Evaluation report
February 2024

County Coroners and Death Investigations

Office of Performance Evaluations
Idaho Legislature

Senator Melissa Wintrow (D) and Representative Douglas T. Pickett (R) cochair the committee.

Office of Performance Evaluations

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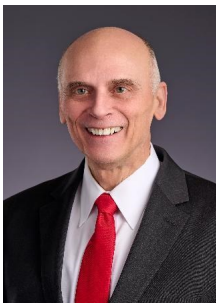
Senators

Melissa Wintrow



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From the director

February 29, 2024

Members
Joint Legislative Oversight Committee
Idaho Legislature

Idaho is one of 28 states that rely on coroners to conduct investigations into cause and manner of death. While the structure of Idaho's death investigation system is not unique, it lacks oversight and direction for coroners on many of their duties.

Idaho Code is vague on several of the duties and responsibilities of the coroner, such as what constitutes an unattended death, the roles of law enforcement and the coroner at the scene of a death, and when a coroner should conduct an autopsy. Instead of guidance from the state, county coroner offices have developed their own internal policies and procedures for death investigations, creating a fractured and inconsistent death investigation system across the state.

We found that Idaho's autopsy rate is the third lowest nationally, and last among states with coroners. In addition, Idaho ranks last of all states in autopsy rates for several metrics, such as for deaths from homicide and child deaths from external or unknown causes.

We have provided several policy considerations for the legislature that can address the gaps in state code guiding coroners and death investigations.

Sincerely,

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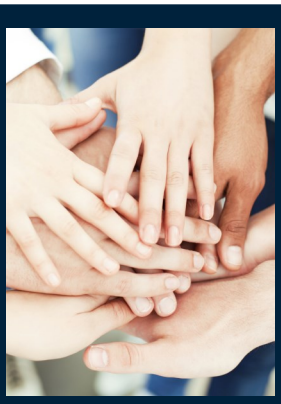

Casey Petti conducted this evaluation. Lauren Bailey and Sasha O'Connell provided quality control for the report.

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Executive summary

Why we were asked to do this evaluation.

The Joint Legislative Oversight Committee directed us to conduct an evaluation on county coroners and death investigations. The study request noted that coroner offices across the state lack uniform standards and face challenges related to funding, staffing, and training. The request asked us to examine the role of state government in regulating county coroners and death investigations, evaluate the performance of the death investigation system, and recommend how the system could be improved.

What we found.

Idaho Code directs coroners to investigate and certify the cause and manner of deaths that occur as a result of violence, have unknown or suspicious circumstances, or involve the death of a child without a known medical disease. Additionally, deaths that occur without a physician in attendance are under the jurisdiction of the coroner.

Idaho is one of 28 states that use county or regional coroners to conduct death investigations. While the design of the system is not unique to Idaho, we found coroners in Idaho have much less guidance from the state on how to operate compared to other states with coroners.

Idaho provides no oversight or assistance for coroners at the state level.

Many states with coroners have state-level entities to provide oversight or assistance to coroners, often in the form of a centralized state-level medical examiner or boards consisting of coroners. These entities often promulgate rules and regulations for coroners to follow when conducting death investigations and in their day-to-day operations, ensuring investigations are conducted in a uniform manner across the state. Statewide medical examiners also usually perform autopsies for coroner offices.

We found that Idaho has no state-level entity that provides oversight or assistance to coroners. Coroners instead must rely on other coroners for informal assistance or guidance when needed. For many counties, Ada County assumes the role typically reserved for the state medical examiner.

Idaho Code provides little to no direction for coroners on many of their critical functions and duties, creating an inconsistent death investigation system across the state.

We found many duties of the coroners were vague, ambiguous, or absent in Idaho Code. This has left coroners to create their own policies and standards to follow, making the death investigation system inconsistent across the state.

Idaho does not explicitly require notification of the coroner for some deaths frequently required in other states.

Deaths reportable to coroners

Idaho Code and Administrative Rules specify 10 types of deaths that need to be reported to coroners for investigation. This is below the national average of 15 types of deaths that must be reported. Idaho does not explicitly require the coroner to be notified for some deaths frequently required in other states, such as deaths involving individuals in jail and police custody, deaths that constitute a threat to public health, or deaths from poisoning and drug overdoses. Expanding the list of reportable deaths can ensure that coroners are immediately notified of deaths that should be under their jurisdiction and that those deaths are investigated.

Unattended deaths

Idaho does not provide a definition of a death without a physician in attendance, known as an unattended death. This has led to an inconsistent definition of unattended death being used across the state, creating ambiguities on who should be certifying a death between coroners and medical personnel. There are also questions around who should certify deaths in instances of an individual passing in an emergency room or after being admitted to a hospital unconscious. Clarifying the definition and timeliness of an unattended death can ensure that the proper authority is certifying deaths.

There is no statewide definition of an unattended death.

Law enforcement jurisdiction

Idaho does not delineate between the roles of coroners and law enforcement in a death investigation. Coroners we interviewed reported incidents where law enforcement had moved decedents from where they were found, removed them from the scene of a death, or altered ligatures and other items prior to informing the coroner of the death or allowing them to access the decedent. This can impact a coroner's ability to determine cause and manner of death and are contrary to national standards. States with coroners often explicitly state in code that a decedent is the responsibility of the coroner, and that the decedent may not be moved or altered without the consent of the coroner. Idaho Code does not provide this jurisdiction to coroners.

Autopsy requirements

Idaho Code instructs autopsies to be performed at the discretion of the coroner or county prosecutor in order to determine cause of death. An autopsy is not required for any type of death. This is contrary to other states and national standards that recommend always performing an autopsy in certain deaths, such as for deaths from criminal violence, as a result of police action or under law enforcement jurisdiction, and from acute workplace injuries. Idaho Code can also be amended to include that autopsies can be performed to determine both cause and manner of death.

Autopsies are not required for any deaths in Idaho.

Coroners are required to complete 24 hours of continuing education every two years, but it is inconclusive how many coroners are actually completing the required education.

Since 2010 Idaho Code has required coroners to complete coroner's school after taking office and participate in 24 hours of continuing education every two years in office. Idaho Code asks the Idaho State Association of County Coroners (ISACC) to identify or sponsor coroner school and continuing education courses and monitor the amount of education completed by coroners. We found that most coroners are either failing to participate in education or are not submitting completed education to ISACC. There is no action taken when a coroner fails to complete the required education. In other states, a coroner who fails to complete the required continuing education can be docked pay, suspended, or removed from office.

Coroners are the lowest paid county-elected officials statewide, and low wages are a barrier to recruiting qualified coroners and deputies.

In 2022 the median coroner pay statewide was $17,969. This was about half the median pay of the next lowest paid county-elected official, commissioners, at $38,054. Coroners often must hold additional employment outside the role of coroner to make financial ends meet. This can be difficult, as coroners are typically on duty 24 hours a day, 7 days a week. We heard from coroners that they frequently must leave their job to respond to a coroner call. Most coroner offices have deputies, but due to low coroner office funding, deputies are often part-time or are paid on a per-call basis. This creates challenges to ensuring that deputy coroners are able to complete education and training recommended by national best practice standards.

From 2018 through 2022, 3.9 percent of deaths in Idaho were autopsied, compared to 7.8 percent nationally.

Idaho's autopsy rate is the third lowest nationally, and last nationally in some key metrics like for deaths of children from external or unknown causes.

Idaho autopsied 3.9 percent of deaths from 2018 through 2022. Nationally 7.8 percent of deaths were autopsied over this period. Idaho's autopsy rate was third lowest nationally and the lowest of all states with coroners.

National standards recommend one autopsy for every 1,000 people that live in a geographic area. From 2018 through 2022, Idaho conducted 0.34 autopsies per 1,000 residents.

In 2018–2022, Idaho autopsied 49 percent of child deaths from external or unknown causes, the lowest nationally. The national autopsy percentage for these deaths was 79 percent. Idaho autopsied 92 percent of homicides over this period, the lowest in the nation. Nationally, 99 percent of homicides were autopsied in 2018–2022. National standards recommend at least 95 percent of homicides be autopsied.

Only two counties, Ada and Canyon, perform their own autopsies. All other counties must contract with Ada or Canyon counties for autopsy services or go out of state to Spokane, Washington. The cost of the autopsy and distance between a county and the closest forensic pathology lab can be a barrier for coroners when trying to get autopsies performed.

1 Introduction

Legislative interest

During the 2023 session, the Joint Legislative Oversight Committee directed our office to evaluate Idaho's death investigation system. The study request is in appendix A. The request asked our office to evaluate the design of Idaho's death investigation system in comparison to other states, examine best practices, and make recommendations for how the system could be improved.

Evaluation approach

In our early discussions with study requesters and stakeholders, we heard that Idaho statute provides little guidance or regulations for death investigations conducted by county coroners. This report describes the role of county coroners in death investigations and identifies policy considerations to remedy identified problem areas. The evaluation scope explains our study objectives in more detail in appendix B.

We analyzed data from the Department of Health and Welfare's Bureau of Vital Records and Health Statistics and Centers for Disease Control and Prevention (CDC). We conducted interviews with Idaho coroners and other stakeholders to gain insight into Idaho's death investigation system and how it can best be improved. The evaluation methodology is in appendix C.

In Idaho, only four types of professionals can certify cause and manner of death.

Upon a death, a certificate of death must be completed and filed by the person in charge of interment of the body within five days of death.[1] Morticians can fill out the demographic information of the certificate while cause and manner of death must be completed and certified by a physician, a physician assistant, an advanced practice professional nurse, or a coroner.

If a deceased person, known as a decedent, was not under a physician's care, it is the coroner's responsibility to certify the death and determine the cause and manner of death.[2] In addition, coroners have jurisdiction over deaths that result from violence, occur under suspicious or unknown circumstances, or involve a child under 18 without a known medical disease. From 2018 through 2022, 20 percent of deaths in Idaho were certified by county coroners.

Cause versus manner of death

Death certificates include both the cause and manner of death.

Cause of death is the underlying condition that led to a death, such as an injury or disease. It is the condition that causes death and does not describe how the condition occurred.

Manner of death is the circumstance that led to the cause of death. There are five classifications for manner of death: natural, accident, suicide, homicide, and undetermined.

Natural deaths are deaths caused by disease or natural processes. Accidents are deaths caused by a chance happening. Suicides are deaths that come from a purposeful, self-inflicted injury. Homicides are deaths that come from one person causing the death of another. Undetermined deaths are deaths where the manner cannot be determined either because of a lack of information or conflicting information.

Cause and manner of death must be certified by a physician, a physician assistant, an advanced practice nurse, or a coroner.

1. Idaho Code § 39-260(1)
2. Idaho Code §§ 19-4301, 39-260(2)

Each county in Idaho operates its coroner office independently.

Idaho's coroner system

Each of Idaho's 44 counties operates a coroner office headed by an elected coroner. When deaths are referred to a coroner's office, the coroner may conduct medicolegal investigations to determine the cause and manner of death. Medicolegal is the blending of medical and legal analysis, and medicolegal death investigations may include scene investigations, blood toxicology tests, autopsies, and interviews with witnesses and family members. US and Idaho administrative code permit coroners access to medical records to assist in identifying a decedent or determining cause of death.[3]

At the conclusion of a medicolegal death investigation, if the coroner determines further investigation is required due to potential criminal activities, Idaho Code instructs a coroner to deliver the information from their investigation to the county prosecuting attorney.[4]

Coroners have additional duties besides determining cause and manner of death, such as authorizing all cremations, arranging the burial or cremation of unclaimed decedents, handling the disposal or transfer of property found on a decedent, responding to stillbirths out of institutions or without an attending physician, and serving as acting sheriff when required.[5] Coroners perform administrative tasks of the office, such as budget setting, hiring and training deputy coroners, and coordinating with other county and local officials and law enforcement agencies.

Coroners have a monthly duty to report to the Department of Transportation any fatalities within their district from motor vehicle-related incidents.[6] Additionally, coroners are required to collect a blood sample for toxicological analysis from all individuals who die in motor vehicle accidents, including pedestrians.[7]

3. 45 CFR 164.512(g)(1), IDAPA 16.05.01.190
4. Idaho Code § 19-4301D
5. Idaho Code §§ 39-268(3), 31-2802, 31-2803, 31-260, 31-2806
6. Idaho Code § 49-1309
7. Idaho Code § 49-1314(1)

Coroners are asked to submit reports and deaths to organizations and databases that track particular deaths, but Idaho Code does not require coroners to provide these submissions. Submissions include the Idaho Violent Death Reporting System, which tracks violent deaths in the state; the Idaho Child Fatality Review Team, who review child deaths from non-medical causes; and the Overdose Detection Mapping Application Program (ODMAP), a national database that tracks drug overdoses.

To be eligible to hold the office of coroner, a candidate must be at least 21 years old and reside in the county in which they seek office for at least one year.[8] Once elected, coroners serve a four-year term. While in office, Idaho Code states that coroners must attend "coroner's school" within the first year of office and complete 24 hours of continuing education every two years in office.[9]

Idaho Code allows coroners to appoint deputies as necessary, though the duties and responsibilities of deputies are not specified in code.[10] We found that deputies tend to be part time or are paid on a per-call basis, meaning that they work as needed to fill in for the county coroner.

Coroners in Idaho must be at least 21 years old and reside in the county where they were elected.

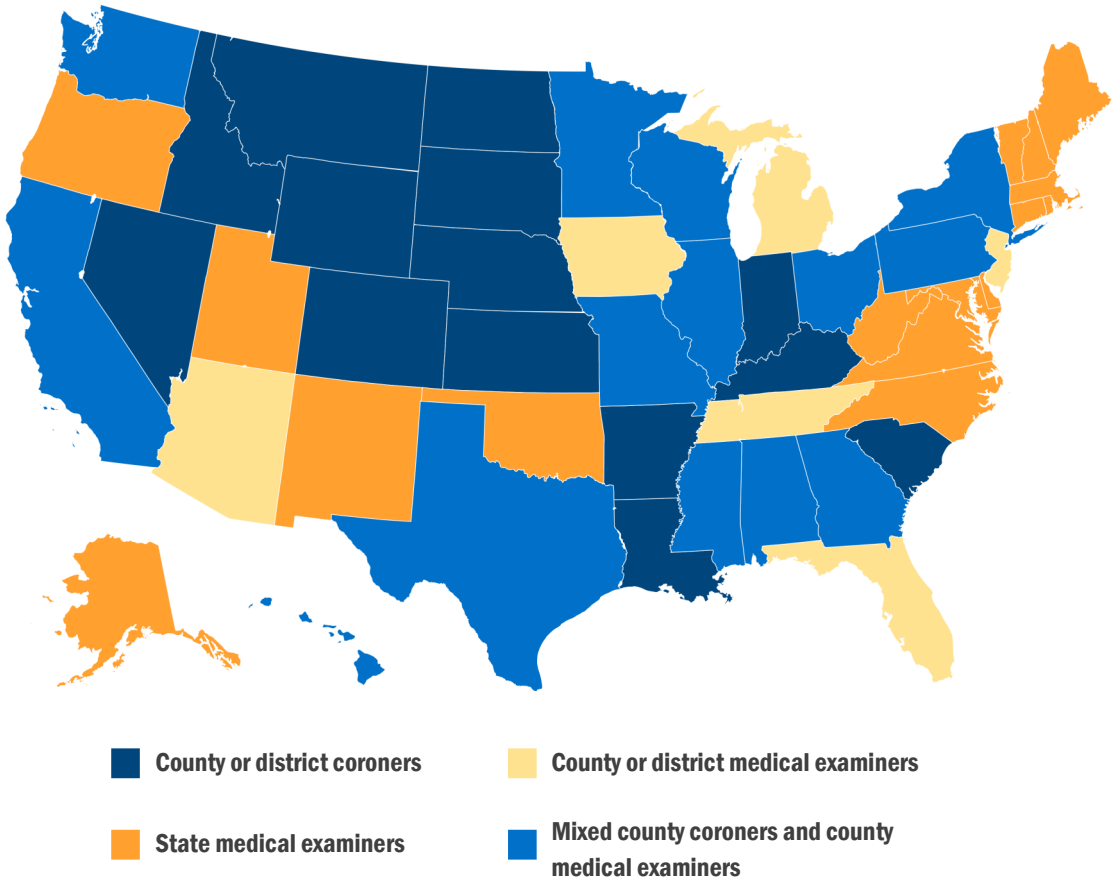
8. Idaho Code § 34-622
9. Idaho Code §§ 34-622(5), 31-2810
10. Idaho Code § 31-2809

2 System Design

Exhibit 1 shows that states use four primary forms of death investigation systems to determine cause and manner of death: county or district coroners, centralized state medical examiners, county or district medical examiners, or a mix of both county coroners and medical examiners.

Exhibit 1

States employ four different types of death investigation systems.



Source: OPE analysis and CDC data.

Idaho is one of 14 states that primarily uses a coroner system to determine cause and manner of death.

Coroner systems rely on county- or district-level coroners to determine cause and manner of death. Coroners are typically elected, though in Kansas and North Dakota coroners are appointed instead of elected.[11] Exhibit 2 shows the states with coroner systems.

Coroners generally do not need to have a medical background to serve in the position, nor do they need to have formal education or training before they run for office. Only in Louisiana, Kansas, and North Dakota are coroners required to be licensed physicians prior to taking on the role.[12] This requirement can be waived in Louisiana and North Dakota if no qualified physician runs for office.

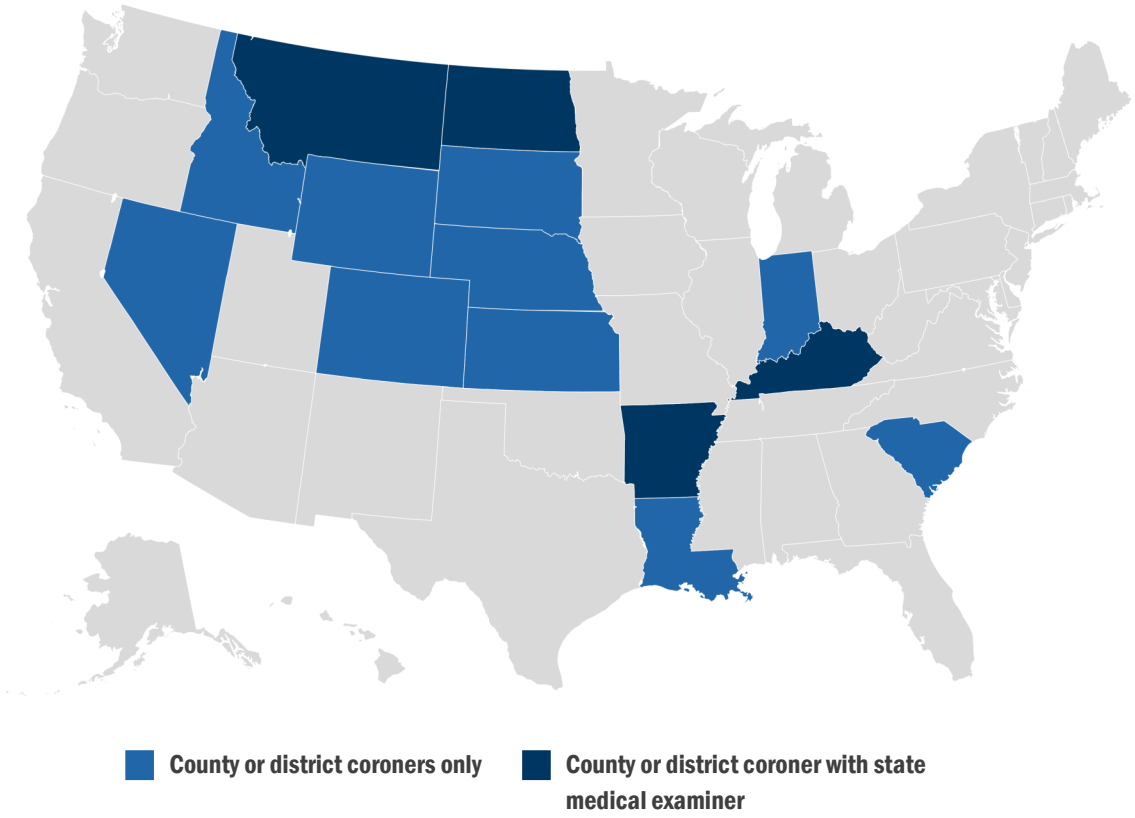
Four of the 14 states with coroner systems also have a state-level medical examiner.[13] In these states, the county coroner is still the primary authority for determining cause and manner of death while the medical examiner provides assistance to the county coroners, such as performing autopsies.

Three of the 14 states with only coroners require coroners to be licensed physicians.

11. Kan. Stat. Ann. § 22a-226(b), N.D. Cent. Code Ann. § 11-19.1-03
12. La Ann. Stat. § 13:5704(A), Kan. Stat. Ann. § 22a-226(a), N.D. Cent. Code Ann. § 11-19.1-04-1
13. Ark. Code Ann. § 12-12-306, Ky Rev. Stat. § 72.210, Mont. Code Ann. § 44-3-211, N.D. Cent. Code Ann. § 23-01-05.4

Exhibit 2

Fourteen states have county or district coroners who conduct death investigations, with four states also having a state medical examiner overseeing the coroners.



Source: OPE analysis and CDC data.

Twenty-two states have medical examiner systems, either at the state, district, or county level.

In contrast to coroners, who are generally elected to their positions, medical examiners are appointed to their roles. Moreover, medical examiners are required to have medical qualifications, often holding medical licenses with a specialization in pathology. Medical examiner systems can be categorized into two main designs: centralized state-level medical examiners and county or district level medical examiners.

State-level medical examiner system

Of the 22 states employing the medical examiner system, 16 states opt for a centralized approach (exhibit 3). In these centralized medical examiner states, a state-level medical examiner's office takes responsibility for conducting death investigations to determine the cause and manner of death. Often these states will appoint regional or local deputy medical examiners throughout the state to facilitate efficient and comprehensive investigations, though all work done is under the purview of the state medical examiner.

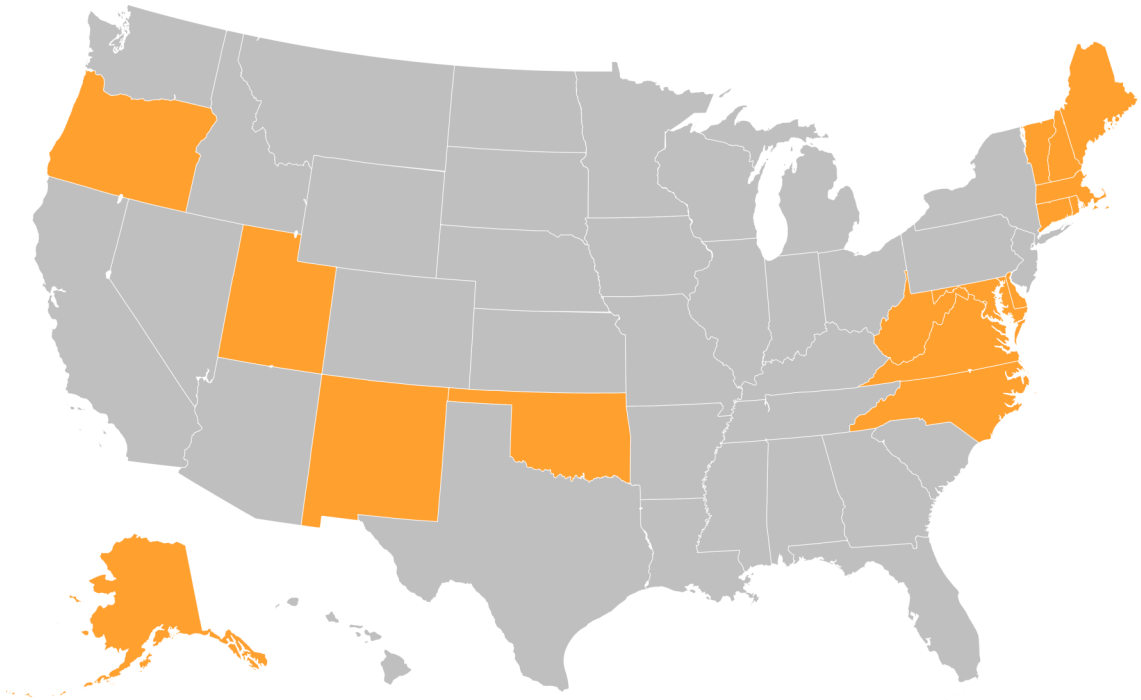
The state medical examiner's office most often operates under the jurisdiction of the state's equivalent to Idaho's Department of Health and Welfare. However, some states choose alternative arrangements, such as placing the medical examiner's office under the purview of a state university (New Mexico), state law enforcement agencies (Oregon and Massachusetts), the attorney general's office (Maine and New Hampshire), or an independent commission or board (Connecticut and Oklahoma).[14]

Medical examiners are typically appointed to the position and have medical backgrounds.

14. N.M. Stat. Ann. § 24-11-1, Or. Rev. Stat. Ann § 146.035, Mass. Gen. Laws Ann. Ch. 38 § 2, Me. Rev. Stat. 22 § 3022, N.H. Rev. Stat. § 611-B:2, Conn. Gen. Stat. Ann. § 19a-401, Okla. Stat. Ann. 63 § 933

Exhibit 3

Sixteen states use state-level medical examiners.



Source: OPE analysis and CDC data.

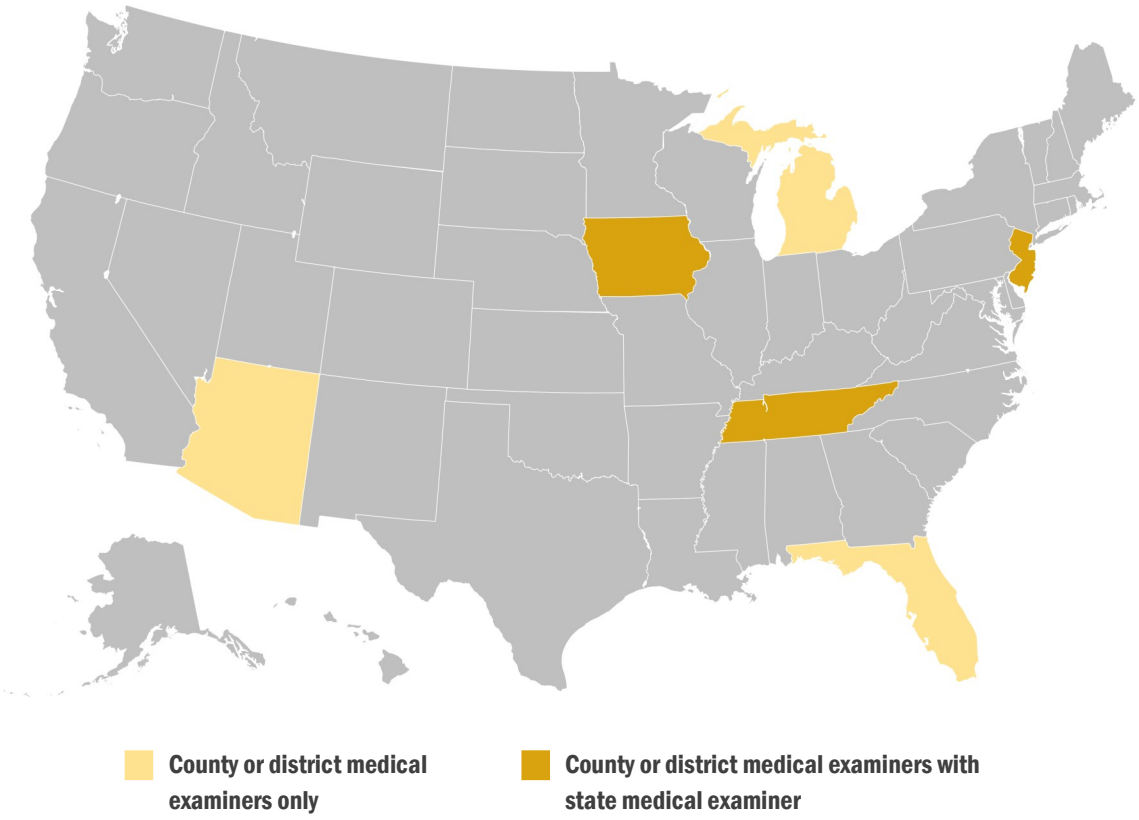
County- or district-level medical examiner system

Six states primarily rely on county or district medical examiners to conduct death investigations, as shown in exhibit 4 on page 19. In five of these states, county-level medical examiners are appointed by county officials, while Florida has a district-level medical examiner system where multiple counties are served by a single appointed district medical examiner. The roles and responsibilities of county and district medical examiners are similar to those of county coroners.

Three of the six states with county- or district-level medical examiner systems also have a state-level medical examiner.[15] As is the case with state medical examiners in county coroner states, the state medical examiner is tasked with assisting the county medical examiner system and conducting autopsies for counties.

Exhibit 4

Six states primarily use county or district medical examiners, with three states also having state medical examiners for oversight.



Source: OPE analysis and CDC data.

15. Iowa Code Ann. § 691.5, Tenn. Code Ann. § 38-7-102, N.J. Stat. Ann. § 26:6B-4

Fourteen states have a mixed county-level coroner and medical examiner system.

In states with both county medical examiners and coroners, the duties of both offices are the same.

County-level coroners and medical examiners exist simultaneously in 14 states (exhibit 5). In these states, a coroner or medical examiner is required based on factors such as population of the county or because of a county resolution.

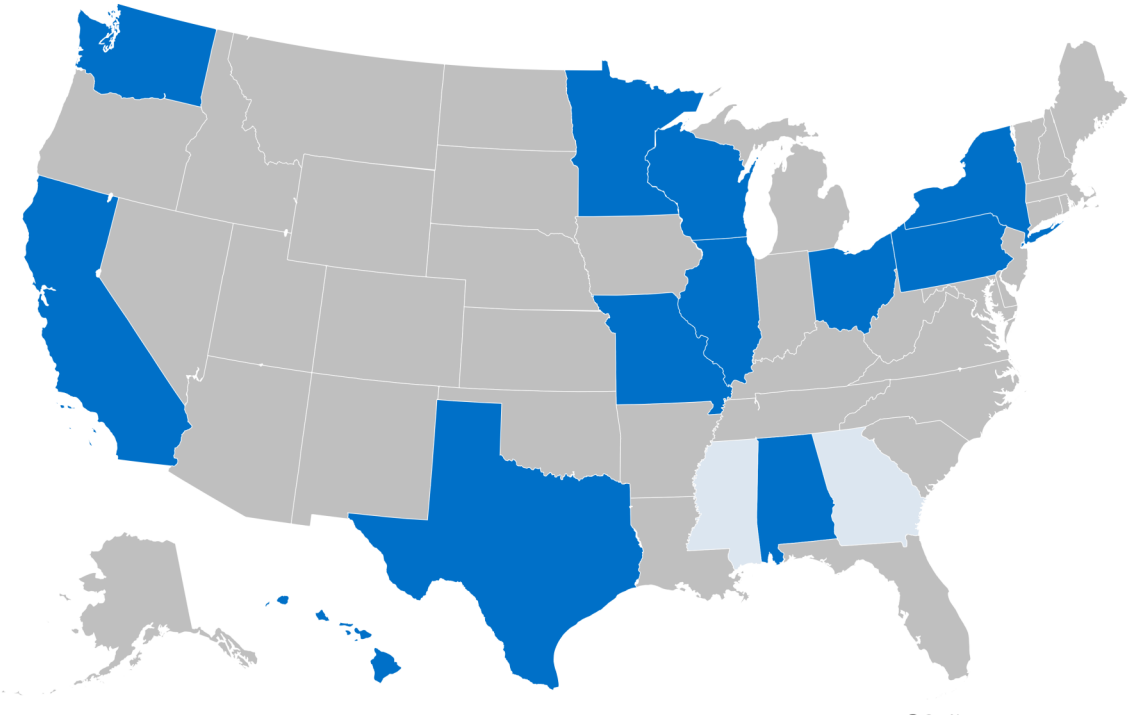
For example, in Washington counties with a population below 250,000 have coroners, while counties above this population threshold may have medical examiners.[16] California allows counties to abolish the office of the coroner in favor of appointed medical examiners should county officials elect to make the switch.[17]

As is the case with states that rely on either coroners or medical examiners exclusively, coroners are typically elected to their position without stringent requirements to hold office, while medical examiners are appointed by county officials and are medical professionals. In Minnesota, coroners are required to be a physician with a valid medical license in the state.[18] In nine of the 14 states, state code requires medical examiners to be licensed to practice medicine.[19] Regardless of the type of system used, the powers and responsibilities of coroners and medical examiners in these states are the same.

16. Wash. Rev. Code § 36.16.030
17. Cal. Gov. Code § 24010
18. Minn. Stat. § 390.005
19. Code of Ala. §§ 45-37-60.02(b) and 45-27-60.01,
Cal. Gov. Code. § 24010,
Ga. Code. Ann. § 45-16-80(c),
Minn. Ann. Stat. § 390.005 subd. 3(a),
Miss Code Ann. § 41-61-57(1),
Mo. Ann. Stat. § 58.705.1,
N.Y. C.L.S. County § 400(4-a),
Tex. Code Crim. Proc. Art. 49.25.2(a)(2),
Wash. Rev. Code. § 36.24.190

Exhibit 5

Fourteen states use a mix of county coroners and medical examiners as the primary investigators of deaths, with two states also having state medical examiners for oversight.



Mixed county coroners and medical examiners only

Mixed county coroners and medical examiners with state medical examiner

Source: OPE analysis and CDC data.

Idaho would likely not see major benefits with a county-level medical examiner system, and a process already exists for counties wanting to make that change.

Idaho's coroner system was created in 1864, 26 years before Idaho became a state.

The coroner system is a vestige of an older era before the rise of modern medicine and medicolegal death investigation practices. Idaho's coroner system was first created in 1864, 26 years before Idaho became a state. The coroner's initial purpose, conducting coroner's inquests, has been replaced by law enforcement, the judicial system, and advances in forensic examinations and autopsies.

Medical examiners, by being medical professionals prior to taking office, are more familiar with medical causes that could lead to death. However, switching over exclusively to a county medical examiner system is not feasible for Idaho, and a state medical examiner system would require a constitutional amendment if the coroner system were to be abolished.

Challenges of a county medical examiner system

Ada County employs all three forensic pathologists working in the state.

In a county-based medical examiner system, rural counties would struggle to find a medical professional that is able and willing to perform the role of a county medical examiner. In some counties it can be difficult to recruit individuals to be the coroner and some coroners reported that they took the role because no one else would. This concern is alleviated in states with mixed coroner and medical examiner systems in which county resolutions or population dictate which type of death investigation system the state employs.

There is a nationwide shortage of forensic pathologists, the physicians who specialize in determining cause and manner of death. Idaho has three licensed forensic pathologists who are all employed by Ada County. Because of their medical expertise and the shortage of professionals in this field, forensic pathologists have salaries much higher than typical county-level employees. In county fiscal year 2022 the average salary of a forensic pathologist in Ada County was $341,000. The three forensic pathologists were the highest paid county employees in county fiscal year 2022.

The limited pool of forensic pathologists and their high salaries underscore the importance of channeling their expertise primarily into conducting autopsies, rather than diverting their attention to administrative roles or on-site death scene investigations.

Coroners are defined as county officers in the Idaho Constitution.[20] The Idaho Constitution and state statute allow counties to modify local government structure if the majority of electors in the affected county approve.[21] County electors can abolish the office of coroner and establish a new office. The new office must perform all the duties of the coroner as outlined in Idaho Code, but the head of the office can be either elected or appointed. Counties have the power to establish a county medical examiner system if they choose. As of yet, no county has made this change.

6 of the 28 states with coroners have state-level medical examiners overseeing coroners.

State-level medical examiner system

Removing the office of the coroner and the responsibilities of the coroner from counties would require an amendment to the Idaho constitution. If county coroners were to be removed, a new regional system would need to be developed to cover the state and ensure that medicolegal death investigations were completed.

If policymakers want to institute a state medical examiner, it would be easier to utilize the county coroner system currently in place for medicolegal death investigations and create a state medical examiner to provide guidance and assistance to county coroners. Of the 28 states with county coroners, six have state-level medical examiners that either oversee or provide support to the coroner system.

In 2000, Idaho policymakers unsuccessfully attempted to create a state-level medical examiner to assist coroners with carrying out their duties. Idaho House Bill 515 would have placed the office of the state medical examiner under the department of self-governing agencies. The medical examiner would have been tasked with creating uniform protocols for death investigations across the state, providing assistance and consultation to coroners and law enforcement officers, and performing autopsies. The bill failed to pass in the Senate.

20. IDAHO CONST. art. XVIII §6
21. IDAHO CONST. art. XVIII §12, IDAHO CODE §§31-5408(4), 31-5510(4), 31-5610(4)

State Oversight

3

Idaho does not have statewide standardized guidelines for coroner duties. This has led to an inconsistent system, where death investigation standards and practices vary from county to county. Each county operates their coroner office independently and under their own rules, leading to death investigations and policies that are not uniform across the state.

The lack of a cohesive state framework for coroner's offices undermines the overall consistency and effectiveness of medicolegal death investigations in Idaho. In this section, we identify gaps in Idaho Code guiding the coroner system and offer policy considerations to address these gaps and align Idaho's system with national standards and other states with coroner systems.

Idaho has 44 counties and 44 death investigation systems.

Idaho has no statewide established guidelines for most county coroner duties. Nearly every aspect of the county coroner role is left to the interpretation of the individual coroner. This extends to how death investigations are conducted, what information is gathered in an investigation, how information is disclosed to the media, how records are kept, how a decedent is transported, and how next of kin are notified of a death.

Many states have entities that provide oversight or assistance to coroners. These are typically in the form of a state medical examiner's office, such as in Montana and Georgia, or state government boards comprised of coroners and other appointed officials, such as in Colorado and Wyoming.[22] These entities often promulgate rules and regulations for coroners, ensuring investigations and day-to-day operations are conducted in a uniform manner across the state. They can also provide assistance and direction to coroners when needed.

Without a state-level entity to provide assistance, Idaho coroners often rely on informal guidance or assistance from other coroners. In many counties, Ada County typically fills the role reserved for the state government, conducting autopsies on behalf of other counties and paying for electronic death investigation reporting and tracking tools. Some coroners mentioned they try to base their office policies on Ada County coroner's policies.

The Idaho State Association of County Coroners (ISACC) provides a code of ethics for coroners to follow, but it is not enforceable nor does it touch on all responsibilities of a coroner.

Idaho has no statewide established guidelines for most coroner duties.

22. Mont. Code Ann. 44-3-211, Ga. Code Ann. § 35-3-153, Colo. Rev. Stat. § 30-10-601.6, Wyo. Stat. § 7-4-211

Only two coroner offices in Idaho hold nationally recognized accreditation.

Best practices recommend for coroner offices to be nationally accredited.

The National Commission on Forensic Science recommends all offices that perform government-funded medicolegal death investigations, including coroner's offices, be accredited. The commission recommends accreditation by either the International Association of Coroners and Medical Examiners (IACME) or the National Association of Medical Examiners (NAME). According to the National Commission on Forensic Science, obtaining accreditation "demonstrates compliance with industry and professional standards and performance criteria and provides an independent measure of assurance to the tax-paying citizens of the community served."[23] Additionally, the commission recommends that all individuals conducting death investigations be registry certified by the American Board of Medicolegal Death Investigation (ABMDI).[24]

Several coroners we interviewed have or are pursuing ABMDI registry certification, which has standards and protocols to follow when conducting death investigations. In order to be registry certified by ABMDI, the applicant must (1) obtain 640 hours of medicolegal death investigation experience or 384 hours of experience with accompanying education and (2) pass an examination. Those holding ABMDI registry certification must also complete 45 hours of approved continuing education every five years.

The cost for a coroner or deputy coroner to apply to be ABMDI registry certified is $400, plus an annual maintenance fee of $50. An ABMDI registry certified coroner must be recertified at a cost of $225 every five years.

23. United States, Department of Justice, National Institute of Standards and Technology, National Commission on Forensic Science, *Accreditation of Medicolegal Death Investigation Offices,* (2015).
24. United States, Department of Justice, National Institute of Standards and Technology, National Commission on Forensic Science, *View of the Commission Certification of Medicolegal Death Investigators,* (2016).

Two county coroner offices, Twin Falls County and Ada County, are IACME accredited. Several other counties reported they are progressing toward accreditation. IACME accreditation requires offices to pass more than 130 standards, such as having established policies for death investigations, record creation and retention, post-mortem examinations, and storage and transport of decedents. Additionally, to be IACME accredited the coroner or lead death investigator in an office must be ABMDI certified and IACME recommends the majority of death investigators in an office be ABMDI certified.

The Ada County coroner's office is also NAME accredited. In order to be NAME accredited, an office must employ forensic pathologists. As such, only Ada County is eligible to receive the accreditation in Idaho. Additionally, a coroner's office is required to successfully complete a peer evaluation that involves a 300-item checklist, ensuring compliance with the standards set by NAME in various areas such as facilities, personnel, death investigations, autopsies, histology, toxicology, reporting, and record keeping.

A few states have incorporated accreditation or certification of death investigators into their laws. In Tennessee, death investigators must either be a medical professional or ABMDI certified and autopsies must be performed at NAME accredited facilities.[25] In Arkansas, death investigators who do not hold a medicolegal death investigation certification from the state are required to be ABMDI certified or hold a certification recognized by ABMDI.[26] A coroner with ABMDI certification is required to be on the Arkansas Child Death Review Panel.[27] Washington will require all coroner and medical examiner offices to hold either IACME or NAME accreditation starting on July 1, 2025, and coroners, medical examiners, and medicolegal death investigators who hold ABMDI certification will not be required to complete training and certification from the state.[28]

Ada County's coroner office is both IACME and NAME accredited.

Two coroner offices in Idaho are IACME accredited.

25. Tenn. Code Ann. §§ 38-7-104(f)(1), 38-7-105(a)
26. Ark. Code. Ann. §§ 14-14-1212(a), 14-15-308(d)(1)(A)
27. Ark. Code Ann. § 20-27-1703(b)(2)
28. Wash. Rev. Code § 36.24.210,
Wash. Admin. Code § 139-27-100(2)(b)(ii)

Application for accreditation from IACME costs between $2,000 to $4,000 depending on the population of the geographic area served. It would cost most coroner offices in Idaho $2,000 for IACME accreditation, which lasts for five years. In addition, there are annual maintenance fees between $300 to $1,200 per year.

Policy consideration

Since 2010, Idaho Code § 39-252 has required the collection of one dollar with every death certificate sold to assist with the cost of coroner education and training. The Legislature could consider updating this section of code to allow for the funds collected to also go toward applying for ABMDI certification or IACME and NAME accreditation. Following other states' examples, education requirements could be modified to exempt coroners who are ABMDI certified. This could increase the number of coroners ABMDI certified in the state.

Encouraging coroners to obtain third-party certification or accreditations of their office would improve the uniformity and standards of death investigations across the state.

Idaho Code should be updated to alleviate ambiguity in the coroner system and align itself with best practice guidelines.

In addition to a lack of oversight or guidance of the coroner system at the state level, we found Idaho Code regulating the coroner system and death investigations to be vague and full of gaps. Statutory vagueness has led to operational discrepancies in coroner systems across different counties. Additionally, this ambiguity may expose counties to lawsuits during disputes over the conduct of death investigations. We found several areas in which Idaho Code could be modified to provide guidelines and clarity for the coroner system.

Deaths reported to coroners

Idaho has one of the least defined characteristics of deaths that must be reported to the coroner or medical examiner in the nation. Idaho Code specifies nine death characteristics that are to be reported to coroners[29]:

1. deaths by violence,
2. homicide,
3. suicide,
4. accident,
5. under suspicious or unknown circumstances,
6. death of a child without a known medical disease,
7. stillbirth without a known medical disease,
8. not under the care of a physician,
9. motor vehicle accidents.

In addition, a tenth reporting requirement is in Idaho Administrative Code for the Board of Correction, which instructs state prison facilities to inform the local coroner of any deaths of inmates.[30]

29. Idaho Code §§ 19-4301, 39-260(2), 34-622
30. IDAPA 06.01.01.312.01

The average number of required reporting death characteristics in all 50 states and the District of Columbia is 15, five more than Idaho's 10. Idaho ranks 40th of 51 nationally in the total number of death characteristics that must be reported to a coroner or medical examiner.

Exhibit 6 shows the top 10 most frequently required death characteristics that must be reported to the coroner or medical examiner.

Exhibit 6

Idaho required reporting to coroners for six of the top 10 most frequently required reporting death characteristics nationwide.

Characteristics that require coroner or medical examiner notification	States that specify that characteristics in state or administrative code	Does Idaho require mandatory reporting of death characteristic to coroner?
Accident	44	Yes
Suspicious, unusual, or unnatural circumstance	44	Yes
Suicide	42	Yes
Unattended by a physicians	40	Yes
In jail or under law enforcement custody of a political subdivision	39	No
In a state prison	38	Yes
Violence	37	Yes
Suddenly when in apparent good health	36	No
May constitute a threat to public health	31	No
Suspected poison, drugs, or toxic agents	28	No

Source: OPE analysis of state code.

Nothing in Idaho Code prevents or prohibits coroners from doing death investigations for deaths outside the listed reporting requirements. However, clarifying state law to further outline the responsibilities of the coroner would provide more guidance to county coroners and clearer justification for conducting investigations. This is especially important in cases where coroners interact with other entities, such as local law enforcement, state hospitals, or places of employment.

Policy consideration

Specifying what cases are explicitly under the purview of the coroner can alleviate some confusion around whose jurisdiction a death falls under and when a death needs to be reported to a coroner. In cases where an individual dies of violence, Idaho Code specifies that the death falls under the jurisdiction of the coroner, even if the individual dies while in the hospital under the care of a physician. Idaho Code should be amended to specify coroner jurisdiction over other types of deaths that are in the public interest even if an individual dies under a physician's care, such as deaths from poisoning, substance overdoses, and deaths that may constitute a threat to public health.

Unattended death

One of the major points of ambiguity of the coroner's role is an unattended death. Unattended deaths are deaths that occur without a physician present. However, there is no statewide accepted definition of the timeliness of "unattended," which leads to confusion over jurisdiction of a decedent.

Coroners we interviewed provided different definitions of unattended deaths. Some mentioned it meant that the decedent had not seen a doctor within the past 10 days while others said up to a year. Other coroners said that "attended deaths" are only when an individual is under end-of-life hospice or hospital care. This ambiguity can lead to friction and confusion between coroners and medical professionals when trying to determine who is responsible for certifying a death certificate.

There is no consistent statewide definition of an "unattended death."

Some states provide timelines for when a decedent last saw a physician in order for a death to be unattended, spanning from 36 hours in Arkansas to 12 months in Utah.[31] Florida provides further context of what constitutes an attended death, such as if the individual was taking medications or had a known medical disease.[32]

Several coroners we spoke with described inconsistent interpretations of who is responsible for certifying deaths in some medical situations, such as emergency room deaths. Colorado code specifies that deaths in emergency rooms are the jurisdiction of the coroner, and Georgia code places coroners in charge of individuals who were admitted into a hospital unconscious and never woke before they passed.[33]

Policy consideration

By clarifying the definition of an unattended death, the legislature would alleviate ambiguity about who is responsible for certifying specific deaths.

Coroner's inquest

Coroner's inquests are heavily discussed in Idaho Code, but we found in practice they are rarely or never used. Inquests were once used to determine cause and manner of death but have subsequently been replaced by forensic pathology and law enforcement. In an inquest, a coroner would summon a jury, collect witness testimony, issue subpoenas, and, in the case of the jury ruling that an individual was responsible for a murder, issue a warrant of arrest. All of these functions have since been supplanted by law enforcement, the judicial system, and forensic pathology.

Policy consideration

Idaho Code § 19-4302 through § 19-4310 on coroner's inquests have remained largely unchanged since Idaho's first territorial laws in 1864. These sections of Idaho Code are outdated and no longer applicable. If policymakers do not want coroners to conduct inquests and instead use modern practices, this section of Idaho Code can be removed.

31. Ark. Code Ann. § 12-12-315(a)(1)(P), Utah Code Ann. § 26B-8-214(1)(a)
32. Fla Ann. Stat. § 382.008(3)
33. Colo. Rev. Stat. § 30-10-606(1)(c), Ga. Code Ann. § 45-16-24(a)(8)

Law enforcement jurisdiction

County coroners reported that questions often arise between law enforcement and the coroner over the jurisdiction of a decedent. Coroners believe the scene of the death is the jurisdiction of law enforcement and the decedent is the jurisdiction of the coroner. However, this is not specified in Idaho Code.

Idaho Code § 19-4301(2) states that when a death occurs and it is not attended or certified by a physician, the coroner should refer the investigation to local law enforcement. Idaho Code does not delineate responsibility between the coroner or law enforcement over a decedent's body.

Coroners we interviewed reported incidents where law enforcement had moved decedents from where they were found, removed them from the scene of a death, or altered ligatures and other items prior to informing the coroner or allowing them to access the decedent. This can impact a coroner's ability to determine cause and manner of death.

Best practices for death investigations state the scene of a death should be thoroughly photographed and examined by death investigators prior to the removal of a body or evidence.[34] It is important in a death investigation for a decedent to be examined as they were found for the purposes of determining manner of death.

Colorado, Indiana, Illinois, Ohio, South Dakota, and Washington have specific language in their code stating that the body of the decedent is the jurisdiction of the coroner and the decedent cannot be moved, altered, or transferred without the consent of the coroner.[35] Some states allow exceptions in order to protect public safety, identify a victim, protect property from damage, or if it interferes with activities carried on where the body was found.

Often decedents are moved from a scene of a death before a coroner is notified of a death.

Several states outline in state code that a decedent and a scene of a death is under the jurisdiction of the coroner.

34. U.S. Department of Justice, National Institute of Justice, *Death Investigation: A Guide for the Scene Investigator*, (2011).
35. Colo. Rev. Stat. § 30-10-606(1.2)(b),
Burns Ind. Code Ann. § 36-2-14-6(d),
55 Il. Comp. Stat. Ann. § 5/3-3019, Ohio Rev. Code Ann. § 313.11(A),
S.D. Codified Laws § 23-14-19, Wash. Rev. Code Ann. § 68.50.010

Policy consideration

Idaho Code can be updated to clarify the roles and responsibilities of coroners and law enforcement in death investigations, specifically around the jurisdiction of a decedent's body at the scene of a death. If policymakers want a decedent at the scene of a death to be under the jurisdiction of the coroner, then Idaho Code should reflect this.

Role of law enforcement in coroner death investigations

We heard some coroners in Idaho rarely, if ever, attend the scene of a death.

Some coroners rely on law enforcement to conduct death investigations on their behalf. While not prohibited in Idaho Code, this is contrary to established best practices that say there should be separate, though cooperative, death investigations conducted by law enforcement and coroners.[36] We heard that some coroners rarely, if ever, go to the scene of a death and instead use pictures and evidence collected by law enforcement as their basis for determining cause and manner of death.

The Organization of Scientific Area Committees for Forensic Science recommends that coroners attend all deaths under certain circumstances, including deaths as a result of violence, suicide, homicide, accident, and traffic related deaths, all of which are under the purview of coroners as defined in Idaho Code.[37]

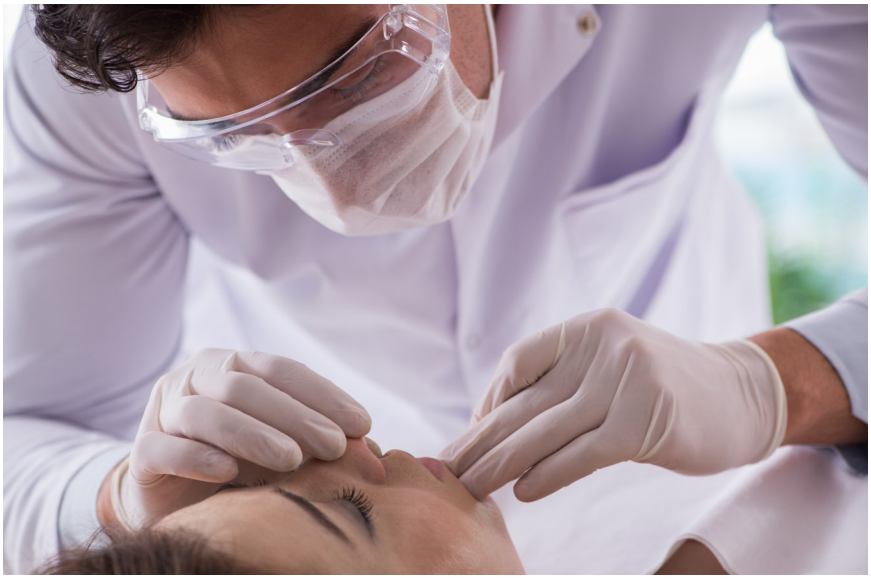
Medicolegal and criminal death investigations do not serve the same purpose and should be conducted separately.

Death investigations conducted by law enforcement and coroners serve different purposes. Law enforcement investigations are focused on determining if a crime was committed, while medicolegal death investigations determine cause and manner of death. A coroner would need to rely on third party information to determine cause and manner of death if they do not conduct the investigation themselves. Additionally, law enforcement cannot fill out a death certificate.

36. Melinek, Judy, Lindsey C. Thomas, William R. Oliver, Gregory A. Schmunk, Victor W. Weedn, and the National Association of Medical Examiners Ad Hoc Committee on Medical Examiner Independence, "National Association of Medical Examiners Position Paper: Medical Examiner, Coroner, and Forensic Pathologist Independence", *Acad Forensic Pathol*, 3(1), (2013): 93-98.
37. Organization of Scientific Area Committees for Forensic Science, Medicolegal Death Investigation Subcommittee, *Medicolegal Death Investigation Response to Death Locations and Incident Scenes: Best Practice Recommendations,* (2022).

Most law enforcement in Idaho only receive a high-level overview of death scene investigations during training. Of the 570 hours of basic law enforcement training provided by Idaho Peace Officers Standards and Training (POST), four hours consist of crime scene investigation instruction. This instruction is to help peace officers determine if a death is from natural causes or if it is a suspicious death. Coroners should have more specific training on identifying cause and manner of death than law enforcement because of the requirement in Idaho Code that coroners partake in continuing education on the subject.

We found one state with a coroner system, Indiana, with a published guidebook that discusses the roles and responsibilities of police officers and coroners at the scene of a death.[38] The guidebook was created by the Indiana State Coroners Training Board. Indiana's guidebook recommends that law enforcement and coroners should work cooperatively in gathering and collecting evidence but should independently render their own conclusions in an investigation.



38. Skelton, David T., Harry L. Marsh, DeVere D. Woods Jr., "A Publication of the Indiana Coroners Training Board," *Indiana State Coroners Training Board*, (2001).

Medicolegal autopsies in Idaho are done at the discretion of the coroner, and no deaths are required to be autopsied.

NAME has 13 types of deaths that should always be autopsied.

Autopsy requirement

Idaho Code states that autopsies are performed at the discretion of the coroner or prosecuting attorney when it is deemed necessary to accurately and scientifically determine the cause of death.[39] While this broad definition allows for coroners to conduct autopsies, it is not in line with national standards. Autopsies are not only used to determine cause of death but are also used to determine manner of death. There can be cases in which the cause of death is easy to determine, but the manner can be difficult without further examination.

NAME recommends 13 situations in which autopsies of decedents should be performed[40]:

1. The death is known or suspected to have been caused by apparent criminal violence,
2. The death is unexpected and unexplained in an infant or child,
3. The death is associated with police action,
4. The death is apparently non-natural and in custody of a local, state, or federal institution,
5. The death is due to acute workplace injury,
6. The death is caused by apparent electrocution,
7. The death is by apparent intoxication by alcohol, drugs, or poison, unless a significant interval has passed, and the medical findings and absence of trauma are well documented,
8. The death is caused by unwitnessed or suspected drowning,
9. The body is unidentified and the autopsy may aid in identification,
10. The body is skeletonized,
11. The body is charred,
12. The forensic pathologist deems a forensic autopsy is necessary to determine cause or manner of death, or document injuries/disease, or collect evidence,
13. The deceased is involved in a motor vehicle incident and an autopsy is necessary to document injuries and/or determine the cause of death.

39. Idaho Code § 19-4301B
40. National Association of Medical Examiners, *Forensic Autopsy Performance Standards*, Gary F Peterson and Steven C Clark, (2022).

Many other states with coroners require autopsies for certain types of deaths. For example, we found that 10 of the 28 states with coroners require an autopsy for the death of a child under certain circumstances.[41] Six coroner states require autopsies of individuals who die in police or state custody.[42]

Policy consideration

Having a detailed list of when autopsies are required or recommended in Idaho Code can strengthen the position of coroners when they determine an autopsy is needed to uncover cause or manner of death. It can also ensure that autopsies are performed in cases where certain individuals, like children, are involved or in instances of deaths resulting from particular causes.

Autopsy performance

Idaho Code does not specify what type of physician may conduct medicolegal autopsies, just that it must be an individual authorized to practice medicine and surgery in the state.[43] This is contrary to best practice guidelines published by NAME, which state that forensic pathologists should conduct all medicolegal autopsies in death investigations.[44] Although most autopsies in Idaho under the guidance of a coroner are currently performed by a forensic pathologist, updating Idaho Code to require a forensic pathologist to conduct autopsies would align with national standards.

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41. Cal. Gov. Code § 27491.41(c),
Ga. Code Ann. § 45-16-27.1(a),
55 Il. Comp. Stat. Ann. § 5/3-3016,
La. Rev. Stat. § 13:5713(C)(1)(a),
Neb. Rev. Stat. Ann. § 23-1824(1),
N.D. Cent. Code § 11-19.1-11-3,
Ohio Rev. Code § 313.121(B),
S.C. Code Ann. § 17-5-520(A),
Tex. Code Crim. Proc. Art. 49.10(e)(2),
Wis. Stat. Ann. § 979.03
42. 55 Il. Comp. Stat. Ann. § 5/3-3015,
Kan. Ann. Stat. § 22a-233(b),
Mont. Code Ann. § 46-4-103(6)(a),
Neb. Rev. Stat. Ann. § 23-1822,
Nev. Rev. Stat. § 209.3815,
Wis. Stat. Ann. § 979.025
43. Idaho Code § 19-4301B
44.National Association of Medical Examiners, *Forensic Autopsy Performance Standards*, Gary F Peterson and Steven C Clark, (2022).

Idaho Code does not prevent a coroner from sharing information gathered in a medicolegal death investigation.

Dissemination of death investigation information

We found that information gathered by coroners in a death investigation is not considered confidential, which can potentially impact an ongoing criminal investigation. While death certificates are confidential for 50 years after death, at which point they enter public record, this is not true for investigatory documents and information gathered by the coroner in the process of a death investigation.[45]

Idaho Code § 74-124 exempts disclosure of investigatory records in certain situations, such as if the disclosure would interfere with law enforcement proceedings, deprive a person of a right to a fair trial, or endanger the life or safety of law enforcement personnel. However, this only applies to information compiled for law enforcement purposes by a law enforcement agency.

The ISACC code of ethics outlines that coroners "shall respect the confidentiality of any information received by him/her in the performance of his/her duties," but coroners are under no legal obligation to follow the ISACC code of ethics.

A study conducted in 2013 by the Office of Legislative Research in Connecticut found that nine states had laws addressing the disclosure of crime scene photos and 26 states had laws addressing the disclosure of autopsy reports.[46] These laws specify what information is open to public dissemination. If the information is considered confidential, the laws specify who is able to receive the information and under what circumstances.

Policy consideration

The Legislature should consider updating Idaho Code to include regulations on confidentiality of information gathered by coroners in a death investigation to lessen the chance of impeding a criminal investigation and respecting the privacy of a decedent's next of kin.

45. Idaho Code § 39-270(e)
46. Connecticut Legislature Office of Legislative Research, *States' Laws on Disclosing Crime Scene Photographs, Autopsy Reports, and 911 Tapes and Transcripts*, (2013)

Handling of remains for religious and spiritual purposes

Idaho Code § 19-4301(5) states that nothing in the section about coroner death investigations "shall be construed to affect the tenets of any church or religious beliefs." However, Idaho has no laws or guidelines specifying how coroners should handle requests from families objecting to an autopsy on spiritual or religious grounds or when an objection can be overruled.

Federal case law permits conducting autopsies of a decedent despite the religious objections of a family as long as there is a compelling state interest to conduct the autopsy and the law or policy guiding the autopsy authorization is generally applicable and facially neutral. That is, the law or policy is consistently and uniformly applied and is not written in a manner that discriminates against a specific group.

Due to the lack of state guidance, coroner offices rely on county-level internal policies of when to do an autopsy. This can potentially lead to civil lawsuits if a religious objection to an autopsy is not properly addressed or if the internal policy is not facially neutral and generally applicable.

In 2022, a decision by a US District Court judge determined that Kootenai County's internal policy on when to conduct autopsies violated a decedent's First and Fourteenth Amendment rights.[47]

Some states with coroners outline how coroners should handle religious or spiritual objections or practices. Coroners in Washington are required to provide family access to a decedent for the purposes of conducting spiritual practices or ceremonies to honor or recognize an indigenous person's passing.[48] Minnesota state law specifies when religious objections to an autopsy can be overruled for a compelling state interest.[49]

Policy consideration

By clarifying in Idaho Code the rights of a family over the handling of a decedent, policymakers can increase transparency of when a family may access a decedent for religious or spiritual purposes and create a uniform policy across the state on how to handle objections of autopsies for religious or spiritual purposes.

Idaho Code does not provide direction to coroners on how to handle objections to autopsies on religious or spiritual grounds.

47. James v. Kootenai Cnty., 631 F. Supp. 3d 919, (D. Idaho 2022)
48. Wash. Rev. Code § 68.50.325
49. Minn. Ann. Stat. § 390.11 subd. 2b

Idaho Code requires coroners to conduct continuing education but there is no enforcement for coroners who do not comply.

Coroners are required to complete 24 hours of continuing education every two years they are in office.

Since 2010, coroners in Idaho have been required to complete "coroner's school" within a year of taking office, as well as participate in 24 hours of continuing education for every two years of holding office.[50] We found that participation in continuing education has been dropping, potentially because the education requirement is not enforced and there are no consequences for not completing the education requirement.

Idaho Code was amended in 2010 to assess a one dollar charge on purchases of death certificates that goes toward funding coroner education.[51] This money goes to ISACC, who then distribute the money to coroners seeking education. As of the publication of this report, the ISACC reported it had $188,000 in its coroner training fund. The Department of Health and Welfare's Bureau of Vital Records and Health Statistics was in the process of distributing an additional $163,000 to the association.

ISACC spent approximately $60,000 on coroner education each year in fiscal year 2021 through fiscal year 2023 and budgeted $58,000 for education in fiscal year 2024.

In addition to receiving funding for coroner training, ISACC is tasked with identifying coroner education courses and monitoring education completed by coroners.[52] We found that most coroners either do not submit their completed education to the association or are failing to participate in education altogether.

50. Idaho Code §§ 34-622(5), 31-2810
51. Idaho Code § 39-252(2)
52. Idaho Code § 31-2810

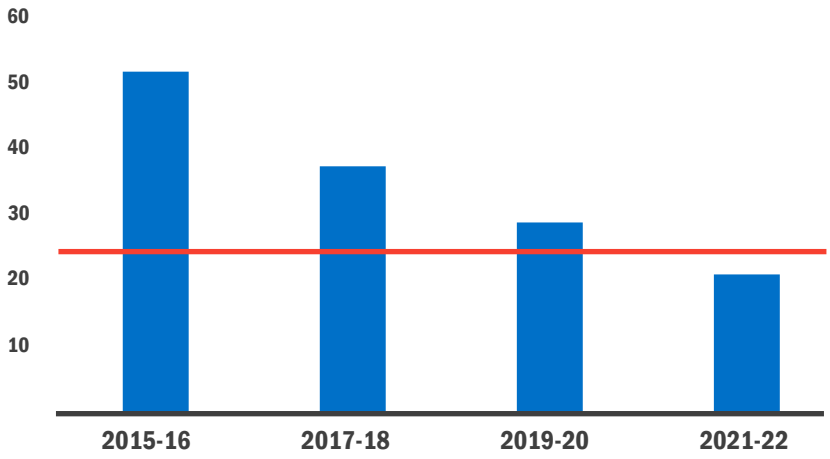
We have education attainment data on 34 coroners for the years of 2021 and 2022.[53] Of those 34 coroners, only 11 coroners completed at least the mandatory 24 hours of continuing education and submitted their education data to ISACC for 2021-22. The remaining 23 coroners either completed less than 24 hours of continuing education or did not submit their information to the association.

We have education attainment data on 22 coroners who have been in office since at least 2015. As seen in exhibit 7, the average amount of education hours submitted for these 22 coroners has continually decreased. It is unclear if this is because coroners are not completing education or if they are not submitting completed education to the association. In 2015-16, 16 of the 22 coroners completed at least 24 hours of mandatory continuing education. By 2021-22, only nine of the 22 coroners completed the minimum mandatory continuing education.

Most coroners are either failing to complete the required continuing education or are not submitting their completed education.

Exhibit 7

The average hours of reported continuing education completed by coroners has been dropping since 2015, and it fell below the required 24 hours in two years for 2021-2022.



Source: OPE analysis of data provided by the Idaho Association of Counties.

53. Once a coroner leaves office their education data is no longer tracked. We do not have education attainment data for the 10 coroners who were in office in 2020 and 2021 but are no longer in the position.

23 of the 28 states with coroners require them to undergo continuing education.

A majority of states that require continuing education for coroners place punitive action on coroners who fail to complete the education requirement.

Other state's education requirements

Of the 28 states with coroners, 23 require some type of education for coroners. Of the five states that do not require education, two require coroners to be licensed physicians and one, Nevada, allows for counties to determine the education requirements of the office.[54]

Often the education courses are created, implemented, and overseen by a government entity. These government entities are most frequently specific coroner education boards, such as in Colorado, Indiana, and Wyoming, or part of their state's equivalent to POST.[55] Of the 23 states that require coroners to participate in education, only three states do not have a state agency or board in charge of overseeing the education. Idaho is one of these three states.

At least half of the states with education requirements for coroners have consequences for not completing the education requirements. Consequences can range from a suspension in pay in Colorado, a suspension from office in Alabama, a forfeiture of office in Montana, and a misdemeanor in Wyoming.[56] Idaho does not have a mechanism in place to hold coroners accountable if they do not complete the required education.

54. Nev. Rev. Stat. § 244.163.1
55. Colo. Rev. Stat. § 30-10-601.6, Burns Ind. Code Ann. § 4-23-6.5-7, Wyo. Stat. Ann. § 7-4-211
56. Colo. Rev. Stat. § 30-10-601.9, Code of Ala. § 11-5-31(g), Mont. Code Ann. § 7-4-2905(2)(b), Wyo. Stat. Ann. § 7-4-103(b)

Washington reimbursement program

Outside of county prosecutors, who are required to be certified with the Idaho State Bar, county elected officials in Idaho are not required to complete any education or training to hold office.[57] To encourage continuing education and training of coroners in Washington, county coroner offices that are accredited by IACME or NAME receive more reimbursement from the state for their autopsy costs than offices without an accreditation.[58] A similar program in Idaho could entice coroners into completing education without the threat of suspension or removal from office.

57. Idaho Code § 34-623(2)
58. Wash. Rev. Code § 68.50.104

Only 2 of the 28 states with coroners define them as first responders.

National organizations recommend that coroners and their staff be classified as first responders.

Both IACME and NAME recommend that coroners be recognized as first responders. However, only Indiana and Washington specify that coroners are first responders.[59] Classifying coroners and their staff as first responders would provide two major benefits to the office: access to workers' compensation for mental -mental injuries and access to state-provided naloxone.

Types of injuries for workers' compensation claims

There are four types of injury claims for workers' compensation: physical, physical-mental, mental-physical, and mental-mental.

Physical-mental injuries are when a worker suffers a physical injury that leads to a mental injury, such as post-traumatic stress disorder (PTSD).

Mental-physical injuries are when an individual suffers a mental injury from work that leads to a physical injury. An example of a mental-physical injury is a heart attack stemming from the stress of a job.

Mental-mental injuries are a mental injury that comes because of mental stress while working. This would include PTSD from witnessing a traumatic event.

59. Burns Ind. Code Ann. § 10-10.5-2-1(8), Wash. Rev. Code § 70.54.430(6)(b)

Workers' compensation for mental-mental injuries

For most workers in Idaho, mental-mental injuries do not qualify for workers' compensation coverage. Idaho Code § 72-451 states that workers' compensation claims must involve physical injury. In 2018, Idaho Code § 72-451 was amended to allow first responders to qualify for workers' compensation for post-traumatic stress disorder (PTSD) arising from a mental injury on the job.

First responders have a higher rate of PTSD and depression than most professions due to the mental demands of the position. Studies have shown that coroners, medical examiners, and their employees have similarly high rates of PTSD and depression.[60] One study found that 15 percent of coroners met criteria for diagnostic levels of PTSD and 22 percent had shown signs of depression.[61] Additionally, the study found 17 percent of medicolegal death investigators working in a coroner's office likely had PTSD and 26 percent showed signs of depression.

Many coroners we interviewed discussed the mental stress of the job, such as exposure to traumatic deaths. Exposure to traumatic deaths is a known contributor to stress and PTSD.[62]

Studies have shown coroners and their employees have a high rate of PTSD and depression.

60. Flannery Jr., Raymond and Thomas Greenhalgh, "Coroners and PTSD: Treatment Implications," *Psychiatric Quarterly*, 89, (2018): 765 -770, doi: 10.1007/s11126-018-9580-9.
61. Brondolo, Elizabeth, Robin Wellington, Elena Brondolo, Thomas J. Brondolo, and Douglas Delahanty, "Work-Related Predictors of Psychological Distress Among Medical Examiner and Coroner Personnel," *Academic Forensic Pathology*, 2, issue 1, (2012): 80-91, doi: 10.23907/2012.011.
62. Raymond and Greenhalgh, "Coroners and PTSD: Treatment Implications", 766.

In addition to handling scenes of deaths, coroners are also responsible for speaking with the family of the deceased and testifying in court, both which have been correlated with secondary post-traumatic stress.[63, 64]

Incorporating coroners and their deputies as qualified first responders under Idaho Code § 72-451(6)(b) would allow coroners and their deputies to receive assistance paying for mental health therapy. Many coroners reported their county did not provide access to a mental health plan for them or their deputies.

The cost to allow coroners and deputy coroners access to workers' compensation for PTSD is unclear. The cost to counties would depend on increases in workers' compensation premiums paid for by the counties. Such increases in premiums would be the result of actuarial analysis done by the workers' compensation insurance company the county employs.

The overall impact on workers' compensation insurance premiums from adding coroners to mental-mental injury coverage would likely not be as large as when first responders were covered for mental-mental injuries starting in 2018. This is due to the lower overall number of coroners and coroner deputies employed by counties compared to first responders employed by counties.

Of the 28 states with coroners, 13 allow coroners access to workers' compensation claims for mental-mental injuries. Access to workers' compensation for mental-mental injuries in these 13 states is due to state laws that apply to all employees, not just coroners. We did not find a state that provides coroners with specific access to workers' compensation for mental-mental injuries.

63. Levin, Andrew P., Heidi Putney, Danielle Crimmins, and Jonathan G. McGrath, "Secondary Traumatic Stress, Burnout, Compassion Satisfaction, and Perceived Organizational Trauma Readiness in Forensic Science Professionals," *Journal of Forensic Sciences,* 66(5), (2021): 1758-1769, doi: 10.1111/1556-4029.14747.
64. Coleman,. Jennifer A., Douglas L. Delahanty, Joseph Schwartz, Kristina Murani, and Elizabeth Brondolo, "The Moderating Impact of Interacting With Distressed Families of Decedents on Trauma Exposure in Medical Examiner Personnel," *Psychol Trauma*, 8(6), (2016): 668-675, doi: 10.1037/tra0000097.

Naloxone

In 2023, the Idaho Legislature passed House Bill 350, which made free naloxone kits provided by the state only available to first responders. As coroners are not classified as first responders, they are not able to receive naloxone from the state. Naloxone is a medicine that can reverse an opioid overdose.[65]

Coroners go into the scene of opioid overdose deaths. They are often responsible for inspecting and transporting decedents that have passed away from drug overdoses. In their normal duties, coroners and their deputies are potentially exposed to opioids, such as fentanyl, which can place their lives in danger.

Policy consideration

The Legislature should consider granting coroners and their staff access to free naloxone kits provided by the state. Specifically allowing coroners to access naloxone would not be unprecedented. In 2023, South Carolina amended state law to recognize coroners as first responders in certain circumstances to allow them to possess and administer opioid antidotes such as naloxone.[66]

65. Idaho Department of Health and Welfare, *Overdose Response*, retrieved from https://healthandwelfare.idaho.gov/services-programs/behavioral-health/overdose-response

66. S.C. Code Ann. § 17-5-135

4 Finances and Equipment

The financial resources and operational capabilities of coroner offices are dependent on county-specific factors. In county fiscal year 2022, the statewide expenditure on coroner offices was a minor fraction of overall county budgets. Coroner's offices were the least funded county offices statewide. We found a notable disparity in coroner funding distribution between counties, with less populous counties often allocating more on a per-capita basis than more populous counties.

Coroners consistently rank as the lowest-paid among county-elected officials, though there is a wide variance in coroner salaries across the state. The lack of essential resources and equipment in many coroner offices further hampers their operational efficiency. Budgetary limitations of coroner offices not only affect coroners but also impact the hiring of deputy coroners and medicolegal death investigators. Overall, the financial challenges faced by coroner offices influence the capacity of coroners in Idaho to meet national standards in medicolegal death investigations.

Counties spent $8.5 million on coroner offices statewide in county fiscal year 2022.

Coroner expenditures represented 0.55 percent of all county budgets in fiscal year 2022. The average expenditure per coroner's office was $193,000. This trails the average expenditure for other county-elected positions, such as commissioners and treasurers.

Expenditure per capita

In county fiscal year 2022 Idaho counties spent $4.39 per-capita on county coroner offices. A 2013 working paper by the Scientific Working Group for Medicolegal Death Investigation recommended spending $3.75 per-capita annually on medicolegal death investigation services, or $4.71 when adjusted to 2022 dollars.[67,68] This recommendation was based on analysis of funding levels needed to provide the basic operational services that meet National Association of Medical Examiners (NAME) accreditation and other professional standards.

As shown in exhibit 8, we found that 19 of Idaho's 44 counties expended above the recommended amount in fiscal year 2022. The majority of those 19 counties were low-population counties. Of the top 10 most populous counties in Idaho, only Ada County had a per capita expenditure above $4.71.

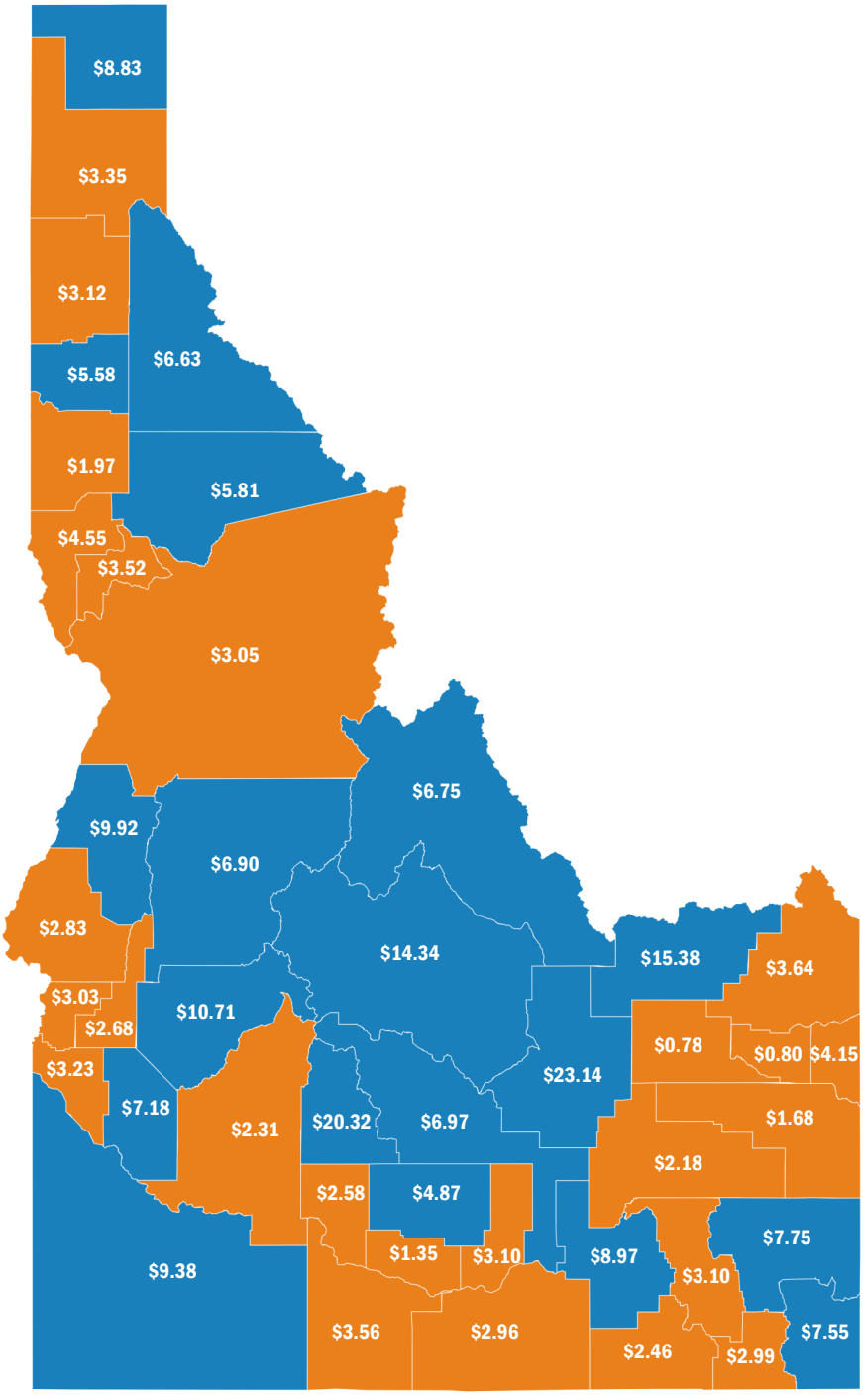
The average expenditure per coroner's office in Idaho was $193,000 in 2022.

In 2022, Idaho counties spent $4.39 per capita on coroner's offices.

67. Scientific Working Group on Medicolegal Death Investigation, System Infrastructure Committee, *Regional Medicolegal Autopsy and Death Investigation Centers: Construction, Staffing, and Costs*, (2013).
68. Dollars are adjusted to 2022 dollars using the U.S. Department of Labor's Bureau of Labor Statistics' annual Consumer Price Index for All Urban Consumers (CPI-U).

Exhibit 8

Nineteen counties had a per-capita expenditure on coroner services above the recommended $4.71 in fiscal year 2022, with the remaining 25 counties spending below that amount.



Source: OPE analysis of Idaho State Controller's Office's Local Transparency Data and US Census Bureau's Annual Estimates of Resident Population for Counties.

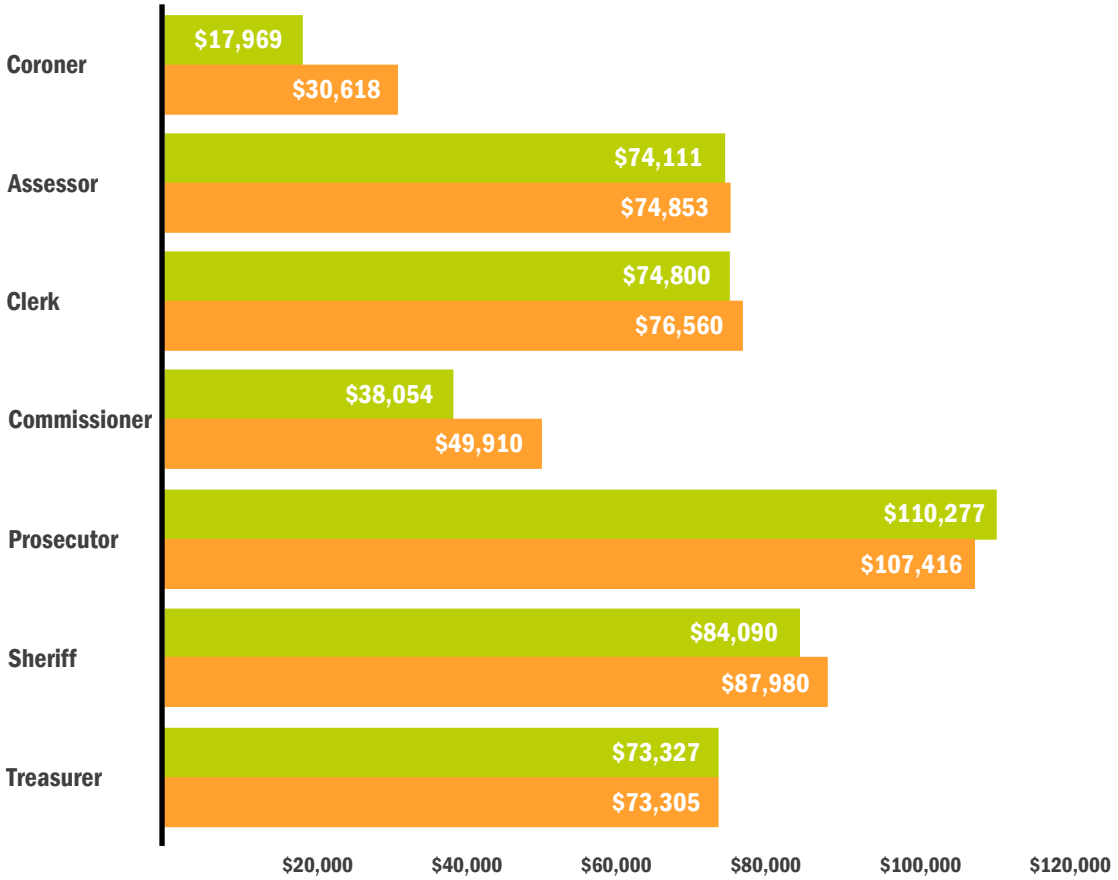
Coroners had the lowest average and median salaries of all county-elected officials in fiscal year 2022.

We found that coroner salaries varied greatly among Idaho counties. In county fiscal year 2022, coroner salaries ranged from $3,160 to approximately $125,000 per year, with a median salary of $17,969 and an average salary of $30,618 per year.

Coroner salaries trail behind salaries for other county-elected officials. Exhibit 9 below compares the average and median wage of coroners to wages received by other county elected officials.

Exhibit 9

Coroners had the lowest median and average salaries of all county elected officials in fiscal year 2022.



Source: OPE analysis of Idaho State Controller's Office's Local Transparency Data.

Coroners were the lowest paid county officials in 42 of Idaho's 44 counties.

In fiscal year 2022, coroners were the lowest paid county elected officials in 42 of 44 counties. Two counties, Owyhee and Payette, had lower salaries for their commissioners than coroners. In three counties, Ada, Bannock, and Bonner, coroner salaries were the same as the assessor, clerk, and treasurer salaries.

Statewide, coroner salaries made up approximately 16 percent of coroner budgets, though this data was heavily skewed by Ada County. When Ada County was removed from the analysis, coroner salaries were approximately 26 percent of coroner budgets in fiscal year 2022.

The Idaho Association of Counties has conducted an annual salary and benefits survey of all 44 counties since 2015. Coroner salaries have increased since the introduction of the salary survey. Coroner salary growth has lagged behind other county-elected officials in terms of actual dollars, but has increased the most in terms of percentage growth.

In the 2015 survey, the average coroner salary was $18,765. In the 2023 survey, the average coroner salary had increased to $31,467. Exhibit 10 shows the growth of average and median salaries of county-elected officials between the association's 2015 and 2023 surveys.

Coroners are on call 24 hours a day, 7 days a week.

Coroners typically need additional income outside of their coroner salary due to their low salaries. Because coroners are on call 24 hours a day, 7 days a week, balancing the responsibilities of a coroner and holding another job can be difficult. Coroners we interviewed reported times when they had to leave their regular job to do their duties as coroner, impacting the income gained from their primary employment.

Most coroners in Idaho are considered part-time employees by their counties. However, some coroners we spoke with reported that even though they are part-time, they often work 40 or more hours per week.

The amount of work a coroner performs fluctuates based on the number of deaths a county experiences and the types of deaths. The time investment for each death investigation varies based on the investigation requirements. For counties in Eastern Idaho, transporting a decedent to Ada County for an autopsy is a two-day commitment alone, in addition to other investigative duties such as scene investigations, gathering medical records, filling out the death certificate, and interviewing witnesses and family.

Exhibit 10

Coroners had the lowest total increase in average and median salary but the highest percentage increase in salary of county officials from 2015–2023.

Official	2015 survey average salary	2023 survey average salary	Increase in average salary	Percentage increase
Assessor	$56,034	$73,462	$17,428	31%
Clerk	$57,388	$77,135	$19,747	34%
Commissioner	$36,512	$49,750	$13,238	36%
Coroner	$18,765	$31,467	$12,702	68%
Prosecutor	$77,491	$109,843	$32,351	42%
Sheriff	$64,106	$88,747	$24,641	38%
Treasurer	$55,860	$74,516	$18,656	33%

Official	2015 survey median salary	2023 survey median salary	Increase in median salary	Percentage increase
Assessor	$53,040	$73,734	$20,694	39%
Clerk	$53,904	$74,880	$20,976	39%
Commissioner	$26,865	$38,043	$11,178	42%
Coroner	$9,500	$17,952	$8,452	89%
Prosecutor	$78,193	$112,258	$34,065	44%
Sheriff	$60,339	$83,969	$23,630	39%
Treasurer	$53,040	$74,489	$21,449	40%

Source: OPE analysis of Idaho Association of Counties annual salary and benefits survey. The table excludes Boise, Elmore, and Lincoln Counties for all offices due to missing or incomplete data. All numbers rounded to closest dollar.

The 2015 survey represents salaries in county fiscal year 2014 and the 2023 survey represents county fiscal year 2022

County financing impacts coroners' ability to perform their duties.

Coroners reported that county financing plays a significant role in their ability to effectively run their office and conduct death investigations. Many coroners mentioned not having access to basic equipment to do their jobs and needing to rely on expensive third parties to transport decedents for autopsies.

Coroner equipment and offices

Equipment provided to the coroners by their counties varies between counties. The National Institute of Justice identifies 44 recommended items for death scene investigations.[69] These include items such as body bags, specimen containers, cameras, and blood test kits. Some coroners we spoke with mentioned that their counties do not provide basic tools to do their job, such as a computer or camera, and instead must use their own personal devices.

Many coroners we spoke with did not have an office provided to them by the county. In these instances, coroners work at alternative locations, such as makeshift offices in their homes or in workspaces provided by their regular job.

Coroners frequently mentioned they did not have a cooler to store decedents or a vehicle to transport decedents.

Most frequently coroners mentioned they did not have a cooler to store decedents nor an adequate vehicle to transport decedents from the scene of a death or to a forensic pathology lab for an autopsy.

Third-party transport of a decedent for autopsy costs from $225—$1,600 per trip.

Many coroners rely on local funeral homes to transport and store decedents. Allowing a third-party to store a decedent breaks the chain of custody in a medicolegal death investigation, which does not align with the National Institute of Justice's best practices. Using third-party storage and transportation can incur additional costs on a county's coroner system. Coroners we interviewed reported the cost for third-party transport of decedents to a forensic pathology lab ranged from $225—$1,600 per trip.

69. U.S. Department of Justice, National Institute of Justice, *Death Investigation: A Guide for the Scene Investigator*, (2011).

To assist coroners with the travel demands of the job, counties in Kansas and Wyoming reimburse coroners for miles traveled while performing coroner duties.[70] In Washington, counties are responsible for autopsy transportation costs but the state may reimburse counties up to 40 percent of costs incurred.[71]

Several coroner states provide funding to coroner offices for death investigation equipment through fees on death certificates. Illinois has a $2 surcharge fee on death certificates, of which 25 percent goes toward coroner equipment.[72] Missouri and Pennsylvania have a $1 fee on death certificates that goes toward coroner training, supplies, and equipment.[73] Nevada has a $4 fee on death certificates that is used for coroner equipment, training, and programs to support the mental health of coroner office employees.[74]

Several states provide funding for equipment in coroner offices through fees collected from death certificates.

Deputies and staff

Funding levels typically do not permit coroners to hire full-time deputy coroners in most counties. Many deputy coroners work on a per-call basis when needed. In fiscal year 2022, there were 93 people employed by coroner's offices statewide in addition to the elected county coroners. This employee count included deputy coroners, medicolegal death investigators, office administrative staff, forensic pathologists, and autopsy technicians. A third of these employees, 31, were employed by Ada County. Eighteen counties had no specific coroner office employees outside of the elected coroner.

Coroner offices employed 93 people besides the coroner in 2022.

Of the 93 coroner office employees, 73 were either deputy coroners or medicolegal death investigators. Deputy coroners and medicolegal death investigators are the individuals who directly help coroners conduct death investigations at the scene of a death. Those two positions had an average annual salary of $27,149 with a median salary of $8,788 statewide in fiscal year 2022, as shown in exhibit 11. We heard from coroners that limited working hours and pay can be a barrier when trying to recruit or retain deputy coroners.

70. Kan. Stat. Ann § 22a-228(b), Wyo. Stat. § 7-4-210(a)
71. Wash. Rev. Code § 68.50.104(2)(a)(i)
72. 410 Il. Comp. Stat. Ann. § 535/25.5
73. Mo. Ann. Stat. § 58.208.1(1), 35 Pa. Stat. § 450.206(c)(3)
74. Nev. Rev. Stat. Ann. § 440.715.1

Idaho Code does not require deputy coroners and medicolegal death investigators to attend training and education, but the International Association of Coroners and Medical Examiners (IACME) and NAME both recommend that employees conducting death investigations receive training and continuing education. Of the 28 states with coroners, at least 15 require deputies to receive some sort of training or education.

As of 2023 Idaho State Association of County Coroners has made funding available to deputy coroners who wish to attend approved training and education opportunities. Coroners mentioned that the limited hours for deputies and the need to have someone available to provide coroner services to a county at all times can limit the ability of deputy coroners to partake in continuing education.

Exhibit 11

The most populous counties in Idaho had higher salaries for coroner deputies and medicolegal death investigators in county fiscal year 2022.

County	Total number of deputies and medicolegal death investigators	Full-time deputies and medicolegal death investigators	Average salary	Median salary
Ada County	14	14	$63,082	$60,705
Bannock County	2	2	$61,826	$61,826
Bonneville County	3	0	$7,077	$6,617
Canyon County	4	4	$60,942	$51,897
Kootenai County	5	2	$46,037	$46,501
Twin Falls County	3	3	$48,450	$39,853
All remaining counties	41	1	$7,966	$4,413
Statewide	73	26	$27,149	$8,788

Source: OPE analysis of Idaho State Controller's Office's Local Transparency Data.

Autopsies and toxicology

Autopsies of decedents cost from $1,800—$2,119 each, depending on what services are performed and which forensic pathology lab is used.[75] Coroners need to budget for the cost of transporting a decedent to the forensic pathology lab. Coroners in Eastern Idaho must also budget for accommodations to stay the night in Ada County. Chapter 5 discusses the cost of autopsies and expenditures on autopsies in further detail.

Autopsies cost $1,800—$2,119 each.

State lab toxicology program

When an individual is suspected to have died of a substance overdose or while under the influence of a substance, coroners will often elect to conduct a toxicology screening. Toxicology screenings can determine what substance, if any, the decedent had in their system when they passed and whether their death came as a result of a substance.

Most coroners use NMS Labs for toxicology tests.

Coroners primarily rely on a private lab in Pennsylvania, NMS Labs, for toxicology screenings. The cost for a postmortem toxicology screen at NMS Labs ranges from $266 to $545, depending on the tier of the screening selected. NMS Labs' basic postmortem toxicology test screens for alcohol and commonly abused illicit and prescription drugs, while the higher tiers provide options to screen for an expanded panel of illicit drugs.

In 2023, the Idaho Crime Lab began a program offering free toxicology tests to coroners.

In 2023, the Idaho State Crime Lab began offering a toxicology screening service for some county coroners as part of the Governor's *Esto Perpetua* initiative to track drug overdoses in the state. The program is free to county coroners and results are expected to take as little as 48 hours once the program is fully online. As of the publication of this report, the service has only rolled out to select counties. The program is planned to open up to all counties in 2024.

75. Ada County increased the cost of full autopsies in 2023, from $2,000 to $2,300 per autopsy. All autopsy data in this report is from prior to the price increase.

The Idaho State Crime Lab could save counties money if coroners elect to use this service in lieu of third-party labs. Additionally, the Idaho State Crime Lab has an agreement with ODMAP and would submit overdose deaths to the database that are not submitted by coroners.

However, the program cannot replace the use of third-party toxicology labs entirely. The state crime lab will only test for illicit substances when they run toxicology screenings. The crime lab will not be checking for substances that are legal to have, such as over-the-counter pharmaceuticals, which could lead to some overdoses being missed. Coroners will still be required to conduct third-party toxicology screenings in some investigations.

Autopsies and Death Investigations

5

Autopsies play a critical role in determining cause and manner of death. Certain factors can influence whether an individual receives an autopsy, such as who certified the death, the age of the decedent, and the distance a county is from a forensic pathology lab. We analyzed data from 2018 through 2022 and found that Idaho's autopsy rate lags behind best practice standards and national averages. Idaho lacks the necessary resources and infrastructure to raise the autopsy rates to align with national standards.

Coroners certified 20 percent of deaths in Idaho from 2018 through 2022.

The number of death investigations conducted by coroners in Idaho is not tracked.

Death investigations conducted by county coroners are not tracked in Idaho. In lieu of this data, we looked at the number of deaths that were certified by coroners as a proxy for the number of death investigations conducted per year.

Deaths certified by coroners do not represent the actual number of death investigations. Deaths that are certified by someone other than a coroner may still have a death investigation conducted, and not all deaths certified by a coroner will have a corresponding death investigation.

Not every death in Idaho is referred to coroners for investigation. Most deaths in the state are certified by medical professionals.

There were 80,422 total deaths in Idaho from 2018 through 2022. Of these deaths, 16,216 were certified by county coroners. Exhibit 12 shows the number of deaths and who certified the death from 2018 through 2022.

Exhibit 12

Physicians certified the majority of deaths in Idaho from 2018 through 2022.

Death certificate certifier	Deaths certified	Percentage of all deaths certified
Physician	54,084	67.3%
Physician assistant	743	0.9%
Advanced practice professional nurse	9,352	11.6%
Coroner	16,216	20.2%
Other or not reported	27	0.03%

Source: The Department of Health and Welfare's Bureau of Vital Records and Health Statistics.

Percentages do not add up to 100% due to rounding.

Most counties rely on Ada County's forensic pathology lab for autopsies.

Of Idaho's 44 counties, only Ada County and Canyon County conduct their own autopsies. Canyon County has a hospital pathologist on staff who conducts autopsies, while Ada County employs three forensic pathologists to conduct autopsies. All other counties in Idaho must contract with a third-party to conduct their autopsies.

Ada County is the primary provider of autopsies for 33 counties. Eight counties in northern Idaho use the Spokane County medical examiner's office in Washington. One county, Owyhee, uses Canyon County for their autopsies. Both the Ada County coroner's office and the Spokane County medical examiner's office are NAME accredited. Ada County also holds an IACME accreditation.

The cost of an autopsy varies by the provider. In 2022 Ada County charged $2,000 for a full autopsy, Spokane County charged $2,119, and Canyon County charged $1,850. Ada County increased the price of a full autopsy to $2,300 in 2023. Both Ada and Canyon counties provide limited autopsies and external inspections at a lower price than a full autopsy, but most work done by Ada and Canyon Counties for other counties were full autopsies.

Collectively, the 42 counties without pathologists spent an estimated $2.8 million on autopsies from 2018 through 2022, not including transportation and any additional costs such as toxicology tests.

Only Ada and Canyon Counties have pathologists who perform autopsies.

From 2018 through 2022, counties spent an estimated $2.8 million on autopsies.

Nearly four percent of deaths in Idaho were autopsied in 2018–2022.

Best practices recommend 1 autopsy for every 1,000 residents in an area.

Idaho conducted 0.34 autopsies for every 1,000 residents.

Autopsies were performed on 3,146 deaths in Idaho between 2018—2022. Autopsy rates can be expressed in two ways. The first is the percentage of deaths that were autopsied. Statewide, 3.9 percent of deaths were autopsied in 2018–2022. The percentage of deaths autopsied varied by county, ranging from a low of 0.4 percent to a high of 16.7 percent. Exhibit 13 on page 63 shows the percentage of deaths autopsied by county.

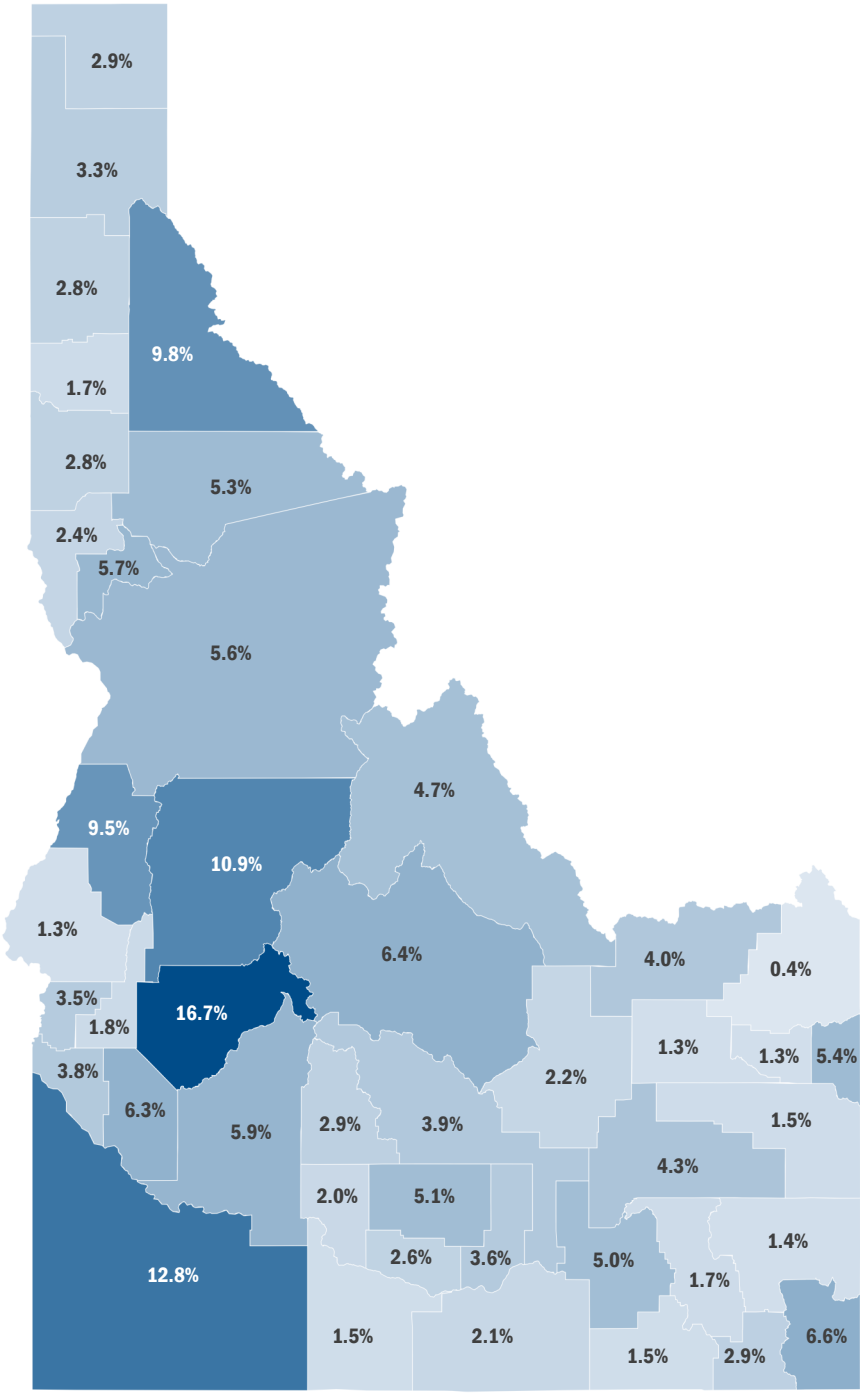
The second way to express autopsy rates is on a per-capita basis. A 2013 report by the Scientific Working Group for Medicolegal Death Investigation recommended one autopsy for every 1,000 people that live in a geographic area.[76] Idaho conducted 0.34 autopsies for every 1,000 residents in 2018–2022. Only three counties, Boise, Owyhee, and Shoshone Counties, autopsied more than the recommended 1 per 1,000 people. Exhibit 14 on page 64 shows the number of autopsies per 1,000 people in each county in Idaho.

Several factors can influence whether or not a death is autopsied. Most notably, the age of a decedent, the location of the death, and the individual who certified the death can influence the odds that a decedent receives an autopsy.

76. Scientific Working Group on Medicolegal Death Investigation, System Infrastructure Committee, *Regional Medicolegal Autopsy and Death Investigation Centers: Construction, Staffing, and Costs*, (2013).

Exhibit 13

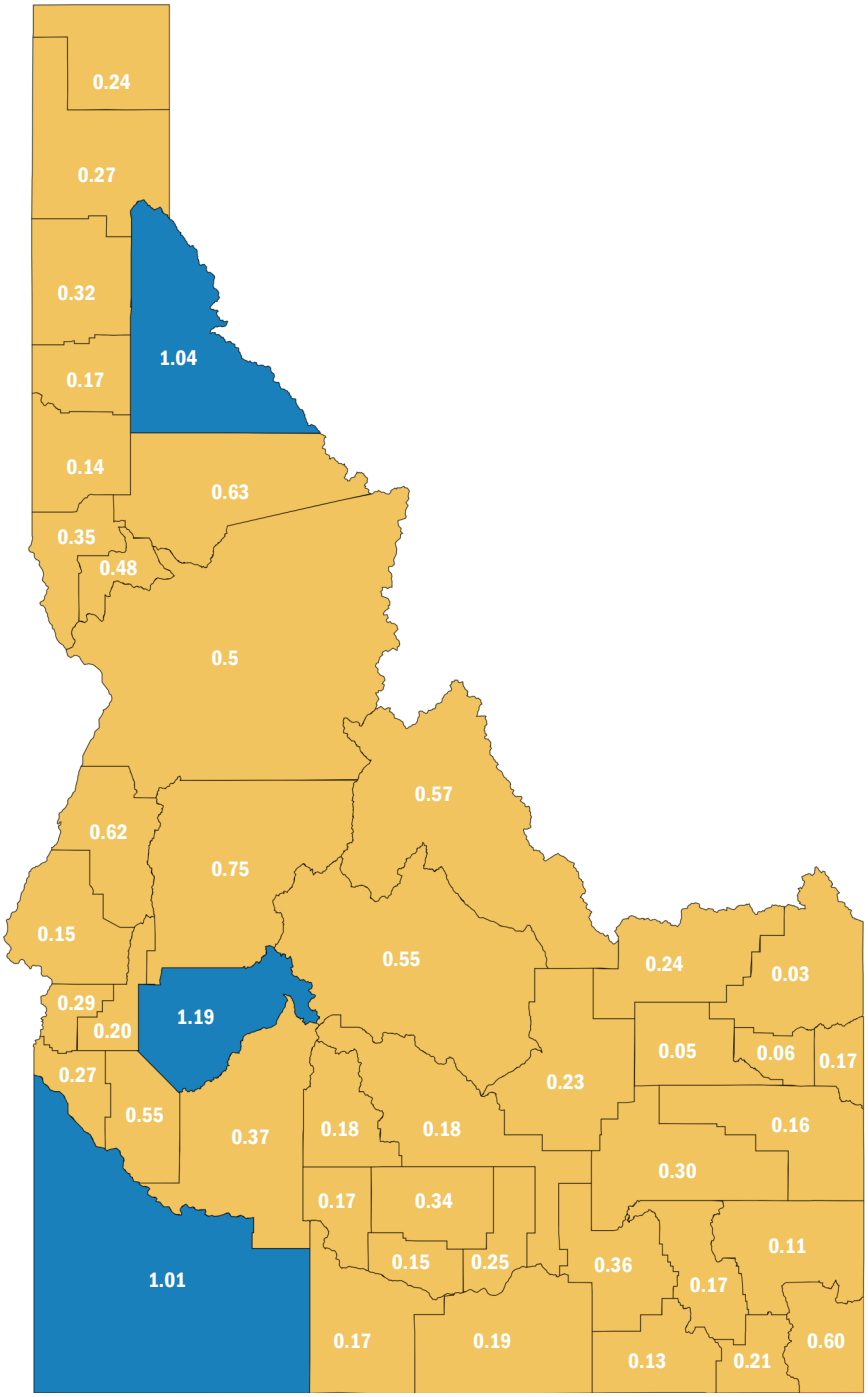
In 2018–2022, counties autopsied between 0.4 percent to 16.7 percent of deaths.



Source: The Department of Health and Welfare's Bureau of Vital Records and Health Statistics.

Exhibit 14

In 2018–2022, three counties exceeded the recommended autopsy rate of 1 per 1,000 residents while 41 counties fell short of the recommendation.



Source: The Department of Health and Welfare's Bureau of Vital Records and Health and US Census Bureau, Population Division data.

Autopsies by age of decedent

Deaths involving individuals who were under the age of 65 were far more likely to have an autopsy than individuals who were 65 or older. Exhibit 15 shows the percentage of deaths that were autopsied by age group from 2018 through 2022.

Older decedents were less likely to be autopsied than younger decedents.

Exhibit 15

Deaths involving individuals under the age of 65 are more likely to be autopsied than deaths involving individuals aged 65 and higher.

Age of decedent	Deaths	Autopsies	Percentage of deaths autopsied
A < 1 year	454	141	31.1%
Age 1-4	98	46	46.9%
Age 5-14	189	51	27.0%
Age 15-24	983	300	30.5%
Age 25-34	1,459	466	31.9%
Age 35-44	2,234	518	23.2%
Age 45-54	3,942	532	13.5%
Age 55-64	9,378	535	5.7%
Age 65-74	16,261	340	2.1%
Age 75-84	21,269	155	0.7%
Age 85 and older	24,155	62	0.3%

Source: The Department of Health and Welfare's Bureau of Vital Records and Health Statistics.

The lower percentage of autopsies for those over the age of 65 is in line with national trends.

Decedents ages 65 and higher comprised 77 percent of all deaths from 2018 through 2022, but only represented 18 percent of the autopsies performed in the state. The lower percentage of autopsies conducted on older adults compared to other decedents aligns with national autopsy rates.[77] A study by the US Department of Justice showed that coroners and medical examiners are "failing to assume jurisdiction over elder deaths that should be investigated."[78]

The four reasons for not assuming jurisdiction of deaths cited in the study were:

- a lack of studies on the prevalence of elder abuse,
- a lack of training on the signs of elder abuse for coroner and medical examiner employees,
- a bias against investigating elder deaths by coroners and medical examiners, and
- limited funding and overwhelming workloads of coroner and medical examiner offices.

At least forty-two government jurisdictions nationwide have set up elder abuse fatality review teams.[79] Fatality review teams can be used to identify patterns of elder abuse and neglect, which can ensure that proper investigations are taking place when needed. In many jurisdictions the coroner or medical examiner is a member of the fatality review team. Idaho does not have a state-level elder abuse fatality review team.

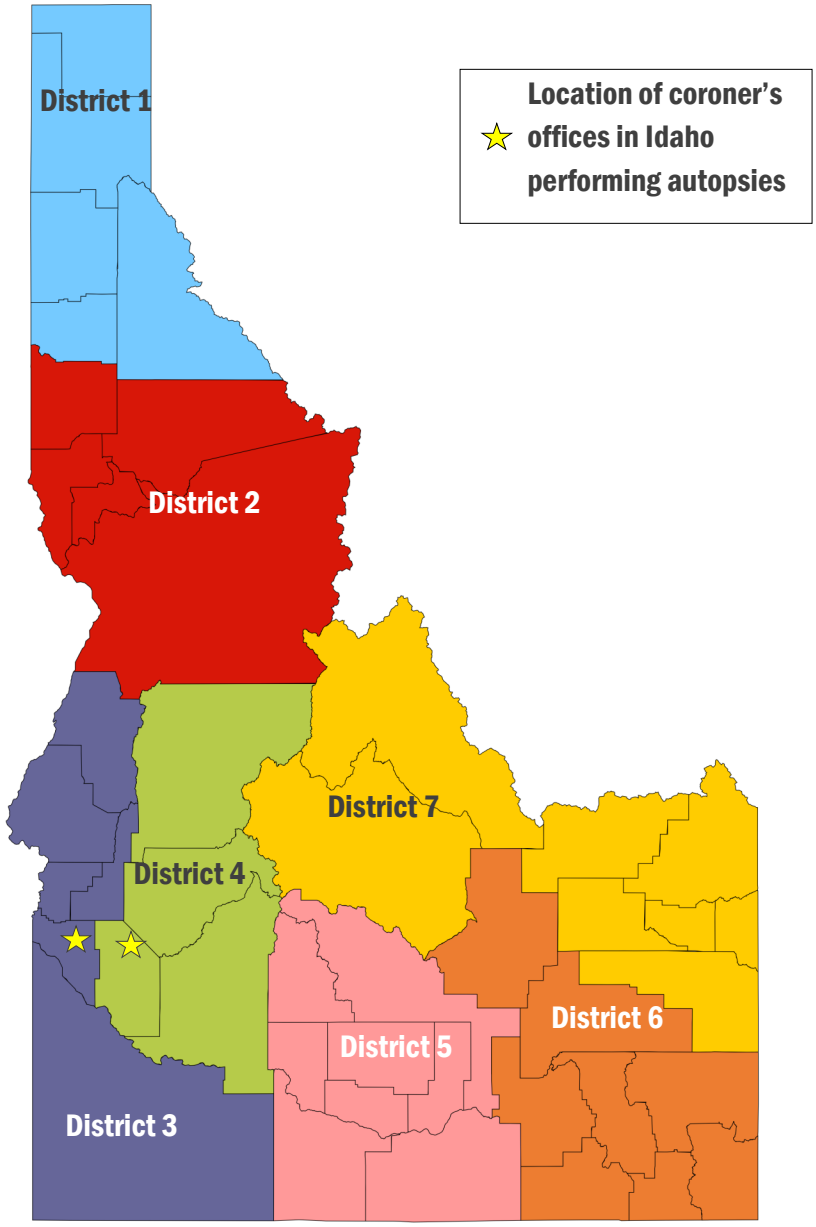
77. Hoyert, Donna L, "Autopsies in the United States in 2020," *U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System,* 72, 5, (2023)
78. Mosqueda, Laura and Aileen Wiglesworth, "Coroner Investigations of Suspicious Elder Deaths," *UC Irvine, School of Medicine*, (2012).
79. Costello, Erica C.R., "Elder Abuse Fatality Review Teams Following the COVID-19 Pandemic," *American Bar Association, Commission on Law and Aging*, 44, 4, (2023): 82-83.

Autopsies by location

Idaho is split into seven different health districts, shown in exhibit 16. The rate of autopsies varied among the health districts. Only health districts 3 and 4 contain coroner offices that perform autopsies.

Exhibit 16

The two counties performing autopsies in Idaho are in public health districts 3 and 4.



Source: The Department of Health and Welfare.

Counties in district 1 and the northern half of district 2 go to Spokane for autopsies.

All counties in districts 4, 5, 6, and 7 go to Ada County for autopsies.

From 2018 through 2022, autopsy rates for health districts 5, 6, and 7 were lower than autopsy rates for other health districts for both the percentage of deaths autopsied and the autopsies performed per 1,000 people. Exhibit 17 shows the number of deaths, autopsies, and the autopsy rate for health districts in 2018 –2022.

Exhibit 17

Health districts 5, 6, and 7 had the lowest autopsy rate in 2018–2022.

Health district	Deaths	Autopsies	Percentage of deaths autopsied	Autopsies per 1,000 residents
1	13,563	429	3.2%	0.34
2	5,648	186	3.3%	0.33
3	11,825	459	3.9%	0.30
4	23,273	1,513	6.5%	0.56
5	8,933	188	2.1%	0.18
6	7,819	204	2.6%	0.23
7	9,361	167	1.8%	0.14

Source: The Department of Health and Welfare's Bureau of Vital Records and Health Statistics.

One contributing factor for the lower autopsy rate of public health districts 5, 6, and 7 might be the distance between the districts and the forensic pathology lab used to conduct autopsies. Exhibit 18 shows the average distance from each health district to the contracted forensic pathology lab.

A 2012 report from the Scientific Working Group for Medicolegal Death Investigation recommended that transport distances "exceed 100 miles in no more than 10 percent of cases."[80] But the majority of counties in Idaho reside over 100 miles away from a forensic pathology lab, including every county in districts 2, 5, 6, and 7. In 2018–2022, 30 percent of autopsies performed at the Ada County coroner's office came from farther away than 100 miles.

The state has taken steps to alleviate the travel time for autopsies conducted by counties in eastern Idaho. In 2022, Idaho House Bill 776 allocated $900,000 for a forensic pathology lab to be built in Bannock County. The remaining $2 million for the estimated cost of the lab would be covered by American Rescue Plan Act money received by Bannock County. The lab is expected to serve 17 counties for their autopsies. As of the publication of this report, the eastern Idaho forensic pathology lab has not opened.

Exhibit 18

Counties in eastern Idaho's 6th and 7th health districts have the furthest distance to travel to reach a forensic pathology lab.

Health district	Average miles to forensic pathology lab	Forensic pathology labs used by member counties
1	80 miles	Spokane County medical examiner's office
2	178 miles	Spokane County medical examiner's office and Ada County coroner's office
3	73 miles	Ada County coroner's office and Canyon County coroner's office
4	61 miles	Ada County coroner's office
5	144 miles	Ada County coroner's office
6	269 miles	Ada County coroner's office
7	286 miles	Ada County coroner's office

Source: OPE analysis, data and interviews with Idaho coroners.

80. Scientific Working Group on Medicolegal Death Investigation, System Infrastructure Committee, *Regional Medicolegal Autopsy and Death Investigation Centers: Construction, Staffing, and Costs*, (2013).

94 percent of autopsies conducted in Idaho were overseen by a coroner.

Autopsies by certifier

Deaths that are certified by a coroner are much more likely to be autopsied than deaths certified by a medical practitioner. Though medical practitioners certify the majority of deaths, very few of these deaths have an autopsy performed. In 2018–2022, 94 percent of autopsies performed in Idaho were deaths certified by coroners. Exhibit 19 shows the number of autopsies by certifier.

While the difference in the percentages of deaths autopsied between hospital and medicolegal deaths is not unusual, Idaho's 18.3 autopsy percentage for coroner cases is still below national averages. A 2017 survey by the US Drug Enforcement Administration found that coroner offices conduct autopsies on an average of 31.5 percent of cases they accept.[81]

Exhibit 19

Coroners oversaw most autopsies conducted in Idaho in 2018–2022.

Death certificate certifier	Deaths certified	Autopsies	Percentage of deaths autopsied
Physician	54,084	177	0.3%
Physician assistant	743	2	0.3%
Advanced practice professional nurse	9.352	5	0.1%
Coroner	16,216	2,961	18.3%
Other or not reported	27	1	3.7%

Source: The Department of Health and Welfare's Bureau of Vital Records and Health Statistics.

81. U.S. Drug Enforcement Administration, Diversion Control Division, *2017 Medical Examiner/Coroner Office Survey Report*, (2018).

Idaho ranked 49 of 51 nationally on autopsy rates from 2018 through 2022.

We used the Centers for Disease Control and Prevention's (CDC) WONDER Multiple Cause of Death database to compare autopsy rates among states. The CDC's data does not indicate who certified a death, and the data includes the autopsy rates of all deaths, irrespective of who certified the death. Additional autopsy data can be found in appendix D.

Idaho Bureau of Vital Records and Health Statistics versus CDC WONDER data

Both Idaho's Bureau of Vital Records and Health Statistics and CDC's WONDER pull data collected from death certificates submitted to the state. However, CDC's WONDER excludes deaths of non-US residents and residents of Guam, Puerto Rico, and the Virgin Islands, while the Bureau of Vital Records and Health Statistics includes these deaths. As such, the death and autopsy totals slightly differ between the two databases.

From 2018 through 2022, there was a difference of 79 deaths and 17 autopsies in Idaho between the two databases. The difference in Idaho's autopsy percentage between the two databases was 0.017 percentage points.

We used data from CDC's WONDER for all comparisons of Idaho death and autopsy data to other states for a consistent comparison across state jurisdictions.

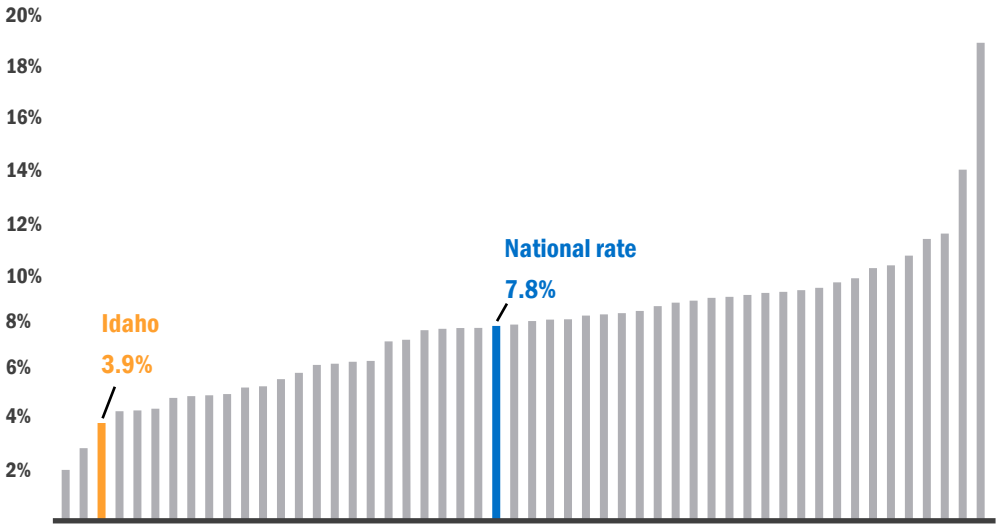
Percentage of deaths autopsied

In 2018–2022, 7.8 percent of all deaths nationwide were autopsied compared to 3.9 percent in Idaho. Only two states had a lower percentage of deaths autopsied: Oregon and Maine. Both states employ a state medical examiner system. Exhibit 20 shows the percentage of deaths autopsied in Idaho compared to other states.

Idaho autopsied 3.9 percent of deaths in 2018–2022, compared to 7.8 percent nationally.

Exhibit 20

In 2018–2022, Idaho autopsied 3.9 percent of deaths, about half the national autopsy percentage.

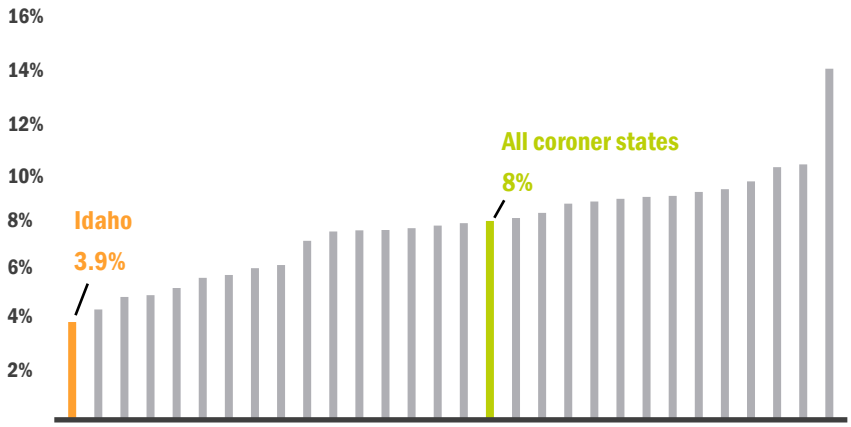


Source: CDC WONDER Provisional Multiple Cause of Death data.

Idaho autopsied a lower percentage of deaths than all other states with a coroner system. As shown in exhibit 21, the percentage of deaths autopsied for the 28 states with coroners was at 8 percent in 2018–2022.

Exhibit 21

Idaho autopsied the lowest percentage of deaths of all counties with coroners in 2018–2022.



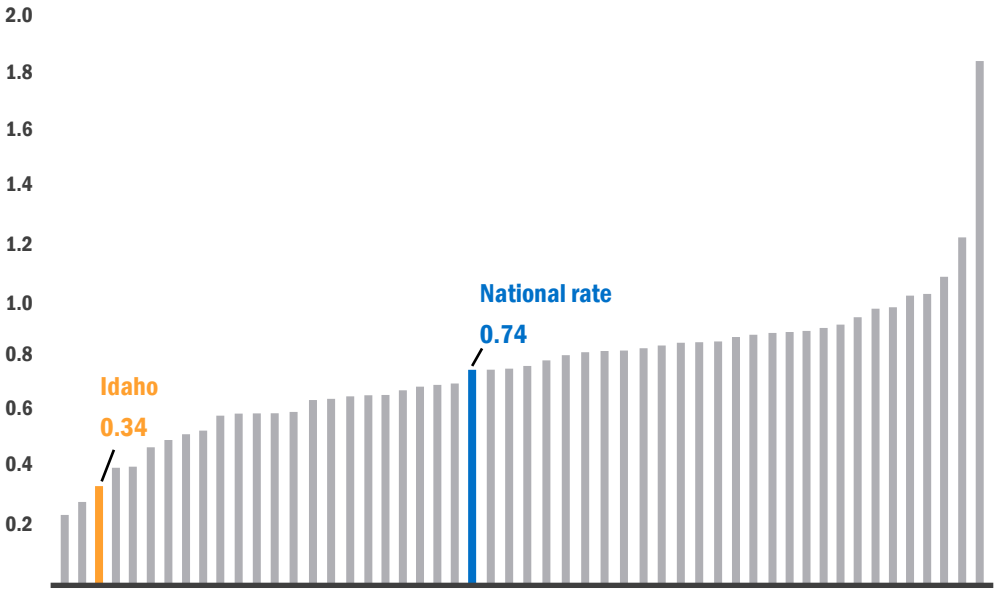
Source: CDC WONDER Provisional Multiple Cause of Death data.

Autopsies per 1,000 people

Idaho again ranks 49th when looking at the number of autopsies per 1,000 people, with Oregon and Maine being the only states with lower rates. As seen in exhibit 22, the national number of autopsies per 1,0000 people was 0.74 in 2018–2022. Four states and the District of Columbia autopsied more than the recommended amount of one autopsy per 1,000 people.

Exhibit 22

Idaho's autopsies per 1,000 residents was below the national rate and third lowest overall in 2018–2022.



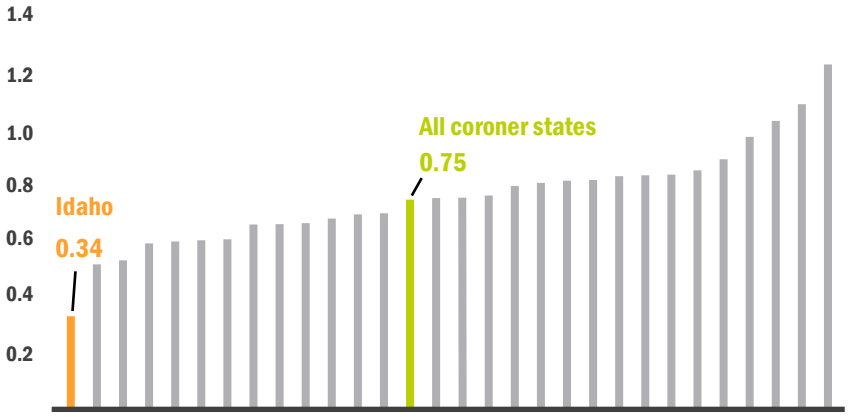
Source: CDC WONDER Provisional Multiple Cause of Death data and US Census Bureau, Population Division data.

Idaho has the lowest autopsies per 1,000 residents of all states with coroners.

Idaho ranked last among coroner states on autopsies per 1,000 people. Coroner states cumulatively conducted 0.75 autopsies per 1,000 people in 2018–2022, over double Idaho's 0.34 per 1,000 people (exhibit 23).

Exhibit 23

Idaho's autopsies per 1,000 residents was less than half the number of autopsies for all states with coroners in 2018–2022.



Source: CDC WONDER Provisional Multiple Cause of Death data and US Census Bureau, Population Division data.

Autopsies for external or unknown causes of death

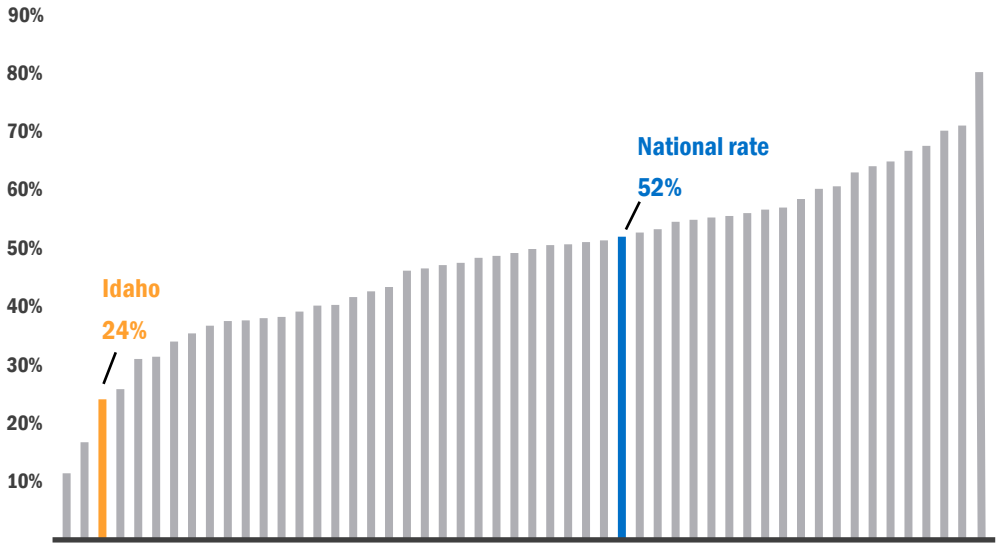
CDC's WONDER data does not delineate by who certified the cause and manner of death on a death certificate. As such, the data presented above includes deaths that happen at a hospital and never come in contact with a medicolegal death investigation system.

To account for this, we ran autopsy data for deaths that came from unknown causes and external causes, such as violence, injuries, and accidents. These deaths are most commonly required to be reported to coroners and medical examiners for evaluation and investigation.

Idaho again ranked third to last nationally on the percentage of deaths autopsied for these types of deaths. Idaho autopsied 24 percent of deaths from external or unknown causes, compared to 52 percent nationally. Exhibit 24 shows the autopsy percentage for deaths from external or unknown causes.

Exhibit 24

In 2018–2022, Idaho autopsied 24 percent of deaths caused by external or unknown causes, which was less than half the national autopsy percentage.



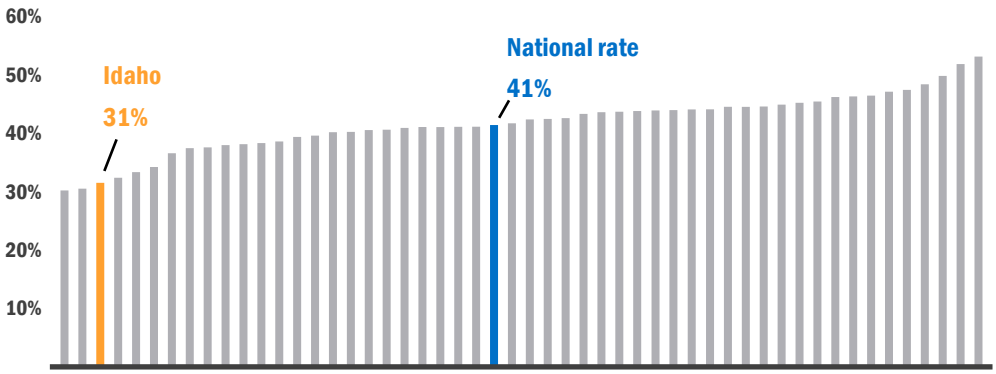
Source: CDC WONDER Provisional Multiple Cause of Death data.

Idaho autopsied the third lowest percentage of child deaths from 2018 through 2022, and the fewest child deaths from external or unknown causes.

Similar to autopsies of all deaths, Idaho ranked 49th of 51 on the percentage of autopsies performed on deaths of children under the age of 18. From 2018 through 2022, there were 929 child deaths in Idaho, of which 291 were autopsied. Idaho autopsied 31 percent of child deaths. Nationally, 41 percent of child deaths were autopsied from 2018 through 2022. The two states with the lowest percentage of autopsies on child deaths over this period, Utah and Oregon, both employ a state medical examiner system. Exhibit 25 shows the percentage of child deaths autopsied from 2018 through 2022.

Exhibit 25

Idaho autopsied 31 percent of child deaths in 2018–2022, compared to 41 percent nationally.



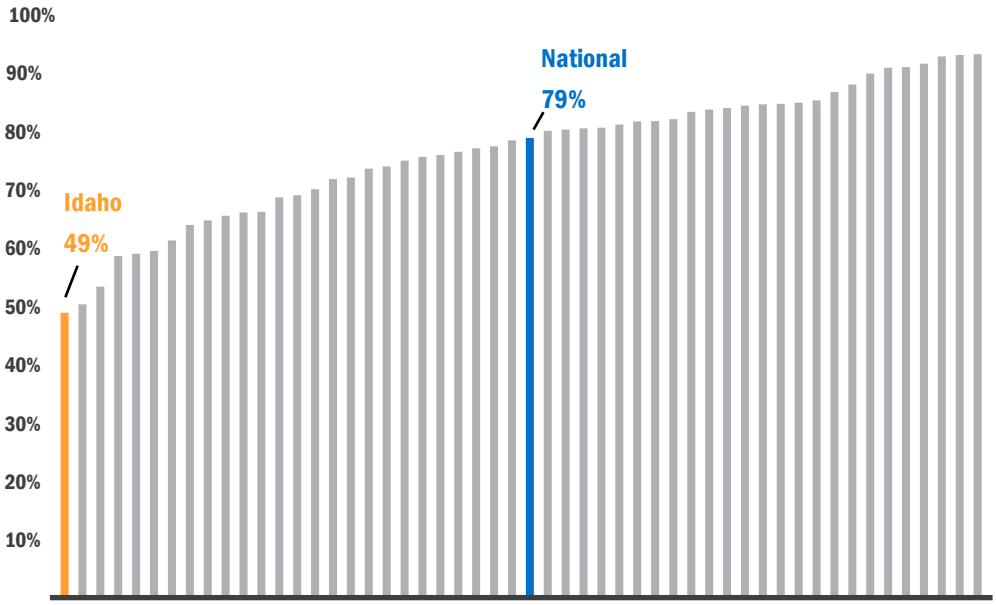
Source: CDC WONDER Provisional Multiple Cause of Death data.

Data include deaths of children that did not come into contact with the coroner system in Idaho, such as child deaths with a known medical disease.

Child deaths that are from unknown or external causes are frequently under the jurisdiction of the coroner or medical examiner. From 2018 through 2022, Idaho autopsied 49 percent of child deaths from unknown or external causes. This was the lowest of all states and 30 percentage points below the national autopsy percentage of 79 percent. Exhibit 26 shows the percentage of child deaths from external or unknown causes autopsied by state in 2018–2022.

Exhibit 26

Idaho autopsied the lowest percentage of child deaths caused by external or unknown causes nationally in 2018–2022.



Source: CDC WONDER Provisional Multiple Cause of Death data.

As part of the Governor's Task Force on Children at Risk, Idaho has the Child Fatality Review Team who review child deaths from non-medical causes in the state. The team is tasked with identifying information and education that is needed to improve the health and safety of Idaho's children, and to identify common links or circumstances in child deaths to prevent similar deaths in the future. The Idaho Child Fatality Review Team was created by an executive order signed in 2012. We found the structure and authority of the review team in Idaho varies greatly from review teams in other states with coroner systems.

Coroners in Idaho are not required to provide information to the Child Fatality Review Team, nor notify the team of a child's death.

Idaho does not require a coroner to be on the Child Fatality Review Team.

Twenty-five of the 28 states with coroners include the authority and purpose of child fatality review teams in their state code. Idaho is one of three coroner states without such code. State code often specifies what information coroners are required to provide to the child fatality review teams. Members of the Idaho Child Fatality Review Team reported difficulties with receiving information from coroners. Some coroners would not provide requested information to the team and the information the team does receive is often inconsistent in detail and scope from county to county.

Other states frequently require coroners to be on either state or local child fatality review teams. For the 25 states with coroners and a statewide child fatality review panel, 14 require coroners to be on the panel, such as Colorado and Louisiana.[82] Coroners have been on the Idaho Child Fatality Review Team in the past, but are not required. As of the publication of this report there is not a coroner on the review team.

Twenty coroner states have local child fatality review teams. Coroners are required to be on the review teams in 16 of those states, including Montana and Nevada.[83] Idaho does not require counties to have local child fatality review teams.

The Idaho Child Fatality Review Team has no official authority to establish coroner training or guidelines around child deaths, but they have recommended additional training for coroners to help them identify sudden infant death syndrome. Additionally, the review team paid for a coroner training on child death investigations in 2019. In at least one state, Arkansas, the child fatality review team has the authority to establish training criteria for coroners on investigating child deaths.[84]

82. Colo. Rev. Stat. § 25-20.5-406(2)(a)(II), La Rev. Stat. § 40:2019(c)(19)
83. Mont. Code Ann. § 50-19-403(2)(c), Nev. Rev. Code § 432B.406(1)(f)
84. Ark. Code Ann. § 20-27-1704(6)

In Idaho, coroners are not required to notify the Child Fatality Review Team of child deaths. Instead, the team is notified through the Department of Health and Welfare's Bureau of Vital Statistics and Records. Vital Statistics and Records need to finalize their data before child deaths are reported to the review team, creating a gap of at least a year between a child's death and when the review team is notified. This is contrary to several coroner states like Georgia, Kansas, and South Carolina that require coroners to notify review teams of child deaths that occur under specific circumstances or with certain characteristics.[85]

85. Ga. Code Ann. § 19-15-3(h), Kan. Stat. Ann. § 22a-242(c), S.C. Code Ann. § 17-5-540

Idaho's coroner system does not have the capacity to meet national standards for autopsy rates.

In 2018–2022, counties would have needed to spend an additional $7.9 million on autopsies to conduct one autopsy per 1,000 residents.

To meet the national autopsy average, counties would have needed to spend an additional $4.7 million in 2018–2022.

Even if coroners were determined to meet national standards for autopsy rates, several barriers prevent them from doing so. A significant increase in coroner spending would be necessary to conduct the recommended number of autopsies. In addition to funding, there are not enough forensic pathology labs or forensic pathologists to conduct autopsies.

Financing

From 2018 through 2022, there were 3,146 autopsies conducted in Idaho. Of those, 94 percent, or 2,961, were autopsies conducted under the direction of a county coroner. Idaho's 42 counties that do not conduct their own autopsies spent an estimated $2.8 million on autopsies from 2018 through 2022. Raising the autopsy rate to either the recommended one autopsy per 1,000 people or to the national autopsy percentage of 7.8 percent of deaths would result in a substantial increase in county budgets for autopsies.

To meet the 1 autopsy per 1,000 people rate, county coroners would need to have conducted 8,697 autopsies from 2018 through 2022, an increase of 5,736 autopsies. This would have cost an additional $7.9 million dollars in autopsy fees for the 42 counties that do not conduct their own autopsies from 2018 through 2022.

To raise the percentage of deaths autopsied to the national average of 7.8 percent, 5,783 autopsies would have needed to be performed under the direction of county coroners from 2018 through 2022. This would represent an increase of 2,822 autopsies and would have cost the 42 counties that do not conduct their own autopsies an additional $4.7 million from 2018 through 2022.

These figures do not account for the additional costs to counties for transportation of decedents to a forensic pathology lab, nor do they account for the additional personnel that would be required at Ada and Canyon counties' coroner's offices to handle the additional number of autopsies.

Access to forensic pathology labs

IACME and NAME both place limitations on the number of autopsies a forensic pathologist can conduct annually. NAME recommends forensic pathologists conduct 250 autopsies per year and with a limit of 325 autopsies per year. IACME permits up to 325 autopsies per year.

Ada County currently employs the only three forensic pathologists in Idaho. The Ada County forensic pathology lab has a theoretical maximum of 750 autopsies per year before they risk NAME accreditation point deductions.

Ada County is currently below this limit, having conducted an average of 391 autopsies and 301 external examinations per year from 2018 through 2021.[86] When calculating the workload for external examinations, this comes out to under 500 autopsies per year.

If all coroner offices in Idaho met the recommendation of one autopsy per 1,000 people, there would have been about 811 more autopsies per year in Ada County and the 33 counties that contract with Ada's forensic pathology lab from 2018 through 2022. If 94 percent of these autopsies were under the direction of coroners, the Ada County forensic pathology lab would have conducted an additional 764 autopsies per year from 2018 through 2022.

An additional 764 autopsies per year plus the 391 autopsies and 301 external examinations already conducted on average would have pushed the total autopsies performed by Ada County above the maximum advised 750 per year, potentially jeopardizing its NAME accreditation. Ada County would have had to employ at least two additional forensic pathologists to accommodate the increased workload. Canyon County would need to conduct an additional 162 autopsies per year in order to conduct one autopsy per 1,000 people in Canyon and Owyhee counties.

NAME and IACME recommend a maximum of 250 to 325 autopsies conducted by a forensic pathologist per year.

Idaho requires additional forensic pathologists to meet national autopsy rates and national standards.

86. NAME states that three to five external examinations are considered to be equivalent to one autopsy when calculating workload for a forensic pathologist. External examinations are conducted by pathologists and have a lower work threshold with only the outside of the decedent being examined and requiring no incisions or examination of organs.

The eight counties that contract with Spokane for autopsies would have conducted an additional 221 autopsies per year from 2018 through 2022. The Spokane Medical Examiner's Office employs four forensic pathologists. It is unclear if they have the capacity to accept an additional 221 autopsies per year, as the additional workload from these eight counties would require the equivalent of a full-time forensic pathologist's entire year caseload.

East Idaho Forensic Pathology Lab

A forensic pathology lab is currently being built in Bannock County, funded jointly by the state of Idaho and Idaho State University. The lab will be guided by a board of directors consisting of coroners, commissioners, and doctors.

In discussions with county coroners, several indicated they plan on using the lab for their autopsies instead of going to Ada County. Seventeen counties are expected to use the lab. A forensic pathologist in eastern Idaho would increase the number of autopsies that could be performed in the state by 250 a year. From 2018 through 2022, there was an average of 74 autopsies a year in counties from health districts 6 and 7, the two easternmost health districts in Idaho that would be likely to use the Bannock County lab.

The lab was originally planned to open in 2023, though there have been challenges with hiring a forensic pathologist to conduct autopsies at the lab. The lab is expected to open in early 2024.

Shortage of forensic pathologists

The United States has an estimated 700 to 750 board certified forensic pathologists.[87, 88] Studies have estimated a need of 1,200 forensic pathologists nationwide to meet NAME accreditation workload standards.[89, 90] The cause of the shortage has been linked to an overall shortage of medical school students and a small number of medical students that pursue work as pathologists.

Because of the national shortage, it would be unlikely that Ada County and Canyon County could hire enough forensic pathologists to conduct all of the autopsies required to meet the best practice standard of one autopsy for every 1,000 people. Spokane County has had a vacant forensic pathologist position for over a year because of the shortage of forensic pathologists.

There is a need for 1,200 forensic pathologists nationally to meet NAME accreditation workload standards.

87. Taylor, Michelle, "Stopping the Shortage 'Cycle': Ways to Fortify the Forensic Pathology Workforce," *Forensic*, (2023).
88. Tatsumi, Kanayo, and Michael Graham, "Death Investigation in the United States: Forensic Pathology," *Missouri Medicine*, 119:5, (2022): 411-415.
89. Weedn, Victor W, and M.J. Menendez, "Reclaiming the Autopsy as a Practice of Medicine," *Am J Forensic Med Pathol*, 00, (2020): 1-7, doi: 10.1097/PAF.0000000000000589
90. U.S. Department of Justice, National Institute of Standards and Technology, National Commission on Forensic Science, Increasing the Number, Retention and Quality of Board Certified Forensic Pathologists, (2015).

Idaho policymakers should consider identifying the types of deaths they want to see autopsied.

It is not likely that all Idaho counties can meet national standards for autopsy rates because of the limitations discussed. In lieu of this, policymakers could identify what types of deaths they want to be autopsied and put systems in place to ensure autopsies are conducted.

In Idaho, coroners perform autopsies at their discretion and there are no types of deaths that require an autopsy. If policymakers want to ensure that deaths of individuals from at-risk populations, such as children under a certain age, older adults who may have experienced elder abuse, or individuals in state custody, are thoroughly investigated and autopsied, Idaho Code could be amended to require autopsies for such deaths.

Idaho's homicide autopsy rate is below best practices and the lowest in the country.

This can also extend to deaths that come as the result of certain actions, such as homicides. From 2018 through 2022, Idaho had the lowest percentage of deaths from homicides autopsied at 92 percent (see appendix D). Over the same time period, 99 percent of homicides were autopsied nationwide. NAME and IACME standards recommend that at least 95 percent of suspected homicides be autopsied.

Idaho's suicide autopsy rate also lags behind national figures. Only 14 percent of suicides in Idaho were autopsied from 2018 through 2022, compared to 51 percent nationally. Idaho's suicide autopsy rate is ranked third to last nationally.

State policymakers could provide partial or full reimbursement for the cost of autopsies they want to have conducted, rather than mandating autopsies for specific cases. This would likely increase the number of autopsies performed for the selected characteristics without needing to mandate that certain deaths are autopsied. States such as Kansas and Washington reimburse coroners for some autopsies performed on children.[91] Washington also reimburses 100 percent of the costs of an autopsy of any maternal deaths in the state.[92]

91. Kan. Stat. Ann. § 22a-245,
Wash. Rev. Code § 68.50.104(2)(b)
92.Wash. Rev. Code § 68.50.104(2)(a)(III)

Request for Evaluation

A

House of Representatives
STATE OF IDAHO
CAPITOL BUILDING
P.O. BOX 83720
BOISE, ID 83720-0038

Dear Representative Cannon and Senator Wintrow, March 22, 2023

Death investigations are a critical public function, but coroners' offices across the state are facing challenges related to funding, staffing, training, and lack of uniform standards. A growing population and recent high profile crimes across the state highlight the importance of quality death investigations is further stressing Idaho's fragmented and inconsistent approach. Improving the quality of death investigations in Idaho could help us solve crimes, better understand public health issues like suicide and substance abuse, and provide families with necessary closure following the death of a loved one.

In an effort to better understand the issues facing Idaho's death investigation system we request the Office of Performance Evaluation investigate the issue and provide information and make recommendations based on the following questions:

1. How would you evaluate the state of Idaho's death investigation system?
2. What is the current role of the state government in regulating county coroners and death investigations?
3. Are our statewide standards for death investigations, death investigators, and county coroner's sufficient?
4. What financial challenges do counties and their coroners face related to death investigations?
5. How could the quality of Idaho's death investigation system be improved and what role could the state play in this?

A report from OPE answering these questions could educate the stakeholders on the issues surrounding Idaho's death investigation system and help inform policy decisions for how state government can assist counties in improving death investigations statewide.

Rep. Colin Nash

Rep. Britt Raybould

Rep. Rod Furniss

B Evaluation Scope

This evaluation will focus on the following objectives:

discuss the role of county coroners in the death investigation system in Idaho, as well as the state's role in facilitation, regulation, and oversight of coroners and death investigations;

identify limitations, shortcomings, or deficiencies in the current death investigation system;

assess county and state spending on coroners and death investigation systems, exploring alternative models from other states for improved service or cost efficiency; and

identify what Idaho can do to ensure that death investigations are conducted in a uniform and sufficient manner.

Methodology

C

This evaluation was designed to look at how the coroner system in Idaho is working compared to national standards and practices of other states. We compared literature reviews, analyzed existing mortality and financial data, and conducted interviews to gather information for the evaluation.

Literature and data review

To establish best practice recommendations for the design and operation of coroner systems and medicolegal death investigations, we used standards and recommendations set forth by the International Association of Coroners and Medical Examiners (IACME), the National Association of Medical Examiners (NAME), the American Board of Medicolegal Death Investigators (ABMDI), the Scientific Working Group for Medicolegal Death Investigation (SWGMDI), and the Organization of Scientific Area Committees for Forensic Science (OSAC).

In addition, we reviewed reports, surveys, and medicolegal needs assessments created by the US Department of Justice's National Institute of Justice, the US Drug Enforcement Administration's National Forensic Laboratory Information System, and US Department of Health and Human Services' Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics. Last, we reviewed other states' statutes that pertained to death investigation systems and their designs.

To analyze the performance of death investigations conducted by Idaho coroners we relied on mortality and autopsy data provided by the Department of Health and Welfare's Bureau of Vital Records and Health Statistics and CDC's WONDER Multiple Cause of Death database.

We aggregated death and autopsy rate data for the years 2018 through 2022 to (1) adhere to the CDC's privacy policy of not displaying statistics with fewer than 10 cases and (2) control for any increases in deaths from the COVID-19 pandemic.

When population is used over a time period, we averaged population counts from the US Census Bureau's Population Division.

For county expenditures on coroner systems and salaries, we used data from Transparent Idaho database operated by the Idaho State Controller.

Interviews and questions

We interviewed and sent questionnaires to the following stakeholders about the death investigation system in Idaho:

- Current and former Idaho state legislators
- County Coroners and deputy coroners
- Idaho Department of Health and Welfare staff
- Idaho State Police staff
- Idaho Peace Officer Standards and Training (POST) staff
- Idaho Child Fatality Review Team staff
- Idaho Association of Counties staff
- Idaho State Association of County Coroners

Additional Autopsy Data

D

The autopsy rates for small metropolitan and micropolitan counties in Idaho rank last in all states that have coroner systems.

Large urban centers tend to perform more autopsies than smaller metropolitan areas. To account for differences in population densities between states, we compared autopsy rates using the National Center for Health Statistics (NCHS) Urban-Rural Classification System for Counties. This system organizes counties into six different classifications based on population and distance to large metro areas. Exhibit 27 defines the six classifications and the number of each type of counties in Idaho as of the latest release of classification in 2013.[93]

Most counties in Idaho are either micropolitan or non-core. Idaho has no counties that are designated as class 1 or 2 counties.

93. The latest release of NCHS Urban-Rural Classification system was in 2013. A new release should be published in 2024. Despite Idaho's population growth, there will likely only be minimal changes to NCHS classifications in the 2024 release as no medium or small metro statistical areas saw enough population growth to be classified at a higher level. Two counties classified as micropolitan in 2013, Jerome and Twin Falls, may be reclassified as small metros in the upcoming release.

Exhibit 27

Most counties in Idaho are classified as either micropolitan or non-core counties.

Classification	Qualifications	Idaho counties
1—Large central metro	Large central metro counties in metropolitan statistical areas (MSA) of 1 million population that: 1) contain the entire population of the largest principal city of the MSA, or 2) are completely contained within the largest principal city of the MSA, or 3) contain at least 250,000 residents of any principal city in the MSA .	0
2—Large fringe metro	MSA counties of 1 million or more population that do not qualify as large central.	0
3—Medium metro	Counties in MSAs of populations of 250,000-999,999.	5
4—Small metro	Counties in MSAs of populations less than 250,000.	7
5—Micropolitan	Counties in micropolitan statistical areas as opposed to MSAs.	15
6—Non-core	Nonmetropolitan counties that did not qualify as micropolitan.	17

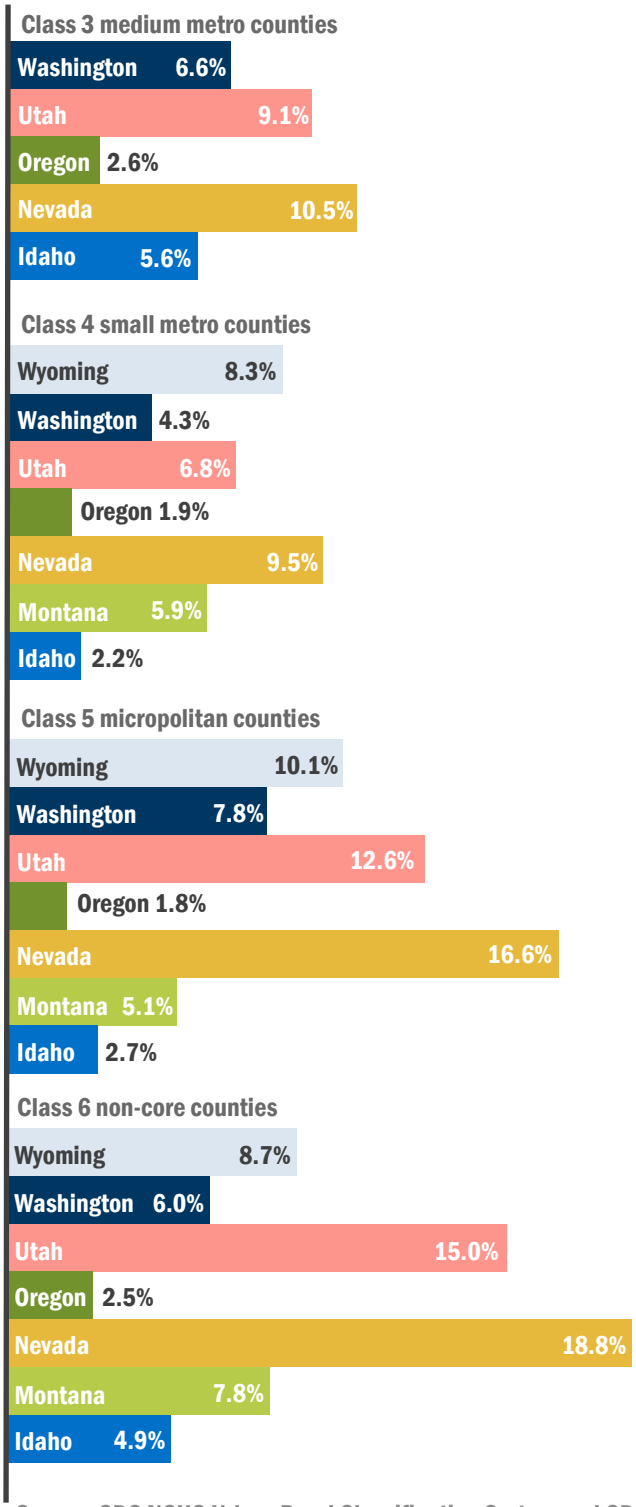
Source: CDC NCHS Urban-Rural Classification System.

Autopsy percentage by county classification, neighboring states

When compared to neighboring states, Idaho counties consistently rank second to last for percentage of deaths autopsied regardless of county classification. Oregon had the fewest deaths autopsied for all four county classifications. Exhibit 28 compares the percentage of deaths autopsied for Idaho and its neighboring states by county classification.

Exhibit 28

Idaho autopsied fewer deaths than most neighboring states regardless of county NCHS classification in 2018–2022.



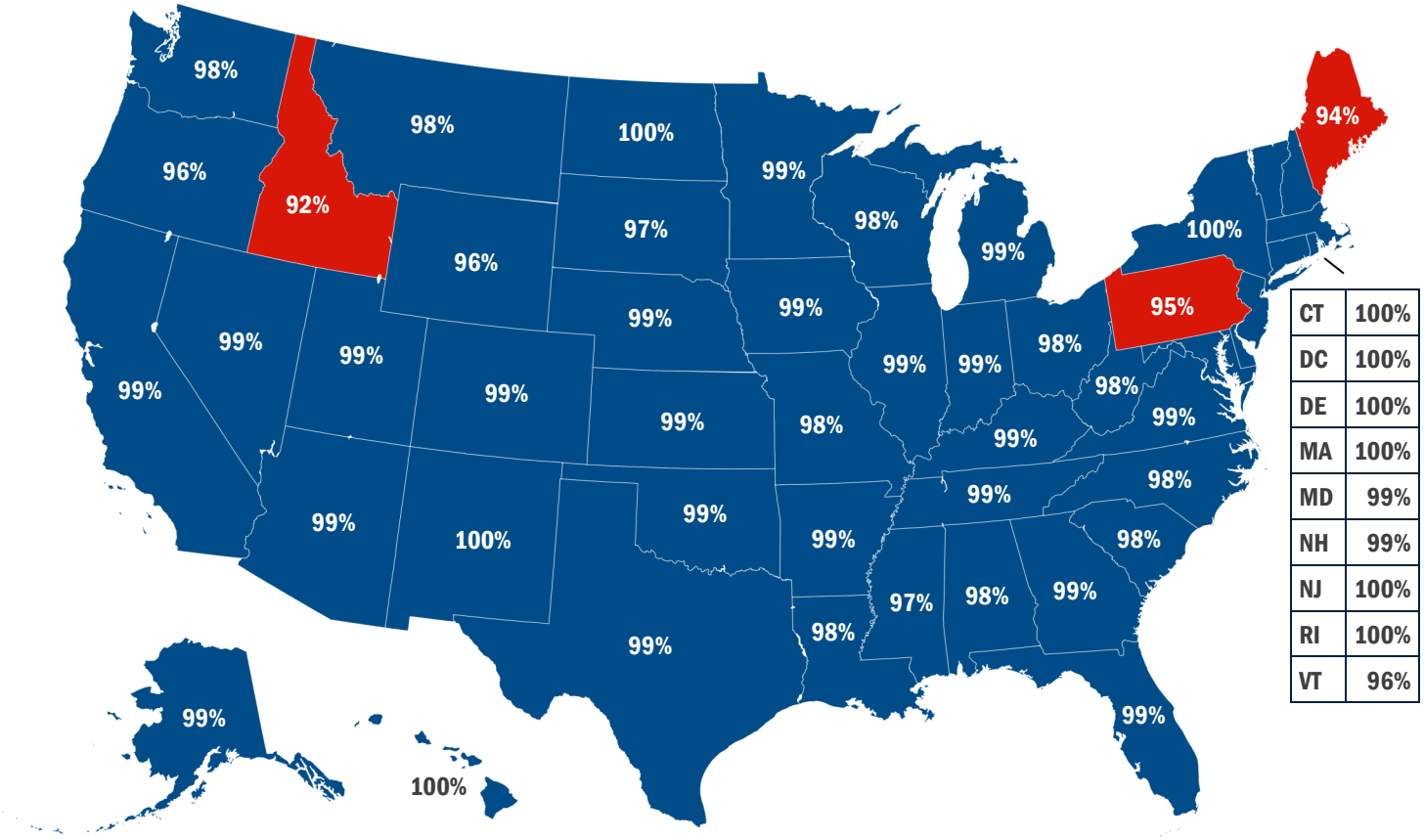
Source: CDC NCHS Urban-Rural Classification System and CDC WONDER Provisional Multiple Cause of Death data. Montana and Wyoming do not have a class 3 county.

Idaho ranks last in homicide autopsy rate for deaths and third to last for suicide autopsy rates.

From 2018 through 2022, 92 percent of known homicides in Idaho were autopsied. Nationally, 99 percent of homicides were autopsied over this period. NAME and IACME standards recommend that at least 95 percent of homicides be autopsied. Three states, Idaho, Pennsylvania, and Maine, autopsied fewer than 95 percent of homicides. Three states autopsied 100 percent of known homicides. Exhibit 29 shows homicide autopsy rates by state.

Exhibit 29

From 2018–2022, three states had a homicide autopsy rate below the recommended 95 percent, including Idaho.



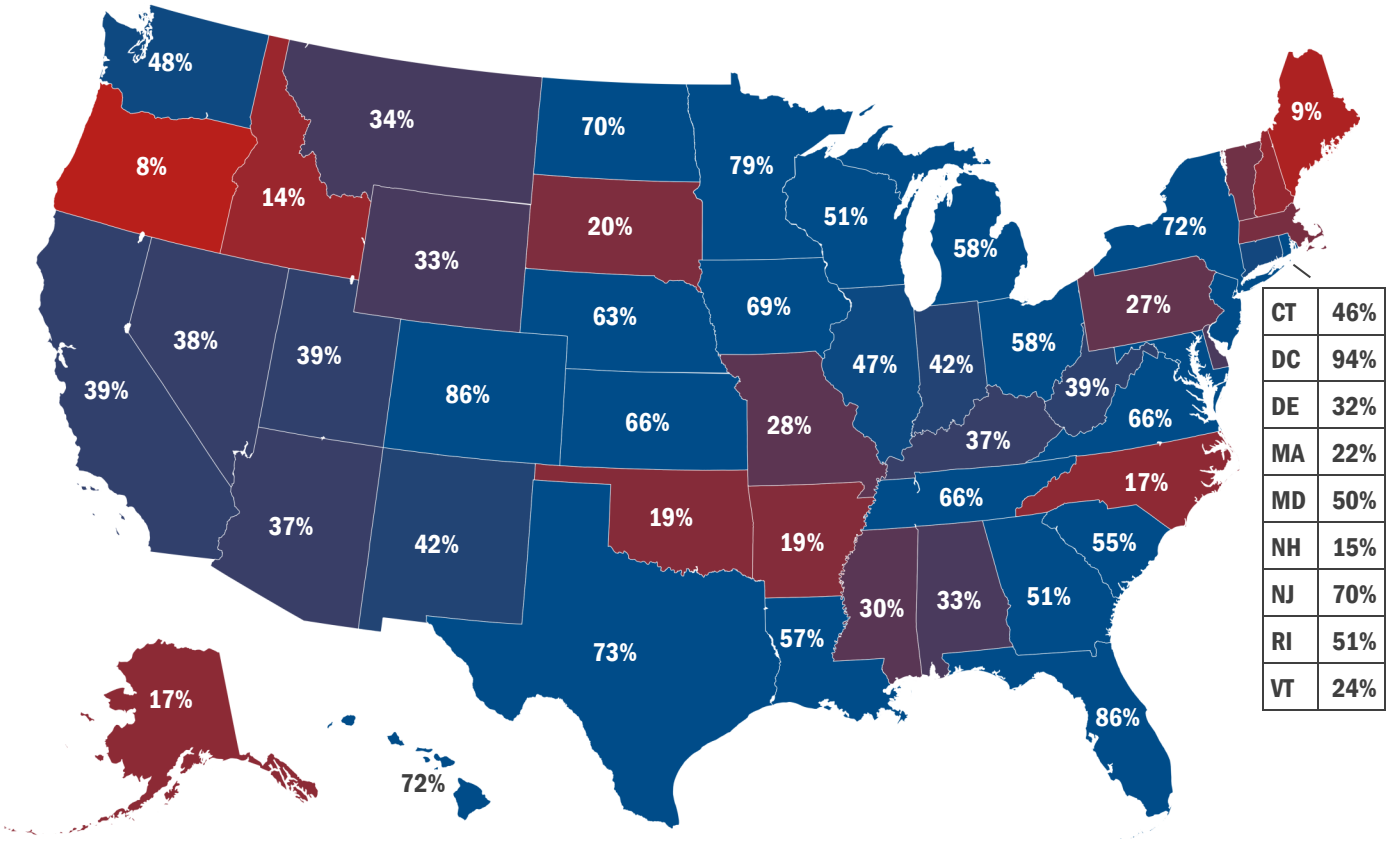
CT	100%
DC	100%
DE	100%
MA	100%
MD	99%
NH	99%
NJ	100%
RI	100%
VT	96%

Source: CDC WONDER Provisional Multiple Cause of Death data. All numbers are rounded to the nearest whole percent.

Idaho autopsied 14 percent of suicides from 2018 through 2022, ranking third to last nationally. Only Oregon and Maine had a lower percentage of suicides autopsied over this period. Nationally, 51 percent of suicides were autopsied. Exhibit 30 shows Idaho's suicide autopsy percentage compared to other states nationally.

Exhibit 30

From 2018–2022, Idaho's suicide autopsy rate was the third lowest nationally, trailing only Oregon and Maine.



CT	46%
DC	94%
DE	32%
MA	22%
MD	50%
NH	15%
NJ	70%
RI	51%
VT	24%

Source: CDC WONDER Provisional Multiple Cause of Death data. All numbers are rounded to the nearest whole percent.

Office of Performance Evaluations

ope

Idaho Legislature