

# **Standards of behaviour**

**The handling of misconduct in fire and  
rescue services**

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# Foreword

Since our responsibilities were extended to the inspection of fire and rescue services in 2017, we have regularly reported on the need for services to tackle misconduct among their staff and to improve their culture. In March 2023, we published our [values and culture spotlight report](#), where we highlighted that while some services had made some improvements since our first round of inspections, too many needed to do more. We haven't been a lone voice. In 2022, London Fire Brigade carried out its own independent cultural review, and other services have subsequently completed similar exercises.

I am pleased to see the beginnings of improvements. Fire and rescue services have raised awareness of the standards of behaviour they expect and have created strategies and action plans, including implementing the [Core Code of Ethics](#). The code was created by the [National Fire Chiefs Council](#), [Local Government Association](#) and [Association of Police and Crime Commissioners](#) at our recommendation. But pockets of unacceptable behaviour remain and further progress is needed, particularly in parts of the misconduct processes.

In response to our request for data, services reported that they raised 512 new disciplinary cases between 1 April 2022 and 31 March 2023 related to misconduct (274 cases) or gross misconduct (238 cases). But it is likely the actual level of misconduct is much higher, because staff may be afraid to raise concerns when they witness or experience misconduct.

Although service leaders should read and act on all elements of this report, I want to highlight the following findings and recommendations in particular.

While bad behaviour can occur anywhere in services, poor behaviour still disproportionately occurs on [watches](#). Watches can be a source of strength when watch members support one another in dealing with their sometimes harrowing work. However, we found that cultures in tightly knit watches and some on-call stations can become toxic when they form 'in groups' and 'out groups'. Despite efforts to address them, negative [watch cultures](#) have shown they can be resistant to change. Stronger reforms are required.

Staff don't have confidence in misconduct processes. Many of the people we spoke with told us they were concerned about what would happen if they raised an issue. They feared they would be labelled a troublemaker or could be shunned by their work colleagues. Services need to create processes and cultures that people have confidence in, and support reporting.

In many services, there is not enough training for those involved in misconduct processes at all stages. Issues include line managers who all too often don't receive training on how to manage the performance of their staff, and not enough training for those who investigate allegations of misconduct, decide cases and hear appeals.

Services need to learn the lessons from their misconduct cases, and this learning needs to be shared across the sector. Many of the fire and rescue services we inspected conducted limited analysis of their caseload. They need to do more to understand what went wrong, why and what needs to be in place to prevent it from happening again.

However, we also identified some parts of misconduct processes that fire and rescue services do well. The welfare support that is provided to complainants and alleged perpetrators is generally good. This is important given how stressful involvement in misconduct processes can be. We would like to see this provision offered to others involved in the process, such as witnesses, investigators, decision-makers and HR advisers. We also found the sanctions applied in misconduct cases are mostly appropriate to the seriousness of the misconduct, the circumstances of the case and any mitigating factors.

Overall, the picture we have found is that services are prioritising tackling misconduct and are making some progress. But many services still have more to do. My hope is that the findings and recommendations in this report can provide practical steps that services can take to bring about the lasting change fire and rescue service staff and the public deserve.



**Roy Wilsher OBE QFSM**

HM Inspector of Fire and Rescue Services

# Summary

## The culture in fire and rescue services

In our '[Values and culture in fire and rescue services](#)' spotlight report, we reported on poor behaviour, including bullying, [harassment](#) and discrimination. Our evidence showed such behaviour wasn't rare. Despite the work of fire and rescue service (FRS) leaders, this behaviour continues. Ten percent of the FRS workforce responded to our staff survey as part of this [thematic inspection](#) on standards of behaviour. Of these 4,422 respondents, 1,509 (34 percent) had experienced misconduct in the previous 12 months. This included rude and offensive behaviour, abuse of power and bullying. Discrimination and harassment also remained a problem. Although the response to the survey was relatively low, it is disheartening that any FRS staff have continued to be negatively affected by the bad behaviour of their colleagues.

But some progress is being made. The leaders we interviewed had prioritised improving the culture in their services and showed us their action plans for tackling misconduct. In the interviews and focus groups we conducted, some staff reported that the initiatives their services were putting in place were improving behaviour. But we also met some who felt the initiatives were superficial in nature.

Efforts by services to raise awareness of the [Core Code of Ethics](#) have been successful. Almost everyone we spoke with knew about the code and could describe its purpose and main elements. In some services it appears to be having a positive effect, but in other services staff said they hadn't noticed any difference since its introduction.

Some services need to provide better training on the code and expected standards of behaviour to new recruits. We were disappointed to find that, instead of instilling good behaviour, there have been cases of new recruits committing serious misconduct during initial training courses. Also, in some cases the service's probationary policy prevented it from immediately dismissing these new recruits without a full misconduct process.

Although poor behaviour can occur elsewhere, for example at on-call stations, in many cases the bad behaviour occurs on [watches](#). There are hugely positive aspects to tightly knit watches, not least the support watch members can provide to one another. But watches can also become toxic when members of staff find themselves excluded from the 'in group' and vulnerable to bullying, harassment and discrimination. We have found that negative [watch cultures](#) are resistant to change. Poor behaviour can be entrenched and normalised. Crew and watch managers can turn a blind eye, side with offenders or even take part in the misconduct themselves. This often seems to occur when managers have been promoted from within the watch, including on a long-term temporary basis, and are strongly connected with its culture. Rotating staff periodically and posting newly promoted staff to a different watch or station could help address this.

### **The extent to which services are identifying misconduct**

Most FRS staff we spoke with thought the process for raising a concern was clear. However, we did find some confusion about the differences between raising a concern, a grievance and whistle-blowing. Whistle-blowing involves disclosing an issue that affects others and falls within specified categories. It is protected by law. Services provide a confidential way for staff to blow the whistle. But almost all the complaints we reviewed that used these processes were personal grievances that were outside the legal definition of whistle-blowing. These cases could have been more effectively handled by raising a concern informally or by raising a grievance.

In most of the services we inspected, we found concerns about using grievance and whistle-blowing processes. Some staff members told us those who raise concerns can experience repercussions. These include exclusion and marginalisation by work colleagues and being singled out and overlooked for promotion or other opportunities by managers. Some staff felt if they raised a concern, the matter wouldn't be treated confidentially or impartially and the process would be long and stressful. Women most often expressed this fear of reporting. These perceptions are a serious problem, whether they are accurate or not.

When we asked managers about their role in identifying conduct issues, many of them were also worried about repercussions and had little faith in the discipline system. Many managers weren't holding regular discussions with staff about their performance, making it hard for them to deal with low-level misconduct issues. This was often due to insufficient training, especially for newly promoted crew and watch managers who mostly had no previous experience of managing staff.

It is likely the actual level of misconduct in FRSs is higher than the evidence suggests. Too many people continue to be negatively affected by the unacceptable behaviour of others rather than use the system they distrust. We doubt that lasting improvements in misconduct and the culture in FRSs are possible without addressing these concerns.

## The effectiveness of misconduct processes

As part of our inspection, we reviewed a sample of 84 grievance cases and 157 discipline cases drawn from 10 inspected services. These cases were all concluded between 1 April 2021 and 31 March 2023. We were pleased to see the more recently concluded cases tended to be better managed than the older cases. But we identified issues throughout this sample.

All the services we inspected had discipline and grievance policies, and several of them had recently reviewed and updated these. Despite the concerns staff had raised with us, in several of the inspected services these policies were working well. But in others we found practice that deviated from the policies substantially. This included the steps taken, when they were taken and who the decision-maker was.

We were particularly concerned about inconsistencies in how operational staff such as firefighters were treated compared to non-operational staff such as administrative and technical workers. Other recurring issues we identified in the cases we reviewed included:

- no clear terms of reference for investigators;
- investigations exceeding the timescales;
- cases being brought forward at the wrong level (misconduct processes can be initiated informally or at any of three stages, depending on the seriousness of the allegations); and
- decision-making about outcomes being recorded with little detail and justification.

Not all the inspected files had all these problems – many had none.

We also identified several underlying issues across many services that we believe are the causes of the problems we saw in the cases we reviewed. These root causes included:

- ineffective case management systems;
- not enough capacity at middle manager level to carry out investigations; and
- the use by some union representatives of tactics that aim to frustrate misconduct processes.

However, the most common and important root cause for the issues we identified with misconduct investigations is the inadequacy of training for those involved in investigating and hearing misconduct cases. From our inspection, it was clear that many investigators received little or no training. They told us they didn't feel confident in the role, they relied heavily on HR advisers for support, and the union representatives supporting the staff alleged to have committed misconduct invariably knew the policies and processes better than they did.



In most of the services we inspected, welfare support was treated seriously and was of good quality. Where we found problems with welfare support, this was because it needed to be more proactively offered, rather than it being fundamentally poor. But we did find support wasn't always equally available to all staff. We found examples of non-operational staff and on-call staff who felt they received less support than their operational and [wholetime](#) colleagues. We also found complainants and alleged perpetrators often received good welfare provision. But support was sometimes not available for others involved in misconduct processes, such as witnesses, investigators and hearing managers. Welfare support is vital and should be equally available to all if needed.

We reviewed the appeals processes for misconduct cases. Of the 128 discipline cases and 84 grievance cases we examined and on which analysis of the appeals process was possible, appeals were only submitted in 21 and 25 cases, respectively. We wouldn't expect all cases to be appealed. But we did identify some areas that could be improved. These included some cases in which the right to appeal didn't appear to have been explained to the staff member, and cases in which services had restricted the right of appeal for staff investigated under an accelerated process. The most common issue was that, as we found with misconduct processes overall, some staff don't have confidence in appeals and don't consider them fair or effective.

Data we received from all 44 services in England shows that in the year April 2022 to March 2023, 41 discipline cases went to appeal out of a total of 199 cases. Of these, just 3 cases (7 percent) were successful. Although we haven't found direct evidence of problems with the effectiveness of appeals, this low success rate, combined with the concerns some staff raised with us, is something that needs to be considered. We also found that those who hear appeals had rarely had training to do so and relied too heavily on HR support and guidance.

We examined the sanctions that were applied in misconduct cases in the inspected services. We found the sanctions were mostly appropriate to the seriousness of the misconduct, the circumstances of the case and any mitigating factors. We also found services were making sure sanctions were consistent. Members of staff received similar sanctions for similar misconduct in similar circumstances. But it was clear that, because the training for many of those involved in the process was inadequate, HR advisers were carrying significant responsibility for this. The quality of HR advice and the capacity of HR departments varied significantly from service to service.

We were also concerned to find cases where people retire or resign when they are due to be dismissed for misconduct. We have previously raised this as a concern and believe that in these circumstances the case should be continued to conclusion. In our values and culture spotlight report, we recommended that a national barred list be established to prevent such unsuitable people from joining another service. So far, progress on this issue has been disappointingly slow.



## Understanding misconduct and sharing lessons learned

As well as examining how effectively the inspected FRSs handled individual instances of misconduct, we also assessed the role of senior leaders and [fire and rescue authorities](#) in providing oversight and scrutiny of their misconduct systems.

Although we saw emerging good practice in some services, we found limited evidence of scrutiny within most of the FRSs we inspected:

- Services' understanding of themes and trends in misconduct cases was low.
- Services often couldn't say whether there was any disproportionality in respect of [protected characteristics](#).
- Scrutiny from fire and rescue authorities was highly variable.

The main reason for this limited oversight and scrutiny was the level of analysis carried out by services on misconduct. Few of the services we inspected had analysed trends or patterns in their misconduct cases, and where analysis was carried out, it tended to be basic. Some services produced breakdowns of the numbers and timescales of cases, but it was unusual to see analytical insights or information about protected characteristics. Most services were aware of the need to better analyse and understand the misconduct they experienced, but they were limited in their ability to do this by their inadequate case management systems.

Many of the services we inspected also need to improve their [organisational learning](#). Identifying and sharing the lessons learned from misconduct cases is a practical way of reinforcing acceptable standards of behaviour. We saw evidence of some organisational learning in most of the services we inspected, but it was limited. It was rare for services to be learning from misconduct cases consistently. We identified evidence of organisational learning in 22 out of 84 grievance cases and in 31 out of the 157 discipline cases we reviewed.

Most of the services we inspected told us they couldn't share lessons learned from misconduct cases with their staff. This was because of the need to maintain the anonymity and confidentiality of the people involved in the cases. This is a legitimate concern, but we don't accept that this problem cannot be dealt with. To better protect people's identity in anonymised cases, we recommend the [National Fire Chiefs Council](#) establishes a national process for sharing the learning from misconduct cases. We also urge chief fire officers to identify practical solutions to this problem at the service level.

## Our recommendations

### The culture in fire and rescue services

#### Recommendation 1

By 1 February 2025, chief fire officers should, as a priority, make sure their staff are aware of, and follow the [Core Code of Ethics](#). Services should build the code into all relevant policies and practices.

#### Recommendation 2

By 1 February 2025, chief fire officers should make sure a policy for probationary staff is in place. This policy should make clear that services can immediately dismiss probationers who fail to meet the required standards of behaviour set out in the [Core Code of Ethics](#) and the [Code of Ethics fire standard](#).

#### Recommendation 3

By 1 May 2025, chief fire officers should make sure their workforce plans allow staff to be moved from a [wholetime watch](#) to a different watch or station, within their contractual requirements, proactively and reactively as required.

By 1 May 2025, chief fire officers should also make sure firefighters who are promoted are posted to a different watch or station, including when the promotion is temporary for two months or more. If this isn't possible, chief fire officers should show how the risks of reinforcing a negative culture have been addressed.

### The extent to which services are identifying misconduct

#### Recommendation 4

By 1 February 2025, chief fire officers should make sure their services create or have access to a dedicated professional standards function to oversee the investigation of concerns raised within a service or from an external source. This should oversee cases to make sure they are investigated in a fair and transparent way, manage complex cases directly and act as a point of contact for all staff involved.

### **Recommendation 5**

By 1 November 2024, chief fire officers should make sure all staff understand how to raise a concern and use grievance and whistle-blowing processes. Chief fire officers should:

- make sure staff know how services will handle responses and maintain confidentiality and anonymity; and
- explain how staff can access services' whistle-blowing capability and the difference between whistle-blowing and other processes for raising concerns.

### **Recommendation 6**

By 1 February 2025, chief fire officers should make sure a programme of training is in place for all supervisors and managers on how to manage staff performance and welfare and how to raise an issue. It should be supported by relevant policies and procedures. Training should include:

- staff welfare and absence management;
- the process for managing individual staff performance, addressing poor performance and potential misconduct issues;
- how to handle difficult conversations and resolve issues informally, if appropriate, when a concern is identified; and
- clarifying the role of HR services in helping managers to deal with staff concerns and misconduct issues.

Chief fire officers should make sure all managers and supervisors attend the training programme.

## **The effectiveness of misconduct processes**

### **Recommendation 7**

By 1 May 2025, chief fire officers should make sure the policies and processes for misconduct are consistent for all staff and are fairly applied within their respective conditions of employment.

By 1 August 2025, the [National Joint Council for Local Authority Fire and Rescue Services](#) and the [National Joint Council for Local Government Services](#), supported by the [National Fire Chiefs Council](#), should make misconduct processes consistent for all staff irrespective of the terms and conditions of their employment.

### **Recommendation 8**

By 1 November 2024, chief fire officers should make sure all allegations of misconduct are handled in a consistent way and staff have confidence in misconduct processes. Chief fire officers should carry out a full review of the processes, from initial identification of a misconduct issue through to the resolution or outcome. This should include a review of how services:

- monitor and manage investigations;
- maintain accurate records; and
- adhere to required timescales.

### **Recommendation 9**

By 1 August 2025, chief fire officers should introduce a case management system if they don't already have one. The case management system should allow data to be produced that will help them to better understand and oversee misconduct cases in their services.

### **Recommendation 10**

By 1 May 2025, chief fire officers should make sure their services have enough capacity to carry out their misconduct investigations. They should consider using external investigators or a similar independent resource to support the process if required.

### **Recommendation 11**

By 1 May 2025, chief fire officers should review the training their services provide for supervisors and managers who investigate misconduct issues at all levels. Chief fire officers should make sure:

- all staff who carry out investigations receive adequate training to carry out the task;
- a programme of refresher training and ongoing support is available so that staff can maintain a level of competence; and
- it is clear how services' HR provision, staff associations and any trade union representative or fellow employee will support the investigation process.

### **Recommendation 12**

With immediate effect, chief fire officers should make sure all staff are aware of the welfare support, including occupational health support, that is available to staff involved in misconduct processes. Chief fire officers should encourage all staff involved in misconduct processes to access this support, whether they are an alleged perpetrator, complainant, witness, investigator or decision-maker.

Welfare personnel should be independent of the investigation and have been appropriately trained for this role.

### **Recommendation 13**

By 1 November 2024, fire and rescue authorities and chief fire officers should consider varying the approach to hearing appeals so that appeals for complex or serious cases are heard by a panel rather than one person.

By 1 February 2025, [fire and rescue authorities](#) and chief fire officers should make sure all service managers and members of fire and rescue authorities who hear appeals receive appropriate training.

Chief fire officers should make sure services have a consistent approach to hearing appeals.

## **Understanding misconduct and sharing lessons learned**

### **Recommendation 14**

By 1 November 2025, chief fire officers should implement a process that makes sure they can oversee and scrutinise their services' performance relating to misconduct issues. This process should provide:

- a strategic overview of performance and analysis of trends, including disproportionality;
- regular reporting of issues, outcomes and trends to the [fire and rescue authority](#); and
- identification of learning outcomes and how they will be shared with fire and rescue service staff, to prevent repeat behaviours.

### **Recommendation 15**

By 1 February 2025, chief fire officers should put in place a process for sharing learning from misconduct cases that have been resolved while preserving the confidentiality of all parties involved. Any learning should feed into the national system, when established.

By 1 May 2025, the [National Fire Chiefs Council](#) should establish a system for sharing learning from more serious cases of misconduct with fire and rescue service staff. The information shared should preserve the anonymity and confidentiality of all parties involved. The College of Fire and Rescue, once it is established, should take responsibility for maintaining this system.

# Introduction

## Background

On 30 March 2023, we published [a spotlight report that focused on the values and culture in fire and rescue services](#) (FRSs) in England. The spotlight report and the 35 recommendations we made led to services prioritising activity to improve values and culture.

While we found some services had improved their values and culture, too many need to do more. We found examples of racist, homophobic and misogynistic behaviour in a quarter of FRSs in England. Such behaviour was often excused as banter. There were allegations of bullying in all services, with some services being far worse than others. Some staff called services a “boys’ club”. People also said they felt they couldn’t report inappropriate behaviour for fear of reprisals.

Our spotlight report findings are similar to those outlined in London Fire Brigade’s and Dorset and Wiltshire FRS’s independent service cultural reviews, where the issues raised were equally disturbing. Since the spotlight report, other services have also conducted cultural reviews. The [Fire Brigades Union](#) has also commissioned independent research into sexual [harassment](#) among its members.

## About us

[His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services \(HMICFRS\)](#) independently assesses the effectiveness and efficiency of police forces and fire and rescue services, to make communities safer. In preparing our reports, we ask the questions that the public would ask, and publish the answers in accessible form. We use our expertise to interpret the evidence and make recommendations for improvement.



## Our commission

Our terms of reference were to carry out an inspection of the handling of misconduct in FRSs in England. This was to include examining:

- the extent to which services are identifying and investigating misconduct;
- the effectiveness of misconduct processes and how consistently they are applied;
- how confident FRS staff are in raising concerns and in misconduct processes; and
- the role of [fire and rescue authorities](#) and other organisations in handling misconduct.

## Methodology

Our inspection took place between October 2023 and January 2024. We carried out detailed inspections of ten FRSs: Cornwall, Dorset and Wiltshire, Greater Manchester, Humberside, Kent, Lincolnshire, Northamptonshire, Staffordshire, Tyne and Wear, and West Midlands.

These services were selected to be a representative sample of FRSs across England in terms of size, location, governance structures and performance. We reviewed their relevant policies and processes; examined a sample of their grievance, discipline, whistle-blowing and public complaints case files; and interviewed and held focus groups with staff in a variety of roles and at all levels of seniority.

We analysed data provided by all 44 FRSs in England about their grievance and discipline cases.

Working with [Crest Advisory](#), we carried out staff surveys in all 44 FRSs in England. We asked staff about their experiences and opinions of the handling of misconduct. We also interviewed former FRS staff to understand their experiences.

We conducted interviews with senior FRS leaders, HR experts, and union and staff association leaders.

We held a focus group to explore the issues affecting staff from minority ethnic backgrounds. We also held focus groups with female staff members to explore the issues that affect them.

## Consultation

We consulted sector leaders on the design of this methodology in August 2023, and on our early findings and proposed recommendations in March 2024. The consulted bodies and individuals included:

- the [Home Office](#);
- the [Local Government Association](#);
- the [National Fire Chiefs Council](#);
- the [Association of Police and Crime Commissioners](#);
- the [Fire Standards Board](#);
- the [Fire Brigades Union](#);
- the [Fire Officers' Association](#);
- the [Fire and Rescue Services Association](#);
- the [Fire Leaders Association](#);
- [Women in the Fire Service UK](#);
- the [Asian Fire Service Association](#); and
- the heads of HR departments, directors of people's services and those in similar roles from selected FRSs and in local government.

We are grateful to these organisations and individuals for their comments and contributions. The findings and recommendations in this report remain our own.

# The culture in fire and rescue services

## Unacceptable behaviour is still a problem, but there are some signs of improvements

In our [values and culture spotlight report](#), we reported on poor values, culture and behaviour, including bullying, [harassment](#) and discrimination, in many of the 44 fire and rescue services (FRSs) in England. Our evidence showed that such behaviour was widespread. In March 2023, we published the spotlight report. It mainly focused on evidence from our second round of FRS inspections (carried out in 2021 and 2022). We issued 35 recommendations as a result, 9 of which aimed to improve the handling of misconduct. The deadlines for completing these nine recommendations have now all passed.

Ten percent of the FRS workforce responded to our staff survey as part of this [thematic inspection](#) on standards of behaviour. Of the 4,422 respondents, 41 percent (1,802) had witnessed misconduct in the previous 12 months, and 34 percent (1,509 out of 4,422) had experienced misconduct over the same period. Although the response rate to the survey was relatively low, this level of misconduct is far too high. The most common forms of misconduct reported through the survey were rude or offensive behaviour, abuse of power, intimidation and other forms of bullying. Respondents told us foul language, including racist, sexist and homophobic language, isn't rare.

Although less common, staff also reported that they had witnessed or experienced more serious discrimination and misconduct. Out of 4,422 staff responding to our survey, 114 reported experiencing sexual harassment in their service in the last 12 months, and 235 out of 4,422 had witnessed sexual harassment of a colleague over the same period. Examples of experiences respondents gave included inappropriate sexual messaging, comments on appearance and unwanted touching. Respondents also told us about the covering up of sexual harassment, and abuse and intimidation of those who report it, so the prevalence could be much higher.

Many staff from minority ethnic backgrounds who responded to the survey and spoke with us face-to-face said they had experienced racism. Many believed that this was an ingrained problem. They said that in their opinion they were treated differently to their colleagues because of the way they look.

Experiences of discrimination against those with other [protected characteristics](#), including homophobia and ableism, were also consistently mentioned. Respondents reported that mental health issues or neurodiversity were blamed for problems in the workplace, and they heard colleagues saying they would treat people with contempt if they found out they were gay.

Worryingly, almost one in every three respondents (29 percent; 1,288 out of 4,422) to our survey reported that they had experienced or witnessed an abuse of power in the previous 12 months. Although these instances of abuse of power varied in nature, a common theme was the perception of senior management “sticking together” to ignore, excuse or allow misconduct. These respondents felt that abuse of power during investigations led to inconsistent and disproportionate outcomes.

But there is some evidence of positive change. Many of the FRS staff we spoke with believed that improper behaviours have reduced and attitudes have improved. They had noticed improvements their services have made to improve the culture. For example, in one service, staff told us about a positive culture within [fire control](#) and an environment where they felt they could speak out freely. Staff told us they enjoyed coming to work: line managers listened to staff, who felt they could be open and honest.

However, not all staff believe that the culture is improving in their service. We also met staff who expressed cynicism about initiatives that services had introduced, which they felt were superficial in nature rather than leading to positive change. For example, in one service, staff told us they felt that the cultural leadership programme hadn't been implemented effectively and that there had been no strategic approach to changing the culture. They went on to say they felt “people are running around with different bits of paper in their hand, get the survey done, get the feedback done”.

On balance, it appears that attitudes and behaviours are showing signs of improvement in FRSs. But often these improvements are too slow, are being built on poor foundations and aren't being made consistently across England. While the overall trend is somewhat positive, this will be little comfort for those who continue to be negatively affected by the unacceptable behaviour of other staff members.

### **Senior leaders are focused on improvements in values and culture, and concerted efforts are being made in all services**

All the senior leaders we interviewed told us they had made improving the values and culture in their services one of their top priorities. All the FRSs we inspected had strategies or action plans focused on tackling misconduct and improving other cultural issues. Many of these plans focused on implementing the recommendations in our values and culture spotlight report. It appears that most leaders have grasped the importance of this agenda and they are making significant efforts to attempt to address it.

For example, in one service, staff told us the new chief fire officer had created a completely new environment, especially around inclusion and in the way that he worked with middle management. He was described as leading by example, by visiting stations and being accessible to staff. He had introduced champions for inclusion at every station and a meeting structure that encourages attendees to participate. Staff felt that this culture change was leading to increased confidence to challenge and report inappropriate behaviour.

This focused attention from leaders is welcome. But considering the varied feedback from members of staff, it appears the improvement activities that services are implementing are not yet accepted by everyone, and their impact may not yet be enough to achieve the cultural shift required. However, we are mindful that cultural change can take a long time to achieve and that sustained effort is required.

### **Most services have positive relationships with their union representatives on discipline and grievance issues**

As part of our inspection, we interviewed trade union representatives who support their members in misconduct proceedings. We asked them about their relationships with FRS leaders on misconduct and wider cultural issues. In most services, trade union representatives and FRS leaders told us that there are good working relationships between services and the trade unions at the local level, at least on these issues. Many chief fire officers held regular meetings with trade union representatives on these topics.

For example, in one service, FRS leaders told us that there was regular collaboration with representative bodies. This included:

- monthly meetings with the [Fire Brigades Union](#);
- a separate committee meeting that scrutinised quarterly dispute resolution reports; and
- a monthly open forum with union representatives that discussed trends in the service's misconduct caseload.

Trade union representatives told us they share a common interest with FRSs in reducing unacceptable behaviour that negatively affects their members, and in making sure misconduct processes are fair and efficient. We were pleased trade union representatives said that some of them had committed to not "defending the indefensible".

These positive relationships and aligned interests are a real strength. Actions to improve culture and behaviour that services can carry out jointly with trade unions or with their support are more likely to be effective.

## **The fire and rescue service's Core Code of Ethics is raising staff awareness of ethical standards but isn't always creating behavioural change**

In May 2021, following our recommendation, the [National Fire Chiefs Council](#), [Local Government Association](#) and [Association of Police and Crime Commissioners](#) developed a [Core Code of Ethics](#) for FRSs, and the [Fire Standards Board](#) introduced a [Code of Ethics fire standard](#). FRS leaders felt this was an important milestone in improving the values and culture in FRSs at the national level.

We discussed the Core Code of Ethics with staff in the services we inspected. All the inspected services have made significant efforts to promote the code with their staff. Almost everyone we spoke with knew about the code and could describe its purpose and some of its major elements. In some services, the code was felt to be having a strongly positive effect. Staff in one service told us that they felt it had become part of daily activity. They said: "It feels a real part of our culture rather than a buzz word or topic."

However, it is also clear that some services have more work to do to turn awareness of the Core Code of Ethics into behavioural change. For example, in one service, staff told us that they hadn't noticed any difference in behaviours since the code was introduced. They said: "This is just lip service. Middle managers don't display the behaviours. They often don't speak to firefighters with respect. They are hypocrites." In another service, a group of firefighters told us that the code was a "tick-box exercise" and nothing more. And in a third service, staff told us that it "wasn't worth the paper it's written on".

### **Recommendation 1**

By 1 February 2025, chief fire officers should, as a priority, make sure their staff are aware of, and follow the [Core Code of Ethics](#). Services should build the code into all relevant policies and practices.

We are concerned that not all services provide guidance or training on their service's values or the Core Code of Ethics for new recruits, or more widely at refresher training. This is a crucial opportunity to set expectations of behaviour at the outset of a new staff member's career that is being missed in some services. We were also dismayed to find that, rather than instilling good behaviour, cases of serious misconduct can occur on initial training courses.

For example, we examined one case in which a recruit was bullied on a team WhatsApp group, which escalated to allegations of sexual assault that were under investigation at the time of our inspection. In another service, we found a case in which a trainee firefighter sexually assaulted a colleague on the initial training course. We were concerned to find that in some cases the service's probationary policy prevented it from immediately dismissing new recruits, who were put through the full misconduct process instead.

## Recommendation 2

By 1 February 2025, chief fire officers should make sure a policy for probationary staff is in place. This policy should make clear that services can immediately dismiss probationers who fail to meet the required standards of behaviour set out in the [Core Code of Ethics](#) and the [Code of Ethics fire standard](#).

### **In many cases, poor behaviour occurs on a watch and isn't being challenged**

In our values and culture spotlight report, we described the damaging effects of subgroups and subcultures within FRSs leading to the development of significant 'in groups' and 'out groups'. Poor culture can occur in on-call and day-crew stations, and in other teams, but it is more prevalent on [watches](#). Watches are common across services and are a long-standing workforce model. The way watches operate is unique to the FRS and often results in staff working together on the same team for many years. Operational staff work, train and eat in close proximity to each other and often sleep at the station overnight while providing emergency response. They are considered families by some operational staff, but they can exclude others and negatively affect people not seen to fit in.

We expressed concerns about the effect watches can have on service cultures or subcultures. We found that, in some services, watches had created their own subcultures that normalised unacceptable behaviours, such as bullying, harassment and discrimination.

Unfortunately, the problem of toxic [watch cultures](#) appears to have persisted. Many services have watches that staff describe as having a different culture to the rest of the service. We found a wide variety of unacceptable behaviours on watches. These included sexist, racist and homophobic language, sometimes excused as "dark humour" or "old-school banter". But these behaviours are unacceptable, unprofessional and highly upsetting and alienating to colleagues. They also included very serious cases of misconduct.

Of particular concern, we met staff in several services who described watch cultures in which line managers were reluctant to challenge misconduct because of a desire to remain popular. This allows poor behaviour to become entrenched and normalised. A member of staff told us: "There is an element of mismanagement. They turn a blind eye and don't look at the truth. This is fostering poor cultures when others see people getting away with it and nothing happens." In some cases, managers were the perpetrators of misconduct. Often this seems to occur when someone is promoted within a watch, including on a long-term temporary basis, and becomes responsible for supervising and managing their former peers.



We did find examples of positive change. For instance, in one service, a firefighter had proactively sought to discuss topics of what is and isn't acceptable within the workplace. She designed and created an open forum for debate, which has been successfully operating for two years.

But these examples are few and are the result of courageous people rather than an improving system. So we consider that more fundamental reform is required to help eliminate toxic watch cultures.

### **Recommendation 3**

By 1 May 2025, chief fire officers should make sure their workforce plans allow staff to be moved from a [wholetime watch](#) to a different watch or station, within their contractual requirements, proactively and reactively as required.

By 1 May 2025, chief fire officers should also make sure firefighters who are promoted are posted to a different watch or station, including when the promotion is temporary for two months or more. If this isn't possible, chief fire officers should show how the risks of reinforcing a negative culture have been addressed.

### **Some staff don't understand service policies on social media use**

The services we inspected all had social media policies that set out when and how it is appropriate to use social media channels. It was also encouraging that 87 percent (3,834 out of 4,399) of staff who responded to our survey said they knew what their service expected of them in their personal use of social media and messaging. But we identified several misconduct cases involving inappropriate use of WhatsApp messaging. And many staff we met said they were confused about how and whether they can use it.

For example, in one service, staff are often asked to take photographs when attending incidents to help promote positive media stories. This can lead to staff using their own private devices to share workplace data and information. In another service, staff told us it would be helpful to know exactly what is and isn't allowed as they felt that so many things can be taken the wrong way.

# The extent to which services are identifying misconduct

There are two main routes by which fire and rescue services (FRSs) can identify instances of misconduct.

The first route is that services can identify misconduct through the normal relationship between a manager or supervisor and their staff. As part of good line management, managers and supervisors can identify and deal with most low-level misbehaviour by taking effective informal action. For more serious or repeated misconduct, managers and supervisors can take formal action through the service's discipline process.

The second route is that staff members who have experienced or witnessed misconduct can take action using the service's grievance process. For the most serious forms of misconduct, such as criminal offences, health and safety risks or attempts to cover up wrongdoing, staff members can use the whistle-blowing process.

Both routes need to work effectively to tackle the problems in culture we identified in [our chapter on the culture of fire and rescue services](#).

## **Staff are aware of how to raise concerns, but services could do more to improve confidence**

### **Staff generally have a good awareness of how they can raise concerns**

In our survey, 62 percent (553 out of 887) of the staff who responded thought the process for raising a concern was very clear or slightly clear. Twenty percent (174 out of 887) felt it was not so clear or not at all clear. The remaining 18 percent (160 out of 887) thought the process was neither clear nor unclear. This is positive. But only 58 percent (403 out of 689) of respondents who had experienced misconduct in the last 12 months thought that reporting processes were clear compared to 76 percent (150 out of 198) of respondents who had not. This could suggest that the experience of using the reporting process had reduced their confidence in it and that it hadn't been as clear as they had expected.

When we spoke with staff about how to raise concerns, they generally agreed they could access discipline, grievance and whistle-blowing policies and showed they knew where to look for them. In one service, posters with a QR code that could be used to raise a concern were prominently displayed in most fire stations to raise awareness. Another service had introduced a “freedom to speak up guardian”, who offered advice, guidance and support to staff members about raising concerns.

### **Staff still feel they can’t raise concerns about poor behaviour**

Despite the fairly good awareness shown by staff about the ways in which they can raise concerns, in most services, some feel unwilling to do so. There is compelling evidence of a widespread fear of using formal reporting processes, such as raising a formal grievance, in FRSs across England. The most common reasons given are:

- a fear of repercussions from senior managers;
- a fear of repercussions from peers;
- a fear that nothing will be done as a result of raising concerns; and
- a fear that confidentiality will not be maintained.

This matches our findings in our [values and culture spotlight report](#). But the evidence we have gathered for this [thematic inspection](#) on standards of behaviour has increased our concerns.

Although the majority (68 percent; 2,986 out of 4,392) of our survey respondents agreed their services took reports of misconduct seriously, some respondents said they felt that reporting bad behaviour and misconduct would lead to punishment and reprisals for the person raising the concern. Some said they had been singled out and overlooked for promotion, which they felt was a direct result of reporting an issue. Some also said they had witnessed others get “punished” for reporting issues. This fear and mistrust was so widespread that many staff members doubted whether our survey was truly confidential and expressed concerns that they would be vulnerable if they disclosed information to us. This was also reflected in the discussions we had with staff during fieldwork.

In our survey, 77 percent (3,405 out of 4,396) of respondents agreed their team would support them if they raised concerns about another team member’s behaviour and attitudes. But some staff told us they were afraid that raising concerns could lead to negative reactions from their peers in the form of exclusion and marginalisation. For example, one former FRS employee told us: “People are, to a point almost, like persecuted, vilified, because they have, like, blown the whistle on individuals.” Another said: “Some people are just taking the abuse, the [harassment](#), because they don’t want to put a target on their back.”

Many staff were also reluctant to raise issues formally because of fears about the misconduct system itself. We found staff widely believed that if they raised concerns, they wouldn't be treated confidentially. For example, survey respondents reported frequent breaches of one-to-one and confidential conversations, and rumours circulating within their services that someone had raised a concern that turned out to be true.

In addition, many staff believed the misconduct system was biased and not impartial, which was closely related to the fear of reprisals. They told us investigations were sometimes conducted by someone close to the person alleged to have perpetrated the misconduct, such as their line manager. They considered such cases to be cover-ups.

Women most often expressed a fear of reporting. For example, one firefighter told us she did speak to her line manager about something and it wasn't dealt with. The manager breached her confidentiality and she felt humiliated by her peers. She was adamant she would never raise a concern again. Another firefighter said when she raised a concern to her manager, she was told it would be held against her when she went for promotion.

Because of this fear of reporting, it is likely that the actual level of misconduct within FRSs is higher than the evidence suggests. Many staff members decide to just put up with unacceptable behaviour rather than use the systems they distrust so thoroughly. Staff in many of the services we visited told us that people don't want to "put their heads above the parapet".

Many services are aware of the negative perceptions staff have about misconduct processes and how this affects their willingness to raise concerns. In our values and culture spotlight report, we recommended that chief fire officers consider creating a professional standards function to oversee cases, make sure they are investigated in a fair and transparent way, and act as a point of contact for all staff involved. A small number of services have created some form of professional standards unit. But in all but the largest services, these aren't a full-time dedicated resource and their staff retain other roles and operational functions. Some smaller services have formed agreements with their local police forces or have employed private companies to provide this function.

The evidence about the effectiveness of these units and other approaches is mixed. Many services are positive about the benefits they are bringing. However, some staff working in HR and professional standards also said that the professional standards functions in some services don't have staff with relevant training and enough staff to meet demand. And some external sources don't have the FRS-specific knowledge needed to be fully effective. But these issues appear to be because the professional standards functions are relatively new. They were still being implemented when we inspected. We still consider that a professional standards function can be an effective tool to improve misconduct processes and increase staff confidence in

those processes. So we are strengthening our values and culture spotlight report recommendation even further.

#### **Recommendation 4**

By 1 February 2025, chief fire officers should make sure their services create or have access to a dedicated professional standards function to oversee the investigation of concerns raised within a service or from an external source. This should oversee cases to make sure they are investigated in a fair and transparent way, manage complex cases directly and act as a point of contact for all staff involved.

#### **In most services, staff are confused about when to use whistle-blowing options**

Whistle-blowing is a specific way in which staff can raise concerns in the public interest, meaning that they concern others, whether staff or members of the public. Whistle-blowers are protected by law and cannot be treated unfairly or lose their job as a result of making the disclosure. This legal protection covers reports called “qualifying disclosures”, in specified categories such as criminal offences, risks to health and safety or miscarriages of justice. It also covers someone covering up wrongdoing within the specified categories. Personal grievances such as bullying, harassment and discrimination aren’t covered by whistle-blowing law unless the case is in the public interest.

In our values and culture spotlight report, we identified that there was no consistent process for FRS whistle-blowers. We recommended that by 1 October 2023, chief fire officers should make sure their services provide a confidential way for staff to raise concerns and that staff are aware of whistle-blowing processes. It was very positive to see the services we inspected for this thematic inspection on standards of behaviour had established anonymous or confidential whistle-blowing processes to address our spotlight report recommendation. All 44 services in England have recently confirmed that they now have confidential ways for staff to raise concerns, including independent reporting lines, in place.

However, as part of this thematic inspection, we assessed 54 cases raised through whistle-blowing processes, of which only 5 met the whistle-blowing criteria as a serious major concern that fell outside the normal grievance or complaint procedure. In the other 49 cases, the whistle-blowing process was incorrectly being used for personal grievances.

This is partly because some staff didn't fully understand what whistle-blowing was and how it differs from other ways of raising concerns. They were also unsure which processes in their service were for whistle-blowing and which were for raising other concerns. In one service, staff told us they didn't see any distinction between whistle-blowing, confidential reporting and raising concerns in their service's communications. This confusion was increased in some services that called the whistle-blowing process a "confidential reporting line". It would be easier for staff to understand which channel they should use to raise concerns if the term whistle-blowing was always used when describing public interest disclosures and was never used to describe other cases.

Other staff appeared to be using whistle-blowing to raise personal grievances because of their perception that normal grievance processes wouldn't be confidential or impartial. In particular, staff used whistle-blowing to raise personal grievances about their line manager. This was because normal grievance processes require them to initially raise concerns with their line manager, that person's line manager or another manager at a similar level of authority.

Whatever the reason for using it, the anonymity of whistle-blowing made it much more difficult for services to investigate and address personal issues raised this way. Services should address staff fears about their normal grievance processes, as set out above, so that they can use those processes with confidence, rather than turning to whistle-blowing channels that are often unsuitable for personal complaints.

Unsurprisingly, given their views on other routes to raise concerns, staff in many services questioned whether whistle-blowing processes were anonymous. They pointed out that they were required to use their normal email address to report issues and felt that this would be used to identify them. Staff also thought that the processes were ineffective, especially if whistle-blowing complaints related to senior people. One person said: "I don't have faith anything would be done."

### **Recommendation 5**

By 1 November 2024, chief fire officers should make sure all staff understand how to raise a concern and use grievance and whistle-blowing processes. Chief fire officers should:

- make sure staff know how services will handle responses and maintain confidentiality and anonymity; and
- explain how staff can access services' whistle-blowing capability and the difference between whistle-blowing and other processes for raising concerns.



## **Supervisors and managers aren't sufficiently trained to manage staff performance, poor behaviour and welfare issues**

### **In most services, managers and supervisors don't have the confidence and knowledge to tackle welfare issues and manage staff performance and behaviour**

All supervisors and managers in FRSs should be having regular discussions with their staff about their well-being, performance and development. This includes identifying conduct issues, providing support, coaching and other corrective action where needed, and making sure of their staff members' welfare and well-being.

Unfortunately, in some services, we have found managers aren't doing this basic aspect of their role.

In some of the services we inspected, we could find no evidence of performance-related conversations in the case files we reviewed. Some of the services don't consistently manage staff performance and development, with one conducting only a single annual meeting between managers and staff. One focus group told us managers "do not have time to performance manage staff". The negative effects of poor management of staff performance and development are likely felt in many ways that go beyond the scope of this thematic inspection. But this poor management certainly provides a weak starting point for identifying and dealing with misconduct. This is particularly important on [watches](#) and other tightly knit teams.

All the inspected services maintain a disciplinary policy that supervisors and managers should use to obtain improvements and remedy poor conduct. This includes an informal process in which the line manager works with the member of staff on their conduct, and three formal processes that can be used depending on the seriousness of the misconduct or if conduct doesn't improve after an intervention at a lower level.

All of these processes, formal and informal, depend on line managers initiating them when required. So we were alarmed by the examples we found of supervisors and managers being unwilling to take that action when needed. One focus group told us that disciplinary matters were considered to be "outside of the job role" of managers in their service.

### **Services need to identify problems earlier because this helps action to be taken sooner and before the situation escalates**

We were concerned that many line managers didn't take effective informal disciplinary action when it was appropriate to do so. It isn't appropriate to treat serious instances of misconduct informally. But for many minor problems, we would expect line managers to speak to the member of staff confidentially about the issue to set clear expectations about the standards of behaviour required. Much of the time, this will quickly and effectively address the issue without the need for a much lengthier and more demanding formal process.



In the cases we reviewed in some services we inspected, there was no evidence of informal action or performance-related conversations before formal action was begun. There appears to be a pattern of unaddressed low-level misconduct on watches and other teams escalating to more significant misconduct requiring formal disciplinary action. One member of staff we spoke with explained how “things can go from nothing to 100 miles per hour” with a disciplinary investigation being initiated without any informal fact-finding or discussion.

### **Better training is needed for new supervisors on promotion**

Some of the reasons why line managers are reluctant to manage staff performance and conduct are cultural in origin. As we have explained above, supervisors and line managers may be promoted, including on a temporary basis, from the crews and watches they now lead. They are strongly connected to the same culture as their former peers they are now responsible for managing. Line managers are also subject to the same fears that deter other staff from raising concerns. Managers told us they believed there would be repercussions if they used disciplinary processes, including being ostracised from the watch or team they were managing. This strongly echoed staff beliefs about grievance processes.

But we also found supervisors and managers were often not given basic training to carry out their new role. In one service, managers told us there was no training for new crew managers on how to manage staff, with new crew managers being expected to pick this up on the job. In another service, a focus group containing watch managers said they hadn’t received any training to equip them to manage grievance or discipline cases. Even in services where managers did receive training on performance management, this sometimes didn’t adequately cover the discipline process. Services also don’t often provide refresher training, despite managers being in these roles for many years.

### **Supervisors and line managers without management skills increase demand for HR support**

One of the knock-on effects of supervisors and line managers not having the right training is the creation of extra demand for support from more experienced managers and HR services. For example, one manager told us: “I wouldn’t know when informal action should be progressed to formal. I would probably ask someone at another station for advice.” This demand puts extra stress on the whole misconduct system because more specialised staff are diverted from investigating and advising on more complex and serious misconduct cases to support basic line management tasks.

## **Recommendation 6**

By 1 February 2025, chief fire officers should make sure a programme of training is in place for all supervisors and managers on how to manage staff performance and welfare and how to raise an issue. It should be supported by relevant policies and procedures. Training should include:

- staff welfare and absence management;
- the process for managing individual staff performance, addressing poor performance and potential misconduct issues;
- how to handle difficult conversations and resolve issues informally, if appropriate, when a concern is identified; and
- clarifying the role of HR services in helping managers to deal with staff concerns and misconduct issues.

Chief fire officers should make sure all managers and supervisors attend the training programme.

# The effectiveness of misconduct processes

The main formal ways fire and rescue services (FRSs) can deal with misconduct cases are through their grievance and discipline processes. The grievance process can be used to cover a range of concerns that staff members may raise with the service. This can include a grievance that they have been affected by the misconduct of another member of staff. The discipline process can be used by a line manager to address misconduct by a member of their team. Disciplinary processes can also be used for performance management and attendance issues that aren't related to misconduct. Grievances can also be raised against the FRS's policies, but these cases are outside the remit of this inspection.

As part of our inspection, we reviewed 84 grievance cases and 157 discipline cases drawn from 10 inspected services. These cases were all concluded between 1 April 2021 and 31 March 2023. Although we noticed a trend in which the more recently concluded cases tended to be of a higher quality than the older cases, we identified significant issues throughout this sample. Our concerns are set out below.

The concerns we have about the effectiveness of misconduct processes are closely linked to the issues of staff and manager confidence in these processes, discussed in [our chapter on the extent to which services are identifying misconduct](#). When managers and staff experience ineffective processes, it undermines their confidence in raising concerns. If managers and staff involved in the processes have low confidence in them, this can further reduce their effectiveness. Breaking this cycle is a significant challenge and co-ordinated action is needed. Attempts to raise confidence will be undermined unless the processes themselves are improved, whereas attempts to improve the processes won't help if managers and staff still don't have confidence in them.

## Most services need to improve how they manage and investigate misconduct

### Policies and procedures for discipline and grievances are inconsistent

The services we inspected all had discipline and grievance policies, which we examined. Encouragingly, several of the services had recently reviewed and updated these policies. These services may have prioritised improvements in response to recent high-profile events highlighting the issue of misconduct in FRSs.

In several of the inspected services, we found these policies were working well. In the case files we reviewed in these services, we found policies and associated guidance being used to make sure decisions were made by the right people at each step of the process. One service used a strategy checklist to make sure cases were dealt with at the appropriate level. The policies were also used to inform the decision-making itself, which usually led to well-justified decisions with clear rationales.

But we didn't find this in all services. In one service, we reviewed 16 case files but found no standard approach for the steps taken, when or who the decision-maker was. In another service, middle managers told us there was no formal process to make sure investigations are consistent and they rely on HR advisers to work with managers to ensure this.

Of particular concern, many people told us that in some services investigations were inconsistent, depending on whether the people involved were operational staff such as firefighters or non-operational staff such as those involved in administrative, technical and community work. We heard this was because of differences between the conditions of employment of these two groups, which are set out in the [grey book](#) and [green book](#). This is partially true as there are differences between the grievance and discipline procedures in the two books. But although conditions of employment are set nationally, we didn't find these inconsistencies in all services.

As well as disparity caused by differences between the grey and green books, we saw evidence in one service that more resources were put into investigations related to operational staff, and that this has a negative effect on investigations into non-operational staff. We conclude that inconsistency in the treatment of staff covered by the grey and green books arises from national discrepancies between the conditions of employment of these two groups and also local decisions about the implementation of these conditions.

Senior staff at brigade manager level operate under a third set of conditions of employment set out in the [gold book](#). Because of the small number of people who are subject to these conditions of employment, we couldn't gather enough evidence during our inspection to reach firm conclusions about the gold book. But it is apparent that these cases can be complicated and where external assistance is required, including for complaints, they should be considered early. In the absence of a national process and structure for considering even the most serious allegations of alleged wrongdoing by FRS staff, [fire and rescue authorities](#) need to make sure that they have robust plans, systems and support in place in order to deal swiftly, fairly and effectively with such complaints, especially where they relate to principal officers and other gold book staff.

## Recommendation 7

By 1 May 2025, chief fire officers should make sure the policies and processes for misconduct are consistent for all staff and are fairly applied within their respective conditions of employment.

By 1 August 2025, the [National Joint Council for Local Authority Fire and Rescue Services](#) and the [National Joint Council for Local Government Services](#), supported by the [National Fire Chiefs Council](#), should make misconduct processes consistent for all staff irrespective of the terms and conditions of their employment.

### Many investigations don't have clear terms of reference

The terms of reference should be the starting point for any misconduct investigation. They should clearly set out:

- how the person concerned is alleged to have breached the standards expected;
- who the investigator will be;
- the provisional time frame for the investigation;
- the relevant policies and procedures to be followed; and
- the sources of the evidence that should be collected, including the people who should be interviewed.

Without clear terms of reference to guide it, an investigation is less likely to be effective.

Although some of the services we inspected provided good terms of reference for all the investigations we examined in our case file review, in others they were poor or missing. For example, in one service several of the case files weren't clear enough and didn't contain specific details of how the person had allegedly breached the standards expected. In one case the allegation wasn't notified to the employee at any point leading up to the investigative interview.

In some of the inspected services, we found cases with no terms of reference at all. In one service, only one of the ten cases we reviewed had terms of reference for the investigation. In another, we didn't see any evidence of investigation plans or terms of reference for any of the investigations.

## **Few services adhere to the timescales for investigations**

Timescales for some parts of misconduct investigations are prescribed by the nationally set conditions of employment (the grey and green books) or are set locally by services through their discipline and grievance policies. However, in most cases, the services we inspected were routinely failing to meet these deadlines, sometimes substantially so. For example, one group of managers related a grievance regarding the use of a judgmental word in a notice of discipline investigation. This case took 407 days to be resolved.

The causes of delays appear to vary greatly. In some instances, the causes may be unfortunate but reasonable. For example, in one service, our discipline case file review found several cases in which investigations were paused due to police involvement. One of these cases took 21 months to complete. But other causes of delays are avoidable. In another service, middle managers felt that one of the barriers to conforming to timetables was that they didn't have enough capacity.

Even some of the relatively straightforward discipline cases we reviewed weren't being managed in a timely manner. For example, one straightforward conduct case involved an employee engaging in secondary employment without seeking approval. The issue took four and a half months to resolve. In another case involving repeated short-term absence, the issue took six months to investigate and a further six months to arrange a hearing.

When investigations exceed their designated timescales, this can have a negative effect on the members of staff involved. Many of the people we interviewed felt exasperated waiting to hear about the progress of their complaint. When the alleged perpetrator isn't suspended or moved, the person who raised the issue still has to work alongside the individual they have made a complaint against. During this time, the reported issues may continue, further affecting their well-being. When the alleged perpetrator is suspended, they can be left in a state of limbo, often going for months without an update. This can be highly stressful, especially in cases where the alleged perpetrator is ultimately found to have no case to answer. Many people told us that the length of misconduct processes can be exhausting for all parties.

## **Some cases are brought forward at the wrong level**

Under the conditions of employment for firefighters (the grey book), formal discipline processes can be initiated at any of three stages:

- First stage: performance and attendance cases where informal action hasn't resolved the problem – can be carried out at [watch](#) or station manager level.
- Second stage: more serious allegations or where support and action haven't resolved the problem, when the alleged offence may require a sanction no greater than a final written warning – should be carried out at group manager level or higher.

- Third stage: all cases where the employee is already subject to a final written warning, or the alleged offence is serious enough that it may require dismissal – should be carried out at area or brigade manager level.

In our inspection, we identified numerous examples of cases relating to low-level allegations that were still the subject of a high-level investigation. For example, in one service a union representative told us about a discipline investigation relating to a member of staff allegedly raising his voice during a professional conversation. This kind of allegation is suitable for informal resolution. But it was treated as a formal discipline case, which took six months to resolve. In another service we inspected, we found a case in which a staff member was alleged to have been rude to a colleague in front of a third-party contractor. This matter was also dealt with by way of a full formal investigation.

Investigators told us they often felt they had to use the third stage process from the start so that the full range of sanctions would be available to the chair of the hearing. We agree that limiting the potential range of sanctions before any investigation has taken place is counter to an effective misconduct process. This requirement should be reconsidered by the National Joint Councils as part of the review we propose in recommendation 7.

On the other hand, we also found evidence of cases that should have been dealt with at the higher stages not being appropriately escalated. For example, one case we reviewed involved a firefighter routinely displaying consistent racist, sexist and homophobic behaviour. This was dealt with using the first stage process, leading to a warning, which didn't change the person's behaviour. On the facts we reviewed, we would have expected such consistent and offensive behaviour to be identified as gross misconduct and handled using the third stage process.

When cases are unnecessarily escalated to a formal process or are allocated to the wrong stage, this can have significant negative effects. When the stage is too high, more intensive investigation will be carried out by a more senior member of staff, causing delays and inefficiency. But when the stage is too low, the appropriate sanction may not be available to the decision-maker.

### **Decision-making about outcomes is sometimes poorly recorded and communicated**

The recording and communicating of the outcomes of misconduct processes were also of concern in some of the cases we reviewed. In one service, we found several grievance case files that didn't contain enough documentation. This included grievance outcomes, investigation reports and hearing outcomes. It wasn't clear if the employee had ever been informed of the outcome in some cases. In another service, line managers said they weren't told about the outcomes of investigations into alleged misconduct by their staff, which made it difficult for them to manage these staff and to provide appropriate support.



But we didn't find this in all services. In one service, we reviewed 11 cases that reached a formal disciplinary hearing. We saw evidence that in all these cases, a written outcome letter was provided on the day of the hearing or the following day. These letters documented whether the allegations were proven or not and any sanctions issued.

### **Recommendation 8**

By 1 November 2024, chief fire officers should make sure all allegations of misconduct are handled in a consistent way and staff have confidence in misconduct processes. Chief fire officers should carry out a full review of the processes, from initial identification of a misconduct issue through to the resolution or outcome. This should include a review of how services:

- monitor and manage investigations;
- maintain accurate records; and
- adhere to required timescales.

### **There are several root causes of ineffectiveness in misconduct processes**

In [the above section](#), we identified several ways in which FRSs' misconduct processes can be inadequate or ineffective. Recommendation 8 will help chief fire officers to identify if any of these problems exist in their services and to take remedial action as required.

In our inspection we also identified several underlying issues across many services that can cause or exacerbate these problems. Action to resolve the immediate issues without addressing the root causes is unlikely to be truly effective as the issues will recur or appear in a different form.

### **Some services don't have an effective case management system**

Poor record-keeping was a recurring issue in several of the services we inspected. Some of the inspected services didn't keep full and thorough records.

Examples included:

- letters detailing outcomes and appeal information being missing;
- letters with information missing, such as the name of the hearing manager and support officer details; and
- some files without the rationale and justification for the decisions made.

In one service, during a review of their discipline cases, we found 5 of the 21 files contained only investigation reports and no other documentation or evidence. None of the files we reviewed contained a clear starting point or decision-making record. In another service, a group of middle managers told us the storage and formatting of records was inconsistent. The group said informal records were kept in people's email folders and could be lost when they changed role, moved to a different service or left the FRS altogether. This could be a problem if someone later seeks a reference, particularly if they move to another service. Good record-keeping is essential to reduce the risk of unsuitable staff moving between services.

However, we also inspected services that managed their cases well. One service had a case management system module built into their main HR system. All cases, formal and informal, were recorded on the case management system. The case management system could also be used by the management information team to produce reports, for example on any disproportionality in the [protected characteristics](#) of complainants and alleged offenders.

### **Recommendation 9**

By 1 August 2025, chief fire officers should introduce a case management system if they don't already have one. The case management system should allow data to be produced that will help them to better understand and oversee misconduct cases in their services.

### **Using external investigators can increase capacity and capability for investigations**

In several of the inspected services, people told us that not having enough capacity, especially at middle manager level, was a significant root cause of many of the issues we identified with misconduct investigations. In particular, the capacity of middle managers to carry out investigations was a barrier to adhering to the timescales. This was because middle managers carried out investigations on top of their existing high workloads.

This is an issue for which some services have been exploring potentially promising practice. One service we inspected outsourced some of its investigations to its local police professional standards department. Another service could call on county council managers to help with investigations. A third service had created a small team of station managers led by a group manager who was dedicated to investigations.

All these solutions have the potential to address the capacity issues that can affect misconduct investigations. Solutions in which the investigation is carried out by a partner agency have the added benefit that they reassure staff the investigation will be independent and impartial. This can build staff confidence in the process.

## **Recommendation 10**

By 1 May 2025, chief fire officers should make sure their services have enough capacity to carry out their misconduct investigations. They should consider using external investigators or a similar independent resource to support the process if required.

### **Union representatives can sometimes use their expert knowledge to extend and frustrate misconduct processes**

During our inspection, investigators and HR advisers regularly told us that union representatives almost always had a better understanding of the service's policies and processes than the service's own investigators and even some HR advisers. This is partly because investigators hadn't received enough training. Investigating managers felt this put them at a significant disadvantage when union representatives supported their members at key stages in formal processes. It is, of course, right that union representatives fully support their members, including during formal discipline and grievance proceedings. That is part of their role as set out in the terms and conditions of staff and a key part of making sure such proceedings are fair.

In many of the services we inspected, we found examples of positive practice. For example, in one service, managers said staff were well supported by the trade unions and were offered good help when they needed it.

However, some of the examples of union representatives' behaviour fire service leaders told us about during our fieldwork appeared to us to go beyond that necessary to provide support to their members. For example, one service told us that one union didn't recognise the fact-finding stage of the discipline process and had advised their members not to take part in it. In the same service, fire service leaders also told us that the same union advised their members to routinely raise grievances about people involved in the process to lengthen the time frames for investigations to be carried out. In another service, fire service leaders said that union representatives attempted to inappropriately influence the outcome of cases by trying to strike deals before the conclusion of formal processes. We heard that in one case a union had sought to use a misconduct case as a bargaining chip in a wider industrial dispute.

Although we don't inspect trade unions, we are compelled to comment here that tactics that attempt to frustrate misconduct processes rather than be involved with them undermine the value unions can bring. The alleged victims in a misconduct investigation are just as likely to be union members as the alleged perpetrators and, whether they are union members or not, they have the same right to a fair and timely resolution.

## **Supervisors and managers need better training, support and oversight to effectively investigate misconduct**

The most common and most important root cause of the issues we have identified with misconduct investigations is the inadequacy of training for middle and senior managers involved in investigating and hearing misconduct cases. In our interviews with those carrying out investigations and in our desktop reviews of training records, it was clear that in some services managers didn't receive training on discipline and grievance. In one service an HR adviser said that no such training had been provided since 2019.

In other services, managers carrying out misconduct investigations had been trained at some point in the past but had received no further support since. One person provided an example of receiving training about discipline "four or five years ago, with no refresher training and only experiential learning since". As a result, some of those conducting investigations told us they didn't feel confident in the role, with one telling us he felt he was "winging it".

In our view, when staff are assigned to investigate or hear misconduct cases without adequate training, they are being set up to fail both the process and, more importantly, those raising or who are the subject of concerns. This shortcoming explains many of the issues we have identified in the cases we reviewed and many of the fears staff raised with us that discouraged them from raising concerns through formal processes.

Some of the inspected services showed positive practice by using mentoring in misconduct cases. This ranged from informal mentoring to help the service maintain consistent decision-making in misconduct hearings and appeals through to more formal arrangements in which experienced investigators offer mentoring and shadowing to less experienced managers. These approaches are promising. But in our view, mentoring can be helpful as a supplement to effective training and is not a replacement for it.

In several of the services we inspected, it was clear inadequate training resulted in an extra burden on their HR departments. In one service the most serious investigations were carried out by the HR team. In most cases, investigators relied heavily on the advice and guidance of an HR adviser throughout the investigation. This is substantially less efficient than training investigators to carry out their investigations with less HR supervision.

## **Recommendation 11**

By 1 May 2025, chief fire officers should review the training their services provide for supervisors and managers who investigate misconduct issues at all levels. Chief fire officers should make sure:

- all staff who carry out investigations receive adequate training to carry out the task;
- a programme of refresher training and ongoing support is available so that staff can maintain a level of competence; and
- it is clear how services' HR provision, staff associations and any trade union representative or fellow employee will support the investigation process.

## **Welfare support to staff involved in misconduct processes is often good but isn't always provided consistently**

Involvement in misconduct processes can be highly stressful. A number of the people we interviewed, particularly those who later left their service, spoke about difficulty sleeping, disruption to family life and relationships, irritability, feelings of reaching a "low point", and feeling "broken" or "tipped over the edge". Staff, union representatives and HR advisers said it wasn't rare for people to take weeks or months off work on sick leave due to symptoms of depression, anxiety and post-traumatic stress caused by the incidents of misconduct they have experienced or engaging with the misconduct process itself. Most worryingly, 6 of the 30 former FRS staff we interviewed explicitly reported suicidal thoughts or actual suicide attempts, and others also implied that is how they felt.

Staff, union representatives and HR advisers said that being suspended could be particularly traumatic. While suspended, staff could find themselves cut off from informal welfare support that comes from being part of a team. Staff and union representatives also told us that suspended staff sometimes didn't receive updates about their case for lengthy periods and were left feeling forgotten or in limbo. Of the 157 discipline cases we examined for this inspection, the person was suspended in 55 cases. Suspension is often needed during an investigation, particularly where the matter is serious and there is no alternative, such as changing shifts or moving to a different part of the service. But the likely impact on staff welfare should be taken into account as part of the assessment when considering suspension.

### **The quality of welfare support is good in most services**

In most of the services we inspected, staff reported that welfare was treated seriously during misconduct processes and that the provision of support was good. In most services, the affected staff are provided with a named person who is responsible for supporting their welfare throughout the process. This role has different names in different services, such as welfare officer, well-being officer or contact officer.

Many services provided extra support if needed. For example, one service had a welfare officer available 24 hours a day, and access to counselling, mediation and stress risk assessments. Another service had a well-being team that could provide access to specialist support to deal with post-traumatic stress and other significant mental health issues. A third service had a trauma support officer and mental health first-aiders, as well as a welfare officer. Staff we spoke with often also referred to the [Fire Fighters Charity](#) and their trade union as being invaluable sources of extra support.

But we didn't find this in all services. In one service, staff reported that well-being support was inconsistent and no more than a tick-box check-up with little proper consideration of the person's welfare. They felt that welfare officers in their service were more a point of contact than a source of welfare provision. In another service, there was no evidence to show welfare support had been offered to staff in any of the grievance case files we reviewed. In one service, staff said well-being provision wasn't proactive enough. A staff member had been signposted to the occupational health team by HR, who told them: "If you want to speak to them, you can." There was no follow-up.

### **Welfare support can be inconsistent**

We were concerned about welfare support not always being equally available to all staff in some of the services we inspected. In one service, we found a perception that well-being routes weren't inclusive for non-operational staff. In another service, on-call staff told us that they hadn't been supported during a long and complex discipline case.

We found good welfare provision in most services for the alleged perpetrator of misconduct and often the complainant. But welfare support for others involved in misconduct processes, such as witnesses, investigators, decision-makers or HR advisers, was less common. Some of the managers we spoke with said their experiences of conducting discipline or grievance cases had left them feeling isolated and under stress.

### **Recommendation 12**

With immediate effect, chief fire officers should make sure all staff are aware of the welfare support, including occupational health support, that is available to staff involved in misconduct processes. Chief fire officers should encourage all staff involved in misconduct processes to access this support, whether they are an alleged perpetrator, complainant, witness, investigator or decision-maker.

Welfare personnel should be independent of the investigation and have been appropriately trained for this role.



## **Service managers and fire and rescue authority members who hear appeals need appropriate training**

FRS staff who have had disciplinary action against them, or who are unhappy with the decision arising from a grievance hearing, can appeal. This is the final stage of the formal process, unless the case is taken to an employment tribunal, which is outside the scope of this inspection.

### **Appeals are rarely made in misconduct cases**

Of the 128 discipline cases reviewed, appeals were submitted in only 21 cases. Appeals appear to be slightly more common in grievance cases. Of the 84 grievance cases we examined, appeals were submitted in 25 cases.

Often an appeal will not be necessary or appropriate, so a low rate of appeals isn't necessarily an issue of concern. For example, an appeal must be made on specific grounds. This could be a procedural defect in the original hearing such that the hearing was unfair, or new evidence that has come to light since the hearing which could affect the decision. If there are no relevant grounds for an appeal in a particular case, an appeal cannot be heard.

However, in our inspection we also found examples where the low rate of appeals did give us concern. For instance, in 20 of the 84 grievance cases we reviewed, we couldn't find evidence that the right of appeal had been explained to the member of staff concerned. This explanation is a vital part of making sure misconduct processes are fair.

There was also some evidence that some services had restricted the right of appeal. In one service an HR adviser told us people could opt into an accelerated process. Their case would be dealt with more quickly, but they had to waive their right to appeal. Although timeliness is a significant issue in many FRSs, appeals are an essential element of a fair misconduct process. One fire and rescue authority told us that it doesn't use the appeals process unless the case relates to a senior member of staff. It should go without saying that the right to appeal a misconduct case should be available to all staff.

More generally, staff in some services told us they don't have confidence in the appeals process. Staff who had appealed cases told us they didn't consider it fair or effective. One member of staff told us: "The appeal was a formality and a decision was already made before." And a union representative described them as a "rubber-stamping exercise". This perception is likely to discourage members of staff from making appeals after having already been through long and stressful investigations and hearings.



## **Appeals in misconduct cases are rarely successful**

We collected data from all 44 services in England. Services reported that, from April 2022 to March 2023, 37 discipline cases had resulted in an appeal. Of these appeals, only 3 were successful (8 percent). As with the rate of appeals, the rate of successful appeals isn't necessarily a problem. This could just indicate that the grounds on which the appeals were made weren't found or weren't enough to make a difference to the outcome.

We haven't found strong evidence to suggest systematic or widespread issues with the effectiveness of appeals that would cause us to be concerned about the rarity of successful appeals. But we note the lack of confidence staff and trade union representatives have in the appeals process. We also have concerns about the effectiveness of misconduct investigations. Close examination of the effectiveness of misconduct appeals will be needed from now on.

## **The approach to misconduct appeals across fire and rescue services is inconsistent**

The FRSs we inspected operate under a variety of different governance arrangements and this is reflected in the approach taken to appeals in misconduct processes. In some of the services, the appeal was heard by the chief fire officer or a senior member of staff. In other services, appeals were heard by the fire and rescue authority. In one of the inspected services, the fire and rescue authority chair made the final decision on all appeals.

Service managers and fire and rescue authority members who hear misconduct appeals have rarely received training to do so

As with our findings on line managers and those who investigate misconduct, many of the strategic managers and governance body members we interviewed told us they had no training to deal with appeal hearings. One of the strategic managers we spoke with had been briefed on guidance from the [Advisory, Conciliation and Arbitration Service \(ACAS\)](#) but nothing more. Another strategic manager said they sought advice from other managers but hadn't received any training.

As we saw with line managers and those conducting misconduct investigations, those who hear appeals appear to overly rely on HR support and guidance. But because of the rarity of appeals, we have fewer case studies on which to base our conclusions.

### **Recommendation 13**

By 1 November 2024, fire and rescue authorities and chief fire officers should consider varying the approach to hearing appeals so that appeals for complex or serious cases are heard by a panel rather than one person.

By 1 February 2025, [fire and rescue authorities](#) and chief fire officers should make sure all service managers and members of fire and rescue authorities who hear appeals receive appropriate training.

Chief fire officers should make sure services have a consistent approach to hearing appeals.

### **Sanctions from misconduct cases are appropriate in most cases**

At the conclusion of a misconduct case, the decision-maker will apply a disciplinary sanction if necessary. This sanction may also be reviewed on appeal and changed if it is found to be too severe. The sanctions available to the decision-maker will depend on the level the case has been allocated. For minor misconduct dealt with informally by a line manager, this could be nothing more than a confidential discussion and a written note that will form part of the member of staff's personal record. In formal processes and for more serious misconduct, the sanction could be a formal warning, a final written warning, demotion, disciplinary transfer, loss of pay or dismissal.

### **Sanctions from misconduct cases are usually appropriate**

An important feature of a fair and effective misconduct system is that the sanctions applied should be appropriate to the seriousness of the misconduct and the circumstances of the case.

We were pleased to find that most sanctions were appropriate. We saw evidence in many services that decision-makers considered mitigating factors when determining outcomes and that decisions were fair, with personal circumstances, previous conduct and length of service considered. Managers we spoke with usually highlighted the guidance they received from HR advisers as being central to making sure the sanctions were appropriate. Some services also provided outcome letters, which explained the reasons behind the hearing manager's decision and provided clarity for those receiving the sanction.

### **Sanctions from misconduct cases are usually consistent**

Another important feature of a fair and effective misconduct system is that the sanctions applied are consistent. Members of staff should receive similar sanctions for similar misconduct in similar circumstances.

In our inspection we were pleased to see services were making sure their sanctions were consistent. Again, this was most often achieved through HR advisers' involvement in the process. HR advisers could provide expert guidance to decision-makers about the sanctions that had been applied in similar cases. Usually, the advisers drew on their subject matter expertise and broad experience of cases to provide this guidance. But in some services, HR departments carried out more structured procedures to help make sure there was consistency of sanctions. For example, one service had created an investigation review group to examine different types of cases.

### **People retiring or resigning during a misconduct case has a negative effect on morale and the culture in the fire and rescue service**

In our [values and culture spotlight report](#) we noted that when someone is due to be dismissed for misconduct, they can retire or resign instead. We considered this evasion of the sanction to be a significant flaw in misconduct arrangements and recommended that such cases be continued to conclusion in the person's absence. We also recommended a national barred list be introduced to reduce the risk of unsuitable people moving between services. This has not yet been established.

In one of the services we inspected, staff told us how people retiring or resigning during misconduct cases has had a negative effect on morale and the culture in the service. Staff said this had led to a loss of confidence in the impartiality of the misconduct system. One notable example was a high-profile case involving a senior officer. Rumours about the case and distrust in the outcome had hampered other cases because the legitimacy of the system as a whole had been challenged. In the same service, 3 of the 15 cases we reviewed ended with the employee retiring or resigning before the disciplinary process concluded.

This issue wasn't limited to one service. In another, we saw evidence of four cases of serious misconduct in which the service allowed the employees to resign during the discipline process. There was limited evidence of any rationale for the matter not being progressed to a conclusion. In a third service, we found a case in which a hearing wasn't held because the person, who had been accused of gross misconduct, resigned.

But some services are tackling this issue. We were pleased to find evidence in several services that disciplinary investigations had continued and hearings were concluded for gross misconduct where the employees had resigned or retired.

# Understanding misconduct and sharing lessons learned

We have so far focused on how effectively individual instances of misconduct are handled in fire and rescue services (FRSs), from first identification to investigation, decision and appeal. As we have described, there are significant opportunities for FRSs to improve at each of these stages. But to achieve lasting change, FRSs need to take action to prevent misconduct occurring in the first place.

In order to prevent misconduct, FRS leaders and [fire and rescue authorities](#) need to oversee and scrutinise any misconduct that takes place in their services. Strong analysis of the problems in their services and sharing the lessons they learn from misconduct cases will help them to take targeted preventative action. The [Local Government Association's good governance guidance](#) provides clear advice on how chief fire officers and fire and rescue authorities should oversee significant misconduct cases.

## **Senior leaders need a better understanding of misconduct in their services if they are to improve staff behaviour and culture**

To make significant progress in tackling this problem, senior leaders and governance bodies need to oversee and scrutinise their discipline and grievance systems. They also need to understand the root causes of misconduct in their services, and any disproportionality in those committing misconduct or being adversely affected by it.

## **Oversight and scrutiny are hampered by poor understanding of the problem and lessons learned from misconduct investigations**

We saw limited evidence of oversight and scrutiny of the causes of misconduct within the FRSs we inspected. In some services we found no evidence that they monitor their disciplinary and grievance processes. Leaders we interviewed often couldn't describe any themes or trends in the misconduct cases in their services, including whether there was any disproportionality in respect of [protected characteristics](#). The role governance bodies play in providing oversight and scrutiny was also highly variable.

For example, in one service a senior officer told us bullying was the underlying cause of most discipline and grievance cases. But they couldn't explain why this behaviour persisted and why women in particular were being treated unacceptably by their colleagues.

However, we did see some emerging good practice. For example, in one service the chief fire officer chaired a monthly strategic HR meeting, which considered management information about discipline and grievance cases and discussed trends and themes. The lessons identified were incorporated into an improvement plan. In another service senior members of the fire and rescue authority and senior leaders of the FRS met on a monthly basis to discuss matters related to grievances and discipline.

### **Analysis of misconduct is limited in most services**

We didn't establish that the reason for poor oversight and scrutiny of misconduct was that leaders and governance bodies weren't making tackling it a priority. Leaders in every service we inspected had grasped the importance of this agenda. The main reason why scrutiny and oversight were poor was that there was not enough analysis to support them. Without a good assessment of the problem and its root causes, leaders and governance bodies are limited in what they can achieve.

Few of the services we inspected analysed the trends and patterns in their misconduct cases. In services that didn't have any such analysis, we unsurprisingly found lower levels of understanding of the underlying reasons for misconduct. Where analysis was carried out, it tended to be basic. For example, in one service we saw a spreadsheet containing a general breakdown of discipline and grievance cases. It included a breakdown of gender and ethnicity but no analysis of any disproportionality. In another service we saw documents with information that was provided to its workforce planning and people board. The information was limited, with charts showing the number of discipline and grievance cases per quarter, the outcomes and reasons. No analytical insights or breakdown of protected characteristics were included in the documentation.

In our [values and culture spotlight report](#), we recommended that services improve their understanding of their staff demographics. Some services are making progress in this regard. One service compiles a quarterly report of cases, outcomes and protected characteristics. Senior staff use this to examine disproportionality and the fire and rescue authority receive it for scrutiny. Another service, which wasn't inspected as part of this [thematic inspection](#) on standards of behaviour, has produced a comprehensive report that provides an overview and comparison of its discipline and complaint cases over time. The report breaks down the number and type of complaints and the gender and ethnicity of the complainants to check for disproportionality. It also includes analytical insights to help inform scrutiny and oversight.

## **The systems to support analysis of misconduct are limited in most services**

In the same way that the services we inspected were aware of the need for better scrutiny and oversight, most of them were aware that they needed better analysis and understanding of misconduct. Their ability to do this analysis was mainly limited by their case management systems.

We discussed the impact of inadequate case management systems on the effectiveness of individual misconduct cases in [our chapter on the effectiveness of misconduct processes](#). But the case management systems we inspected also rarely produced meaningful management information. One service, for example, used its county council's case management system. This system only allowed it to access data about how many people had been dismissed or whether a warning had been given. No thematic monitoring could be carried out with the data available.

We did see some positive examples. One service had a case management system module built into its HR system that could produce reports. All cases (informal and formal) were recorded on the case management system. The reports included data on case type and the length of time cases were taking. The service's management information team could break reports down to show protected characteristics and the source of complaints.

### **Recommendation 14**

By 1 November 2025, chief fire officers should implement a process that makes sure they can oversee and scrutinise their services' performance relating to misconduct issues. This process should provide:

- a strategic overview of performance and analysis of trends, including disproportionality;
- regular reporting of issues, outcomes and trends to the [fire and rescue authority](#); and
- identification of learning outcomes and how they will be shared with fire and rescue service staff, to prevent repeat behaviours.

## **Services need to identify learning from misconduct cases and find appropriate ways of sharing it with their staff**

The main reason services need to improve their analysis, scrutiny and oversight of misconduct cases is so that they can identify [organisational learning](#) from them. Understanding the issues behind a particular misconduct case and finding out how to prevent those issues from reoccurring is a practical way of tackling misconduct at its root and improving culture.



## **Services struggle to identify learning from misconduct cases**

Most of the services we inspected showed some evidence of organisational learning in some cases. But it was rare for services to learn lessons from cases consistently. There was little evidence in some services of any organisational learning from misconduct cases at all. We found evidence of organisational learning in 22 of the 84 grievance cases we reviewed as part of this inspection and in 31 of the 157 discipline cases we reviewed.

Some of the inspected services were learning lessons. For example, in one service HR advisers told us that HR records organisational learning from significant cases using an operational assurance team that collects feedback from staff who carried out the investigations. In the same service, a board had been established, chaired by the chief fire officer, to identify learning from previous cases. The governance body also identified emerging themes in misconduct cases which they included in training courses to improve awareness.

## **Services aren't sharing lessons learned effectively**

Even where services are gathering organisational learning, they often find it difficult to share those lessons with their staff. When lessons learned aren't shared and changes implemented, the value of those lessons is substantially decreased. Even in the service mentioned above, in which HR, the chief fire officer and the governance body were identifying organisational learning, staff we spoke with told us it wasn't shared with them.

In most of the services we inspected, staff told us they couldn't share the outcome and learning because the cases were confidential. This issue was particularly challenging for the smaller services we inspected. Because of their smaller size, they had relatively few misconduct cases and were concerned that it would be easier to identify people even when the cases were anonymised.

Services are right to be concerned about the confidentiality of their misconduct processes. As we discuss in [our chapter on identifying misconduct](#), many staff fear their confidence will be breached if they raise a concern, and this can deter them from raising a concern or grievance.

But services not sharing organisational learning and outcomes appears to have done little to protect the confidentiality of those involved in misconduct cases. In many of the inspected services, staff told us that rumours and gossip about misconduct cases were very common, despite the lack of information from the service. It was put best by the member of staff who told us: "The outcomes of discipline and grievances generally come through on the grapevine. Maybe if we were told what has happened and the outcomes of discipline cases then we could learn from that on station, and it stops the rumours."



The challenges of maintaining confidentiality in misconduct cases while also sharing learning from those cases is, inevitably, leading to opportunities being missed to prevent misconduct from arising in the first place and improving the culture in FRSs. Although this barrier isn't insignificant, it can be overcome. In recommendation 15, we propose a national system is established to address the concerns that smaller services with relatively few cases have raised with us about protecting confidentiality.

We also urge chief fire officers to identify practical solutions to help learning at the service level. These could include, but aren't limited to, communicating only the learning and not the case itself, and batching cases and communicating the learning from them as a batch. We also recommend that chief fire officers learn from other local services about how they overcome confidentiality barriers, for example when [safeguarding children](#) and [vulnerable adults](#).

### **Recommendation 15**

By 1 February 2025, chief fire officers should put in place a process for sharing learning from misconduct cases that have been resolved while preserving the confidentiality of all parties involved. Any learning should feed into the national system, when established.

By 1 May 2025, the [National Fire Chiefs Council](#) should establish a system for sharing learning from more serious cases of misconduct with fire and rescue service staff. The information shared should preserve the anonymity and confidentiality of all parties involved. The College of Fire and Rescue, once it is established, should take responsibility for maintaining this system.

# Annex A – Progress against our values and culture spotlight report recommendations

Our '[Values and culture in fire and rescue services](#)' spotlight report contains 35 recommendations. These recommendations aim to help fire and rescue services (FRSs) improve their values, culture, fairness and diversity. They are for both national bodies that have the power to make changes and FRSs. An update on progress against these recommendations is set out below.

We issued 14 recommendations to the following national bodies: the [Home Office](#), the [Fire Standards Board](#), the Government, the [Local Government Association](#), the [National Fire Chiefs Council \(NFCC\)](#) and National Employers. By April 2024, 9 of the 14 recommendation deadlines had passed. One recommendation was issued to police chief constables.

We issued 20 recommendations to chief fire officers. All 20 recommendation deadlines have now passed. All 44 services have self-reported that they have made progress against the majority of these recommendations. But some haven't yet provided information that demonstrates their progress. And some recommendations don't appear to have been progressed by some services.

In January 2024, we asked services for further detail on the progress they have made against each recommendation. We will be monitoring their progress, including through our inspections when appropriate, to make sure our recommendations have been completed.

We have also reminded chairs of [fire and rescue authorities](#) of their responsibilities. The '[Fire and Rescue National Framework for England](#)' states that fire and rescue authorities must give due regard to our reports and recommendations and – if recommendations are made – prepare, update and regularly publish an action plan, detailing how the recommendations are being implemented. These plans will usually be developed by the FRS.

Worryingly, by April 2024, 13 fire and rescue authorities and their equivalents still hadn't published action plans in response to our values and culture spotlight report recommendations. A further 17 authorities had only published partial information. Many didn't publish anything at all until after we reminded them of their responsibilities in this regard. We urge fire and rescue authorities to make sure they are publishing action plans that address our spotlight report recommendations.

### **Raising concerns (recommendations 1–5)**

All services have provided updates to show their progress on completing our recommendations relating to raising concerns. However, by April 2024, 6 services had made some progress on, but not fully implemented, recommendations 1, 3 and 5. In these recommendations we asked chief fire officers to:

- make sure their services provide a confidential way for staff to raise concerns;
- review the support available for staff who have raised concerns; and
- make sure they provide accessible information for all staff and members of the public on how they can raise concerns and access confidential support.

Also, 34 services reported that they had completed recommendation 4, while 10 services were in the process of implementing this recommendation. This recommendation requires chief fire officers to assure themselves that updates on how concerns are being handled are shared with those who have raised them.

As part of recommendation 2, we asked National Employers, the Local Government Association and the NFCC to review any current independent arrangements whereby staff can raise concerns outside their FRS. We also recommended that they make sure all FRS staff have access to an independent reporting line that can be used as a confidential way to raise concerns outside their own FRS. These bodies have confirmed that all FRSs in England now have an independent reporting line in place.

Several NFCC products are in place to help FRSs to review and improve their policies and practices around [safeguarding](#) and the independent reporting of allegations. We consider recommendation 2 to be completed.

### **Background checks (recommendations 6–10)**

We welcome the work by the Government to amend [Schedule 1 of the Rehabilitation of Offenders Act 1974 \(Exceptions\) Order 1975](#). These amendments came into force in July 2023 and help services to access higher levels of [Disclosure and Barring Service \(DBS\)](#) checks more efficiently, reducing potential risks to public safety because services will have a better understanding of the people they are employing. We consider recommendation 6 to be completed.

In response to recommendation 6, in April 2024, the Home Office was working with the NFCC's Safeguarding Board to consider the need for enhanced checks for all staff, and whether the existing provision in the [Police Act 1997 \(Criminal Records\) Regulations 2002](#) is sufficient and proportionate. Making sure this legislation, or a similar appropriate legislatively enabled solution, makes detailed provisions for FRSs would complete recommendation 7, which had a deadline of 1 May 2024. We look forward to receiving a further update on this recommendation in due course.

The Fire Standards Board, working with the NFCC, has amended three of its standards:

- [Leading the service](#);
- [Leading and developing people](#); and
- [Safeguarding](#).

These standards now include statements on the requirements for background checks and making safeguarding an integral part of services' organisational cultures. The suite of approved fire standards can be accessed on the Fire Standards Board website. The NFCC has also worked with partners, including the DBS, on guidance and sector-specific training to help services implement these standards.

By amending these standards, we consider recommendation 8, which concerns standards on background checks, to be completed. By completing recommendation 8, services should be able to complete recommendation 9 without delay.

Most services have said they are making progress on reviewing their background check arrangements and making sure DBS check requests are submitted. This means most have made progress towards completing recommendation 9. They have implemented more rigorous recruitment systems and processes to safeguard communities and the fire and rescue workforce across England. However, by April 2024, four services hadn't reported any progress on making sure appropriate DBS checks have been submitted for staff and volunteers.

In recommendation 10, we recommended that chief constables should make sure they are appropriately using their [Common Law Police Disclosure](#) powers in circumstances involving FRS employees. This would mean chief constables would pass relevant information about FRS employees to the service that employs them. However, by April 2024, six chief constables still hadn't confirmed that they have implemented this recommendation.

## Misconduct handling (recommendations 11–19)

As stated above, the Fire Standards Board, working with the NFCC, has amended three of its standards, which also aim to improve the handling of misconduct. Recommendation 11 concerns standards on how services should handle staff disclosures, complaints and grievances. Recommendation 13 concerns standards on how services should handle misconduct and safeguarding-related allegations and outcomes.

By amending these standards, we consider recommendations 11 and 13 to be completed. The NFCC has worked with partner organisations, including the Fire Standards Board, on guidance and sector-specific training to help services implement these standards. The NFCC has also produced 'Managing Allegations Guidance' to support services.

The completion of recommendations 11 and 13 means that services should now be able to complete recommendations 12 and 14. In these recommendations we asked chief fire officers to provide us with assurances that they had implemented the standards stated in recommendations 11 and 13.

While many FRSs have completed recommendations 12 and 14, others are making good progress in integrating the relevant standards into their services' appropriate policies, procedures and systems. A minority of services haven't reported any progress on these recommendations.

In recommendation 17, we said chief fire officers should notify HMICFRS of any allegations that have the potential to constitute staff gross misconduct that:

- involve allegations of a criminal nature that have the potential to affect public confidence in FRSs;
- are of a serious nature; or
- relate to assistant chief fire officers or those at equivalent or higher grades.

All 44 FRSs reported that they have implemented this recommendation. We consider this recommendation to be completed.

Thirty-seven services have reported completing recommendation 18, and 7 services have made progress towards completing it. This recommendation requires FRSs to make sure all parties are supported during ongoing investigations. In this inspection, we have found that welfare provision during misconduct processes is generally good.

The Home Office has stated that the findings from this report will inform its next steps in progressing recommendation 19, which asks the Home Office to examine whether any appeals processes for FRS misconduct cases are appropriate. We look forward to receiving a further update soon.

In recommendation 15, we asked the Home Office to make sure there is a process to handle misconduct allegations against chief fire officers. The Home Office is considering an escalation process for allegations, including how data is shared and managed. It has also reported that it will respond to people who report misconduct allegations and signpost them to avenues of redress. Given that the deadline for this recommendation was 1 October 2023, we hope to receive a further update from the Home Office on this soon.

Potential obstacles have been raised about completing recommendation 16, which relates to a national barred list that holds details of staff who have been dismissed for gross misconduct. We have discussed the recommendation with the Home Office, NFCC and Local Government Association, who have raised concerns about completing the recommendation. Proposed alternative and extra measures have been considered to meet the recommendation aims in the interim, but none had been agreed by April 2024. A barred list is still desirable and would help to improve the values, culture and behaviours in services. We continue to monitor progress on this recommendation.

### **Leadership (recommendations 20–24)**

The majority of services have said that they have made progress towards completing our recommendations relating to leadership. However, by April 2024, two services hadn't yet reported any progress on recommendations 22 and 24, which relate to 360-degree feedback processes, and monitoring [watch](#) and team cultures.

### **Management and leadership training and development (recommendations 25 and 26)**

By April 2024, five services hadn't yet reported any progress on recommendation 26, which relates to how the training and support offered to staff in management and leadership development can be improved. The Fire Standards Board's Leading the service fire standard and [Code of Ethics fire standard](#); the [Core Code of Ethics](#); and various NFCC products, development programmes and guidance should help services to meet recommendation 26.

The deadline for recommendation 25, which recommends that the Government establishes a College of Fire and Rescue, isn't until 1 January 2025. However, it is encouraging that the Home Office expressed its commitment to creating a college as part of its [response to the Fire Reform White Paper](#), which was published in December 2023. It is considering how to set up the college and will continue to work with sector leaders, the frontline and existing comparable organisations, such as the [College of Policing](#), as it develops its plans for the college.

The NFCC has been working closely with partners, including the Home Office, to improve the training and support FRSs offer to staff in management and leadership development. In addition to meeting the requirements of recommendation 26, this is part of the NFCC's broader work to continually improve professionalism and leadership development in FRSs, which has been integrated into its [Culture Action Plan](#). This work includes:

- strategic continuous professional development masterclasses;
- listen and learn sessions;
- a suite of online products to develop service leaders;
- a supervisory leadership development programme;
- the NFCC Direct Entry Scheme; and
- a middle leadership programme.

The Home Office sponsors the NFCC's work in this area through an improvement grant. This work remains a core pillar within the Home Office's wider reform plans to strengthen and improve leadership and talent management, including improving diversity of thought and experience in FRSs through direct entry. The Home Office is also working with the Local Government Association to consider how fire and rescue authority members' leadership and assurance skills can be strengthened.

While we are pleased to hear about the steps the NFCC and others have taken, we can't consider recommendation 26 to be completed until all services have reported enough progress. It remains the responsibility of individual services to maximise the benefit provided by NFCC products to improve leadership and culture within their service. The NFCC's implementation support team will continue to support individual FRSs to implement the fire standards and to use and incorporate NFCC tools and products into their policies and practices as appropriate. We urge the five services that haven't yet reported any progress on recommendation 26 to make use of this support.

### **Diversity data (recommendations 27–31)**

Most services have said that they have made progress towards completing our recommendations relating to diversity data. However, by April 2024, seven services hadn't yet reported any progress on recommendation 27, which relates to equality impact assessments being fit for purpose and meeting the requirements of the NFCC's equality impact assessment toolkit.

The lack of reported progress by some services on recommendation 27 is concerning. Services' inability to effectively assess the equality impacts of their strategic plans, operational policies, procedures and activities could result in difficulties in identifying and reducing the strategic and operational risks posed to our communities and the FRS workforce.



In October 2023, the Home Office published its latest FRS workforce statistics. The Home Office has made changes to include more specific detail on [protected characteristics](#) by FRS staff rank. However, we expect to see more detail on leavers before recommendation 29 can be considered completed.

### **Improving diversity (recommendation 32 and 33)**

Most services have said that they have made progress towards completing our recommendations relating to improving diversity. However, by April 2024, one service hadn't yet reported any progress on recommendation 33. In this recommendation, we asked chief fire officers to develop plans to promote progression paths for existing staff in non-operational roles and to put plans in place to reduce any inequalities of opportunity.

### **The Core Code of Ethics (recommendation 34)**

All services have said that they have made progress towards completing recommendation 34. In this recommendation, we asked chief fire officers to review their implementation of the Core Code of Ethics and make sure it is being applied throughout their services. We consider this recommendation to be completed.

### **The Fire and Rescue National Framework for England (recommendation 35)**

We recommended that, by the end of the Parliament at the time the report was published (in March 2023), the Government at that time should consider the findings and recommendations in this report when refreshing the '[Fire and Rescue National Framework for England](#)'. We are pleased to report that the Government at the time of writing (in April 2024) plans to publish a revised framework for public consultation later in 2024.

# Annex B – About the data

Data in this report is from a range of sources, including:

- a survey for current staff;
- interviews with former staff;
- HMICFRS data collection;
- case file reviews; and
- our inspection fieldwork.

## Methodology

### Survey for current staff

We worked with [Crest Advisory](#) to survey staff working in fire and rescue services (FRSs) in England about their experiences relating to misconduct. The survey asked whether they had personally experienced and/or witnessed misconduct, as well as questions about training, perceptions and their understanding of policies and procedures.

The online survey was open from 1 November to 15 December 2023. Crest worked with a nominated contact within each service to promote the survey. We received 4,422 individual responses, equating to 10 percent of the workforce. Most questions were optional. The number of respondents to each question is shown throughout the body of this report where data is referenced.

The survey was a voluntary sample and response rates vary by service, so results may not be representative of the whole sector.

More information on the survey design and limitations can be found in the full research report '[Misconduct in fire and rescue services in England](#)'.

### Interviews with former staff

We also worked with Crest Advisory to interview former FRS staff in England.

Participants could volunteer to participate in an online interview by expressing interest through a questionnaire that was promoted by sector stakeholders. To be eligible, participants had to have left the sector within the last five years and have a personal experience relating to misconduct while in service.

Between 6 December 2023 and 8 February 2024, Crest carried out 31 interviews. Thirty of these were used to inform the analysis. This report contains quotes from individual interviews.

More information about the interview methodology can be found in the full research report.

### **HMICFRS data collection**

Twice a year, we collect data from all 44 services in England for the purposes of inspection.

In autumn 2023, we collected more data for the purposes of this [thematic inspection](#). We asked services about their grievance, disciplinary and complaint cases, including what they were related to, what the outcomes were and what the [protected characteristics](#) of those involved were.

Analysis was limited by the small number of cases reported in some services, as well as the completeness and quality of data provided by others.

### **Case file reviews**

We carried out a case file review in ten FRSs in England. We examined case files relating to:

- grievances (84 cases);
- disciplinaries (157 cases);
- complaints/whistle-blowing (54 cases);
- background checks (93 cases); and
- training (82 cases).

Some analysis was only possible for a subset of all cases or for cases relating to certain services. Throughout the narrative, the number of cases is stated.

The cases we reviewed were based on a non-statistical sample, so the results aren't representative of all services in England.

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