



HM Inspectorate
of Probation

An inspection of probation services in:

Derbyshire PDU

The Probation Service – East Midlands Region

HM Inspectorate of Probation, May 2025

Contents

Foreword.....	3
Ratings.....	4
Recommendations	5
Background.....	6
1. Organisational arrangements and activity.....	7
2. Service delivery.....	14
Annexe one – Web links.....	20

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The role of HM Inspectorate of Probation

HM Inspectorate of Probation is the independent inspector of youth justice and probation services in England and Wales. We report on the effectiveness of probation and youth justice service work with adults and children.

We inspect these services and publish inspection reports. We highlight good and poor practice and use our data and information to encourage high-quality services. We are independent of government and speak independently.

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Foreword

This was the first inspection of Derbyshire Probation Delivery Unit (PDU) since it was established after the unification of probation services in 2021. Concerningly, this inspection highlighted several significant problems relating to culture, morale, and workloads. The lack of a clear, coherent, and consistent vision for the PDU meant that staff did not always understand what they were accountable for. This was particularly evident in the implementation of meaningful work with people on probation. The quality of work to manage people on probation was insufficient on all four of our standards of casework. Overall, we have rated this PDU as 'Inadequate'.

Divisions and sometimes hostility between all grades of staff within Derbyshire PDU were significant and worrying. Staff wanted to do a good job, but morale was low, which was related to a difficult working environment, perceptions around a culture of blame, and people not feeling valued. The number of staff in the PDU was stabilising and workloads were improving, but leaders had not done enough to support staff through continuous change. As a result, practitioners were not yet feeling the relief from working with lower caseloads. Disappointingly, we found deficits across all standards of our framework and improvements were required in the quality of casework, particularly regarding keeping people safe.

Leaders had some insight into the difficulties within the PDU and had sought to address these by working with the Tackling Unacceptable Behaviours Unit. This included work delivered specifically around discrimination and victimisation awareness, gaslighting, microaggressions, and psychological safety. However, this needed more priority from leaders across the PDU to ensure that the work was having the required impact. Leaders needed to be much clearer in their messaging to all staff across the PDU.

More positively, we saw strong working relationships between PDU leaders and strategic agencies, including Derbyshire Police and health providers. The PDU had improved systems for obtaining domestic abuse information and had co-located skilled practitioners within the police and children's services. However, when PDU staff received information from other agencies, they did not always follow it up or use it to assess and manage the risk of harm posed by individuals, and too few meaningful interventions were being delivered.

Derbyshire PDU's problems were being made worse by over-complicated processes, which was leading to practitioner fatigue and limited capacity at senior probation officer grade. Local leaders had much to do on establishing a clear, coherent vision for the PDU, uniting and enabling staff across all grades to be accountable and secure in their understanding of the priorities, notably work to keep people safe. This will be a considerable challenge, and support may be required from beyond the PDU. However, with the necessary improvements, Derbyshire PDU has every chance of delivering an effective service in the future.



Martin Jones CBE

HM Chief Inspector of Probation

Ratings

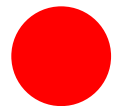
Derbyshire PDU

Fieldwork started February 2025

Score **2/21**

Overall rating

Inadequate



1. Organisational arrangements and activity

P 1.1 Leadership

Inadequate



P 1.2 Staffing

Requires improvement



P 1.3 Services

Requires improvement



2. Service delivery

P 2.1 Assessment

Inadequate



P 2.2 Planning

Inadequate



P 2.3 Implementation and delivery

Inadequate



P 2.4 Reviewing

Inadequate



Recommendations

As a result of our inspection findings, we have made a number of recommendations that we believe, if implemented, will have a positive impact on the quality of probation services.

Derbyshire PDU should:

1. clearly communicate strategic priorities and make sure that these are understood by probation practitioners and middle managers
2. develop practitioners' confidence and skills in the use of professional curiosity and challenging conversations to identify, analyse, assess, plan, and respond to indicators of risk effectively
3. ensure that domestic abuse and safeguarding information is complete and analysed sufficiently in all cases to inform the quality of assessment, planning, review, and management of people on probation
4. ensure that middle managers have enough capacity to provide the appropriate level of oversight according to the needs of staff members and level of casework in the team
5. work with providers of commissioned rehabilitative services and other partner organisations to improve the volume and quality of referrals
6. fully take into account the views of people on probation to inform service development.

Background

We conducted fieldwork in Derbyshire PDU over a period of two weeks, beginning 24 February 2025. We inspected 38 community orders, 22 releases on licence from custody, and one case that had both a community order and a period of licence supervision from custody, where sentences and licences had started during two separate weeks, between 15 and 21 July 2024 and 19 and 25 August 2024. We also conducted 50 interviews with probation practitioners.

The Probation Reset policy was in use during the time of this inspection. Of the cases we inspected, 11 out of 62 were subject to Probation Reset. This meant that these individuals had their supervision suspended for the final third of their supervision period.

Derbyshire is one of six PDUs in the East Midlands region. The PDU has offices in Chesterfield, Buxton, and Derby, with satellite offices operating out of police stations in Ilkeston and Swadlincote. Reporting arrangements are also facilitated in Glossop, using a local community centre.

Derbyshire PDU has a vast geographical footprint, comprising urban, city, and rural areas. It covers much of the same area as Derbyshire County Council, a non-metropolitan county with eight districts, and some postcodes in the Derby unitary authority area.

Staff employed within the PDU provide a service to magistrates' courts in Chesterfield and the Crown Court in Derby. There are two prisons in Derbyshire, HMP Sudbury and HMP Foston Hall.

The population of Derbyshire at the time the inspection was announced was estimated to be 811,449. At the point the inspection was announced, Derbyshire PDU had a caseload of 1,112 people on probation who were subject to community sentences and 544 people who were being supervised on licence from prison. In total, 383 individuals were being managed in custody before release.

Nacro provided commissioned rehabilitative services (CRS) for accommodation support; Ingeus delivered personal wellbeing and finance, benefit, and debt support; and Women's Work provided women's services. Services were provided by Derbyshire Recovery Partnership to support those with drug and alcohol needs, and by the Department for Work and Pensions for employment coaching. Derbyshire PDU co-commissioned (with Derby City PDU) the High-Risk Offender Accommodation Support Service Partnership (HiRO) project in Derbyshire, a supported housing specialist service for high-risk offenders at risk of homelessness.

Derbyshire PDU was not subject to prioritisation framework arrangements.¹ This meant that it was not subject to any demand management principles, in terms of what it was required to prioritise in service delivery.

¹ The prioritising probation framework is a post-pandemic tool to help regions adapt how they deliver probation services locally according to numbers of available staff.

1. Organisational arrangements and activity

P 1.1. Leadership



The leadership of the PDU enables delivery of a high-quality, personalised, and responsive service for all people on probation.

Inadequate

Strengths:

- Derbyshire PDU had well-established, strong relationships with strategic partnerships. The Probation Service was recognised as a valued partner, represented at all relevant boards and subgroups.
- The PDU had effectively managed the first tranche of prisoners released under the standard determinate sentence 40 (SDS40) scheme. Leaders had taken a coordinated approach, ensuring that all agencies were informed and engaged in supporting people being released from prison.
- Leaders had sought the support of the Tackling Unacceptable Behaviours Unit (TUBU) in response to feedback from all staff grades about longstanding cultural issues. TUBU completed a climate assessment and, in response to findings, delivered sessions on discrimination and victimisation awareness, gaslighting awareness, microaggressions, and psychological safety. Further work was needed to ensure that all staff understood the importance of this work and to embed the values within the PDU culturally.
- Reasonable adjustments were made for staff with a disability. In our survey, 67 per cent of respondents said that managers were supportive in implementing these adjustments.
- Some evidence of learning from Serious Further Offences (SFOs) was demonstrated by the PDU's improved systems for obtaining safeguarding and domestic abuse information. This was particularly evident at court and in management oversight at the allocation stage.

Areas for improvement:

- The PDU's failure to set out a clear vision and priorities for practitioners was reflected in the casework inspection, with all four of our standards rated 'Inadequate'. There were deficits in the work completed across all teams within the PDU, especially in the work to keep people safe.
- The head of PDU was not sufficiently visible to middle managers or providing enough support and direction to them. There was a lack of clarity about how responsibilities between the deputy and head were being delivered. Leaders needed to do more to ensure that practitioners had confidence and clarity on priorities, and that they were equipped with the necessary skills to keep people safe.
- Risks to service delivery were only partially understood. A risk register was in place and appropriately outlined identified concerns. However, there was limited evidence of mitigation, and cultural issues, disparities in service provision, and the impact of Probation Reset were not fully recognised.

- Longstanding cultural divisions between grades of staff were evident in some locations within the PDU and leaders had failed to address these. There was limited communication between offices and no sense of 'one PDU'. Action to remedy the culture was urgently needed.
- Priorities were not clearly communicated by leaders. Staff reported limited direction or assistance but collectively felt that everything was a priority. Messaging from leaders needed to be much clearer, particularly around expectations of key priorities and how to implement them.
- Despite action taken by the PDU in response to unacceptable behaviour experienced by some staff, a lack of effective communication left some unclear about how such issues were addressed, and this undermined their confidence in this.
- The management of quality in the PDU was insufficient, mainly as a result of poor prioritisation and the lack of a targeted approach. This meant that practitioners were not held to account and that sentence management was not effective. For example, we assessed only 24 per cent of the cases we inspected as having sufficient oversight.
- Learning from previous SFOs was not being fully translated into improved practice. There was limited evidence of local leaders encouraging a learning culture.

P 1.2. Staffing



Staff are enabled to deliver a high-quality, personalised, and responsive service for all people on probation.

Requires improvement

Strengths:

- There was an improving picture of staffing figures within the PDU, which meant that probation services officer (PSO) and case administrator posts were almost fully staffed. There was a deficit of around 15 per cent at probation officer grade, but there were more people in post than in the previous year. Senior probation officer posts were slightly overstaffed.
- Attrition rates were below the regional average and most staff had at least five years of experience in post.
- Over half of the cases inspected had the same practitioner for the whole of their licence or order. This meant that professional relationships between practitioners and people on probation were stable. In our inspection of casework, work by practitioners to engage with people on probation during the delivery of sentences was generally strong.
- A bespoke offer for reflective supervision, facilitated by the offender personality disorder clinical lead, was very well received by the small number of practitioners and middle managers who had had the opportunity to access it.

Areas for improvement:

- There was very poor morale across the PDU, for different reasons in each location. Staff in rural locations felt isolated and less important in comparison with those in more urban locations. In urban locations, there was a lack of cohesion and shared values between leaders and middle managers, and of good working relationships across grades. Evidence of the behaviours identified by the TUBU over the previous 12 months were visible to inspectors.
- Processes to welcome and induct new staff were not equitable across all grades. Administrators and receptionists did not have access to a structured induction and training process.
- Only 24 per cent of the cases we inspected had sufficient management oversight. Senior probation officers had unmanageable workloads and were not being given sufficient direction about priorities. Staff across all grades reported that the visibility of line managers was poor, which affected perceived levels of support. Several practitioners had experienced frequent changes in line manager, resulting in inconsistent and shifting expectations that were difficult to manage.
- Staff training was not leading to good-quality casework. Too much emphasis was placed on self-directed online learning. Staff were using protected learning time to catch up on administrative tasks rather than on professional development. This resulted in staff not being confident, particularly in the delivery of toolkits and structured interventions with people on probation.

- Work to engage people on probation had not been viewed as a priority, which meant that the PDU was missing an opportunity to draw upon lived experience to inform how services were being delivered.

P 1.3. Services



A comprehensive range of high-quality services is in place, supporting a tailored and responsive service for all people on probation.

Requires improvement

Strengths:

- Appropriate Multi-Agency Public Protection Arrangements (MAPPA) were in place, particularly at Levels 2 and 3. Partnership working between the PDU and the police was collaborative and effective.
- The offender personality disorder pathway and intensive intervention and risk management service run jointly with health partners provided a positive service for a small number of people on probation. The scheme was helping to support practitioners, through joint working of complex cases and a bespoke offer for reflective supervision that was valued across grades.
- Accessibility issues at the Chesterfield office meant that it was unsuitable for people on probation with poor mobility. In recognition of this, the head of PDU had identified and secured alternative arrangements for such individuals reporting in Chesterfield.
- Mental health treatment requirements were being delivered in the PDU. Processes were well understood, priority groups of people on probation had been identified, and peer mentors were involved.
- The PDU had led a collaborative strategic response to the SDS40 scheme, with core partner agencies indicating that they had been kept well informed, which had supported preparation for the first tranche of those people to be released early from custody.
- Referral routes for CRS were clear. Co-location was in place for some services, including those for women, which meant that practitioners were able to seek guidance, build relationships, and share information with partnership staff.
- Systems for accessing police domestic abuse information were clearly showing positive results. Only 11 per cent of the cases we inspected did not have access to domestic abuse intelligence at the point that assessments were being completed. Information exchange was supported by a dedicated PSO who was working alongside the police to handle information requests.
- A PSO had been seconded to the local authority to support information sharing between the PDU and children's services. This was enabling better relationships with local social workers and their managers, and in some cases was leading to referrals being made when they might not otherwise have been. Not all practitioners were receiving timely access to safeguarding information, but that had improved since the PSO had been in post.

Areas for improvement:

- CRS providers were ready and willing to work with more people on probation but were not receiving enough referrals from probation practitioners. When referrals were received, too many were rejected, which meant that valuable practitioner time was wasted and people on probation were not getting access to the support

they needed. Senior leaders in the PDU were not doing enough to drive up the rate and quality of referrals.

- Delivery of toolkits and structured interventions was disappointing, with only 27 per cent of all structured interventions and 35 per cent of all toolkits completed successfully. Rurality and the vast geographical footprint of Derbyshire PDU presented people on probation with significant difficulties in accessing their appointments – both in office locations and for staff conducting necessary home visits. People on probation in rural locations did not have equitable access to accredited programmes. Leaders needed to do more to explore and consider ways of reducing barriers for people on probation in relation to accessing help and support.
- Accredited programme commencement rates needed to improve. Only 31 per cent of accredited programmes for individuals convicted of sexual offences had started. Only 39 per cent of accredited programmes other than for individuals convicted of a sexual offence, had commenced.
- The implementation and delivery of sentences was insufficient in most of the cases we inspected. Concerningly, the delivery of services to keep people safe and reduce the risk of harm posed by people on probation was found to be insufficient. Only 34 per cent of cases were assessed as sufficient. Practitioners were not engaging often enough with partnership agencies, including the police and children's services, in response to escalations in risk and ongoing risk management.
- We found insufficient senior leadership liaison between the PDU and CRS providers. While managers acknowledged that there were wider national and regional issues with contacts, not enough efforts had been made at PDU level to overcome challenges to ensure an increased understanding of the service offer and improve the quality of referrals.

Diversity and inclusion

Strengths:

- The PDU utilised relevant data to understand the ethnic profile of staff and people on probation. The proportion of staff from Black, Asian, and minority ethnic backgrounds was reflective of the population in Derbyshire.
- The seconded probation officer role in youth justice services had been vacant for some time. However, the PDU had recently filled the vacancy, which would support the transition of children into adult probation services. The PDU had agreed a care experience protocol with strategic partners to support work with young adults further.
- Co-location between the Women's Work and probation practitioners was taking place in all offices, and women-only reporting was planned. A women's concentrator model was also being planned in Derbyshire PDU, which was an encouraging response to concerns around disproportionality.
- In 71 per cent of the cases we inspected, practitioners were building on the strengths of the person on probation and enhancing protective factors. This meant that practitioners were often responsive to past trauma, neurodiversity, and other personal characteristics.

Areas for improvement:

- Not all women on probation were referred to Women's Work when they should have been. This was a missed opportunity to engage and support women with services to enhance desistence and reduce risk.
- Tracking of specific groups of people on probation and demographics needed to be developed in the PDU, to understand more about whether adaptations for those transitioning from youth offending services to probation and care experienced individuals were needed.
- The PDU did not have enough information about the outcomes and experiences of neurodivergent people on probation, which meant that leaders could not be sure that services were meeting their needs.
- A partnership with the English Football League to support Black, Asian, and minority ethnic men on probation was not being used at all, which meant that relevant people were missing out on potentially useful activities.

2. Service delivery

P 2.1. Assessment



Assessment is well-informed, analytical, and personalised, involving actively the person on probation.

Inadequate

Our rating² for assessment is based on the percentage of cases we inspected being judged satisfactory against three key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Does assessment focus sufficiently on engaging the person on probation?	60%
Does assessment focus sufficiently on the factors linked to offending and desistance?	76%
Does assessment focus sufficiently on keeping other people safe?	34%

- Analysis of desistance factors in offending was done well by practitioners. Of the cases we inspected, 79 per cent identified and analysed the strengths and protective factors of the person on probation. This was the highest rated area of casework across all stages of sentence management. Practitioners drew on additional sources to identify concerns such as mental health, substance use, and transient lifestyles, and understood how these key factors could impact on reoffending and desistance. This was a strong area of work across both licence and community cases and demonstrated that practitioners generally understood what was likely to help people on probation to change.
- Access to good-quality safeguarding information was a significant problem in assessments of keeping people safe. Only 26 out of 60 relevant cases we looked at had sufficient information from social care services on children associated with people on probation. In some assessments, critical information on children's involvement with social care services was not explored or used to identify fully the risks posed by people on probation. This meant that not all potential victims were clearly identified in all assessments.
- Access to police information on domestic abuse was better. In 89 per cent of cases, relevant police domestic abuse information had been obtained. In most cases, practitioners followed up and used this information in their assessments, although this was less consistent in cases managed by Professional Qualification in Probation (PQiP) and PSO grade practitioners.

² The rating for the standard is driven by the score for the key question, which is placed in a rating band. [Full data and further information about inspection methodology is available in the data workbook for this inspection on our website.](#)

- Improvements were required to ensure that assessments drew appropriately and sufficiently from all available sources. Practitioners needed to be more professionally curious regarding individuals' past behaviour and analyse this along with information from other agencies. This was judged to have been completed sufficiently in only 42 per cent of cases and was even weaker in cases managed by PQiP and PSO grade practitioners.

P 2.2. Planning



Planning is well-informed, holistic, and personalised, involving actively the person on probation.

Inadequate

Our rating³ for planning is based on the percentage of cases we inspected being judged satisfactory against three key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Does planning focus sufficiently on engaging the person on probation?	56%
Does planning focus sufficiently on reducing reoffending and supporting desistance?	76%
Does planning focus sufficiently on keeping other people safe?	44%

- Two-thirds of sentence plans for people on probation set out clear arrangements for how work would be delivered. Planning in 81 per cent of the cases we inspected clearly set out a level, pattern, and type of contact to engage the individual and support the effectiveness of interventions.
- Planning to reduce the risk of reoffending was a strength across the cases we inspected. Practitioners understood what people on probation needed to support desistance, including identifying sources of support, in three-quarters of the cases we inspected.
- As with assessment, too few cases sufficiently identified all risk factors present or prioritised those that were most critical. Less than half of the cases we inspected were judged sufficient by inspectors.
- Less than half of the cases we inspected referenced necessary constructive or restrictive interventions to manage risk of harm. We saw too few cases where sufficiently robust risk management and contingency plans were in place. Without the appropriate risk and contingency plans to address identified risks, practitioners were not fully able to mitigate the risks posed by individuals.

³ The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. [Full data and further information about inspection methodology is available in the data workbook for this inspection on our website.](#)

P 2.3. Implementation and delivery



High-quality well-focused, personalised, and coordinated services are delivered, engaging the person on probation.

Inadequate

Our rating⁴ for implementation and delivery is based on the percentage of cases we inspected being judged satisfactory against three key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Is the sentence or post-custody period implemented effectively with a focus on engaging the person on probation?	79%
Does the implementation and delivery of services effectively support desistance?	55%
Does the implementation and delivery of services effectively support the safety of other people?	34%

- Engaging people on probation in work to address their offending was seen in 79 per cent of the cases we inspected. This demonstrated practitioners' flexibility to changes in the personal circumstances of people on probation. In 81 per cent of the cases we looked at, practitioners were judged to have focused sufficiently on maintaining an effective working relationship with the person on probation, including by considering their diversity needs.
- It was encouraging to see that, in most cases, practitioners routinely considered how to build upon the individual's strengths and protective factors. This was evidenced by our finding that the sentence plan had been implemented and delivered in 71 per cent of the cases we inspected.
- Appointments with practitioners were set at an appropriate time, frequency, and location to meet the needs of the person on probation in two-thirds of the cases we inspected. This was a strength in regard to supporting desistance from offending.
- Concerns regarding work to keep people safe were significant in relation to the delivery of sentences. Information about contact or potential contact with children was not verified or explored enough by practitioners. Consequently, information pertinent to risk was not considered or acted upon. In implementation and delivery, PSO cases scored particularly low, with only 24 per cent of the cases we inspected supporting the safety of others effectively. Improvements were required to coordinate and involve other agencies to manage and minimise the risk of harm to others. Only one-third of the cases we inspected

⁴ The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. [Full data and further information about inspection methodology is available in the data workbook for this inspection on our website.](#)

were judged as sufficient. This was a missed opportunity for key services to have an appropriate input into keeping people safe.

- Improvements to protect actual or potential victims were required. Only 16 out of 60 relevant cases were judged to be sufficient. Examples included limited evidence of ongoing exploration or liaison with partners, despite information pertinent to risk being identified and known.

P 2.4. Reviewing



Reviewing of progress is well-informed, analytical, and personalised, involving actively the person on probation.

Inadequate

Our rating⁵ for reviewing is based on the percentage of cases we inspected being judged satisfactory against three key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Does reviewing focus sufficiently on supporting the compliance and engagement of the person on probation?	63%
Does reviewing focus sufficiently on supporting desistance?	55%
Does reviewing focus sufficiently on keeping other people safe?	37%

- Less than half of the cases we inspected meaningfully involved the person on probation in reviewing their progress and engagement. This underpins findings that limited evidence of active reviewing was taking place, both in terms of general reviews of progress made and, crucially, in response to new information obtained.
- Practitioners were not routinely involving people on probation and key people in their lives when reviewing risk of harm. Less than half of the cases we inspected were informed by the necessary input from other agencies, such as the police and children's services, in the management of risk of harm. This meant that practitioners' understanding of risk was not always informed by information held by other agencies.
- Formal reviews were completed in only 15 out of 44 relevant cases as a record of the management of the risk of harm. This meant that there was limited evidence of appropriate liaison with partnership agencies or evidence of consideration as to how potential victims might be safeguarded.

⁵ The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table.

Annexe one – Web links

- Full data from this inspection and further information about the methodology used to conduct this inspection is available [on our website](#).
- A glossary of terms used in this report is available on our website using the following link: [Probation Inspection - Glossary of terms](#).