The Children Act 2004[1] provided the legislative framework for the original Child Death Overview Panels (CDOPs) which were established in North and South of Tyne in 2008 and which were supported by well-established local child death review arrangements and reporting arrangements into the Local Safeguarding Children Boards (LSCBs). However, new legislation, the Children and Social Work Act 2017[2] has resulted in amendments to the Children Act 2004 and subsequently changes to the statutory responsibilities for child death reviews.

The responsibility for ensuring child death reviews are carried out is now held by the "***child death review partners***", who, in relation to a local authority area in England, are defined as the local authority (LA) for that area and any clinical commissioning groups (CCG) operating in the LA area.

The CDR partners must make arrangements to carry out child death reviews and these arrangements should result in the establishment of a CDOP or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate, the deaths in that area of non-resident children. The CDOP should cover a geographical footprint that enables it to typically review at least 60 child deaths per year.

In order to comply with the statutory guidance[3] the CDR partners for the following localities have agreed to establish one CDOP to cover their combined geographical footprint:

- Northumberland
- North Tyneside
- Newcastle
- Gateshead
- South Tyneside
- Sunderland

This CDOP, to be known as the ***North and South of Tyne CDOP,*** (the CDOP) will typically review at least 60 deaths per year which will better enable thematic learning

[1] CA 2004
[2] Children & SW Act 2017
[3] Child Death review Statutory Guidance 2018: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

in order to identify potential safeguarding or local health issues that could be modified in order to protect children from harm and, ultimately, save lives.

The CDOP will carry out its functions mindful of the potential impact upon the bereaved family and in accordance with the CDR Statutory Guidance. The CDOP is the final assurance point once all multi-agency information has been collected, collated and analysed at a local level via the Child Death Review Meeting and professionals who have known the child and family, including the key worker.

In preparation for the establishment of one CDOP the CCGs have commissioned eCDOP to support them in the collation of information and learning. Preliminary use of this system has started and a process is in place to ensure that any cases not completed are uploaded onto this system by January 2020.

A working group has been established across the 6 LA areas. It has developed a comprehensive implementation plan which covers:

- Leadership
- Organisational Alignment
- Learning
- Performance and Quality Assurance Framework
- Communication
- Review/Evaluation of Arrangements
- Voice of the parent/family/carer

The group has ensured that both CDOPs are working consistently in preparation for their first joint panel in early 2020.

The progress of the implementation plan is being monitored by the statutory partners and the Tyne, Wear and Northumberland Safeguarding Partnership.

Link to the Child Death Review leaflet: '*When a child dies: A guide for parents and carers'* which explains the process for parents and carers and provides information on support services: https://www.england.nhs.uk/wp-content/uploads/2018/07/parent-leaflet-child-death-review-v2.pdf