

THE PUBLIC EDITION

A SYSTEM THAT CANNOT SEE ITSELF

What the ACT can and cannot show about ten years of domestic and family violence reform, what two bills before the Assembly would change, and seven things that could start this week.



The Territory built the response and never built the scoreboard. The process that can remove a person from a home without notice sits outside the risk standard the government wrote for itself.



Full document and technical volume —
dfvrisk.com.au

THE SHORT VERSION

This is the short version. It contains no argument that is not made at length, with sources, in the technical volume. Every figure in it comes from a document anyone can obtain. Where the record does not support a conclusion, it says so. It is written to be read in fifteen minutes.

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1 The finding, in one paragraph

THE FINDING

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

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

FOUR NUMBERS, EACH CHECKABLE IN AN AFTERNOON

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.

No performance monitoring strategy or evaluation framework

for the levy — ACT Auditor-General, Report 10 of 2024, November 2024.

8 of 13

deceased victims had been wrongly recorded as the aggressor while alive — misidentified, in the review's word — ACT death review, 2025.

0 of 17

requirements of the international risk management standard, AS ISO 31000:2018 — which the ACT Government mandates for everything it does — are fully met by its 2022 family violence risk framework. Eight are not met; nine are partly met.

2019–20

— the last year the Magistrates Court published protection-order application statistics.

2 Two bills before the Assembly

THE BOTTOM LINE ON BOTH BILLS

But the concerns are significant enough to warrant revision of both bills before passage rather than amendment at the margin.

This edition is published in response to two bills now before the Assembly. Both are well-intentioned. Both respond to real failures. Both also attach serious consequences for a person to a single decision that the Territory has never assessed against written criteria,

never recorded in a form a court can read, and never counted: who is at risk, and from whom. The full analysis, and every amendment drafted, is in the technical volume at Chapter 19 and Appendix G9.

The Family, Personal and Sexual Violence Legislation Amendment Bill 2025 repairs several things — good character in sentencing, protected confidences, remote appearance in court, a broken cross-reference — and those repairs should pass. It also repeals the after-hours orders a judicial officer now makes and replaces them with fourteen-day safety notices issued by a police officer of sergeant rank or above, with two years' imprisonment for breach.

THREE BEST

The respondent's views must be considered before a notice issues, as far as practicable. Nothing requires that before an interim court order.

The notice handed to the respondent states how each ground is satisfied and is explained in person; cross-notices are barred because police "may be unable to identify the primary aggressor".

Firearms can be seized at the moment of service, a dead cross-reference is fixed, and a written record is required at every branch of the decision.

THREE WORST

The applicant and the decision-maker are the same organisation, the test is a belief that there is "a risk", and the judicial scheme is repealed rather than supplemented.

Reasons with content are required for a refusal but not for a decision to issue; the issue record stays in police files; only the notice reaches the court; the respondent's day in court is "as soon as practicable" and the application must be dismissed if no date is free.

Nothing measures it. The review clause names no data and no indicator; the government could give the Committee one number about the scheme it is repealing; and a notice no court has seen follows a person into national recognition, later court history, working-with-vulnerable-people checks and tenancy.

TWO BILLS BEFORE THE ASSEMBLY / CONTINUED

The Crimes (Coercive Control) Amendment Bill 2026 creates an offence of coercive control carrying seven years' imprisonment, commencing two years after it becomes law, with an advisory committee from day one and a review three years after the offence starts.

THREE BEST

The course-of-conduct provisions solve the problem that has defeated prosecutions of ongoing, repeated abuse elsewhere — the prosecution can charge a pattern rather than a single incident — while still having to say what conduct, and over what period.

Oversight is set up first and the offence is held for two years.

One definition of family violence serves civil and criminal law; what the prosecution must prove about the accused's intention — the fault element — is explained as a safeguard against misidentifying victims; and the 2024 bill's strict liability, which would have allowed conviction without proof of intention, 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.

The committee only advises the Minister, its members are the Minister's choice, and it expires a year after the offence starts and two years before the review can begin.

No safeguard operates until a person has been charged — every safeguard is a matter for trial; the offence starts on a fixed date rather than when the system is shown to be ready; and a seven-year maximum, which leaves the prosecution no power to elect a summary hearing, lets the accused choose the Supreme Court.

THE STANCE THIS WORK TAKES

It is good to see change, and some of these changes are good. But the concerns are significant enough to warrant revision of both bills before passage rather than amendment at the margin. Part 2A of the first Bill should be rebuilt around a documented decision, reasons that reach the court and the person restrained, a fixed day in court, and a published count. The second Bill should commence when the Territory can show it is ready — a tested method for deciding who is coercing whom, a published baseline, a review that measures, and a committee that outlives it — not when a calendar says so. The amendments that would do this are drafted, and none of them raises a threshold or shortens the protection either instrument gives. The author is willing to contribute to that work, and comments received will be carried into a second edition. The Standing Committee on Legal Affairs was due to report on the second Bill on 11 September 2026, after the evidence in this edition was frozen; where its recommendations meet the concerns set out here, that will be said plainly and recorded at dfvrisk.com.au.

3 What this covers, and what it does not

WHAT THIS SECTION SHOWS

This examines the second side — limiting harm once violence has occurred — because that is the side the ACT built.

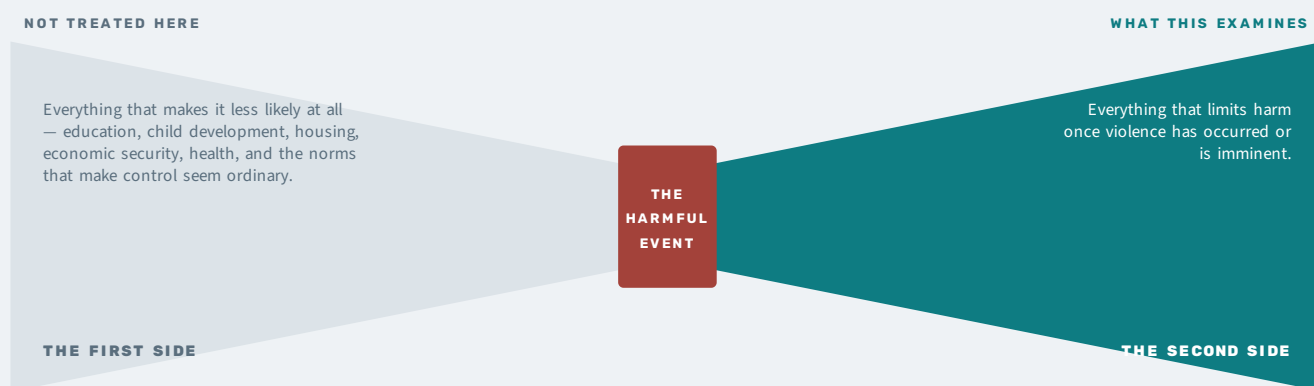
Risk management divides a problem at the point where the harmful event happens. On one side is everything that makes it less likely at all — education, child development, housing, economic security, health, and the norms that make control seem ordinary. On the other is everything that limits harm once violence has occurred or is imminent. Practitioners draw it as a bow tie, with the event as the knot.

The *Family Violence Act 2016* is a protection-order and enforcement instrument. The 2022 risk framework assesses risk as it stands at the moment of assessment. Crisis response took 34 to 46 per cent of levy-supported initiatives annually; prevention took 12 to 20 per cent,

and those shares did not materially move across the eight years the Auditor-General examined.

The first side is not treated here, and that is not a judgment about its importance. Only prevention changes the rate at which violence begins, and a response system that worked perfectly would still process whatever the prevention system sent it. But that is a broader question with a different evidence base, and it deserves its own study. The 2026 Strategy is the first ACT document in this field to put prevention on the page properly; what it has not yet done is build it, and the substantive redesign is scheduled for 2028 to 2032.

THE BOW TIE / WHERE THIS WORK SITS



Practitioners draw it as a bow tie, with the event as the knot. Source: section 3.

NEITHER SIDE CAN YET BE SHOWN TO BE WORKING

So neither side can currently be shown to be working. One is described and not yet operating. The other is operating and not measured.

4 What the household pays for

WHAT THIS SECTION SHOWS

The correct verdict on value for money is therefore "not proven".

Every rates notice 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.

ACT AUDITOR-GENERAL, REPORT 10 OF 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"**.

THE SAFER FAMILIES LEVY / AMOUNTS, NOT OUTCOME EVIDENCE

\$30

Household levy, from 1 July 2016

\$70

Household levy, 2026–27

more than

\$46 million

Raised by 30 June 2024

Household charges and cumulative revenue have different units and time bases; they are not points on a single scale. Source: section 4.

WHAT THE HOUSEHOLD PAYS FOR / CONTINUED

WHAT CANNOT BE ESTABLISHED

The following cannot be established from any public source:

NOT COLLECTED	cost per victim made safe;
NOT COLLECTED	cost per repeat assault, serious injury, suicide or homicide averted;
NOT COLLECTED	the rate at which the wrong person is identified as the aggressor, or whether it has changed;
NOT COLLECTED	change in reoffending attributable to behaviour change programs;
NOT COLLECTED	comparative outcomes for people of different sexes, genders or communities;
NOT COLLECTED	the cost of unmet demand — waitlists, unanswered calls, people turned away.

Source: section 4. Each is absent from the public record because the underlying data is not collected in a form that permits it.

This is not a list of things nobody has bothered to calculate. It is a list of things that **cannot** be calculated, because 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.

5 What was built, stated fairly

WHAT THIS SECTION SHOWS

A promise to build something is also a statement about what does not yet exist.

WHAT THE TERRITORY BUILT, 2016–2026

Family Violence Act 2016
Safer Families Levy begins

2016



Information-sharing
legislation

2024



2022

Family violence risk
assessment framework



2026

Ten-year Strategy
and First Action Plan



CALENDAR POSITION ONLY – NOT A PERFORMANCE SERIES

A criticism that ignores what has been built since 2016 is not credible. Since 2016 the ACT has passed the *Family Violence Act 2016*, introduced the levy, 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, behaviour change programs, health-justice partnerships and five Aboriginal community-controlled organisations, published a risk framework in 2022 and information-sharing legislation in 2024, and released a ten-year Strategy in May 2026.

Three things deserve specific credit. Indexed, ongoing base funding from 2029–30 lets a service plan and retain staff, after a decade of four-year packages. The 2026–27 Budget factsheet is the most transparent allocation document the Territory has produced. And 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.

The 2026 Strategy also, on a full-text check, does not use the word "baseline" or the word "indicator" once, and sets no numeric target and names no accountable agency for any of its six outcomes. It states its headline prevalence figure at two different values six pages apart — "approximately 1 in 5" ACT women, and "42% of women – or an estimated 73,200 women" — for the same measure. The likely explanation is a drafting error, in which a qualifying word was lost between drafts. It matters because a strategy required to publish a baseline would have had to reconcile those two sentences: one of them would have become the number everything else was judged against. Among the things its action plan promises to build by 2028 is a monitoring and evaluation framework. **A promise to build something is also a statement about what does not yet exist.**

THE ACT LEGISLATIVE ASSEMBLY, CIVIC SQUARE

Photograph: Nick-D, CC BY-SA 4.0, via Wikimedia Commons

6 The root cause, in plain terms

WHAT THIS SECTION SHOWS

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.

The ACT Government requires risk to be managed to a recognised standard — AS ISO 31000:2018 — across all of its functions. Procurement is assessed that way. Public events are assessed that way. Staff travel is assessed that way.

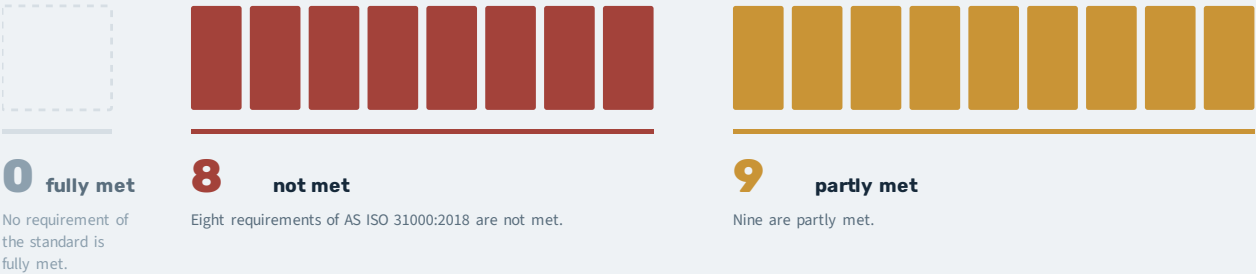
One decision is not. It can remove a person from their home without notice, suspend the licence they need to

work, and interrupt their contact with their children. It is taken in minutes, on material from one side.

Tested clause by clause, the July 2022 family violence risk framework meets **none** of the 17 requirements of AS ISO 31000:2018 fully: eight are not met, nine partly met.

ASSESSED AGAINST AS ISO 31000:2018 / 17 REQUIREMENTS

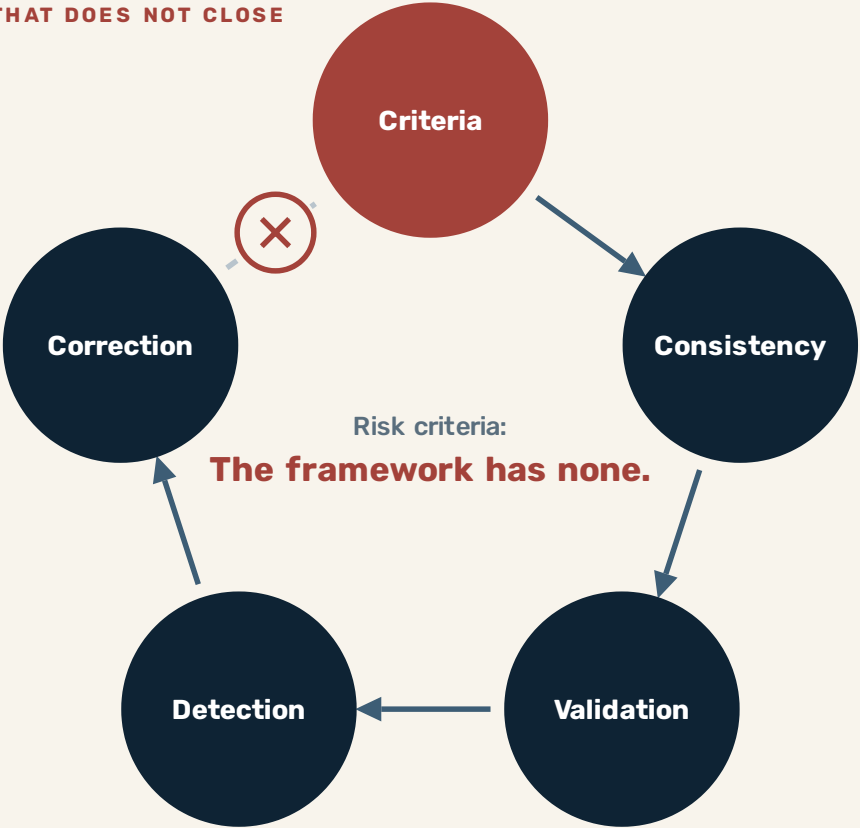
THE JULY 2022 FAMILY VIOLENCE RISK FRAMEWORK, TESTED CLAUSE BY CLAUSE



This is the author's clause-by-clause assessment, not an independently certified score, and not a percentage. Source: sections 1 and 6.

THE ROOT CAUSE, IN PLAIN TERMS / CONTINUED

THE DEPENDENCY THAT DOES NOT CLOSE



Conceptual dependency. Not a measured process.

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 has none.

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 ROOT CAUSE

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.

7 Why exhortation has not worked

WHAT THIS SECTION SHOWS

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.

Two errors are possible at every decision. Failing to protect someone who is then harmed produces a coronial process, a review, media attention, and a decision that can be traced back to the person who made it. Restricting someone who was not a danger produces criminal charges, lost employment, removal of children and lost housing — and is entirely uncounted, because nothing counts it.

So 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. Training says consider the less restrictive option. The incentive says choosing it exposes you and choosing the other does not. That is why the fixes below are structural rather than exhortations.

TWO ERRORS ARE POSSIBLE AT EVERY DECISION

ERROR ONE

Failing to protect someone who is then harmed

produces a coronial process, a review, media attention, and a decision that can be traced back to the person who made it.

VISIBLE AND ATTRIBUTABLE

ERROR TWO

Restricting someone who was not a danger

produces criminal charges, lost employment, removal of children and lost housing — and is entirely uncounted, because nothing counts it.

INVISIBLE

Both consequences are as described in section 7. Only one of them is counted.

8 What the deaths show

168

Since 2000 the Territory has recorded 168 fatal incidents in a domestic and family violence context. It cannot say what any of them tell it.

WHAT THIS SECTION SHOWS

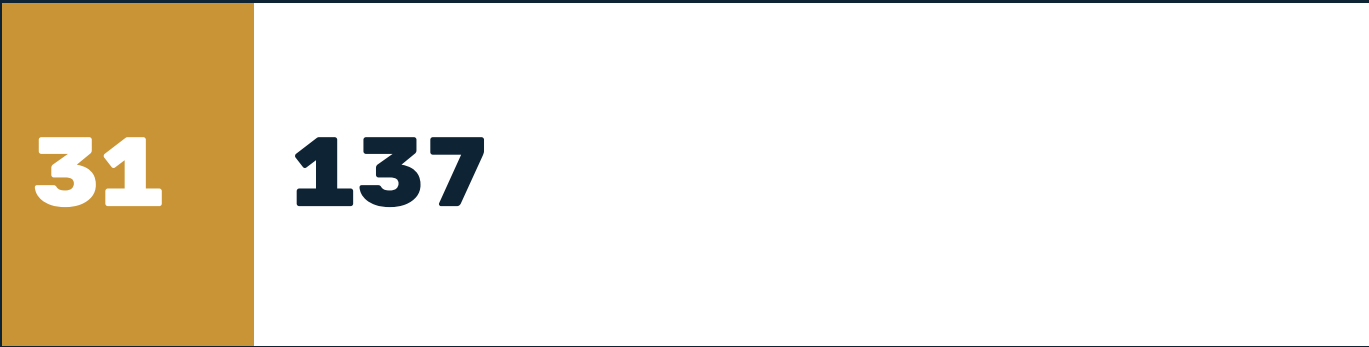
The signal the system watches for is usually absent.

The 2023 death review examined 12 homicides in depth. Coercive control was present in almost all of them, and in about 9 of the 12 there was no significant physical violence before the killing. The thing the system is built

to detect — a reported incident of physical violence — was missing in three of every four killings it examined closely.

TWENTY-FIVE YEARS OF THE REGISTER

168 FATAL INCIDENTS RECORDED IN A DFV CONTEXT SINCE 2000



Homicides

Non-homicide deaths

More than four other deaths for every homicide. Counts, not rates.

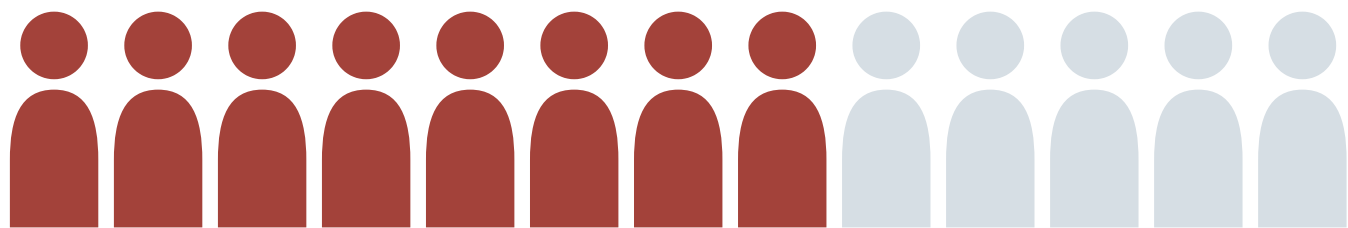
Source: section 8. Registry totals for 2000–2024. Counts, not rates in any wider population.

WHAT THE DEATHS SHOW / CONTINUED

THE ERROR THE SYSTEM DOES NOT COUNT

The error the framework exists to prevent is documented, and has never been measured.

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 — two within three months of death.

5 were not so recorded.

NEVER MEASURED
The Territory found this error because it went looking. It has never published a rate for it.

Source: section 8, ACT death review 2025. A reviewed cohort of 13, not a population error rate.

Of 13 deceased people the 2025 review assessed as victims, 11 were women, and **8 had been wrongly recorded by police or another agency as the predominant aggressor before they died** — two within three months of death. The consequences recorded include being criminally charged, losing employment, having children removed, and being incarcerated. Four of the 13 had been the respondent to an order where, on the review's own reading of the files, the applicant appears to have been the aggressor. The Territory found this error because it went looking. It has never published a rate for it, and it has never looked for the same error in the other direction.

The review put two of the eight into its own words: *"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. Nothing in the Territory's data would have shown either error while it could still be corrected, because nothing counts it.

WHAT THE DEATHS SHOW / CONTINUED

WHAT THE REGISTER HOLDS

Most deaths in this system are not homicides.

DEATHS RECORDED IN A DFV CONTEXT, 2020-2024 / n = 49



11 homicides and 38 that were not, 29 of them suicides. Other non-homicide deaths = 38 minus 29. Counts, not population rates.

Source: section 8. Other non-homicide deaths derived as 38 minus 29. Counts, not rates.

Between 2020 and 2024 the register recorded 49 deaths: 11 homicides and 38 that were not, 29 of them suicides. Over 25 years it holds 31 homicides and 137 non-homicide deaths — more than four other deaths for every homicide. Almost everything in the system is built around those 31 homicides. 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. Neither states which deaths this system is responsible for preventing, counts the deaths that are not homicides, or names an agency that holds them.

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

The 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. 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.

Deaths are a floor, not a measure. A death is the only outcome in this system recorded reliably. Nothing counts the harm short of it: not the people who lost work, housing or contact with their children after an allegation, and not the people in acute distress who did not die. So these deaths are not the extent of the damage; they are the part the Territory is obliged to write down.

And they are small numbers. Thirteen and 25 are not rates in any wider population. A death enters the register only when an agency identifies it as occurring in this context. Ten of the 11 homicides could not be analysed because proceedings were on foot — so the 38 are what remained after the most fully investigated deaths were set aside.

9 The question nobody has asked

THE BOTTOM LINE

Between November 2025 and April 2026 the basic data was sought. The four answers are the finding.

WHAT WAS ASKED, AND WHAT CAME BACK / NOVEMBER 2025 – APRIL 2026

NO FIELD	The ACT Suicide Register has no field recording whether a deceased person was subject to a family violence order at the time of death.
NO REVIEW	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.
READ EVERY CASE	ACT Policing advised that producing the figures would require an officer to read every recorded suicide case.
REFUSED	Court statistics on interim orders were refused, on the ground that outcomes are not administrative in nature.

Source: section 9. Each short label restates the answer given in that response.

None of that is evidence of concealment, and none of it is treated as such here. Each answer has an ordinary administrative explanation. 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.

10 Seven things that could start this week

WHAT EACH OF THE SEVEN COSTS

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

#	ACTION	WHO
1	Add a field to the Suicide Register recording family violence order status at death, and publish the death review's existing cohort data by sex, cause of death and order status	ACT Coroners Court; death review
2	Add a queryable status flag to the police records system, set when an order is served	ACT Policing
3	Publish an implementation tracker for every death review and audit recommendation: owner, due date, status, evidence	Responsible directorate
4	Publish quarterly court statistics on applications, interim orders, orders made without notice, conditions, outcomes and timeliness	ACT Courts
5	Commission inter-rater reliability testing on the current risk instrument, registering the protocol, the pass mark and the withdrawal trigger before recruitment	Framework owner, with an independent analyst
6	Name an accountable position for each Strategy outcome, with the measures it will be assessed against	Government
7	Publish an operational plan for coercive control and systems abuse: tools, training, charging guidance, and a protocol against recording a victim as the aggressor	Directorate; ACT Policing

Item 5 is the most important. It uses standardised written cases and no client data, which is what removes the privacy approvals that would otherwise dominate the timeline, and 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 before commencing offences that turn on the same judgment. **The only outcome with no value is continuing not to**

know. Fieldwork takes six weeks and the whole study about five months, at roughly \$147,000; what belongs inside a hundred days is the decision to proceed and the publication of the pass mark before anyone knows the result.

Item 4 is a resumption, not a new capability. The Magistrates Court published family violence order application counts in its annual reviews until 2019–20 — 1,249 applications and 1,152 interim applications that year. It has published no annual review since, in a period in which the Supreme Court has published five.

11 Five reforms

THE CONDITION ON REFORM 2

The structured-assessment duty does not commence until the registry time is funded. An unfunded form is worse than the present practice.

THE FIVE REFORMS

1	Rewrite the risk framework so that it actually functions as one.
2	Require a structured risk assessment before an interim order is made without the respondent present.
3	Give the respondent a fast way back into court, and make the reasons say something.
4	Require a safety and support step when an order is served.
5	Publish the money and the results.

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 account. Add defined likelihood and consequence scales, a stated risk tolerance, a comparison of the options, a residual risk statement with a named acceptor, named risk owners, and framework-level monitoring. Replace the sex-specific primary aggressor indicators with an evidence and pattern method that applies to any person and permits the answer "unresolved".

2. Require a structured risk assessment before an interim order is made without the respondent present.

It does not change the threshold, does not delay urgent action and does not invalidate orders. It requires the decision to rest on a documented analysis, prepared at the registry inside the window the court already works to.

The structured-assessment duty does not commence until the registry time is funded. An unfunded form is worse than the present practice.

That condition is in the draft clause, not only in the costing. A form added to an unchanged workload gets

signed rather than done: worse decisions, better documentation.

FIVE REFORMS / CONTINUED

REFORM 3

Give the respondent a fast way back into court, and make the reasons say something.

Section 91B of the Act gives an applicant refused an order a same-day review and a hearing within two days, and says the respondent need not be told about it. A respondent restrained by an order that was granted has no equivalent, and no outer limit at all.

Section 68 already requires a court to record its reasons for making an order, and "protection order" is defined to include an interim one. What it does not do is say what those reasons must contain, and nothing on the public record shows that any has ever been published or counted. This reform gives the duty content: what material the court relied on, whether any came from a second independent source, why the matter could not wait for a listing

This gives them one request and the same two-day period, with the protective conditions continuing and the Magistrate able to confirm, amend or revoke. The protected person gets notice, an appearance by video link, and one adjournment to find a lawyer.

with both parties present, and what less restrictive course was considered. A copy goes to the respondent, with the protected person's address and anything that would endanger a person withheld. And because the Act gives no review or appeal against an ordinary interim order made without notice, the existing review provision is extended to reach one, so that the two duties have a remedy.

A QUESTION FOR THE ASSEMBLY, PUT AS A 24-MONTH TRIAL

And one question the Assembly should decide on a trial. Where a Magistrate cannot tell from the material which party is the person most in need of protection, they could make equivalent conditions binding both until the first contested listing. Conduct by both parties would not by itself be enough, and conduct that looks like hitting back would have to be disregarded. Not a default and not a finding: no firearms suspension, no finding of family violence, nothing disclosable — though contravening it would be an offence, which is what would make it a protection. That last point needs an

express provision to work: section 43 of the Act reaches a person *against whom* an order is made, so the drafting has to deem the protected person into it for that purpose and no other. No jurisdiction has run this, so it is put only as a 24-month trial that cannot start until a baseline exists, monitored by sex and by Aboriginal and Torres Strait Islander status, expiring unless the Assembly votes to keep it. The strongest objection — that it may deter people from applying at all — cannot be answered from any record, and is not answered here.

FIVE REFORMS / CONTINUED

REFORMS 4 AND 5

Require a safety and support step when an order is served. Publish the money and the results.

4. Require a safety and support step when an order is served.

A scripted welfare question set, written information about support, and a recorded offer of referral, with an escalation pathway where the answers indicate acute risk. This is the control now absent at the moment of highest risk.

A sixth measure is a Cabinet process change: no material justice or service reform funded without a published whole-of-system demand and capacity model

5. Publish the money and the results.

One annual ledger covering every initiative: budget, actual expenditure, funding source, recipient, cohort served, targets, achieved outputs and outcomes, evaluation status and cost per result. With it: quarterly court statistics, an implementation tracker, published validation results for every instrument in use, and correction of the record when an order ends.

naming the agency expected to absorb any unfunded demand.

What this would cost. About \$1.7 million one-off and between about \$0.7 and \$1.2 million a year — between about \$4.4 and \$6.3 million over four years. The range is wide because two of the quantities that drive it are not published anywhere, which is the same missing data the rest of this describes. It is about 3 to 4 per cent of the \$151.4 million of direct investment announced over the same period, and more than the \$3.6 million allocated to building the system rather than running it. A government could fairly say it would consume that allocation entirely. Adopting the package without funding it would be worse than rejecting it.

WHAT THIS WOULD COST.

about
\$1.7 million
one-off

about
\$0.7–1.2 million
a year

about
\$4.4–6.3 million
over four years

About 3 to 4 per cent of the \$151.4 million of direct investment announced over the same period.

12 What this does not say

WHAT THE EVIDENCE DOES NOT CARRY

The evidence shows differences in service reach and framework design, not intent.

It does not say the money was wasted.

That would require expenditure data, outcome data and a comparison, and none 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 framework design, not intent. What it 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 is wrong.

In the deaths reviewed for 2025, 24 of 25 identified as perpetrators were male, 11 of 13 identified as victims were female, and every male perpetrator targeted a female victim. A system that concentrates on violence against women and children is responding to its own evidence. The argument is only that a system built around the modal case still has to be able to see the others.

It does not say that orders cause deaths.

Orders are made in situations that are already dangerous. That is the leading hypothesis and it has never been tested.

It does not say false allegations are common.

The technical volume examines three ACT matters — two where an allegation was believed and did not survive examination, one where a child's danger was reported repeatedly and not assembled. A case can show how a failure happens; it cannot show how often it happens. The consensus that deliberately false allegations are a small minority of reports, and that under-reporting is the far larger problem, is accepted and not disturbed.

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.

The proposed replacement framework is itself unvalidated, by its own standard, and must not be used on anyone before its reliability has been measured and published, with the result that would cause it to be withdrawn stated in advance.

13 What the government has said, and how to answer this

THE STANDARD THIS WORK SETS ITSELF

That is the standard asked of the Territory. It applies here first.

The Territory has answered the Auditor-General. Its response to Report 10 of 2024 agreed to the recommendations, and the First Action Plan of May 2026 commits to a monitoring and evaluation framework by 2028. Nothing in it disputes the finding that none existed. On the death reviews, the 2026 Strategy adopts two findings and commits to no count of the deaths that are not homicides. On the court statistics and the Suicide Register field, the four answers quoted at section 9 are the government's position as at the cut-off.

No agency has been shown this text before publication, and none has had the chance to answer it.

That is a gap, and it is treated as one. Any agency, officer or service named by function here that considers a statement wrong is asked to say so, with the document that shows it. A correction will be published in the same place and at the same prominence as the statement it corrects, and listed at dfvrisk.com.au. That is the standard asked of the Territory. It applies here first.

WHO WROTE THIS, AND BY WHAT STANDARD.

This work was written by a risk-management practitioner, not a lawyer, a social worker or a police officer, and its method is the one the ACT Government applies to itself: AS ISO 31000:2018. It uses no confidential material and no case file. Everything in it comes from documents anyone can obtain, frozen at 2

September 2026, and every figure was checked against its source. People are named only where a public record already attributes the finding to them. The author's standing and a full disclosure are at the back, under "About the author".

14 How to check any of this

WHY THIS IS CHECKABLE

Each takes minutes, and each returns an answer that does not depend on trusting anything written here.

Twenty-six public documents carry the argument. The most important ten:

#	DOCUMENT	DATE
1	ACT Auditor-General, <i>Safer Families Levy</i> , 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	ACT DFSV Strategy 2026–2036 and First Action Plan 2026–28	27 May 2026
8	ACT Legislative Assembly Hansard, 16 September 2025 and 10 June 2026	2025–2026
9	<i>Family, Personal and Sexual Violence Legislation Amendment Bill 2025</i> , Explanatory Statement, and Standing Committee on Legal Affairs Report 7	3 Dec 2025; 24 Apr 2026
10	<i>Crimes (Coercive Control) Amendment Bill 2026</i> and presentation speech, Hansard 28 May 2026	28 May 2026

FOUR CHECKS ANYONE CAN RUN IN AN AFTERNOON.

1. Search the 2026 Strategy and the First Action Plan for "baseline", "indicator" and "misidentification". Count the results.
2. Find in the two death review reports the number of non-homicide deaths, and how many were suicides. Then search the Strategy for "suicide".
3. Open the ACT Courts annual reviews page and count the Magistrates Court annual reviews published since 2019–20.
4. Compare the 2026 Strategy at page 5 and at page 11 on how many ACT women have experienced physical or sexual violence since the age of 15.

THE VERDICT

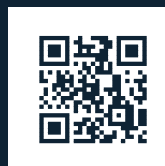
Promising architecture. Incomplete implementation. Unproven aggregate impact. And a system that, by its own records, cannot yet tell whether it has caused harm.

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.

The technical volume sets out the evidence for every statement above, with sources, together with a rewritten risk framework, drafted legislation, a full assessment of the two bills with drafted amendments, a costing, a comparative note on what other jurisdictions publish, an account of what was verified and what cannot be, a findings register, and two constructed critiques of the argument with responses. It carries a foreword by Dr Gavriel Schneider.

Both volumes of this work are public. This edition is the shorter of the two: the technical volume is longer, not more candid, and nothing in it is withheld from here.



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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, 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. 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 and no argument in it depends on any. 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 by anyone. The work stands on its own merits or it does not stand at all.