
BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: S-4577.2/16 2nd draft

ATTY/TYPIST: AR:eab

BRIEF DESCRIPTION: Establishing a maternal mortality review panel.

1 AN ACT Relating to establishing a maternal mortality review
2 panel; and adding a new section to chapter 70.54 RCW.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** A new section is added to chapter 70.54
5 RCW to read as follows:

6 (1) For the purposes of this section, "maternal mortality" or
7 "maternal death" means a death of a woman while pregnant or within
8 one year of delivering or following the end of a pregnancy, whether
9 or not the woman's death is related to or aggravated by the
10 pregnancy.

11 (2) A maternal mortality review panel is established to conduct
12 comprehensive, multidisciplinary reviews of maternal deaths in
13 Washington to identify factors associated with the deaths and make
14 recommendations for system changes to improve health care services
15 for women in this state. The members of the panel must be appointed
16 by the secretary of the department of health, must serve without
17 compensation, and must include:

- 18 (a) An obstetrician;
- 19 (b) A physician specializing in maternal fetal medicine;
- 20 (c) A neonatologist;
- 21 (d) A midwife with licensure in the state of Washington;

1 (e) A representative from the department of health who works in
2 the field of maternal and child health;

3 (f) A department of health epidemiologist with experience
4 analyzing perinatal data;

5 (g) A pathologist;

6 (h) A representative of the community mental health centers; and

7 (i) A member of the public.

8 (3) The maternal mortality review panel must conduct
9 comprehensive, multidisciplinary reviews of maternal mortality in
10 Washington from reported deaths and from deaths identified by linkage
11 of state vital records and administrative data. The panel must use
12 the patient's inpatient medical records, outpatient medical records,
13 root cause analyses, autopsy reports, and other available relevant
14 information in its review. The panel may not call witnesses or take
15 testimony from any individual involved in the investigation of a
16 maternal death or enforce any public health standard or criminal law
17 or otherwise participate in any legal proceeding relating to a
18 maternal death.

19 (4)(a) The maternal mortality review panel's proceedings,
20 records, and opinions are confidential and are not subject to
21 disclosure under chapter 42.56 RCW. Panel members may not be
22 questioned in any civil or criminal proceeding regarding the
23 information presented in or opinions formed as a result of a meeting
24 of the panel. This subsection does not prevent a member of the panel
25 from testifying to information obtained independently of the panel or
26 which is public information.

27 (b) The maternal mortality review panel and the secretary of the
28 department of health may retain identifiable information regarding
29 facilities where maternal deaths, or from which the patient was
30 transferred, occur and geographic information on each case solely for
31 the purposes of trending and analysis over time. All individually
32 identifiable information must be removed before any case review by
33 the panel.

34 (5) Health care providers, health care facilities, clinics,
35 laboratories, and medical examiners must report maternal deaths to
36 the maternal mortality review panel and to the secretary of the
37 department of health within ninety days of the death. If a root cause
38 analysis of a maternal death has been completed, the findings of the
39 analysis must be included in the records supplied to the panel.

1 (6) By July 1, 2017, and biennially thereafter, the maternal
2 mortality review panel must submit a report to the secretary of the
3 department of health and the health care committees of the senate and
4 house of representatives. The report must protect the confidentiality
5 of all decedents and other participants involved in any incident. The
6 report must be distributed to relevant stakeholder groups for
7 performance improvement. Interim results may be shared at the
8 Washington state hospital association safe tables for performance
9 improvement. The report must include the following:

10 (a) A description of the adverse events reviewed by the panel
11 during the preceding twenty-four months, including statistics and
12 causes blinded by patient, provider, and organization; and

13 (b) Evidence-based system changes and possible legislation to
14 improve maternal outcomes and reduce preventable maternal deaths in
15 Washington.

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