Douglas County Coroner's Office

Coroner Jill E. Romann

2021

Annual Report

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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 in the loss, this report is dedicated.

Table of Contents

Transfers/Hospice/Agency Assist/Referrals

Law Enforcement Interface

Miscellaneous

A Personal Message from Coroner Romann

It's time again for a recap of the past year here at the Douglas County Coroner's Office. The balance of this Annual Report will give you the statistical look at our operations and activities. Hopefully, the numbers will reflect real recovery from Covid-19. But before we do that, I'd like to credit my staff who made it all happen. I am deeply indebted to each and every one of them and am truly proud of their accomplishments. The citizens of Douglas County are the beneficiaries of our attention to detail, personal service around-the-clock, and budgetary management. And, despite the turmoil surrounding Tri-County Health, our devotion to Medical Science and Public Health shall not be diminished.

History has it that I am the first professional Coroner to be elected in Douglas County. That gives me somewhat of an advantage. Below is a list of refinements and significant improvements here at DCCO. Some are earlier in my 7-1/2 years in office while others are more contemporary. Some have statewide impact, while others are countywide and local. It is our collective wish that future Coroner's will constructively adapt to growth in the County and build on the professional ethos and sentiment brought together here in Douglas County during our tenure.

Jill E. Romann, BS, F-ABMDI #185
Douglas County Coroner

Duties of 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.

Deaths meeting the referenced 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.

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 bacterial, industrial hazardous material or radiation.
- ✓ All industrial accidents.
- ✓ Skeletonized Remains.
- ✓ 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.
- ✓ From disease, which may be hazardous or contagious or which may constitute a threat to the health of the general public.

The Douglas County Coroner's Office operates 24/7/365 serving the citizens of Douglas County!

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.

our core values

SERVICE

COMPASSION

PROFESSIONALISM

DIGNITY

INTEGRITY

Highlights

"Your organization runs like a smooth machine, and I have never heard any Law Enforcement agency report anything negative about you or your investigators"

Tracey Montano, Deputy Director

Unified Metropolitan Forensic Crime Laboratory

"We know your staff comes highly prepared, and you hire people with integrity"

Det. Shannon Jones

Lone Tree Police Department

Professionalism

- DCCO became **nationally accredited** by the International Association of Coroner's and Medical Examiners (IACME) in 2021
- **Orchestrated** a Coroner's Office focused as a specialty medical discipline in contrast to a subsidiary of Law Enforcement.
- DCCO has the highest number of **Board-Certified** Medicolegal Death Investigators with the American Board of Medicolegal Death Investigators in all of Colorado and perhaps the nation.
- **100%** of autopsies are completed by a **Board-Certified**, forensic pathologist: raising the standards.
- **Instituted** infant death re-enactments.
- Instituted the **first comprehensive** clinical suicide investigative survey, which Colorado Department of Public Health and Environment has adopted and promoted.
- **Stratified** a professional tiered merit advancement program based on national testing.
- Medicolegal Death Investigators **assumed the role** of Victim Advocates for death notification.
- DCCO is a leader in both Colorado and Wyoming in **organ and tissue donations year over year.**
- Coroner Romann **twice chaired** North Central Region Mass Fatality Unit (10-counties).
- **Returned** the Coroner's **Annual Report** for transparency and accountability to the citizens and taxpayers.
- **Established** quality assurance programs for operational effectiveness and efficiency.
- **Established relationships**
  - Boston University **CTE** Center
  - University of Colorado **Forensic Investigation Research Station**
- **Vastly improved relationships with Law Enforcement.**
- Implemented state-of-the-art case management system making statistical data **time relevant to public health and citizens.**
- Changed to mobile investigation, which permits **condensed work hours, less wait time at death scenes.**
- **Dynamically reduced timing** of medical record reviews by engaging with Colorado State Health Information Exchange
- **Established** electronic fingerprint comparison program.
- **Time saved** with advanced medication technology device.
- Upgraded **Web Site**
- Trained Board-Certified Medicolegal Death Investigators, to sign death certificates and produce pending death certificates **expediting the process for families and funeral homes.**

Budget

- **REDUCED THE AVERAGE COST** PER CASE BY **17% despite a 96% increase in caseload since taking office (2015).**
- Reduced the cost of toxicology, by joining a multi-county **consortium contract.**
- **Stopped** Douglas County taxpayers from **subsidizing** Pueblo County autopsies.
- Improved upon a foundational relationship with 18th Judicial District Public Administrator wherein the cost of **county burials was reduced.**
- **Eased law enforcement workload by training** the MDIs in in-house fingerprint comparison.
- **REDUCED** the Coroner's fleet **by 50%,** approximately $8,000 per year.
    - **Surrendered the Elected Official/Coroner vehicle!**
    - Gradually turned in the **four** pickup trucks for **two professionally** equipped transport vehicles.
- **Purchased safety prams,** reducing the risk of back injuries and day's off. Increasing vigilance on risk management issues and improved investigator morale.
- **Tightened the potential for payroll abuse AND** created **faster response time by eliminating investigators from responding to scenes from their homes.**
- Instituted paper reduction, **saving thousands of dollars annually.**
- Reduced the cost of biohazard disposal.
- **Eliminated the unneeded expense of dosimeter** readers.

Customer and Employee Service

- Initiated "Service Experience Program-2020" **Not top-down management."** It's a 360 review and input by employees
- Began a **postvention** program wherein medicolegal death investigators reach out to families with a sympathy card and personal message of support.
- Physically staff the office 24/7 **without increase in costs**
    - We are **open during lunch** for routine needs
    - We are open in the middle of the night **to facilitate donation**
- **Added an as needed autopsy assistant** to help when caseloads are high.
- Created a **student forensic laboratory** for mentoring high school students and teachers in death investigations.
    - DCCO hosts approximately **500 students per year** both in the classroom and forensic laboratory
        - Forensics
        - Pre-law
        - Pre-med
        - Criminal justice
- **Raised thousands of dollars per year** for civic organizations.
- **Broadened** and redecorated the Douglas County family room and employee areas.

"The opportunity to spend months in the autopsy suite assisting the forensic pathologist performing autopsies was invaluable! My career as a medicolegal death investigator and as an RN was enhanced enormously. I now enter death scenes with skill-based confidence pulling from everything I learned while I was assisting in the autopsy suite."

Kristin Alldredge, BSN, RN, MDI-I Douglas County

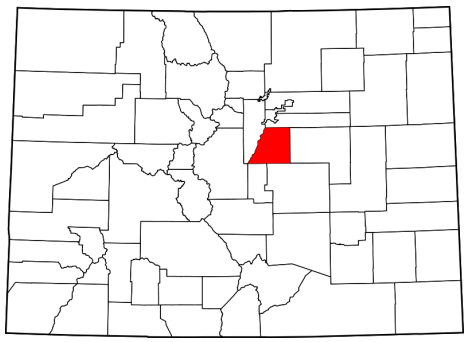
'The culture in this office is the best in the state. I have worked in three counties and helped in four. DCCO is amazing. You support your employees more than any other office. You put a high value on training and education; you put the employee first."

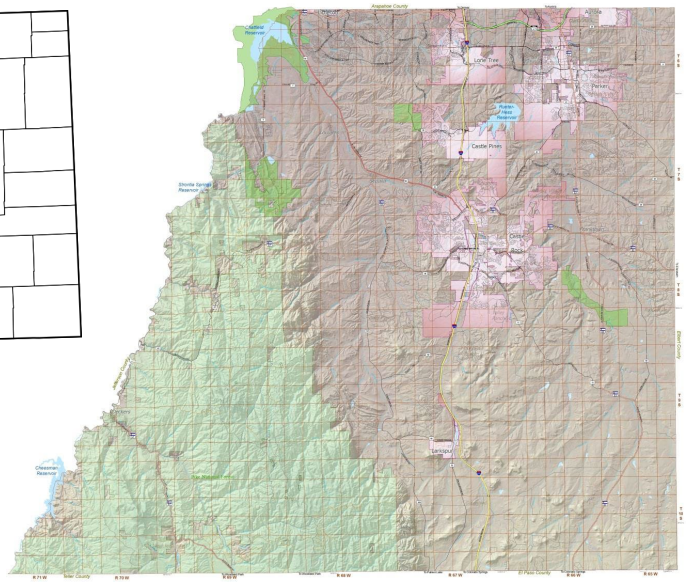
Elizabeth Ortiz, F-ABMDI

All the above accomplishments were successfully done while absorbing an increase of 96% call volume since taking office in 2015.

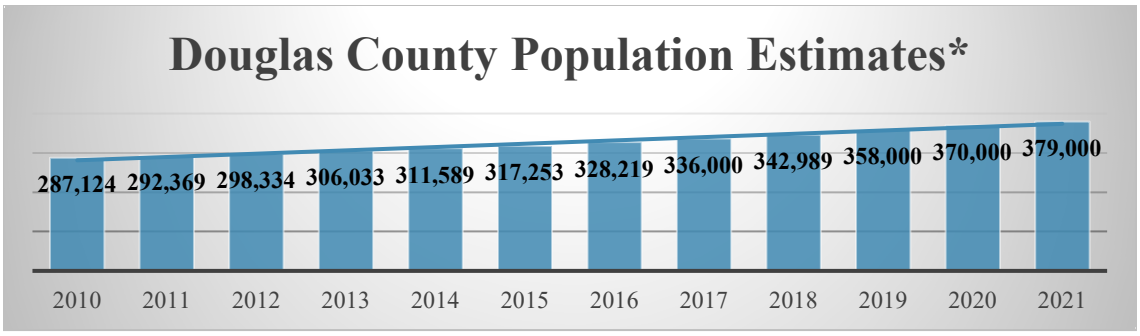
Jurisdictional Boundaries

Jurisdictional boundaries of the Douglas County Coroner's Office lie coextensive with the boundaries of Douglas County, Colorado. 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. 2016-2020 Source Douglas County Community Development

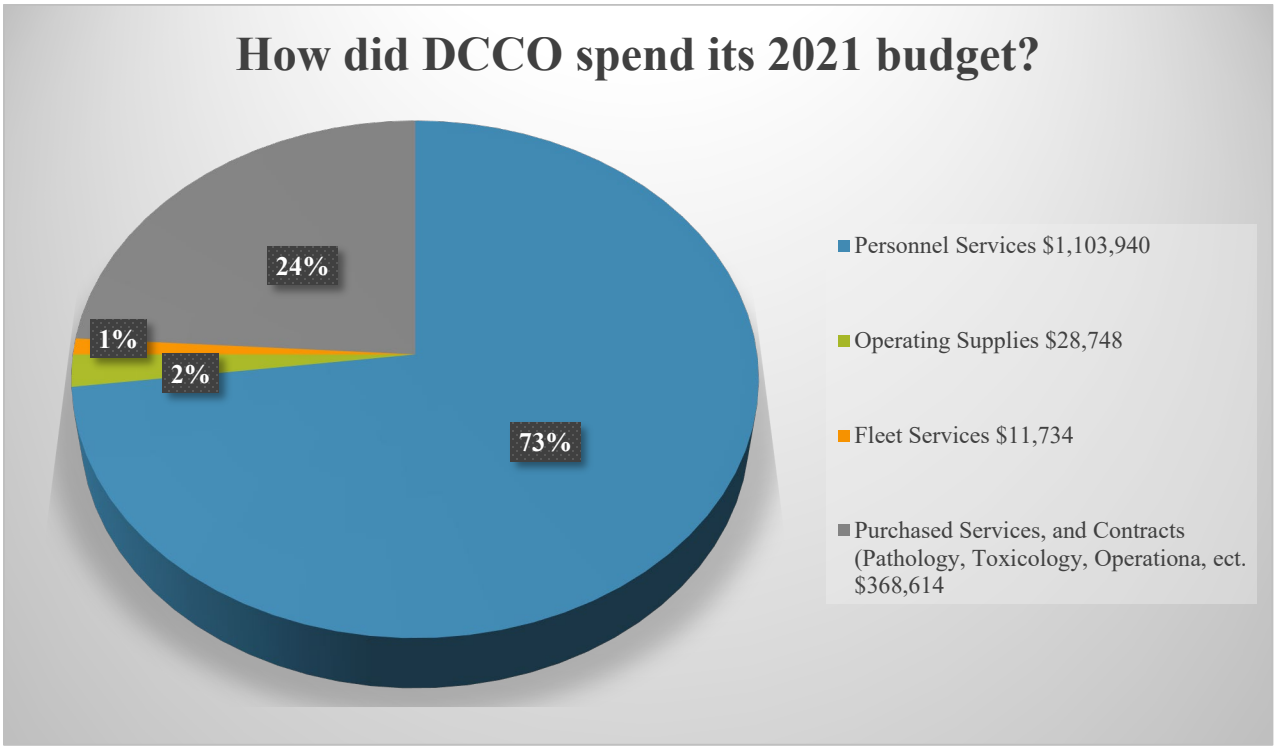
Budget

Funding

Funding for the Coroner's Office originates from the Douglas County general fund. In 2021, the County Manager and Commissioners approved a budget of $1,515,248. This amount represented less than 1% of the total 2021 General Fund, which was $147 million. It represented 0.3% of the total 2021 Douglas County annual budget of $452.2 million.

Expenditures

Expenditures for the year totaled $1,513,038. Expenditures included Personnel Services, Operating Supplies, Fleet Services, and Purchased Services and Contracts.

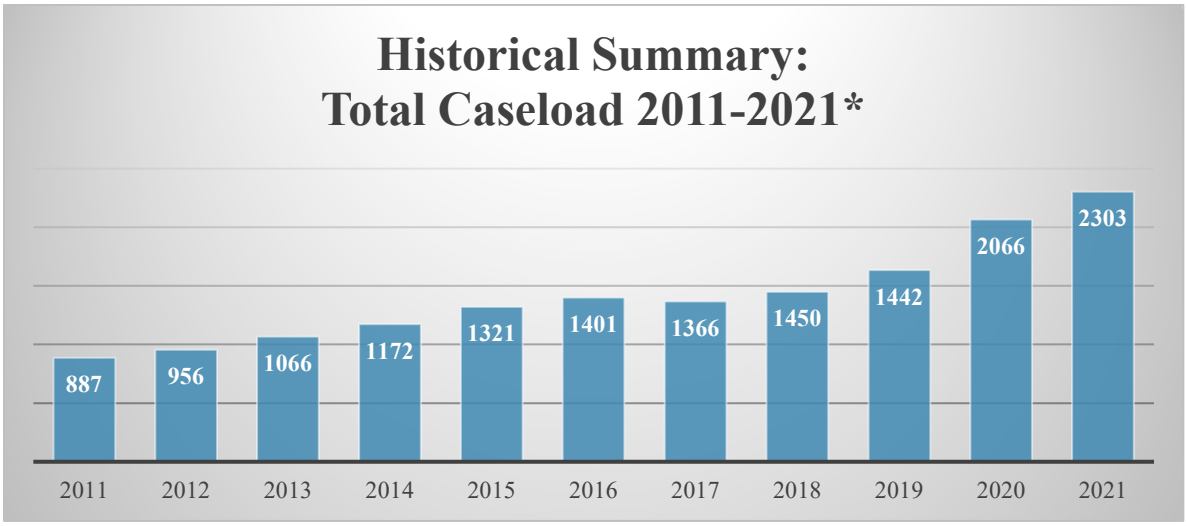


Revenues

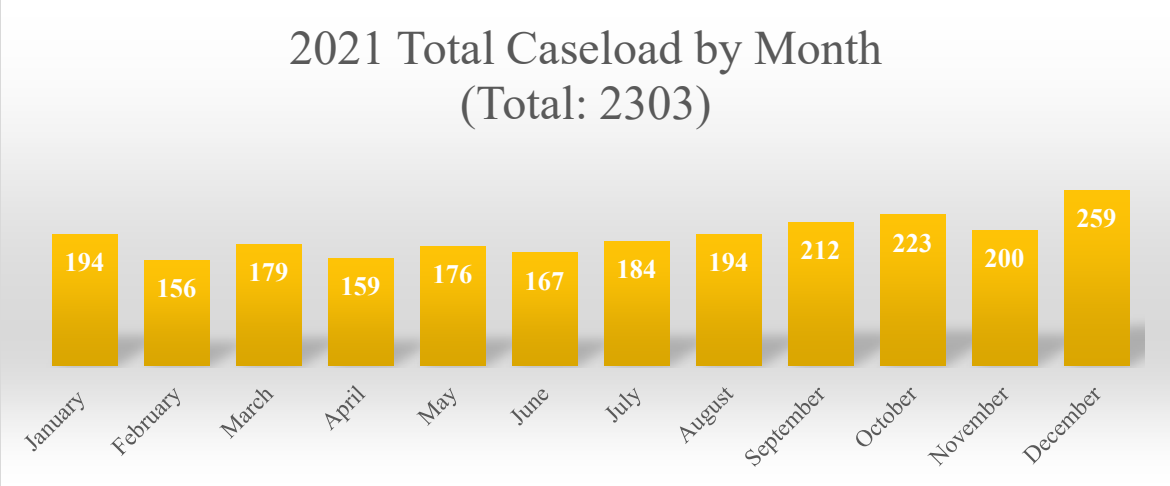
On occasion, the office receives revenue for various operational and administrative functions. For example, in 2021 DCCO received funds for a private autopsy performed in the facility and a refund from the Colorado Coroner's Association Conference. Total revenue for 2021 was $1250.

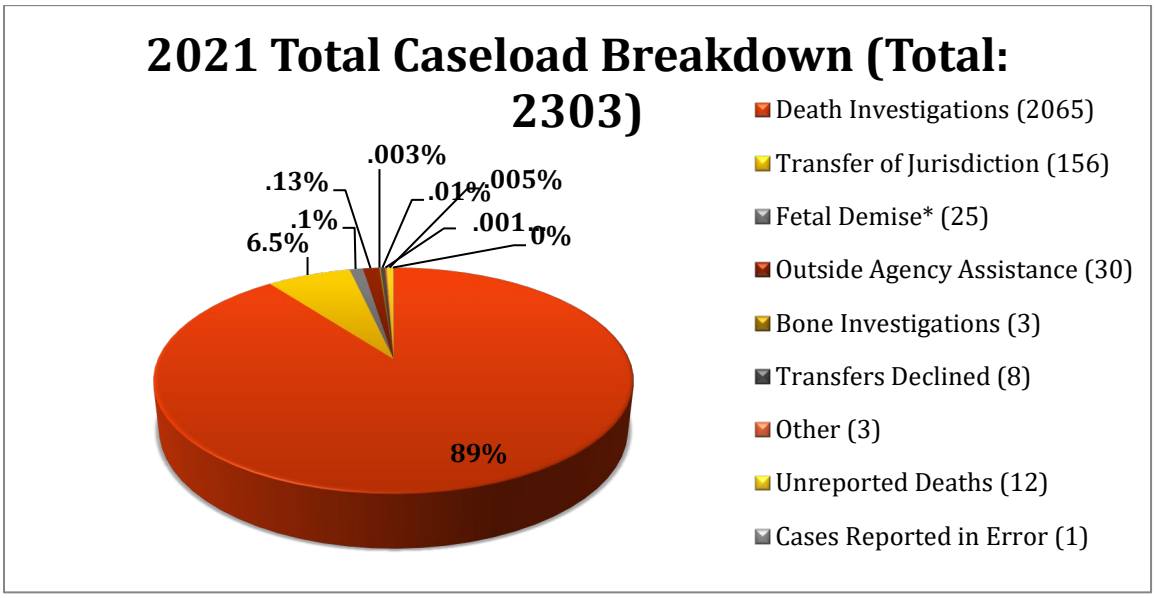
Caseload

The overall total caseload for 2021 was 2303, which included Death Investigations (2065), Fetal Demises (25), Bone Investigations (3), Outside Agency Assistance (30), Transfers of Jurisdiction (156), Transfers Declined (8), Unreported Cases (12), Other (3), and Cases Reported in Error (1).



*Adjusted to DCCO caseload only





**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.*

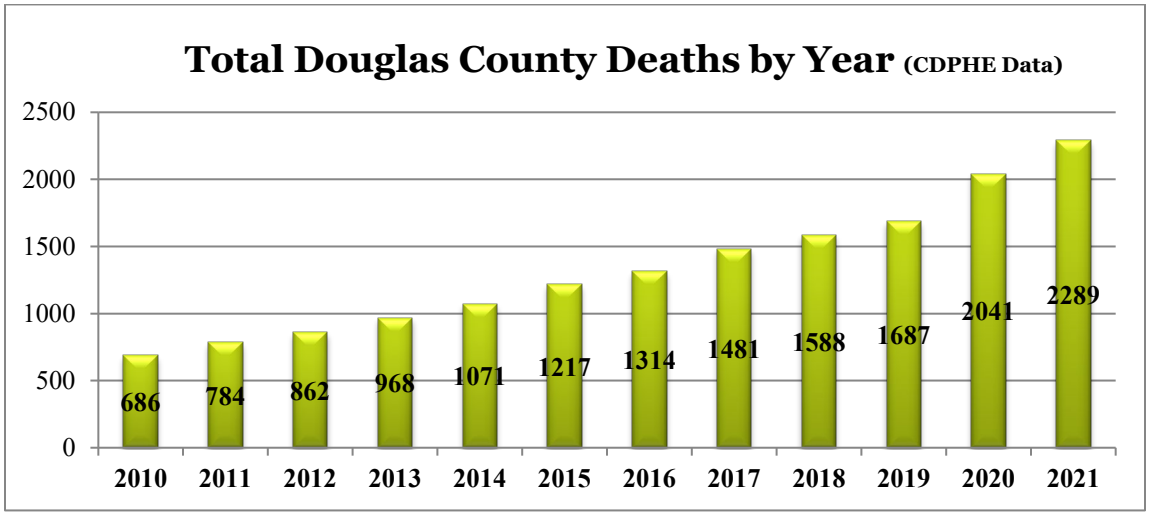
2016 – 2021 Comparison

	2015	2016	2017	2018	2019	2020	2021	Y to Y % Change
Overall Caseload	1474	1526	1373	1442	1634	2066	2303	11%↑
Death Investigations	1209	1252	1215	1308	1496	1841	2065	12%↑
Fetal Demises	32	36	27	30	35	35	25	29%↓
Bone Investigations	6	4	4	2	3	11	3	73%↓
Outside Agency Assistance	8	7	12	9	10	15	30	100%↑
Transfer of Jurisdiction	66	100	105	90	84	143	156	9%↑
Autopsy Referrals	153	125	7	0	1	0	0	0%
Transfers Declined	0	0	0	0	3	7	8	14%↑
Other**	0	2	2	3	2	4	3	25%↓

*** (3) Other cases, (12) Unreported Deaths, (1) Case reported in error*

Of the overall caseload in 2021, not all cases are considered jurisdictional; Transfer of Jurisdictions, Outside Agency Assists, Transfers of Jurisdiction which we declined, 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 (2087); Death Investigations (2065), and Fetal Demises (25).**

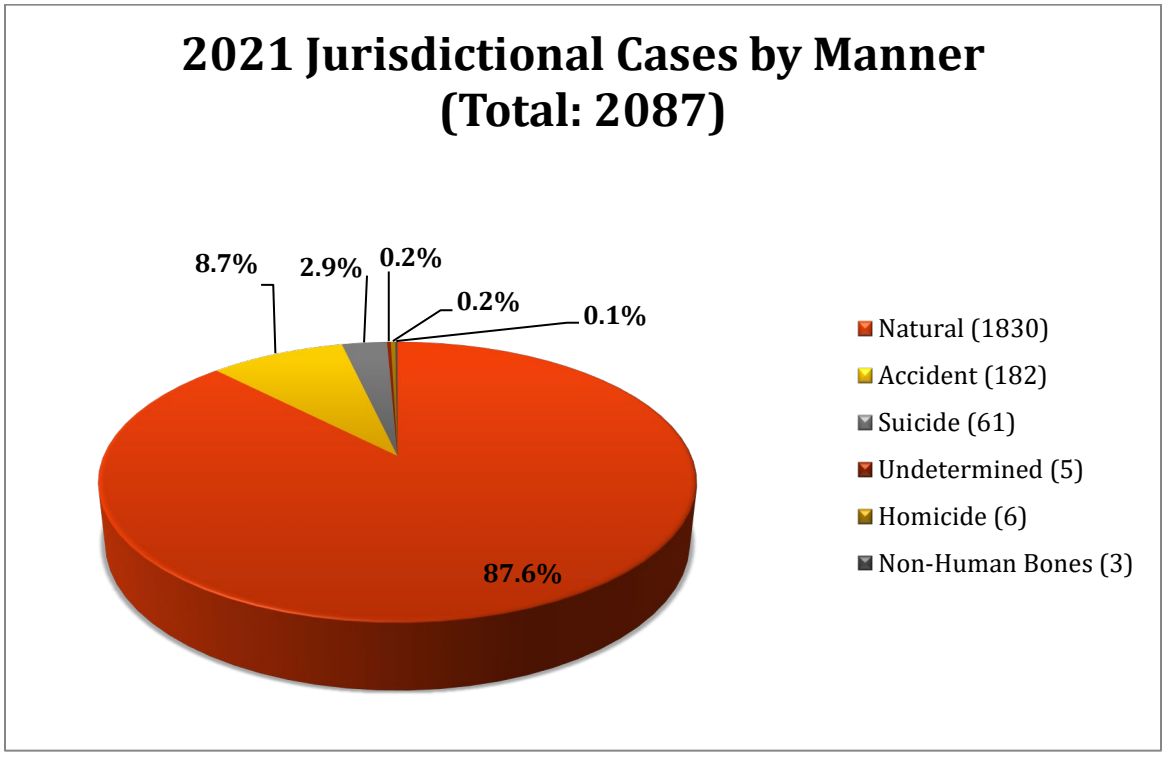
A death certificate is required to be filed with the Colorado Department of Public Health & Environment (CDPHE) for each death that occurs in Douglas County. Discrepancies may exist between CDPHE and Douglas County statistics due to transfer of jurisdiction and the locations of death listed on the death 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. **99%** of all deaths occurring in Douglas County that were filed with the Colorado Department of Public Health and Environment (CDPHE) in 2021 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 in error. The average annual increase of deaths reported by CDPHE in Douglas County between 2010 and 2021 has been **10.5%** per year. The increase of deaths from 2019 to 2021 has been **17%**.



** 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.



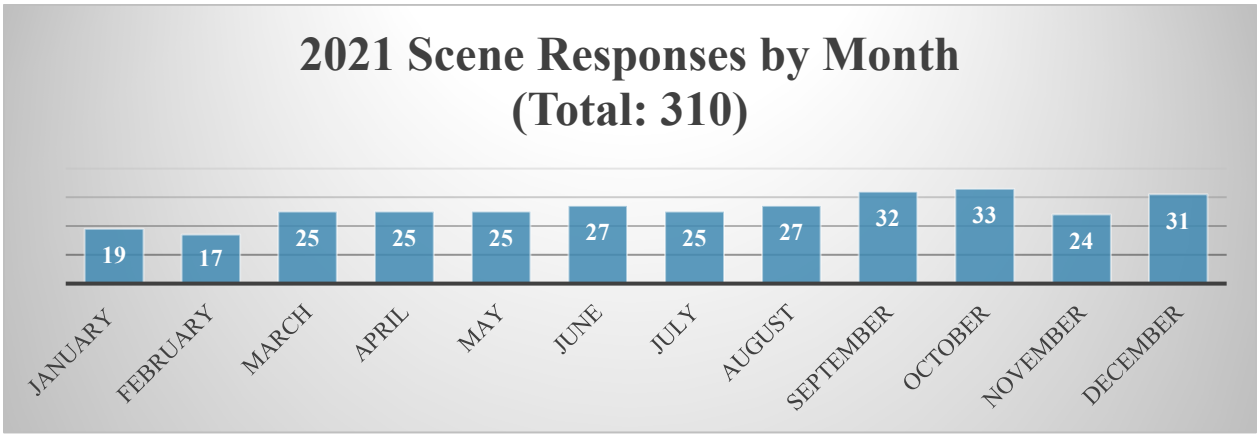
2013 – 2021 Comparison

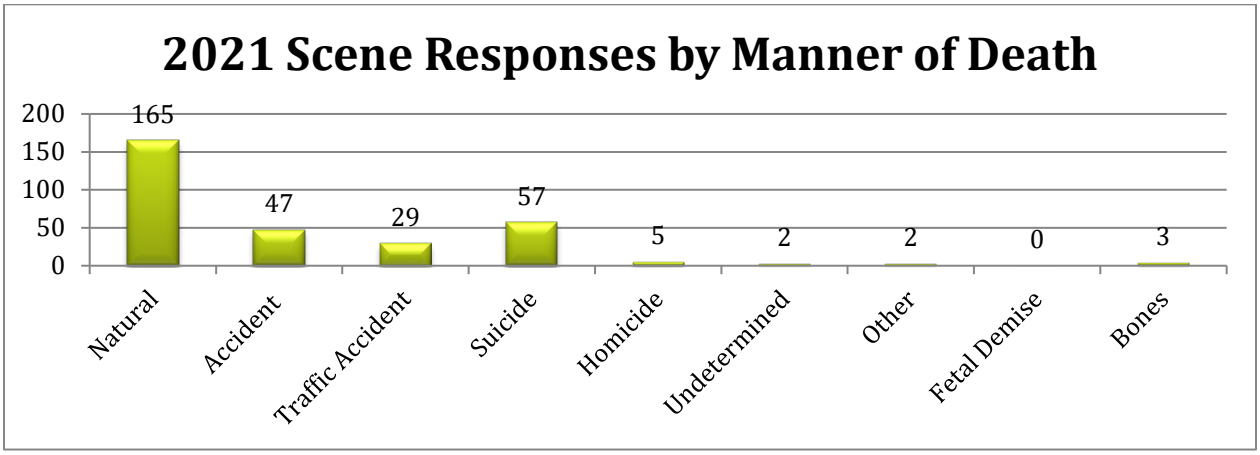
	2013	2014	2015	2016	2017	2018	2019	2020	2021
Natural	844	952	1065	1061	1061	1157	1346	1639	1830
Accident	97	104	106	106	121	111	112	174	182
Suicide	57	47	58	57	44	60	58	54	61
Homicide	0	2	2	4	6	3	5	3	5
Undetermined	5	6	7	7	3	7	10	6	6
Non-Human Bones			6	4	4	2	3	11	3

Scene Responses

The Douglas County Coroner's Office responded to 310 death scenes which accounted for **16.9%** of all the jurisdictional deaths reported to the Coroner's Office in 2021. 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.



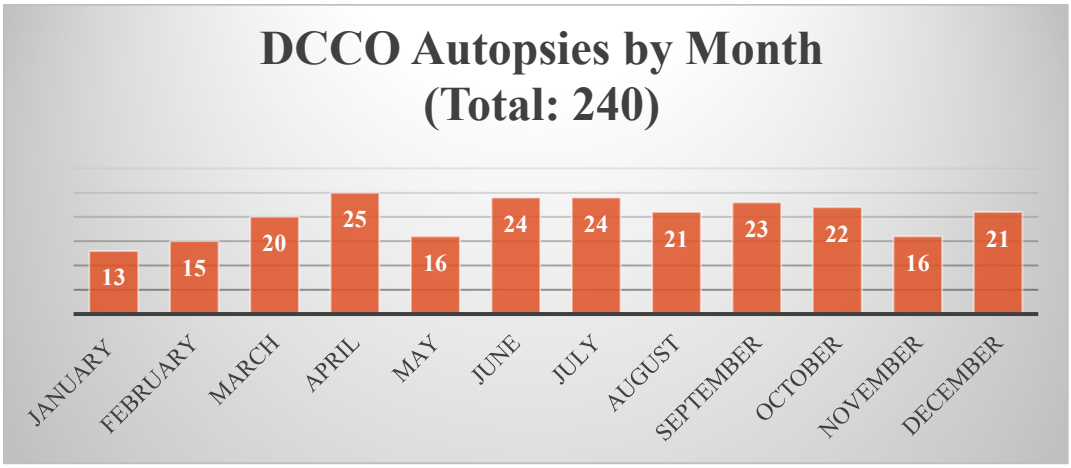


Of the 310 scene responses, 294 decedents were transported to the Coroner's Office, all 294 were transported by DCCO investigators.

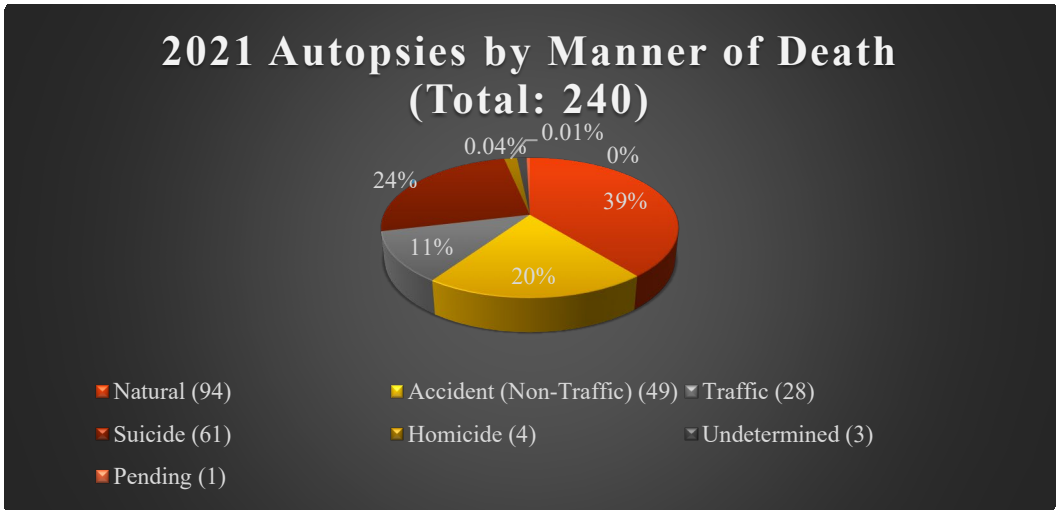
Autopsies

Of the cases the Douglas County Coroner's Office retained jurisdiction over in 2021, 240 or **11%** of the cases required an autopsy to aid in the determination of the cause and manner of death. In the majority of these 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.

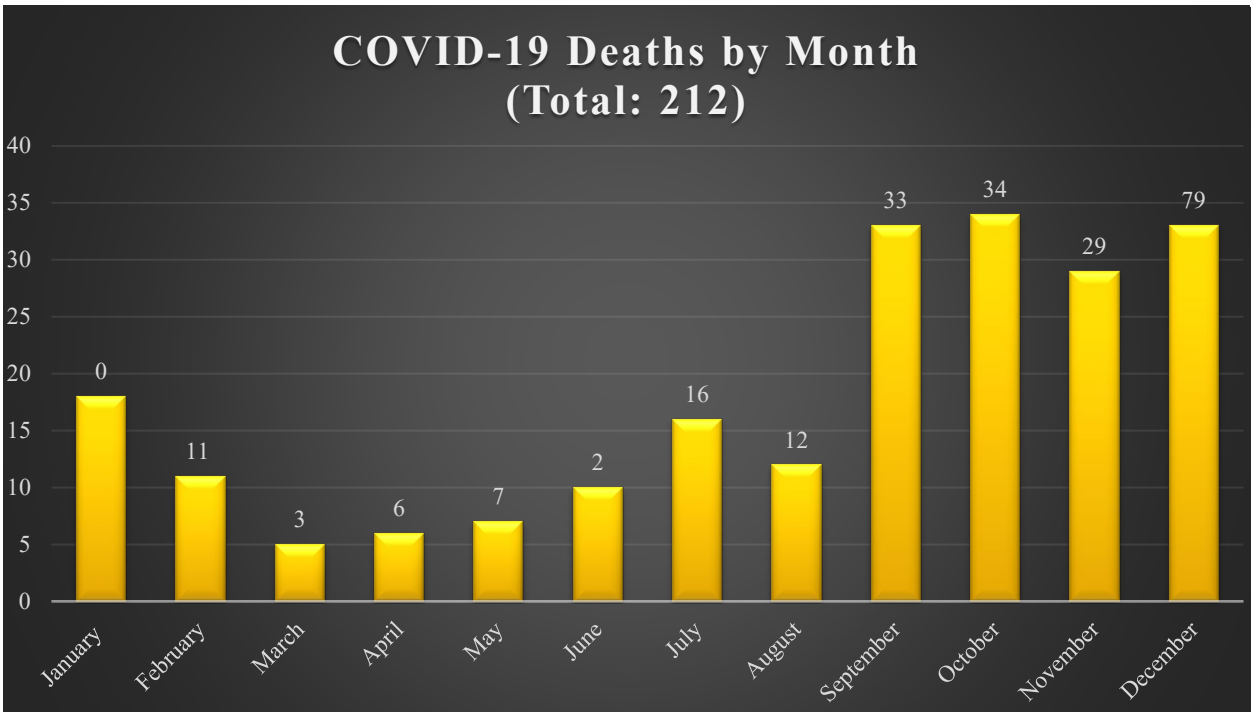
Autopsies are performed in deaths where there is a lack of an established medical history, most suicides, most traffic incidents, and deaths where there is possible criminal action. An autopsy may not be performed in the instance where an individual was hospitalized and the medical record thoroughly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

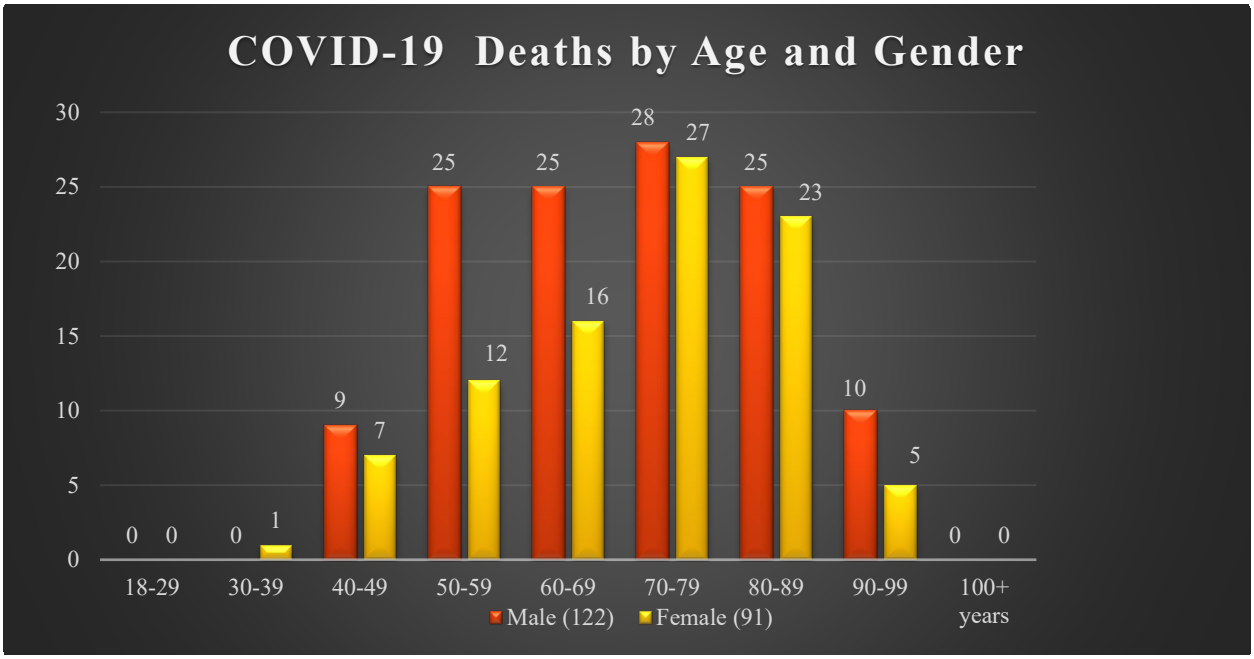


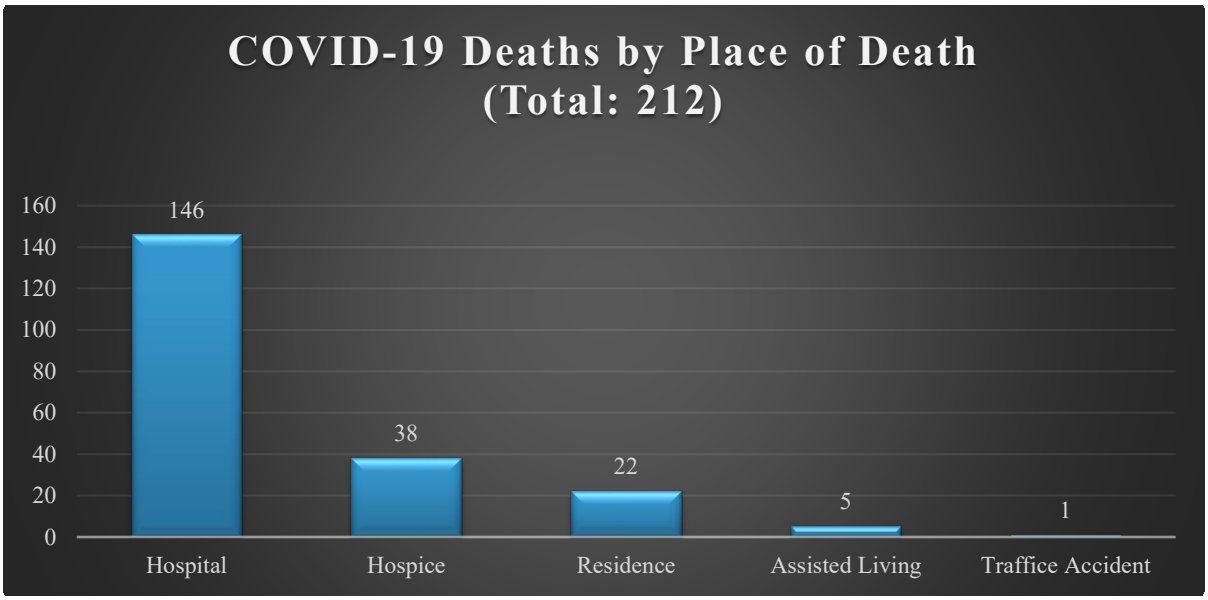
Of the 240 autopsies performed in 2021, all were full autopsies except for one skeletal exam. Toxicology studies were performed in 205 cases. **49**% of toxicology was completed in under 30 days. Due to the COVID pandemic, toxicology studies took longer in 2021 than in 2020 due to staff shortages.

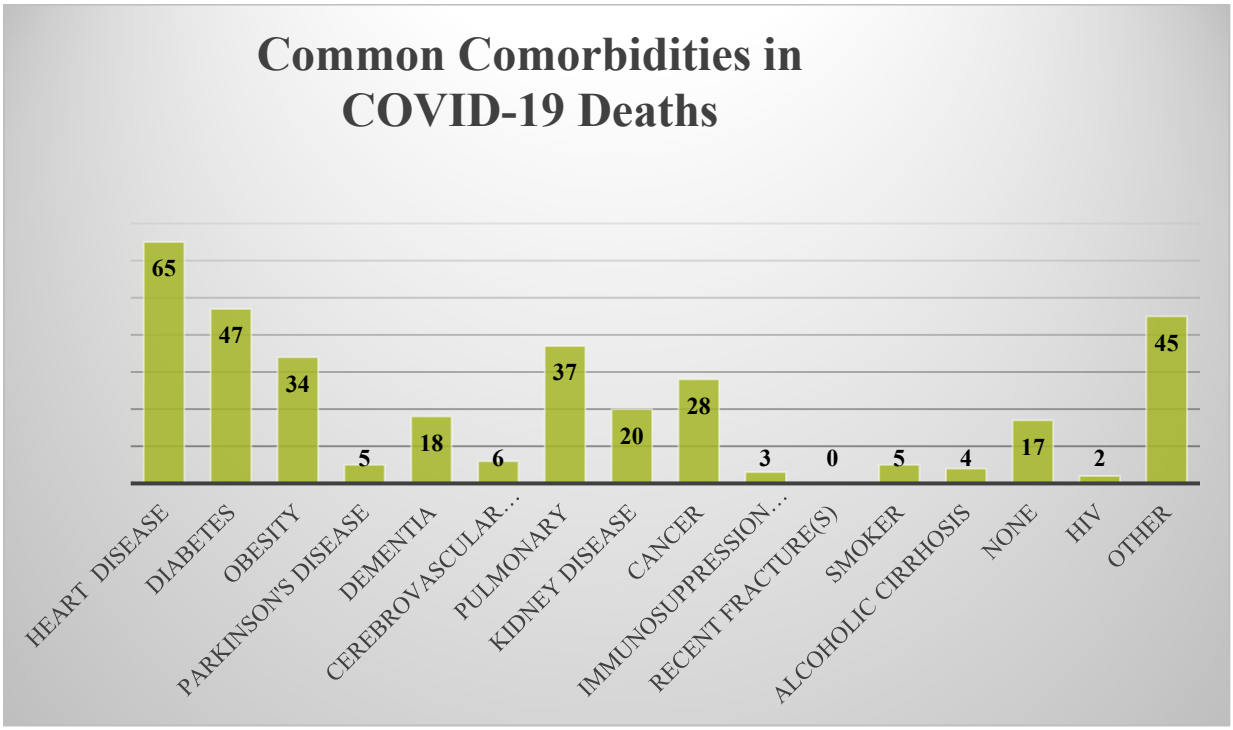


Covid-19 Death Reporting









Some COVID-19 deaths will involve multiple co-morbidities while there are others with no co-morbidities.

Cause-of-Death Reporting:

When reporting cause of death on a death certificate, DCCO uses any information available, such as medical history, medical records, laboratory tests, an autopsy report, or other sources of relevant information. Similar to many other diagnoses, a cause-of-death statement is an informed medical opinion that should be based on sound medical judgment drawn from clinical training and experience, as well as knowledge of current disease states and local trend.

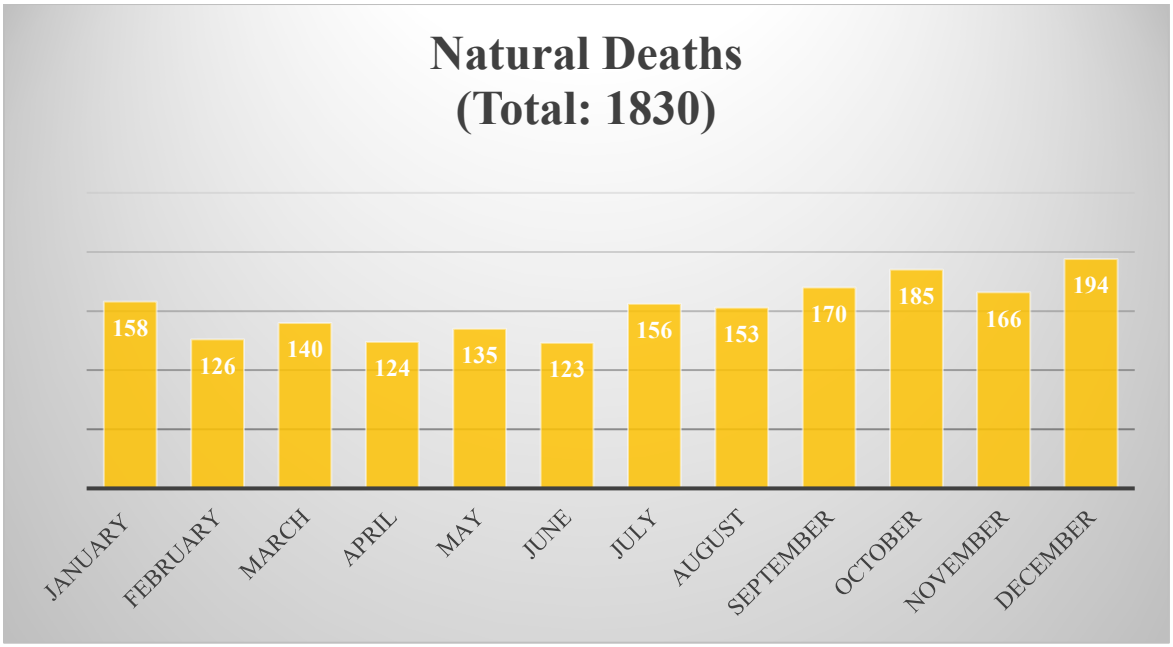
Statistics by Manner of Death

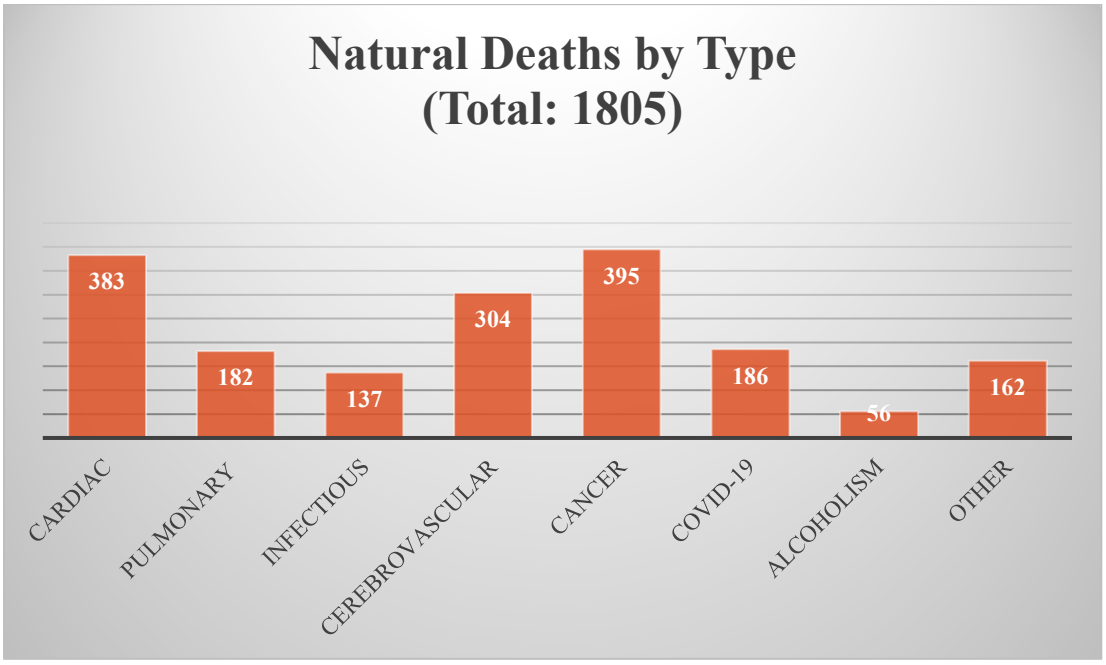
Natural Deaths

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).

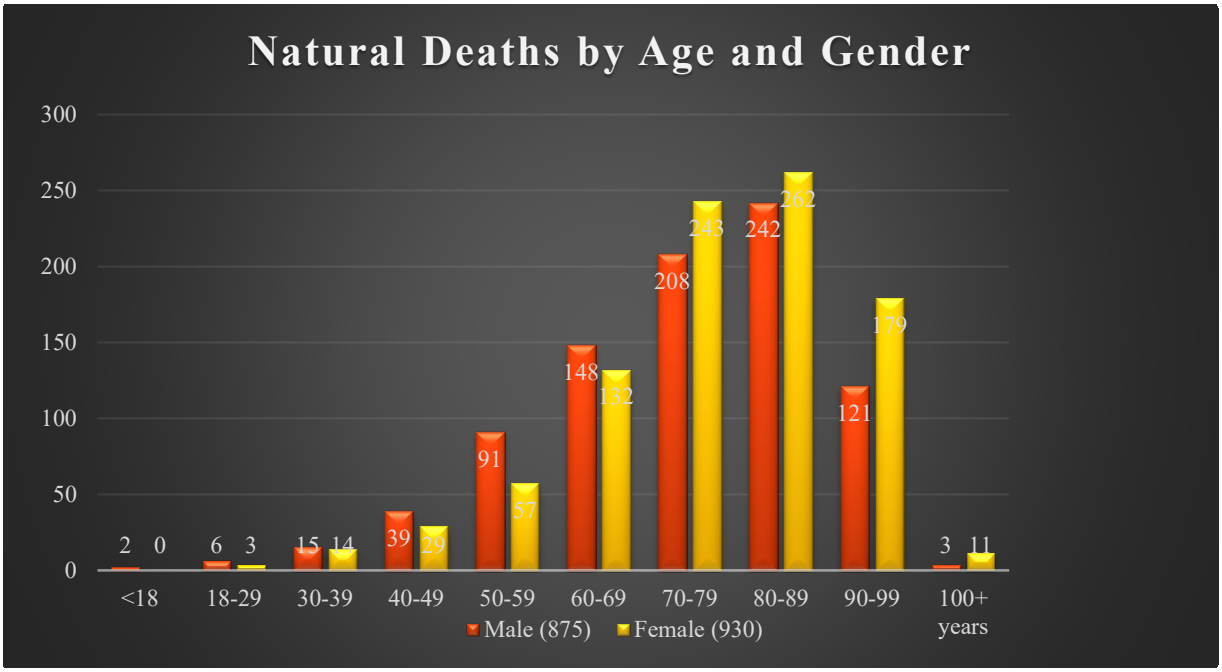
In many instances when a natural death is reported, the decedent's physician will issue the death certificate. The majority of deaths reported to the Coroner's Office are deaths due to natural causes.

Natural deaths accounted for **87.6%** of the total DCCO jurisdictional deaths for 2021.



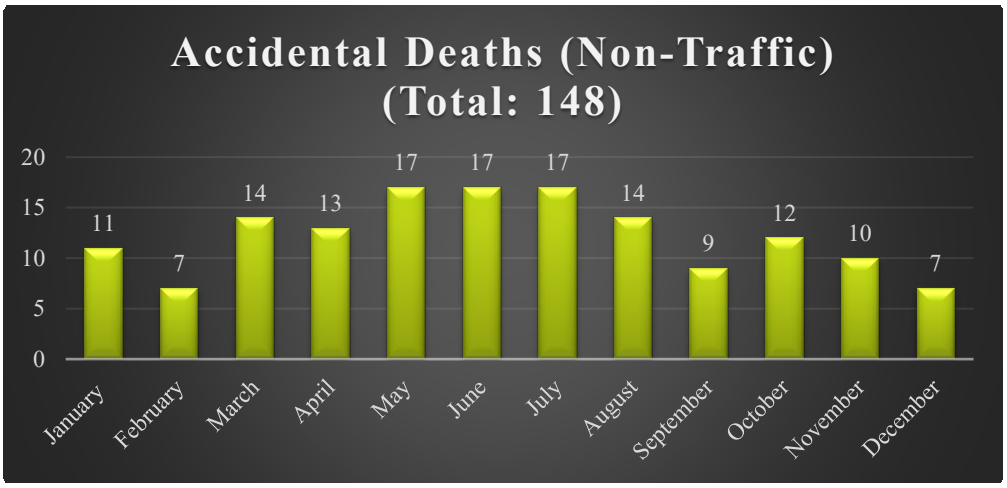


Of natural deaths, 383 were deemed cardiac related, 182 pulmonary, 137 infectious, 304 cerebrovascular, 388 cancer, COVID-19 186, Alcoholism 60, and 136 other related deaths. This does not include the 25 fetal demise deaths that were reported in 2021.

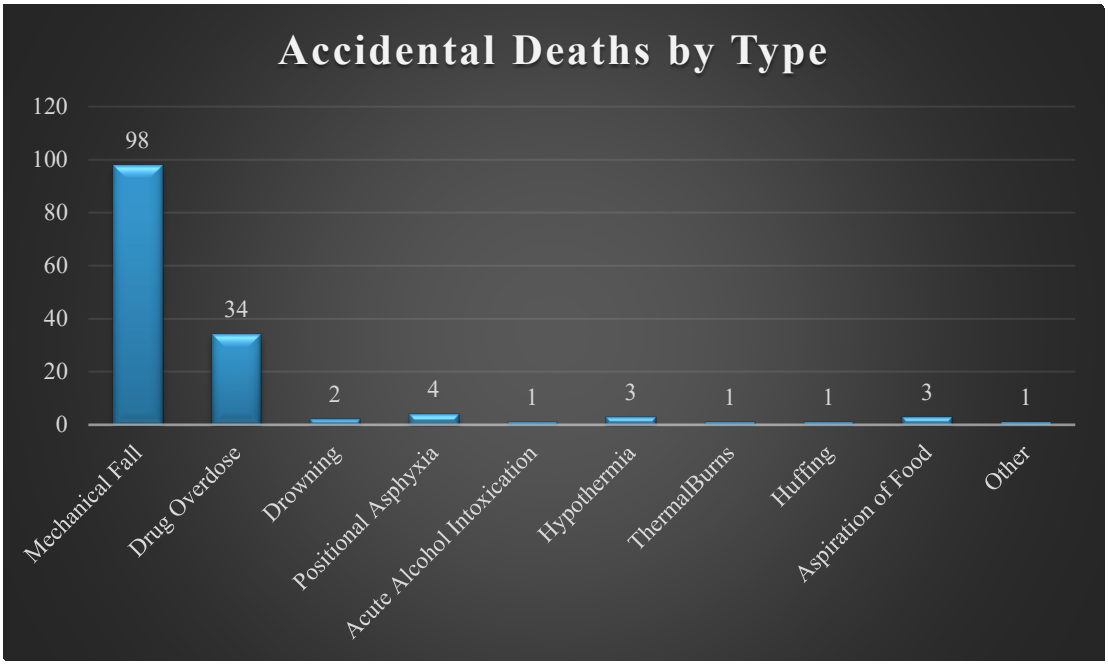


Accidental Deaths

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.

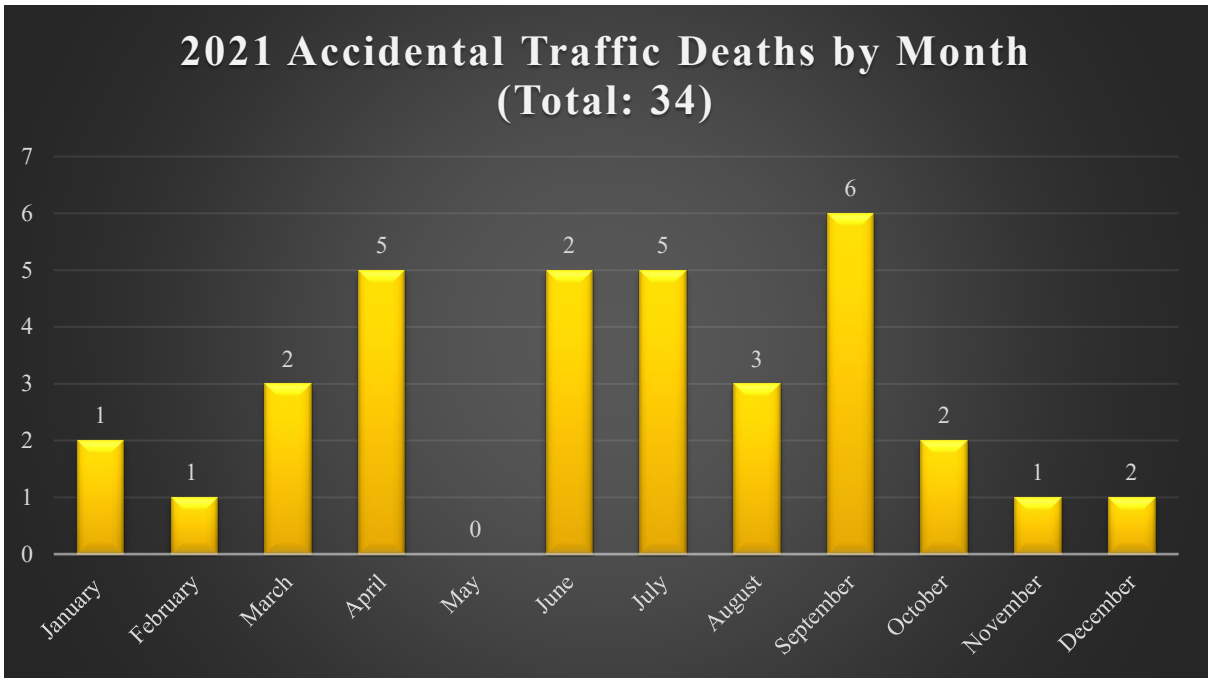


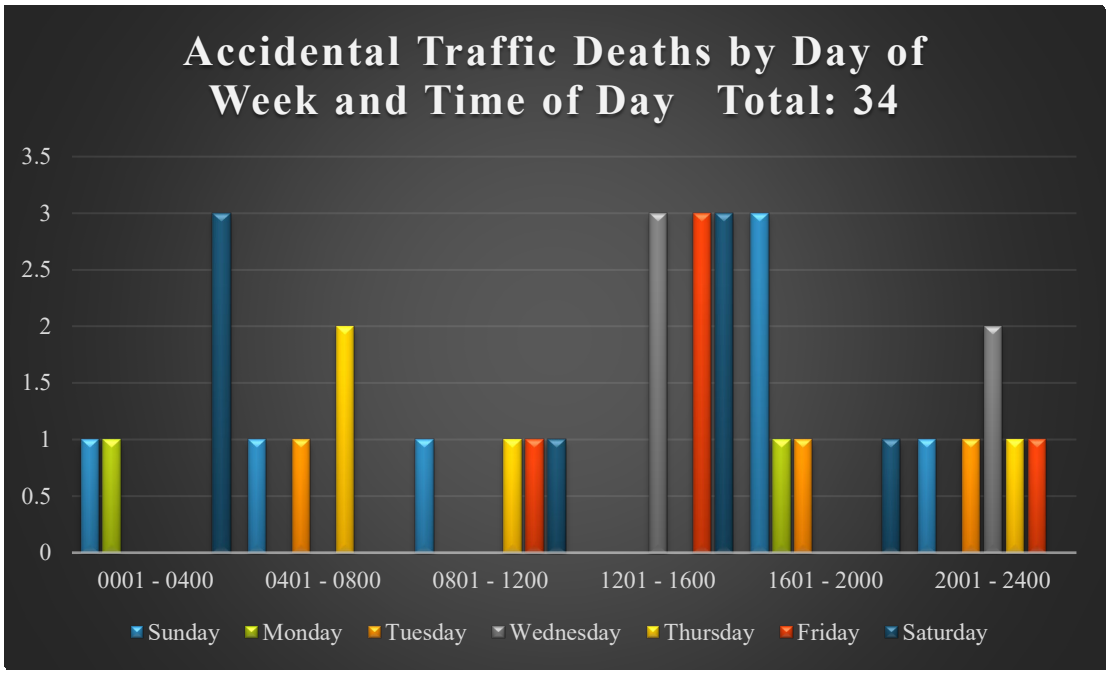
Non-Traffic accidental deaths accounted for **6.4%** of the total DCCO jurisdictional deaths for 2021. Of the Non-Traffic related accidental deaths reported to the Douglas County Coroner's Office, most of the deaths were related to an unintentional drug overdose or complications of a mechanical fall; typically, a fracture or head injury.

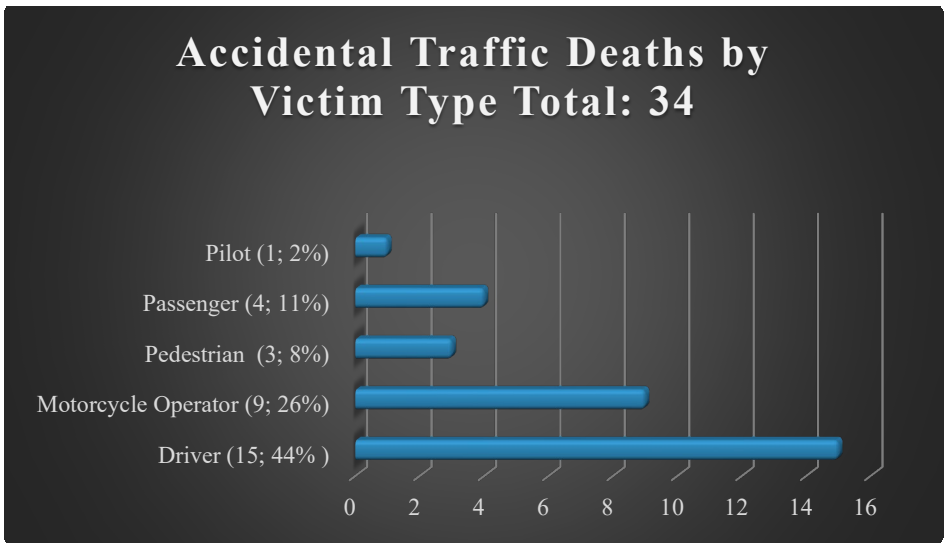


Traffic related accidental deaths include deaths in which the deceased was an occupant of a motor vehicle, motorcycle, tractor, bicycle, pedestrian, etc. involved in a motor vehicle-pedestrian incident.

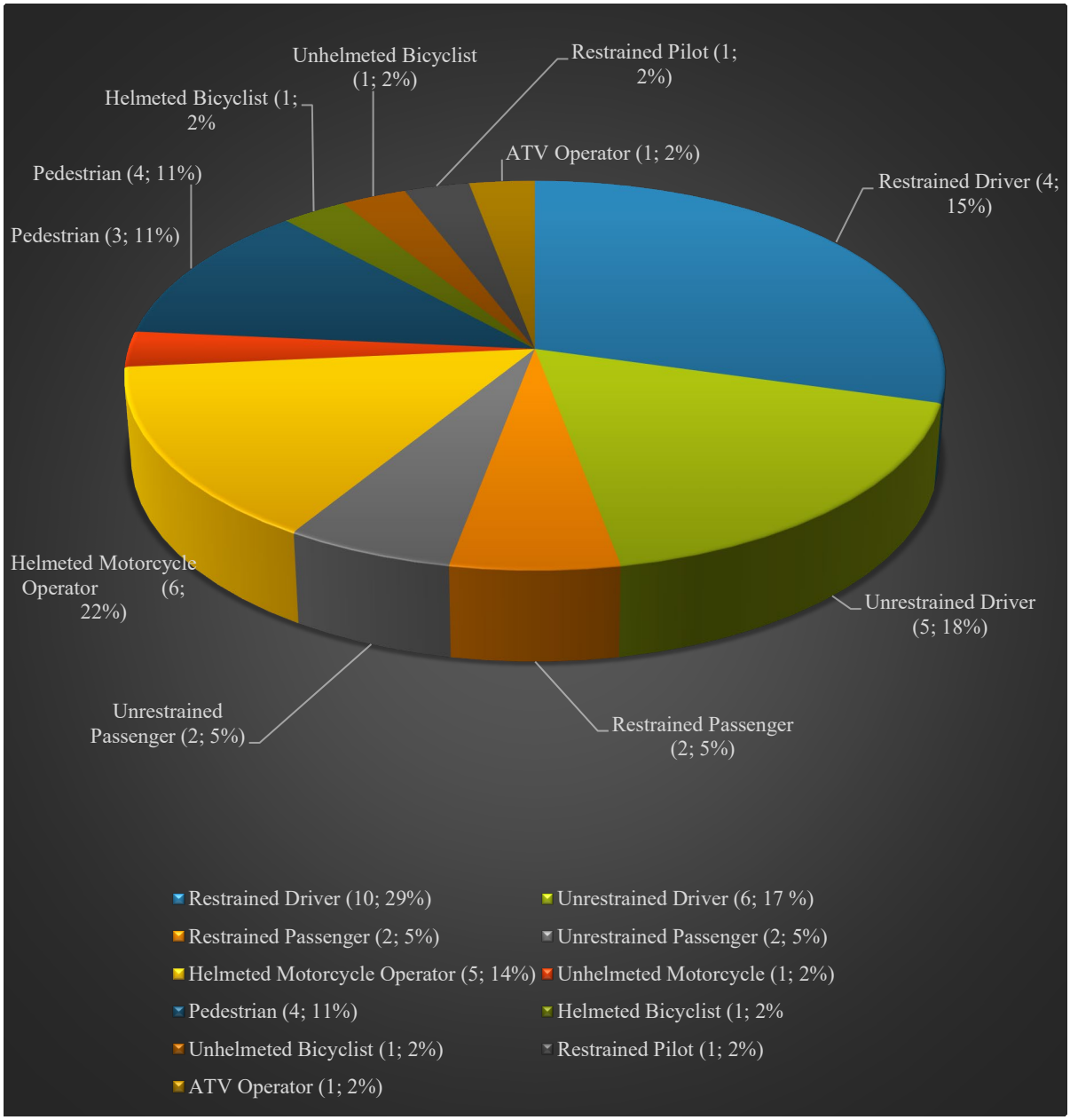
Traffic related accidental deaths accounted for **1.4%** of the total DCCO jurisdictional deaths for 2021.

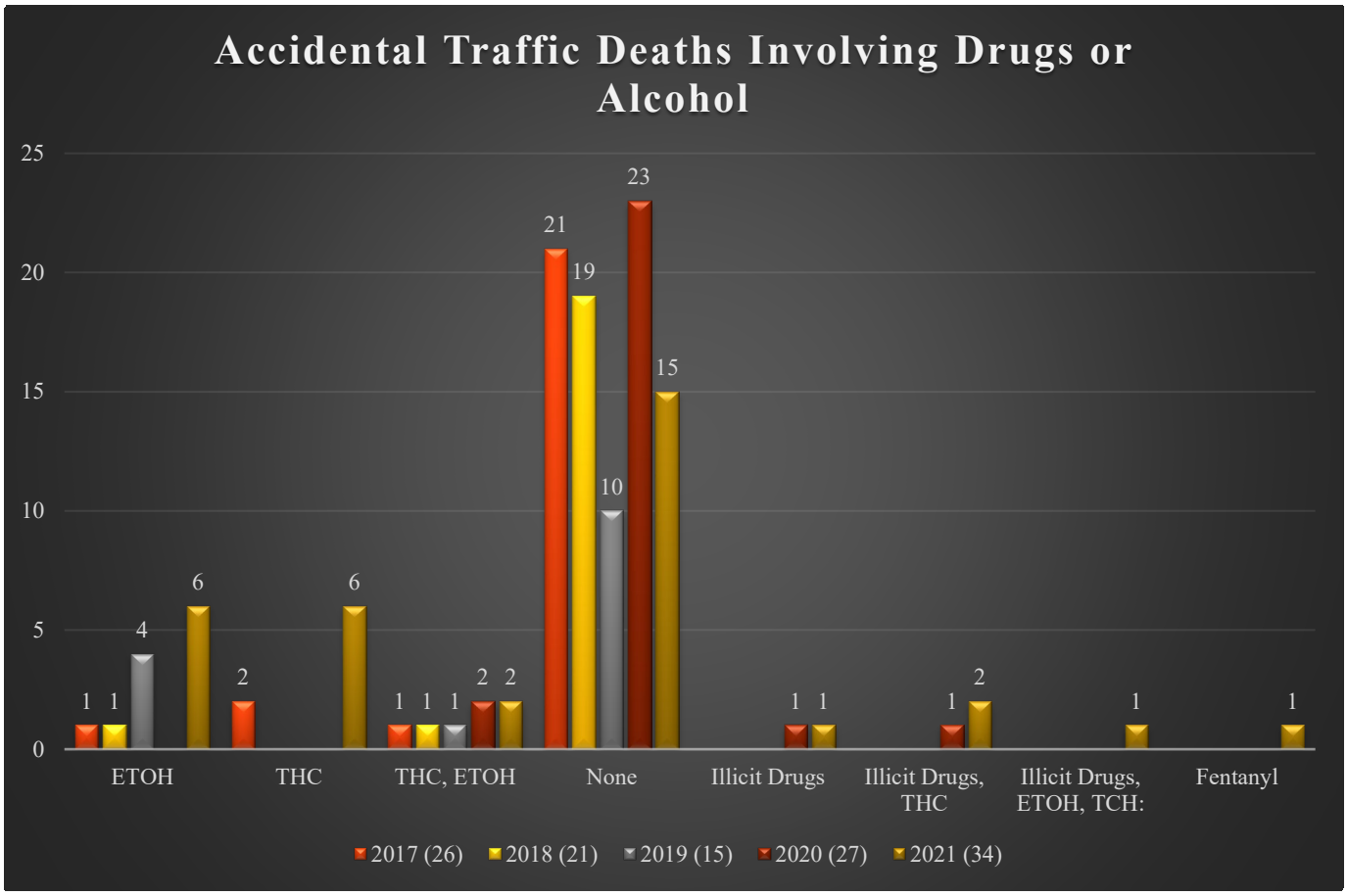



Accidental Traffic Deaths by Day of Week and Time of Day Total: 34
3.5
3
2.5
2
1.5
1
0.5
0
0001 - 0400
0401 - 0800
0801 - 1200
1201 - 1600
1601 - 2000
2001 - 2400
Sunday
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday


Accidental Traffic Deaths by Victim Type Total: 34
Pilot (1; 2%)
Passenger (4; 11%)
Pedestrian (3; 8%)
Motorcycle Operator (9; 26%)
Driver (15; 44%)
0
2
4
6
8
10
12
14
16

Safety Equipment in Accidental Traffic Deaths (Total: 27)

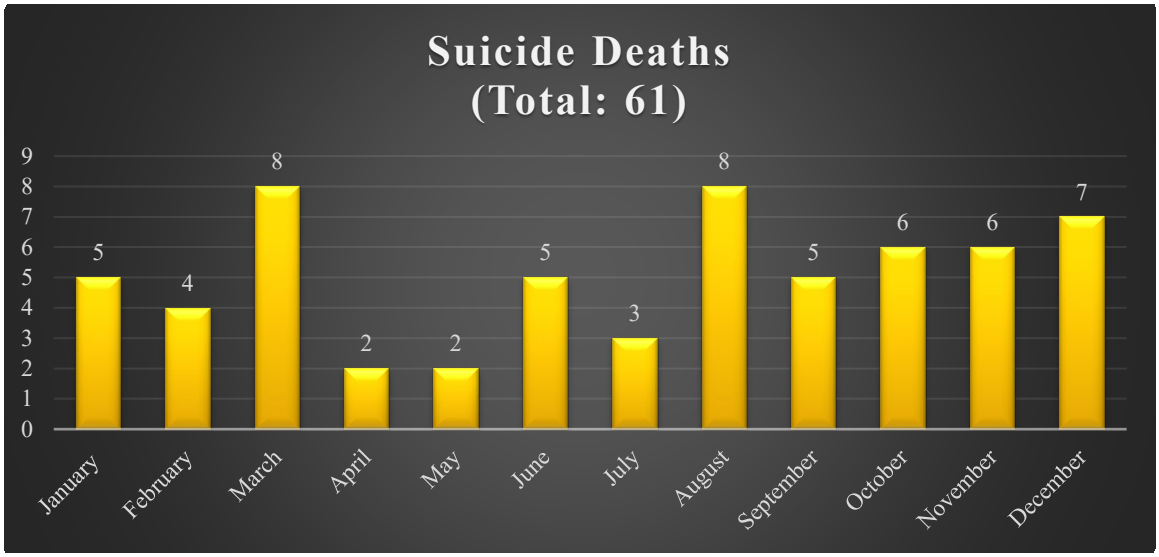


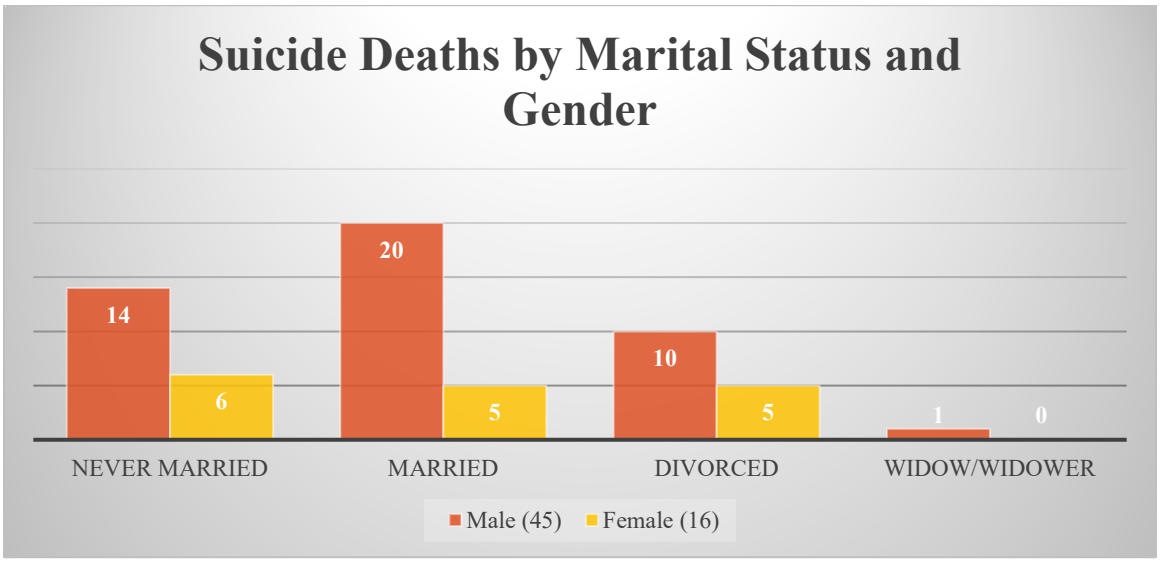

Accidental Traffic Deaths Involving Drugs or Alcohol
25
20
15
10
5
0
1 1 4 6 2 6 1 1 1 2 2 21 19 10 23 15 1 1 1 2 1 1
ETOH
THC
THC, ETOH
None
Illicit Drugs
Illicit Drugs, THC
Illicit Drugs, ETOH, TCH:
Fentanyl
2017 (26)
2018 (21)
2019 (15)
2020 (27)
2021 (34)

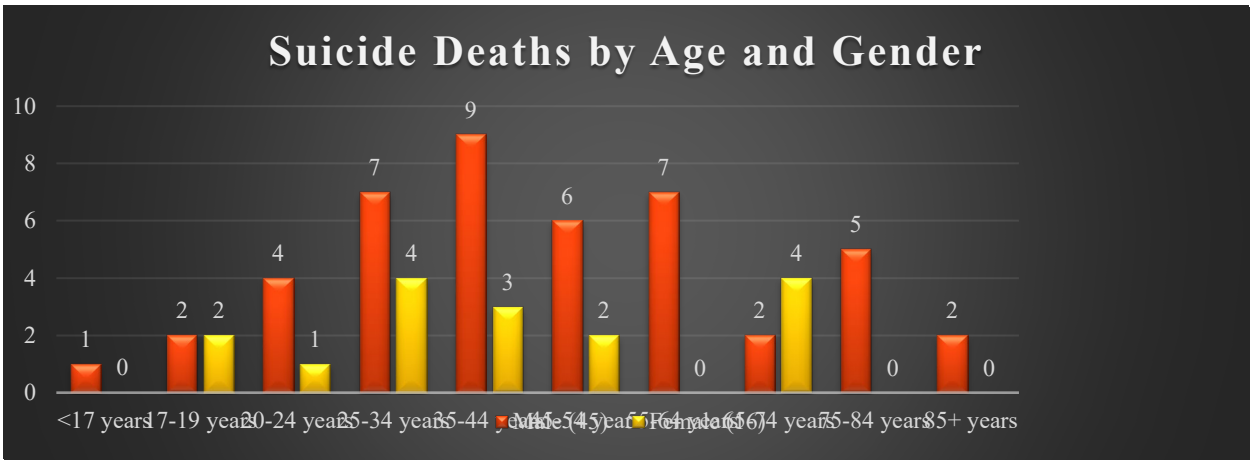
Suicide Deaths

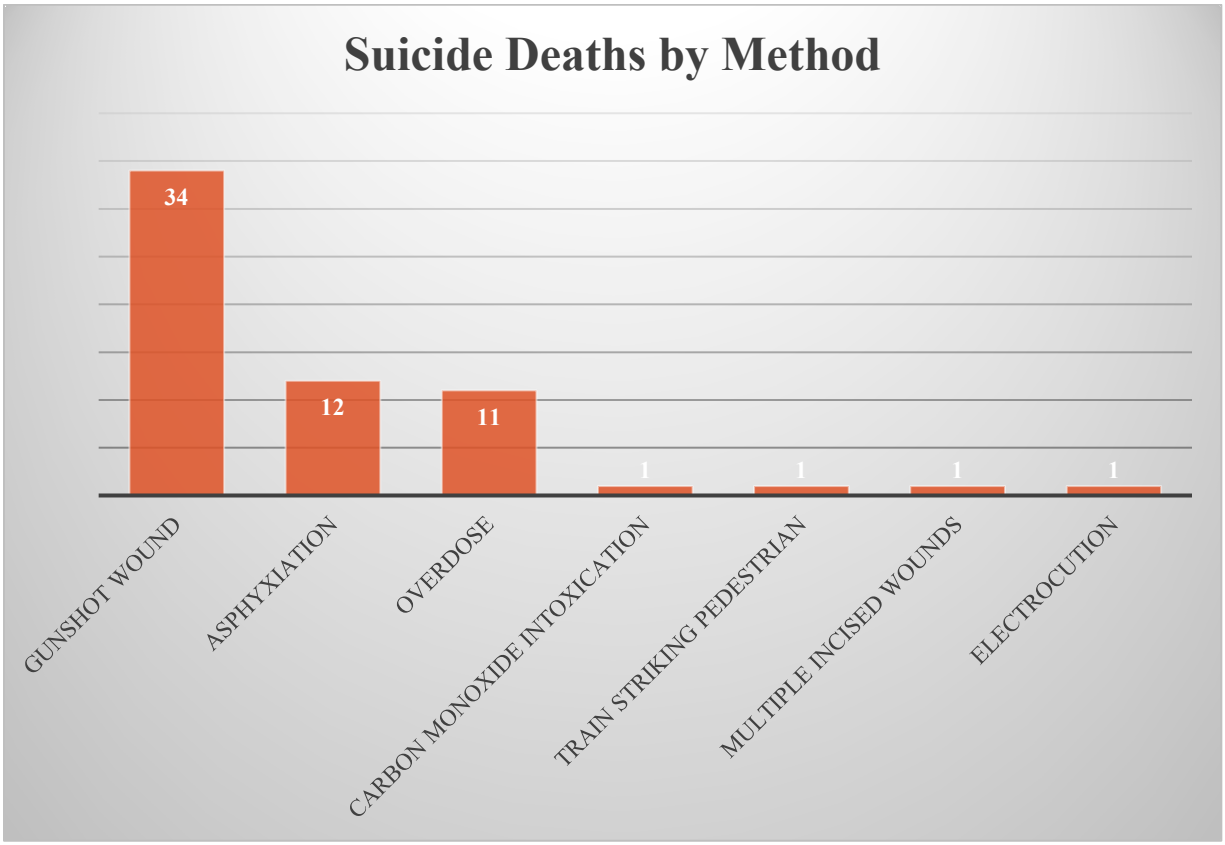
Deaths that are classified as suicide are those that occurred as a result of self-inflicted injury. In 2021, **73%** of the deaths were those of males, which is consistent with nationwide figures. The most common method of suicide in 2021 was firearm related **(55.7%)** followed by asphyxiation, most commonly due to hanging **(19%)**.

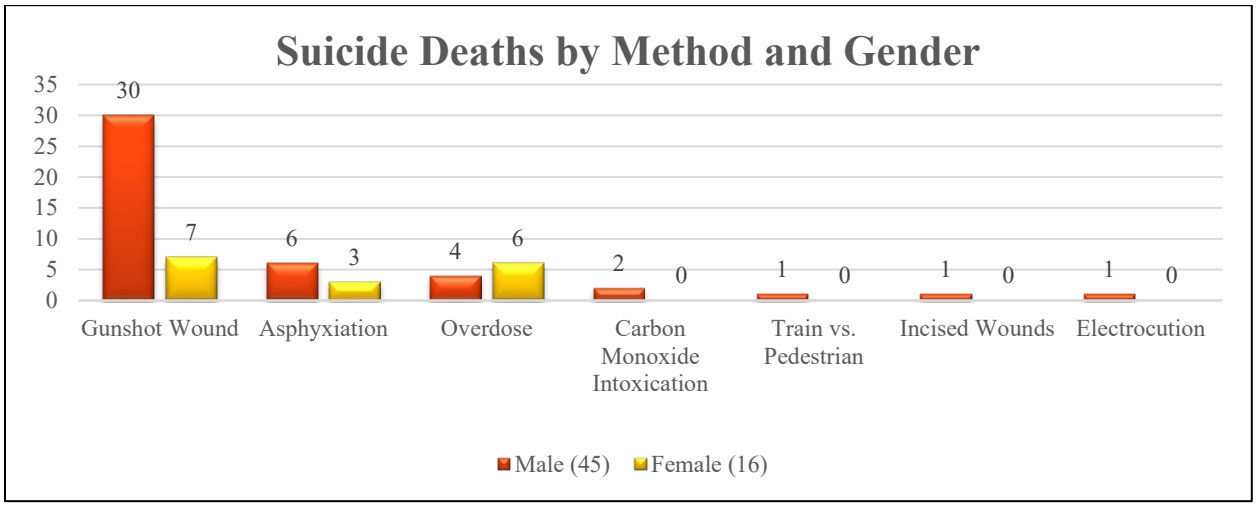
Suicide deaths accounted for **2.6%** of the total DCCO jurisdictional deaths for 2021.






Suicide Deaths by Age and Gender
10
8
6
4
2
0
1
0
2
2
4
1
7
4
9
3
6
2
7
0
2
4
5
0
2
0
<17 years
17-19 years
20-24 years
25-34 years
35-44 years
Female (67)
75-84 years
85+ years


Suicide Deaths by Method
34
12
11
1
1
1
1
GUNSHOT WOUND
ASPHYXIATION
OVERDOSE
CARBON MONOXIDE INTOXICATION
TRAIN STRIKING PEDESTRIAN
MULTIPLE INCISED WOUNDS
ELECTROCUTION



Colorado Department of Public Health and Environment, Center for Health & Environmental Data, also tracks suicide statistics on their website. This site has interactive data for the entire state of Colorado. https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=y&:showAppBanner=false&:showShareOptions=true&:display_count=no&:showVizHome=no#4

Suicides in Colorado: Counts

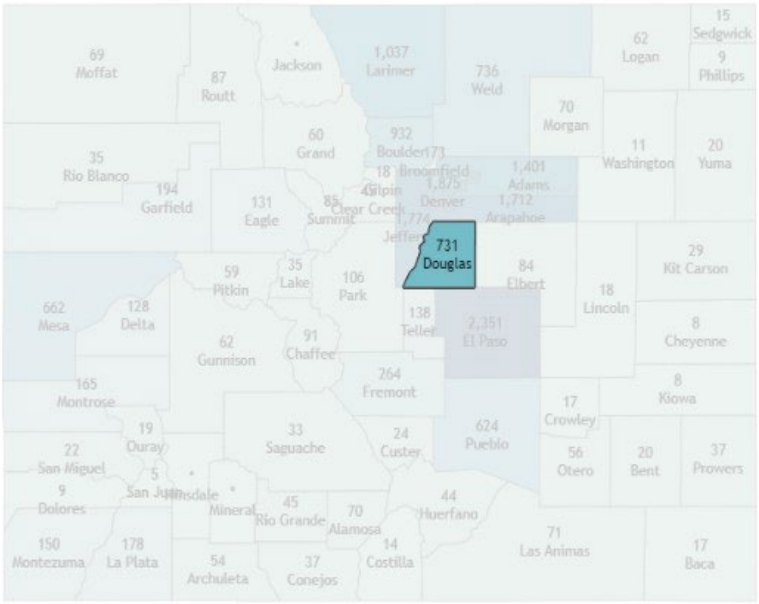
Colorado Vital Statisitics Program, (death certificate)

Select years:

2004 — 2020

Select method used to inflict the fatal injury:

All methods



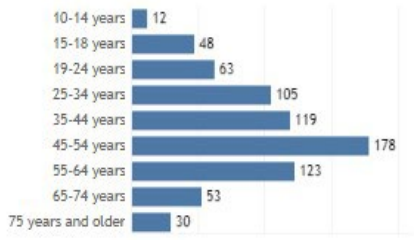
Total suicides for selected populations and years:

731

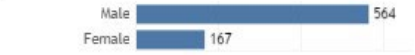
Number of suicides by demographics

Click on one or more subgroups below to filter all other charts to that group(s); click again to deselect

by age



by sex



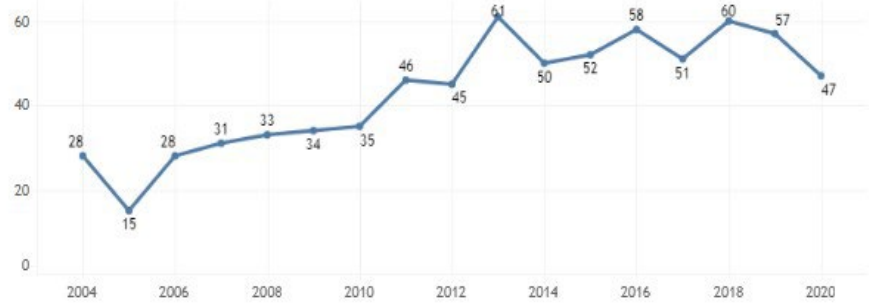
by ethnicity

by race

Selected population for all charts on this page

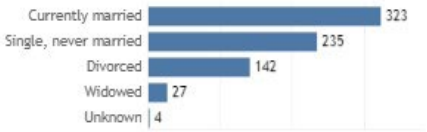
Age: All, Sex: All, Ethnicity: All, Race: All, Marital status: All, Veteran status: All, Method: All methods, County: Douglas

Number of suicides per year, 2004-2020



by veteran status (ever in U.S. Armed Forces)

by marital status



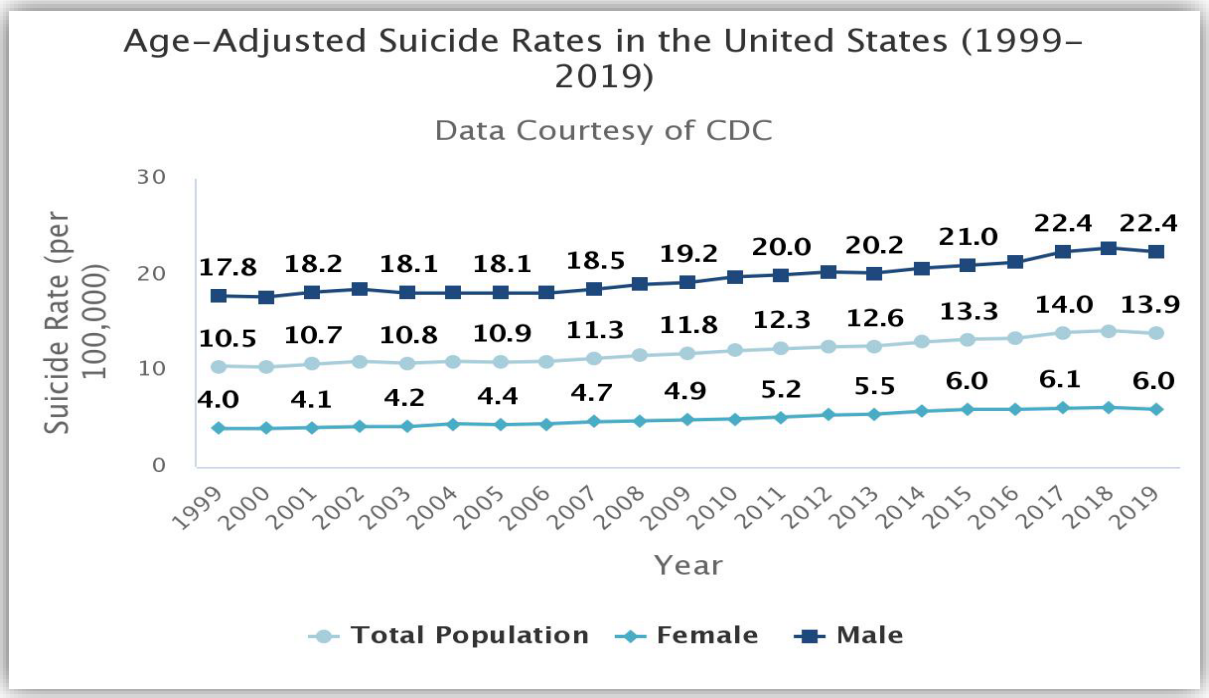
National Suicide Data

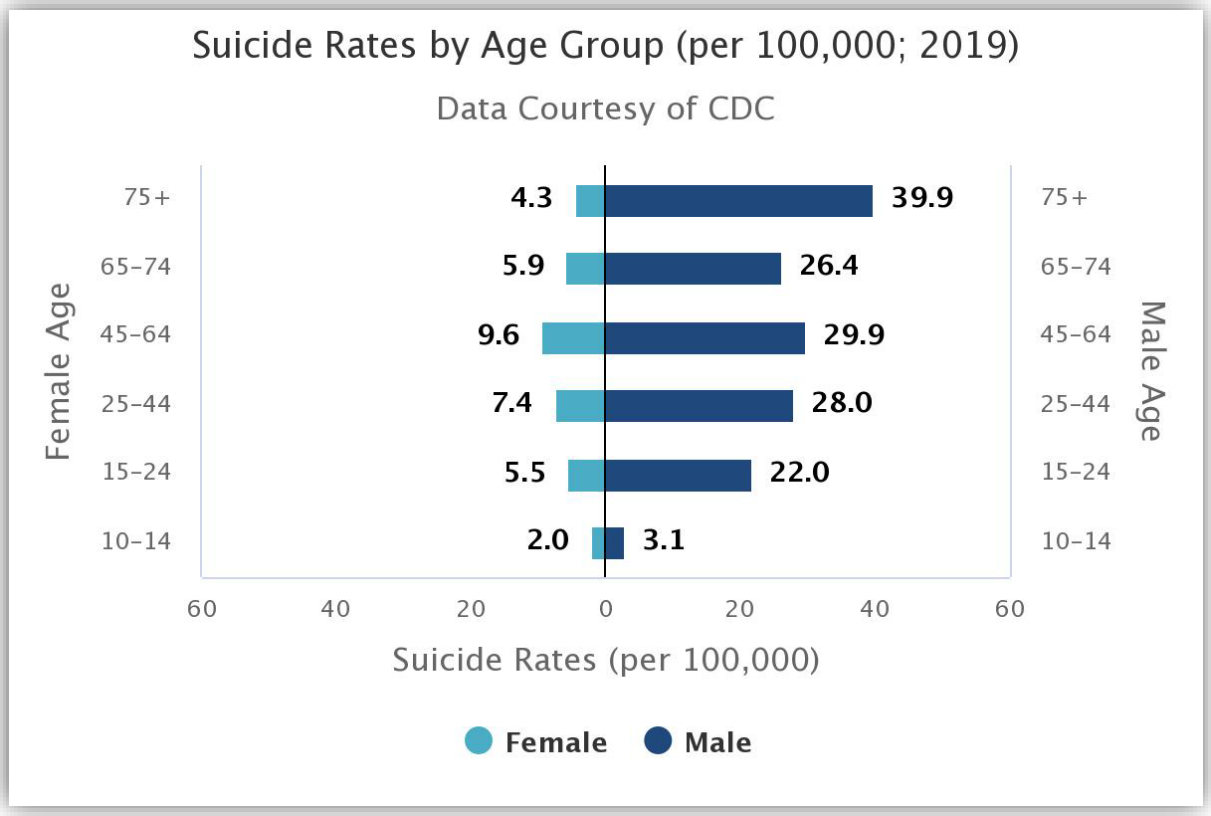
Notable findings:

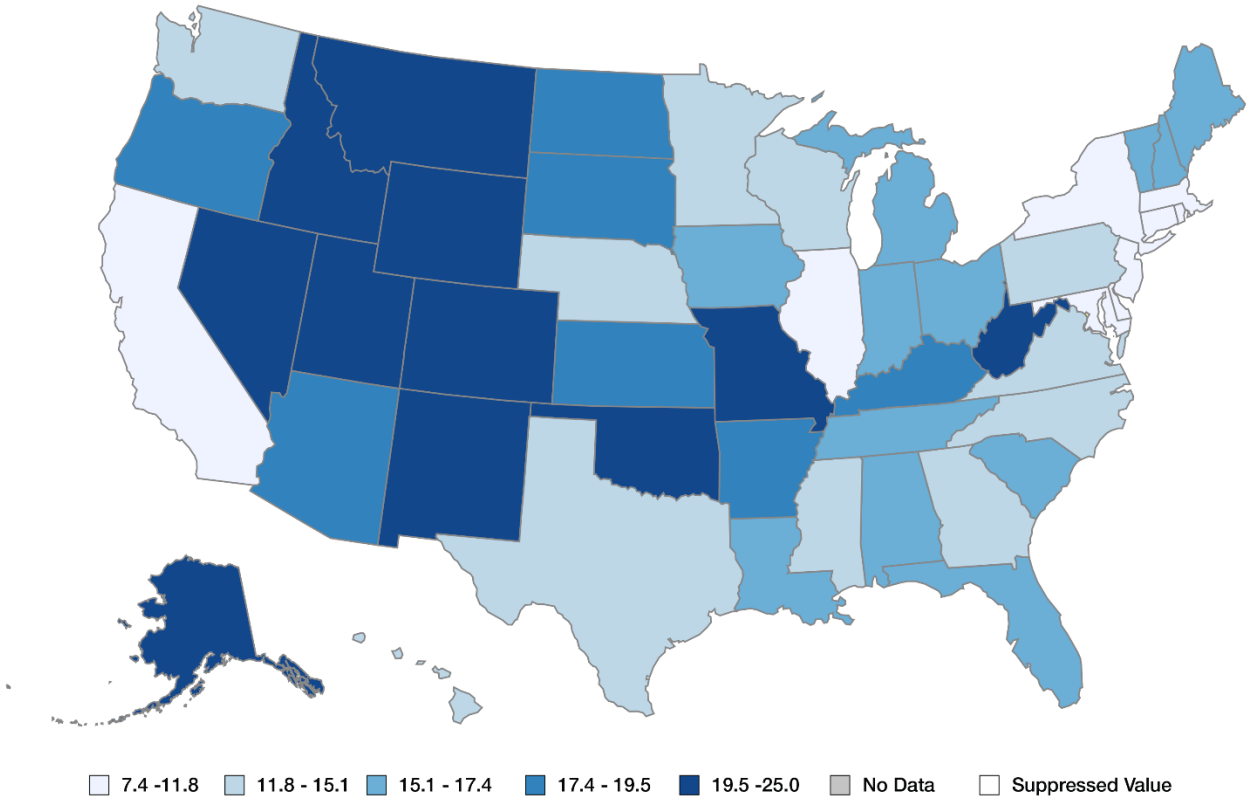
- Douglas County's overall suicide rate is somewhat higher than the national average.
- The rate has fallen somewhat over the last several years due to population growth.
- Men commit suicide at significantly higher rates than women both in Douglas County and nationally.
- The rate among men was generally higher than the nationwide average from 2015 to 2018 (2017 was lower) but now appears closer to or lower than the US rate.
- Between 2004-2020 the rate of suicide was highest among Douglas County men aged 45-54, and above the national average for that age group.
- The rate among women appears higher than the US rate, 2015 and 2017 excluded.
- The rate among women 45+ in particular, appears higher than the US rate for those age ranges.

Year	Douglas County Population	Suicides	Douglas County Suicide Rate (Per 100,000 population)	US Rate (per 100,000)
2015	322,319	58	17.99	13.3
2016	328,548	57	17.35	13.4
2017	336,149	44	13.09	14
2018	343,326	58	17.5	14.2
2019	351,528	56	16.5	13.9
2020	357,187	54	15.12	TBD
2021	379,000	61	17	TBD

Population estimates from State Demography Office
Reference Rate from National Institute of Mental Health
https://www.nimh.nih.gov/health/statistics/suicide.shtml


Age-Adjusted Suicide Rates in the United States (1999-2019)
Data Courtesy of CDC
Suicide Rate (per 100,000)
30
20
10
0
17.8 18.2 18.1 18.1 18.5 19.2 20.0 20.2 21.0 22.4 22.4
10.5 10.7 10.8 10.9 11.3 11.8 12.3 12.6 13.3 14.0 13.9
4.0 4.1 4.2 4.4 4.7 4.9 5.2 5.5 6.0 6.1 6.0
1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019
Year
Total Population
Female
Male


Suicide Rates by Age Group (per 100,000; 2019)
Data Courtesy of CDC
Female Age
75+ 4.3 39.9
65-74 5.9 26.4
45-64 9.6 29.9
25-44 7.4 28.0
15-24 5.5 22.0
10-14 2.0 3.1
Male Age
60 40 20 0 20 40 60
Suicide Rates (per 100,000)
Female
Male


7.4 -11.8
11.8 - 15.1
15.1 - 17.4
17.4 - 19.5
19.5 -25.0
No Data
Suppressed Value

Homicide Deaths

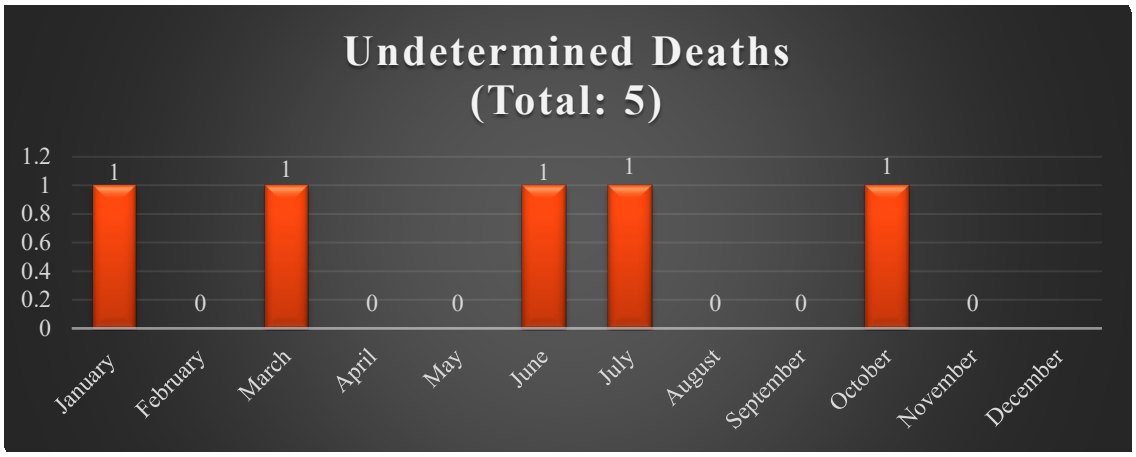
Homicide deaths are those deaths occurring as a result of, the act of another person, or “death at the hand of another.” For purposes of classifying the manner of death as a homicide, there is no need to imply criminal intent.

Homicide deaths accounted for **0.2%** of the total DCCO jurisdictional deaths for 2021.

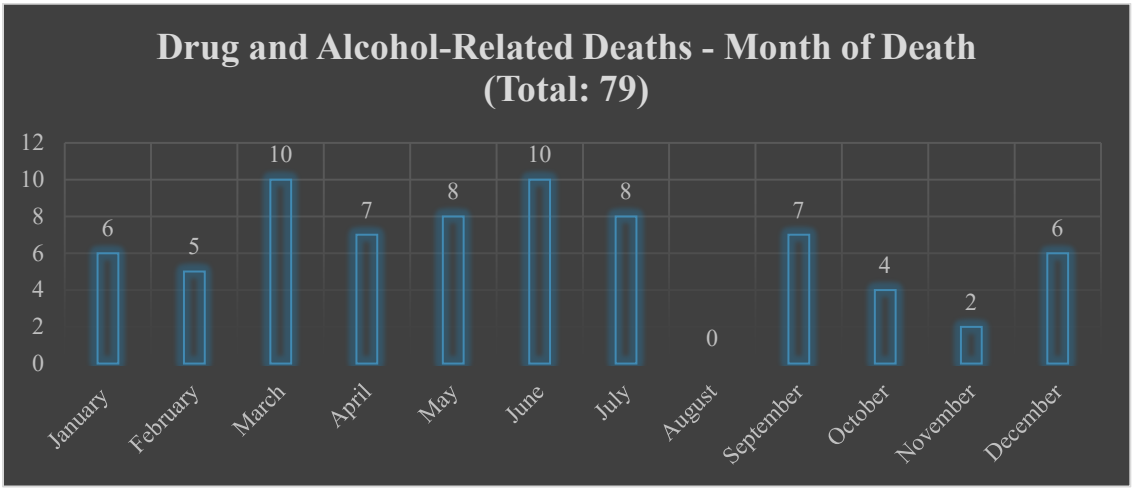
Undetermined Deaths

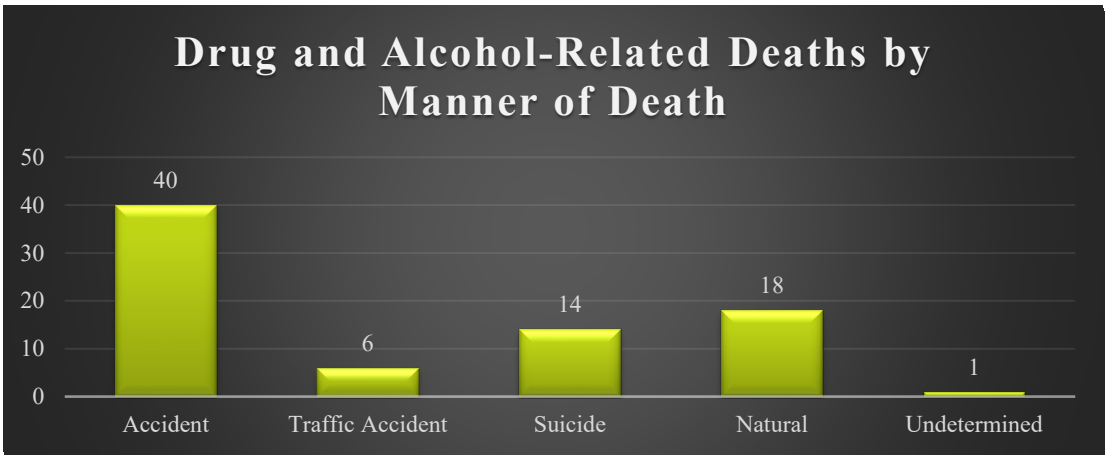
Deaths that are classified as undetermined are those deaths in which, after a thorough investigation and consideration of all information available, one manner of death is no more compelling than another manner of death. There are some instances where the cause of death is apparent; however, the circumstances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

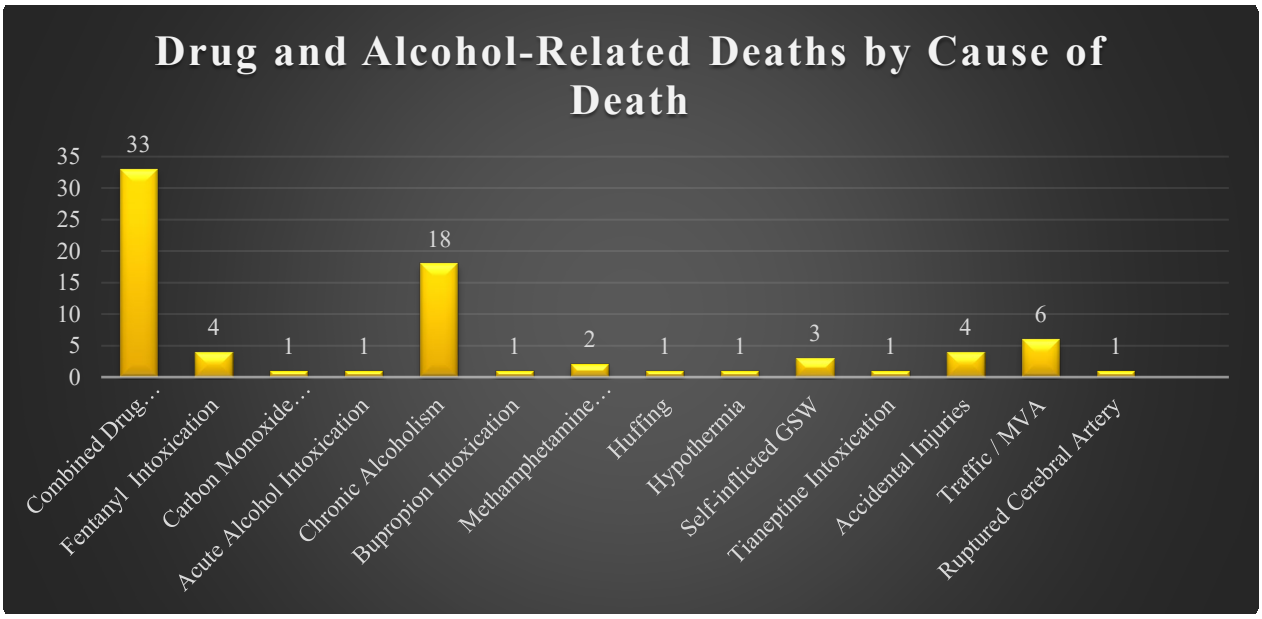
Undetermined deaths accounted for **0.2%** of the total DCCO jurisdictional deaths for 2021.



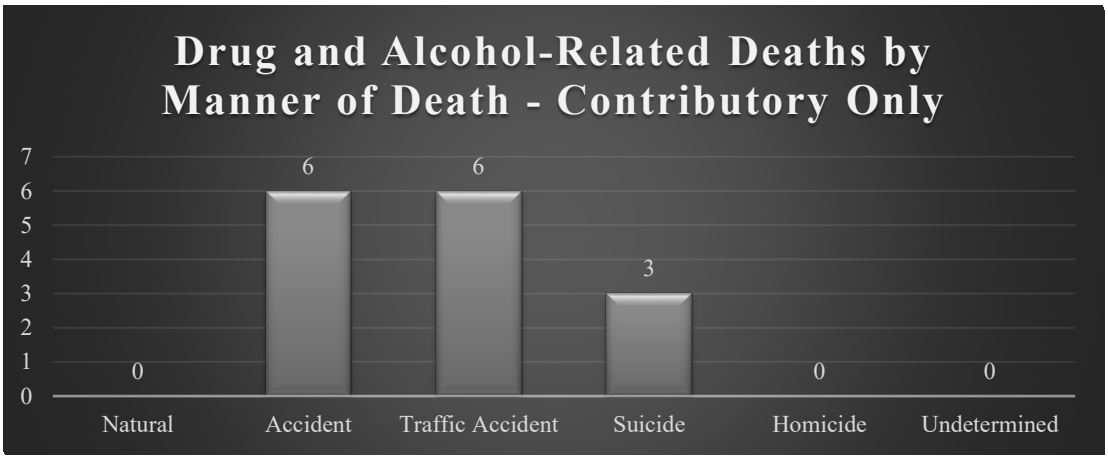
Drug & Alcohol-Related Deaths

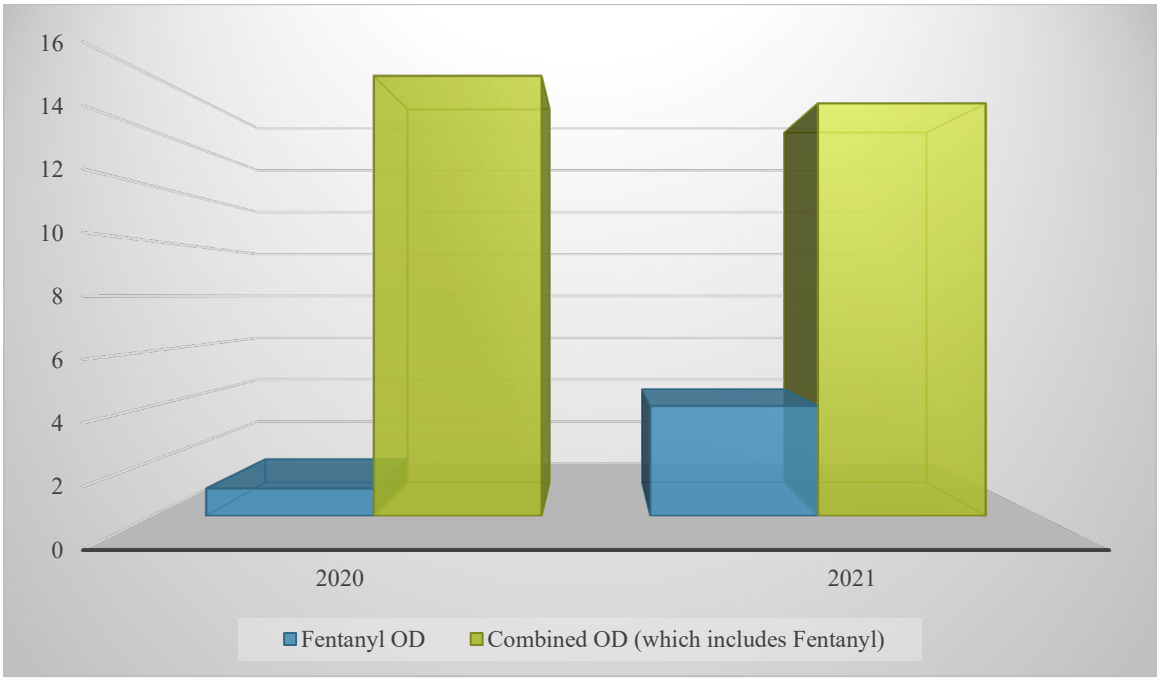





Drug and Alcohol-Related Deaths by Cause of Death
35
30
25
20
15
10
5
0
33
4
1
1
18
1
2
1
1
3
1
4
6
1
Combined Drug…
Fentanyl Intoxication
Carbon Monoxide…
Acute Alcohol Intoxication
Chronic Alcoholism
Bupropion Intoxication
Methamphetamine…
Huffing
Hypothermia
Self-inflicted GSW
Tianeptine Intoxication
Accidental Injuries
Traffic / MVA
Ruptured Cerebral Artery


Drug and Alcohol-Related Deaths by Month- Contributory Only (Total: 15)
6
5
4
3
2
1
0
1
1
3
1
1
5
1
0
2
0
0
January
February
March
April
May
June
July
August
September
October
November
December

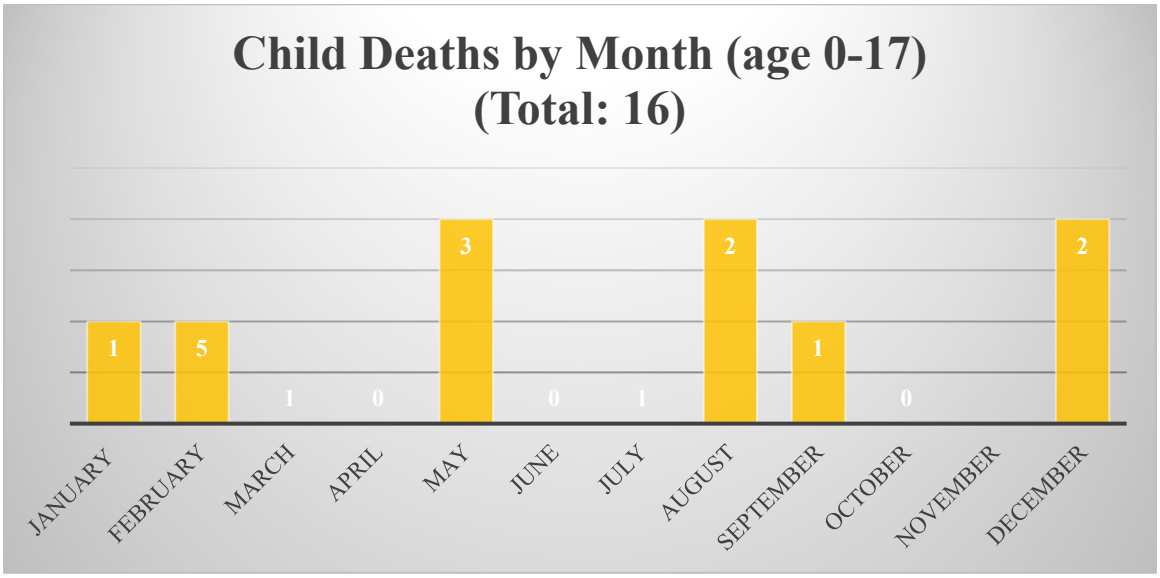

Drug and Alcohol-Related Deaths by Manner of Death - Contributory Only
7
6
5
4
3
2
1
0
0
6
6
3
0
0
Natural
Accident
Traffic Accident
Suicide
Homicide
Undetermined

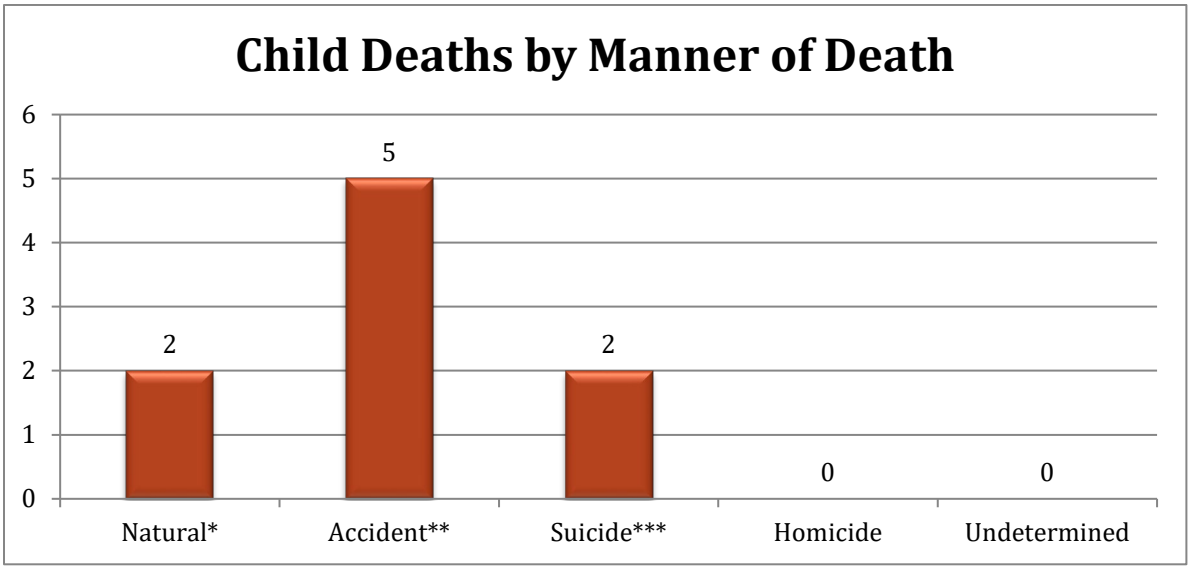

16
14
12
10
8
6
4
2
0
2020
2021
Fentanyl OD
Combined OD (which includes Fentanyl)

Child Deaths

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

Child deaths accounted for **0.7%** of the total DCCO jurisdictional deaths for 2021.





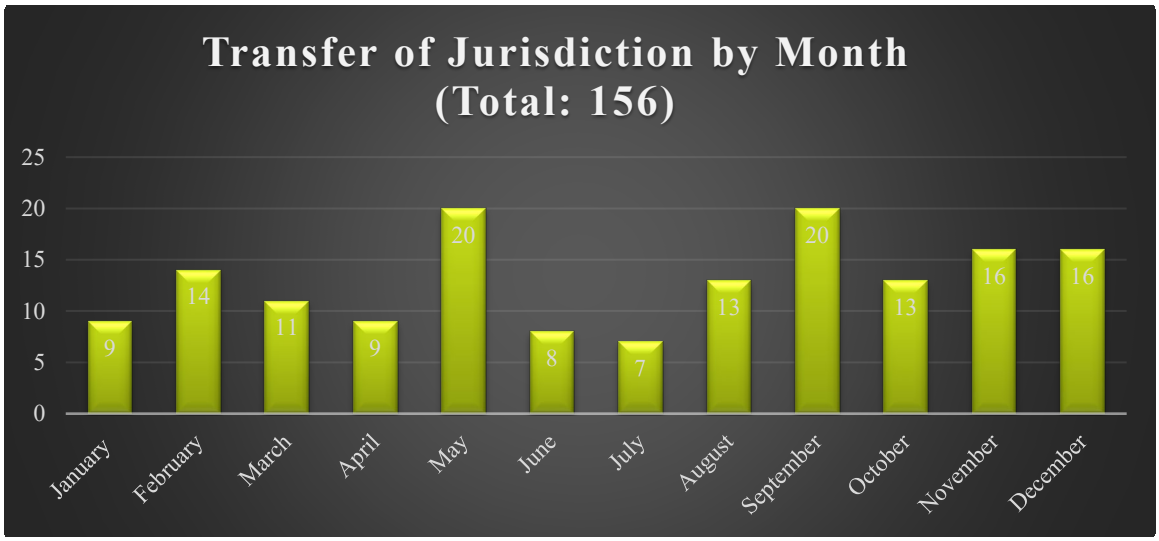
**Of the eleven (2) natural deaths, one (1) death was due to chronic static encephalopathy, and one (1) was due to chronic kidney disease.*

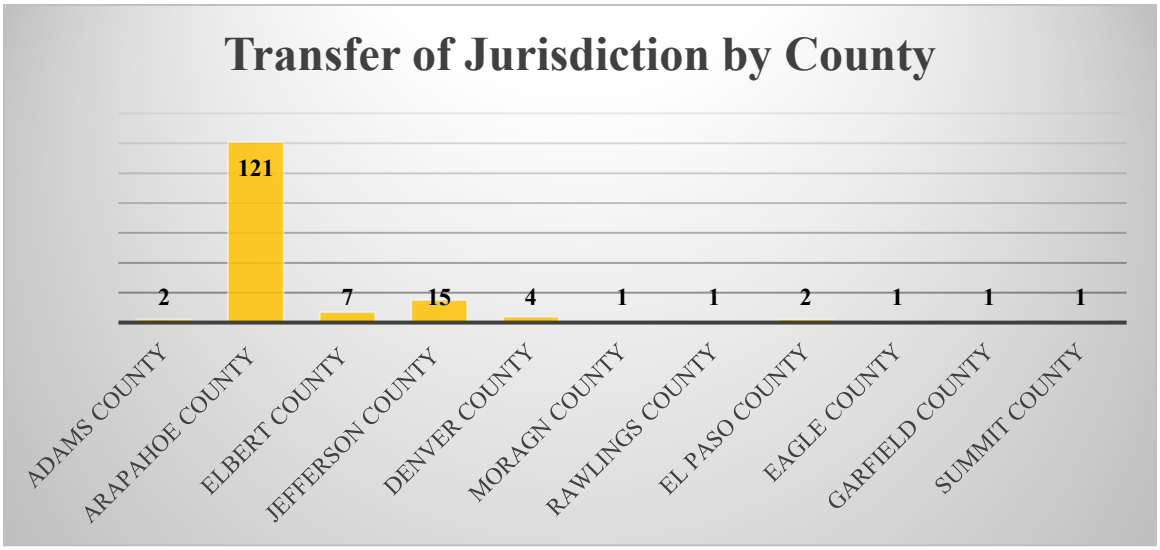
***Of the five (5) accidental deaths, one (1) was due to a motor vehicle collision, two (2) were due to drug intoxication, one (1) was due to positional asphyxia, and one (1) was due to drowning.*

****The two (2) suicide deaths were due to asphyxiation*

Transfer of Jurisdiction

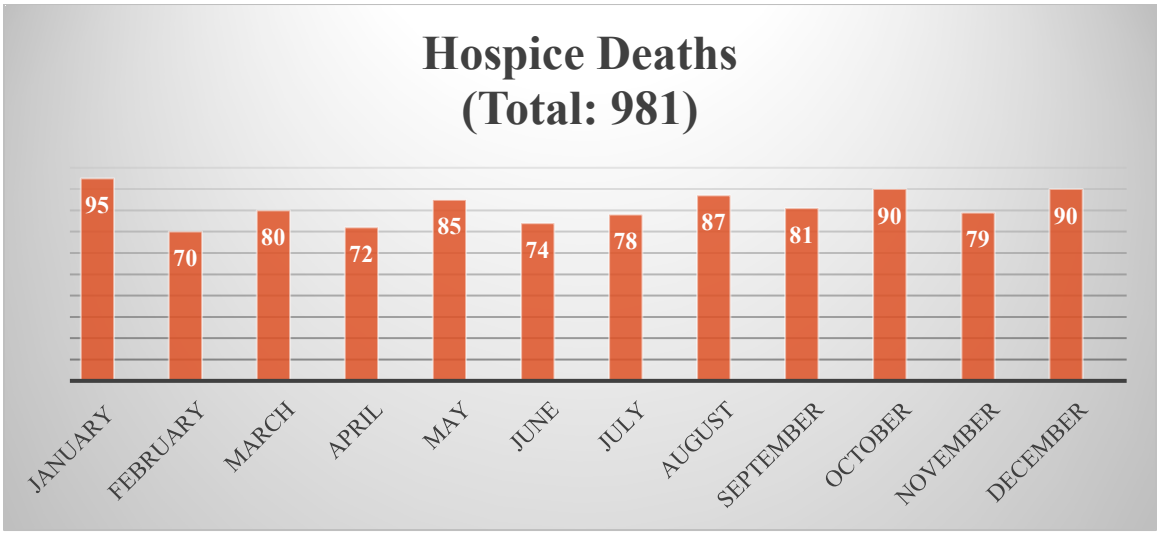
On occasion, a death occurs in Douglas County but the initiating event to the death occurred in another jurisdiction. These deaths can include those where an individual is transported to a hospital in Douglas County, from a location such as a residence in another jurisdiction, or deaths that occur due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





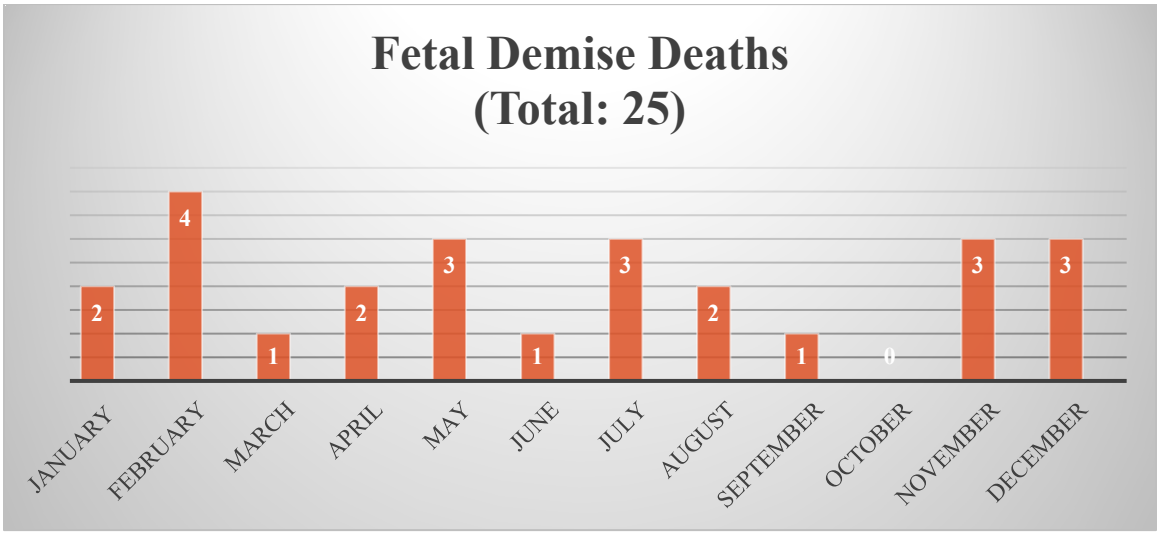
Hospice Deaths

All hospice deaths that occur in Douglas County are reportable to the Coroner's Office. In 2021, 981 deaths were reported by hospice agencies. Of the 981 hospice deaths, 923 (**94%**) were natural hospice deaths and 58 (5**%**) were accidental hospice deaths. Hospice deaths accounted for **42%** of all jurisdictional deaths reported to the Douglas County Coroner's Office in 2021.



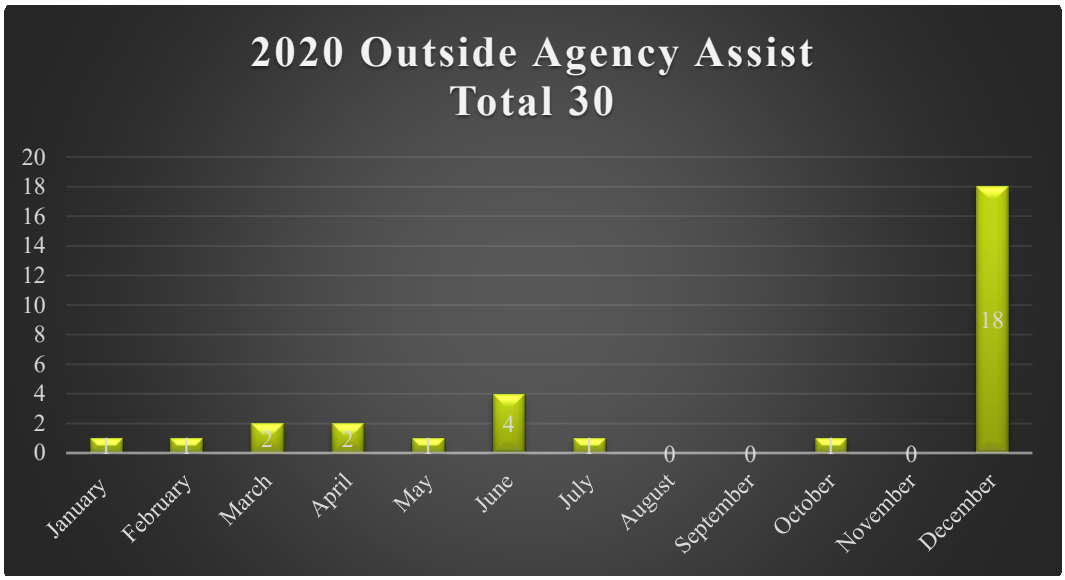
Fetal Demise Deaths

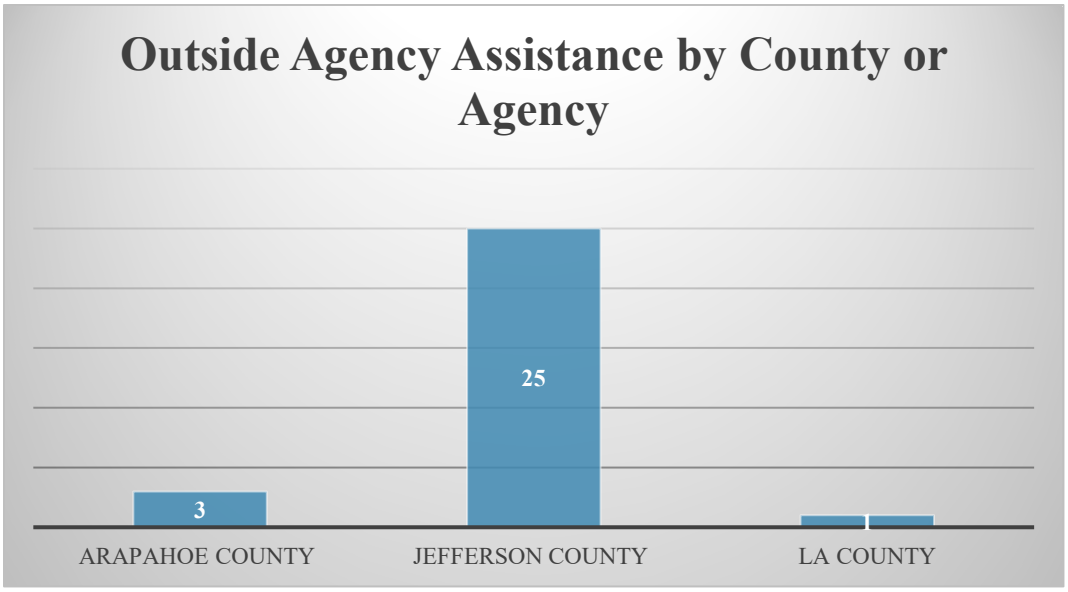
All fetal demise deaths over the gestational age of 20 weeks that occur in Douglas County are reportable to the coroner's office. In 2021, 25 fetal deaths were reported by hospitals.



Outside Agency Assist

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 and the use of our in-house X-ray machine.

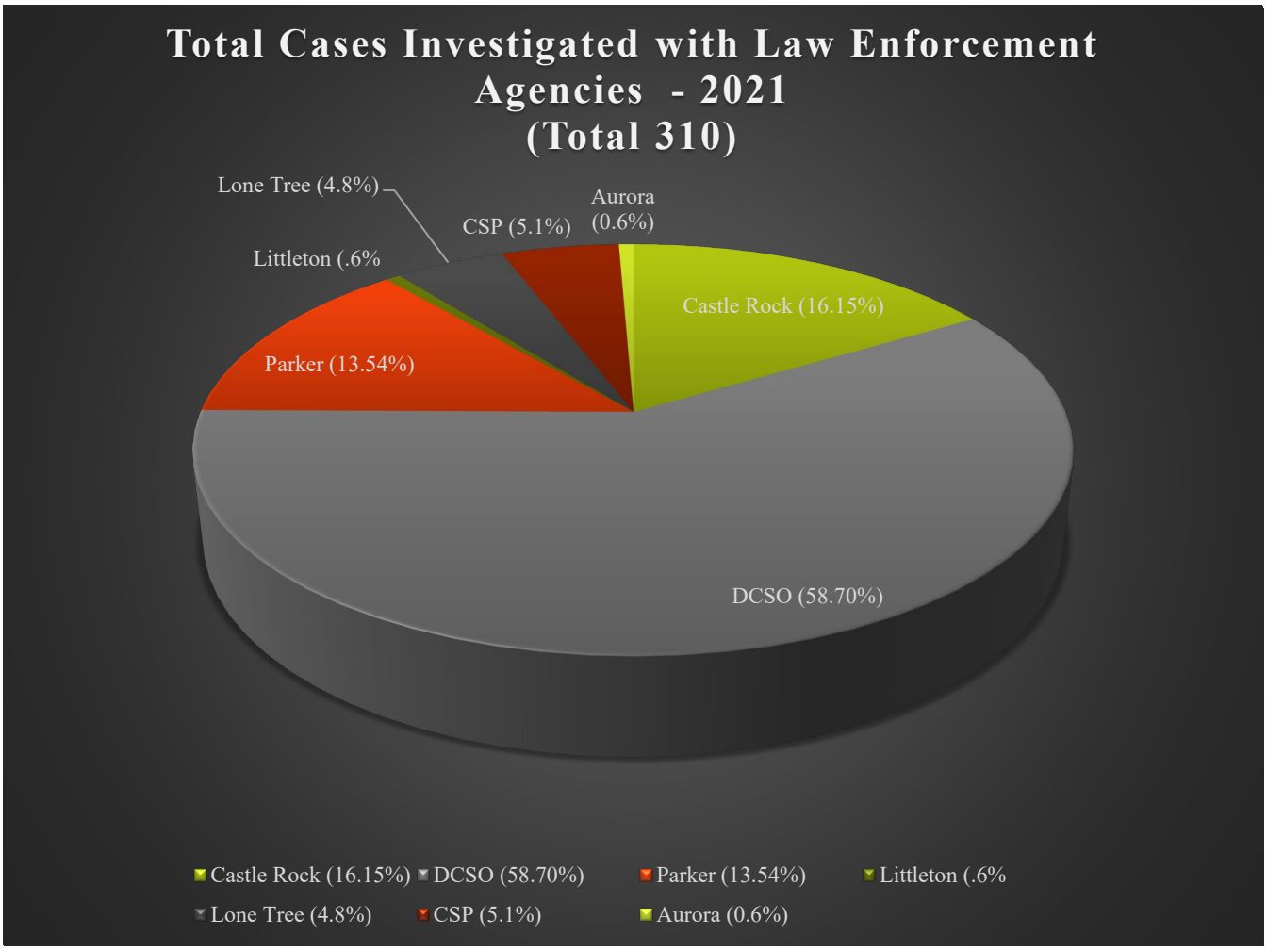


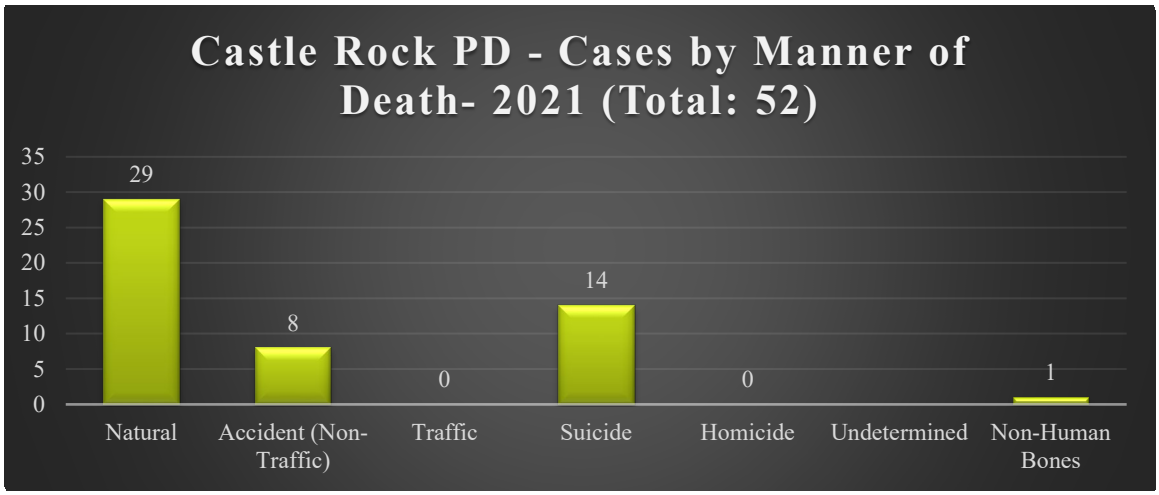


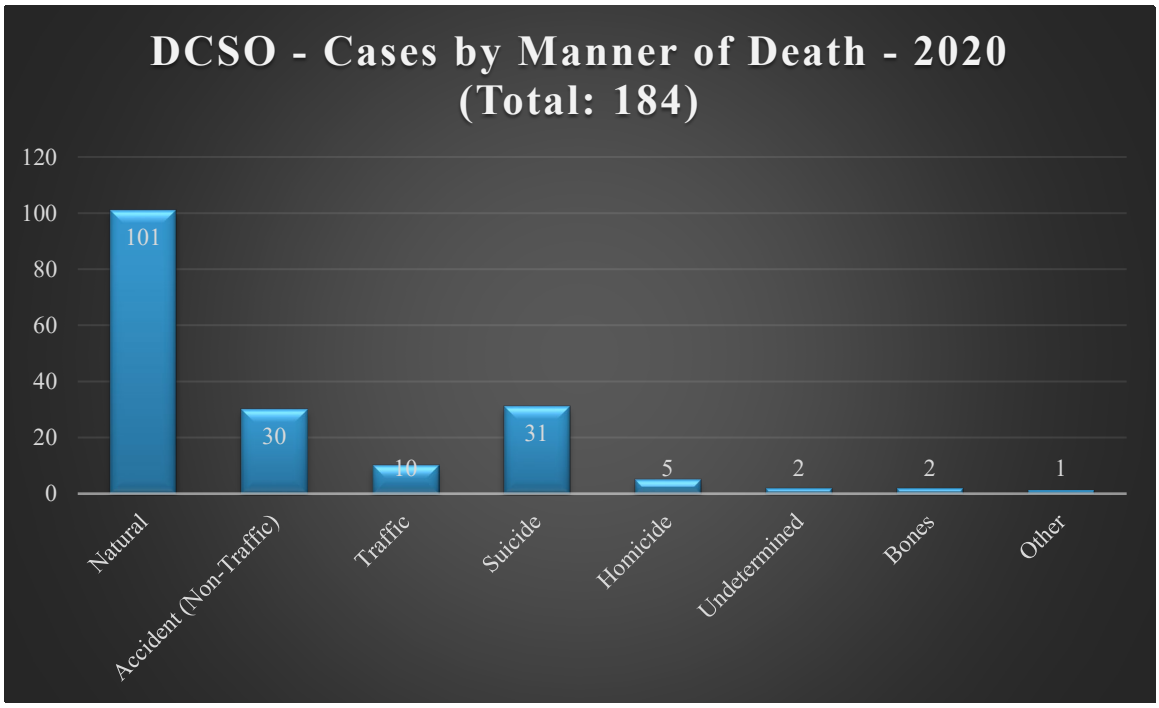
Law Enforcement Agencies

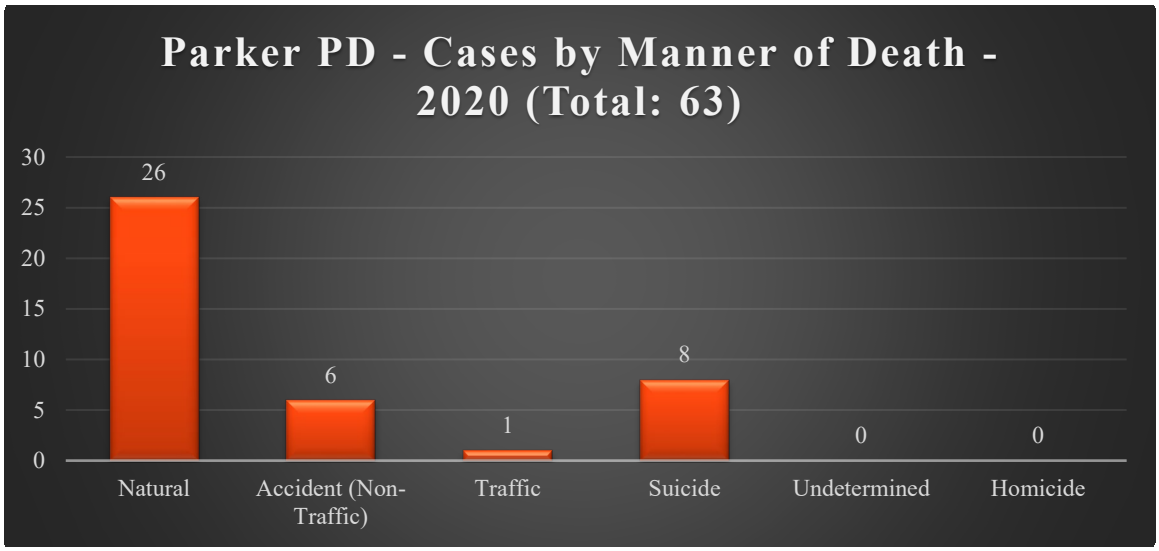
The Douglas County Coroner's Office works in collaboration with Law Enforcement Agencies with jurisdiction in Douglas County. Law Enforcement Agencies in Douglas County include the Aurora Police Department, Castle Rock Police Department, Colorado State Patrol (CSP), Douglas County Sheriff's Office (DCSO),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

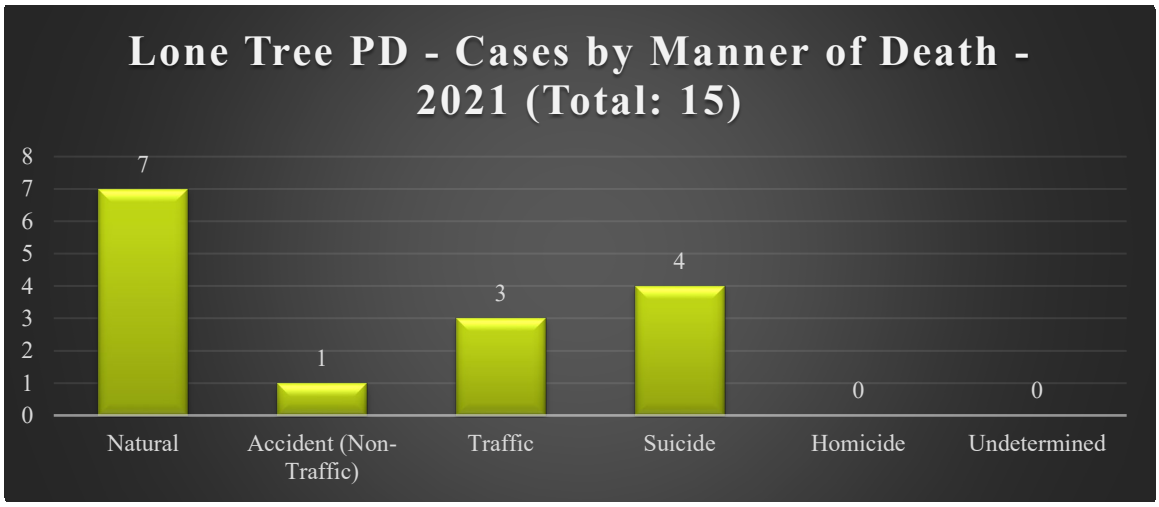
Of note: The total cases investigated with Law Enforcement may differ from the scene responses made by the Coroner's Office; due to some deaths having been delayed due to hospitalization following an incident or having occurred at a care facility where no response from the Coroner's Office was necessary.

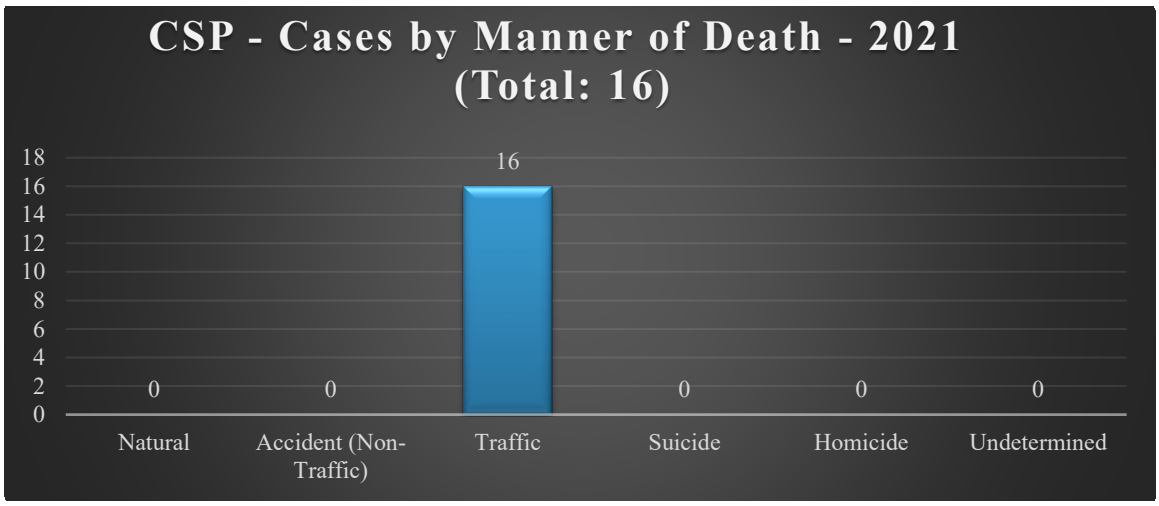

Total Cases Investigated with Law Enforcement Agencies - 2021 (Total 310)
Lone Tree (4.8%)
CSP (5.1%)
Aurora (0.6%)
Littleton (.6%
Castle Rock (16.15%)
Parker (13.54%)
DCSO (58.70%)
Castle Rock (16.15%)
DCSO (58.70%)
Parker (13.54%)
Littleton (.6%
Lone Tree (4.8%)
CSP (5.1%)
Aurora (0.6%)

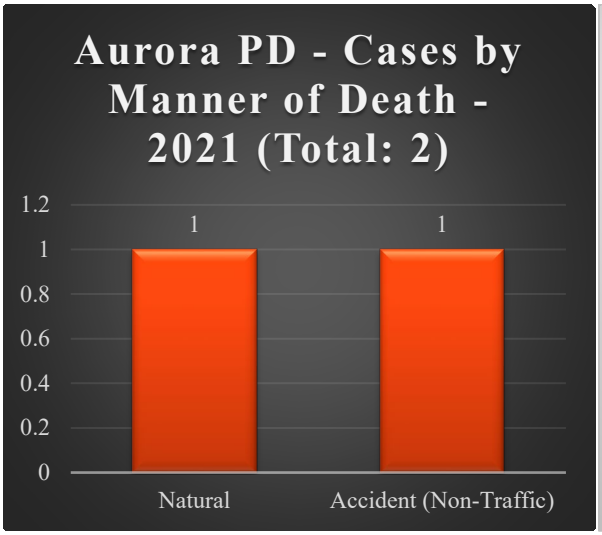

Castle Rock PD - Cases by Manner of Death- 2021 (Total: 52)
35
30
25
20
15
10
5
0
29
8
0
14
0
1
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined
Non-Human Bones

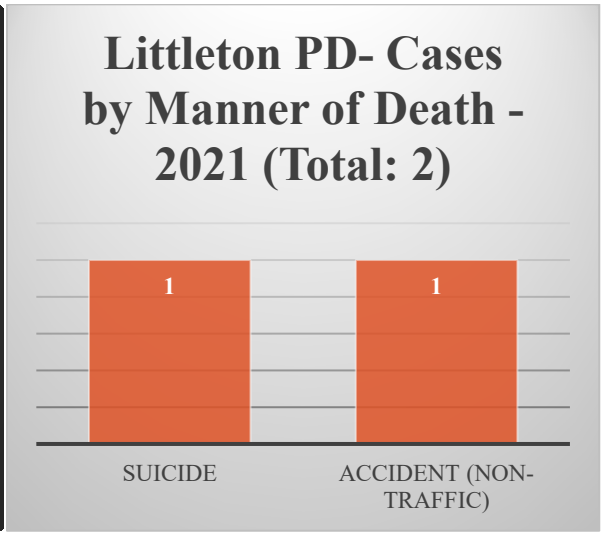

DCSO - Cases by Manner of Death - 2020 (Total: 184)
120
100
80
60
40
20
0
101
30
10
31
5
2
2
1
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined
Bones
Other


Parker PD - Cases by Manner of Death - 2020 (Total: 63)
30
25
20
15
10
5
0
26
6
1
8
0
0
Natural
Accident (Non-Traffic)
Traffic
Suicide
Undetermined
Homicide


Lone Tree PD - Cases by Manner of Death - 2021 (Total: 15)
8
7
6
5
4
3
2
1
0
7
1
3
4
0
0
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined


CSP - Cases by Manner of Death - 2021 (Total: 16)
18
16
14
12
10
8
6
4
2
0
0
0
16
0
0
0
Natural
Accident (Non-Traffic)
Traffic
Suicide
Homicide
Undetermined

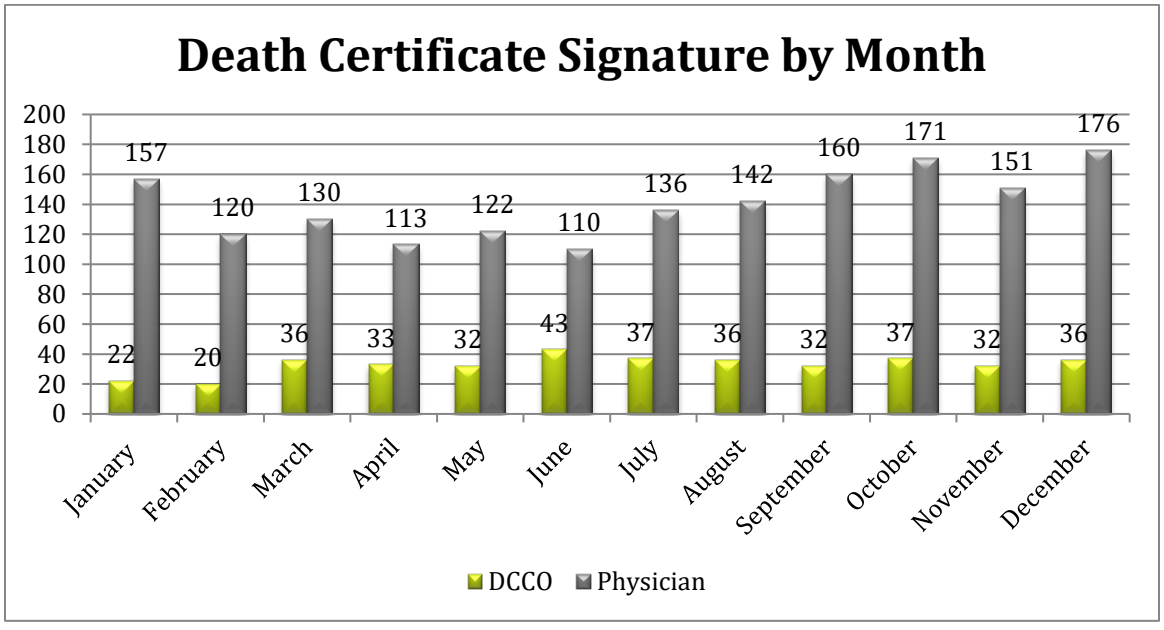

Aurora PD - Cases by Manner of Death - 2021 (Total: 2)
1.2
1
0.8
0.6
0.4
0.2
0
1
1
Natural
Accident (Non-Traffic)


Littleton PD- Cases by Manner of Death - 2021 (Total: 2)
1
1
SUICIDE
ACCIDENT (NON-TRAFFIC)

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. Unlike other surrounding counties, the Douglas County Coroner's Office does not co-sign death certificates with physicians, so as to not cause funeral homes extra work submitting death certificates to multiple agencies. 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 2084 reported cases to DCCO, death certificates were signed by DCCO and 1698 death certificates were signed by a private physician.



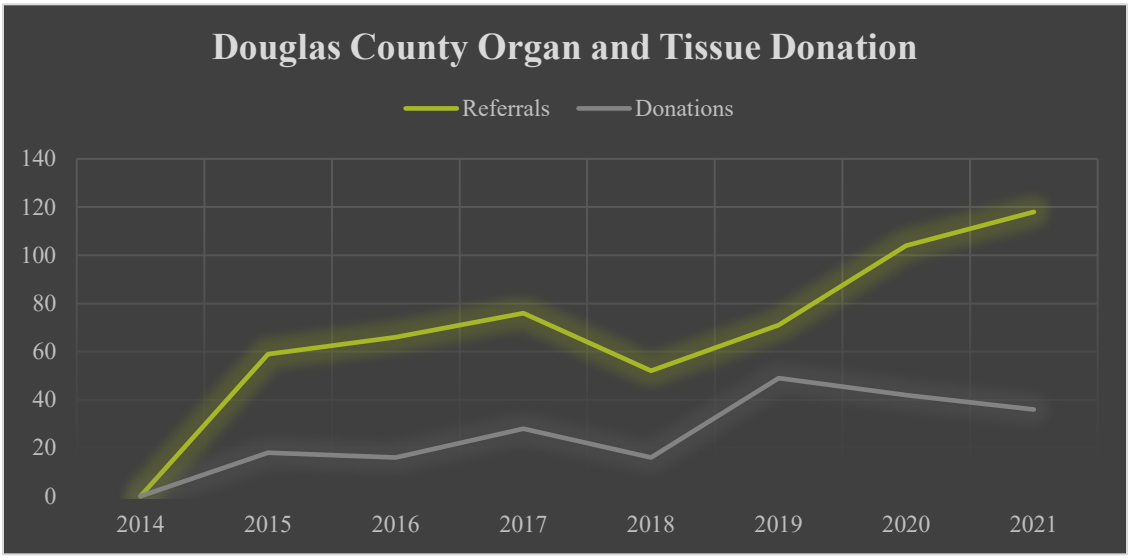
Organ & Tissue Donation

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 and rights of the deceased and their families.**

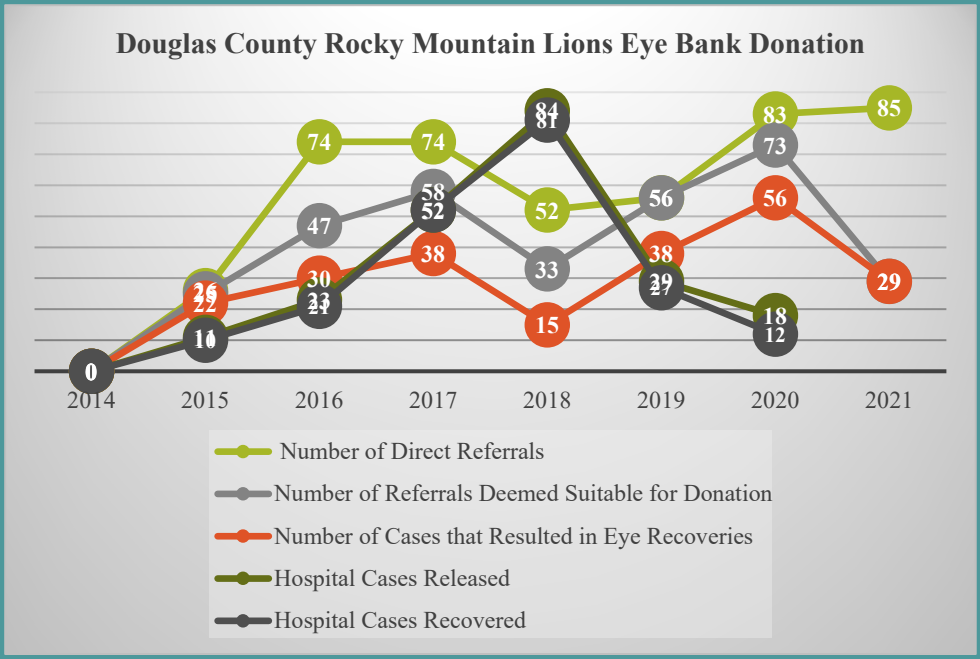
We are committed to saving lives with tissue and organ donation.

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 2010-2015, the Douglas County Coroner's Office did not allow referrals to be made to Donor Alliance. In 2015, when Coroner Romann took office, she immediately changed office policy in order to honor individuals' rights, and the rights of the next-of-kin and allow donation. As a result, since that time, DCCO has helped hundreds of families honor their loved one's rights. 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 2021, the Douglas County Coroner's Office made 85 direct referrals to RMLEB; with 73 of those deemed suitable for donation. Out of those referrals, 56 cases resulted in eye recoveries; with 29 corneas successfully transplanted.



Additionally, there were 139 cases that were referred to RMLEB by local hospitals in deaths where the Douglas County Coroner's Office had jurisdiction over. Of those cases 151 donors were recovered, and of the recovered cases 86 were successfully transplanted.

"I wanted to thank you and your staff on behalf of the eye bank for all your collaboration and helping us accomplish our sight-saving mission whenever it's possible with eye donors that fall under your jurisdiction. You and your team play an important role in fulfilling the wishes of eye donors and the families, and we look forward to continuing a great working relationship with your office."

Ben Samuels, Public and Professional Relations Coordinator,
Rocky Mountain Lions Eye Bank

Unidentified Remains

Unclaimed Bodies / Exhumations

The Douglas County Coroner's Office had no unclaimed bodies in 2021. In addition, The Douglas County Coroner's Office had no exhumations in 2021.

Year in Review

Service • Integrity • Dignity

Professionalism • Compassion