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**SUBSTITUTE SENATE BILL 6534**

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**State of Washington                      64th Legislature                      2016 Regular Session**

**By** Senate Human Services, Mental Health & Housing (originally sponsored by Senators O'Ban and Becker)

READ FIRST TIME 02/05/16.

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;

1 (e) An advanced registered nurse practitioner who practices in  
2 obstetrics;

3 (f) A representative from the department of health who works in  
4 the field of maternal and child health;

5 (g) A department of health epidemiologist with experience  
6 analyzing perinatal data;

7 (h) A medical examiner;

8 (i) A representative of the community mental health centers; and

9 (j) A member of the public.

10 (3) The maternal mortality review panel must conduct  
11 comprehensive, multidisciplinary reviews of maternal mortality in  
12 Washington. The panel may not call witnesses or take testimony from  
13 any individual involved in the investigation of a maternal death or  
14 enforce any public health standard or criminal law or otherwise  
15 participate in any legal proceeding relating to a maternal death.

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

24 (b) The maternal mortality review panel and the secretary of the  
25 department of health may retain identifiable information regarding  
26 facilities where maternal deaths occur and geographic information on  
27 each case solely for the purposes of trending and analysis over time.  
28 All individually identifiable information must be removed before any  
29 case review by the panel.

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

36 (6) By July 1, 2017, and biennially thereafter, the maternal  
37 mortality review panel must submit a report to the secretary of the  
38 department of health and the health care committees of the senate and  
39 house of representatives. The report must protect the confidentiality  
40 of all decedents and other participants involved in any incident. The

1 report must be distributed to relevant stakeholder groups for  
2 performance improvement. Interim results may be shared at the  
3 Washington state hospital association safe tables for performance  
4 improvement. The report must include the following:

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

8 (b) Evidence-based system changes and possible legislation to  
9 improve maternal outcomes and reduce preventable maternal deaths in  
10 Washington.

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