An Interview With Dr. Michael Durfee

Carolyn Beeler

In 1977, Michael Durfee was working as a child psychiatrist in the Los Angeles County foster care program when he initiated the first child death review. The project started small; he recruited a public health nurse to help him go through coroner's reports. Reviewing the cases, he says, was a way for him to cope with the fear of a child dying under his care, and an attempt to hold accountable those persons charged with protecting children.

The following year, Durfee launched the first organized, multi-agency child death review process. He thought that the anger people naturally feel when a child dies could potentially be channeled into something positive. If he could get the involved professionals to meet together, they could share what they knew about the child, and they might also find out what went wrong and how they had missed it. A group would also have the strength to face an issue individuals don't typically want to deal with.

For the first review group, Durfee gathered representatives from the Los Angeles police department, the sheriff's office, the coroner's office, and the district attorneys office, as well as workers in child protective services, mental health, and public health. Durfee indicates that at first, they were hesitant to talk about child deaths, but they soon saw the value in the reviews.

His model caught on. In 1982, the second child death review group was launched in San Diego County. Since then, teams have been organized in every U.S. state as well as in Canada, Australia, New Zealand, Hong Kong, Singapore, Japan, the UK, Lebanon, Malaysia, and the Philippines.

The *APSAC Advisor* spoke to Dr. Durfee about the evolution of child death review over the last 30 years. We have included a summary of his responses.

What are the greatest advancements that have been made in child death reviews since the first one you started in 1978?
First, there's more acknowledgment among the general public and among professionals that child abuse and child death exist. That allows teams to grow, and it gives their work more acceptance in the community. I could not have started this in 1968. At that time, there wasn't the cultural ability to accept new ideas about the potential for parents to seriously harm their children. And now, I think the review groups have encouraged even more acceptance by making child death something we can talk about and deal with.

Second, child death review is a fairly simple, self-sustaining process. Reviewing cases one by one allows agencies to share what they know about a child and family. The simplicity of the model, combined with the growing cultural acknowledgement of child death, helped to expand the model to 11 nations with almost no major source of support. Very few interventions have done that.

What are the elements of a successful child death review?

- **An inclusive case intake policy.** You need inclusive intake so you're not just looking at the notorious cases. In an ideal world, you'd look at all coroners' cases for people under age 18. If you have a 16-year-old who everyone knows committed suicide, and you're not sure if she was pregnant, you need to ask, "I wonder if she was molested and that's why she killed herself." You have to look at all the cases, not just the ones you want to, so cases don't fall through the cracks.
- **A review group that incorporates all professionals who were involved with the family.** Every group and agency that was involved with the case should be at the review. Preferably, you need to have line-level workers from all the agencies there.
- **A good system to collect and share information.** If you have five agencies that know the same family, you need to have one central way to share all that is known about that family. The most common way is to talk about it—which is better than nothing—but it's even better to put all that information into a database for everyone's reference.
- **A program to address nonfatal severe cases.** Some states already have these, and many death review groups also occasionally look at nonfatal severe cases. But there needs to be a systematic, organized review of all serious nonfatal cases. A child shouldn't have to die before agencies work with each other.
- **Grief and mourning programming for kids and families.** An ideal child death review program would have a systematic intake program for kids and families who are traumatized, including programming, like kids' groups and parents' groups that meet following a child death.
- **A way to meet other child death review teams in the area.** If you meet other teams, you may ask yourself, "Should we do what they're doing?" And it also creates connections among people in different jurisdictions, so if there's a multi-county case, line workers can talk to each other and communicate rather than going through managers, or not talking at all.

Child death reviews have been conducted for more than 30 years. What are some of the remaining challenges?
There's a major technical deficit with child death reviews: the failure to systematically act on lessons that come from the death.

Why is that?
To really learn from what we're doing, we have to examine ourselves, and we don't want to do that. If you unearth an old case to review and reveal that it was mismanaged, what are you going to do with that? Do you tell the defense the wrong guy is in jail; do you admit that your agency was at fault? Georgia's child death review team got an outside group (Emory University) to do an evaluation of their program, and I would recommend that for all teams.

In a perfect world with unlimited resources, what would child death reviews look like?
In a perfect world, groups would be more focused, their outcomes would be more predictable, and their activities would be more integrated—both within the group and with other programs. Part of this would be because of new computer programs and software. But the biggest change in a perfect world would be that teams would be tolerant of failure. If I can't say "I screwed up" in a child death review, there's a limited amount of learning that can happen for the future. Some people tell me they don't point fingers. I say, "If I screw up and a kid dies, you're going to be *nice* to me?" Pointing fingers is ok when it's done constructively and without placing blame. We keep score when young children play sports. We can measure ourselves when we address the death of a child. We must be able to learn from our mistakes.

Michael Durfee, MD, is retired after having worked with child abuse programs for 35 years. He now serves as the chief consultant to the ICAN National Center on Child Fatality Review.

About the Author
Carolyn Beeler is a freelance journalist. She works in both print and public radio and enjoys reporting on issues of social inequality. She has worked for National Public Radio, National Geographic Traveler, and Condé Nast Traveler.