Bannock County Coroner

2024 Annual Report

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Message to the Board of Commissioners and Citizens of Bannock County

The Bannock County Coroner's Office is statutorily obligated to investigate and determine the cause and manner of all deaths that are unattended, accidental, violent in nature, suspicious, or in the death of a child that occurs in Bannock County. Our investigations are parallel to but separate from the law enforcement investigation. The Office of the Coroner certifies the death certificate after an investigation and postmortem examination of the decedent as required by law. Complete findings of the death investigation are distributed to law enforcement agencies as appropriate and can be made available to families upon request.

The main duties of the Office of the Coroner are to determine the cause and manner of death, and certify deaths that are reported to the coroner. The cause of death is the disease process or injury that resulted in death. There are thousands of diseases and injuries that may result in death. The manner of death is a classification in which a determination is made regarding whether the death resulted from natural causes, homicide, suicide, accident, or classified as undetermined based on a lack of definitive evidence.

Information collected during the investigation helps clarify the circumstances, such as the sequence of events prior to death. Evidence collected during an investigation and/or postmortem examination may help lead to the arrest or successful conviction of a suspect in a criminal case. Because deaths occur around the clock, coroner staff must be available 24 hours a day, 365 days per year.

For the first time in Bannock County, the staff of the Bannock County Coroner's Office have been certified with the American Board of Medicolegal Death Investigators (ABMDI). With the skill and experience of the ABMDI-certified death investigators and board-certified forensic pathologists working within accreditation standards, we believe the quality of death investigations in Bannock County is among the best in the State. The death scene investigation reports filed by the investigators are very thorough and comprehensive. Our investigators also extend their duties to the community by answering questions and addressing concerns regarding deaths within the county. Investigators frequently make

personal contact with family members of a deceased and assist them by providing appropriate answers regarding the circumstance of the death.

The Bannock County Coroner's Office utilizes MDI Log for case management and storage. MDI Log is a comprehensive investigative report/database system that enables the Coroner to review death scene investigation information from a secure internet site at any time of the day. MDI Log enables investigators to input death scene investigation reports in an efficient manner. MDI Log has enabled us to evolve and has become a valuable tool for our office and it is now utilized by many medical examiners and coroner's offices across the county.

To the Bannock County Board of Commissioners, I ask for your support of the growth and evolution of this office and the services we provide to the citizens of Bannock County.

Thank You,

Coroner T. Danner

Bannock County Coroner's Office Staff

Torey Danner
Coroner

J.R. Farnsworth
Chief Deputy Coroner

Bridger Barnes
Medicolegal Death Investigator

Mission Statement: *We will serve and advocate for the deceased and their families with compassion and professionalism while being diligent and transparent in our investigations.*
Vision Statement: *Lead the region in medicolegal death investigations through education and accreditation.*
Values: *Bannock County Coroner's office values honesty, transparency, compassion, integrity, and the fostering of relationships.*

Goals and Objectives

- Maintain a strong foundation that is sustainable for the evolution and growth of our office.
- Continue working to become accredited by the International Association of Coroners and Medical Examiners (IACME).
- We are committed to advancing the Coroner Office's goal of establishing a fully self-sufficient operational facility.

Ada County Forensic Pathology

Richard Riffle
Coroner

Brett Harding
Chief Deputy Coroner

Christina Di Loreto
Forensic Pathologist

Garth Warren
Forensic Pathologist

Chiara Mancini
Forensic Pathologist

Types of Deaths Reportable to the County Coroner

Idaho Title 19 Chapter 43 mandates that specific types of death are to be referred to the coroner for investigation. These deaths include sudden and unexpected deaths, accidental deaths, and violent deaths. The coroner has the authority under Idaho Statute 19-4301B to order an autopsy at any time it is deemed necessary to determine or confirm the cause and manner of death.

TITLE 19 CRIMINAL PROCEDURE CHAPTER 43 CORONER'S INQUESTS

19-4301. COUNTY CORONER TO INVESTIGATE DEATHS. (1) When a county coroner is informed that a person has died, the county coroner shall investigate that death if:

(a) The death occurred as a result of violence, whether apparently by homicide, suicide or by accident;

(b) The death occurred under suspicious or unknown circumstances; or

(c) The death is of a stillborn child or any child if there is a reasonable articulable suspicion to believe that the death occurred without a known medical disease to account for the stillbirth or child's death.

(2) If a death occurs that is not attended by a physician and the cause of death cannot be certified by a physician, the coroner must refer the investigation of the death to the sheriff of the county or the chief of police of the city in which the incident causing the death occurred or, if such county or city is unknown, to the sheriff or chief of police of the county or city where the body was found. The investigation shall be the responsibility of the sheriff or chief of police. Upon completion of the investigation, a written report shall be provided to the coroner of the county in which the death occurred or, if such county is unknown, to the coroner of the county where the body was found.

(3) A coroner in the county where the incident causing the death occurred or, if such county is unknown, the coroner in the county where the body was found, may conduct an inquest if there are reasonable grounds to believe as a result of the investigation that the death occurred as provided in subsection (1) of this section.

(4) If an inquest is to be conducted, the coroner shall summon six (6) persons qualified by law to serve as jurors for the inquest.

(5) Nothing in this section shall be construed to affect the tenets of any church or religious belief.

Bannock County Coroner Cases for 2024

with comparison to 2023 and 3-year average

Population (Census Estimation July 1, 2023) 90,400

	2023	2024	Inc/Dec	3-yr Avg
Cases Reported to Coroner	**645**	**675**	**4.65%**	**654**
Number of deaths requiring Full Autopsy (including toxicology)	**30**	**21**	**-30.00%**	**25**
Number of deaths requiring External Autopsy	**0**	**1**	**100.00%**	**0**
Number of cases accepted jurisdiction	**200**	**200**	**-0.50%**	**207**
Number or External Examinations of a Decedent	**191**	**184**	**-3.67%**	**190**
Number of cases receiving scene investigations	**191**	**198**	**3.67%**	**194**
Number of cases reviewed w/o accepted jurisdiction	**445**	**475**	**6.74%**	**451**
Number of bodies transported by the office	**30**	**29**	**-3.33%**	**28**
Number of cases with only toxicology	**44**	**50**	**13.64%**	**42**
Number of Unidentified bodies	**0**	**0**	**No Change**	**0**
Number of Exhumations	**0**	**0**	**No Change**	**0**
Number of Donor Referrals	**11**	**33**	**200%**	**15**
Number of Procurements completed by Referral	**7**	**3**	**-57%**	**3**
Number of Unclaimed Decedents	**5**	**1**	**-80.00%**	**1**
Number of Cremations Approved	**570**	**568**	**-0.35%**	**550**
Number of Death Notifications conducted	**24**	**18**	**-25.00%**	**18**

Autopsies by Month

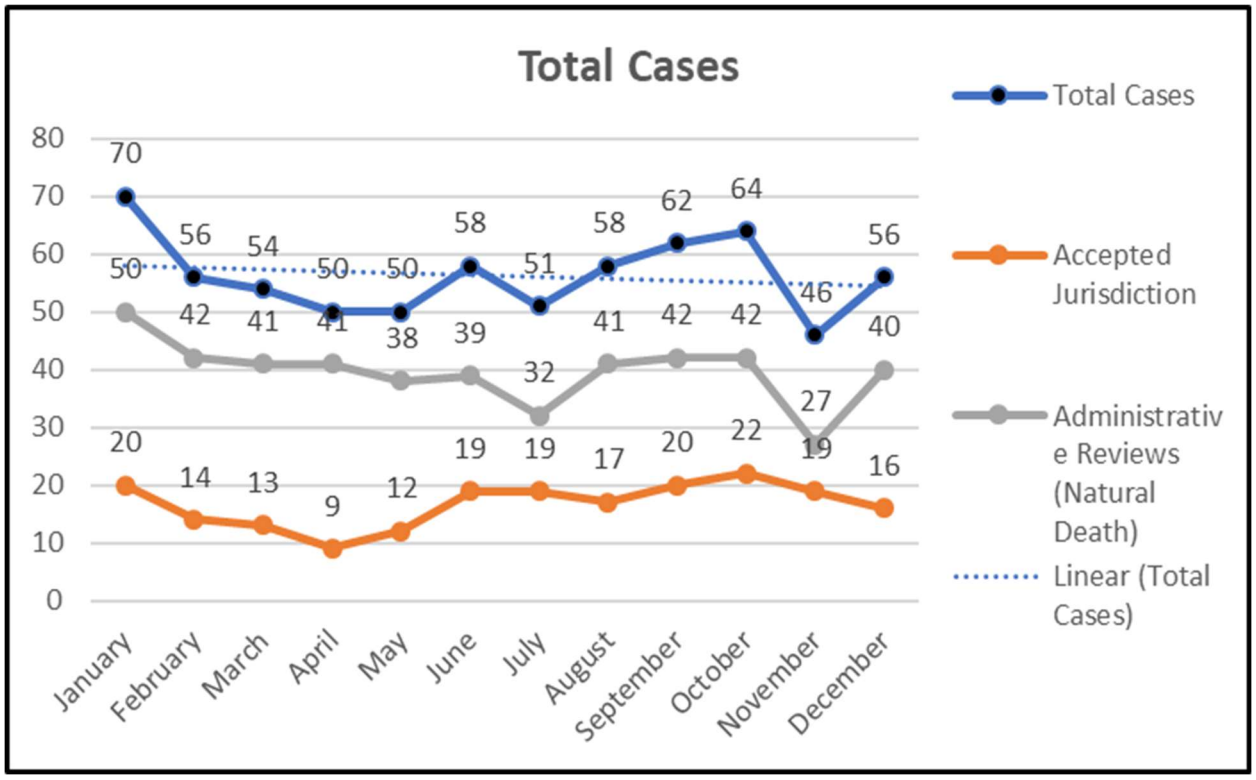
January	February	March	April	May	June
3	2	1	0	3	1
July	August	September	October	November	December
3	1	0	4	2	1

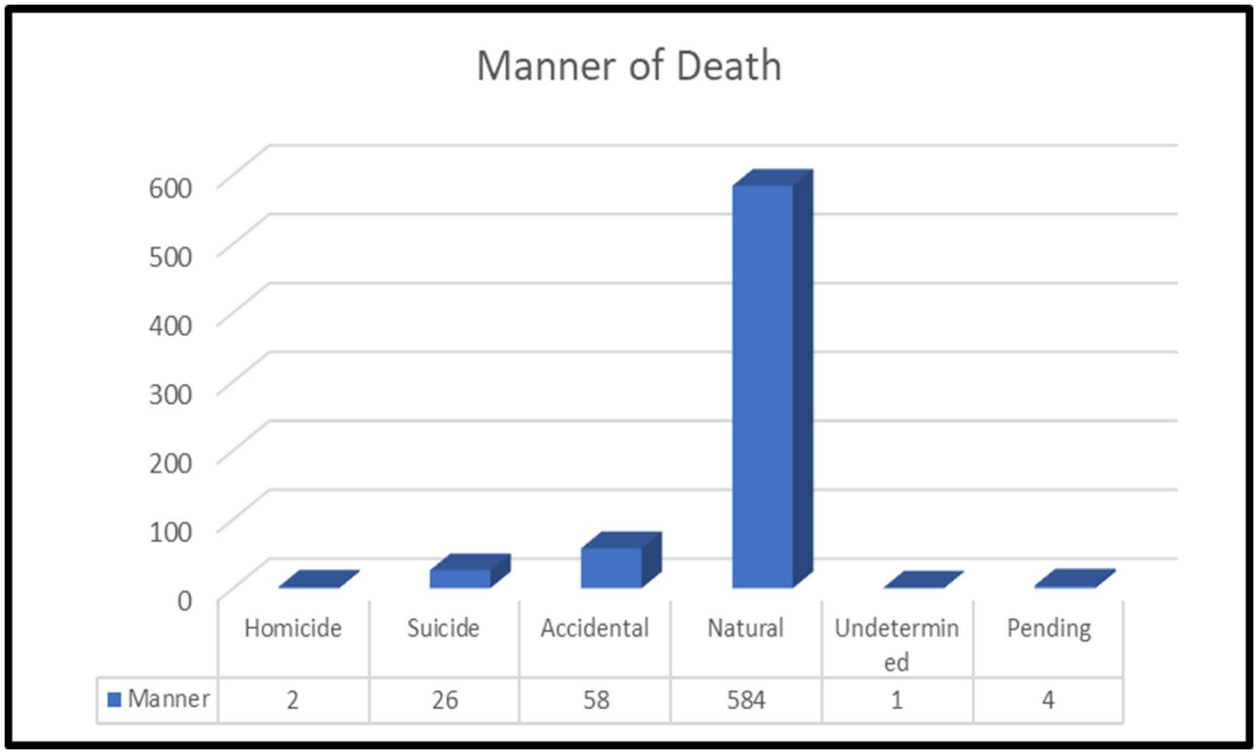
Summary of 2024

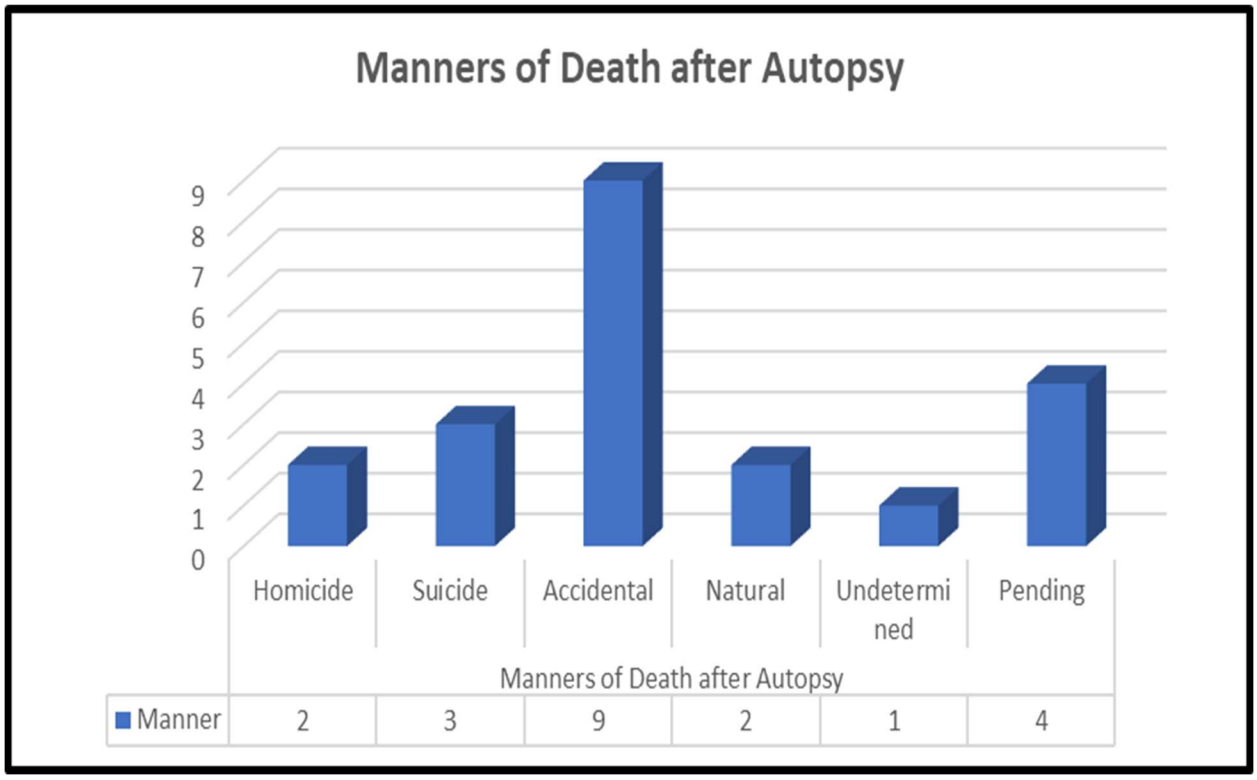
In 2024 Bannock County had a decrease in autopsies and an increase in cases receiving only toxicology testing. Not all cases reported to the Coroner receive scene investigations. Cases can be reported to the Coroner due to Idaho Statute, or hospital policy which requires notification of the Coroner if an individual dies in the hospital within 24 hours of admittance, the cause of death is certified by a doctor that needs further review, or the need for a cremation authorization. These cases are considered for jurisdiction and either denied or accepted. In 2024, there was a total of 675 cases reported to the Coroner's Office. Out of those, 475 cases required a Coroner Review. Of the 200 cases under the Coroner's Jurisdiction, 51.74% (11% Increase from 2023) of the calls came outside the office hours of 9 am to 5 pm, 22% (4% decrease of 2023) of the calls occurred on the weekend, and 9% (200% increase of 2023) of the calls included calls that happened while on a scene or responding to another call at the same time. The Median response time from notification of the Coroner to arrival on the scene was 20 minutes.

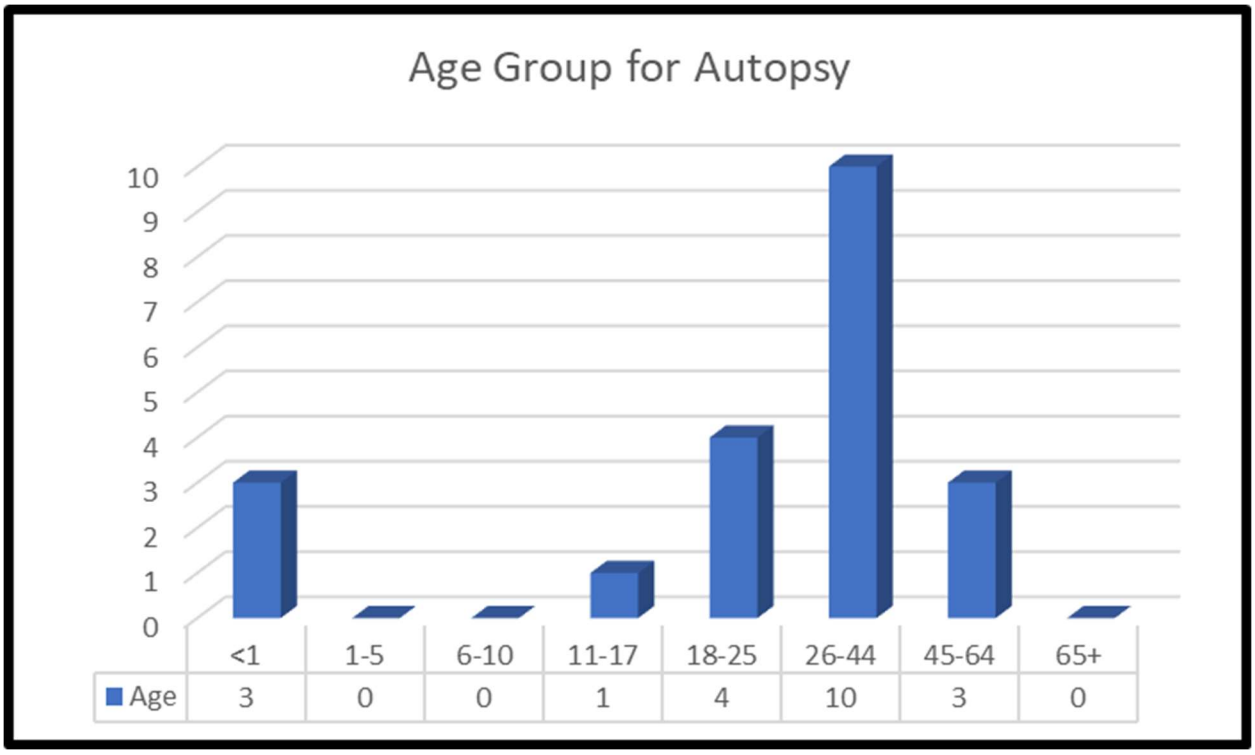
Almost all Coroner cases with accepted jurisdiction receive a body examination, a scene investigation, or both to determine cause and manner. The investigation helps the medicolegal investigator decide if the case can be completed with a review of medical records, a review of medical records and toxicology, or if a full autopsy is needed. Scientific standards, methods of investigation, and standards for accreditation are produced by the American Academy of Forensic Sciences (AAFS), the American Board of Medicolegal Death Investigators (ABMDI), the National Association of Medical Examiners (NAME), and the International Association of Coroners and Medical Examiners (IACME). In conjunction with information gathered from the scene, these organizations provide guidance when either toxicology or an autopsy is needed in addition to scene investigation. In 2024, fifty (50) of the cases were determined to require toxicology testing, and twenty-one (21) cases required full autopsies. Toxicology testing increased by 13.64%, while autopsies declined by 30.00 %

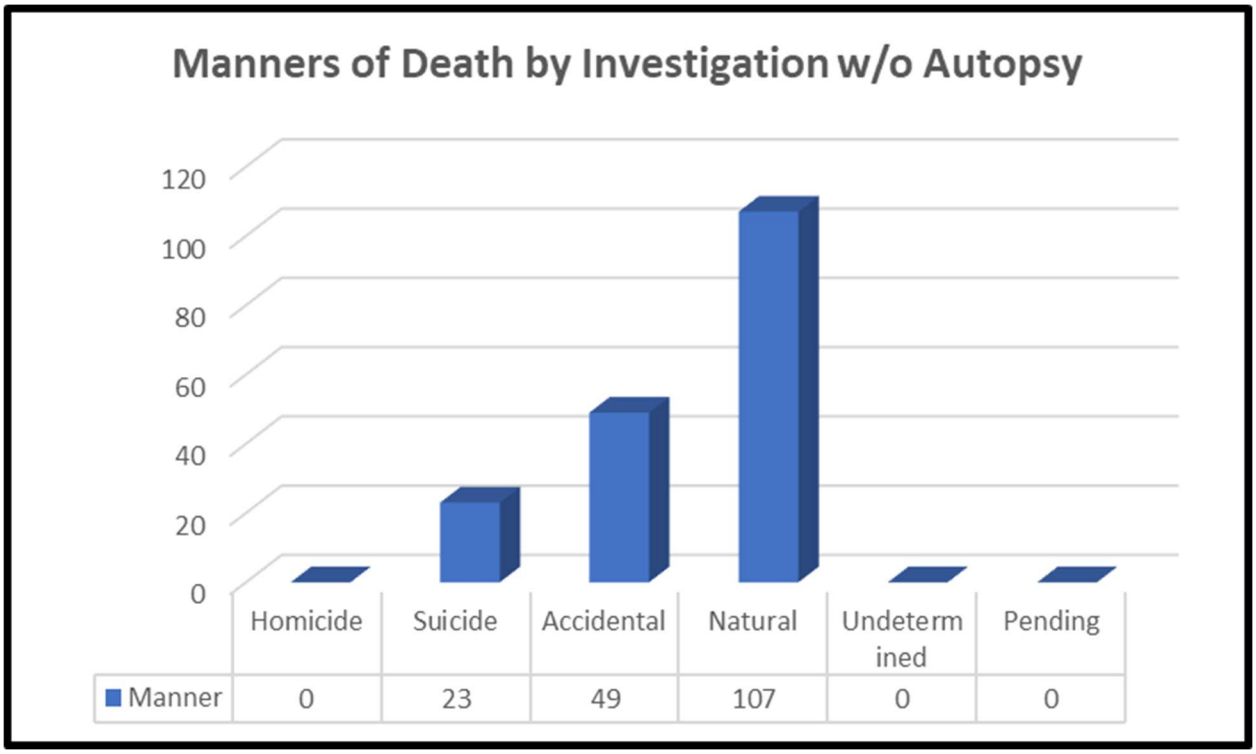
These changes can be attributed to investigator training and experience, drug activity within the area, suicides due to mental health issues, an aging population, and growth in the population within the area. The following pages provide data in the different causes and manners of death.

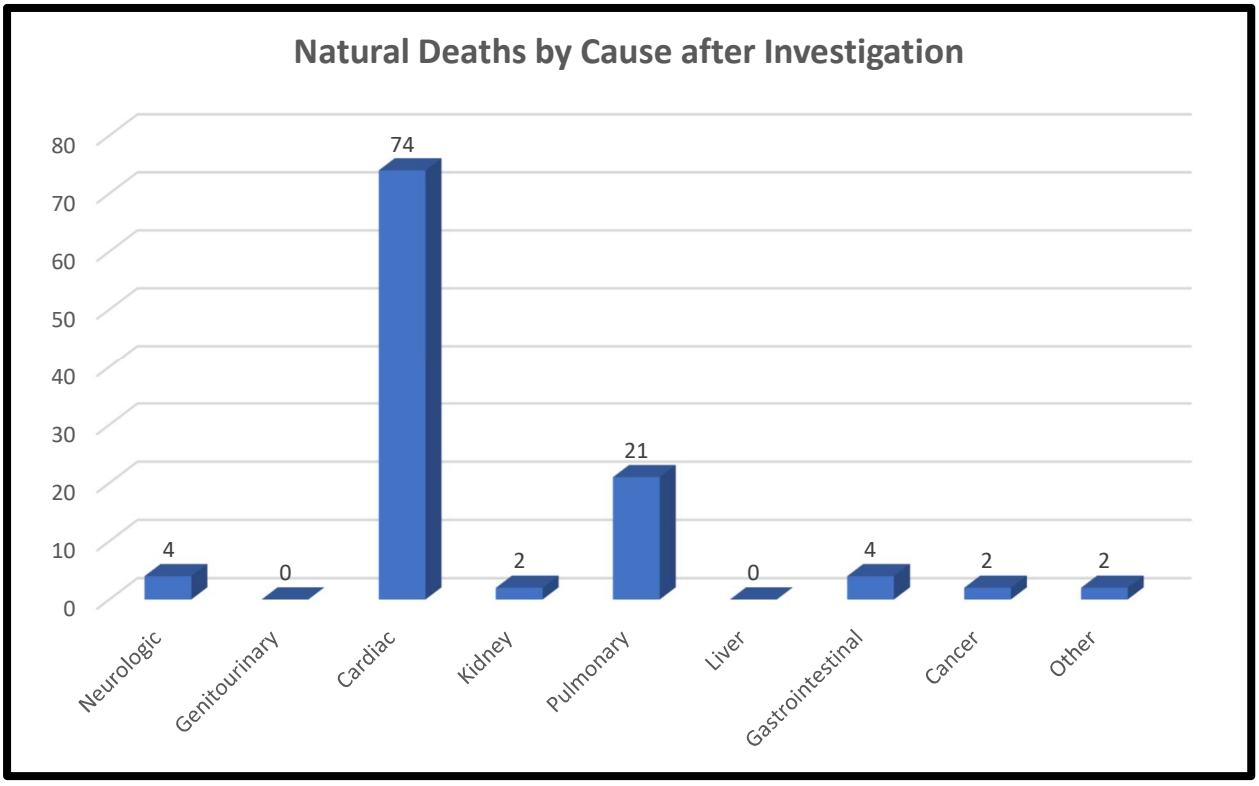

Total Cases
Total Cases
Accepted Jurisdiction
Administrative Reviews (Natural Death)
Linear (Total Cases)
80
70
60
50
40
30
20
10
0
70
56
54
50
50
58
51
58
62
64
46
56
50
42
41
41
38
39
32
41
42
42
27
40
20
14
13
9
12
19
19
17
20
22
19
16
January
February
March
April
May
June
July
August
September
October
November
December

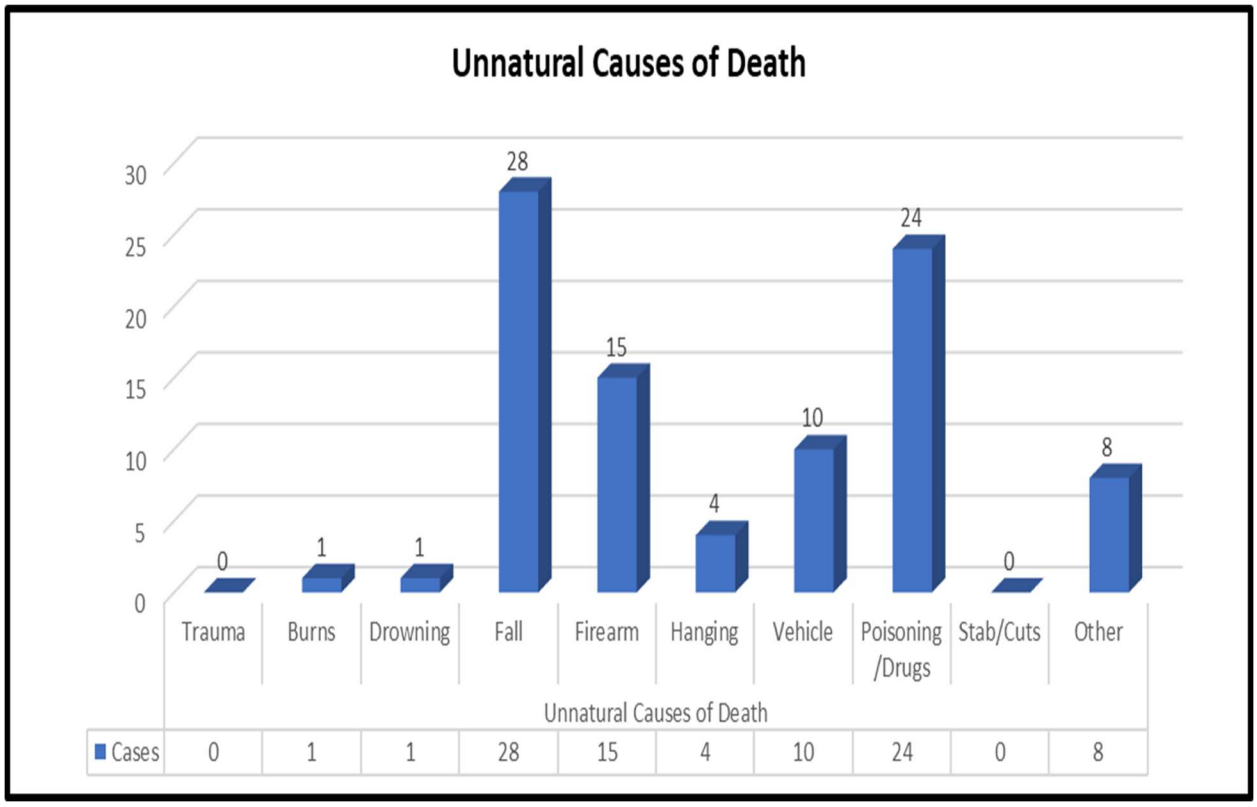

Manner of Death
600
500
400
300
200
100
0
Homicide
Suicide
Accidental
Natural
Undetermined
Pending
Manner
2
26
58
584
1
4

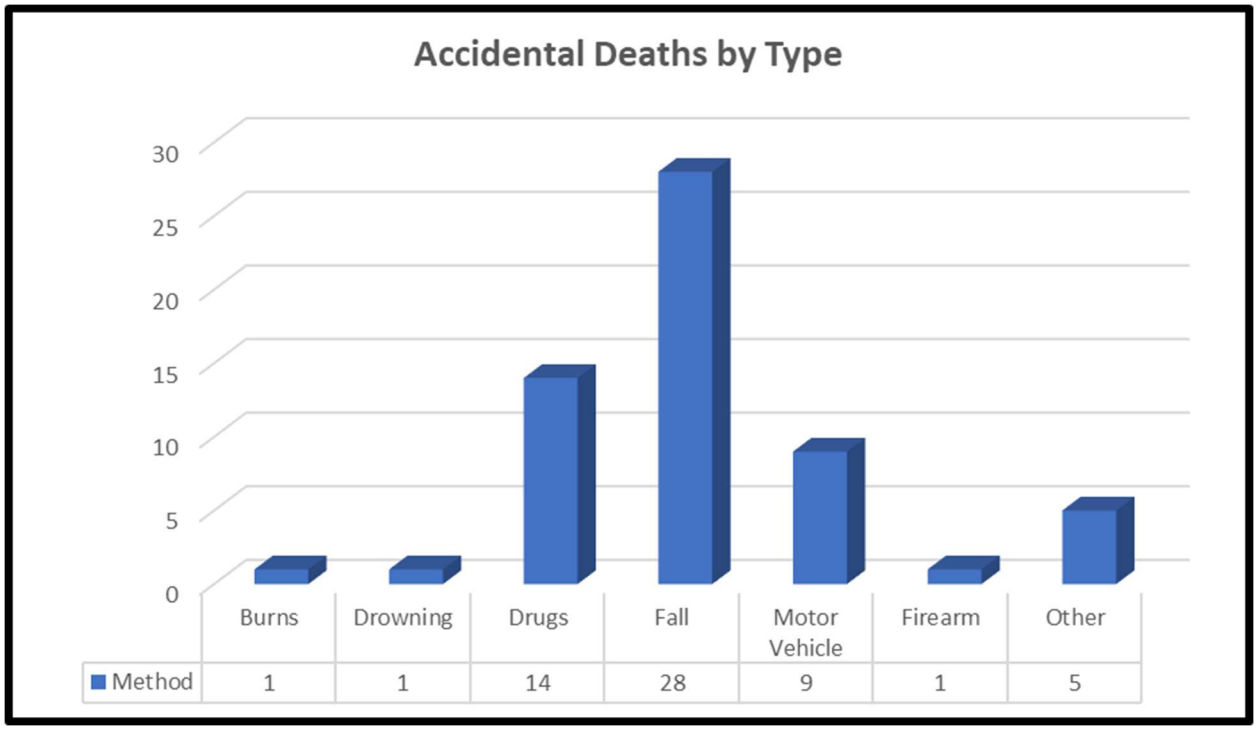

Manners of Death after Autopsy
9
8
7
6
5
4
3
2
1
0
Homicide
Suicide
Accidental
Natural
Undetermined
Pending
Manners of Death after Autopsy
Manner
2
3
9
2
1
4

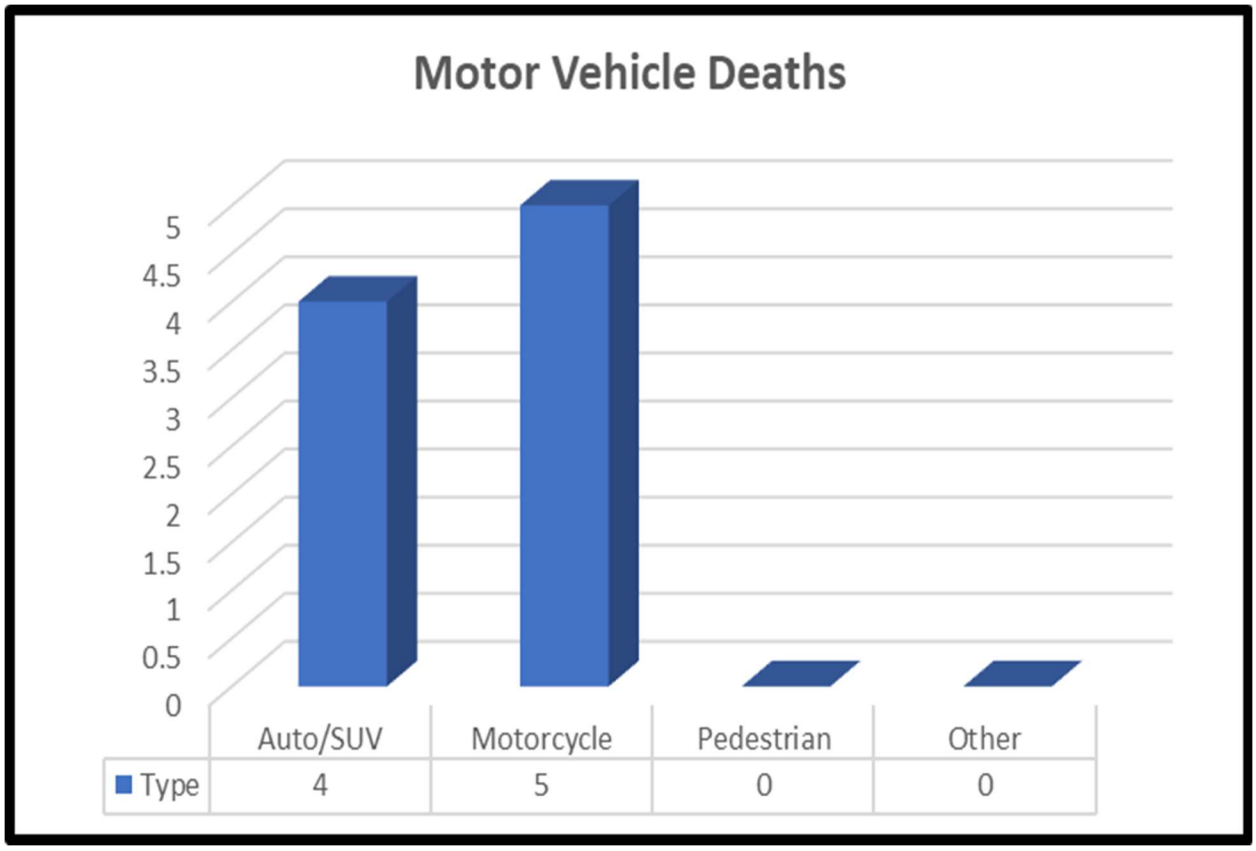

Age Group for Autopsy
10
9
8
7
6
5
4
3
2
1
0
<1
1-5
6-10
11-17
18-25
26-44
45-64
65+
Age
3
0
0
1
4
10
3
0

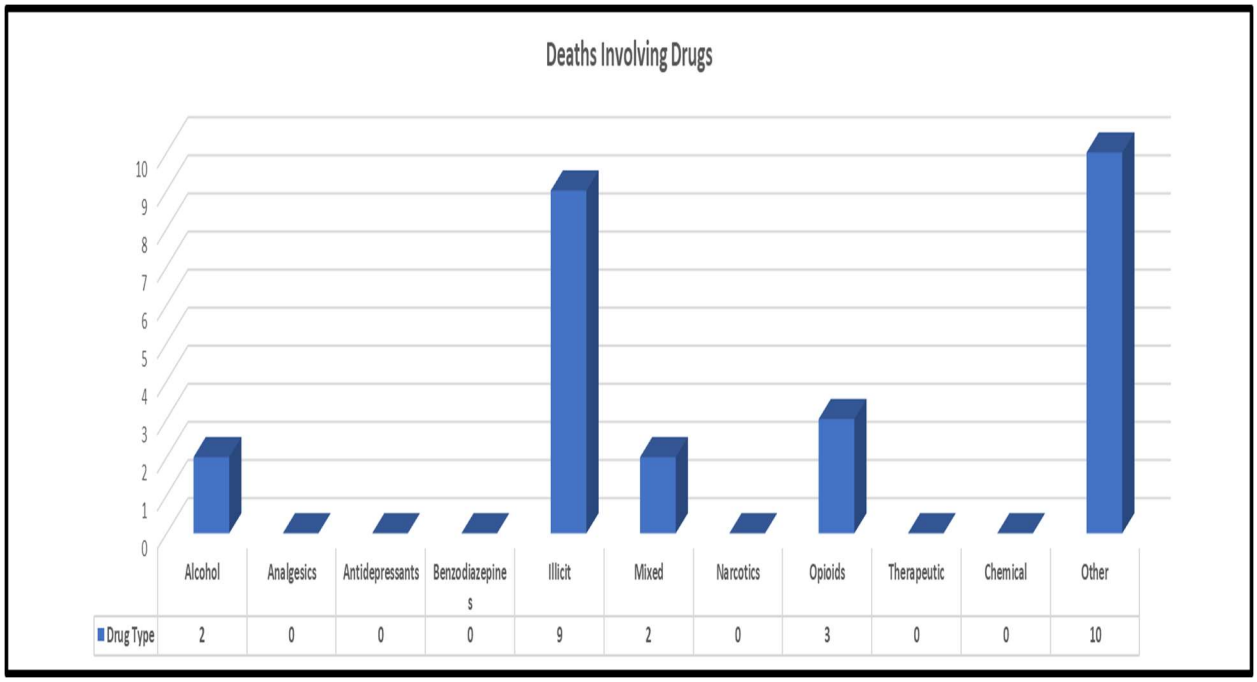

Manners of Death by Investigation w/o Autopsy
120
100
80
60
40
20
0
Homicide
Suicide
Accidental
Natural
Undetermined
Pending
Manner
0
23
49
107
0
0

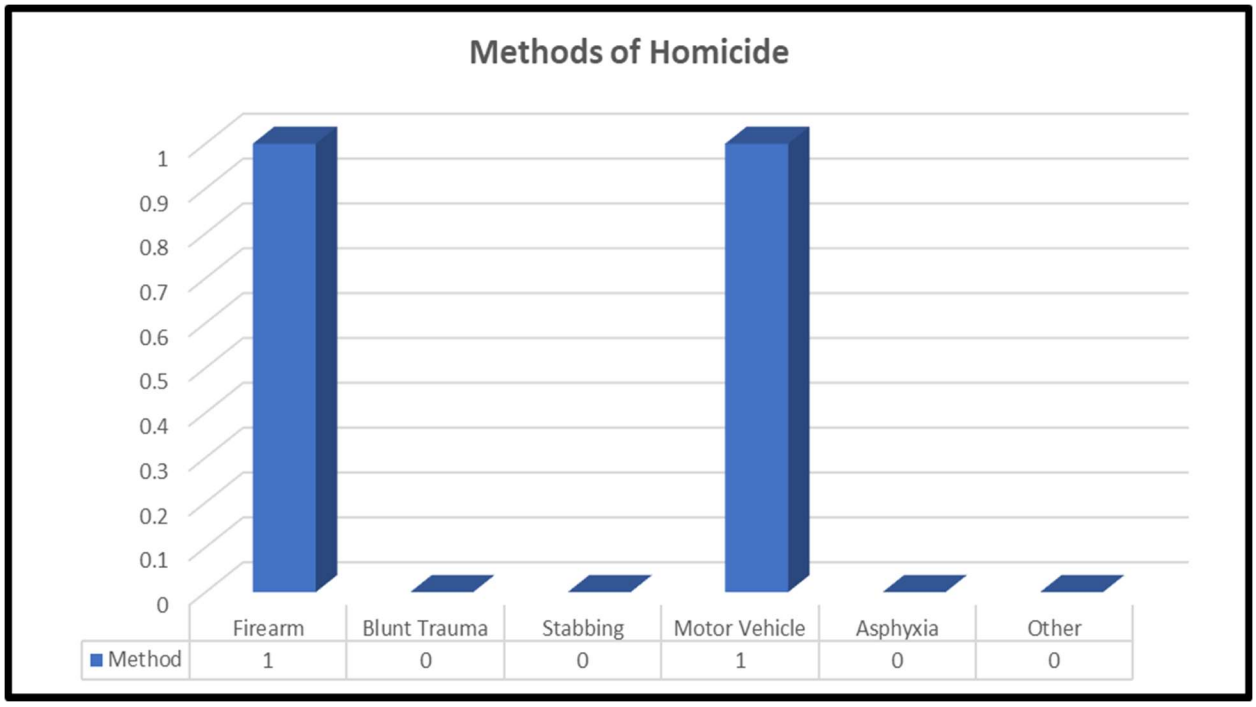

Natural Deaths by Cause after Investigation
80
70
60
50
40
30
20
10
0
4
0
74
2
21
0
4
2
2
Neurologic
Genitourinary
Cardiac
Kidney
Pulmonary
Liver
Gastrointestinal
Cancer
Other

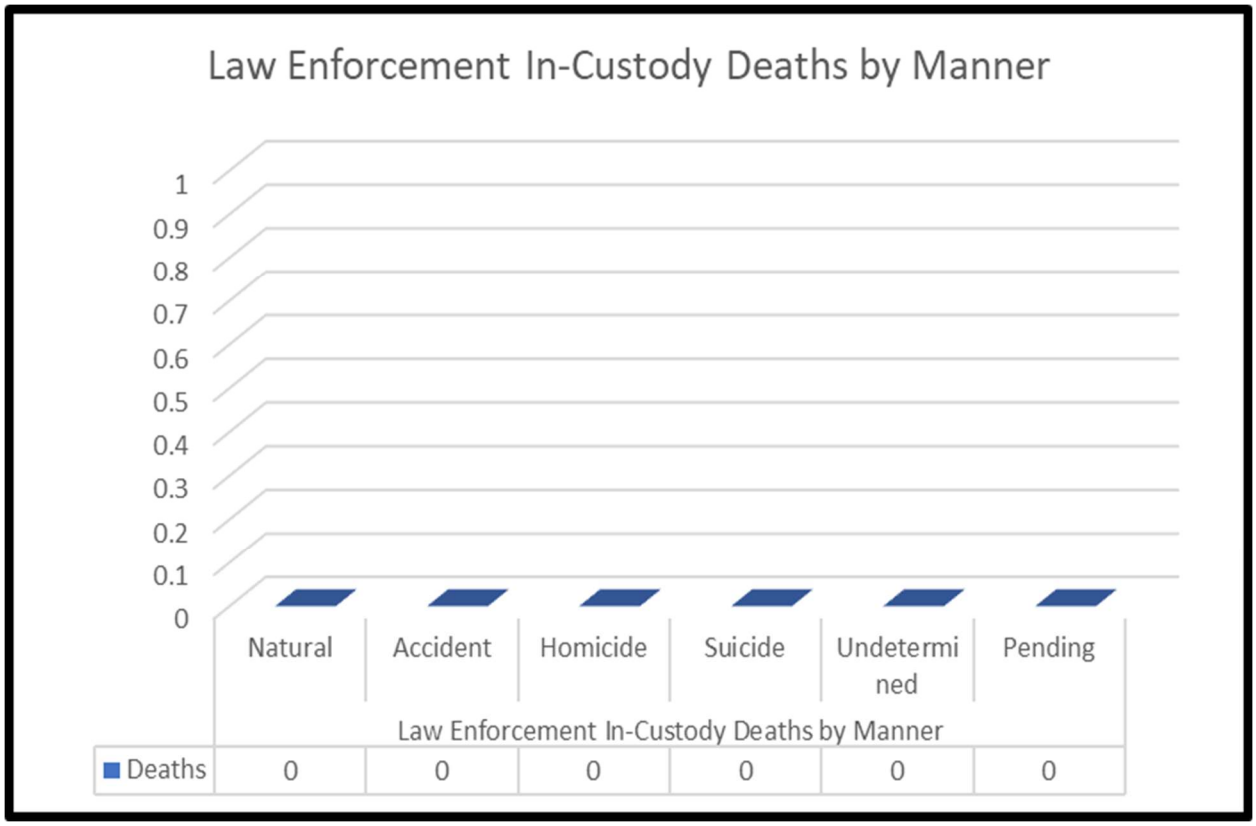

Unnatural Causes of Death
30
25
20
15
10
5
0
0
1
1
28
15
4
10
24
0
8
Trauma
Burns
Drowning
Fall
Firearm
Hanging
Vehicle
Poisoning /Drugs
Stab/Cuts
Other
Unnatural Causes of Death
Cases 0 1 1 28 15 4 10 24 0 8

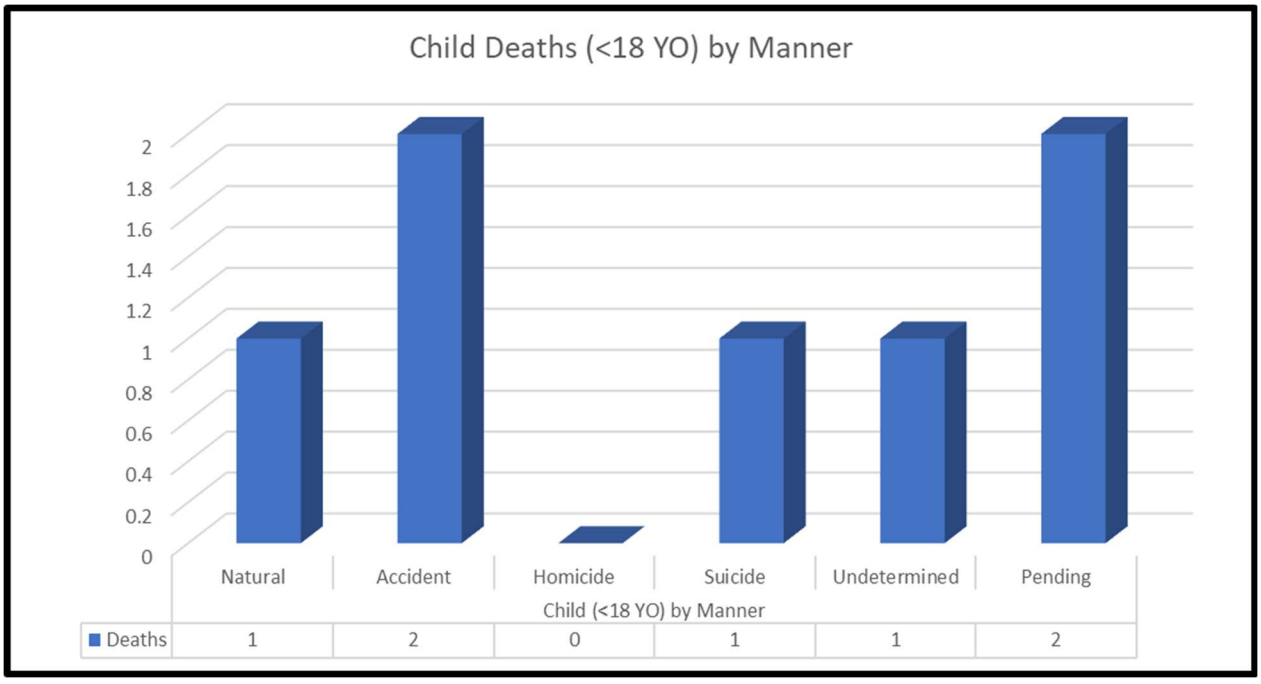

Accidental Deaths by Type
30
25
20
15
10
5
0
Burns
Drowning
Drugs
Fall
Motor Vehicle
Firearm
Other
Method 1 1 14 28 9 1 5

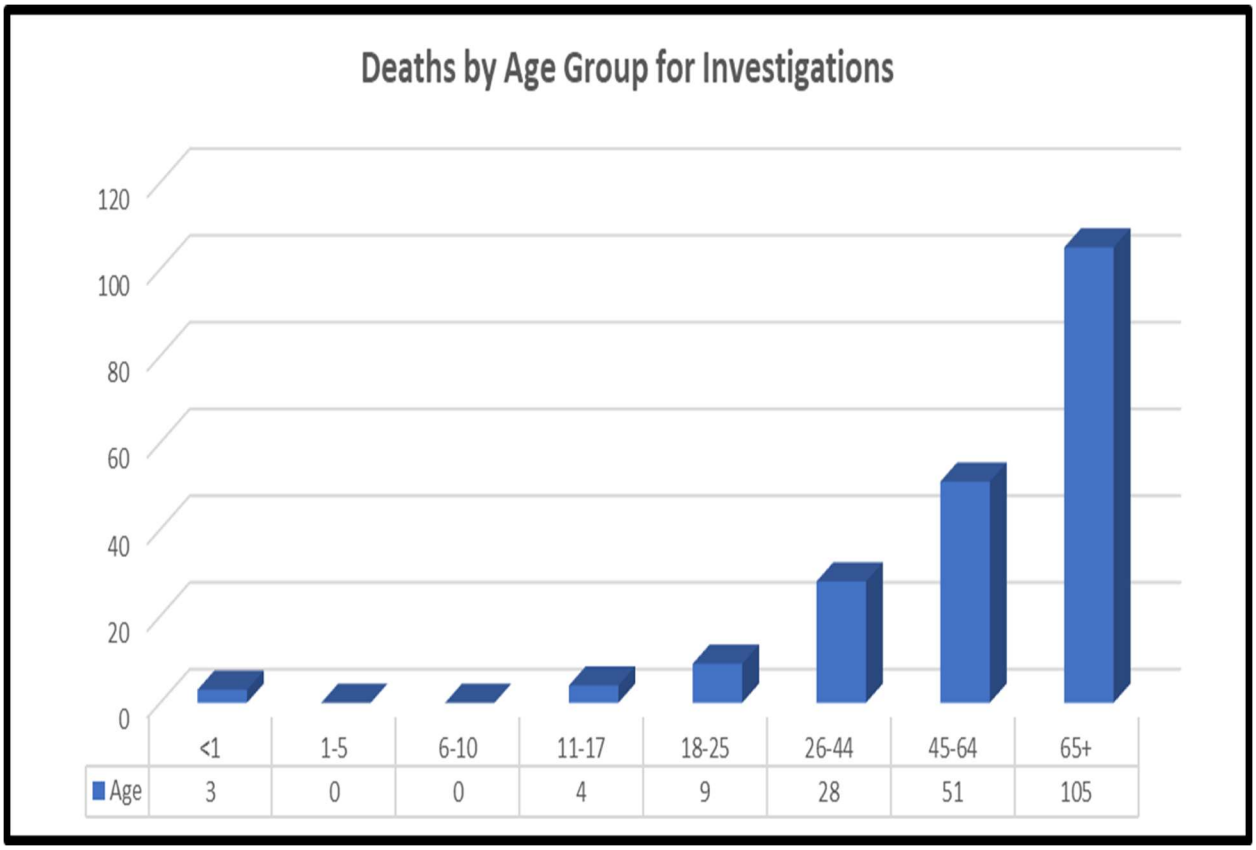

Motor Vehicle Deaths
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Auto/SUV
Motorcycle
Pedestrian
Other
Type
4
5
0
0


Deaths Involving Drugs
10
9
8
7
6
5
4
3
2
1
0
Alcohol
Analgesics
Antidepressants
Benzodiazepines
Illicit
Mixed
Narcotics
Opioids
Therapeutic
Chemical
Other
Drug Type
2
0
0
0
9
2
0
3
0
0
10


Methods of Homicide
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Firearm
Blunt Trauma
Stabbing
Motor Vehicle
Asphyxia
Other
Method
1
0
0
1
0
0


Law Enforcement In-Custody Deaths by Manner
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Natural
Accident
Homicide
Suicide
Undetermined
Pending
Law Enforcement In-Custody Deaths by Manner
Deaths
0
0
0
0
0
0


Child Deaths (<18 YO) by Manner
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Natural
Accident
Homicide
Suicide
Undetermined
Pending
Child (<18 YO) by Manner
Deaths
1
2
0
1
1
2


Deaths by Age Group for Investigations
120
100
80
60
40
20
0
<1
1-5
6-10
11-17
18-25
26-44
45-64
65+
Age
3
0
0
4
9
28
51
105

Idaho Department of Health & Welfare **2022** Annual Report for Bannock County's Profile

Live Births	Infant Deaths	Perinatal Deaths	Reported Deaths
1017 **Change from 2021** (8% Dec)	4 (20% Dec)	3 (40% Dec)	885 (5% Dec)

Cause of Death	***Total***	***% of all deaths***	***% of Change from 2021***
Heart Disease	146	16.5%	- 16.57 %
Malignant Neoplasms	149	16.84%	+ 31.86 %
Accident	60	6.78%	+ 11.11 %
Chronic Lower Respiratory Diseases	52	5.88%	- 7.14 %
Alzheimer's Disease	49	5.42%	- 7.55 %
Covid-19	40	4.52%	-68.50 %
Cerebrovascular Diseases	42	4.75%	- 6.67 %
Diabetes Mellitus	23	2.60%	-28.13 %
Suicide	31	3.50%	+ 29.17 %
Chronic Liver Disease and Cirrhosis	26	2.94%	+ 23.81%
Parkinson's Disease	13	1.47%	+ 116.67 %
All other causes	254	28.70%	+ 7.63 %

Age at Death

<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
4	0	2	12	24	43	48	114	170	245	223

Leading Causes of Mortality

Total Deaths	Diseases of Heart	Malignant Neoplasms	Accident	Chronic Lower Respiratory Diseases	Alzheimer's Disease
885	146	149	60	52	49