Coroner Jill E. Romann

2016 ANNUAL REPORT

Douglas County Coroner's Office

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DOUGLAS COUNTY COLORADO
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Cover: Coroner Romann speaks at a news conference December 1, 2016.

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 in the loss, this report is dedicated.

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A Personal Message from Coroner Romann

Welcome to the 2016 Annual Report from your Douglas County Coroner's Office. In keeping with the goal of maintaining a high standard of visible accountability for the Office, I am proud to submit the following summary and data of our 2016 activities.

This summary serves multiple purposes. For those who have referenced the 2015 Annual Report, it should be a "refresher" of terminology, definitions, jurisdictional responsibilities, and statistics. For those new to the report, it will provide an insightful look at the office foundations, so that the reader might quickly appreciate the significance of the statistical details found within. From this vantage point, the reader will quickly see the Coroner's function is not just the dispensation of the deceased, but a dynamic "hub" of information important to different management offices within the county, state, and at the national level. For instance, in 2016 in our county, we have a dramatic increase of 80% in motor vehicle fatalities! These statistics coalesce partners in safe driving campaigns. This helps traffic planners pick out hazardous locations of heavy traffic patterns, leading to vehicular fatalities; helps Law Enforcement focus on areas of extra needed enforcement. This information may also help citizens and citizen groups, such as those who have brought attention to our legislators of the proposed legislation (SB17-027 to increase penalty while texting during driving). Other statistics include child deaths, which are especially tragic, but the investigative benefit of each will help us protect children now and in our future. Suicide deaths are complicated issues of national importance. The locations, age, gender, circumstances, and mechanisms of death by suicide translate into vital understanding about mental health in our communities.

On a brighter side, the Coroner's Office is a focal point of organ and tissue donation, which saves lives and relieves pain for unfortunate, but still living recipients. Academic medical research is important for the benefit of everyone. When asked, family members frequently want their loved one to continue giving through life-saving, life-enhancing, and research opportunities.

Since our office is part of a national data network, it is part of a bigger picture which helps to improve our standard of living in America. Clearly, the Douglas County Coroner's Office functions far beyond the idea of a single benefit to our community. My belief is that a well-run government office works daily with efficiency, time-worn and honed integrity, norms and accountability. Your Coroner's charge is to provide for the living, while caring for the deceased. And with that, I again, say "welcome." Now, onto the facts and figures….

Sincerely, Coroner Jill Romann

Duties of the Coroner's Office

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.

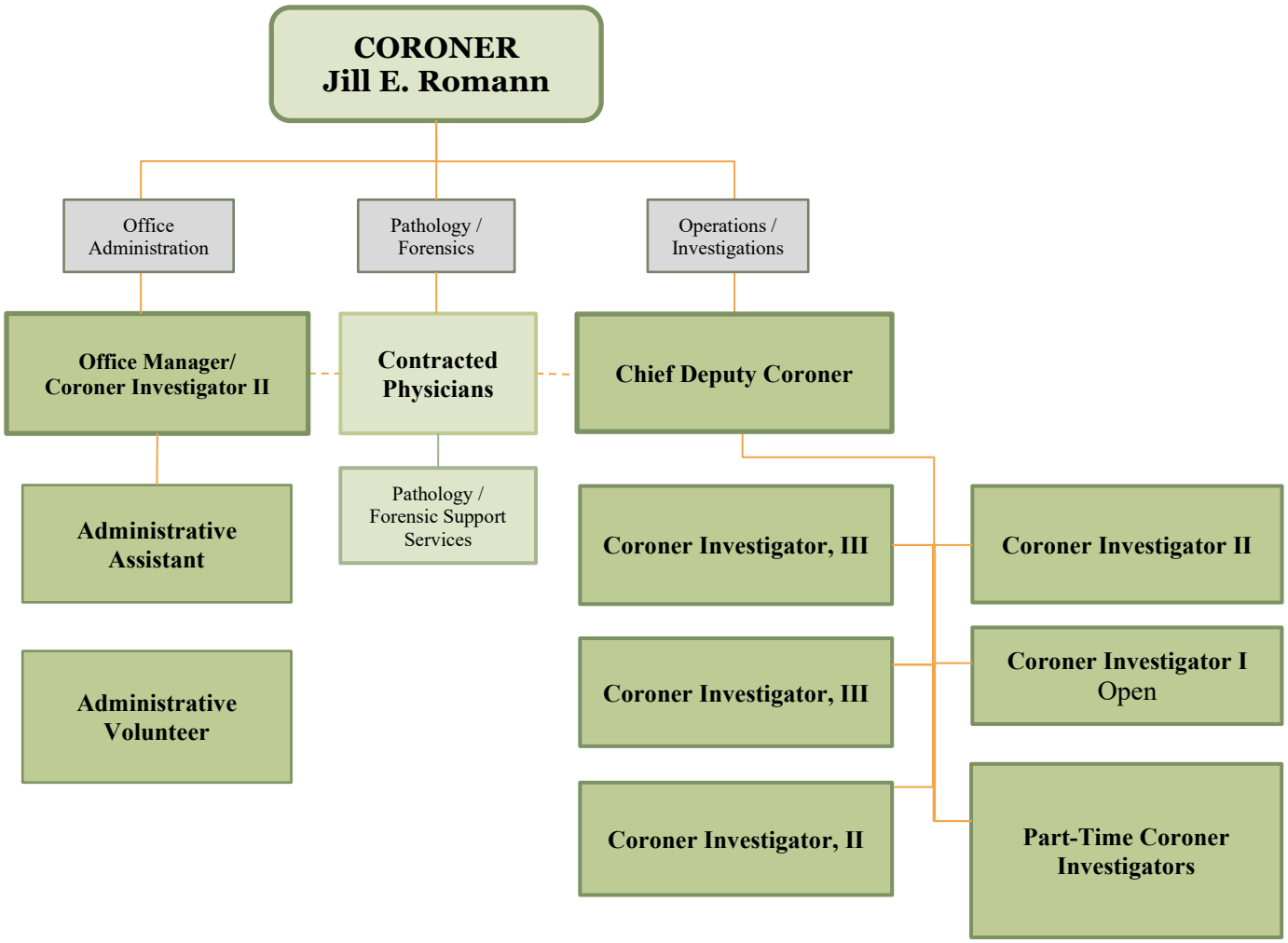
MISSION STATEMENT

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 completion of associated responsibilities. To this end, we strive for nothing less than excellence in practice, integrity, compassion, and continuous advancement in the field.

CORE VALUES

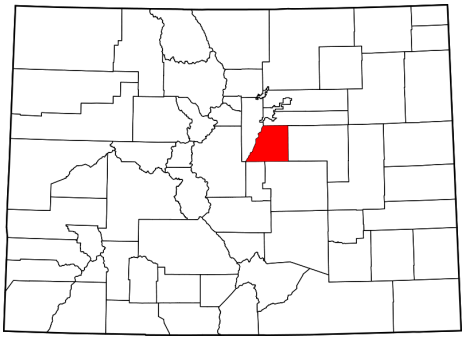
SERVICE ◻ COMPASSION ◻ PROFESSIONALISM ◻ DIGNITY ◻ INTEGRITY

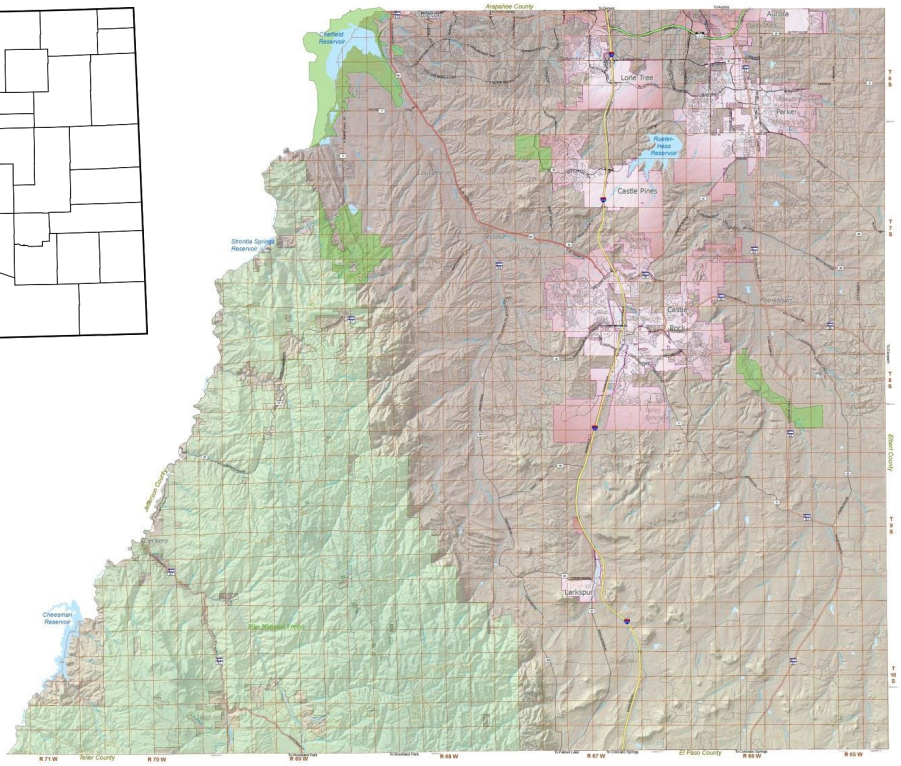
DCCO Organizational Chart



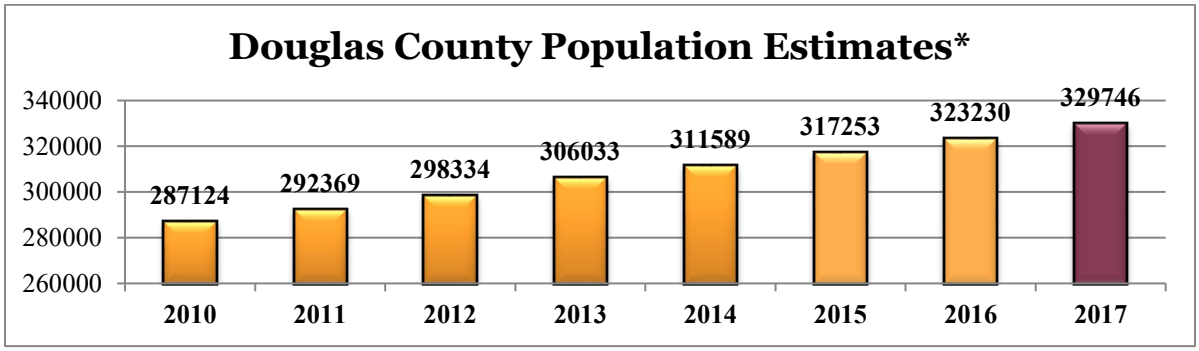
Jurisdictional Boundaries

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 as of 12/2016*

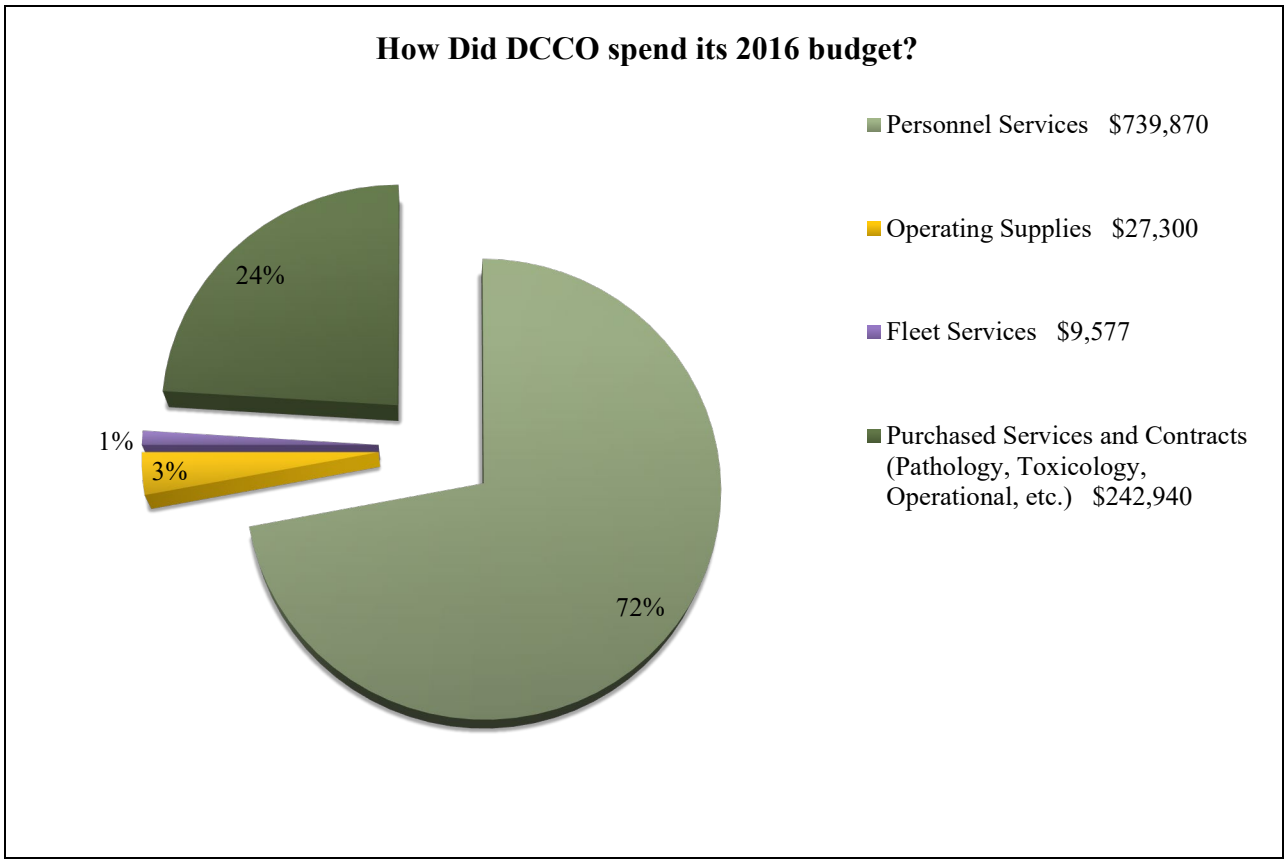
Budget

Funding

Funding for the Coroner's Office originates from the Douglas County general fund. In 2016, the county manager and commissioners approved an adopted budget of $1,107,688, representing a **0% increase over 2015**. DCCO's budget was less than **1**% of the total 2016 General Fund, which was $128.3 million. It represented approximately **0.3**% of the total 2016 Douglas County annual budget of $346 million.

Expenditures

Total expenditures for the year were $1,019,687, **8% under budget, with a savings of $87,980 returned to the general fund.**



Over the past 2 years, Coroner Romann and her staff have saved taxpayers nearly a quarter of a million dollars. $242,109 to be exact!

Revenues

The office received revenue from two sources in 2016. The first being referral services, where neighboring counties and medical professionals are charged for the use of conducting autopsies which they perform at our facility. The second was for associated administrative fees. Total revenue for 2016 was $8,899. This money went directly to the general fund. It did not go towards the Coroner's budget as additional funding.

Accountability to the Taxpayer

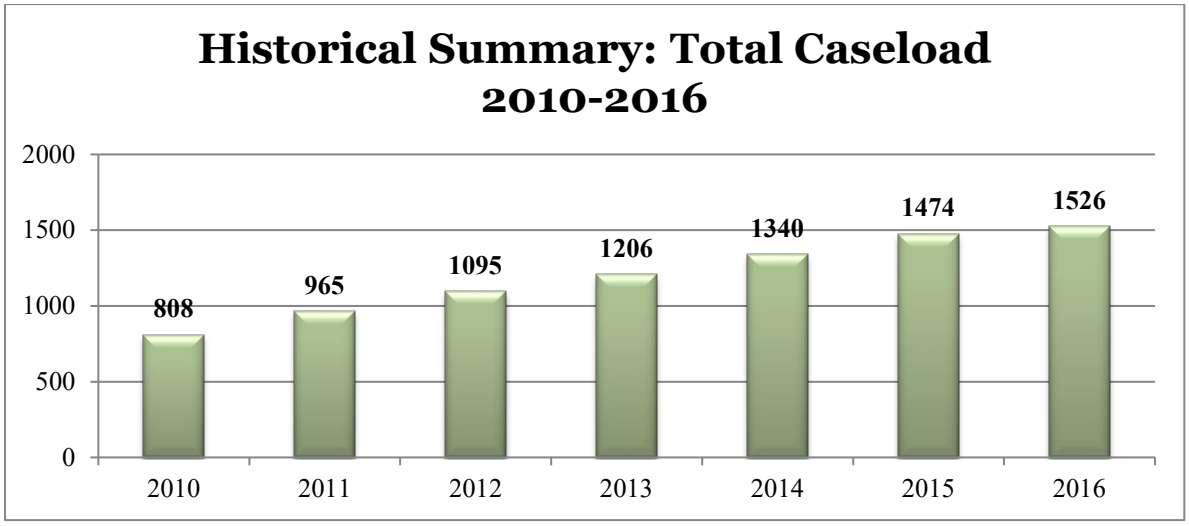
Coroner Romann takes very seriously the responsibility of balancing conservative fiscal oversight on behalf of the taxpayer, with maintaining the highest level and quality of service delivery to the citizens. One of the best ways to track fiscal responsibility and efficiency is to calculate the cost-per-case; or simply divide the total tax dollars spent by the number of cases handled. In 2016, the cost-per-case dropped from $739 in 2015 to $727 in 2016.

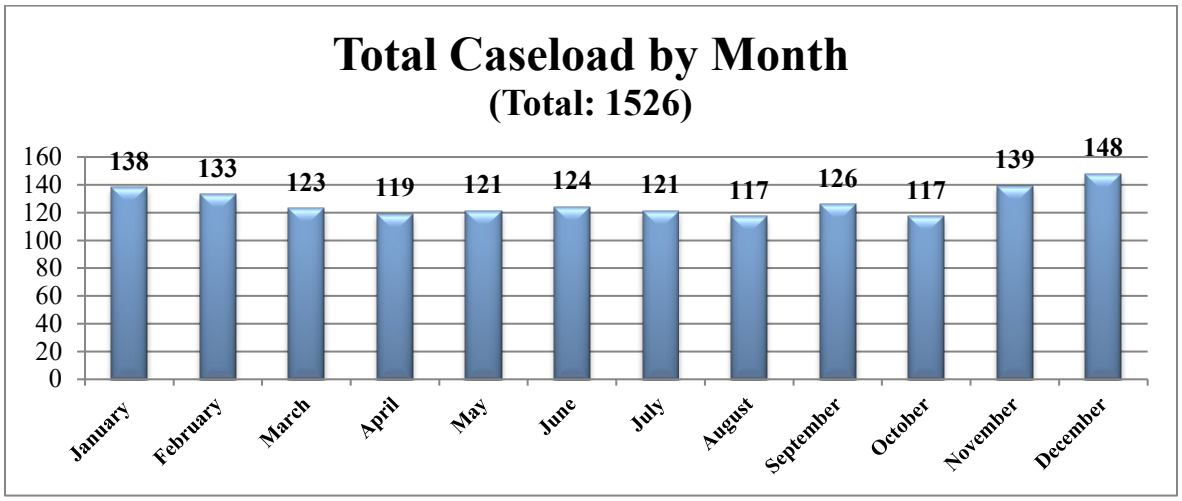
	Previous Administration		Coroner Romann's Administration	
	2013	2014	2015	2016
Population	306,033	311,589	317,253	323,230
Caseload*	1066	1172	1320	1401
Actual Dollars Spent	$870,769	$924,536 6.1% Increase	$976,251 5.5% Increase	$1,019,687 4.4% Increase
Cost per Case	**$816**	**$788**	**$739**	**$727**

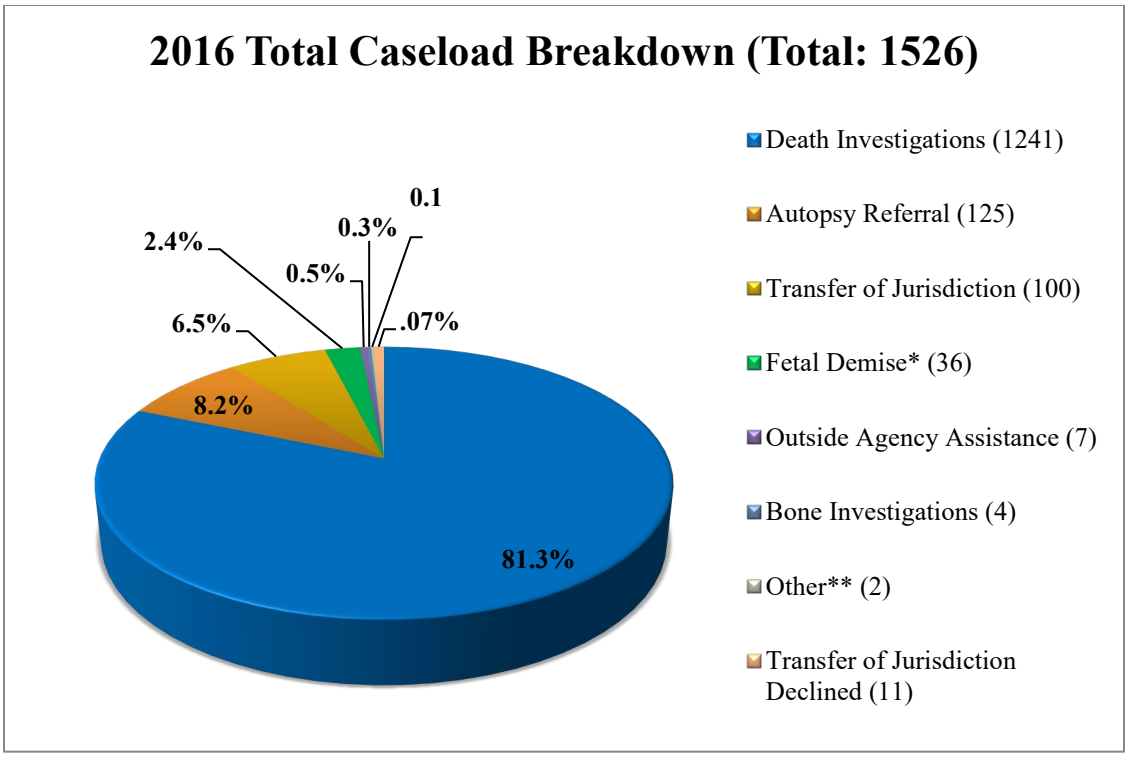
**Caseload is calculated by subtracting Autopsy Referrals from Overall Caseload.*

2016 CASELOAD

The overall total caseload for 2016 was 1526, which included Death Investigations (1252), Fetal Demises (36), Bone Investigations (4), Outside Agency Assistance (7), Transfers of Jurisdiction (100), Autopsy Referrals (125) which are out of county/private autopsies conducted at our facility, and Other (2).







**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.*

2015 – 2016 Comparison

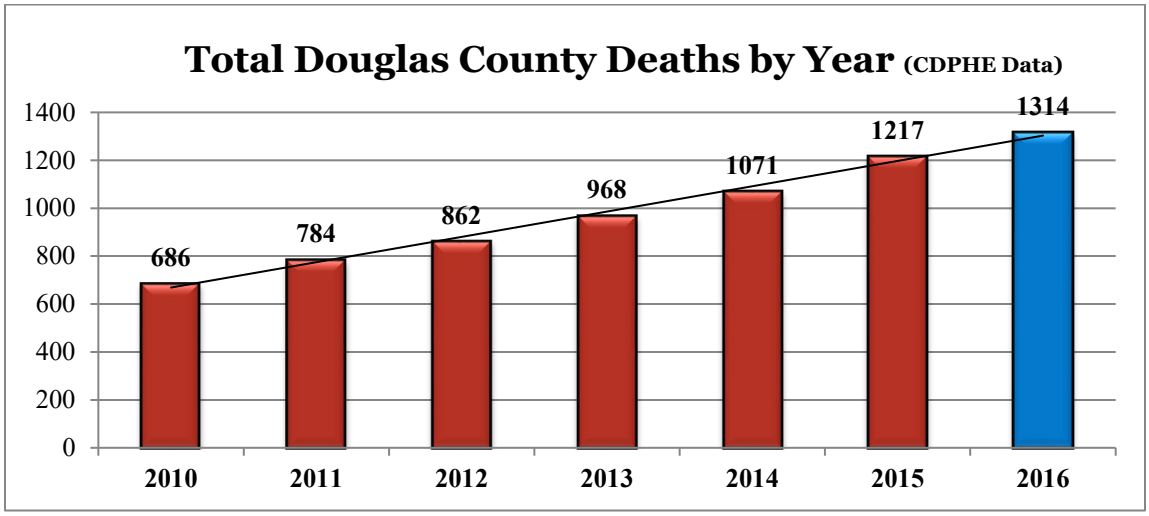
	2015	2016	% Change
Overall Caseload	1474	1526	3.5% ↑
Death Investigations	1209	1252	3.4% ↑
Fetal Demises	32	36	11.1% ↑
Bone Investigations	6	4	33.3% ↓
Outside Agency Assistance	8	7	12.5% ↓
Transfer of Jurisdiction	66	100	34% ↑
Autopsy Referrals	153	125	18.3% ↓
Other**	0	2	

***(1) Unclaimed Found Urn; (1) Memorial Site Investigation*

Of the overall caseload in 2016, not all cases are considered jurisdictional; Autopsy Referrals, Transfer of Jurisdictions, Outside Agency Assists, Transfers of Jurisdiction which we declined, Non-Human Bone Investigations, and Other. While cases require work to meet obligations of the office, they are not considered jurisdictional. Therefore, the following statistics contained in this report focus only on cases which DCCO retained jurisdiction (1235); Death Investigations (1241), and Fetal Demises (36).

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

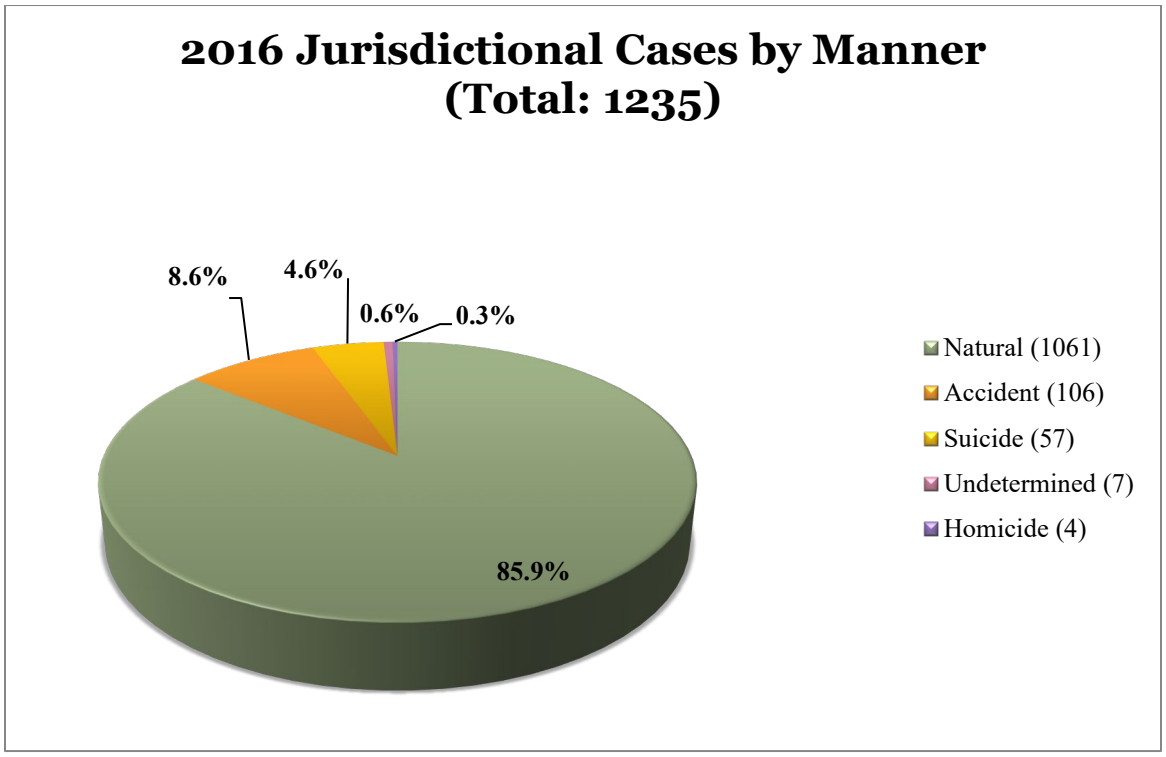
A death certificate is required to be filed with the Colorado Department of Public Health & Environment (CDPHE) for each death that occurs in Douglas County. Discrepancies may exist between CDPHE and Douglas County statistics due to transfer of jurisdiction and the locations of death listed on the death certificate. The chart below reflects the total number of death certificates filed with CDPHE that list the death as occurring in Douglas County since 2010. **98%** of all deaths occurring in Douglas County that were filed with the Colorado Department of Public Health and Environment (CDPHE) in 2016 were reported to the Douglas County Coroner's Office. There were thirty-one (31) deaths that occurred in Douglas County (per CDPHE) that were not reported to the Douglas County Coroner's Office. The average annual increase of deaths in Douglas County between 2010 and 2016 has been **11%** per year.



** Source Colorado Department of Public Health & Environment*

Jurisdictional 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. In addition, there are cases where the coroner's office investigates suspicious death related circumstances. Legally there are five manners of death: Natural, Accidental, Suicide, Homicide, and Undetermined.



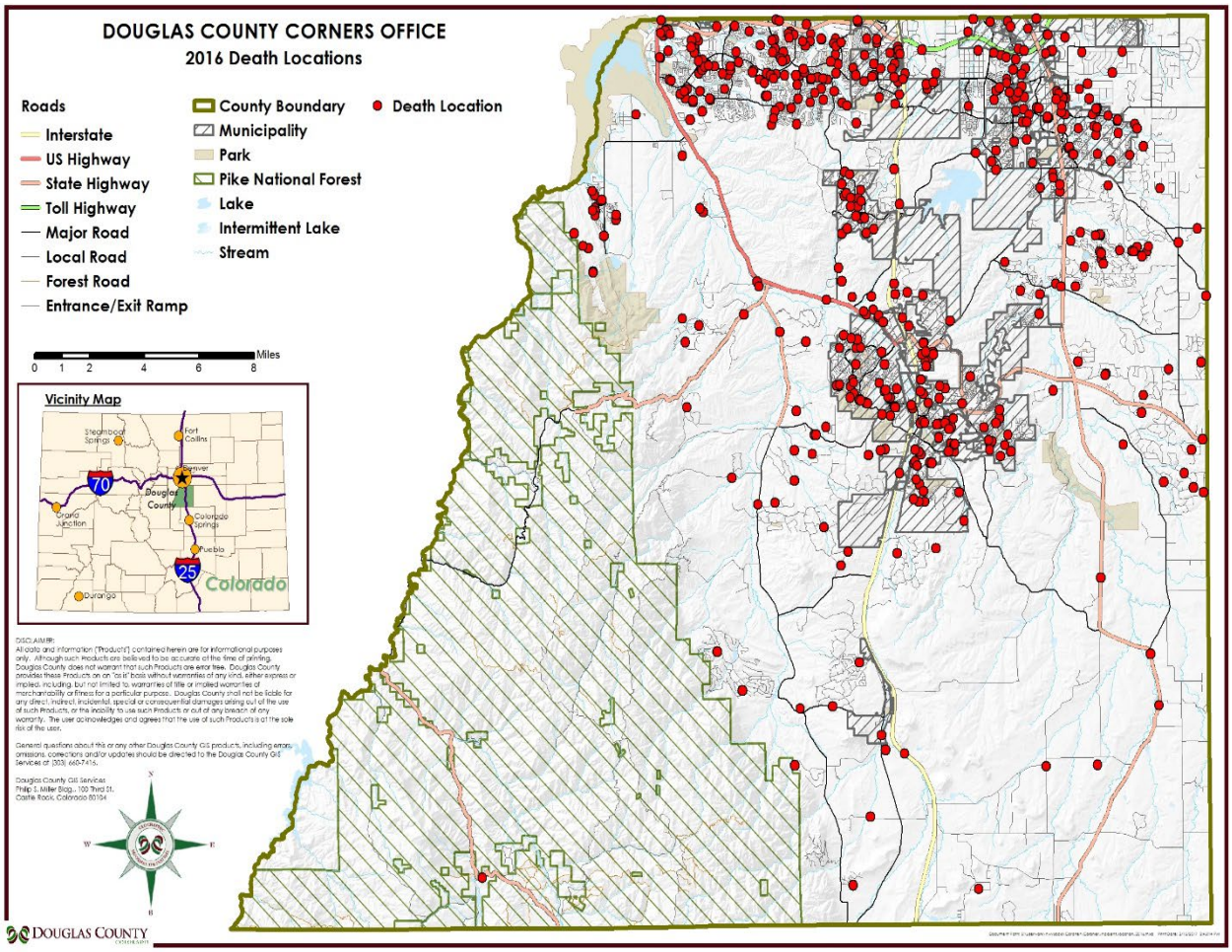
2013 – 2016 Comparison

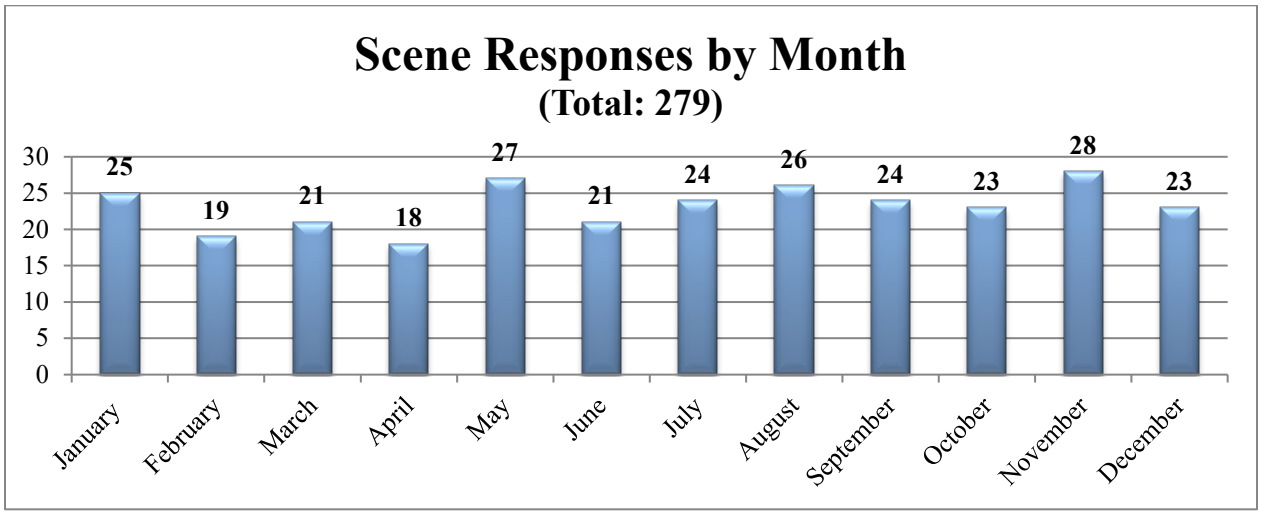
	2013	2014	2015	2016
Natural	844	952	1065	1061
Accident	97	104	106	106
Suicide	57	47	58	57
Homicide	0	2	2	4
Undetermined	5	6	7	7

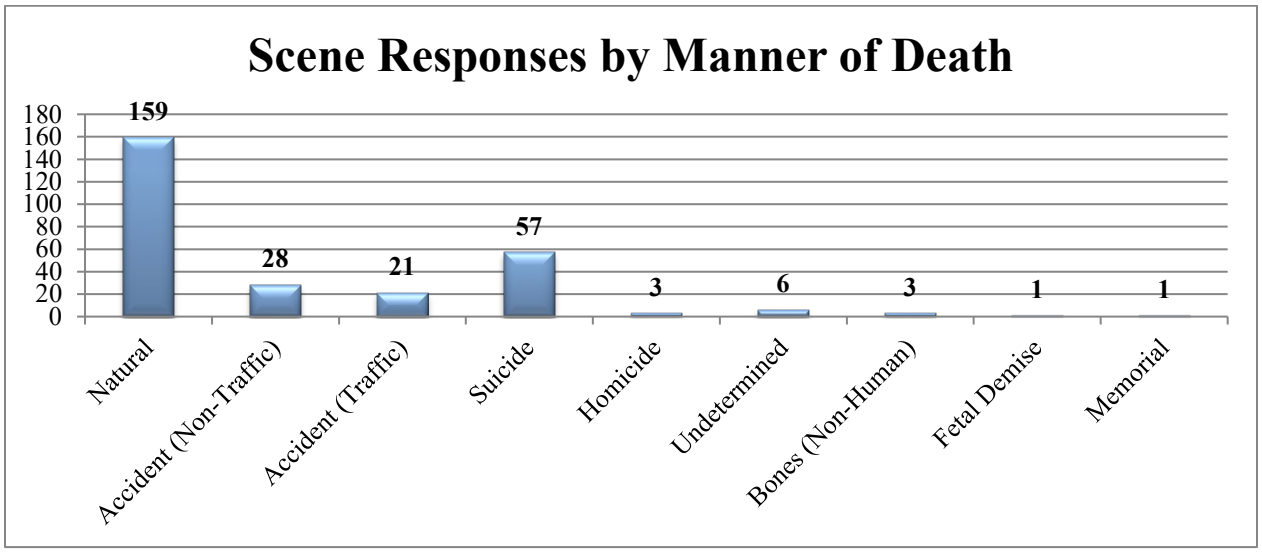
Scene Response

The Douglas County Coroner's Office responded to 279 death scenes which accounted for **22.5%** of all the jurisdictional deaths reported to the Coroner's Office in 2016. 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 surrounding 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.

After a scene investigation, the Medicolegal Death Investigator decides 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.





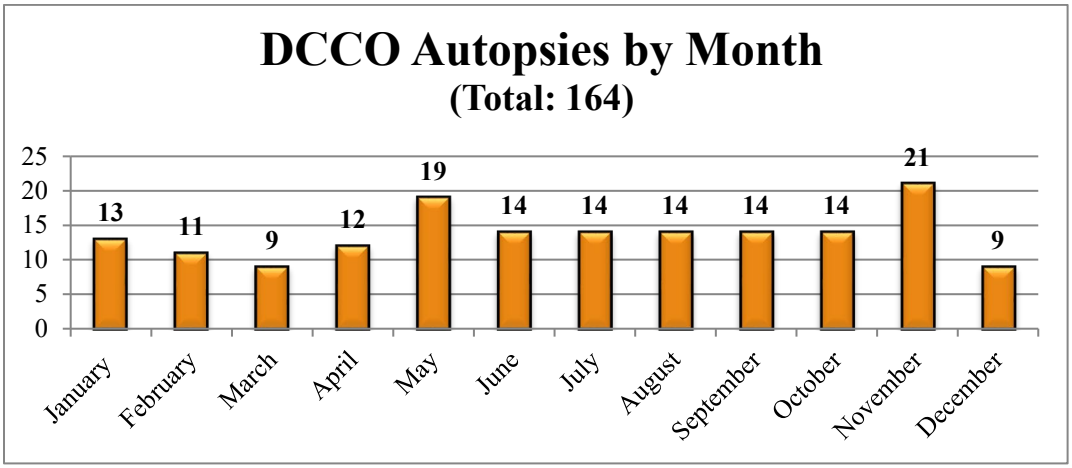


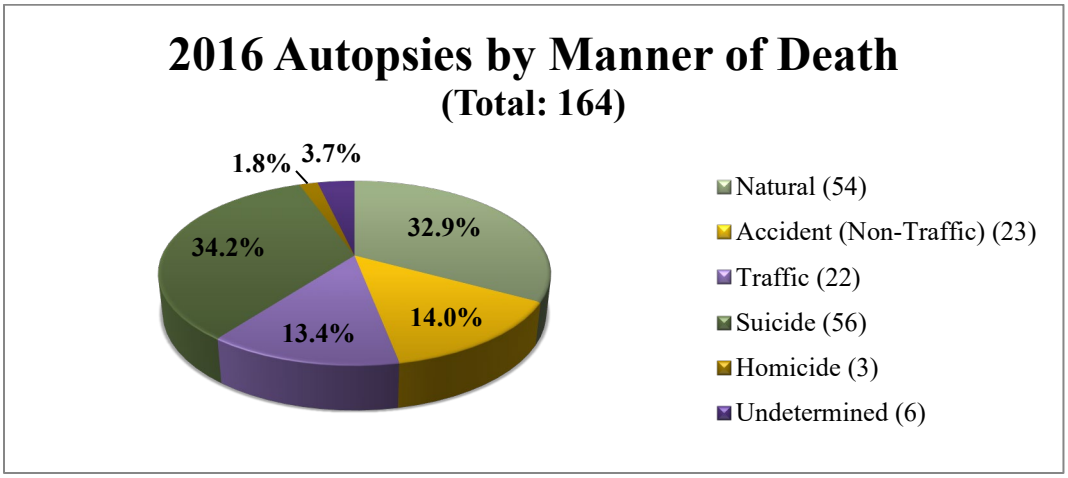
Of the 341 decedents transported to the Coroner's Office, 220 were transported by DCCO investigators. The remaining 121 were transported by transport services, other counties, and Donor Alliance.

Autopsies

Of the cases the Douglas County Coroner's Office retained jurisdiction over in 2016, 164 or **13.2%** 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 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 which led to the death.





Of the 164 autopsies performed in 2016, 156 were full autopsies, 1 was an external-only autopsy, and 7 were head-only autopsies. Toxicology studies were performed in 156 cases. **100**% of toxicology was completed in under 60 days.

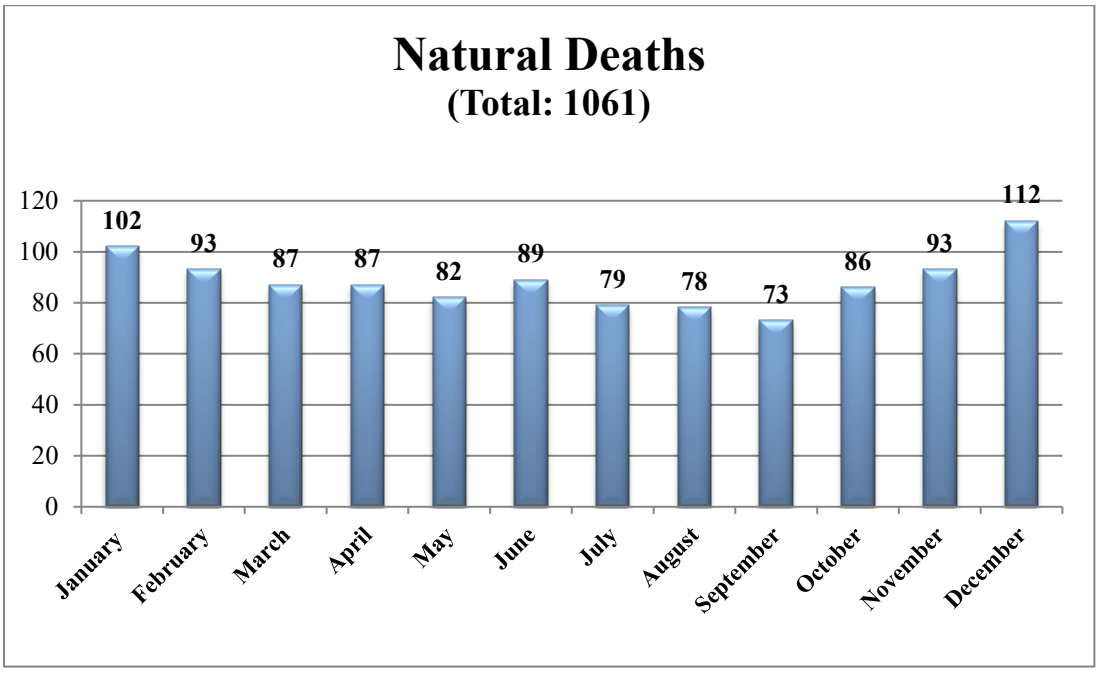
STATISTICS BY MANNER OF DEATH

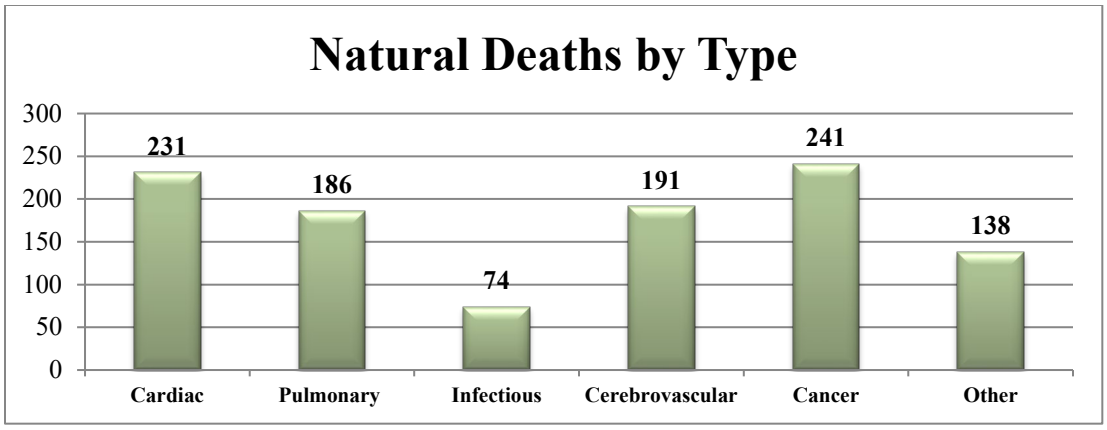
Natural Deaths

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).

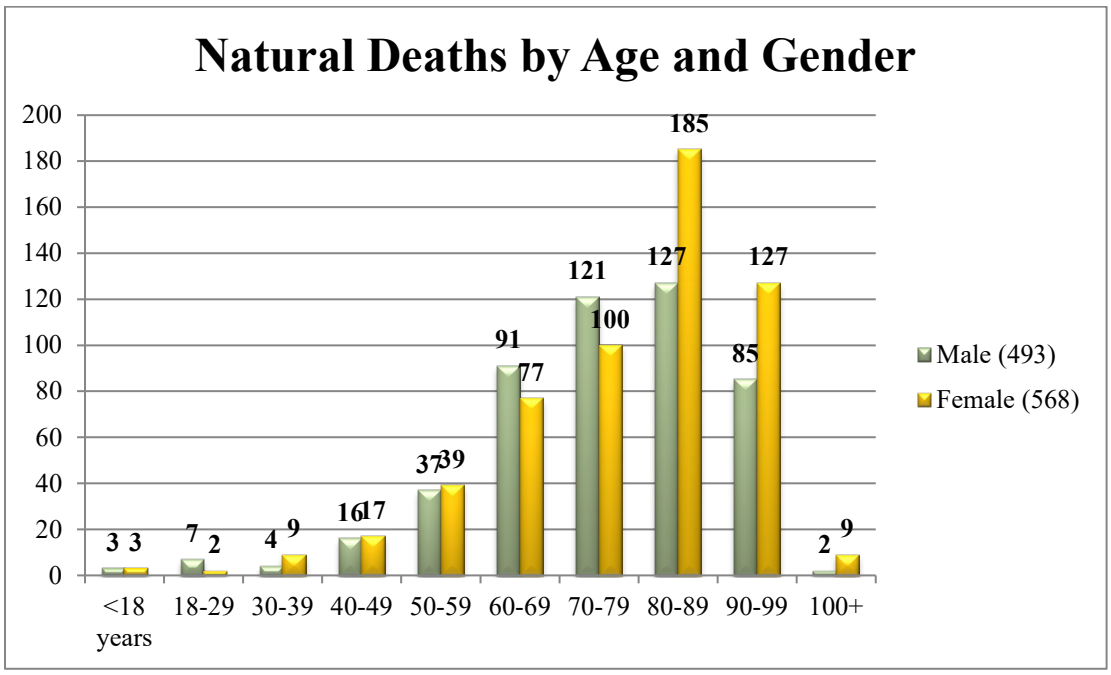
In many instances when a natural death is reported, jurisdiction of the case is released back to the decedent's physician who will issue the death certificate. Most deaths reported to the Coroner's Office are deaths due to natural causes.

Natural deaths accounted for **85.9%** of the total DCCO jurisdictional deaths for 2016.





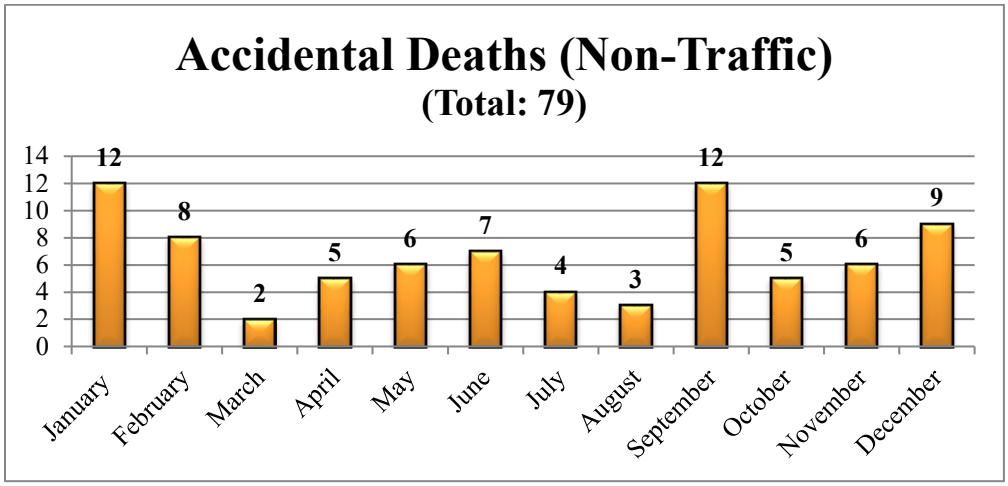
Of natural deaths 231 were deemed cardiac related, 186 pulmonary, 74 infectious, 191 cerebrovascular, 241 cancer, and 138 other



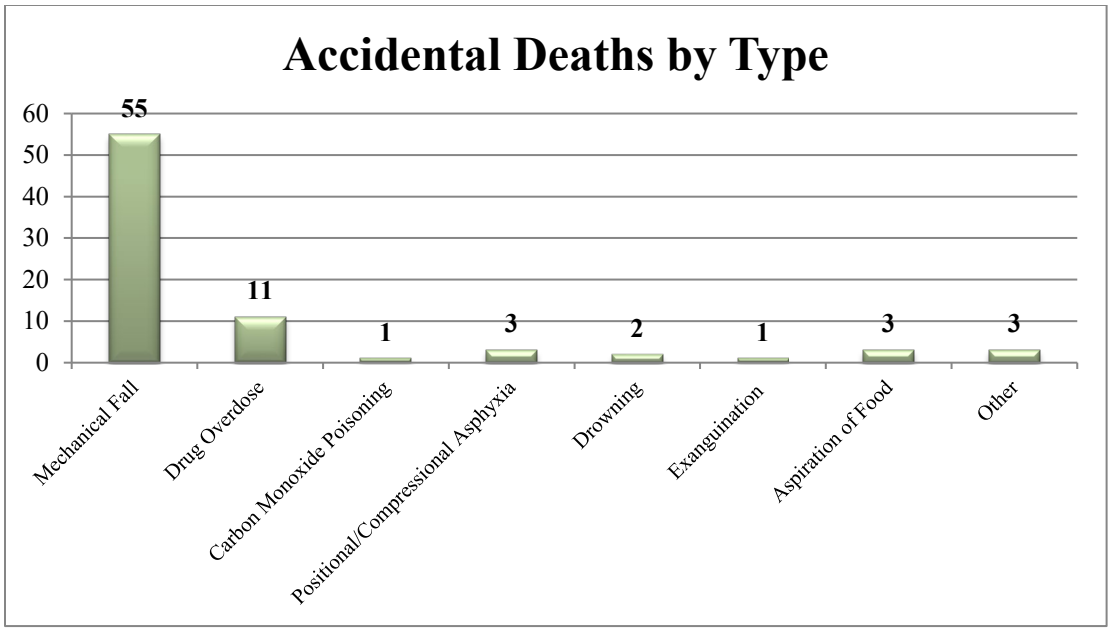
Accidental Deaths

Accidental deaths are deaths that result from injury or poisoning that occurred without the intent for harm or to cause death. They are divided into Non-Traffic, and Traffic related sub-categories.

Non-traffic accidental deaths accounted for **6.4%** of the total DCCO jurisdictional deaths for 2016.

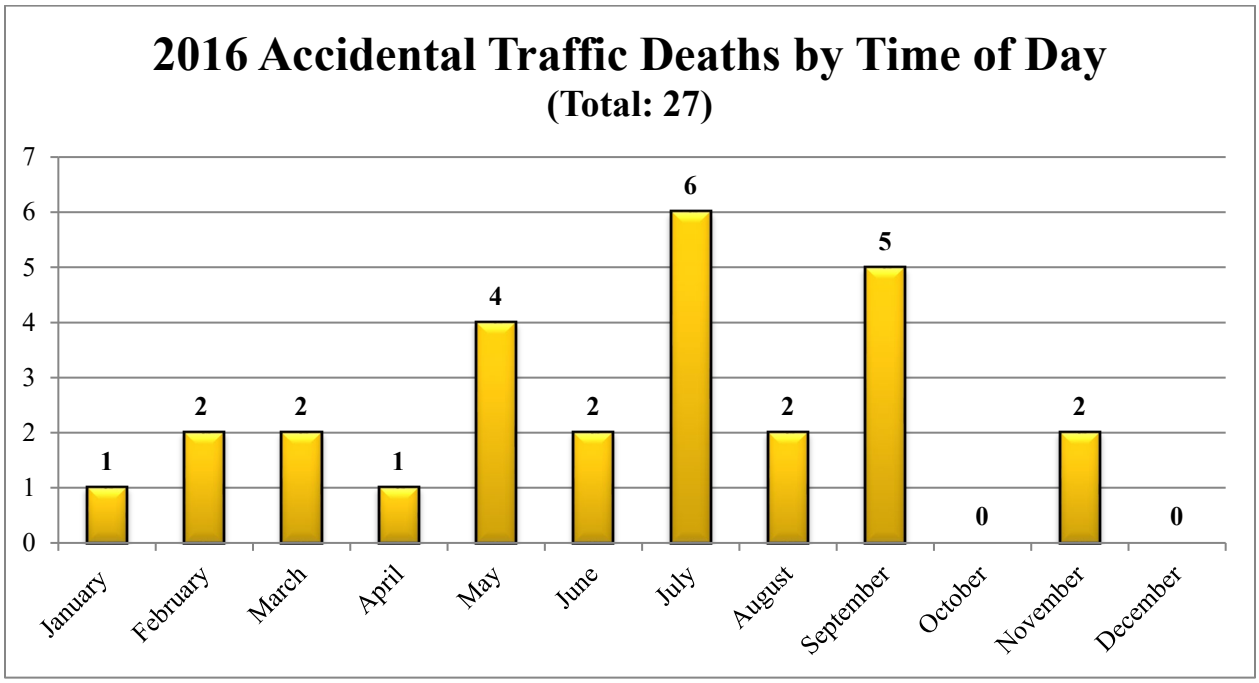


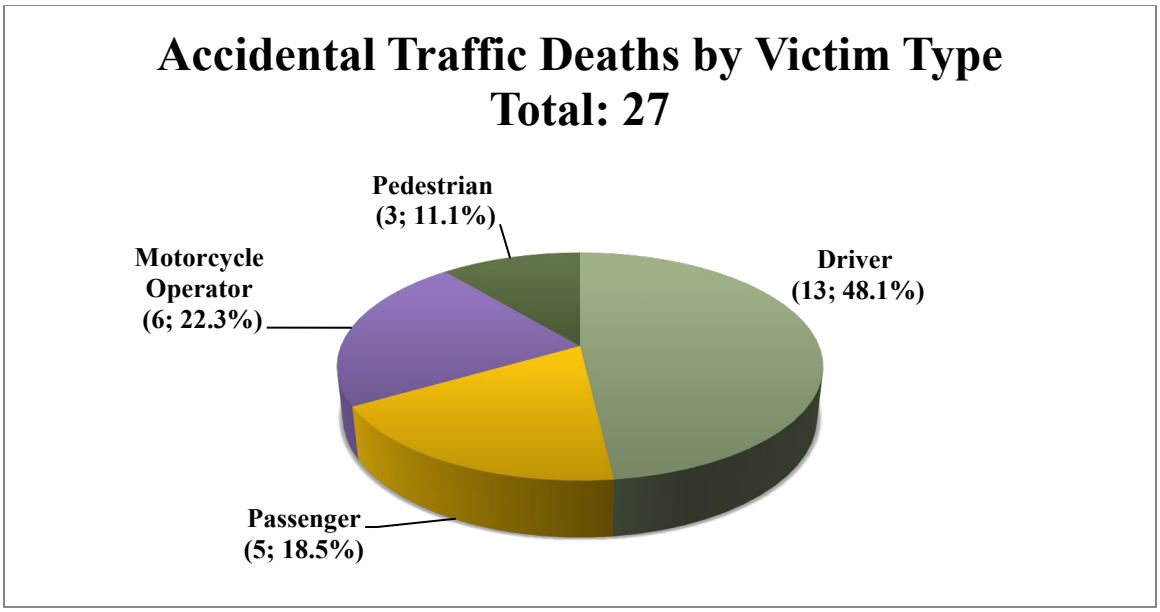
Of the non-traffic related accidental deaths reported to the Douglas County Coroner's Office, most of the deaths were related to complications of a mechanical fall, typically a fracture or head injury, or an unintentional drug overdose.

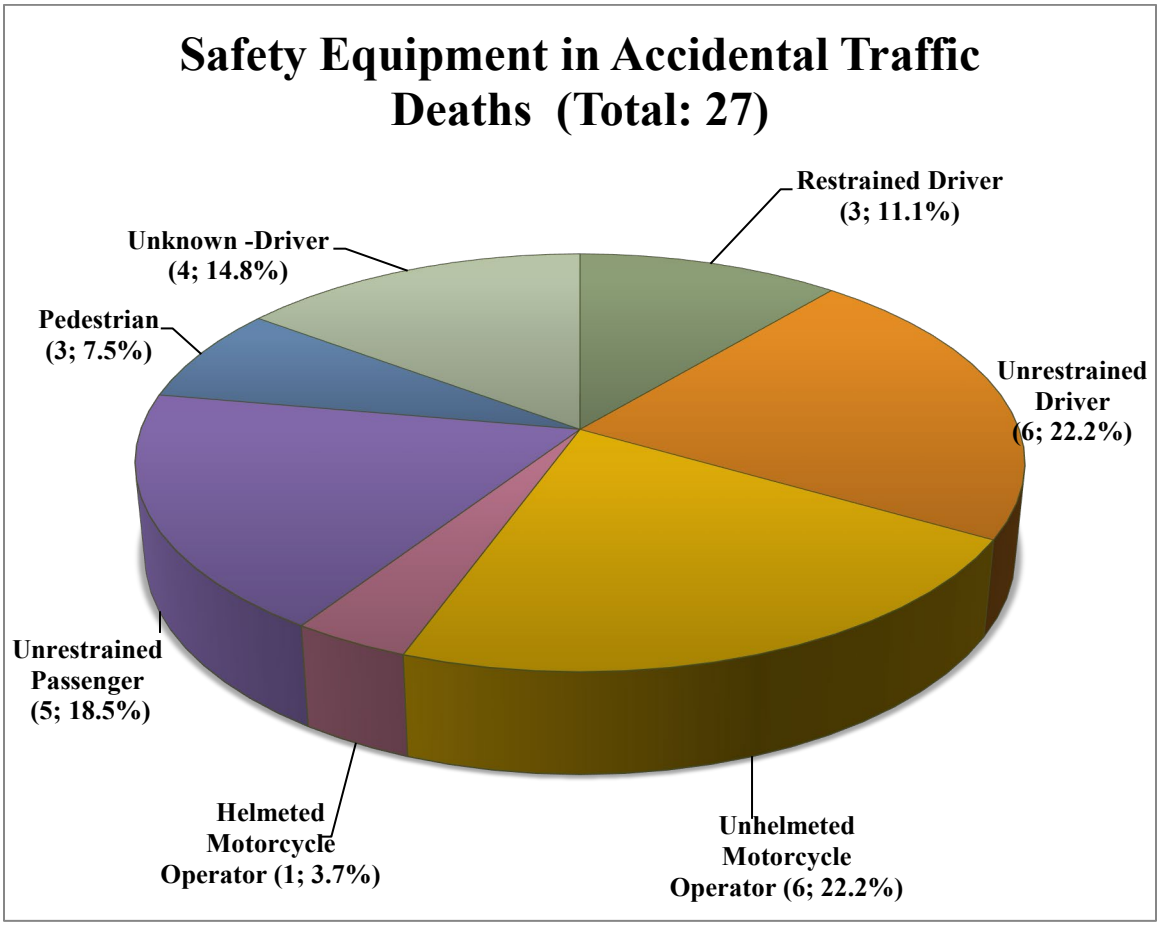


Traffic related accidental deaths include deaths in which the deceased was an occupant of a motor vehicle, motorcycle, tractor, bicycle, or a pedestrian involved in a motor vehicle-pedestrian incident.

Traffic related accidental deaths accounted for **2.2%** of the total DCCO jurisdictional deaths for 2016.



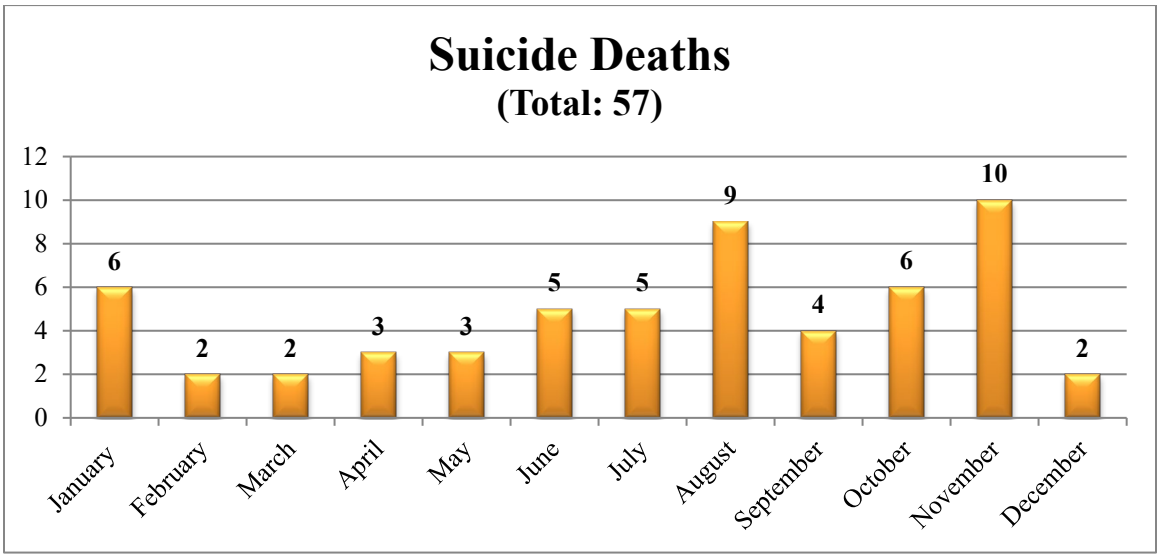

Accidental Traffic Deaths by Victim Type
Total: 27
Pedestrian
(3; 11.1%)
Motorcycle
Operator
(6; 22.3%)
Driver
(13; 48.1%)
Passenger
(5; 18.5%)

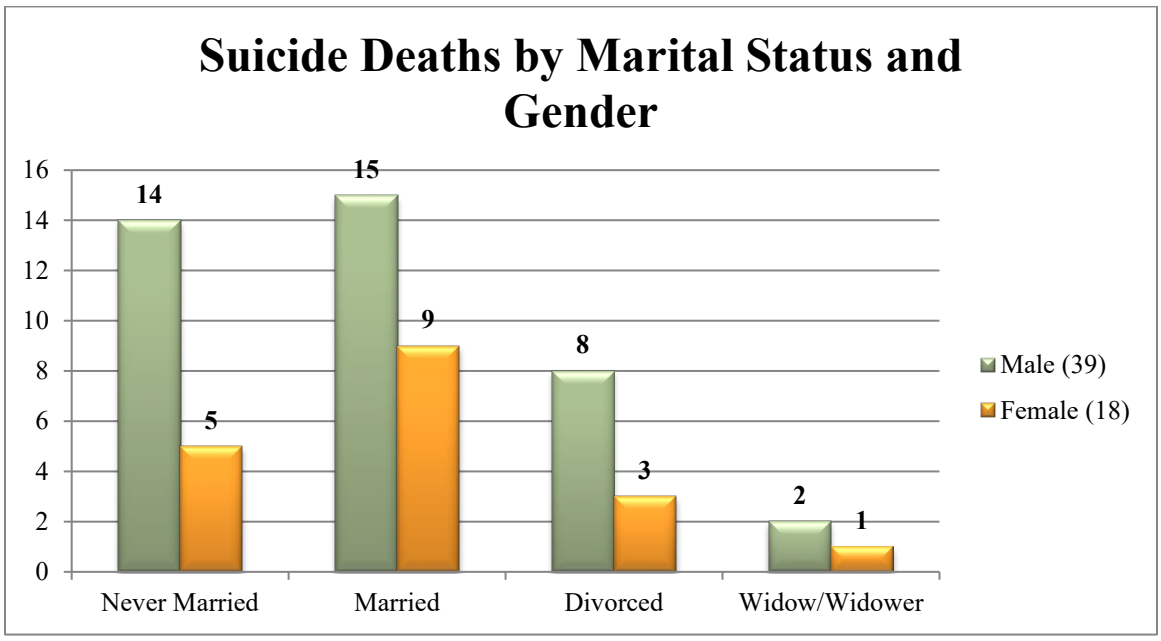

Safety Equipment in Accidental Traffic
Deaths (Total: 27)
Restrained Driver
(3; 11.1%)
Unknown -Driver
(4; 14.8%)
Pedestrian
(3; 7.5%)
Unrestrained
Driver
(6; 22.2%)
Unrestrained
Passenger
(5; 18.5%)
Helmeted
Motorcycle
Operator (1; 3.7%)
Unhelmeted
Motorcycle
Operator (6; 22.2%)

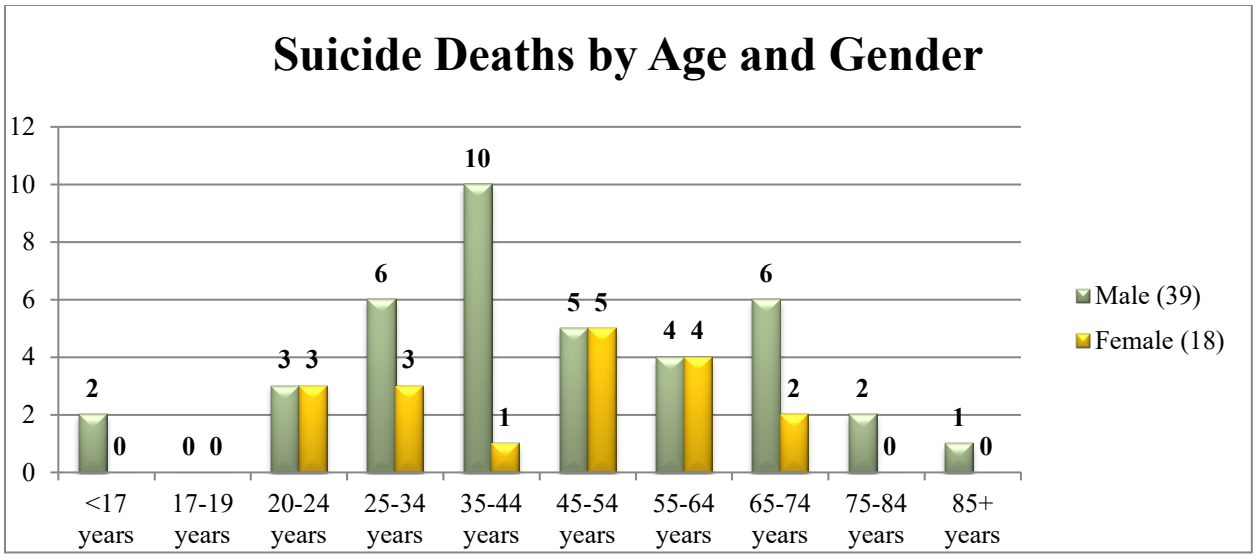
Suicide Deaths

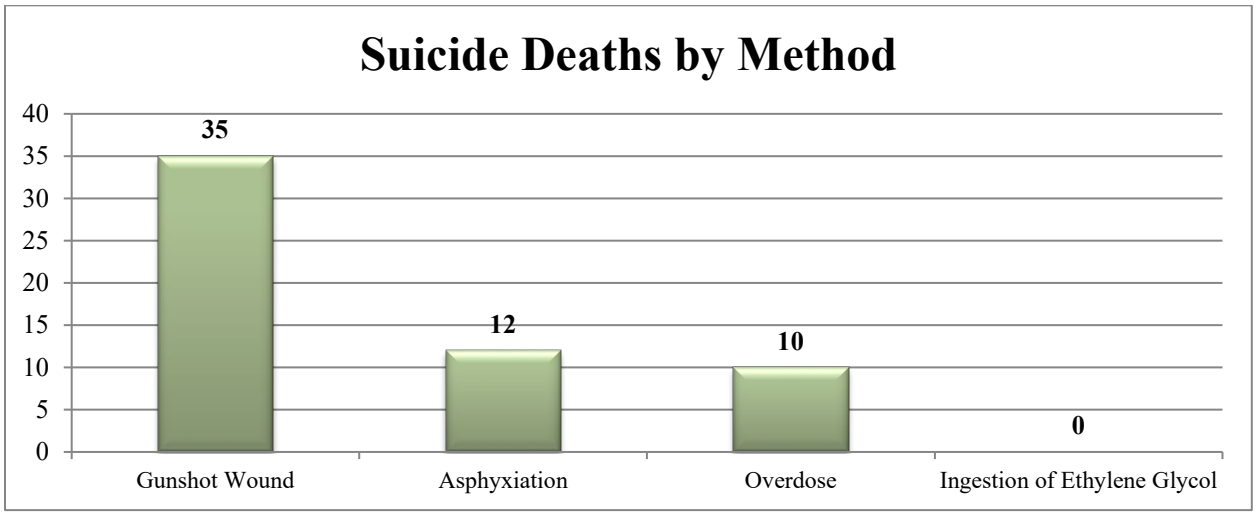
Deaths that are classified as suicide are those that occurred as a result of self-inflicted injury. In 2016, **68.4%** of the deaths were those of males, which is consistent with nationwide figures. The most common method of suicide in 2016 was firearm related **(61.4%)** followed by asphyxiation, most commonly due to hanging **(21.1%)**.

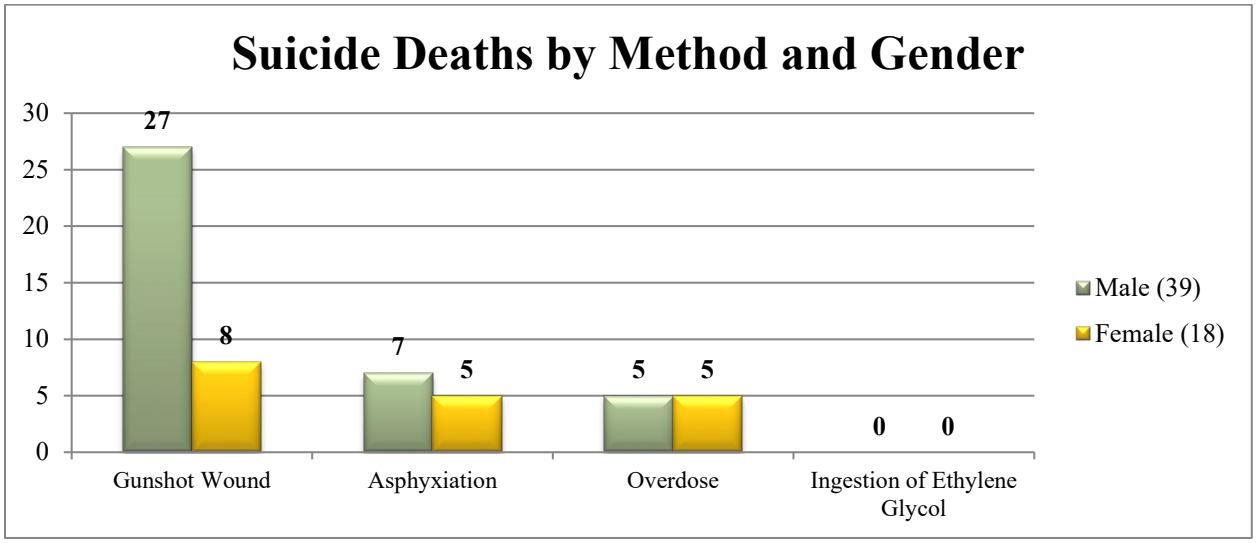
Suicide deaths accounted for **4.6%** of the total DCCO jurisdictional deaths for 2016.






Suicide Deaths by Age and Gender
12
10
8
6
4
2
0
2
0
0 0
3 3
6
3
10
1
5 5
4 4
6
2
2
0
1
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 (39)
Female (18)

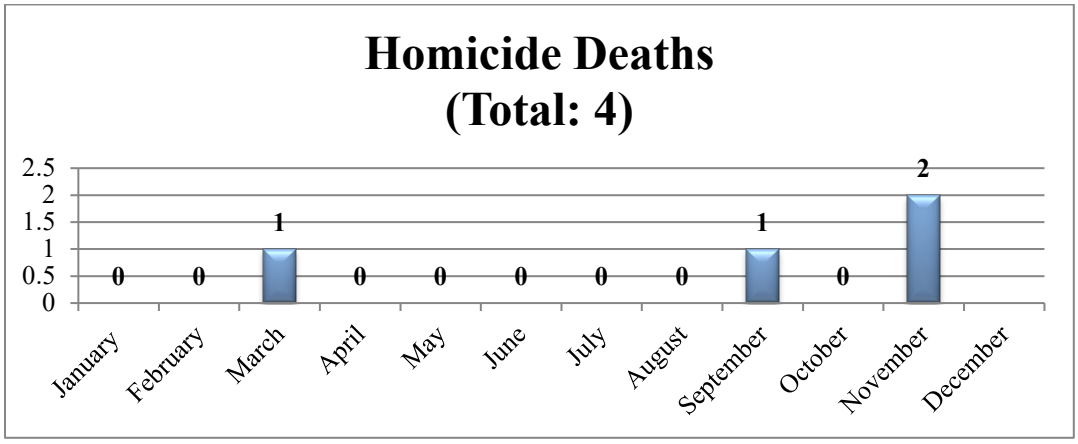

Suicide Deaths by Method
40
35
30
25
20
15
10
5
0
35
12
10
0
Gunshot Wound
Asphyxiation
Overdose
Ingestion of Ethylene Glycol


Suicide Deaths by Method and Gender
30
25
20
15
10
5
0
27
8
7
5
5
5
0
0
Gunshot Wound
Asphyxiation
Overdose
Ingestion of Ethylene Glycol
Male (39)
Female (18)

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.

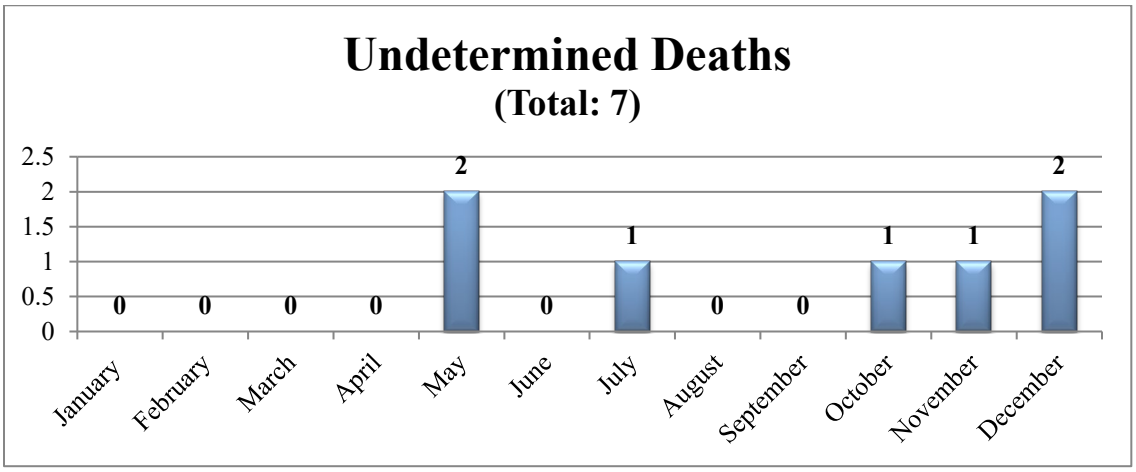
Homicide deaths accounted for **0.3%** of the total DCCO jurisdictional deaths for 2016.



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.

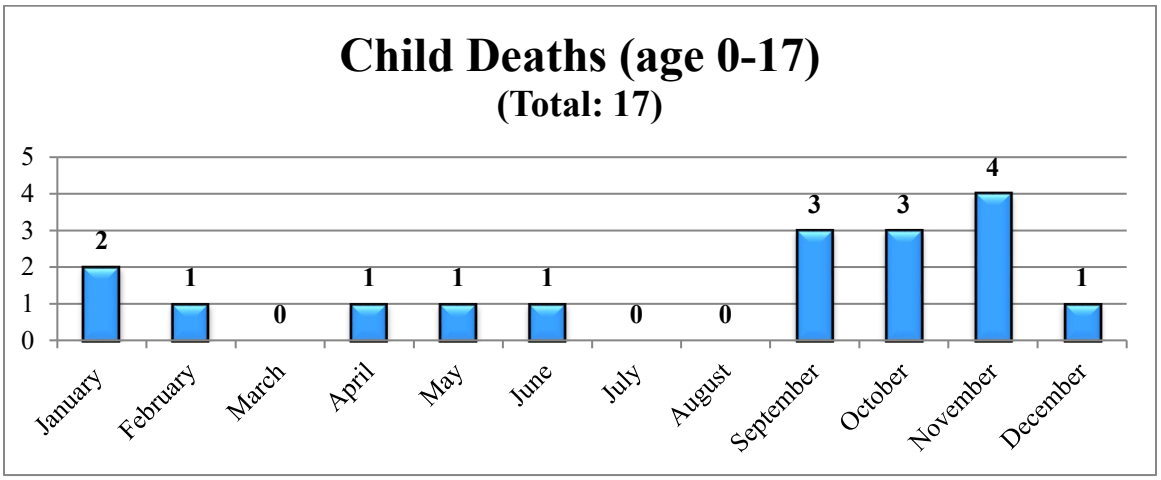
Undetermined deaths accounted for **0.6%** of the total DCCO jurisdictional deaths for 2016.

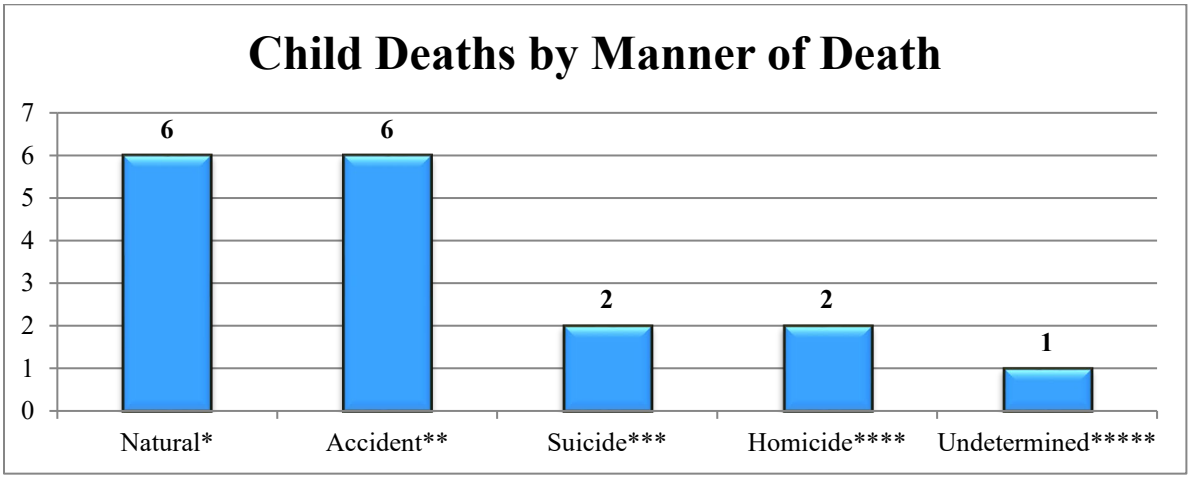


Child Deaths

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

Child deaths accounted for **1.4%** of the total DCCO jurisdictional deaths for 2016.





**Of the six (6) natural deaths, one (1) death was due to premature delivery, one (1) was due to chromosomal abnormalities, one (1) was due to pulmonary hemorrhage, one (1) was due to cancer, one (1) was due to renal agenesis, and one (1) was due to peritonitis due to ruptured appendix.*

***Of the six (6) accidental deaths, two (2) were due to drowning, one (1) was due to heroin intoxication, one (1) was due to positional asphyxia, one (1) was due to aspiration, and one (1) was due to a motor vehicle accident.*

****Of the two (2) suicide deaths, one (1) a 15-year-old, was due to asphyxiation and one (1) a 13-year-old, was due to self-inflicted gunshot wound.*

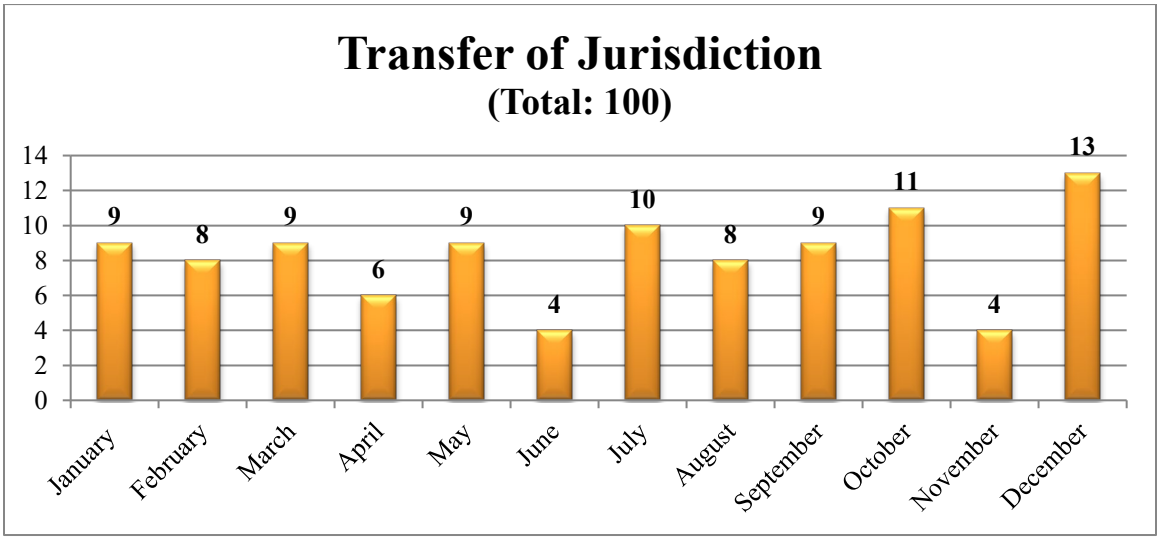
*****Two (2) homicide deaths were due to gunshot wounds.*

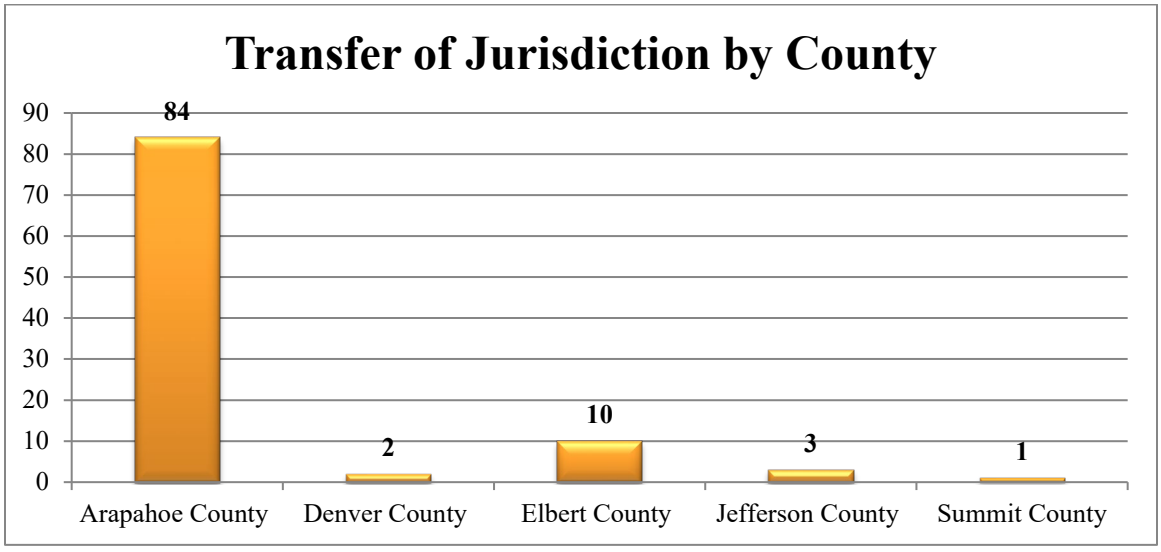
******One (1) undetermined death was a 15-month-old child.*

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, 55 deaths occurred at Parker Adventist Hospital, 43 occurred at Sky Ridge Medical Center, 1 occurred at Castle Rock Adventist Hospital, and 1 occurred at Children's Hospital Highlands Ranch Campus.



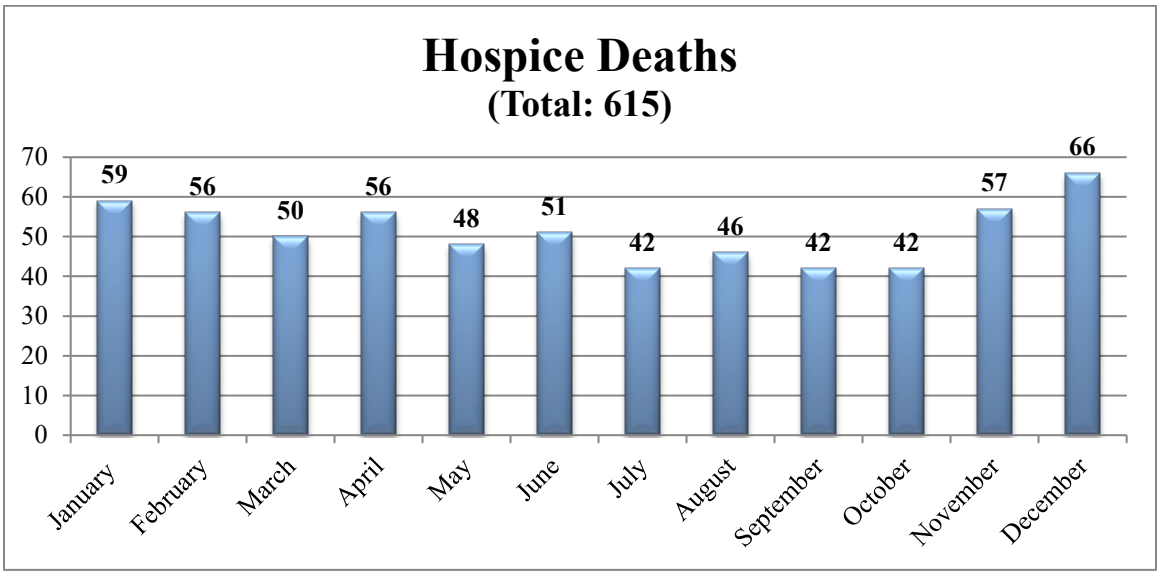


Hospice Deaths

All hospice deaths that occur in Douglas County are reportable to the Coroner's Office. In 2016, 615 deaths were reported by hospice agencies with deaths that occurred in Douglas County.

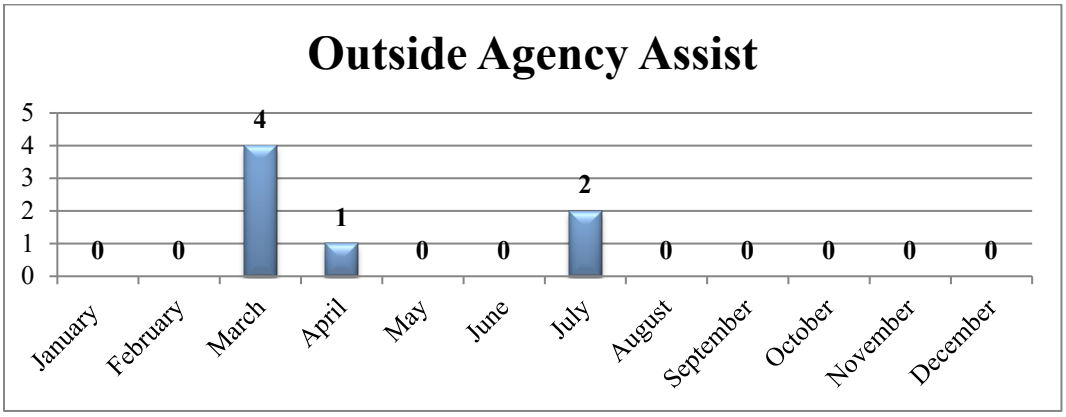
Of the 615 hospice deaths, 582 (**94.6%**) were natural hospice deaths and 33 (**5.4%**) were accidental hospice deaths.

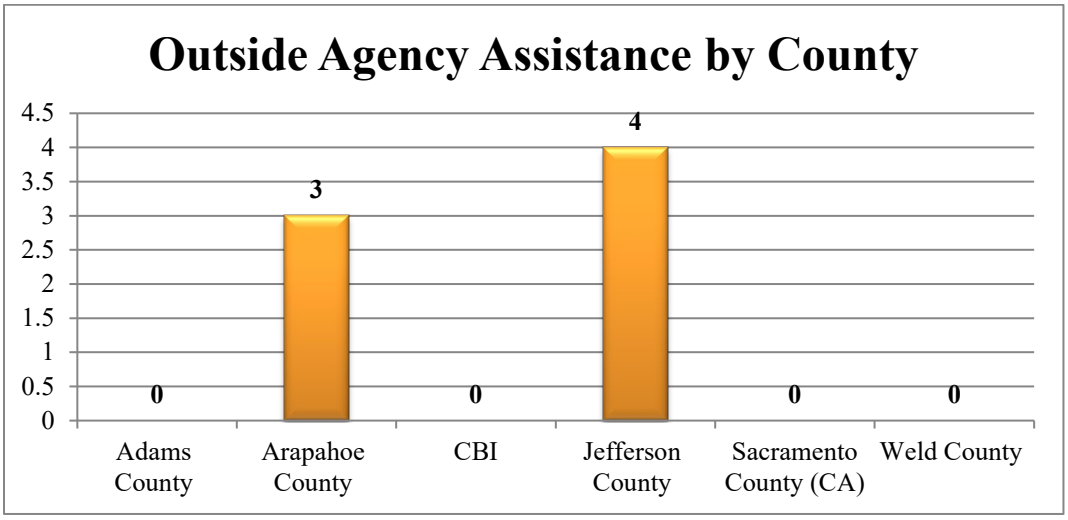
Hospice deaths accounted for **49.6%** of all deaths reported to the Douglas County Coroner's Office in 2016.

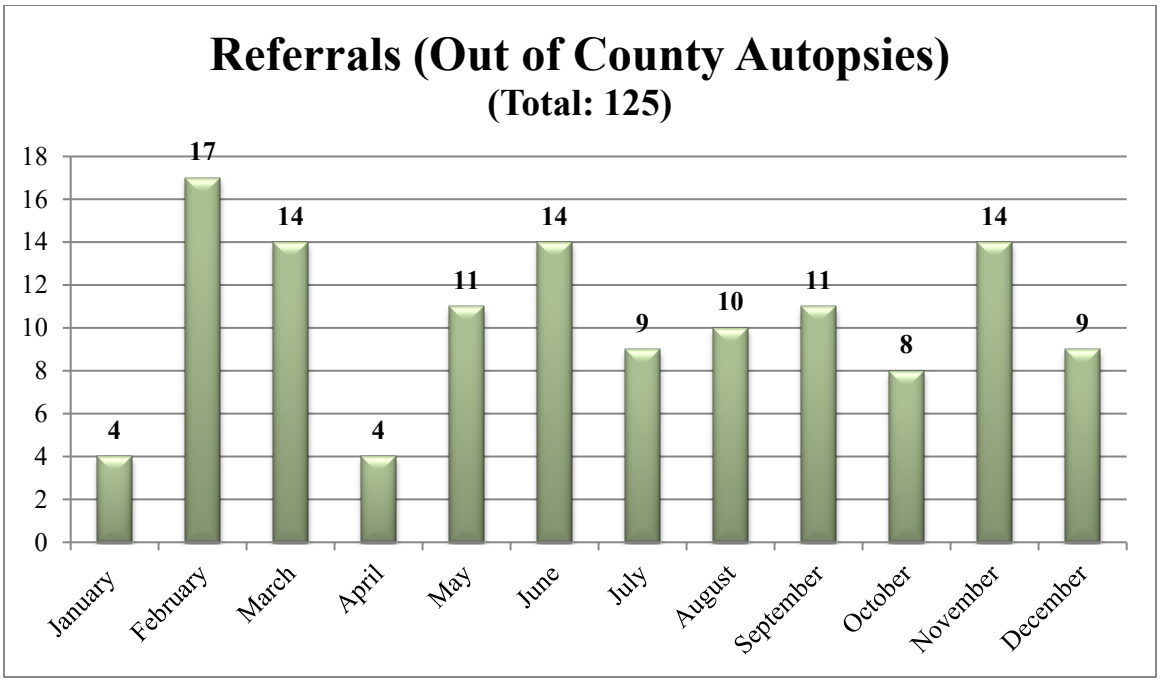


Outside Agency Assistance

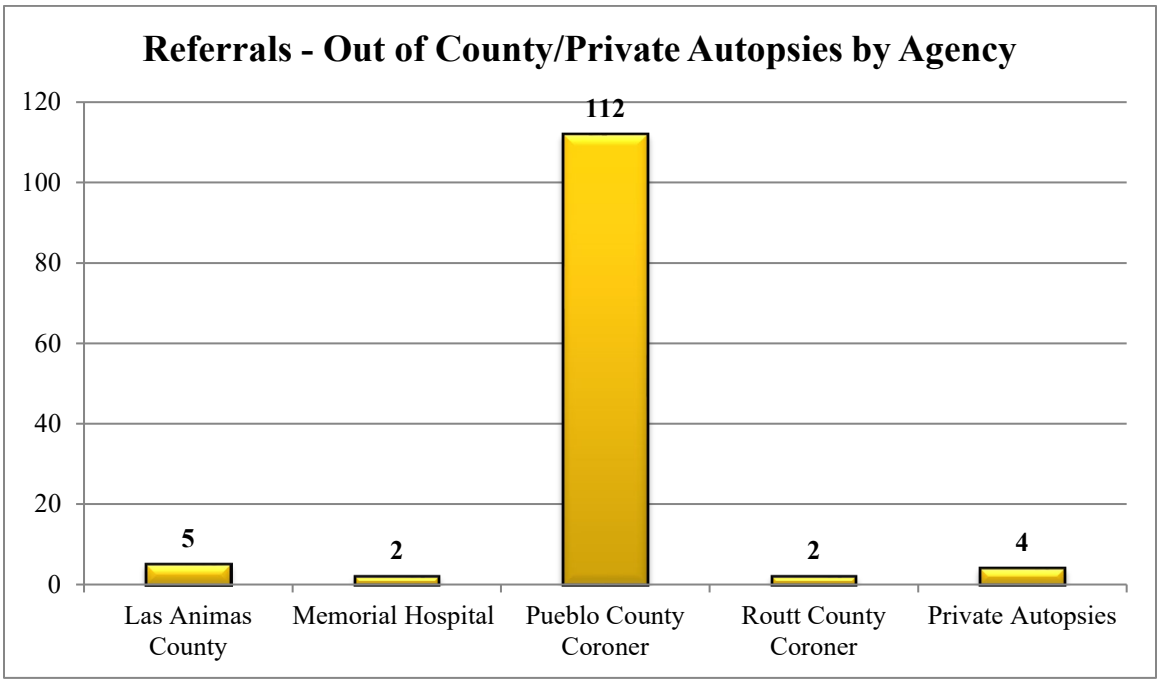
One of the mandated responsibilities of the Coroner's Office is identifying, locating, and notifying legal next-of-kin. The Douglas County Coroner's Office also assisted other agencies with performing death notifications for legal next-of-kin located in Douglas County for deaths that occurred in another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







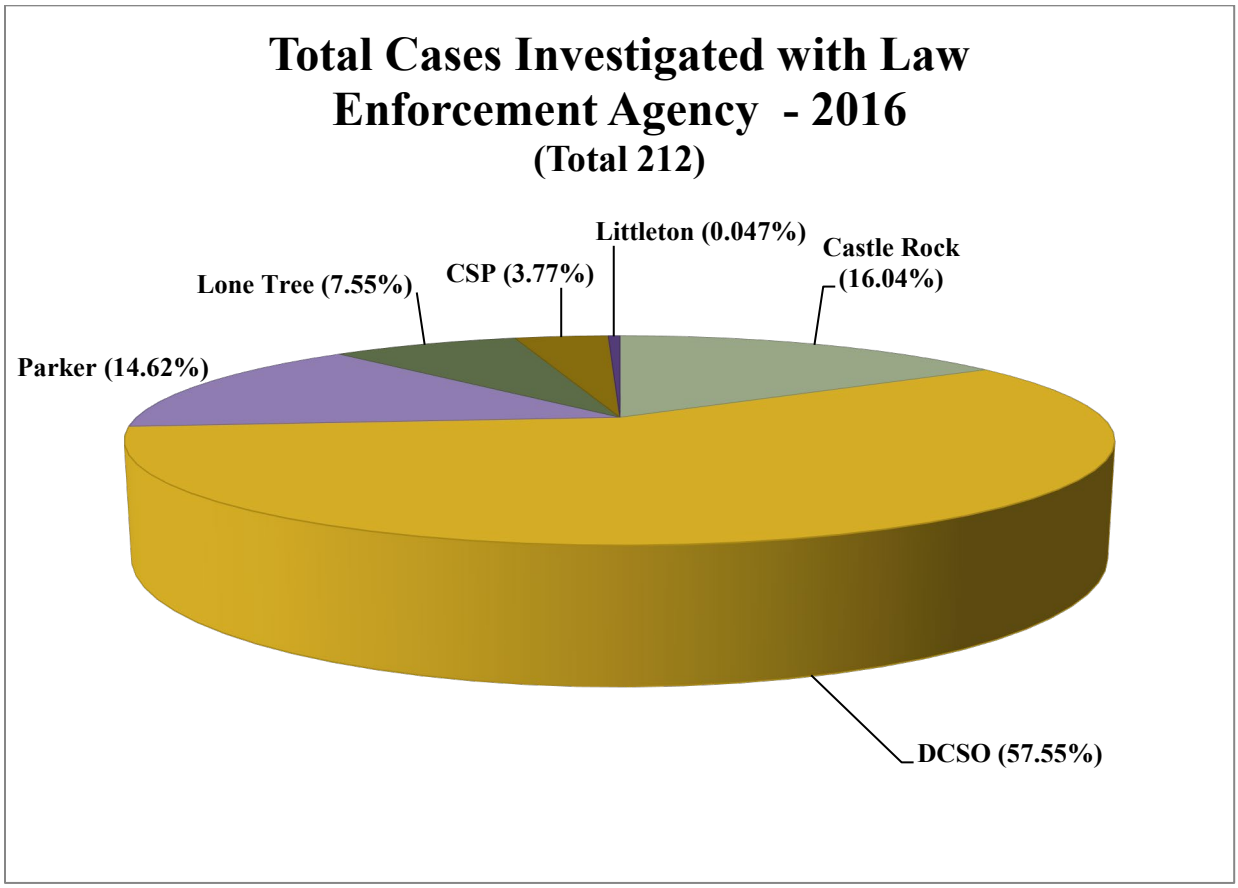
The Douglas County Coroner's Office also assists outside agencies (Coroner's Offices and hospitals) with performing autopsies at their request. The autopsies are performed by a contracted group of forensic pathologists, notably a board-certified forensic pathologist based out of the Douglas County Coroner's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

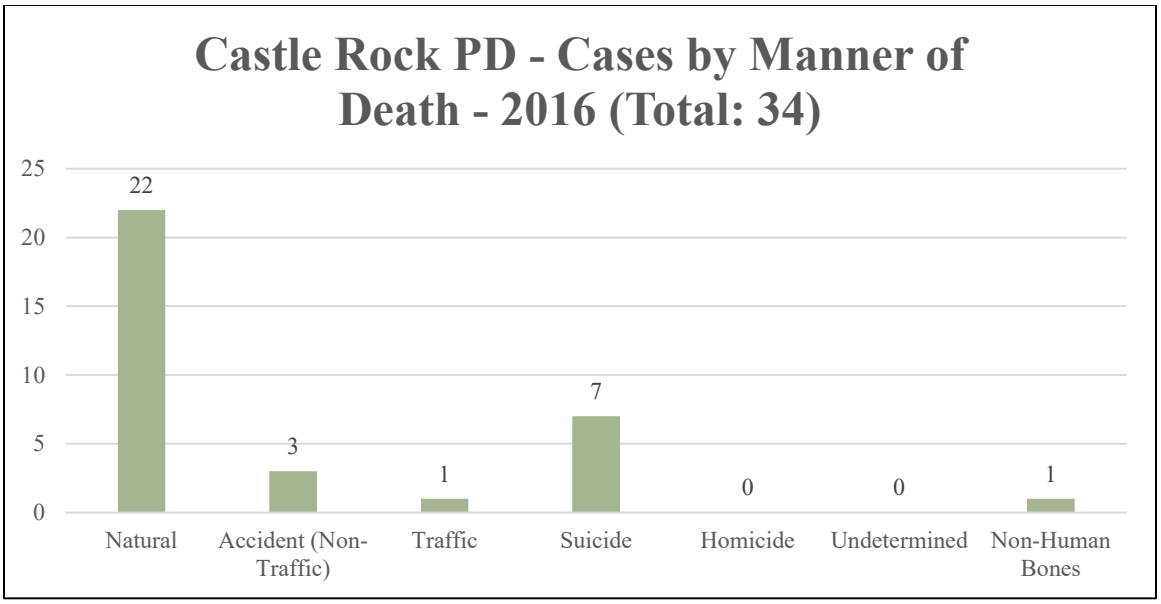


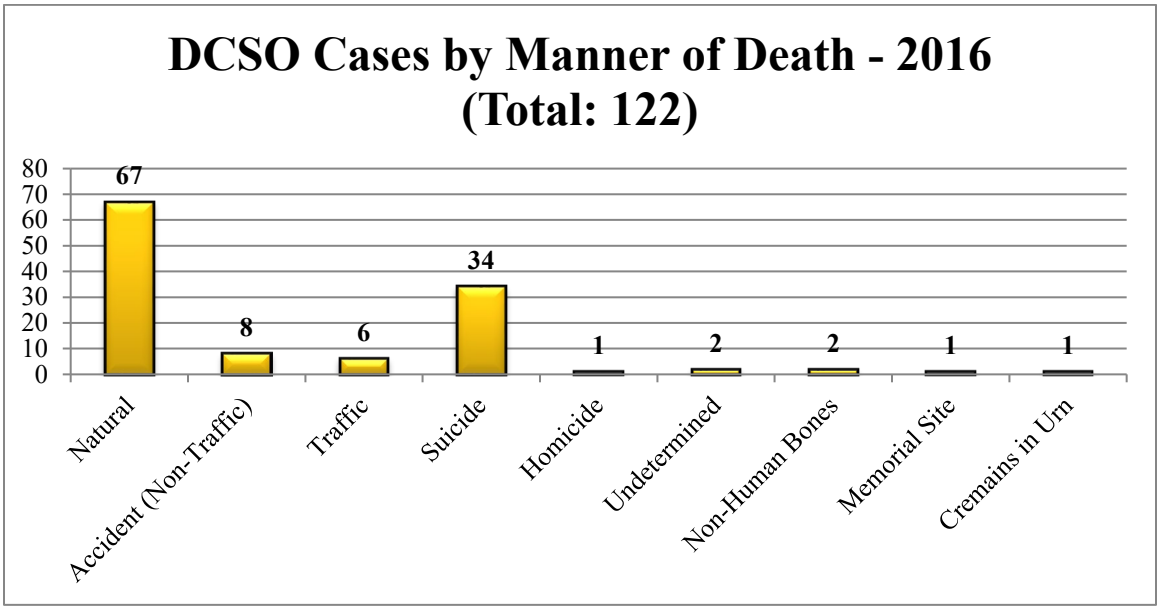
Law Enforcement Agencies

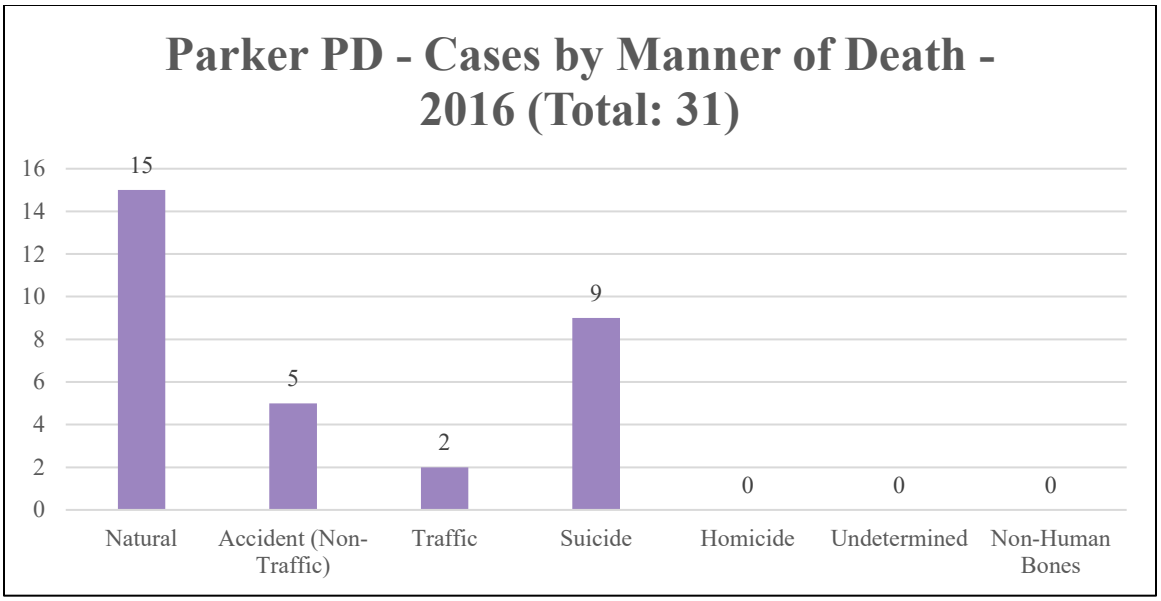
The Douglas County Coroner's Office works in collaboration with Law Enforcement Agencies with jurisdiction in Douglas County. Law Enforcement Agencies in Douglas County include the Aurora Police Department, Castle Rock Police Department, Colorado State Patrol, Douglas County Sheriff's Office, Littleton Police Department, Lone Tree Police Department, and Parker Police Department.

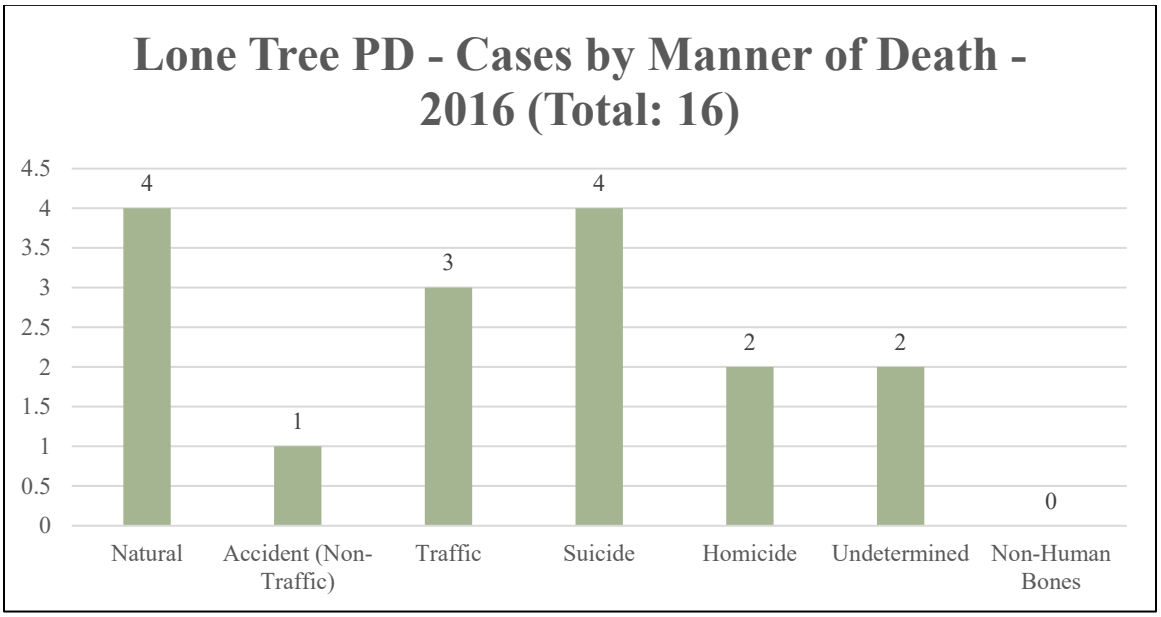
Of note: The total cases investigated with law enforcement may differ from the scene responses made by the Coroner's Office; due to some deaths, having been delayed due to hospitalization following an incident or having occurred at a care facility where no response from the Coroner's Office was necessary.

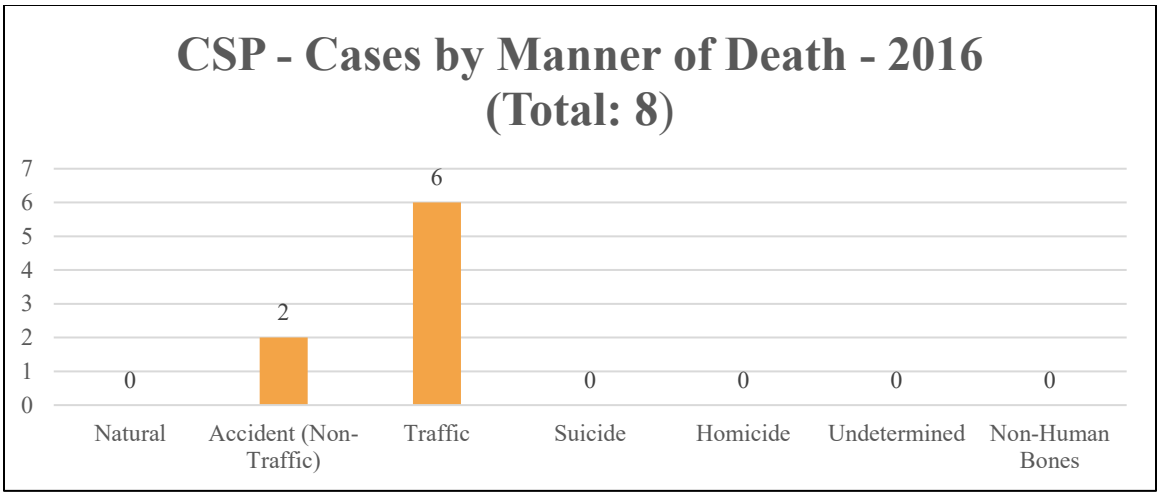


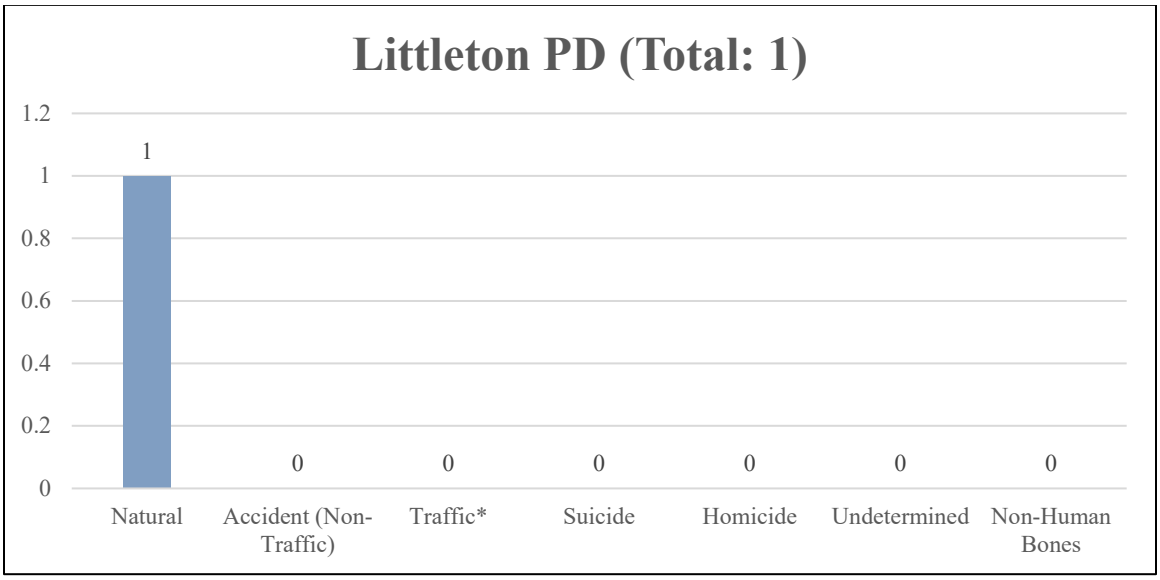

Castle Rock PD - Cases by Manner of Death - 2016 (Total: 34)
25
20
15
10
5
0
22
3
1
7
0
0
1
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined
Non-Human Bones


DCSO Cases by Manner of Death - 2016 (Total: 122)
80
70
60
50
40
30
20
10
0
67
8
6
34
1
2
2
1
1
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined
Non-Human Bones
Memorial Site
Cremains in Urn


Parker PD - Cases by Manner of Death - 2016 (Total: 31)
16
14
12
10
8
6
4
2
0
15
5
2
9
0
0
0
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined
Non-Human Bones


Lone Tree PD - Cases by Manner of Death - 2016 (Total: 16)
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
4
1
3
4
2
2
0
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined
Non-Human Bones

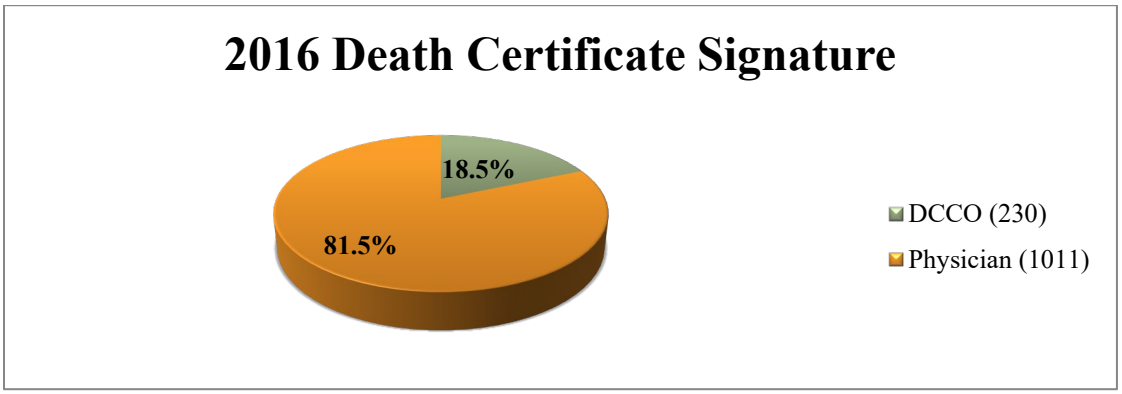

CSP - Cases by Manner of Death - 2016
(Total: 8)
7
6
5
4
3
2
1
0
0
2
6
0
0
0
0
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined
Non-Human Bones

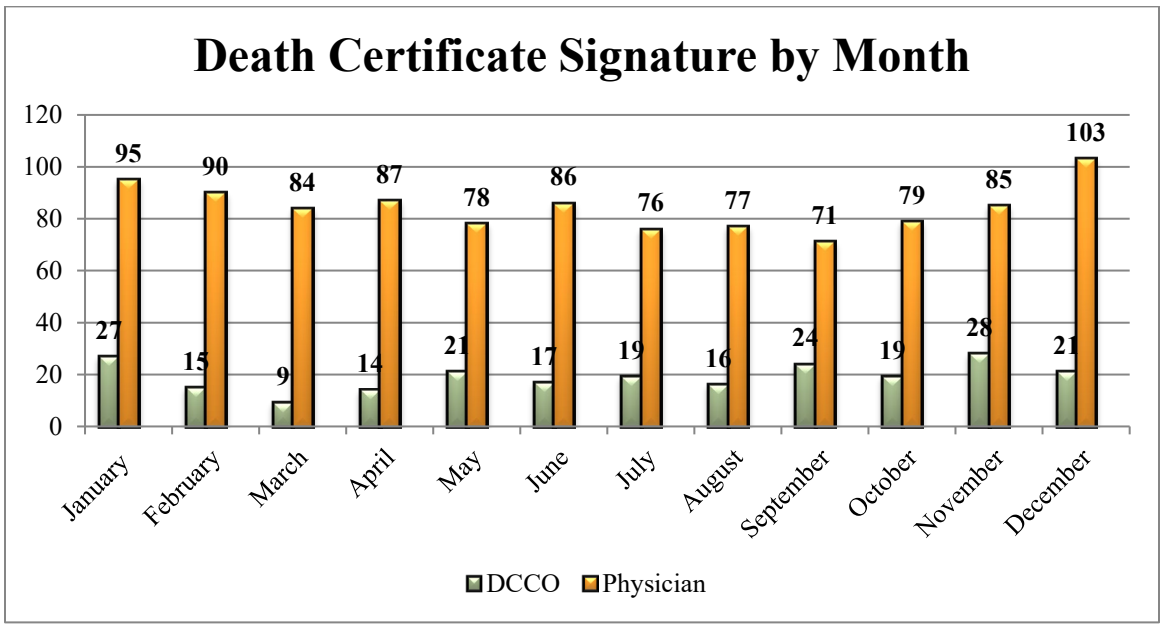

Littleton PD (Total: 1)
1.2
1
0.8
0.6
0.4
0.2
0
1
0
0
0
0
0
0
Natural
Accident (Non-Traffic)
Traffic*
Suicide
Homicide
Undetermined
Non-Human Bones

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 1241 reported cases to DCCO, 230 of the death certificates were signed by DCCO and 1011 of the death certificates were signed by a private physician.



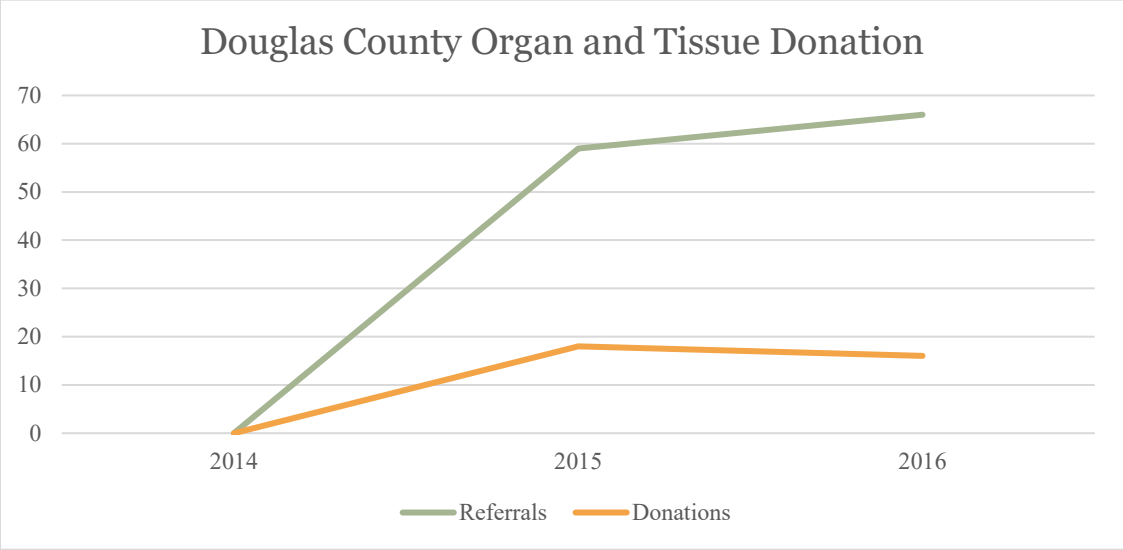


Organ and Tissue Donation

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 themselves 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 whenever applicable effective collaboration with the donation agencies in Colorado (Donor Alliance and Rocky Mountain Lions Eye Bank) to honor the wishes of the deceased and/or their families.**

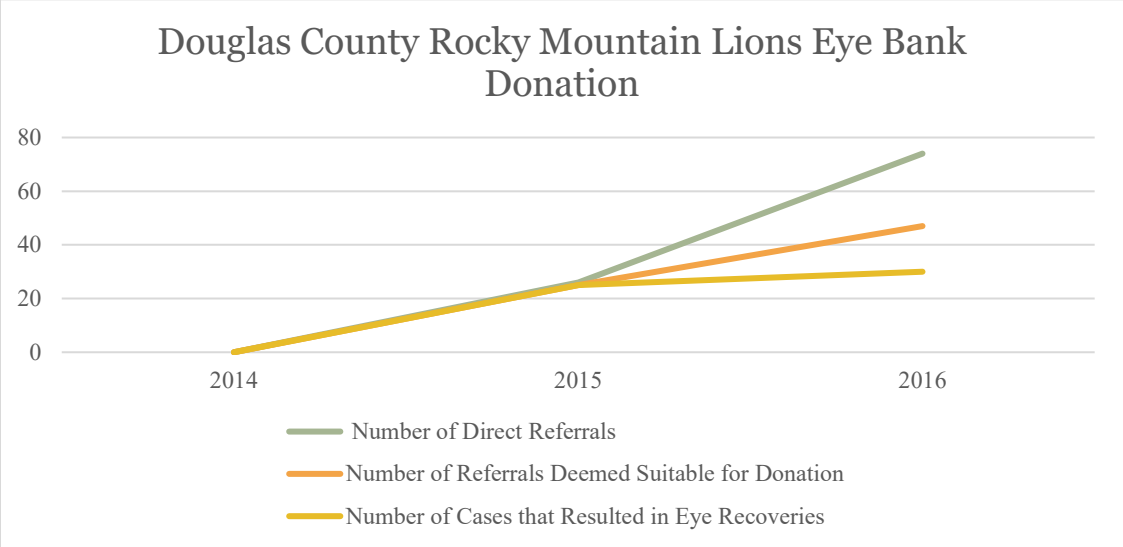
After approval for release by the Coroner's Office, referrals are made to the procurement agencies either from a hospital or directly from a Coroner's Office. The procurement agencies then work with the family of the individual to determine if the individual is medically suitable to be a donor.

DONOR ALLIANCE
Organ & Tissue Donation



In 2014, the Douglas County Coroner's Office did not make referrals for donation to Donor Alliance. In 2015, the number exponentially increased to 59 referrals; 18 of which were deemed suitable for donation. In 2016, 66 were referred, with 16 deemed suitable for recovery of tissue and/or bone where recovery took place.

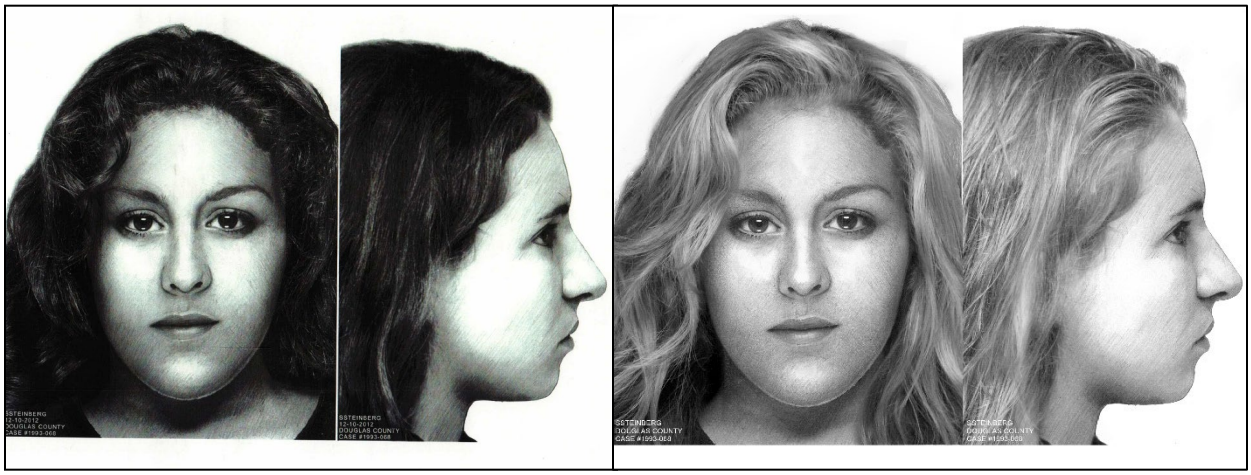
In 2014, the Douglas County Coroner's Office did not make any direct referrals to the Rocky Mountain Lions Eye Bank (RMLEB) for cornea donation. As with skin and tissue donation, after taking office in 2015, Coroner Romann made honoring the wishes and rights of the decedent and their families a priority thus instituting office policy that changed the face of donation for Douglas County. In 2015 the Douglas County Coroner's Office made 26 direct referrals to RMLEB; 25 of those referrals were deemed suitable for donation with 22 of those cases recovering corneas. In 2016, the number of direct referrals was 74, with 47 of those deemed suitable for donation and 30 recoveries taking place.



Additionally, there were 23 cases that were referred to RMLEB by local hospitals on deaths where the Douglas County Coroner's Office had jurisdiction. All 23 of these referred donors were deemed suitable for donation with 21 where recovery took place.

Unidentified Remains

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 23 years after her death. Her remains are currently being held at the Coroner's Office. The Douglas County Coroner's Office is committed to using all avenues available to identify her in hope of reuniting her with her family.



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

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.

2016 Updates

In partnership with the Douglas County Sheriff's Office, the coroner's office continues to work diligently on attempting to identifying Jane Doe. In 2016, panoramic radiography (x-ray) of the head was obtained. Panoramic radiography of the head allows for a two-dimensional x-ray that captures the entire head and especially the mouth in a single image. This includes all teeth, upper and lower jaw bones, and surrounding tissue. This evidence was added to previously taken x-rays to offer better enhancement of possible leads.

DCCO continues to follow-up on "hits" with NAMUS, a national missing and unidentified persons system. The Douglas County Coroner's Office is committed to using all avenues available, and to not give up on identifying her in hope of reuniting her with her family one day.