Review of March 2026 Investigation

Matter: Incident of 26 March 2026
Appeal lodged: 11 August 2026
Grounds received: 1 and 3 September 2026

Role labels are used throughout in place of names, consistent with the March 2026 Incident Report to Community: Owner/Initial Investigator, Second Investigator (Safety Officer), Consent Monitor, Reporting Party, Reported Party, Witness. Note that the Reporting Party is also referred to within this document as the “appellant”, as the procedural expectations of a reporting party differ from someone requesting an appeal.

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1. Scope and standard

What this review is: An assessment of whether the investigation was conducted fairly; whether its findings were reasonably supported by the evidence received; whether correct procedures were followed; and whether the outcome was reasonable and proportionate.

What it is not: A re-investigation of the events of the session in March 2026. No finding is made about what occurred between the parties during that session. Neither party has been asked to re-evidence their account.

Standard applied:
For each appeal ground stated, two main questions have been applied:
1) Did the process fall below a reasonable standard, and if so,
2) Could that have affected the fairness of the process or its outcome?

Findings available for this review: Upheld, partially upheld, not upheld, or outside the scope of appeal.

Framing: Findings exclusively attach to decisions and systems/protocols, not to individuals. Where a decision is found to have been sub-par or “wrong”, that is a statement about the decision and about the policy that permitted it; this allows for

prudent recommendations and amendments to be made without degenerating to character judgements. This decision was informed by the policies of the wider Safety Network.

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2. Ground 1: Evidence not reasonably addressed

2.1 The ground

The Reporting Party states that photographic evidence of injury was offered during the investigation and was not taken, and that material evidence was therefore missing from the investigation's consideration.

2.2 What the record shows

- Casa did not request photographs or medical documentation from the Reporting Party. The March 2026 report records the rationale: *"We did not ask for medical reports as we believe reporters."* Casa accepted in their investigation that the bruising was severe and lasted three weeks.
- The Reporting Party states the photographs were offered and declined. This is confirmed by Casa.
- Casa concedes in its own report that the rationale was never explained to the Reporting Party at the time: *"We should have explained to the Reporting Party that the reason we did not need to see their photos is because we believe survivors."*
- The extent, location and duration of injury, and its relationship to bruising from an earlier session that evening, were not resolved. The March report lists "communication about prior bruising" among its stated areas of disagreement.

2.3 Analysis

The principle Casa applied is sound, and its purpose is well established: a person who reports harm should not carry a burden of proof, and should not be required to produce injury documentation in order to be taken seriously. Requiring proof from reporting parties (especially of an intimate nature) is a known driver of under-reporting and of secondary harm.

The principle was, however, misapplied. Its function is to remove a requirement placed upon the Reporting Party. It was instead used to decline evidence the Reporting Party volunteered. Those are materially different acts. The first protects a Reporting Party from having to prove themself; the second removes their ability to substantiate their own

account when they have chosen to do so. A Reporting Party who offers evidence is exercising their voice, and declining it substitutes the investigation's judgement for theirs about what they need. It is acknowledged and supported that this decision, whilst misaligned, was not made in bad faith. It is further acknowledged that this still contributed to a feeling of unfairness, uncertainty, and confusion for the Reporting Party, and that these feelings formed a part of the motivation for appeal.

The photographs would likely not have settled the disputed facts of the session: they could not speak to whether the visual check of the affected area was adequate (elaborated on in section 6.4), how often pain checks happened, or to the bratting question.

The primary issue is that there is no way that Casa could have suitably established the above. They turned down the Reporting Party's offer of photographs without asking what they depicted/showed; declining evidence can be the right call under appropriate circumstances, but it cannot be the right call when made without knowing what is being declined. The appellant offered the material evidence they had, and had it refused without appropriate explanation. That harm is real whether or not the photographs would have made material difference to the outcome of the investigation. A reporter told nothing about why their evidence was declined is left unable to distinguish "we believe you" from "we are not interested", a point that the March report/feedback document concedes directly.

2.4 Finding

Partially upheld.

Not upheld insofar as the ground implies the investigation disregarded evidence in its possession, or that the outcome would have differed had the photographs been taken. Neither is supported. The photographs would not have spoken to the central disputes, and the injury itself was never contested.

Upheld as to the manner in which the decision was made. Casa declined evidence a party had offered without viewing it, without asking what it showed, without recording a reason specific to this case, and without explaining the decision to them at the time. A decision to exclude evidence may be sound; it cannot be sound when taken in ignorance of what is being excluded. Casa concedes the failure to explain the "why" of that decision to the appellant in the case report.

This defect did not affect the outcome. It affected the fairness of the process as the Reporting Party experienced it, and it left the investigation unable to

demonstrate that its evidence handling was considered and compassionate rather than reflexive.

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3. Ground 2: Procedural error (delay)

3.1 The ground

The appellant states that the investigation was delayed intentionally by the Owner/Initial Investigator.

3.2 What the record shows

Date	Event
26 March 2026	Incident
May 2026	Informal report made to a Consent Monitor
14 July 2026	Formal report left at Casa by the Consent Monitor
15 July 2026	Report received by the Owner
20 July 2026	Initial investigation opened

Approximately sixteen weeks elapsed between the incident and the opening of an investigation. The record attributes the May-July portion to a Consent Monitor's uncertainty about whether the matter should be escalated: *"The consent monitor was not sure whether to report it or not and it was brought to the Owner in July."* Casa opened its investigation five days after receiving the report.

Casa's safety procedures at the time contained no acknowledgement requirement, no stage turnaround times, and no defined route by which a Consent Monitor holding an uncertain disclosure could escalate it without first deciding its merits.

3.3 Analysis

The allegation as framed - intentional delay by the Owner - is not supported. The substantial delay preceded the Owner's involvement, and Casa acted within five days of receiving the report.

The underlying complaint is nonetheless well founded. A disclosure of harm sat unactioned for roughly four months. No one acknowledged receipt to the person who

made it. No one explained what would happen or when. The Reporting Party's experience of institutional indifference during that period follows directly from the absence of a system/protocol designed to prevent it, and consequential subjective experience of unfairness is understandable.

This is the appropriate reading of the ground: not misconduct of the Owner, but a design failure within organisational protool with a real and foreseeable effect on the person it failed.

A related matter falls outside these grounds, but has been considered as part of this assessment. The Consent Monitor who received the disclosure was subsequently suspended pending investigation, which several external Safety Network respondents identified as carrying the appearance of retaliation. This review makes no finding on that separate process. It records only that where the CM who received a disclosure becomes the subject of proceedings arising from it, the organisation carries a heightened obligation to demonstrate that the process afforded that person notice, the grounds, an opportunity to respond, and the offer of future education on the correct conduct. Having reviewed evidence concerning communication with the CM, it is supported that Casa afforded them the above opportunities.

3.4 Finding

Partially upheld.

Not upheld as to intentional delay by the Owner/Initial Investigator. There is no existing evidence to support this.

Upheld as to systemic procedural failure. The absence of acknowledgement requirements, turnaround times and an escalation route permitted a report to remain unactioned for approximately four months and left the Reporting Party without information, support, or contact throughout.

This defect did not affect the substantive outcome. It materially affected the fairness of the process as experienced by the Reporting Party.

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4. Ground 3: Conflict of interest and investigator independence

A note on what impartiality and independence are understood to mean in this review:

Three different things are used quite interchangably in the appeals policy, and separating them makes this ground significantly easier to answer.

Impartiality is about a person's mind: whether they can approach a matter with an open one. It is largely unknowable from outside.

Independence is about position: whether someone's relationships, obligations or interests are such that their judgement could be shaped by them, whatever their intentions.

Apprehension of bias is about perception: what a fair-minded person, knowing the relationships involved, would reasonably conclude about the process.

4.1 The ground

The Reporting Party states that a conflict of interest existed from the outset and affected the entire process; that the Second Investigator was not impartial by reason of relationships with Casa and with the Reported Party; and that the ground rests on the cumulative effect of both allocation decisions.

4.2 What the record establishes

The initial allocation. Casa's own relationship matrix records the Owner's relationships with the Reported Party as: colleague ("Tour Whore"), non-kink educator at Casa, regular transport to and from the venue, and occasional overnight stays at the Owner's home. The Owner nonetheless opened and held the investigation. The parties dispute whether handover occurred at two or four days; there is no change to the outcome based on that difference.

Casa has already conceded this point in its own published report: *"Some consensus that the initial investigation could not be considered fair or impartial, given the Owner's relationship with the Reported Party. Feedback is that this should have triggered immediate handover."* And: *"We should have identified the conflict of interest immediately and allocated a Safety Officer to handle the investigation from the start."*

The Safety Network's feedback identified the Owner's role and conflict as *"the most significant gap raised across multiple responses."*

The second allocation: Casa's relationship matrix records the Second Investigator as having "no known relationship" with either the Reporting Party or the Reported Party.

The same matrix records them as a friend of the Owner, a co-Consent Monitor, and the Owner's "Accountability Officer (personal)."

The appellant states that the Second Investigator is a friend of both Casa and the Reported Party. Whilst the Second Investigator is confirmed to be a friend of the organisation, there is no evidence to support that they had a friendship or relationship with the Reported Party which would cause a conflict of interest.

4.3 Analysis

The initial allocation was a clear failure. Household-adjacent contact, regular transport and shared professional roles are among the most straightforward conflict of interest triggers there are. That the conflict was identified and acted on within days is to Casa's credit; that it required days rather than being obvious at receipt is the defect.

Casa's principal answer (that the allocation complied with the policy as it then stood, and that the policy has since been amended) is both factually correct and fails to answer the ground in terms of impartiality. The Reporting Party's complaint is precisely that a policy permitting a conflicted investigator to receive and open a report is itself the error. A process that produces a reasonable apprehension of partiality is defective whether or not it was followed correctly, which is why the policy was changed.

On cumulative effect: the appropriate test is not whether any individual (specifically Owner or Second Investigator) acted in bad faith. It is whether a fair-minded observer, aware of the relationships involved, would reasonably apprehend that the process was not conducted with impartiality. In a community the March report itself describes as small and densely interconnected (*"All people involved in this matter had personal relationships with multiple others"*) that apprehension is available on the initial allocation alone, before the Second Investigator's role is considered.

Casa's report speaks to much of the above, and its Action Plan places the recusal rule at Urgent Critical. That is the correct response and it is recorded here as such.

4.4 Finding

Upheld in part

Upheld as to the initial allocation. The Owner/Initial Investigator held relationships with the Reported Party that should have triggered immediate recusal at the point of receipt. The investigation was opened and held for a period notwithstanding. This is conceded by Casa in its own report and was the dominant concern in Safety Network feedback. The corrected Urgent Critical recusal placement is genuinely corrective to this issue.

No finding is made as to the alleged relationship between the Reported Party and the Second Investigator.

Upheld as to cumulative effect. The combined effect of the allocation decisions was capable of producing a reasonable apprehension that the process was not impartial. This finding does not require (and does not imply) actions made in bad faith by any individual.

This defect was capable of affecting the fairness of the process.

An additional note:

Most organisations investigate their own internal issues/reports, which is workable where certain conditions hold: the investigator, decision-maker and appeal reviewer are different people; no reporting line runs between investigator and party; nobody has a personal stake in the outcome; and the organisation is large enough that an involved party with a conflict of interest can simply be replaced.

Casa meets few of these conditions, and it is not due to a failure of effort. Casa is small and owner-operated. The pool of people competent and able to assess kink-specific safety questions are drawn almost entirely from the same scene. Most significantly, forming relationships is what the venue is for; the relational density that produced this conflict is not a flaw in the design of the space, but the entire focus of the design. Casa's own report recognises this: *"All people involved in this matter had personal relationships with multiple others."*

The realistic conclusion is that for serious or contested matters, structural independence is not achievable inside Casa at its current scale. This is a matter of arithmetic rather than of anyone's conduct, and it indicates two valuable points:

1) External involvement belongs at the start of serious matters, not only at appeal. The current policy indicates an external reviewer at Stage Eight and only "wherever practicable."; a conflict of interest does its damage at intake, which is where it needs to be caught. This is addressed further in section 6.2 (procedural recommendations).
2) Where structural independence cannot be achieved, procedural transparency carries a more significant load. Reasoning documented at each decision point; both parties given the same information at the same time; findings that record evidence separately to interpreting it; potentially even a second reader before

anything is issued. None of this makes an internal investigator independent, but it helps to make the process clear, consistent, and fair.

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5. Matters within scope but not raised by appellant

These have been addressed based on contextual evidence/material, in the interests of further assessment of fairness. They are recorded as observations rather than findings, and recommendations follow at section 6.

5.1 Asymmetry of engagement: The Reported Party met investigators in person. The Reporting Party engaged in writing only. Casa's position (that the Reported Party requested the meeting, and that requiring a reporter to attend in person would impose an unreasonable burden) is *factually* correct. The problem arises elsewhere: there is no record that the same range of formats was offered to both parties, and the difference was never explained. A party who learns that another was met in person, having themself only been messaged, will reasonably read that as differential treatment regardless of how or why it turned out that way.

5.2 Support and information (as indicated by recipient CM and their report): No acknowledgement of receipt; no explanation of process or timeline; no named point of contact; no support person offered; no status updates.
Existing evidence states that the appellant experienced the questioning as interrogation - which Casa concedes: *"This was communicated in a manner that lacked compassion."* Each of these is collectively determinative of how a process is experienced. The relevant mechanism is well documented: harm arising from an institution's response to a disclosure compounds the original harm, and is frequently reported as more damaging than it, because it withdraws or negatively affects an expectation of protection and care from the organisation.

5.3 Findings language (from case report): The March report attributes the Reporting Party's experience of the final sequence to a misreading of a countdown, and the Reported Party's conduct in the session to inexperience and overconfidence. Both of these findings narrate interior states rather than recording what was said and what was corroborated, and the pairing reads as explaining one party's perception of events back

to them while accounting for the other's conduct. This is a substantial part of why the process was experienced as unkind, independent of its conclusions.

5.4 Conduct during the appeal period: The appeal has proceeded against a background of public case discussion (specifically on Fetlife) including the identification of a named safety volunteer and Reported Party. Separately, the Reporting Party set a submission date citing health, sole caregiving and a family law matter, and was moved to a five-day deadline under indication that the matter would otherwise close. The appeals policy contains no timelines, no extensions provision, and no closure mechanism; the deadline accordingly had no basis in the policy under which it was imposed.

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6. Recommendations

6.1 Structural

1. Automatic recusal rule with defined triggers: household or cohabitation contact, financial interdependence, sexual or romantic relationship, close personal friendship, supervisory or employment relationship. Recusal is automatic at the beginning of the process and assessed at the point of receipt, not on request.
2. Named standing alternate decision-maker in a situation where the Owner is recused based on a conflict of interest. Should the alternate also be identified to have a conflict of interest, the case is escalated directly to external review (eg. by someone in the wider Safety Network, or someone from the resource-mapping document mentioned shortly).
3. Written conflicts declaration completed at case allocation and disclosed to both parties, with a right to object and external determination of any objection.
4. Acknowledgement of every report within 48 hours, published stage turnaround times, and a named point of contact for each party.
5. Evidence policy: No party is required to supply proof, in line with Casa’s current protocol. However, evidence voluntarily offered by any party is received and logged. Where it is not relied upon, the reason is recorded and explained to that party at the time. This applies symmetrically to material concerning any party, from any source.
6. Reporter's Charter/Standard Operating Protocol (SOP) setting out what a person can expect at each stage, issued on receipt of every report.
7. Anti-retaliation policy (with respect to doxxing, recusal/suspension/case closure without explanation) covering reporters, corroborating witnesses, CMs, and appellants, extending through to the conclusion of any appeal.

6.2 Procedural

8. Equal-opportunity engagement offers: Every party is offered the same range of engagement formats: in person, voice, written, with a support person present. The offer and the choice should be recorded as part of the case protocol.
9. Support-person entitlement for every party at every stage.
10. Capacity and extensions provision: A party may request an extension on health or caregiving grounds without disclosing medical information (as they are not in contract with the organisation). Extensions are granted or refused in writing with reasons. A maximum period applies, with a review point. Closure for non-engagement requires prior written warning and must be provided for in both investigation and appeal policy.
11. Consent Monitor escalation route: clarification of the process that would allow an uncertain disclosure to be passed upward without the Monitor first determining its merits, likely via peer (fellow CM) consultation; Casa has confirmed that their current Consent Monitors have been retrained as a result of this process.
12. Findings-drafting standard: Findings record what each party stated, what was corroborated, and what could not be resolved. They should not narrate motive or interpret a party's perception back to them; character judgements and inferences about intention do not belong in formalised case findings.
13. No public communication by Casa or the wider Safety Network about a live report or case without the Reporting Party's prior written consent. Where an immediate safety risk requires community warning (re: the disclosure discussion organised/cancelled), only de-identified risk information is issued, and the Reporting Party is notified before publication. The recommendation that this be extended to the wider Safety Network is due to character judgements/inferences of bad faith intent made on the Safety Network WhatsApp group chat whilst the case was still live, which is in direct conflict with the existing protocol documents published by the Safety Network.

6.3 Conduct and community safety

14. Anti-doxxing and non-interference standard: This addresses conduct toward people within the kink/BDSM/fetish community exclusively, not opinion about process or personal experience. It prohibits publishing identifying information about any party, witness, volunteer or attendee: legal name, employer, image, address; contacting or pressuring parties or witnesses about their evidence; and organised targeting of individuals for their association with the venue. It applies identically to Casa's owners, staff and volunteers and to community members. It does not restrict any person from describing their own experience, raising concerns about the process, or seeking support.

This distinction should be stated explicitly in the online policy documentation. Casa has been emphatic about their aversion to silencing discussion about this investigation online, as they promote freedom of speech and open dialogue between affected persons. However, it should be acknowledged clearly in their online policy documents that they recognise their right to act/speak out against conduct intending to out or doxx individuals involved in the case.
Section 26 of the POPIA act is specifically relevant to our community, as our activity within the kink/BDSM/fetish scene is often something we seek to keep separate from other parts of our lives (especially work, and employers). Section 26 speaks to “special personal information”, which includes particulars of an individual’s sex life; any online identification/doxxing of someone who forms part of our community, due to the specific nature of our community, violates this section.

15. Support for those affected: Concrete, specified support for any person harmed in connection with a Casa process, issued as a standalone commitment rather than as part of these findings. Resource-mapping of persons well-educated in legal matters (potentially even willing lawyers within the community), proximal community counsellors, etc. - having one concrete form link on the Casa website where people are able to contribute or volunteer resources/contact information they believe may be valuable, and having one dedicated person on the Casa team to add whatever information is sent through to a resource document, would be adequate. That document can then be distributed immediately to all involved persons at the beginning of an investigation, to provide equal-opportunity support pathways.

6.4 Health and safety input

I want to address a few points that are important to consider in further investigations, and can be provided as clear explanations to physiological questions of injury during sessions. Independent of this investigation and process, future educational sessions will be offered to players and community members about the physiology of kink practices; I think having access to this kind of plain-language information is a valuable form of harm reduction.

16. The obvious one first, bruise visibility arrives significantly after an impact session: Blunt impact ruptures capillaries at the moment of contact, but the extravasated blood takes hours to migrate to the skin’s surface and become visible. Therefore a visual skin check performed shortly after a session, or shortly before a second

one on the same evening, will systematically under-detect damage - especially when the initial impact was delivered using “thuddy” tools such as paddles/floggers/thumpers/bats/etc. A “clear-looking” area is not the same as an uninjured one.

17. Blood pooling tracks away from where the force lands: Extravasated blood follows fascial planes (connective tissue) and gravity. Discolouration can appear below, or offset from, the location of impact. This makes retrospective attribution of a mark to a particular strike/particular session unreliable, and makes "avoid the marked areas" significantly less protective than it sounds. The boundary of injured tissue is not the boundary of visible marking - again, especially when “thuddy” tools are used.
18. Marks from consecutive sessions are not separable after the fact: Where two sessions occur in one evening on overlapping regions, the resulting presentation is cumulative. Without significant time between the two, and a photograph taken a significant amount of time after the first and before the second, no photographs after a second session would apportion injury between them.
19. Real-time pain reports are a poor proxy for tissue damage: Sympathetic arousal and endogenous opioid release (endorphins, as a result of the play) raise pain-receptor thresholds substantially. A receiver can accurately report a strike as tolerable in the moment, while that strike is still causing significant capillary and soft-tissue injury. Honest checks, honestly answered, can therefore still coexist with unintended injury. One of the contested issues from the initial investigation was the occurrence of appropriate check-ins throughout the session; even if those check-ins had occurred, awareness of the physiological consequences of sustained impact on an already-impacted area is essential to both session safety and aftercare reccommendations.

Therefore, two health and safety notes need to be made. Firstly, visual inspection fails as a preventative process because it’s checking for injury that may not yet be visible (and this is especially true following “thuddy” impact sessions). Secondly, pain reporting fails because the sensory channel it requires is suppressed (by the endorphins from session one) at the time of check-ins/asking. Neither are bad-faith practices, but both are the wrong instrument to answer the question of harm-reduction during a second session.

The recommendation is to replace the pre-session inspection standard with a temporal one, held by the top and bottom as a dyad rather than administered by the venue (and incorporated into training and educational sessions, as well as available as printed information within the venue or digitally on the site):

1. A default recommendation against repeat impact to the same body regions within the same evening from two separate impact tops, and a stated window (24-48 hours is a good starting bracket, as most people will see visible bruising arise within the first day).
2. Where parties choose to override the presumption, that override is an explicit negotiation item rather than a judgement call made from a visual check by a top.
3. Any second session in an evening is negotiated as additive to the first, not as independent of it, with reduced intensity as the default starting position. Whilst we expect tops to be educated, we should also expect them (with the permission of the bottom) to be capable of communicating concerns related to safety of consecutive plays.
4. Skin checks are retained, but with a clear caveat that they identify areas already visibly compromised without necessarily clearing an area as “safe” (once again, especially after the initial impact was delivered with “thuddy” tools. Canes/whips leave more immediate visible marks, which is where skin checks are immediately valuable).
5. The check-in by the top should move later (hours after, or next-day contact) because that is when a bottom is able to actually report “accurately”. That should form a part of the negotiation, guided by the top, and be an offer rather than something imposed on the bottom.
6. Self-documentation by parties, for their own records, continues to be kept by them and not by the venue. It is not feasible for Casa to retain or request health information about attendees/their sessions, and adds another layer of POPIA complications that would put both them and attendees at risk.

6.5 Amendments to the appeals policy

The policy under which this appeal proceeded requires revision before it is next used; both the Reporting Party/appellant and reviewer have been working from the draft appeal document, so these would be valuable additions to the final format.

18. Resolve the internal contradiction between *"the independent review will normally be considered final"* and *"the final organisational decision remains with Casa Kink."* As drafted, these are inconsistent and make it unclear whether or not Casa retains “veto power” over the review process. State which elements bind Casa/ which remain organisational discretion, and why (eg. how extension of the appeal process may affect venue functioning between final case report reccommendations being implemented and possible review recommendations being received).
19. Insert timelines for each stage, an extensions provision (crucial in order to maintain fairness to appellant), and a case/appeal closure mechanism with prior

written warning. As it stands, none of these exist within the draft appeal document.

20. Terms of reference for the reviewer, specifying: a single defined channel for communication with the organisation; that the reviewer does not take direction from the organisation on communications with an appellant; that appellant correspondence is not shared with the organisation; and that the reviewer's findings are not shown to either party in draft.
21. The appeal timetable is not set by the party under review: It is set by the reviewer or, alternatively, by organisational appeal policy in writing.
22. Appellant support: Written guidance for the appellant on formulating grounds, and an entitlement to a support person/advocate (as provided by the aforementioned resource-mapping document). An appellant asked to select from a list of formal grounds without assistance may produce something that is then rejected as not meeting them, which has the possibility of generating a further experience of unfairness for the appellant.
23. Broaden the evidence ground: "New material evidence that was not reasonably available" excludes the situation that arose in this case: evidence that existed, was offered, and was not taken. Add a section covering evidence that was available to the investigation but not obtained. Additionally, separate evidence as pertaining to the review from investigation-specific evidence. Online discussion of the investigation, postings from the apellant, Safety Network, organisation, etc. all provide important contextual information for a reviewer (which is essential, as one of the requirements to be a reviewer is that they cannot have been involved in the initial investigation).

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7. Summary of findings

Ground	Finding
1) Evidence not reasonably addressed	Partially upheld
2) Procedural error: delay	Partially upheld
3) Conflict of interest / independence	Partially upheld

Three defects capable of affecting the fairness of the process are established, each of which are acknowledged to have negatively affected the appellant’s experience of the process. No finding is made that any individual acted in bad faith.

The outcomes imposed on the Reported Party are not recommended to be changed, with the caveat of further education on the health and safety elements of visual checks and topping judgement calls. Safety Network feedback found them broadly proportionate, and they align with the Reporting Party's own stated preference for a community-focused rather than punitive resolution. No party has appealed them.

Casa Kink identified and published a substantial proportion of these failures in their case report document, prior to this appeal being lodged. That is recorded here as a material point, and all recommendations made within this review are aimed at closing the gaps left by the corrections to investigation policy and procedure outlined in that report. Further recommendations made seek to consolidate and strengthen the appeal document.
