Bannock County Coroner

2025 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 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 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.

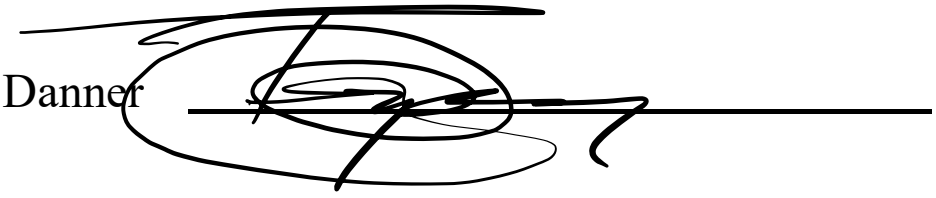
For the first time in Bannock County, the staff of the Bannock County Coroner's Office have been certified with the American Board of Medicolegal Death Investigators (ABMDI). With the skill and experience of the ABMDI-certified death investigators and board-certified forensic pathologists working within 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 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.*

Ada County Forensic Pathology

Richard Riffle
Coroner

Brett Harding
Chief Deputy Coroner

Christina Di Loreto
Forensic Pathologist

Garth Warren
Forensic Pathologist

Wai Szeto
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 to order an autopsy at any time it is deemed necessary to determine or confirm the cause and manner of death.

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 is a suspected homicide, suicide, or occurring under suspicious or unknown circumstances;

(b) The death appears to be accidental or following an injury;

(c) The death was a result of suspected unlawful use of controlled substances or the use or abuse of chemicals or toxic agents;

(d) The death occurred while the person was incarcerated in any jail or correctional facility or the person was a ward of the state;

(e) The death appears to be by disease, injury, or toxic agent during or arising from employment;

(f) The death was an unattended death that occurred outside of a physician's current care or hospice care;

(g) The remains of the deceased are scientifically or visually unidentifiable due to the remains being skeletal or charred;

(h) The person was admitted to a hospital emergency room unconscious and unresponsive, with or without cardiopulmonary resuscitative measures being performed, and died within twenty-four (24) hours of admission without regaining consciousness or responsiveness, unless a physician was in attendance within thirty-six (36) hours preceding presentation to the

hospital, or, in cases in which the decedent had a pre-diagnosed terminal or bedfast condition, a physician was in attendance within thirty (30) days preceding presentation to the hospital;

(i) The death may constitute a threat to public health; or

(j) The death is of a child if there is a reasonable articulable suspicion to believe that the death occurred without a known medical disease to account for the 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 shall perform a medicolegal death investigation working with 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 criminal investigation shall be the responsibility of the appropriate law enforcement agency. The medicolegal death investigation shall be the responsibility of the coroner. Upon completion of the criminal 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, and the coroner's medicolegal death investigation report shall be given to the law enforcement agency responsible.

(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 2025

with comparison to 2023 and 3-year average

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

	2024	2025	Inc/Dec	3-yr Avg
Cases Reported to Coroner	**675**	**645**	**-4.44%**	**655**
Number of deaths requiring Full Autopsy (including toxicology)	**21**	**39**	**77.27%**	**31**
Number of deaths requiring External Autopsy	**1**	**0**	**-100.00%**	**0**
Number of cases accepted jurisdiction	**200**	**187**	**-6.50%**	**196**
Number or External Examinations of a Decedent	**184**	**181**	**-1.63%**	**185**
Number of cases receiving scene investigations	**198**	**185**	**-6.57%**	**191**
Number of cases reviewed w/o accepted jurisdiction	**475**	**458**	**-3.58%**	**459**
Number of bodies transported by the office	**29**	**44**	**51.72%**	**34**
Number of cases with only toxicology	**50**	**41**	**-18.00%**	**45**
Number of Unidentified bodies	**0**	**0**	**No Change**	**0**
Number of Exhumations	**0**	**0**	**No Change**	**0**
Number of Donor Referrals	**33**	**26**	**-21.21%**	**23**
Number of Procurements completed by Referral	**3**	**2**	**-33.33%**	**4**
Number of Unclaimed Decedents	**1**	**13**	**1200.00%**	**6**
Number of Cremations Approved	**568**	**574**	**1.06%**	**571**
Number of Death Notifications conducted	**18**	**26**	**44.44%**	**23**

Autopsies by Month

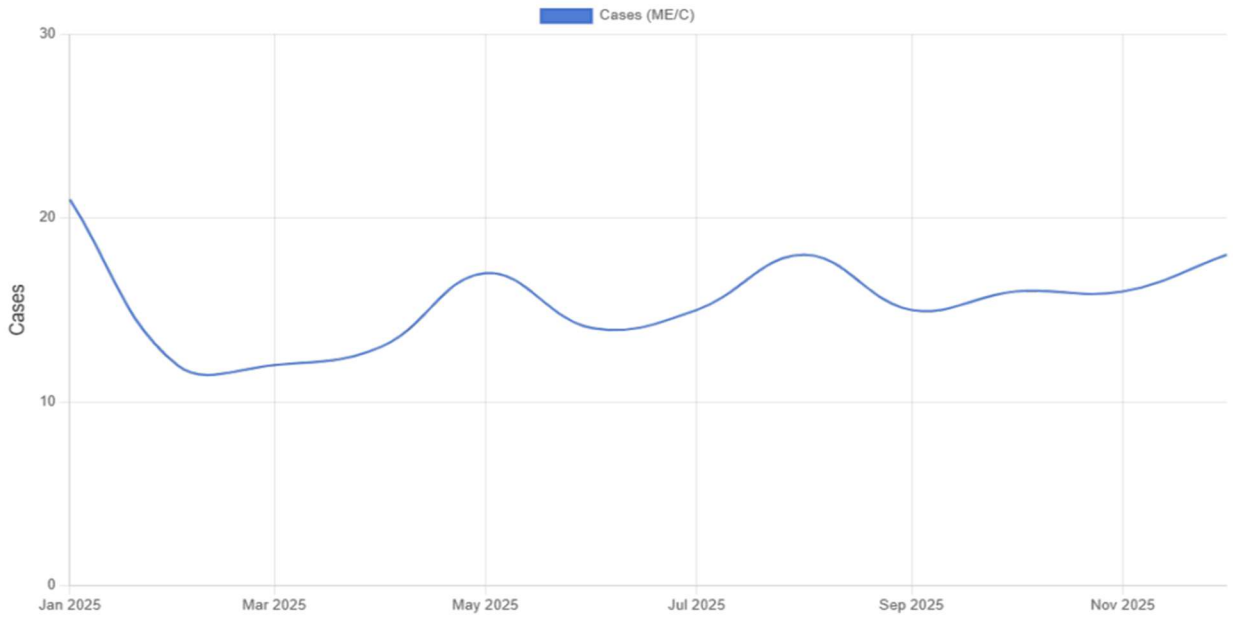
January	February	March	April	May	June
7	0	1	2	2	2
July	**August**	**September**	**October**	**November**	**December**
1	5	4	6	5	4

Summary of 2025

In 2025, Bannock County saw increases in autopsies and a decrease in cases receiving only toxicology testing. Not all cases reported to the Coroner receive scene investigations. Cases can be reported to the Coroner under Idaho Statute or hospital policy, which requires notification of the Coroner if an individual dies in the hospital within 24 hours of admission, the cause of death is certified by a doctor, requires further review, or a cremation authorization is needed. These cases are considered for jurisdiction and either denied or accepted. In 2025, there was a total of 645 cases reported to the Coroner's Office. Out of those, 458 cases required a Coroner Review. Of the 187 cases under the Coroner's Jurisdiction, 40.64% (27% decrease from 2024) of the calls came outside the office hours of 9 am to 5 pm, 29% (23% increase of 2024) of the calls occurred on the weekend, and 6% (33% decrease of 2024) 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 19 minutes. Forty-one (41) of the cases were determined to require toxicology testing, and thirty-nine (39) cases required full autopsies. Toxicology testing decreased by 18%, while autopsies increased by 77%. Each case is thoroughly investigated, which is essential for the medicolegal death investigator to determine the cause and manner of death.

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 on the different causes and manners of death.

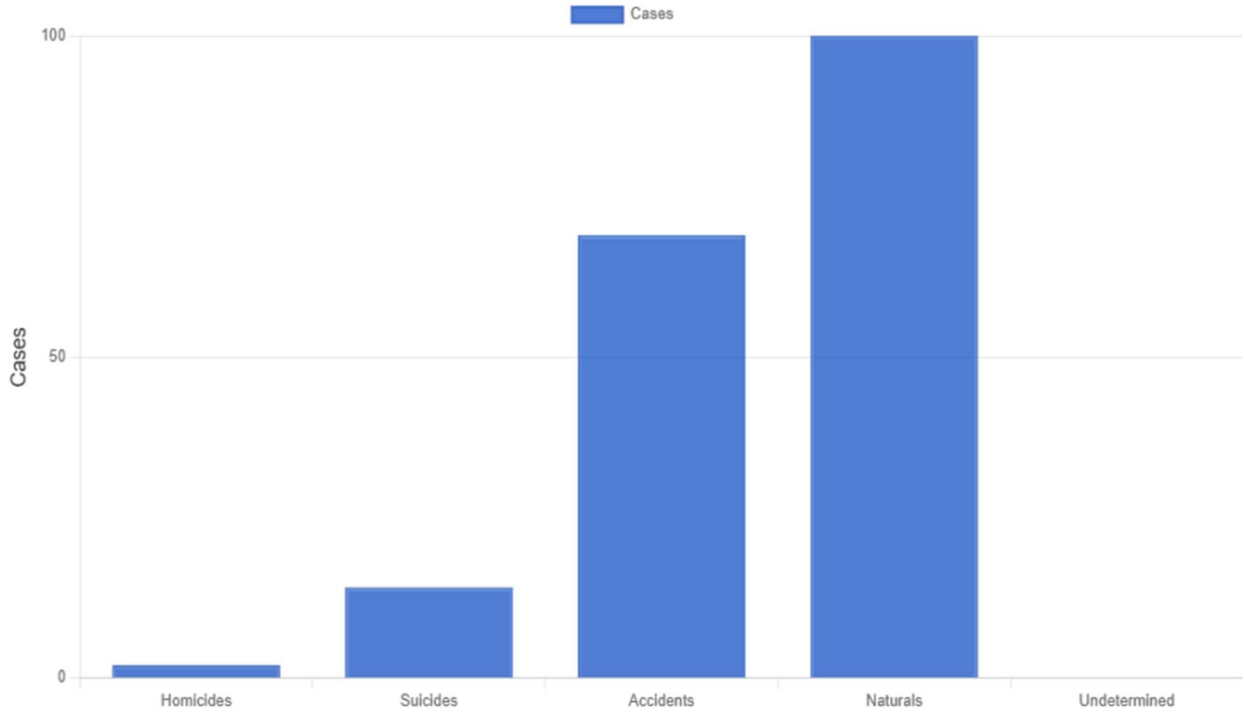
Cases Created



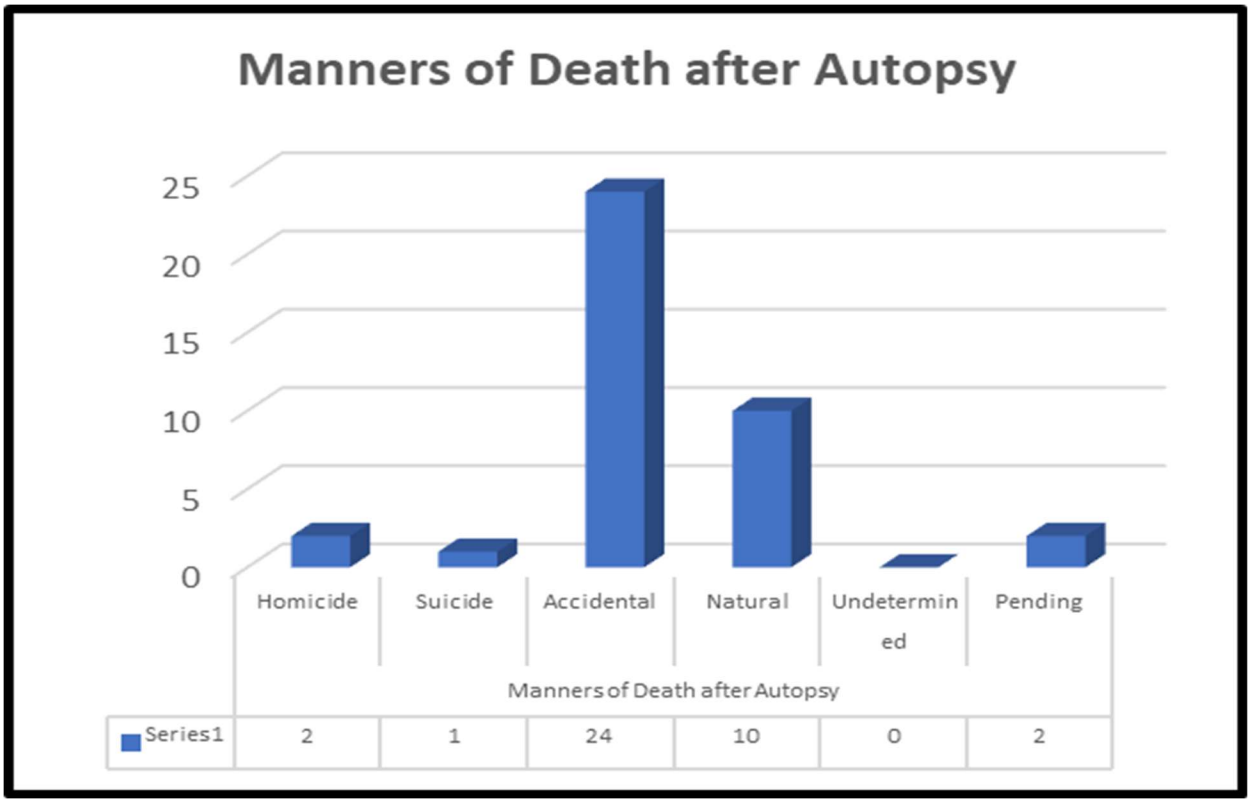
	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
Cases (ME/C)	21 (11.23%)	12 (6.42%)	12 (6.42%)	13 (6.95%)	17 (9.09%)	14 (7.49%)	15 (8.02%)	18 (9.63%)	15 (8.02%)	16 (8.56%)	16 (8.56%)

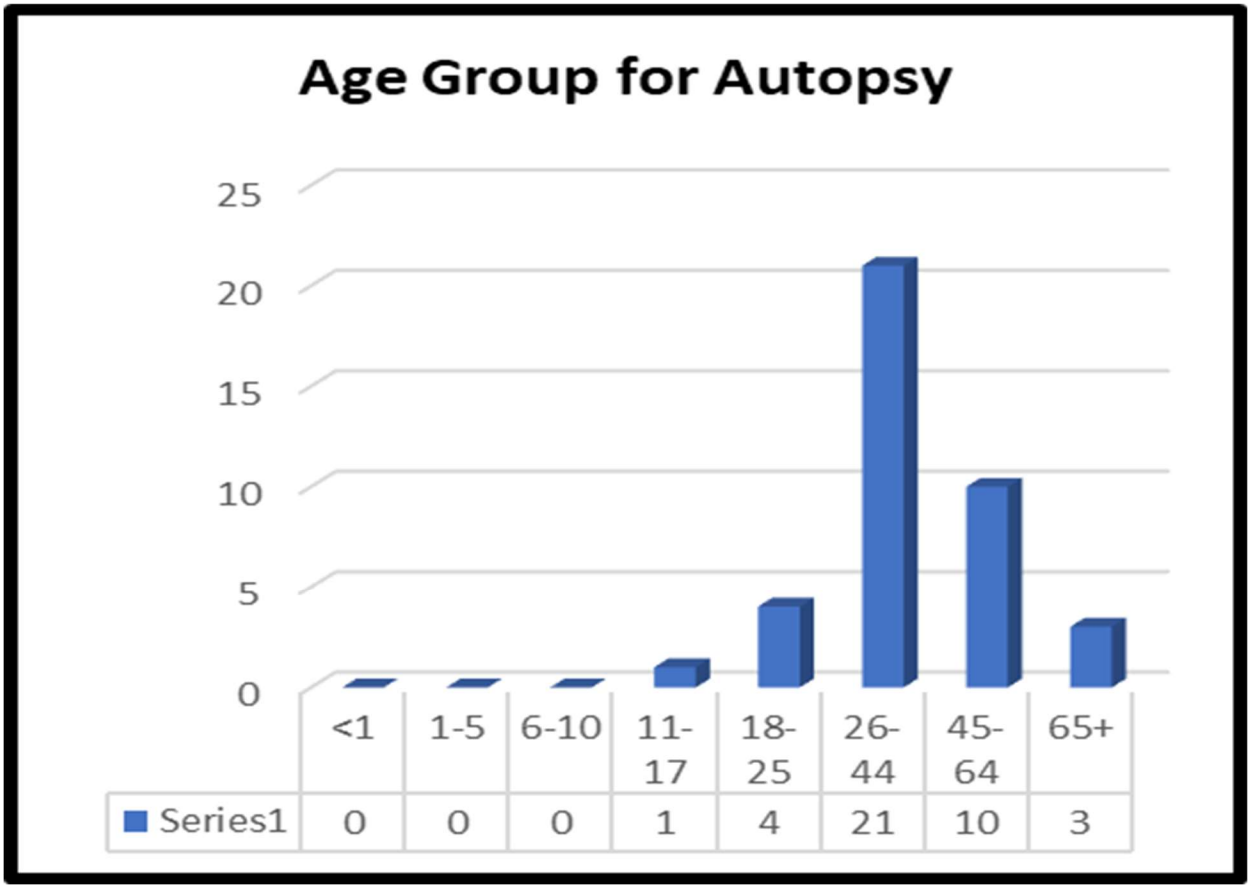
	Dec 2025	Total
Cases (ME/C)	18 (9.63%)	187 (100.0%)

Manner of Death

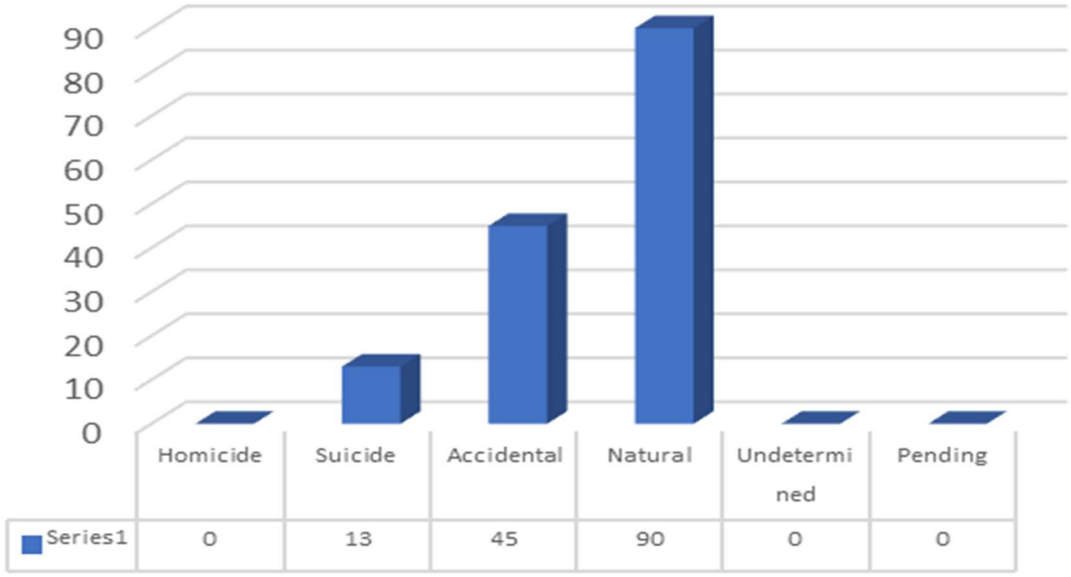


	Homicides	Suicides	Accidents	Naturals	Total
Cases	2 (1.08%)	14 (7.57%)	69 (37.3%)	100 (54.05%)	185 (100.0%)

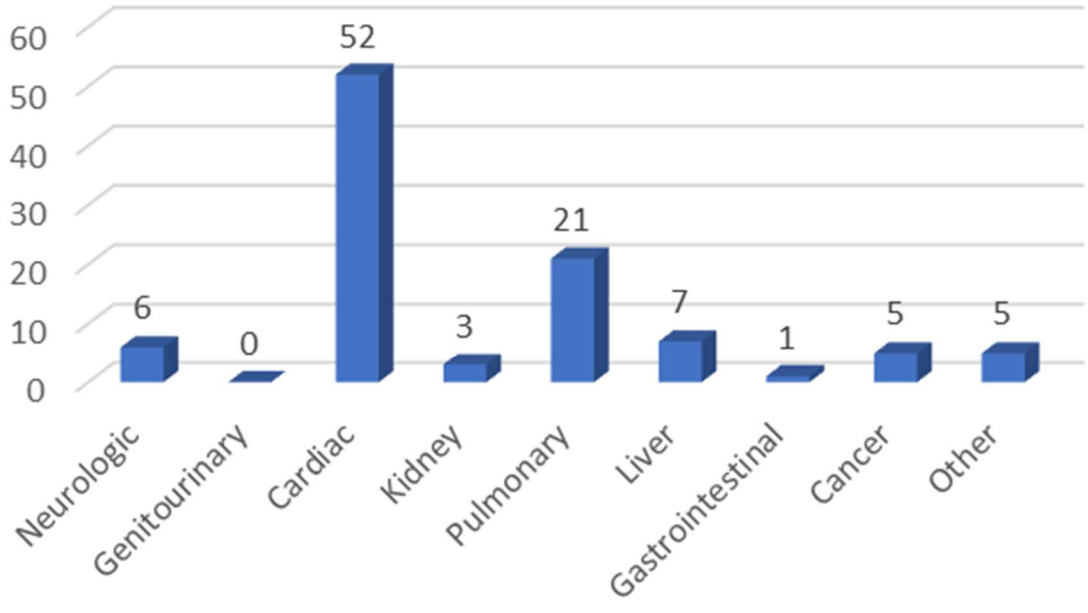

Manners of Death after Autopsy
25
20
15
10
5
0
Homicide
Suicide
Accidental
Natural
Undetermined
Pending
Manners of Death after Autopsy
Series1
2
1
24
10
0
2

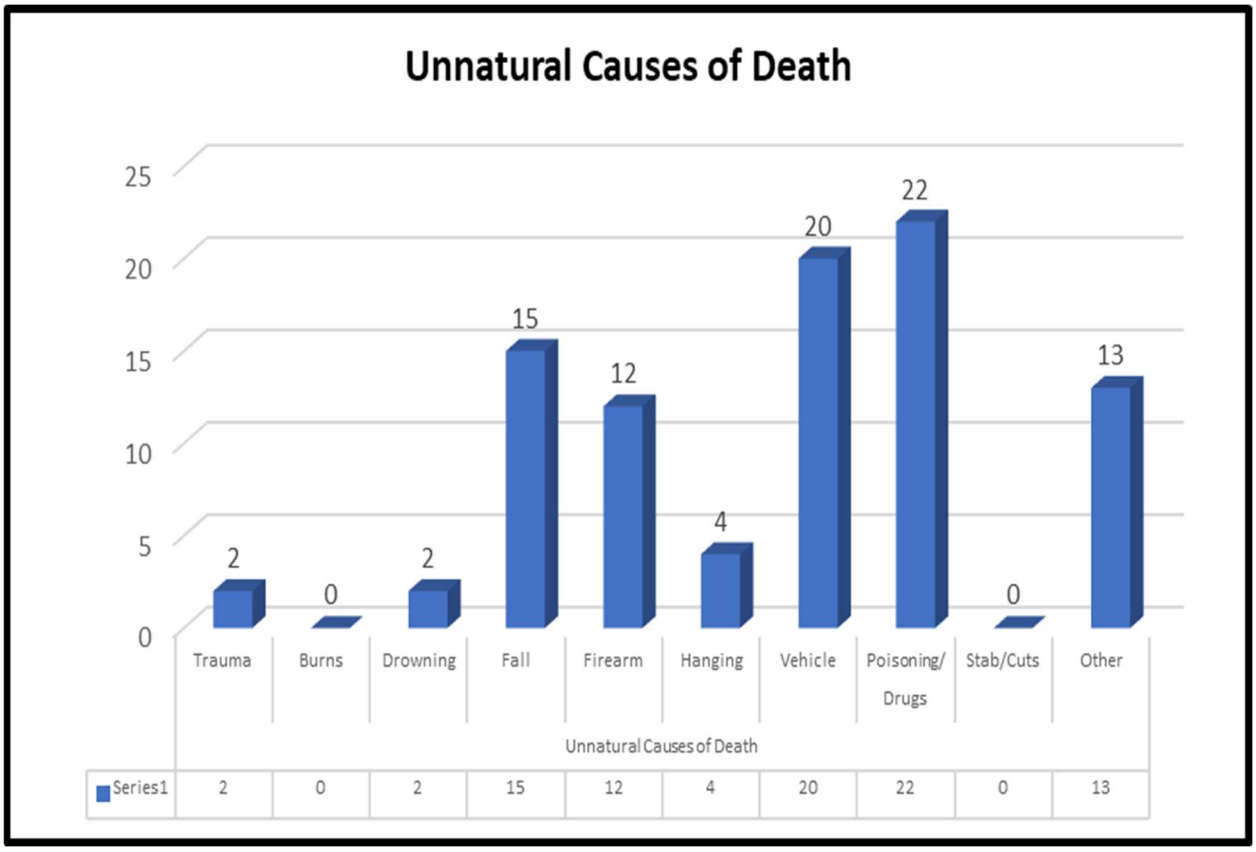

Age Group for Autopsy
25
20
15
10
5
0
<1
1-5
6-10
11-17
18-25
26-44
45-64
65+
Series1
0
0
0
1
4
21
10
3

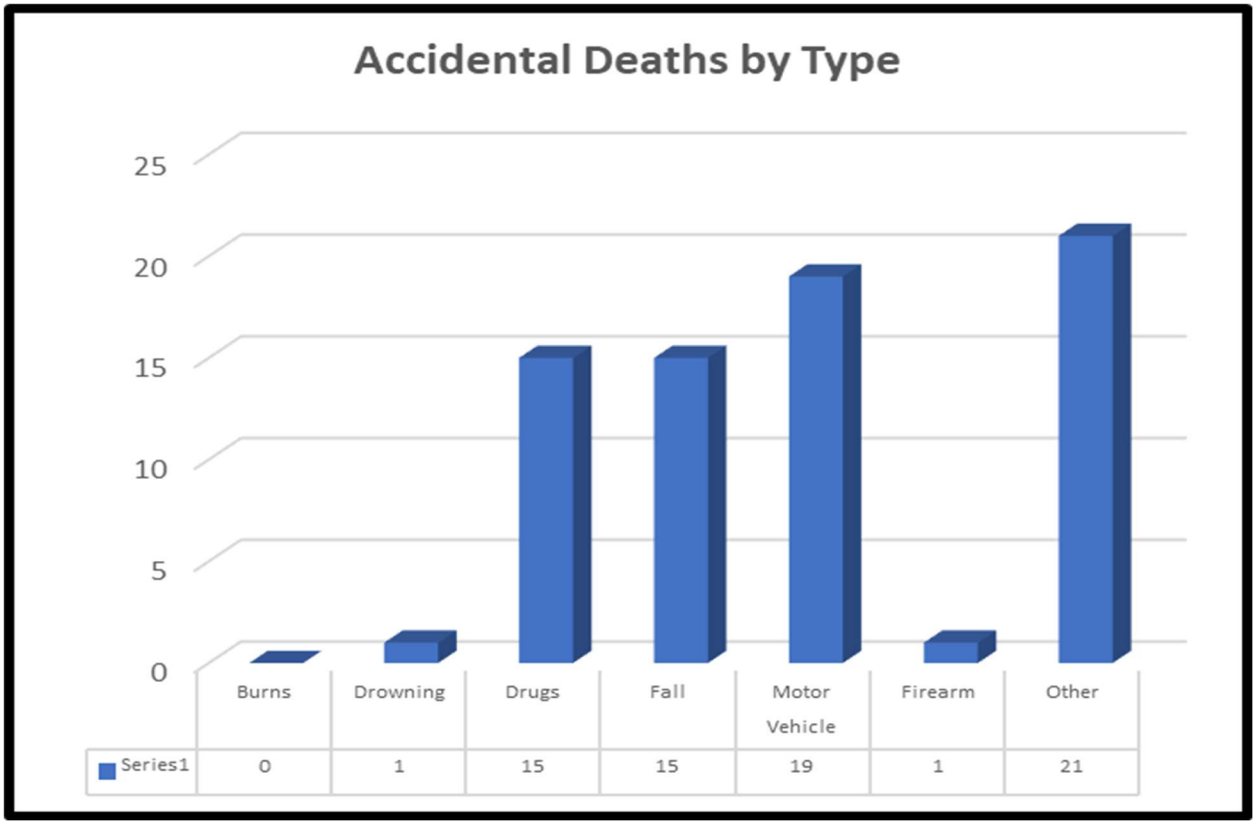
Manners of Death by Investigation w/o Autopsy

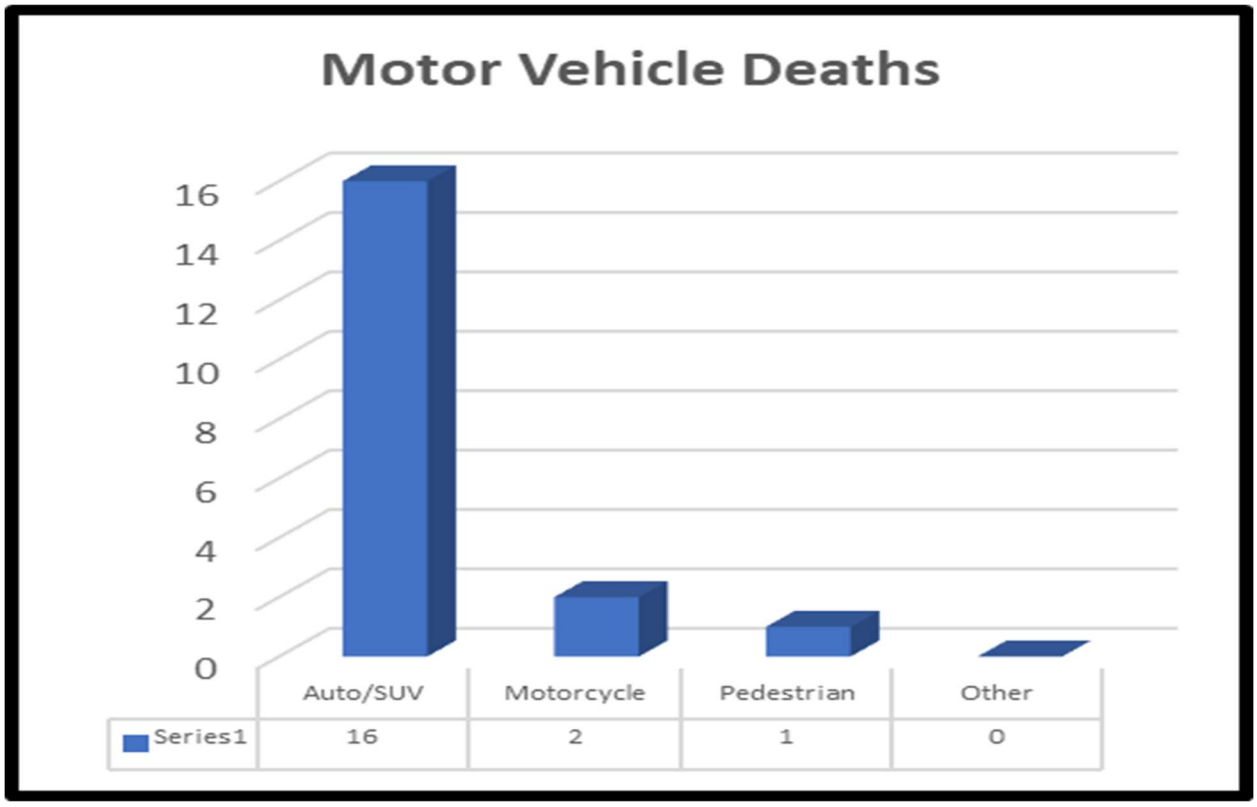


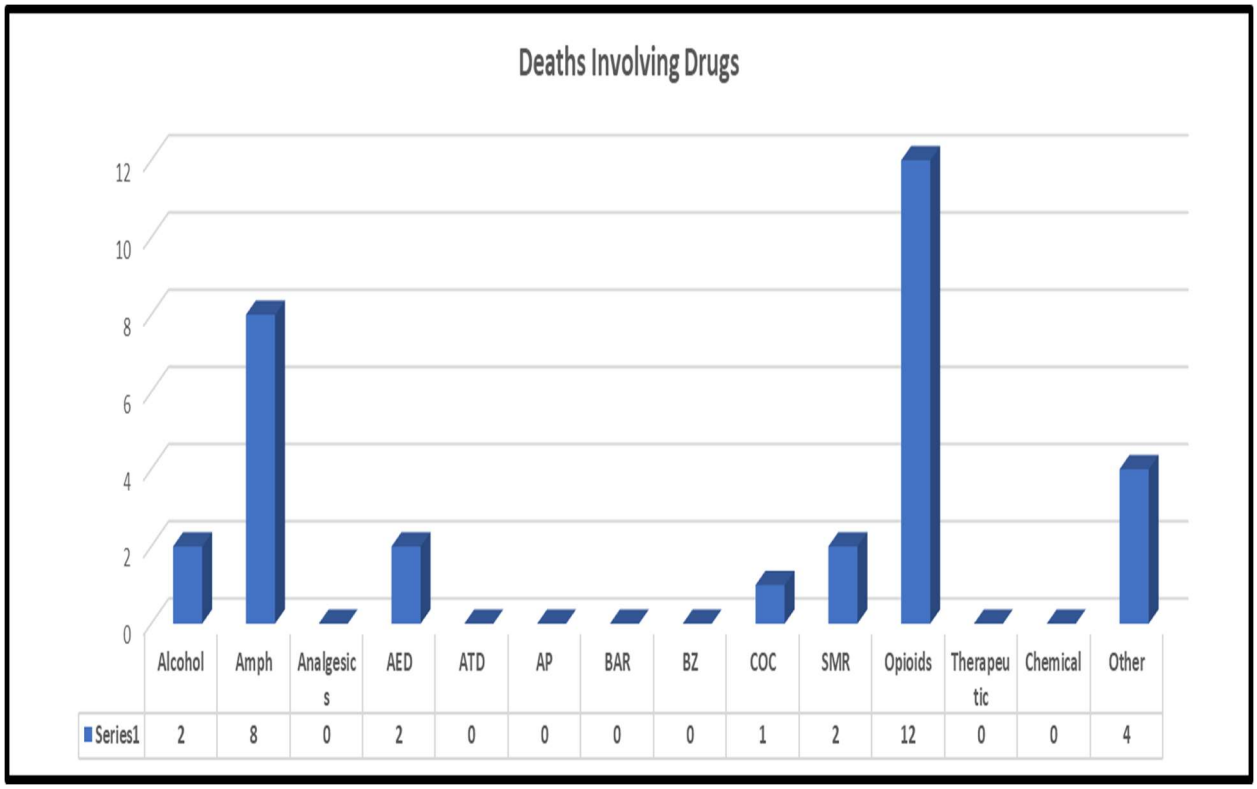
Natural Deaths by Cause after Investigation



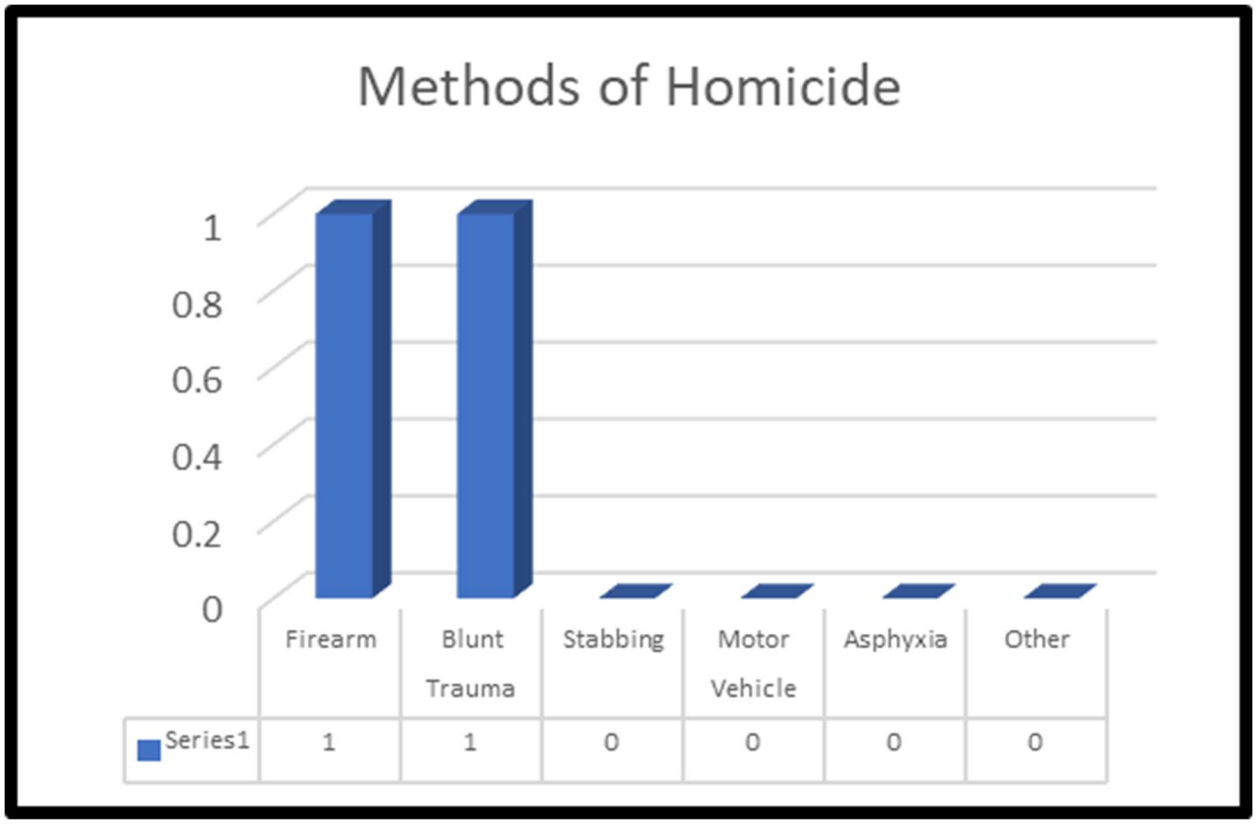

Unnatural Causes of Death
25
20
15
10
5
0
2
0
2
15
12
4
20
22
0
13
Trauma
Burns
Drowning
Fall
Firearm
Hanging
Vehicle
Poisoning/ Drugs
Stab/Cuts
Other
Unnatural Causes of Death
Series1
2
0
2
15
12
4
20
22
0
13

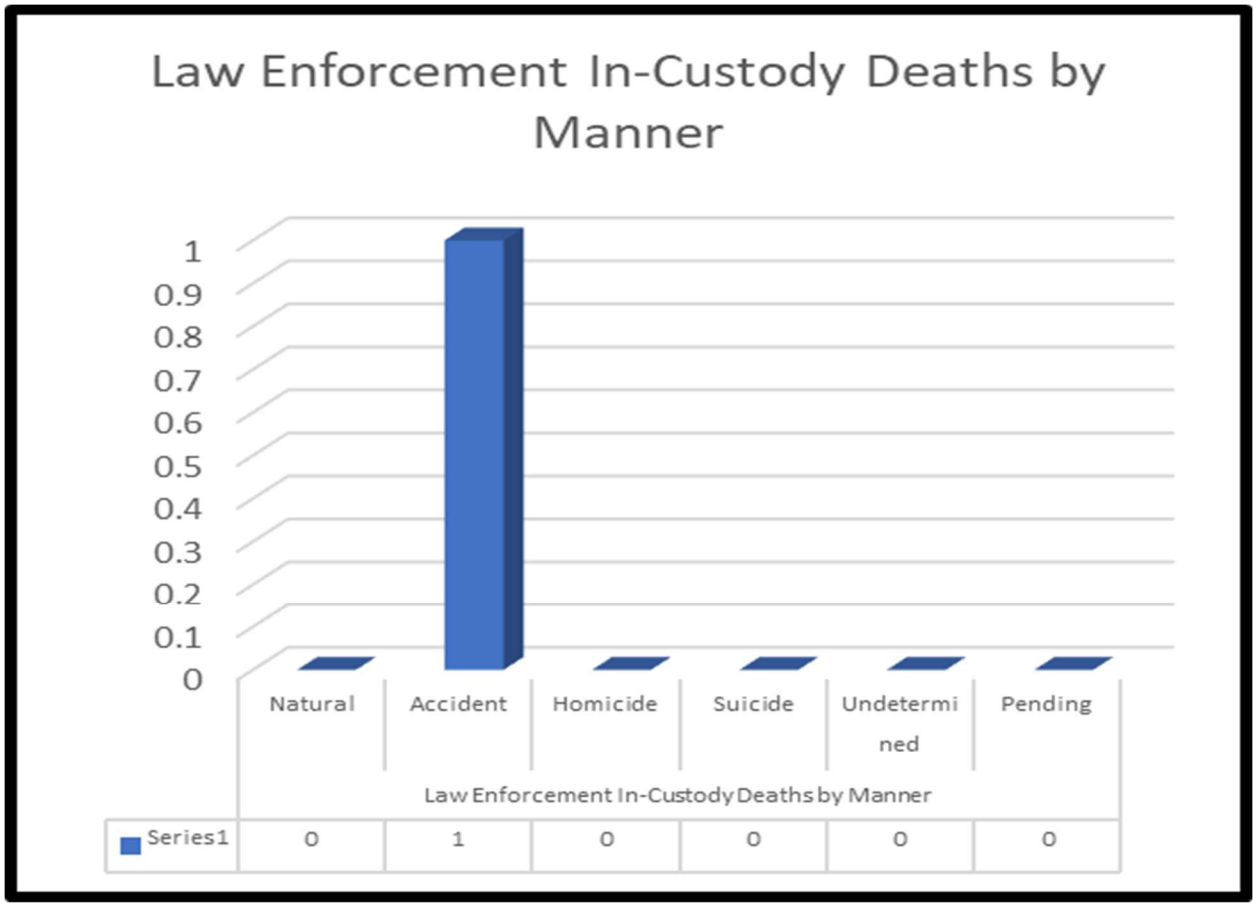

Accidental Deaths by Type
25
20
15
10
5
0
Burns
Drowning
Drugs
Fall
Motor Vehicle
Firearm
Other
Series1
0
1
15
15
19
1
21

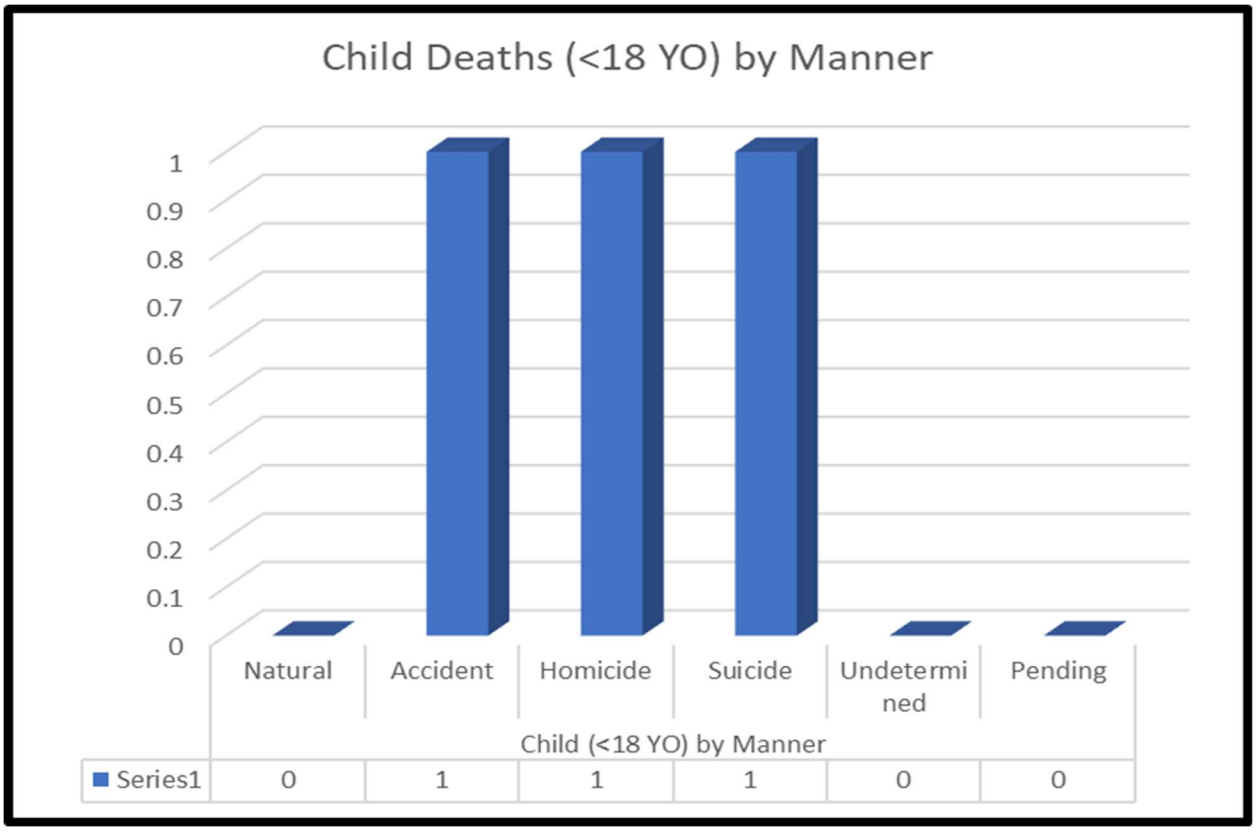


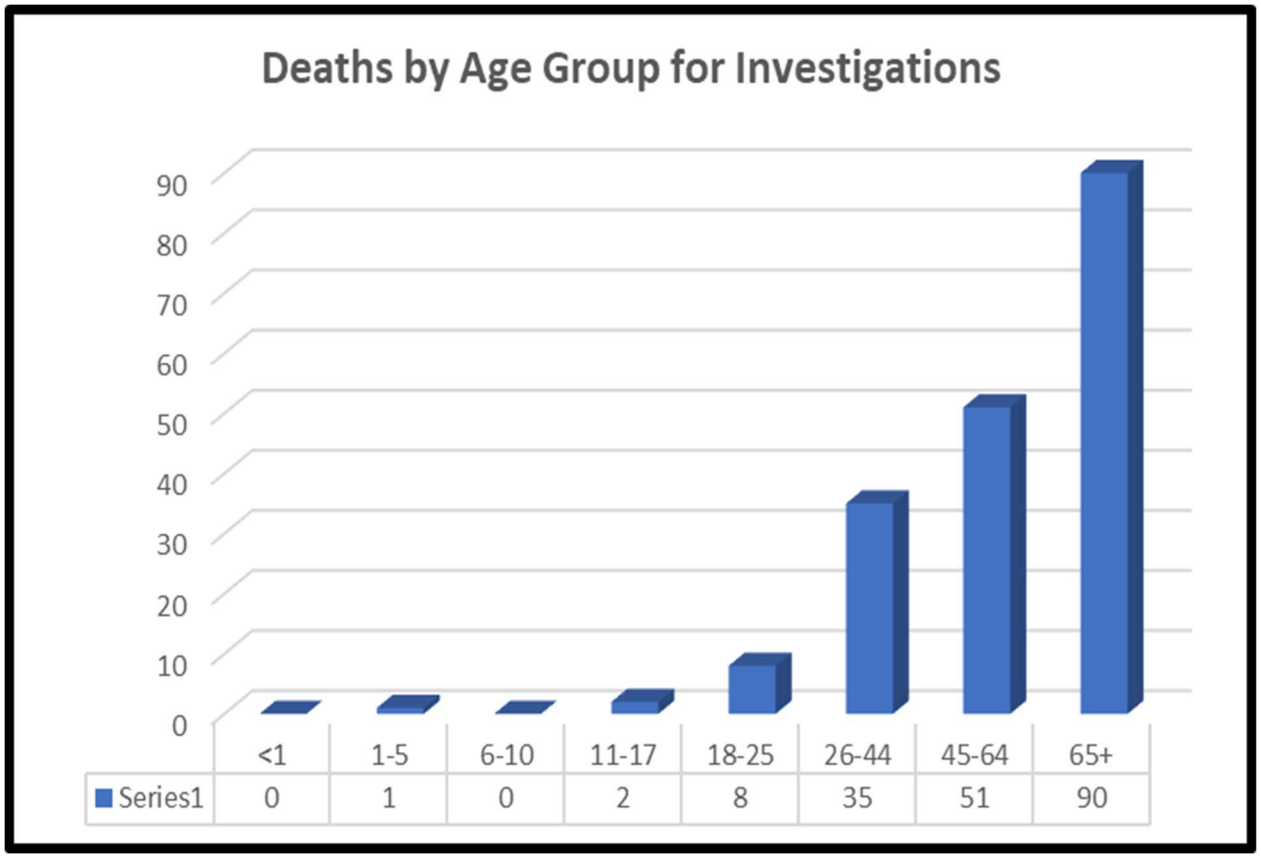


Legend: AMPH – Amphetamine; AED – Anti-convulsant; ATD – Anti-depressant; AP – Anti-Psychotic; BAR – Barbiturate; BZ – Benzodiazepine; COC – Cocaine; SMR – Muscle Relaxer;


Methods of Homicide
1
0.8
0.6
0.4
0.2
0
Firearm
Blunt Trauma
Stabbing
Motor Vehicle
Asphyxia
Other
Series1
1
1
0
0
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
Series1
0
1
0
0
0
0


Child Deaths (<18 YO) 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
Child (<18 YO) by Manner
Series1
0
1
1
1
0
0


Deaths by Age Group for Investigations
90
80
70
60
50
40
30
20
10
0
<1
1-5
6-10
11-17
18-25
26-44
45-64
65+
Series1
0
1
0
2
8
35
51
90

Idaho Department of Health & Welfare **2024** Annual Report for Bannock County's Profile

Live Births	Infant Deaths	Perinatal Deaths	Reported Deaths
1,114 **Change from 2023** (5.3% Inc)	13 (117% Inc)	10 (25% Inc)	873 (6% Increase)

Cause of Death	***Total***	***% of all deaths***	***% of Change from 2023***
Heart Disease	162	18.56 %	+ 20.00 %
Malignant Neoplasms	155	17.76 %	+ 8.73 %
Accident	54	6.19 %	+ 5.88 %
Chronic Lower Respiratory Diseases	49	5.61 %	- 19.67 %
Alzheimer's Disease	56	6.42 %	+ 30.23 %
Cerebrovascular Diseases	31	3.55 %	- 6.06 %
Diabetes Mellitus	24	2.75 %	0 %
Suicide	27	3.09 %	+ 12.50 %
Chronic Liver Disease and Cirrhosis	19	2.18 %	- 24.00 %
Parkinson's Disease	11	1.26 %	+ 10.00 %
Nutritional Deficiencies	21	2.41 %	+ 75.00 %
All other causes	264	30.24 %	+ 25.12 %

Age at Death

<1	**1-4**	**5-14**	**15-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75-84**	**85+**
13	1	4	10	17	32	49	99	172	255	221

Leading Causes of Mortality

Total Deaths	**Diseases of the Heart**	**Malignant Neoplasms**	**Alzheimer's Disease**	**Accident**	**Chronic Lower Respiratory Diseases**
873	162	155	56	54	49

Disposition Method

Burial/Entombment	**Cremation**	**Donation**	**Removal from Idaho**	**Other**
269	560	2	42	0

Path: Healthandwelfare.idaho.gov\About DHW\Reports & Statistics\Vital Records and Health Statistics\Idaho Health Statistics Fact Sheets and Annual Reports\Vital Statistics Annual Reports\Mortality Annual Reports\2024_Mortality