



The
Evidence
of Us

FORMAL SUBMISSION — REVISED AND SUPERSEDING EDITION

From Recognition to Measurable Safety

A national systems-governance and accountability proposal for the Second Action Plan under the National Plan to End Violence against Women and Children 2022–2032

V5.1 Final Post-Lodgement Author-Reviewed and Expanded Edition

17 August 2026

Governments should be measured by the safety they achieve, not merely the processes they administer.

CURRENT AUTHOR-APPROVED EDITION — PREPARED FOR RESUBMISSION TO DSS WITH A REQUEST TO SUPERSEDE V4.1

This V5.1 edition is the current author-approved public edition. It is prepared for resubmission to the Department of Social Services with a request that it supersede V4.1 prospectively for ongoing policy consideration, publication, citation and circulation. V4.1 remains the unchanged historical record lodged on 31 July 2026; DSS acceptance of supersession is not asserted unless and until confirmed.

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IMPORTANT INFORMATION

Content note, purpose, privacy and evidence status

This submission discusses domestic and family violence, coercive control, sexual violence, child-safety concerns, litigation-related harm, traumatic separation, economic abuse and institutional responses. It is a policy submission. It does not ask the Department of Social Services to make any individual allegation, reopen any court matter or make findings about any professional named.

All lived-experience material is aggregated, paraphrased or deliberately generalised. Names, precise dates, locations, case numbers, contact details and distinctive family facts have been removed. Raw survey data, raw communications records, child records and potentially identifying screenshots are not attached.

EVIDENCE SAFEGUARD Evidence is identified, where practicable, as respondent report, direct survey count, official evidence, policy analysis, inference or recommendation. These categories are not interchangeable. A respondent account is not an independently established finding; equally, the absence of administrative outcome data is not evidence that no systemic problem exists.

Acknowledgement

The Evidence of Us acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters across Australia and recognises their continuing cultures, communities, authority and leadership. We acknowledge the disproportionate impacts of family violence, state intervention, child removal and institutional harm experienced by First Nations women, children, families and communities. Reform must be designed with, led by and accountable to Aboriginal and Torres Strait Islander peoples, consistent with self-determination.

We acknowledge every woman, child, young person and adult survivor whose experience, evidence and courage have informed this work including those who disclosed harm and were not believed, those separated from children or other safe relationships, those still navigating violence and systems after leaving, and the families of women and children whose lives were lost through homicide or suicide. Their experiences must not be reduced to illustrations, consultation themes or isolated incidents.

Authorship, contributions and rights

This submission should be read alongside the DSS Second Action Plan submission lodged by [REDACTED] and [REDACTED] including Appendix A, Appendix B and Appendix C, which provide public-safe supporting evidence and policy architecture. This separate The Evidence of Us™ (TEOU) submission separately addresses The Evidence of Us™ framework, governance architecture, authorship, attribution and protected implementation pathway.

[REDACTED] conceived and developed The Evidence of Us Systems Governance and Accountability Architecture™ and the TEOU methodologies used in this submission.

[REDACTED] Founder of Ancestral Echoes Collective, independent lived-experience researcher and systems accountability analyst, conceived and developed the foundational family-law accountability-gap work, created and stewards the Every Voice Matters Survey™. Her research, survey design and evidence, policy-development pathways, and work concerning independent judicial accountability and post-order child safety materially informed the family-law evidence, analysis and recommendations contained in the DSS Second Action Plan submission package lodged by [REDACTED] and [REDACTED] on 31 July 2026, together with its public-safe supporting appendices. Her work also materially informed the separate The Evidence of Us™ submission. These acknowledgements do not alter the separate ownership and attribution of Every Voice Matters Survey™, the TEOU governance architecture or other independently developed source material.

This submission was jointly developed and co-authored by [REDACTED] Co-authorship of the submission does not alter the separate ownership and attribution of the TEOU governance architecture, Every Voice Matters Survey™, or independently developed source material.

The independently developed specialist family-safety court proposal referenced in this submission is attributed to [REDACTED] is acknowledged as the source of that proposal only. This attribution does not imply organisational membership, co-authorship of this TEOU submission, assignment of intellectual property, endorsement of every recommendation, or shared ownership of TEOU™, TEOU methodologies, Every Voice Matters Survey™, or other independently developed source material.

Participation in consultations, source discussions, roundtables or evidence exchanges does not imply organisational membership, co-authorship, endorsement, licensing rights or transfer of intellectual property unless expressly agreed in writing.

Named TEOU methods and Every Voice Matters Survey™ are marked with ™. The symbol identifies claimed unregistered trade marks; it does not indicate registration. Descriptive public-policy proposals remain unmarked. The complete mark-control notice appears in Appendix 6, section A6.2.

Public-policy consideration, limited submission permission and reservation of rights

The authors and relevant rights holders submit this V5.1 edition to support government consideration of the systemic problems, evidence, reform objectives and high-level recommendations it identifies. V4.1 remains the unchanged historical record first lodged on 31 July 2026. V5.1 is prepared for resubmission with a request that it become the operative version prospectively; that request does not assert DSS acceptance before written confirmation.

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DECISION BRIEF

Document relationship

This TEOU submission is the governance, implementation and accountability uplift to the companion public DSS package. The documents form a connected submission set but remain separate works with separate appendix systems, attribution controls, preferred citations and version histories.

Table F.1 - Companion-document relationship and cross-reference matrix

Companion public DSS package	Main TEOU submission
Main submission sections 1–2 — connected problem and reform propositions	Sections 2–3 — structural diagnosis and governing architecture
Main submission section 3 and Appendix B, Part 1 — independent judicial integrity	Section 9.2 — IJIAC; section 11 — delivery architecture; Recommendation 8
Main submission section 4 and Appendix B, Part 2 — Rapid Child-Safety Reassessment	Sections 6 and 9.3; child-safety recommendations; Table 12.3 child outcomes
Main submission section 6 and Appendix A — Every Voice Matters public evidence	Sections 1.3 and 9.1; TEOU Appendix 2; controlled qualitative evidence status
Main submission section 5 and Appendix C — First Action Plan implementation audit	Sections 2.1 and 11; TEOU Appendix 5; implementation and data recommendations
Main submission section 7 — decisions requested	Section 12 and Table 12.2 — consolidated recommendations

Executive summary

Australia has developed sophisticated language, policy frameworks, service systems, risk tools, inquiries and professional guidance addressing domestic, family and sexual violence. The central unresolved problem is not simply recognition. It is the absence of a consistently enforceable chain between recognised risk, assigned responsibility, protective action, measured outcome, independent review and correction.

The central question is not whether a system recorded risk. It is what happened after risk was recorded and who was responsible for checking whether the response made women and children safer.

The Second Action Plan consultation paper identifies five connected priorities: **victim-survivors; prevention and early intervention; children and young people in their own right; people who use violence; and system integration and workforce. It also recognises fragmentation, systems abuse, the need to understand coercive control, and the need for stronger monitoring and coordination** (DSS and ANROWS 2026, pp. 7–10, 43–50). This submission supports those directions and proposes the accountability machinery required to make them measurable.

The Domestic, Family and Sexual Violence Commission's July 2026 Monitoring and Reporting Framework is a significant advance. It explicitly seeks to bridge activity reporting and measurable changes. It also records the scale of the remaining data problem: 89 of 131 Performance Measurement Plan measures (68 per cent) lacked data; 22 of the 42 measures with data relied on four-year national surveys; and only 60 of 122 measures aligned to the six long-term outcomes had identified data sources (DFSV Commission 2026a, pp. 16–17).

That measurement deficit must also be read against delivery under the First Action Plan 2023–2027. The Plan created substantial national machinery, but the published record does not yet demonstrate with equal clarity whether that activity made women and children safer. At 30 June 2025, the Activities Addendum listed 583 activities. Only 112 were marked “finished”, while 79 remained in planning. Critically, the Addendum defines “finished” as the service or outcome being no longer available, not as evidence that the intended result was successfully achieved.

The implementation record is therefore mixed: institutions, frameworks, reforms and hundreds of activities have been established, but national coverage, continuity, fidelity and outcome proof remain incomplete. The Second Action Plan must correct this by distinguishing implementation from activity, and activity from demonstrated safety outcomes.

This submission therefore proposes a permanent, cross-system accountability architecture that complements the Commission's monitoring role. It would not replace courts, regulators, child protection, police or the Commission. It would connect their responsibilities through public implementation controls, shared risk-to-outcome data, independent thematic review, rapid child-safety reassessment, professional accountability and mandatory corrective-action pathways.

The evidence base combines official law and policy, published research, prior reform reports, a de-identified qualitative review of approximately 95,000 words across 11 supplied documents, an anonymised roundtable issues extraction, and limited preliminary descriptive results from Every Voice Matters™ national lived-experience survey. None of the lived-experience sources is presented as population-representative or as establishing an adjudicated fact. Their value is in revealing recurring, testable system questions that official data should be capable of answering.

MEASURE. REVIEW. REFORM. TM Measure what happened. Review whether it worked. Reform what caused harm.

The proposed national package

Table ES.1 - Proposed national package

No.	Recommendation at a glance
1	Make measurable safety, rights and verified conduct change an organising principle of every Second Action Plan action.
2	Establish a permanent national DFSV systems-accountability function that complements existing institutions and compels correction.
3	Adopt a National Cross-Sector DFSV Risk Identification, Assessment, Management and Response Model and a National Mandatory Reporting, Escalation and Response Model.
4	Create shared risk, evidence, pattern and cumulative-harm standards covering the full course of abusive conduct and disclosure-process evidence.
5	Establish the National DFSV and Family-Safety Data Uplift and Risk-to-Outcome Infrastructure across all levels, arms and relevant providers.
6	Implement the Child Safety Signal-to-Outcome Pathway™, rapid reassessment and a National Child Sexual Abuse Disclosure, Investigative Interview and Support Standard.
7	Establish a National Court-Connected Child Evidence, Expert Accreditation and Accountability Scheme, including regulations under s 11K and enforceable assurance standards.
8	Design a constitutionally bounded Independent Federal Judicial Integrity and Accountability Commission for conduct, pattern analysis, referral and systemic reporting — not merits review.
9	Provide a lawful, independent Rapid Child-Safety Reassessment pathway for credible post-order deterioration and supported return to court.
10	Establish permanent, paid lived-experience and First Nations governance with measurable influence over implementation, evaluation and correction.
11	Enact a comprehensive federal Human Rights Act with public-authority duties, family-law audit, accessible remedies and measurable rights outcomes.
12	Commission an independent national family-law child-safety outcomes review covering the past decade of parenting, residence-transfer and relocation decisions involving domestic, family or sexual violence, coercive control, child abuse or child sexual abuse, together with prospective post-6 May 2024 longitudinal evaluation.
13	Regulate and assure ICLs, family consultants, Court Child Experts, single experts and other influential child-facing professionals by function and competence.
14	Measure perpetrator conduct, tactic substitution, compliance, sustained behaviour change and victim-survivor and child safety across systems.
15	Create accessible remedy and restoration pathways where systems or orders failed to protect children and victim-survivors.
16	Publish recommendation-by-recommendation implementation status, outcome evidence, responsible owners, deadlines and corrective action.
17	Discuss an appropriately funded, non-exclusive TEOU development, validation and pilot engagement, subject to procurement and probity.

1. Purpose, scope and evidence

This submission responds to the consultation on the Second Action Plan under the National Plan to End Violence against Women and Children 2022–2032. It is directed to policy, implementation and system design. It does not seek merits to review individual family-law decisions.

1.1 Evidence sources

Table 1.1 - Evidence sources

Evidence layer	Use in this submission
Official law and public policy	Current Commonwealth legislation, DSS consultation material, DFSV Commission reports and frameworks, court guidance, government responses and parliamentary and law-reform reports.
Published research	Australian and international research on coercive control, systems abuse, children's participation, traumatic separation, stress buffering, cultural and access barriers, and integrated risk response.
Every Voice Matters Survey™	A survivor-led, voluntary and anonymous national survey with 219 valid timestamped responses. Only limited, source-controlled descriptive counts are used here.
De-identified qualitative review	A review of 11 supplied documents, approximately 95,000 words, coded for recurring system issues. Repetition within duplicated chat material was not counted as corroboration.
Roundtable themes	An anonymised issues extraction from a family-law lived-experience roundtable and written chat notes. It records themes and proposals, not consensus or verified case findings.
Policy analysis	TEOU analysis connecting evidence to governance functions, owners, outcome measures and corrective-action pathways.

1.2 Evidentiary limits

- Every Voice Matters Survey™ is self-selected, non-probability and retrospective; it cannot estimate prevalence across all Australian family-law matters.
- Survey responses were not routinely matched to court or agency records and do not establish causation.
- Question denominators vary because respondents could skip questions; every published figure states its numerator and denominator.
- The qualitative documents and roundtable notes contain reported experiences and policy discussion. They identify recurring signals and research questions, not adjudicated facts.
- No raw free text, child records, identifying quotations or screenshots are published.
- Contested concepts are not treated as diagnoses or findings. Emerging or unvalidated frameworks are not relied upon as clinical proof.
- Recommendations are proposals for legal, constitutional, operational and lived-experience co-design; detailed specifications should be funded, tested and independently evaluated.

1.3 Preliminary Every Voice Matters Survey™ descriptive findings

The closed source contains 219 valid timestamped responses. The figures below are direct counts from the controlled production instructions. They describe what respondents reported; they do not represent all Australian family-law users.

Table 1.2 - Preliminary Every Voice Matters Survey™ descriptive findings

Measure	Count	Rate	Interpretive control
Abuse before separation	202 / 215	94%	Four valid records did not contribute to this question.

Measure	Count	Rate	Interpretive control
Abuse continuing after separation	215 / 217	99%	Respondent-reported continuation after separation.
Labelled "high conflict"	174 / 217	80%	Kept distinct from whether the framing was considered incorrect.
Reported the matter was incorrectly treated as "high conflict"	172 / 214	80%	A reported system-framing concern, not an independent finding.
Notice of Risk / Form 4 filed	157 / 215	73%	Question-specific denominator.

Table 1.2 (continued) - Preliminary Every Voice Matters Survey™ descriptive findings

Measure	Count	Rate	Interpretive control
Parental alienation raised	169 / 214	79%	Records that the concept was raised, not whether it was valid.
Alienation reportedly used to dismiss abuse	143 / 200	72%	Conditional eligible base; respondent interpretation.
Reported legal abuse	200 / 217	92.2%	Respondent-reported experience; not a legal finding.
Reported abuse through children	193 / 217	88.9%	Respondent-reported experience involving children.
Health affected work fully or partly	191 / 212	90.1%	Reported effect on capacity to work.
Housing stability affected fully or partly	163 / 215	75.8%	Reported effect on housing stability.
Financial hardship as a court-process impact	200 / 214	93.5%	Multiple impacts could be selected.

These figures warrant independent file audit and linked administrative research. They should not be used to infer that every allegation was substantiated, that every professional response was incorrect, or that the sample mirrors the wider family-law population.

Taken together, these results identify a cumulative reported harm pathway: abuse continuing after separation and through legal or associated systems, followed by reported consequences for children, health, employment, housing and financial stability. The figures do not establish national prevalence or adjudicated facts. They do establish a coherent pattern requiring independent file audit, linked administrative research and public outcome reporting.

2. The structural diagnosis

2.1 Recognition without accountable response

Australia does not have a simple knowledge deficit. It has an implementation, measurement and accountability deficit. Harm may be recognised in legislation, strategy, training, a form or a screening result, yet the system may remain unable to show whether that recognition changed the decision, interrupted the violence or improved safety.

Activity counts are necessary but not sufficient. A completed risk form, a referral, a professional appointment, a training session, a specialist list or a published protocol does not establish that the intended safety outcome occurred. This distinction is now reflected in the DFSV Commission's systems-based Monitoring and Reporting Framework. The Second Action Plan should convert that principle into enforceable implementation controls across all funded actions and intersecting systems.

From system failure to accountable human action

"System failure" and "institutional failure" describe structural and governance failures, but they must not become linguistic hiding places that end the accountability inquiry. Systems and institutions do not act in isolation. They operate through people exercising statutory authority, judicial power, professional judgment, administrative discretion, supervisory responsibility and institutional leadership.

Institutions do not implement reform in the abstract — people do. Implementation is not demonstrated merely by passing legislation, issuing policy, funding programs, establishing procedures or delivering training. Reform is implemented when the people responsible for applying it change their decisions, conduct and practice in accordance with the reform, and when those changes produce safer, lawful and accountable outcomes.

Where harmful conduct continues after a problem has been recognised and reform introduced, accountability must move beyond the statement that "the system failed". It must establish who held the relevant responsibility; what law, duty, standard or evidence applied; what that person or responsible body did or failed to do; what happened to the woman or child affected; who reviewed the decision or conduct; and what corrective action followed.

Individual accountability does not displace institutional accountability. Both are necessary. Institutions remain responsible for governance, safeguards, supervision, standards, data, complaints, review and correction. The people exercising authority within those institutions must also be accountable for how they use the power, discretion and professional judgment entrusted to them.

Systems act through people. If the conduct of those exercising power does not change, the system has not changed.

2.2 Incident fragmentation, pattern blindness and cumulative harm

Abusive behaviour and its effects are cumulative and contextual. Coercive control is one pattern-based form of abuse, but pattern recognition must not be confined to coercive control or to any single category of conduct. It applies to the full course of abusive behaviour, including physical violence, sexual violence, threats, intimidation, emotional and psychological abuse, stalking, surveillance, isolation, financial and economic abuse, technology-facilitated abuse, property damage, abuse involving children or third parties, legal and systems abuse, and institutional enablement or failure.

A pattern may consist of repeated conduct of the same kind or different tactics that accumulate, alternate, escalate, pause, re-emerge, change form or move across settings and systems. A lapse of time, separation, expiry or variation of a protection order, or completion of anger management, counselling or a behaviour-change program does not, by itself, erase history or establish that risk has ended. The relevant question is whether the full history has been assessed with current evidence and whether independently verifiable behaviour and safety outcomes demonstrate sustained change.

PATTERN RECOGNITION AND CUMULATIVE HARM PRINCIPLE™ *No incident stands alone. Pattern, context and cumulative harm must be recognised.*

Scope of the Principle. Pattern recognition applies to the full course of conduct and is not limited to coercive control. It requires decision-makers to examine how abusive behaviours interact, accumulate, repeat, escalate, pause, change form or move across time, relationships, institutions and systems, and to assess the resulting cumulative harm to adults and children.

2.3 The cross-system failure pathway

Table 2.1 - Cross-system failure pathway

Stage	System event	Accountability risk
1	Disclosure or observable safety signal	A victim-survivor, child, professional or record identifies risk.
2	Fragmented recording and thresholds	Different systems hold different facts and apply different tests.
3	Context loss or reframing	Coercive control becomes conflict; trauma or protection becomes instability or non-compliance.
4	High-impact decision or intervention	A legal, administrative or service response occurs without a shared outcome baseline.
5	Unmeasured consequences	Safety, health, contact, schooling, housing, work and financial outcomes are not routinely linked.
6	Fragmented complaint or appeal	Each body narrows the issue to its remit; cost and delay restrict correction.
7	No owner of the cumulative outcome	Learning is not converted into mandatory institutional change.

2.4 Why this is a national-plan issue

The failure pathway spans Commonwealth, state and territory responsibilities. It moves through family law, family-violence orders, police, child protection, health, education, housing, migration, child support, social security, taxation, financial services, legal assistance and private court-connected providers. No single jurisdiction or profession can correct it alone. The Second Action Plan is the appropriate mechanism for setting shared national outcome duties while preserving the lawful functions of each institution.

3. The governing architecture

3.1 The Evidence of Us™ contribution

The Evidence of Us™ is an emerging, unincorporated initiative led by [REDACTED] and a developing body of systems-governance work. As at 17 August 2026, it has no incorporated legal structure, ABN or separate legal personality and should not be represented as a company or incorporated organisation. The initiative converts lived experience and other knowledge into structured, testable evidence; connects evidence to named responsibility; measures real-world safety and rights outcomes; and requires independent review and correction where intended outcomes are not achieved. It is independent of government, courts, statutory bodies and service providers.

The Evidence of Us Systems Governance and Accountability Architecture™ is the master architecture. The Evidence of Us Framework™ provides the knowledge-to-accountability method. The Evidence Cycle™ carries evidence through accountability and reform. The Pattern Recognition and Cumulative Harm Principle™ operates across every stage. The strategic concepts are sufficiently developed for policy consideration; detailed legal powers, data standards, thresholds, costings and accreditation instruments should be built through funded multidisciplinary and lived-experience co-design.

The architecture maps responsibility horizontally across Commonwealth, state/territory and local government and across the legislative, executive and judicial arms, while tracing risk and outcomes vertically through family law, child protection, policing, health, education, housing, criminal justice, migration, taxation, social security and DFSV services. It provides a common accountability spine without displacing constitutional or institutional roles.

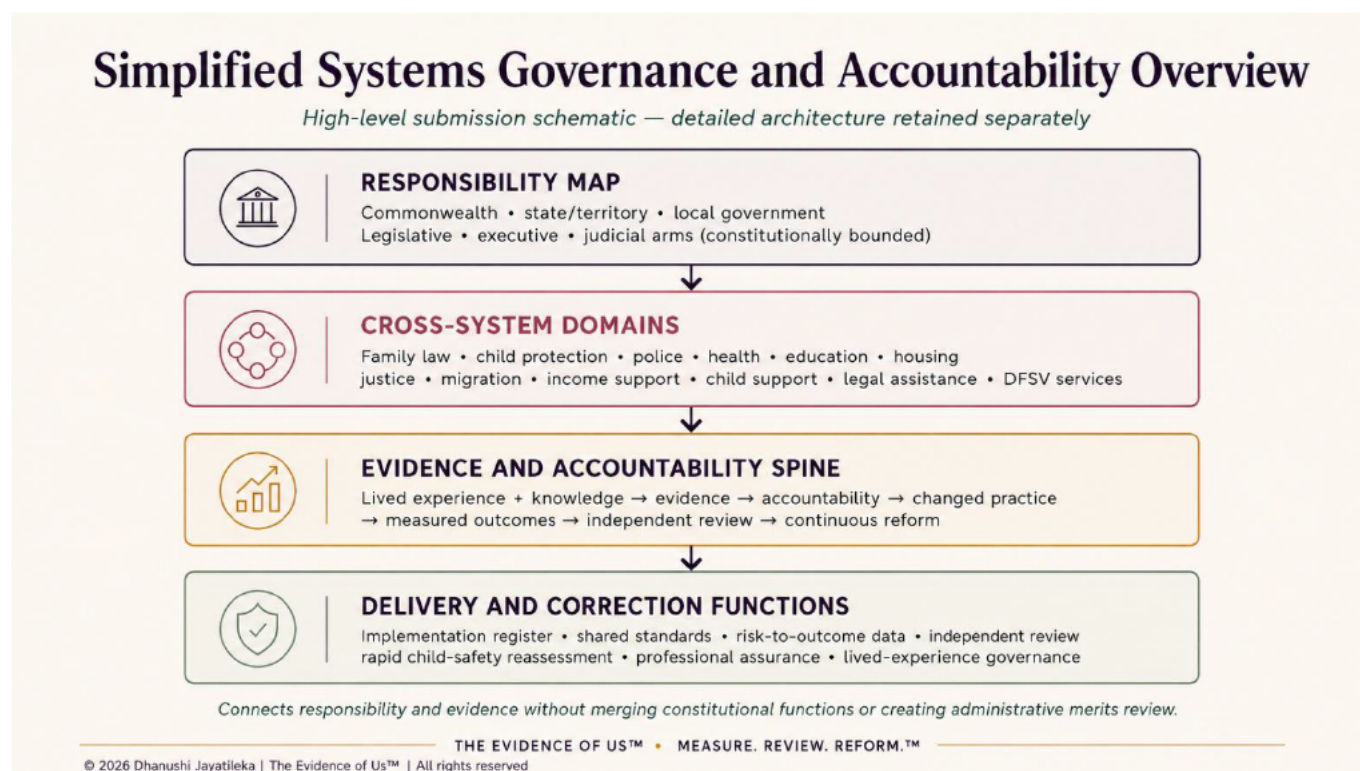
Cross-domain transferable design

Domestic, family and sexual violence is the first substantive worked application of The Evidence of Us Systems Governance and Accountability Architecture™; it is not the limit of the architecture's design. The architecture is intended to be transferable and adaptable to other complex public-interest domains in which lived experience and other evidence are fragmented across institutions, no single body holds the whole picture, responsibility is dispersed, and activity is more readily measured than whether people became safer or outcomes improved.

The core accountability spine remains constant: lived experience and other knowledge are converted into evidence; evidence is connected to named responsibility; reform is translated into changed practice; outcomes are measured; implementation and impact are independently reviewed; and failure triggers correction and renewed evidence gathering. The Pattern Recognition and Cumulative Harm Principle™ operates across that spine.

Transferability does not mean a single generic tool can be imposed unchanged on every field. Each application must be adapted through domain-specific legal and policy analysis, specialist and lived-experience expertise, affected-community governance, culturally safe and rights-based safeguards, appropriate data and evidence standards, defined outcomes, validation, piloting and independent evaluation. ***The architecture is transferable, but it is not one-size-fits-all.***

Figure 3.1 - The Evidence of Us Systems Governance and Accountability Architecture™



Four-layer diagram showing the TEOU responsibility map, cross-system domains, evidence and accountability spine, and delivery and correction functions.

Evidence status: Concept-stage architecture. Table 11.1 remains the authoritative description of the eight delivery functions. The figure connects functions but does not combine constitutional powers.

3.2 The Evidence Cycle

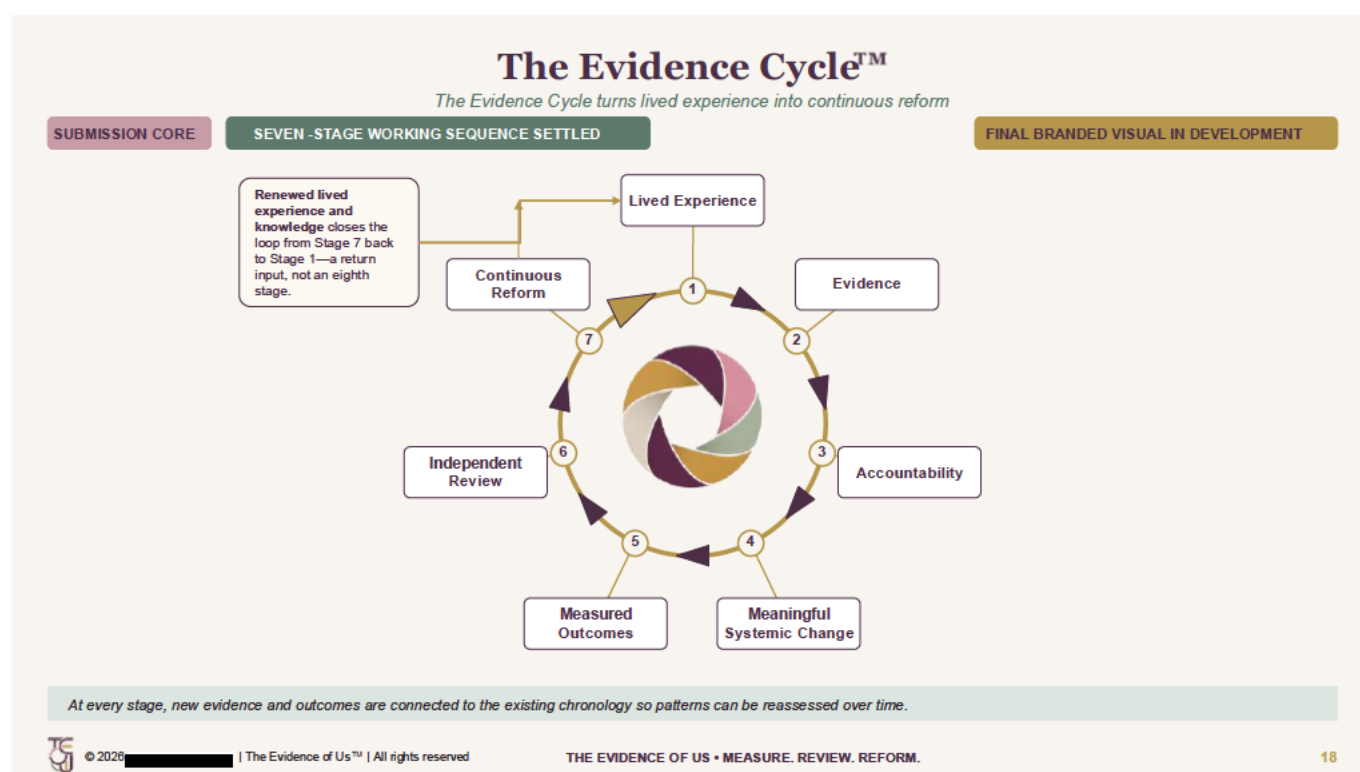
Table 3.1 - The Evidence Cycle™

Stage	Function	Minimum discipline
1	Lived experience	Safely governed accounts, child voice, community and practitioner knowledge.
2	Evidence	Classification, provenance, chronology, triangulation, uncertainty and pattern analysis.
3	Accountability	Named decision-maker, duty, action, reason, deadline and public reporting obligation.
4	Meaningful systemic change	Law, funding, standards, service design and workforce reform translated into specified, observable and auditable changes in professional and institutional decision-making, conduct and practice.

Stage	Function	Minimum discipline
5	Measured outcomes	Evidence that intended professional and institutional conduct changed, linked to measurable safety, rights, perpetrator-behaviour, health, housing, economic, child and access outcomes.
6	Independent review	Independent verification of implementation fidelity, conduct change and its connection to real-world outcomes through evaluation, audit, complaint aggregation, thematic investigation and learning.
7	Continuous reform	Corrective action where implementation, conduct or outcomes did not improve; updated practice and renewed evidence gathering.

CROSS-CUTTING RULE At every stage, information must be connected to the existing chronology so that interpersonal and institutional patterns can be reassessed over time.

ACCOUNTABILITY TRACE For this architecture, accountability must be traceable from the institution to the responsible role, the decision, action or omission, the applicable duty or standard, the human outcome, the review and the correction.



The Evidence of Us Policy-to-Practice-to-Safety Accountability Test™

A law, policy, standard, funding commitment, service redesign or training program is not evidence of meaningful systemic change merely because it exists or was delivered. The responsible body must specify the professional and institutional decisions, conduct and practices expected to change; establish baseline and target indicators; verify whether the change occurred and was sustained; connect the change to safety, rights and equity outcomes; and trigger corrective action where practice or outcomes do not improve.

The test has three gates:

1. **Reform delivery:** Was the law, policy, funding, standard, service redesign or workforce intervention actually implemented?
2. **Practice and conduct change:** Did observable professional and institutional decisions, actions, conduct and behaviour change as intended, consistently and over time?
3. **Safety and rights outcomes:** Did those changes reduce harm and improve safety, rights, access and equity for victim-survivors and children?

A reform should not be reported as complete unless all applicable gates are evidenced. Where causation cannot be established, the uncertainty must be recorded rather than presenting activity as impact.

3.3 Complementing the DFSV Commission

The DFSV Commission already has an independent monitoring, coordination and strategic-advice role. Its 2026 framework moves national reporting toward systems and outcomes and places lived experience within accountability. TEOU's proposal should therefore be implemented in legal partnership with, not in competition with, the Commission.

Table 3.2 - Complementing the DFSV Commission

Function	Distinct contribution
DFSV Commission	Independent national monitoring, strategic advice, systems-barrier identification, lived-experience evidence and yearly reporting.
Proposed implementation mechanism	Named owners, deadlines, funding controls, cross-portfolio delivery, public status and corrective-action duties.
Proposed specialist review functions	Complaint aggregation, fidelity audit, child-safety outcome review, professional and institutional thematic investigation, and lawful referral.
Shared national data capability	Link risk, intervention and de-identified outcomes while protecting privacy and judicial independence.

PART II — CONSULTATION PRIORITY 1

4. Priority 1 — Victim-survivors

CONSULTATION FOCUS Improve safety, support, justice, recovery and healing; recognise coercive control; improve policing and justice; address technology-facilitated harm and systems abuse; and remove unequal barriers.

What the evidence points to

Victim-survivors may need to navigate many institutions at once while the person using violence moves tactics between them. The de-identified material describes legal process, subpoenas, financial depletion, service requirements, child-contact arrangements, child support, housing, technology and administrative systems operating as connected sites of post-separation control.

The Family Law Council's March 2025 report expressly examined disincentives to disclosing family violence and systems abuse. The Australian Government's September 2025 response to the family-violence-orders inquiry also recognised the need for reforms to eliminate opportunities for systems abuse, research misidentification and build a national outcomes measurement framework. The Second Action Plan should turn those directions into coordinated delivery.

National advertising that urges victim-survivors to leave violence without ensuring a continuous and accountable post-separation safety pathway is incomplete and, in the present Australian system, can be irresponsible. Separation can increase risk. Women and children—who must be recognised as victim-survivors in their own right—may then encounter failure across police, child protection, housing, income support, health, education and legal systems.

The crescendo can occur in adversarial family-law proceedings, where repeated litigation, aggressive or retraumatising questioning, pressure to consent to unsafe arrangements, unaffordable legal costs and the reframing of trauma or protective action as conflict can compound the original violence. Some victim-survivors report financial devastation, loss of care of their children and coerced ongoing parenting contact with a person they identify as abusive. Robust process and procedural fairness do not require conduct that is abusive in effect or orders whose safety outcomes are never reviewed.

Action required

- Adopt a national systems-abuse protocol covering litigation, child support, social security, tax, finance, superannuation, migration, housing, technology and administrative decision-making.
- Require participating agencies to identify perpetrator pattern, primary aggressor, cross-system repetition, victim-perpetrator misidentification and foreseeable retaliation.
- Create a safe single-entry referral and navigation pathway with warm handovers, consent controls, multilingual access and continuity of case responsibility.
- Require complaints responses to state jurisdiction, evidence considered, findings, corrective action, reasons and review rights; referral without ownership must not constitute resolution.
- Protect therapeutic, health and safety-seeking records from unnecessary or harmful use while preserving fair process and lawful evidence access.
- Measure recovery and safety across housing, income, debt, health, employment, child wellbeing and further system contact—not only service contacts completed.
- Fund long-term recovery and healing, including legal and financial advocacy, rather than limiting support to immediate crisis exit.

How success should be measured

Table 4.1 - Priority 1 success measures

Measure	Why it matters
Time from first high-risk signal to coordinated safety response	Tests whether recognition produces timely protection.

Measure	Why it matters
Repeat disclosure burden and failed referrals	Shows whether integration reduces re-traumatisation.
Post-intervention safety, housing, health, work and debt outcomes	Separates activity from recovery.
Misidentification review and correction rates	Tests whether perpetrator pattern is being recognised.
Complaint outcomes and institutional corrective action	Shows whether remedy exists beyond redirection.

PART II — CONSULTATION PRIORITY 2

5. Priority 2 — Prevention and early intervention

CONSULTATION FOCUS Strengthen prevention across institutions and communities, recognise harm earlier, respond before escalation, and address the structural and gendered drivers that enable violence.

Prevention must include institutional design

Primary prevention is essential, but the Second Action Plan must also prevent institutions from becoming channels through which coercion continues. A system may unintentionally reward repetition, resource disparity, procedural ambush, fragmented allegations or strategic complaints. Safety by design requires identifying those opportunities before harm escalates.

Action required

- Apply safety-by-design reviews to Commonwealth and intergovernmental systems, including application, review, debt, payment, information-sharing and complaint processes.
- Require early identification of post-separation coercive control and system-enabled abuse at predictable contact points: police, health, schools, workplaces, Centrelink, Child Support, taxation, housing, legal assistance and courts.
- Build a national capability for pattern-based risk assessment that distinguishes coercive control from situational conflict and records uncertainty and competing explanations.
- Fund community-led prevention and early intervention for First Nations, migrant and refugee, regional and remote, disability and LGBTIQ+ communities, with community authority over design and evaluation.
- Treat housing, income security, affordable legal help, digital safety and access to health care as prevention infrastructure.
- Measure whether an intervention reduced harmful behaviour, prevented escalation and reduced repeat system contact—not merely whether a program was delivered.
- Create a universal, government-funded parenting-education pathway through maternity care, child and family health, general practice, early-childhood services and schools. Programs such as Tuning in to Kids, Tuning in to Teens and Circle of Security provide useful foundations; Australia should also develop a contemporary universal program addressing gender equality, shared care, respectful relationships, non-violent conflict and patriarchal entitlement. It must be framed as education and support for all parents—not punishment or surveillance.
- Provide repeated, age-appropriate education from the early years on coercive control, consent, fear-based compliance, unhealthy relationships, help-seeking and digital abuse, supported by a genuine whole-school model with trained educators, trusted adults, confidential disclosure pathways and specialist referral.
- Fund specialised family-violence-informed parenting, therapeutic and psycho-educational services when DFSV, coercive control or child abuse is alleged or identified. Services must support protective parenting, address abusive behaviour where appropriate and keep children's safety central.
- Make implementation of court- or child-protection-recommended therapy, assessment and support a shared, system-supported responsibility. One parent must not be left alone to find services, coordinate appointments, fund care and overcome consent or continuity barriers.
- Provide children with age-appropriate explanations and implementation support from trained professionals after family-law or child-protection decisions, and support parents to communicate safely through life-changing transitions.
- Protect the capacity and wellbeing of frontline non-legal services through safe caseloads, supervision, specialist secondary consultation and secure multi-year funding. Referral without available service capacity is not early intervention.

A practical prevention test

Did the system interrupt coercive control, or did it displace the same control into a new legal, financial, administrative or technological channel?

National cross-sector risk identification, assessment, management and response

Prevention infrastructure must include housing, income security, affordable legal assistance, digital safety and access to health care. The Second Action Plan should adopt and implement a **National Cross-Sector DFSV Risk Identification, Assessment, Management and Response Model** establishing mandatory core definitions, shared risk language, pattern- and cumulative-harm analysis, structured professional judgment, escalation thresholds, documented risk-management action, cross-system information transfer, review requirements and measurable safety outcomes, supported by validated sector- and population-specific tools.

It should also establish a **National Mandatory Reporting, Escalation and Response Model** for child abuse, child sexual abuse, children's exposure to family violence, and serious or imminent DFSV risk across all relevant sectors, including health and education. The model must prescribe who must act, what must be reported, referred or escalated, to whom, within what timeframe, what protective response must follow, and how action and safety outcomes will be reviewed.

The descriptive national model titles are public-policy proposals. The working TEOU concept names — **The Evidence of Us Cross-System Risk-to-Safety Architecture™** and **The Evidence of Us Report-to-Response Accountability Pathway™** — remain concept-stage assets requiring mark clearance, technical development, validation and piloting.

PART II — CONSULTATION PRIORITY 3

6. Priority 3 — Children and young people in their own right

CONSULTATION FOCUS Centre children's voices, rights and safety across prevention, response and recovery; provide developmentally appropriate support; and involve children meaningfully in policies and services.

From child voice to child-safety action

The National Plan and consultation paper recognise children as victim-survivors in their own right. The DFSV Commission has stated that their voices must be listened to and acted upon and has identified family court and justice participation as an urgent priority. The current Family Law Act 1975 (Cth) also contains important protections: the child's best interests are paramount (s 60CA); s 60CC requires consideration of safety, child views, developmental, psychological, emotional and cultural needs, caregiver capacity and safe relationships; s 60CG addresses unacceptable family-violence risk; and Independent Children's Lawyers must generally meet children aged five and over, subject to statutory exceptions (s 68LA).

The gap is not the complete absence of duties. It is the absence of a nationally consistent and auditable pathway showing what happened after a child signalled fear, risk or deteriorating wellbeing.

THE EVIDENCE OF US CHILD SAFETY SIGNAL-TO-OUTCOME PATHWAY™ child safety signal → contextual and cumulative-harm assessment → protective decision → action → explanation to the child → follow-up → measured safety outcome

A de-identified illustration

A deliberately generalised child-completed therapeutic record reviewed for this submission illustrates the risk-to-action gap. The child differentiated ordinary school and friendship concerns from higher-level worries about family safety and dangerous people. The child also recorded anticipatory distress associated with contact and a cluster of emotional, cognitive, behavioural and physical responses.

The record does not, by itself, establish abuse, identify who caused the fear or support a clinical diagnosis. It is nevertheless a contemporaneous child-generated safety signal requiring structured, trauma-informed inquiry. The correct system question is: what was done with the information; how were competing explanations tested; what protective response followed; and did the child become safer?

Abrupt transfers, “cold swaps” and contact moratoriums

“Cold swap” is community shorthand, not a recognised legal or clinical term. In this submission it means an abrupt change in a child's primary residence or caregiving arrangement with little or no preparation, transition, leave-taking or developmentally appropriate explanation. A contact moratorium means a court-ordered or institutionally imposed period during which a child cannot communicate with a former primary or significant attachment caregiver.

Immediate separation may be necessary where a caregiver presents an established and unacceptable safety risk. Attachment does not prove safety, and preserving contact must never override protection. Equally, a necessary separation may still be distressing or traumatic. The National Child Traumatic Stress Network recognises that caregiver separation may be experienced as overwhelming where it is sudden, unexpected, prolonged or accompanied by cumulative stressors. Supportive adult relationships can buffer children's stress responses (NCTSN 2016, pp. 1–4; Center on the Developing Child n.d.).

The defensible policy proposition is therefore not that every transfer or moratorium causes trauma. It is that these interventions combine recognised psychological risk exposures and create a foreseeable duty to assess, justify, mitigate and review their effects. Quietness, rapid compliance or the absence of an immediate crisis should not be treated as proof of safety.

Six linked child-safety reforms

Table 6.1 - Six linked child-safety reforms

Reform	Minimum national requirement
1. Child-safety signal protocol	Preserve the signal, connect the chronology, assess cumulative harm and record what action follows

Reform	Minimum national requirement
2. Abrupt-transfer and contact-moratorium safeguards	Necessity, proportionality, transition support, explanation, early review and wellbeing monitoring
3. Rapid Child-Safety Reassessment	Independent intake, urgent safeguarding, evidence coordination and supported lawful return to court
4. National Child Sexual Abuse Disclosure, Investigative Interview and Support Standard	Trauma- and developmentally informed forensic competence, planned non-disclosure response and therapeutic continuity
5. Child-evidence and expert assurance	Role clarity, contact schedules, longitudinal evidence, factual correction, accreditation, complaints and audit
6. Risk-to-outcome data	Link disclosure and safety signals to interviews, protective action, decisions, review and later child outcomes

Child-safety safeguards

- A child's account should trigger inquiry—not automatic acceptance and not automatic disbelief.
- Children must have culturally safe, disability-accessible and developmentally appropriate ways to communicate.
- Any complete or substantial contact restriction should be individually justified, proportionate, time-limited and subject to early and periodic review.
- Safe supervised, therapeutic or indirect connection should be considered where appropriate and not contraindicated by risk.
- Children must receive an age-appropriate explanation of what happened after they spoke.
- Serious deterioration in safety, physical or mental health, schooling or functioning must trigger reassessment.

A child's best interests do not invariably require a relationship with both parents. Co-parenting assumes relative safety, trust and equality of power—conditions that coercive control removes. Where abuse is established or credible risk requires protection, systems should use safe, accountable parallel-parenting or other protective arrangements, with clear boundaries, ongoing risk assessment and no presumption that contact itself proves or produces safety.

THE ACCOUNTABILITY TEST Did the child become safer? Were safe relationships and supports preserved? Did the system identify and respond when the intervention itself produced distress, deterioration or harm?

The law changed. The evidence must show whether practice changed.

Most of the parenting reforms enacted in 2023 commenced on 6 May 2024. They simplified the statutory best-interests factors, removed the presumption of equal shared parental responsibility, strengthened information sharing and expanded requirements for Independent Children's Lawyers to meet children. These were necessary legal changes. Their enactment, however, is not evidence that judicial reasoning, court-connected professional conduct or child-safety outcomes changed in practice.

The available post-commencement public record describes training, risk-screening, information-sharing and case-management activity. It does not yet provide a national independent audit showing whether child safety signals and views were assessed differently; whether identified family violence and child abuse changed reasons, safeguards and orders; whether information was available and used at the relevant decision point; or whether children became safer after orders were made.

A 2025 review of the 2021 court restructure recorded positive practitioner perceptions of improved judicial understanding of family violence and risk. Those perceptions are relevant. The review was not an evaluation of the 2023 parenting amendments, its public survey was small, and broader review of the Family Law Act was outside its terms. It cannot answer the post-reform outcome question.

Contemporaneous lived-experience evidence continues to report disclosures being minimised, reframed or disconnected from protective action. That evidence does not establish what occurred in every case. It establishes a sufficiently serious signal to require independent post-implementation judgment analysis, file audit and longitudinal child-safety review.

The Act changed. The evidence must now show whether the bench, court-connected professionals and linked agencies changed — and whether children became safer.

Establish a National Child Sexual Abuse Disclosure, Investigative Interview and Support Standard

Public-evidence control: A de-identified lived-experience account considered during development is not reproduced in this public edition because the dated source-authorisation and chronology-verification gates were not available in the supplied release record. The reform case below rests on public research, official guidance and source-controlled aggregate evidence.

Establish and independently audit a national standard that treats trauma- and developmentally informed practice as an essential component of forensic competence not as an optional therapeutic addition.

The Standard must require nationally consistent, role-specific and independently assessed competency in child trauma psychology, neurodevelopment, grooming and disclosure dynamics, developmental and disability-accessible communication, neutral forensic interviewing, non-disclosure and recantation, therapeutic-forensic boundaries, longitudinal evidence, cultural safety, bias and systems abuse.

Forensic integrity and trauma-informed practice must not be treated as competing objectives. Interviews must remain neutral, non-leading, recorded and capable of legal scrutiny while providing developmentally appropriate preparation, rapport, pacing, psychological safety, communication adjustments, controlled attendance, appropriate breaks and a planned response when a child does not disclose during one interview.

A child's silence, fragmented account, delayed disclosure, partial disclosure, changed language or recantation must not automatically be treated as proof that abuse did not occur. Trauma-informed practice must not require an allegation to be accepted without investigation. The obligation is to assess the complete disclosure chronology, interview conditions, corroborative and longitudinal evidence, competing explanations, current risk and uncertainty.

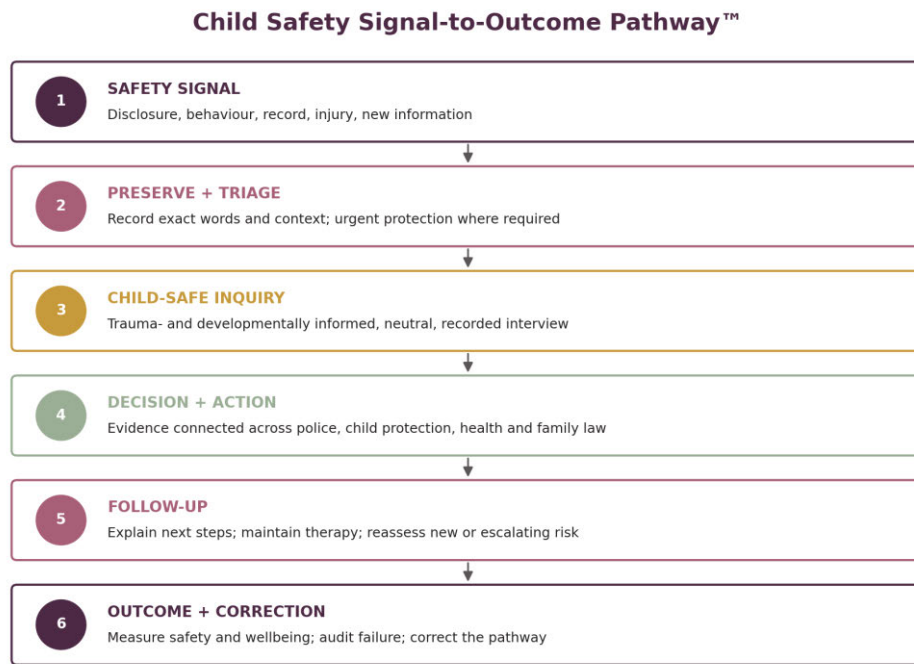
The Standard must include separate competency schedules for police and specialist child-protection investigators; child-protection practitioners; treating psychologists, counsellors and health professionals; Court Child Experts, family consultants, single experts, psychologists and psychiatrists; Independent Children's Lawyers; judicial officers; and legal practitioners.

Training attendance is not proof of competence. Accreditation must require supervised practice, observed simulations, structured assessment, audit of recorded interviews and professional reports, specialist supervision, continuing professional development and time-limited reaccreditation.

Mandatory modules must cover:

1. child trauma psychology and neurodevelopment;
2. grooming and child-sexual-abuse disclosure dynamics;
3. developmental, disability and communication competence;
4. integration of psychological knowledge with neutral forensic method;
5. psychological and environmental safety;
6. non-disclosure, recantation, uncertainty and continuing risk;
7. therapeutic-forensic boundaries and longitudinal evidence;
8. bias, coaching or alienation propositions, credibility and systems abuse; and
9. vicarious trauma, specialist supervision and reflective practice.

The rigid tick-box is not forensic integrity. Completion of training is not competence, and procedural compliance is not proof that a child was heard, understood or protected.

Figure 6.1 - Child Safety Signal-to-Outcome Pathway™

Six-stage child-safety pathway from safety signal through preservation, child-safe inquiry, decision and action, follow-up, and outcome correction.

Independent national family-law child-safety outcomes review

Commission the independent national review set out in section 9.3A. It should combine a retrospective review of the past decade of parenting decisions concerning where a child lives, changes or transfers of primary residence, and relocation, in matters where domestic, family or sexual violence, coercive control, child abuse or child sexual abuse was alleged, notified, evidenced or found, with a prospective longitudinal evaluation of matters commenced or substantially determined after 6 May 2024, using a pre-reform comparator where legally and methodologically appropriate.

The review should cover the Federal Circuit and Family Court of Australia — Divisions 1 and 2 — the Family Court of Western Australia and relevant appeal data, while protecting decisional independence and individual confidentiality. It must examine whether reasons addressed each material child-safety signal and child view; whether information-sharing powers delivered usable material before decisions; whether Independent Children's Lawyer duties were performed; whether disclosures were assessed as a process; whether coaching or alienation propositions were tested against the full evidence; whether abrupt transfers and contact moratoriums recorded necessity and safeguards; and what happened to children at six, 12 and 24 months.

Measures should include subsequent safety, reported violence or abuse, police and child-protection involvement, further proceedings, changes in living arrangements or contact, health, wellbeing, education and functioning, serious harm, self-harm, suicide and death where lawfully and ethically capable of analysis.

PART II — CONSULTATION PRIORITY 4

7. Priority 4 — People who use violence

CONSULTATION FOCUS Support earlier identification, accountability and behaviour change while prioritising victim-survivor safety and strengthening the evidence base for different cohorts and interventions.

Accountability must follow the behaviour across systems

A person using violence may be visible to several institutions without any institution seeing the whole pattern. Accountability is weakened when programs record attendance but do not measure change; when system-enabled tactics are treated as ordinary dispute conduct; or when the burden of monitoring and proving ongoing harm remains with the victim-survivor.

Action required

- Develop a national perpetrator-pattern and system-enabled-abuse data standard that records behaviour across time and institutions while protecting privacy and procedural fairness.
- Require behaviour-change interventions to report safety-linked outcomes, including repeat violence, stalking, systems abuse, breach behaviour and victim-survivor reports—not only completion.
- Create safe feedback channels so victim-survivor information can inform program risk management without making participation or contact a precondition for the other person's intervention.
- Strengthen early intervention at health, workplace, gambling, alcohol and other substance-use, education, digital-platform and justice contact points without treating those factors as excuses for violence.
- Design culturally safe interventions with First Nations and diverse communities and distinguish accountability from criminalisation-only approaches.
- Evaluate whether institutional processes discourage, interrupt or unintentionally facilitate continuing control.

Core measures

Table 7.1 - Activity measures and required perpetrator-outcome measures

Activity measure	Required outcome measure
Program referral and attendance	Documented change in harmful behaviour and victim-survivor safety.
Order or warning issued	Compliance, repeat conduct, escalation and system displacement.
Systems-abuse flag	Protective intervention, cross-agency response and reduction in repeat misuse.
Early-intervention contact	Reduced progression to further violence and improved safety.

PART II — CONSULTATION PRIORITY 5

8. Priority 5 — System integration and workforce

CONSULTATION FOCUS Create connected, capable and trauma-and violence-informed systems across health, housing, policing, justice, education, child protection and specialist services, with stronger information sharing and implementation.

Integration requires more than referral

Integration is not achieved merely because agencies can exchange information. It requires common risk concepts, explicit decision responsibility, interoperable records, consent and privacy safeguards, an escalation pathway, outcome ownership and correction when the response fails.

The National Strategic Framework for Information Sharing and the Family Law Amendment (Information Sharing) Act 2023 strengthened court access to child abuse, neglect and family-violence risk information. The next accountability question is whether the information was available at the relevant decision point, how it affected the response and whether the outcome was safer.

Non-legal services often provide the practical safety response when a victim-survivor and children leave: crisis accommodation, safety planning, counselling, trauma recovery, financial and health support, school assistance, advocacy, cultural support and connection to community. That work can be undone when specialist assessments are not shared safely, understood or given appropriate weight in policing, child protection and family law, and trauma responses or protective action are reframed against the person seeking safety.

Non-legal services must form an integrated, trauma-informed safety network around the child and victim-survivor, with consent-based information sharing, recognised specialist evidence, warm referrals, continuing advocacy and feedback loops when a legal or administrative outcome appears to increase risk. The system test is simple: did the combined response make the family safer after disclosure and separation, or return them to danger through fragmented decisions?

A role-specific workforce accreditation, competency and accountability model

Training, qualification, professional registration, function-specific accreditation and accountability are related but are not interchangeable.

The Second Action Plan should establish a tiered national workforce-assurance model proportionate to each role's authority, frequency of contact with victim-survivors and children, and capacity to affect safety outcomes.

The proposed shared national risk, evidence, cumulative-harm and safety-outcome standard should draw on MARAM's multi-agency risk-governance strengths; incorporate Safe & Together's perpetrator-pattern, child-centred and protective-parent-partnering practice where relevant; and align with national risk-assessment and coercive-control principles. These frameworks provide practice foundations. They do not replace professional registration, function-specific or organisational accreditation, independent complaints jurisdiction, corrective action or safety-outcome audit.

Table 8.1 - Role-specific workforce accreditation, competency and accountability model

Accountable group	Minimum national assurance and recommended uplift
System leaders, departments, regulators, commissioners and funders	Defined statutory, policy and contractual responsibility for implementing the shared national standard; commissioning only appropriately qualified or accredited services; named ownership of escalation and safety outcomes; linked data, complaints and critical-incident review; publication of implementation gaps, corrective actions and responsible bodies.
Judicial officers and registrars	Mandatory role-specific competency assurance through judicial education and governance, including induction and annual development; coercive control, cumulative harm, child trauma and development, systems abuse, cultural safety and disability competence; aggregate implementation and outcome reporting without interference with individual merits, decisions or judicial independence.
Court administration, registry staff and contracted security personnel	Role-tiered competency in safe engagement, privacy, safety planning, distress identification, protected attendance arrangements, risk escalation, referral and incident documentation; supervision, complaint pathways and audit of compliance with court-safety procedures.

Accountable group	Minimum national assurance and recommended uplift
Lawyers, barristers and Independent Children's Lawyers	Professional regulation supplemented by a mandatory specialist family-law DFSV and child-safety credential for relevant publicly funded, panel-appointed and court-connected work; competency in systems abuse, child engagement, cultural safety, evidence chronology and record integrity; effective regulator and funder complaints, remediation and panel-suspension pathways.
Police, prosecutors and specialist investigators	Assessed agency credential and periodic reassessment in coercive control, pattern and cumulative-harm recognition, sexual violence, non-fatal strangulation, technology-facilitated abuse, trauma-informed evidence gathering, child sexual-abuse disclosure, disability and cultural safety; supervisory review, recorded-practice or file audit, cross-jurisdictional escalation and independent complaints.
Child-protection and statutory child-and-family practitioners	Mandatory role-specific practice credential grounded in the shared national risk standard and Safe & Together-informed practice; perpetrator-pattern mapping, child-impact assessment, protective-parent partnership, cumulative-harm analysis, child participation, multidisciplinary consultation and reasoned decision records; specialist supervision, file audit, complaints, remediation and outcome review.
Court Child Experts, family consultants, family report writers, single experts, psychologists and psychiatrists undertaking court-connected assessments	Underlying professional registration or qualification plus national family-law function-specific accreditation. Mandatory competence in family violence, coercive control, child sexual abuse, trauma psychology, child development and disclosure, disability, cultural safety, forensic method, systems abuse and longitudinal evidence. Public register, source and method disclosure, conflict and limitation disclosure, peer or file audit, factual-correction process, independent complaints, suspension and reaccreditation.
Health, mental-health, social-work and therapeutic practitioners	Applicable professional registration or independent professional accountability, supplemented by role-tiered competency in trauma- and violence-informed psychology, child sexual-abuse disclosure, complex and developmental trauma, coercive control, risk identification, safe documentation, information sharing and warm referral. Specialist roles require supervision, continuing development and audit. Where national professional registration does not exist, equivalent independent credential and complaints coverage should be established.
Accredited family-dispute-resolution practitioners, mediators and family counsellors	Retain existing accreditation requirements but add nationally consistent, assessed competence in structured family-violence and child-safety screening, coercive control, bargaining-power inequality, child-abuse risk, safe cessation, escalation, referral and post-process safety. Periodic reassessment, record standards, complaints and audit should apply.
Children's contact, changeover, supervision and transfer services and other post-separation court-connected providers	Individual-practitioner and organisational accreditation; fit-and-proper-person and child-safety screening; mandatory competence in grooming, child sexual abuse, coercive control, child distress and Safe & Together-informed practice; safety plans, observation-versus-opinion standards, distress escalation, record retention, child feedback, pricing transparency, insurance, independent complaints, audit and enforceable consequences.
Specialist DFSV, sexual-assault, community-controlled and culturally specific services	National minimum qualification and supervised-practice benchmark, informed by Victoria's specialist-family-violence minimum-qualification model; specialist risk assessment, trauma- and violence-informed practice, cultural safety, lived-experience expertise, secondary consultation, reflective supervision and workforce-wellbeing safeguards; organisational quality assurance, accessible complaints and outcome evaluation.
Housing, homelessness, income, child-support and financial-support services	Foundational or intermediate competency in economic abuse, systems abuse, address and information safety, flexible evidence requirements, emergency housing and income continuity, risk escalation and warm referral; organisational audit of decisions that delay safety, terminate support or return victim-survivors and children to danger.
Education and early-childhood workforces	Foundational and designated-practitioner competency in identifying family violence and child harm, responding to disclosures, mandatory reporting, developmental and disability-accessible communication, perpetrator-aware safety planning, secure records, information sharing and escalation; nominated safeguarding leads, supervision and feedback when reported risk remains unresolved.
Interpreters, translators, disability-communication professionals and cultural-support workers	Appropriate foundational professional credential plus role-specific DFSV competence in confidentiality, conflicts, trauma-informed communication and accurate interpretation of coercive control, sexual violence, threats, systems abuse and child-safety information; accessible complaints and removal from safety-critical panels where standards are breached.
Perpetrator-intervention and behaviour-change providers	Practitioner and program accreditation against national standards; risk assessment and reassessment, victim-partner safety contact, information sharing, breach and escalation protocols, program-fidelity audit, complaints, transparent completion criteria and evaluation of behaviour and safety outcomes—not attendance alone.

All roles should be mapped to three nationally consistent assurance levels: foundational competence for workers who may receive a disclosure or identify risk; intermediate competence for workers who regularly assess, refer, share information or coordinate responses; and specialist competence for practitioners who conduct comprehensive assessments, investigate, provide expert opinions, manage high risk or make decisions materially affecting safety.

Training attendance must not be treated as proof of competence. Assurance should include observed or simulated practice, structured assessment, appropriate supervision, record or file audit, complaints, remediation, periodic reassessment and evidence about whether identified risk was translated into protective action and improved safety outcomes.

The FCFCOA Family Violence Plan requires judges to undertake Safe & Together family-violence training, or other nominated training, within their first year of appointment and some form of family-violence training annually thereafter. Registrars are subject to corresponding induction and annual-training requirements. Within the Courts, the remaining gap is therefore not simply whether training exists, but whether role-specific competence is demonstrated, applied in practice and connected to safer outcomes. Across the wider workforce, both training coverage and competency assurance remain inconsistent.

Children's contact services must be described accurately. The Family Law Amendment Act 2024 created an enabling statutory framework for later regulation; it did not itself establish a complete operational national accreditation scheme. Section 10A of the Family Law Act 1975 permits Accreditation Rules to provide for individual CCS practitioners and CCS businesses and to address standards, continuing obligations, monitoring, complaints, review, suspension or cancellation and related consequences. Section 10KH makes offence provisions conditional on the Accreditation Rules providing for the relevant accreditation. The Attorney-General's Department continues to describe the reform as a framework for later regulation and states that the impact analysis following the 2025 consultation is to be completed.

Two existing foundations support the proposed uplift. The National Office for Child Safety uses Tier 1 foundational, Tier 2 building and Tier 3 specialist knowledge; this submission adapts that logic as foundational, intermediate and specialist competence. Victoria's updated Mandatory Minimum Qualifications Policy for specialist family-violence response roles took effect on 31 March 2026 and provides a credible workforce benchmark.

System and workforce actions

- Establish a national shared risk, evidence, cumulative-harm and safety-outcome standard.
- Audit Lighthouse/Family DOORS Triage, Evatt, Magellan and comparable pathways for fidelity, accessibility and post-intervention outcomes while recognising their existing safety purpose.
- Create a privacy-preserving minimum dataset that follows risk to response and outcome across institutions.
- Require role-specific competency assessment, continuing development, periodic reassessment, complaints and remediation.
- Fund specialist secondary consultation for universal services and regional, remote and culturally specific workforces.
- Publish implementation gaps, responsible bodies and corrective actions rather than reporting only training and tool-completion counts.

PART III — CROSS-CUTTING ACCOUNTABILITY

9. Family law and justice accountability

9.1 The accountability gap

Appeal, judicial-conduct complaint, professional regulation, institutional audit and urgent child-safety reassessment are different functions. Treating appeal as the answer to every concern leaves a gap: appeals address legal error and orders, are time-bound and costly, and do not aggregate cross-case conduct, implementation or outcome patterns.

The Every Voice Matters Survey™ evidence demonstrates why formal availability does not equal practical access. Among the 136 respondents who answered why they had not appealed, 89 selected prohibitive cost, 79 reported feeling too disadvantaged to pursue an appeal, 71 reported insufficient information or support, and 57 said housing, crisis, safety or health circumstances made an appeal impossible. These are respondent reports rather than findings about individual cases, but they show why appeal cannot perform the missing accountability function.

Court-controlled complaint processes, professional regulators and service complaint bodies have legitimate but limited remits. Australia still lacks a single nationally consistent independent mechanism capable of linking family-law risk, institutional response, complaint patterns and de-identified post-order outcomes while directing issues to the body lawfully authorised to act.

9.2 Independent Federal Judicial Integrity and Accountability Commission (IJIAC)

The Australian Government accepted in principle the Australian Law Reform Commission's recommendation to establish a federal judicial commission and consulted on design in 2023. As at 17 August 2026, no Commonwealth legislation establishing a standing federal judicial commission was identified in the official legislative and policy sources reviewed; the 2023 consultation and later departmental records remain the relevant public scoping record. The Second Action Plan should support implementation of a constitutionally appropriate body.

Reform has stalled because several different questions have repeatedly been collapsed into one. Protecting judicial independence has been treated as though it prohibits independent investigation; appeal as though it provides conduct accountability; internal court complaint handling as though it is external review; and the section 72 removal mechanism as sufficient despite being an extreme, all-or-nothing constitutional safeguard. Each proposition leaves the missing middle untouched.

Responsibility is dispersed between courts, heads of jurisdiction, professional regulators, the Attorney-General and Parliament. Each has a legitimate but limited remit, and no institution owns the cumulative pattern or has a mandatory duty to convert repeated concerns into public systemic learning and corrective action.

The solution is a restrained investigative body limited to independent intake and triage; conduct and capacity investigation with procedural fairness; pattern aggregation and own-motion systemic review; de-identified public reporting; recommendations; and lawful referral. Its enabling legislation must expressly prohibit merits review, rehearing evidence, overturning or staying orders, directing judges, disciplining or removing judges, or exercising federal judicial power. Transparent appointments, specialist capability and mandatory institutional responses would provide the accountability currently absent while preserving Chapter III judicial independence.

Table 9.1 - IJIAC design elements

Design element	Proposed function or limit
Would	Receive and triage complaints independently; aggregate repeat patterns; examine conduct or capacity with procedural fairness; undertake own-motion systemic reviews; publish de-identified themes and recommendation status; refer serious matters through constitutional pathways.
Would not	Act as an appeal court; rehear evidence; overturn, vary or stay orders; direct a judge how to decide; exercise federal judicial power; or remove a judge outside section 72 of the Constitution.

Table 9.1 (continued) - IJIAC design elements

Design element	Proposed function or limit
Specialist capability	A family-violence and child-safety thematic review function with DFSV, child development, disability, culture, data and lived-experience expertise.
Governance safeguard	Judicial expertise without institutional control by the bodies reviewed; transparent appointment, procedural fairness, privacy and public-response duties.

9.3 Independent Rapid Child-Safety Review and Reassessment Panel

A statutory, trauma-informed Rapid Child-Safety Review and Reassessment Panel should convert credible new or escalating risk information into timely protection and, where an operative parenting order may need to change, a properly supported application to the authorised court. The Panel would not conduct merits review or administratively override an order. Its functions would be independent intake, specialist triage, evidence coordination, urgent safeguarding referral, assisted court return, follow-through and de-identified system learning.

Trigger. The pathway would be activated by credible information indicating a material new risk, escalation in known risk, serious deterioration in a child's safety, health, wellbeing, schooling or functioning, or significant evidence that was unavailable when the operative order was made. A child, parent, lawyer, doctor, school, police officer, child-protection agency or authorised service could refer a matter.

Composition and independence. The Panel should include expertise in family violence and coercive control, child development and trauma, child protection, disability, cultural safety, family law and evidence assessment, with protected lived-experience participation. No member should have participated in the original professional or decision-making chain. The Panel should be institutionally separate from the court registry, the original court-appointed professionals and IJIAC, while maintaining lawful referral arrangements with each.

Immediate protection and triage. Intake must never replace mandatory reporting or emergency intervention. Apparent acute risk should be referred to police, child protection or emergency services on the same day. Specialist multidisciplinary triage should occur within one business day for acute risk and within two business days otherwise, assessing novelty, credibility, escalation, immediacy, cumulative harm and the child's voice.

Evidence coordination. With consent or other lawful authority, the Panel should obtain the operative order, the material on which it was based and relevant new police, child-protection, health, school or service information. It should identify what is genuinely new, preserve safety-critical evidence, prevent unnecessary repetitive interviewing of the child and provide written triage reasons.

Assisted court return. Where the statutory threshold is met, the pathway should provide funded legal assistance to prepare the appropriate application, affidavit, risk notice and urgency request. Legislation or practice directions should establish expedited targets for judicial consideration, procedural fairness, written reasons and any necessary interim protection. Only the court may suspend, vary or discharge an order.

Follow-through and system learning. The pathway should record disposition, referrals, timeframes and the de-identified safety outcome, and test whether the intervention operated on time and reduced risk. De-identified trends should be supplied to IJIAC and the Domestic, Family and Sexual Violence Commission. Systemic concerns may support thematic review, but protected case material and the merits of individual orders remain subject to existing law.

Safeguards. The scheme must include child-safe participation, procedural fairness, written triage reasons, escalation and review rights, auditable timeframes, controls for bad-faith referrals that do not punish trauma or imperfect drafting, legal assistance, interpreters, disability access and secure remote participation.

9.3A Independent national family-law child-safety outcomes review

Australia cannot determine whether family-law reform has protected children without examining what happened after high-impact parenting decisions. Court activity, reasons for judgment, risk notices, professional reports and orders record processes and decisions; they do not establish whether the child subsequently became safer.

Commission an independent national review comprising: (a) a retrospective review of the past decade of parenting decisions concerning where a child lives, changes or transfers of primary residence, and relocation, in matters where domestic, family or sexual violence, coercive control, child abuse or child sexual abuse was alleged, notified, evidenced or found across the Federal Circuit and Family Court of Australia — Divisions 1 and 2 — and the Family

Court of Western Australia; and (b) a prospective longitudinal evaluation of decisions made following the 6 May 2024 family-law reforms.

The review must examine what risk information was available; how it was treated; which professionals and decision-makers exercised relevant functions; what protective or other orders followed; and what subsequently happened to the child. Outcomes must include subsequent reported violence or abuse, police and child-protection involvement, further proceedings, changes in living arrangements or contact, health, wellbeing, education and functioning, serious harm, self-harm, suicide and death where lawfully and ethically capable of analysis.

This is a systemic and outcomes review, not appellate or merits review. It would not overturn or re-determine individual parenting orders. Its purpose is to identify patterns in risk recognition, professional and judicial response, decision-making and subsequent child-safety outcomes, and to determine what reform, correction or further investigation is required.

A parenting decision cannot be evaluated solely by whether the proceeding was completed. The accountability question is whether the child was safer afterwards.

9.4 Specialist integrated family-safety court feasibility

A separately authored proposal by [REDACTED] recommends a Victorian pilot of a specialist family-safety court model. This submission supports a funded legal and constitutional feasibility study and independent pilot evaluation of integrated court models, with clear jurisdiction, child-safety, due-process, cultural-safety and outcome safeguards. The proposal should be assessed as an independent contribution and not represented as TEOU intellectual property.

9.4A Why incremental adjustment of the adversarial model is insufficient

The accountability gap is not produced only by missing complaint mechanisms. It is also produced by a design mismatch. The adversarial model is structured around opposing parties, competing narratives and episodic determination. Family violence and child-safety matters require cumulative pattern recognition, multidisciplinary expertise, safe evidence gathering, longitudinal review and the capacity to respond when risk changes after an order.

In this setting, ordinary procedural tools can become instruments of systems abuse. Repeated applications, subpoenas, aggressive cross-examination, delay and escalating legal costs may extend coercive control. Trauma may be misread as unreliability or instability; protective behaviour may be reframed as obstruction; and children's changing developmental and safety needs may be reduced to a fixed contest between adult positions.

Further training and specialist lists are valuable but cannot, by themselves, correct the underlying design. The Second Action Plan should support legal and constitutional development of a two-track family-justice model: a more formula-based, administratively supported property and financial pathway with anti-abuse safeguards and judicial determination where required; and a multidisciplinary, trauma-informed and investigative child-safety pathway with effective due-process safeguards, judicial authority where constitutionally required, continuing outcome review and rapid reassessment when credible evidence of deterioration emerges.

This is not a proposal to remove lawful judicial supervision or procedural fairness. It is a proposal to stop forcing financial division, coercive-control risk, child development and post-order safety through one adversarial architecture and then treating completion of proceedings as proof of safety.

9.5 Targeted Royal Commission and immediate implementation

Australia requires two connected tracks. First, reforms already supported by sufficient evidence must be implemented immediately. Second, a time-limited Royal Commission into femicide and systemic DFSV failures should use compulsory powers to obtain fragmented or withheld records, examine recurring cross-jurisdictional failure, system-enabled coercive control, misidentification, child-safety outcomes, deaths and serious harm, and identify effective remedies. Its recommendations must have named owners, deadlines and public implementation tracking, and its work must feed a permanent accountability architecture rather than another cycle of delay.

9.6 Outcome accountability for specialist family-law pathways

As at November 2024, the Federal Circuit and Family Court of Australia reported more than 17,000 Family DOORS Triage screens, 12,000 case-file reviews and 3,000 Evatt List placements. These figures demonstrate reach, not whether women and children became safer. Evatt admission depends on screening, Triage Counsellor review and

allocation by an Evatt Judicial Registrar; national reporting must therefore show who entered, who did not, why, and what outcome followed.

- Publish national outcomes for Lighthouse/Family DOORS Triage, Evatt and Magellan matters: referrals, acceptance and exclusion reasons, risk categories, interim and final parenting outcomes, residence transfers, contact arrangements, child-protection involvement and subsequent child and victim-survivor safety indicators.
- Implement the independent national family-law child-safety outcomes review in section 9.3A, including high-risk matters involving child sexual abuse, coercive control, family-violence orders, serious child-protection concerns, residence transfer and relocation. The central question must be: what happened to the child after the order?
- Require a written risk-to-order account showing how Notices of Risk, family-violence orders, police and child-protection material, child disclosures and other identified risks were translated into protective orders—or why the decision departed from them.
- Create an external complaint and systemic-review route where a specialist pathway identifies serious risk but the later process or outcome does not demonstrably protect the child or victim-survivor.
- Evaluate specialist pathways and coercive-control reforms independently, with lived-experience governance and post-order safety measures rather than Court self-reporting of throughput alone.

9.7 Immediate family-law safety reforms

The following safeguards should be progressed now, with detailed legislative and constitutional design, procedural fairness and an urgent implementation timetable.

Table 9.2 - Immediate family-law safety reforms

Immediate safeguard	Minimum action
Reform interim hearings	Ensure safety-critical interim decisions use the best available evidence, give proper weight to family-violence and child-protection concerns, and permit unacceptable risk to be identified on credible evidence without waiting for preventable harm.
Decision-making responsibility	Where a child primarily lives with a protective parent because of family violence or serious safety concerns, allocate decision-making responsibility so it cannot be used to continue coercive control or manufacture repeat litigation.
Recovery enforcement	Require an urgent child-safety triage before police enforce a recovery order where credible new DFSV or child-safety evidence has emerged; police should not be required to enforce contact blindly in the face of unresolved serious risk.
Unsafe orders and abrupt transfers	Create a rapid mechanism to pause and independently reassess parenting orders after serious new evidence or deterioration, and an expedited route to correct an unsafe placement or transfer where authorised review finds that safety has been compromised.
Therapeutic record privacy	Require strict necessity, proportionality and judicial control before subpoena or use of counselling, psychological or health records, protecting safety-seeking and therapeutic confidentiality while preserving lawful fair process.
Unsupported alienation claims	Do not permit a parental-alienation label or theory to substitute for evidence. Assess behaviour, context, coercive control, child safety and competing explanations before drawing conclusions about a child's resistance or a protective parent's conduct.
Child representation and ICL model	Independently review whether the Independent Children's Lawyer model requires fundamental redesign or replacement. Child representation must be accountable to the child's rights and safety and must not presume that a relationship with both parents is beneficial.
Legal costs and protective funding	Introduce a DFSV family-law legal-cost cap and protective funding scheme, with early scrutiny of abusive, vexatious or unnecessarily repetitive litigation. No parent should face financial ruin to pursue a child's safety.

9.8 National Court-Connected Child Evidence, Expert Accreditation and Accountability Scheme

Australia has professional registration or association oversight for some experts, but no operational, comprehensive national accreditation and regulatory system for the specialised family-law functions performed by

all Court Child Experts, Panel Family Consultants, private family report writers, single experts, psychologists, psychiatrists and social workers whose opinions materially influence parenting and child-safety decisions.

Appointment is not accreditation. Professional registration is not family-law expertise. A brief assessment may answer a narrow forensic question; it cannot erase a child's longitudinal record.

The *Family Law Amendment Act 2023* inserted Part IIIAA, sections 11H–11M, into the *Family Law Act 1975*. Section 11K authorises regulations dealing with standards, recognition, monitoring, complaints, training, a public register, suspension or cancellation and circumstances in which courts must not rely on reports by unrecognised writers. The current *Family Law Regulations 2024* do not establish that scheme.

The inquiry occurred. The consultation occurred. Parliament enacted the regulatory power. The regulations required to make that protection operational have not followed.

Establish a **National Court-Connected Child Evidence, Expert Accreditation and Accountability Scheme**, with the National Court-Connected Child Evidence and Expert Assurance Standard operating as its enforceable practice standard. Coverage should follow function and influence, not professional title, employer or contracting arrangement.

Minimum requirements are:

1. role-specific accreditation in family violence, coercive control, child sexual abuse, trauma psychology, child development and disclosure, disability, cultural safety, forensic method, family-law evidence, bias, systems abuse and longitudinal evidence;
2. a universal report schedule disclosing qualifications, accreditation, competencies, contact duration, participants, records reviewed and not reviewed, collateral sources, methods, conflicts, limitations and reasons for departing from longitudinal evidence;
3. an independent regulator and public register;
4. an accessible complaints pathway covering competence, methodology, ethics, bias, conflicts, factual error, report quality and compliance, without purporting to overturn judicial decisions;
5. urgent referral of credible child-safety deterioration;
6. risk-based and random audit, remediation, supervised practice, suspension and time-limited reaccreditation;
7. coordinated referral to Ahpra, National Boards, social-work and health-complaints bodies, legal regulators and court governance; and
8. privacy-protected analysis of recommendations, court reliance, complaints, corrections and longitudinal child-safety outcomes.

Assurance boundary: *Cross-examination tests evidence in one proceeding. It is not accreditation, professional regulation, complaints investigation or child-safety assurance.*

10. Inclusion, culture and human rights

10.1 First Nations self-determination

First Nations governance must be foundational rather than an add-on. The architecture should align with Our Ways – Strong Ways – Our Voices and Closing the Gap Outcome 13, recognise family and kinship structures, and be designed and governed with Aboriginal Community Controlled Organisations, First Nations women, children, Elders, legal services and data-sovereignty expertise. National comparability must not erase community authority or permit unsafe data extraction.

10.2 Migrant, refugee and transnational safety

Migrant and refugee women may experience immigration-related threats, language barriers, social isolation, financial abuse, dowry abuse, transnational family pressure, risks linked to documents or children overseas, and fear that seeking help will affect visa status or community standing. Research consistently identifies additional service barriers and the need for integrated, trauma-informed and community-led responses (AIFS 2018b; ANROWS 2016).

- Qualified independent interpreters and translated, accessible information at every decision point.
- Risk screening for visa, dowry, document, remittance, transnational child, overseas asset and extended-family abuse.
- Secure referral between DFSV, migration, family law, housing, financial counselling and consular or transnational legal services.
- Community-led prevention that does not transfer responsibility to community gatekeepers or expose victim-survivors.
- Disaggregated outcome data with small-cell and mosaic-identification safeguards.

Culture must never be treated as a defence to violence; equally, cultural difference must not be pathologised or used to misidentify victim-survivors. Children, relatives, community members and alleged perpetrators must not be used as interpreters. Specialist multicultural services require secure funding, while mainstream institutions remain responsible for culturally safe, legally fair and effective practice.

10.3 Disability, sexuality, location and life-course

Every mechanism should be disability-accessible and inclusive of LGBTIQ+ people, older women, young people, regional and remote communities, and people experiencing multiple forms of disadvantage. Supports must account for communication needs, dependence on carers, inaccessible housing, reproductive coercion, service scarcity, privacy in small communities, transport, digital exclusion and the higher burden created when systems require repeated proof.

10.4 International human-rights obligations, documented concerns and domestic implementation gaps

Australia's ratification of a treaty creates an international obligation, but in Australia's dualist legal system it does not, without implementing legislation, make every treaty right directly enforceable in domestic law. Statements of Compatibility and parliamentary scrutiny are important, but they do not provide a complete individual remedy.

The submission therefore calls for a comprehensive federal Human Rights Act that gives effective domestic legislative protection to relevant rights and obligations in the seven-core international human-rights treaties to which Australia is a party, supported by a national framework, review of family-law legislation and practice, public-authority duties, accessible complaints and remedies, independent monitoring, and measurable rights outcomes.

The reform should include a positive duty on Commonwealth public authorities and relevant contracted providers to act compatibly with protected rights and give proper consideration to rights; explicit protection for children's best interests, participation, safety and development; substantive equality and freedom from gender-based violence; non-discrimination; privacy and family life; fair process and effective remedy; and relevant health, housing and economic-security rights.

Courts and judicial functions require constitutionally appropriate treatment that protects decisional independence while addressing legislation, procedure, court administration, public-authority functions and court-connected

services. An audit and amendment program should cover the *Family Law Act 1975*, the FCFCOA framework, delegated legislation, administrative systems and professional standards.

The Human Rights Bill 2026, introduced by a private member on 25 May 2026, remained before the House of Representatives in the parliamentary record reviewed for this edition. The Parliamentary Joint Committee's 2024 inquiry and the Australian Human Rights Commission's Free & Equal model provide substantial reform foundations, but enactment and implementation remain matters for Parliament and government.

Treaty-to-accountability matrix

Treaty / rights engaged	Documented accountability concern	Controlled evidence language	Required domestic response
CRC arts 3, 9, 12, 19 and 24	Best interests, child participation, safety, health and contact decisions	The right is engaged; evidence may raise a risk of incompatibility. A violation is stated only where authoritatively found.	Child-centred duties, participation, safety reasons, review and effective remedy
CEDAW arts 2, 5 and 16; GR 35	Gender stereotyping, gender-neutral treatment of gender-based violence, economic inequality and access to justice	Use treaty-body concerns and evidence-led analysis; do not state that every decision privileges fathers' rights.	Substantive equality, due diligence, violence-aware decision-making and remedies
ICCPR arts 2, 7, 14, 17, 23, 24 and 26	Fair process, privacy, family life, child protection, equal protection and remedy	Individual claims of bias or unfairness require evidence and cannot be generalised automatically.	Fair-hearing safeguards, non-discrimination, complaint and judicial remedies
CAT art 16	Severe retraumatisation and state due-diligence concerns	May potentially engage CAT art 16 or ICCPR art 7; the legal threshold requires specialist analysis.	Independent investigation, prevention and effective remedy
ICESCR arts 10, 11 and 12	Family protection, housing, health and economic insecurity	Documented outcomes engage obligations; causation and breach require evidence.	Prevention, progressive realisation, non-discrimination and outcome measurement
CRPD	Disability access, freedom from violence, access to justice and children's rights	Assess intersectional barriers and required adjustments.	Accessible process, communication support, data and remedy
ICERD	Racial equality, effective protection and differential system outcomes	Disaggregate evidence safely and avoid stereotyping.	Culturally safe design, First Nations governance and effective protection

International recognition without domestic duties, enforceable remedies and measured implementation leaves the accountability gap intact.

PART IV — DELIVERY

11. National delivery architecture

The package requires distinct but connected functions. Final institutional form should be settled through legal and constitutional design. The essential requirement is that no function is omitted and no existing body is assumed to perform a task outside its authority.

11.0 What the First Action Plan established—and what remains unfinished

The First Action Plan translated prevention, early intervention, response, and recovery and healing into ten actions with shared government responsibility, governance, annual reporting and a promised performance framework. Material implementation occurred: the Domestic, Family and Sexual Violence Commission is operating and reporting to Parliament; an Outcomes Framework and Performance Measurement Plan have been published; the Activities Addendum has expanded; family-law parenting reforms commenced in May 2024; and court risk screening, information sharing and specialist case management have continued.

The unfinished work is equally material. Public reporting remains dominated by activities, availability and lifecycle status rather than linked evidence that risk recognition changed decisions or improved safety. National fidelity and outcome evidence for specialist pathways remain incomplete. No Commonwealth legislation establishing a standing federal judicial integrity and accountability institution was identified in the official sources reviewed as at 17 August 2026. No independent post-order child-safety outcome review consistently follows serious risk from disclosure through response, order and lived outcome. Cross-system complaint information remains fragmented, and recommendations still lack a single public register showing ownership, deadline, funding, implementation evidence and corrective action.

The Evidence of Us Systems Governance and Accountability Architecture™, defined in section 3 and translated into the eight national delivery functions in Table 11.1, directly answers those deficits. The implementation register creates ownership and public memory; shared risk and evidence standards reduce fragmentation; national risk-to-outcome data connect what was known with what happened; IJIAC fills the conduct-accountability gap without invading judicial power; rapid child-safety reassessment responds to credible post-order deterioration; professional assurance addresses court-connected roles; and permanent lived-experience governance tests whether implementation is safe and effective in practice.

Table 11.1 - Required national delivery functions

Required function	Minimum capability
1. Outcome and implementation control	Every action has an owner, funding source, deadline, outcome indicator, public-reporting duty and corrective-action trigger.
2. Public implementation register	One national view of accepted, partial, delayed, rejected and completed recommendations, with reasons and evidence of impact.
3. Shared risk and evidence standard	Common language for coercive control, pattern, cumulative harm, primary aggressor, child signals, uncertainty and decision reasoning.
4. Risk-to-outcome data	Privacy-protected linkage of risk, response, decision, service and longitudinal safety outcomes.
5. Independent review and complaint aggregation	Systemic pattern analysis across institutions, professional roles and complaints, with lawful referral and public response.
6. Rapid child-safety reassessment	Safe intake and prompt authorised reconsideration where serious new evidence or deterioration emerges.
7. Workforce and provider assurance	Competency assessment, accreditation where appropriate, audit, remediation and enforceable complaint pathways.
8. Lived-experience and community governance	Remunerated, safe and decision-relevant participation with attribution, consent, data governance and withdrawal protections.

11.0A National DFSV and Family-Safety Data Uplift and Risk-to-Outcome Infrastructure

National data uplift is safety infrastructure, not a secondary technical project. In 2026 it is unacceptable for governments, courts and publicly funded systems to recognise serious data gaps while continuing to make high-impact decisions without the infrastructure needed to test what was known, what was done and whether women and children became safer.

The Second Action Plan should establish a funded, time-bound national uplift spanning Commonwealth, state/territory and local government and the legislative, executive and judicial arms. It should cover police, child protection, health, education, housing, income support, child support, migration, taxation, legal assistance, courts and tribunals, DFSV services, ICL schemes, family consultants, Court Child Experts, single experts, report writers, psychologists, psychiatrists, contact services and other relevant providers.

Judicial data must be governed with heads of jurisdiction and court administrations, preserving decisional independence, privacy and publication restrictions. It must not create executive merits review, judge-level political ranking or identification of families.

Minimum program components are:

1. a national data-holdings and gap audit identifying datasets, legal authority, custodians, fields, linkage barriers, missing variables, retention and reporting gaps;
2. a common minimum dataset and dictionary covering risk signals, course of conduct, child disclosures and views, Notices of Risk, information sharing, specialist pathways, ICL and expert involvement, orders, residence changes, contact restrictions, protective action, complaints and later outcomes;
3. privacy-protected linkage connecting what was known, who held it, when it became available, what decision or action followed and what happened at six, 12 and 24 months, with First Nations data sovereignty;
4. aggregate judicial and professional decision analysis showing how family violence, child abuse, child views and linked-agency evidence affected decisions and safeguards;
5. national and jurisdictional outcome and equity reporting with small-cell and mosaic-identification protection;
6. public accountability for missingness, incompatible definitions, unlinked systems and non-reporting;
7. accredited independent research and evaluation access; and
8. a public implementation register naming milestones, owners, funding, legal barriers, first-report dates, unresolved gaps and corrective action.

The timetable should commence with the holdings and gap audit in the first 100 days, establish the minimum specification and baseline in Year 1, and publish the first linked risk-to-outcome report in Year 2.

Commissioning a review is not implementation. Accepting a recommendation is not proof that it was administered. Reporting activity is not proof that women and children became safer.

11.1 Five-year implementation pathway

Table 11.2 - Five-year implementation pathway

Timing	Delivery milestone
First 100 days	Name lead ministers and officials; establish a cross-portfolio delivery board; publish the initial recommendations register; preserve survey and lived-experience evidence; commence legal mapping and procurement design.
Year 1	Co-design standards and minimum data; establish baseline audits; develop the judicial commission exposure pathway; design child-safety reassessment and systems-abuse protocols; select pilots.
Years 2–3	Pilot child-safety, professional-assurance, shared-risk and integrated-service mechanisms; independently evaluate safety, culture, access, due process, unintended effects and cost.
Years 4–5	Scale proven mechanisms through legislation, regulations, court rules, accreditation, service contracts and intergovernmental agreements; publish annual outcomes and corrective plans.

Timing	Delivery milestone
Ongoing	Annual independent review; deeper two-year evaluation; corrective-action plan within 90 days where outcomes stall, worsen or remain unmeasured.

11.2 Governance safeguards

- Judicial independence: no administrative body may determine merits, vary orders or direct judicial decisions.
- Procedural fairness: affected institutions and professionals receive notice, an opportunity to respond and review appropriate to the function.
- Privacy and family-law publication restrictions: no public reporting identifies parties, children, witnesses or associated people.
- First Nations data sovereignty and community authority: governance and access rules are co-designed and enforceable.
- Lived-experience safety: participation is voluntary, remunerated, supported and never used as a substitute for implementation.
- Evidence integrity: sources retain provenance, status, limitations, disagreement and uncertainty.
- Correction: every adverse or null outcome has a named responsibility for review and response.

11.3 Lived-experience governance and systemic-harm reporting

Australia should establish a National Lived Experience Governance Framework defining lived-experience expertise and minimum standards for safe, paid and decision-relevant participation. It should protect consent, confidentiality, intellectual property and attribution; prevent tokenism, extraction and retraumatisation; and require visible influence over policy, practice, training, evaluation and reform.

A permanent structure should provide paid and diverse victim-survivor and child and young-person participation, including First Nations, CALD, disability, LGBTIQ+, regional, remote and migrant communities. Participants should have workplace-style protections, independent advice and access to collective representation so they can raise unsafe engagement or disagreement without retaliation or loss of future opportunity.

A safe national pathway should receive reports of systemic harm—not merely complaints about one professional—identify recurring patterns across police, child protection, legal services, family reports, contact services and courts, require a published response and escalate serious matters to independent review. Within The Evidence Cycle™, the operational sequence is: lived experience → evidence → independent review → corrective action → measured safety outcomes → public reporting → continuous reform.

11.4 Resourcing approach

The submission does not propose a final costing. Detailed costs depend on institutional form, data linkage, pilot sites, legislative design and the scale of service investment. The Second Action Plan should fund a design and pilot phase with independent evaluation, separate lived-experience participation funding, legal and privacy advice, First Nations governance, accessibility and technical data capability. Funding should be milestone-based but not so short-term that it prevents longitudinal outcome measurement.

Funded development and implementation pathway

The reforms proposed in this submission will require more than policy endorsement. Several supporting architectures, frameworks and methods identified by The Evidence of Us™ remain at concept stage and require properly resourced technical development, multidisciplinary co-design, independent validation, legal and ethical review, piloting, evaluation and implementation planning.

The Evidence of Us™ invites the Department of Social Services, the Domestic, Family and Sexual Violence Commission and relevant implementation partners to discuss an appropriately funded, staged development and pilot engagement. Any engagement would be separately scoped and contracted in accordance with applicable procurement, probity, value-for-money and public-accountability requirements. Further details are provided in TEOU Appendix 8.

12. Consolidated recommendations

The recommendations operate as one architecture. Indicative leads should be confirmed through intergovernmental and constitutional design. “DSS” includes National Plan governance partners; “AGD” means the Attorney-General’s Department.

Non-negotiable implementation rules

Table 12.1 - Non-negotiable implementation rules

Rule	Minimum requirement
Ownership	No action without a named owner, funding source, deadline, outcome measure and corrective-action trigger.
Evidence	No activity, tool, training or referral should be reported as success without fidelity and outcome evidence.
Participation	No lived-experience consultation should substitute for implementation, decision power, safe attribution or feedback.
Rights and culture	No national standard or dataset should proceed without First Nations governance, privacy, accessibility and cultural-safety controls.
Institutional limits	No complaint or review mechanism should be represented as an appeal or given powers it cannot lawfully exercise.
Urgency	No inquiry should delay reforms already supported by sufficient evidence.

Table 12.2 - Consolidated V5.1 recommendations

No.	Consolidated recommendation	Indicative lead	Timing
1	Make measurable safety, rights and verified conduct change an organising principle of every Second Action Plan action.	DSS / DFSV Commission	Immediate
2	Establish a permanent national DFSV systems-accountability function that complements existing institutions and compels correction.	Australian Government with states/territories	Design in Year 1
3	Adopt a National Cross-Sector DFSV Risk Identification, Assessment, Management and Response Model and a National Mandatory Reporting, Escalation and Response Model.	DSS / AGD / jurisdictions	100-day scoping; Year 1 design
4	Create shared risk, evidence, pattern and cumulative-harm standards covering the full course of abusive conduct and disclosure-process evidence.	DSS / AGD / jurisdictions	Year 1
5	Establish the National DFSV and Family-Safety Data Uplift and Risk-to-Outcome Infrastructure across all levels, arms and relevant providers.	DSS / DFSV Commission / ABS / AIHW / courts / jurisdictions	Audit in 100 days; first linked report Year 2
6	Implement the Child Safety Signal-to-Outcome Pathway™, rapid reassessment and a National Child Sexual Abuse Disclosure, Investigative Interview and Support Standard.	AGD / DSS / National Office for Child Safety / jurisdictions	Co-design Year 1; pilot Year 2
7	Establish a National Court-Connected Child Evidence, Expert Accreditation and Accountability Scheme, including regulations under s 11K and enforceable assurance standards.	AGD / Parliament / independent regulator	Exposure design Year 1
8	Design a constitutionally bounded Independent Federal Judicial Integrity and Accountability Commission for conduct, pattern analysis, referral and systemic reporting — not merits review.	AGD / Parliament	Exposure paper Year 1
9	Provide a lawful, independent Rapid Child-Safety Reassessment pathway for credible post-order deterioration and supported return to court.	AGD / jurisdictions / legal assistance bodies	Pilot-ready design Year 1
10	Establish permanent, paid lived-experience and First Nations governance with measurable influence over implementation, evaluation and correction.	DSS / DFSV Commission	Immediate
11	Enact a comprehensive federal Human Rights Act with public-authority duties, family-law audit, accessible remedies and measurable rights outcomes.	Parliament / AGD	Published legislative pathway

No.	Consolidated recommendation	Indicative lead	Timing
12	Commission an independent national family-law child-safety outcomes review: a retrospective decade review of parenting, residence-transfer and relocation decisions involving domestic, family or sexual violence, coercive control, child abuse or child sexual abuse across the Federal Circuit and Family Court of Australia — Divisions 1 and 2 — and the Family Court of Western Australia, together with a prospective post-6 May 2024 longitudinal evaluation.	AGD / independent evaluators / courts	Commence Year 1
13	Regulate and assure ICLs, family consultants, Court Child Experts, single experts and other influential child-facing professionals by function and competence.	AGD / regulator / professions	Year 1–2
14	Measure perpetrator conduct, tactic substitution, compliance, sustained behaviour change and victim-survivor and child safety across systems.	DSS / jurisdictions / service funders	Year 1 dataset
15	Create accessible remedy and restoration pathways where systems or orders failed to protect children and victim-survivors.	AGD / jurisdictions / legal assistance bodies	Design Year 1
16	Publish recommendation-by-recommendation implementation status, outcome evidence, responsible owners, deadlines and corrective action.	All responsible bodies	Continuous
17	Discuss an appropriately funded, non-exclusive TEOU development, validation and pilot engagement, subject to procurement and probity.	DSS / DFSV Commission / partners	Separate scoping

12.1 Minimum national outcome dashboard

Table 12.3 - Minimum national outcome dashboard

Domain	Minimum public measures
Delivery and ownership	Owner, funding, deadline, reach, implementation status and unresolved dependencies
Implementation fidelity	Whether the reform was used as designed, at the required quality and across relevant settings
Responsible-role and institutional conduct	Changes in decisions, risk identification, reasons, referrals, escalation, protective action, follow-up, compliance and correction by the people and bodies responsible.
Child disclosure and interviewing	Disclosure-to-interview time; interview purpose and number; adjustments; support; action after non-disclosure; child experience; audit and correction
Expert evidence	Accreditation, report audit, factual correction, complaints, remediation, suspension, reasons for departing from longitudinal evidence and later child outcomes
Judicial and professional decision evidence	Whether material safety signals, child views and linked-agency evidence affected reasons, safeguards and decisions, reported only in privacy-protected aggregate form
Family-law child-safety outcomes review	Decade review and post-6 May 2024 cohort: risk raised; professional and judicial response; residence transfer or relocation; protective action; police and child-protection involvement; further proceedings; and child safety, health, education and functioning at six, 12 and 24 months.
Safety and rights outcomes	Repeat harm, post-order deterioration, child wellbeing, health, housing, economic security, access, remedy and rights-compatible decisions at six, 12 and 24 months
Perpetrator behaviour	Repetition, tactic substitution, escalation, compliance and independently verified sustained behaviour change
Data quality	Coverage, missingness, incompatible definitions, linkage, timeliness and corrective action
Equity	Results for First Nations, CALD, disability, LGBTIQ+, regional and remote cohorts with safe suppression controls
Sustainability	Whether conduct and outcome improvements persist beyond initial rollout

CORRECTIVE-ACTION TRIGGER Where an indicator shows no improvement, worsening harm or an inability to measure the intended outcome, the responsible body should publish a corrective-action plan within 90 days.

CONCLUSION

From recognition to measurable safety

Taken together, the evidence reveals more than a collection of service gaps. It documents an entrenched national governance and accountability failure with consequences that include continuing violence, profound psychological injury, homelessness, family separation, suicidality, suicide, femicide and the murder of women and children.

Women must not disappear within the generic language of “victim-survivors”, and children must not be treated merely as witnesses to violence against an adult. Women, children and young people are harmed in their own right. Some are murdered. Some die by suicide after prolonged abuse, coercive control, sexual violence, post-separation abuse, institutional disbelief or repeated unsuccessful attempts to obtain protection. Children lose mothers; mothers lose children; and surviving families carry lifelong harm.

Causation and individual responsibility for any death must be determined through proper investigation. The demonstrated relationship between DFSV, cumulative trauma and suicidality and repeated evidence of missed opportunities for intervention cannot be minimised. Governments cannot claim to understand preventable harm while DFSV-related homicide and suicide, and deaths following contact with multiple systems, are not consistently identified, linked, reviewed and publicly reported.

Serious risk can intensify after separation and at the intersection of family law, child protection, policing, health, education, housing and economic-security systems. Family law cannot remain outside the national DFSV accountability framework. Judicial officers, Independent Children’s Lawyers, family consultants, report writers, psychiatrists, psychologists, family therapists, contact-service practitioners and other court-appointed or court-relied-upon professionals can profoundly shape the safety, liberty, family relationships and future wellbeing of women and children.

Those roles require enforceable standards, demonstrated DFSV and child-safety competency, transparent appointment, evidentiary discipline, conflict-of-interest safeguards, accessible complaints, independent investigation and meaningful consequences for unsafe or professionally deficient practice. Judicial independence protects impartial decision-making; it must not be used as a barrier to transparency, institutional learning or accountability for systemic safety outcomes.

Legislative amendments, government responses, funding announcements, training and new programs matter, but they do not establish that people became safer. Activity is not implementation. Referral is not protection. A court order is not evidence of safety. A closed complaint is not evidence that no professional or institutional failure occurred.

Australia has decades of inquiries, research, lived-experience evidence and reform recommendations, together with tested child-and youth-specific models that show measurable benefits. Yet implementation remains fragmented, access unequal, professional oversight inconsistent and the outcomes of high-impact institutional decisions largely hidden.

The condition of the system must be brought into the open: who knew, what action was taken, what decisions were made, whose evidence was accepted or rejected, whether risk increased after intervention, and what happened to the women and children affected. Where a woman or child is murdered, dies by suicide, suffers serious harm or is returned to continuing danger after seeking help or entering a government or court system, the outcome must trigger independent cross-system review and enforceable corrective action.

Australia does not have a knowledge deficit. It has an implementation, measurement, professional-accountability and governance deficit—and women and children are carrying the harm, sometimes with their lives.

Measure. Review. Reform.™

TEOU APPENDIX 1

About the Co-Authors and Independent Specialist Proposal Attribution

Standing, expertise, contribution and intellectual attribution

Purpose of this appendix

This appendix records the standing and complementary contributions of the two co-authors and the separate source of a specialist family-safety court proposal. The named profiles ensure that lived-experience, professional and intellectual work remains connected to the people who developed it.

The profiles exclude raw evidence, private contact information and identifying family-law details. They establish authorship and expertise without asking the Department to determine any individual matter.

Preferred citation

Jayatileka, D. and Butcher, S. (2026). The Evidence of Us™ submission to the Second Action Plan consultation. The Evidence of Us™.

Co-Author | Founder, The Evidence of Us™ | Writer | Speaker | Lived Experience Expert | Governance & Systems Accountability Advocate

MsC (International Business), BBA, DipFP, CSPO, is the Founder of **The Evidence of Us™** and the voice of **#dhanushislivedexperience**. She is a writer, speaker, lived-experience expert and governance and systems accountability advocate working across domestic, family and sexual violence, family law, child protection, institutional accountability, economic abuse and the experiences of culturally and linguistically diverse women and children.

Dhanushi brings a 25-year corporate career across three continents, including 16 years in Australian banking and financial services with the Westpac Group, Commonwealth Bank and ANZ. Her work spans project, product and process management, regulatory transformation, governance, risk, compliance, controls and continuous improvement.

Her advocacy is grounded in lived experience of domestic and family violence, post-separation abuse and fragmented responses across family law and associated safety systems. She applies formal governance disciplines to test whether policy commitments produce measurable safety, accountability and correction.

Dhanushi conceived, developed and authored The Evidence of Us Systems Governance and Accountability Architecture™ and related TEOU methodologies. She led this submission's structure, integrated drafting, cross-system evidence synthesis, accountability architecture and reform recommendations.

Co-Author | Founder, Ancestral Echoes Collective | Independent Lived-Experience Researcher | Systems Accountability Analyst

is the Founder of Ancestral Echoes Collective, and voice of **#ausinosparamas**, an independent lived-experience researcher, writer and systems accountability analyst specialising in domestic, family and post-separation abuse within legal and institutional systems.

Stephanie brings more than 25 years of experience working in and around courts and legal services in Western Australia. Her professional background includes service as an Associate in the Federal Court of Australia, legal transcription across courts, tribunals and police interviews, and legal administration, providing operational knowledge of court procedure, evidence handling and the gap between formal safeguards and real-world outcomes.

Her research focuses on the disconnect between recognised risk, policy intent and the safety outcomes experienced by women and children. She developed the foundational family-law accountability-gap work and created and stewards the **Every Voice Matters Survey™**, a national lived-experience evidence stream.

Stephanie contributed independently developed source documents, survey evidence, legal and institutional analysis, family-law accountability work, policy pathways and substantive review. She is joint co-author; her Every Voice Matters Survey™, associated evidence and pre-existing research remain separately attributed.

Independent source attribution — specialist family-safety court proposal

is acknowledged as the independent author of the specialist family-safety court proposal referenced in this submission. This records provenance only; no additional personal credentials are asserted in this public edition.

The present submission attributes the specialist proposal to . She is acknowledged as the source of that proposal only. No reusable instrument or detailed implementation toolkit from her independent work is reproduced here.

Attribution safeguard

Joint authorship applies to this TEOU submission only. It does not assign joint authorship or ownership of any pre-existing framework, methodology, survey, dataset, research stream or specialist proposal incorporated or referenced within it. Each independently developed body of work remains attributed to its originator.

attribution does not imply organisational membership, co-authorship, assignment of intellectual property, endorsement of every recommendation, or shared ownership of TEOU™, TEOU methodologies, the Every Voice Matters Survey™, or any other independently developed source material.

Participation in consultations, source discussions, roundtables or evidence exchanges does not imply organisational membership, co-authorship, endorsement, licensing rights or transfer of intellectual property unless expressly agreed in writing.

Associated documents and preferred citations

Main TEOU submission: Jayatileka, D. and Butcher, S. (2026), *From Recognition to Measurable Safety: A national systems-governance and accountability proposal for the Second Action Plan*, The Evidence of Us™.

Companion public DSS package: Butcher, S. and Jayatileka, D. (respective attributed contributions) (2026), *From Recognition to Measurable Safety: Completing the Accountability Chain in the Second Action Plan*, DSS V2.1 post-lodgement author-reviewed edition, The Evidence of Us™, 18 August 2026.

TEOU APPENDIX 2

Every Voice Matters Survey™: method and publication controls

Table A2.1 - Every Voice Matters method and publication controls

Control	Position
Survey identity	Every Voice Matters Survey™—a national family-court lived-experience survey.
Creator and data custodian	[REDACTED]
Valid closed response count	219 timestamped responses; one additional spreadsheet row was blank and untimestamped.
Sample	Voluntary, anonymous, self-selected and non-probability; not population-representative.
Verification	Responses were not routinely matched to court or agency records.
Causation	Cross-sectional and retrospective; reported patterns do not establish causation.
Question denominators	Usually 213–217; each published figure must state its own base.
Raw data	Restricted and not annexed. No raw free text or identifying material is included.
Current use	Limited preliminary descriptive counts only. Cross-variable findings remain subject to controlled cleaning, denominator checks and owner approval.
Re-use	No permission is implied to copy, adapt, republish or analyse the survey instrument or raw data outside agreed governance.

The survey's value in this submission is as an early-warning and question-generating evidence source. Its recurring reports should guide independent file audit, administrative data design and properly funded research. Preliminary results may change if final controlled quality assurance identifies denominator or coding issues.

Controlled qualitative evidence note

A preliminary keyword-assisted and manual review identified a small set of valid responses that unambiguously reported child sexual-abuse concerns or disclosures after ambiguous references were excluded. Recurring reported themes concerned minimisation or reframing of disclosure; failure to connect the child's words, behaviour and records; absence of protective response; and brief interviews that did not recreate relational conditions of prior disclosure. No numeric thematic statement is authorised for external release until a reproducible coding protocol, exclusions, question-specific denominators, survey-owner approval and co-author sign-off are complete. No raw free text is reproduced.

TEOU APPENDIX 3

De-identified DFSV system-issue map

Table A3.1 - De-identified DFSV system-issue map

System domain	Recurring de-identified issue
Risk identification	Inconsistent screening; coercive control reframed as conflict; victim–perpetrator misidentification; thresholds differ across systems.
Children	Disclosures, fear and somatic distress are fragmented; no independent voice-to-action route; contact compliance replaces safety review.
Family-law procedure	Repeated litigation, coerced consent, unequal enforcement and unaffordable correction extend control or silence new safety evidence.
Experts and providers	Qualifications, methods, conflicts, factual correction, records, fees, audit and complaints lack transparent national assurance.
Health and education	Trauma is pathologised; disclosure can be chilled by record use; school and health observations may not reach decision-makers in context.
Police and child protection	Relevant information and risk assessments are not reconciled with federal parenting decisions; responsibility moves between jurisdictions.
Economic and social harm	Legal cost, supervised-contact fees, loss of work, debt and housing instability compound violence and restrict review rights.
Complaints and remedies	Processes are fragmented, remit-limited and redirect rather than resolve; no body owns the cumulative outcome.
Data and sentinel events	National data rarely link risk to decisions and later outcomes, including serious deterioration, self-harm or suicide-related signals.
Intersectionality	Disability, culture, language, visa status, First Nations experiences, sexuality, age and location alter both risk and access.
Lived-experience governance	Unsafe consultation, unclear consent, missing attribution and extraction without feedback can reproduce institutional power.

This map summarises reported issues across the qualitative source set. It is not a prevalence estimate. Each domain should be tested through linked administrative data, file audit, judgment analysis, professional record review and survivor-safe independent research.

V5.1 child-safety system-map additions

The Children and Police/child-protection rows must include disclosure continuity, investigative-interview fidelity, action after non-disclosure, therapeutic continuity, follow-up and linked child outcomes. The court-connected professional row must include role clarity, contact duration, longitudinal evidence, factual correction, accreditation, complaints, audit and corrective action.

TEOU APPENDIX 4

The accountability test for every Second Action Plan action

1. What precisely is the harm, risk or implementation failure?
2. What evidence and prior government commitment already recognise it?
3. What mechanism is meant to respond?
4. Which institution and which responsible role own implementation, decision-making and cross-system coordination?
5. What decisions, actions, conduct or professional practice must change, and who is responsible for that change?
6. What outcome is the mechanism designed to produce?
7. What data will demonstrate delivery, conduct change and safety/rights outcomes — and for whom?
8. When and how will results be published?
9. What independent body will review implementation fidelity, conduct and outcomes?
10. Who is responsible for review and correction where implementation, conduct or outcomes fail, and what remedy is available?

This appendix should be read with the three-gate Policy-to-Practice-to-Safety Accountability Test™ in section 3.2.

TEOU APPENDIX 5

Family law legislative, inquiry and implementation chronology (1975–2026)

TEOU Appendix 5 demonstrates the policy failure loop. Material action occurred and must be acknowledged. The recurring failure is that recommendations were often only partly accepted, dispersed across separate initiatives, left without one public owner or deadline, or not followed by recommendation-by-recommendation implementation and outcome evidence.

Commissioning a review is not implementation. Accepting a recommendation is not proof that it was administered. Reporting activity is not proof that women and children became safer.

Part A — Legislative and institutional reform timeline (1975–2026)

Table A5.1A - Family-law legislative and institutional reform timeline

Year / reform	Verified legal or structural change	Implementation and outcome evidence	Rights engaged and accountability question
1975 — <i>Family Law Act 1975</i>	Established the federal family-law framework; commenced in 1976.	Enactment created the jurisdiction; later evidence and amendments show continuing safety, participation and systems-integration challenges.	Present-day relevance includes child best interests, safety, participation, equality, privacy, family life, fair process and remedy. This does not imply every later treaty obligation was enforceable in 1975. Were safety and rights protected in practice?
1991 — <i>Family Law Amendment Act 1991</i>	Inserted the then Division 12A child-abuse allegation notice and notification machinery; numbering later changed.	Formal notice machinery is not outcome evidence. Audit whether notices produced timely information, protective action and safer outcomes.	CRC arts 3, 12 and 19 are now relevant to best interests, voice and protection. Did notification lead to protection?
1995 — <i>Family Law Reform Act 1995</i>	Reframed parenting concepts and implemented substantial elements of the ALRC's complex-contact work.	Implementation occurred; later reviews continued to identify violence-screening, child-participation and safe-contact gaps.	Best interests, participation, safety and effective remedy. Did the reforms improve safety?
2006 — shared-parental-responsibility reforms	Changed parenting law and created a stronger shared-parenting framework.	Subsequent evaluation identified confusion and safety concerns; activity and legal change did not establish safer outcomes.	Child safety, gender equality, fair process and family life. Did the framework operate safely?
2011–2012 — family-violence amendments	Expanded family-violence and abuse definitions and safety emphasis.	AIFS later found greater emphasis but inconsistent screening and professional response.	Due diligence, child protection and substantive equality. Did stronger laws change decisions and outcomes?
2017 — House inquiry	<i>A Better Family Law System</i> recommended national risk assessment, earlier violence determination, information sharing, professional regulation and safer processes.	Mixed and partial implementation across later measures; no single integrated accountability chain.	Safety, child participation, equality and remedy. Which recommendations were implemented?
2018 — cross-examination Act	Prohibited direct personal cross-examination in specified family-violence circumstances and created a legal-aid pathway.	Important procedural protection; access, coverage, timeliness and outcome effects require continuing evaluation.	Fair process, safety and access to justice. Was the protection accessible and effective?
2019 — ALRC Report 135	Recommended broad structural reform, including mandatory national accreditation for private family report writers.	Selected recommendations progressed. The full blueprint was not adopted as one integrated program.	Child safety, competence, accountability and remedy. What was implemented—and what remains?
2021 — FCFCOA structure	The FCFCOA commenced on 1 September 2021 under one administrative structure, retaining Divisions 1 and 2.	A 2025 review recorded positive and critical practitioner views; safety, specialisation, timeliness and access outcomes require transparent evaluation.	Access to justice, fair process, safety and effective remedy. Did restructuring improve or worsen safety and access?
2022 — Hague family-violence amendment	Clarified that family-violence risk may be considered under the grave-risk exception and strengthened protective-condition powers.	Family violence was expressly recognised, but consideration remained discretionary and non-return was not automatic.	Child safety, protection from violence and family life. Did the amendment change judicial practice and prevent unsafe returns where family violence was raised?

Year / reform	Verified legal or structural change	Implementation and outcome evidence	Rights engaged and accountability question
2023 Acts / 6 May 2024 commencement	Acts Nos 87 and 88 of 2023 simplified best-interests factors, removed the equal-shared-parental-responsibility presumption and strengthened information sharing.	Training and implementation activity is reported; no published national evaluation yet demonstrates changed reasoning and longitudinal child-safety outcomes.	Child best interests, safety, participation, equality and privacy. Did legislative change alter practice and safety?
2023 — Part IIIAA, ss 11H–11M	Parliament created power for family-report-writer standards, recognition, monitoring, complaints, training, public registration and enforcement.	The current <i>Family Law Regulations 2024</i> do not activate a comprehensive scheme.	Competence, child safety, procedural fairness and remedy. Why is the regulatory scheme not yet operational?
2024 Act / 10 June 2025 commencement	Family Law Amendment Act 2024 (No. 118 of 2024) introduced further reforms, including protected confidences and an enabling framework for the later regulation and accreditation of children's contact services.	The framework is not a complete operational national accreditation scheme. Operation depends on Accreditation Rules and related implementation. The Attorney-General's Department states that the post-consultation impact analysis is to be completed.	Privacy, child safety, participation, service quality and effective complaint and review pathways. When will accreditation operate in practice?
2025–2026 — continuing accountability gap	Existing appeal, internal complaint, reconsideration and constitutional mechanisms remain. No Commonwealth legislation establishing a standing federal judicial commission was identified in the official sources reviewed as at 17 August 2026.	Outcome evidence remains fragmented. Regulatory, judicial-integrity and post-order child-safety proposals remain to be designed, legislated or implemented through the appropriate lawful processes.	Judicial independence must coexist with conduct integrity, systemic review and effective remedy. Who independently reviews conduct and outcomes?

Part B — Evidence, inquiry and implementation chronology (1995–2026)

The detailed 1995–2026 source-by-source implementation chronology remains in the internal evidence and change-control record and is not reproduced in this public edition. This avoids publishing unverified recommendation-by-recommendation status labels or numeric implementation conclusions. The verified legislative and institutional chronology above is sufficient for the public policy proposition that enactment, activity and review must be distinguished from completed implementation and measured safety outcomes.

The family-report-writer implementation gap

The 2019 ALRC recommendation, 2021–2023 consultation and the statutory authority in section 11K form a direct example of the policy-failure loop. Section 11K permits regulations dealing with recognition, monitoring, complaints, training, publication, suspension, cancellation and consequences for family report writers. As at 17 August 2026, no comprehensive activating instrument was identified among the current Family Law instruments on the Federal Register of Legislation. The public position should therefore be described as legislative authority without a completed operational national scheme, not as an existing accreditation system.

TEOU APPENDIX 6

Principal references

- Australian Bureau of Statistics (ABS) 2023, *Personal Safety, Australia, 2021–22*. [Access source](#)
- Australian Government 2022, *National Plan to End Violence against Women and Children 2022–2032*. [Access source](#)
- Australian Government 2025, *Response to the House of Representatives Standing Committee report: Inquiry into Family Violence Orders*, especially Recommendation 10. [Access source](#)
- Australian Human Rights Commission 2023, *Revitalising Australia's Commitment to Human Rights: Free & Equal Final Report 2023*, Recommendations 3 and 7. [Access source](#)
- Australian Institute of Family Studies (AIFS) 2018a, *Children and young people in separated families: Family law system experiences and needs*. [Access source](#)
- Australian Institute of Family Studies (AIFS) 2018b, *Intimate partner violence in Australian refugee communities*. [Access source](#)
- Australian Institute of Family Studies (AIFS) 2023, *Coercive Control Literature Review*. [Access source](#)
- Australian Institute of Family Studies (AIFS) 2026, *Children's support needs following parental separation*. [Access source](#)
- Australian Institute of Health and Welfare (AIHW) 2026, *Family, domestic and sexual violence*. [Access source](#)
- Australian Law Reform Commission 2019, *Family Law for the Future: An Inquiry into the Family Law System*, Report 135. [Access source](#)
- Australian Law Reform Commission 2021, *Without Fear or Favour: Judicial Impartiality and the Law on Bias*, Report 138. [Access source](#)
- Australia's National Research Organisation for Women's Safety (ANROWS) 2016, *Promoting community-led responses to violence against immigrant and refugee women: ASPIRE final report*. [Access source](#)
- Australia's National Research Organisation for Women's Safety (ANROWS) 2018, *National Risk Assessment Principles for family and domestic violence*. [Access source](#)
- Attorney-General's Department 2023, *Scoping the Establishment of a Federal Judicial Commission: Discussion Paper*, especially pp. 17–24. [Access source](#)
- Attorney-General's Department 2025, *Family Law Council: Protecting victims of family violence, including children—disincentives to disclosure and systems abuse*. [Access source](#)
- Attorney-General's Department 2026, *Family Law Information Sharing*. [Access source](#)
- Center on the Developing Child at Harvard University, *Toxic Stress*. [Access source](#)
- Department of Social Services and ANROWS 2026, *Evidence to action: informing direction for the Second Action Plan*, especially pp. 7–10 and 43–50. [Access source](#)
- Department of Social Services 2026, *Consultation on the Second Action Plan—Formal submissions*. [Access source](#)
- Domestic, Family and Sexual Violence Commission 2025, *Yearly Report to Parliament 2025*. [Access source](#)
- Domestic, Family and Sexual Violence Commission 2026a, *Monitoring and Reporting Framework*, especially pp. 6 and 16–17. [Access source](#)
- Domestic, Family and Sexual Violence Commission 2026b, *Children and Young People Roundtable Summary Report*. [Access source](#)
- *Family Law Act 1975* (Cth), current compilation, especially ss 60CA–60CG, 67ZBB–67ZBE and 68LA. [Access source](#)
- Federal Circuit and Family Court of Australia 2023, *Family Violence Plan*. [Access source](#)

- Federal Circuit and Family Court of Australia, *Family Violence Best Practice Principles*, current edition. [Access source](#)
- Federal Circuit and Family Court of Australia, *Guidelines for Independent Children's Lawyers*. [Access source](#)
- Federal Circuit and Family Court of Australia 2024, *Two years of Lighthouse*. [Access source](#)

Attorney-General's Department 2026, Children's Contact Services Reform. [Access source](#)

National Office for Child Safety 2026, Practice guide for workers and organisations. [Access source](#)

Victorian Government 2026, Multi-Agency Risk Assessment and Management Framework. [Access source](#)

Victorian Government 2026, Mandatory minimum qualifications for specialist family violence response roles. [Access source](#)

Safe & Together Institute 2026, Core Training and Trainer Certification Program. [Access source](#)

Parliament of Australia 2026, Human Rights Bill 2026 — bills before the House of Representatives. [Access source](#)

- Joint Select Committee on Australia's Family Law System 2021, *Second Interim Report*, Recommendation 15. [Access source](#)
- National Child Traumatic Stress Network 2016, *Children with Traumatic Separation: Information for Professionals*, pp. 1–4. [Access source](#)
- Royal Commission into Domestic, Family and Sexual Violence (South Australia) 2025, *With Courage*, especially Recommendations 14–20 and 39. [Access source](#)

Internal evidence sources used under restricted governance

Every Voice Matters Survey™: controlled production instructions, direct descriptive counts and denominator notes (July 2026). Raw

data not attached.

De-identified qualitative evidence review of 11 supplied documents, approximately 95,000 words (July 2026). Source documents not

attached.

Family-law lived-experience roundtable: anonymised issues, solutions and recommendations extraction (29 July 2026). No

attributable quotations used.

██████████ The Evidence of Us introduction and development roadmap and related systems-governance working papers (July 2026).

██████████, National Specialist Family Safety Court—Victorian Pilot proposal, version 0.4 (independently authored contribution, July 2026).

A6.2 Historical V4.1 lodged-edition control

This table reproduces the author-confirmed control status and DSS Engage selections for the immutable V4.1 lodged edition; it is not the V5.1 current-edition control record.

Table A6.1 – Historical V4.1 lodged-edition control

Field	Value
Title	From Recognition to Measurable Safety
Version	4.1
Date	31 July 2026
Co-authored by	██████████
Status	Final submission document for formal DSS lodgement

Field	Value
Privacy	Aggregated and de-identified; restricted source material not annexed
Contact	Supplied through the DSS Engage portal
Publication	Approved for public disclosure subject to DSS privacy and moderation processes; restricted evidence and raw data are not annexed
Lodgement capacity	I'm responding as an organisation
Organisation represented	The Evidence of Us™
Publication consent	I agree for my submission to be disclosed to the public
AI-processing consent	I do not consent to the use of AI tools to process information I submit

Trade mark and intellectual-property control: The Evidence of Us Systems Governance and Accountability Architecture™, The Evidence of Us Framework™, The Evidence Cycle™, Pattern Recognition and Cumulative Harm Principle™, The Evidence of Us Child Safety Signal-to-Outcome Pathway™ and Measure. Review. Reform.™ were developed by and are attributed to [REDACTED] Every Voice Matters Survey™ was created by and is stewarded by [REDACTED] Generic public-policy proposals remain unmarked. Independently developed source material retains its separate authorship and ownership.

TEOU APPENDIX 7

Public Version History and Post-Lodgement Change Register

Table A7.1 - Public version history

Version	Date	Status	Material change
V4.1	31 July 2026	Immutable lodged edition	Formal TEOU submission lodged through the DSS consultation process
V5.0	11 August 2026	Controlled-review, post-lodgement author-reviewed and expanded edition	Incorporates author-approved PLR-01–PLR-09 changes; does not retrospectively alter the lodged V4.1 file
V5.1	17 August 2026	Current author-approved revised and superseding edition; prepared for resubmission, with DSS confirmation pending	Incorporates PLR-10 finalisation: supersession status; confirmed DSS portal selections; TEOU unincorporated-status and rights-holder corrections; public-policy and IP controls; Section 8 workforce rebuild; children's contact-services legal correction; removal of gated public case material; Appendix 5 verification control; and final pagination, TOC and release formatting. It also makes accountable human action explicit; establishes the independent national family-law child-safety outcomes review; strengthens the outcome dashboard; and aligns the Appendix 4 accountability questions.

Material V5.1 changes include: prospective supersession and public-release controls; confirmed DSS Engage selections; correction of TEOU's unincorporated legal status and rights-holder language; a strengthened limited submission permission and reservation-of-rights framework; the whole-of-system Section 8 workforce accreditation, competency and accountability model; accurate treatment of the children's contact-services enabling framework; removal of public material that remained source-authorisation-gated; explicit accountable-human-action and responsibility tracing; an independent national family-law child-safety outcomes review; strengthened outcome and accountability questions; and final document-control, contents, pagination and formatting corrections.

Companion alignment note — 18 August 2026: The companion public DSS package was issued as DSS V2.1 — Post-Lodgement Author-Reviewed Edition and aligned to the final TEOU V5.1 section and page locations; no material policy change was made. The detailed TEOU and DSS Post-Lodgement Author Review and Consolidated Change Register V1.2 — 18 August 2026 remains a separate internal controlled record and also records the V5.1 author decisions because no separate decision-log document was supplied.

TEOU APPENDIX 8

Capability, Commissioning and Funded Development Proposal

Purpose

This submission identifies The Evidence of Us™ architectures, frameworks, pathways, principles, tests and methods intended to support implementation of national accountability reform. Assets recorded as concept stage are developed intellectual propositions and structured directions for further work. They are not represented as fully validated, accredited, tested or operational products.

TEOU seeks the opportunity to develop these assets through appropriately funded consultancy, commissioned research, co-design, validation, piloting, implementation support and evaluation with DSS, the DFSV Commission and relevant government, academic, professional, First Nations, community and lived-experience partners.

Proposed staged engagement

1. **Scope, provenance and requirements definition:** confirm the policy problem, intended users, operating environments, provenance, evidence and implementation requirements.
2. **Technical development and multidisciplinary co-design:** develop operating models, definitions, decision pathways, governance, data specifications, implementation tools and safeguards.
3. **Independent validation and assurance:** obtain independent research, legal, human-rights, child-safety, cultural-safety, privacy, data-governance, professional-practice and implementation review. TEOU self-assessment would not be presented as independent validation.
4. **Pilot design and readiness:** select settings, establish governance and ethics, define baselines and outcomes, train participants and establish fidelity and corrective-action mechanisms.
5. **Pilot delivery and independent evaluation:** test whether the asset changes professional and institutional conduct and improves safety, rights, access and equity.
6. **Implementation, capability transfer and continuous improvement:** refine the assets and develop controlled training, licensing, assurance, audit and improvement arrangements.

Each commissioned work package should have a defined scope and success criteria, deliverables, milestones, decision authority, budget, evidence standard, outcome measures and publication arrangements.

Public-policy independence

The Evidence of Us™ supports lawful public consideration of the systemic problems and reform objectives identified in this submission. Submission for policy consideration does not constitute an assignment, licence, waiver, dedication to the public domain or authorisation to reproduce, adapt, operationalise, commission, commercialise or represent as independently developed any protected TEOU-originating material, distinctive architecture, framework, model, method, implementation design, technical specification, terminology, training content or confidential know-how. Government may develop public policy through lawful processes. Where implementation would substantially reproduce, adapt, incorporate or use a Reserved Asset, the parties should first determine provenance, rights-holder, development status and permitted use through a separate written agreement. Nothing here asserts ownership over general facts, law, public-domain material or ideas incapable of protection. The relevant rights holders reserve all rights not expressly granted in writing; no implied licence is granted.

Intellectual property and attribution

Receipt, consideration or publication of this submission does not transfer copyright, trademarks, confidential know-how, data, technical materials or independently created contributor intellectual property. Future engagement must separately identify background and project intellectual property, government-use rights, sublicensing, publication, confidentiality, attribution, moral rights, branding, reserved materials, commercialisation and protection of lived-experience evidence.

Procurement and partnership status

This appendix is an invitation to discuss a possible funded pathway. It is not a tender response, quotation, government commitment, request for exemption from competitive procurement or assertion of entitlement to public funding. Any engagement remains subject to priorities, funding, legal authority, due diligence, supplier capacity and applicable Commonwealth procurement or grants requirements.

TEOU invites government to invest in the structured development, independent validation and authorised, quality-assured implementation of TEOU-originating development-stage assets designed to translate recognised policy needs into accountable system design.

Table A8.1 - TEOU Frameworks, Models and Methods Register

Asset name	Category	Creator / rights-holder	First documented use	Development status	Public-policy function	Relationship	Evidence / validation	Public disclosure boundary	Further work	Mark status	Licensing position
The Evidence of Us Systems Governance and Accountability Architecture™	Architecture	██████████ developed and used under The Evidence of Us™ name	V4.1 and earlier controlled development	Concept stage	Connect responsibility, evidence, outcomes, review and correction	Master architecture	Policy logic developed; independent validation pending	Strategic architecture public; implementation specifications reserved	Co-design, legal/data design, pilot and evaluation	™ claimed; clearance pending	Written agreement required for operational use or implementation of reserved assets; trademark use separately controlled.
The Evidence Cycle™	Framework/cycle	██████████ developed and used under The Evidence of Us™ name	Pre-existing TEOU work; V4.1	Developed concept	Seven-stage evidence-to-reform cycle	Accountability spine	Policy application developed; validation pending	High-level seven-stage structure public; detailed methodology, instruments and implementation tools reserved	Measures, governance, pilot and audit	™ claimed; clearance pending	Written agreement required for operational use or implementation of reserved assets; trademark use separately controlled.
Pattern Recognition and Cumulative Harm Principle™	Principle	██████████ developed and used under The Evidence of Us™ name	V4.1	Developed concept	Prevent incident fragmentation across conduct and systems	Cross-cutting principle	Scope clarified in V5.1; operational tool not validated	Principle public; mapping instruments reserved	Taxonomy, chronology protocol and validation	™ claimed; clearance pending	Written agreement required for operational use or implementation of reserved assets; trademark use separately controlled.

Asset name	Category	Creator / rights-holder	First documented use	Development status	Public-policy function	Relationship	Evidence / validation	Public disclosure boundary	Further work	Mark status	Licensing position
Policy-to-Practice-to-Safety Accountability Test™	Test/method	██████████ developed and used under The Evidence of Us™ name	Post-lodgement PLR-02	Concept stage	Test delivery, conduct change and safety/rights outcomes	Bridge between Evidence Cycle stages 4–7	Independent validation pending	Three gates public; scoring tools reserved	Indicator specification, pilot and evaluation	™ claimed; clearance pending	Written agreement required for operational use or implementation of reserved assets; trademark use separately controlled.
Child Safety Signal-to-Outcome Pathway™	Pathway	██████████ developed and used under The Evidence of Us™ name	V4.1; expanded through V5.1	Concept stage	Connect child safety signal to action, outcome and correction	Child application of architecture	Policy pathway developed; pilot pending	High-level policy pathway public; decision rules, thresholds, operating protocols and implementation specifications reserved.	Cross-jurisdictional design and pilot	™ claimed; clearance pending	Written agreement required for operational use or implementation of reserved assets; trademark use separately controlled.
Cross-System Risk-to-Safety Architecture™	Working architecture name	██████████ developed and used under The Evidence of Us™ name	PLR-01	Concept stage	Support national cross-sector risk model	Supporting method	Not validated or operational	Name and strategic purpose public	Technical model, safeguards and evaluation	™ claimed; clearance pending	Written agreement required for operational use or implementation of reserved assets; trademark use separately controlled.

Asset name	Category	Creator / rights-holder	First documented use	Development status	Public-policy function	Relationship	Evidence / validation	Public disclosure boundary	Further work	Mark status	Licensing position
Report-to-Response Accountability Pathway™	Working pathway name	██████ developed and used under The Evidence of Us™ name	PLR-01	Concept stage	Connect reporting duties to action and review	Supporting method	Not validated or operational	Name and strategic purpose public	Thresholds, workflows, pilots and audit	™ claimed; clearance pending	Written agreement required for operational use or implementation of reserved assets; trademark use separately controlled.
Every Voice Matters Survey™	Survey and dataset	██████████████████	Independent pre-existing work	Operational survey; analysis controlled	Lived-experience evidence generation	Linked evidence source, not a TEOU-owned method	Self-selected survey; limitations stated	No raw data, instrument or coding workbook disclosed	Owner-approved analysis, ethics and validation	Separately claimed mark	Rights remain with ██████████
Specialist family-safety court proposal	Independent policy proposal	██████████████████	Separate DSS submission	Independent proposal	Fit-for-purpose family-safety court option	Referenced contribution only	Requires feasibility, legal and pilot design	No transfer to TEOU	Independent scoping and evaluation	Descriptive / no TEOU mark	Rights remain with ██████████



The Evidence of Us™

Policy • Research • Systems Accountability • Impact

Thank you