

County Coroners and Death Investigations

Report highlights

February 2024

Idaho Code provides little direction for coroners on many of their duties, creating an inconsistent death investigation system across the state.

3.9% of deaths in Idaho were autopsied during 2018–2022, the third lowest nationally. Nationwide 7.8% of deaths were autopsied over this period.

49% of child deaths from external or unknown causes were autopsied in Idaho during 2018–2022, the lowest in the nation. The national autopsy rate was 79% over the same period.

92% of homicides in Idaho were autopsied during 2018–2022, which was the lowest in the nation. National standards recommend at least 95% of homicides be autopsied.

\$17,969 was the median coroner salary in Idaho in 2022, about half as much as the next lowest median salary for a county-elected official.

Low budgets impact the ability of coroners to adequately conduct death investigations by limiting coroners' access to investigatory tools, access to autopsies, and ability to hire and train deputy coroners.

Idaho has no state-level entity that provides oversight or assistance to coroners.

Without state-level assistance, coroners instead must rely on other coroners for informal assistance or guidance when needed, and use Ada and Canyon Counties and Spokane County, Washington to conduct their autopsies.

Many states with coroners have state-level entities that provide coroner oversight or assistance. These entities often promulgate rules and regulations for coroners to follow when conducting death investigations and often conduct autopsies for coroner offices.

Idaho Code is ambiguous on coroner duties.

Idaho Code does not define what is considered a death attended by a physician, creating uncertainty between coroners and medical personnel about who should be certifying some deaths.

Idaho Code does not define the roles and responsibilities of law enforcement and coroners in a death investigation, leading to instances where a decedent is moved by law enforcement before a coroner is notified of the death. Many states specify that the body of a decedent is under the jurisdiction of the coroner and cannot be moved without the coroner's consent.

Idaho Code does not provide direction on what types of deaths should be autopsied, what information coroners can publicly disclose from death investigations, or how to address spiritual or religious objections to autopsies.

It is unclear how much continuing education coroners are actually completing.

Coroners are required to partake in coroner's school after entering office and complete 24 hours of continuing education every two years. Most coroners in Idaho are either not reporting completed education or are not participating in education altogether. Additionally, reported education completed by coroners has been dropping since 2015. We found that there are no consequences for not completing the required continuing education.

View the report at: www.legislature.idaho.gov/ope/

