County coroners and death investigations

January 29, 2025

Presented by
Casey Petti
Principal
Evaluator

Office of Performance Evaluations
ope
Idaho Legislature

Agenda

Background

State oversight

Coroner funding

Autopsy rates

Coroners

Elected at county level

Serve in office for four years

Must be 21 years old and reside in the county where they are elected

Primary function is to conduct medicolegal death investigations

State of Idaho
CERTIFICATE OF DEATH

DATE FILED BY STATE REGISTRAR:

STATE FILE NO.

Local Reg. No.

DECEDENT

TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN

FOR INSTRUCTIONS SEE HANDBOOKS

PARENTS

INFORMANT

DISPOSITION

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

(ITEMS 30-38 TO BE USED FOR EXTERNAL CAUSES ONLY (CORONER))

CERTIFIER

IF DEATH WAS DUE TO OTHER THAN NATURAL CAUSES, THE CORONER MUST COMPLETE AND SIGN THE CERTIFICATE

REGISTRAR

MORTICIAN: Complete/Verify and File Within 5 Days of Death

CERTIFIER: Complete Within 72 Hours of Death

MORTICIAN: Complete/Verify

* 1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix)
2. SEX
3. SOCIAL SECURITY NUMBER
4a. AGE-Last Birthday (Years)
4b. UNDER 1 YEAR Months Days
4c. UNDER 1 DAY Hours Minutes
5. DATE OF BIRTH (Mo/Day/Yr)
6. BIRTHPLACE (City and State, Territory, or Foreign Country)
7a. RESIDENCE - STATE OR FOREIGN COUNTRY
7b. COUNTY
7c. CITY OR TOWN
7d. STREET AND NUMBER
7e. APT. NO.
7f. ZIP CODE
7g. INSIDE CITY LIMITS? Yes No
8. MARITAL STATUS AT TIME OF DEATH
Married Married, but separated Widowed Divorced Never married Unknown
9. SURVIVING SPOUSE'S NAME (If wife, give maiden name)
10. EVER IN U.S. ARMED FORCES? Yes No
11a. FATHER'S NAME (First, Middle, Last, Suffix)
11b. BIRTHPLACE (State, Territory, or Foreign Country)
12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)
12b. BIRTHPLACE (State, Territory, or Foreign Country)
13a. INFORMANT'S NAME (Type or print)
13b. RELATIONSHIP TO DECEDENT
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)
* 14. METHOD OF DISPOSITION
Burial Cremation Donation Entombment Removal from Idaho Other (Specify)
15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)
* 16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY
* 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
* 17b. LICENSE NUMBER (Of licensee)
18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? Yes No

PLACE OF DEATH (19-22)
* 19a. IF DEATH OCCURRED IN A HOSPITAL: Inpatient ER/Outpatient DOA Hospice facility Nursing home/Long term care facility Decedent's home Other (Specify)
* 19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL:
* 20. FACILITY NAME (If not facility, give street and number)
* 21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE
* 22. COUNTY OF DEATH
* 23. DATE OF DEATH (Mo/Day/Yr) (Spell month)
24. TIME OF DEATH (24hr)
25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month)
26. TIME PRONOUNCED DEAD (24hr)

27. CAUSE OF DEATH
PART I. Enter the chain of events -- diseases, injuries, or complications -- that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line.
Approximate Interval: Onset to Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (or as a consequence of):
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death) b. DUE TO (or as a consequence of):
c. DUE TO (or as a consequence of):
d.
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I
28a. WAS AN AUTOPSY PERFORMED? Yes No
28b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? Yes No
29. DID TOBACCO USE CONTRIBUTE TO DEATH? Yes Probably No Unknown
30. IF FEMALE (Aged 10-54): Not pregnant within past year Pregnant at time of death Not pregnant, but pregnant within 42 days of death Not pregnant, but pregnant 43 days to 1 year before death Unknown if pregnant within the past year
31. MANNER OF DEATH Natural Accident Suicide Homicide Pending Investigation Could not be determined
32. DATE OF INJURY (Mo/Day/Yr) (Spell month)
33. TIME OF INJURY (24hr)
34. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.)
35. INJURY AT WORK? Yes No
36. LOCATION OF INJURY: State City/Town or County Zip Code
Street and Number or Location Apartment Number
37. DESCRIBE HOW INJURY OCCURRED. IF TRANSPORTATION INJURY, STATE THE TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable
TRANSPORTATION INJURY ONLY Pedestrian Other (Specify)
38a. WAS DECEDENT Driver/Operator Passenger
38b. WHAT SAFETY DEVICE(S) DID DECEDENT USE/EMPLOY? Seat Belt Child safety seat Helmet Air bag None Unknown
39a. CERTIFIER (Check only one, based on official capacity for this certificate)
PHYSICIAN - To the best of my knowledge, death occurred at the time, date, and place, and due to the natural cause(s)/manner stated.
PHYSICIAN ASSISTANT
ADVANCED PRACTICE PROFESSIONAL NURSE
CORONER - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
39b. LICENSE NUMBER
39c. DATE SIGNED MM DD YYYY
Signature and Title of Certifier
* 39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print)
40a. REGISTRAR'S SIGNATURE
40b. DATE SIGNED MM DD YYYY

STATISTICAL INFORMATION
41. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life) Do not use retired
42. KIND OF BUSINESS/INDUSTRY
43. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death)
8th grade or less (includes none)
9th - 12th grade, but no diploma
High school graduate or GED completed
Some college credit, but no degree
Associate degree (eg, AA, AS)
Bachelor's degree (eg, AB, BA, BS)
Master's degree (eg, MA, MBA, MEd, MEng, MS, MSW)
Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)
44. DECEDENT OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino)
No, not Spanish/Hispanic/Latino
Yes, Mexican, Mexican American, Chicano
Yes, Puerto Rican
Yes, Cuban
Yes, other Spanish/Hispanic/Latino (Specify)
45. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
White
Black or African American
American Indian or Alaska Native (Name of the enrolled or principal tribe)
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Other Asian (Specify)
Native Hawaiian
Guamanian or Chamorro
Samoan
Other Pacific Islander (Specify)
Other (Specify)

* At a minimum, complete items 1; 14; 16; 17a; 17b; 19a or 19b; 20; 21, 22, 23, and 39d for the 24-Hour Report and Authorization for Final Disposition

Rev. 5/2010

251222

VITAL STATISTICS COPY

SAMPLE

Idaho's death investigation system

Morticians can fill out most of a death certificate

Cause and manner of death must be filled out by physician, physician assistant, advanced practice professional nurse, or the coroner

Office of Performance Evaluations ope Idaho Legislature

Cause vs manner of death

Cause – the underlying condition that led to a death

Manner – the circumstances that led to the cause of death

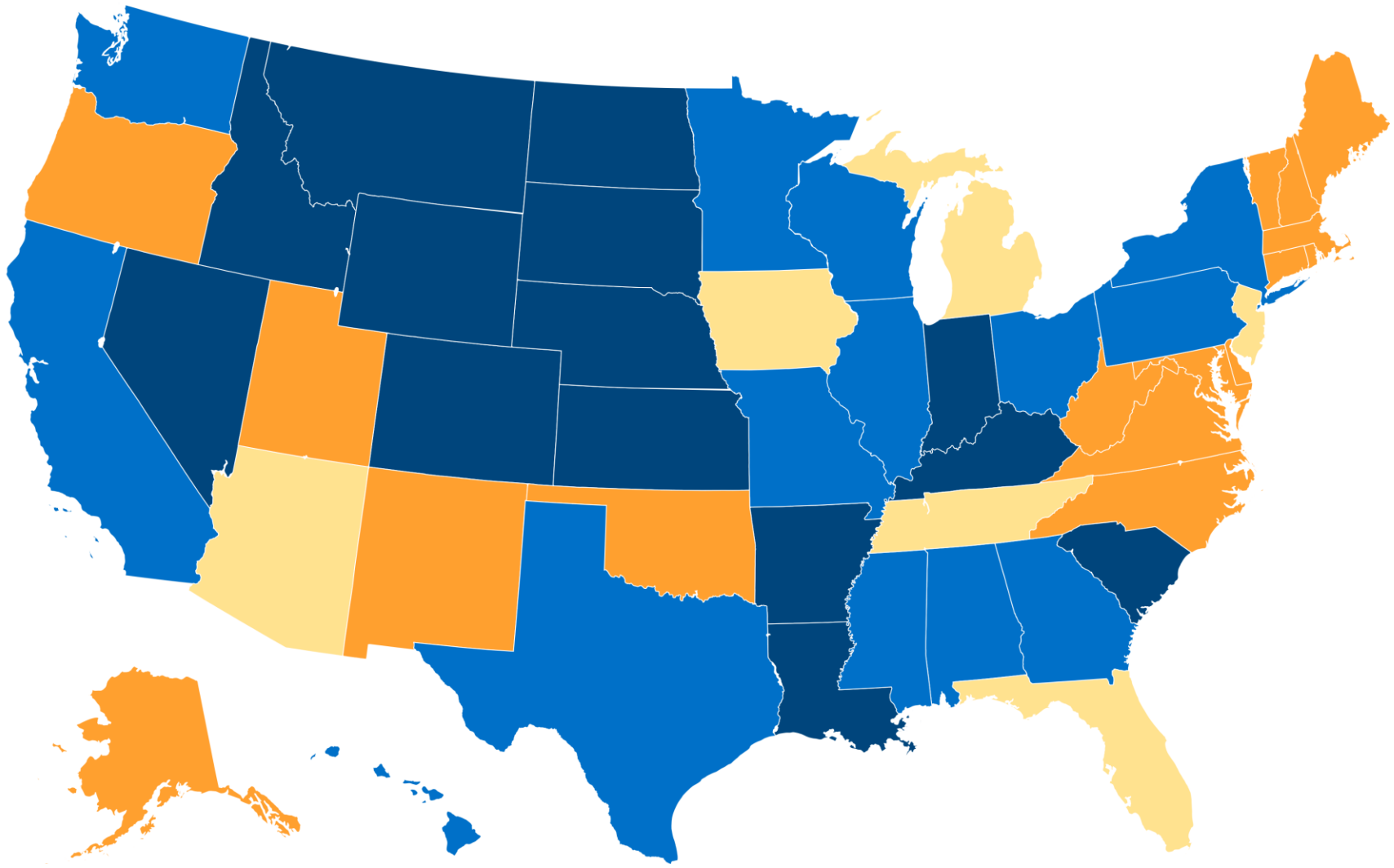
1. **Natural**
2. **Accident**
3. **Homicide**
4. **Suicide**
5. **Undetermined**

14 States with county or district coroners

14 with mixed county coroners and county medical examiners

6 with county or district medical examiners

16 with centralized state medical examiners



State oversight:

State entity and certification

State medical examiner:

- Arkansas
- Georgia
- Kentucky
- Mississippi
- Montana
- North Dakota

Coroner boards:

- Colorado
- Indiana
- Nebraska
- South Carolina
- Texas
- Wyoming

Coroner training boards or state oversight of coroner education:

- Alabama
- California
- Illinois
- Missouri
- New York
- Pennsylvania
- South Dakota
- Washington

Idaho is one of 8 coroner states with no state oversight or assistance entity.

Accreditation and certification

Office accreditation

National Association of Medical Examiners (NAME)

International Association of Coroners and Medical Examiners (IACME)

Coroner certification

American Board of Medicolegal Death Investigators (ABMDI)

Policy consideration

Since 2010, Idaho has collected a $1 fee on death certificates to go toward coroner education.

The legislature should consider expanding the usage of the fee to go toward office accreditation and coroner certification.

State oversight:

State code

Deaths reportable to coroners

Idaho Code:

1. Violence
2. Homicide
3. Suicide
4. Accident
5. Under suspicious or unknown circumstances
6. Child without a known medical disease
7. Stillbirth without a known medical disease
8. Not under care of a physician (unattended deaths)
9. Motor vehicle accidents

Idaho Administrative Rule:

10. Deaths in a state prison

Deaths reportable to coroners

The national average for deaths explicitly reportable to a medicolegal death investigation system is 15.

Idaho does not explicitly require mandatory reporting to the coroner for deaths in local law enforcement custody, deaths at the workplace, or deaths that may constitute a threat to public health.

Unattended death

There is no statewide definition of an “unattended death,” leading to different definitions and timelines between counties.

Idaho Code is ambiguous on who is responsible for certifying deaths in an emergency room or deaths of individuals admitted to the hospital unconscious.

Law enforcement role and jurisdiction

Idaho Code does not delineate between the roles of coroners and law enforcement at a scene of a death.

Coroners reported situations where law enforcement had moved, altered, or removed ligatures from a decedent before being notified of a death.

Law enforcement role and jurisdiction

Several coroner states have specific language in their code stating that the body of a decedent is the jurisdiction of the coroner.

In these states a decedent cannot be moved, altered, or transferred without the consent of the coroner.

Section 301

The Roles of Police Officers and Coroners

Section 301.1 Introduction 63
Section 301.2 Search, Collection, Preservation and Processing of Evidence 64
Section 301.3 The Importance of Physical Evidence 64
Section 301.4 Physical Evidence Cannot Generally Be Retracted 64
Section 301.5 Physical Evidence Is Not Subject to Subjective Analysis 64
Section 301.6 Physical Evidence Can Often Be Linked to a Specific Person or Event Through Scientific Analysis 64
Section 301.7 Physical Evidence Does Not Fall under the Fifth Amendment's Protection Against Self-incrimination Clause 65
Section 301.8 Physical Evidence and the Courts 65
Section 301.9 Case Resolution 65
Section 301.10 Fewer Plea Bargains 65
Section 301.11 More Appropriate Sentences 65
Section 301.12 Obstacles to Use of Physical Evidence in Court 65
Section 301.13 The First Responder 66
Section 301.14 Three Basic Methods of Determining Death 67

Section 301.1

Introduction

The roles of law enforcement officers and coroners are slightly different at a death scene. Law enforcement officers are concerned with whether a crime has occurred. They approach each unknown death scene with the idea that a crime has occurred and they work backward from that premise. Once they have established that a crime has not occurred, their mission has been fulfilled.

The role of the coroner is broader in nature. The coroner is concerned with establishing the manner and cause of death in all unknown-cause deaths. The importance of the coroner's investigation is not diminished if a crime has not occurred. The difference between a suicide and an accident can often be very important to the victim's family. Many insurance policies will not pay off on a suicide. Also, some life insurance policies pay double or triple the value of the life insurance policy if the insured's death is ruled an accident. Thus, the coroner's role is more extensive than that of law enforcement officers.

There are two major considerations for coroners in their relationship to law enforcement personnel and agencies: cooperation and independence. *Cooperation* between the coroner and law enforcement personnel will be mutually beneficial. The coroner will benefit from the experience, expertise and resources provided by law enforcement officers. Law enforcement personnel will benefit from the coroner's experience and expertise in establishing manner and cause of death.

Cooperative relationships seldom develop spontaneously. All parties need to work to build productive working relationships. While partnerships inspire cooperation, hierarchical relationships can limit the flow of information. Law enforcement officers often arrive at death scenes long before coroners can free themselves from other duties and obligations. The frustrations of those waiting to move forward and those caught in the frenzy of clearing their schedule can easily be misinterpreted. Unless everyone appreciates the demands placed on all parties, the working environment can be poisoned. Team building requires constant work.

Once the coroner has ruled the death was not the result of a criminal act, law enforcement personnel can be released from the scene. However, most agency personnel will remain on the scene as long as they can be of assistance to the coroner.

Independence is perhaps the *key* element in the coroner/law enforcement relationship. The coroner and the law enforcement personnel at the scene should pursue their investigation in a cooperative manner. The search, collection and packaging of evidence, and documenting the scene should be done together. However, the coroner and the law enforcement investigators should be independent of each other in rendering a

Section 301 The Roles of Police Officers and Coroners

Law enforcement role and jurisdiction

Some coroners may rely on law enforcement to conduct death investigations.

While not explicitly forbidden in Idaho Code, this is contrary to national standards.

Coroner education

Since 2010, coroners have been required to complete "coroner's school" after taking office and 24 hours of continuing education every two years in office.

Coroner education

The reported hours of continuing education completed by a 22 coroner cohort has been decreasing since 2015.

	Average hours submitted by coroner cohort	Percent of coroner cohort above 24 hours of continuing education	Percent of cohort submitting no hours
2015-2016	51	73%	9%
2017-2018	37	64%	5%
2019-2020	28	50%	5%
2021-2022	20	41%	18%

Coroner education

20 of the 23 states that require coroner education provide state oversight for completion of education.

Most coroner states have consequences for coroners who fail to complete required continuing education.

Other areas of Idaho Code

No deaths in Idaho are required to be autopsied

Dissemination of death investigation information

Handling of remains for religious and spiritual purposes

Coroner and first responder status

National organizations recommend coroners be classified as first responders.

Coroners and their staff have similarly high rates of PTSD and other mental injuries as first responders.

Coroner funding

Coroner access to equipment

Some coroners do not have offices, instead working out of their homes.

Coroners mentioned not having access to basic equipment to do their jobs, such as a computer or a camera.

Most frequently, coroners mentioned not having a vehicle to transport decedents or a cooler to store decedents.

Coroners had the lowest median and average salary of all county-elected officials in 2022

	Median Salary	Average Salary
Coroner	$ 17,969	$ 30,618
Assessor	$ 74,111	$ 74,853
Clerk	$ 74,800	$ 76,560
Commissioner	$ 38,054	$ 49,910
Prosecutor	$110,277	$107,416
Sheriff	$ 84,090	$ 87,980
Treasurer	$ 73,327	$ 73,305

Low pay can be a barrier to recruiting, retaining, and training deputy coroners

County	Total number of deputies and medicolegal death investigators	Median salary	Average salary
Statewide	73	$8,788	$27,149
Ada County	14	$60,705	$63,082
Bannock County	2	$61,826	$61,826
Bonneville County	3	$6,617	$7,077
Canyon County	4	$51,897	$60,942
Kootenai County	5	$46,501	$46,037
Twin Falls County	3	$39,853	$48,450
All 38 remaining counties	41	$4,413	$7,966

Autopsy rates

Autopsy background

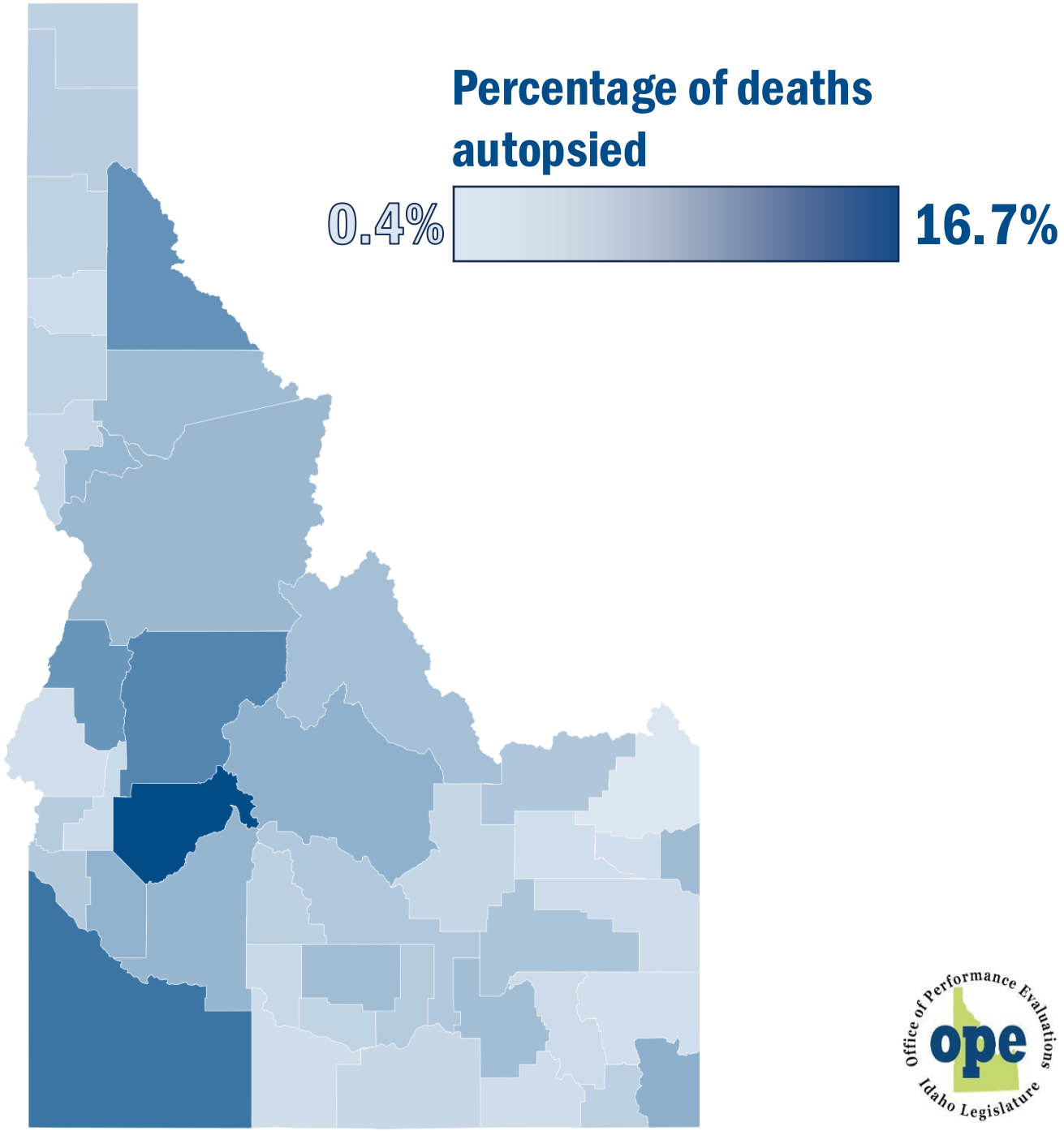
Only Ada and Canyon Counties conduct their own autopsies.

All other counties contract with Ada (33), Canyon (1), or Spokane, Washington (8) for autopsy services.

Autopsies cost between $1,800-$2,300 each.

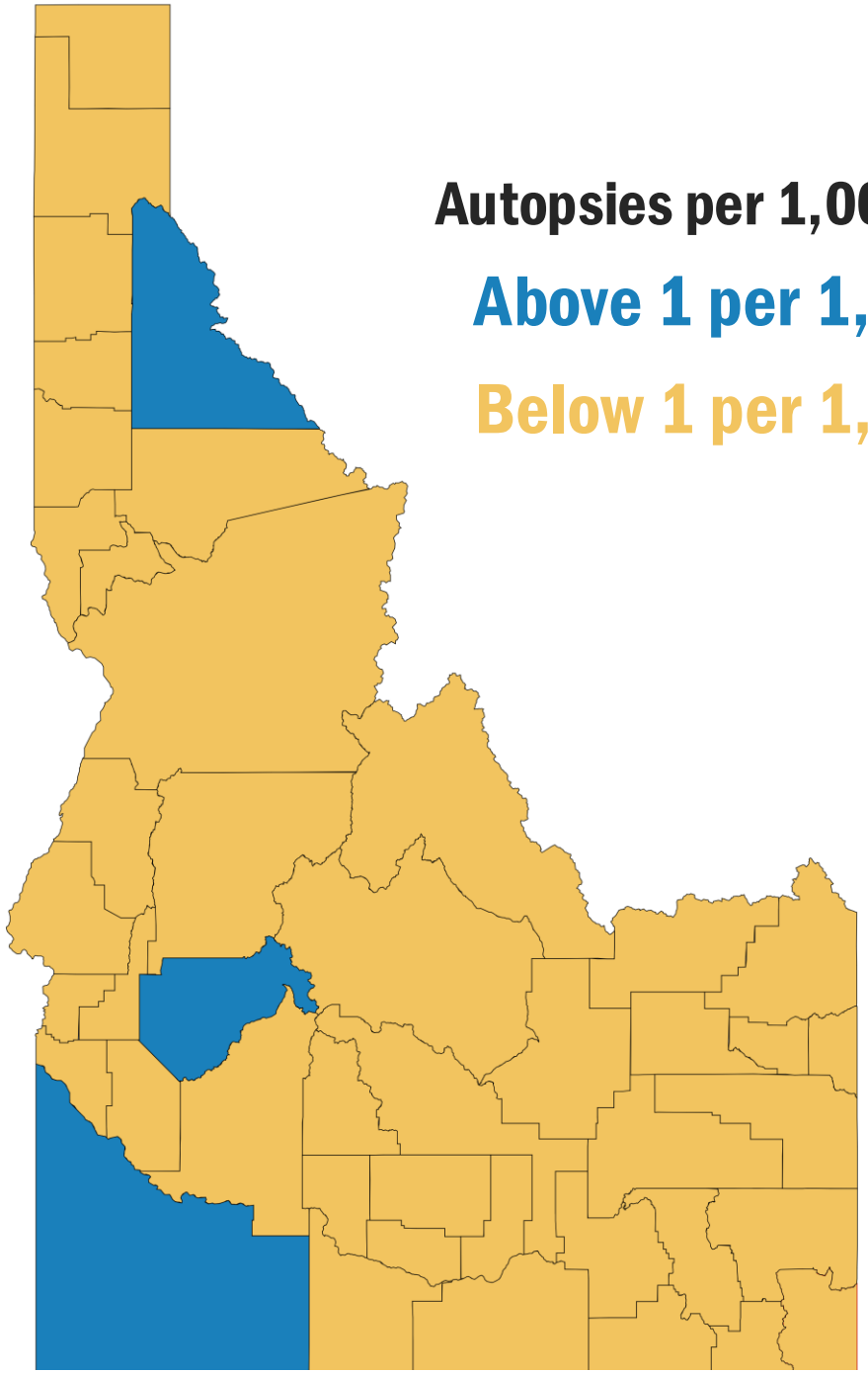
3.9% of deaths statewide were autopsied from 2018 through 2022

Counties spent an estimated $2.8 million on autopsies over this period.



National standards recommend 1 autopsy for every 1,000 people in a geographic area

Idaho conducted 0.34 autopsies per 1,000 residents from 2018 through 2022



Factors that influence autopsy rates

1. The age of the decedent
2. Who certifies the death
3. The location of the death

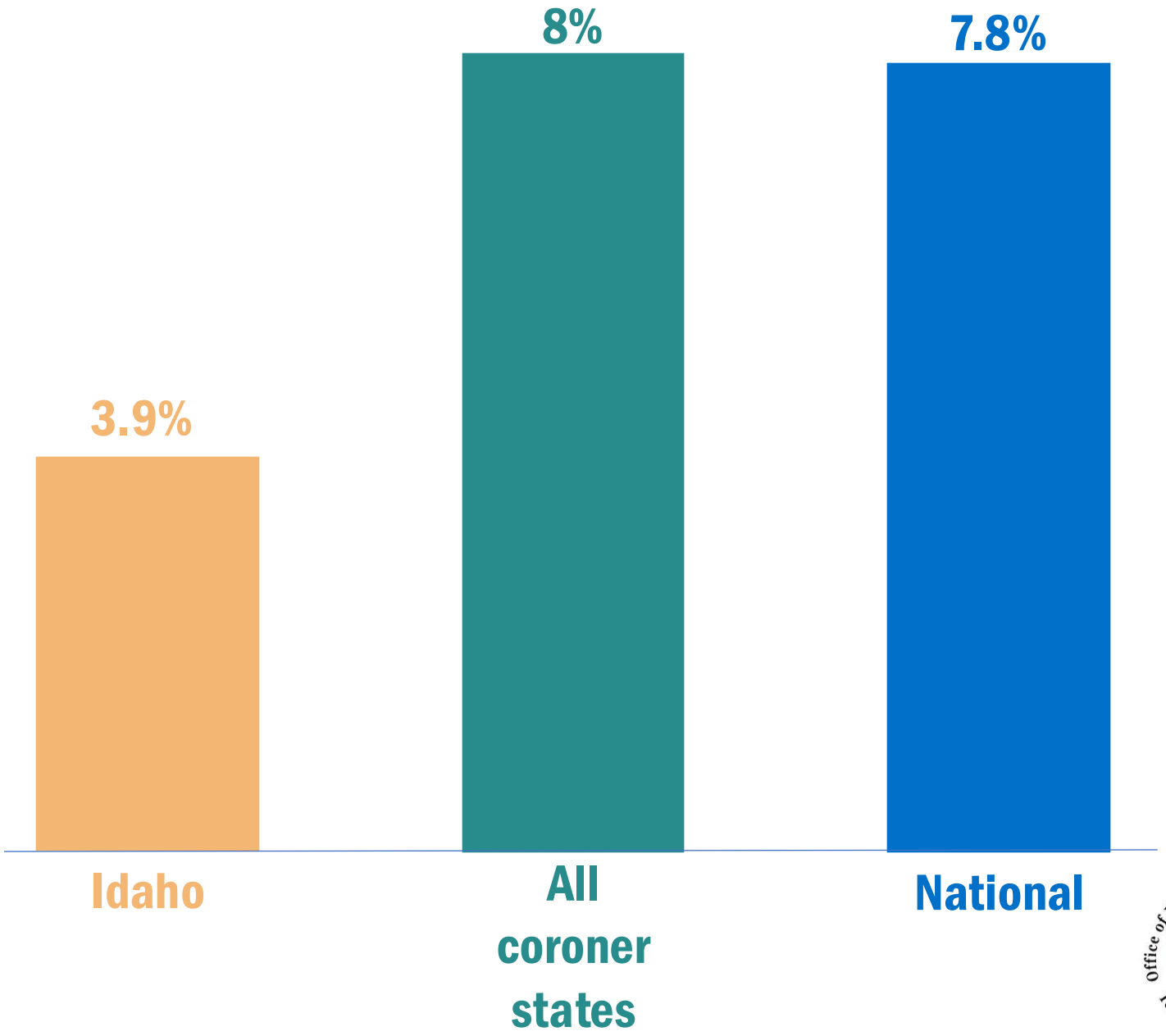
Bannock County Forensic Pathology Lab

The Bannock County forensic pathology lab will make it easier for counties in Eastern Idaho to conduct autopsies.

The opening of the lab has been delayed in part because of a national shortage of forensic pathologists.

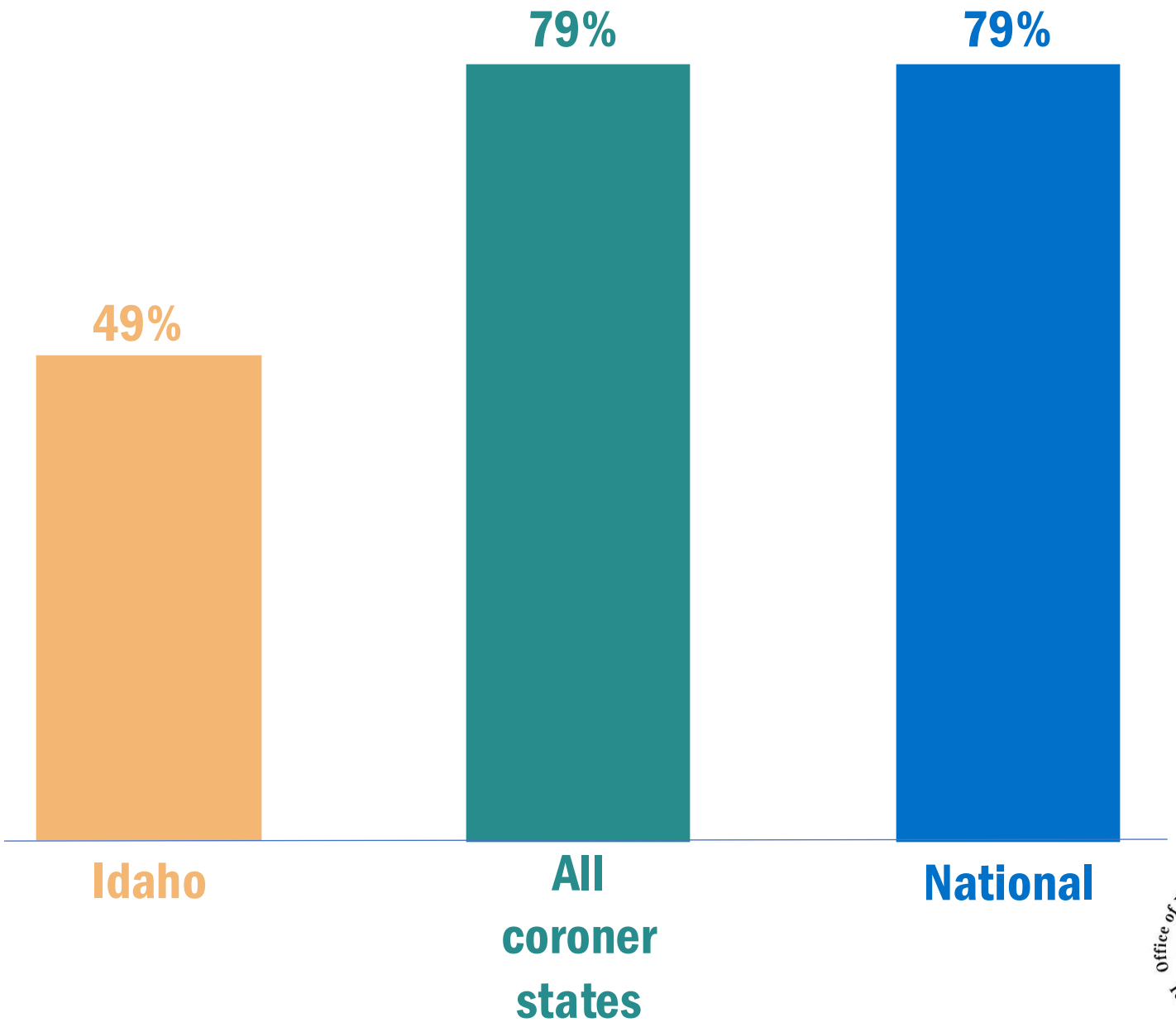
Autopsy rate all deaths

Idaho ranked 49th of 51 nationally for the percentage of deaths autopsied from 2018 through 2022



Child deaths from external or unknown causes

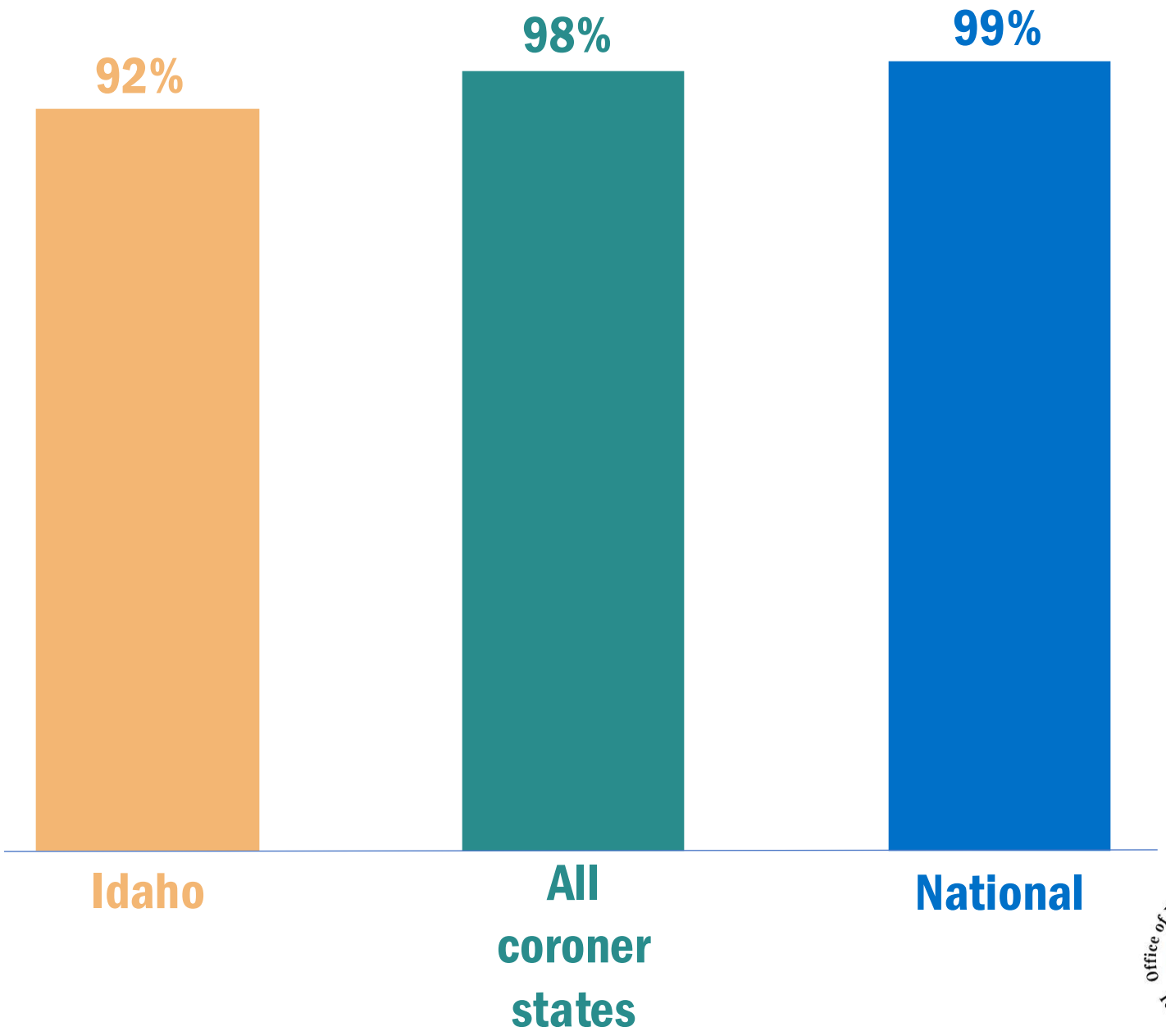
Idaho ranked 51st of 51 nationally for percentage of child deaths from external or unknown causes autopsied.



Deaths from homicide

Idaho ranked 51st of 51 nationally for percentage of homicides autopsied.

National standards recommend at least 95% of homicides are autopsied.



Future of autopsies

Idaho does not have enough forensic pathologists in the state to bring autopsy rates up to national rates or standards.

Counties would need to spend $1-$2 million more per year on autopsies to meet national rates.

Questions

Please feel free to contact me:

Casey Petti

(208) 332-1474

cpetti@ope.Idaho.gov

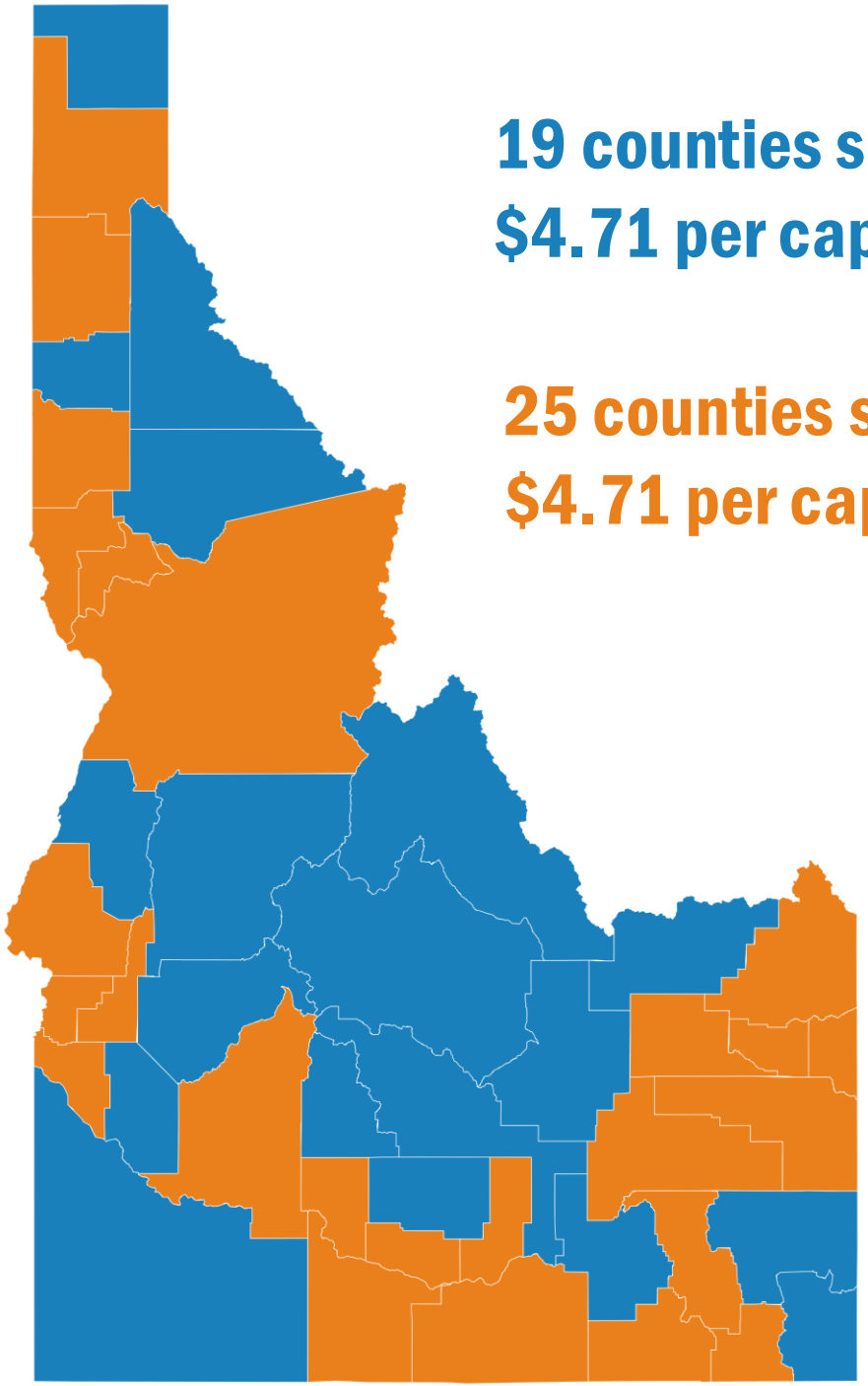
Handling of remains for religious and spiritual purposes

Idaho has no laws or guidelines specifying how coroners should handle requests from families objecting to an autopsy on spiritual or religious grounds.

Without guidance at the state level, coroner offices must create their own system of handling objections to autopsies, potentially opening up coroner offices to civil litigation.

Counties spent $4.39 per capita on coroner offices in 2022

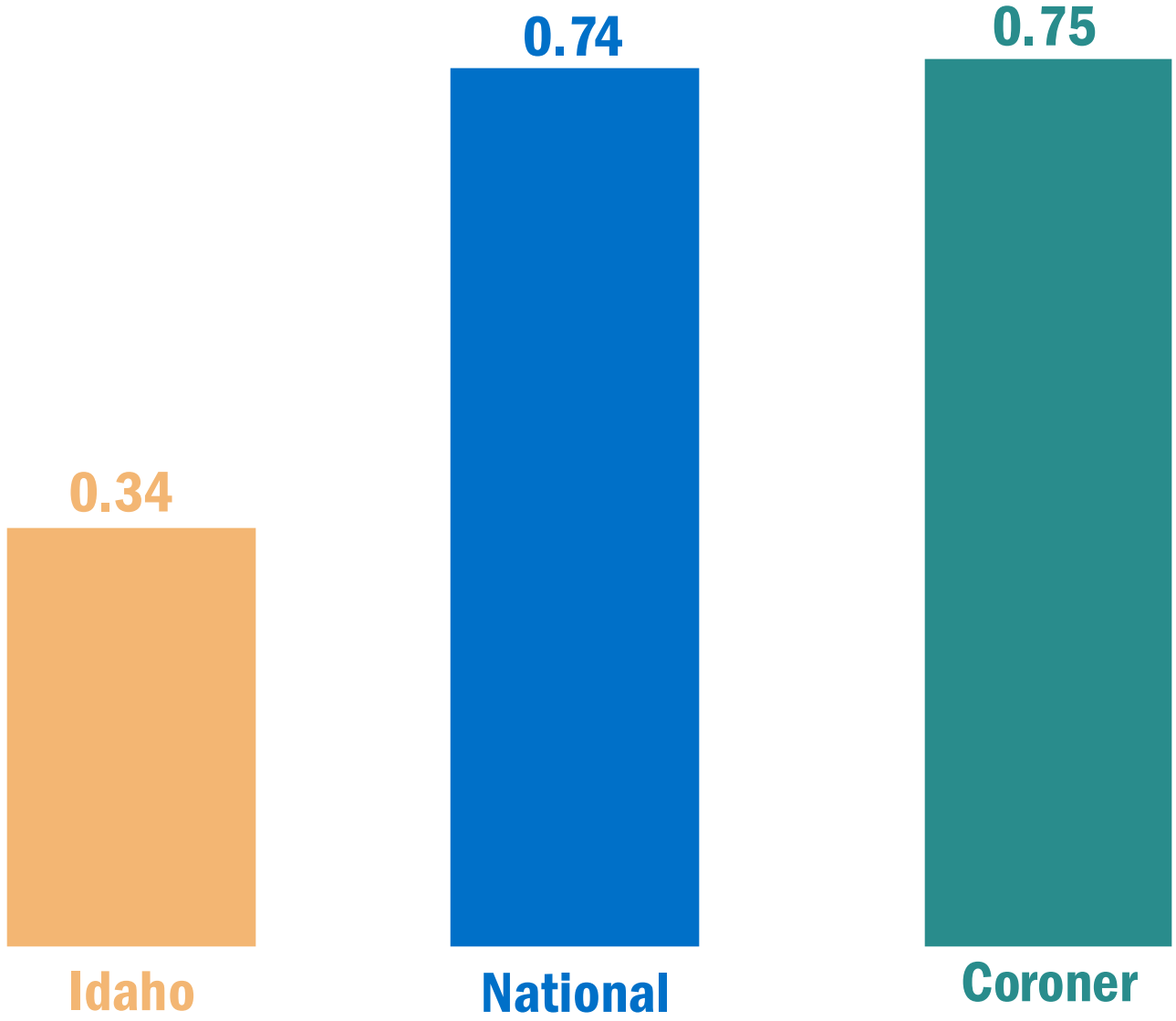
National standards recommend a per-capita expenditure of $4.71 on medicolegal death investigation services



19 counties spent above $4.71 per capita

25 counties spent below $4.71 per capita

Idaho ranked 49th of 51 nationally for autopsies per 1,000 residents from 2018 through 2022



Autopsy requirement

Autopsies in Idaho are performed at the discretion of the coroner or county prosecutor to determine cause of death.

NAME recommends 13 situations where autopsies should be performed

Many coroner states require autopsies for some deaths, such as a child or those who die in police or state custody