Washington State Department of Health

Maternal Deaths 2014-2016

Washington State Maternal Mortality Review Panel

The Washington State Legislature established a Maternal Mortality Review Panel within the Department of Health in 2016. The Panel reviews maternal deaths in the state and produces findings and recommendations to prevent future maternal deaths.

Goals of the review include determining whether a death was related to pregnancy, whether it was preventable, the factors that contributed to the death, and opportunities for interventions.

By analyzing maternal deaths, the health system can be more effective at addressing the factors causing these deaths.

The MMRP is made up of more than 60 perinatal and women's health and service professionals from diverse backgrounds who live and work throughout the state. Panel members are appointed by the Secretary of Health and serve on the panel for three to five years. Panel members must adhere to strict confidentiality rules and have no access to any identifiable information. Panel members are not paid for their participation.

100

Pregnancy-associated deaths

Death of a woman during pregnancy or within a year of pregnancy from any cause.

30

Pregnancy-related deaths

Death of a woman during pregnancy or within a year of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

60%

Pregnancy-related deaths were preventable

October 2019

DOH 141-012

Summary of findings from the review of 2014-2016 maternal deaths

Rates of maternal mortality in Washington are stable. Historical data collected on maternal deaths that occurred between 2000 and 2016 show maternal mortality rates in Washington varied over time, but are relatively stable and are not increasing like they are nationally.

In 2014-2016, there were:

100 pregnancy-associated deaths, which are deaths that occurred during pregnancy or within the first year after pregnancy from any cause.

This includes deaths from all types of causes, including obstetric complications, motor vehicle accidents, cancer, and homicide.

30 pregnancy-related deaths, which are deaths that the state's maternal mortality review panel decided were directly caused by or linked to complications from pregnancy, a chain of events started by pregnancy, or an unrelated condition that was made worse by pregnancy.

The leading causes of pregnancy-related deaths were mental and behavioral health conditions

The leading underlying cause of *pregnancy-related* deaths (N=30) were mental and behavioral health conditions (30%), suicide and substance overdose/ poisoning). This was followed by hemorrhage during childbirth or soon after, (20%) and hypertensive disorders in pregnancy (10%).

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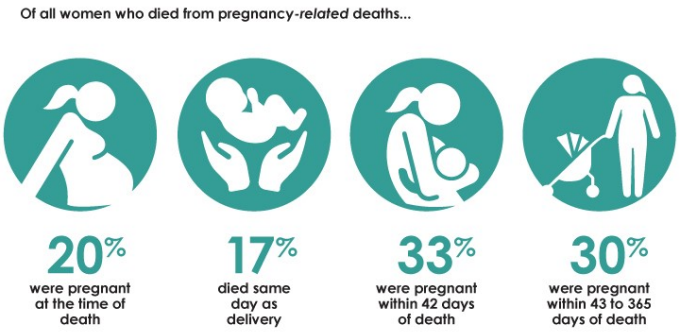
60% of pregnancy-related deaths occurred during pregnancy or within the first six weeks of pregnancy.



The leading factors contributing to deaths include access to health care services, quality of care and provider skill, and lack of care coordination.

The Maternal Mortality Review Panel identified factors that contributed to pregnancy-related deaths, including:

- Access to health care services,
- Gaps in continuity of care (especially postpartum),
- Gaps in clinical skill and quality of care (including delays in diagnoses, treatment, referral and transfer), and

Find out more about maternal deaths in Washington State and what is being done to improve health care for women. Go to doh.wa.gov/maternalmortality.

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