Washington State Department of
Health

Maternal Mortality Review Panel:

An early look at 2017 Maternal Deaths

The Washington State Maternal Mortality Review Panel conducts multidisciplinary reviews of maternal deaths to determine if the deaths were related to pregnancy and if the deaths were preventable. Based on these findings, the Panel makes recommendations to reduce preventable maternal deaths and improve women's health care in the state.

Maternal mortality reviews provide an in-depth understanding of the issues that impact maternal health and lead to poor outcomes, and the people who are most affected by poor outcomes and inequities in maternal care. They also provide insight into the quality and state of perinatal health care and systems.

The Panel reviews maternal deaths yearly. This is a summary of preliminary maternal mortality data covering 2017 maternal deaths for the state of Washington. Complete data analyses and recommendations were not yet determined at the time of the publication of the 2019 legislative report. Results presented include data from the Panel's decisions on pregnancy-relatedness and preventability. Full analyses and interpretation of this data will be published in the next legislative report.

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An Early Look at 2017 Maternal Deaths

In 2017, there were 87,508 live births. Preliminary data shows:

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Pregnancy-associated deaths

Deaths that occurred during pregnancy or within one year after the end of pregnancy from any cause.

- ⇒ **The average age at death was 31 (±4.2).**
- ⇒ **The majority were non-Hispanic white women (n=16).**
- ⇒ **Most of the women had at least some college education (n=19).**
- ⇒ **The majority of women who died were married (n=15).**

The leading causes of deaths were from mental and behavioral health conditions, cardiac related issues, cancer, and motor vehicle accidents.

- ⇒ The majority of pregnancy-associated deaths were determined to be from natural causes (n=20).
- ⇒ Substances, including prescription and illicit drugs, and alcohol, were involved in just under a third of pregnancy-associated deaths.
- ⇒ The majority of pregnancy-associated deaths occurred during pregnancy or within 42 days of pregnancy.

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Pregnancy-related deaths

These are deaths the Panel determined were directly caused by a pregnancy complication, initiated by pregnancy, or a condition made worse by pregnancy.

This includes deaths related to behavioral health conditions that resulted in suicide and substance overdose.

2017 Pregnancy-related maternal mortality ratio

13.7 deaths

per 100,000 live births

Work to prevent these deaths is already under way

The Department of Health, the Maternal Mortality Review Panel and key partners are working to reduce preventable maternal deaths by implementing recommendations outlined in the 2019 legislative report and through ongoing quality improvement initiatives and efforts.

Read the latest maternal mortality report and learn what is being done to improve health care for women at **doh.wa.gov/maternalmortality**.

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