2017 ANNUAL REPORT

Douglas County Coroner's Office

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DOUGLAS COUNTY COLORADO

WWW.DOUGLAS.CO.US

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

Dear Citizens,

Did you know about 36% of Americans live in areas where minimal or no special training is required to conduct death investigations? It is a travesty. Minimum qualifications for election as Coroner typically include being a registered voter, having a high school diploma, meeting a minimum age requirement, being free of felony convictions, and completing a training program.

As a Medicolegal Death Investigator (MDI), whose professional career spans more than 30 years in the field, I am proud to announce that the Douglas County Coroner's Office not only meets, but exceeds, national standards for death investigations. All investigative staff are certified by the Colorado Coroner's Association, 75% are certified by the American Board of Medicolegal Death Investigators (ABMDI), and three are Board Certified Fellows; ABMDI's highest certification. Half of the staff also have their master's degree. Please stop by and meet my incredible staff; we welcome you and your questions.

In the pages that follow, our Medicolegal Death Investigators, prove that we not only shine with our advanced degrees and board certifications, but we also meticulously scrutinize our use of your tax contributions.

We hope you enjoy the 2017 Douglas County Coroner's Office Annual Report and, as always, "Stay safe out there!"

Sincerely, Coroner Jill Romann, F-ABMDI 185

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 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.
- Taking 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 helping them through the grieving process.

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

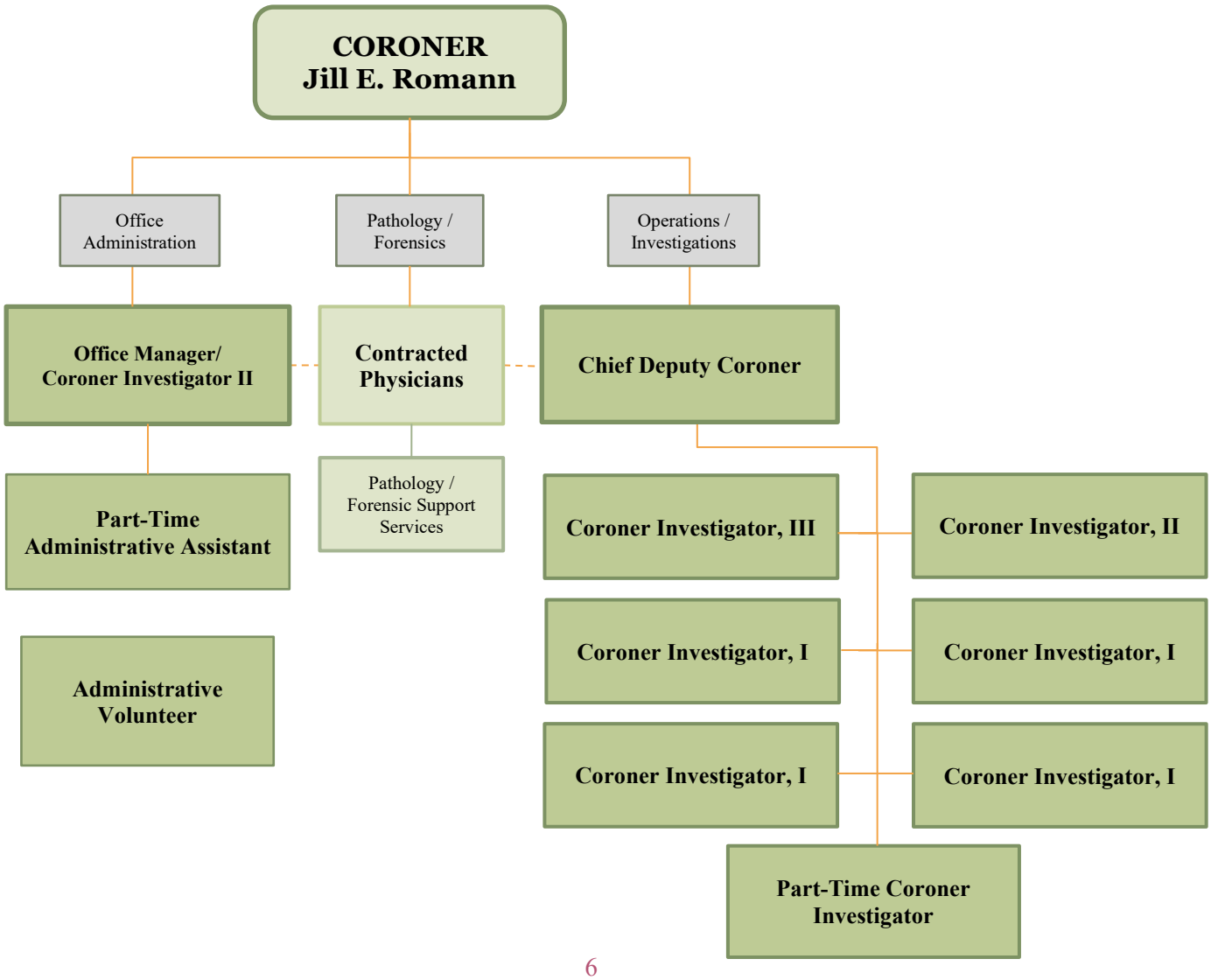
MISSION STATEMENT

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

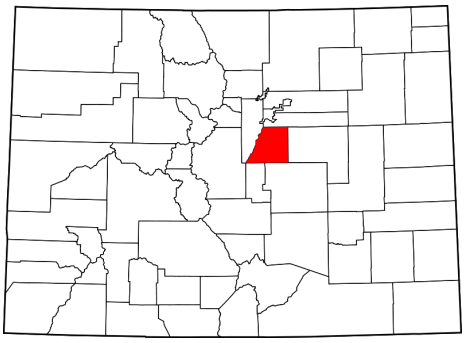
SERVICE □ COMPASSION □ PROFESSIONALISM □ DIGNITY □ INTEGRITY

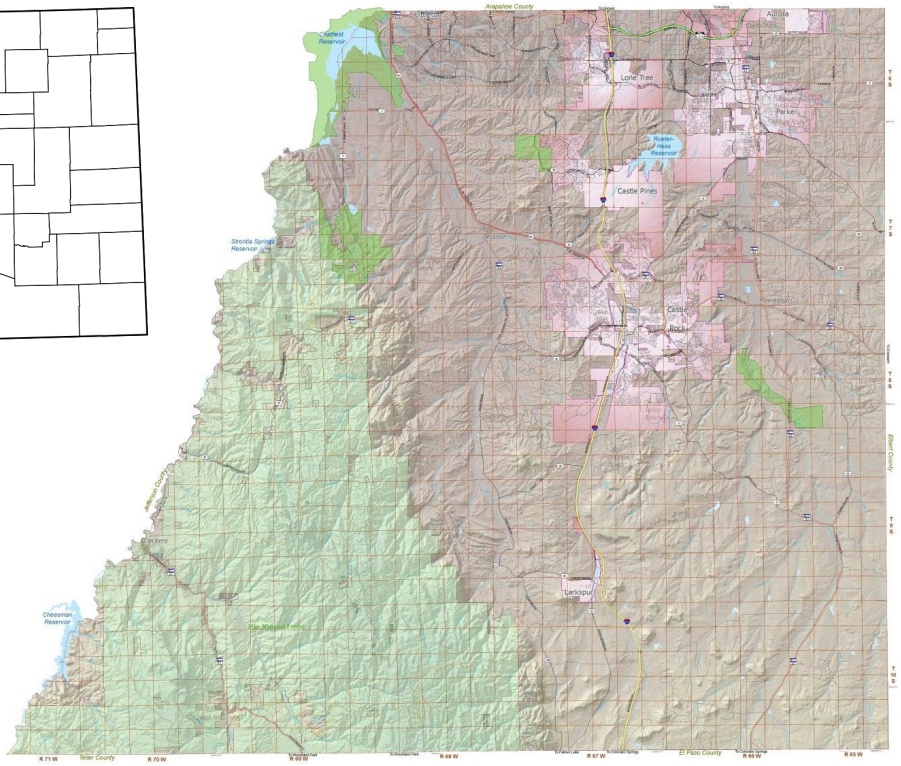
DCCO Organizational Chart



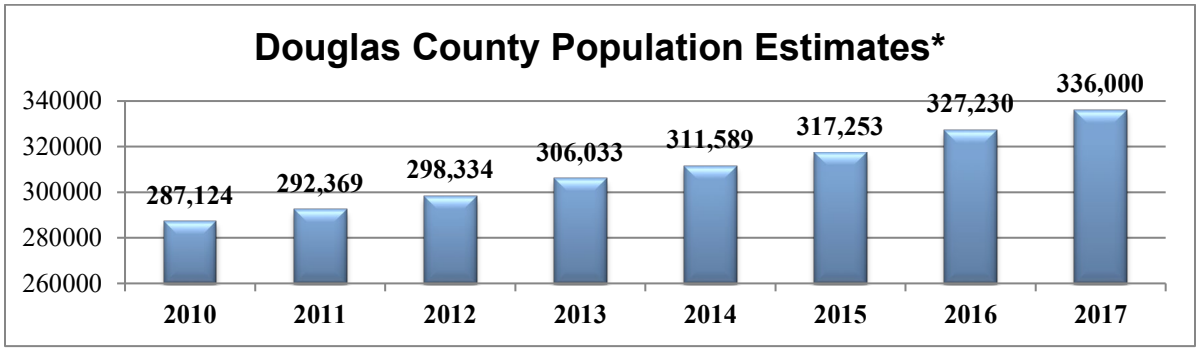
Jurisdictional Boundaries

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 Forest.





Population of Douglas County



2010-2015 Source CO State Demography Office. 2016-2017 Source Douglas County Community Development

Budget

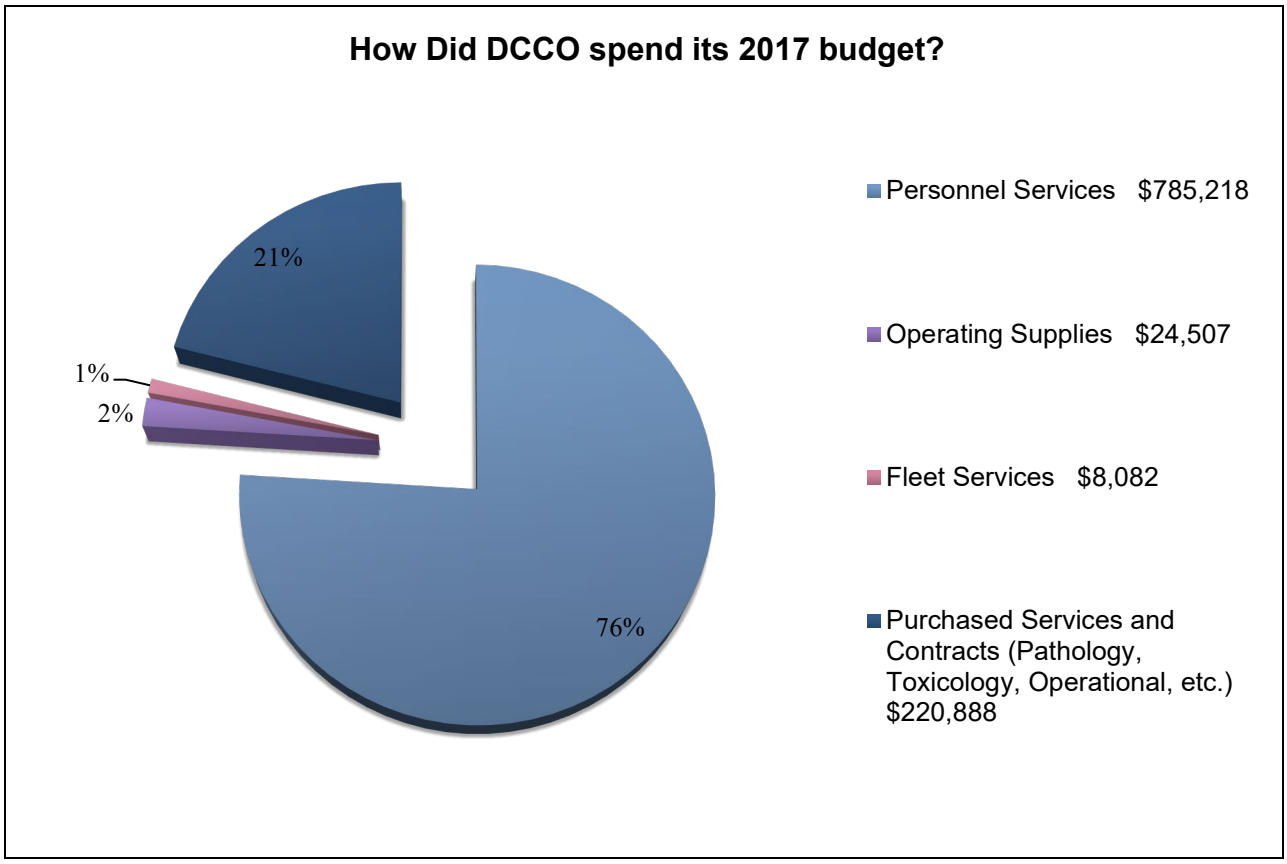
Funding

Funding for the Coroner's Office originates from the Douglas County general fund. In 2017, the County Manager and Commissioners approved an adopted budget of $1,107,668, representing a **0% increase over 2016**. DCCO's budget was less than **1**% of the total 2017 General Fund, which was $137.4 million. It represented approximately **0.3**% of the total 2017 Douglas County annual budget of $372.6 million.

Transparency to the Taxpayer

Expenditures

Total expenditures for the year were $1,038,696, **6% under budget, with a savings of $68,972 returned to the general fund.**



Revenues

On occasion, the office allows for the use of our facilities to outside counties, for the purpose of conducting an autopsy. A fee is paid by that county, recovering the cost of expenses. This fee is recorded as revenue received by DCCO. Total revenue for 2017 was $1,135. This money went directly to the general fund. It did not go into the Coroner's budget as additional funding.

Accountability to the Taxpayer

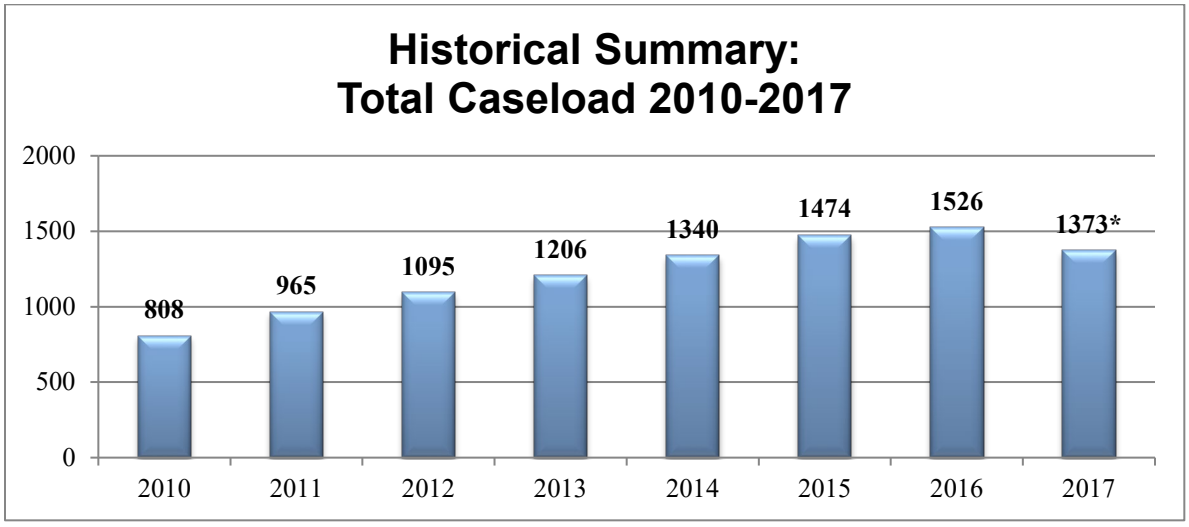
Coroner Romann takes very seriously the responsibility of balancing the delivery of outstanding service to the citizen, with strict fiscal oversight on behalf of the taxpayer. One of the best ways to track fiscal responsibility and efficiency is to calculate the cost-per-case; or simply divide the total tax dollars spent by the number of cases handled. In 2017, the cost-per-case increased slightly due to a lower than expected caseload for the year as well as purchases in technology that will lower costs in the future. The cost-per-case for 2017 was $760.

	Previous Administration		Current Administration		
	2013	2014	2015	2016	2017
Population	306,033	311,589	317,253	327,230	336,000
Caseload*	1066	1172	1320	1401	1366
Adopted Budget	$1,077,882	$1,076,345	$1,108,664	$1,107,668	$1,107,668
Actual Dollars Spent	$870,769	$924,536 6.1% Increase	$976,251 5.5% Increase	$1,019,687 4.4% Increase	$1,038,696 1.8% Increase
Cost per Case	**$816**	**$788**	**$739**	**$727**	**$760**

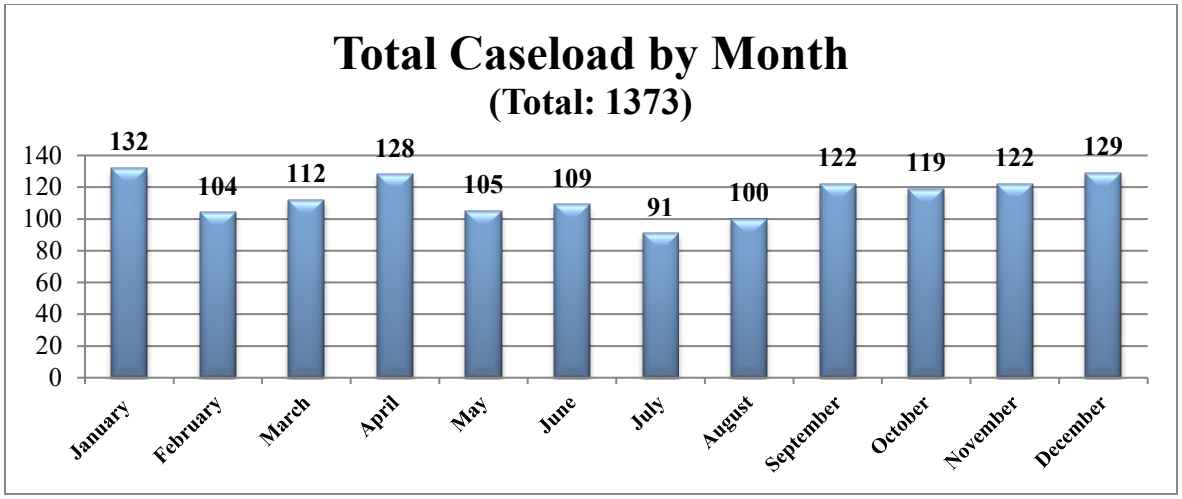
**Caseload is calculated by subtracting Autopsy Referrals from Overall Caseload.*

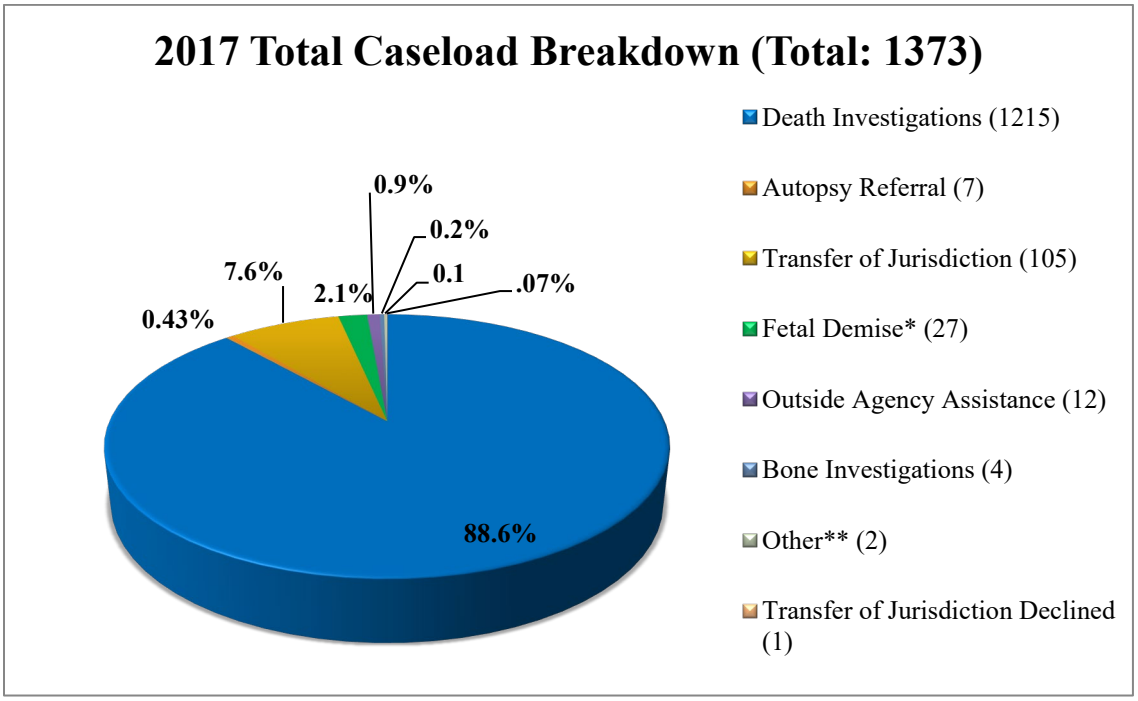
2017 CASELOAD

The overall total caseload for 2017 was 1373, which included Death Investigations (1215), Fetal Demises (27), Bone Investigations (4), Outside Agency Assistance (12), Transfers of Jurisdiction (105), Autopsy Referrals (7) which are out of county/private autopsies conducted at our facility, Other (2), and (1) Pending.



DCCO call volume did not decrease, by intention referrals were decreased by 94%.





**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.*

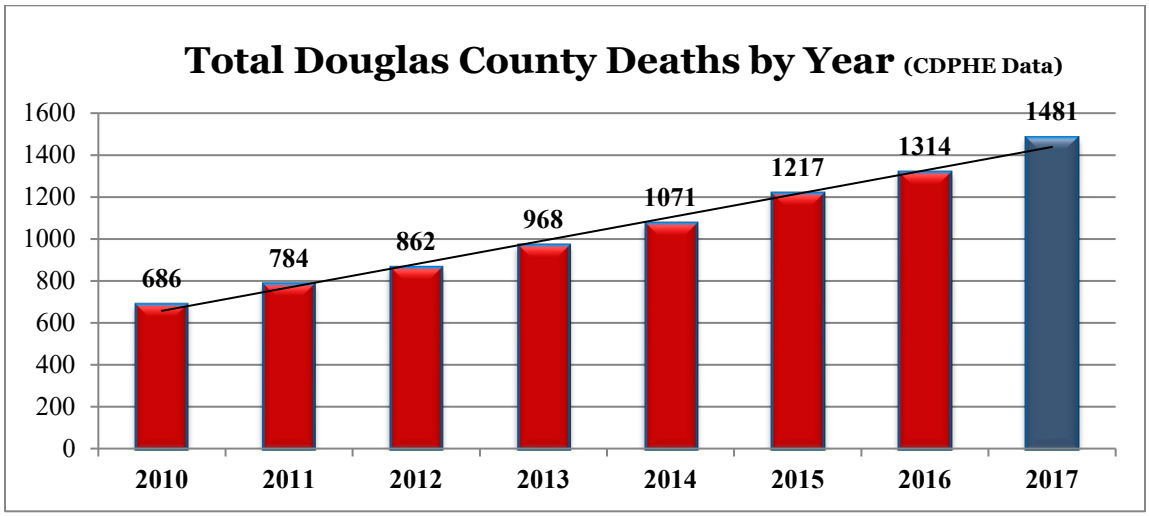
2015 – 2017 Comparison

	2015	2016	2017	% Change
Overall Caseload	1474	1526	1373	10.0% ↓
Death Investigations	1209	1252	1215	3.0% ↓
Fetal Demises	32	36	27	25.0% ↓
Bone Investigations	6	4	4	0.0%
Outside Agency Assistance	8	7	12	41.7% ↑
Transfer of Jurisdiction	66	100	105	4.8% ↑
Autopsy Referrals	153	125	7	93.6% ↓
Other**	0	2	2	0.0%

***(1) Ancient Remains (1) Historical Burial Site*

Of the overall caseload in 2017, 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 (1215), and Fetal Demises (27).

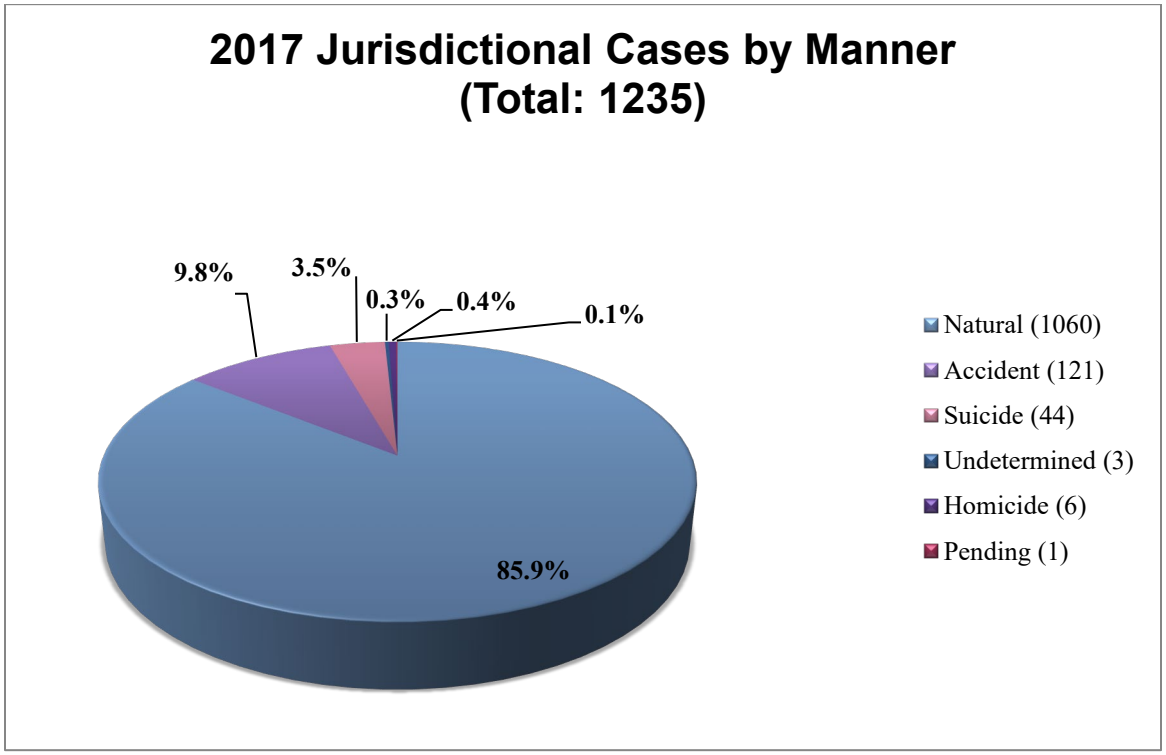
A death certificate is required to be filed with the Colorado Department of Public Health & Environment (CDPHE) for each death that occurs in Douglas County. Discrepancies may exist between CDPHE and Douglas County statistics due to transfer of jurisdiction and the locations of death listed on the death 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 2017 were reported to the Douglas County Coroner's Office. The difference between CDPHE figures and DCCO figures is other county's deaths the state reported as DCCO cases. The average annual increase of deaths reported by CDPHE in Douglas County between 2010 and 2017 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.



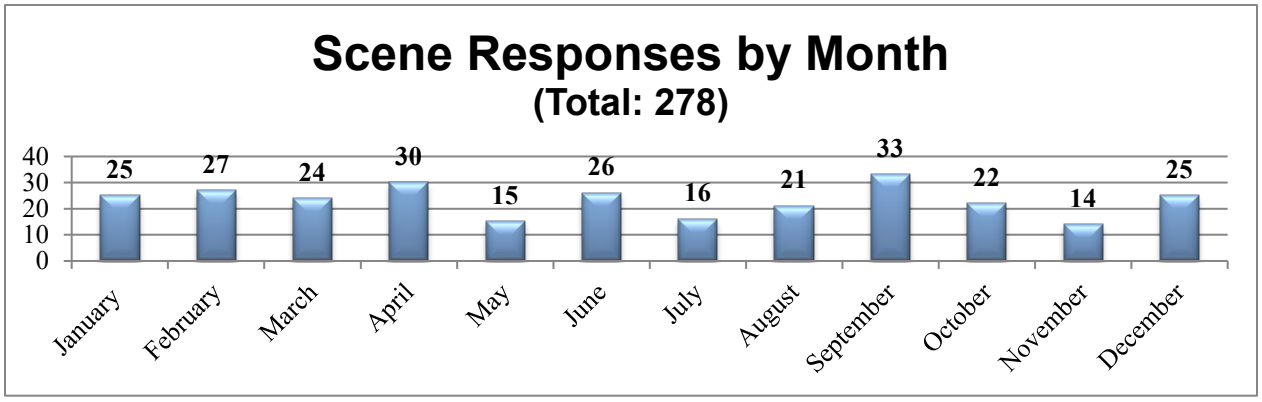
2013 – 2017 Comparison

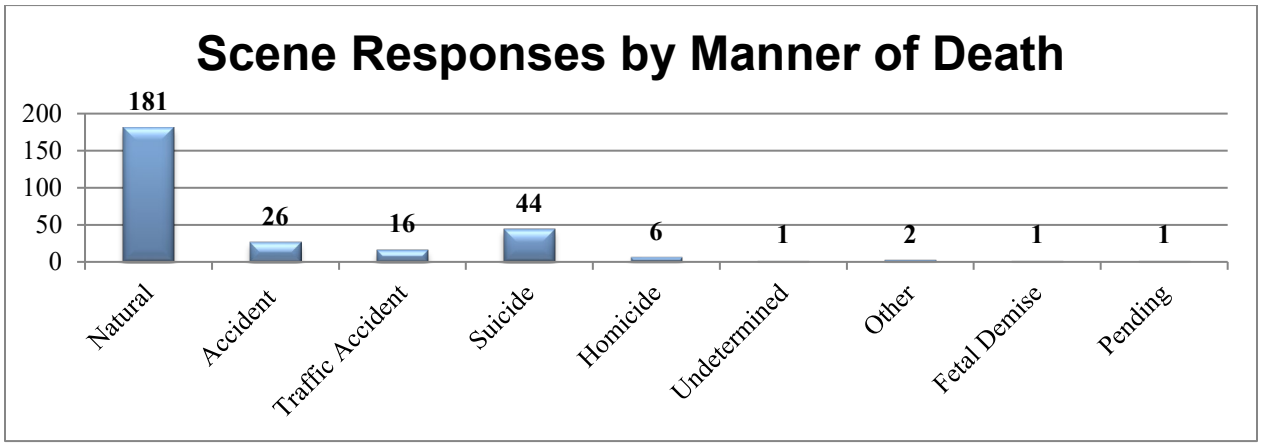
	2013	2014	2015	2016	2017
Natural	844	952	1065	1061	1060
Accident	97	104	106	106	121
Suicide	57	47	58	57	44
Homicide	0	2	2	4	6
Undetermined	5	6	7	7	3
Pending	0	0	0	0	1

Scene Response

The Douglas County Coroner's Office responded to 278 death scenes which accounted for **22.5%** of all the jurisdictional deaths reported to the Coroner's Office in 2017. 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 next-of-kin's choosing. 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.



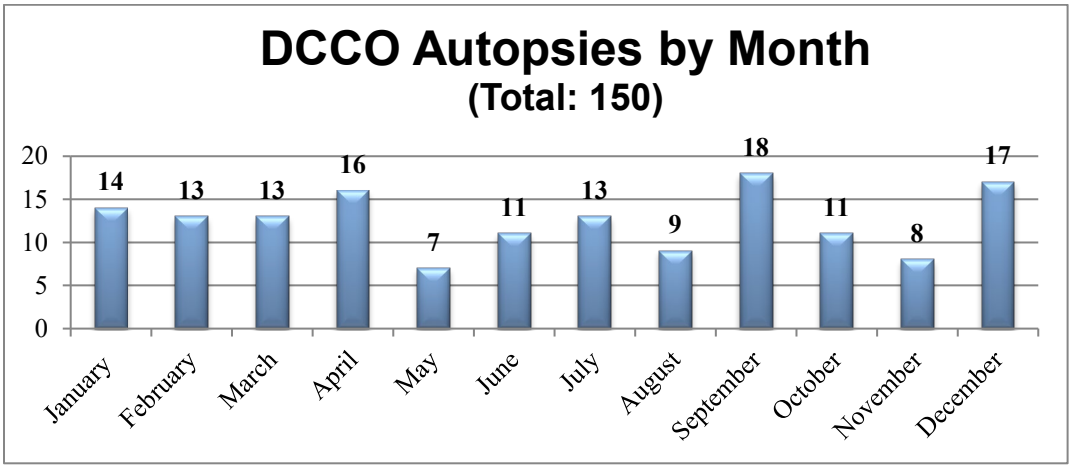


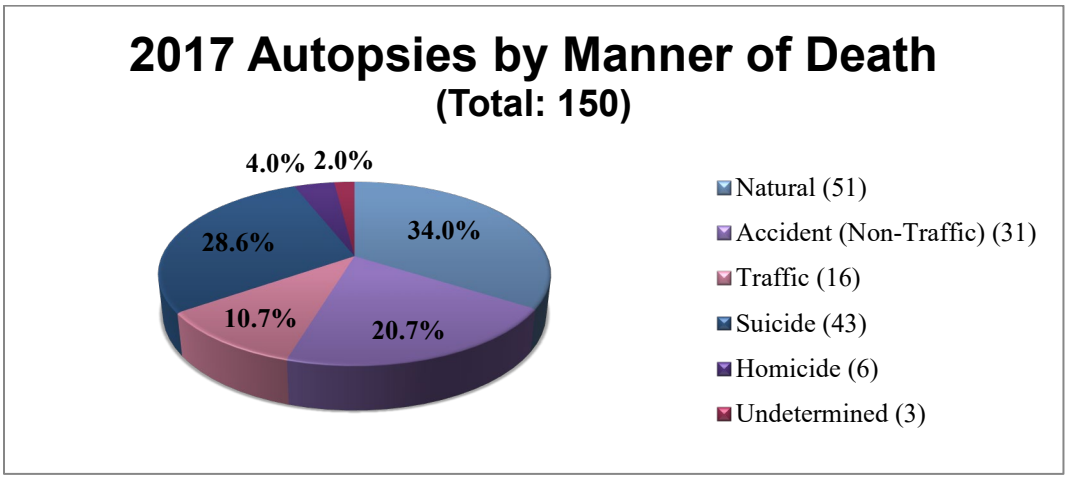
Of the 265 decedents transported to the Coroner's Office, 220 were transported by DCCO investigators. The remaining 31 were transported by external transport services, other counties, and Donor Alliance. Scene responses for 2017 were one less than 2016, even though our overall case load was down it was due to the intended decrease of referrals.

Autopsies

Of the cases the Douglas County Coroner's Office retained jurisdiction over in 2017, 150 or **12.2%** 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 was 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 sustained injuries, which clearly led to the cause of death.





Of the 150 autopsies performed in 2017, all were full autopsies. Toxicology studies were performed in 148 cases. **100**% of toxicology was completed in under 60 days.

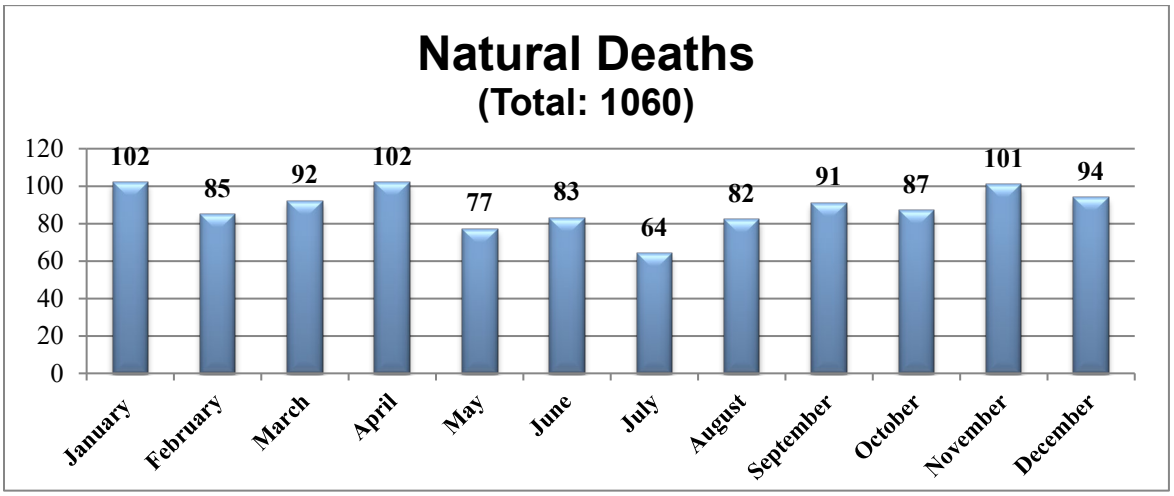
STATISTICS BY MANNER OF DEATH

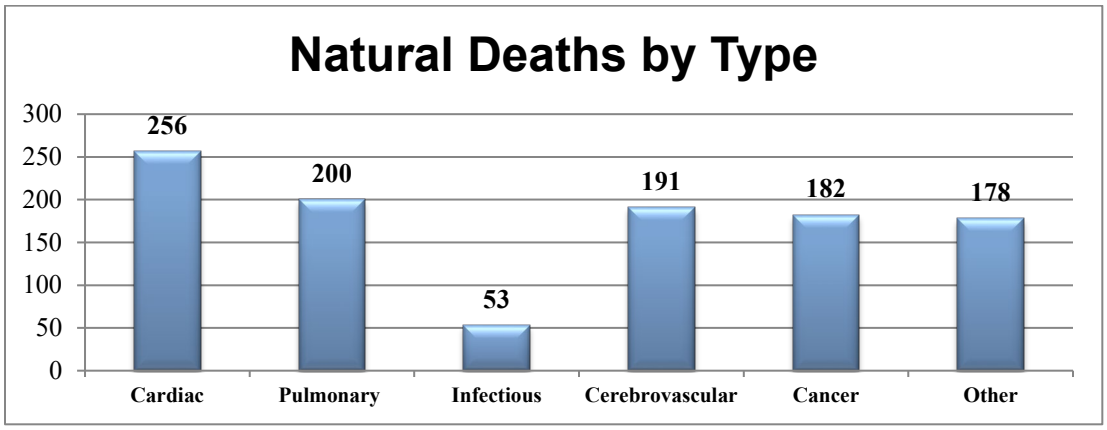
Natural Deaths

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).

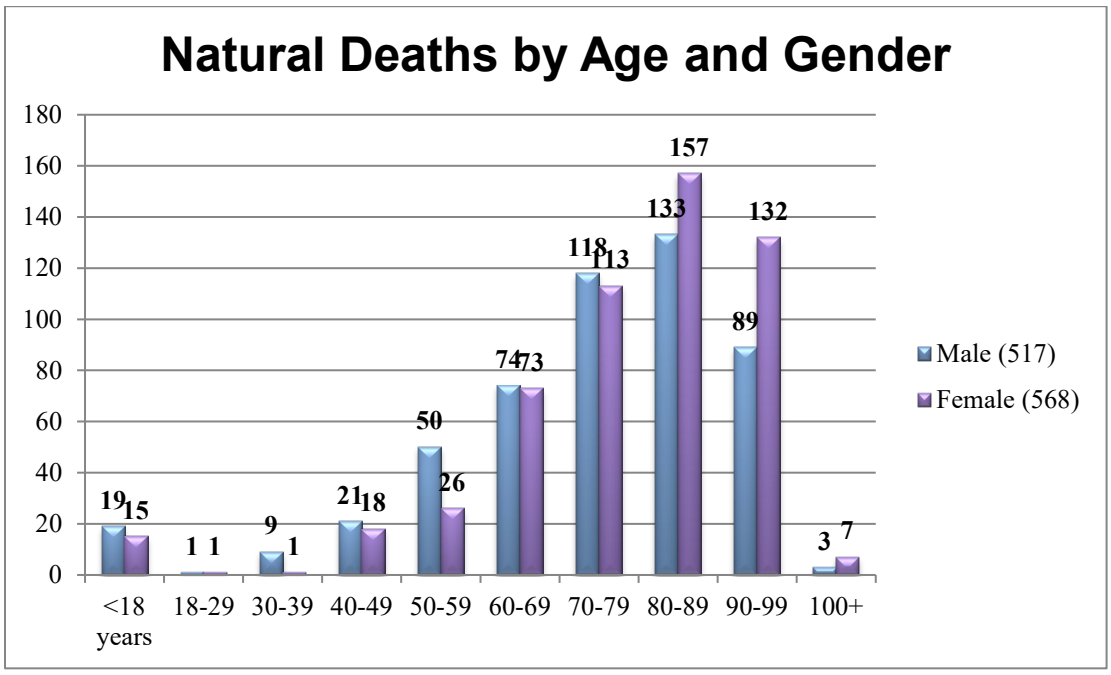
In many instances when a natural death is reported, the decedent's physician will issue the death certificate. The majority of deaths reported to the Coroner's Office are deaths due to natural causes.

Natural deaths accounted for **85.8%** of the total DCCO jurisdictional deaths for 2017.





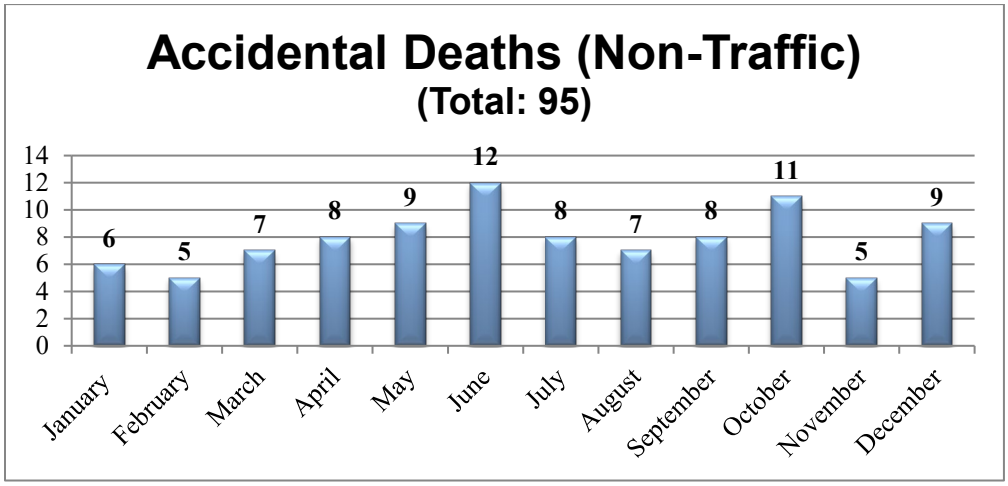
Of natural deaths 256 were deemed cardiac related, 200 pulmonary, 53 infectious, 191 cerebrovascular, 182 cancers, and 178 other.



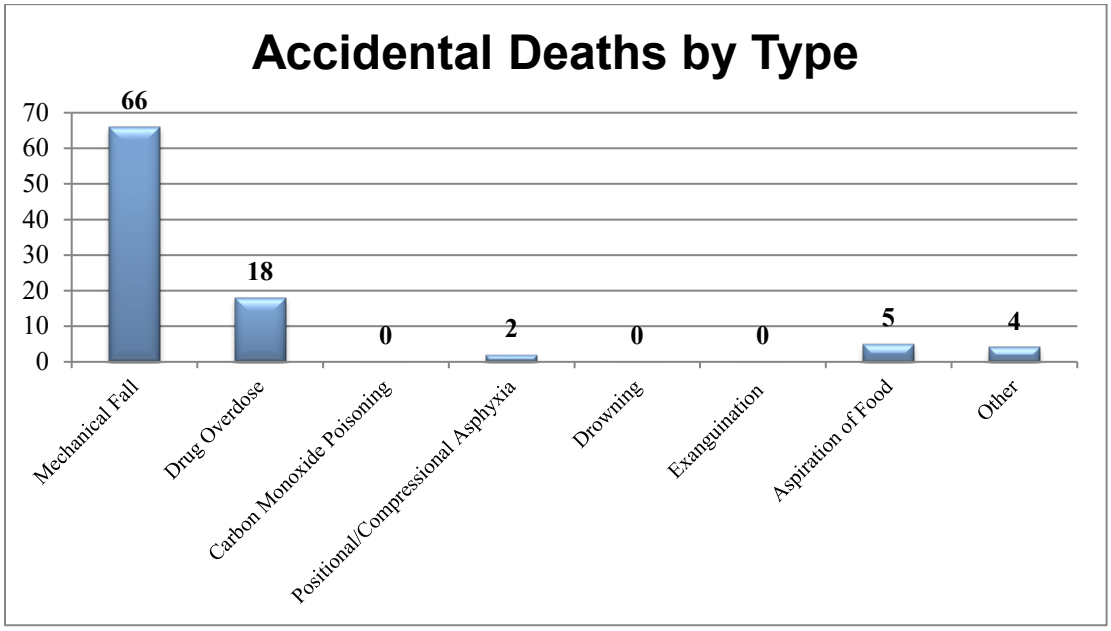
Accidental Deaths

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 2017.

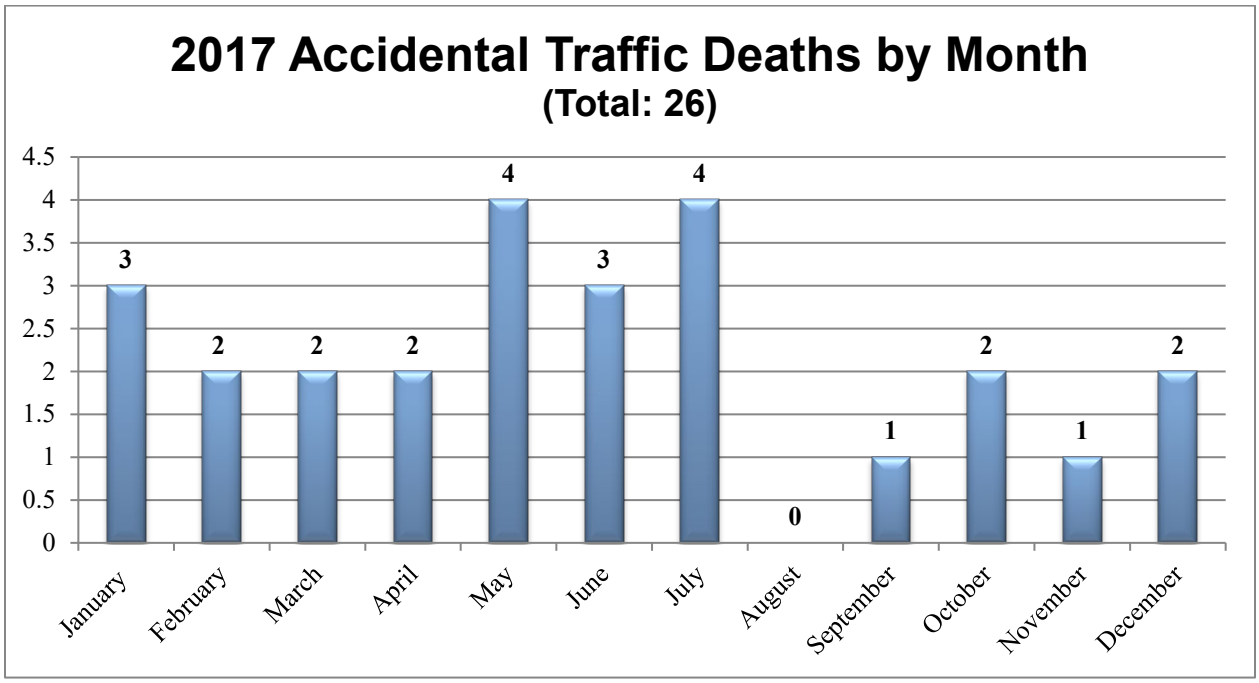


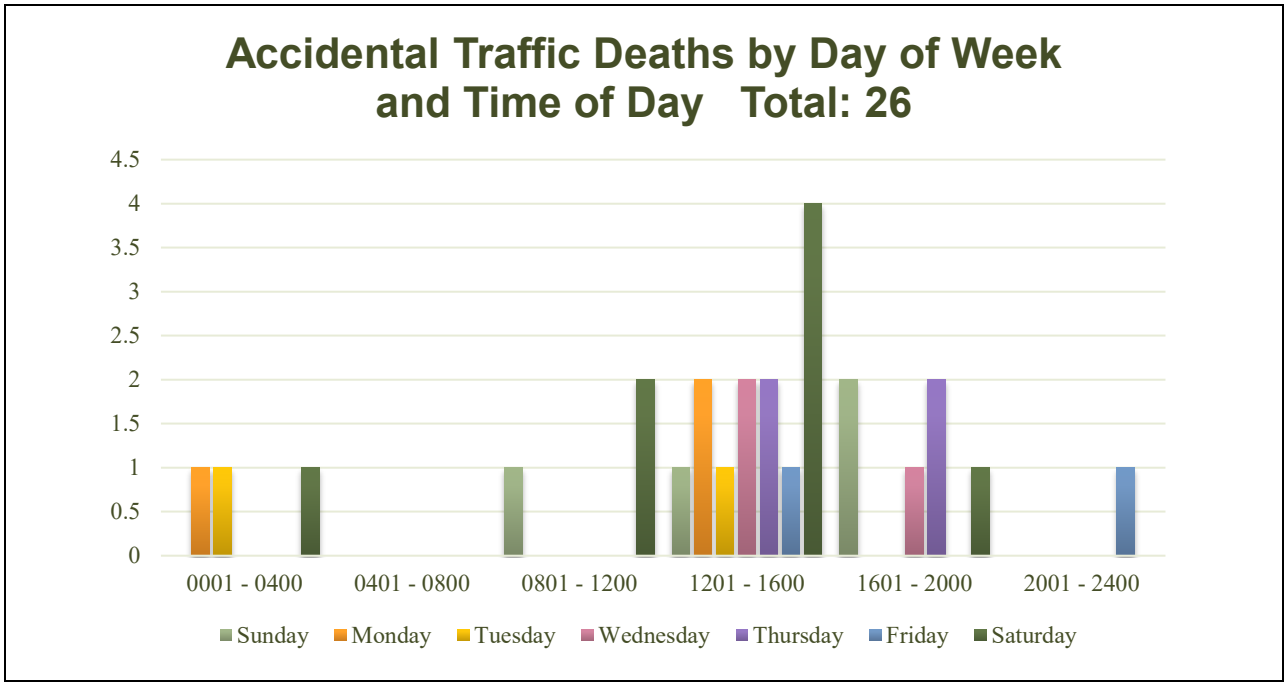
Of the Non-Traffic related accidental deaths reported to the Douglas County Coroner's Office, most of the deaths were related to an unintentional drug overdose or complications of a mechanical fall; typically a fracture or head injury.

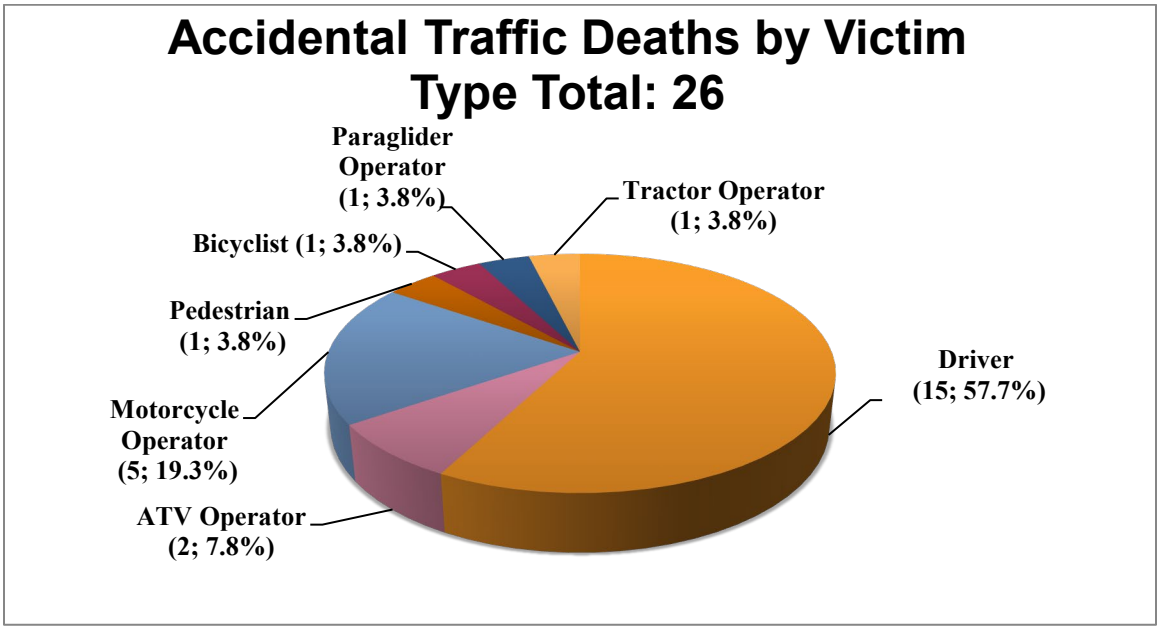


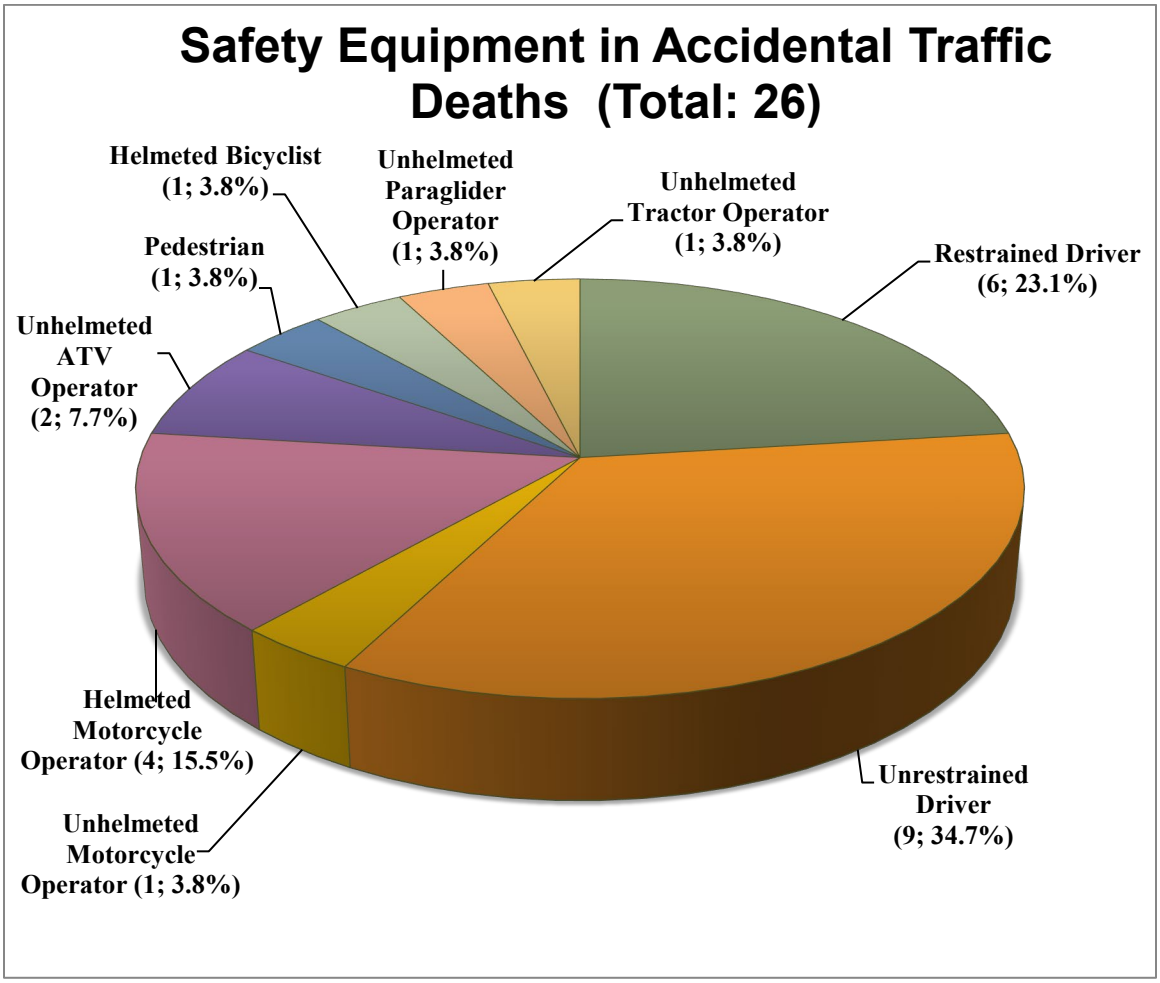
Traffic related accidental deaths include deaths in which the deceased was an occupant of a motor vehicle, motorcycle, tractor, bicycle, or a pedestrian involved in a motor vehicle-pedestrian incident.

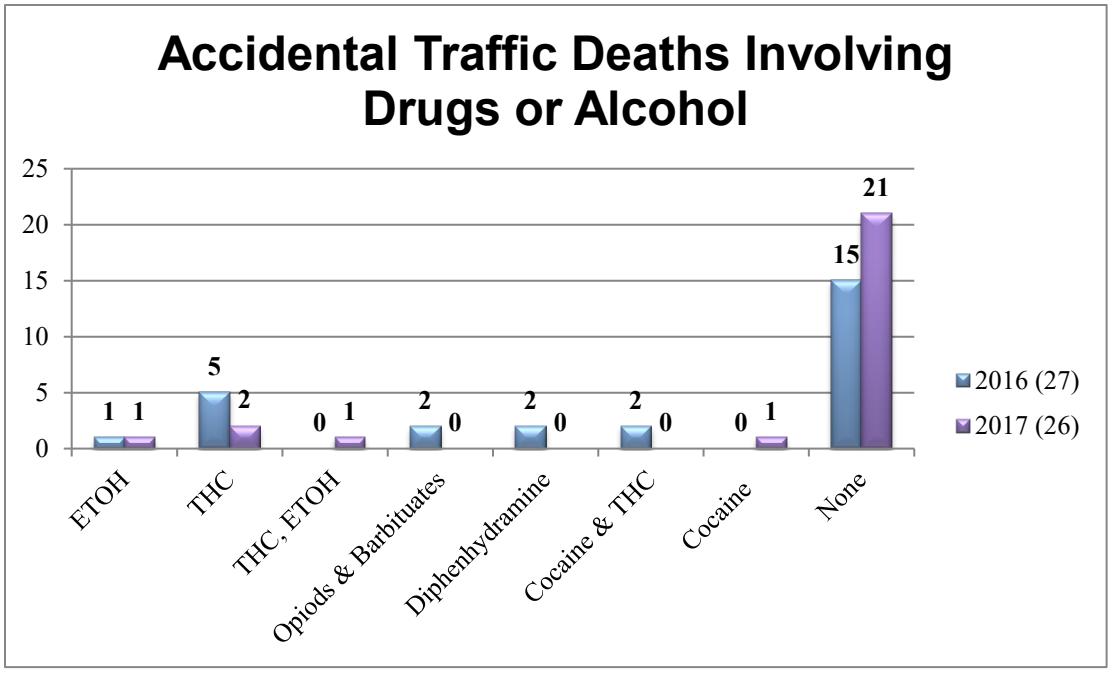
Traffic related accidental deaths accounted for **2.1%** of the total DCCO jurisdictional deaths for 2017.




Accidental Traffic Deaths by Day of Week and Time of Day Total: 26
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
0001 - 0400
0401 - 0800
0801 - 1200
1201 - 1600
1601 - 2000
2001 - 2400
Sunday
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday


Accidental Traffic Deaths by Victim Type Total: 26
Paraglider Operator (1; 3.8%)
Tractor Operator (1; 3.8%)
Bicyclist (1; 3.8%)
Pedestrian (1; 3.8%)
Motorcycle Operator (5; 19.3%)
ATV Operator (2; 7.8%)
Driver (15; 57.7%)

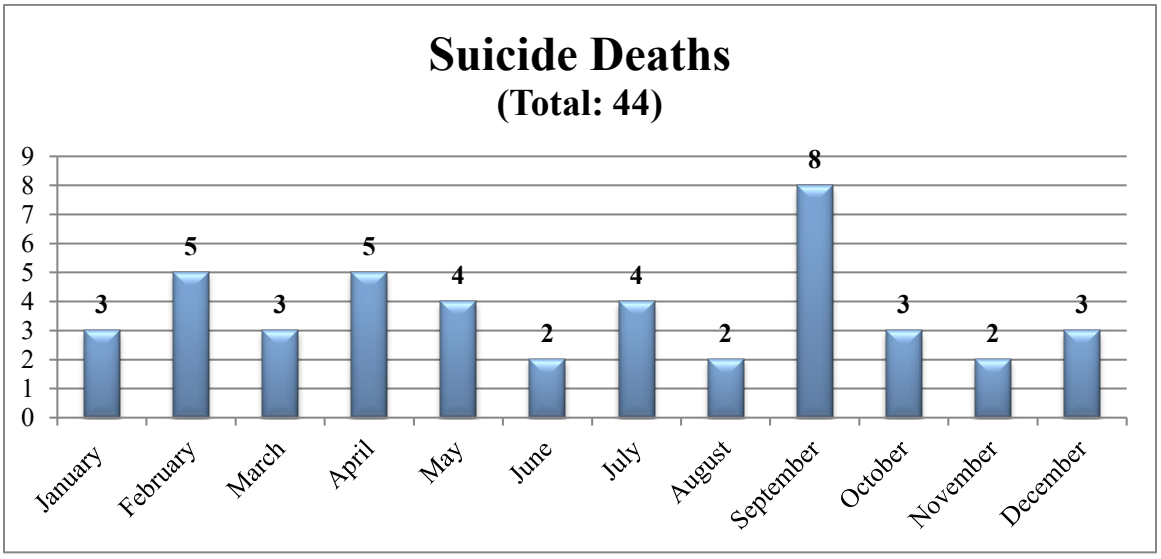

Safety Equipment in Accidental Traffic Deaths (Total: 26)
Helmeted Bicyclist (1; 3.8%)
Unhelmeted Paraglider Operator (1; 3.8%)
Unhelmeted Tractor Operator (1; 3.8%)
Restrained Driver (6; 23.1%)
Pedestrian (1; 3.8%)
Unhelmeted ATV Operator (2; 7.7%)
Helmeted Motorcycle Operator (4; 15.5%)
Unhelmeted Motorcycle Operator (1; 3.8%)
Unrestrained Driver (9; 34.7%)

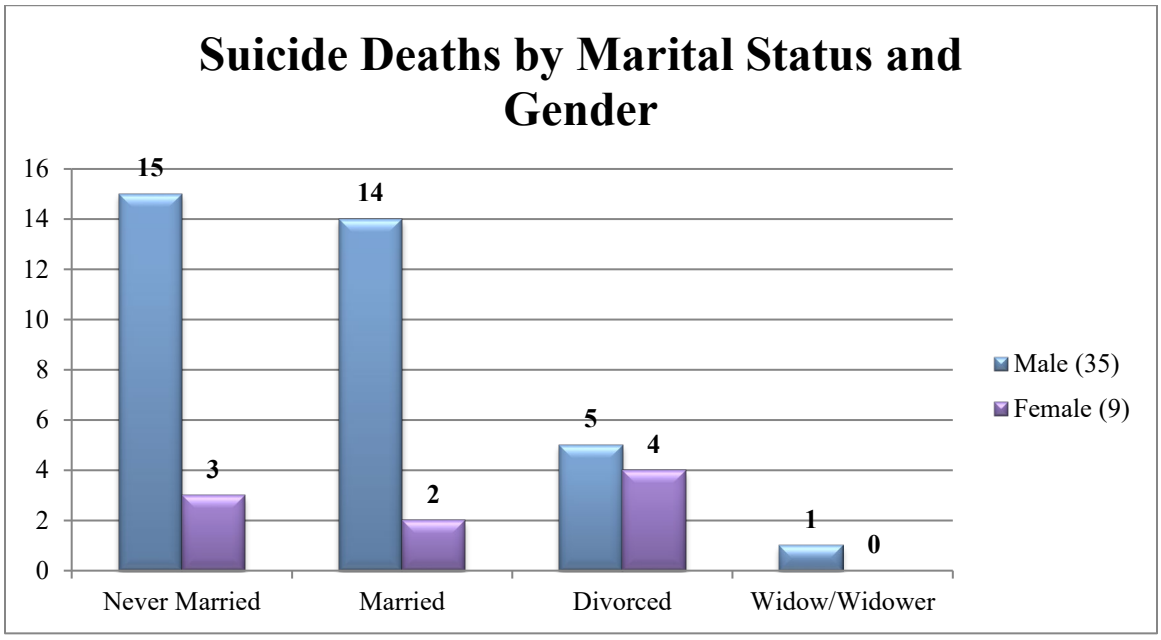

Accidental Traffic Deaths Involving Drugs or Alcohol
25
20
15
10
5
0
1 1
5 2
0 1
2 0
2 0
2 0
0 1
15 21
ETOH
THC
THC, ETOH
Opiods & Barbituates
Diphenhydramine
Cocaine & THC
Cocaine
None
2016 (27)
2017 (26)

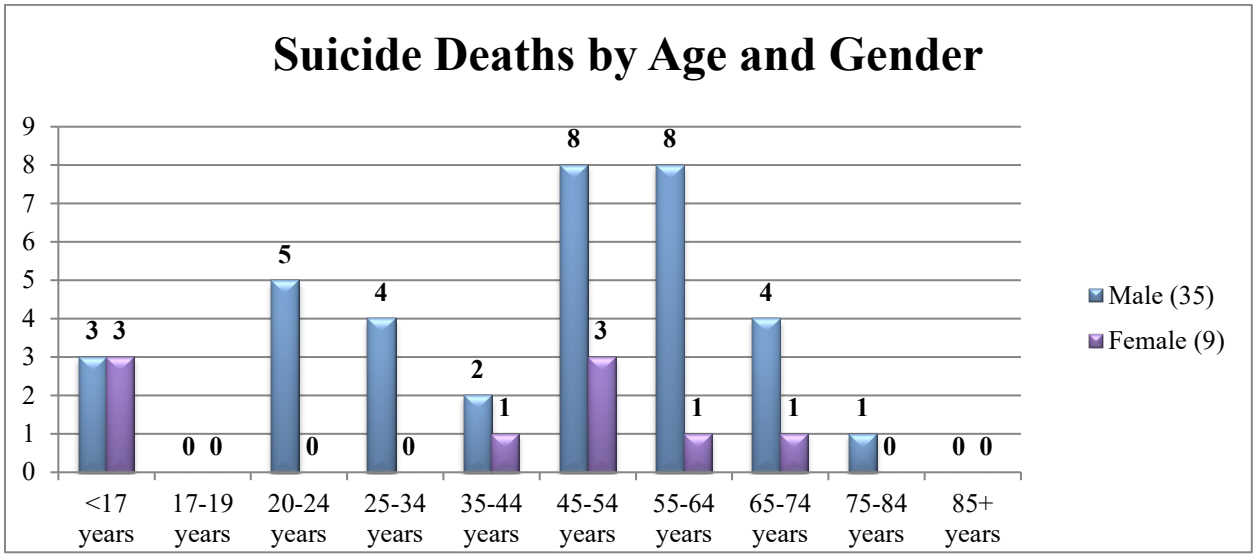
Suicide Deaths

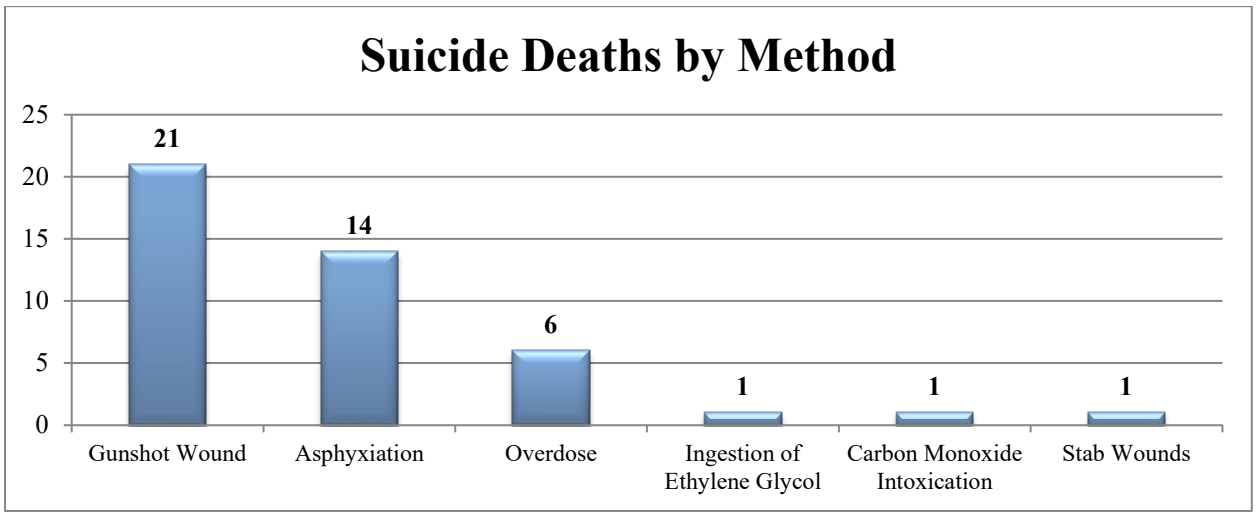
Deaths that are classified as suicide are those that occurred as a result of self-inflicted injury. In 2017, **80%** of the deaths were those of males, which is consistent with nationwide figures. The most common method of suicide in 2017 was firearm related **(48%)** followed by asphyxiation, most commonly due to hanging **(32%)**.

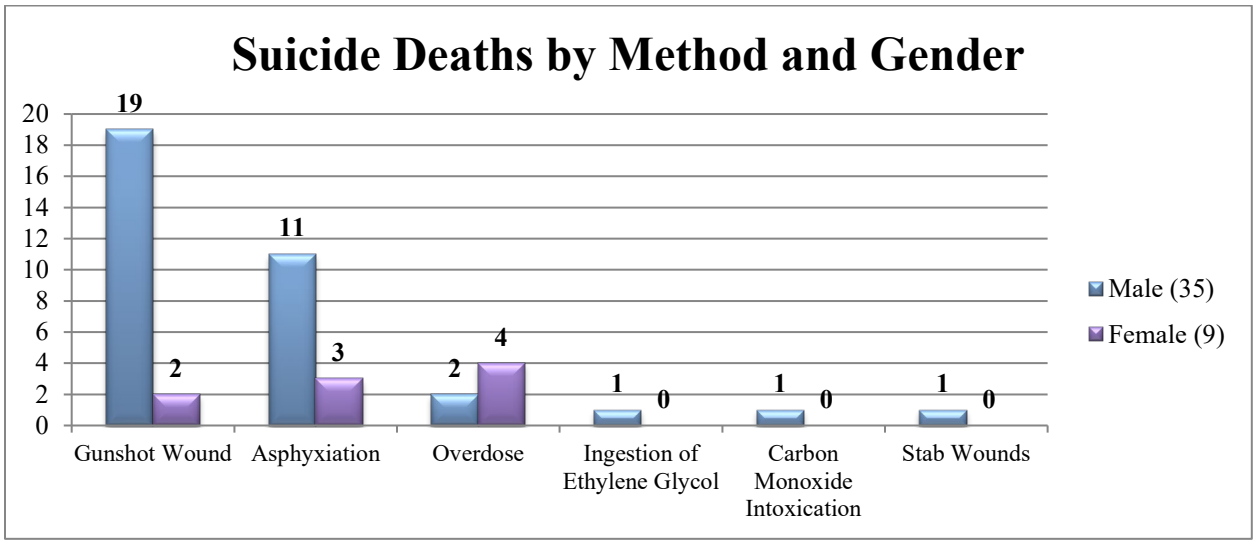
Suicide deaths accounted for **3.6%** of the total DCCO jurisdictional deaths for 2017.






Suicide Deaths by Age and Gender
9
8
7
6
5
4
3
2
1
0
3 3
0 0
5
0
4
0
2
1
8
3
8
1
4
1
1
0
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 (35)
Female (9)

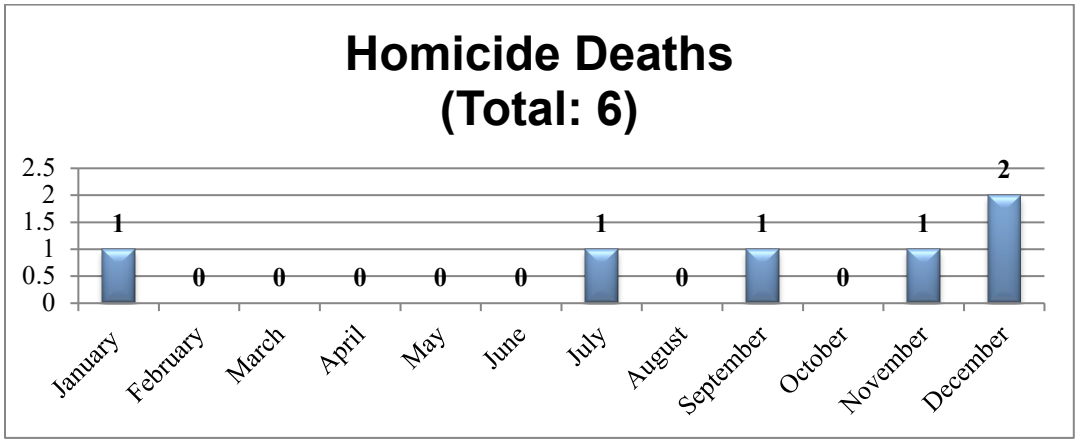

Suicide Deaths by Method
25
20
15
10
5
0
21
14
6
1
1
1
Gunshot Wound
Asphyxiation
Overdose
Ingestion of Ethylene Glycol
Carbon Monoxide Intoxication
Stab Wounds


Suicide Deaths by Method and Gender
20
18
16
14
12
10
8
6
4
2
0
19
2
11
3
2
4
1
0
1
0
1
0
Gunshot Wound
Asphyxiation
Overdose
Ingestion of Ethylene Glycol
Carbon Monoxide Intoxication
Stab Wounds
Male (35)
Female (9)

Homicide Deaths

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

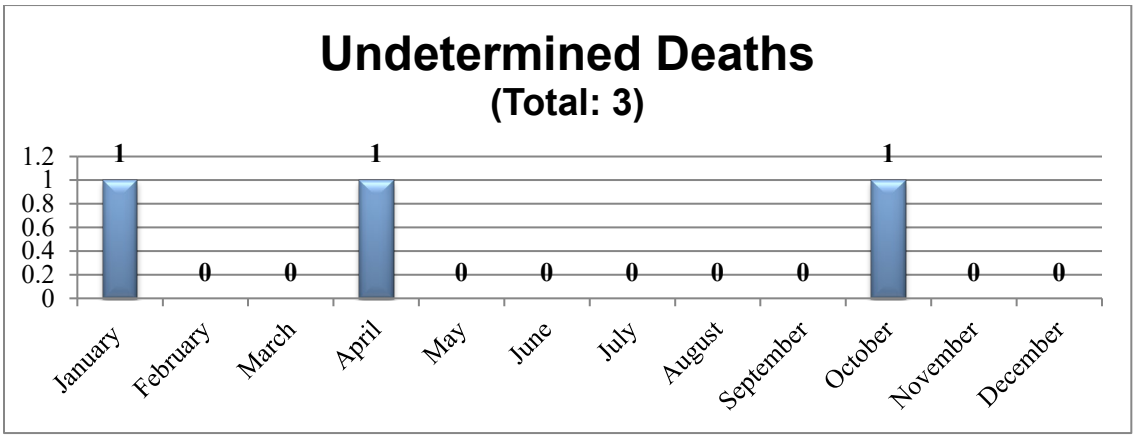
Homicide deaths accounted for **0.5%** of the total DCCO jurisdictional deaths for 2017.



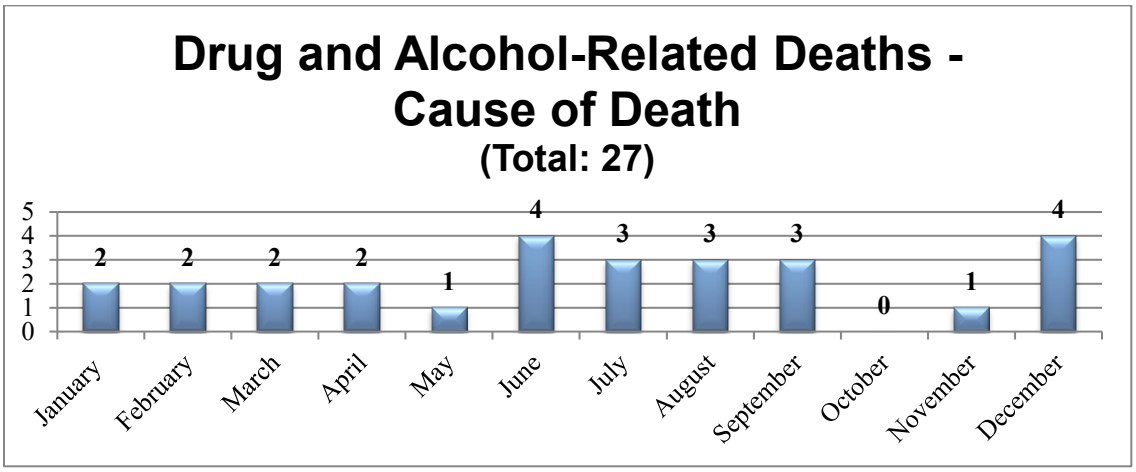
Undetermined Deaths

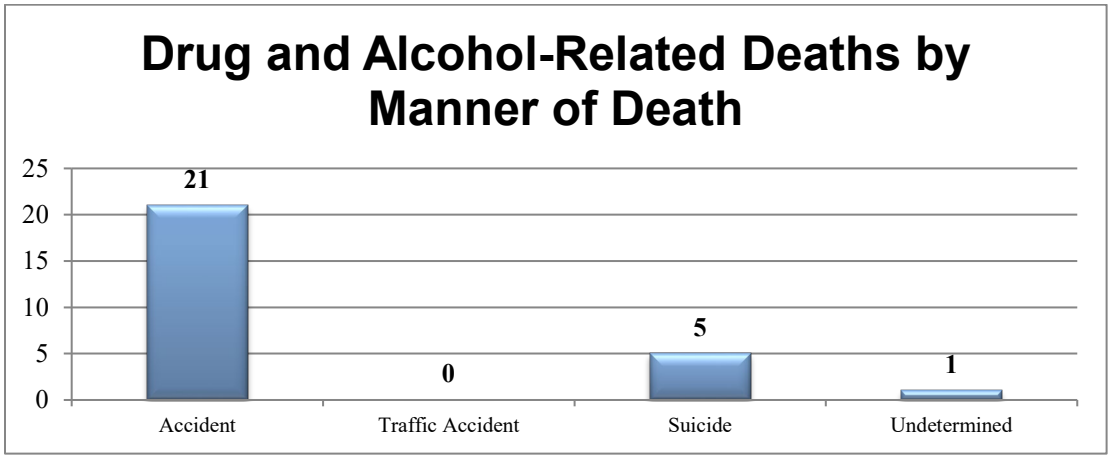
Deaths that are classified as undetermined are those deaths in which, after a thorough investigation and consideration of all information available, one manner of death is no more compelling than another manner of death. There are some instances where the cause of death is apparent; however, the circumstances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

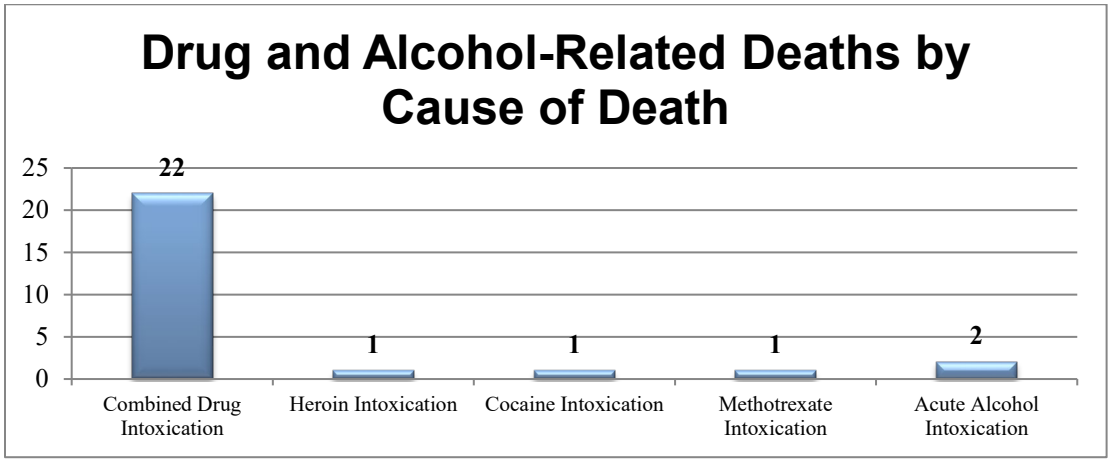
Undetermined deaths accounted for **0.2%** of the total DCCO jurisdictional deaths for 2017.

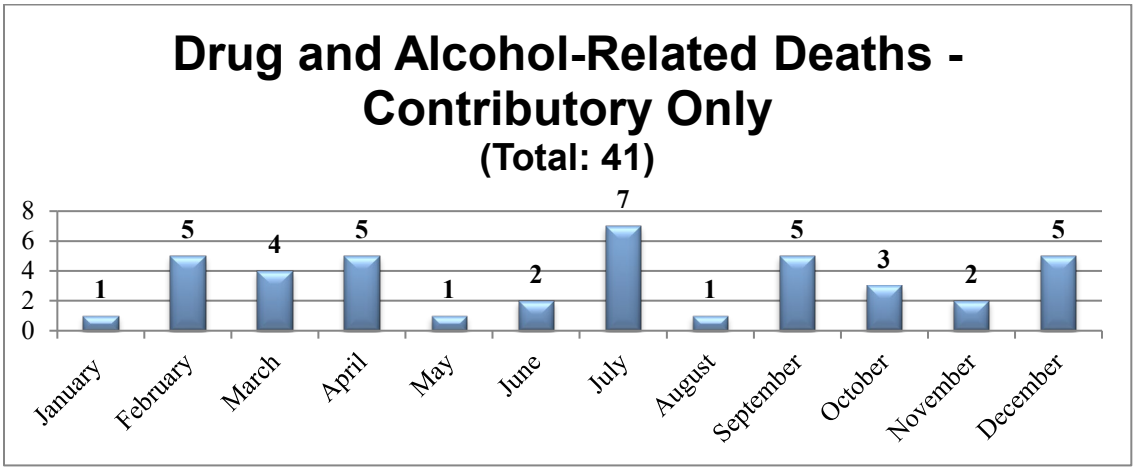


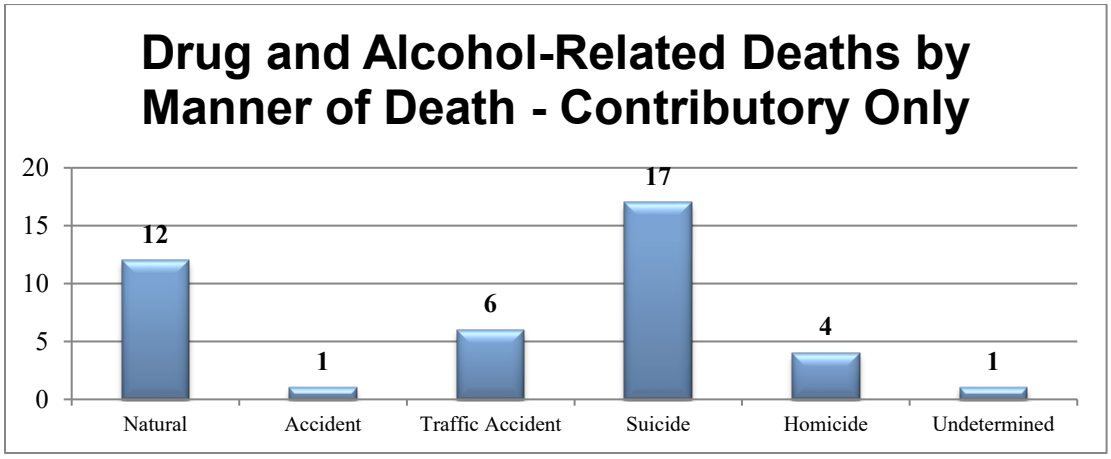
Drug and Alcohol-Related Deaths







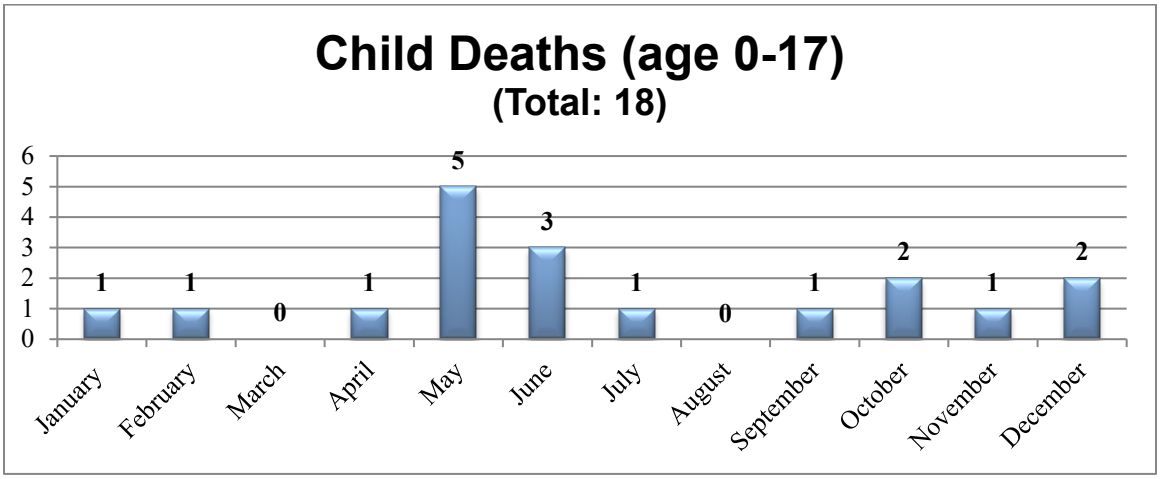

Drug and Alcohol-Related Deaths - Contributory Only
(Total: 41)
8
6
4
2
0
1
5
4
5
1
2
7
1
5
3
2
5
January
February
March
April
May
June
July
August
September
October
November
December

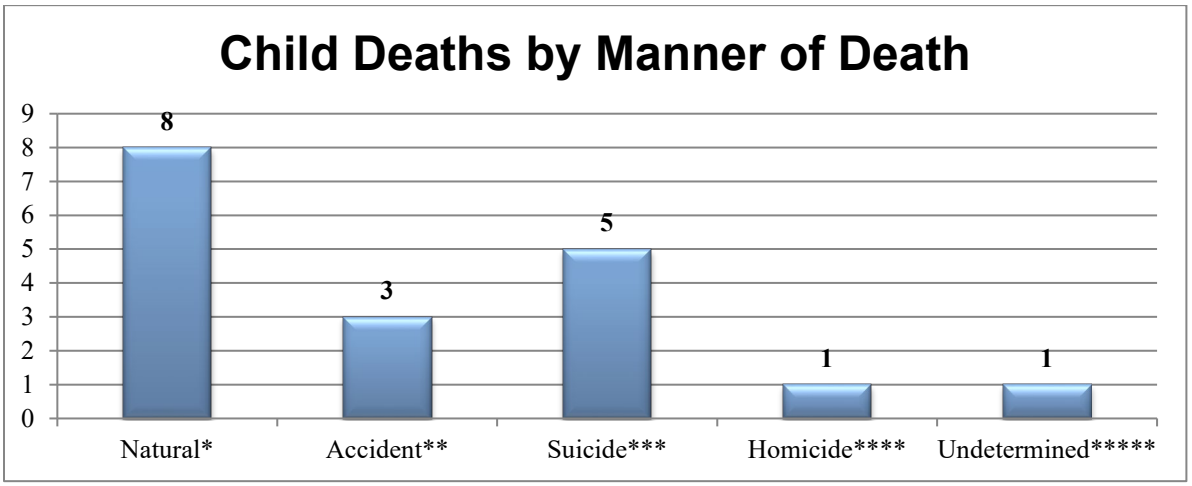

Drug and Alcohol-Related Deaths by Manner of Death - Contributory Only
20
15
10
5
0
12
1
6
17
4
1
Natural
Accident
Traffic Accident
Suicide
Homicide
Undetermined

Child Deaths

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

Child deaths accounted for **1.5%** of the total DCCO jurisdictional deaths for 2017.





**Of the eight (8) natural deaths, two (2) deaths were due to premature delivery, one (1) was due to chromosomal abnormalities, two (2) were due to acute respiratory failure, one (1) was due to cancer, one (1) was due to cardiorespiratory failure, and one (1) was due to electrolyte imbalance due to infection.*

***Of the three (3) accidental deaths, one (1) was due to motor vehicle accident, one (1) was due to aspiration of a food bolus, and one (1) was due to positional asphyxia.*

****Of the five (5) suicide deaths, two (2) a 16-year-old and a 17-year-old, were due to asphyxiation, one (1) a 13-year-old, was due to self-inflicted gunshot wound, one (1) a 14-year-old, was due to acetaminophen overdose, and one (1) a 13-year-old, was due to combined drug intoxication.*

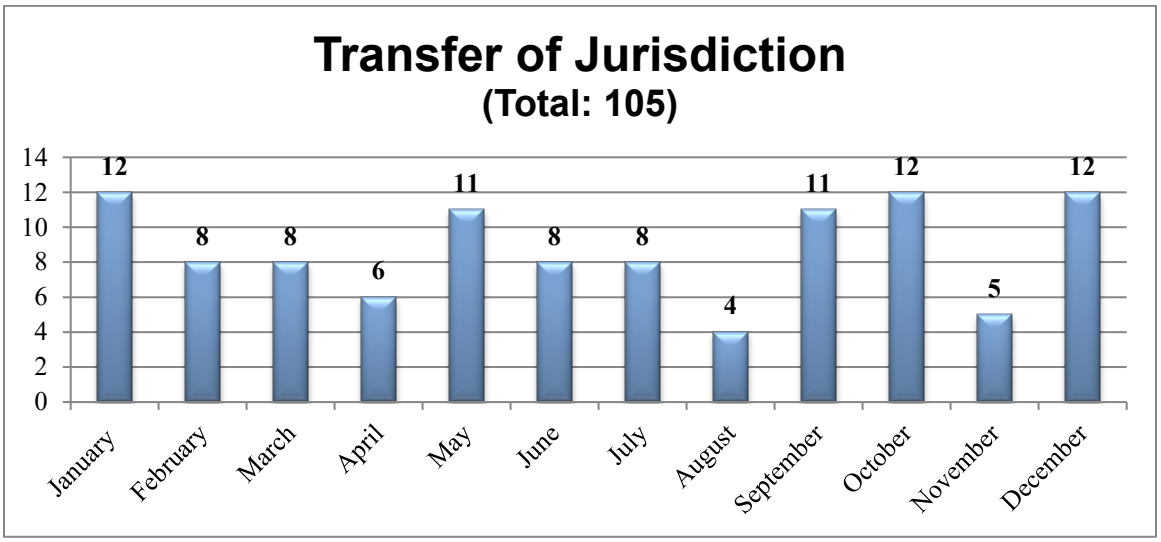
*****One (1) homicide death was due to gunshot wounds.*

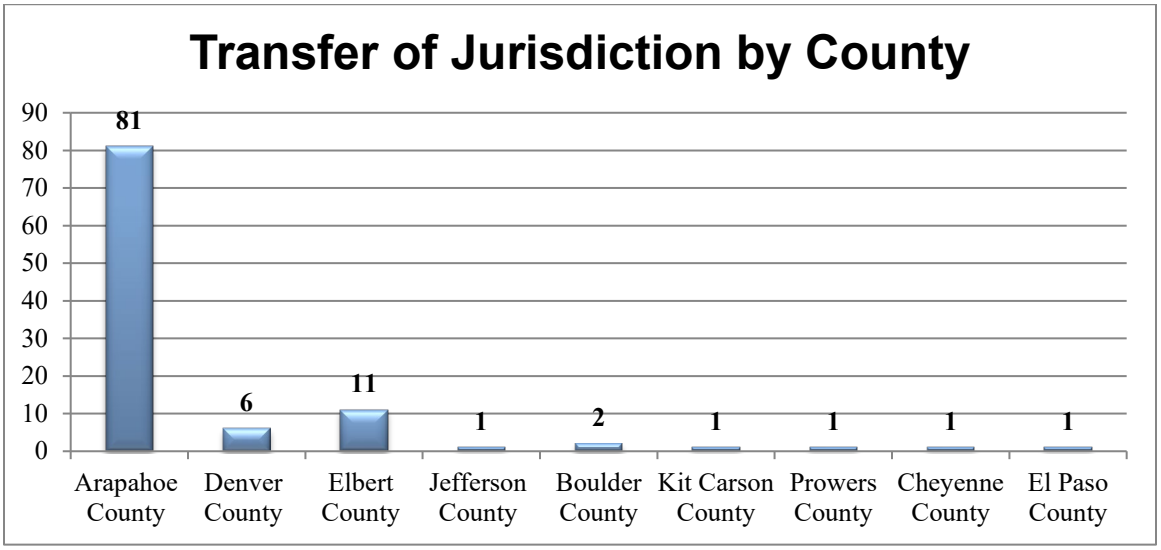
******One (1) undetermined death was a 6-month-old child.*

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 those where an individual is transported to a hospital in Douglas County, from a location such as a residence in another jurisdiction, 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, 59 deaths occurred at Parker Adventist Hospital, 36 occurred at Sky Ridge Medical Center, three (3) occurred at The Center at Lincoln, three (3) occurred at the decedent's residence, and four (4) occurred at various skilled nursing facilities in Douglas County.



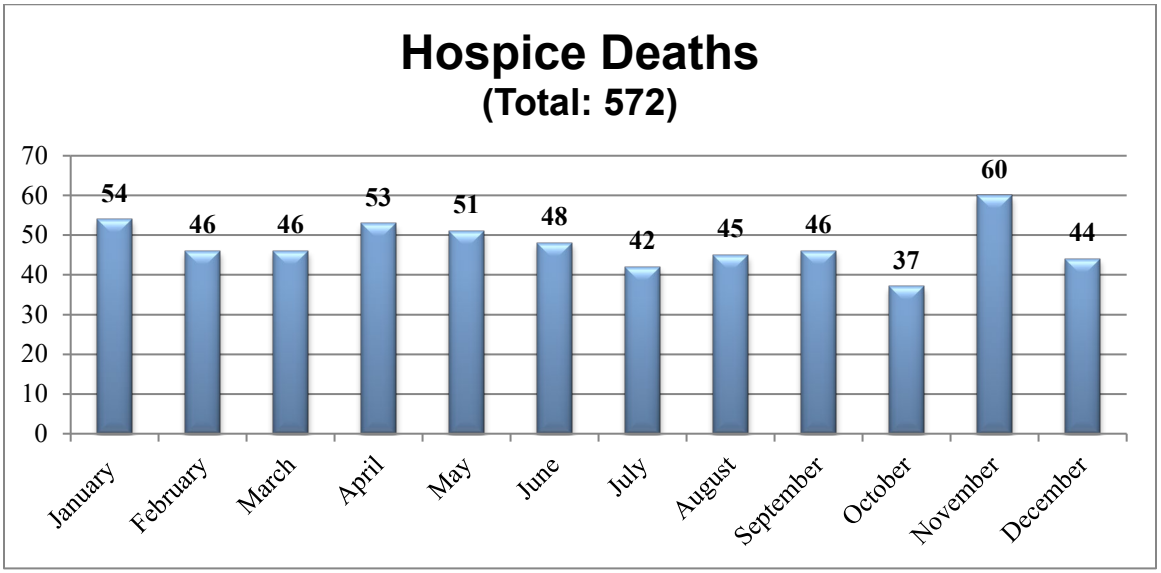


Hospice Deaths

All hospice deaths that occur in Douglas County are reportable to the Coroner's Office. In 2017, 572 deaths were reported by hospice agencies.

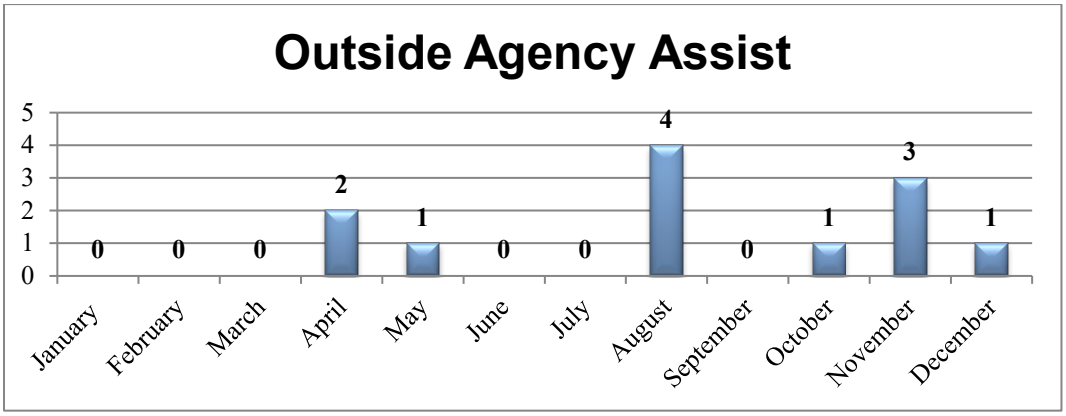
Of the 572 hospice deaths, 537 (**93.9%**) were natural hospice deaths and 35 (**6.1%**) were accidental hospice deaths.

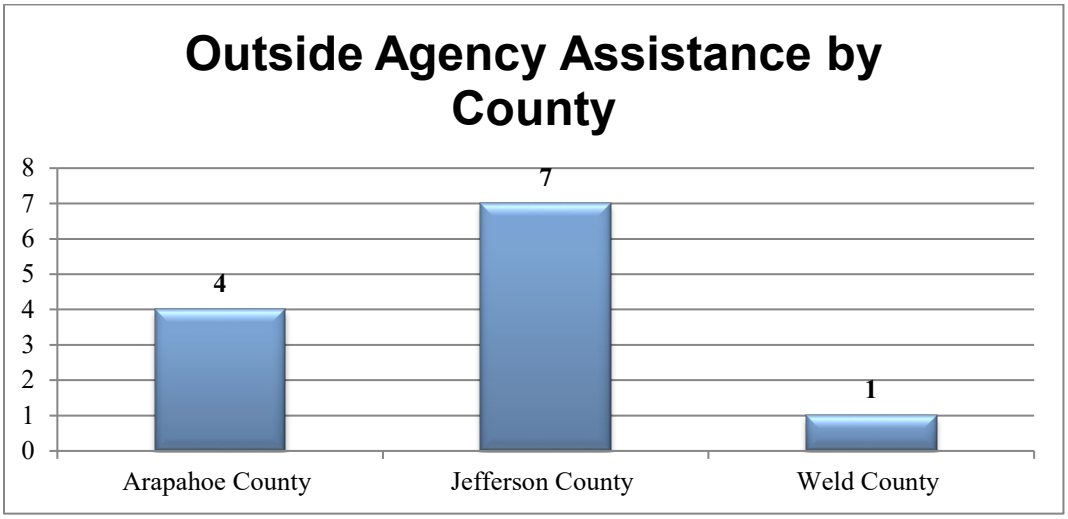
Hospice deaths accounted for **46.3%** of all deaths reported to the Douglas County Coroner's Office in 2017.

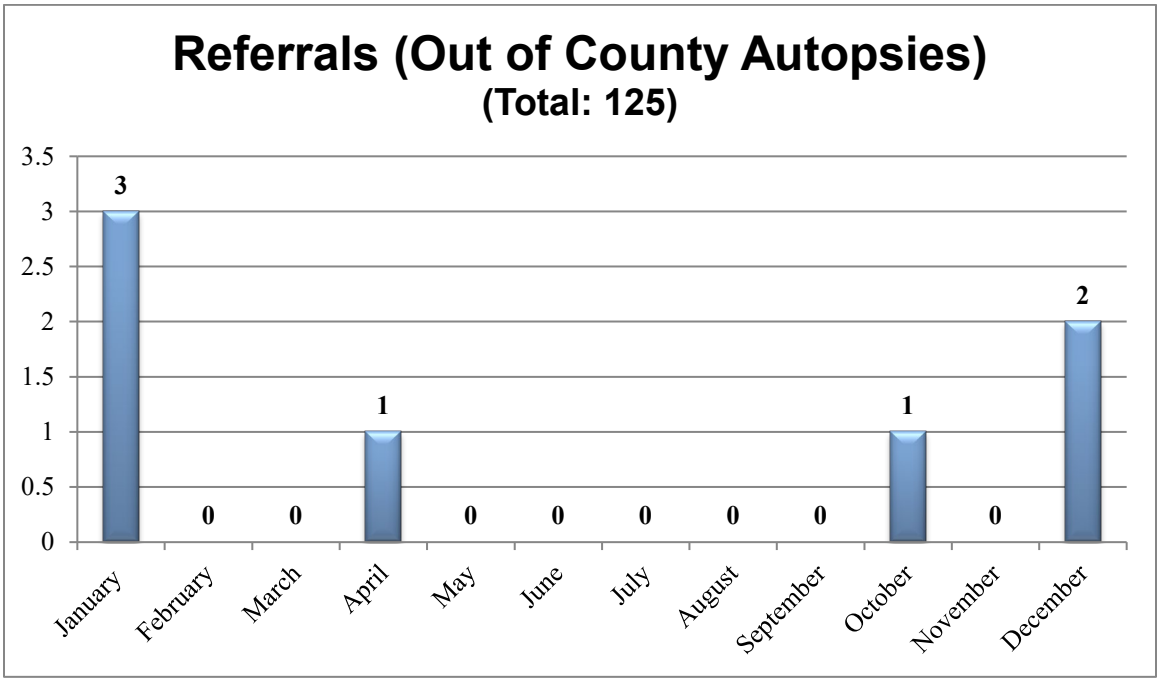


Outside Agency Assistance

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.





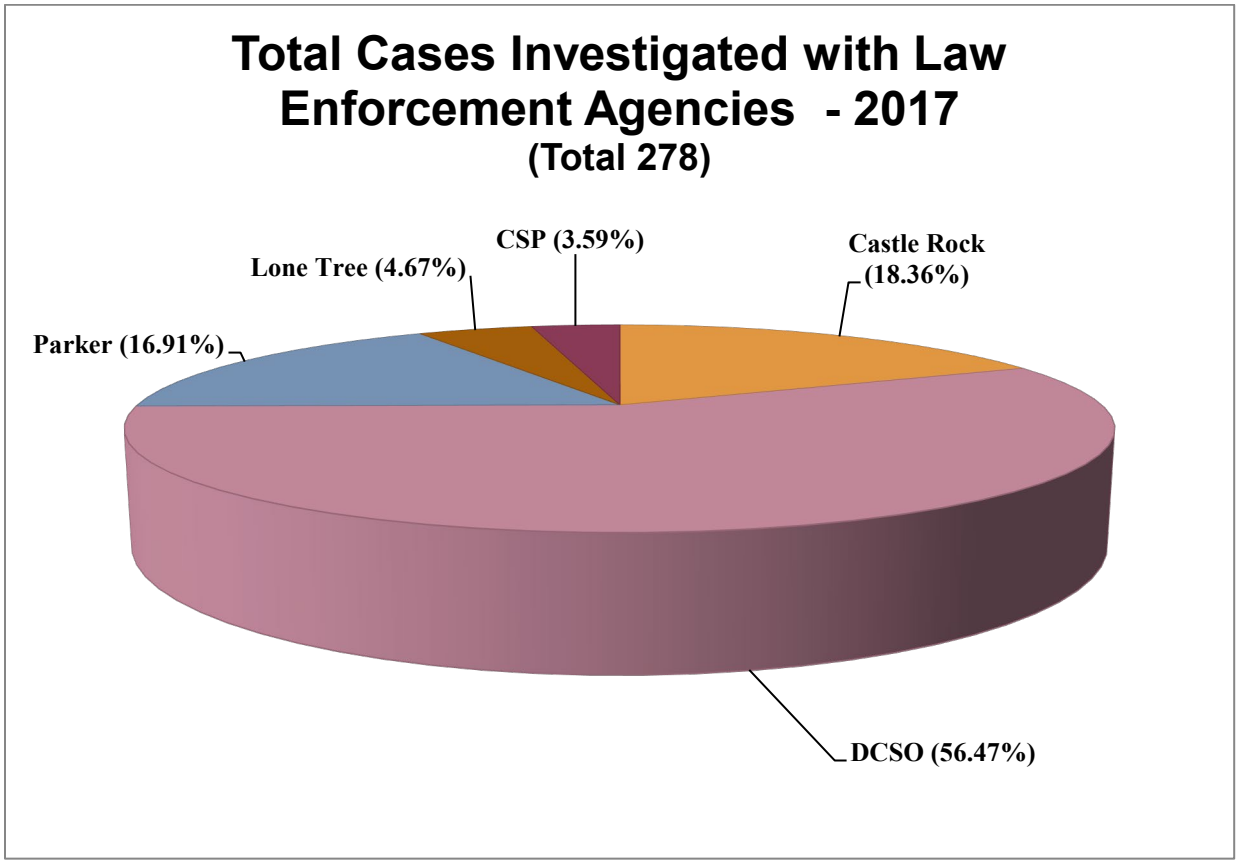


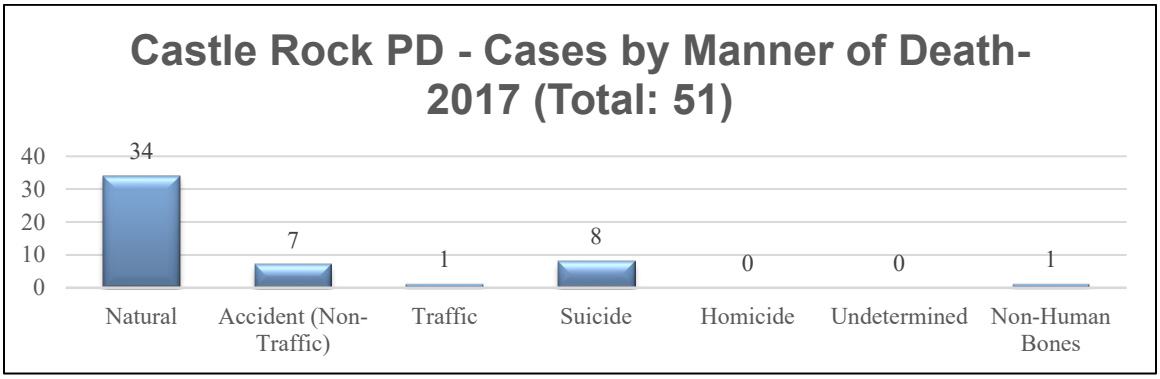
The Douglas County Coroner's Office also assists outside agencies (Coroner's Offices and hospitals) with performing autopsies at their request. The autopsies are performed by a contracted group of forensic pathologists, notably a board-certified forensic pathologist, based out of the Douglas County Coroner's Office facility. In 2017, we performed four (4) autopsies for Las Animas County and three (3) autopsies for Pueblo County.

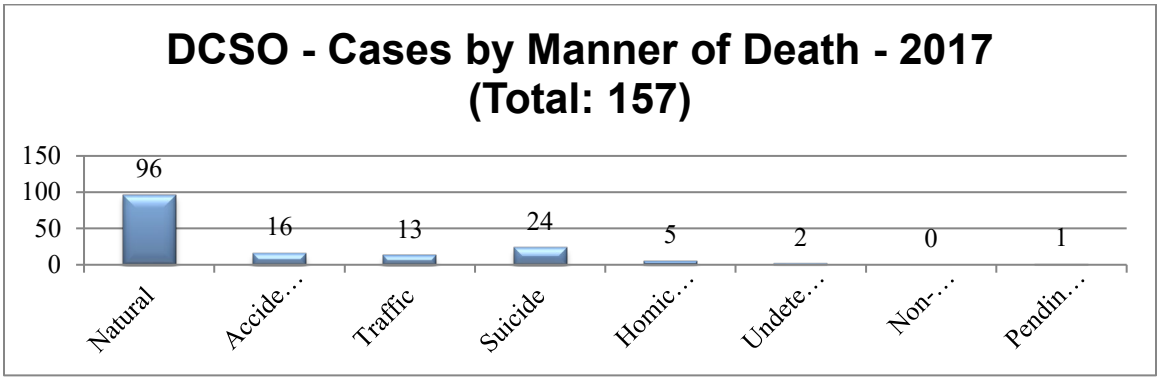
Law Enforcement Agencies

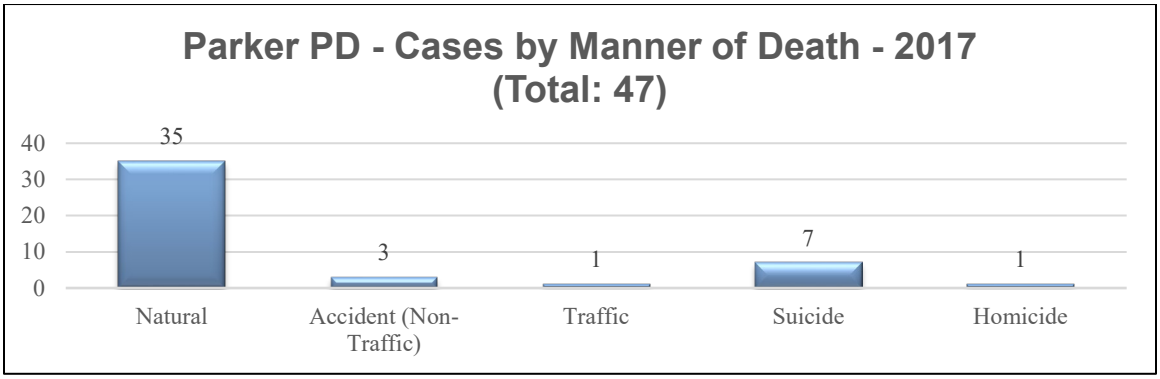
The Douglas County Coroner's Office works in collaboration with Law Enforcement Agencies with jurisdiction in Douglas County. Law Enforcement Agencies in Douglas County include the Aurora Police Department, Castle Rock Police Department, Colorado State Patrol (CSP), Douglas County Sheriff's Office (DCSO),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

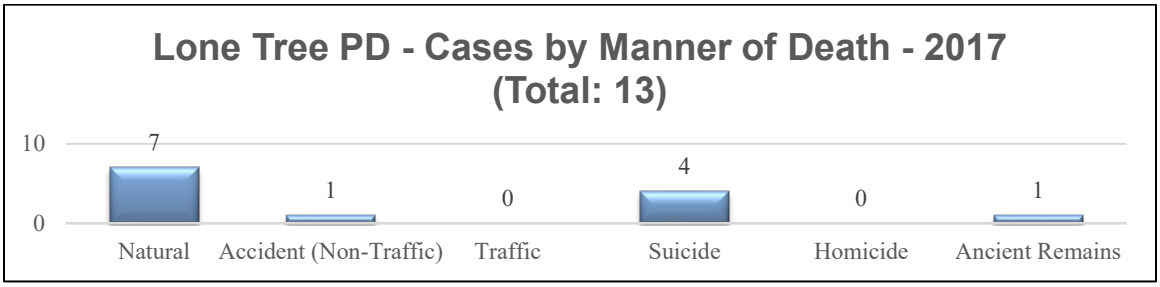
Of note: The total cases investigated with Law Enforcement may differ from the scene responses made by the Coroner's Office; due to some deaths having been delayed due to hospitalization following an incident or having occurred at a care facility where no response from the Coroner's Office was necessary.

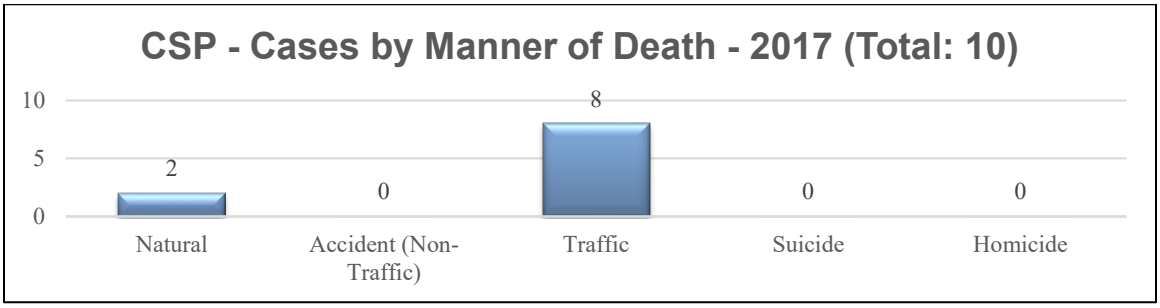



Castle Rock PD - Cases by Manner of Death- 2017 (Total: 51)
40
30
20
10
0
34
7
1
8
0
0
1
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined
Non-Human Bones


DCSO - Cases by Manner of Death - 2017 (Total: 157)
150
100
50
0
96
16
13
24
5
2
0
1
Natural
Accide…
Traffic
Suicide
Homic…
Undete…
Non-…
Pendin…


Parker PD - Cases by Manner of Death - 2017 (Total: 47)
40
30
20
10
0
35
3
1
7
1
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide

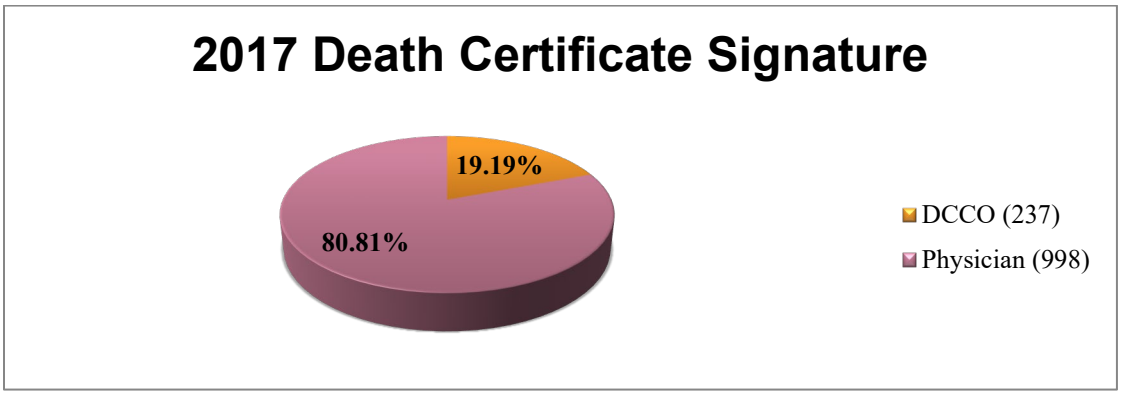

Lone Tree PD - Cases by Manner of Death - 2017 (Total: 13)
10
0
7
1
0
4
0
1
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Ancient Remains

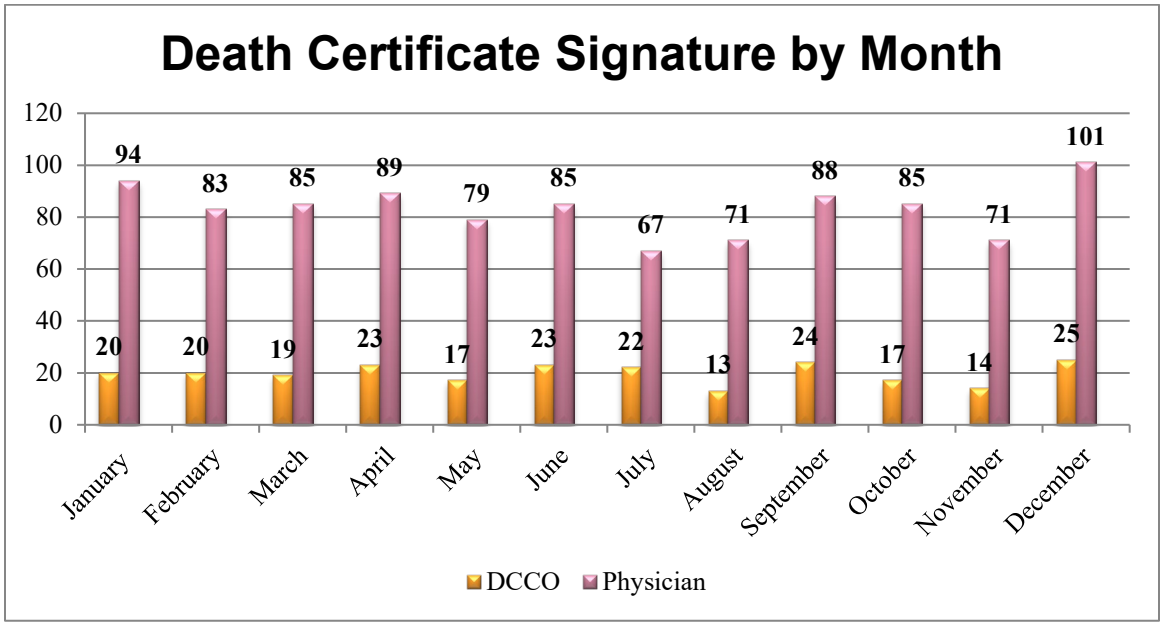

CSP - Cases by Manner of Death - 2017 (Total: 10)
10
5
0
2
0
8
0
0
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide

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 1235 reported cases to DCCO, 237 of the death certificates were signed by DCCO and 998 of the death certificates were signed by a private physician.



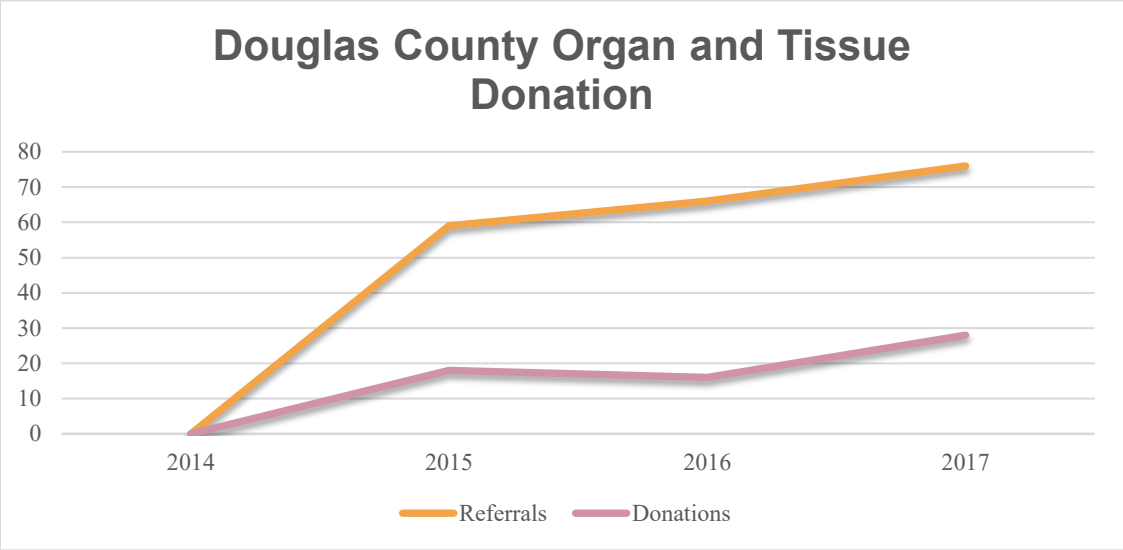


Organ and Tissue Donation

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, bone, tissues, corneas, or other body parts prior to their death, by placing themselves on the donor registry. After death, an individual's next-of-kin can provide authorization for recovery if they so wish. **It is the goal of the Douglas County Coroner's Office to facilitate, whenever applicable, effective collaboration with the donation agencies in the Denver Metro Area of Colorado (Donor Alliance and Rocky Mountain Lions Eye Bank) to honor the wishes of the deceased and/or their families.**

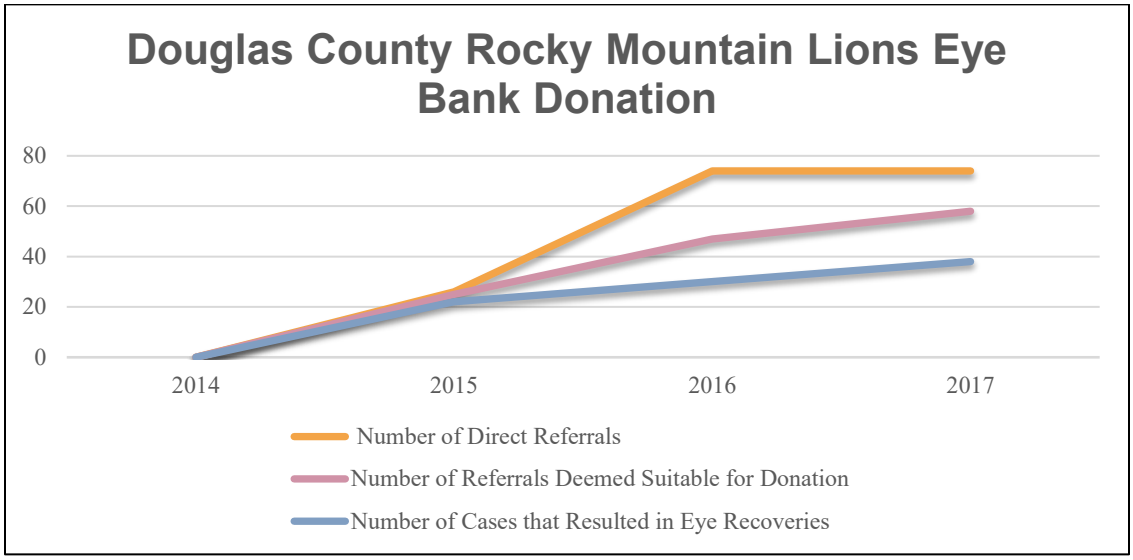
After approval for release by the Coroner's Office, referrals are made to the procurement agencies either from a hospital or directly from a Coroner's Office. The procurement agencies then work with the family of the individual to determine if the individual is medically suitable to be a donor.

DONOR ALLIANCE
Organ & Tissue Donation



In 2014, the Douglas County Coroner's Office did not allow referrals to be made to Donor Alliance. In 2015, when Coroner Romann took office, she changed office policy to honor individuals' rights and the rights of the next-of-kin to become donors. As a result, in 2015 the Office referred 59 cases; 18 cases of which were deemed suitable for donation. In 2016, 66 cases were referred, with 16 cases deemed suitable for recovery of tissue and/or bone where recovery took place. In 2017, 76 cases were referred, with 28 cases deemed suitable for recovery of tissue and/or bone where recovery took place.

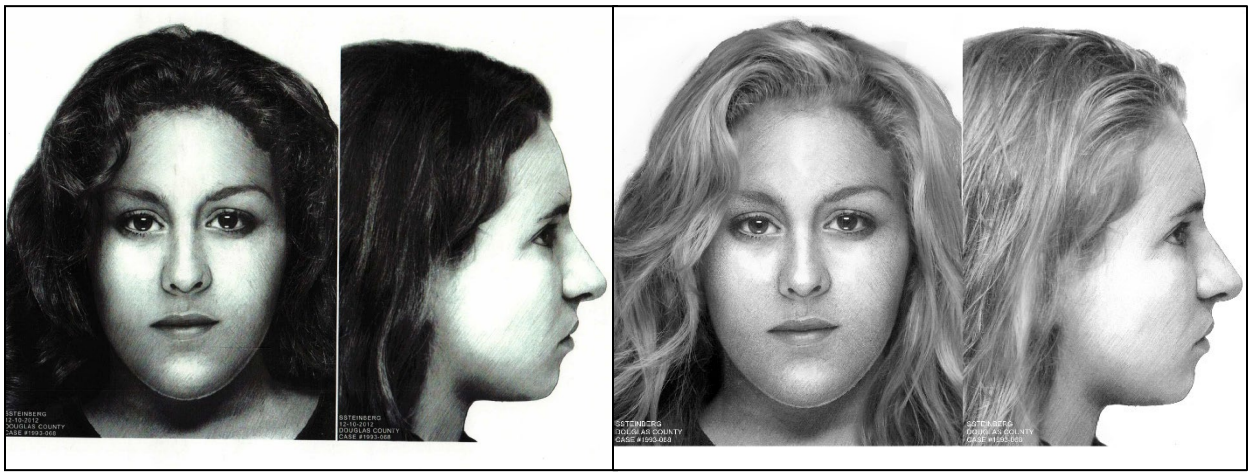
As in 2014, the Douglas County Coroner's Office did not make any direct referrals to the Rocky Mountain Lions Eye Bank (RMLEB) for cornea donation. As with skin and tissue donation, after taking office in 2015, Coroner Romann made honoring the wishes and rights of the decedent and their families a priority, 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 recovery of corneas in 22 of these cases. In 2016, the number of direct referrals was 74, with 47 of those deemed suitable for donation and 30 recoveries taking place. In 2017, the number of direct referrals was 76, with 28 of those deemed suitable for donation and recoveries taking place.



Additionally, there were 52 cases that were referred to RMLEB by local hospitals in deaths where the Douglas County Coroner's Office had jurisdiction. All 52 of these referred donors were deemed suitable for donation, with recovery taking place on all.

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 24 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, after valiant efforts to identify her were unsuccessful, the decedent was buried in Cedar Hill Cemetery (Castle Rock, CO) under the name of Jane Doe. On October 12, 2012, her remains were exhumed from her grave for additional forensic analysis, which 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.

2017 Update

In partnership with the Douglas County Sheriff's Office (DCSO), the Douglas County Coroner's Office (DCCO) continues to work diligently on attempting to identifying Jane Doe. This year the focus was placed on working with a Forensic Case Manager at the National Center for Missing and Exploited Children to bring the case up for a Comprehensive Case Review, which would include a 1-2 day presentation and workshop headed by the Center at their headquarters in Alexandria, VA. Both DCCO and DCSO would present the case to a panel of subject matter experts, representing the FBI, NCIS, and many cold case forensic team specialties. Tentative plans are in place to conduct the review in 2018. In addition, DCCO continues to follow-up on "hits" with NAMUS, a national missing and unidentified persons system.