Coroner Jill E. Romann

2015 ANNUAL REPORT

Douglas County Coroner's Office

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DEDICATION

We recognize that each case within this report represents the death of a person; whose absence is grieved by beloved family, friends, and our community. To those individuals, their loved ones, and to all the citizens of Douglas County who share the loss, this report is dedicated.

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A Personal Message from Coroner Romann

On behalf of the Douglas County Coroner's Office, I welcome you to the *2015 Annual Coroner's Report*. The last annual report published by this office was for 2010, and after taking office in January of 2015, I felt strongly about returning this most important reporting process to the citizens and taxpayers of Douglas County. This report reflects the kind of accountability and transparency that the public should expect from their elected officials.

In addition, as your elected Coroner, I advocate for public health. This report offers valuable statistical information that reflects patterns of disease and trauma within our community that result in premature death. This information is immensely valuable to medical professionals, including our hospital's morbidity and mortality conferences, toxicology and pharmacy professionals, the National Center for Disease Control and our TriCounty Health Department. Our community professionals including Douglas County schools, child fatality review board, law enforcement agents, and of course, our faith based organizations. Simply put, it demonstrates how the Coroner's role is not just reactive, but also plays a vital role in a community's health, strengthening overall public awareness, identifying medical trends, and thus making our community better informed.

Standing by my election commitments, I'm thrilled to announce we made significant strides at accomplishing our goals. In 2015 we:

- **Elevated delivery of truly professional medicolegal death investigation.**
- **Rebuilt professional relationships with law enforcement and other outside agencies.**
- **Achieved the highest level of conservative fiscal responsibility and efficiency by delivering to the taxpayer the lowest cost-per-case in history of the department.**
- **Increased organ donation referrals by 100% and increased tissue donation by 95%, honoring the rights of Douglas County citizens.**

The citizens of Douglas County have a Coroner's Office of which they can be justly proud!

With that said, there is much more work to be done. My professional staff and I remain committed to delivering to the citizens the highest degree of service achievable, while conservatively watching the bottom line of the taxpayer. It's a privilege to serve the citizens of Douglas County. If you have any questions or need any additional information, please feel free to contact me at (303) 814-7150.

Sincerely,

Jill E. Romann, Douglas County Coroner

Duties of the Coroner

The Coroner's Office is a statutory office, mandated by the Colorado Constitution and Colorado Revised Statutes (C.R.S.) 30-10-601 through 621. Under these statutes, the Coroner's primary role is to make proper inquiry regarding the cause and manner of death of any person who dies under the jurisdiction of the office.

Types of deaths that are reported to the Coroner:

- No physician in attendance.
- The attending physician is unable or unwilling to certify the cause of death.
- The attending physician has not been in actual attendance within the past 30 days prior to death.
- All cases in which trauma may be associated with the death, such as traffic accidents, gunshots, falls, etc. This includes inpatients who have sustained fractures any time in the past.
- Deaths by poisoning, suspected poisoning, chemical or bacteria, industrial hazardous material or radiation.
- All industrial accidents.
- Known or suspected suicides.
- Deaths due to self-induced or unexplained abortion.
- Operating room deaths and deaths that occur during a medical procedure.
- All unexplained deaths (deaths that occur in healthy individuals).
- Deaths that occur within 24 hours of admission to a hospital or nursing care facility.
- Deaths in the custody of law enforcement.
- Deaths of persons in the care of a public institution.

Deaths meeting the above criteria are investigated by the Coroner, with jurisdiction that may or may not be assumed in individual cases with autopsies performed as determined necessary by the Coroner. Per statute, autopsies must be performed by a Forensic Pathologist (CRS 30-10-606.5). The result of the investigation determines final cause and manner of death.

The cause of death is defined as the disease or injury that resulted in the death of an individual. The manner of death is ruled as Natural, Accident, Homicide, Suicide, or Undetermined. Undetermined Manner of Death includes deaths in which the manner could not clearly be determined, as in some drug overdoses where there is no clear evidence as to whether the event occurred with intent or accidently. Undetermined is also used for Sudden Unexpected Infant Death Syndrome (SUIDS), and in other cases, such as found skeletal remains, where no other clear manner of death can be determined.

In addition, associated responsibilities of the Coroner's Office include but are not limited to:

- Legal pronouncement of death
- Legal identification of the deceased
- Take custody of the body and personal belongings
- Legal identification and notification of Next of Kin
- Issuance of death certificates
- Helping families understand the actions of the Coroner's Office, and through the grieving process

The Douglas County Coroner's Office operates 24/7/365.

Mission Statement

MISSION STATEMENT

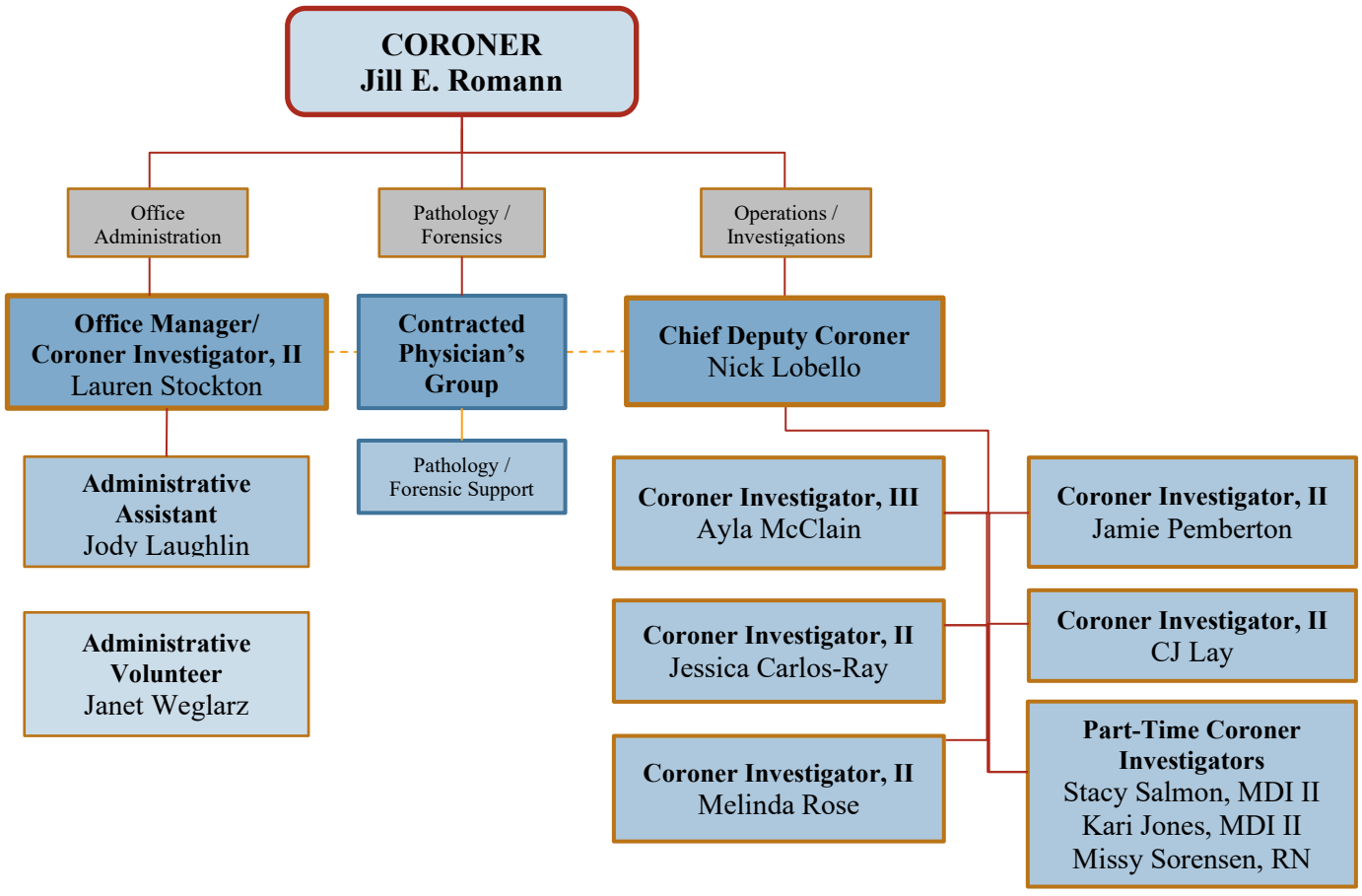
As an impartial, independent agency, our mission is to serve the public by providing the citizens of Douglas County, medical professionals, and members of the justice system with accurate, scientific, and unbiased medical based determination of cause and manner of death, as well as associated responsibilities. To this end, we strive for nothing less than excellence in practice, integrity, compassion, and continuous advancement in the field.

CORE VALUES

SERVICE • COMPASSION • EXCELLENCE

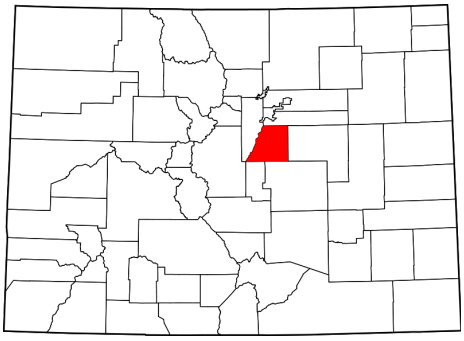
CARE • PROFESSIONALISM • DIGNITY • INTEGRITY • RESPECT

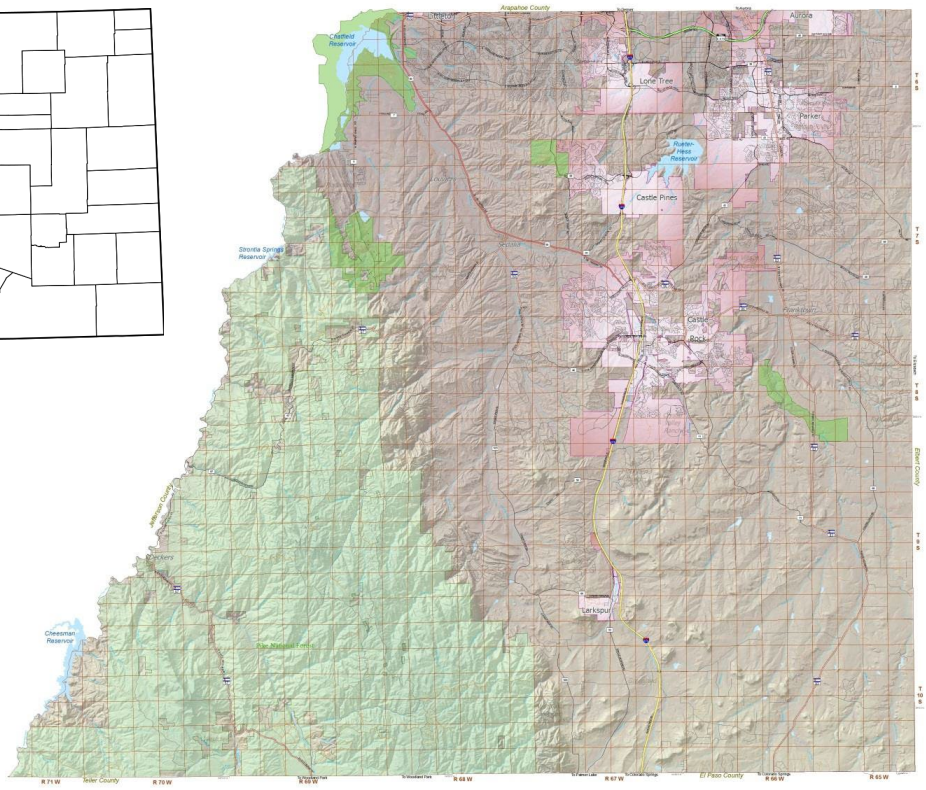
DCCO Organizational Chart



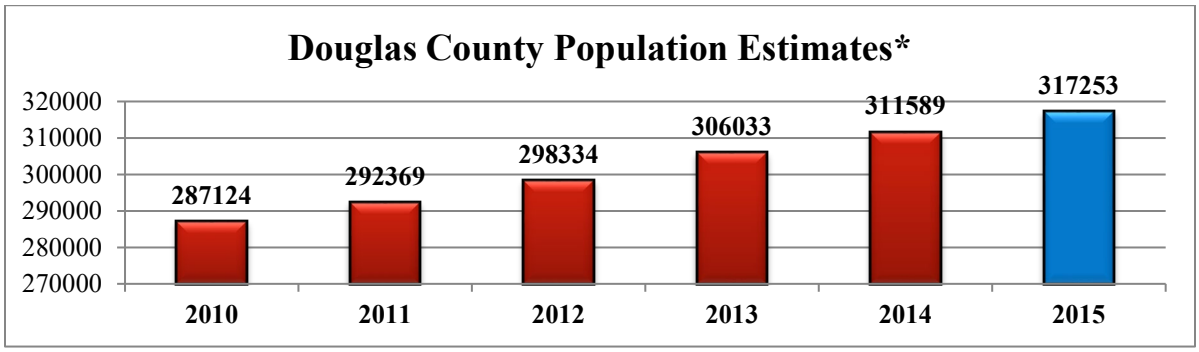
Jurisdictional Boundaries

The jurisdictional boundaries of the Coroner's Office lie within the boundaries of Douglas County. Douglas County lies virtually in the geographic center of Colorado and is approximately 844 square miles in size. It's located between Colorado's two largest cities, Denver and Colorado Springs, and offers a wide array of urban and rural regions. Incorporated municipalities include Aurora, Castle Pines, Castle Rock (County seat), Larkspur, Littleton, Lone Tree, and Parker. Elevations range from 5,400 feet in the northeast to 9,836 feet at Thunder Butte in Pike National Forrest.





Population of Douglas County



**Source CO State Demography Office*

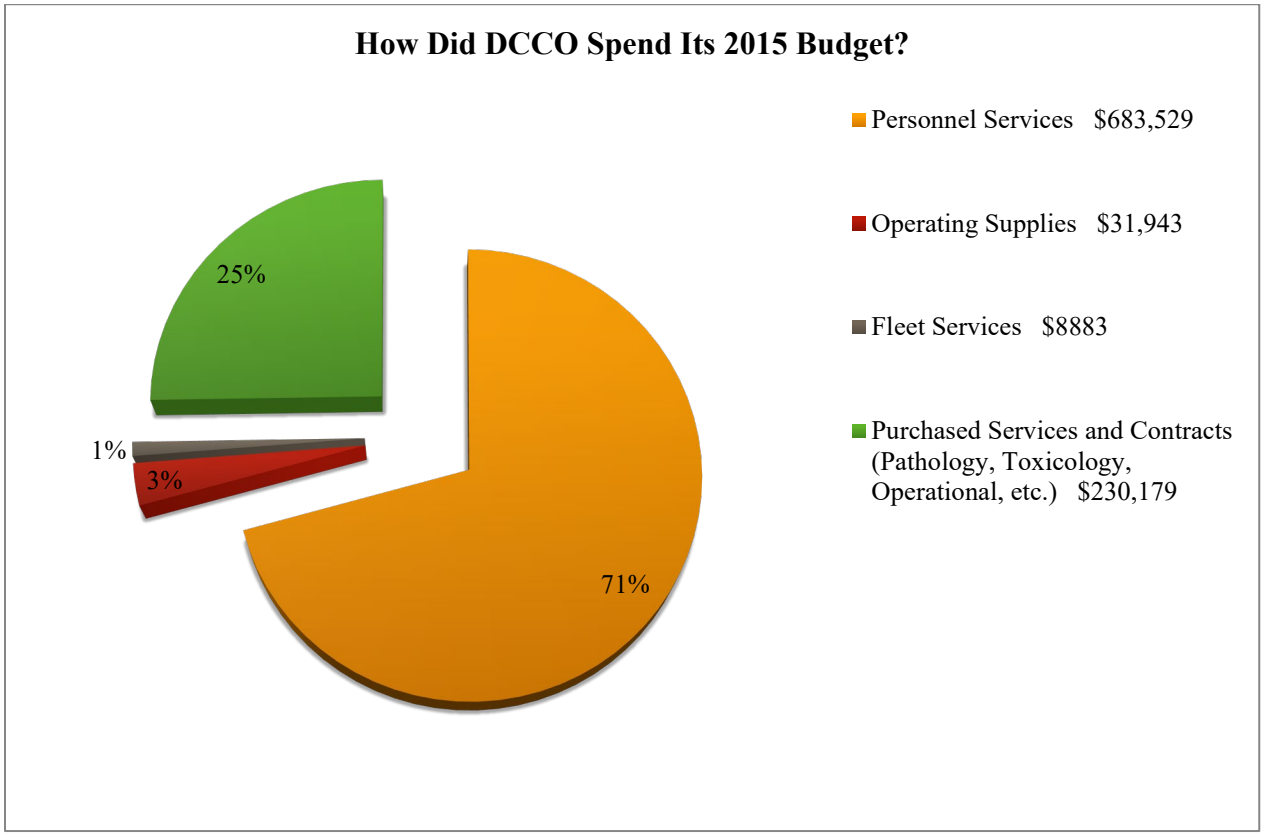
Budget

Funding

Funding for the Coroner's Office originates from the Douglas County general fund. In 2015, the county manager and commissioners approved a projected budget of $1,108,664 for DCCO. This number represented less than 1% of the total 2015 General Fund, which was $114.4 million. It represented less than 0.3% of the total 2015 Douglas County annual budget of $331.2 million.

Expenditures

Total expenditures for the year were $954,535, **14% under budget, with a savings of $154,129 returned to the taxpayers** through the general fund.



One of the best ways to track fiscal responsibility and efficiency is to calculate the cost-per-case; or simply, the total tax dollars spent divided by the number of cases handled. Thanks to the hard work and dedication by Coroner Romann and her staff to taxpayer fiscal responsibility, DCCO operated under the most efficient budget in its history; and did so with almost tripling the savings of cost-per-case as the year before. Although case volume will continue to rise, Coroner Romann has made fiscal responsibility and conservative oversight a top priority of her administration.

	Previous Administration		Coroner Romann's Administration
	2013	**2014**	**2015**
Population	306,033	311,589	317,253
Total DCCO Cases	1066	1172 9.9% Increase	1321* 12.6% Increase
Actual Dollars Spent**	$875,202	$929,186 6.1% Increase	$954,534 3.2% Increase
Cost-per-Case	**$821/case**	**$792/case** **3.6% Decrease**	**$722/case** **9.5% Decrease**

**Please see Overall Caseload section for case breakdown*

***Source Douglas County Finance Department*

Revenues

The office received revenue from two sources in 2015. The first being referral services, where neighboring counties and medical professionals are charged for use of conducting autopsies at our facility. The second was for associated administrative fees. Total revenue for 2015 was $18,215. **This money went directly to the general fund. It did not go towards the Coroner's budget as additional funding.**

2016 Budget Forecasting

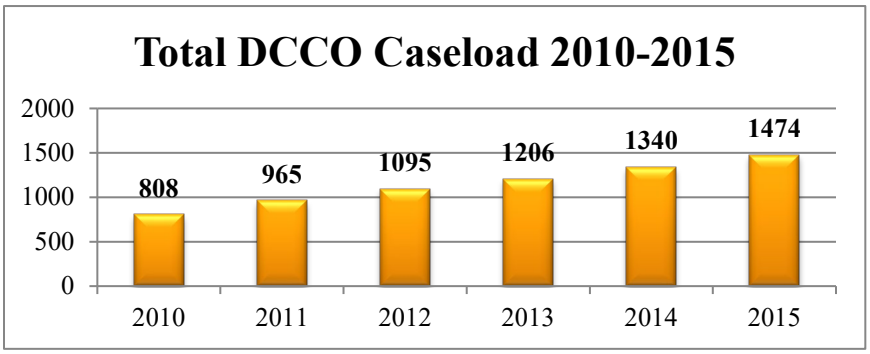
Balancing expected growth in call volume and increased work load, while keeping a conservative eye on expenditures, can sometimes prove to be difficult. However, as mentioned, Coroner Romann has made fiscal accountability and responsibility a top priority in her administration. As a result, through the continued improvement of managing operations, Coroner Romann has asked for a **0% budget increase from the County for 2016**. Staff members have set specific goals to work more efficiently, and continue to decrease the cost-per-case.

Overall Case Load

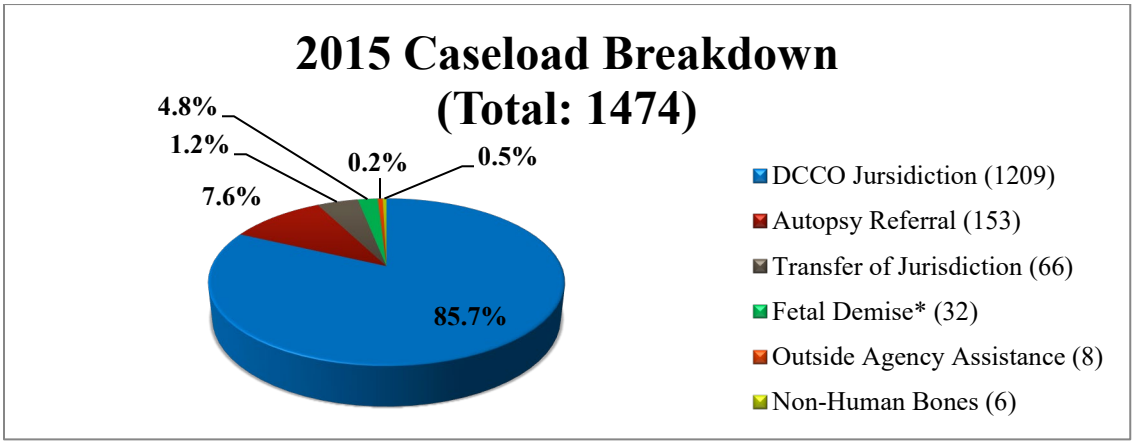
Douglas County Caseload

Total caseload for 2015 was 1474, which included all reportable deaths as well as fetal demises, non-human bone(s), out of county autopsies, and outside agency assistance calls. The statistics contained in this report focus on the reportable deaths in which DCCO retained jurisdiction.

The chart below reflects the total cases reported to the Douglas County Coroner's Office in 2015. **99.3%** of all deaths occurring in Douglas County that were filed with the Colorado Department of Public Health and Environment (CDPHE) were reported to the Douglas County Coroner's Office. There were only five (5) deaths that occurred in Douglas County (per CDPHE) that were not reported to the Douglas County Coroner's Office.



Of note: In 2015, the Douglas County Coroner's Office accepted jurisdiction of deaths that occurred in another county on 52 occasions. These death certificates were therefore filed in another county and are not reflected in the total Douglas County death numbers from CDPHE.



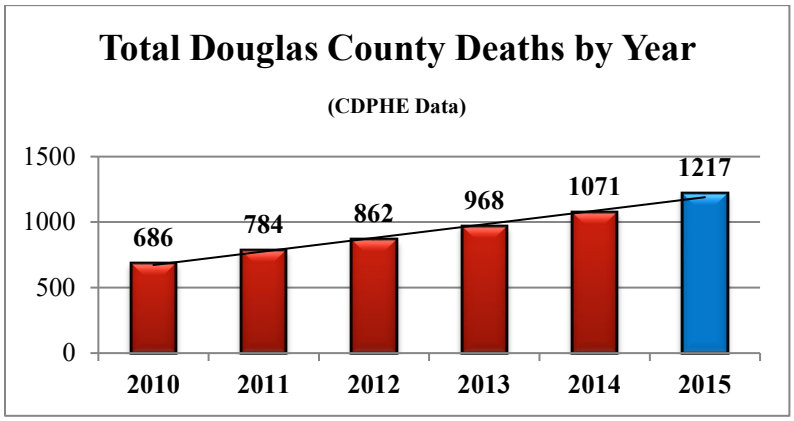
**A fetal demise is defined as "death prior to the complete expulsion or extraction from its mother of a product of human conception, occurring after the twentieth week of pregnancy, and does not include "induced termination of pregnancy" as defined by CRS §25-2-102.*

The Douglas County Coroner's Office retained jurisdiction over 1209 deaths in 2015.

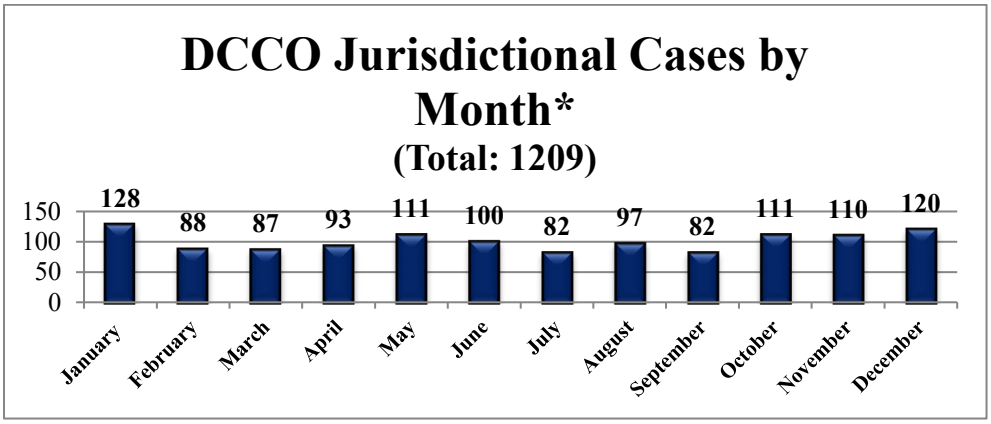
Of note (*from Budget section): In 2015, DCCO retained jurisdiction over 1209 deaths; however, total DCCO caseload in which personnel time and DCCO budget was expended include all cases investigated except the Autopsy Referrals for out of county cases (153 cases of the 1474 to equal 1321).

Deaths in Douglas County According to CDPHE (Filed Death Certificates with the State)

A death certificate is required to be filed with the Colorado Department of Public Health & Environment (CDPHE) for each death that occurs in Douglas County. The discrepancy between CDPHE and Douglas County statistics are due to transfer of jurisdiction on the case and the location of death listed on the death certificate. The chart below reflects the total number of deaths certificates filed with CDPHE that list the death as occurring in Douglas County since 2010. The average yearly increase in deaths in Douglas County between 2010 and 2015 was **12.2%**.



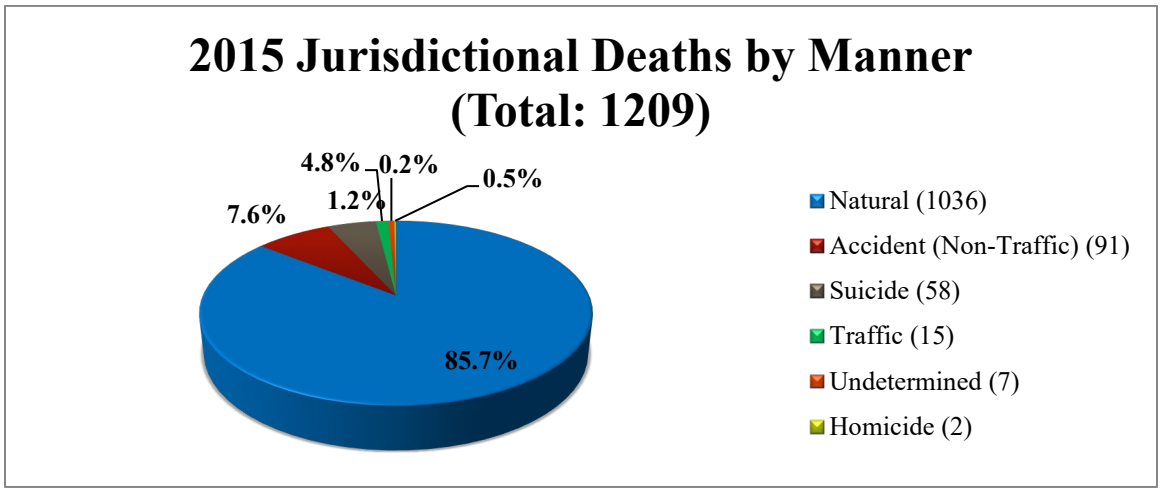
** Source Colorado Department of Public Health & Environment*



**These totals do NOT reflect cases that were transferred to another jurisdiction, fetal demises, non-human bone cases, out-of-county autopsies, or outside agency assist cases.*

As previously mentioned, one of the primary responsibilities of the Coroner's Office is determining the cause and manner of death. The cause of death is the condition (disease or injury) that created the sequence of events that resulted in the death, and the manner of death is based on the circumstances surrounding the cause of death. There are five manners of death: Natural, Accidental, Suicide, Homicide, and Undetermined.

It should be noted that the medicolegal determination of a manner of death of homicide does not imply criminal intent.

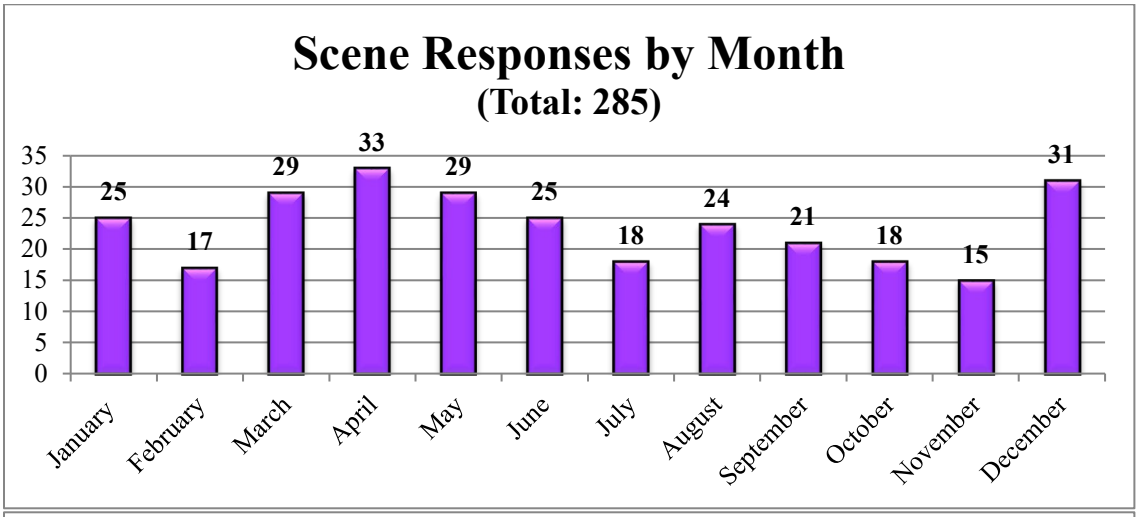


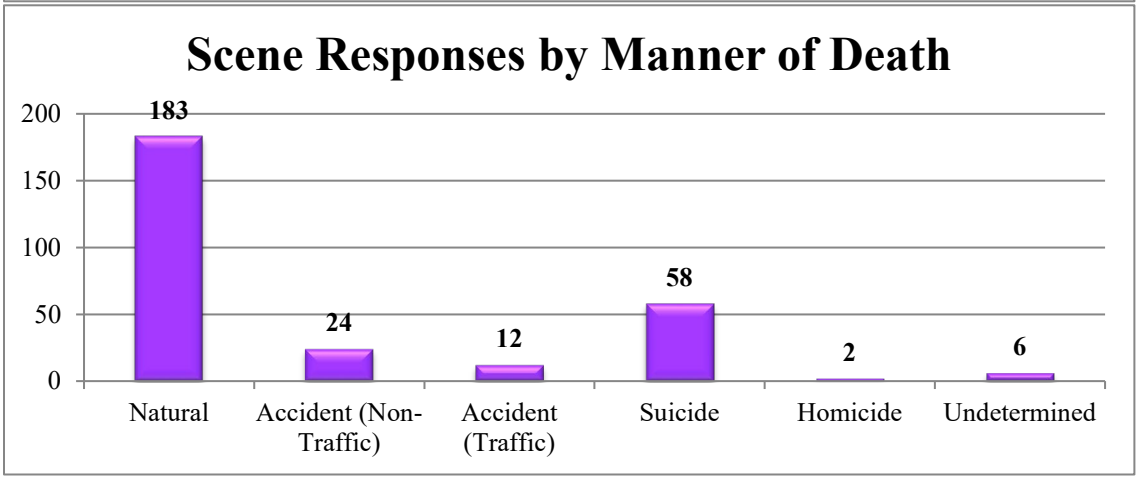
For statistical purposes, traffic fatalities have been categorized separately from the remaining accidental deaths

Scene Response

The Douglas County Coroner's Office responded to 285 death scenes which accounted for **23.6%** of all of the deaths reported to the Coroner's Office in 2015. A scene response is typically made at the request of a law enforcement agency; however, the Coroner's Office also responds to calls at hospitals and care centers at their discretion based on the circumstances reported to surround the death. When law enforcement is involved in a scene investigation, the law enforcement agency has jurisdiction of the scene while the Coroner's Office has jurisdiction over the body and items directly relating to the death. A collaborative approach is used in these investigations to aid the Coroner's Office in determining the cause and manner of death, and the law enforcement agency in determining if a crime has occurred.

At the conclusion of a scene investigation, the Medicolegal Death Investigator makes a determination whether to transport the body to the Coroner's Office for further examination/investigation or to release the body directly from the scene to a mortuary of the choosing of the next-of-kin. The Coroner's Office may also transport a body to the office as a courtesy hold for the next-of-kin while a mortuary selection is being made.

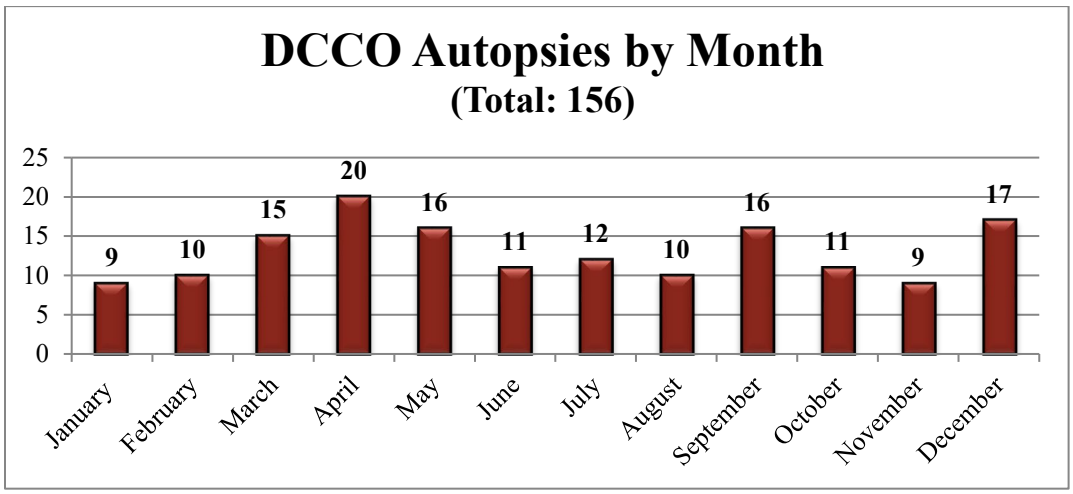


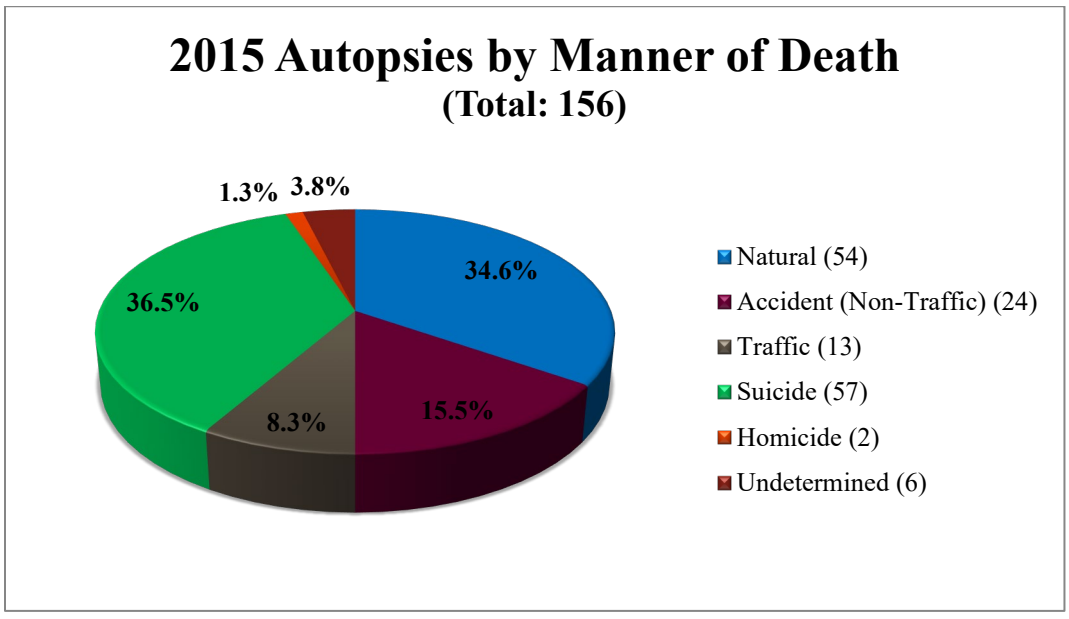


Autopsies

Of the 1209 cases the Douglas County Coroner's Office retained jurisdiction in 2015, 156 or **12.9%** of the cases required an autopsy to aid in the determination of the cause and manner of death. In the majority of cases where an autopsy is performed, toxicology and/or histology studies were also performed. Toxicology testing screens for alcohol, illicit drugs, prescription medications, and other substances, while histology testing allows the board certified forensic pathologist to study tissues on a microscopic level.

Autopsies are performed in deaths where there is a lack of an established medical history, most suicides, most traffic incidents, and deaths where there is possible criminal action. An autopsy may not be performed in the instance where an individual was hospitalized and the medical record thoroughly documented injuries sustained.



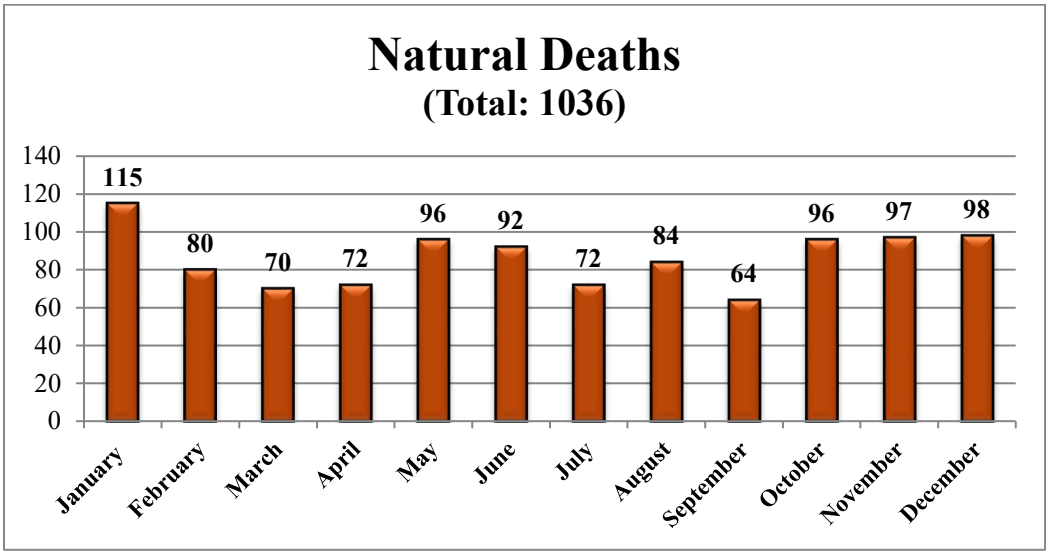


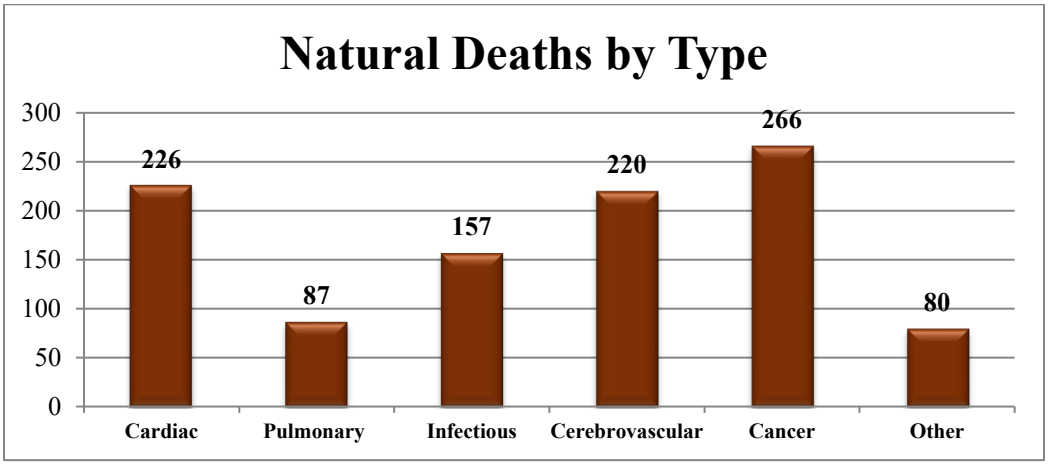
Natural Deaths

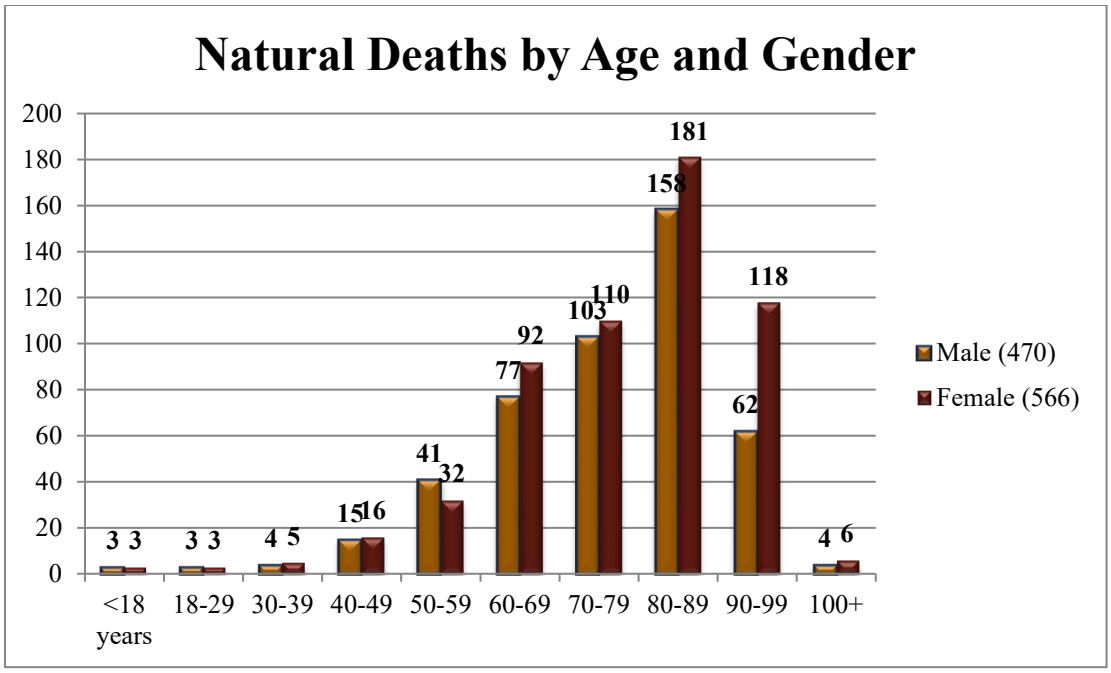
Natural deaths are classified as deaths occurring due to a natural disease and/or aging process. For statistical purposes, the natural deaths reported to the Douglas County Coroner's Office are broken down into deaths due to cardiac disease (i.e. cardiomyopathy or atherosclerotic cardiovascular disease), pulmonary disease (i.e. chronic obstructive pulmonary disease), infectious disease (i.e. pneumonia or sepsis), cerebrovascular disease (i.e. dementia or amyotrophic lateral sclerosis), cancer, or other disease (i.e. renal failure or complications of diabetes).

In many instances when a natural death is reported, jurisdiction of the case is released back to the decedent's physician who will issue the death certificate. The majority of deaths reported to the Coroner's Office are deaths due to natural causes.

Natural deaths accounted for **85.7%** of the total DCCO caseload for 2015.



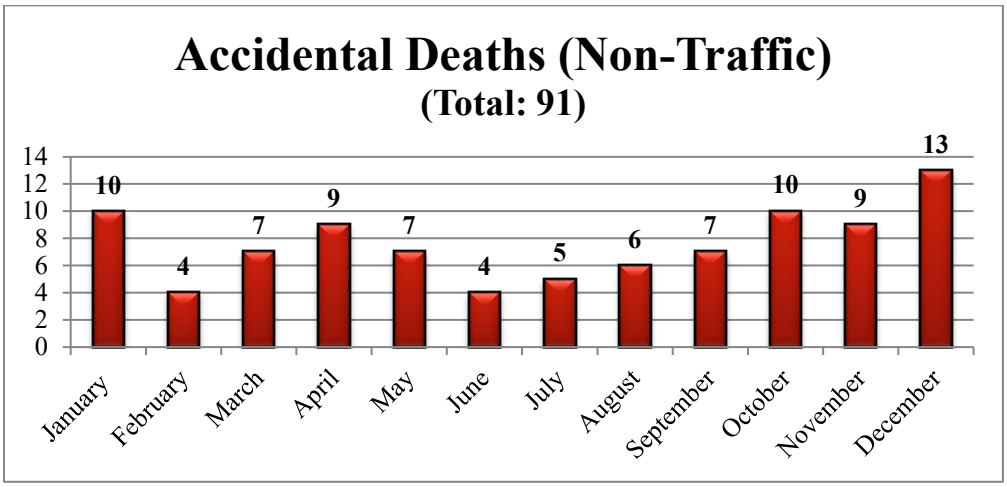



Natural Deaths by Age and Gender
200
180
160
140
120
100
80
60
40
20
0
3 3
3 3
4 5
15 16
41 32
77 92
103 110
158 181
62 118
4 6
<18 years
18-29
30-39
40-49
50-59
60-69
70-79
80-89
90-99
100+
Male (470)
Female (566)

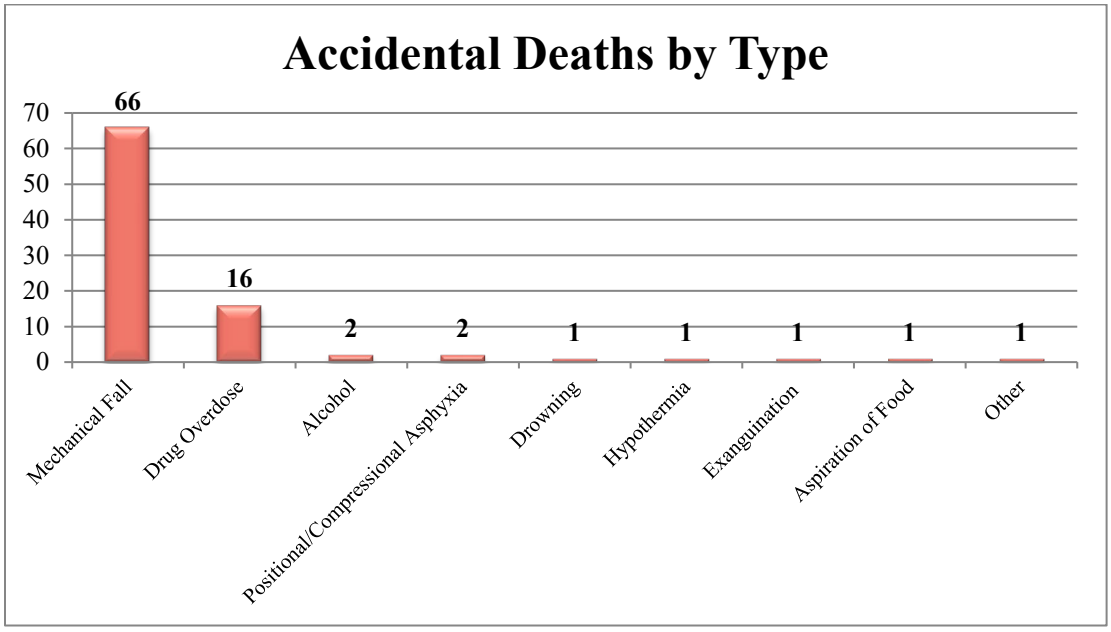
Accidental Deaths

Accidental deaths are deaths that result from injury or poisoning that occurred without the intent for harm or to cause death.

Non-traffic accidental deaths accounted for **7.5%** of the total DCCO caseload for 2015.



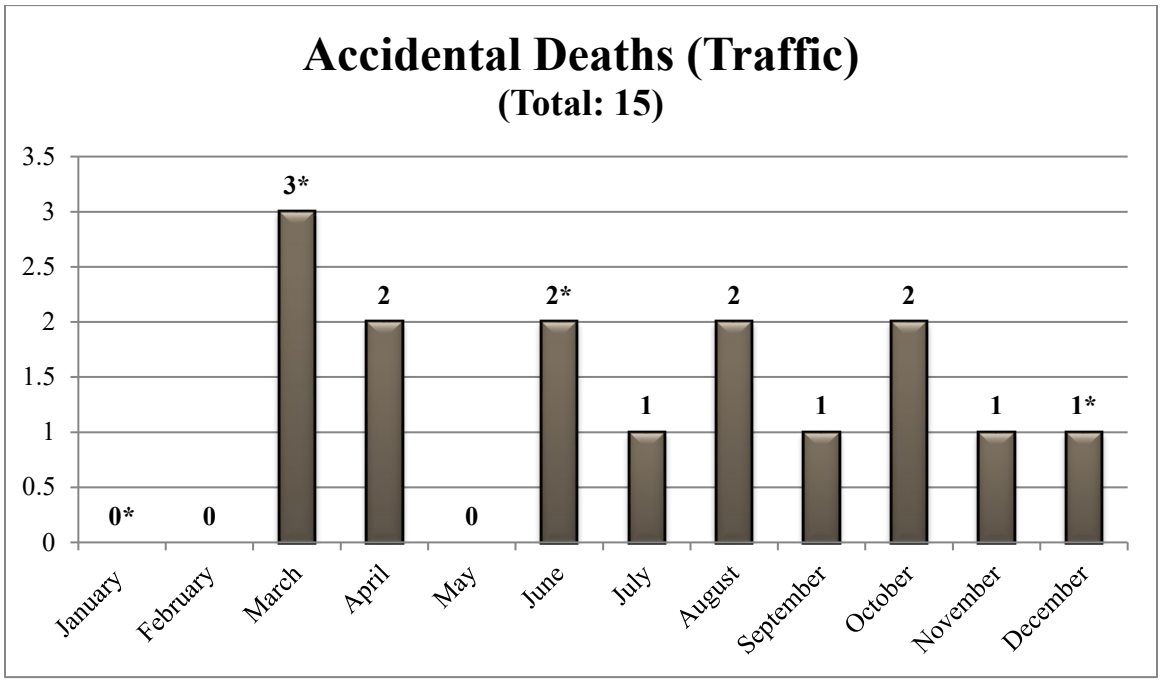
Of the non-traffic related accidental deaths reported to the Douglas County Coroner's Office, the majority of the deaths were related to complications of a mechanical fall, typically a fracture or head injury, or an unintentional drug overdose.

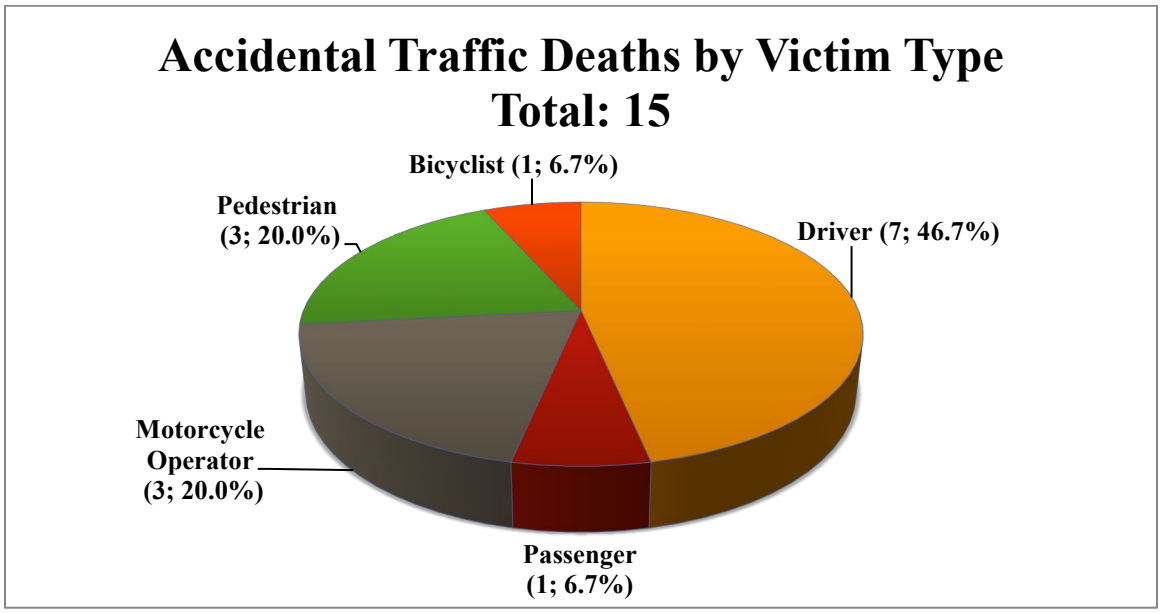


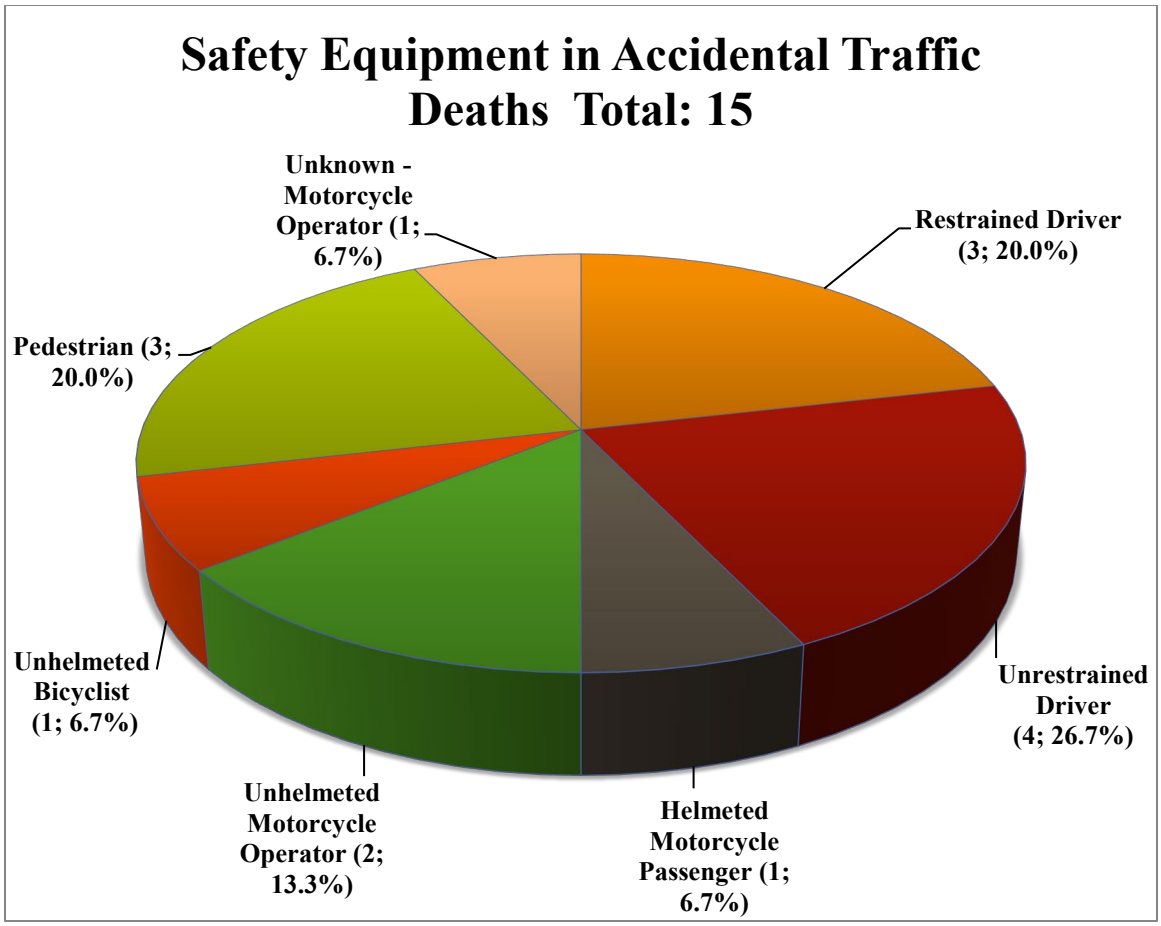
Traffic related accidental deaths include deaths in which the deceased was an occupant of a motor vehicle, motorcycle, tractor, bicycle, or a pedestrian involved in a motor vehicle-pedestrian incident.

Of note: Five additional traffic related deaths were reported, but the manners of death were classified as natural (2) or suicide (3) and, therefore, are not included in the accidental deaths data.

Traffic related accidental deaths accounted for **1.2%** of the total DCCO caseload for 2015.



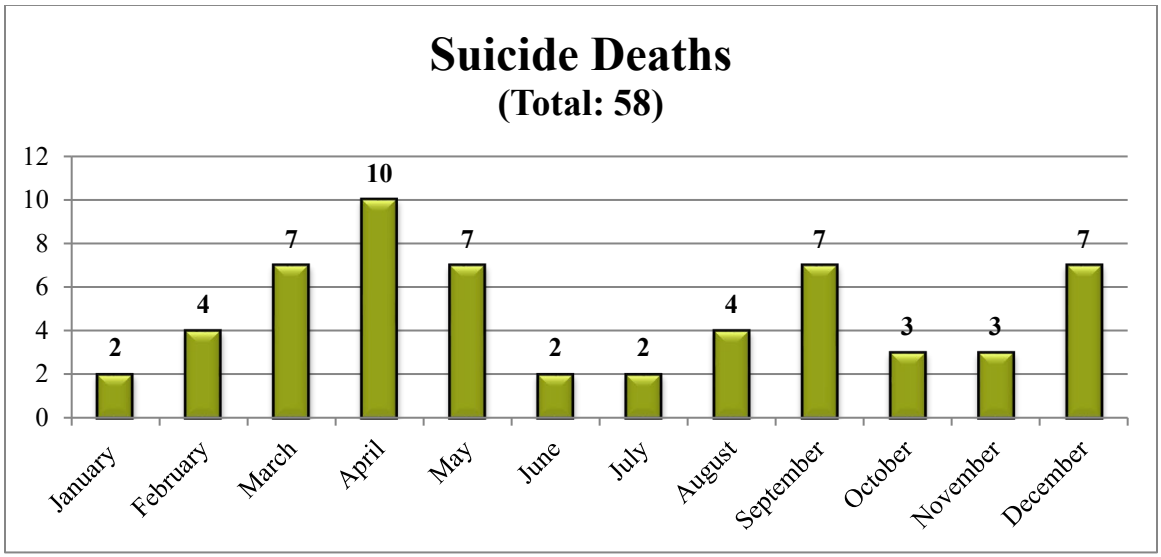


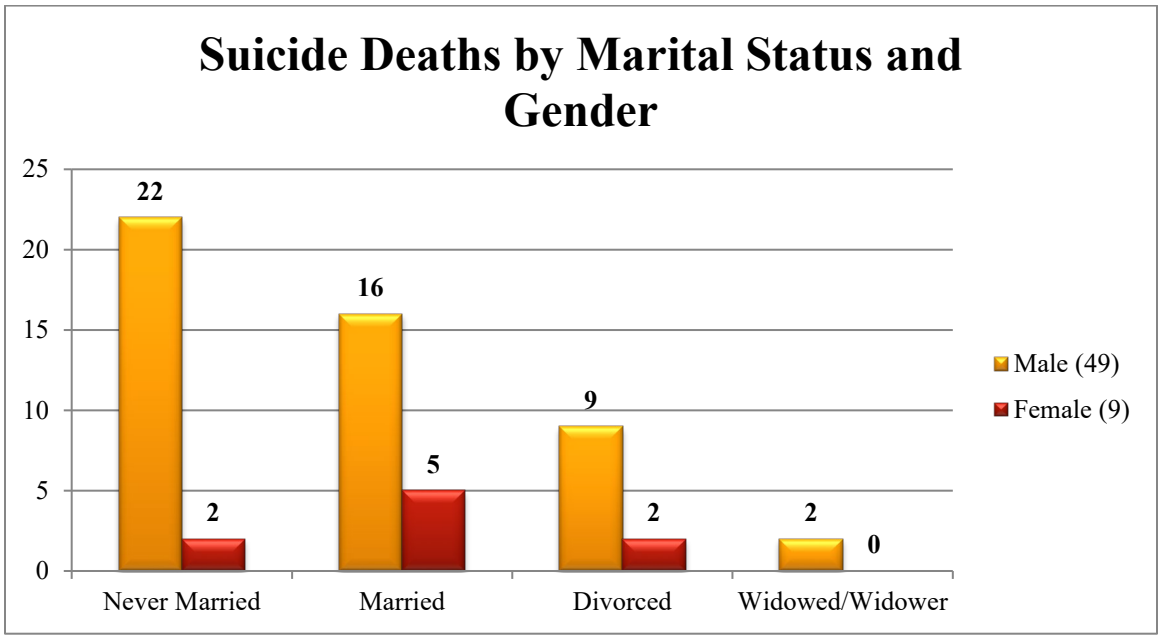

Safety Equipment in Accidental Traffic Deaths Total: 15
Unknown - Motorcycle Operator (1; 6.7%)
Restrained Driver (3; 20.0%)
Pedestrian (3; 20.0%)
Unhelmeted Bicyclist (1; 6.7%)
Unrestrained Driver (4; 26.7%)
Unhelmeted Motorcycle Operator (2; 13.3%)
Helmeted Motorcycle Passenger (1; 6.7%)

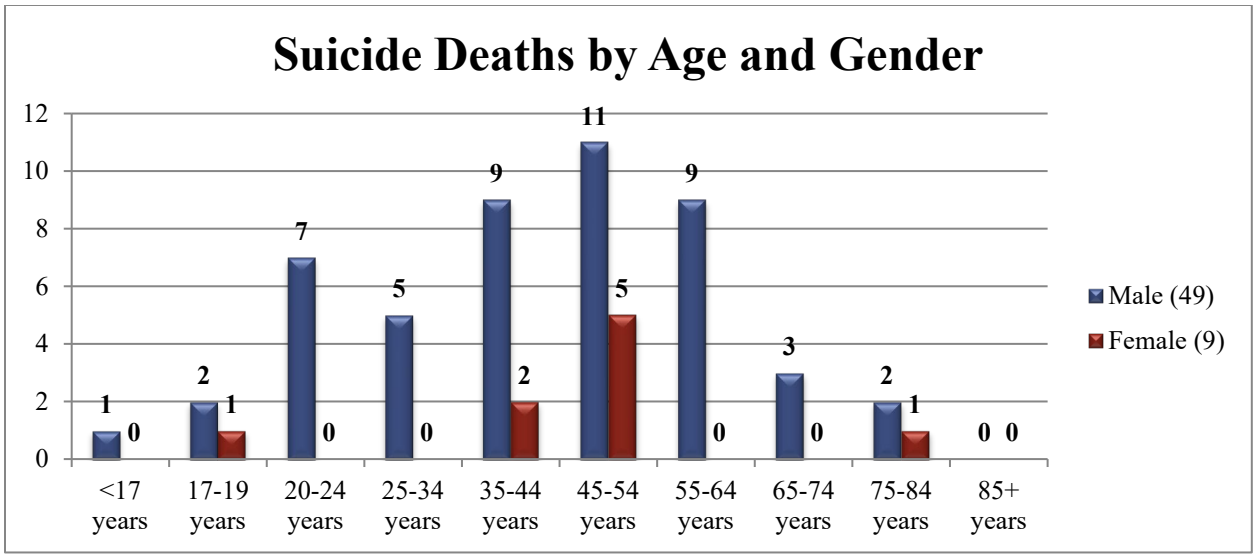
Suicide Deaths

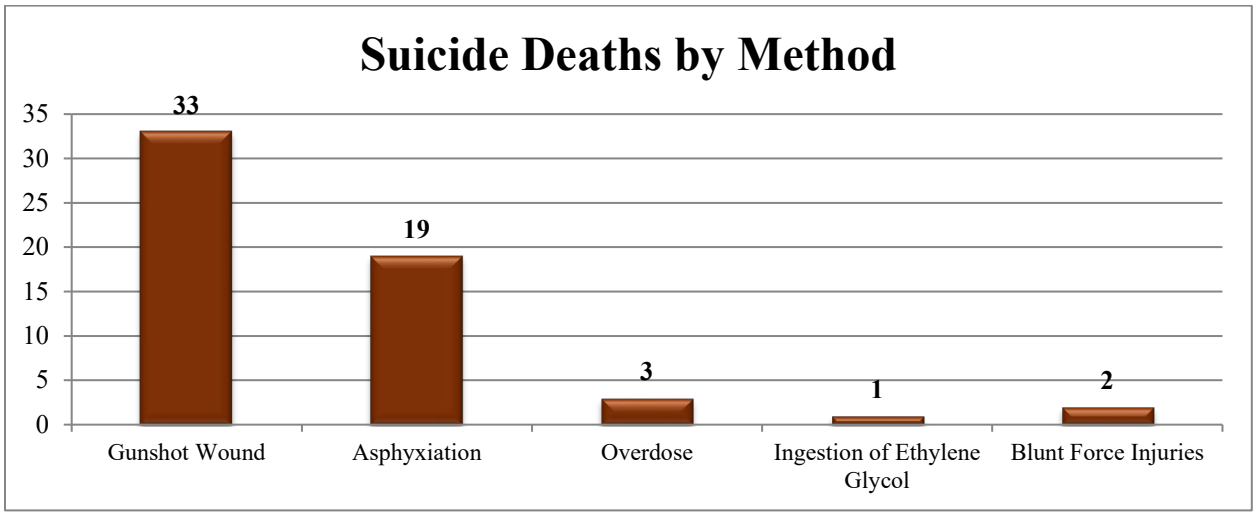
Deaths that are classified as suicide are those that occurred as a result of self-inflicted injury. In 2015, **84.5%** of the deaths were those of males, which is consistent with nationwide figures. The most common method of suicide in 2015 was firearm related **(56.9%)** followed by asphyxiation, most commonly due to hanging **(32.8%)**.

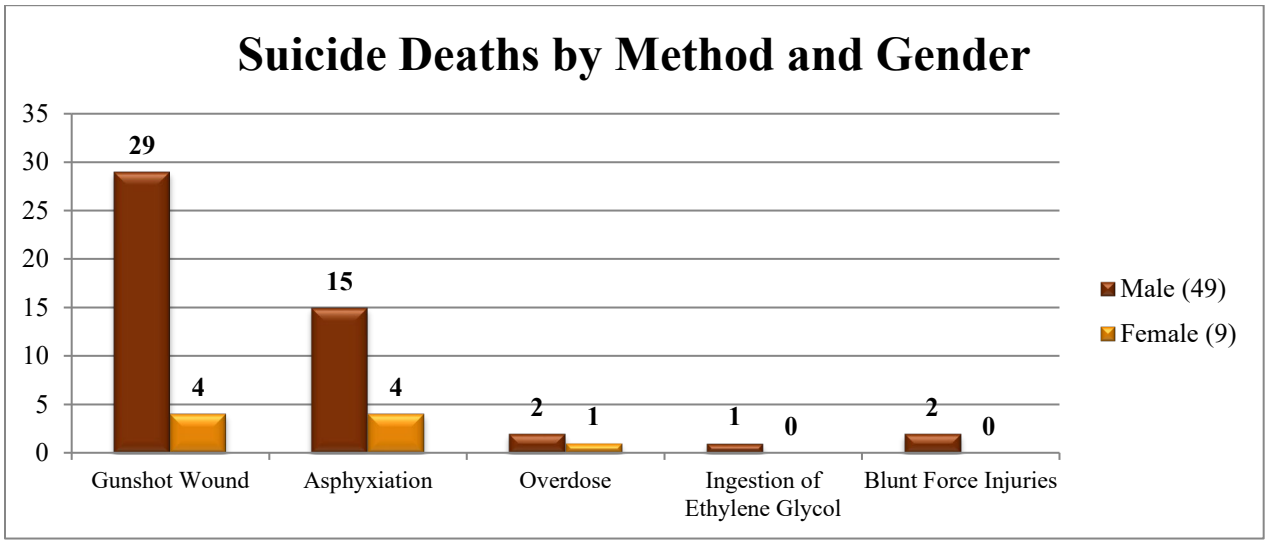
Suicide deaths accounted for **4.8%** of the total DCCO caseload for 2015.






Suicide Deaths by Age and Gender
12
10
8
6
4
2
0
1
0
2
1
7
0
5
0
9
2
11
5
9
0
3
0
2
1
0 0
<17 years
17-19 years
20-24 years
25-34 years
35-44 years
45-54 years
55-64 years
65-74 years
75-84 years
85+ years
Male (49)
Female (9)

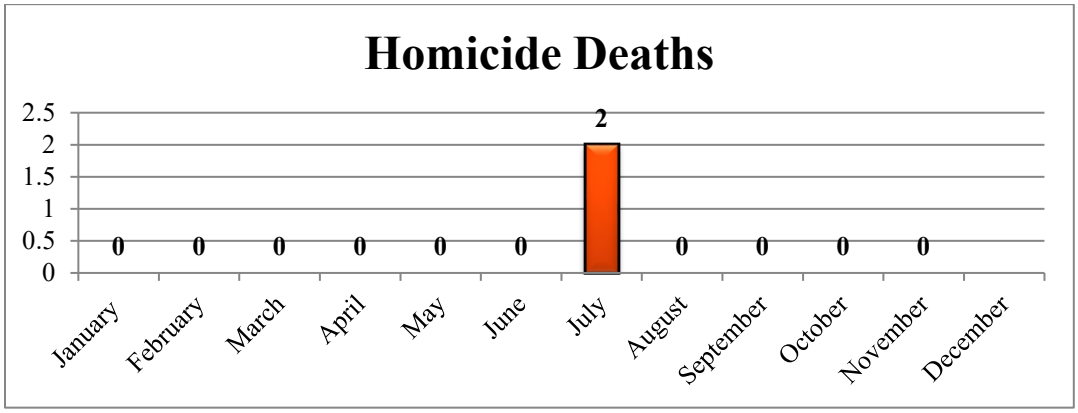

Suicide Deaths by Method
35
30
25
20
15
10
5
0
33
19
3
1
2
Gunshot Wound
Asphyxiation
Overdose
Ingestion of Ethylene Glycol
Blunt Force Injuries


Suicide Deaths by Method and Gender
35
30
25
20
15
10
5
0
29
4
15
4
2
1
1
0
2
0
Gunshot Wound
Asphyxiation
Overdose
Ingestion of Ethylene Glycol
Blunt Force Injuries
Male (49)
Female (9)

Homicide Deaths

Homicide deaths are those deaths occurring as a result of the acts of another person or "death at the hand of another." For purposes of classifying the manner of death as a homicide, there is no implied criminal intent.

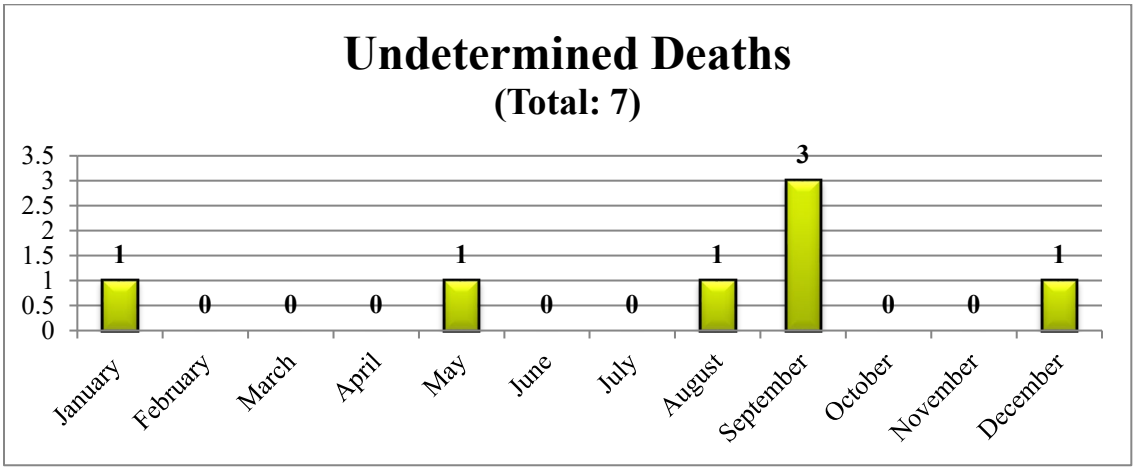
Homicide deaths accounted for **0.2%** of the total DCCO caseload for 2015.



Undetermined Deaths

Deaths that are classified as undetermined are those deaths in which, after a thorough investigation and consideration of all information available, one manner of death is no more compelling than another manner of death. There are some instances where the cause of death is apparent; however, the circumstances leading up to the cause of death are unable to be determined based on the evidence.

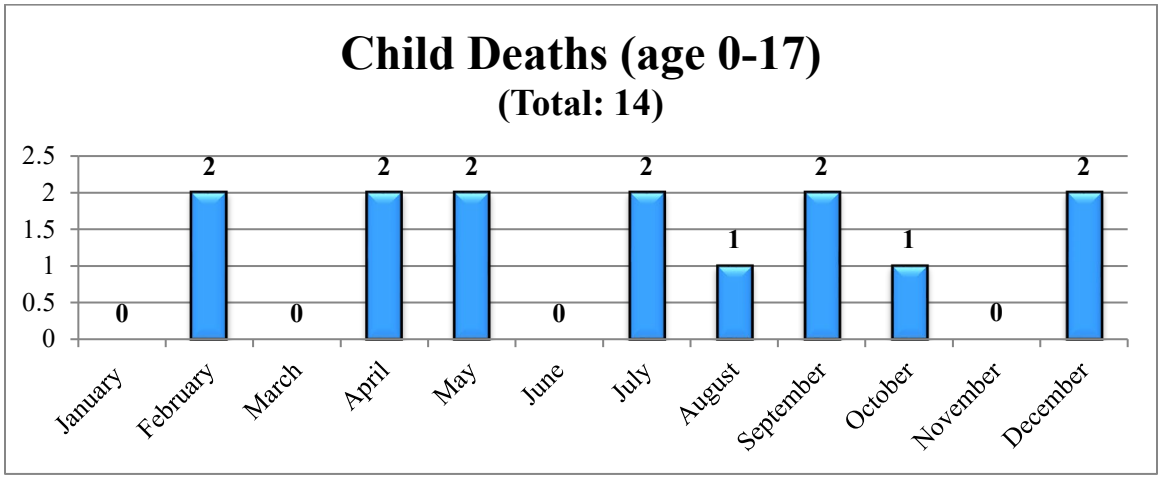
Undetermined deaths accounted for **0.6%** of the total DCCO caseload for 2015.

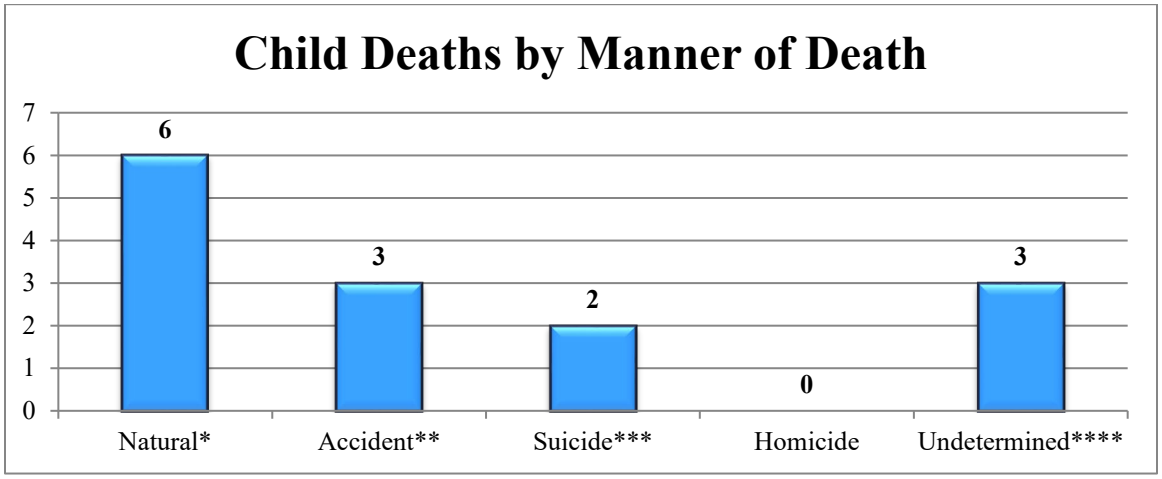


Child Deaths

Child deaths calculated below are deaths of individuals under the age of 18 years-old.

Child deaths accounted for **1.2%** of the total DCCO caseload for 2015.





**Of the six (6) natural deaths, one (1) death was due to premature delivery, one (1) was due to prematurity, chromosomal abnormalities, and congenital anomalies, one (1) was due to an intractable seizure, one (1) was due to cardiac arrhythmia, one (1) was due to a pulmonary thromboembolism, and one (1) was due to abdominal compartment syndrome.*

***Of the three accidental deaths, one (1) was due to exsanguination due to ingestion of a battery, one (1) was due to heroin intoxication, and one (1) was due to positional asphyxia.*

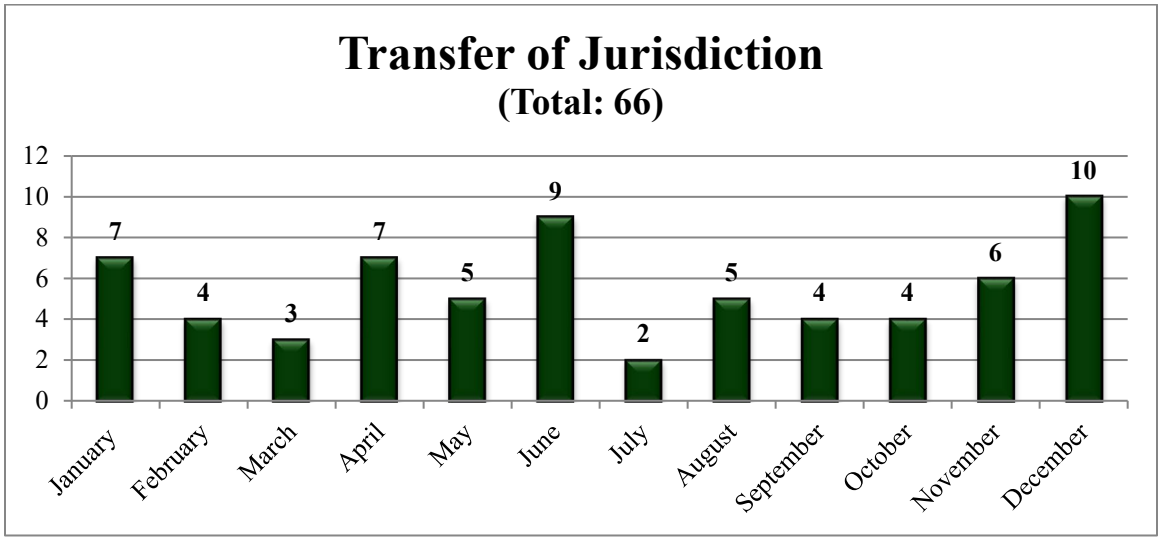
****Of the two suicide deaths, one (1) a 17 year-old, was due to asphyxiation and one (1) a 16 year-old, was due to a self-inflicted gunshot wound.*

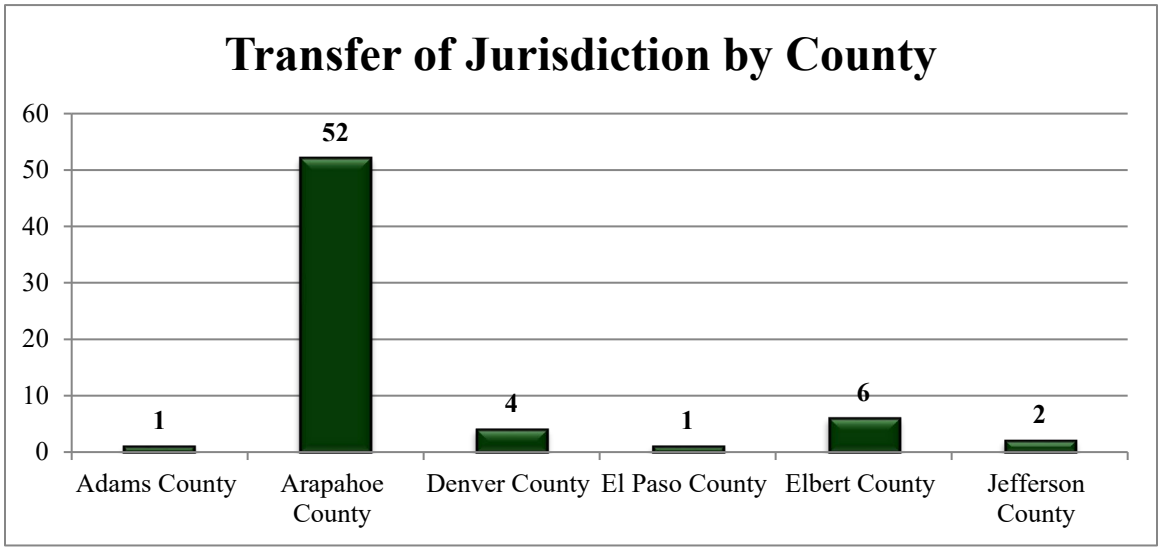
*****Of the three undetermined deaths, two (2) cases were the deaths of children aged 1 year-old and 3 month-old and one (1) was a hospital death of a 16 minute-old newborn with no cause of death listed on the death certificate.*

Transfer of Jurisdiction

On occasion, a death occurs in Douglas County; but, the initiating event to the death occurred in another jurisdiction. These deaths can include deaths where an individual is transported from a location, such as a residence, in another jurisdiction to a hospital in Douglas County or deaths that occur due to an injury that (s)he sustained in another jurisdiction. Transfer of jurisdiction of cases is permitted under Colorado Revised Statute §30.10.606.

Of the cases transferred to another jurisdiction, 13 deaths occurred at Parker Adventist Hospital and 9 occurred at Sky Ridge Medical Center.



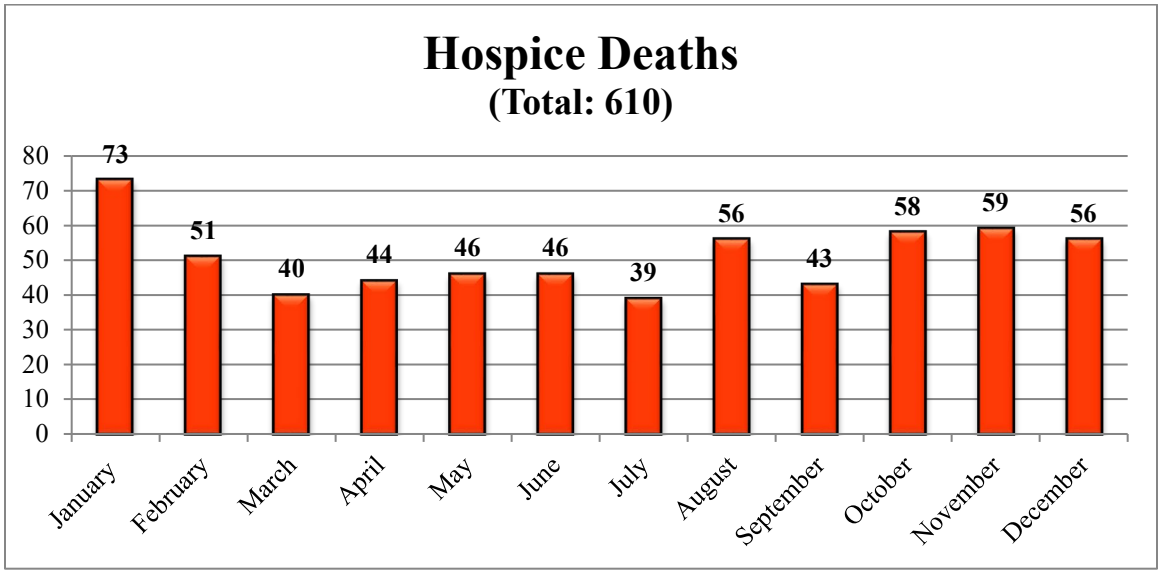


Hospice Deaths

All hospice deaths that occur in Douglas County are reportable to the Coroner's Office. In 2015, 610 deaths were reported by hospice agencies operating in Douglas County.

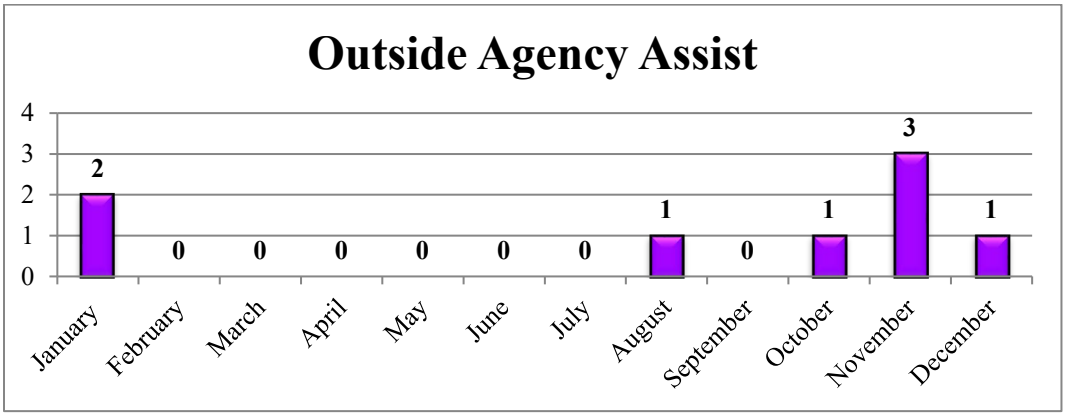
Of the 610 hospice deaths, 573 (**93.9%**) were natural hospice deaths and 37 (**6.1%**) were accidental hospice deaths.

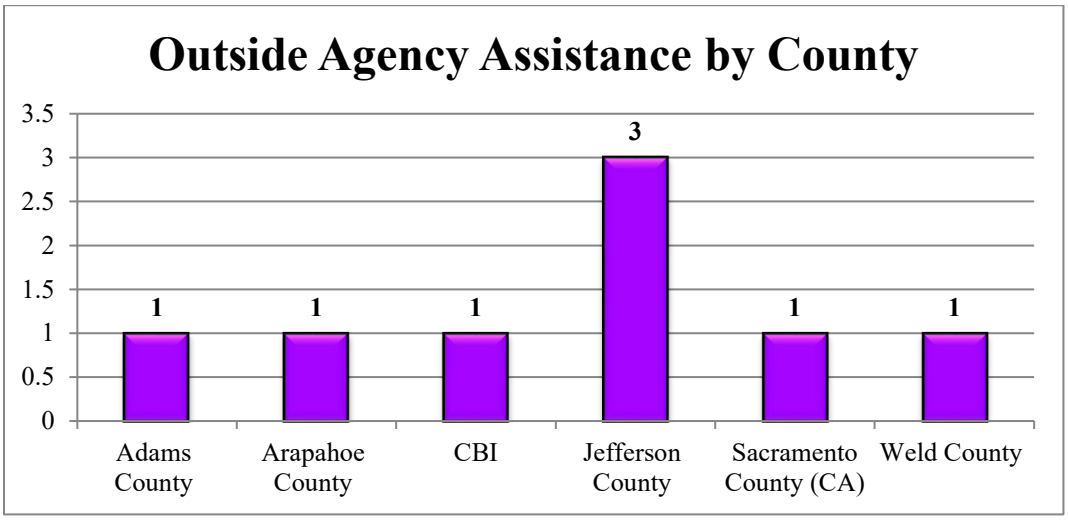
Hospice deaths accounted for **50.5%** of all deaths reported to the Douglas County Coroner's Office in 2015.



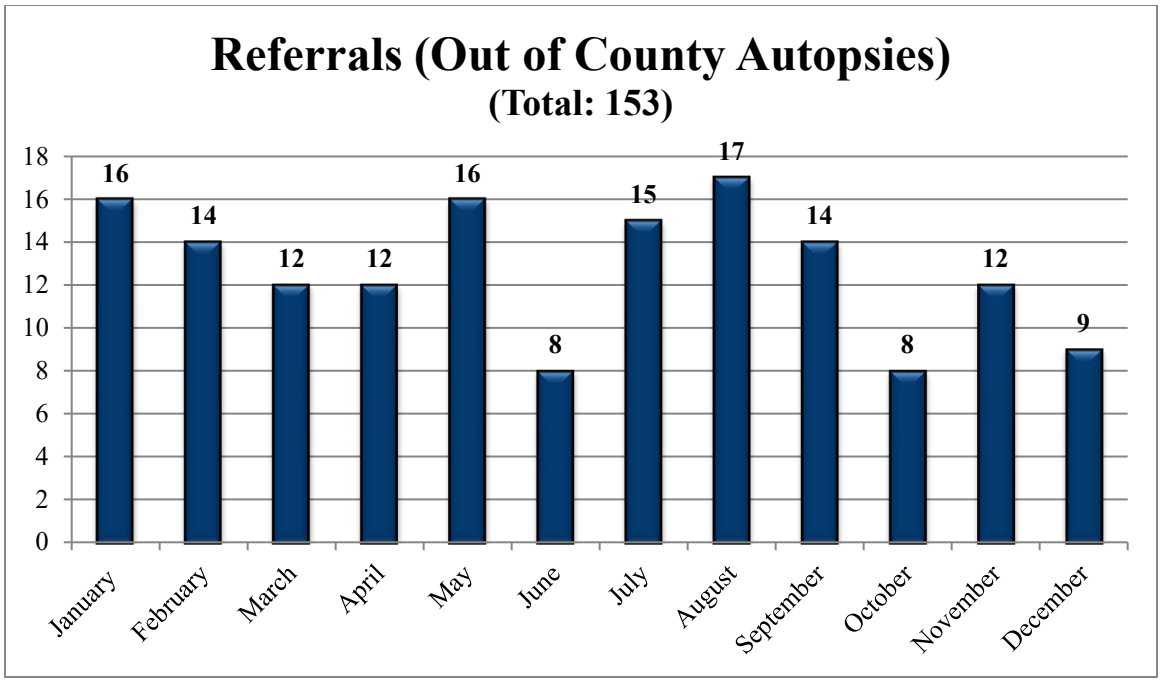
Outside Agency Assistance

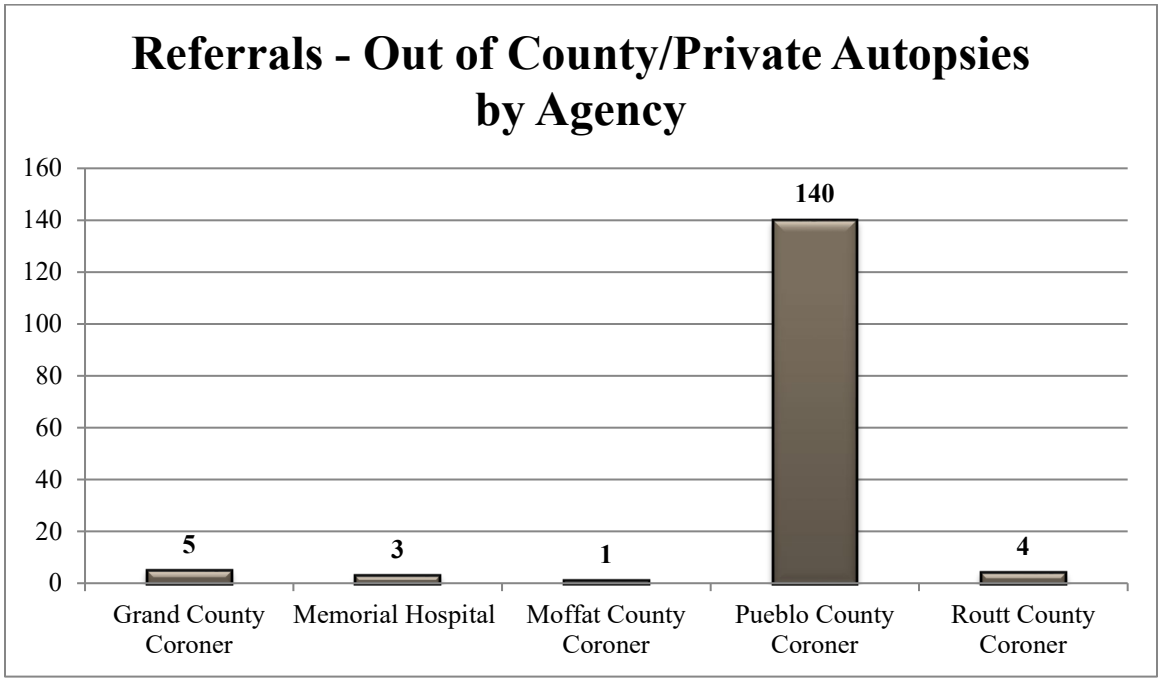
One of the responsibilities of the Coroner's Office is locating and notifying next-of-kin. The Douglas County Coroner's Office also assisted other agencies with performing death notifications for next-of-kin located in Douglas County for deaths that occurred in another jurisdiction.





The Douglas County Coroner's Office also assists outside agencies (Coroner's Offices and hospitals) with performing autopsies at their request. The autopsies are performed by a contracted group of forensic pathologists, notably a board-certified forensic pathologist based out of the Douglas County Coroner's Office facility.

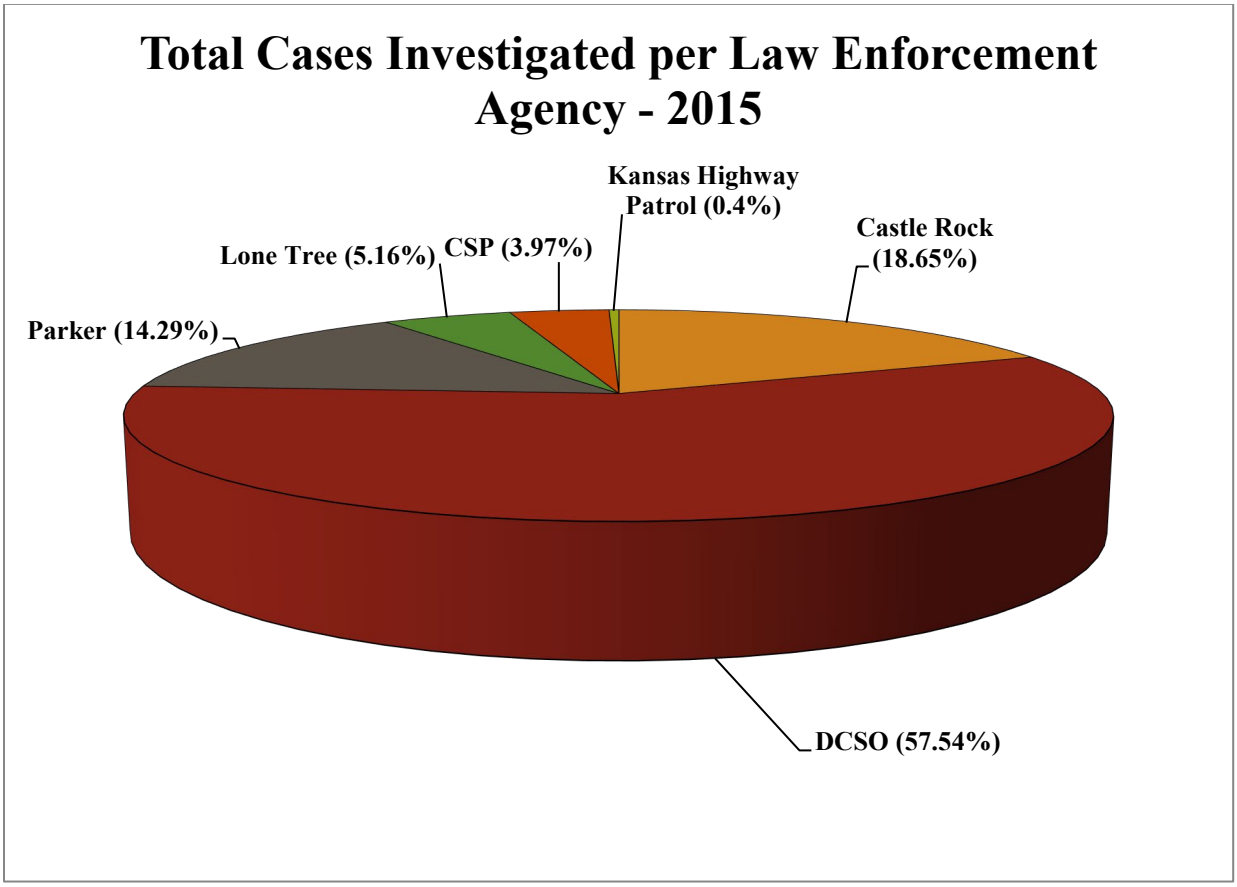

Referrals (Out of County Autopsies)
(Total: 153)
18
16
14
12
10
8
6
4
2
0
16
14
12
12
16
8
15
17
14
8
12
9
January
February
March
April
May
June
July
August
September
October
November
December

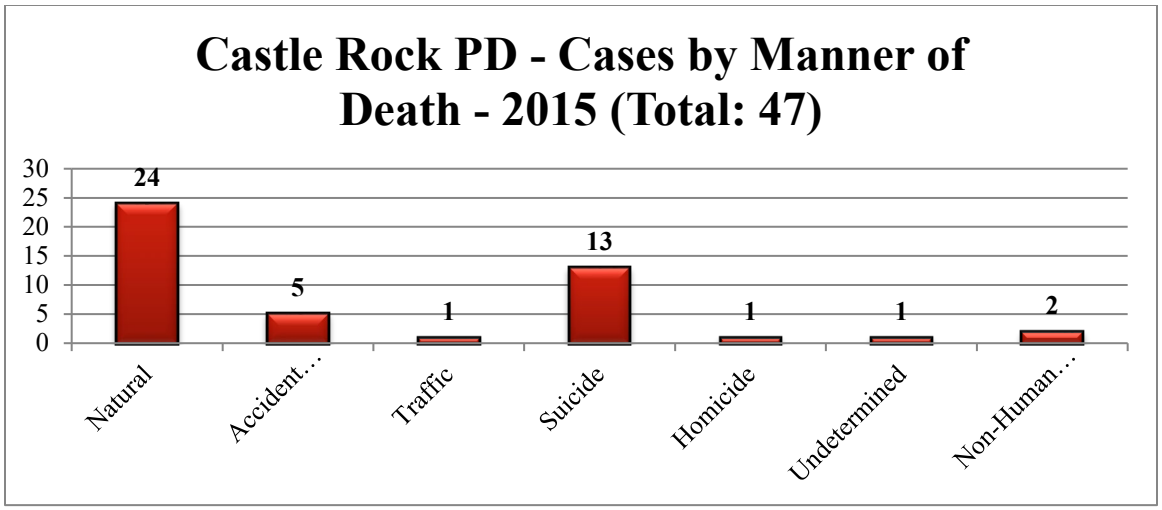

Referrals - Out of County/Private Autopsies
by Agency
160
140
120
100
80
60
40
20
0
5
3
1
140
4
Grand County Coroner
Memorial Hospital
Moffat County Coroner
Pueblo County Coroner
Routt County Coroner

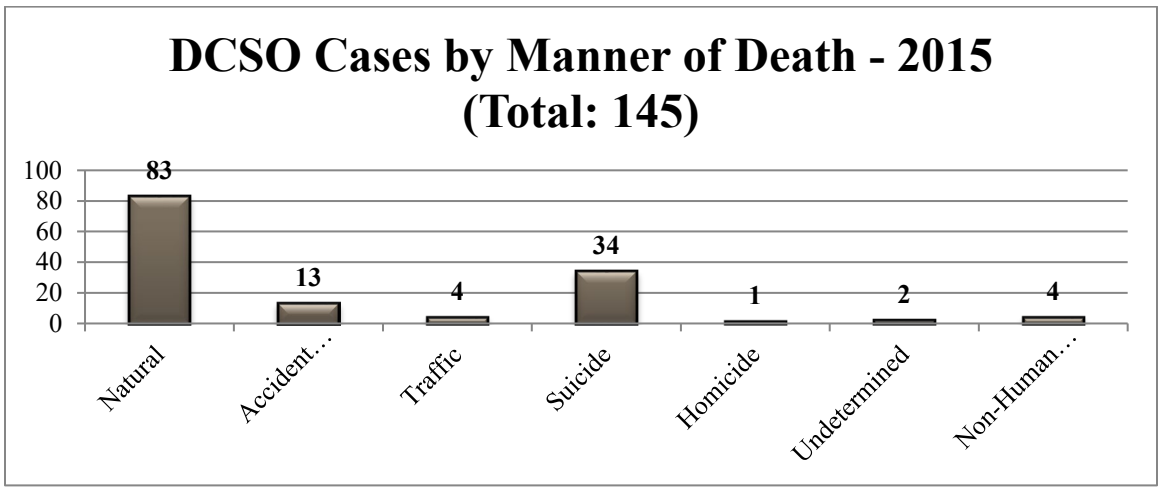
Law Enforcement Agencies

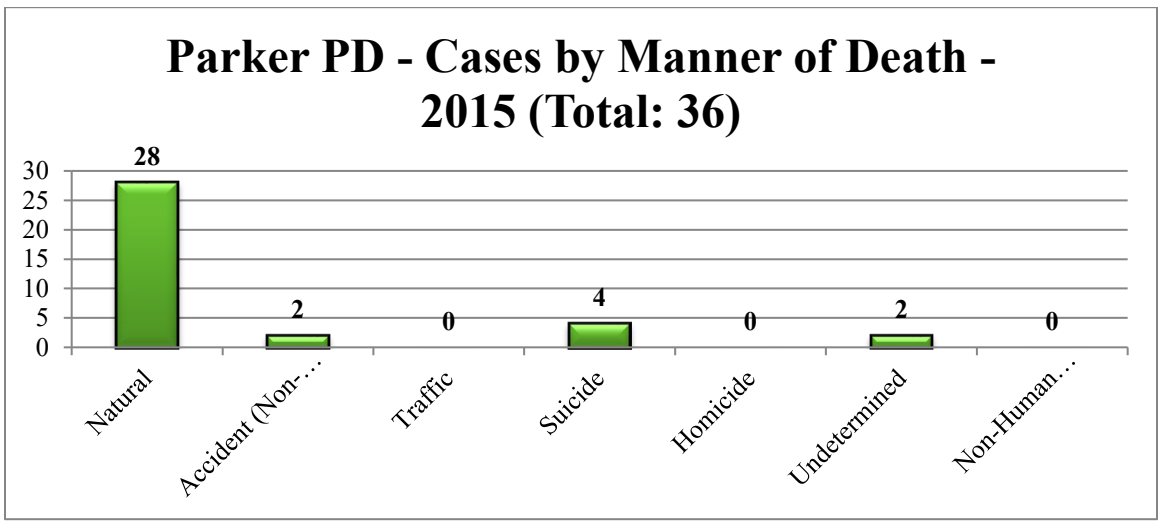
The Douglas County Coroner's Office works in collaboration with Law Enforcement Agencies with jurisdiction in Douglas County. Law Enforcement Agencies in Douglas County include the Aurora Police Department, Castle Rock Police Department, Douglas Colorado State Patrol (CSP), County Sheriff's Office (DCSO), Littleton Police Department, Lone Tree Police Department, and Parker Police Department. In 2015, the Coroner's Office also worked with the Kansas Highway Patrol regarding the death of an individual who was transported via air ambulance to Sky Ridge Medical Center following a traffic incident in Kansas.

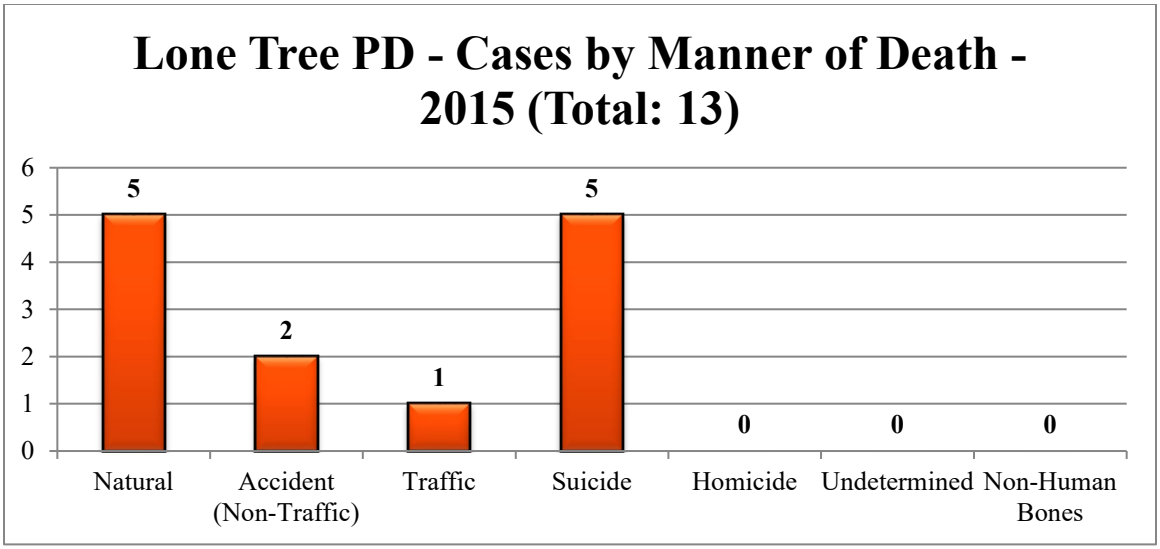
Of note: The total cases investigated with law enforcement may differ from the scene responses made by the Coroner's Office; due to some deaths having been delayed due to hospitalization following an incident or having occurred at a care facility where no response from the Coroner's Office was necessary.

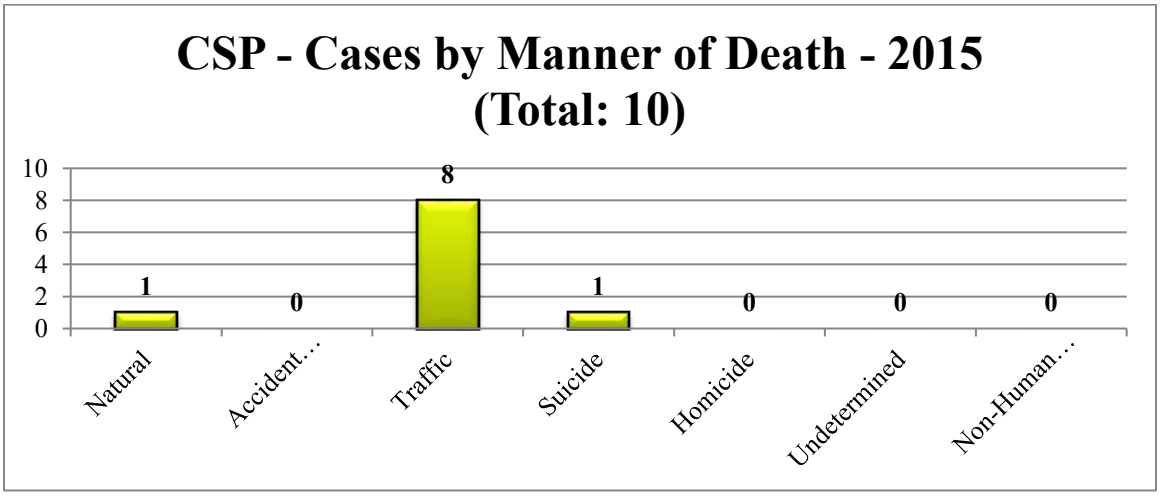


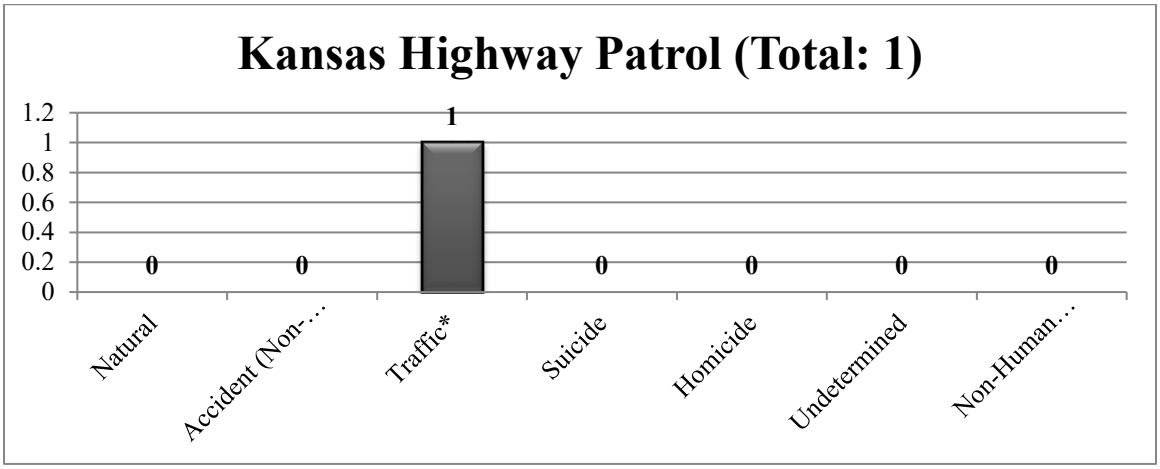

Castle Rock PD - Cases by Manner of Death - 2015 (Total: 47)
30
25
20
15
10
5
0
24
5
1
13
1
1
2
Natural
Accident…
Traffic
Suicide
Homicide
Undetermined
Non-Human…


DCSO Cases by Manner of Death - 2015 (Total: 145)
100
80
60
40
20
0
83
13
4
34
1
2
4
Natural
Accident…
Traffic
Suicide
Homicide
Undetermined
Non-Human…


Parker PD - Cases by Manner of Death - 2015 (Total: 36)
30
25
20
15
10
5
0
28
2
0
4
0
2
0
Natural
Accident (Non-…
Traffic
Suicide
Homicide
Undetermined
Non-Human…





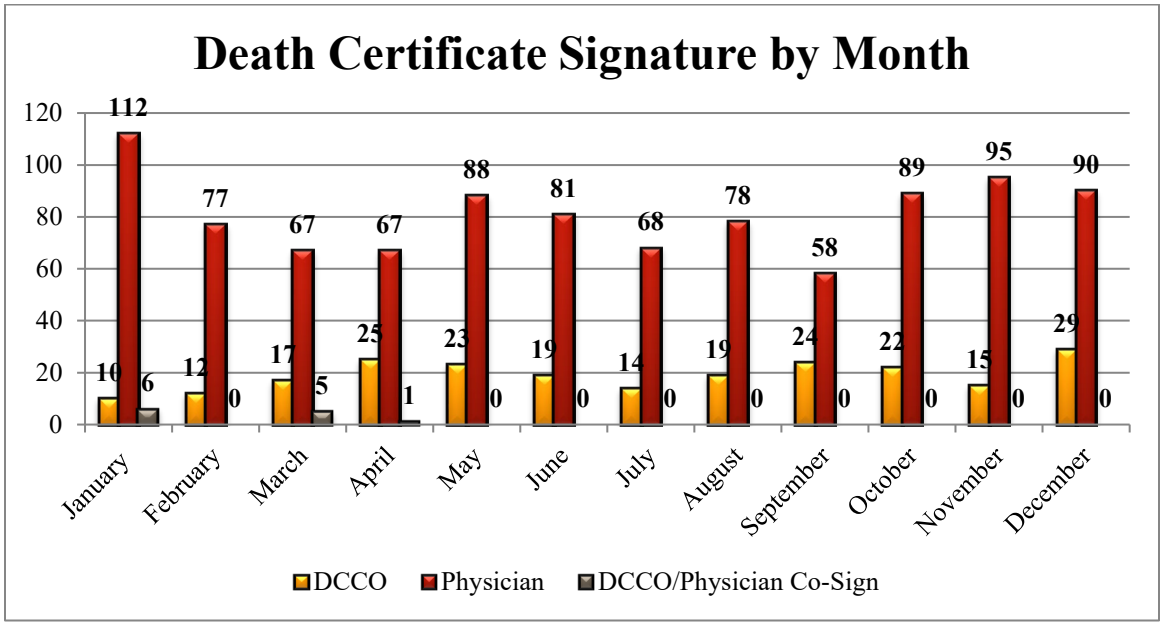


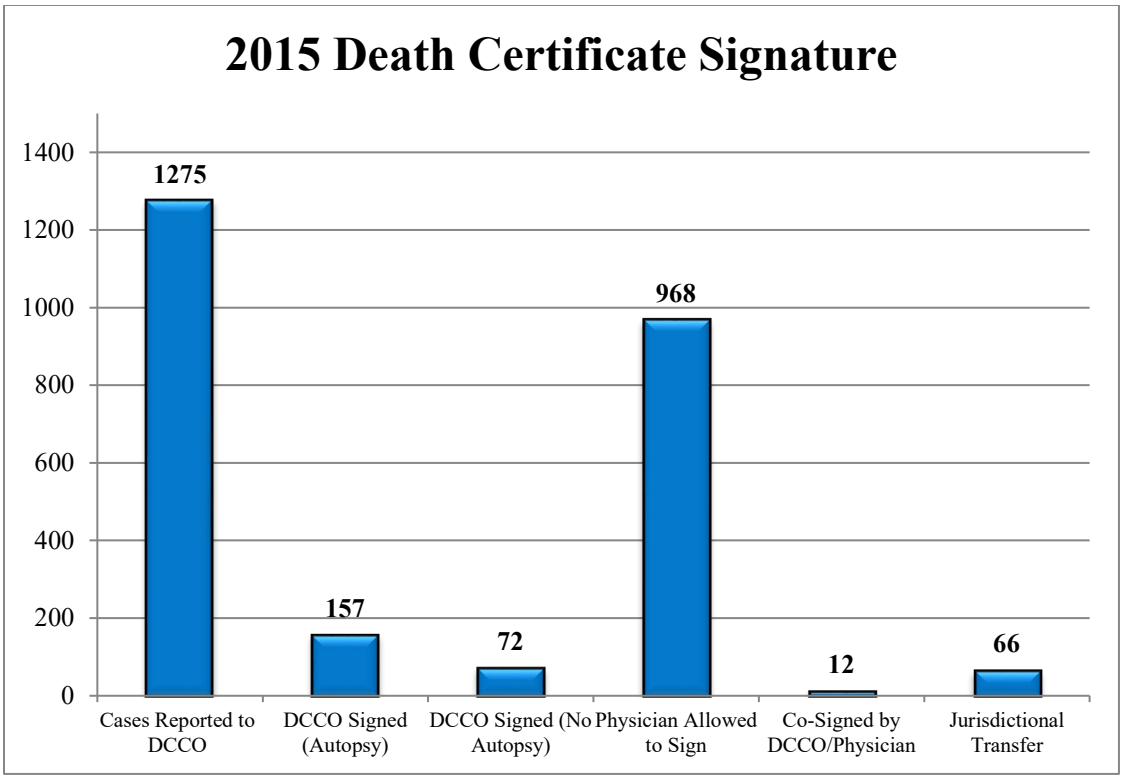
**This case was a 21 year-old female who was airlifted to Sky Ridge Medical Center following a MVC in Kansas.*

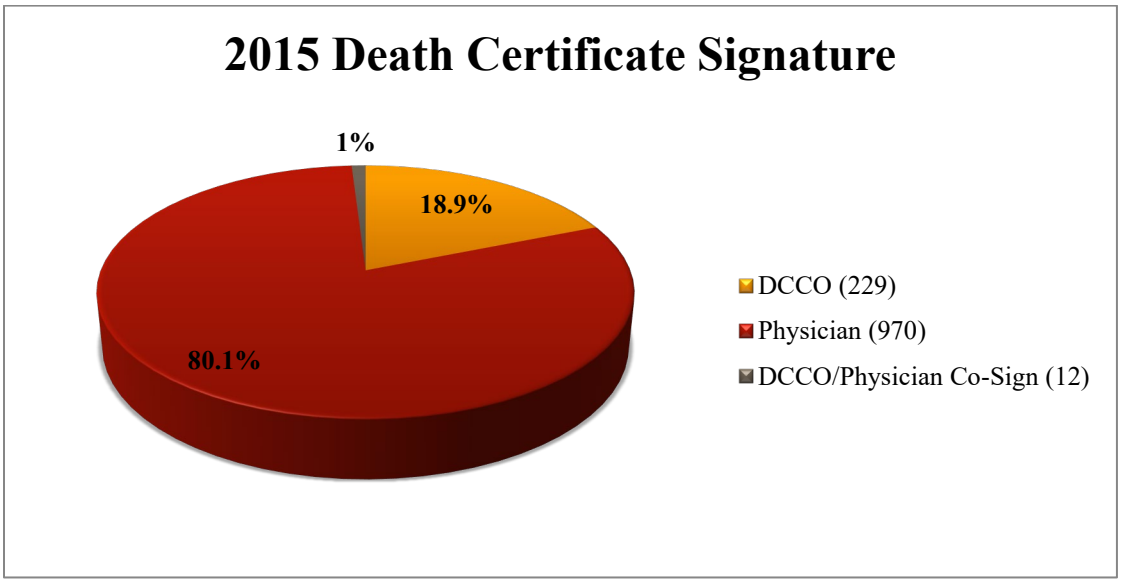
Certification of Death Certificates

When a case is reported to the Coroner's Office, the death certificate for the case can be handled in multiple different ways: the case can be released to a private physician to sign the death certificate; the Coroner's Office can assume jurisdiction of the case and perform an investigation (may or may not include a physical examination such as an autopsy) to determine cause and manner of death and issue a death certificate; or the coroner can co-sign a death certificate with a private physician following an investigation into the cause and manner of death. The Douglas County Coroner's Office also received reports of deaths that occurred in Douglas County that are subsequently transferred to another jurisdiction due to the location of an initiating event (see Transfer of Jurisdiction in this report).

Of the 1209 reported cases to DCCO, 229 of the death certificates were signed by DCCO and 970 of the death certificates were signed by a private physician. There were 12 death certificates that were signed by a private physician and co-signed by DCCO; these death certificates were completed under the previous administration.




2015 Death Certificate Signature
1400
1200
1000
800
600
400
200
0
1275
157
72
968
12
66
Cases Reported to DCCO
DCCO Signed (Autopsy)
DCCO Signed (No Autopsy)
Physician Allowed to Sign
Co-Signed by DCCO/Physician
Jurisdictional Transfer


2015 Death Certificate Signature
1%
18.9%
80.1%
DCCO (229)
Physician (970)
DCCO/Physician Co-Sign (12)

Organ and Tissue Donation

The Uniform Anatomical Gift Act was passed in the United States in 1968 with subsequent revisions being made in 1987 and 2006. The Act has put in place a regulatory framework for the donation of corneas, tissues, organs, and other body parts. An individual can provide first-person consent to be a donor of organs, tissues, corneas, or other body parts such as bone, prior to their death by placing themself on the donor registry. After death, an individual's next-of-kin can provide authorization for recovery. It is the goal of the Douglas County Coroner's Office to facilitate effective collaboration with the donation agencies in Colorado (Donor Alliance and Rocky Mountain Lions Eye Bank) to honor the wishes of the deceased or their families for the individual to be a donor.

Referrals are made to the procurement agencies either from a hospital or directly from a Coroner or Medical Examiner's office. The procurement agencies then work with the family of the individual to determine if the individual is medically suitable to be a donor.

DONOR ALLIANCE
Organ & Tissue Donation

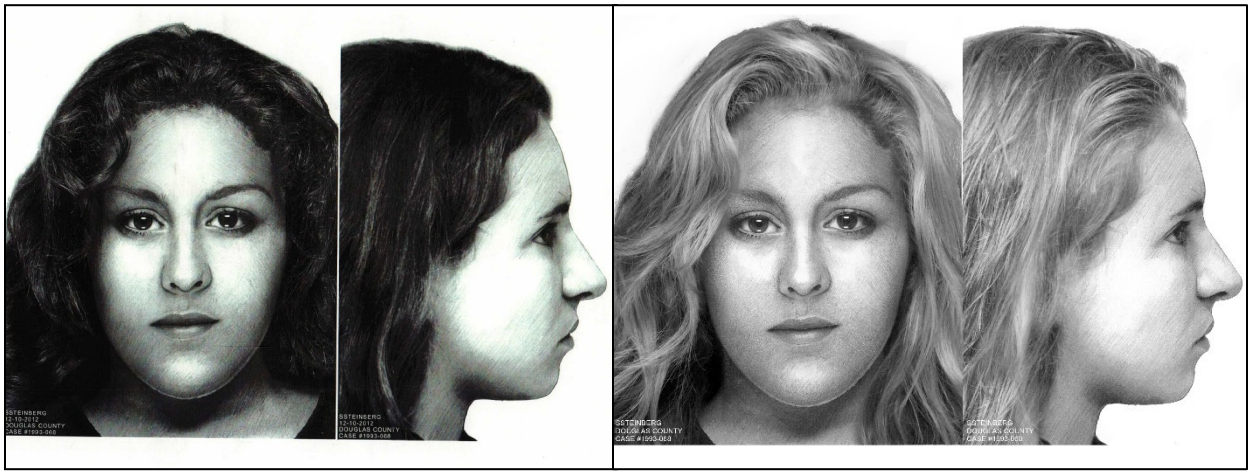
In 2014, the Douglas County Coroner's Office made no direct referral for donation to Donor Alliance. In 2015, the number exponentially increased to 59 referrals; 18 of those referrals were deemed suitable for donation by Donor Alliance and the recovery of tissue and/or bone took place.

rmleb
ROCKY MOUNTAIN LIONS EYE BANK
Share the circle of light

In 2014, the Douglas County Coroner's Office did not make any direct referrals to the Rocky Mountain Lions Eye Bank (RMLEB) for cornea donation. In 2015, the Douglas County Coroner's Office made 26 direct referrals to RMLEB; 25 of those referrals were deemed suitable for donation and the recovery of corneas took place.

Additionally, there were 33 cases that were referred to RMLEB by local hospitals on deaths where the Douglas County Coroner's Office had jurisdiction. All 33 of these referred donors were deemed suitable for donation and cornea recovery took place.

Unidentified Remains



Left: Forensic Artist Rendering from 2012. Right: Updated Forensic Artist Rendering in May 2015. Both by S. Steinberg

The Douglas County Coroner's Office has one open case of unidentified remains, a cold case from 1993. On June 15, 1993, a young female was discovered in the southwest region of Douglas County near Rainbow Falls campground. She was found wearing only a black Harley-Davidson T-shirt and a few pieces of jewelry. The Douglas County Coroner's Office, in cooperation with the Douglas County Sheriff's Office, has continued working on the Jane Doe case 22 years after her death.

In 1993, the decedent was buried in Cedar Hill Cemetery (Castle Rock, CO) under the name of Jane Doe, after valiant efforts to identify her were unsuccessful. On October 12, 2012, her remains were exhumed from her grave for additional forensic analysis that was not available at the time of her death. A complete DNA analysis was obtained and a new forensic artistic rendering was completed by Samantha Steinberg, a forensic artist at the Miami-Dade Police Department. Her remains are currently being held at the Coroner's Office.

2015 Updates

In partnership with the Douglas County Sheriff's Office, evidence that was collected at the time of the incident in 1993 was re-examined in 2015 in hope of uncovering new clues. During this re-evaluation, hair from the decedent located in evidence was determined to be lighter than originally documented. An updated forensic artistic rendering was completed to reflect the corrected hair color.

In addition, in August 2015, a new anthropological analysis was completed. The age range was adjusted to very late teens to early twenties based mostly on postcranial skeletal development and dental development. Prior age range was thought to be early to late teens. Additional analyses of the bones are suggestive of possible anemia and sacralized vertebra. These anatomical anomalies help individualize Jane Doe even more when compounded with the prior splenectomy and unrestored dentition originally known. This information was shared with NAMUS, a national missing and unidentified persons system. The Douglas County Coroner's Office is committed to using all avenues available to identify her in hope of reuniting her with her family.