NCVPP

National Centre for Violence Against Women & Girls and Public Protection

Practice Advice to Support the Writing of Individual Management Reviews

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College of Policing

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Contents

Produced by the Vulnerability Knowledge and Practice Programme (VKPP) as part of the National Centre for Violence Against Women and Girls and Public Protection.

1. Maximising the quality of statutory safeguarding reviews and individual management reviews

1a. The development of practice advice

Individual management reviews (IMRs) were established within the statutory guidance for domestic homicide reviews (DHRs). Guidance notes that IMRs provide an opportunity for 'agencies to look openly and critically at individual and organisational practice, and the context within which people were working, to see whether the homicide indicates that changes can and should be made' (Home Office, 2011). There is an emphasis on IMRs identifying where changes to practice are necessary, how these changes will be actioned, and also identifying examples of good practice within the individual organisation's response (Home Office, 2016). Importantly, IMRs should build an understanding of what happened and why, and how future practice can be improved.

Whilst a few examples exist, there is a notable gap in the provision of guidance for police review officers writing IMRs, particularly those contributing to reviews other than DHRs. Clear guidance is crucial to ensure that reviews are high-quality and extract valuable learning. Examples of what 'good' looks like for IMR reports are also limited.

In light of this identified gap, we have produced this practice advice to support the writing, and enhance the quality, of IMRs. This advice has been informed by our own work exploring the quality of IMRs and statutory reviews, alongside the evaluation of a number of report templates provided by forces or produced as part of statutory guidance documents/toolkits. A full list of the sources used can be found in Appendix A.

We recognise that there is significant variation in terms of how policing review teams operate across England and Wales. Forces often work across a number of local authority areas and with a diverse range of statutory review authors. This means they are often asked to work to a wide range of templates and with authors who have different approaches. This may explain some of the variation we have observed in our own work looking at IMRs.

1b. Evaluating the quality of statutory reviews

Since the inception of the Vulnerability Knowledge and Practice Programme (VKPP), now working as part of the National Centre for VAWG and Public Protection (NCVPP), one of our key workstreams has focused on the analysis of statutory reviews, including safeguarding adult reviews (SARs), local child safeguarding practice reviews (LCSPRs) (previously serious case reviews (SCRs)), DHRs[1]; and multi-agency public protection arrangement (MAPPA) reviews.

1 Consultation is ongoing which proposes renaming these to Domestic Abuse Related Death Reviews (DARDRs).

Statutory reviews are reports produced after incidents of death, serious harm or neglect to examine the circumstances around the case, and prior agency involvement, with the purpose of extracting learning to avoid the occurrence of a similar incident (CPS, 2023). Our previous work has identified concerns regarding:

1. The quality of the reviews themselves.
2. A lack of consistency concerning the recording of protected characteristics within reviews.
3. Issues concerning the extraction and implementation of learning and recommendations from reviews, particularly for policing.

Our findings are similarly echoed within the wider literature, with authors emphasising the need for reviews to be of high-quality (Rowlands & Bracewell, 2022; Preston-Shoot, 2021); for reviews to clearly set out recommendations for practice (CSPRP, 2024a); and a lack of consistency in reporting victim characteristics within reviews (CSPRP, 2023; Local Government Association, 2024; Dickens et al., 2021).

1c. A focus on individual management reviews

Similarly to statutory reviews, previous research has identified concerns regarding the quality of IMRs (Local Government Association, 2024) alongside questions about the level and depth of reflective analysis contained within these reviews (Preston-Shoot, 2021).

To explore this further, we engaged in an analysis of a sample of 48 IMRs from 11 police forces across England and Wales (VKPP, 2025[2]) to explore the quality of these reviews. Key findings from this analysis were:

1. Most of the IMRs had a clear focus and were clear to follow. For some IMRs however, there was a lack of focus on the victim and on the context of the review.
2. Variation was observed in the length of IMR reports and in the length of time taken to complete the IMR, although this was not directly linked to the overall quality of the review.
3. For nearly half of the sample, an analysis of 'why' events had occurred was included but not to a great degree. This reduced the learning that could be taken from the review.
4. Most language used was appropriate, however we did see some limited examples of victim-blaming language.
5. Victim characteristics were inconsistently captured, with most reviews capturing the age and sex of the victim. For all other characteristics, including ethnicity and disability, over half of the sample did not clearly record this information.
6. Only approximately a quarter of IMRs fully captured the voice of the victim, and a very small number considered race, culture and intersectionality[3] successfully.
7. Just under half of the sample commented on how to remedy the identified practice issues in the future, while half identified examples of good police practice.
8. There was an emphasis on learning for both the system and the individual, however we did identify a greater focus on system-learning.

2 An internal report has been produced for this work and is available on request.

3 Crenshaw (1989) defines intersectionality as a "metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking".

9. Just over half of the IMRs included at least one recommendation. Recommendations did not, however, clearly identify how progress would be assessed, nor did they often include clear timeframes for implementation.

10. Only two IMRs clearly outlined how the identified learning would be fed back into the system.

Our findings supported the development of a number of indicators of what 'good' looks like for IMRs. These findings are presented below.

IMRs are an iterative process and enable two-way dialogue between the IMR author and the statutory review author to ask questions of agencies to ensure that effective, and high-quality learning is taken from tragic incidents. We recognise that each review will have its own terms of reference (ToR) and that templates provided by statutory review authors can vary.

This practice advice is not intended to replace the ToR or IMR template. Instead, this document provides a checklist of the information that should be considered to ensure the highest quality information is captured within IMRs and used to inform the statutory review. This resource does not present an exhaustive or prescriptive list of either the structure of, or what should be contained within, an IMR.

There may be additional sections within IMRs that are not covered in this document, such as a statement of author independence or information on the forces' structure. Advice should therefore be sought from the statutory review overview author on what the IMR should contain, and IMR authors should consult with statutory review authors if they wish to make edits to the template they provide. IMR authors are also able to request a practitioner briefing from the statutory review overview author to enable them to ask questions about the expectations and requirements of the IMR.

IMRs provide a valuable opportunity for you, as review officers, to:

1. Be transparent about what information is available to you.
2. Identify where information is not available and where questions and uncertainties exist.
3. Critically analyse what went well, and be upfront about missed opportunities in police practice.
4. Be assertive in identifying learning and recommendations to improve police practice and ensure that individuals are effectively safeguarded.

The checklist below, along with the advice on individual sections within the IMR, is intended to support you to do this effectively. This resource will also be used to inform the Review Officer Training Course delivered by the College of Policing.

Please note:

- This practice advice does not replace statutory guidance, or the guidance and direction provided by statutory review authors.
- Ensure you liaise with the statutory review author to obtain clarity on what should be included within the review and discuss any proposed changes to their template with them in advance.

2. Practice advice regarding individual management reviews

Recording the victim/suspect's characteristics

- ✓ Have you clearly recorded all the known characteristics of the victim and suspect within the IMR, and identified where this information is not known?
- ✓ Have you considered how professional decision making has been influenced by the victim/suspect's characteristics?
- ✓ Have these characteristics, and how they intersect, been considered throughout the analysis?
- ✓ Have you taken these characteristics into account when considering the victim/suspect's interaction with services and the relevance of these characteristics to the incident?

The importance of appropriate language

- ✓ Is the language used to describe the victim and their actions neutral in tone, avoiding assumptions or judgements?
- ✓ Is the language used within the IMR clear to a range of audiences, with definitions provided where specialist terminology and acronyms are used?
- ✓ Have you considered how the language you use could be interpreted and received by the victim or their friends and family, if included in the published statutory review?

IMR methodology

- ✓ Have you clearly recorded the steps taken to conduct the IMR, including identifying which systems have been accessed, and what interviews have been conducted?
- ✓ Have you identified the sources of information you have not been able to access, and the reasoning for this?
- ✓ If you have utilised a specific methodological approach when conducting the IMR, have you identified this within the report?

Overview of police contact

- ✓ Have you presented a clear overview of all relevant events of police contact concerning the victim/suspect within the timescale under review?
- ✓ Have you avoided repetition of the presentation of significant events, where possible?

Analysis of police practice

- ✓ Have you critically analysed all relevant police contact throughout the review period?
- ✓ Have you explicitly identified whether practice was consistent with policies/ procedures at the time of the incident?
- ✓ Have you ensured that missed opportunities and evidence of good practice, where identified, are highlighted within the review?
- ✓ Have you addressed all points within the terms of reference?

Identification of learning points

- ✓ Are the learning points clearly defined and linked back to the significant incidents within the review?
- ✓ Have you identified where action has already been taken to address the identified learning points, where appropriate?

Recommendations

- ✓ Are the recommendation(s) clearly aligned to the learning identified within the review?
- ✓ Have you ensured that recommendation(s) are outcome-based and adhere to the SMART criteria, where this information is available to you?
- ✓ Have you completed the action plan template in full?

Getting learning back into the system

- ✓ Where this information is known, have you clearly identified who holds ownership for implementation of the recommendation(s)?
- ✓ Have you clearly recorded the IMR request and completion date, including providing a clear rationale for any delays in the process?
- ✓ Have you linked in with your force's vulnerability and public protection strategy?

2a. Recording the victim/ suspect's characteristics

The aim of statutory reviews is to identify lessons to avoid the recurrence of a similar incident in the future. Guidance emphasises the central role of the victim (Home Office, 2024) and the importance of reviews in presenting an understanding of the victims' lived experiences. Exploring the victims' protected characteristics is important to develop an understanding of their experiences of victimisation and vulnerability, and thus should be considered within the review process (Home Office, 2024). Within our sample however, only a very small number of IMRs fully captured the characteristics of the victim.

The Equality Act (2010) identifies nine protected characteristics: age; gender reassignment; marriage and civil partnership; pregnancy and maternity; disability; race including colour, nationality, ethnic or national origin; religion or belief; sex; and sexual orientation. The Act legally protects individuals from being discriminated against on the basis of these characteristics.

Without accurate recording and appropriate consideration of this information, we cannot know the relevance of these factors to the incident itself, and our understanding of the impact of certain characteristics on professional decision-making will similarly be incomplete (Child Safeguarding Practice Review Panel (CSPRP), 2022; 2025). Furthermore, without accurate recording of this information, the ability of agencies to understand how certain crimes may be impacting particular groups is limited and systemic practice issues concerning particular groups may be missed (Research in Practice, 2024).

We do however recognise the challenges for police authors in recording and including this information within IMRs including:

- The absence or inaccurate recording of this information within police databases.
- Concerns regarding the disclosure of sensitive information within statutory reviews for fear of identifying the individual or disclosing personal information not known to the victims' friends or family.

Whilst some of these may be beyond the control of IMR authors to moderate, we would strongly encourage including this information where it is known. Recording this information in the internal IMR is important for a number of reasons:

1. It keeps the victim as the focus within the report and ensures that all elements of their identity are considered, including how they may intersect.
2. For internal agency use, it will help to identify if any systemic practice issues concerning particular individuals/groups exist. This will inform the development of appropriate learning points and recommendations and ensure that victims are better protected.
3. Having a better understanding of how certain individuals may be affected by particular incidents is important to ensure equitable service access. It also encourages multi-agency services, including the police, to consider how they can adapt to meet the diverse needs of individuals (Chantler et al., 2023; Chantler et al., 2024).

To ensure these characteristics are included within IMRs, it may be helpful to include a table to support the recording of the characteristics of the victim and suspect. Within our analysis of IMRs, we identified that having a clear table at the beginning of the document which provided details of the victim and suspect characteristics was beneficial to support understanding and emphasised the focus on these individuals. An example table is provided below (see Table 1). This table could also be replicated for other relevant individuals where appropriate.

An additional table, with suggested categories under each of the headings, is included within Appendix B. This includes identifying where information about characteristics is not known to you as the IMR author.

Table 1

Example of a table to be used to record the protected and other relevant characteristics of the victim and suspect within an IMR.

	Victim Details	Suspect Details	Are there any known restrictions to this information being published within the statutory review? (If yes, please provide details)
Name (including aliases) Pseudonym to be used in published review			
Address			
Date of Birth			
Sex			
Gender Reassignment[4]			
Ethnicity			
LGBTQ+			
Religion/Faith			
Disability Status			
Was the individual pregnant at the time of the incident?			
Is the individual married or in a civil partnership?			
Are there any other characteristics, not captured under the Equality Act, which are relevant to the review?			

4 We are mindful that there may be some concerns about including this information due to legislation within the Gender Recognition Act (2004). Please consult your own data protection or legal team to seek further guidance on this, where necessary.

Discussions with statutory review authors highlighted that using the name of the victim within the report, as opposed to their initials, can ensure that the focus is maintained on them throughout the report. The inclusion of the names of all relevant individuals also facilitates easier identification of these individuals. This information will be removed by the statutory review author, prior to publication.

Things to Consider

- ✓ Have you clearly recorded all the known characteristics of the victim and suspect within the IMR, and identified where this information is not known?
- ✓ Have you considered how professional decision making has been influenced by the victim/suspect's characteristics?

Intersectionality

To support the identification of learning, it is important that reviews go further than simply presenting the victim/suspect's characteristics. They should also consider the ways in which different aspects of a person's identity overlap to shape their lived experience. As a result of these intersecting identities, individuals may be at increased risk from abuse, and may find it more difficult to access services (Home Office, 2024). Intersectionality is defined as an understanding of the multiple vulnerabilities and disadvantages that a person can experience. These can compound to create specific and unique obstacles for individuals that are not explained by individual characteristics alone (Crenshaw, 1989). Within our analysis of IMRs, we observed limited consideration of intersectionality. In order to ensure that IMRs are considering intersectionality throughout, we would encourage reflection on:

- What barriers have been experienced by the victim/suspect and how have these impacted their lived experience and interaction with services?
- The accessibility of services to the victim/suspect.
- How have the victim/suspect's different characteristics interacted to influence how they were viewed and treated by others, including by police officers and staff?
- Is there evidence that the characteristics of the victim/suspect impacted the decision making of police personnel?[5]

Things to Consider

- ✓ Have these characteristics, and how they intersect, been considered throughout the analysis?
- ✓ Have you taken these characteristics into account when considering the victim/suspect's interaction with services and the relevance of these characteristics to the incident?

5 The following resource may be beneficial to support you to develop your understanding of intersectionality and to consider how to address intersectionality within reviews: https://www.youtube.com/watch?v=SIgZ_Ncp5zc

2b. The importance of appropriate language

Individual management reviews are a mechanism for extracting system learning for agencies. However, using language which appears to blame the victim can shift the focus to what victims themselves could or should have done differently, as opposed to focusing on extracting agency learning (Dangar et al., 2023). Using victim-blaming language within reviews can also give a false impression of the victims' agency at the time of the incident (Dangar et al., 2023). It is therefore important to ensure that the language used within IMRs is professional and respectful in tone and does not apportion blame to individuals involved in the case, particularly the victim.

There is a significant volume of literature which evidences the impact of victim-blaming language more widely, noting that a professional narrative which imposes blame on victims can affect the professional response to these individuals (IOPC, 2024; UK Council for Internet Safety, 2024).

Within our analysis of IMRs, we largely observed the use of appropriate and sensitive language. However, within a quarter of our sample, we identified potentially inappropriate language. This included comments on the victim's health and wellbeing, and comments which appeared to apportion blame to victims for their own victimisation.

To support you in ensuring that the language used is appropriate within IMRs, it is important to be mindful that:

1. Victims are not responsible for their own victimisation and it is not the responsibility of victims to ensure that agencies can support them. Agencies need to consider how they can modify their approaches to ensure that their services are accessible to all.
2. If known, use the language the individual prefers or uses to describe themselves and their experiences.
3. Be mindful of how your language may impact individuals from different ethnic backgrounds and heritages - for example, avoid the use of the term "hard to reach".
4. Be mindful of how the language you use can influence the perceived agency of the victim and describe events and behaviour objectively.
5. Avoid the use of criminalising language when discussing suspected suicide, for example, avoid use of the term "suspected to have committed suicide" and instead use "the victim is suspected to have taken their own life" or "suspected to have died by suicide".
6. Ensure the focus is on police/agency learning, as opposed to providing recommendations for what victims could have done differently.
7. Ensure you do not make assumptions about the mental health of the victim or suspect.

Where quotes or inferences about the victim are included, ensure you clearly identify where this information was obtained (for example information within police databases, information provided by the victim themselves) and it is clear that these are not your personal views or reflections. Ensure that direct quotes are attributed to the individual who made them.

You may observe the use of problematic or victim-blaming language within police databases or records. It is important to recognise and identify this within the IMR and to consider how this language may have influenced how the victim was perceived by agencies. We recognise that language and policy is ever changing. It is therefore helpful to frame this language within the context of policy and accepted terminology at the time of the incident.

The following guidance/resources may be of benefit to support you to reflect on and consider the language you are using within reports:

1. An appropriate language guide, produced by the Hydrant Programme: Appropriate-Language-Guide-Final-English.pdf
2. Guidance on the importance of language related to domestic abuse, produced by NSPCC: Why language matters: domestic abuse is broader than domestic violence | NSPCC Learning
3. Guidance for professionals on the appropriate use of language produced by Women's Aid: Appropriate language guidance for professionals

It is also important that language used throughout the IMR is clear and comprehensible to a wide range of audiences, including those without specialist knowledge of policing structures, policies and procedures. This includes statutory review chairs and authors who are likely to come from a variety of backgrounds. Where possible, IMRs should avoid the use of jargon and acronyms. IMR authors should also be mindful that terminology is not used universally throughout forces and may be used in different ways by different forces. Where the use of specialist terminology and acronyms is considered necessary, it is important that all terms are clearly defined.

Things to Consider

- ✓ Is the language used to describe the victim and their actions neutral in tone, avoiding assumptions or judgements?
- ✓ Is the language used within the IMR clear to a range of audiences, with definitions provided where specialist terminology and acronyms are used?
- ✓ Have you considered how the language you use could be interpreted and received by the victim, or their friends and family, if included in the published statutory review?

2c. IMR methodology

Within our IMR analysis, three-quarters of the sample identified the sources of information used to inform the report. These sources included information captured on police records and databases, interviews with relevant police officers and staff, and references to local and national guidance. Some IMRs also included information about the finalisation of the report, including the quality assurance process and arrangements for debriefing staff.

In order to ensure clarity and transparency about the process of conducting the IMR, it is important for the author to clearly identify the sources of information used to inform the review including:

- The police databases and systems accessed, including any systems you have been unable to access and the reasoning for the access limitations.
- Information regarding relevant force policies you have used to inform the review, including links to these policies where they are available.
- Information regarding national guidance and policies relevant to the review, including statutory guidance or authorised professional practice, alongside links to such guidance where available.
- Information about interviews with relevant police officers and staff including:
    - Details of police officers and staff involved in the events under review. Names of involved individuals should be used within the IMR to enable easy identification by statutory review authors, particularly when cross referencing with other agency reports. These details will be later removed by the statutory review author.
    - Information about which of the above individuals you have spoken to as part of the review, and the information obtained as part of this process.
    - Information about which officers and staff involved in the events you have been unable to speak to, and the reasoning for this.

Within our analysis of IMRs, we did not observe any review which noted use of a specific methodological approach. Whilst this is not expected practice, you should clearly identify if you have utilised a specific methodological approach, for example, a systems thinking approach[6] (Munro, 2010), when completing the IMR.

Things to Consider

- ✓ Have you clearly recorded the steps taken to conduct the IMR, including identifying which systems have been accessed, and what interviews have been conducted?
- ✓ Have you identified the sources of information you have not been able to access, and the reasoning for this?
- ✓ If you have utilised a specific methodological approach when conducting the IMR, have you identified this within the report?

6 Munro. (2010). The Munro Review of Child Protection: Part One: A Systems Analysis: TheMunroReview-Part_one.pdf

2d. Overview of police contact

Within our analysis, we noted that most IMRs within the sample presented a full and clear overview of relevant agency contact. Reviews which began with a clear summary of events were observed to be the easiest to follow and maintained a clear focus throughout.

It is important that sufficient detail is provided to ensure the reader has a clear understanding of the context surrounding the review, and of the relevant events of agency contact with the victim/suspect within the timescale under review. We did however see some evidence of substantial repetition between the overview of agency involvement and the analysis of agency involvement. This limited the clarity of the IMR.

It is helpful to provide a clear overview of the context surrounding the review at the outset of the report. The inclusion of a table to set out all further significant events of police contact within the timescale under review may also be helpful. This can maintain the focus on key events and enable the reader to clearly identify the level of prior agency involvement with the victim and/or suspect.

The overview of agency contact should:

- Provide clear details about all relevant events within the timescale under review, in a chronological order. This should also identify whether agency contact was with the victim, suspect, or other relevant individual.
- Identify which agency/agencies were involved in the relevant events, and note the action taken by agencies in response to this.
- Avoid repetition where possible, to ensure the review is concise and clear to the reader.

There may be relevant events of police contact with individuals involved in the case which fall outside the timescale under the review. Consideration should be given to including this information within the IMR, where relevant and appropriate to do so.

Things to Consider

- ✓ Have you presented a clear overview of all relevant events of police contact concerning the victim/suspect within the timescale under review?
- ✓ Have you avoided repetition of the presentation of significant events, where possible?

2e. Analysis of police practice

IMRs should provide an overview of what happened, but crucially, must also provide an analysis of the agency response in order to facilitate learning. Most IMRs within our sample provided at least some analysis of the police response and how this impacted the incident that triggered the review. Just under half, however, did not include this to a great degree.

The use of dedicated sections for analysis, where this was contained to one section or dispersed throughout the report in relation to each key incident, was associated with clear and consistent analysis. As detailed above, the inclusion of analysis against each significant incident can be particularly helpful to ensure the analysis is clear and targeted and avoids repetition of the significant events. Authors should also consider the agency response to incidents as a whole, to avoid a siloed approach to evaluating agency practice and learning.

We observed some inconsistency in the depth of analysis offered by IMR authors, with some IMRs including no analysis and others including analysis that lacked detail. Higher quality IMRs were noted to identify actions and decisions which went against expected practice and offered an explanation as to why this may have occurred.

Whilst not consistent throughout our sample, some IMRs we reviewed included analysis which also demonstrated an awareness of the contexts within which individuals were working. For example, analysis may have identified a lack of information sharing and then gone further to explore the factors which inhibited information from being shared e.g. high levels of demand, insufficient training, lack of clear processes to facilitate information sharing. This was helpful to generate learning which was not directed towards individuals, and instead focused learning on what change is required for agencies to maximise opportunities for expected practice to be adhered to.

Analysis against significant events should clearly identify and reflect on:

Whether or not the practice/approach was appropriate and consistent with force/national policies and procedures at the time of the incident. This should identify:

1. Practice which was consistent with policies and procedures.
    a. analysis should clearly identify where practice was appropriate and was consistent with force policies/national guidance.
2. Practice which was consistent with policies and procedures, but such policies were not appropriate.
    a. analysis should also identify circumstances where appropriate policies and procedures were adhered to, however should note where policies were not appropriate or require revision in order to effectively support and protect victims. Evaluation of practice should consider individual force guidance and policies that were in place at the time, whilst also acknowledging and identifying where guidance has since changed.

3. Practice which was not consistent with policies and procedures.
    a. analysis should also identify where practice did not meet the expectations of practice/ policies/guidance. Where such practice is identified, IMR authors should consider the contexts within which individuals were working to understand more clearly what barriers may have existed to individuals adhering to expected practice and other explanations for why certain actions were taken.
    b. the purpose of IMRs is to provide a critical evaluation of the agency response and should not seek to apportion blame to officers and staff involved.
4. Evidence of good practice.
    a. analysis should clearly identify if practice went beyond standard procedures and demonstrated evidence of good practice. Practice as usual should be not identified as good practice.

Analysis should also reflect on how the issues identified within the case are linked, and should consider the interaction and connection between incidents. This is important to develop a wider picture of agency learning and avoids a siloed view of agency practice.

Evaluation of the agency response should only consider the individual force response and should not bring in wider evaluation of other agencies involved. This will be addressed within the statutory review.

Analysis should also specifically address, and fully respond to, the terms of reference (ToR) set by the statutory review author. If you are unable to address any element of the ToR, you should clearly identify the reasoning for this within the IMR.

Things to Consider

- ✓ Have you critically analysed all relevant police contact throughout the review period?
- ✓ Have you explicitly identified whether practice was consistent with policies/ procedures at the time of the incident?
- ✓ Have you ensured that missed opportunities and evidence of good practice, where identified, is highlighted within the review?
- ✓ Have you addressed all points within the terms of reference?

2f. Identification of learning points

Learning points provide an opportunity to identify what agency learning can be taken from the review and should propose questions to enable deeper reflection on the significant events (Dickens et al., 2022). In contrast, recommendations provide clear outcomes and direction about what response/change is needed from the police to address the identified learning. Learning points and recommendations should be distinct from each other.

Within our sample, we identified that approximately a quarter of IMRs did not identify any learning points and, for a small number, it was unclear how many learning points were identified due to unclear wording. IMR authors should therefore ensure that learning points are clearly identified within the report or should clearly state if no agency learning has been identified.

Of the IMRs which did include learning points, we observed a trend towards increased identification of learning for the system as opposed to individual learning. This is a positive finding which adheres to the principles of learning for reviews, namely an avoidance of reviews as a mechanism for blame and an emphasis on the importance of reviews generating wider systems-based learning and practice improvement.

We acknowledge that, due to the length of time taken to complete the IMR, there can be occasions where learning is identified however action has already been taken to address this. There can also be occasions where the police are able to quickly implement and respond to any identified learning, without the need to wait for publication of the statutory review. It remains important however to acknowledge and note this within the IMR in order to ensure full transparency of the learning that has been identified.

IMRs may also identify similar learning to that identified within previous reviews. This should be acknowledged by the IMR author to clearly evidence where consistency appears within the learning, and where previous learning has already been identified and acted on, therefore avoiding the need to identify similar learning within the present review.

Learning points can be most clearly expressed when:

1. It is clear where the learning point originates from, and it is clearly evident how the identified learning links to the incident under review.
2. They are succinct, concise, and clearly identified within the IMR.
3. They are written in plain English and avoid the use of acronyms, jargon, and specialist terminology.

Things to Consider

- ✓ Are the learning points clearly defined and linked back to the significant incidents within the review?
- ✓ Have you identified where action has already been taken to address the identified learning points, where appropriate?

2g. Recommendations

In our own analysis of IMRs, we explored the quality of recommendations and assessed these against the SMART criteria to determine if they were: specific, measurable, achievable, realistic, and time bound.

We observed that, in the IMRs which identified recommendations, most recommendations were realistic and achievable. Some also included recommendations which were specific. However, only a limited number of IMRs within our sample included recommendations which had clear measures against them, or clear time parameters set for implementation.

Clear recommendations were considered to be those that were meaningful and relevant to the review – by giving clear detail about who has ownership, what the improvement should look like, and how to measure the desired change. It is further important that recommendations clearly set out the intended outcome.

Good recommendations are those that:

1. Align to the SMART criteria.
2. Are explicit and clear about what needs to be achieved and how and are not open to individual interpretation.
3. Provide a clear rationale behind why the recommendation has been made, and how the recommendation aligns to the learning points, themes, and findings identified within the review.
4. Provide clear steps for implementation of the recommendation, with time parameters set for each stage of implementation.
5. Clearly identify the intended outcome of the recommendation.
6. Clearly identify who has responsibility for actioning the recommendation.
7. Include clear metrics for how progress against the recommendation will be measured and how successful implementation will be achieved.
8. Are mindful of the context and constraints within practice. IMR authors should not be discouraged, however, from making aspirational recommendations and should not just recommend already agreed practice.
9. IMR authors should also include recommendations for national bodies, for example the College of Policing, where relevant and appropriate to do so.

IMR authors should seek to include information which addresses all elements of the SMART criteria within the review recommendations, where this information is known and is available to them. We are however mindful that IMR authors may sometimes experience challenges identifying and addressing all elements of this criteria, and it is the responsibility of both the IMR author and review team lead to agree on the recommendations originating from the review. The involvement of line managers/leads in formulating the recommendations is also important to ensure that these are realistic and achievable for the agency and are proportionate to the identified learning. A summary document for leads has been developed which is supplementary to this practice advice and may be of benefit here.

The use of action plans can be helpful to clearly identify the recommendation, the owner of the recommendation, timescales for implementation, and to track progress against the recommendation.

Within our sample however, we observed variable use of action plans[7] and a number of occasions where, despite the action plan template being included within the IMR, it was not completed in detail and did not address the specific areas within the action plan.

Statutory review authors will provide guidance and direction on action plan templates to enable you to clearly set out the recommendations from the IMR. You should ensure these are filled out in full, where possible, to support the effective implementation of, and tracking of progress against, the recommendations you have made. If you are unable to respond to any aspect of the action plan, this should be noted within the action plan template.

Things to Consider

- ✓ Are the recommendation(s) clearly aligned to the learning identified within the review?
- ✓ Have you ensured that recommendation(s) are outcome-based and adhere to the SMART criteria, where this information is available to you?
- ✓ Have you completed the action plan template in full?

7 We are however mindful that action plans can sometimes be contained on separate documents and may not have been shared with us by forces when submitting their IMRs for review. Our observations may therefore not be a true reflection of the use of action plans within IMRs.

2h. Getting learning back into the system

Despite the function of reviews being to learn from prior incidents to avoid the occurrence of a similar incident in the future, only two IMRs within our sample clearly outlined how the identified learning would be fed back into the system.

We observed a lack of detail within some IMRs concerning the implementation of learning and the governance structures in place to support this. Furthermore, some IMRs, whilst identifying that changes had been made or were in development in response to the identified learning, did not provide detail regarding how these changes had been implemented. We are however mindful that the responsibility to disseminate and act on the learning falls outside the role of the police IMR author and so this may explain the lack of detail seen in this area.

Whilst limited within the sample, we did observe a small number of IMRs which provided some evidence of how the learning would be disseminated, including through training, communication with relevant staff members, and updates to policy. A number of IMRs also clearly identified how the proposed changes could be evidenced which was a positive finding.

Where this information is known and is available to the IMR author, the review should:

- Clearly identify the owner responsible for implementing the recommendations.
- Clearly identify the intended outcome of the recommendation and how the impact or change originating from the recommendation will be measured.
- Provide detail around the processes to track the implementation of learning.
- Provide detail about the processes for disseminating identified learning.

The statutory review process is also often criticised due to the length of time it can take for the review to be completed, leading to a significant delay in the ability of learning to influence practice or policy. In light of this, within our sample, we investigated the length of time between the date of the incident and when the IMR was completed. Notable variation was observed in regard to this, however the reasoning for the delay was often unclear. IMRs also did not always clearly identify the completion date or provide clarity about whether delays were due to delays in initiating the review, or whether the IMR itself had taken significant time to compete.

To ensure greater clarity regarding the timescale of completion for the IMR, the report should specify:

1. The date of the incident which triggered the IMR.
2. The date the IMR was requested, including identifying any delays and the reasoning for these.
3. The date the IMR was completed by the review author.
4. The date the IMR was quality assured and signed off.

Clearly recording the request date of the IMR and the date of completion is important to ensure transparency around the IMR process and is also important to understand the practice and policy context within which the incident occurred.

Things to Consider

- ✓ Where this information is known, have you clearly identified who holds ownership for implementation of the recommendation(s)?
- ✓ Have you clearly recorded the IMR request and completion date, including providing a clear rationale for any delays in the process?
- ✓ Have you linked in with your force's vulnerability and public protection strategy?

3. Summary

IMRs, and statutory reviews, are crucial documents to facilitate agency learning from tragic incidents, providing recommendations for practice to avoid the occurrence of a similar future incident. IMRs also have a crucial role in supporting agencies to better understand and respond to incidents of neglect, harm and abuse and to protect victims.

Significant previous research, alongside internal work conducted by the VKPP, has extracted key learning and themes, including concerns regarding the quality of statutory and individual management reviews. This is observed to limit the learning that can be taken from such incidents. Issues concerning the quality of IMRs should however be considered in light of the absence of clear guidance for police IMR authors – a gap which this document seeks to address.

This document provides practice advice and direction on what 'good' looks like concerning the information provided within IMRs and provides checklists for police review officers to keep in mind whilst writing IMRs. These are centred around the need for IMRs to:

- clearly record the victim and suspects' protected characteristics where this information is known
- be written using appropriate language and avoid the use of victim-blaming language
- include a clear methodology and details of agency contact which presents an overview of the relevant incidents without unnecessary repetition
- critically analyse the actions and decisions taken by the police and evaluate whether these were appropriate at that time
- identify clear learning points that are relevant to the case
- identify clear recommendations to improve future practice, with clear ownership and mechanisms to follow up on the implementation of these
- provide clear direction for how the learning will be fed back into the system

We are mindful of the varied local authorities and statutory review authors that police review officers work with, which results in varied templates and expectations for IMR authors. This document is therefore not intended to be an exhaustive or prescriptive list and is intended to be applicable to a number of different templates.

We hope that this practice advice will help you to ensure that the IMRs you author are of the highest quality, maximising the vital learning that is taken from the review.

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Appendix A: Sources of information

1. Analysis of a sample of 48 IMRs that related to DHRs, SARs, and LCSPRs, along with joint reviews, one learning lessons review, and one OWHR. IMRs were obtained from a sample of 11 forces covering 10 regions across England and Wales.
2. Analysis of an IMR template provided by one English force.
3. Evaluation of a number of toolkits/templates included within guidance documents including:
    a. The toolkit documents provided to support the Single Unified Safeguarding Review (SUSR) system published in January 2025. https://www.gov.wales/single-unified-safeguarding-review-toolkit
    b. The IMR template provided within the DHR draft statutory guidance published in May 2024. https://www.gov.uk/government/consultations/updating-the-domestic-homicide-review-statutory-guidance/draft-domestic-homicide-review-statutory-guidance-accessible#dhr-toolkit
    c. The template for a child practice review, included within the thematic report analysing child practice reviews within Wales published by the Welsh Safeguarding Board in August 2023. https://safeguardingboard.wales/wp-content/uploads/sites/8/2023/10/Full-Report-Child-Practice-Reviews-Wales-2023.pdf

Appendix B: Example table to record the characteristics of the subjects within the review

Table 2

Example of a table to be used to record the protected and other relevant characteristics of the victim and suspect within an IMR.

	Victim Details	Suspect Details	Are there any known restrictions to this information being published within the statutory review? (If yes, please provide details)
Name (including aliases) **Pseudonym to be used in published review**			
Address			
Date of Birth			
Sex e.g. Male, Female, Intersex, or Information Not Known/Not Recorded			
Gender Reassignment[8] e.g. Gender identity the same as sex registered at birth; Gender identity different from sex registered at birth (e.g. trans/transgender); Non-binary; All other gender identities; or Information Not Known/Not Recorded			
Ethnicity e.g. White British; Irish; Gypsy or Irish Traveller; Any other white background; White and Black Caribbean; White and Black African; White and Asian; Any other Mixed/Multiple ethnic background; Indian; Pakistani; Bangladeshi; Chinese; Any other Asian background; African; Caribbean; Any other Black/African/Caribbean background; Arab; Any other ethnic group; or Information Not Known/Not Recorded			

8 We are mindful that there may be some concerns about including this information due to legislation within the Gender Recognition Act (2004). Please consult your own data protection or legal team to seek further guidance on this, where necessary.

LGBTQ+ e.g. Yes; No; Possibly but Unclear; or Information Not Known/Not Recorded			
Religion/Faith e.g. Christian; Buddhist; Hindu; Jewish; Muslim; Sikh; Atheist; Other Faith/Religion; or Information Not Known/Not Recorded			
Disability Status e.g. Yes – Disability present at time of incident (please specify); Yes - Disability present but not at time of incident (please specify); No; Possibly but Unclear; or Information Not Known/Not Recorded			
Was the individual pregnant at the time of the incident? e.g. Yes; No; Possibly but Unclear; Not Applicable; or Information Not Known/Not Recorded			
Is the individual married or in a civil partnership? e.g. Yes; No; Possibly but Unclear; or Information Not Known/Not Recorded			
Are there any other characteristics, not captured under the Equality Act, which are relevant to the review? (for example, information about mental health diagnoses[9]; information about known substance use; information about neurodivergence; any other characteristics identified within the terms of reference)			

9 Whilst mental health conditions are not formally recognised as a protected characteristic, mental health has been identified as an important factor within statutory reviews (CSPRP, 2024b) and is helpful to develop a full understanding of the individuals lived experience.

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