

# The Collective Safeguarding Responsibility Model: 12 C's

THE ENACTMENT OF 'SAFEGUARDING IS EVERYONE'S RESPONSIBILITY'

## AUTHORS

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# Introduction to Collective Safeguarding responsibility Model: The 12Cs

The 12C Model is derived from a robust research evidence base and developed in partnership with key stakeholders. This research has explored multi-agency safeguarding in relation to children, adults and families, through a variety of thematic areas.

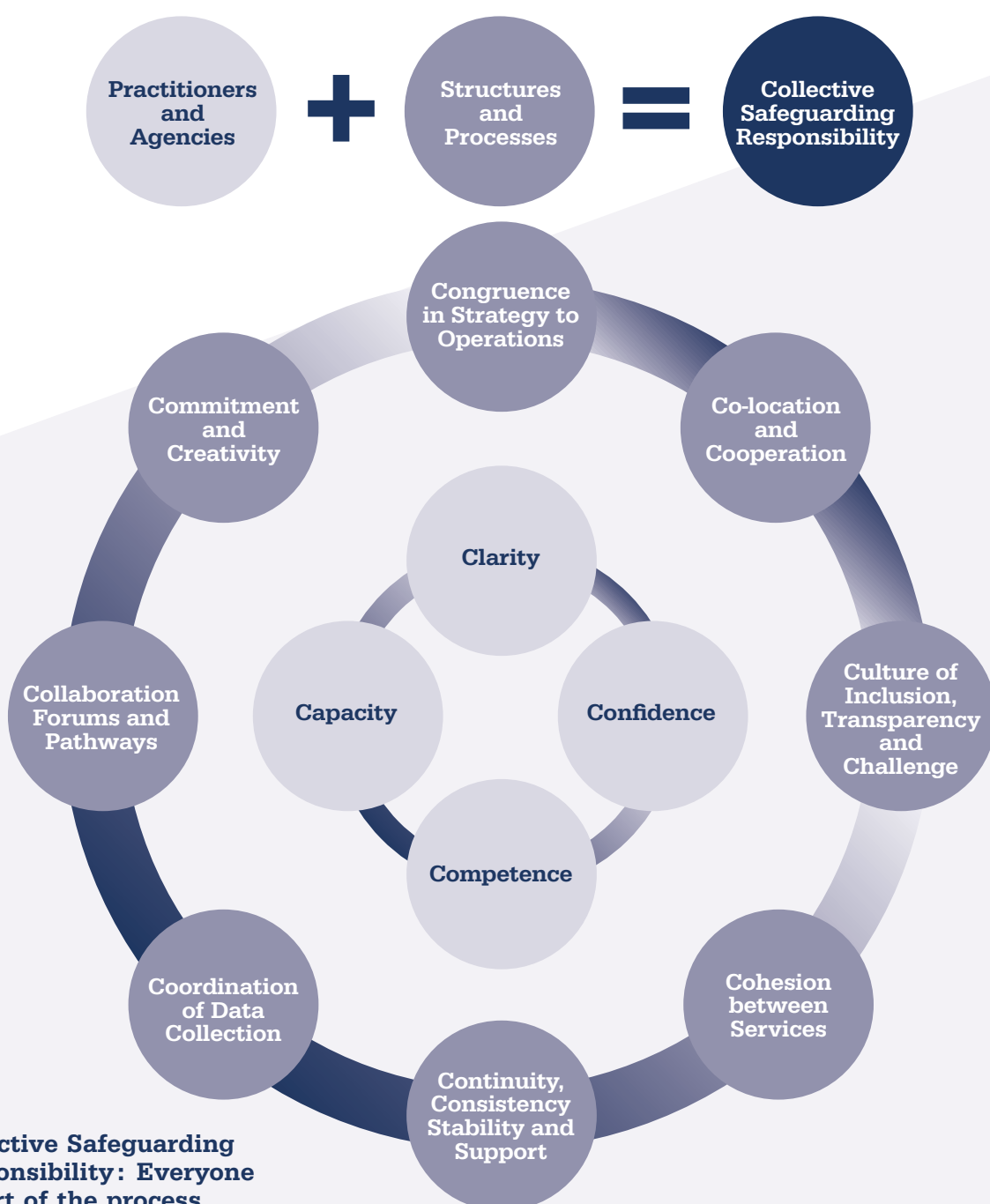
Whilst each specialist area of safeguarding has its own unique features, characteristics and challenges, there are patterns which reoccur when identifying and responding to risk. A multi-agency response to safeguarding is widely accepted as the most effective approach by policy makers, senior leadership teams and practitioners alike. Yet, despite a wealth of academic literature, several high-profile inquiries and a plethora of policy, implementation of effective multi-agency safeguarding remains a significant challenge. Challenges include a lack of clarity in relation to safeguarding roles, remits, responsibilities and expectations of partner agencies. In addition, there can be uncertainty in applying a shared understanding of thresholds and decision-making for risk, support and intervention. The sharing of relevant information in an appropriate and timely manner is frequently highlighted as an ongoing barrier to collaborative working. Underpinning this, there is often fragmentation and disconnect across agency structures, processes and procedures. Whilst alignment and joint access across sector systems would undoubtedly be beneficial, establishing and maintaining functional working relationships between key practitioners is integral to collaboration. Collaborative working arrangements must also be reviewed and evaluated to understand impact and optimise effectiveness.

Safeguarding is a community endeavour, whereby the whole is greater than the sum of its parts. No single agency can assume safeguarding responsibility for children, adults and families. Whilst safeguarding is indeed everyone's responsibility, we need to go further to ensure that this responsibility is a **collective one**.

# The Collective Safeguarding Responsibility Model: 12 C's

## THE ENACTMENT OF 'SAFEGUARDING IS EVERYONE'S RESPONSIBILITY'

The Collective Safeguarding Responsibility Model: 12 Cs, illustrates the enactment of '*Safeguarding is Everyone's Responsibility*'. The model offers a guidance tool for Regional Safeguarding Boards, Safeguarding Partnerships and Local Authorities to demonstrate measures which are being adopted locally to facilitate, coordinate, and evidence the implementation of multi-agency safeguarding.



## DEFINITIONS

### PRACTITIONERS AND AGENCIES: AGENCIES AND PRACTITIONERS

**Clarity:** Clarity must be provided to practitioners regarding the expectations of safeguarding responsibilities. This is within their own role, as well as partner agencies' roles and remits, particularly regarding anticipated outcomes and likely timelines. Seeking clarity must be an ongoing process at various stages in the safeguarding process.

**Confidence:** Practitioners must have belief in their ability and skillset to fulfil their safeguarding role. This is within their own agency and in partnership with others through collaboration. Practitioners require opportunity and space, to process and reflect on their own experiences and to learn from other agencies. Building confidence is an ongoing process.

**Competence:** Practitioners must have investment into developing their skills, experience, and knowledge to fulfil their safeguarding role within their own agency and in partnership with others, through collaboration. Practitioners require opportunity and space to process and reflect on their own experiences and to learn from other agencies. Developing competence is an ongoing process.

**Capacity:** Practitioners must be provided with adequate time, space, and resource to effectively fulfil their safeguarding duties and to do so in partnership with the relevant partner agencies.

### STRUCTURES AND PROCESSES:

#### Congruence in Strategy to Operations:

Congruence between senior leadership level, the frontline workforce, and all levels in between, in relation to safeguarding responsibility, is imperative. Implementation of this congruence should facilitate a 360-degree, fluid exchange of communication which promotes achievable objectives, shared understandings and provides a comprehensive overview of any safeguarding challenges, as and when they arise.

**Co-location and Cooperation:** To establish, develop and sustain partner relationships, there should be protocols and working arrangements which guide, facilitate, and support this process. Relationships must be continually and actively invested in, and not assumed to be an automatic by-product of safeguarding being legally mandated as 'everyone's responsibility'.

### Culture of Inclusion, Transparency and Challenge:

Consideration should be given to how all relevant agencies and practitioners can be meaningfully included in safeguarding process. Promotion of ongoing, open dialogue between all relevant partners is required and must be maintained. Professional challenge should be enabled and encouraged, to advocate for appropriate and holistic safeguarding support. This must actively be implemented into a workplace culture which is endorsed both strategically and operationally.

**Cohesion between Services:** The potential fragmented nature attached to working with multiple agencies should be recognised, acknowledged, and addressed. Actions must be taken to align safeguarding processes to enable seamless transitions between services. This can include shared responsibility, joint ownership, and collaborative case management between agencies, enabling a flexible and personal safeguarding response which reflects the evolving nature of concerns.

### Continuity, Consistency, Stability and Support:

Service delivery should have consistency in the support provided. There should be stability in workforces to allow for relationships to develop with families and individuals and to offer continuity with development plans. This requires ongoing strategic planning regarding both in the long-term and the short-term, to invest in current retention of staff and future recruitment. The funding of commissioned services should endeavour to be long-term wherever possible. Appropriate support and supervision must be provided to staff, in addition to promoting opportunities for career development and progression. Organisations should seek to understand and respond to staff wellbeing.

**Coordination of Data Collection:** Performance management data and frontline practice are inextricably linked. Practice should be accurately reflected in data collection and data collection should meaningfully inform practice. This requires both qualitative and

**“ Clarity must be provided to practitioners regarding the expectations of safeguarding responsibilities. ”**



quantitative data analysis. Multi-agency data should be coordinated, collated, analysed, and disseminated to understand not only any safeguarding activity undertaken, but to determine the effectiveness and impact of any such activity.

#### **Collaboration Forums and Pathways:**

Understanding the experiences of those who have accessed safeguarding services, is paramount in determining the effectiveness of any safeguarding intervention. Collaboration forums and pathways should be developed and promoted to ensure the perspectives of those individuals and families are heard, understood and acknowledged. Collaboration should be

facilitated during periods of service intervention and feedback sought retrospectively after intervention. This process must be widely accessible, with appropriate support provided. Prioritisation, management and ownership of collaboration forums and pathways should hold both strategic and operational level responsibility and be utilised to inform future service delivery.

**Commitment and Creativity:** Creativity, innovation and a progressive approach are integral to collective safeguarding responsibility. There must be a commitment to the sustainability and evolution of multi-agency working within safeguarding, with designated leadership and accountability across sectors.

# Good Practice Examples:

## PRACTITIONERS AND AGENCIES

There are examples of good practice being undertaken to develop **Clarity, Confidence and Competence**, across regional areas. **Capacity** was noted to be influenced by supportive leadership and through effective processes and structures, but ultimately it is driven by adequate resource, appropriate investment, and sustainable funding.

#### • **A Regional Threshold Document**

This was noted to be beneficial for agencies from different sectors to clarify safeguarding referral expectations. Alongside this document, was the consistent review of safeguarding demand on services, shared within multi-agency panels and meetings. This enabled practitioners to have continued clarity on the changing nature of the vulnerability, whilst being cognisant of their agency thresholds and processes, to be able to respond appropriately according to their own agency remit.

#### • **Joint-agency Scrutiny of Cases**

Scrutiny of reviews such as Child and Adult Practice Reviews were completed as part of some regular multi-agency forums. This provided a platform to scrutinise decisions across the agencies and identify ownership of roles and thresholds to ratify the current arrangements. This included asking questions such as how different agencies would have responded in this situation and questioning whether the same outcome have occurred. This process allowed each agency and practitioner's role to be understood in addition to clarifying and reviewing the processes and structures in place to safeguard.

#### • **Sector Specific Multi-Agency Representation within Safeguarding Team/ Hub or MASH**

This was felt to increase clarity in sector specific processes, which in turn affected confidence and competence in referring agencies responding to safeguarding concerns. For example, having the Police based within the Safeguarding Hub alongside Social Workers, was noted to speed up decision-making, subsequent action and follow up, as there was a sector specific knowledge of agency remit. In addition to the Police, having Educational Link Workers based within the Safeguarding Team also enhanced clarity of submitting referrals, managing risk, and ascertaining the most appropriate and up to date information. This clarity also allowed for a development of confidence and competence as link workers also facilitated training for practitioners.

#### • **Referral Audits**

Referral Audits were being undertaken to examine referrals which had been submitted from a specific sector such as Education, to ascertain what more could have been done and by whom, at various stages, to prevent a young person being involved within the child protection system. This could identify and assess whether having the 'what matters' conversation earlier, if appropriate, would have changed the outcome. Identifying the points within the safeguarding process where there are issues and providing feedback and additional training, if required, was seen to increase the confidence of practitioners in gathering the information from the person of concern. Therefore, this could result in higher quality and appropriate referrals.

- **Informal Consultations with Multi-agency Safeguarding Hub (MASH), Safeguarding Hub/Team**

This consultation allowed for clarification on safeguarding concerns by offering advice at the point in which is required. It also facilitated discussions regarding what information was necessary from referring agencies to ensure that a referral had the appropriate level of detail to direct action. These conversations also helped to build up relationships and enabled feedback discussions to take place to understand updates and progression of referrals.

- **Multi-agency Training**

This was noted to be key in ascertain clarity for the multi-agency safeguarding process. Allowing practitioners from different sectors to come together to learn about specific safeguarding issues in a collaborative environment allowed for a shared learning, holistic understanding, and a collective responsibility to be developed. This enhanced practitioner confidence and competence in responding to safeguarding concerns. This training was felt to be required regularly, to reflect current trends, challenges, and emerging practice.

## STRUCTURES AND PROCESSES

### CONGRUENCE IN STRATEGY TO OPERATIONS:

- **Operational Practitioner Experience**

When leaders had had frontline practitioner experience it was seen as advantageous to understanding the operational issues, challenges and pressures. This supported a broader understanding and holistic approach when resolving any potential disconnect between strategic vision and operational viability.

- **Strategic and Operational Joint Decision-Making**

Examples of two senior practitioners screening referrals which come into a MASH, in addition to a Principal Social Worker, allowed for greater discussion, trust and accountability within a team. It also contributed to less pressure and anxiety in making decisions in silo.

- **Proactive Managers and Leaders**

Having managers and leaders who were prepared to 'roll their sleeves up' and get involved with frontline activities to ensure that they had up to date knowledge in responding to current safeguarding



challenges was viewed as valuable. As was having managers present, who were visible and engaged in conversational discussions with team members, either over video calls or face to face.

- **Multi-sector Experience**

When managers and leaders had significant experience of safeguarding such as within a certain profession and then moved to manage another team, this was found to potentially influence the way that team understands and applies safeguarding knowledge within their role. This contributed to an aligned vision and enhanced overall collective safeguarding responsibility.

## **CO-LOCATION AND COOPERATION:**

- **Hybrid Multi-agency Front Door**

Having the Police co-located within the Safeguarding Hub/ MASH was noted to have multiple benefits in facilitating joint work, initiating timely discussions and faster decision-making. It shaped future action and allowed for clarity regarding roles and sectors and remit at various stages of the safeguarding process, as opposed to a one-off interaction.

Having the opportunity for other agencies to base themselves out of the Hub, such as Early Intervention and Prevention Teams, Youth Justice and Health Professionals, on certain days of the week was beneficial to establish relationships and communicate updates. This enabled an organic process for practitioner relationships to develop, in turn creating a basis for a collective safeguarding responsibility.

- **Inclusion of Domestic Abuse as Safeguarding Hub**

Including Domestic Abuse Practitioners within the MASH or Safeguarding Hub was seen as advantageous in ensuring that appropriate and timely advice and expertise was utilised in decision-making. It also generated a shared knowledge and understanding and facilitated relationship development for those cases requiring ongoing safeguarding support. Having IDVAs (Independent

Domestic Violence Advocates) also based within hospitals was felt to be beneficial for providing that point of crisis support and linking agencies.

- **Early Intervention and Prevention Co-located Teams**

The co-located teams of Health and Social Care including Social Workers, Family Support Workers, Health Visitors and Midwives, all based within one building was felt to have benefits for allowing a joint approach between practitioners and making it a more streamlined and accessible service for families, to have one central base. Some areas also had a wider remit of agencies collaborating from one base, on a flexible basis, such as Housing and Psychological Wellbeing advisors.

- **Inclusion of Children's and Adult's Services**

The inclusion of Children's and Adult's Services being located together within the same office or building, was felt to be beneficial for building those practitioner relationships and ascertaining a crucial insight into the processes and structures and key partner organisations. This was particularly key for when responding to whole family issues.

- **Cooperative Working Base Arrangements**

In rural locations whereby co-location was not as logistically accessible, some areas stated that they would utilise partner agencies buildings to base themselves on certain days. This strengthened the relationships between practitioners and enhanced cooperation in joint working and understanding different remits, without the bind of having to work from a central location. It also had the benefit of working from an area which may be based to where families and individuals live for home visit and direct work.

## **CULTURE OF INCLUSION, TRANSPARENCY AND CHALLENGE:**

- **Inclusion and Representation Meetings**

Having an inclusive approach involving Statutory and Voluntary and Charity Sector agencies, at both operational level and strategy level for multi-agency meetings was considered key, ensuring that unique perspectives and knowledge are shared, facilitating a holistic safeguarding response.

- **Clear Guidance Documents**

Clear processes, protocols and procedures that were documented, available and promoted to practitioners was fundamental in ensuring there was consistency in understanding. For example, the Protocol for the Resolution of Professional Differences, was highlighted as allowing appropriate levels of challenge and escalation to be facilitated formally, should it be required.

**“ Congruence between senior leadership level, the frontline workforce, and all levels in between, in relation to safeguarding responsibility, is imperative. ”**



### • Investment in Culture of Professional Challenge

In addition to formal guidance and protocols, an active commitment and investment to developing a culture of professional challenge was reported by some areas, facilitated by leadership. All agencies and practitioners were recognised and valued as having key knowledge, skills and expertise and therefore were encouraged to contribute and express their opinions.

### COHESION BETWEEN SERVICES:

#### • Combined Children's and Adult's Safeguarding Team

In some areas there was restructuring to formulate one safeguarding team for Children's and Adult's safeguarding. This was noted to increase understanding of the whole family, create a shared understanding of vulnerability, and remove silo practice. It was also felt to increase resilience within the Social Service workforce and develop competence and confidence as individual practitioners.

#### • Integrated Duty Desks

Within Adult's Services it was highlighted that practitioners from different agencies were involved in a rota for receiving and responding to referrals which came in from the duty desk. This allowed for a shared learning and perspective to be developed as well as a collective responsibility.

### • Joint Case Management

There were examples of joint case management systems which allowed for the most appropriate service to lead but enabled ongoing review which allowed for a more seamless service transition. For example, Occupational Health and Adult Safeguarding were identified in one area as having a system whereby the lead professional can be flexibly changed accordingly, dependent on the circumstances, based on regular discussions and reviewing shared information between the two teams, to ascertain appropriate response to families and individual's needs.

#### • Transitional Support

For families who may no longer require statutory intervention, it was noted that by having Early Intervention Practitioners invited to their final meeting it provided a comprehensive introduction. This was argued to facilitate greater engagement between families and Early Intervention and Prevention Services, ensuring families had a continuation of support to prevent crisis, where appropriate. This joint working between Statutory and Early Intervention and Prevention was also highlighted as being beneficial when there were concerns a family required an escalation in support from Early Intervention to Statutory. In this scenario, joint meetings to the family between services were considered effective.

#### • Aligned Forms and Protocols

There were examples whereby agencies working alongside each other in the Safeguarding Hubs were combining forms to save on duplication such as Social Services and Police. In addition, one area aligned referral processes within the Hub to ensure that any referrals requiring Youth Justice support were taken off the system and transferred to Youth Justice system, within a short timeframe. This ensured that they were actioned efficiently, regardless of point of entry.

### CONTINUITY, CONSISTENCY, STABILITY AND SUPPORT,:

#### • Recognition, Development and Progression

There were examples of rewarding staff and recognising their hard work, such as giving practitioners a day's leave to thank them. There were also examples of investments in current staff and working to develop skills with clear opportunities for career progression.

#### • Staff Wellbeing

Examples of investment in wellbeing included providing opportunities to participate in therapeutic support, providing courses and access to specialist practitioners when required, such as providing support for trauma, was noted by





some organisations. A culture of approachability was noted in some areas whereby practitioners felt they could comfortably approach managers and leaders to discuss concerns or worries. There were also notable opportunities to facilitate casual, non-work-related conversations which occurred both face-to-face and online.

#### • **Recruitment**

Some local authorities were actively sponsoring individuals to become qualified as Social Workers and paying for qualifications and providing a variety of holistic placements to develop experience.

### **COORDINATION OF DATA COLLECTION:**

#### • **Shared Databases**

Despite challenges, there were examples whereby WCCIS was being utilised across agencies and this enabled a sharing of timely information. For example, one region highlighted that Domestic Abuse Practitioners having access to the system allowed them to understand immediately if there was social service involvement which was key in multi-agency working. There were some examples whereby safeguarding practitioners were able to access different organisations databases, such as police officers who were seconded to organisations such as Youth Justice and those working closely with Education, who were given log on details to the schools database.

#### • **Data Reports**

A good example of bringing different aspects of data together was seen in a reporting format called AAA: Alerts, Assurance and Achievements. This ensured that within the report was the inclusion of areas of concern and escalation, but also understanding what has gone well and the impact of their work. This was forwarded to the whole organisation and used to inform future service delivery.

#### • **Documenting Incremental Progress**

There were examples within local authorities whereby there was a focus on the safeguarding journey of families and individuals and a recording of incremental steps of progress.

#### • **Analysis of Data Trends and Deep Dives**

There were examples of analysis being conducted including quantitative data and audits, to explore cohorts of service users, levels of engagement and patterns and thematic trends in data. This was used to influence future decision-making, processes, and pathways. For example, a triage system to ascertain which families and individuals who had been referred needed that immediate contact from an agency during a crisis and those

who could be placed on the standard waiting list, to increase engagement of support. Other examples allowed for more specific and tailored responses to safeguarding issued and designated pathways to respond to a particular type of vulnerability, such as child criminal exploitation and county lines.

### **COLLABORATION FORUMS AND PATHWAYS:**

#### • **'What Matters' Agenda**

The introduction of the 'what matters' agenda in Wales has provided a vehicle for formalising collaborative working with service users and families and ascertaining what matters to them at the first point of contact and assessment, as well as developing a plan of support.

#### • **Independent Advocacy**

This was something which was promoted by local authorities, but which was facilitated by outside organisations. The use of an Advocate provides an important mechanism in which services can work in partnership to support the service user. It was also mentioned that in instances where an individual is deemed not to have capacity there are different communication aids and close working with the family and friends, yet it was acknowledged that independent named Advocates can be helpful as well to represent a service user's views.

#### • **'Distance Travelled' Tool**

In Early Intervention and Prevention Teams, consultation was sought with families at the beginning of the partnership working to understand where they felt they needed support and this was completed when support interventions were coming to an end, to understand what progress had

been made, in the form of a scoring system and accompanying narrative.

- **Satisfaction Survey**

Early Intervention and Prevention Teams offered out Satisfaction Survey's to Adults and Children to understand if their support had benefitted families and in what way, and what could have been done better. It also explored further details around whether families felt respected, understood, supported, and if they acknowledged their progress and fundamentally, if they felt practitioners were clear.

- **Interactive Feedback Apps**

Within Youth Justice there were examples of interactive apps being utilised to understand the experiences that young people had working with Youth Justice practitioners, how they had helped, in what was and how this could be improved. Again, with a focus on whether they felt they were listened to, respected, understood, and supported. Crucially, there were plans to not just offer this opportunity for feedback at the start and the end of the safeguarding intervention process, but also at a review point during the middle of the partnership working so that any changes could be acted upon.

- **Consultation Projects on Service Delivery Design**

Examples were discussed whereby young people were invited to feedback on their experiences, including groups of young people who were cared for by the local authority, and to have an input into future service design and delivery. This was in the form of a creative approach such as allowing young people to create poems, songs, and raps to express their opinions.

- **Conversations with Former Service Users**

Conversations with individuals and families who have previously accessed local authority support

were being conducted by one local authority, to understand their experience of receiving safeguarding interventions to learn what could be done better to provide the most effective service possible.

- **Resident and Carer Forums**

Within Adult's care provision there were examples of residents and carers forums, whereby families and individuals had a platform to be consulted and opportunity to raise concerns and suggestions.

- **Peer-led Service User Groups**

Peer-led service user groups were identified in a local authority, whereby a service user group initiated between practitioners and service users could be consulted on their views, and experiences to feedback into future service delivery. It also provided an opportunity for peer-led support and for service users to form connections and friendships.

- **Independent Evaluation**

In some organisations, particularly the third sector, there were examples of independent evaluations being commissioned to understand effectiveness and impact of service delivery and these included consultations and interviews with service users to understand their perspectives and experiences. This could then influence future practice and service delivery.

## **COMMITMENT AND CREATIVITY:**

- **Creating Opportunities for Practitioners to Network**

It was noted that having the opportunity for practitioners across agencies to come together through training and networking was fundamental in forming relationships, creating shared understanding, and stimulating rich discussions and debates. It also offers a space to reflect and discuss current safeguarding challenges across sectors. Opportunities to celebrate practitioners for their commitment and achievements was also suggested to recognise good practice.

- **Valued Contributions from Team Members**

Having the opportunities for teams to be consulted to contribute to key decision-making for services was recognised as motivating and key to stimulating creativity and sharing positive ways of working.

- **Innovative Working**

It was highlighted that some leaders and managers are proactive in encouraging, embracing, and facilitating new ways of working which require a change from the working norm. This drive to be brave and initiate change and different ways of working, was noted to be helpful from top-down management but also utilising ideas from the ground up.



# 12Cs Self-Assessment Framework V1

The 12Cs is an evaluative tool and each of the 12 components can be quantitatively and qualitatively evaluated to assess strengths and weaknesses of multi-agency policy/practice interventions and measure and progress. The two examples below are aligned to Care Inspectorate Wales and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) but can be amended accordingly.

C8: Congruence in Strategy to Operations					
HMICFRS Gradings	1	2	3	4	5
	Inadequate	Requires Improvement	Adequate	Good	Outstanding
HMICFRS Definitions	There are causes for concern and recommendations must be made and addressed	Intervention has demonstrated few, if any, of the characteristics of good performance, and substantial number of areas require improvement	Intervention demonstrated some of the characteristics of good performance, areas for improvement identified	Intervention substantially demonstrated all the characteristics of good performance	Intervention substantially exceeded the characteristics of good performance
12Cs Progress	Practice Intervention/ Policy identified but not progressed	Practice Intervention/ Policy identified and agreed by key partners. Implementation plan finalised, start date agreed	Practice Intervention/ Policy initiated, implemented and undergoing review and refinement	Practice Intervention/ Policy fully implemented, embedded and functioning well	Practice intervention/ Policy embedded, functioning optimally, sustainably and exceeding expectations
Self-assessment score			X		
Evidence for self-assessment score	Narrative explaining the evidence for self-assessment score reached. Examples should specifically identify any Policy or Practice interventions/support				
Accountability, Ownership and Governance	Who is the lead person/people/ agency responsible for coordinating/driving action on this?				
Stakeholder Partners	Which stakeholders/partners are part of the delivery/achievement of this component and what is their role?				
Specific Action Plan	What is required to implement, improve, or sustain work on this component?				
Implementation Timeframe	What are the timeframes and review points: Strategic Longer-term/ Operational Shorter-term?				

CIW Gradings	1	2	3	4	5	6
	Unsatisfactory	Weak	Adequate	Good	Very Good	Excellent
CIW Definitions	Major weaknesses - urgent remedial action required	Important weaknesses - priority action required	Strengths just outweigh weaknesses	Important strengths, with some areas for improvement	Major strengths	Outstanding or sector leading
12Cs Progress	Practice Intervention/ Policy identified but not progressed	Practice Intervention/ Policy identified, key partners consulted, logistical requirements discussed	Practice Intervention/ Policy agreed by key partners, implementation plan finalised, start date agreed	Practice Intervention/ Policy implemented and in early stages of operation, undergoing review	Practice Intervention/ Policy implemented operating well, undergoing refinements where necessary	Practice Intervention/ Policy embedded, functioning optimally and sustainable





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