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Mothers in recurrent care proceedings: New evidence for England and Wales

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Report

This report provides an updated picture of the scale and pattern of mothers in recurrent care proceedings in England and Wales. It uses full-service population data produced routinely by Cafcass and Cafcass Cymru. Descriptive statistics are combined with statistical analysis of women's risk of return to court.

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The summary and report are also available in Welsh at the above link.

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Contents

Summary

A sizeable proportion of mothers who appear in a first set of care proceedings will return to court in a new set of proceedings and lose multiple children from their care. Given the continued high demand on the family courts in England and Wales, the question of how to prevent women's repeat appearances in care proceedings remains a critical issue for the family justice system, for the families involved and wider society.

This research provides an updated picture of the scale and pattern of mothers in recurrent care proceedings in England and Wales using population data produced routinely by Cafcass and Cafcass Cymru between 2011/12 and 2020/21.

In order to try and better understand the profile and needs of women in recurrent proceedings – and hence better tailor services – the analysis distinguishes between mothers who return to court with a new child (typically a new baby) and mothers who return to court with the same child because a care arrangement has broken down or requires changing (for example, placement with family and friends).

In terms of women returning to court with a new child (referred to in the analysis as 'Pathway 1'), the service challenge is how to help manage the pain of removal of a first or subsequent children following care proceedings and ensure intensive support of sufficient quality and capacity is available to help mothers (and their partners) avoid the removal of a subsequent baby.

In terms of women returning to court with the same child (Pathway 2), the challenge is how to support alternative caregiver arrangements, or support reunification, to ensure these that plans for the child have a greater chance of success.

Key findings

- In England and Wales approximately 1 in 4 women are at risk of returning to court for subsequent care proceedings within 10 years of their first appearance in care proceedings. This finding is consistent with findings reported in 2015 for England and 2017 for Wales.
- Approximately 1 in 5 mothers who return to court with a new child (as opposed to the child who was the subject of previous proceedings) are at risk of returning to court within 10 years.

- The risk of returning to court is highest within the first three years of the initial proceedings. Following a first return to court, risk of further returns, increases.
- The risk of returning to court is higher for mothers who first gave birth when young and if the child in the first set of proceedings is subject to a placement order (plan for adoption). In both England and Wales, a high proportion of mothers in recurrent care proceedings (more than 40%) are estimated to be aged 14–19 at the birth of their first child.
- There are marked regional differences between rates of recurrence in London and the South West on the one hand, and other areas of England on the other. There are particularly high rates in the North East, the Midlands, Yorkshire and the Humber, and the North West.

Key recommendations

To progress an agenda to reduce recurrent care proceedings, the following five points are key.

- Preparation for parenthood needs to start prior to a first pregnancy and support for young parents, including care leavers, needs to be strengthened in pregnancy, during care proceedings and beyond. This research highlights a high risk of return to court for young mothers, building on previous research that reported that many of these young mothers are also care leavers (Broadhurst et al. 2017; Broadhurst and Mason 2020; Boddy et al. 2020).
- Evidence of a heightened risk following a first repeat appearance suggests that the best solution to the possible pattern of repeat proceedings once a child has been removed would be to offer all parents in that situation intensive and tailored support to rebuild their lives. A universal entitlement to continuing help from specialist adult-focused services would be the best way forward.
- The bar needs to be raised in terms of ensuring resources are available for the collection and synthesis of local area evaluation data (while recognising the challenge of finding funds for small-scale evaluation). At present services are holding valuable data – but there is limited collation of this data across services. At a national level, HM Courts & Tribunals Service should examine options for including monitoring data on recurrence within family court statistics.
- Evaluation outcome data must be compared with what we might have expected had services not been available.
- Investment and service development must align more closely with regional need. For areas with high rates of care proceedings, it may be difficult to move resources upstream to prevent recurrence, therefore allocation of funding proportionate to need is required.

Definitions and terminology

Cafcass and Cafcass Cymru

The Children and Family Court Advisory and Support Service in England and Wales provides independent advice to the courts about the best interests of the child in all cases of care proceedings. Because a guardian is appointed for the duration of care proceedings, records routinely produced by Cafcass and Cafcass Cymru are an invaluable resource for research.

Care proceedings

Care proceedings are issued under section 31 of the Children Act 1989 when a child has suffered from – or is considered at risk of suffering – significant harm.

First repeat and second repeat

The episodes of care proceedings that follow the index episode.

Hazard rate

The conditional probability that a mother returns to court in year *t*, given that she has not returned before.

Index episode

The first set of proceedings within our observational window (2011/12 to 2020/21) for any given mother.

Legal episode, episodes or proceedings

The activity that takes place in the family court between the issue of care proceedings and the closure of the case by Cafcass or Cafcass Cymru.

Mother

Refers to mothers linked to their biological children within case management data produced routinely by Cafcass and Cafcass Cymru.

Pathways 1 and 2

In this report, we use these terms to distinguish between women returning to court with a new child (referred to in the analysis as ‘Pathway 1’) and women returning to court with the same child (Pathway 2).

Survival analysis

A collection of statistical procedures for analysing the expected duration until an event such as recurrent care proceedings occurs. These methods enable a more reliable calculation of the probability of events when individuals are followed up for variable lengths of time.

Introduction

A sizeable proportion of mothers who appear in a first set of care proceedings will return to court in a new set of proceedings and lose multiple children from their care. Given the continued high demand on the family courts in England and Wales, the question of how to prevent women's repeat appearances in care proceedings remains a critical issue for the family justice system, the families involved and wider society.[1]

As well as placing considerable demands on local authorities and the courts, repeat involvement in care proceedings causes severe distress for mothers, their partners and wider family networks (Broadhurst et al. 2017; Broadhurst and Mason 2020; Boddy et al. 2020). Although professionals must take action to safeguard children – including curtailment or removal of parental responsibility – it is equally vital that all avenues of support are pursued to prevent repeat family court involvement.

Following the publication of the first estimate of mothers' repeat appearances in care proceedings in England, which found that at least 1 in every 4 women was at risk of return (Broadhurst et al. 2015),[2] awareness of what is commonly termed the 'repeat removals' problem has grown, catalysing change in the landscape of preventative provision.[3] A very useful mapping exercise by Mason and Wilkinson (2021, forthcoming) sheds light on the number of services operating in England. This mapping exercise, recently updated, uncovered specialist services (or developments underway) in 84 local authorities – and the absence of specialist services in 46 local authorities. In a further 22, it was unclear whether services were available (Mason and Wilkinson 2021).[4] For those fortunate to receive a service, intensive relationship-based support has helped many mothers

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[1] Sir Andrew McFarlane described the volume of outstanding work in the family court as 'at an all-time high' (McFarlane 2022). The COVID-19 pandemic has placed further stress on courts that have been severely stretched for a number of years.

[2] The original estimate was based on mothers observed across a 7-year observational window.

[3] In addition to Pause (piloted in 2013) a number of other recurrent services were being set up in 2014: Suffolk (Positive Choices), Salford (Strengthening Families) and Brighton and Hove (Looking Forward). The Reflect service in Wales followed in 2016. Since then many more services have been developed. See the Supporting Parents website, https://supportingparents.researchinpractice.org.uk/, which contains a map of services, information about the online Community of Practice of recurrent care services and links to resources developed by and for such services.

[4] For a full breakdown of the number of services in each region see https://supportingparents.researchinpractice.org.uk/ and also Mason and Wilkinson (2021, p.9).

change the course of their lives beyond the close of care proceedings.[5] A small but important body of evaluative evidence (Cox et al. 2017, 2020; Roberts et al. 2018; Boddy et al. 2020) provides consistent evidence that women engaged with preventative services are less likely to appear in subsequent care proceedings. There is consistent evidence that with the right help, repeat removals are not inevitable, and that despite the recovery challenge, many mothers can engage with services and turn their lives around.[6] Mason and Wilkinson (2021) outline the common components of current service provision, which include intensive help to stabilise lives and address histories of trauma, including child removal. In addition, services proactively help mothers engage with a range of physical, sexual and mental health services.

However, practice pioneers note that many of these services are very small and have also voiced concerns about the sustainability of services because funding is often insufficient and time-limited. Indeed, some promising interventions have already closed, despite indications of their effectiveness.[7] Hard-pressed local authorities have struggled to consistently commit spending to projects designed to prevent recurrent care proceedings in the face of competing priorities (Mason and Wilkinson 2021).

At present, there is also a lack of national data and local analysis about rates of recurrent care proceedings in England and Wales:

- local authorities are not required to routinely report the number of recurrent care proceedings in government returns
- government statistics do not include any snapshot or trend data on recurrent care proceedings[8]
- family courts do not routinely record or flag recurrent cases.

This means that local authorities are typically unaware of the extent of recurrent care proceedings in their areas, or associated costs. Moreover, there has been insufficient national integration of evaluation data. At present, we do not know how many women nationally are being reached by services, nor do we know if services are targeted at areas with the highest need. The Mason and Wilkinson (2021) mapping exercise did not extend to obtaining data on the number of women who had received services or outcomes. It is therefore vital that we continue to monitor

[5] For outcome data see Boddy et al. (2020) and Cox et al. (2020).

[6] Outcome data on proportions of mothers who have avoided subsequent care proceedings is available in Boddy et al. (2020) and Cox et al. (2020, 2021).

[7] For example, nine Pause practices (local services) have closed in England and other recurrent care services in England and Wales have also either closed or had their budgets severely reduced.

[8] Cafcass publishes statistics on care proceedings, but no statistics on recurrence. The Ministry of Justice (MoJ) publishes family court statistics, but none on recurrence. This stands in contrasts to the criminal courts, where recidivism is monitored in government statistics.

progress towards reducing recurrent care proceedings, given uneven developments in England and questions about the scale of expansion in both England and Wales.

Contribution of this report

This report provides an updated picture of the scale and pattern of mothers in recurrent care proceedings in England and Wales, using full-service population data produced routinely by Cafcass and Cafcass Cymru between 2011/12 and 2020/21. The mother is the unit of analysis. The full analytical sample comprises 90,820 mothers in England and 5,637 mothers in Wales.

The report provides descriptive statistics and uses statistical (survival) modelling to estimate the risk of women's return to court. The report adapts methods developed by Broadhurst and colleagues (2015, 2017). In addition, the analyses benefit from a longer observational window than previously (10 years as opposed to 7 years). As well as estimating the risk of return across the full observational window, analyses are also completed and compared before and after 2014. This is because policy and legislative changes introduced in 2013/14 have made measurable changes to practice regarding the duration of proceedings (e.g. the 26-week statutory timeframe for care proceedings).[9] In addition, a number of high-profile family court judgments (2013/14) are considered to have reduced the number of children placed for adoption. Moreover, most new preventative services gathered pace in the second half of our observational window (2014/15–2020/21). Separating our analysis in this way enables a comparison of the scale and pattern of women's repeat appearances in care proceedings before and after 2014, in light of recent policy, legislative and practice developments. However, as above, shortfalls in national data mean it has not been possible to directly probe any causal relationship between service provision and recurrent proceedings.

As well as providing an updated picture of recurrent care proceedings on a large sample of mothers in England and Wales, the findings also advance knowledge by further differentiating recurrence. We describe two different types of recurrent pathways and provide a series of analyses that describe more precisely women in repeat removal cases (Pathways 1 and 2 – see below and Figure 1 for a fuller description). For the first time, we also establish whether women with a record of a first repeat set of care proceedings are at heightened risk of further repeat proceedings. In addition, we examine variance in rates of recurrent care proceedings at the regional level and local authority level, to provide a clearer picture of where services are most needed.

[9] The Children and Families Act 2014 introduced a number of important changes, outlined in the next section.

Although the findings in this report build on and advance knowledge, a number of questions remain outstanding. The final section of this report highlights these questions and outlines next steps regarding research.

Using standalone Cafcass or Cafcass Cymru data, we have not been able to address questions about recurrence and ethnicity or disability, because data is not yet sufficiently mature or available. Cafcass has started to collect data on both ethnicity and disability, but we will only be able to use this data to probe recurrence once data across a number of years is available.

Care proceedings in England and Wales

In England and Wales, section 31 (s.31) of the Children Act 1989 sets out the threshold for issuing care proceedings, which is that a child has suffered or is likely to suffer significant harm as a result of parental action or inaction. This harm can arise from abuse or neglect (Brandon et al. 1999). Care proceedings increased sharply from 2008/9, and in 2015, Sir James Munby, the then President of the Family Division, declared a looming crisis in the family court because of the rising volume of care proceedings (Munby n.d.). The Care Crisis Review followed in 2017/18, setting out options for change aimed at refocusing practice on effective and timely support to prevent the need for care proceedings, wherever possible (Family Rights Group 2018). More recently, recommendations made by the Public Law Working Group (2021) in response to continued pressures on the family court have also sought to strengthen opportunities for preventing care proceedings by, *inter alia*, improving timely and family inclusive pre-proceedings practice.[10]

However, the volume of care proceedings has remained high, and the COVID-19 pandemic has exacerbated pressures on the courts due to a backlog of cases.[11] At present, record numbers of children are in care in England, and numbers remain high in Wales.[12] Moreover, the volume of care proceedings is not evenly distributed – rather the highest volumes are concentrated in areas recording the greatest levels of socio-economic deprivation (Pattinson et al. 2021; Doebler 2022). Rates of children in care are also strongly associated with deprivation (Bywaters et al. 2016; Bennett et al. 2020). For all these reasons, it is vital that both jurisdictions

[10] The Public Law Working Group is a group appointed by the President of the Family Division Sir Andrew McFarlane and led by Mr Justice Keehan, that aimed to review and make recommendations about child protection and the Family Court, in light of further increases in care proceedings 2016/17 and 2018/19. The Public Law Working Group stresses the importance of ensuring wider family networks are valued and supported to provide alternative care, where children cannot live with their parents.

[11] See Footnote 1.

[12] Year ending 31 March 2021, 80,850 children were in care in England, continuing an upward trend (Department for Education 2022). In Wales there were 7,265 children in care in 2021, also continuing an upward trend (Stats Wales 2021).

continue to seek alternatives to care proceedings, which includes reducing parents' risk of involvement in repeat proceedings.

At the close of care proceedings, children can return to parents, may be placed with foster carers or with family and friends, or may be adopted. Although care proceedings do not always result in the permanent removal of the child from their parents' care, in a high proportion of cases involving children under a year old in England and Wales, those children will be adopted (Broadhurst et al. 2022). Broadhurst et al. (2018) found that on average, 47% of newborn babies were subject to plans for adoption (placement orders) between 2010/11 and 2016/17. Moreover, care proceedings are being issued for an increasing number of babies at birth, with the most deprived areas recording the highest rates over time (Pattinson et al. 2021; Doebler 2022). Out-of-home care can be very beneficial for children. However, this is not consistently the case for all children. Presently, too little is known about outcomes for siblings removed sequentially from the same mothers and fathers. Recent research in Scotland reported that only a small proportion of infants were placed with their biological siblings (Cusworth et al. 2022). Nor do we know what the longer-term impact is for babies when they are removed at birth.

For researchers seeking to understand changes over time regarding care proceedings, a number of important developments in 2013/14 warrant consideration. First, a statutory timeframe for the completion of care proceedings 26 weeks, was introduced with the Children and Families Act 2014 (s.14(2)). At the time the legislation was implemented it was not unusual for proceedings to last 40–50 weeks. Previous research on recurrent care proceedings noted a high proportion of overlapping or consolidated proceedings because a new baby was born during the course of a first set of proceedings (Broadhurst 2017).[13] Broadhurst et al. measured overlapping proceedings noting that, in 36% of cases, an application for a new child was issued while proceedings for an older sibling were ongoing (2015). Given a far shorter statutory timeframe for the completion of care proceedings, we would expect the proportion of consolidated cases to decrease. The second important development in the year 2013/14 was the judgment made, and guidance given, in the high-profile Re B-S (2014) case, following the earlier case of Re B (2013).[14] In this case, then President of the Family Division, Sir James Munby, reiterated that adoption without the consent of the parents was an extreme option, a last resort only to be considered where there was no other option.

[13] Previously, if a baby was due to be born during the course of care proceedings for an older sibling, it was not unusual for the court to consolidate proceedings, such that both the newborn and older sibling were considered together in a single set of proceedings. However, a shorter statutory timeframe for care proceedings means that a) it is less likely that a new baby is born during proceedings and b) that the court is willing to delay an on-going set of proceedings because this would mean original proceedings exceed the 26-weeks target.

[14] Re B (Care Proceedings: Appeal) *[2013] UKSC 33, [2013] 2 FLR 1075 and* Re B-S (Adoption: Application of s 47(5)) *[2013] EWCA Civ 1146, [2014] 1 FLR 1035*.

As a result, Sir James argued for far better analysis of all permanency options for children. Following Re B-S there has been a drop in the number of children who are placed for adoption and a concurrent rise in special guardianship orders (CoramBAAF n.d.). Taking into account these case law developments in 2013/14 is important, because prior research has reported that a high proportion of infants in repeat proceedings are subject to adoption plans (Broadhurst et al. 2015; 2017).

Recurrent care proceedings: What do we know?

In 2015, Broadhurst and colleagues published the first estimate of recurrent care proceedings in England, establishing the scale and pattern of women's repeat appearances in care proceedings (Broadhurst et al. 2015). Since then, further estimates have been produced for England and Wales (Broadhurst et al. 2017; Alrouh et al. 2020). These quantitative studies of mothers and recurrent care proceedings have consistently reported the following.

- A sizeable proportion of mothers return to court following a first (index) set of proceedings. Based on the total number of recurrent mothers, at least one in every four women is estimated to be at risk of recurrence within seven years.[15]
- The risk of recurrence is greatest in the first three years that follow index proceedings. The average interval between care proceedings is less than two years.
- The majority of first and second repeat episodes of care proceedings concern babies less than a month old.[16]
- Mothers who experience recurrent care proceedings become first-time mothers at a far younger age than the general population.

A rich volume of qualitative research, including evaluation studies, has also been published nationally and internationally, focusing on mothers and recurrent care proceedings, as well as the removal of babies at birth (Taplin and Mattick 2015; Broadhurst and Mason 2020; Boddy et al. 2020; Mason and Wilkinson 2021; Cox et al. 2017, 2020, 2021). The original recurrent care studies (Broadhurst et al. 2015, 2017) prompted the *Born into Care* series (Broadhurst et al. 2018; Alrouh et al. 2020; Griffiths et al. 2020), given the high number of care proceedings issued for babies close

[15] The first estimate of recurrent mothers included all cases of recurrent mothers, whether women returned to court with a new child or the same child. The analyses provided in this report differentiate mothers; although by far the majority of recurrent cases will include a child the court has not seen before (typically a new baby).

[16] Broadhurst et al. (2015) reported that over 70% of first repeat cases concerned a baby aged less than a year old, and 60% concerned a newborn baby.

to birth, when mothers have a history of child removal. The *Born into Care* series has also included qualitative research. This body of literature has consistently reported the following.

- Crisis following child removal heightens the risk of drug and alcohol use. It can also trigger or worsen mental health conditions such as depression, anxiety and suicidal ideation (Crawford et al. 2009; Broadhurst and Mason 2020).
- Women's sense of connection to their children does not cease with child removal, rather women self-identify as mothers – although living apart from their children (Boddy et al. 2020; Morriss 2018).
- Women are acutely aware of the stigmatised nature of child removal and typically have few opportunities for confiding in, or seeking comfort from, others who have experienced the removal of their children (Taplin and Mattick 2015; Morriss 2018; Broadhurst and Mason 2020).
- Grief is both acute and enduring following child removal, and is experienced by mothers, partners, and wider family networks (Boddy et al. 2020).
- Women consistently complain that they cannot access appropriate mental health services (Broadhurst et al. 2017).
- The pain of child removal is compounded by the fact that many at-risk mothers experience other intersecting vulnerabilities such as marginalisation, childhood histories of abuse, poverty, and a heightened likelihood of having spent time in care themselves (Broadhurst et al. 2017; Harwin et al. 2018; Boddy et al. 2020; Cusworth et al. 2022).
- The removal of a baby at birth is particularly traumatic and women feel that their legal rights are fundamentally breached when required to attend court in the immediate post-partum period (Broadhurst et al. 2022).

One major study of fathers in recurrent care proceedings has also been completed, which uncovers significant gender differences in the pattern of recurrence for mothers and fathers (Philip et al. 2021). Specifically, while fathers also experience recurrent care proceedings, most cases involve single mothers or newly partnered mothers. Fathers are more likely to appear in care proceedings that concern a child the court has seen before, such as where child reunification has broken down (Bedston et al. 2019). Single fathers rarely appear in recurrent care proceedings (Bedston et al. 2019).

Overall, the published research provides important insights on the prevalence of recurrent care proceedings in England and Wales, as well as family experience.

Service developments

In England and Wales, parents have historically had few avenues of support following the removal of their children through care proceedings. Aside from short-term counselling for parents whose children have been adopted (Neil et al. 2010), there is no formal legislative mandate on services in England or Wales to provide help for parents' own rehabilitation – even if this has been recommended by the courts during care proceedings (Cox et al. 2012; Broadhurst et al. 2017). The same service deficits are evident in a number of international contexts with similar child protection systems, such as the US, Canada, Australia and New Zealand (Grant et al. 2011, 2014; Taplin and Mattick 2015; Wise 2021). However, the statistical discovery of recurrence, together with the energy and commitment of practice pioneers, has turned the tide on a history of neglect when it comes to parents' support and rehabilitation needs following the removal of their child, although there is much more that needs to be done.

Multiple new practice initiatives have been developed to help parents avoid repeat care proceedings. New services work with parents following the removal of their children, or during a subsequent pregnancy (Cox et al. 2017, 2020, 2021; Roberts et al. 2018; Boddy et al. 2020). Most services focus on women, or women and their partners, and do not work with fathers on their own. Most offer tailored, intensive support over an 18-month to 2-year period. A mapping report produced by Mason and Wilkinson (2021) captures the content and approach of many services in England and is a useful reference document.[17] As noted by Mason and Wilkinson, service developments are not yet evenly spread across England. In addition, many services are locally developed, with small teams. While their work is ground-breaking, it is only meeting a fraction of the need. In Wales, in 2018, Welsh Government committed to the rollout of the Reflect programme – however there has been no further published data on this expansion.[18]

To date, there has been limited analysis of the factors that are associated with parents' risk of repeat care proceedings. Rather, referrals to bespoke services are largely based on practitioner recommendations.

Overall, evaluative evidence is that services are far more successful in preventing parents' appearances in care proceedings than standard local

[17] This website, hosted by Research in Practice, includes a map indicating where a service was located at the time of the mapping exercise: https://supportingparents.researchinpractice.org.uk, contains resources and materials for recurrent care services and is linked to the online Community of Practice of recurrent care services.

[18] The Reflect programme provides intensive relationship-based support to mothers to help stabilise lives, provides emotional support to address issues of loss, and encourages mothers to engage with physical, emotional and reproductive health services. See: Roberts et al. 2018.

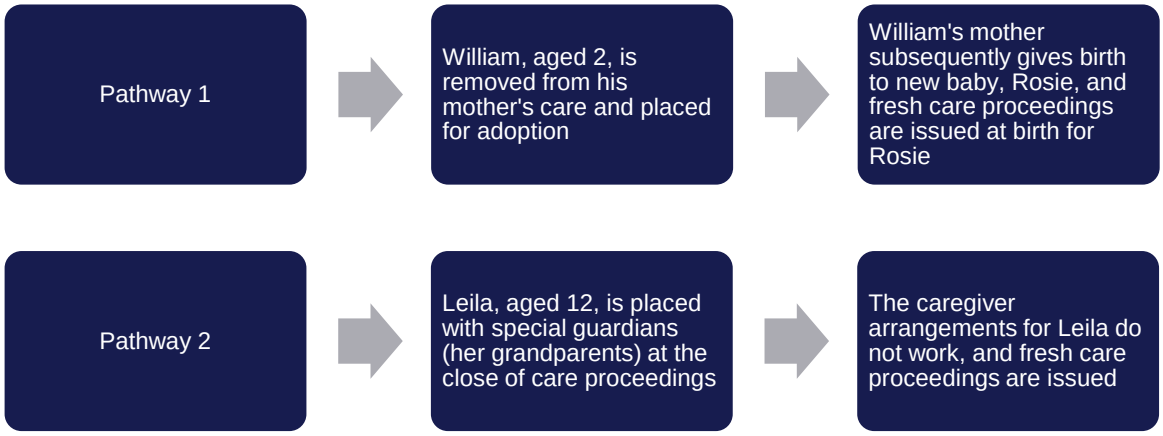
authority social work practice (Boddy et al. 2020; Cox et al.2020, 2021; Roberts et al. 2018), providing a strong warrant for wider rollout of such services.

Differentiating recurrent pathways through care proceedings

Since the production of the first estimate of recurrent care proceedings in 2015 (Broadhurst et al. 2015), knowledge of patterns of recurrence has evolved. Two types of recurrent pathways are now recognised in policy and practice (Figure 1).

- Pathway 1 concerns by far the majority of mothers, and in these cases, a mother returns to court with at least one new child (typically a baby), following the removal of an older child. It is this latter group of mothers who are best described as experiencing the repeat removal of their children.
- Pathway 2 concerns a minority of mothers who return to court with a child or children the court has seen before (same child). In these cases a caregiver arrangement has typically broken down or requires changing (e.g. return to extended family or parents) and the court is required to consider a new care plan for the same child.

Figure 1: Illustrative examples of types of recurrent pathways



Although continuing to monitor the total volume and rates of recurrent care proceedings is important, it is also important to differentiate pathways. Distinguishing between pathways is important as they have different policy and practice implications.

- In Pathway 1, the majority of new practice solutions are focused on how to help mothers (and their partners) manage the pain of removal of a first or subsequent children following care proceedings and ensuring intensive support of sufficient quality and capacity is

available to help parents avoid the removal of a subsequent baby. Supporting women to access reproductive, physical, and mental health services is central to prevention projects. Many of them work with parents during a new pregnancy to support the possibilities of the new baby remaining at home.

- In Pathway 2, the challenge for practitioners is how to support alternative caregiver arrangements for children, or support child reunification, to ensure care plans have a greater chance of success.

In practice, case pathways can be more complicated, and a parent may move between pathways, following a first repeat episode. However, for the purposes of all analyses completed in this report, we have differentiated between cases with previous children only and cases with at least one new child:

- descriptive statistics draw comparisons between the two pathways.
- survival analysis is used to estimate the risk of return for all women in recurrent care proceedings, but also estimates the risk of return for women in Pathway 1 only.

Why focus on mothers?

All statistical analyses in this report are based on mother and child. There are four key reasons for this focus.

- The majority of new preventative services either work with mothers or mothers and their partners, but do not work with fathers on their own. Therefore, it is more useful for preventative services if new estimates focus on changes in women's risk of return. Mason and Wilkinson (2021) identified only 5 out of 75 services working with fathers without their partners.
- A proportion of records of care proceedings do not include fathers (estimates vary for England and include estimates of missing fathers in 20%–40% of cases).[19] Where records are available, using fathers as the unit of analysis runs into the requirement to distinguish between fathers and male partners, as well as multiple 'fathers' listed on a case. As such, it is difficult to benchmark recurrence using fathers as the unit of analysis.

[19] Broadhurst et al. (2017) reported fathers listed in 81.2% of index proceedings, but lower rates of fathers named on the care application in subsequent proceedings. Masson et al. 2008 reported that in only 63.0% of proceedings involving a mother was the father also listed (based on all care proceedings, that is, without distinguishing recurrence).

- Unlike the majority of mothers, who return to court because of the birth of a new baby, fathers are more likely to return to court in a case that concerns reunification breakdown (Pathway 2). The primary focus of new preventative initiatives is Pathway 1.
- Previous estimates produced by the authors (Broadhurst et al. 2015, 2017) have focused on mothers, enabling comparison with the current report.

However, this is not to negate the importance of helping recurrent couples or fathers in practice. The work of Philip et al. (2020) provides a wealth of insights into fathers' experiences of loss, together with recommendations for practice, and has challenged services to factor in fathers. Bedston et al. (2019) also advanced knowledge by capturing the complex pattern of fathers' recurrence, in relation to mothers and children.

Methods

Data and sampling

The primary source of data, access and clearance

Records routinely generated by Cafcass [England] and Cafcass Cymru between 2011/12 and 2020/21 were the primary source of data for this report. Records were accessed via the SAIL [Secure Anonymised Information Linkage] Databank at Swansea University (Ford et al. 2009; Johnson et al. 2020). The SAIL Databank is a secure trusted research environment, which provides researchers with access to anonymised individual-level, population-scale records and enables accurate data linkage. All research proposals using SAIL are subject to approval by the Information Governance Review Panel (SAIL IGRP 0929).

Data restructuring

Unit of analysis

The mother is the unit of analysis. The data was restructured by linking each mother to all of her s.31 care and supervision applications, and then linking children to their mothers' records (see Appendix A for further details).

Determining the index episode

In England, it was possible to review records between 2007 and 2011/12, and remove mothers who appeared in care proceedings before 2011/12. Given that most mothers who record a recurrent episode do so within three years, we can be confident that in most cases in England, the mother's index appearance is her first appearance. However, for Wales, as there is limited data available before 2011/12, it has not been possible to perform the same kind of check. Hence, we have retained the language of 'index' appearance to denote first appearance in the datasets.

Rationalising legal order data[20]

Multiple combinations of legal orders can result at the close of care proceedings. In keeping with previous studies by the team (Broadhurst et

[20] Cafcass and Cafcass Cymru do not record child placement data, so we have inferred the most likely permanency outcomes given the legal orders made. To gain a more accurate picture of children's final placements, it would be necessary to link Cafcass data to records for looked-after children in England and Wales. The Family Justice Data

al. 2015, 2017), we have grouped legal orders and combinations into the following four categories:

- with parents
- with family and friends
- in care
- placed for adoption.

See further detail on the rationalisation of legal order data in Appendix A.

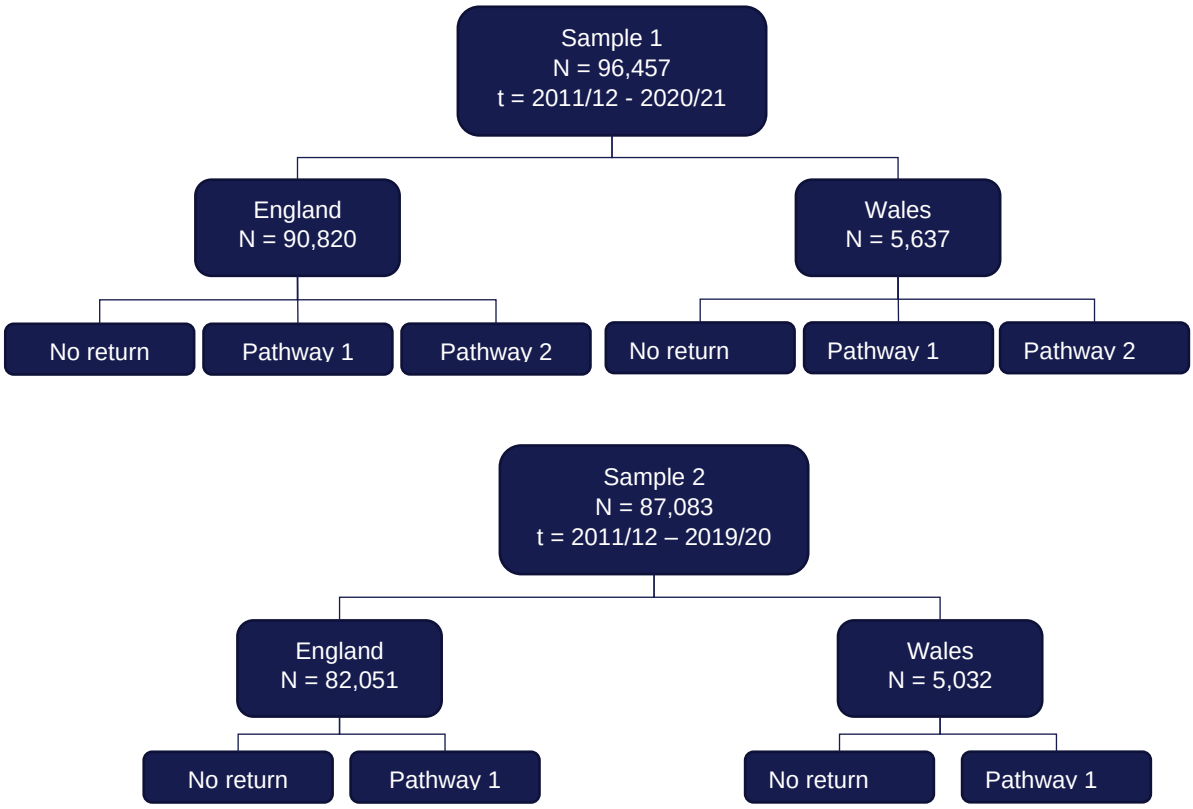
Final samples

We performed our analyses on two samples, as shown in Figure 2.

- The first sample included all mothers who had at least one recorded set of proceedings under s.31 of the Children Act 1989 between 2011/12 and 2020/21. The data was stratified according to Pathway 1 and Pathway 2. The full sample consists of 96,457 mothers in total (90,820 mothers in England and 5,637 mothers in Wales).
- The second sample was limited to s.31 proceedings between 2011/12 and 2019/20, so that all mothers have a minimum of one-year follow-up. This allows most cases to conclude by the end of the observation window, and their legal outcomes to be recorded. The restricted sample consisted of 87,083 mothers in total (82,051 mothers in England and 5,032 mothers in Wales).

Partnership is striving to improve the quality of linkages for Welsh data in this respect and to acquire similar data for England.

Figure 2: Sample selection



Note: For the purpose of the survival analyses, we reclassified Pathway 2 mothers in Sample 2 as 'no return'. Sample 2 is based on a smaller observation window than Sample 1, which allows for a minimum of one year follow-up in the survival analyses. All descriptive analyses are based on Sample 1, and all survival analyses are based on Sample 2.

The analytical strategy has comprised the production of descriptive statistics, and statistical modelling using survival analysis, to estimate a mother's risk of returning to court. Funnel plots were produced to probe variation between regions of England and Wales. Funnel plots were also used to probe local authority variation within England, and separately within Wales. In all analyses, we use a p-value of 0.05 as the threshold for statistical significance.

A complete overview of the raw counts and percentages of mothers in index and repeat s.31 proceedings between 2011/12 and 2020/21 are provided in Table 1. These include mothers who do not return to court within our observational window ('no return'),[21] mothers who return with at least one new child (Pathway 1) and mothers who return with a previous child only (Pathway 2). We identified 90,820 and 5,637 mothers in s.31 proceedings in England and Wales, respectively. Of these, 17,205 and 920

[21] Those may include mothers who have not yet had a chance to return to court (i.e. recent cases).

mothers were identified at first repeat proceedings.[22] A total of 112,781 s.31 applications in England and 6,753 in Wales were captured in our observational window.

Prior research on recurrent care proceedings in England and Wales (Broadhurst et al. 2017; Alrouh et al. 2020) provided an overview of the number and percentage of recurrent mothers. In this study, the volume of mothers in repeat s.31 proceedings has increased due to the longer observation window and the general increase in the number of care proceedings overtime. Notwithstanding the fact that raw counts underestimate the problem, this point is important for service planners.[23]

Table 1: Raw counts of mothers in repeat s.31 proceedings in England and Wales between 2011/12 and 2020/21

	England	Wales
Total number of mothers	90,820	5,637
Total number of applications	112,781	6,753
Number of mothers per episode		
Index episode	90,820	5,637
1st repeat	17,205	920
2nd repeat	3,707	144
3rd repeat	826	41
4th + repeat	223	11

Limitations

Reliable data has been available from Cafcass [England] since 2007. This means that the research team has been able to review and remove records for mothers whose index appearance pre-dated our observational window (i.e. mother's index appearance was recorded between 2007/8 and 2010/11). Given, that risk of return is greatest within three years, we can be fairly confident that the majority of mothers included in our sample recorded their index (first) appearance in 2011/12. However, for Wales, because data produced routinely does not have such a long history, we are less certain that the mother's index appearance is in fact, her first appearance. Over time, it will be possible to deal with the issue of left truncation of the Welsh data and revise estimates.

[22] Based on 10 years of data, descriptive statistics about multiple repeats are far less reliable, because the length of the observation window is insufficient to capture the number or proportion of multiple repeats for mothers appearing more recently in the dataset.

[23] It is worth noting, however, that mothers in our sample are observed for varying amounts of time. This means that some mothers who enter the dataset towards the end of the observation period may not have been followed long enough to determine whether they return for a subsequent set of care proceedings. A more statistically rigorous method is used to calculate a mother's risk of returning to family court using Sample 2 (see: 'Modelling the scale and pattern of recurrence').

As explained in the body of the report, we are not yet able to use data on ethnicity or disability to probe recurrence because, again, we do not have data over a long enough timeframe. By linking data to a range of other health, education and demographic data, it will be possible to more fully understand factors associated with risk of recurrence. The Family Justice Data Partnership is moving forward with this work.

It is also important to note that, while we have focused on formal family court proceedings, children in England and Wales can be placed in in care voluntarily, in England and under s.20 CA 1989 and In Wales under s.76 The Social Services and Well Being (Wales) Act 2014. Had we broadened our lens beyond formal legal proceedings, we would no doubt have captured a different picture of women's repeat losses of children to out-of-home care.

Findings

Differentiating recurrent mothers: a descriptive profile of mothers and children in Pathways 1 and 2

As our knowledge of recurrent care proceedings evolves, it is important to distinguish mothers who are returning to court because a new child (typically a new baby) is considered at risk of significant harm (Pathway 1), and those who are returning to court because a care arrangement for a child has broken down (Pathway 2). In this section, we present the descriptive statistics for women who return to court in England and Wales on this basis, between 2011/12 and 2020/21. We focus on information at index and a first repeat set of proceedings, because very few women in Pathway 2 will record a second repeat.

All variables and their corresponding frequencies and percentages for Pathway 1 and Pathway 2 mothers are shown in Table B.1 (England) and Table B.2 (Wales) in Appendix B. Mothers who do not return to court within our observational window are also included for reference, but are not discussed below.

The total number of mothers in Pathways 1 and 2

In England, 73,615 mothers had only one set of s.31 care proceedings, 12,772 (14.1%) returned with at least one new child (Pathway1), and 4,433 (4.9%) returned with a previous child (Pathway 2).

In Wales, most mothers (4,717) had only one set of s.31 care proceedings, 777 (13.8%) returned with at least one new child (Pathway 1), and 143 (2.5%) returned with a previous child (Pathway 2).

Thus, by far the majority of recurrent mothers return to court with a new child the court has not seen before. This finding is in line with previous research (Broadhurst et al. 2015).

Estimated age of mothers at their first birth

Comparing women's ages at entry to motherhood (Figure 3),[24] we find that in Pathway 1, women who return to court with a new child (typically a baby), had their first child at a younger age than mothers in Pathway 2 who return with a child who has been subject to previous care proceedings. This finding is in line with previous quantitative and qualitative research, which found that early entry to motherhood is associated with risk of recurrent appearances in care proceedings (Broadhurst et al. 2015, 2017; Boddy et al. 2020).

However, Pathway 2 also includes many young mothers. Findings for both pathways reflect the fact that, overall, mothers who appear in care proceedings tend to become first-time mothers at an earlier age than those in the general population.

We estimate that in England:

- 17.9% of mothers in Pathway 1 were first-time mothers when aged 14–17 years
- 15.2% of mothers in Pathway 2 were first-time mothers when aged 14–17 years
- 23.9% of mothers in Pathway 1 were first-time mothers when aged 18–19 years
- 18.2% of mothers in Pathway 2 were first-time mothers when aged 18–19 years.

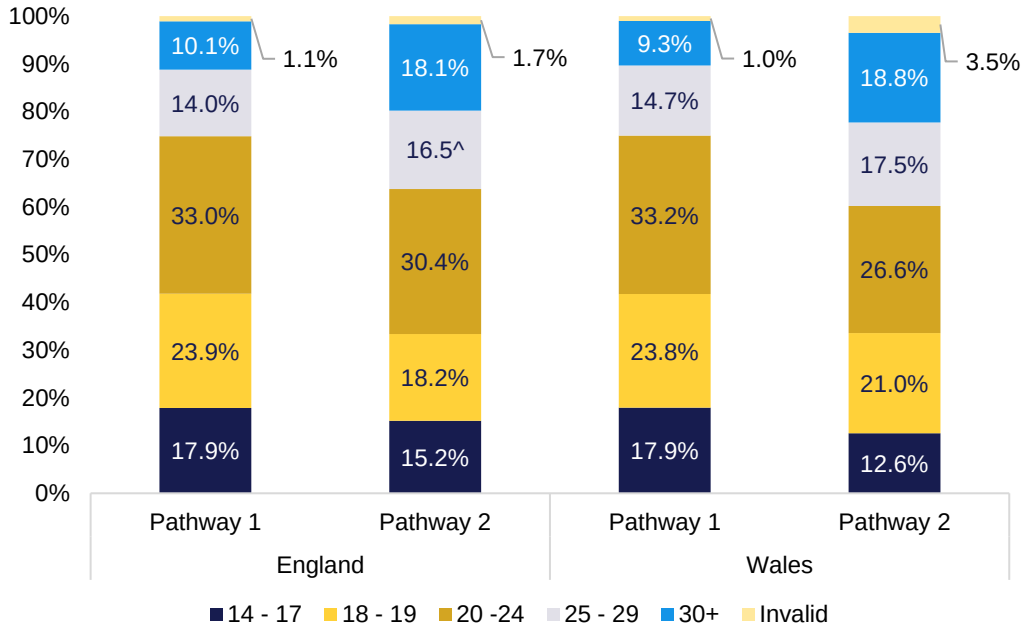
In Wales, the picture is similar:

- 17.9% of mothers in Pathway 1 were first-time mothers when aged 14–17 years
- 12.6% of mothers in Pathway 2 were first-time mothers when aged 14–17 years
- 23.8% of mothers in Pathway 1 were first-time mothers when aged 18–19 years
- 21.0% of mothers in Pathway 2, were first-time mothers when aged 18–19 years.

In the general population of England and Wales, the mean maternal age at first birth ranged from 29.7 years in 2011 to 30.7 years in 2020 (ONS 2020). Thus, mothers in care proceedings are markedly younger than in the general population. In England and Wales, we estimate that 41.8% of mothers in Pathway 1 were aged 14–19 years of age at their first birth.

[24] Mother's age at entry to motherhood is inferred from the mother's age and age of her oldest child in a first set of proceedings. That is, we assume, the mother's oldest child is her first child and then infer the mother's age of entry to motherhood on that basis. This is an estimation. A more accurate picture can be derived by linking maternity data or hospital episode data – where this data spans sufficient years. At present, by putting knowledge from qualitative studies together with this descriptive data, it is reasonable to conclude that early entry to motherhood is associated with recurrence.

Figure 3: Women's estimated age at entry to motherhood



Age of the youngest child at first repeat proceedings

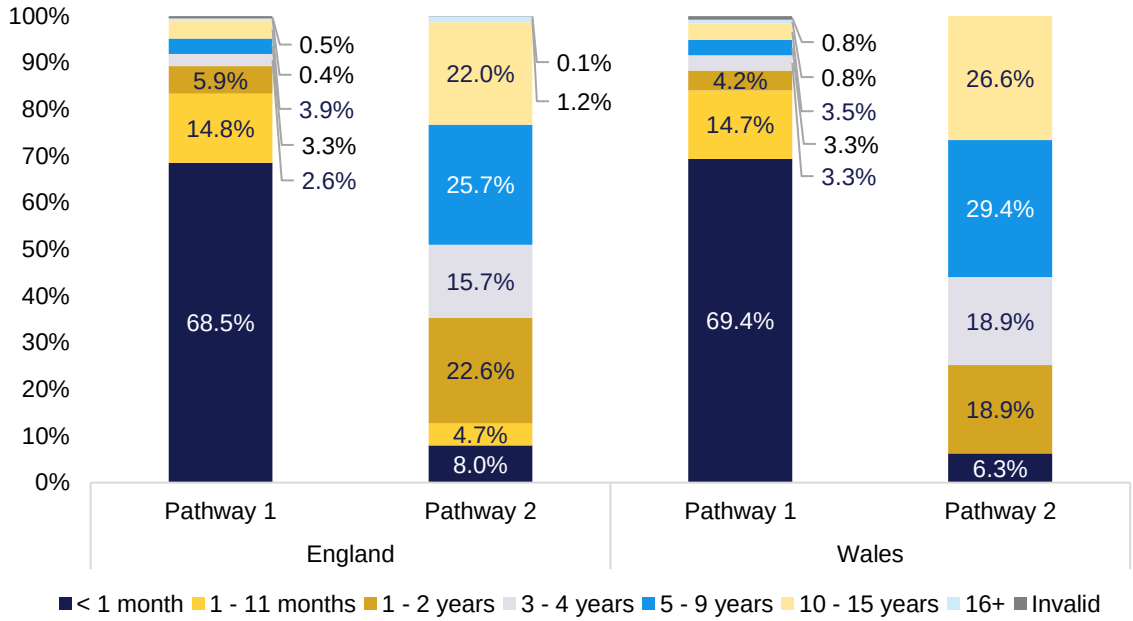
In England, by far the majority (83.3%) of first repeat cases with at least one new child (Pathway 1) involved babies aged 11 months or younger, 11.8% involved children aged 1–9 years, and only 4.3% involved children aged 10 years or older (Figure 4). Focusing on first repeat cases concerning a child or children the court has seen previously (Pathway 2), only 12.7% involved children aged 11 months or younger, most involved children aged 1–9 years (64.0%), and 23.2% involved children aged 10 years or older.

A similar pattern is observed in Wales. Most first repeat proceedings with at least one new child (Pathway 1) involved babies aged 11 months or younger (84.1%), while 10.8 % involved children aged 1–9 years, and 4.3% involved children aged 10 years or older. Again, regarding Pathway 2, the picture is very different, with only a minority of cases concerning babies.

This finding is in line with previous research. By differentiating the pathways, it is possible to more clearly identify the very high number of first repeat episodes that concern babies in Pathway 1 – with the greatest proportion concerning babies in the first month of their lives.[25]

[25] Previous findings from Broadhurst et al. 2015, are broadly consistent.

Figure 4: Age of the youngest child

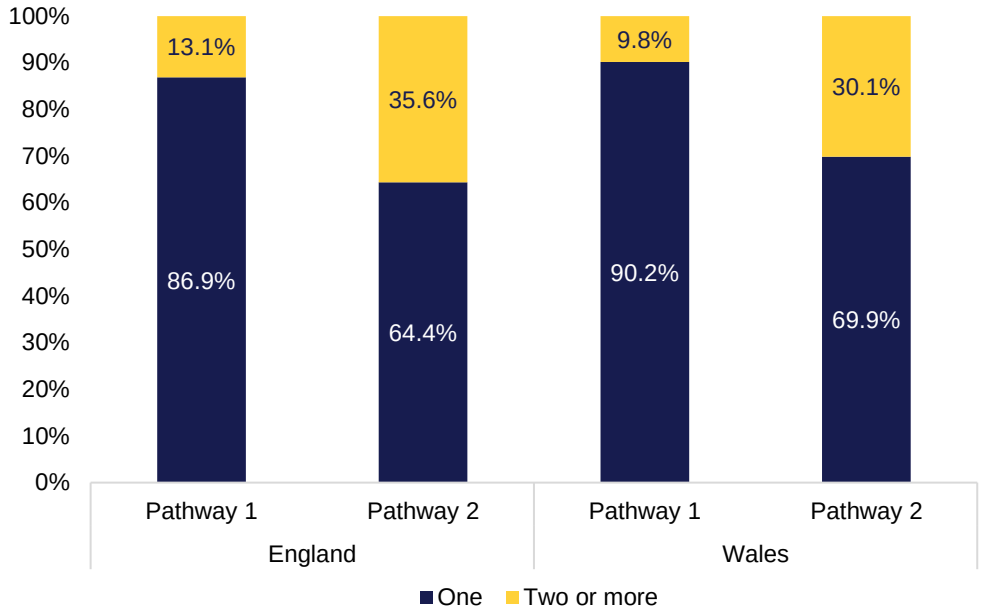


Note: Percentages are based on the first repeat episode for Pathway 1 and Pathway 2 mothers in England and Wales. For Pathway 2 mothers in Wales, the < 1 month category has been merged with the 1– 11 months category, and the 10–15 years category has been merged with the 16+ and Invalid categories.

Number of children

In terms of the number of children (Figure 5), most proceedings in England have a single child as the subject in both types of recurrent pathways; 86.9% (Pathway 1) and 64.4% (Pathway 2) at the mother's first repeat. In Wales, 90.2% (Pathway 1) and 69.9% (Pathway 2) of first repeat proceedings have a single child as the subject. Again, the findings are not unexpected for Pathway 1, and regarding Pathway 2, more cases than in Pathway 1 appear to concern sibling groups.

Figure 5: Number of children



Note: Percentages are based on the first repeat episode for Pathway 1 and Pathway 2 mothers in England and Wales.

Legal orders

There are clear differences in the pattern of legal order outcomes for children in Pathway 1 and Pathway 2 (Figure 6). When mothers in Pathway 1 return to court with a new child (which we know concern babies in most cases), a high proportion of first repeat (38.6%) cases in England result in placement orders for children, indicating a plan for adoption. Very few children become subject to standalone supervision orders, which are typically made when children return to parents' care. The pattern of legal orders in Pathway 1 in England is as follows:

- 38.6% of children are subject to placement orders (plan for adoption)
- 20.6% of children are subject to full care orders (in care)
- 22.3% of children are subject to special guardianship orders or child arrangement orders (with wider family and friends' network)
- 12.7% of children are subject to supervision orders or 'order of no order' (with parents)
- 2.6% are categorised as 'Other'.

Focusing on legal order outcomes for children in Pathway 2, we find that most children were not subject to final orders suggesting permanent severance of parental rights – that is, only 12.1% of children were subject to a placement order. Rather, the vast majority of children were subject to a care order (38.8 % in first repeat) or placed with friends and family (20.1% in first repeat) or with parents (13.5%). So, we see a very different picture of final legal order outcomes when compared with Pathway 1 in

terms of the split between adoption plans and return home to family or parents. The pattern of legal orders in Pathway 2 in England is as follows:

- 38.8% of children are subject to care orders (in care)
- 20.1% of children are subject to special guardianship orders or child arrangement orders (with family and friends)
- 13.5% of children are subject to supervision orders/order of no order (with parents)
- 12.4% are categorised as 'Other'[26]
- 12.1% of children are subject to placement orders (plan for adoption).

In previous reports we have discussed the shifting use of care orders for babies in Wales, and we noted that more and more babies are subject to care orders at the close of care proceedings in Wales. Practitioners have shared with us that, in contrast to England, kinship foster care is typically preferred with a child placed under a care order (rather than special guardianship). Similarly, many babies may be placed at home on care orders rather than supervision orders.[27] This pattern of legal order usage makes inferences about where a child is living far more difficult.

The pattern of legal orders in Pathway 1 in Wales is as follows:

- 53.4% of children were subject to a care order (in care, including in care at home with parents or with kin)
- 26.1% of children are subject to placement orders (plan for adoption)
- 6.8% of children are subject to family orders
- 2.9% are categorised as 'Other'
- 2.6% are subject to supervision orders (with parents).

The pattern of legal orders in Pathway 2 in Wales is as follows:

- 58.7% of children were subject to a care order
- 10.5% were subject to family orders
- 9.8% were categorise as 'Other'
- 8.4% were subject to a plan for adoption
- 5.0% were subject to supervision orders or no order (with parents).

Data for looked-after children in Wales has been acquired by the SAIL Databank and work is underway to improve the quality of linkage to Cafcass data. This linkage is essential, in order to gain greater accuracy and clarity on legal order and placement outcomes for children in care proceedings in Wales.

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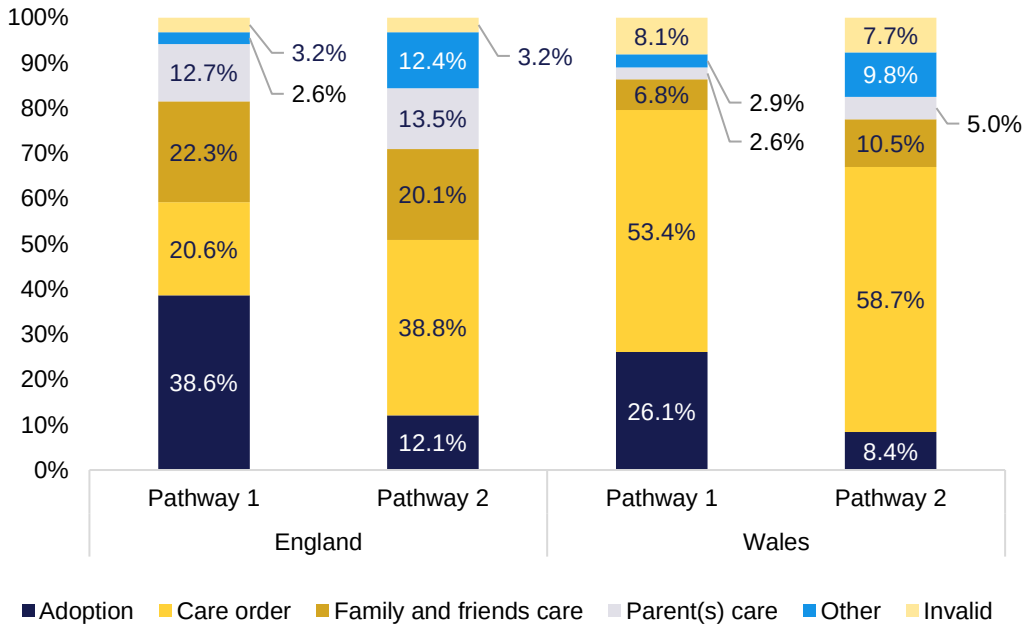
[26] These include all other types of recorded legal orders. For example, emergency protection orders, child arrangement orders (spend time with), and parental responsibility orders.

[27] Care orders are also used in England when children are sent home. The only way to arrive at a more accurate picture of the child's actual placement is to link Cafcass and looked-after children data.

Figure 6: Legal order outcomes



Note: Percentages are based on the first repeat episode for Pathway 1 and Pathway 2 mothers in England and Wales.

Pathway 1 mothers: Further descriptive findings

Based on information available within Cafcass and Cafcass Cymru data, it is possible to provide further descriptive insights relevant to Pathway 1.

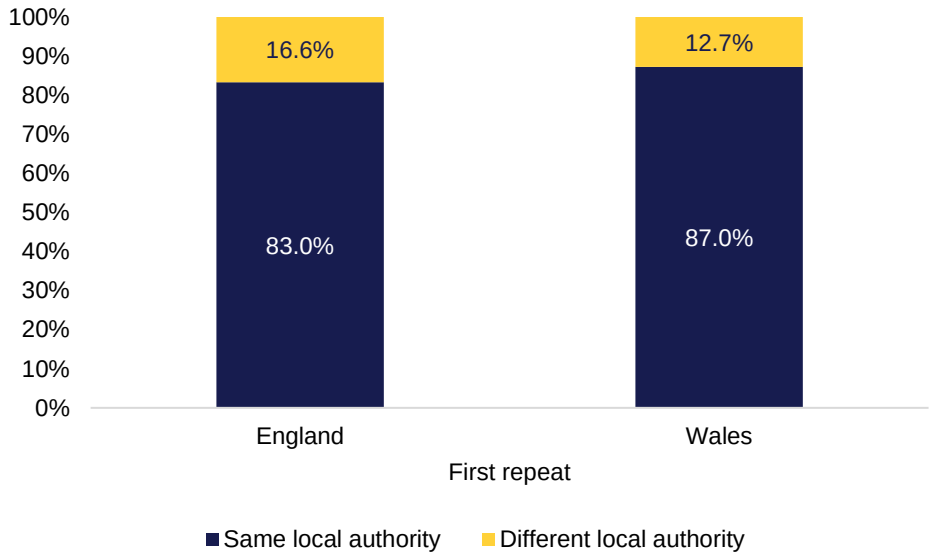
We examine changes over time in light of key legislative, policy and practice changes in England, before and after 2014. Changes over time regarding overlapping or consolidated proceedings, which typically occur because a new baby is born during the course of proceedings concerning an older sibling, warrant examination. Given the high rates of adoption of infants in Pathway 1, we have also probed changes before and after 2014, given that we know adoption has markedly decreased in England and Wales, following the high-profile judgments of Re B and Re-B-S.

Movement between local authorities (mothers)

There is some concern that women with a history of care proceedings move between local authorities, with the hope of leaving their histories behind, or in a search of a local authority that responds differently to their case. We were able to capture mothers' movement between local authorities in first repeat proceedings compared to the index episode within each region (Figure 7). The vast majority of first repeat cases (Pathway 1)

were in the same local authority as the index case in both England (83%) and Wales (87%). This indicates that a substantial percentage of mothers involved in repeat care proceedings were unlikely to have relocated across local authority boundaries.[28]

Figure 7: Movement between local authorities



Are overlapping or consolidated proceedings reducing in number?

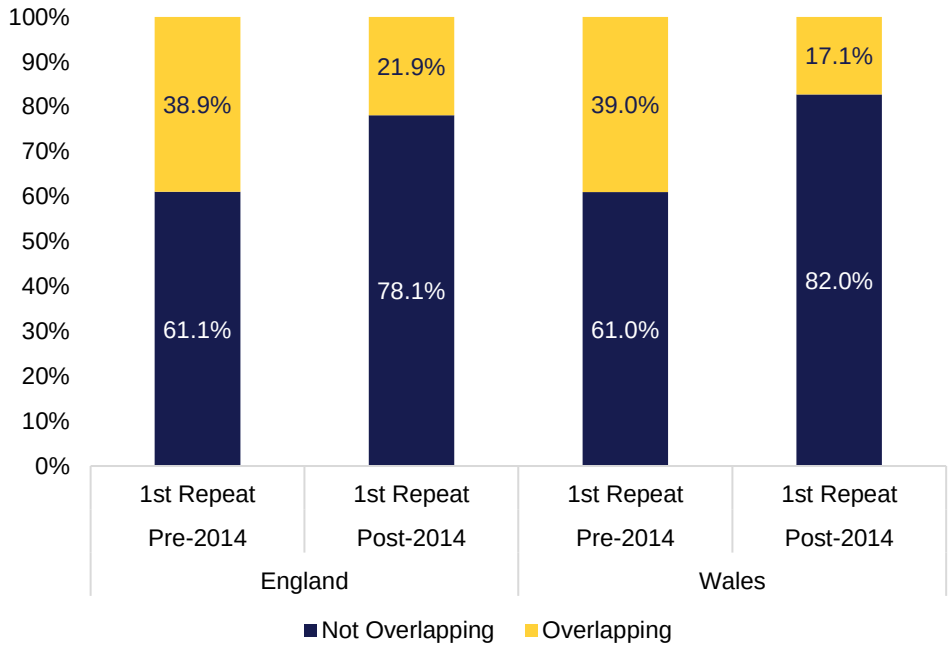
In previous analyses based on older data (Broadhurst et al. 2015), we identified a sizeable proportion of recurrent care proceedings where new proceedings started before a first set of proceedings had concluded (typically the mother gives birth to a new baby before proceedings have concluded about an older child). Given changes in the duration of care proceedings since 2013/14, we have examined whether we are seeing similar – or as might be anticipated smaller – proportions of overlapping proceedings.

Focusing only on mothers in Pathway 1, Figure 8 displays the percentage of overlapping proceedings before and after 2014. In England and Wales, respectively, 38.9% and 39.0% of first repeat cases overlapped with the index before 2014, compared to only 21.9% and 17.1% after 2014.

By shortening proceedings to 26 weeks, it appears less likely that mothers will have given birth to a new baby during the course of proceedings. It also indicates that the courts are perhaps less likely to 'wait' for the birth of a new baby and plan for both the older and new sibling within the same set of consolidated proceedings.

[28] Mothers may, however, have moved house within local authority boundaries. This will be explored in subsequent research.

Figure 8: Percentage of overlapping episodes of care proceedings before and after 2014



Technical note

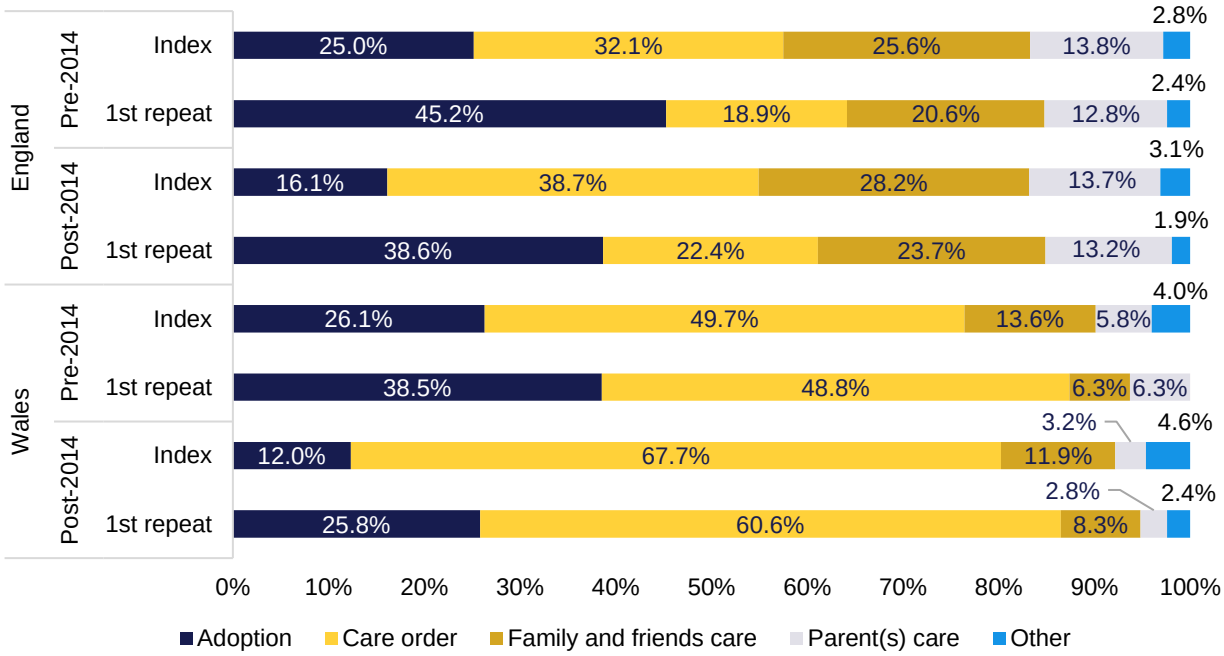
Statistically significant bivariate differences between groups were assessed using a chi-square ($\chi 2$) test. The results show significant differences in the proportion of proceedings which overlap before and after 2014 in England ($\chi 2 = 672.2$, $p < .001$) and Wales ($\chi 2 = 44.2$, $p < .001$). See Table B.3 in Appendix B.

Is the number of infants and children subject to adoption plans reducing after 2014?

Figure 9 shows the distribution of legal outcomes before and after 2014 for index and first repeat proceedings for mothers falling into Pathway 1.

It is clear that in both England and Wales, more infants and children are subject to adoption plans at a first repeat set of proceedings and this remains the same after 2014. However, overall, the percentage of cases ending in adoption plans at first repeat have decreased significantly since 2014. For example, before 2014, 45.2% and 38.5% of first repeat episodes resulted in adoption in England and Wales respectively, compared to only 38.6% and 25.8% afterwards.

Figure 9: Legal orders before and after 2014



Technical note

These differences were statistically significant in both regions ($\chi 2 = 711.4$, $p < .001$ [England], $\chi 2 = 177.6$, $p < .001$ [Wales]) (see Table B.4 in Appendix B).

Modelling the scale and pattern of recurrence

Estimating women's risk of return is more reliable when we use methods of survival analysis (Lemeshow et al. 2011), rather than simply relying on raw counts of mothers. Given the data available to the team, it has not been possible to follow up all mothers for the same period of time.[29] Moreover, mothers appearing in the dataset in the most recent years may not yet have had time to return. If we simply count 'returns' we will underestimate the rate of recurrence in our study population. Methods of survival analysis enable the analyst to consider both of these issues when producing estimates and provide some 'correction'.

In this section of the report, we share findings based on our estimate of risk for all recurrent mothers (Pathways 1 and 2) to enable readers to compare

[29] For example, mothers who record an index episode in the year 2011/12 can be followed up for a period of 10 years, whereas mothers who record an index episode in 2017/18 can only be followed up for three years.

our new findings more readily with those reported previously by Broadhurst et al. 2015, 2017 and Alrouh et al. 2020. Previous studies did not differentiate pathways. We then report our estimate of risk for mothers in Pathway 1 only to provide a more precise picture of recurrent mothers.

In both cases, the analytical sample consists of 82,051 mothers in England and 5,032 mothers in Wales between 2011/12 and 2019/20.

Technical note

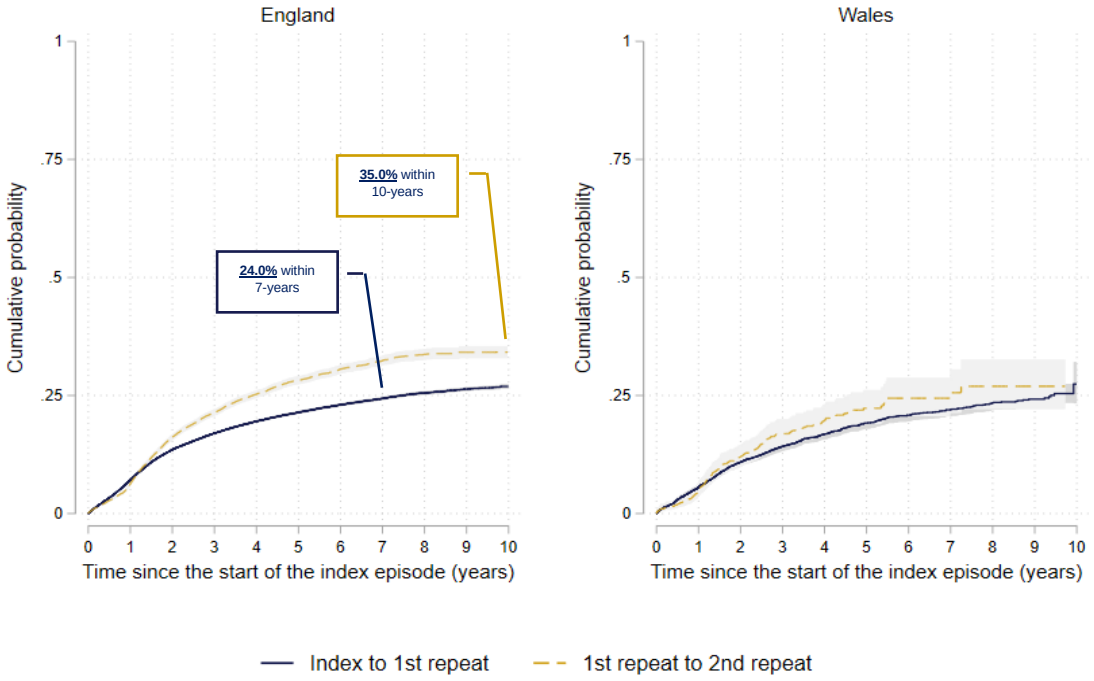
The Kaplan-Meier estimator was used to compute the probability of a mother in England or Wales entering a first and second repeat set of proceedings with (1) at least one new child or a previous child (Pathway 1 mothers and Pathway 2 mothers) and (2) at least one new child (Pathway 1 mothers). The time to first and second repeat cases was modelled using a continuous time duration model. For the first repeat, we assumed survival time began at the date of issue of an index proceeding and lasted until the date of issue of the first repeat proceeding or the end of our observation window. For the second repeat, we assumed survival time began at the date of issue of the first repeat proceeding and lasted until the date of issue of the second repeat proceeding or the end of our observation window.

For this report, we rely on a visual representation of the Kaplan-Meier estimator and the statistical comparison of survival rates. This method is used to estimate the unadjusted probability of recurrence, which means that we do not control for or assess potential covariates that could be associated with a mother's risk of recurrence. For example, whether mothers are engaged with preventative services or whether they are located in certain local authorities where services are more readily available.

Risk of return with either a new or a previous child (Pathways 1 and 2)

Figure 10 presents the cumulative probability of entering a (1) first repeat set of proceedings, and (2) second repeat set of proceedings with a new or previous child (Pathway 1 and Pathway 2).

Figure 10: Probability of recurrence from (1) index to first repeat and (2) first repeat to second repeat (Pathways 1 and 2)



Note: The shaded area represents the 95% confidence interval. N = 82,051 (England), N = 5,032 (Wales). In the figures we report the recurrence rate. Recurrence rate = 1 – survival rate.

In England, the cumulative probability of a mother entering her first repeat proceedings with either a new or previous child is 24.0% within 7 years, and 27.1% within 10 years. In Wales, the 7 and 10-year probability of recurrence was 23.2% and 26.5%, respectively. This means that in England and Wales, roughly 1 in 4 women is at risk of return within 10 years from the issue of their index set of proceedings. Thus, our estimates of the probability of recurrence remain largely consistent with those reported in 2015 and 2017 for England and 2020 for Wales (Broadhurst et al. 2015, 2017; Alrouh et al. 2020). When we observe mothers for a longer period, we see a marginal increase in the cumulative probability, but overall, the statistics indicate a problem that has not changed since the publication of original benchmarking statistics.

Risk of return with a new child only (Pathway 1 mothers)

In the sections that follow, we first provide an estimate of the risk of appearing in repeat care proceedings for all Pathway 1 mothers. Next, we explored whether and how, the risk of returning varies by:

- mother's estimated age at first birth
- legal outcomes for children at the close of care proceedings
- timeframe of proceedings (pre- and post-2014)
- region.

We performed further statistical tests to ascertain differences according to these lines of enquiry.

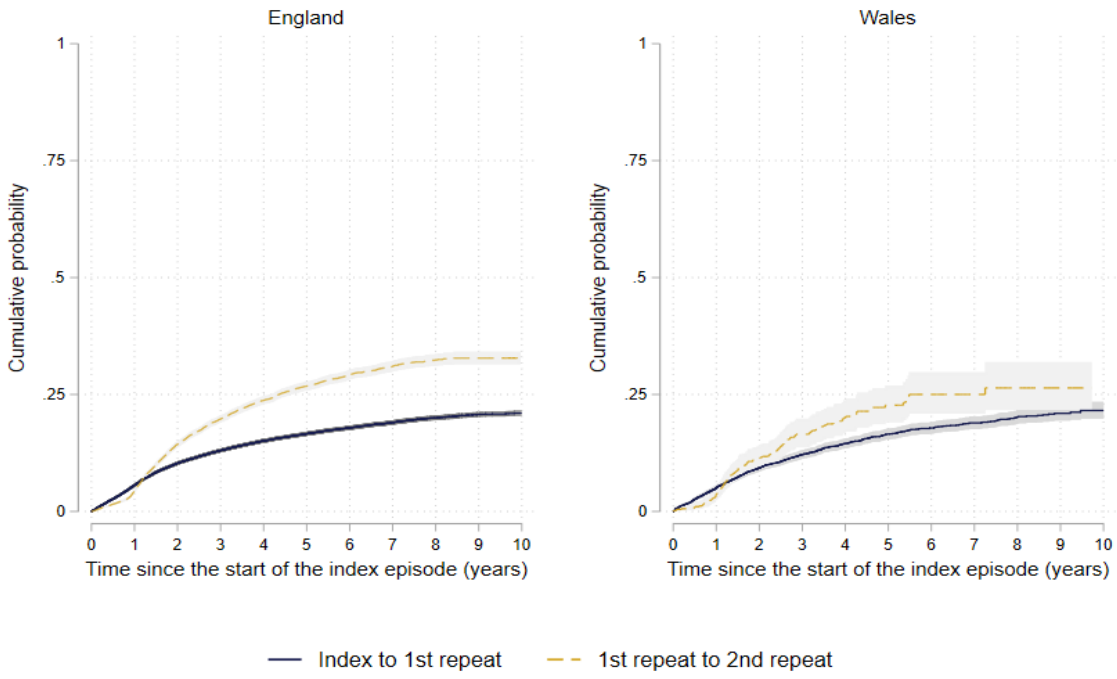
Technical note

The log rank test is used to compare survival curves. In the case of non-proportional hazards (i.e., intersecting survival curves), we used the Peto-Prentice test to detect statistically significant differences between groups (Dormuth et al. 2022).

Probability of recurrence in England and Wales

Figure 11 presents the cumulative probability of entering a first repeat set of proceedings, and second repeat set of proceedings, with at least one new child (Pathway 1).

Figure 11: Probability of recurrence from index to first repeat, and first repeat to second repeat (Pathway 1 only)



Note: The shaded area represents the 95% confidence interval. N = 82,051 (England), N = 5,032 (Wales). In the figures we report the recurrence rate. Recurrence rate = 1 – survival rate.

Index to first repeat

In England, the results show that the risk of returning within 7 years is 19.0%, increasing to 21.1% within 10 years. Similarly, in Wales, the risk of returning is 19.0% and 21.7% within 7 and 10 years respectively. This suggests that in England and Wales, roughly 1 in every 5 mothers in Pathway 1 is likely to return to court within 10 years from the issue of their index set of proceedings.

Using the life-table method (see Table B.5 in Appendix B), the 7-year overall survival of mothers in England was 81.0% and the 10-year overall survival was 78.9%. In Wales, 7-year overall survival was 81.0% and 10-year overall survival was 78.3%.

Technical note

Survival distributions for England and Wales were constructed using the life-table method. The survival function is calculated as the cumulative probability that a mother will have not experienced a second set of s.31 care proceedings. The life tables are summarised in one-year intervals. For example, a 10-year overall survival rate of 0.80 means that there is an 80% probability that mothers will have not returned to family court after 10 years since the start of their index episode.

First repeat to second repeat

A key question that has not previously been addressed in published research is whether the risk of return to court increases following a first repeat set of proceedings. This is an important question, with critical practice implications regarding the timing and targeting of preventative help.

The results show that the risk of a second repeat episode is markedly higher. Mothers who record a first repeat episode are at heightened risk of a second repeat episode. In England 33.0% of mothers are at risk of returning in a second episode within ten years, and in Wales, this is 26.9%.

The estimated overall survival for mothers in England who had first repeat proceedings (Note: In the life tables we report the survival rate. Recurrence rate = 1 – survival rate.

Table B.6 (in Appendix B) was 68.9% at 7 years and 67.0% at 10 years. The survival rates for Wales were 74.8% at 7 years and 73.1% at 10 years.

Technical note

The Peto-Prentice test indicates significant differences in the survival functions between England and Wales for the first to second repeat ($\chi 2 = 4.4$, $p < .05$) but not for the index to first repeat ($\chi 2 = 0.5$, $p > .10$) (See Table B.7 in Appendix B). That is, the probability of recurrence from index to first repeat is the same in England and Wales, but regarding a second repeat, the risk is higher in England.

When comparing the survival curves for the index to first repeat with first repeat to second repeat, significant differences were observed in England ($\chi 2 = 449.5$, $p < .001$) and Wales ($\chi 2 = 8.7$, $p < .01$). This means that for mothers in both England and Wales, the probability of recurrence is greater from first to second repeat proceedings than from index to first repeat proceedings. See Table B.8 in Appendix B.

Figure 12 displays the hazard rate estimates and 95% confidence intervals for the index to first repeat and first repeat to second repeat in England and Wales.

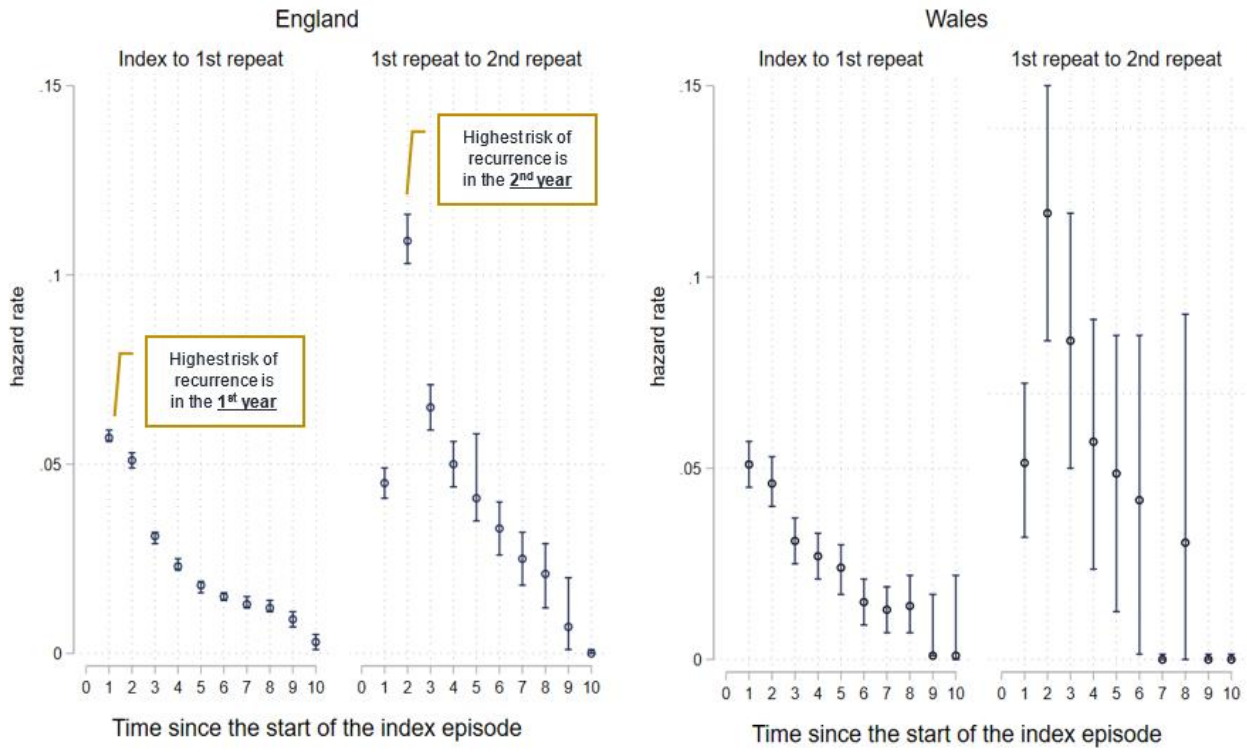
The hazard rate shows that, overall, the risk of returning to court for s.31 proceedings in England is highest in the first three years and begins to decline thereafter.[30]

Concerning the risk of a mother entering her first repeat proceedings in England, we observe that the risk is highest in the first year. The risk of a mother entering her second repeat proceedings on the other hand is

[30] The hazard rate refers to the conditional probability that a mother returns to court in year *t*, given that she has not returned before.

highest in the second year. In Wales, the wide confidence intervals around the estimates do not enable a conclusive interpretation of the results.

Figure 12: Hazard rate of a mother enter her first and second repeat proceedings

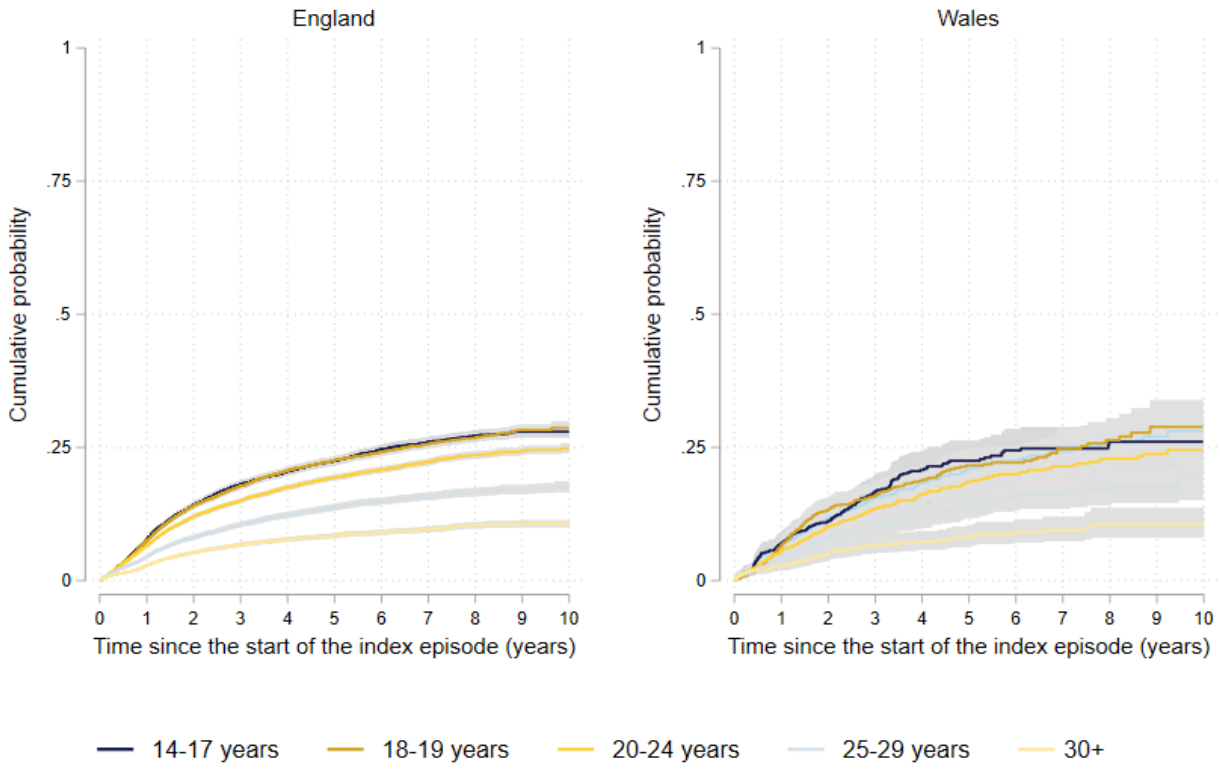


Note: Blue bands indicate 95% confidence intervals.

Probability of recurrence by mother's age at first birth

An association between a mother's age at first birth and risk of recurrence has been reported (Broadhurst et al. 2015, 2017). In this study we have repeated this analysis. Kaplan-Meier estimates by mother's age at first birth are shown in Figure 13. In both nations, women who had their first child at a younger age were at a higher risk of returning to court. The results show that in England and Wales, 28.0% and 26.1%, respectively, of those who were aged 14–17 when they had their first child were likely to reappear in care proceedings within 10 years.

Figure 13: Probability of recurrence by mother's age at first birth



Note: The shaded area represents the 95% confidence interval. N = 82,051 (England), N = 5,032 (Wales). In the figures we report the recurrence rate. Recurrence rate = 1 – survival rate. N at *t* < 1 for each age category are included in Table B.9 (Appendix B).

The probability of recurrence decreases to 10.8% in England and 10.5% in Wales for mothers who had their first child at the age of 30 or older. This implies that, in both England and Wales, about 1 in 10 women in the 30+ age category is likely to reappear in a subsequent set of proceedings within 10 years, compared to roughly 1 in 4 in the youngest age group.

Survival probabilities generally increased with mother's age at first birth (see Table B.9 in Appendix B). For example, 10-year overall survival in England and Wales ranged from 72% for those aged 14–17 years to 89% for those aged 30 years or older.

All pairwise comparisons in England and Wales were statistically significant except for those between the two youngest age categories (see Table B.10 in the Appendix B). That is, the probability of recurrence does not differ significantly between mothers who had their first child aged 14–17 years and mothers who had their first child aged 18–19 years.

These findings confirm previous research, which indicates that young mothers, particularly those who have their first child as teenagers, are at a significantly high risk of recurrence.

See Figure C.1 in Appendix C for a plot of the hazard rates in England and Wales by the mother's age at first birth.

Probability of recurrence by legal order outcome for the child

A key question is whether there is any relationship between risk of return for mothers and the legal order outcome at the close of proceedings for her child.[31] Kaplan-Meier estimates by child legal outcome are shown in Figure 14. The results show that adoption orders are associated with the highest rate of recurrence in England and Wales. And even more importantly, we find that 34.0% of mothers in England whose child or children were subject to a plan for adoption were likely to return within 10 years, compared to just 16%, 23.0%, 14.3%, and 9% for care orders, placement with family and friends, placement with parent(s), and other placement types, respectively.

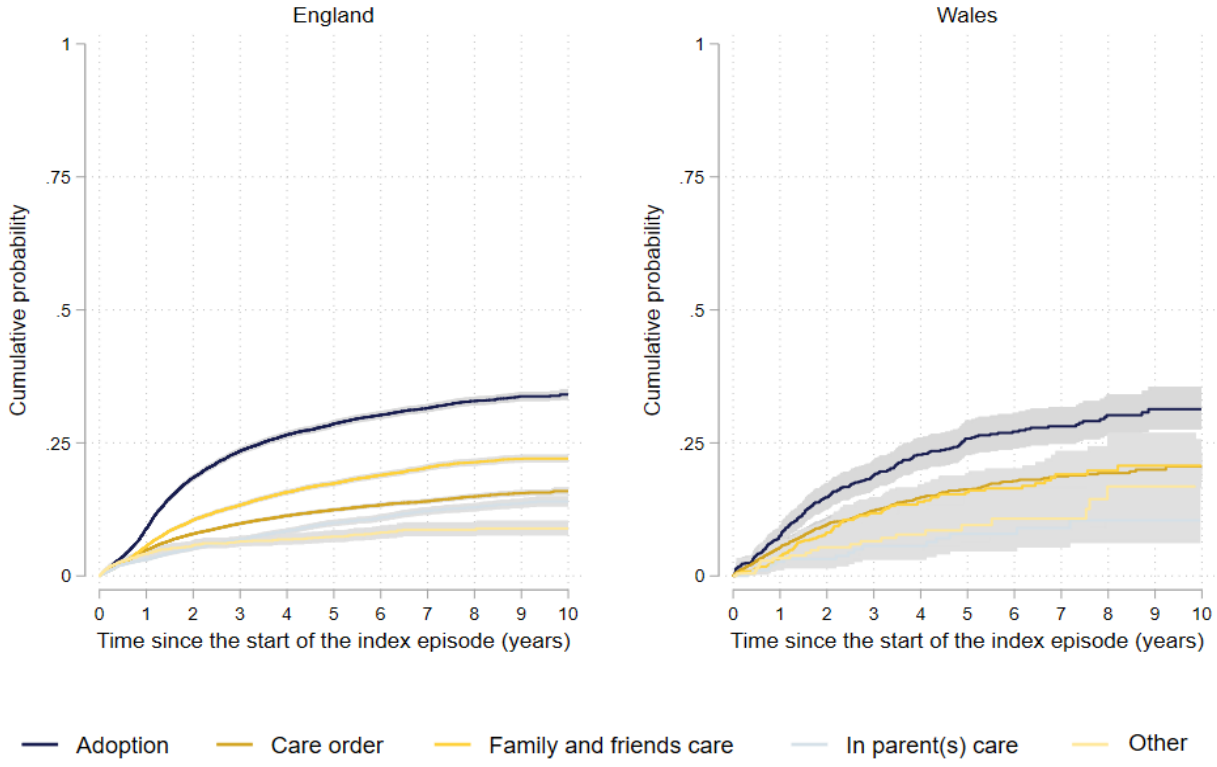
Similarly, in Wales, adoption is associated with the highest rate of recurrence (31.1%), followed by placement with family and friends (21.1%), care orders (20.9%), other placement types (16.6%), and parent(s) care (10.8%).

Accordingly, the 10-year survival probabilities (see Table B.11 in Appendix B) in England were highest for other placement types (91%) and lowest for adoption orders (66.0%), whereas in Wales, they were highest for parent(s) care (89.2%) and lowest for adoption orders (68.9%). All pairwise comparisons were statistically significant in England ($p < .05$) but not in Wales ($p > .10$). See Table B.12 in Appendix B.

See Figure C.2 in Appendix C for a plot of the hazard rates in England and Wales by legal order outcomes.

[31] See Appendix A for details about how legal order data was rationalised.

Figure 14: Probability of recurrence by legal order



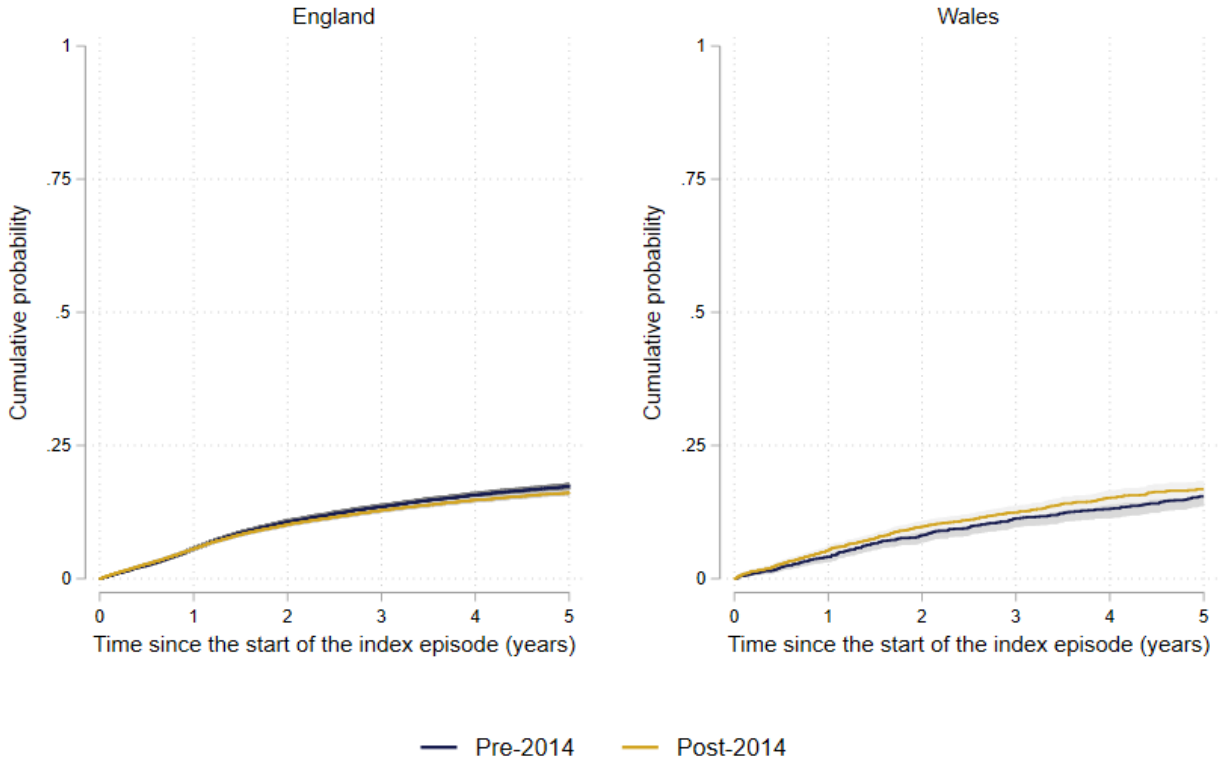
Note: The shaded area represents the 95% confidence interval. N = 82,051 (England), N = 5,032 (Wales). In the figures we report the recurrence rate. Recurrence rate = 1 – survival rate. N at *t* < 1 for each legal order category are included in Table B.11 (Appendix B).

Probability of recurrence before and after 2014

To explore an association between the 26-week statutory time limit introduced with the Children and Families Act 2014 on the probability of recurrence and given developments in preventative service developments, we have estimated the Kaplan-Meier survival curves before and after 2014 (Figure 15). For these analyses, we have limited the follow-up period to five years. This means that, compared to using the full observation window of 10 years, more mothers in the restricted 5-year sample will not yet have had time to return (i.e. experience a second set of care proceedings). This may lead to an artificially lower rate of recurrence.[32]

[32] For the rate of recurrence in England and Wales (10-year observation window), we rely on the estimates in the 'Probability of recurrence in England and Wales (Pathway 1 mothers)' section.

Figure 15: Probability of recurrence, before and after 2014



Note: Follow-up was limited to five years. The shaded area represents the 95% confidence interval. N = 82,051 (England), N = 5,032 (Wales). In the figures we report the recurrence rate. Recurrence rate = 1 – survival rate. N at *t* < 1 for the pre- and post-2014 categories are included in Table B.13 (Appendix B).

The results show marginal differences in the probability of recurrence before and after 2014 in England and Wales. Specifically, in England, the risk of returning to court is slightly higher pre-2014 (17.4%) than after 2014 (16.2%). Turning to Wales, the risk of returning to court within 5 years was 16.9% after 2014, compared to 15.5% before 2014.

The 5-year overall survival in England was slightly higher (83.8%) post-2014 compared to pre-2014 (82.6%) (see Table B.13 in Appendix B). In Wales, the 5-year overall survival was 84.5% pre-2014 and 83.1% post-2014.

Technical note

The stratified Peto-Prentice test was statistically significant in England ($\chi^2 = 12.5$, $p < .001$), but not in Wales ($\chi^2 = 1.9$, $p > .10$) (See Table B.14 in Appendix B)..

These findings suggest that in England the post-2014 period is associated with a marginally lower risk of recurrence compared to the pre-2014 period, whereas in Wales, the risk of recurrence remains the same post-2014. As

noted above, however, these findings should be interpreted with caution given the restricted follow-up period.[33]

See Figure C.3 in Appendix C for a plot of the hazard rates in England and Wales by pre- and post-2014.

Understanding regional variation (Pathway 1)

A key question is whether risk of recurrence varies by region (Pathway 1). To address this question funnel plots were used to measure and visualise regional variation in the 10-year recurrence rate for mothers in England, and for Wales. At the level of the region, we have compared the whole of Wales with regions of England, given the far smaller population size in Wales.

However, for comparisons within countries, we have looked at variation between local authorities in England. We have separately explored variation between local authorities in Wales.

The funnel plots were constructed by plotting the 10-year recurrence rate against the number of mothers in s.31 care proceedings in each region of England and for Wales.

For each funnel plot below, the straight horizontal line represents the national rate. The dotted lines depict the 95% and 99.7% control limits representing two and three standard deviations, respectively, from the national rate based on our x-axis values. Regions that appear outside of the control limits (dotted lines) are identified as deviating from the national rate or as being a potential outlier.

Region-level variation

Figure 16 shows the 10-year recurrence rate for each of the 9 England regions and Wales – that is, the probability that a mother will return to court within 10 years of her index episode. Each data point represents the estimate for one region. We find that Wales and the South East fall within the control limits. The East of England, London, and the South West had significantly lower rates of recurrence than the national rate, whereas the North East, West Midlands, North West, East Midlands, and Yorkshire and the Humber had significantly higher rates of recurrence. When we compare London with a recurrence rate of 17.2%, this is markedly lower than the

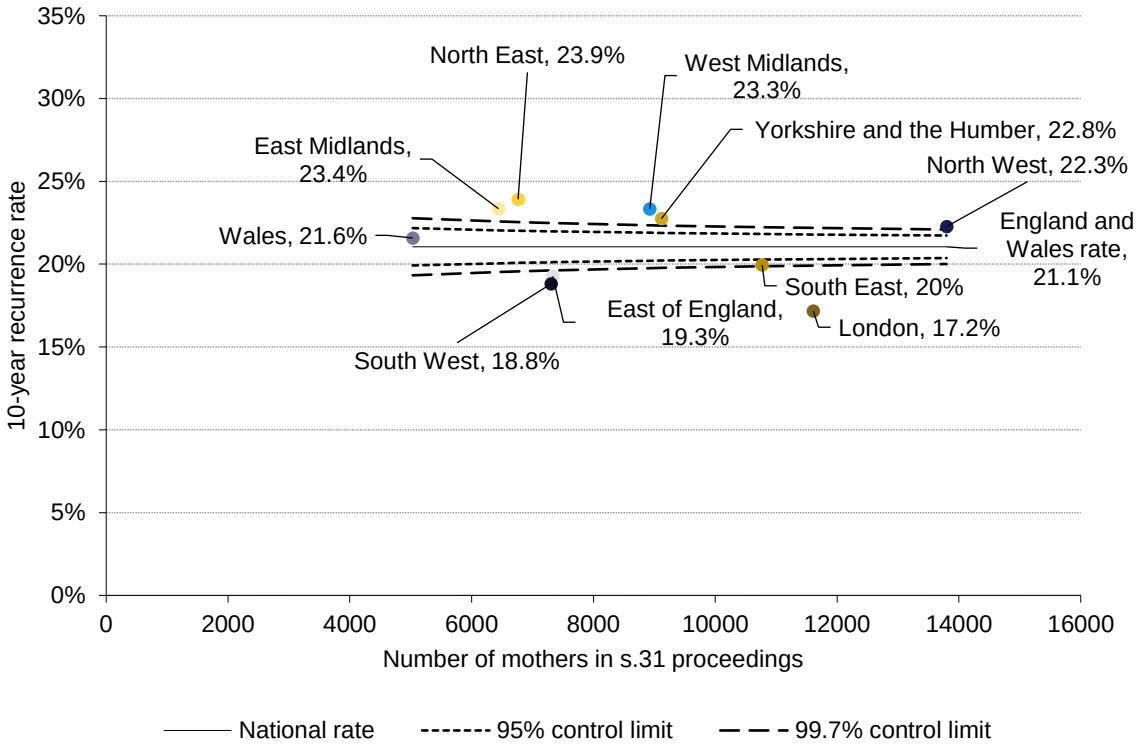
[33] For example, mothers who entered the sample in 2017/18 may not have had the chance to return to family court. We also examined over time change in the rate of recurrence in England and Wales. These results can be found in Table B.16 in Appendix B and Figure C.4 in Appendix C.

North East at almost 24%. Overall, we see a divide between London and the South, and the Midlands and the North.

This variance is not surprising given what we know from the *Born into Care* series about higher rates of newborns in care proceedings in the North East for example, and far lower rates in London (see Broadhurst et al. 2018; Alrouh et al. 2020). As we have noted above, 82.2% of children in Pathway 1 are babies at a first repeat set of care proceedings. Hence, we would expect to see consistency at a regional level between rates of recurrence and newborns in care proceedings.

The 10-year survival probabilities for each region can be found in Table B.15 in Appendix B.

Figure 16: Funnel plot depicting the probability of recurrence by English region and Wales



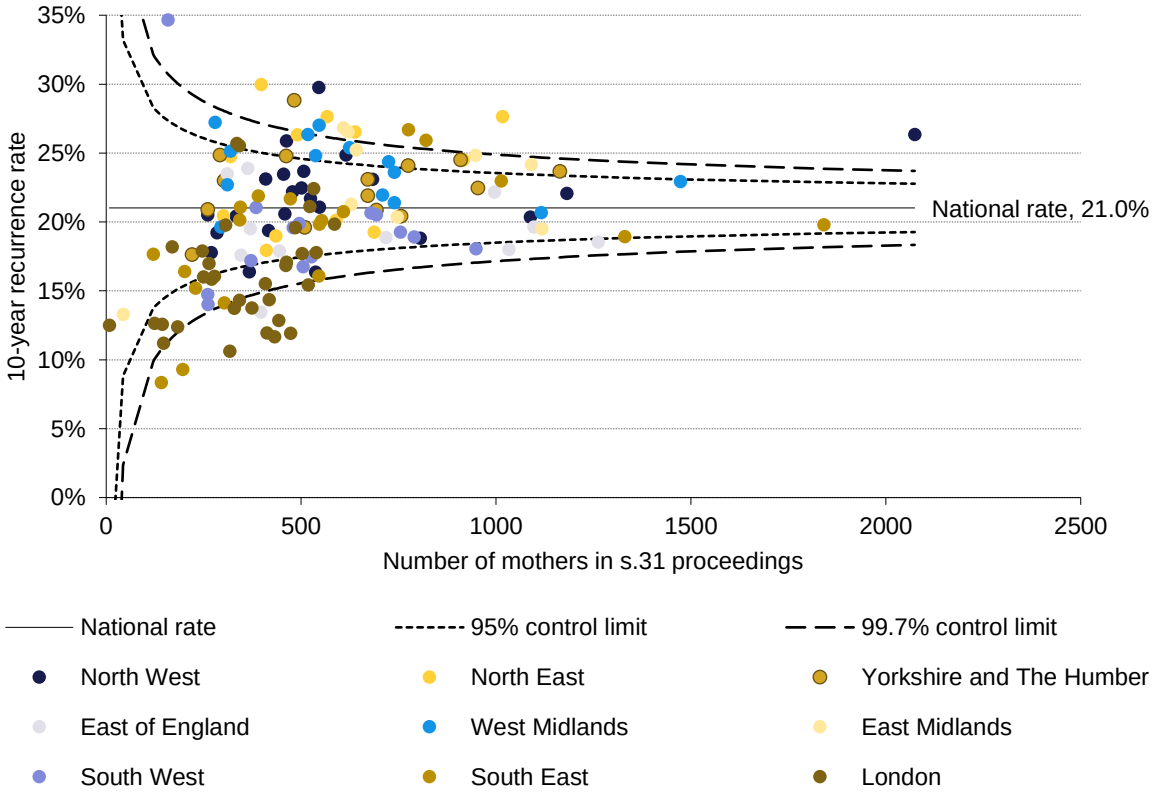
Local authority-level variation

Figure 17 and Figure 18 show the 10-year recurrence rate for each of the local authorities in England and Wales separately. The distribution of the recurrence rate shows most local authorities falling within the control limits in both nations.

In England, 34 local authorities (23%) had recurrence rates below the 95% lower control limit, including 13 local authorities from 3 regions (10 in London, 2 in the South East, and 1 in the East of England) with recurrence rates below the 99.7% lower control limit. These local authorities are considered as low outliers. In contrast, there are 31 local authorities (21%)

high outliers (i.e. with recurrence rates above the 95% higher control limit), including 13 local authorities (4 in the North East; 2 in each of the North West, East Midlands, South East; and 1 in each of Yorkshire and the Humber, West Midlands and South West) with recurrence rates above the 99.7% higher control limits. Again, we see a split between London and the South (generally lower recurrence rates), and the Midlands and the North (generally higher recurrence rates), but it is also important to note that there is often variation between local authorities within the same region.[34]

Figure 17: Funnel plot of the probability of recurrence by local authority in England

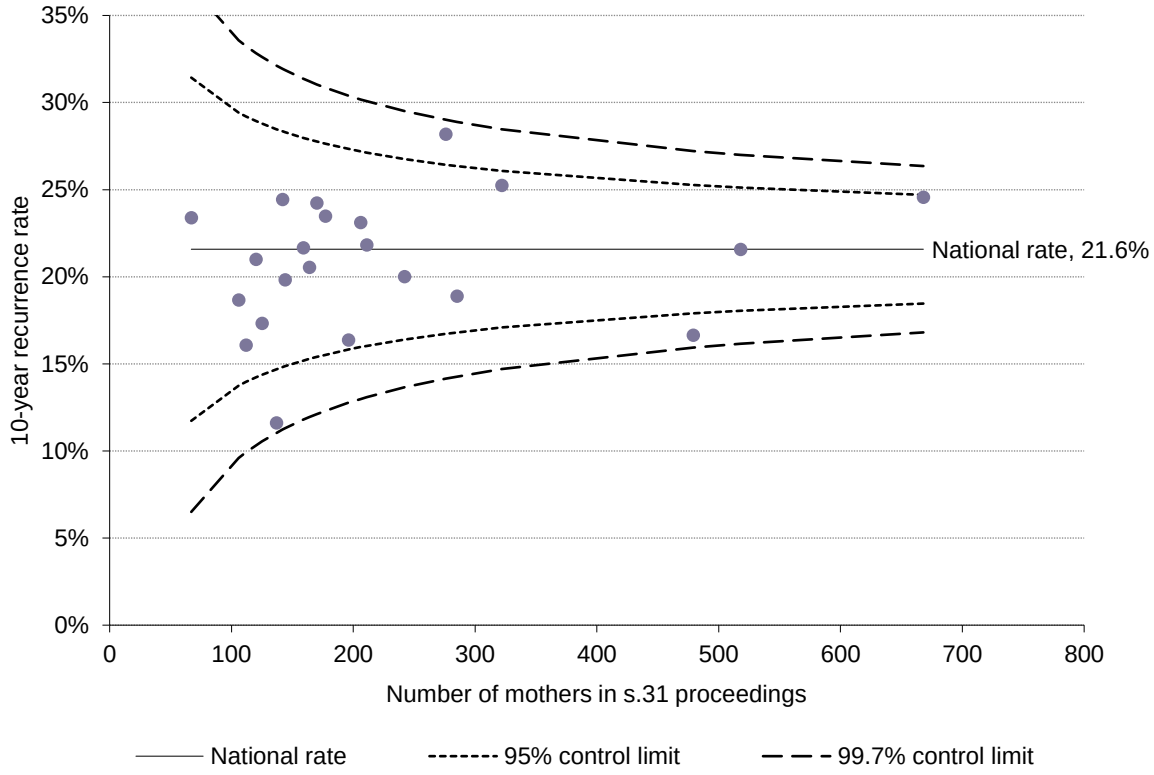


Most local authorities (Figure 18) in Wales lie close to the Welsh national rate. However, compared to the Welsh national average, two local authorities show significantly lower rates, and one local authority shows significantly higher rates.

Thus, by probing regional and local authority variation, we begin to see the areas with the highest need, where provision needs to be scaled up, to tackle higher than expected rates of recurrence.

[34] See further funnel plots illustrating the variation between local authorities for each of the regions in Appendix C (Figure C.5 to Figure C.13)

Figure 18: Funnel plot of the probability of recurrence by local authority in Wales



Discussion

The findings in this report indicate that, in England and Wales, a sizeable proportion of mothers are likely to return to court, having appeared previously in care proceedings.

- Based on all women in recurrent care proceedings, over a 10-year period (2011/12–2020/21), we estimate that 1 in 4 women is at risk of returning, and for the youngest mothers, this risk increases to 1 in 3.

The findings we report are very similar to those we reported for England in 2015 (see Broadhurst et al. 2015, based on cases issued between 2007 and 2014) and for Wales in 2020 (see Alrouh et al. 2020, based on cases issued between 2011 and 2018). Findings are similar in respect of both the risk of return and the pattern. However, it is important to emphasise that the number of mothers returning to court (raw count) has markedly increased.

- Given there has been a marked increase in the volume of care proceedings nationally, more mothers are returning to court. This means the challenge for service provides is also greater simply on account of finding the resources to help a larger number of mothers.

As stated, since the first estimates were published for England in 2015, our knowledge of patterns of women's return to court has evolved. Therefore, in this report we have produced a profile of mothers against two distinct pathways which have enabled a clearer picture of mothers in 'repeat removal' cases to be uncovered.

- Regarding Pathway 1, we have uncovered concerning findings about the scale of teenage motherhood, based on our age estimates. A high proportion of mothers are estimated to be between 14 and 19 years at entry to motherhood. We have also captured a more precise picture of the proportion of repeat cases that concern babies.

Based on the findings from survival analysis, we see a generally static picture of risk for Pathway 1 mothers. Findings indicate that, as yet, we are not seeing any significant reduction in the probability of women returning to court in England and Wales for a first set of care proceedings. Regarding Pathway 1, approximately 1 in 5 mothers will return to court following an index appearance, typically in proceedings that concern a baby.

For the first time, we have also established that for Pathway 1 mothers:

- the risk of returning to court increases after a first repeat episode
- there are marked regional differences in England.

Profiling mothers in Pathway 1 – early motherhood

A concerning finding from our new analyses of mothers in recurrent care proceedings is the high proportion of very young mothers in Pathway 1. In stark contrast to the general population, 42% of mothers were estimated to be aged between 14 and 19 years old at entry to motherhood. Moreover, exploratory analysis of factors associated with heightened risk of return to court using methods of survival analysis also underscores the vulnerability of young mothers. This finding is in keeping with qualitative studies, which have also uncovered the vulnerability of teenage mothers in care proceedings. Studies report that young mothers are not able to draw on sufficient support to enable them to cope with the demands of motherhood. In general, young mothers at risk of appearing as respondents in care proceedings are poorly prepared for motherhood emotionally and financially. From earlier research (Broadhurst et al. 2017; Broadhurst and Mason 2020; Boddy et al. 2020), we also know that many of these mothers are care leavers.

On the basis of our new findings, it is clear that far more attention must be paid to the needs of young mothers, their partners and wider family networks. To date, much of the published research literature on care proceedings has not distinguished parents in terms of age. Yet young parents wrestling with their own developmental needs – and typically with very limited social and financial resources – clearly warrant special attention in terms of how they are supported to navigate the family justice system, and indeed, prior to care proceedings. The Family Rights Group and the Youth Advocacy Service have developed some excellent resources to help more young parents retain the care of their children and/or navigate the family justice system.[35] In addition, further work is needed to understand: the scope of preventative practice when young parents face care proceedings; the consistency of tailored support and advocacy prior to and during care proceedings; and what help young parents receive if children are removed from their care. Anecdotal evidence from practitioners is that young parents are more likely to disengage during the course of care proceedings and to decline services offered, which may help to explain heightened risk of return to court.

Service developments – are they of timely and sufficient scale?

This report provides new statistics on risk of return to court in respect of all mothers in recurrent care proceedings and mothers in Pathway 1. As

[35] See Family Rights Group, Advice for Young Parents: https://www.frg.org.uk/ypa/

above, despite almost a decade of research and service innovation, the national picture is of little change in England and Wales when we measure the risk of a first repeat set of care proceedings at a national level. Moreover, given the increase in the volume of care proceedings in England and Wales, far more mothers have a recurrent profile, which increases the challenge for practitioners seeking funding for bespoke services.

So, how do we explain these statistics? Regarding Wales, a decision to roll out the Reflect initiative was only made in 2018 and is incomplete, hence it is most likely too early to detect a significant change in statistics, given the most recent data available to us for this report was for the year ending 2020/21. In addition to Reflect, other services addressing recurrence have been developed, such as Jig-So in Swansea and Baby in Me in Newport.[36] However there remain areas of Wales where women are unlikely to be able to access bespoke services aiming to prevent recurrent proceedings. Our new statistics provide further evidence of the need to ensure that the momentum is not lost to spread and scale the Reflect programme given positive evaluative evidence, and to ensure ongoing support for the other promising initiatives working with parents during pregnancy. In addition, future monitoring of rates of recurrent proceedings will remain important.

In England, as stated in the background sections to this report, service developments have a much longer history. But developments have been uneven across the country – some preventative services have closed and there are many areas with no service at all. Although there is a lack of robust national data on service developments, it is likely that they are simply of insufficient scale to reduce women's risk of return. Mason and Wilkinson's (2021, forthcoming) mapping document provides an excellent overview of approaches to practice, but was not designed to elicit robust evidence about the scale of initiatives, their duration, or how many women in total in England had received a service. Pamela Cox and colleagues (2020) have invested significant energy in developing a valuable evaluation toolkit made available online as an open-source resource, but argue that published evaluations are few in number. A multisite evaluation of Pause by Janet Boddy and colleagues (2020) provides robust evidence of the value of this service in preventing repeat removals for many women.

In formulating our recommendations from this research, we have been greatly aided by conversations with practice pioneers. Practitioners agree that service developments are currently of insufficient scale to meet the needs of women requiring help. In the context of a growing population of recurrent mothers, it is highly likely that services are struggling to offer intensive support to even a fraction of the mothers that require it. Undoubtedly, without the range of services now available, the number of recurrent mothers would be higher – hence it is imperative that funding is provided to aid expansion so that all parents who experience the removal

[36] See: https://sbuhb.nhs.wales/news/swansea-bay-health-news/jig-sos-success-with-swansea-families/; and https://www.barnardos.org.uk/what-we-do/services/baby-me

of a child through care proceedings can receive an appropriate level of support. Conversations with practitioners reflect the evolving nature of practice developments in this area of service delivery. For example, a number of services began with a model that intervened later in the 'risk cycle' (after a second or third removal) rather than during or following a first set of care proceedings. As such they were focused on preventing multiple repeat care proceedings, rather than addressing the needs of 'new recurrent mothers'. However, the recent service mapping update (Mason and Wilkinson 2021, forthcoming) and conversations with practitioners via the national Community of Practice[37] suggests that a number of services have reflected that they might not be intervening early enough. As a result, some have amended their service criteria and scope and are now offering a service to parents after their first child is removed from their care or in some instances – when there is significant concern that a separation at birth may be necessary – during pregnancy. National investment in support for evaluation is essential if we are to understand the impact of these small-scale but vital innovations. It is only through more detailed evaluative work that we will be able to understand more fully, the impact of services at a regional and national levels.

The analyses we present in this report estimate risk from women's index appearance to their first repeat set of care proceedings. Although it is vital that intensive, therapeutic support is offered to mothers who have lost multiple children from their care, surely we would want to avoid this trauma for mothers, partners and wider kin by offering help at a far earlier point? An argument in favour of earlier intervention is supported by the findings shared in this report, which indicate that there is a greater risk of a second repeat set of care proceedings, following a first repeat. In previous research, we have argued that it may be difficult to change local authority and family court perceptions of risk, if a mother has a history of repeat appearances in care proceedings (Broadhurst and Mason 2020).

Finally, it is vital that regional and national policymakers and practice leads recognise the multifaceted nature of the needs of parents in care proceedings and seek to pool funding across health and social care to prevent recurrent care proceedings. Prior work by the team has already evidenced the mothers and fathers in care proceedings are more likely than the general population to turn to emergency or crisis healthcare provision (Griffiths et al. 2020; Johnson et al. 2022). To date there has been limited analysis of how cross-sector funding and provision might work to ensure more durable funding – and provide a more integrated response to the needs of parents in care proceedings.

[37] https://supportingparents.researchinpractice.org.uk/

Intervening earlier in the risk cycle

Intervening early in the cycle of repeat care proceedings requires effective and timely identification and referral of mothers – that is, before a first repeat. However, at present, local authority and court processes do not readily lend themselves to early intervention. The majority of local authorities do not routinely capture parents' appearances in repeat care proceedings. Data is largely child-focused. Nor are there any official monitoring statistics at a national level. In addition, the courts do not systematically flag recurrent cases. Thus, the main mechanism for referral to intensive therapeutic services is referral by a professional on the basis of personal knowledge of mothers with a history of repeat removal. A more systematic approach will be needed if mothers at risk of return are to have a fighting chance of avoiding a first repeat set of proceedings.

Using data available from Cafcass and Cafcass Cymru, we have (as above) established that the youngest first-time mothers are most likely to return to court, as are those whose child is subject to a plan for adoption (placement order) at the index set of proceedings. The challenge going forward is to build a more comprehensive picture of a broader range of factors associated with recurrence, using linked health, social care and demographic information.

Of course, by far the best solution would be to offer all parents who have had a child removed from their care intensive and tailored support to rebuild their lives from specialist adult-focused services as well as children's services. A universal entitlement to continuing help is without doubt the best way forward (Care Crisis Review 2018)**.**

Aligning service development with regional need

This is the first time that regional differences regarding recurrence have been probed, based on Pathway 1. When we throw the spotlight on Pathway 1, we see considerable variation in rates of recurrence, as might be expected between London and the South, and the Midlands and the North – rates show the greatest variance when we compare London and the North East. These findings are not surprising given related research on newborn babies in care proceedings (Broadhurst et al. 2018). In addition however, it is important to note that where rates of recurrent care proceedings are the highest, so too are national rates of teenage pregnancy. Again, that teenage pregnancy rates appear to map onto rates of recurrence is not surprising, given what we know about the over-representation of teenage mothers in care proceedings. The North East currently has the highest rate of teenage pregnancy (ONS 2022) and from this study, the highest rate of care proceedings. In previous reports we

have also noted the very difficult socioeconomic context for practitioners and families in the North East, due to insufficient funding for preventative services (Pattinson et al. 2021).

However, as yet, service developments have not been informed by mapping of rates of recurrence by region. Of course, both numbers and risk matter in terms of service planning. However, where rates of recurrent care proceedings are high, a greater concentration of families and communities will experience this form of state intervention. Looking ahead, it is imperative that a national strategy to tackle recurrent care proceedings is informed by a regional analysis of care and recurrent care proceedings.

Conclusion

In order to progress an agenda to reduce recurrent care proceedings, the following five points are key.

- The high risk of return to court for young mothers identified in this report builds on previous research that reports that many of these young mothers are also care leavers (Broadhurst et al. 2017; Broadhurst and Mason 2020; Boddy et al. 2020). This finding provides further evidence that support for young parents, including care leavers, needs to be strengthened in pregnancy, during care proceedings, and beyond. Indeed, better preparation for parenthood needs to start prior to a first pregnancy.
- The evidence of the heightened risk following a first repeat appearance in proceedings suggests that by far the best solution to the possible pattern of repeat proceedings once a removal has taken place would be to offer all parents in that situation intensive and tailored support to rebuild their lives from specialist adult-focused services. A universal entitlement to continuing help is without doubt the best way forward.
- The bar needs to be raised in terms of ensuring resources are available for the collection and synthesis of local area evaluation data (while recognising the challenge of finding funds for small-scale evaluation). At present services are holding valuable data – but there is limited collation of this data across services. At a national level, HM Courts & Tribunals Service should examine options for including monitoring data on recurrence within family court statistics.
- Evaluation outcome data must be compared with what we might have expected had services not been available.
- Investment and service development must align more closely with regional need. For areas with high rates of care proceedings, it may be difficult to move resources upstream to prevent recurrence, therefore allocation of funding proportionate to need is required.

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Appendix A

This technical appendix includes four brief sections on (1) the administrative data held by the Child and Family Court Advisory Support Service (Cafcass), (2) the construction of our research database, (3) the aggregation of multiple legal orders, and (4) the research dataset.

Cafcass administrative databases

Digital case records held centrally by Cafcass and Cafcass Cymru served as the primary source of data for this study. Cafcass [England] introduced its case management system (CMS) in 2007, which was replaced by an electronic case management system (ECMS) in July 2014. Cafcass Cymru has its own case management system, with useable records available from 2011.

These administrative data systems are electronic relational databases containing both numerical and text-based data that can be managed, queried, and manipulated using Structured Query Language (SQL) based software.

For further details on the Cafcass (CMS and ECMS) and Cafcass Cymru relational databases, methodology, data linking process, and inclusion criteria, please consult the following technical data resources:

- Alrouh, B. and Broadhurst, K. (2015). *Vulnerable birth mothers and recurrent care proceedings: Estimating recurrent care proceedings using CAFCASS administrative data - a technical appendix*. http://wp.lancs.ac.uk/recurrent-care/files/2015/12/TechnicalAppendixRC_2015_V1.0.pdf
- Bedston, S., Pearson, R.J., Jay, M.A., Broadhurst, K., Gilbert, R., and Wijlaars, L. (2020). Data resource: Children and Family Court Advisory and Support Service (Cafcass) public family law administrative records in England. *International Journal of Population Data Science*, 5 (1). https://doi.org/10.23889/ijpds.v5i1.1159
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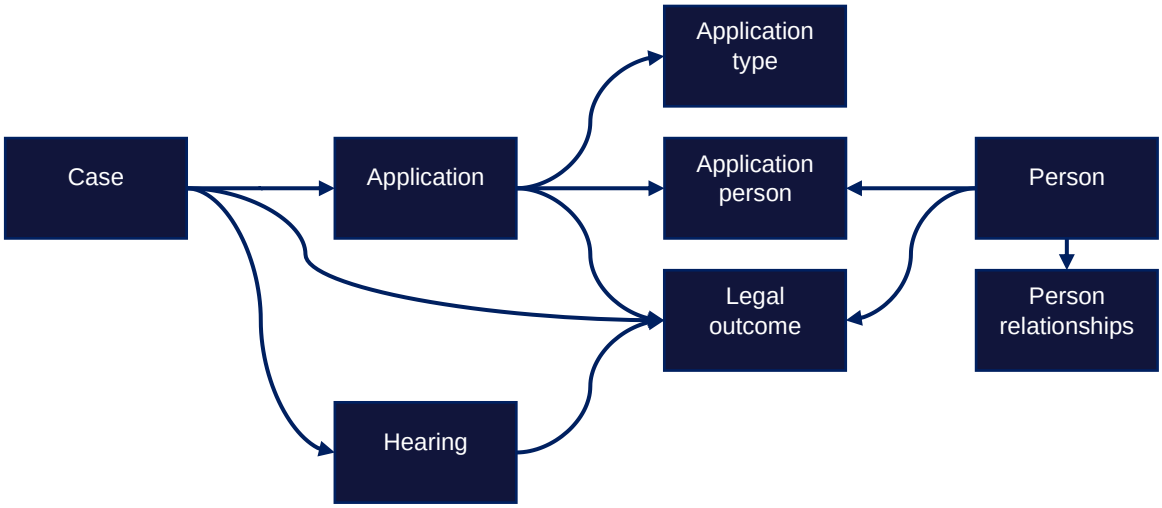
A full list of all the tables and variables in Cafcass and Cafcass Cymru data is available from: https://web.www.healthdatagateway.org/search?search=Cafcass&tab=Datasets

Cafcass harmonised database

The SQL relational database harmonises the three different case management systems – Cafcass CMS, Cafcass ECMS, and Cafcass Cymru – accounting for the differences between them to produce a linked dataset for the purpose of our research. Figure A.1 displays the entity relationship diagram (ERD) for the harmonised Cafcass and Cafcass Cymru research database.

Figure A.1: Cafcass harmonised database: Entity relationship diagram



Note: The arrows illustrate the relationship between the tables in the Cafcass data sample used in the study.

Table A.1: Cafcass harmonised database – tables and variables

Table name	Key variables for this study
Case	**Cafcass ID:** Differentiates between Cafcass (CMS/ECMS) and Cafcass Cymru cases
	Case ID: Unique identifier code given for each case
	Law type: Differentiates between public and private law
	Case status: Differentiates between closed (i.e. completed) and ongoing cases
	Local authority: The local authority of the case
	Closure date: The date of completion for the whole case
Application	**Application ID:** Unique identifier code given for each application
	Case ref: References the case ID in the case table
	Court: The court where the application was lodged
	Issue date: Start date of the application
	Completion date: End date of the application
Application type	**Case ref:** References the case ID in the case table
	Application ref: References the application ID in the application table
	Application type: The type of the application (e.g. supervision, care)
Hearing	**Case hearing ID:** Unique identifier code given for each hearing
	Case ref: References the case ID in the case table
	Hearing date: The date of the hearing
	Hearing type: The type of the hearing (e.g. first, review, final)
Person	**Person ID:** A unique identifier code given for each person
	Date of birth: The date of birth of the person
	Gender: Differentiates between male, female, and unidentified
Person relationships	**Person relationship ID:** A unique identifier code for each relationship
	Person 1 ref: 1st person ID. References the person ID in the person table
	Person 2 ref: 2nd person ID. References the person ID in the person table
	Relationship type: The type of relationship between person 1 and person 2 (e.g. parent, child, sibling)
Application-person	**Application ref:** References the application ID in the application table
	Person ref: References the person ID in the person table
	Is applicant: Whether the record refers to an applicant
	Is respondent: Whether the record refers to a respondent
	Is subject: Whether the record refers to a subject
	Is other: Whether the record refers to any other role on the application
	Is party: Whether the record refers to person who is a party to the proceedings
Legal outcome	**Case ref:** References the case ID in the case table
	Application ref: References the application ID in the application table
	Person ref: References the person ID in the person table
	Hearing ref: References the hearing ID in the hearing table
	Legal outcome type: The type of the legal order (e.g. care, placement, supervision)
	Legal outcome type: The date of the legal outcome
	Is final: Whether the record refers to a final legal order

Aggregation of legal order categories

Given that Cafcass does not record child placement data, and Cafcass Cymru only records final legal order data by application and not by child, we inferred the child's permanency outcomes based on the final legal order (Broadhurst et al. 2015). We created four legal order categories and ranked them according to the level of intervention, ranging from least interventionist to most interventionist (Table A.2).

Table A.2: Legal order categories

	Legal order as recorded in Cafcass	Analytical categories
1.	**Order not made**	With parents
2.	**Order of no order (ONO)**	
3.	**Supervision order (SO)**	
4.	**Family assistance order (FAO)**	
1.	**Child arrangements order (CAO)**	With family and friends
2.	**Special guardianship order (SGO)**	
1.	**Care order (CO)**	In care
1.	**Placement order (PO)**	Placed for adoption
2.	**Adoption order (AO)**	

Note: * Includes applications that were 'refused', 'dismissed' or 'suspended'.

Research dataset

The focus of the study was on s.31 proceedings under the Children Act 1989. All mothers observed between 2011/12 and 2020/21 fiscal years in England and Wales were included in the analysis.

The SQL research database was used to restructure a longitudinal dataset (see Figure A.2) by linking each mother to all of her s.31 care and supervision applications, and then linking children and their legal outcomes to their mothers' records.

Figure A.2: Research dataset: Linked episodes

The final research dataset includes the following specified in Table A.3.

Table A.3: Research dataset: Variables

Variable name	Meaning
Cafcass ID	Differentiates between Cafcass (CMS/ECMS) and Cafcass Cymru cases
Episode number	The number of the episode (Index, first repeat, second repeat)
S31 issue year	The fiscal year of the first s.31 application issue date in this episode
Mother's age at first birth	Mother's age at entry to motherhood is inferred from the age of her oldest child in a first set of proceedings, and the mother's age. We assume the mother's oldest child is her first child.
Mother's age at start of episode	The age of the mother at the start date (first s.31 application issue date) of this episode
Number of children	Number of children who are subject to this episode of proceedings
Youngest child's age	The age of the youngest subject in this episode at the start date (first s.31 issue date) of the episode
Movement between LAs	Indicates if the local authority of this episode is different from the local authority of the previous episode
Highest legal order	Inferred child's permanency outcomes based on the final legal order (see Table A.2)
Recurrence status	Differentiates between No return, Pathway 1 (return with at least 1 new child), Pathway 2 (return with a previous child)
Proceedings overlap	Indicates whether this episode started before the completion of the previous episode
Interval between proceedings	The length of time between the start of the previous episode and the start of this episode
Pregnancy interval	The length of time between mother's pregnancies. This is inferred from the birth of the youngest child in the previous episode and the birth of the oldest new child in this episode (minus 9 months for an approximate pregnancy period)
Is next proceedings	Indicates whether the mother has a further episode after this one. This is used as a *recurrence event* in the survival analysis
Survival time	The time between the start of this episode and either the start of the next episode, or the end of the observation window. This is used as the *time* in the survival analysis

Appendix B

Table B.1: Descriptive statistics, England, 2011/12–2020/21

	No return		Pathway 1 At least one new child				Pathway 2 Previous child			
	Index		Index		First repeat		Index		First repeat	
	N	[%]	N	[%]	N	[%]	N	[%]	N	[%]
Number of mothers	73,615	[100.0]	12,772	[100.0]	12,772	[100.0]	4,433	[100.0]	4,433	[100.0]
Type of s.31 application[1]										
Care order	65,789	[89.4]	11,821	[92.6]	11,599	[90.8]	3,861	[87.1]	3,743	[84.4]
Supervision order	7,826	[10.6]	951	[7.4]	1,173	[9.2]	572	[12.9]	690	[15.6]
Age of mother at first birth										
14–17 years	8,508	[11.6]	2,287	[17.9]	*NA*	*NA*	673	[15.2]	*NA*	*NA*
18–19 years	12,027	[16.3]	3,050	[23.9]	*NA*	*NA*	805	[18.2]	*NA*	*NA*
20–24 years	20,614	[28.0]	4,213	[33.0]	*NA*	*NA*	1,347	[30.4]	*NA*	*NA*
25–29 years	12,965	[17.6]	1,791	[14.0]	*NA*	*NA*	731	[16.5]	*NA*	*NA*
30+	15,872	[21.6]	1,288	[10.1]	*NA*	*NA*	801	[18.1]	*NA*	*NA*
Invalid/Missing	3,629	[4.9]	143	[1.1]	*NA*	*NA*	76	[1.7]	*NA*	*NA*
Age of mother at the start of proceedings										
14–17 years	2,095	[2.8]	623	[4.9]	98	[0.8]	120	[2.7]	36	[0.8]
18–19 years	3,894	[5.3]	1,406	[11.0]	737	[5.8]	254	[5.7]	163	[3.7]
20–24 years	12,132	[16.5]	3,766	[29.5]	3,500	[27.4]	811	[18.3]	677	[15.3]
25–29 years	13,292	[18.1]	3,058	[23.9]	3,383	[26.5]	926	[20.9]	798	[18.0]
30+	38,849	[52.8]	3,819	[29.9]	4,958	[38.8]	2,267	[51.1]	2,704	[61.0]
Invalid/Missing	3,353	[4.6]	100	[0.8]	96	[0.8]	55	[1.2]	55	[1.2]

	No return		*Pathway 1* At least one new child				*Pathway 2* Previous child			
	Index		Index		First repeat		Index		First repeat	
	N	[%]	N	[%]	N	[%]	N	[%]	N	[%]
Age of the youngest child										
< 1 month	10,251	[13.9]	2,493	[19.5]	8,754	[68.5]	581	[13.1]	356	[8.0]
1–11 months	14,163	[19.2]	3,671	[28.7]	1,890	[14.8]	825	[18.6]	210	[4.7]
1–2 years	13,786	[18.7]	3,325	[26.0]	759	[5.9]	926	[20.9]	1,001	[22.6]
3–4 years	8,237	[11.2]	1,353	[10.6]	335	[2.6]	542	[12.2]	695	[15.7]
5–9 years	13,570	[18.4]	1,214	[9.5]	422	[3.3]	776	[17.5]	1,140	[25.7]
10–15 years	12,684	[17.2]	627	[4.9]	498	[3.9]	413	[9.3]	974	[22.0]
16+	754	[1.0]	26	[0.2]	52	[0.4]	6	[0.1]	51	[1.2]
Invalid/Missing	170	[0.2]	63	[0.5]	62	[0.5]	364	[8.2]	6	[0.1]
Number of children										
1	41,441	[56.3]	7,417	[58.1]	11,094	[86.9]	1,744	[39.3]	2,854	[64.4]
≥2	32,174	[43.7]	5,355	[41.9]	1,678	[13.1]	2,689	[60.7]	1,579	[35.6]
Highest legal order										
Adoption	12,015	[16.3]	4,566	[35.8]	4,933	[38.6]	346	[7.8]	535	[12.1]
Care order	27,457	[37.3]	3,439	[26.9]	2,627	[20.6]	880	[19.9]	1,722	[38.8]
Family and friends care	19,343	[26.3]	3,570	[28.0]	2,850	[22.3]	1,339	[30.2]	890	[20.1]
Parent(s) care	9,637	[13.1]	925	[7.2]	1,620	[12.7]	1,658	[37.4]	597	[13.5]
Other	2,498	[3.4]	164	[1.3]	327	[2.6]	171	[3.9]	549	[12.4]
Invalid/Missing	2,665	[3.6]	108	[0.8]	415	[3.2]	39	[0.9]	140	[3.2]

Note: Percentages may not add to 100 due to rounding. NA = not applicable.

Table B.2: Descriptive statistics, Wales, 2011/12–2020/21

	No return		Pathway 1 At least one new child				Pathway 2 Previous child			
	Index		Index		First repeat		Index		First repeat	
	N	[%]	N	[%]	N	[%]	N	[%]	N	[%]
Number of mothers	4,717	[100.0]	777	[100.0]	777	[100.0]	143	[100.0]	143	[100.0]
Type of s.31 application[1]										
Care order	4,646	[98.5]	770	[99.1]	764	[98.3]	138	[96.5]	122	[85.3]
Supervision order	71	[1.5]	7	[0.9]	13	[1.7]	5	[3.5]	21	[14.6]
Age of mother at first birth										
14–17 years	556	[11.8]	139	[17.9]	*NA*	*NA*	18	[12.6]	*NA*	*NA*
18–19 years	810	[17.2]	185	[23.8]	*NA*	*NA*	30	[21.0]	*NA*	*NA*
20 – 24 years	1,352	[28.7]	258	[33.2]	*NA*	*NA*	38	[26.6]	*NA*	*NA*
25–29 years	821	[17.4]	114	[14.7]	*NA*	*NA*	25	[17.5]	*NA*	*NA*
30+	967	[20.5]	73	[9.4]	*NA*	*NA*	27	[18.9]	*NA*	*NA*
Invalid/Missing	211	[4.5]	8	[1.0]	*NA*	*NA*	5	[3.5]	*NA*	*NA*
Age of mother at the start of proceedings										
14–17 years	152	[3.2]	35	[4.5]	41	[5.3]	5	[3.5]	14	[9.8]
18–19 years	286	[6.1]	90	[11.6]	*	*	*	*	*	*
20–24 years	847	[18.0]	229	[29.5]	214	[27.5]	26	[18.2]	*	*
25–29 years	955	[20.2]	191	[24.6]	206	[26.5]	42	[29.4]	39	[27.3]
30+	2,289	[48.5]	227	[29.2]	311	[40.0]	65	[45.5]	85	[59.4]
Invalid/Missing	188	[4.0]	5	[0.6]	5	[0.6]	5	[3.5]	5	[3.5]
Age of the youngest child										
< 1 month	863	[18.3]	163	[20.9]	539	[69.4]	12	[8.4]	9	[6.3]
1–11 months	944	[20.0]	213	[27.4]	114	[14.7]	34	[23.8]	*	*
1–2 years	846	[17.9]	215	[27.6]	33	[4.2]	37	[25.8]	27	[18.9]
3–4 years	553	[11.7]	72	[9.2]	26	[3.3]	10	[7.0]	27	[18.9]
5–9 years	731	[15.5]	74	[9.5]	26	[3.3]	29	[20.3]	42	[29.4]
10–15 years	732	[15.5]	40	[5.1]	27	[3.5]	21	[14.7]	38	[26.6]
16+	34	[0.7]	*	*	6	[0.8]	*	*	*	*
Invalid/Missing	14	[0.0]	*	*	6	[0.8]	*	*	*	*

	No return		Pathway 1 At least one new child				Pathway 2 Previous child			
	Index		Index		First repeat		Index		First repeat	
	N	[%]	N	[%]	N	[%]	N	[%]	N	[%]
Number of children										
1	2,856	[60.5]	462	[59.5]	701	[90.2]	67	[46.8]	100	[70.0]
≥2	1,861	[39.4]	315	[40.5]	76	[9.8]	76	[53.1]	43	[30.0]

	No return		Pathway 1 At least one new child				Pathway 2 Previous child			
	Index		Index		First repeat		Index		First repeat	
	N	[%]	N	[%]	N	[%]	N	[%]	N	[%]
Highest legal order										
Adoption	634	[13.4]	204	[26.2]	203	[26.1]	10	[7.0]	12	[8.4]
Care order	2,663	[56.4]	413	[53.2]	415	[53.4]	63	[44.1]	84	[58.7]
Family and friends care	524	[11.1]	83	[10.7]	53	[6.8]	31	[21.7]	15	[10.5]
Parent(s) care	188	[3.9]	15	[1.9]	20	[2.6]	15	[10.5]	7	[5.0]
Other	212	[4.5]	22	[2.8]	23	[2.9]	10	[7.0]	14	[9.8]
Invalid/Missing	496	[10.5]	40	[5.1]	63	[8.1]	14	[9.8]	11	[7.7]

Note: Highlighted cells with an asterisk (N < 5) have been merged. Percentages may not add to 100 due to rounding. NA = Not applicable.

Table B.3: Chi-square test of the distribution of overlapping episodes pre- and post-2014

England		Wales	
Test statistics (df)	p-value	Test statistics (df)	p-value
672.2 (2)	0.000	44.2 (1)	0.000

Table B.4: Chi-square test of the distribution of legal orders pre- and post-2014

England		Wales	
Test statistics (df)	p-value	Test statistics (df)	p-value
711.4 (4)	0.000	177.6 (4)	0.000

Table B.5: Survival and hazard rates of a birth mother entering her first repeat proceedings with at least one new child in England and Wales, at yearly intervals from the date of issue of her index proceedings

England							
	Survival rate				**Hazard rate**		
N	Years	Estimate	**SE**	**95% CI**	Estimate	SE	95% CI
82,051	<1	0.943	0.000	(0.94, 0.95)	0.057	0.000	(0.05, 0.06)
77,419	<2	0.896	0.001	(0.89, 0.90)	0.051	0.000	(0.04, 0.05)
65,368	<3	0.869	0.001	(0.86, 0.87)	0.031	0.000	(0.02, 0.03)
54,762	<4	0.848	0.001	(0.84, 0.85)	0.023	0.000	(0.02, 0.03)
44,475	<5	0.833	0.002	(0.83, 0.84)	0.018	0.000	(0.01, 0.02)
34,657	<6	0.820	0.002	(0.81, 0.82)	0.015	0.000	(0.01, 0.02)
26,437	<7	0.810	0.002	(0.80, 0.81)	0.013	0.001	(0.01, 0.02)
19,620	<8	0.799	0.002	(0.79, 0.80)	0.012	0.001	(0.00, 0.01)
12,979	<9	0.791	0.002	(0.78, 0.79)	0.009	0.001	(0.00, 0.01)
6,233	<10	0.789	0.002	(0.78, 0.79)	0.003	0.001	(0.00, 0.01)
Wales							
N	Years	Estimate	**SE**	**95% CI**	Estimate	SE	95% CI
5,032	<1	0.949	0.003	(0.94, 0.96)	0.051	0.003	(0.04, 0.06)
4,779	<2	0.906	0.004	(0.89, 0.91)	0.046	0.003	(0.04, 0.05)
4,016	<3	0.878	0.005	(0.86, 0.88)	0.031	0.003	(0.03, 0.04)
3,311	<4	0.854	0.006	(0.84, 0.86)	0.027	0.003	(0.01, 0.03)
2,606	<5	0.834	0.006	(0.82, 0.84)	0.024	0.003	(0.01, 0.03)
1,935	<6	0.821	0.007	(0.80, 0.83)	0.015	0.003	(0.01, 0.03)
1,461	<7	0.810	0.007	(0.79, 0.82)	0.013	0.003	(0.01, 0.02)
1,089	<8	0.798	0.008	(0.78, 0.81)	0.014	0.004	(0.01, 0.02)
787	<9	0.790	0.008	(0.77, 0.81)	0.001	0.004	(0.00, 0.02)
428	<10	0.783	0.001	(0.76, 0.80)	0.001	0.006	(0.00, 0.02)

Note: In the life tables we report the survival rate. Recurrence rate = 1 – survival rate.

Table B.6: Survival and hazard rates of a mother entering her second repeat proceedings with at least one new child in England and Wales, at yearly intervals from the date of issue of her index proceedings

England							
	Survival rate				**Hazard rate**		
N	Years	Estimate	**SE**	**95% CI**	Estimate	SE	**95% CI**
11,620	<1	0.955	0.002	(0.952, 0.959)	0.045	0.002	(0.041, 0.049)
11,107	<2	0.856	0.003	(0.849, 0.862)	0.109	0.003	(0.103, 0.116)
8,341	<3	0.801	0.004	(0.794, 0.809)	0.065	0.003	(0.059, 0.071)
6,324	<4	0.762	0.004	(0.753, 0.770)	0.050	0.003	(0.044, 0.056)
4,581	<5	0.731	0.005	(0.721, 0.740)	0.041	0.003	(0.035, 0.058)
3,189	<6	0.707	0.005	(0.696, 0.717)	0.033	0.003	(0.026, 0.040)
2,195	<7	0.689	0.005	(0.677, 0.700)	0.025	0.004	(0.018, 0.032)
1,413	<8	0.675	0.006	(0.662, 0.687)	0.021	0.004	(0.012, 0.029)
685	<9	0.670	0.007	(0.656, 0.683)	0.007	0.004	(0.001, 0.020)
127	<10	0.670	0.007	(0.656, 0.683)	0.000	0.000	(0.000, 0.001)
Wales							
N	Years	Estimate	**SE**	**95% CI**	Estimate	SE	**95% CI**
675	<1	0.962	0.007	(0.945, 0.974)	0.037	0.008	(0.023, 0.052)
649	<2	0.884	0.012	(0.857, 0.907)	0.084	0.010	(0.060, 0.108)
484	<3	0.832	0.015	(0.799, 0.861)	0.060	0.011	(0.036, 0.084)
342	<4	0.799	0.017	(0.761, 0.831)	0.041	0.009	(0.017, 0.064)
240	<5	0.771	0.02	(0.729, 0.807)	0.035	0.012	(0.009, 0.061)
156	<6	0.748	0.022	(0.700, 0.789)	0.030	0.013	(0.001, 0.061)
105	<7	0.748	0.022	(0.700, 0.789)	0.000	0.000	(0.000, 0.001)
60	<8	0.731	0.027	(0.673, 0.781)	0.022	0.020	(0.000, 0.065)
29	<9	0.731	0.027	(0.673, 0.781)	0.000	0.000	(0.000, 0.001)
12	<10	0.731	0.028	(0.673, 0.781)	0.000	0.000	(0.000, 0.001)

Note: In the life tables we report the survival rate. Recurrence rate = 1 – survival rate.

Table B.7: Results of log-rank and Peto-Prentice tests comparing Kaplan-Meier survival curves

Index to 1st repeat			
		Wales	
Test		**Chi-square**	**p-value**
Log-rank (Mantel-Cox)	England	0.5	0.458
Peto-Prentice	England	0.7	0.377

1st repeat to 2nd repeat			
		Wales	
Test		**Chi-square**	**p-value**
Log-rank (Mantel-Cox)	England	4.4	0.036
Peto-Prentice	England	4.9	0.026

Table B.8: Results of log-rank and Peto-Prentice tests comparing Kaplan-Meier survival curves – index to first repeat vs first repeat to second repeat

England			
		1st repeat to 2nd repeat	
Test		**Chi-square**	**p-value**
Log-rank (Mantel-Cox)	Index to 1st repeat	500.4	0.000
Peto-Prentice	Index to 1st repeat	449.5	0.000

Wales			
		1st repeat to 2nd repeat	
Test		**Chi-square**	**p-value**
Log-rank (Mantel-Cox)	Index to 1st repeat	9.6	0.002
Peto-Prentice	Index to 1st repeat	8.7	0.003

Table B.9: Survival and hazard rates of a mother entering her first repeat proceedings by mother's age at first birth

England										
	Survival rate					**Hazard rate**				
Years	**14–17**	**18–19**	**20–24**	**25–29**	**30+**	**14–17**	**18–19**	**20–24**	**25–29**	**30+**
N	**10,540**	**14,451**	**23,525**	**13,949**	**16,021**	**10,540**	**14,451**	**23,525**	**13,949**	**16,021**
<1	0.922	0.924	0.934	0.955	0.971	0.081	0.078	0.067	0.045	0.029
<2	0.857	0.859	0.879	0.918	0.946	0.072	0.073	0.061	0.039	0.025
<3	0.819	0.822	0.849	0.894	0.931	0.046	0.044	0.034	0.026	0.015
<4	0.794	0.792	0.824	0.876	0.922	0.030	0.036	0.030	0.019	0.010
<5	0.774	0.773	0.805	0.861	0.915	0.025	0.025	0.022	0.017	0.007
<6	0.753	0.758	0.791	0.850	0.909	0.027	0.019	0.018	0.013	0.007
<7	0.739	0.743	0.777	0.841	0.903	0.018	0.020	0.018	0.010	0.006
<8	0.727	0.731	0.763	0.833	0.896	0.016	0.015	0.017	0.009	0.008
<9	0.720	0.716	0.755	0.827	0.892	0.009	0.020	0.010	0.007	0.003
<10	0.720	0.713	0.750	0.822	0.892	0.000	0.004	0.001	0.005	0.000
Wales										
Years	**14–17**	**18–19**	**20–24**	**25–29**	**30+**	**14–17**	**18–19**	**20–24**	**25–29**	**30+**
N	**653**	**932**	**1,475**	**847**	**943**	**653**	**932**	**1,475**	**847**	**943**
<1	0.929	0.934	0.945	0.959	0.972	0.073	0.067	0.055	0.041	0.028
<2	0.887	0.866	0.898	0.919	0.948	0.046	0.075	0.050	0.042	0.024
<3	0.833	0.840	0.865	0.899	0.933	0.063	0.030	0.038	0.022	0.016
<4	0.791	0.811	0.838	0.881	0.926	0.052	0.035	0.030	0.021	0.006
<5	0.773	0.782	0.816	0.857	0.918	0.022	0.036	0.027	0.027	0.009
<6	0.754	0.776	0.801	0.841	0.909	0.025	0.006	0.018	0.019	0.009
<7	0.750	0.752	0.785	0.837	0.906	0.005	0.032	0.019	0.004	0.004
<8	0.739	0.736	0.771	0.827	0.895	0.014	0.020	0.018	0.011	0.012
<9	0.739	0.712	0.763	0.820	0.895	0.000	0.033	0.010	0.009	0.000
<10	0.739	0.712	0.752	0.800	0.895	0.000	0.000	0.014	0.000	0.000

Note: In the life tables we report the survival rate. Recurrence rate = 1 – survival rate.

Table B.10: Results of log-rank and Peto-Prentice tests comparing Kaplan-Meier survival curves – mother's age at first birth

England									
		18–19		20–24		25–29		30+	
Test		**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**
Log-rank (Mantel-Cox)									
	14–17	0.05	0.826	46.4	0.000	327.4	0.000	1030.7	0.000
	18–19			51.8	0.000	359.8	0.000	1116.1	0.000
	20–24					190.5	0.000	834.1	0.000
	25–29							195.3	0.000
	30+								
Peto-Prentice									
	14–17	0.08	0.783	46.2	0.000	326.0	0.000	1023.2	0.000
	18–19			50.8	0.000	356.6	0.000	1105.0	0.000
	20–24					189.4	0.000	826.5	0.000
	25–29							193.4	0.000
	30+								
Wales									
		18–19		**20–24**		**25–29**		**30+**	
Test		**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**
Log-rank (Mantel-Cox)									
	14–17	0.00	0.950	3.2	0.069	14.7	0.001	55.2	0.000
	18–19			3.9	0.047	16.4	0.000	59.8	0.000
	20–24					6.5	0.010	41.8	0.000
	25–29							13.6	0.000
	30+								
Peto-Prentice									
	14–17	0.01	0.923	3.4	0.062	14.8	0.001	54.3	0.000
	18–19			4.0	0.045	16.3	0.000	58.8	0.000
	20–24					6.4	0.010	40.9	0.000
	25–29							13.3	0.000
	30+								

Table B.11: Survival and hazard rates of a mother entering her first repeat proceedings by highest legal order

England										
	Survival rate					Hazard rate				
Years	Adoption	Care order	Family and friends care	Parent(s) care	Other	Adoption	Care order	Family and friends care	Parent(s) care	Other
N	16,211	29,471	22,195	11,276	2,456	16,211	29,471	22,195	11,276	2,456
<1	0.910	0.951	0.944	0.969	0.958	0.093	0.050	0.057	0.031	0.042
<2	0.814	0.920	0.894	0.947	0.942	0.111	0.032	0.053	0.022	0.016
<3	0.764	0.901	0.866	0.931	0.934	0.063	0.021	0.032	0.017	0.008
<4	0.734	0.886	0.842	0.915	0.931	0.039	0.016	0.028	0.017	0.004
<5	0.713	0.875	0.825	0.902	0.926	0.028	0.012	0.020	0.016	0.005
<6	0.697	0.866	0.809	0.890	0.918	0.023	0.010	0.019	0.011	0.008
<7	0.684	0.859	0.795	0.877	0.913	0.018	0.008	0.017	0.014	0.005
<8	0.670	0.850	0.785	0.870	0.913	0.020	0.010	0.012	0.008	0.000
<9	0.662	0.843	0.778	0.862	0.910	0.012	0.008	0.008	0.008	0.003
<10	0.660	0.840	0.777	0.857	0.910	0.002	0.004	0.001	0.006	0.000
Wales										
Years	Adoption	Care order	Family and friends care	Parent(s) care	Other	Adoption	Care order	Family and friends care	Parent(s) care	Other
N	783	2,798	575	188	209	783	2,798	575	188	209
<1	0.924	0.946	0.963	0.973	0.966	0.078	0.054	0.037	0.027	0.034
<2	0.851	0.903	0.918	0.967	0.946	0.082	0.047	0.048	0.005	0.021
<3	0.810	0.877	0.881	0.944	0.934	0.049	0.029	0.040	0.025	0.012
<4	0.771	0.853	0.859	0.944	0.921	0.049	0.027	0.025	0.000	0.014
<5	0.741	0.837	0.841	0.920	0.903	0.039	0.019	0.021	0.025	0.019
<6	0.728	0.821	0.833	0.920	0.892	0.017	0.018	0.009	0.000	0.012
<7	0.718	0.812	0.808	0.910	0.892	0.014	0.010	0.031	0.013	0.000
<8	0.698	0.806	0.801	0.892	0.834	0.027	0.007	0.008	0.017	0.066
<9	0.689	0.800	0.789	0.892	0.834	0.013	0.008	0.014	0.000	0.000
<10	0.689	0.791	0.789	0.892	0.834	0.000	0.018	0.000	0.000	0.000

Note: In the life tables we report the survival rate. Recurrence rate = 1 – survival rate. < = less than.

Table B.12: Results of log-rank and Peto-Prentice tests comparing Kaplan-Meier survival curves – legal order

		England							
		Care order		Family and friends care		Parent(s) care		Other	
Test		**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**
Log-rank (Mantel-Cox)									
	Adoption	1736.7	0.000	632.2	0.000	1298.8	0.000	402.1	0.000
	Care order			229.3	0.000	48.5	0.000	43.1	0.000
	Family and friends care					315.1	0.000	133.3	0.000
	Parent(s) care							10.2	0.001
	Other								
Peto-Prentice									
	Adoption	1701.7	0.000	637.2	0.000	1307.8	0.000	384.8	0.000
	Care order			218.6	0.000	51.7	0.000	40.9	0.000
	Family and friends care					317.6	0.000	126.5	0.000
	Parent(s) care							8.9	0.002
	Other								
		Wales							
Test		**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**
Log-rank (Mantel-Cox)									
	Adoption	32.1	0.000	16.7	0.000	25.6	0.000	18.7	0.000
	Care order			0.1	0.757	9.3	0.002	4.6	0.032
	Family and friends care					7.8	0.005	3.4	0.065
	Parent(s) care							1	0.310
	Other								
Peto-Prentice									
	Adoption	31.5	0.000	17.3	0.000	25.7	0.000	19.1	0.000
	Care order			0.2	0.69	9.5	0.002	4.8	0.028
	Family and friends care					7.8	0.005	3.5	0.062
	Parent(s) care							0.9	0.320
	Other								

Table B.13: Survival and hazard rates of a mother entering her first repeat proceedings before and after 2014

		England		
	Survival rate		Hazard rate	
Years	Pre-2014	Post-2014	Pre-2014	Post-2014
N	24,454	57,597	24,454	57,597
>1	0.943	0.944	0.058	0.057
>2	0.893	0.898	0.054	0.049
>3	0.865	0.871	0.032	0.030
>4	0.843	0.851	0.025	0.022
>5	0.826	0.838	0.019	0.016
		Wales		
	Survival rate		Hazard rate	
Years	Pre-2014	Post-2014	Pre-2014	Post-2014
N	1,325	3,707	1,325	3,707
>1	0.959	0.946	0.041	0.054
>2	0.918	0.902	0.043	0.047
>3	0.886	0.875	0.035	0.030
>4	0.869	0.848	0.019	0.031
>5	0.845	0.831	0.028	0.020

Note: In the life tables we report the survival rate. Recurrence rate = 1 – survival rate. < = less than.

Table B.14: Results of log-rank and Peto-Prentice tests comparing Kaplan-Meier survival curves before and after 2014

	England	
Test	**Chi-square**	**p-value**
Log-rank (Mantel-Cox)		
	13.7	0.002
Peto-Prentice		
	12.5	0.000

	Wales	
Test	**Chi-square**	**p-value**
Log-rank (Mantel-Cox)		
	1.7	0.185
Peto-Prentice		
	1.9	0.168

Table B.15: Survival and hazard rates of a mother entering her first repeat proceedings in England by region

					England				
Survival rate									
Years	**East Midlands**	**East of England**	**London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire and the Humber**
N	**6,439**	**7,332**	**11,608**	**6,762**	**13,793**	**10,768**	**7,301**	**8,924**	**9,115**
<1	0.940	0.947	0.957	0.951	0.937	0.945	0.952	0.929	0.936
<2	0.883	0.902	0.921	0.903	0.886	0.903	0.909	0.874	0.884
<3	0.854	0.876	0.898	0.875	0.858	0.875	0.884	0.842	0.855
<4	0.833	0.859	0.880	0.851	0.838	0.853	0.860	0.821	0.835
<5	0.816	0.846	0.869	0.830	0.824	0.839	0.846	0.803	0.816
<6	0.804	0.833	0.857	0.814	0.810	0.828	0.835	0.792	0.800
<7	0.791	0.824	0.847	0.796	0.799	0.820	0.824	0.781	0.787
<8	0.780	0.812	0.840	0.779	0.789	0.807	0.816	0.774	0.775
<9	0.769	0.806	0.834	0.764	0.780	0.805	0.811	0.767	0.771
<10	0.766	0.806	0.832	0.758	0.776	0.799	0.811	0.765	0.771
Hazard rate									
Years	**East Midlands**	**East of England**	**London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire and The Humber**
N	**6,439**	**7,332**	**11,608**	**6,762**	**13,793**	**10,768**	**7,301**	**8,924**	**9,115**
<1	0.061	0.053	0.043	0.050	0.064	0.056	0.048	0.073	0.065
<2	0.062	0.049	0.038	0.051	0.055	0.044	0.046	0.060	0.057
<3	0.033	0.028	0.024	0.031	0.032	0.031	0.027	0.037	0.033
<4	0.024	0.019	0.020	0.028	0.023	0.025	0.027	0.025	0.023
<5	0.020	0.015	0.013	0.024	0.017	0.016	0.016	0.021	0.023
<6	0.015	0.016	0.014	0.019	0.016	0.013	0.013	0.014	0.019
<7	0.016	0.010	0.011	0.022	0.013	0.010	0.012	0.013	0.017
<8	0.013	0.014	0.008	0.022	0.013	0.015	0.009	0.008	0.014
<9	0.015	0.006	0.008	0.019	0.011	0.003	0.007	0.009	0.006
<10	0.004	0.000	0.002	0.007	0.004	0.007	0.000	0.003	0.000

Note: In the life tables we report the survival rate. Recurrence rate = 1 – survival rate. < = less than.

Table B.16: Results of log-rank and Peto-Prentice tests comparing Kaplan-Meier survival curves by fiscal year

		England											
		12/13		13/14		14/15		15/16		16/17		17/18	
Test		**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**
Log-rank (Mantel-Cox)													
	2011/12	5.0	0.025	20.6	0.000	6.5	0.010	8.4	0.003	6.7	0.009	27.3	0.000
	2012/13			5.6	0.018	0.1	0.720	0.3	0.552	0.1	0.827	8.3	0.004
	2013/14					3.9	0.047	3.4	0.065	5.2	0.022	0.1	0.728
	2014/15							0.1	0.826	0.0	0.871	6.1	0.013
	2015/16									0.1	0.685	5.5	0.019
	2016/17											8.0	0.004
	2017/18												
Peto-Prentice													
	2011/12	4.4	0.035	19.5	0.000	6.2	0.012	7.7	0.005	5.9	0.014	25.2	0.000
	2012/13			5.5	0.018	0.2	0.683	0.4	0.540	0.0	0.835	7.9	0.004
	2013/14					3.7	0.053	3.3	0.069	5.2	0.022	0.1	0.767
	2014/15							0.0	0.851	0.1	0.823	5.6	0.018
	2015/16									0.2	0.663	5.1	0.024
	2016/17											7.6	0.005
	2017/18												

		Wales											
		12/13		13/14		14/15		15/16		16/17		17/18	
Test		**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**	**Chi-square**	**p-value**
Log-rank (Mantel-Cox)													
	2011/12	1.4	0.230	3.4	0.065	4.4	0.036	4.3	0.038	5.0	0.024	2.1	0.145
	2012/13			0.4	0.494	0.7	0.380	0.6	0.423	0.8	0.362	0.0	0.884
	2013/14					0.0	0.879	0.0	0.958	0.0	0.910	0.4	0.543
	2014/15							0.0	0.906	0.0	0.952	0.7	0.410
	2015/16									0.0	0.944	0.5	0.459
	2016/17											0.7	0.386
	2017/18												
Peto-Prentice													
	2011/12	1.3	0.241	3.3	0.068	4.3	0.037	4.2	0.039	5.1	0.024	2.2	0.135
	2012/13			0.5	0.486	0.8	0.369	0.6	0.408	0.9	0.334	0.1	0.824
	2013/14					0.0	0.873	0.0	0.943	0.0	0.881	0.4	0.587
	2014/15							0.0	0.911	0.0	0.976	0.6	0.445
	2015/16									0.0	0.925	0.5	0.498
	2016/17											0.7	0.410
	2017/18												

Table B.17: Outcomes for women who became pregnant while completing the programme at Pause in Hackney, London (2013–2022)

	N	**[%]**
Total number of infants	22	[100.0]
Outcomes		
Permanent removals	8	[36.4]
Mother's care	14	[63.6]

Note: Data on the total number of mothers who became pregnant during the programme in Hackney 2013–2022 is unavailable.

Table B.18: Outcomes for women who gave birth in the three years following the completion of the programme at Pause in Hackney, London (2013–2022)

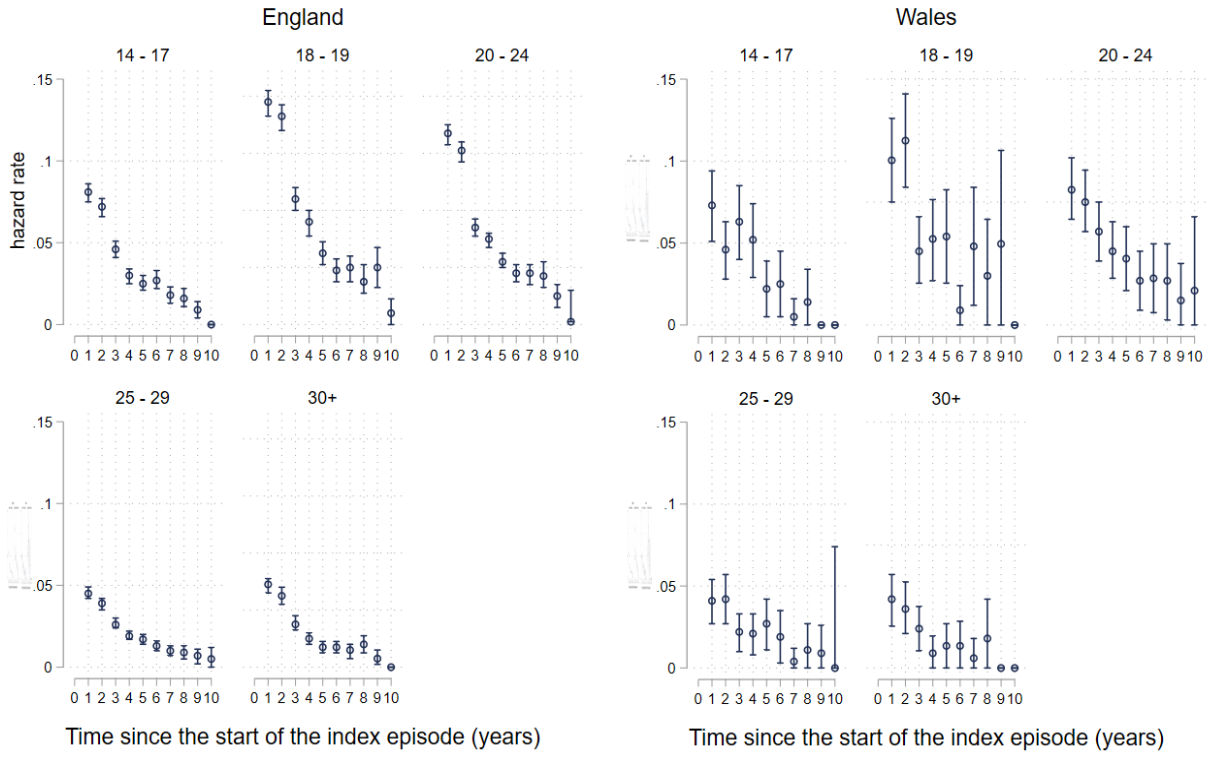
	N	[%]
Total number of infants	60	[100.0]
Outcomes		
Permanent removals	15	[25.0]
Mothers Care	40	[66.7]
Unknown	5	[8.3]

Note: Pause does not always remain in contact with women who have completed the programme.[38] This means that these figures are based on women who have notified Pause of the birth of a new child. Data on all the women who gave birth in the three years following the completion of Pause in Hackney between 2013 and 2022 is unavailable.

[38] For example, if women do not consent, if women relocate, or if a Pause practice closes.

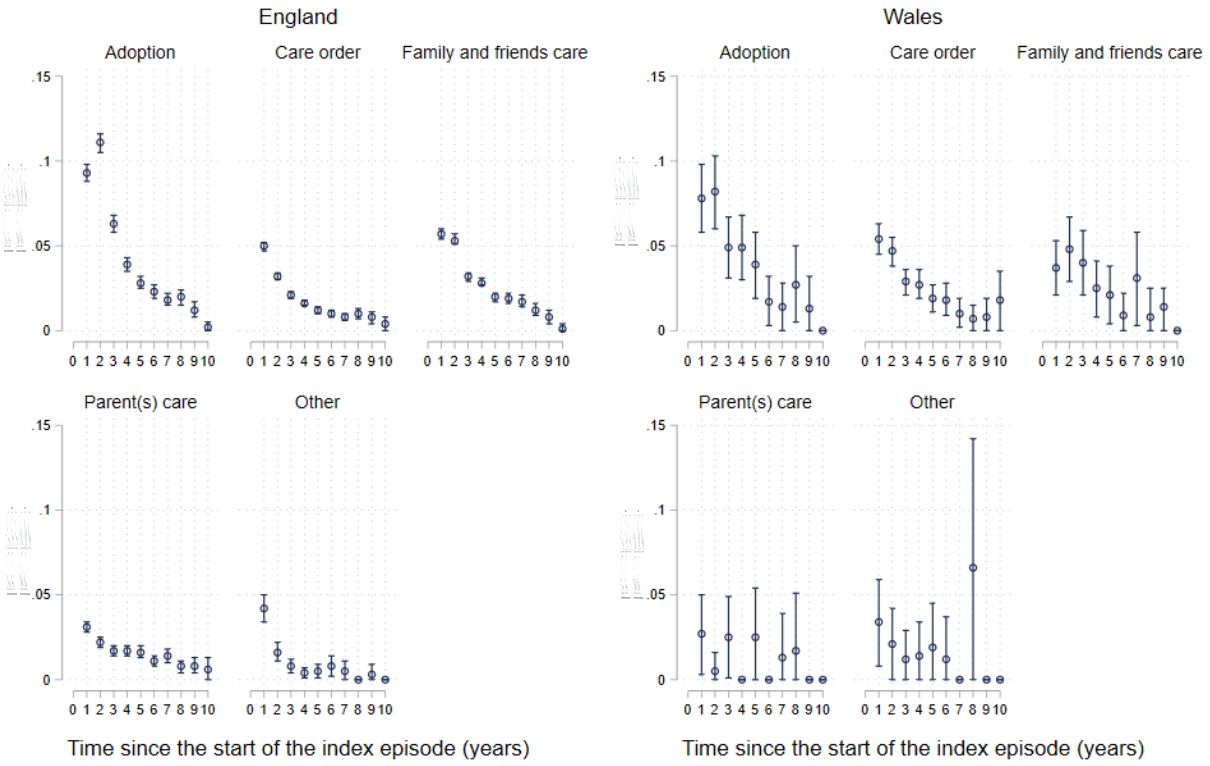
Appendix C

Figure C.1: Hazard rates, stratified by mothers' age at first birth



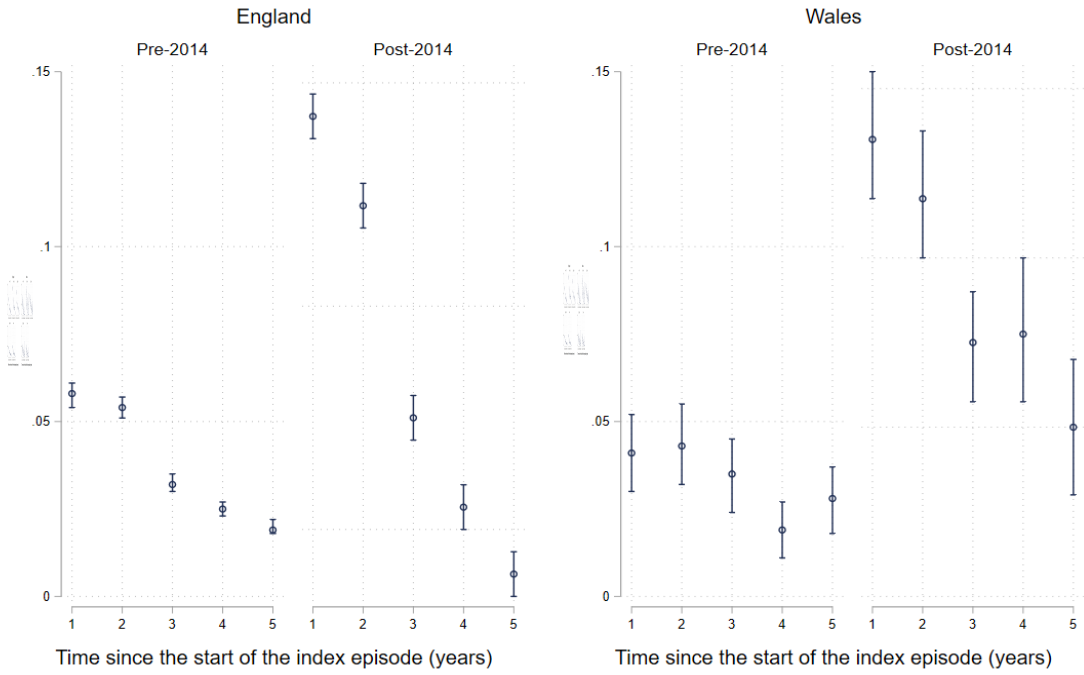
Note: Blue bands indicate 95% confidence intervals.

Figure C.2: Hazard rates, stratified by legal order outcomes



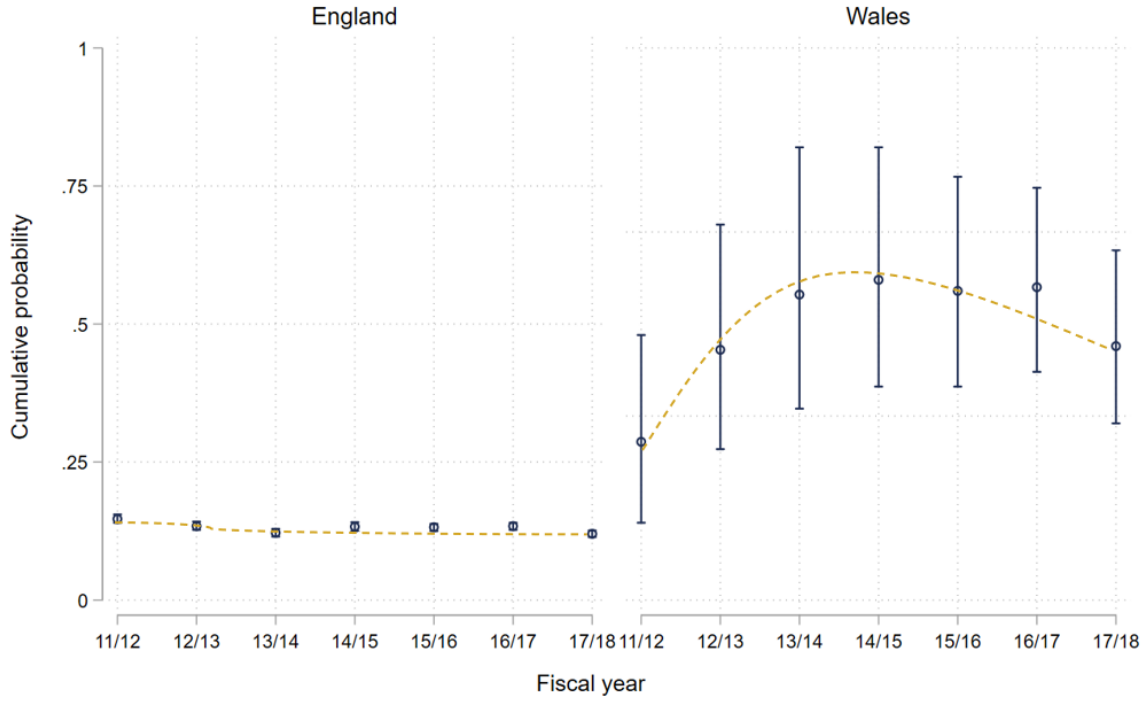
Note: Blue bands indicate 95% confidence intervals.

Figure C.3: Hazard rates, stratified by pre- and post-2014



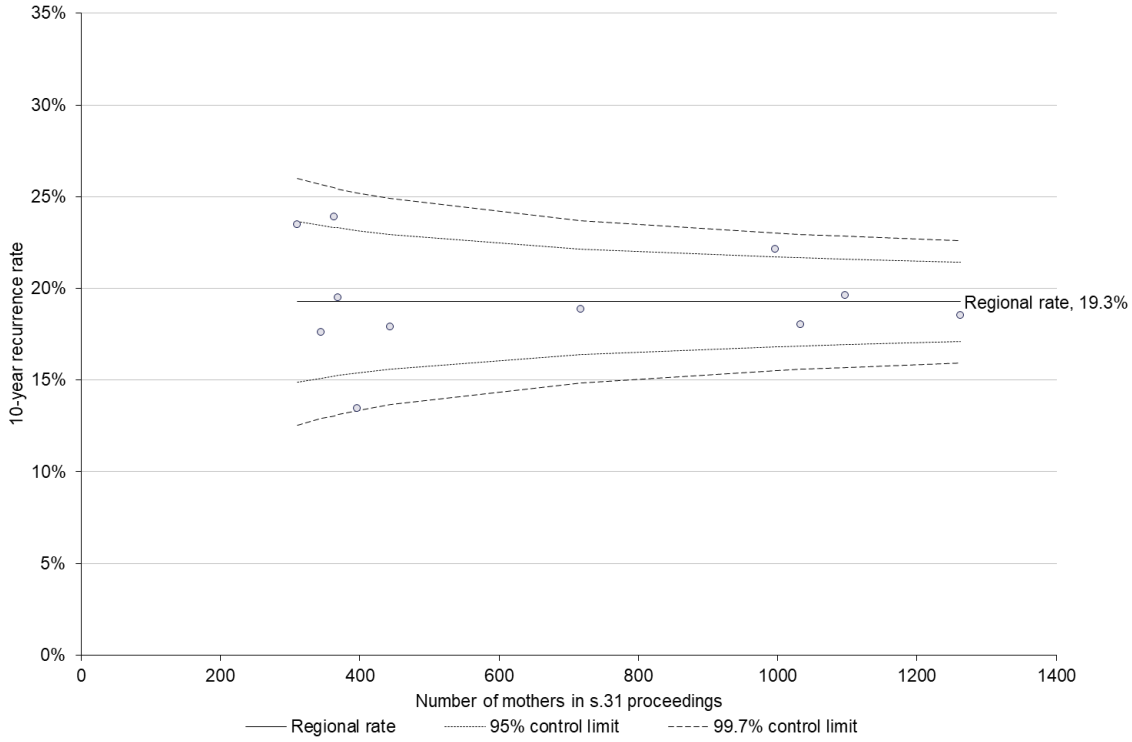
Note: Based on five-years follow-up. Blue bands indicate 95% confidence intervals.

Figure C.4: Three-year probability of recurrence



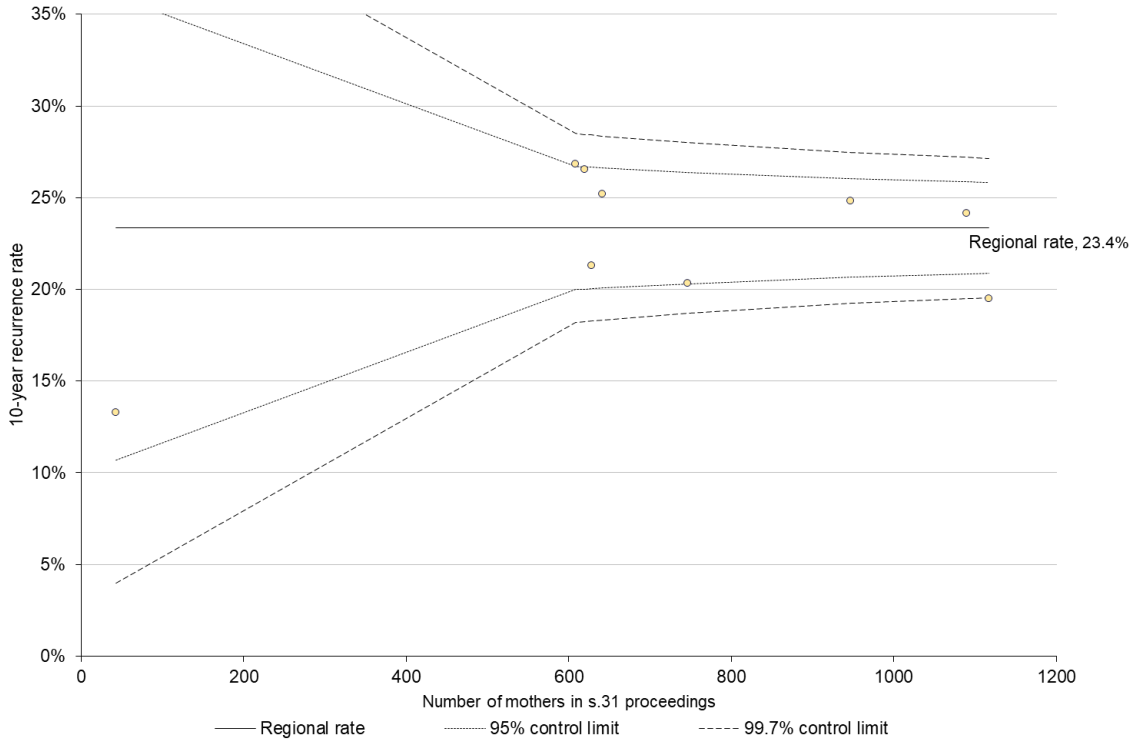
Note: The plot is based on three years' follow-up; therefore, we exclude the 2018/19 and 2019/2020 fiscal years. Blue bands indicate 95% confidence intervals.

Figure C.5: Funnel plot of the probability of recurrence in East England by local authority



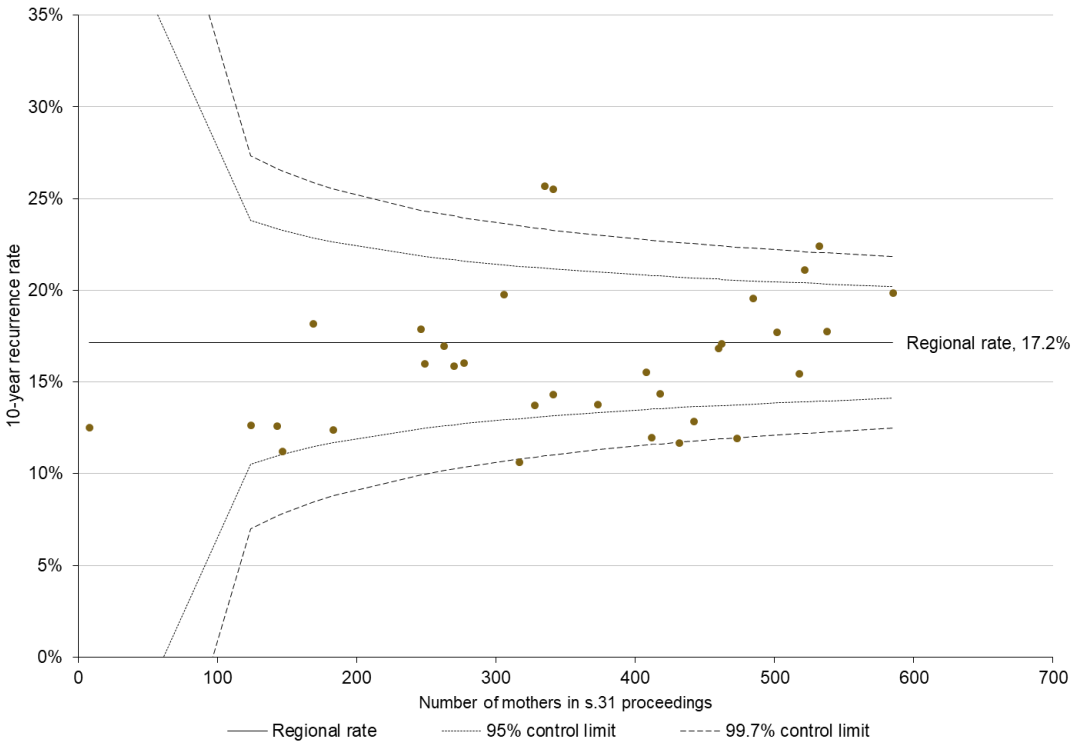
Note: Funnel plot shows all local authorities in East England.

Figure C.6: Funnel plot of the probability of recurrence in East Midlands by local authority



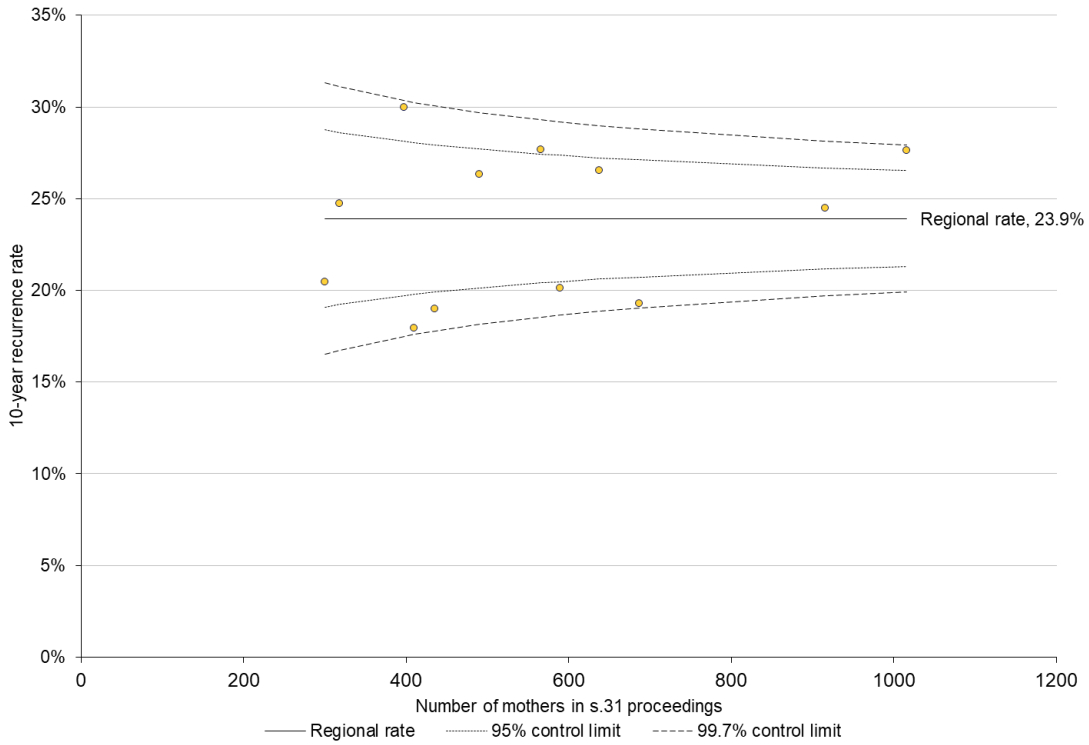
Note: Funnel plot shows all local authorities in East Midlands.

Figure C.7: Funnel plot of the probability of recurrence in London by local authority



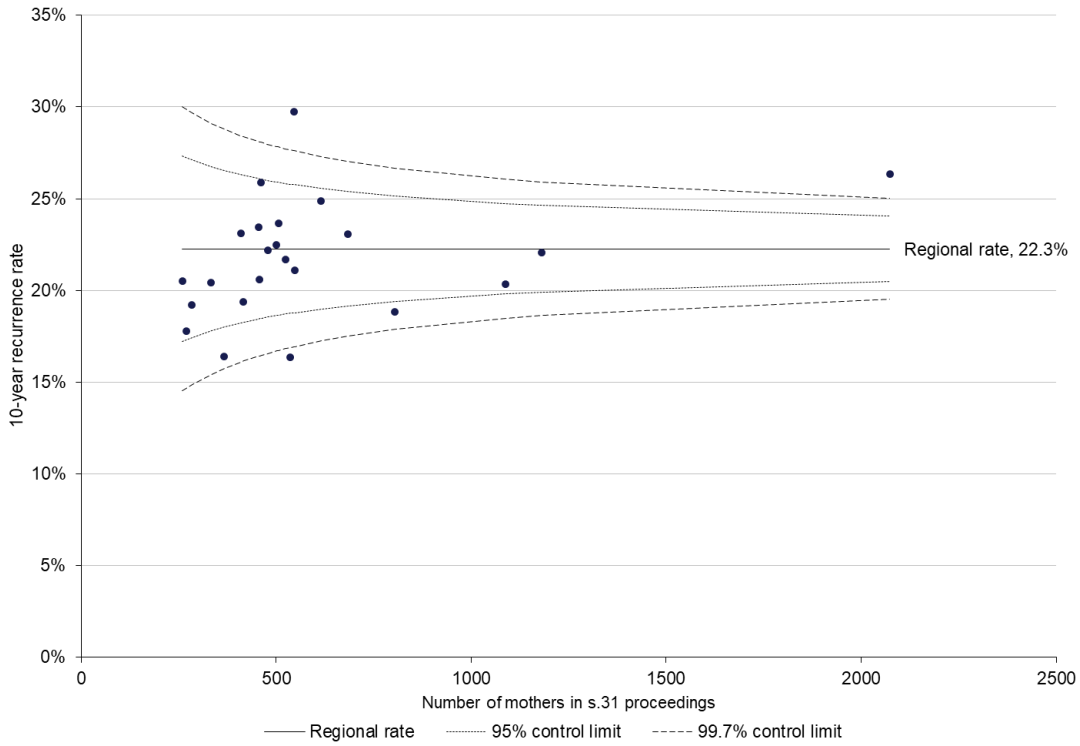
Note: Funnel plot shows all local authorities in London.

Figure C.8: Funnel plot of the probability of recurrence in the North East by local authority



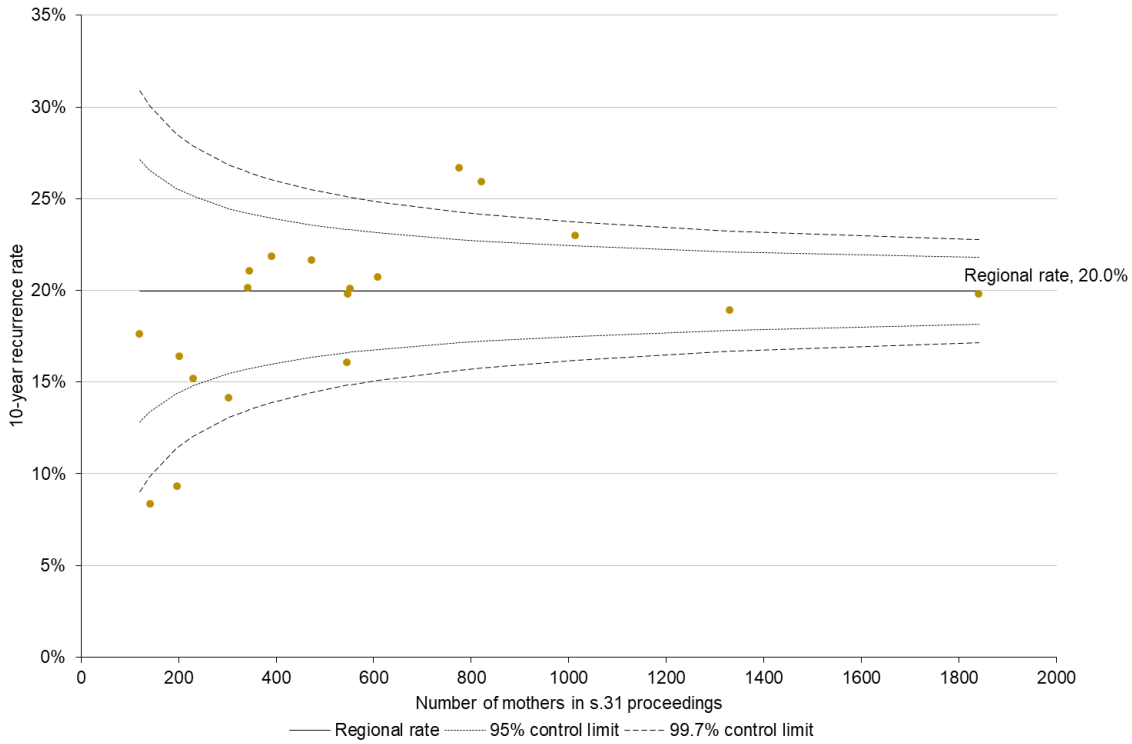
Note: Funnel plot shows all local authorities in the North East.

Figure C.9: Funnel plot of the probability of recurrence in the North West by local authority



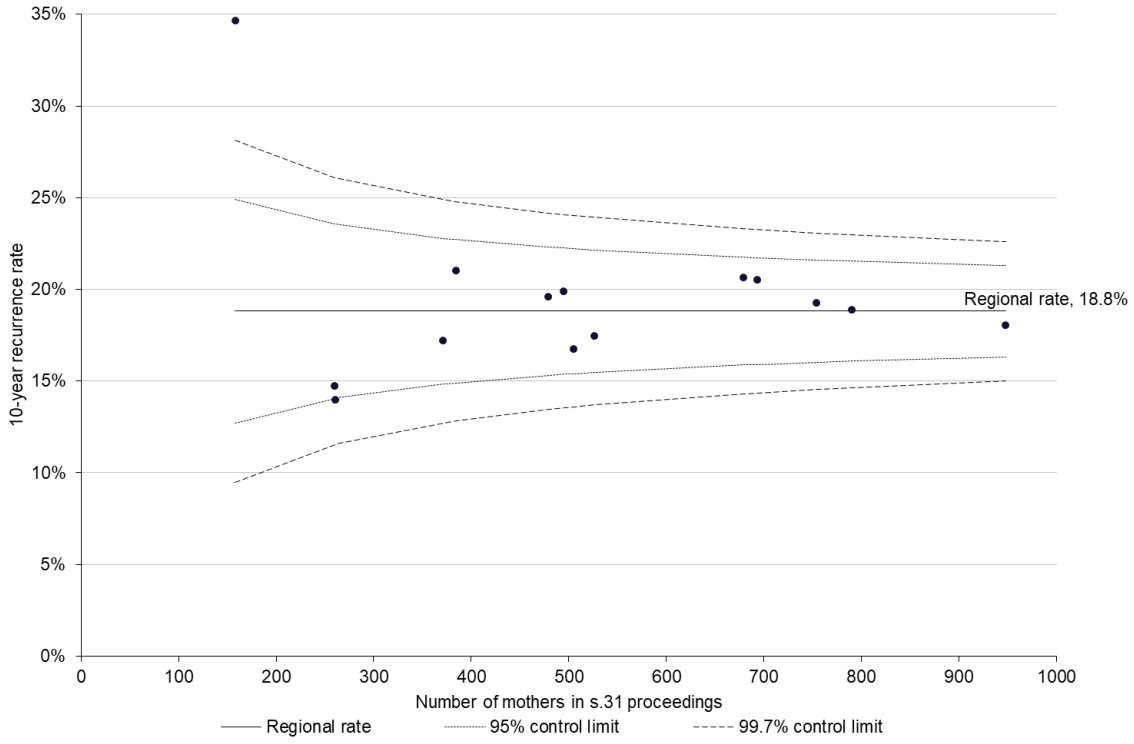
Note: Funnel plot shows all local authorities in the North West.

Figure C.10: Funnel plot of the probability of recurrence in the South East by local authority



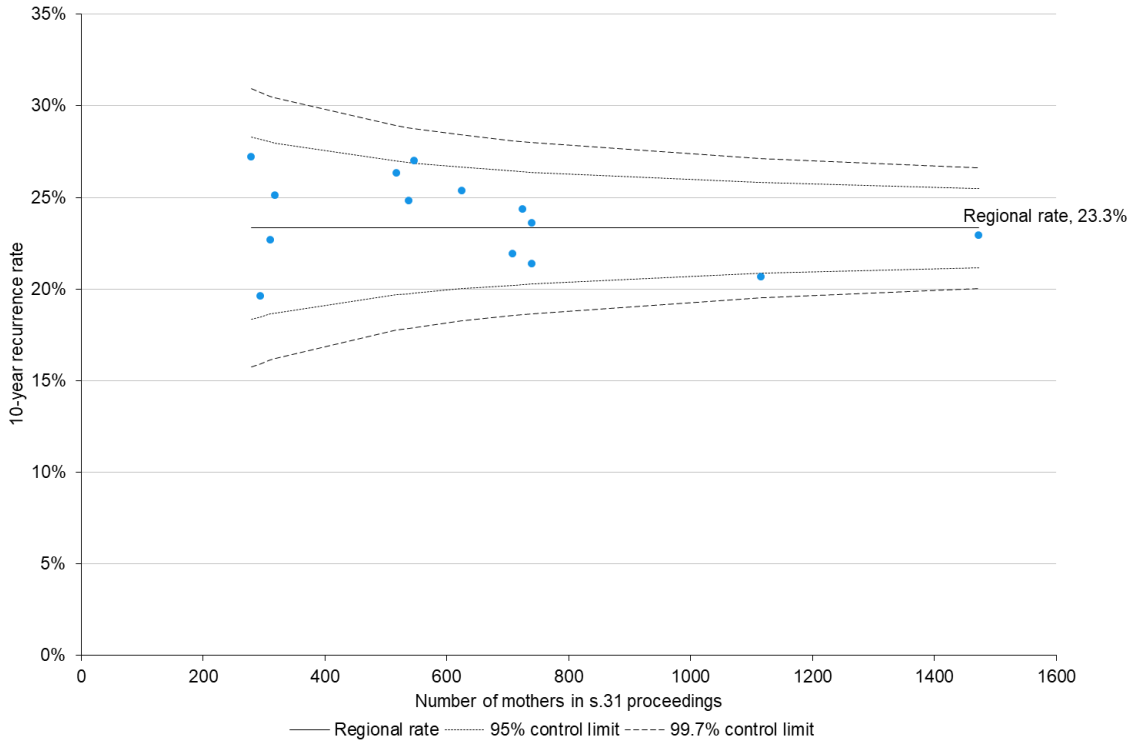
Note: Funnel plot shows all local authorities in the South East.

Figure C.11: Funnel plot of the probability of recurrence in the South West by local authority



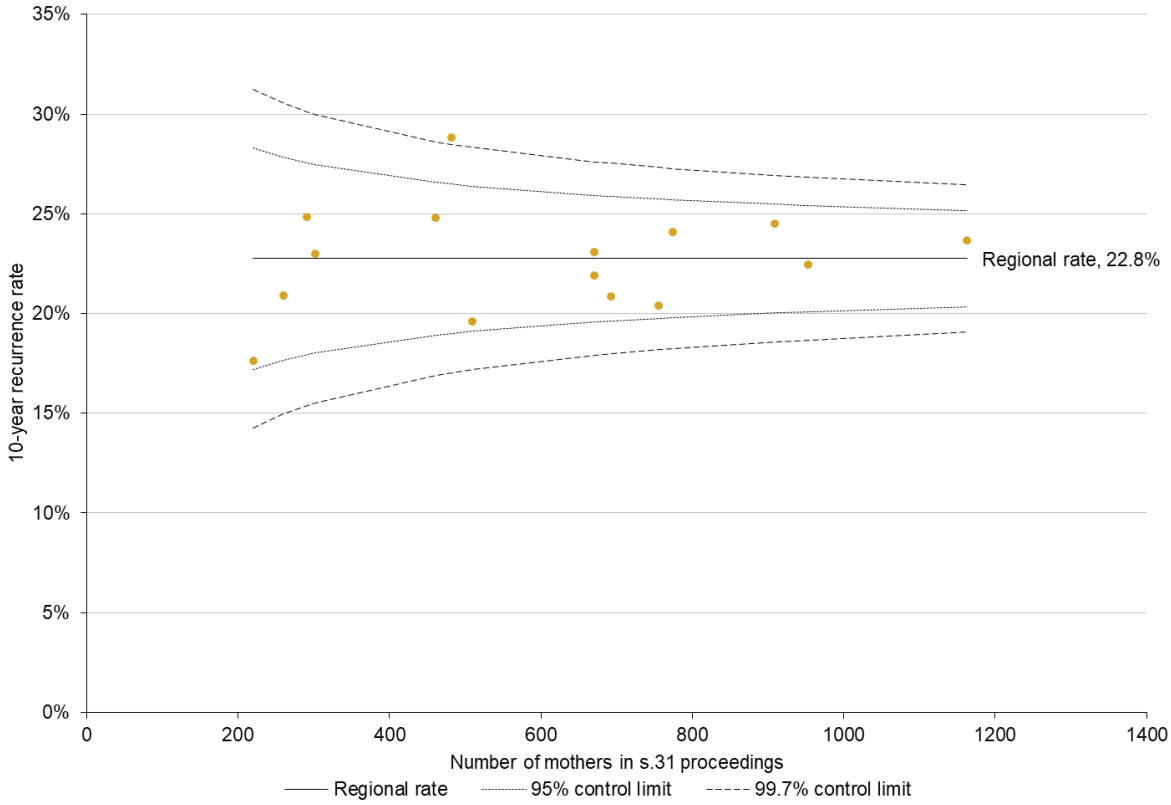
Note: Funnel plot shows all local authorities in the South West.

Figure C.12: Funnel plot of the probability of recurrence in the West Midlands by local authority



Note: Funnel plot shows all local authorities in the West Midlands.

Figure C.13: Funnel plot of the probability of recurrence in Yorkshire and the Humber by local authority



Note: Funnel plot shows all local authorities in Yorkshire and the Humber.

Nuffield Family Justice Observatory

Nuffield Family Justice Observatory (Nuffield FJO) aims to support the best possible decisions for children by improving the use of data and research evidence in the family justice system in England and Wales. Covering both public and private law, Nuffield FJO provides accessible analysis and research for professionals working in the family courts.

Nuffield FJO was established by the Nuffield Foundation, an independent charitable trust with a mission to advance social well-being. The Foundation funds research that informs social policy, primarily in education, welfare, and justice. It also funds student programmes for young people to develop skills and confidence in quantitative and scientific methods. The Nuffield

Foundation is the founder and co-funder of the Ada Lovelace Institute and the Nuffield Council on Bioethics.

Family Justice Data Partnership

The Family Justice Data Partnership is a collaboration between Lancaster University and Swansea University, with Cafcass and Cafcass Cymru as integral stakeholders. It is funded by Nuffield Family Justice Observatory.

SAIL Databank

Cafcass [England] and Cafcass Cymru data used in this study is available from the Secure Anonymised Information Linkage (SAIL) Databank at Swansea University, Swansea, UK, which is part of the national e-health records research infrastructure for Wales. All proposals to use this data are subject to review and approval by the SAIL Information Governance Review Panel (IGRP). When access has been granted, it is gained through a privacy-protecting safe-haven and remote access system, referred to as the SAIL Gateway. Anyone wishing to access data should follow the application process guidelines available at: www.saildatabank.com/application-process

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