



Maternal Deaths 2014–2020

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 approximately 70 perinatal 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 one or more three-year terms. Panel members must adhere to strict confidentiality rules and have no access to any identifiable information. Panel members are not paid for their participation.

March 2023

224

Pregnancy-associated deaths

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

97

Pregnancy-related deaths

Death of a person 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 physiological effects of pregnancy.

80%

of pregnancy-related
deaths were preventable

Summary of findings from the review of 2014–2020 maternal deaths

Rates of maternal mortality in Washington are stable. Historical data collected on maternal deaths that occurred between 2000 and 2020 show maternal mortality rates in Washington have varied over time, but are relatively stable and are not increasing like they are nationally.

In 2014–2020, there were:

224 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.

97 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 underlying causes of pregnancy-related deaths were mental and behavioral health conditions.

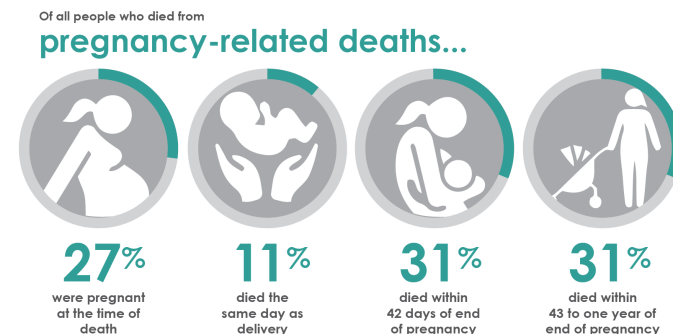
The leading underlying causes of the 97 pregnancy-related deaths were behavioral health conditions (32 percent), predominantly by **suicide** and **overdose**. Other common causes included **hemorrhage** (12 percent) and **infection** (9 percent).



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69 percent of pregnancy-related deaths occurred during pregnancy or within the first six weeks after pregnancy.



The leading factors that contributed to preventable deaths included care quality, access to health care and support services, appropriate screening and follow-up, and discrimination.

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

- Gaps in clinical skills and quality of care
- Bias and discrimination
- Lack of screening, appropriate follow-up for risk factors, care coordination or continuity of care, or access to health care and behavioral health treatment.

Factors were exacerbated by social and structural determinants of health such as housing instability and systemic racism.



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

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