Understanding California's Child Fatality Surveillance System (CCFSS) Data

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Background

Access to and an understanding of child death data is critical to state and community efforts to prevent and reduce childhood fatalities in California[1]. The California Child Fatality Surveillance System (CCFSS)[2], formerly known as the Fatal Child Abuse and Neglect Surveillance (FCANS) System, is used to track data on child fatalities that occur in California. The California Department of Public Health, Injury and Violence Prevention Branch provides limited reimbursement ($150 per case) to counties that voluntarily submit child fatality data into the CCFSS[3]. Submission of all child fatality cases into the CCFSS can support California's Child Death Review Teams' (CDRT) efforts to improve the investigation of fatal child abuse and neglect cases, as well as other child fatalities, and identify where opportunities exist to prevent and reduce child death.

To learn more about California's child fatality review and surveillance responsibilities, please reference Penal Code §11174.32.

[1] The term "child" is defined in this resource as individuals under the age of 18.

[2] This system was formerly known as the Fatal Child Abuse and Neglect Surveillance (FCANS) Program.

[3] Funding for reimbursement is $150 per case submitted and available on a first come, first serve basis, until funds are expended.

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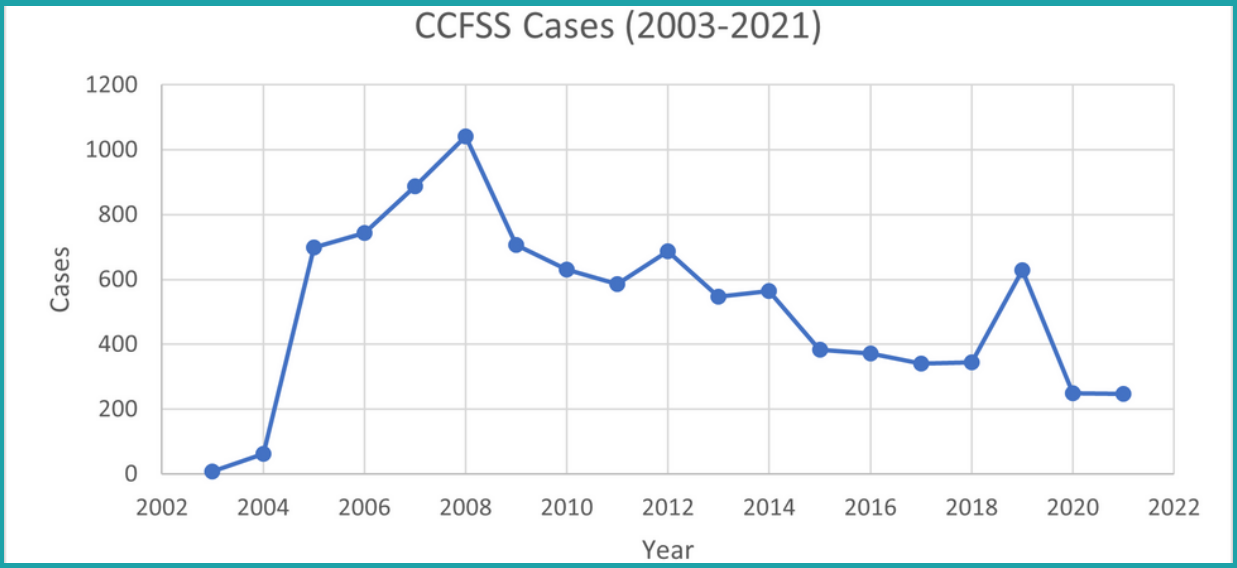
Since 2003, County CDRTs have submitted child fatality cases into the CCFSS. Nearly 10,000 cases have been entered with the highest number of cases submitted in 2008 (1,041) by thirty-one counties. It is important to note that these cases are not representative of all child fatalities that occurred in California in that year. Thirty-nine of fifty-eight California counties have submitted child fatality data into CCFSS from 2003 to 2021 at least once; as such, not all child fatalities that occurred in the state are captured.

Figure 1 depicts a steady incline in case submission until 2008, followed by a decline in case submission soon thereafter. This decline could be explained by a state budget deficit that year that led to a reduction of program support for child fatality review and surveillance. Given that all California counties do not report child fatalities to CCFSS at this time, there is inconsistency in reporting of child death data and the CCFSS should not be considered a comprehensive source for data on child fatalities currently.

OVERVIEW OF CCFSS DATA

Figure 1. Number of CCFSS Cases Submitted, 2003* - 2021



* CCFSS case submission began in 2003. Two retrospective cases from the 1995 were excluded.

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The CCFSS collects data on the official manner of death for children.

Table 1 describes the official manner of death among reported cases in California from 2003-2021. Coroners most often declare the official manner of death. Most child deaths reported in CCFSS occurred as a result of accidents/unintentional injuries (3,274).

Table 1. Official Manner of Death from Reported Cases of Child Death in California, 2003 - 2021

Official Manner of Death	Cases	Percent (%)
Unintentional Injury	**3274**	**33.5**
Natural	**2160**	**22.1**
Undetermined	**1621**	**16.6**
Homicide	**1151**	**11.8**
Suicide	**618**	**6.3**
Missing	**548**	**5.6**
Pending	**278**	**2.9**
Unknown	**111**	**1.1**

The CCFSS also collects data on primary causes of death for children. The most common primary cause of death reported to the CCFSS from 2003 to 2021 was from an external cause of injury (5,107) **(Table 2)**. Examples of external causes of injury include motor vehicles and other modes of transportation, drowning, assault, and poisoning.

Table 2. Primary Cause of Death Among Reported Cases of Child Death in California, 2003 - 2021

Primary Cause of Death	Cases	Percent (%)
From external cause of injury	**5107**	**52.3**
From a medical condition	**2631**	**27.0**
Undetermined if injury or medical cause	**1176**	**12.1**
Unknown	**347**	**3.6**
Missing	**500**	**5.1**

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Resources

The data collected from CCFSS can be used to improve and support the investigation and prevention of child fatalities in California. The following recommendations and strategies may support efforts to prevent and reduce child fatalities and improve the health and wellbeing of California's children.

Recommendations/Strategies	Resources
Engage with community coalitions who are working to create policy change that improves the lives of children and prevents childhood adversity.	To locate a local coalition or advisory body working to improve the lives of children, please utilize the Essentials for Childhood Initiative California Child Wellbeing Coalition e-Guide.
Ensure all child deaths are reviewed by a CDRT, reported to the CCFSS, and that communities are engaged in primary prevention efforts to prevent and reduce child death.	To learn more about how counties can report child deaths and to receive reimbursement, please contact ivpb@cdph.ca.gov.

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CDPH California Department of PublicHealth

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