# Bannock County Coroner

## 2023 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 the death of a child that occur 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 on 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 is 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 pathologist, 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

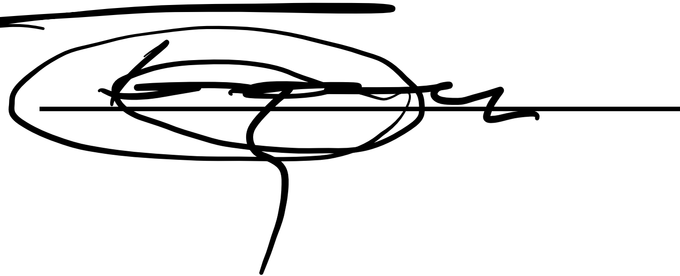
and assist them by providing appropriate answers regarding the circumstances of the death.

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 country.

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

- Develop a strong foundation that can sustain evolution and growth to meet the needs of the office.
- Finalize the accreditation process to become an accredited office by the International Association of Coroners and Medical Examiners (IACME).
- Complete a policy and procedure manual that covers all the requirements of the IACME requirements.
- Implement an executable plan for a secure morgue/inspection facility belonging to Bannock County to provide for self-sufficient operations.

# 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.

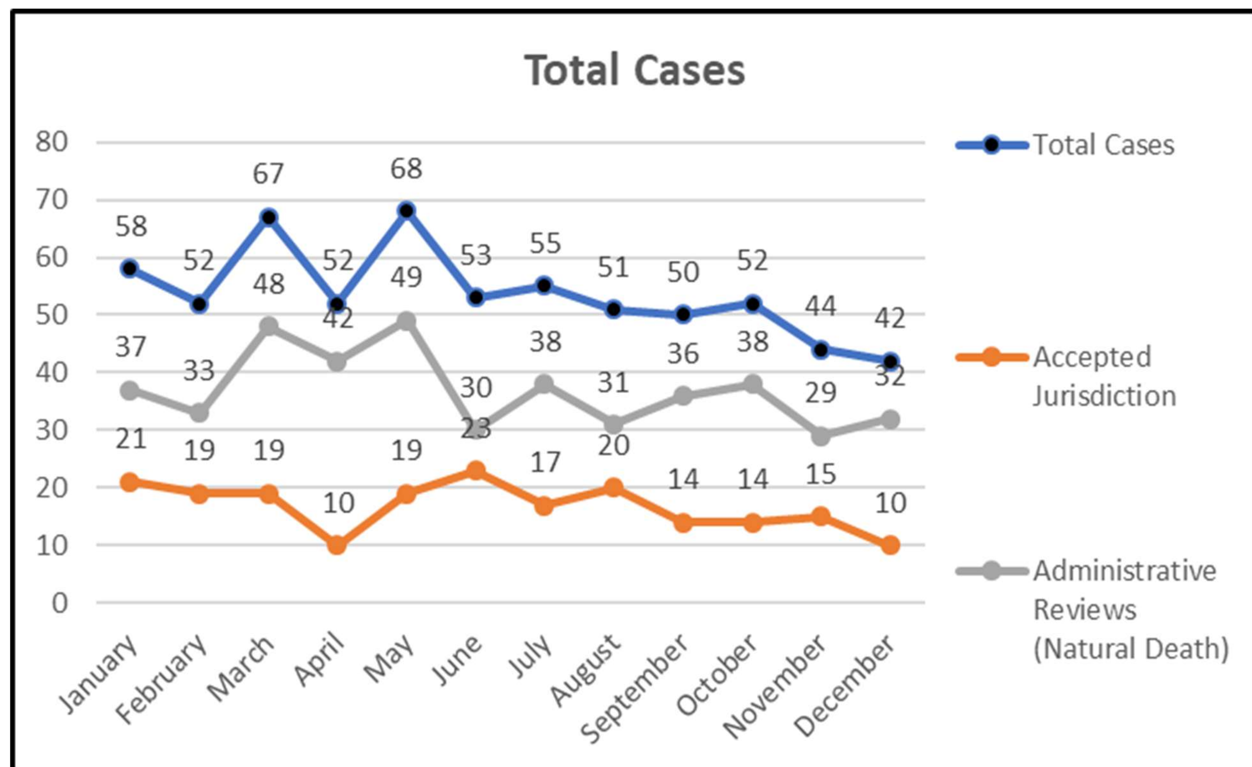
(5) Nothing in this section shall be construed to affect the tenets of any church or religious belief.

# Bannock County Coroner Cases for 2023

with comparison to 2022

Population (Census Estimation July 1, 2022) 89,517

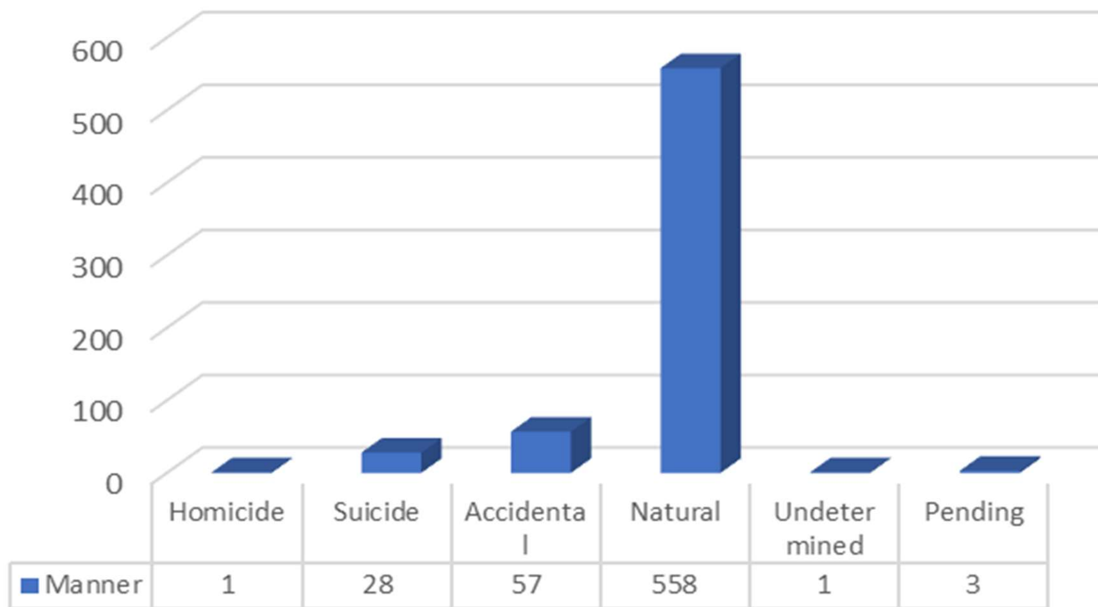
| | 2022 | 2023 | Difference |
|---|---|---|---|
| Cases Reported to Coroner | 653 | 644 | (-1.38 %) |
| Number of deaths requiring Full Autopsy (including toxicology) | 24 | 30 | + 25.00 % |
| Number of cases accepted jurisdiction | 220 | 200 | (- 9.09 %) |
| Number or External Examinations of a Decedent | 196 | 190 | (- 3.06 %) |
| Number of cases receiving scene investigations | 193 | 191 | (- 1.04 %) |
| Number of cases reviewed w/o accepted jurisdiction | 434 | 444 | + 2.30 % |
| Number of bodies transported by the office | 24 | 30 | + 25.00 % |
| Number of cases with only toxicology | 32 | 44 | + 37.50 % |
| Number of Unidentified bodies | 0 | 0 | No Change |
| Number of Exhumations | 1 | 0 | - 100.00% |
| Number of Donor Referrals | 0 | 11 | >100 % |
| Number of Procurements completed by Referral | - | 7 | >100 % |
| Number of Unclaimed Decedents | 4 | 5 | + 25.00% |
| Number of Cremations Approved | 517 | 570 | + 10.25 % |
| Number of Death Notifications conducted | 15 | 24 | + 60.00 % |

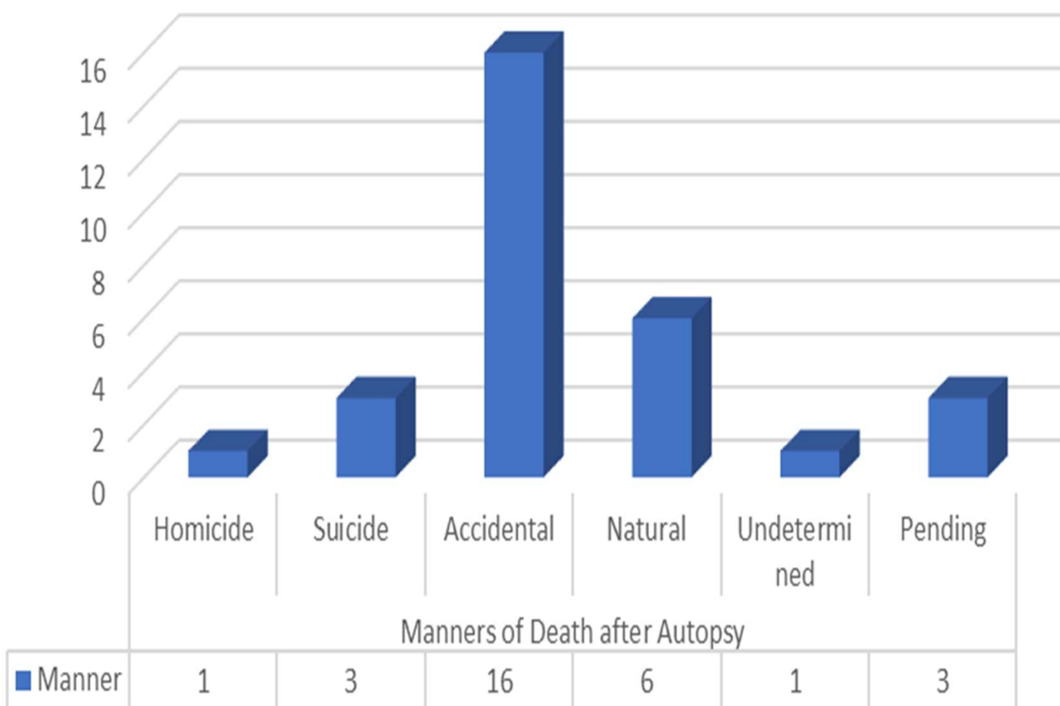


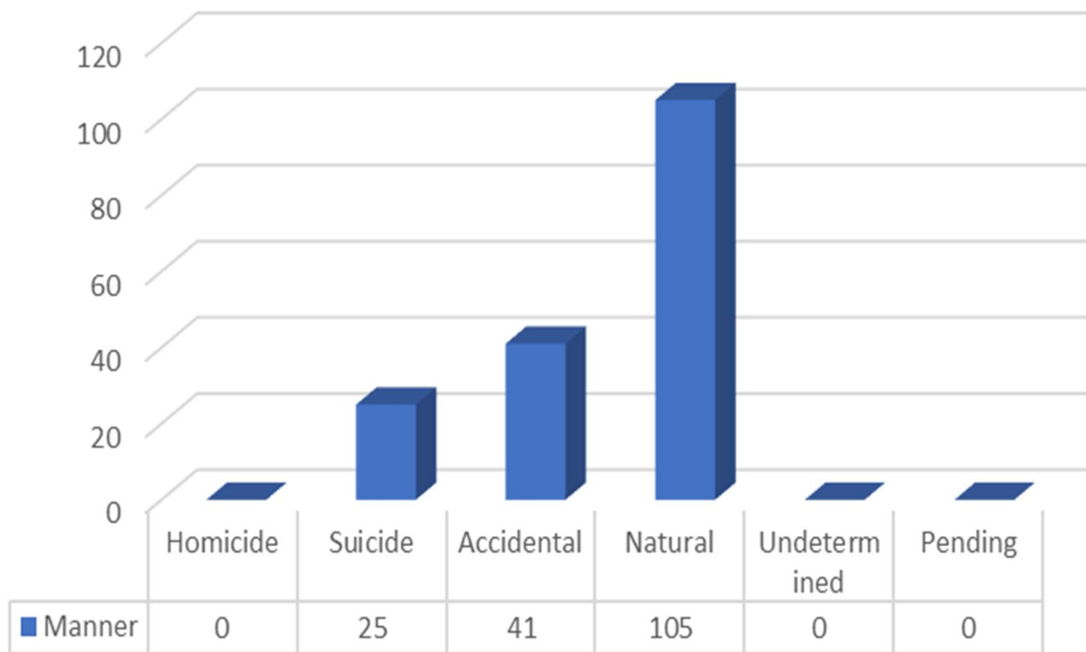
**Summary of 2023**

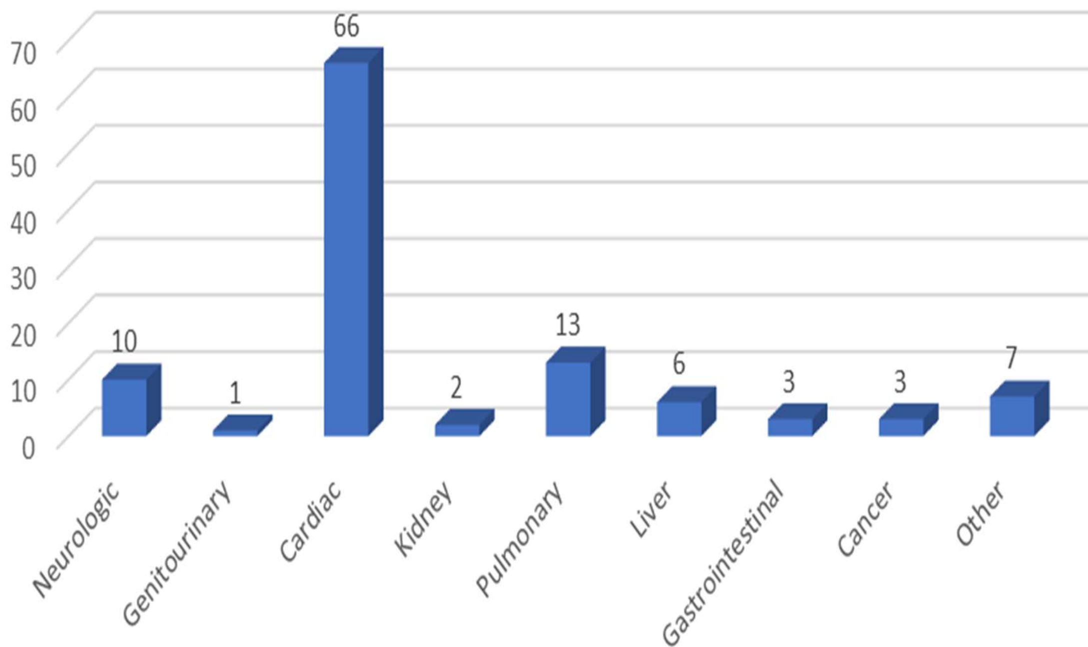
In 2023, Bannock County had increases in completed autopsies and cases receiving only toxicology testing. Not all cases reported to the Coroner receive scene investigations. Cases can be reported to the Coroner due to Idaho Statute, or hospital policy, which requires notification of the Coroner if an individual died in the hospital within 24 hours of admittance, the cause of death 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 2023, there was a total of 644 cases reported to the Coroner's Office. From those, 444 cases required a review, and jurisdiction was declined. Of the 200 cases under the Coroner's Jurisdiction, 46.5% of the calls came outside the office hours of 9 am to 5 pm, 23% of the calls occurred on the weekend, and 3% of the calls included calls that happened while on scene or responding to another call at the same time. The Median response time from notification of the Coroner to arriving on scene was 26 minutes. The Median on-scene time was 1 hour and 21 minutes. Forty-four (44) of the cases were determined to require toxicology testing, and thirty (30) cases required full autopsies. Both categories had a 25% or greater increase from the previous year.

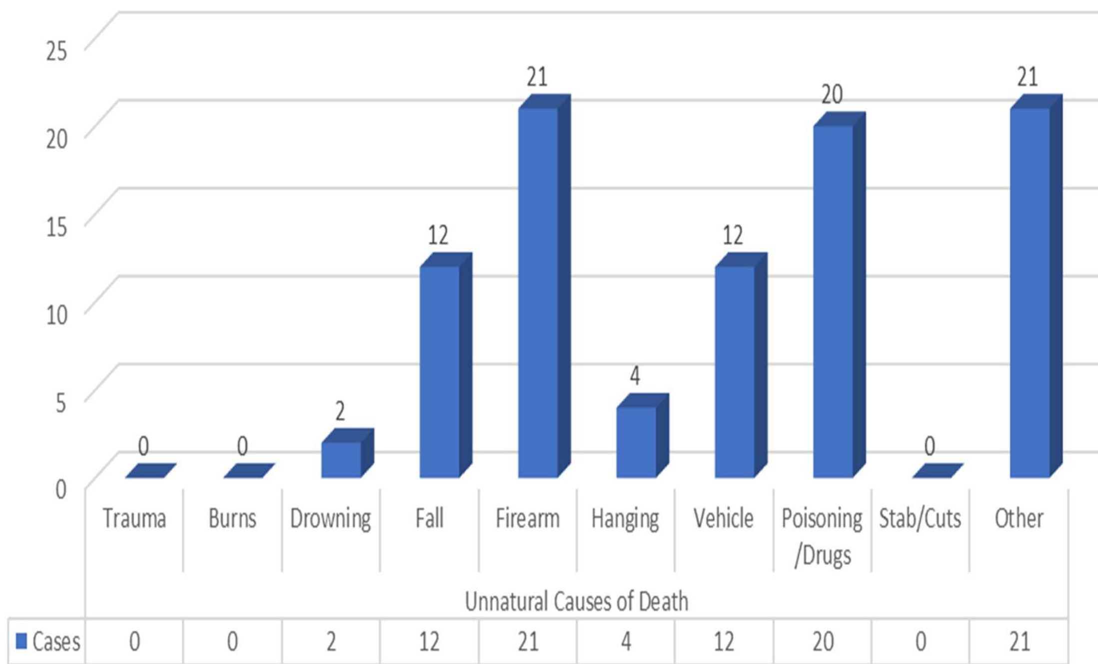
These increases can be attributed to drug activity within the area, suicides due to mental health issues, an aging population, and growth in the population within the area. The following pages provide data on the different manners and causes of death.


Manner of Death
600
500
400
300
200
100
0
Homicide
Suicide
Accidenta
l
Natural
Undeter
mined
Pending
Manner
1
28
57
558
1
3

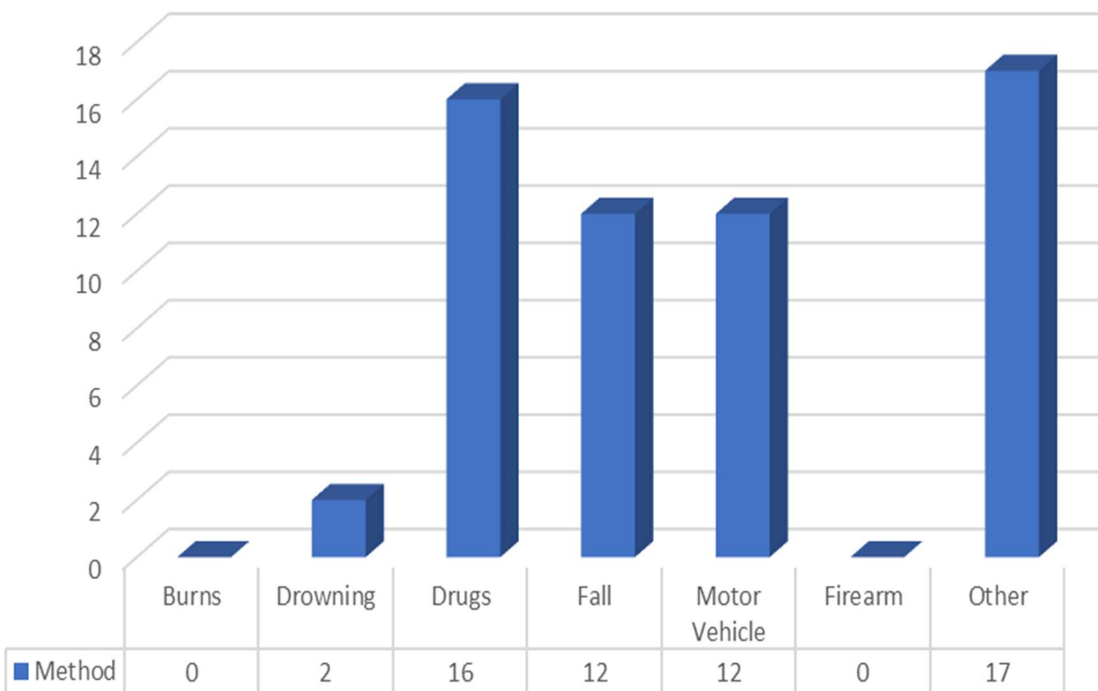

Manners of Death after Autopsy
16
14
12
10
8
6
4
2
0
Homicide
Suicide
Accidental
Natural
Undetermi
ned
Pending
Manners of Death after Autopsy
Manner
1
3
16
6
1
3


Manners of Death by Investigation w/o Autopsy
120
100
80
60
40
20
0
Homicide
Suicide
Accidental
Natural
Undetermined
Pending
Manner
0
25
41
105
0
0

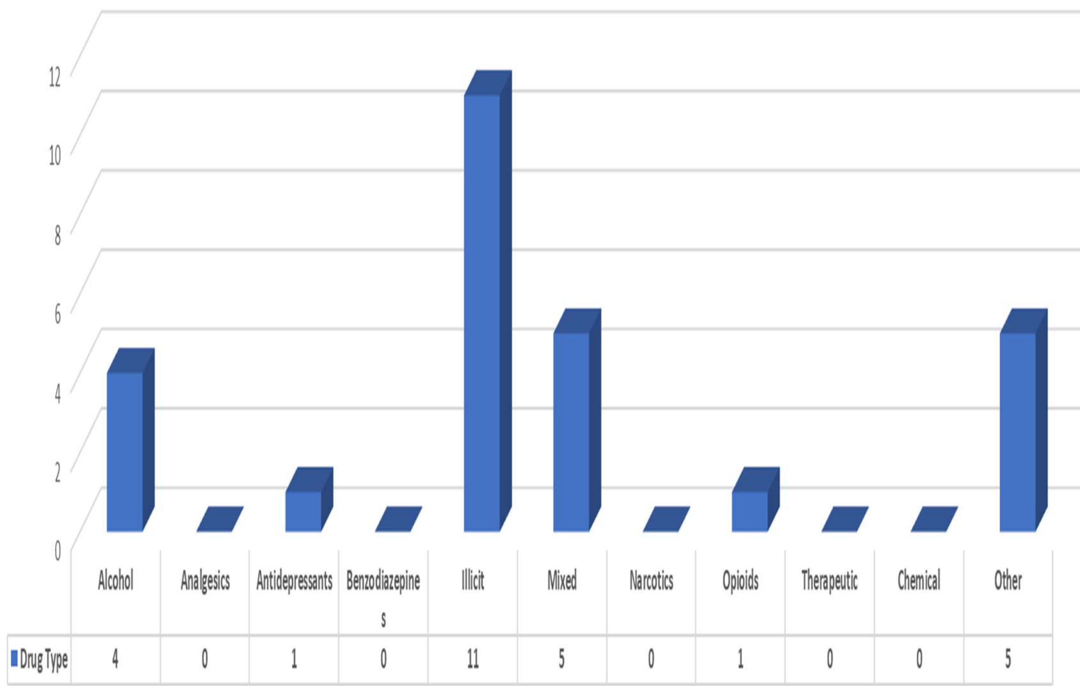

Natural Deaths by Cause after Investigation
70
60
50
40
30
20
10
0
10
1
66
2
13
6
3
3
7
Neurologic
Genitourinary
Cardiac
Kidney
Pulmonary
Liver
Gastrointestinal
Cancer
Other

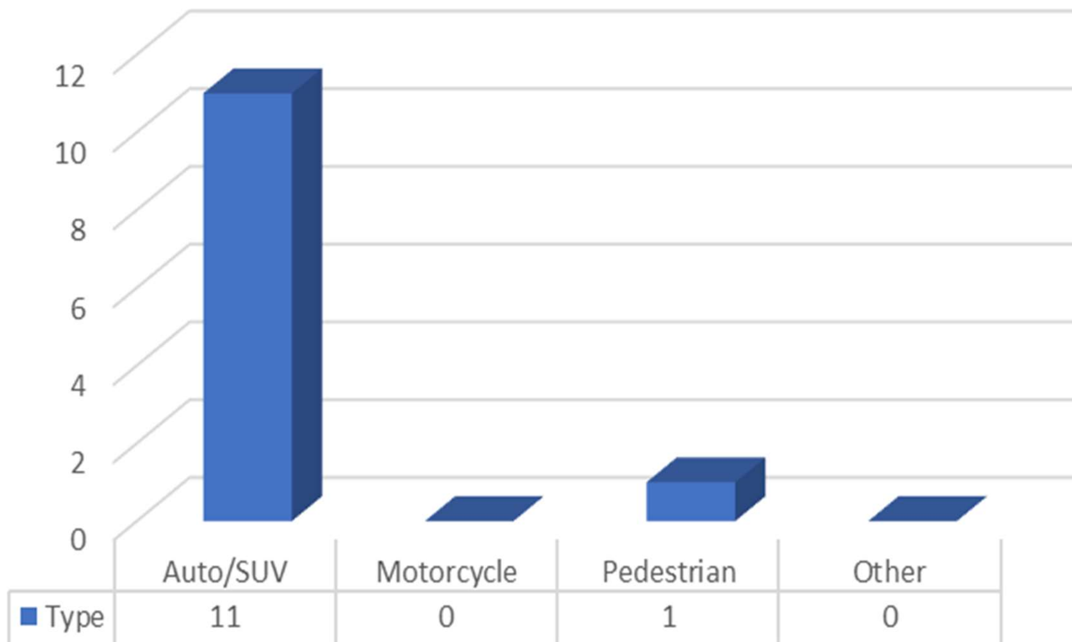


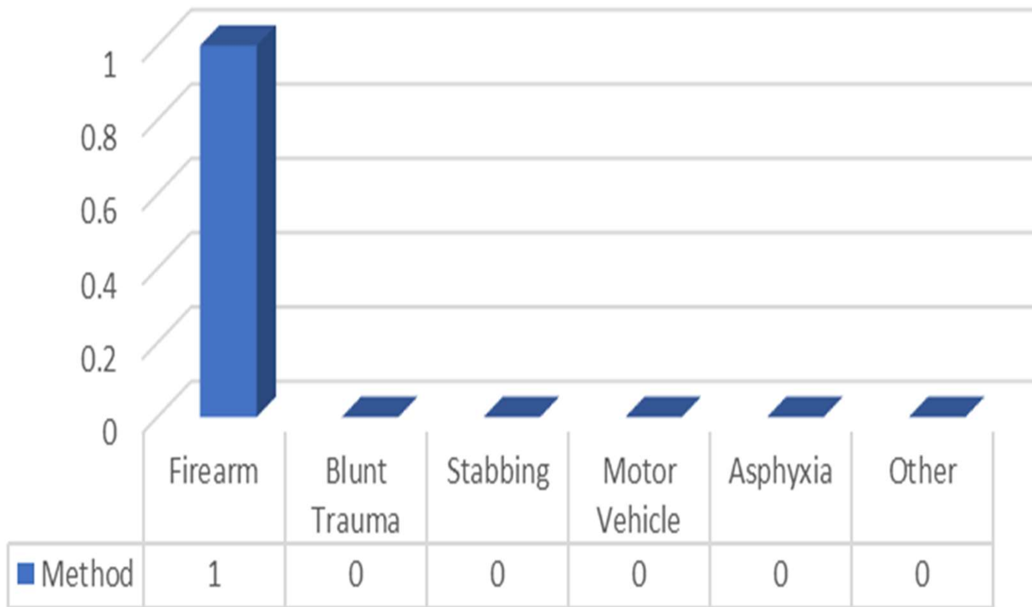

| | Trauma | Burns | Drowning | Fall | Firearm | Hanging | Vehicle | Poisoning /Drugs | Stab/Cuts | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| Cases | 0 | 0 | 2 | 12 | 21 | 4 | 12 | 20 | 0 | 21 |

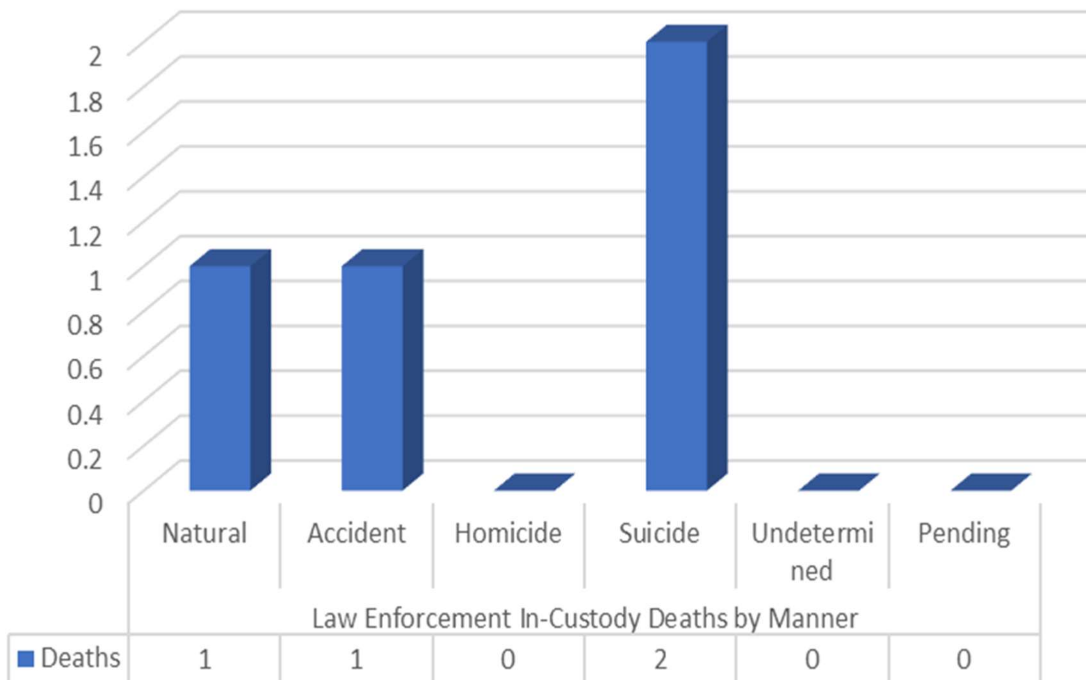


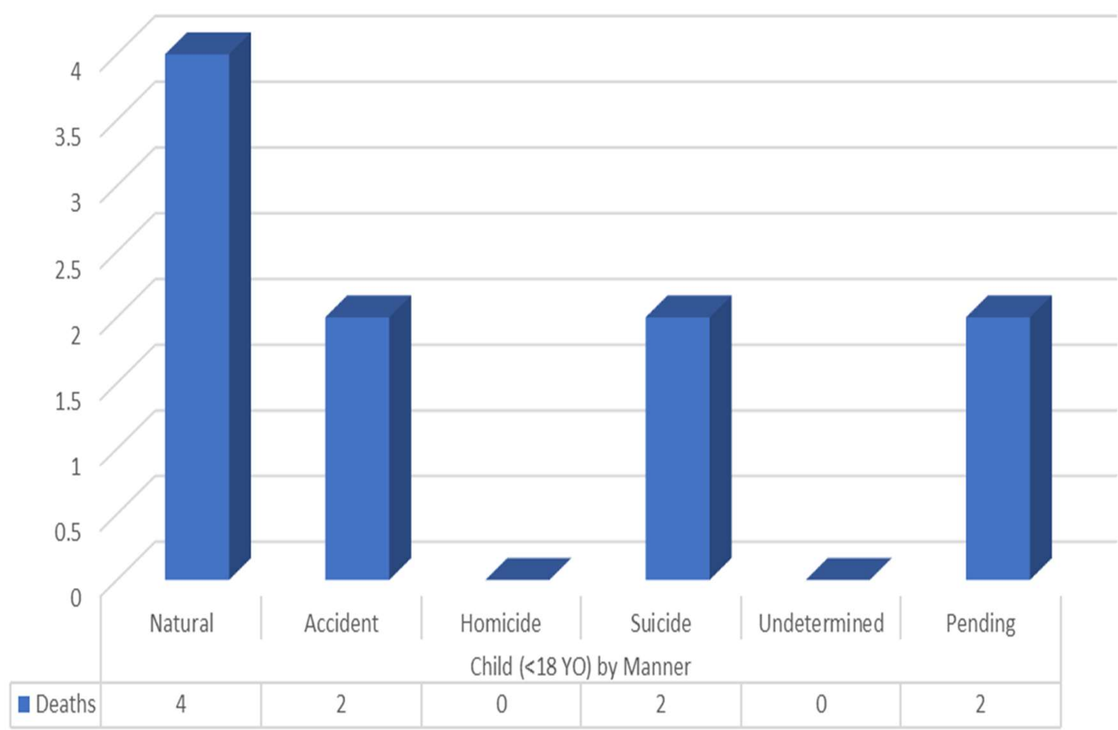

| | Burns | Drowning | Drugs | Fall | Motor Vehicle | Firearm | Other |
|---|---|---|---|---|---|---|---|
| Method | 0 | 2 | 16 | 12 | 12 | 0 | 17 |

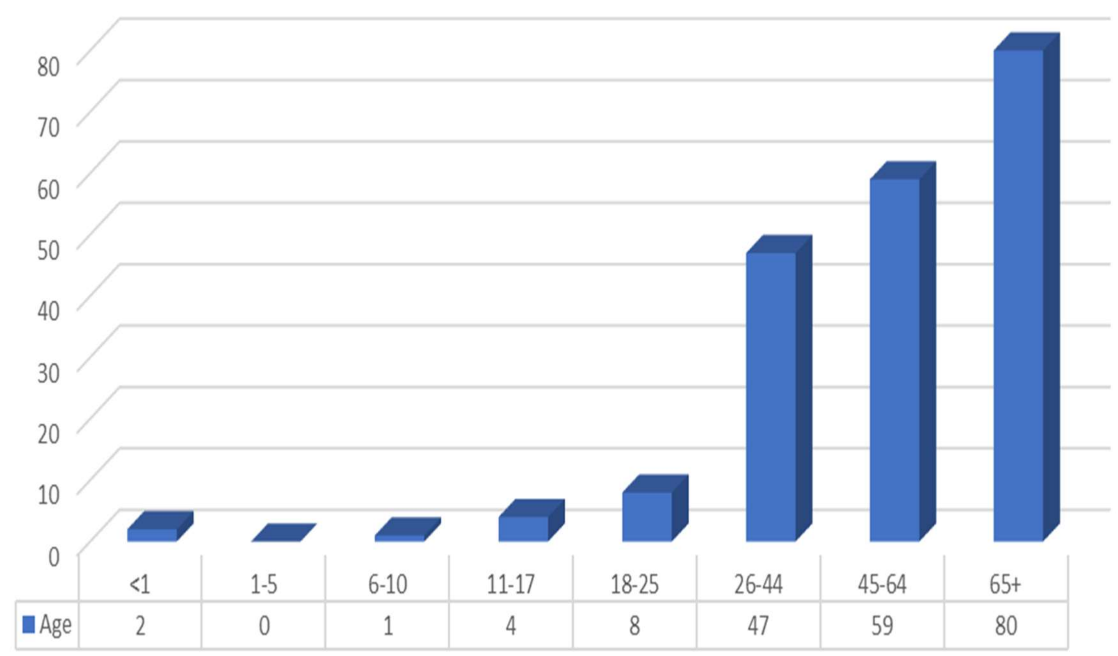

Deaths Involving Drugs
12
10
8
6
4
2
0
Alcohol
Analgesics
Antidepressants
Benzodiazepines
Illicit
Mixed
Narcotics
Opioids
Therapeutic
Chemical
Other
Drug Type
4
0
1
0
11
5
0
1
0
0
5


Motor Vehicle Deaths
12
10
8
6
4
2
0
Auto/SUV
Motorcycle
Pedestrian
Other
Type
11
0
1
0


Methods of Homicide
1
0.8
0.6
0.4
0.2
0
Firearm
Blunt Trauma
Stabbing
Motor Vehicle
Asphyxia
Other
Method
1
0
0
0
0
0


Law Enforcement In-Custody Deaths 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
Undetermi ned
Pending
Law Enforcement In-Custody Deaths by Manner
Deaths
1
1
0
2
0
0


Child Deaths (<18 YO) by Manner
4
3.5
3
2.5
2
1.5
1
0.5
0
Natural
Accident
Homicide
Suicide
Undetermined
Pending
Child (<18 YO) by Manner
Deaths
4
2
0
2
0
2


Deaths by Age Group for Investigations
80
70
60
50
40
30
20
10
0
<1
1-5
6-10
11-17
18-25
26-44
45-64
65+
Age
2
0
1
4
8
47
59
80

| Idaho Department of Health & Welfare **2022** Annual Report for Bannock County's Profile | | | | | | |
|---|---|---|---|---|---|---|
| Live Births | Infant Deaths | Perinatal Deaths | Reported Deaths | | | |
| 1017<br>**Change from 2021** (8% Dec) | 4<br>(20% Dec) | 3<br>(40% Dec) | 885<br>(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 % |