the outcome measure being switched to the one that performed best. It prevents a marginal result being described as adequate. And it prevents non-publication, because the existence of the study is public from the start.

Any departure from the registered plan is reported in the results with its reason, in a section headed as such.

O8. Independence

The framework owner supplies the instrument, the guidance and access to the assessor population. It does not design the vignettes, hold the data, run the analysis, or approve the report before publication.

The vignette design, data custody, analysis and reporting sit with a party that had no role in writing the instrument. A university research centre, the Australian Institute of Criminology, or Australia's National Research Organisation for Women's Safety are all appropriate. The contract states that the analysing party publishes the result irrespective of what it shows, and that the framework owner may publish a response alongside it but may not delay or condition its release.

An Aboriginal and Torres Strait Islander governance arrangement covers the ACCO subsample and pair 4, including data sovereignty over anything reported about that sub-sample.

O9. Publication

The full result is published within eight weeks of the close of data collection. Published together: the statistics with intervals, the vignette set, the coding frame, the assessor role-group counts, the departures from the registered plan, and the de-identified item-level data.

A stated date, and what happens if it passes. If the result has not been published within eight weeks, that fact is itself reported to the Assembly, with the reason. A study that is registered and then not reported is a worse outcome than a study never run, because it consumes the assessors' time and leaves the question open while appearing to have addressed it.

O10. Ethics and approvals

Assessors are the research participants. Human research ethics approval covers their participation, their consent, and the protection of their individual results from their employers.

No client data is used, so no privacy approval relating to a client is required and no consent from any person affected by violence is sought or needed. This is the design choice that makes the study fast, and it is the reason the vignette sourcing rules in O2.2 are strict rather than convenient.

O11. Who runs it, what it costs, how long it takes

O11.1 Cost

An estimate, with the assumptions exposed. It is not a quotation.

Item	Assumption	Estimate
Vignette development and expert panel	15 professional days plus 5 panellists for 2 days each	$38,000
Protocol, analysis plan, pre-registration, ethics application	10 professional days	$14,000
Survey platform build and testing	Off-the-shelf platform, custom instrument logic	$12,000
Recruitment and administration	Coordination across five role groups over 3 weeks	$18,000
Analysis and report	15 days of an independent statistician and a lead author	$30,000
Aboriginal and Torres Strait Islander governance and data sovereignty arrangement	Paid advisory time and a separate reporting process	$16,000
Contingency	15 per cent	$19,000
Sub-total, study cost		**$147,000**
Assessor time, if separately funded	150 assessors × 3 hours at an average $85 per hour, including on-costs	$38,000
Total, if assessor time is funded rather than absorbed		**$185,000**

Two figures are given because the answer depends on a decision the Territory has to make explicitly. If assessor time is absorbed within agencies, the study costs about $147,000 and imposes about 450 hours of workforce time. If it is funded, it costs about $185,000. Absorbing it is defensible and is what usually happens. Stating that it is being absorbed is what prevents the cost being described as nil.

For scale: $147,000 is about 4 per cent of the $3.6 million over four years announced for foundational system infrastructure alongside the 2026 Strategy, and about 0.1 per cent of the $151.4 million of direct investment over the same period.

O11.2 Time

Stage	Duration
Vignette development and panel review	6 weeks
Protocol, pre-registration and ethics	6 weeks, overlapping the above by 3
Recruitment	3 weeks, overlapping ethics approval by 1 to 2
Data collection	3 weeks
Analysis	4 weeks
Report and publication	4 weeks

Stage	Duration
Elapsed, end to end	**21 to 22 weeks** (6 + 3 + 1 to 2 + 3 + 4 + 4)

What falls inside a hundred days, and what does not. The fieldwork takes weeks: recruitment and data collection together are six weeks, and they are the only part that touches operational staff. The whole study, from a decision to proceed to a published result, is about five months. The hundred-day commitment is therefore to **commission it, register the protocol and publish the thresholds** within a hundred days, with the result following in the same year. That is what Chapters 1 and 18 state, and it is the only version that can be met.

O12. Applying the same protocol to the replacement framework

Chapter 15 proposes a replacement. Appendix A specifies it. Neither has been tested, and the argument of these chapters would be worthless if the replacement were exempted from the standard it applies to the instrument it criticises.

The protocol above applies to the replacement unchanged, with three additions.

1. **The same vignette set is used**, so the two instruments can be compared directly on identical material. The comparison is reported as a difference with a confidence interval, not as two separate figures placed side by side.
2. **The unresolved option is available in both arms.** If the replacement's reliability advantage comes entirely from assessors declining to classify, that is a real finding about the replacement and is reported as one rather than counted as agreement.
3. **The withdrawal trigger is the same, and applies to the replacement first.** If the replacement returns κ below 0.40 on classification, it is not deployed. If it returns a figure no better than the current instrument, the case for replacing the current instrument on reliability grounds fails, and the remaining case for the rewrite rests on the ISO 31000 conformance findings in Chapter 8, which are a separate argument and would have to be made on their own.

The replacement is not exempt from its own standard, and stating the trigger in advance is the demonstration.

Appendix P — A sketch cost model for the reforms proposed here

Status. An estimate, built from published figures where they exist and from stated assumptions where they do not. It is not a costing, it has not been prepared with any agency, and every number in it is capable of being wrong. Its purpose is to expose the arithmetic so that a person who disagrees can identify which assumption they disagree with.

Why it exists. Chapter 6 and Chapter 16 criticise the Territory for funding justice and service reform without a published demand and capacity model that names the agency expected to absorb any unfunded remainder. A work that makes that criticism and then proposes five reforms without costing them would be applying a standard to others that it declines to meet. A wrong but transparent estimate is a contribution. Silence is the thing being criticised.

How to read it. Every table separates the **volume** assumption, the **unit** assumption and the **result**. Change any input and the result changes; the arithmetic is shown so that it can be redone. Where a figure is not published, that fact is stated in the row rather than hidden in the total.

P1. The volume base, and the number that is missing

P1.1 What is published

The ACT Magistrates Court published Protection Unit statistics in its annual reviews. The most recent published series is:

Applications	2015–16	2016–17	2017–18	2018–19	2019–20
Family violence order applications for final orders	—	181	1,035	1,159	1,249
Applications that included an application for an interim order	—	163	1,092	1,106	1,152
Personal protection order applications	695	752	676	818	945

The 2016–17 family violence figures are a part year: the *Family Violence Act 2016* commenced on 1 May 2017.

One row does not sit inside the other, and the annual reviews do not present them as a set and a subset. In 2017–18 the interim figure of 1,092 exceeds the final-order figure of 1,035. That is not an error in transcription; it is what the published series says, and it is why the second row is not labelled "of those" here. The most likely explanation is that the two rows count different things — applications lodged in the year against applications in which an interim order was sought at any point, including on matters lodged earlier — but the annual reviews do not say, and nothing in the public record settles it. That uncertainty sits underneath the 92 per cent used below, and a reader who thinks the rows cannot be combined should treat every volume in this appendix as unfounded rather than merely uncertain.

Subject to that, two things are visible. Applications rose about 12 per cent and then about 8 per cent in the two full years for which comparison is possible. And in 2019–20 the interim figure is about 92 per cent of the final-order figure.

P1.2 The series stops

The ACT Magistrates Court has not published an annual review since 2019–20.

As at 2 September 2026 the ACT Courts annual reviews page listed Supreme Court annual reviews for each year to 2024–25, and Magistrates Court annual reviews to 2019–20 and no later. Five Supreme Court reviews have been published in the period in which no Magistrates Court review has.

That is worth stating plainly, because it changes the character of the finding at Chapter 11. The proposition there is that court statistics on interim family violence orders were refused on the ground that outcome data is not administrative in nature. What the annual review series shows is that the Magistrates Court **published application and interim application counts annually, as a matter of course, until 2019–20**. The figures exist, the court has produced them before, and the format is on the public record. What lapsed was the publication.

So the recommendation at Chapter 16 Reform 5 is not a request to build something. It is a request to resume something.

P1.3 The projection used here

Because the series stops, the volumes below are projected, and the projection is the largest single source of error in this appendix. **Every figure in this appendix is therefore carried as a low, illustrative-central and high case. The central case is not data. It is one arithmetic path through two unpublished quantities, and it is marked *illustrative* wherever it appears.**

Quantity one — application volume.

Growth assumption	Applications, 2025–26	Including an interim application, at 92%
Low: 3 per cent a year	about 1,490	about 1,370
Illustrative central: 5 per cent a year	*about 1,675*	*about 1,540*
High: 8 per cent a year	about 1,980	about 1,820

Five per cent is used as the illustrative central case because it sits below the two observed years and above general population growth. It is a guess, and it is labelled as one. Nothing in the public record supports it over the other two.

Quantity two — the proportion heard in the absence of the respondent, which is not published at all. It is precisely the figure refused under freedom of information in February 2026. Practice Direction 1 of 2026 lists interim applications before the Registrar within two business days of filing, and service on the respondent follows the making of an order, so the great majority of interim applications are determined before the respondent has been heard. The range used here is **70 to 92 per cent**, with **85 per cent** as the illustrative central assumption.

Combining the two gives the volume base used throughout this appendix.

Case	Applications including an interim application	Share heard without the respondent	Determinations a year in the absence of the respondent
Low	about 1,370	70%	**about 960**
Illustrative central	*about 1,540*	*85%*	***about 1,310***
High	about 1,820	92%	**about 1,675**

The spread is a factor of about 1.7 from end to end. Every recurrent cost driven by volume in this appendix moves with it, and a reader who prefers the low case should reduce those costs by about a quarter and a reader who prefers the high case should increase them by about a quarter.

Two published numbers would delete this entire section. Item 4 of the hundred-day list produces both.

P2. Reform 1 — the framework rewrite and alignment

Item	Assumption	One-off	Recurrent
Rewrite the framework and instruments	Drafting, expert panel, consultation, publication. Partly displaces work already funded: the 2026–27 Budget provides two years of funding to operationalise the updated framework through training	$250,000	—
Inter-rater reliability study	Appendix O, assessor time absorbed within agencies	$147,000	—
Retest at three years	Same study, repeated	—	$49,000 a year, annualised
Alignment reporting by prescribed entities	About 25 entities, 3 days each in year one, 1 day a year after	$75,000	$25,000
Framework-level monitoring and annual report	0.4 FTE analyst at $185,000 including on-costs	—	$74,000
Subtotal		**$472,000**	**$148,000 a year**

P3. Reform 2 — structured assessment before an order is made without notice

This is the reform with the largest recurrent workforce implication, and the one most likely to fail if it is funded at zero.

Step	Volume	Unit	Hours a year
Complete the structured assessment	1,310 ex parte determinations	30 minutes	655
Registrar or magistrate reads the assessment	1,310	10 minutes	218
Record reasons referring to the assessment and the plan	1,310	10 minutes	218
Quality assurance sample, 10 per cent	131	30 minutes	66
Total			**1,157**

At 1,600 productive hours a year, that is about **0.72 full-time equivalent**, split between a registry assessment role and judicial or quasi-judicial time.

Item	Assumption	One-off	Recurrent
Registry assessment capacity	721 hours (the assessment, 655, and the quality assurance sample, 66), 0.45 FTE at $145,000 including on-costs	—	$65,000
Registrar and magistrate time	436 hours (reading the assessment, and the reasons referring to it under s 47A(5); the additional content required by s 68A is costed separately at P4.2), 0.27 FTE at $310,000 including on-costs	—	$84,000

Item	Assumption	One-off	Recurrent
Forms, guidance and case management system changes	Approved forms, workflow, storage, access and audit fields	$320,000	—
Training	60 registry and judicial officers, 1 day, plus refresher	$60,000	$15,000
Subtotal		**$380,000**	**$164,000 a year**

The rows follow the hours table above them: 721 + 436 = 1,157 hours. Registry and judicial time are booked separately because judicial time is costed at about 2.1 times the registry rate, so an error that cancels in the hours does not cancel in the cost.

The sensitivity that matters, on two axes at once. At 20 minutes per assessment the total falls to 0.59 FTE; at 45 minutes it rises to 0.93 FTE. Applying the volume range at P1.3 as well, and carrying the $15,000 training line at every point, the recurrent cost of this reform runs from about **$110,000** (low volume, 20 minutes) to about **$245,000** (high volume, 45 minutes), against the illustrative central case of $164,000. The working, at the rates in the table: low — 960 assessments at 20 minutes (320 hours) plus a 10 per cent quality assurance sample at 30 minutes (48 hours) is 368 registry hours, $33,000; reading and reasons at 10 minutes each (320 hours) is $62,000; with training, $110,000. High — 1,675 assessments at 45 minutes (1,256 hours) plus the sample (84 hours) is 1,340 registry hours, $121,000; reading and reasons (558 hours) is $108,000; with training, $245,000. The instrument at Appendix B is designed for 20 minutes at the point of filing; 30 minutes is used in the table because a new process is slower than a mature one for at least the first year.

The commencement condition. Section 47B at Appendix G1 prevents this provision commencing until the resourcing has been provided and a statement identifying it, the volume assumed and the assessment time assumed has been presented to the Legislative Assembly. That is in the drafting rather than in this appendix, because Appendix P8 establishes what happens when a documentation duty lands on an unchanged workload.

P4. Reform 3 — expedited return, reasons with content, and a reciprocal-conditions trial

What is costed here. Reciprocal conditions are not proposed as a default applying to every determination made in the absence of a respondent, and are not costed as one. Reform 3 has two elements that apply in every such case — an expedited return on request, and content for the reasons the court already has to record — and a third that is put as a question and applies only in the narrow class of case where the court records that it cannot identify the person most in need of protection. **The cost of a trial is not the cost of a default.**

P4.1 Element one — the expedited return

The volume driver is not the number of orders. It is the proportion of respondents who request a listing, and nothing published bears on it. The range below spans a plausible interval and is not narrowed by evidence.

Case	Determinations without the respondent	Request rate	Additional listings a year	Court and registry time at 25 minutes each
Low	about 960	10%	about 96	about 40 hours
Illustrative central	*about 1,310*	*20%*	*about 260*	*about 110 hours*
High	about 1,675	35%	about 590	about 245 hours

The 25 minutes is split 15 minutes of magistrate time and 10 minutes of registry time. At the rates stated below that is $48.50 plus $15.17 a listing. A fixed $180 a listing is added for courtroom, recording, notice and file handling. Each listing therefore costs about $244.

Item	Assumption	One-off	Recurrent
Additional magistrate and registry listing time	The range above, at about $244 a listing: 15 minutes at $194 an hour, 10 minutes at $91 an hour, plus $180 fixed. 96 × $244 = $23,400; 260 × $244 = $63,400; 590 × $244 = $144,000	—	**$23,000 to $144,000** (*illustrative central $63,000*)
Listing, notice and case management system changes	Request pathway, service of reasons with the order	$85,000	$12,000
Duty lawyer and Legal Aid exposure	Not estimated — see P9	—	not established
Subtotal		**$85,000**	**$35,000 to $156,000** (*central $75,000*)

Rates are the same throughout this appendix: $310,000 ÷ 1,600 hours = $194 an hour for a magistrate or registrar, $145,000 ÷ 1,600 = $91 for registry. The row shows its working.

The request rate is the single figure that would most change this estimate, and it is the one nobody holds. A jurisdiction that ran this for a year would know it.

P4.2 Element two — content for the section 68 reasons

Section 68 already requires reasons to be recorded, so the additional cost is the difference between what is recorded now and what section 68A would require, plus the service of a copy on the respondent. The marginal time is small; it is the discipline rather than the drafting that takes effort.

Step	Volume	Unit	Hours a year, central
Additional content in the recorded reasons	1,310	8 minutes	175
Producing and serving a copy with the order	1,310	2 minutes	44
Quality assurance sample, 10 per cent	131	20 minutes	44
Total, illustrative central			**263**

Applying the same rates — the reasons content and the quality assurance sample are judicial at $194 an hour, the production and service of the copy is registry at $91 — the central case is about $47,000 a year, and at the volume range about **$34,000 to $60,000** (*illustrative central $47,000*), plus **$60,000** one-off for forms and templates. The recording of judicial reasons is costed at the judicial rate, not the registry rate: it is work a judicial officer does.

P4.3 Element three — the reciprocal-conditions trial

This element applies only where the court records that it cannot identify the person most in need of protection. **Nothing published establishes how often that is.** The proportion could be 5 per cent of ex parte determinations or 40 per cent, and the honest position is that the first year of the reasons obligation at P4.2 is what would produce the number. The range below is illustrative in the strict sense: it shows what the arithmetic does, not what the answer is.

Case	Determinations without the respondent	Share in which the court records it cannot identify	Reciprocal conditions made, at 60% of those	Operational hours a year
Low	about 960	5%	about 30	about 10
Illustrative central	*about 1,310*	*15%*	*about 118*	*about 40*
High	about 1,675	40%	about 400	about 135

Item	Assumption	One-off	Recurrent
Baseline measurement before commencement	Two years of the measures at section 21A(8), reconstructed from court and police records	$95,000	—
Pre-registered evaluation and public reporting	Independent, annual, for the life of the trial	$60,000	$55,000
Statutory review at 18 months	Section 21A(10), $45,000 annualised over the 24-month trial	—	$22,500
Court and registry operation	The hours above, at 20 minutes for each set of conditions made: 10 minutes of magistrate time at $194 an hour and 10 minutes of registry time at $91 an hour for explanation at the counter, about $47.50 a set. 30 × $47.50 = $1,400; 118 × $47.50 = $5,600; 400 × $47.50 = $19,000	—	$1,400 to $19,000 (*central $5,600*)
Subtotal, trial period only		**$155,000**	**$79,000 to $97,000** (*central $83,000*)

Three things about this subtotal.

It is a **trial cost, not a standing cost.** The provision expires at 24 months unless the Assembly resolves otherwise, so $155,000 one-off and about $83,000 a year for two years is the exposure, not a recurrent commitment. **More than nine-tenths of it is measurement rather than operation** — $77,500 of the $83,000 recurrent, and $310,000 of the $321,000 two-year total ($155,000 one-off plus two years at $83,000). That is the point: the reform is put in order to be measured, and if a reader thinks the measurement is not worth $310,000 they are objecting to the right number.

It is **the smallest operational cost and the largest measurement cost** of anything in this package. A reader who thinks the trial is not worth running should say so on the measurement cost, not on the court time.

The unquantified risk is unchanged and remains the largest number in this appendix that has no number. If reciprocal conditions produce additional contravention charges, the cost falls on police, the Director of Public Prosecutions, Legal Aid and the courts, and none of it is above. Each additional 100 contravention charges a year implies, on rough professional-time assumptions, in the order of 250 to 400 hours across prosecution and defence, or about $90,000 to $150,000. Narrowing the trigger reduces the number of orders that could generate such charges very substantially against the earlier default design — from every ex parte determination to between 3 and 24 per cent of them across the range in the table above, which is a reduction of between about three-quarters and about 97 per cent. It does not make the figure estimable, because no jurisdiction has run either design. **That is the reason the provision cannot commence until the baseline exists, and the reason it expires unless the Assembly acts.** An unquantifiable cost is not a reason not to proceed. It is a reason not to proceed blind.

P4.4 Reform 3 in total

	One-off	Recurrent, a year
Expedited return	$85,000	$35,000 to $156,000 (*central $75,000*)
Reasons with content	$60,000	$34,000 to $60,000 (*central $47,000*)
Reciprocal-conditions trial (24 months only)	$155,000	$79,000 to $97,000 (*central $83,000*)
Total	**$300,000**	**$148,000 to $313,000** (*illustrative central $205,000*)
Total excluding the trial	**$145,000**	**$69,000 to $216,000** (*central $122,000*)

The second row is the one a government that declines the question at Chapter 16 section 4.4 would be looking at.

P5. Reform 4 — a safety and support step at the point of service

Chapter 16 sets out three versions. All three are costed, because a proposal that offers only the most expensive version will achieve nothing.

Service events. Interim orders served, plus final orders, plus re-service where the first attempt fails.

The base for this line is every interim order, not only those made in the absence of the respondent. Section 70C, "Service of protection orders", requires the registrar to serve an interim order on the respondent as soon as practicable, whether or not the respondent was present when it was made, so the base at the central case is the full interim figure of about 1,540 rather than the 1,310 determinations made without the respondent. And the final-order figure of "about 900" appeared with no derivation, contrary to this appendix's own rule that an unpublished figure is stated in the row rather than hidden in the total; it is a residue assumption — of about 1,540 applications including an interim application, an assumed 55 to 60 per cent proceed to a final order — and **it is not published anywhere**.

On that basis: about 1,540 interim and about 880 final, with a 15 per cent re-service rate, giving about **2,780 service events a year** at the central case. Across the volume band at P1.3, on the same method (interim figure plus 57 per cent of it as final orders, times 1.15), the range is about 2,470 to 3,290. The tables below use 2,780, and every row in them is computed on that base.

Version A — scripted welfare question set, written information, recorded offer of referral

Step	Volume	Unit	Hours a year
Additional time at service	2,780	10 minutes	463
Record the outcome in the police system	2,780	3 minutes	139
Referral handling by a specialist service	Assumed 30 per cent acceptance: 834	2 hours	1,668
Escalation pathway where answers indicate acute risk	Assumed 8 per cent: 222	1 hour	222
Total			**2,492**

Item	Assumption	One-off	Recurrent
ACT Policing time	602 hours (the first two rows), 0.38 FTE at $165,000 including on-costs	—	$63,000
Specialist service referral capacity	1,890 hours (the last two rows), 1.18 FTE at $135,000 including on-costs	—	$159,000
Script, guidance, training, police system field	Including the queryable flag at hundred-day item 2	$210,000	—
Version A subtotal		**$210,000**	**$222,000 a year**

Version B — accompanied service in defined high-risk categories

Additional to Version A. Assumed 15 per cent of service events, or about 417 a year, attended by a specialist worker alongside police, at 2.5 hours each including travel and recording: about 1,040 hours, or 0.65 FTE at $135,000.

Version B additional: $88,000 a year.

Version C — clinical support offered to both parties

Additional to Versions A and B. Assumed 20 per cent uptake across 2,780 service events, or about 556 people, at three sessions each at $190 a session: 556 × 3 × $190 = $316,920.

Version C additional: $317,000 a year.

Version	Recurrent, a year	Cumulative
A — the legislated minimum	$222,000	$222,000
B — accompanied service, by regulation	$88,000	$310,000
C — clinical support, by regulation	$317,000	$627,000

Chapter 16 recommends Version A as the legislated duty with B and C enabled by regulation. The table is the reason: the legislated floor is affordable now, and the stronger versions can be commenced when they are funded rather than being the reason nothing commences.

P6. Reform 5 — publishing the money and the results

Item	Assumption	One-off	Recurrent
Quarterly court administrative statistics	Extract, validation and publication from existing systems. The court published this series annually until 2019–20	$120,000	$40,000
The investment and results ledger	0.5 FTE analyst at $170,000 including on-costs, plus publication	$60,000	$85,000
ACT Suicide Register field	Schema change, guidance, and a data entry step inside a process that already runs	$55,000	$8,000
Police records system flag	System change request, set when an order is served	$65,000	$8,000
Implementation tracker	Assembly and publication of existing information, 0.15 FTE	$20,000	$26,000
Subtotal		**$320,000**	**$167,000 a year**

P7. The totals, and what they sit beside

Read as a band, not as a number. Two published figures do not exist — the annual volume of determinations made in the absence of a respondent, and the proportion of those in which the court cannot identify the person most in need of protection — and both drive the recurrent side. The totals below are therefore given as low, illustrative-central and high. **The central column is not an estimate in the ordinary sense. It is one path through two unknowns, and a reader who quotes it without the band is quoting something this appendix does not assert.**

	One-off	Recurrent, a year — low	Recurrent, a year — *illustrative central*	Recurrent, a year — high
Reform 1 — framework rewrite, validation and alignment	$472,000	$130,000	*$148,000*	$170,000
Reform 2 — structured assessment before an ex parte order	$380,000	$110,000	*$164,000*	$245,000
Reform 3 — expedited return, reasons with content, trial	$300,000	$148,000	*$205,000*	$313,000
Reform 4 — safety and support at service, Version A	$210,000	$182,000	*$222,000*	$280,000
Reform 5 — publishing the money and the results	$320,000	$150,000	*$167,000*	$190,000
Total, legislated minimum	**about $1.68 million**	**about $720,000**	***about $906,000***	**about $1.20 million**
Total excluding the reciprocal-conditions trial	**about $1.53 million**	**about $641,000**	***about $823,000***	**about $1.10 million**
Reform 4, Versions B and C added	—	$332,000	*$405,000*	$510,000

Where the low and high columns come from. Reform 2 and Reform 3 are derived above, on the volume range at P1.3 and the stated unit ranges. Reforms 1, 4 and 5 are not volume-driven in the same way, and their bands are a stated judgment rather than a derivation: **minus 12 and plus 15 per cent** on Reform 1 (the analyst and alignment lines are fixed; the retest interval is not), **minus 18 and plus 26 per cent** on Reform 4 and on its Versions B and C (service events move with the volume range and the referral-handling line is the most uncertain figure in this appendix), and **minus 10 and plus 14 per cent** on Reform 5 (system-change estimates, which historically run over). Those percentages are assumptions and are labelled as such. A reader who rejects them should reject the low and high totals with them; the central column does not depend on them.

Over four years, the legislated minimum runs from about **$4.4 million to about $6.3 million**, with an illustrative central case of about **$5.1 million**. Those are one-off plus four years of the recurrent cost excluding the trial, plus two years of the trial, because the provision at section 21A expires at 24 months unless the Assembly resolves otherwise. With the stronger service versions of Reform 4 added for all four years the range is about **$5.7 million to $8.3 million**.

The arithmetic, so it can be redone: low = $1.682m one-off + (4 × $0.641m) + (2 × $0.079m) = $4.404m. Central = $1.682m + (4 × $0.823m) + (2 × $0.083m) = $5.140m. High = $1.682m + (4 × $1.101m) + (2 × $0.097m) = $6.280m. With Versions B and C: low $4.404m + (4 × $0.332m) = $5.732m; high $6.280m + (4 × $0.510m) = $8.320m.

A band is given rather than a single figure, and it is wide. That is the honest position rather than a defect: the volume assumption and the ex parte share that would narrow it have never been published, which is the finding of Chapter 10 applied to this work's own arithmetic.

For scale, and drawing on Chapter 3:

Comparison	Amount over four years
Total direct domestic, family and sexual violence investment, 2026–27 Budget	$151.4 million
Additional funding announced, 2026–27 Budget	$47.8 million
New foundational system infrastructure announced with the 2026 Strategy	$3.6 million
The reform package in this work, legislated minimum	**about $4.4 to $6.3 million**
The reform package with the stronger service versions	**about $5.7 to $8.3 million**

The package therefore costs between **2.9 and 4.1 per cent** of total direct investment over four years, between **9.2 and 13.1 per cent** of the additional funding, and **more than the $3.6 million allocated to foundational system infrastructure at every point in the range**.

That last comparison is the honest one to draw attention to, and it cuts against the argument of these chapters as easily as for it. The reforms proposed here are not free, and they are not marginal against the money actually allocated to building the system rather than running it. A government could reasonably say that this package would consume the whole of the foundational infrastructure allocation and then some.

Two things can be said in response, and neither is a knockdown. The first is that a large part of the package is one-off, and that the recurrent cost — between about $720,000 and $1.20 million a year — is between about **1.9 and 3.2 per cent** of direct annual investment, taking $151.4 million over four years as about $38 million a year. The second is that the alternative to measuring is not saving the money; it is spending the rest of it without knowing what it does, which is the finding at Chapter 3.

P8. Where each cost falls, and who absorbs it if it is not funded

This is the table the Cabinet measure at Chapter 16 section 7 would require of any reform, including this one.

TABLE P.1

The unfunded remainder

Every unfunded cost in the package is absorbed by taking time away from the same decisions the reform is meant to improve.

COST	FALLS ON	ABSORBED BY	CONSEQUENCE
Structured assessment before an ex parte order	ACT Courts registry	the registry, from time now spent on the same decisions	Worse decisions with better documentation: a form to be signed, not an analysis.
Reasons with content under s 68A	registrars and magistrates	judicial time, against a two-day timetable	Reasons remain compliant and stop being informative.
Expedited return listings	ACT Courts	the existing list, against a two-day timetable	Delay in other lists, or listings that are nominal. The element most likely to be quietly absorbed, because it produces no artefact anyone counts.
Reciprocal conditions, if the trial proceeds	registry	registry counter time	Longer queues where applicants are most distressed.
Welfare step at service	ACT Policing	frontline patrol time	The script is completed nominally, or service is delayed.
Referral handling	specialist services	existing crisis capacity	Directly reduces crisis line answer rates — the substitution Chapter 5 documents.
Framework rewrite and validation	Community Services Directorate	existing framework owner capacity	The validation is deferred, which is the failure the package exists to correct.
Quarterly statistics and the ledger	ACT Courts	existing analyst capacity	Publication slips, as it did after 2019–20.
Additional contravention charges, if the trial proceeds	DPP; Legal Aid; the courts	the Director of Public Prosecutions	The Director has already told the Assembly that staff do not have time to prepare matters properly.
Representation at expedited returns	Legal Aid	the existing duty scheme	Not estimated anywhere in the appendix.

On that basis, a decision to adopt the package without funding it would be worse than a decision to reject it.

This is the table the Cabinet measure at Chapter 16 would require of any reform, including this one.

Appendix P, section 8. Section P9 lists seven omitted costs, among them the protected person's limb of Reform 4 and Legal Aid duty lawyer capacity.

The pattern in the right-hand column is the point. Every unfunded cost in this package is absorbed by taking time away from the same decisions the reform is meant to improve. That is not a special feature of these reforms. It is what Chapter 6 establishes has happened to every justice reform of the past decade that was funded at the front end and not at the interfaces.

A government that adopts this package and funds none of it will produce the appearance of reform and none of the substance. **On that basis, a decision to adopt the package without funding it would be worse than a decision to reject it**, because it would consume the argument for reform without producing the result, and it would foreclose the same proposal being made again for a decade.

P9. What is not costed here

Stated so that the total is not read as complete.

- **The framework rewrite's downstream training** across all prescribed entities beyond the alignment reporting above. The 2026–27 Budget provides two years of training funding; what happens after that is not costed by anyone.
- **The linked data asset** at Chapter 17, which is the largest single item in Part III and is properly a multi-year capital proposal.
- **The rapid fatality and near-fatality review** at Chapter 17 section 5. It is a standing multidisciplinary function with a statutory basis, operating alongside the retained biennial report, and its cost depends on the number of eligible events a year, which is not published. Nothing here estimates it.
- **Housing and income measures.** Chapter 5 and Chapter 13 establish that the least restrictive option frequently does not exist because there is nowhere for either party to go. Creating it is a housing budget question of an entirely different magnitude, and nothing in this appendix should be read as suggesting the reform package addresses it.
- **The protected person's limb of Reform 4.** Chapter 16 section 5.4 requires that written information and a recorded offer of referral also go to the protected person. All three costed versions in this appendix are respondent-facing, and that limb has no version, no roster and no cost here. It is not a small omission: it creates demand on the same specialist services that Chapter 5 records as unable to answer every crisis call, and Chapter 16 section 7 — this work's own Cabinet measure — requires a business case to name the agency expected to absorb an unfunded remainder. The agency here is the specialist service sector, and this appendix should have said so in a table rather than in a list of omissions.
- **Legal Aid and duty lawyer capacity at the expedited return.** The entitlement at section 47C creates listings at which respondents will frequently be unrepresented. Nothing here estimates the demand that places on the duty scheme, and it is not a trivial omission: an expedited listing that a person attends without advice is a smaller improvement than the reform claims.
- **The cost of the errors the package is meant to reduce**, in either direction, which cannot be estimated because the Territory does not count them. That absence is the subject of Chapter 11.

The last of those is the one that would decide whether this package is good value, and it is the one that cannot be calculated. A reader is entitled to weigh that against everything above.

Appendix Q — Two adversarial reads

What this is. Two constructed critiques of this work, written as strongly as they can be written, each followed by a response.

Both are constructed. Neither is attributed to any real person or organisation, neither reproduces anything said by one, and neither should be read as representing the views of any body named anywhere in these pages. They are steelmen: the argument an intelligent, well-informed opponent would make, put in that opponent's voice and not softened.

They attack the package as first proposed. Two things they attack are no longer in it: reciprocal conditions as a default are withdrawn, and the recorded-reasons proposal has become content for the duty section 68 already imposes. The critiques are left as written, because a critique rewritten to fit the answer is not a check. Where a criticism describes a version of the package that is not the one proposed here, the response says so.

Why they are here. A work that documents a system's inability to check itself, and then publishes no adversarial check on itself, has a problem. The test of the exercise is whether the responses concede anything. Several criticisms are conceded below. Where a criticism is not conceded, the response says so and gives its reasons, rather than absorbing the objection politely and changing nothing.

Q1. From a specialist domestic and family violence practitioner

Constructed. Not attributed.

. . .

I have read this closely, and my objection is not that any particular figure in it is wrong. Most of them are right, and some of them are findings my sector has been making for years. My objection is to what the work is shaped like.

It is a respondent-centred book that does not know it is one.

Look at where the reforms sit. A structured assessment before an order is made. A mutual order so the respondent is not alone in being restrained. A welfare check when the respondent is served. Recorded reasons so the restraint can be reviewed. Five reforms, and the moment each of them addresses is the moment the state restrains a man.

Now look for the reform that operates at the moment a woman is being strangled in her kitchen. There isn't one. Chapter 4 tells me that in about 9 of the 12 homicides the Territory examined there was no significant prior physical violence, which is the most important operational finding in the whole book, and then the book moves on. Eleven homicides in five years, and they are set aside on the ground that the review could not analyse them.

I understand the argument for that. I am telling you what the shape of the thing communicates, which is not the same as what its sentences say.

The suicide analysis carries more moral weight than twenty-five cases can bear.

Twenty-one people, over five years, in a city of 470,000. The book says repeatedly that it makes no causal claim, and I accept that it means it. But the disclaimer is in the text and the emphasis is in the architecture. It is in the prologue, the title, the findings list, the proposed graphics. A reader who takes nothing else away will take away that men are killing themselves because of family violence orders. You have written six careful paragraphs saying that is not the claim. They will not survive the first headline.

And the cohort is not what it is being asked to be. These are 25 people a review classified as perpetrators by reading files. Ten of the 11 homicides were excluded because proceedings

were on foot. You are building an argument about a system on the residue of what a review could not examine.

The framework adds process at the point of highest urgency.

I have read Appendix B. It is a serious document and I would use it if I had two hours. I have twenty minutes and a queue. Your own cost appendix says the structured assessment is 30 minutes of registry time across 1,310 matters a year and concedes that if it is unfunded it becomes a form to be signed. That is exactly what will happen, and the result will be worse decisions with better documentation — your phrase, not mine.

And mutual orders as a default is the worst idea in the book.

Every specialist service in the country will tell you what cross-orders are used for, and we will tell you because we have watched it happen for thirty years. Your carve-out does not remove the lever. It removes the licence suspension. The lever is that the man now has an order he can point to, and contact she initiates becomes a potential offence, and there is a document that says she is also a person somebody needed protection from. You have made that automatic. Nobody even has to ask for it any more.

You say the deterrence risk cannot be estimated. That is true, and it is my objection, not your answer. The people who will not apply are the people already least likely to: women in insecure housing, women on temporary visas, Aboriginal women who expect child protection to follow the police through the door. Your own Chapter 10 says the ACT cannot see those cohorts in its data. So when they stop applying, your evaluation will not detect it.

Two smaller things.

The lived-experience section is careful and I do not think it is wrong. It will still be quoted, without its qualifications, by people arguing that survivors should be believed less. You do not control that, and knowing you do not control it does not discharge the responsibility.

And every dollar here is a dollar not spent on a crisis line that already cannot answer its calls. You cost your package at something between four and six million dollars over four years, and you cannot tell me which. I can tell you exactly what four years of that money would do in a refuge.

Response

Taking the seven points in the critic's order: three are not conceded (the shape of the work, "respondent-centred", and opportunity cost); one is partly conceded (the small numbers); one landed hard enough to remove a reform from the package (mutual orders as a default); one is conceded outright and changes a recommendation (process at the point of urgency); and one is noted without being conceded as a defect (the lived-experience section).

On the shape of the work: not conceded. It is a scope decision, and it is a risk-management one.

The critic's list of the reforms is not accurate, and the inaccuracy matters. Of the five reforms in the package, two do not sit at the moment of restraint at all: Reform 1 rewrites the risk framework every agency uses from first contact, and Reform 5 publishes the money and the results. The critic's "five reforms" names four, one of which — the default mutual order — is no longer proposed. Three of the five do sit at the moment of restraint. That is not an unexamined bias in the work; it is the boundary of what the work is about, and the boundary is drawn where risk management ordinarily draws it.

Risk management divides a hazard at the event. On the left sit the controls that make the event less likely to happen at all — likelihood management. On the right sit the controls that limit harm once it has occurred or is imminent, stop it escalating, and prevent the next one — consequence management. The picture is a bow tie and the event is the knot.

This is a study of the right-hand side of the bow tie — consequence management — and the right-hand side is what the Territory built. The *Family Violence Act 2016* is, in operation, a protection-order and enforcement instrument. The 2022 framework assesses risk as

it stands at the moment of assessment. The coordination architecture convenes agencies around people already identified. Crisis response took 34 to 46 per cent of levy-supported initiatives annually against 12 to 20 per cent for prevention, and those shares did not materially move across the period the Auditor-General examined. The system under examination here is a consequence-management system, and it is examined on its own terms.

The critic's real complaint is that the left-hand side is missing, and it is — deliberately. Likelihood management is a broader public policy package than this one. It runs through education, child development, housing, economic security, health and mental health services, alcohol policy, and the norms that shape behaviour long before any agency in this field meets anybody. Its lead indicators are early-intervention and population measures, not court and service data. It requires a different evidence base to write about and it deserves its own volume, which this is not and does not pretend to be. Chapter 1 says so in its scope statement and Chapter 2 section 8 sets out what the Territory has and has not built on that side.

Prevention is not being treated as peripheral, and the work says the opposite. Chapter 2 section 8.4 states it directly: a right-hand side that worked perfectly would still process whatever the left-hand side sent it, and only likelihood work changes the base rate. The 2026 Strategy is credited there for being the first ACT document in this field to put that side on the page, with a four-stage continuum, a dedicated social-change outcome, and a commitment to primary prevention infrastructure. What it is not credited with is having built it: the first tranche funds the development of a model, and the substantive redesign sits in the 2028–32 window.

So the answer to "where is the reform that operates at the moment a woman is being strangled in her kitchen" is that it is on the other side of the knot, in a different volume, and that neither volume can currently show that its side works. That is the finding this one makes about the side it examines, and Appendix L section L13 makes the symmetrical point about the other.

One thing in the critique is accepted, and one is answered.

The one answered is the roughly 9 in 12 finding — coercive control present, no significant prior physical violence. The critic is right that it is the most important operational finding in the fatality record. The critic is wrong that the work "moves on" from it. Detecting a pattern of control where there has been no serious assault is the job of a risk assessment instrument, and it is the failure the current framework's unweighted list cannot correct. Chapter 15 and Appendix A keep coercive control as a pattern, give it a coding rule as a Tier 2 pattern indicator, and place in Tier 1 several factors that involve no prior assault at all: threats to kill, stalking, separation within three months, escalation, and threats of suicide by the person using violence (findings F15.1, F15.5 and F15.6). A high rating under that instrument does not depend on a history of physical violence, which is the point the 9 in 12 finding makes. Chapter 9 and Appendix A replace the demeanour-based aggressor indicators with a pattern-and-evidence method for the same reason. That is the reform that operates before the kitchen. What the work does not claim is that any instrument, including that one, has been shown to find the pattern in time: that is what the validation at Appendix O exists to test, and it is why nothing is deployed before it is run.

The one accepted is about communication rather than substance. A reader who does not hold the bow tie in mind will read the shape of the reform package as a statement about whose harm counts. That reader is owed the scope in plain terms, early and unprompted, rather than left to infer it. The text states the scope on the second page of Chapter 1 and analyses it at Chapter 2 section 8.

On "respondent-centred": rejected, and the record is the reason.

The reform package concentrates where this system's own operations produce harm, and the record shows that harm running in both directions. Eight of the 13 deceased victims the review examined had been wrongly recorded as the aggressor while alive, with consequences

including criminal charges, removal of children and incarceration. Twenty-one of the 25 people it recorded as having used violence died by suicide. Those are not two constituencies competing for sympathy. They are one failure — a classification made without criteria and never checked in either direction — seen from opposite ends.

Every reform in the package operates on that failure rather than on one of its two outcomes. Criteria that produce consistent answers protect the person the answer is about, which is more often a woman. A structured assessment before an ex parte order is as likely to establish that protection is needed as that it is not. A classification method that permits "unresolved" and applies identically to any person is the direct remedy for misidentifying victims as aggressors, which is the error the Territory has actually documented. And of the seven hundred-day items, items 1, 3, 6 and 7 are not respondent-facing at all.

A package aimed at the accuracy of a decision is not respondent-centred merely because inaccurate decisions restrain people. It is centred on the decision.

On the small numbers: partly conceded, and the concession is about emphasis rather than accuracy.

The claim made is about measurement, not causation, and it is a narrow one: 29 deaths in five years are the largest category among the deaths the 2025 review was able to examine — in-depth analysis of the 11 homicides was not possible — the Territory has never cross-tabulated data it already holds, and the classification error was searched for in one direction only. Every one of those is true on the government's own documents.

The critic's point is that the architecture carries an implication the text disclaims, and that is a fair description of how a reader receives a long document. The prologue was rewritten for exactly that reason: it now opens on the measurement failure, puts the homicide findings first, and presents the two cohorts as two directions of one problem rather than as a hierarchy. The selection-bias box the critic is describing appears beside every substantive use of the cohort, and says in terms that the 38 are what remained after the most fully investigated deaths were set aside.

Whether that is enough is a matter of judgment on which reasonable people will differ. Responsibility for emphasis is accepted. The figures are not withdrawn.

On process at the point of urgency: conceded outright, and it changes a recommendation.

The critic has quoted the cost appendix accurately, including against itself.

The response is therefore not an argument but a condition, and it is stated in Appendix P sections 3 and 8, in Chapter 16 section 3.2b and in the draft section 47B, and repeated here: **a structured assessment obligation that is not funded should not be commenced.** Not commenced late, or commenced in a reduced form — not commenced. An unfunded assessment obligation produces documentation without analysis, and the current process, which at least does not pretend, is preferable to that.

That is a real cost to the argument. It means Reform 2 is conditional on a budget decision that may not be made, and it means the reform cannot be claimed as free.

On mutual orders: conceded as to the default, and the reform is withdrawn in that form.

Three things in the critique are accepted. The lever is not removed by the carve-out; the critic is right that the licence consequence is what the carve-out removes and the lever is something else. The deterrence risk falls hardest on the cohorts the Territory's data cannot see. And — the point that decided it — a default operates *before* the rebuttal, on the decision whether to apply at all, so the fact that the default was rebuttable on recorded reasons answered nothing about the objection. A person weighing whether to seek protection weighs the rule, not the exception.

What remains is narrower and is put as a question rather than a recommendation. Where the court records under the new section 68A that it cannot identify which party is the person most in need of protection, it **may** include equivalent conditions binding both parties. In

every case where the court can make that identification, and records that it can, the one-way order is unaffected. The provision cannot commence before its baseline is published, and it expires at 24 months unless the Legislative Assembly votes to continue it. Chapter 16 section 4.4 sets it out; Appendix G8 drafts it.

That is a real loss to the argument and it should be recorded as one. The finding underneath the original proposal is unchanged: the current arrangement makes an asymmetric classification at the point of least information, and the Territory's own record contains 4 of 13 deceased victims who had been the respondent to an order where the evidence indicates the applicant was the aggressor. Those four are the cost of the present design and they are not hypothetical. What the narrowing concedes is that the work could not show that the proposed remedy would not cost more, in a population that cannot be seen in the data, and that a reform in that position should not be the headline of a package.

The critic's objection about invisible cohorts survives into the narrowed provision and is adopted in full: the evaluation measures applicant composition by sex and by Aboriginal and Torres Strait Islander status, and a fall concentrated in a cohort identified as vulnerable to misidentification is itself a repeal trigger.

On the lived-experience section: noted, and not conceded as a defect in the text.

The material may be quoted without its qualifications. That is true of every finding in this work, including the fatality figures the critic has just asked to be handled more carefully, and it is not a reason to write any of them differently. The mitigation that is available has been applied: each qualification sits in the same sentence as the claim it qualifies, not in a footnote; Chapter 14 section 13 states its conclusion in terms — that a person's own account is a primary input for every person, and that the argument about what a kind of evidence can carry applies with equal force to the documentary evidence this work is built on. What is accepted is narrower: that the risk of selective quotation is real, and that stating it does not remove it.

On opportunity cost: not conceded, but the trade-off is real.

Four years of that money would fund real service capacity, and that is a genuine loss. The imprecision the critique attacks is conceded and is the point of Appendix P1.3: two of the quantities that drive the total are not published, and the range is wide because the record is thin, not because the arithmetic is careless. The current band is at Appendix P7. The counter is in Chapter 3: the alternative to spending money on measurement is not saving it. It is spending the remaining $151.4 million without being able to say what any of it achieved, which is the finding the Auditor-General made in 2024 and the government has not disputed. A refuge funded from an unmeasured portfolio is one budget cycle from being defunded for reasons nobody can contest.

Q2. From a defence or human rights lawyer

Constructed. Not attributed.

. . .

I agree with the diagnosis and I think the remedy is timid to the point of being decorative.

The ex parte reforms do not go far enough, and the book knows it.

You have established that a registry officer, in minutes, on one party's material, can remove a person from their home, suspend the licence they work under and interrupt their contact with their children. You have established that the applicant who is refused has a same-day review right and a hearing within two business days, and that the respondent who is restrained has nothing.

Your remedy for that is a form and a paragraph of reasons.

The proportionate remedy is obvious and you decline to propose it: where an order is made in the absence of a respondent, the respondent gets an expedited inter partes return as of right, within a fixed short period, on the same footing the applicant already enjoys. You do not propose it. You propose that the decision-maker write down why.

Recorded reasons without a right of review change very little.

Reasons are a mechanism for review. Where there is no expedited review, reasons are read by nobody in the window in which they would matter. Your own material shows a registry under time pressure and a two-day statutory timetable. What you will get is a paragraph of boilerplate, and boilerplate is what recorded-reasons obligations produce everywhere they exist without a corresponding right to challenge what was recorded.

Division 4.1A (now 4.1B) may create the invalidity ground your savings clause says it does not.

You provide that non-compliance "does not of itself invalidate an interim order, but may be taken into account on review or appeal". That is a familiar formulation and it is not as safe as you think. Once a statute requires a court to be satisfied of something before proceeding, a party will argue that a failure to be so satisfied is jurisdictional, and the savings clause will be read against a court's obligation to act within power. The practical effects are defensive documentation and satellite litigation about the quality of an assessment, in a jurisdiction that cannot fund the litigation it already has.

Mutual orders are a fig leaf, and the fiction is doing the work.

You make an order restraining a person, and provide that it is "not a finding" that they have committed family violence, and that it is not an order made against them for the purposes of any other law. Either the reciprocal limb has real consequences, in which case it is a restraint imposed on a person about whom the court has no evidence, or it has none, in which case it is decorative.

You cannot have both. What you have done is create a category of order that restrains without finding, and courts have historically found such categories difficult, because the consequence follows from the fact of the order, not from the label the statute attaches to it.

Putting the complicity question in an annex is evasion.

You spent a chapter establishing that s 43(4) is absolute and admits no exception for deliberate inducement. Then you withdrew the proposal and put it in an annex as a question. Either the gap matters or it does not. A question in an annex is what an author does when they want the credit for raising something and none of the cost.

And you propose no remedy for the person who was wrong-footed.

Your whole case is that the Territory cannot tell whether it has caused harm. Suppose it could. Suppose an order was made ex parte, the licence was suspended, the man lost the contract he holds it for, and the order was discharged at the first contested hearing. What do you propose for him? Nothing. No correction of record, no expungement, no compensation pathway, not even a requirement that the discharge be recorded in the systems that recorded the order. You rely on *Human Rights Act* section 28 proportionality throughout and propose no remedy for a disproportionate limitation.

Response

Two of these are conceded and produce amendments. One is taken seriously and referred out. Two are answered, and one of those answers turns on a premise the critique does not examine.

On the expedited return as of right: conceded, and adopted.

The critic is right, the omission was an error, and the reform package is amended.

The entitlement is now the first element of Reform 3, and it is now the headline of that reform rather than an addendum to another one: where an interim order is made in the absence of the respondent, the respondent is entitled to an inter partes return within the same

period the applicant enjoys on a refusal — a hearing before a Magistrate within two business days of a request. The asymmetry Chapter 7 documents was described as a finding and then not remedied, which is the criticism, and it is a fair one.

Two qualifications, which reduce the concession without removing it. The entitlement is to a listing, not to a discharge, and the protective conditions continue until the return. The resource implication is real, and it is costed at Appendix P4.1 — between about $35,000 and $156,000 a year depending on a request rate nobody publishes, plus $85,000 one-off. What is still not costed is the demand this places on the duty lawyer scheme, and that is recorded at Appendix P9 rather than resolved.

On recorded reasons: conceded, and it is the same amendment — and the work had the law wrong.

The critic's analysis is correct: reasons without a review are boilerplate. The amendment above supplies the review, which is what makes the reasons operative. The two should have been proposed together and were not, and they now are, as the two inseverable elements of Reform 3.

A second point belongs here, and it narrows the reform rather than the criticism. **Section 68 of the *Family Violence Act 2016* already requires a court to record the reasons for making a protection order, and the Dictionary defines *protection order* to mean an interim order or a final order.** The duty has applied to ex parte interim orders since the Act commenced. What the section does not do is state what the reasons must contain, require that they be given to the respondent, or provide for publication or aggregation — and nothing in the public record indicates that any reasons recorded under it have ever been counted, sampled or read outside the file. So the reform is not the creation of a duty. It is the supply of content to one that exists and does nothing, which is a narrower proposal and a better-founded one.

On the invalidity ground: taken seriously, and referred out.

This is a drafting question that this work is not in a position to settle, and Appendix G says on its face that its provisions are not parliamentary drafting.

The risk the critic identifies is real. Three responses are available and each has a cost. The savings clause could be strengthened, which invites the same argument at one remove. The obligation could sit in the Court Procedures Rules and a practice direction rather than in the Act, which reduces the litigation risk and also reduces the obligation to something a court can disapply. Or the obligation could be expressed as a duty on the registry to prepare the assessment rather than as a condition of the court's satisfaction, which largely removes the jurisdictional argument and weakens the requirement.

The preference here is the third. It should be settled by parliamentary counsel, and if it cannot be settled safely, the critic's warning should prevail over that preference: an obligation that generates satellite litigation in this jurisdiction would do more harm than the practice it corrects.

On mutual orders: the design is narrowed, and what survives of the answer is set out below.

This critic attacks the reciprocal limb from the opposite direction to Q1 — not that it endangers applicants, but that it restrains a person about whom the court has no evidence. The specialist critique at Q1 succeeded in narrowing the provision, and a reader is entitled to ask whether this critique has been quietly abandoned along with it. It has not. The three answers below are unchanged in substance and now apply to a discretionary power in a defined class of case rather than to a default, which strengthens the first answer and weakens the third considerably.

First, the premise. The objection is that the reciprocal limb is "a restraint imposed on a person about whom the court has no evidence". That describes the condition of the interim jurisdiction as a whole, and it is stated here not to excuse the reciprocal limb but to locate it.

At an ex parte interim hearing the court must be satisfied that an order is necessary — section 21 is a real threshold and nothing here proposes weakening it. But section 13 sets the balance of probabilities, section 13A provides that the Magistrates Court need not comply with the rules of evidence, section 65 allows the court to inform itself in any way it considers appropriate, and, where a police officer is the applicant, section 62A permits evidence by affidavit sworn before a sergeant. The material is routinely one party's account, untested, at a hearing of the interim order held not later than two days after the application is received, which the other party does not attend and often does not know about.

So the court frequently has no tested evidence about **either** party at that moment. What it has is an assertion from one of them. The narrowed proposal does not add a second restraint on that basis in the ordinary case. It applies only where the court records that, on the material before it, it cannot say which party is the person most in need of protection. In that class of case the court is not choosing between an evidenced restraint and an unevidenced one; it is choosing between a one-way restraint whose direction it cannot support and a symmetrical, stripped-down restraint that expires at the first contested listing. The justification is confined to that class, and the reasons record makes the class visible and countable.

The comparison with the existing one-way order is therefore not the answer; it is the context. The one-way order carries the firearms suspension, the exclusion condition and the disclosable record that the reciprocal limb does not, and the objection to restraint without tested evidence lands on it first. That does not license the reciprocal limb. It explains why the limb is stripped of those consequences.

Second, the fiction. The construct is real and is not denied: section 21A(4) permits conditions without satisfaction of the section 21 matters as to the applicant, and section 21A(6) provides that the limb is not a finding. That is a legal fiction, deliberately adopted.

The reason it is preferred to the alternatives is that the alternatives are worse, and the critic's "either real consequences or decorative" dichotomy is false. The limb carries exactly one consequence — contravening it is an offence under section 43 — and is stripped of the collateral consequences that would otherwise attach. That is neither of the critic's two options. It is a deliberate selection of which consequence is proportionate to a restraint adopted because the court has heard one party.

A reciprocal limb with the **full** automatic consequences would suspend the firearms licence of every applicant who obtains an ex parte order and give them a disclosable record, falling hardest on the group the Territory's own review shows is most often misclassified. A limb with **no** consequence would be decorative, as the critic says. The middle course is the proposal.

Third, and it is a good deal less than it first appears: the reciprocal limb narrows the section 43(4) problem, and only in the minority of cases where it applies.

Section 43(4) provides that a protected person commits no complicity offence by aiding, abetting, counselling, procuring or being knowingly concerned in a contravention of the order made for their protection. That is the gap the annex to Chapter 16 examines and declines to propose an offence for.

Where reciprocal conditions are made, the arithmetic changes — but not by itself. It is tempting to say that a protected person who initiated prohibited contact would be caught by section 43(1)(a) as a person present when the order was made. That does not work. Section 43(1) applies to "a person against whom a family violence order is made" who was present or was served, and a protected person bound by a reciprocal condition is not a person against whom the order is made. Without an express provision the conditions would carry no offence at all. Appendix G8 contains that provision at section 21A(6A), confined by (6B) so that it does not make the protected person a respondent for anything else. **With it**, a protected person who initiates prohibited contact commits a primary contravention of a condition binding

them under section 43(2), and section 43(4) does not assist, because it immunises complicity in another's contravention and not a person's own.

The boundary of that claim, stated so it is not overread. It does not substantially answer the mischief that a complicity offence would be drafted to address. Two limits apply. It reaches only conduct breaching a condition binding the person who engaged in it — the symmetrical conditions: contact, approach, communication, third-party contact — and never the inducement of a breach of an asymmetric condition such as an exclusion, which binds one party only. And it operates only in the class of case where the court recorded that it could not identify the person most in need of protection, which on any plausible assumption is a minority of ex parte matters. In every ordinary one-way case section 43(4) operates exactly as it does today. This is therefore not an answer to the annex question. It is a reason for leaving that question open rather than answering it with a new criminal liability, and no more.

What remains of the objection. The critic is right that courts have found restraint-without-finding categories difficult, and that the consequence follows from the fact of an order rather than from the label a statute attaches to it. That is a drafting risk and it is real. It is why section 21A(6) enumerates the specific consequences that are excluded rather than relying on a general statement, and why the provision should be settled by parliamentary counsel, who may conclude that the enumeration needs to be longer. If it cannot be drafted so that the exclusions hold, the reform should not proceed, because the collateral consequences are what would make it harmful.

On the annex: answered, and the criticism partly holds.

The characterisation is wrong as to the reason and fair as to the effect.

The reason the proposal was withdrawn is stated in the annex and is evidentiary: the ACT frequency of deliberate inducement is unmeasured, and the comparative charging data from jurisdictions without a blanket exemption has not been assembled here. The annex states the three specific things that would move it back into the package. That is not a rhetorical device; it is a description of what is missing.

Where the critic is right is that a question in an annex, in a work that proposes five reforms with drafting attached, will read to many readers as having it both ways. The response is that a proposal advanced on evidence the work does not have would be the more serious failure, and that the same standard is applied to the work's own framework in Chapter 15, which is described as unvalidated and made conditional on a test it may fail.

On a remedy for the person wrong-footed: conceded, and it is the more serious of the two gaps.

The critic is right and the omission is worse than the first one, because it goes to the coherence of the argument. A work whose central finding is that the Territory cannot tell whether it has caused harm should not be silent about what happens when it can.

A minimum is adopted here, and it is deliberately minimal because anything larger is beyond what the record in these pages supports.

1. **Correction of record.** Where an interim order is discharged, or an application is withdrawn or dismissed, the discharge is recorded in every system that recorded the order, including the police records system and any firearms registry entry, within a stated period. At present the making of an order propagates and the ending of one does not reliably follow it.
2. **Reinstatement of a suspended authority.** Where a licence was suspended under section 44 and the order is discharged, reinstatement is administrative and automatic on the discharge rather than requiring a fresh application.
3. **A recorded count.** The number of interim orders discharged, withdrawn or dismissed at first contested hearing is published quarterly under Reform 5. It is one of the measures that would begin to show the rate at which the second kind of error occurs.

What is **not** proposed is a compensation pathway. Not because the case for one is weak, but because designing it would require knowing the rate and the severity of the harm, and Chapter 11 establishes that nobody does. Item 3 above is the step that would make the question answerable. Proposing a remedy scheme sized to an unknown quantity would be the same error this work criticises elsewhere, and the critic is entitled to record that as an unsatisfying answer.

Q3. What the two critics agree on

They disagree about almost everything, and they converge on two points. Both are conceded above and both are worth stating separately, because a criticism made from opposite directions is usually correct.

An obligation without resourcing produces documentation rather than analysis. The practitioner says a registry under time pressure will complete a form. The lawyer says a decision-maker without a review will write boilerplate. They are describing the same mechanism from different ends, and they are right. It is the reason Appendix P section 8 traces every unfunded cost to the decision it degrades, and the reason Reform 2 should not commence unfunded.

The work proposes measurement and then relies on it existing. Several answers above end at the same place: the evaluation will show whether the critic is right. Both critics could reply that a package whose defence is "we will find out" is asking to be trusted with an experiment on people who did not volunteer. That is a fair statement of what is being proposed, and the only thing that distinguishes it from the arrangement being criticised is that the result would be published in advance of anyone knowing it, and the withdrawal trigger stated before the data exists. Whether that distinction is sufficient is a question for the Assembly, which is where the reciprocal-conditions question is put.

Appendix R — Comparative note: what other jurisdictions publish, and what is known about the instruments

What this is. Two comparisons, held apart on purpose.

The first takes four things a jurisdiction can do about protection orders — publish the numbers, require reasons when it acts without the respondent present, give its risk framework statutory force, and record order status when someone dies — and records which of six jurisdictions does each. The second takes the four named risk instruments most often cited in this field and records what has been published about their reliability and their accuracy.

Verification. All comparative entries were verified on 3 September 2026. Where a point could not be verified, the cell says so. "Not established" means the record was searched and did not settle the question.

R1. Four things other jurisdictions publish

Jurisdiction	Order statistics published?	Reasons required when the court proceeds in the respondent's absence?	Risk framework given statutory force?	Order status recorded at death?	Notes
ACT	Lapsed. *ACT Magistrates Court Annual Review* series ends at 2019–20: 1,249 family violence applications for final orders, 1,152 including an interim application. No successor publication.	Yes in form, empty in content. *Family Violence Act 2016* s 68 requires a court making a protection order to record its reasons, and the Dictionary definition reaches interim orders, so the duty covers orders made in the respondent's absence. No content prescribed. No reasons recorded under s 68 have been published or counted. Section 39 separately requires reasons where an exclusion condition is refused, with no equivalent where one is imposed.	No. The July 2022 ACT Domestic and Family Violence Risk Assessment and Management Framework has no statutory force and self-describes as a working document.	Mixed. The ACT DFV Review records order status at death: 2025 Biennial Report, 9 of the 25 deceased people the review recorded as perpetrators were respondents to a current order; 3 of the 13 deceased victims were protected persons on one. The ACT Suicide Register has no such field, and no agency has cross-tabulated the two.	The only one of the six not currently publishing an order series, having published one until 2019–20.

Jurisdiction	Order statistics published?	Reasons required when the court proceeds in the respondent's absence?	Risk framework given statutory force?	Order status recorded at death?	Notes
Victoria	Yes. Victorian Family Violence Database (Crime Statistics Agency), 2024–25 edition released 3 December 2025, with Magistrates' Court tables. A distinct interim or ex parte series is not established.	None identified. *Family Violence Protection Act 2008* s 53 carries no reasons duty; s 53(1C) permits an interim order on consent or without opposition "without being satisfied as to any matter". Recorded as none identified, not as none existing.	Yes. *Family Violence Protection Act 2008* Pt 11, ss 188–193: ministerial approval of the framework, mandatory alignment of policies, procedures, guidance and tools by prescribed organisations, contract alignment (s 191), annual report to Parliament (ss 192–193). MARAM gazetted 25 September 2018; Pt 11 commenced 27 September 2018; phase 2 prescription 19 April 2021. Latest statutory annual report 2024–25.	Indirectly. The Victorian Systemic Review of Family Violence Deaths is non-statutory and a network member; the national minimum dataset records current or historical orders — 96 cases, 42.9 per cent, of male-perpetrated homicides in the 2022 report. A Victoria-specific published variable was not verified.	The only statutorily mandated risk framework of the six.
NSW	Partly. BOCSAR apprehended violence order statistics and ADVO infographic (December 2025): 52,757 ADVOs commenced in 2025; 107,830 in force in the December quarter. Local Court Annual Review 2024: 47,453 domestic violence lodgements, 37,125 final orders, with no provisional, interim or final breakdown, stated expressly.	No. *Crimes (Domestic and Personal Violence) Act 2007* s 22(3) permits an interim court order where the defendant is neither present nor notified; ss 28 and 28A do the same for provisional police orders. Neither carries a reasons duty. Reasons duties appear only in narrow unrelated situations: ss 17(4), 20(4), 38(3), 53(7).	No. The DVSAT and Safer Pathway are administrative.	Yes, systematically. Domestic Violence Death Review Team, *Coroners Act 2009* Ch 9A s 101J(1). Annual Report 2021–23 tabulates current ADVOs between predominant abuser and victim (Table 3.4), their duration (Table 3.5, n=64), and historical ADVOs (Table 3.6).	Order status at death published as tables, not narrative.

Jurisdiction	Order statistics published?	Reasons required when the court proceeds in the respondent's absence?	Risk framework given statutory force?	Order status recorded at death?	Notes
Queensland	Yes, the most granular of the six. Queensland Courts' domestic and family violence statistics, covering 2021–22 onward, current to 31 July 2026: initiating applications 1,660 year to date; vary applications 1,054; orders made split into protection orders 1,408, temporary protection orders 1,007 (28 per cent of all orders made) and vary protection orders 1,139, with breakdowns by sex, age, relationship, lodging authority and court location.	No. *Domestic and Family Violence Protection Act 2012* s 39 (hearing in the absence of the respondent), s 40 (hearing before service) and s 27(b) (temporary orders before service) contain no reasons requirement, and none was found elsewhere.	No. The DFV Common Risk and Safety Framework (version 2) is whole-of-system policy guidance.	Partly. DFV Death Review and Advisory Board, *Coroners Act 2003* s 91ZB. The 2023–24 report identifies that "there were often existing protection orders in place" as a lethality indicator, but publishes no order-at-death figure.	The only one to publish temporary order volumes as a separate countable series.
New Zealand	Yes, at application level. Ministry of Justice justice statistics data tables, Protection Order applications series: total applications, applications involving children, age, gender and ethnicity of applicants and respondents, and a flowchart through the court. Latest period December 2025; page updated 17 March 2026. Whether the tables break out without-notice applications is not established.	Not established. The *Family Violence Act 2018* has no section headed "reasons"; without-notice applications are governed by ss 75–78. Whether Family Court Rules 2002 r 220 imposes a duty could not be verified.	No. The Family Violence Risk Assessment and Management Framework is guidance. Statutory hooks exist but activation is not established: *Family Violence Act 2018* s 22 (duty to comply with a code of practice), s 254 (power to issue codes), s 42 (assessment following a Police Safety Order).	Yes. Family Violence Death Review Committee; statutory powers under Sch 5 of the *Pae Ora (Healthy Futures) Act 2022* transferred on 1 July 2023 to a single National Mortality Review Committee, family violence death review continuing as a workstream. Sixth report (2020): 38 per cent of male predominant aggressors in intimate partner homicide were respondents to a protection order, over half of whom breached it before the homicide.	Publishes both the application series and the order-at-death proportion.

Jurisdiction	Order statistics published?	Reasons required when the court proceeds in the respondent's absence?	Risk framework given statutory force?	Order status recorded at death?	Notes
England and Wales	Partly. Family Court Statistics Quarterly, latest covering January to March 2026, published 25 June 2026. December quarter 2025: 8,887 domestic violence remedy orders applied for, 9,260 made; non-molestation orders 82 per cent of applications and 94 per cent of orders; occupation orders 18 per cent and 6 per cent. Does not distinguish orders made without notice.	No, and the asymmetry is precisely documented. President of the Family Division's Guidance 2026 on non-molestation orders under the *Family Law Act 1996*, in force 12 January 2026, requires reasons only when refusing a without-notice application on the papers (para 12(B)). On granting, para 27 requires recitals that the order was made in the respondent's absence, that only the applicant's evidence was considered, and that no finding of fact was made; para 26 requires the set-aside statement under FPR 18.10(3) and 18.11. No duty to articulate reasons for granting. *Family Law Act 1996* s 45 imposes none. Judicial guidance, not statute or rule.	No. DASH has no statutory basis; College of Policing practice recommends DARA for frontline officers with DASH "or an alternative" for secondary assessment. *Domestic Abuse Act 2021* s 84 permits guidance to which public-function holders "must have regard", but mandates no framework and no tool.	Partly. Domestic homicide reviews under *Domestic Violence, Crime and Victims Act 2004* s 9 are qualitative, with no standardised national order-at-death field. The police-led Domestic Homicide Project Year 4 Report (March 2025, covering April 2020 to March 2024) records protective orders in place against the suspect as significantly associated with high-risk and serial perpetrator identification ($p<.001$, Phi 0.375), and previous breach in 12 per cent of cases (n=131). *Victims and Prisoners Act 2024* s 19 remains not in force.	Statistics and death review both exist; neither isolates the without-notice decision.

What the table shows

No jurisdiction of the six was found to do all four things, and one cell — the New Zealand reasons duty — remains unresolved, so that is a statement about what the search found rather than a finding. Victoria has the only risk framework with statutory force, and no reasons duty for interim orders was identified in its Act. Three publish order status at death in a countable form: New South Wales and New Zealand through their death review bodies, and the ACT through its own death review, which reported 9 of 25 people recorded as perpetrators and 3 of 13 victims as parties to a current order. New South Wales has no reasons duty, and the New Zealand position is not established. Queensland publishes the most granular temporary protection order data of the six — the only place where the volume of orders made before service can be read off a public series — and has neither a reasons duty nor a statutory framework. England and Wales has the most carefully drafted position on reasons, and it runs the wrong way.

That last point is worth isolating, because it is the same asymmetry the ACT has under s 39 of the *Family Violence Act 2016*. The ACT requires reasons where an exclusion condition is refused and not where one is imposed. England and Wales requires reasons where a without-notice order is refused and not where one is granted. New South Wales requires reasons under ss 17(4) and 20(4) where the court declines a premises-access prohibition that was sought, and not where it grants one. Three jurisdictions, drafting independently, put an express, content-bearing reasons duty at the point where the court declines to restrain, and no equivalent content at the point where it restrains. The ACT is not an exception to the pattern in whether reasons are required: section 68 does require reasons for **making** a protection or-

der, and section 104 (a) requires them for making an after-hours order. What the ACT does not do is prescribe what those reasons must say — the only content-bearing reasons provision in its Act, section 103, applies to a **refusal**, and section 104 (b) puts the refusal record on the court record while giving the record of reasons for making an order no destination at all. So the asymmetry in the ACT is not in whether reasons are required but in how much is required and where the record goes.

A fourth instance, in a bill. The Family, Personal and Sexual Violence Legislation Amendment Bill 2025, before the Assembly at the evidence cut-off, would repeal Part 7 and with it sections 103 and 104. The replacement scheme reproduces the pattern. A senior police officer refusing a family violence safety notice must record reasons "including each ground in section 13B that was not satisfied" (new s 13N (1)(e)); an officer issuing one must make "a written record of the matters considered" (new s 13H (3)); both stay in the police records, and only the notice itself is given to the registrar (new s 13M). Four drafting exercises — three enacted, one before a legislature — now show the same shape: content for the decision not to restrain, a bare record for the decision to restrain. Chapter 19 §2.4 sets it out and Appendix G9.2 drafts the correction.

Police-issued notices elsewhere, as the Explanatory Statement puts it. The same Bill's Explanatory Statement states: "Other than the ACT, all states and territories allow for police officers to issue short-term protection notices or orders" (ES p 24), citing the New South Wales Standing Committee on Social Issues (2012), a Western Australian review (2008) and Reeves (2022). That is recorded here as the Explanatory Statement's claim with its citations. It was not independently verified for this appendix, and the four columns in the table above do not include it. The same page records the contrary view as the Explanatory Statement describes it: "There is some evidence that a judicial officer is better placed to issue immediate protection orders in family violence circumstances, including outside of court hours, and that police should only be able to issue protection notices where it is not reasonable or practicable for the matter to be considered by a judicial officer", citing the Australian Law Reform Commission's Report 114 at [9.45] (ES p 24). The Bill adopts the first proposition and not the limit in the second (Chapter 19 §2.1). What the other jurisdictions publish about their police notices — volumes, revocations, reversals — was not examined and is not established.

This table is implementation design, not proof of better outcomes. Nothing in it establishes that Victorian or Queensland victims are safer, or that New Zealand's death review has prevented a death. It establishes only that certain things are being written down somewhere. A published series is a precondition for knowing whether a system works. It is not a finding that the system works.

Read against that table, the ACT is not uniquely bad. On the reasons duty it may be ahead in form, and the claim has to be stated carefully. Section 68 imposes a recording duty that reaches interim orders made in the respondent's absence, and no equivalent duty was found in any of the other five. That is a statement about what the search found, not about what exists: the Victorian entry reads "none identified" because a complete word-search of the Act was not achievable, and the New Zealand entry reads "not established" because the relevant rule could not be retrieved. Either could turn out to carry a duty. What can be said without qualification is that the ACT's hook exists, that it is empty — no content prescribed, nothing published, nothing counted — and that an empty duty is what Reform 3 proposes to fill rather than replace. On order status at death the ACT's position is mixed rather than middling. Its death review publishes the variable as a count, which Queensland's does not and Victoria's was not verified to do. Its Suicide Register has no field for it, and nobody has joined the death review's cohort data to the register or to the police record. The ACT therefore holds the variable in the one place that examines a small cohort every two years, and not in the two systems that record every death and every order as they occur. On statutory force it sits with four of the other five.

Where the ACT sits at or near the bottom is published statistics, and there it is alone in one respect. The other five publish something current: Victoria a database released in December 2025, New South Wales a quarterly infographic, Queensland a dashboard current to July 2026, New Zealand tables updated in March 2026, England and Wales a series published in June 2026. The ACT published a series and stopped. Of the six, the ACT is the only one that does not currently publish such a series, having published one until 2019–20. Whether any of the other five has discontinued and resumed a series was not examined. The problem is not that the Territory never built the series. The series existed and was allowed to end.

R2. Four named instruments, and what is published about them

DASH. The Domestic Abuse, Stalking and Harassment and Honour-Based Violence checklist is a 27-item structured professional judgment tool used by frontline police in most United Kingdom forces, with the officer grading the case standard, medium or high. The largest published test is Turner, Medina and Brown (2019), covering incidents from a large metropolitan force between 2013 and 2015, of which 41,570 involved intimate partner violence and 19,510 did not — against revictimisation involving serious harm within 365 days. The officer's own DASH-based grading achieved an area under the curve of 0.544 for intimate partner cases and 0.543 for the rest, which the authors describe as little better than random, chance being 0.50. Modelling the DASH questions directly by logistic regression, rather than using the officer's grading, improved this only to 0.596 and 0.581. A more favourable later study, Caulfield, Gray, Edwards and Snowden (2025), reported 0.67 (95 per cent confidence interval 0.59 to 0.75) for deadly violence and 0.62 (0.58 to 0.66) for persistent abuse, but the deadly-violence sample was very small: 62 cases with an index DASH, of which only 16 were graded high risk. Both studies measure discrimination for police-recorded revictimisation. Neither measures homicide.

SARA. The Spousal Assault Risk Assessment is a structured professional judgment guide, not an actuarial scale. The assessor codes a fixed set of risk factors and then exercises discretion to produce a summary risk rating, or, in Version 3, "Conclusory Opinions" about case prioritisation, risk of serious or imminent harm, and the management required. Kropp and Hart (2000) pooled six samples of adult male offenders, 2,681 in total, and reported that inter-rater reliability was high for judgments about the presence of individual risk factors and for overall perceived risk, and that the Summary Risk Rating had good reliability and validity. The underlying coefficients could not be obtained from an accessible source and are therefore not stated here. A more recent study, much smaller but far better specified and far more fully reported, is much less flattering. Bryce, Riachi, Spivak and McEwan (2026) followed 125 Australian males with prior intimate partner violence for four years against new intimate partner violence charges. Inter-rater reliability for total scores was excellent, at an intraclass correlation of .94. For the Conclusory Opinions — the part that drives decisions — the intraclass correlation ranged from .54 to .92, predictive validity from .51 to .61 as an area under the curve, and sensitivity between about a sixth and a third, meaning most of those later charged had not been flagged as high case priority. Confidence intervals for those figures are not reproduced here because they were not obtainable; at 125 cases an area under the curve of .61 would carry an interval reaching well towards .50, and .51 is chance. The range should be read as weak-to-absent discrimination rather than as a precise estimate. The distinction matters beyond SARA. The reliability of coding and the reliability of judgment are different quantities, and the gap between them is where an instrument fails. Both are published for SARA. Neither is published for the ACT framework.

ODARA. The Ontario Domestic Assault Risk Assessment is actuarial rather than clinical: 13 items scored yes or no, summed, the total mapped to an empirically derived recidivism probability. It was developed by Hilton and colleagues with the Ontario Provincial Police and first published in 2004. It predicts any future police-recorded assault against an intimate partner.

It does not predict homicide and it does not predict severity. In the standardisation sample it distinguished 175 recidivists from 414 non-recidivists over five years with a receiver operating characteristic area of .77 (Cohen's d of 1.1); a second sample of 100 identified wife assaulters produced .72. It degrades on cross-validation: .67 in Hilton and Harris (2009), or .74 excluding ambiguous non-recidivists, and .64 in Hilton and colleagues (2010). The reliability figure located in the sources consulted for the original instrument is a standard error of measurement of .48 between research assistants and minimally trained police officers, rather than an intraclass correlation or a kappa. Whether the 2004 development paper also reports an intraclass correlation could not be verified from the copy consulted, and is left as not established. A later study using a police sample (Moser and Campbell, University of New Brunswick, 2012) is reported as giving an intraclass correlation of .80 for a revised version of the instrument; that figure is taken from a secondary description of the study and was not read in the original, so it is recorded here as reported rather than as verified. The calibration figure most often quoted — roughly 7 per cent of men scoring zero reoffending within about five years, against 74 per cent of those scoring 7 or more — is a base-rate statement about that sample. It is not a statement of accuracy for any individual and should not be read as one.

MARAM. The Victorian framework is not a scored instrument. It is a whole-of-system framework given statutory force by Pt 11 of the *Family Violence Protection Act 2008* and approved by ministerial instrument gazetted on 25 September 2018, comprising evidence-based risk factors, screening and identification tools, brief and comprehensive assessment tools, and practice guides that prescribed framework organisations must align to. There is no published inter-rater reliability figure: no kappa, no intraclass correlation. There is no published predictive validity figure: no area under the curve. No published figure of either kind was located, and the Victorian Government's own material does not cite one. Consistently with the standard set at the head of this appendix, that is recorded as a search that did not settle the question rather than as proof of absence — although it is a search of the framework's own published documentation, including the statutory five-year evidence review, which is where such a figure would be expected to appear if it existed. The Victorian Government's own material on the tools states only that the risk factors were informed by international evidence-based reviews and consultation with academics and expert professionals, and that new evidence will emerge as professionals use the tools — validation deferred to future practice rather than reported. The statutory five-year evidence review, conducted between November 2022 and November 2023 across 225 stakeholders in 81 organisations and producing 17 recommendations, all accepted, found MARAM a valuable resource supporting a shared understanding, and reports no psychometric testing. The Family Violence Reform Implementation Monitor's legislative review of Pt 11 concluded that inconsistent alignment and a lack of alignment progress was limiting the overall effectiveness of Part 11, and did not evaluate the assessments' scientific properties at all.

Set the ACT's 2022 framework against those four. It has no published inter-rater reliability figure. It has no published predictive validity figure of any kind. Neither is surprising on its own. The sharper point is upstream of both: the framework does not identify which instrument, if any, its risk factors derive from. DASH, SARA and ODARA each have a citable literature with numbers in it, favourable and unfavourable. A reader who wants to know what is known about the ACT's factors cannot begin, because there is no stated parent instrument to look up. The absence is not of a validation study but of the address at which one would be found.

That gap is common rather than unique, and the comparison should be made honestly. Victoria has the strongest statutory mandate of the six, and has no published reliability figure for MARAM either. Two jurisdictions — one with a gazetted ministerial instrument and an annual report to Parliament, one with a self-described working document — have arrived at the same evidentiary position on the tools their practitioners use. That is a finding about the

field. It is not an excuse for the ACT, and it does not reduce by one the number of decisions made in the Territory on a framework whose accuracy has never been measured.

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What this appendix does not establish

A table of published artefacts is not evidence about outcomes. Every entry above records whether a document exists, whether a duty is written down, or whether a variable is collected. None of it records whether anyone is safer. No comparison here shows any of the six jurisdictions to have a system that is working, and none should be read as a recommendation to copy a jurisdiction. Victoria's statutory framework has no published accuracy figure. Queensland's granular statistics are counts of orders, not counts of harm prevented. New Zealand's order-at-death proportion describes deaths that occurred. The England and Wales guidance places its only reasons duty on refusal. The comparison establishes what is being written down, and where the ACT sits in that distribution. It establishes nothing about whether writing it down has helped anyone.

Corrections

If an agency, officer or reader considers a statement in this work wrong, write to `contact@dfvrisk.com.au` with the document that shows it. Corrections will be published at the same prominence as the statement they correct, and listed at dfvrisk.com.au.

Nothing about the argument here requires that it be free of mistakes. It requires that mistakes be findable, and corrected in the open rather than defended.

Updates, the public edition and a comment form: **dfvrisk.com.au**

The public edition, *A System That Cannot See Itself: The Public Edition*, is Book 1 of *The ACT Domestic and Family Violence Review*. This is Book 2.

About the author

Julian Talbot is a risk-management practitioner. He is the lead author of the *Security Risk Management Body of Knowledge*, the author of *Control Effectiveness Assessment: Criteria, Evidence, and a Scale Two Assessors Can Share*, and the author or co-author of a dozen other books on risk and security management. He is a Fellow of the Risk Management Institution of Australasia, a Fellow of the Institute of Strategic Risk Management, and holds a Master of Risk Management. The method applied throughout this work — AS ISO 31000:2018, the standard the ACT Government applies to itself — is the one he has practised and taught for three decades.

He has also experienced the domestic and family violence system from the inside. Full disclosure: the author has been a protected person under an interim family violence order and has been a respondent to an interim family violence order. No detail of any such matter appears in this work, no argument in it depends on any, and nothing that could identify any party to any proceeding has been published. That experience is the reason the questions were asked. It is not the reason for the answers, which rest on the public record and can be checked against it by anyone, using the sources listed in every chapter and the account of what was verified at Appendix N. The work stands on its own merits or it does not stand at all.