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Overcoming Ignorance-Making in Acknowledging and Responding to Harm in Custodial Settings: The Use of Open Disclosure

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Abstract

Although preventable harm in custodial settings has been widely documented, progress towards implementing the reforms that are often identified in reviews and inquiries into the quality of care afforded has been slow. It has even been suggested that government departments routinely engage in the practice of *ignorance-making* — the intentional use of strategies to deny the ongoing experience of harm, to deflect attention away from the statutory body, and/or to minimise responsibility. One means of countering such practice is *open disclosure*; a process that involves acknowledging and apologising for harm, and engaging directly with affected individuals and families. In this article we examine the occurrence of preventable harm in custodial settings, employing a case study from Australia's Northern Territory to contrast criminal justice responses with the more transparent approaches that have been adopted in healthcare. We put forward recommendations to improve harm recognition, embed meaningful apology, and strengthen systemic accountability in custodial settings in Australia.

Keywords: Preventable harm; open disclosure; youth justice; watch house; custody.

Introduction

Numerous inquiries into the safety and quality of correctional systems both in Australia and across the world have drawn attention to various ways in which harm occurs to people in custody (e.g., Criminal Justice Inspection Northern Ireland, 2019; Dolovich, 2022; The Howard League for Penal Reform, 2006; Royal Commission into Aboriginal Deaths in Custody, 1991). While these typically result in recommendations for wholesale change (such as for the implementation of more developmentally appropriate, trauma informed, restorative, culturally responsive services that are grounded in systems and structures to support human rights), translating recommendations into meaningful reform has proven difficult (see Case, 2021; Criminal Justice Inspection Northern Ireland, 2019; Day et al., 2022). Perhaps most telling, it is now over thirty years since the landmark Royal Commission into Aboriginal Deaths in Custody handed down its 339 recommendations for change, many of which have only been partially implemented or simply remain unaddressed (Department of Prime Minister and Cabinet, 2018). Stanley et al. (2024) have argued that a reluctance by government agencies to openly acknowledge the harms that have occurred is a key barrier to reform. They document instances of what they term intentional "ignorance making," whereby government representatives actively seek to minimise and neutralise complaints, deflect criticism, and re-assert the legitimacy and goodness of the state. Their analysis illustrates how this can be achieved through the use of a range of different strategies, including: a)

the state claiming a lack of knowledge of harms that have occurred; b) offering only a narrow acknowledgement of survivors' identities and needs; c) blaming others for causing harm; d) engaging in bureaucratic and legal debates to deflect responsibility; e) presenting the problem in terms of the failings of individuals rather than of systems; f) confining abuse narratives to the past; g) asserting new norms of partnership to suggest that problems have been resolved; and h) imagining a decolonial future where harm does not occur. In short then, Stanley and colleagues argue that representatives of government subvert open and honest conversation about the harms that have occurred, that they disregard the needs of those who have been affected, and actively avoid engaging in discussion about whose duty it is to meet those needs, how things might be set right, and how to best reduce the chances of more harm occurring.

In this article we apply this critical lens to examine these issues in terms of how justice agencies might best respond to harm caused to people in custody in Australia. This follows a series of recent articles—and a recent Senate inquiry into the youth justice system—that have sought to understand just why it is that reform has proven so challenging. This work has focussed, for example, on the need to strong leadership in justice agencies (Butcher et al., 2024, 2025a), on overcoming the fear of being blamed when things go wrong (Butcher et al., 2025b), and the fear of being labelled "the part that broke" in the system (Tomcazk et al., 2023). It is common, for example, for prisoner suicides to be investigated in ways that are both reductionist and that seek to identify linear cause and effects by seeking to identify procedural non-compliance rather than engaging with the broader dynamic and complex systems and organisational cultures that exist within custodial settings (Butcher et al., 2025a; 2025b; Tomczak et al., 2022; 2023). We suggest here that there is also a need for an open and honest conversation to "set things right" and help to prevent re-occurrence and identify opportunities to adopt new approaches to improve safety. Specifically, we recommend that criminal justice agencies adopt a process of "open disclosure" that is increasingly being used following cases of medical harm (Philpott et al., 2024). This is, in part, in response to reports that family members of people who have died in custody have been reported experiencing a lack of transparency and poor communication from prison officials (Roulston et al., 2021), and relates to basic processes such as significant time delays in the notification of harm, and the longer delays that occur before official investigations examine the circumstances of what happened (e.g., Tomczak & Cook, 2023). A case study of the harm being caused to children who are currently in custody in the police watch house of the Northern Territory (NT), Australia is presented to illustrate some of the issues that arise and how an open disclosure process might be helpful. We begin by discussing the notion of "preventable harm," and what this means in a custodial context.

Preventable Harm During Incarceration

Preventable harm is a term that is used in healthcare settings to refer to unintended physical injuries or complications from medical care that could have been reasonably avoided. In the custodial setting a number of different types of preventable harm arise, including those that relate to the provision (or absence of provision) of adequate healthcare, exposure to institutional violence, and experiences of inhumane living conditions including the use of administrative segregation or solitary confinement. These are presented as obvious examples of unintended harm that can reasonably be avoided. They occur in the context of more systemic issues that create the cultures in which harm arises and is compounded. For example, a review of the adult custodial corrections system of Victoria in Australia described a workforce that was, in part, "intent on dehumanising and exerting power and displaced control over people in custody" (Victorian Government, 2022 p. 33) and where practices such as the excessive use of force and inappropriate strip searching were commonplace.

Adequate Healthcare

People in prison are more likely to have poorer physical health, higher rates of mental illness, behavioural disorders and substance misuse, chronic disease and infectious diseases than those in the general population (Australian Institute of Health and Welfare [AIHW], 2023; Keers et al., 2023). While it can be argued that people in custody may have increased access to health care, factors undermine the quality of care that is available and can contribute to mortality and morbidity. These include prison specific factors such as the availability of staff and escorts to clinic or offsite hospital appointments, delayed pathways into psychiatric inpatient care, and altered prescribing criteria (particularly for drugs of potential abuse) (Kajeetpa et al., 2021). For example, psychiatric prisoner patients who are discharged from secure units in the United Kingdom have been shown to be more likely to have shorter stays and be at higher risk of future violence, with a lower prevalence of protective factors than their peers (Leonard et al., 2022). Despite the widely acknowledged need to provide healthcare in prisons that is equivalent to that available in the community (i.e., to comply with the Mandela Rules), the ability of correctional staff to facilitate access to adequate healthcare is limited and a key contributory factor in deaths in custody (Armitage, 2023; Hosking, 2025). Standardised mortality rates in prisons are known to be up to 50 per cent higher than in the general population in some jurisdictions (Tomczak et al., 2023), with evidence that overcrowding increases the risk of potentially preventable mortality in prisoners in both the United States and Australia (Kajeetpa, 2021; Kinner et al., 2025). Women in prison have also been shown to have poorer access

to healthcare, with one-fifth of midwifery appointments being cancelled, a key reason being lack of access to escort staff. These women are also twice as likely to enter pre-term labour (Davies et al., 2022).

Prison suicide is also a concern both in Australia (Miles et al., 2024) and internationally, with the suicide rate of prisoners being consistently higher than that of the general population. In prison, men typically have a rate of suicide three times greater than their peers, and women nine times higher, which is thought to be a result of the complex interaction of individual/clinical and prison ecological factors (Fazel et al., 2017).

Physical and Sexual Abuse

The abuse of those in prison, although likely to be under-reported, is so widespread that it has been described as "part of the prison experience" (AIHW, 2022; Wolff & Shi, 2009, p. 58). In one survey of people in prisons in Queensland, Australia, more than one in three (34%) males and one in five (20%) females reported having been physically assaulted while in prison, with 2.9% of males and 3.8% of females reporting a sexual assault (Butler et al., 2010). A meta-analysis conducted by Caravaca-Sanchez and colleagues (2023) showed an estimated prevalence rate of physical victimisation of 18.8% and sexual victimisation of 12.4%, with female prisoners also reported to be more likely to be sexually or physically victimised than male prisoners and First Nations women three times more likely to report sexual abuse. Notable instances of custodial officer perpetrated physical and sexual violence have also been reported (McClellan, 2024; Ombudsman NSW, 2024; Public Safety Canada, 2021). The most recent official data shows that the assault and serious assault rates across Australian prisons (prisoner on prisoner and prisoner on staff) have increased over the last decade (Productivity Commission, 2025)

Segregation

Despite the methodological issues that arise in researching this topic (Gendreau & Labrecque, 2016) sufficient evidence has now accumulated to conclude that segregation leads to adverse physical, emotional, and psychological consequences for the individual. These will, however, vary with the pre-morbid adjustment of the individual and the context, length and conditions of confinement, previous experience of trauma, and the involuntary nature of confinement as punishment, and confinement that persists over a sustained period (Shalev & Edgar, 2015). The most widely reported adverse effects are psychological, although physiological effects are also commonly observed. Some of these may be physical manifestations of psychological stress, but the lack of access to fresh air and sunlight and long periods of inactivity are likely also to have physical consequences (see Shalev, 2011). In 2011, the United Nations Special Rapporteur on Torture concluded that solitary confinement was a harsh measure which may cause serious psychological and physiological adverse effects on individuals that could violate the international prohibition against torture and cruel, inhuman or degrading treatment. He called for the absolute prohibition of prolonged solitary confinement, defined as a period in excess of 15 days confinement (United Nations Special Rapporteur on Torture, 2011). Similarly, there is more recent evidence that being held under 24-hour lighting in prisons and confinement cells is harmful, causing sleep deprivation, depression, anxiety and suicidal tendencies (Jaech, 2022).

Systemic Drivers of Crime and Harm

There are a range of systemic drivers of crime that are inextricably linked to experiences of carceral harm. For example, the landmark Royal Commission into Aboriginal Deaths in Custody (RCIADIC) (1987–1991) identified the important role that systemic factors of crime have in explaining Aboriginal deaths in custody. These included higher rates of alcohol consumption, high rates of policing, surveillance and gaoling, larger families and lower rates of educational attainment. Incarceration, as a colonial practice, has been shown to disconnect First Nations individuals from land, community, family and cultural obligations which continues cycles of victimisation and violence within First Nations communities (Australian Law Reform Commission, 2018).

There is also a well-established link between young people who have experienced child maltreatment, statutory involvement in the child protection system and subsequent youth offending, with dual involved young people having higher rates of emotional abuse, physical abuse and neglect and more likely to have experienced multiple abuses (Justice Health and Forensic Mental Health Network, 2017). In one study, the prevalence of adverse childhood experiences was reported to be as high as 89% for young people involved in the youth justice system (Malvaso et al., 2020). Another study reported that over half of those in contact with the criminal justice system aged between 10-13 had previous involvement with police as victim-survivors of family violence (Baidawi et al., 2024). It is in this context that young people who are incarcerated under the age of 14 are "almost certain" to be incarcerated as an adult (Noetic., 2010 p. 114).

The Custodial Duty of Care

A duty of care is the legal obligation for prison authorities to protect the safety and well-being of those in custody through, for example, the provision of a safe living environment and ensuring access to necessary healthcare. This is a legal responsibility, with Morrissey (2018) in an analysis of Australian legislation, noting remarks made in *New South Wales v Bujdoso* where the Australian High Court cited the following passage*:*

> The duty on those responsible for one of Her Majesty's prisons is to take reasonable care for the safety of those who are within, including the prisoners. Actions will lie, for example, where a prisoner sustains injury as a result of the negligence of prison staff; or at the hands of another prisoner in consequence of the negligent supervision of the prison authorities, with greater care and supervision, to the extent that is reasonable and practicable, being required of a prisoner known to be potentially at greater risk than other prisoners; or if negligently put to work in conditions damaging to health; or if inadequately instructed in the use of machinery; or if injured as a result of defective premises (at [46]).

Morrissey (2018) argues that Australian prison authorities will generally owe a person in prison a non-delegable duty of care, while noting that there are more onerous requirements to establish a breach of duty than in common law. Section 5B of the Western Australian Civil Liability Act 2002, for example, suggests that, in general, a person is not liable for harm caused by their fault in failing to take precautions against a risk of harm unless: (a) the risk was foreseeable; (b) the risk was not insignificant; and (c) a reasonable person would have taken those precautions in the same circumstances.

The United Nations minimum standards for the treatment of prisoners (UNODC, 2019) are also relevant here. Rule 3, for example, states that "the prison system shall not, except as incidental to justifiable separation or the maintenance of discipline, *aggravate the suffering* inherent in such a situation" (p. 3, emphasis added). Rule 5 states that "prison administrations shall make all reasonable accommodation and adjustments to ensure that prisoners with physical, mental or other disabilities have full and effective access to prison life on an equitable basis" (p. 3), and that people in prison should enjoy the same standards of health care that are available in the community (Rule 24). These rules also outline the requirements for independent investigations when the death of a person in custody occurs or when there is serious injury (Rule 71).

Open Disclosure

Open disclosure is a process used in healthcare that constitutes an "open discussion with a patient about an incident that resulted in harm to that patient while they were receiving healthcare" (Harrison et al, 2019, p. 5). It has been utilised in the United States since 1995, and in Australia since 2003 (and now forms part of the national safety standards). Open disclosure is rooted in transparency and honesty after an adverse event has occurred and requires health professionals and hospitals to express regret about an incident (which should explicitly include the words "I am sorry" or "we are sorry"), provide a factual account of the incident, explain the outcomes of any incident analysis and describe measures to prevent similar incidents occurring (Australian Commission on Safety and Quality in Healthcare, 2020; Kim & Lee, 2020). It is based on the principle that people have a right to know what has happened. Importantly, an open disclosure process is not used in lieu of complaints processes or other conciliation mechanisms (van der Walk & Rogan, 2023) that may include reparation or restitution for harm caused. It is important to note, however, that investigations into prison complaint systems routinely identifies a lack of trust from those in custody, along with a fear of complaining making their individual situation worse, or even an acceptance of harm as "this is what prison is like" (Banwell-Moore & Tomczak, 2023).

In some jurisdictions legislation has now been passed to require open disclosure and legally protect apologies from being used in subsequent legal matters. For example, in the United Kingdom, "duty of candour" legislation requires health service organisations to disclose events and apologise, with Scotland and Ireland having similar requirements (Philpot et al., 2025). In the United States, an "apology law" has been enacted to prevent the apologies of healthcare workers being used as legal evidence against them in court. In Australia, standardised national guidelines have now been developed to assist healthcare professionals in effective communication with the patient or their family (Kim & Lee, 2020).

The guiding principles are open and timely communication, acknowledgement, apology or expression of regret (though not admitting liability), supporting the needs of family or patients, supporting the needs of those providing care, integrating clinical risk management and systems improvement and good governance (Holmes et al., 2019). A process that applies these principles is expected to maintain a trusting relationship between patients and healthcare professionals, and to reduce the cost of malpractice claims and payouts (with one health system in the United States reducing litigation costs by one third after the introduction of an open disclosure process (Kim & Lee, 2024). There are additional organisational benefits that arise, including through increases to overall organisational safety and public trust (see Australian Commission on Healthcare Safety and

Quality, 2022), as well as strengthening incident reporting cultures and responses to immediate safety risks (Philpot et al., 2024).

A Case Example: Children in Police Watch Houses

In this section we illustrate the ideas of preventable harm and duty of with a contemporary example from the Northern Territory. Substantial concerns have been raised about the use of police watch house and ongoing breaches of human rights (*Two Women Locked in a Cell with up to 20 People in "Disgusting" NT Watch House*, 2025). It has been reported, for example, that children as young as 11 are being held in the watch house, with adults housed in surrounding cells (Dick, 2025a). Under a Freedom of Information request, the Australian Broadcasting Corporation reported there have been 20 incidents of self-harm involving children, 19 of which were Aboriginal children. Twelve of the incidents necessitated a transfer to hospital (Hislop & Garrick, 2025). Union representatives (Lathouris & Dick, 2025), lawyers, as well as those who have been detained, have described living conditions as unsanitary, with up to 20 people confined in a small room with no fresh air or natural lighting (Kellaway, 2025). Those in custody were reported as being required to eat in the same location where others are toileting and in view of others (Lathouris & Dick, 2025). Reports also suggest that there is no access to showers (Brennan, 2025), and that people are being held under 24 hour lighting fluorescent lighting, often for weeks at a time (Hislop & Garrick, 2025), with a lack of access to lawyers (Dick, 2025b).

The context for this level of what we would describe as preventable harm is the systemic failure of the NT justice system. At the last census, the NT had a population of 233,000 with a median age of 23 years. Twenty six percent of the population identified as Aboriginal or Torres Strait Islander (ABS, 2021). In March 2025, 1,381 people per 100,000 were imprisoned – over 1% of the Territory's total population (ABS, 2025). According to police data, approximately 1.5% of children have spent time in police watch house in a six month period (Garrick & Hislop, 2025). The NT's youth justice system has, of course, been under significant scrutiny following the abuse of young people in detention that was documented in Royal Commission into the Protection and Detention of Children in the Northern Territory (2017). Since then, however, the NT's custodial population has only grown, with infrastructure and services now widely acknowledged to be unable to manage the high rates of demand. This has resulted in the corrective services using police watch houses to detain remandees or sentenced prisoners for protracted periods of time.

The current government response to the crisis has been to expand the custodial estate and increase the role of private correctional officers in response to a staffing shortage. Critics, however, argue that children do not belong in police watch houses or prisons (Amnesty International, 2019). Most tellingly, a letter of concern written by medical professionals to about the likelihood of harm being caused to young people received the following response from the Chief Minister: "My advice to […] the 45 paediatricians who wasted their time writing to me is that you should spend more time supporting Territory children because that is your job" (Northern Territory, 2025, p. 29).

We chose this example to highlight some of the issues that face the sector in responding to harms that occur in custody. The purpose here is not to enter a political debate about the use of imprisonment or wider policy positions, but to consider how government agencies might best fulfil their duty of care to those in custody and respond appropriately to harm when it occurs. There are, of course, already a range of complaint mechanisms within centres of detention, including internal complaints processes (notwithstanding recommendations to enhance these; see Queensland Police Service, 2025), complaints to human rights commissions and/or inspectors and ombudsman. However, we suggest that in addition to these there is also a place for government agencies to respond to preventable harm by open and honest conversation that can help to "set things right," to prevent re-occurrence, and to identify opportunities to adopt new approaches to support safety. In the example of the use of police watch houses in the NT, the preventable harms that arise are uncontested. They relate to: a) overcrowding; b) lack of privacy; c) inhumane conditions (no showering, eating where others are toileting, constant lighting, lack of fresh air); d) self-harm; and e) young people being detained in proximity to adult detainees. It is reasonable, in our view at least, for those personally affected (individuals, family members, and communities) to have the opportunity to engage with custodial service providers to better understand the issues, the impacts on those directly involved, and the steps in place to prevent further harm from occurring.

An open disclosure in the context of family concerns about their children who are detained in a NT police watch house would involve senior representatives from correctional services and NT Police seeking advice from a community representative (which may be appropriate cultural broker or peacemaker or liaison officer) to plan the open disclosure meeting and ensure all required family members are invited and present on the day. This would also include consideration of the location that the open disclosure meeting is to occur. Guidance should also be obtained prior to the meeting about how to best support distressed family members, and considerations of culturally safe and appropriate communication (such as gender mix or interpreters). A

cultural broker may also be required to attend the meeting to support with explanations (but not assume responsibility for the open disclosure) and provide support to the family and young person during the open disclosure. The meeting should include an expression of regret for the preventable harm experienced using the words "I am sorry" or "we are sorry." Apologies, particularly in a First Nations context given historical injustices, are focussed on having a narrative function (identifying the wrong, in this case, the preventable harm; the wrongdoer, which may be the state, rather than individuals; the victim, in this case the young person), a disavowal of past acts, and a commitment to repair (McLachlan, 2013). Hence, the use of the word "sorry" is critically important to engage in meaningful dialogue and support truth telling and healing.

An apology would likely be grounded in the acknowledgement of the difficulty of having a young person in such an environment. This would be followed by a factual account of what occurred for the young person in their period of detention in the watch house (including where self-harm occurred, the conditions that the young person experienced, and may include efforts that were used to expedite the young person to move to a more appropriate setting and any limitations that were experienced). It may also identify what support needs the young person or their family might have (this may be in relation to trauma experienced, offer of support and referral, who the family can contact if they have follow up questions) and, identify support needs for watch house police officers or correctional staff who have witnessed harm (which may be actual or vicarious trauma or moral injury). As well, it would include listening to the affected young person, family, and staff to identify any immediate systems improvements or describe any investigation processes that may take place to reduce the harm (for example, may be privacy screens in the toilet, a commitment to working together with First Nations communities in a meaningful way to address root cause offending behaviours). There will also be an opportunity to identify any questions the family might have on-going, or would like to be examined in an incident review, and identify opportunities to meet with the family and young person again and to discuss the outcomes of any review or follow up support required. Debriefing would also be offered to the staff who had undertaken the open disclosure, with a factual report written regarding the open disclosure. This open disclosure conversation may be an iterative process over several meetings to support understanding, dialogue and communicating findings.

Discussion

It is now widely accepted that, in medical settings at least, traditional adversarial processes of dispute resolution for medical injury involve considerable stress for both families and care providers (Southwick et al., 2015). Not only do they focus on the needs and perspectives of clinicians, hospitals, and their liability insurers, but they overlook the importance of engaging patients about their experience; something that has now been identified as fundamental to quality improvement and patient-centred care (Schulz-Moore et al., 2021). It is in this context that there is merit in moving to a system of open disclosure in a criminal justice context where there are poor mechanisms for meeting injured parties needs for information, corrective justice, and reconciliation. Nonetheless, while the ethical argument for open disclosure is strong, realising the process in practice is inevitably going to prove more challenging. Even in healthcare, open disclosure was used in only 17% of instances where harm had occurred with key barriers arising from the interplay between open disclosure and incident investigation processes, role boundaries, work routines, communication skills, and policy co-ordination between local, jurisdictional, and national guidance (Harrison et al., 2019). Similarly, staff may be reluctant to admit error and worry about medico-legal implications (Philpot et al., 2024; Holmes et al., 2019). The training of staff to undertake open disclosure is key to successful implementation. Staff may, for example, only be trained in open disclosure in educational settings and be ill-prepared to deal with both the demands and unpredictability of unfolding open disclosure conversations in the real world. Agencies may see open disclosure as the role of only those in safety governance roles, or approach the process as a discrete, tick box exercise. Concern has also been raised that suboptimal open disclosure may result in further patient harm (Holmes et al., 2019). These challenges can only be expected to be more pronounced in criminal justice settings. This underscores the importance of a system wide approach to open disclosure, based on local policy development, implementation, training, championship and leadership (Adams et al., 2024). Given the extent of concerns about the safety and quality of custodial services and systems, the motivation of government agencies to address and resolve harm may be low (Stanley et al., 2024). It may well be that intentional "ignorance making" is the norm and will remain a key contributing factor to maintaining system stasis.

In order to progress work in this area there is a need for clear operational definitions about what constitutes preventable harm in the custodial environment, and how this might be reliably measured. In the absence of a clear definition, data collection will remain challenging, and it is difficult to imagine how rates of preventable harm might be identified and rectified systematically. In fact, it has been noted that performance thresholds and minimum standards for prisons are rarely set or examined empirically (Auty & Liebling, 2024). This, of course, contributes to ignorance making through the organisational defence of simply *not knowing* that there is a problem (Stanley et al., 2024). It is also important to note that administrative datasets, including those reported for the NT watch houses, have been determined to be error laden and so must be interpreted with caution (Garrick & Hislop, 2025).

As part of clinical governance processes, health services are required to report on different types of harm, based upon their relatively severity under a process known as Severity Assessment Codes (SAC). Generally, those incidents categorised as SAC1 include any incident that results in serious physical or psychological harm to a patient (such as a near miss that could have resulted in death, surgery performed on wrong site, wrong patient or wrong surgery resulting in harm or death, unintended retention of a foreign object resulting in serious harm or death, suspected suicide of an inpatient in psychiatric care, medication error resulting in serious harm, use of restraint that results in serious harm or death, discharge of an infant or child to an unauthorised person and wrong positioning of a nasogastric tube resulting in serious harm or death). SAC2 incidents are those that cause harm that results in an increased length of stay, require additional intervention or a near miss. SAC3 incidents are those that cause minor harm (Department of Health, 2025). Depending on the level of harm, particular incident investigation processes may be enacted (some under legal privilege, such as a Root Cause Analysis), and require varying levels of open disclosure responses. SAC reporting also allows for a system wide examination of all incidents, by severity, and rates of open disclosures are generally monitored against each SAC incident. A similar process may be mapped in custodial settings, assessing the potential for the various types of harm that may occur by their relatively severity.

More widely there is a need for criminal justice agencies to commit to community engagement, trust building, and developing workforces that support cultural engagement. The historical harms inflicted upon First Nations and Global South communities by colonial-settler systems are well documented, such as the removal of children, segregation, suppression of cultural practice, forced assimilation. These harms have been described as genocide in various inquiries (Human Rights and Equal Opportunity Commission, 1997; National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). These historical harms contribute to the vast over-representation of First Nations people in criminal justice setting and directly influence how First Nations people engage with state services. Correctional services should perhaps follow the lead of health services in Australia and Aotearoa New Zealand which have developed bespoke advice on how open disclosure should be facilitated with First Nations patients and communities (Clinical Excellence Commission, 2024; Hauora Tairawhiti, 2012). Future research and policy development should seek to understand how open disclosure can be undertaken in a culturally safe and responsive manner, and also understand the extra emotional and practical burden that is placed upon First Nations staff when responding to incidents of harm.

In summary, this article discusses the types of harm that occur in correctional settings, illustrated by a case study in Australia's Northern Territory. We have examined a potential process of apology for use when preventable harm has occurred that recognises the importance of early and open, transparent discussion. Of course, concerns regarding liability will inevitably remain, particularly when expressions of regret or apologies are made. It is important to note, however, that open disclosure and processes of conciliation and inquiry are not mutually exclusive. Healthcare agencies have shown that effective communication reduces medico-legal liabilities and improves the satisfaction of clinicians and people and their families. Health care clinicians and hospital organisations operate within well-established codes of ethics—beneficence, non-maleficence, autonomy, and justice—which provide important cultural enablers to facilitate open dialogue about harm. How such frameworks might be aligned with prevailing correctional cultures, and the associated need for reform in this area (see, for example, Victorian Government, 2022), requires targeted consideration, system enablement, resourcing and very likely, legislative reform. This extends to examining how the ethical and professional obligations of different health care disciplines intersect with instances of preventable harm, particularly given the inherent power dynamics involved in providing care within custodial settings. Looking forward, one area of potential exploration is the development of a universal code of ethics tailored to correctional services. What is clear though, is in order to make meaningful gains in addressing harm in places of detention, active strategies need to be deployed against ignorance making - the first of which is a systemised process to acknowledge - and apologise - when harm has occurred.

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