Today is the day, the Center for Children’s Justice hopes to hear from Tom Corbett and Tom Wolf about their intentional and specific child protection strategies.

In early September, C4CJ asked Tom Corbett and Tom Wolf to answer 12 very intentionally drafted child protection questions.

The questions tackled leadership and priorities:

In light of the number and diversity of programs, services and funding streams within the jurisdiction and oversight of the current Department of Public Welfare; how will you meaningfully use the Office of Governor to prioritize the safety, well-being and permanency of Pennsylvania’s infants, children and youth?

Prevention and supporting families with young children was front-and-center including with this question:

Within your early childhood care and education plan, do you have specific strategies and outcome measures to improve the safety, health (including mental health), and permanency for children from birth to age three? Please highlight how these

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Join us on October 9th to talk the Corbett, Wolf child protection agenda and where to next in 2015

On Thursday, October 9th we’ll join with child protection allies from across PA to talk through what we learned about the child protection agendas of Tom Corbett and Tom Wolf.

We’ll also get updated (and where needed strategize) about some of the outstanding child protection issues pending in the PA General Assembly and Congress (e.g., background checks, mandatory reporting, the future of evidence-based home visiting, and increased information sharing

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Pennsylvania earns a D for transparency when a child dies or nearly dies due to child abuse
Between 2009 and 2013, the Pennsylvania Department of Public Welfare (DPW) reports that 308 fatalities and 413 near-fatalities linked to suspected child abuse were recorded at the state’s child abuse reporting hotline – ChildLine.

State law (Act 33 of 2008) requires that suspected child abuse fatalities and near-fatalities be reviewed by DPW. This state-level review “shall be commenced immediately upon receipt of a report to the department” and should aim to “coordinate” with the county-level review also required by Act 33.

After DPW completes its review, the agency is required to issue a report that includes the following:

1. Insight into the circumstances of the child’s fatality or near fatality;
2. The “nature and extent” of the DPW review.

In August 2011, Pennsylvania Governor Corbett declared August 26th “Alayja Coleman Day.” Alayja was 14 months old when her badly decomposed body was found inside a suitcase left by the curb for trash pickup. Her mother was convicted in connection to the child’s starvation death.

In his proclamation the Governor wrote: “Alayja’s story is a tragic and horrendous one, but what is even more horrific is that there are other children across our nation currently in circumstances as brutal as she endured for 14 months. Let this tragedy of a beautiful life cut short serve as a

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State-by-state variation in how to learn from and be transparent about child abuse fatalities

Arizona, Colorado, Florida, and Michigan are just some of the states that have had their child protection policies and practices under the microscope and is in the media’s spotlight due to children dying from child maltreatment.

The Miami Herald Innocents Lost series included a searchable database of children complied from death reviews, police reports and interviews that led the Herald to identify “Hundreds of children who died of abuse or neglect whose families had contact with the agency over the previous five years — far more than the state reported.”

The Denver Post undertook an investigative series – Failed to Death. In it they explored how screened out reports, overworked caseworkers, families with complex economic and social challenges are among the backdrop to far too many child obituaries.

The media has been critiqued and criticized for some of its work, but one side effect has been a

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Lack of data leaves open the question of how many PA children die or nearly die from child abuse

The legislative record for Senate Bill 1147, which became Act 33 of 2008 illustrates the intent of the General Assembly to build “objective expertise and transparency of the facts of each tragic case so that our communities and the State can learn from the cases and take immediate steps to prevent future harm to our children.”

A key word in the Senate’s legislative journal was “immediate.” Lawmakers and advocates envisioned that Act 33 reviews and reports, at the local and state level, would be quite timely occurring in close proximity to the fatality or near-fatality. This reflects that the reviews were both about the need to dig deep and learn on behalf of the individual victim child, but also to be certain that systemic policy or social work practices did not compromise protections for the collective community of PA’s children.

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