Bingham County Coroner

2024 Annual Report Submitted By Coroner James "Jimmy" Roberts

Bingham County Coroner
501 N. Maple St. #303
Blackfoot, 83221

Last Revised: January 6, 2025

Table of Contents

Message to the Board of Commissioners and Citizens of Bingham County

The Bingham County Coroner's Office investigates sudden, violent, unexpected, and suspicious deaths that occur in Bingham County. The Office of the Coroner certifies a death after investigation and postmortem examination and issues the death certificate as required by law. Complete findings of the death investigation are distributed to families and law enforcement agencies as appropriate.

Idaho's coroner offices are independent, investigative, government agencies. Coroner's medicolegal death investigations are unique, unbiased, and conducted without undue influence from other agencies within the government or criminal justice system. This approach assures that the conclusions of the coroner's investigational process are unbiased and valid, thereby maintaining the public trust in the fairness of the investigational process.

The main duties of the Office of the Coroner are to determine the time, cause, and manner of death and certify deaths that are reported to the coroner. The cause of death is the disease process or injury that resulted in death. There are thousands of diseases and injuries that may result in death. The manner of

death is a classification in which a determination is made regarding whether the death resulted from natural causes, homicide, suicide, or an accident. On occasion, the manner of death is classified as undetermined if a clear manner of death cannot be identified.

Information collected during the investigation process helps clarify the circumstances, such as the sequence of events prior to death. Evidence collected during an investigation and/or postmortem examination may help lead to the arrest or successful conviction of a suspect in a homicide case or ensure that an innocent person is not wrongly convicted. Because deaths occur around the clock, Coroner's staff members are available 24 hours a day, 365 days per year.

With the skills and experience of the medicolegal death investigators and board-certified forensic pathologists with our contracted pathology center in Ada County, we believe the quality of death investigations in Bingham County is among the best in the State.

Where do our standards come from?

National Association of Medical Examiners (N.A.M.E.) and the International Association of Coroners and Medical Examiners (I.A.C.M.E.) These organizations develop and maintain the national standards in the United States of America regarding death investigations. Our investigators are encouraged to secure certification as a Medicolegal Death Investigator through the rigorous standards of the American Board of Medicolegal Death Investigators (ABMDI). To be eligible to sit for the certification exam each investigator must obtain 640 points based on education, training, and supervised investigations of many different types of death. Each investigator is required to undergo a rigorous in-house training program and obtain certification from the American Board of Medicolegal Death Investigators (ABMDI). This is of critical importance because it is not widely understood that a thorough medicolegal death investigation is required for the forensic pathologist to determine the cause and manner of death. Without this required investigation the manner and even the cause of death could be undetermined.

The death scene investigation reports filed by the investigators are very thorough and supply comprehensive information to the coroner, law enforcement, prosecutor, families, the Idaho Bureau of Vital Records and Health Statistics, Violent Death Reporting System, Centers for Disease Control, Idaho Child and Infant Fatality Review Team, Idaho Transportation Department, and Southeastern Idaho Public Health, as well as other public health agencies. Thorough reporting of this information contributes to understanding death statistics and trends on a local, state, and federal level, as well as creating a global understanding. The data provided by the coroner's office impacts public health policies and funding and helps ensure public safety.

Infant Deaths

The medicolegal death investigation of an infant is of critical importance. Often infant deaths are the result of unsafe sleeping environments that are not revealed upon autopsy. The circumstances leading up to the death are of critical importance in revealing the true case. Without this needed investigation the cause of death may not be revealed, and the death will be classified as undetermined. This could result in a second infant being placed in the same unsafe sleeping environment and tragically, another infant death. Careful investigations of the scene of death, along with doll reenactments, is now the gold standard in medicolegal death investigations.

Ongoing Threats to the Community

The Coroner’s Office investigations often will expose dangers that have claimed the life of a victim. Additionally, the coroner’s office may also expose hazards that pose a continuing threat to others. These include unrecognized carbon monoxide leaks, electrical hazards, communicable diseases, animal attacks,

unrecognized homicides, and unsafe environments. Sharing the cause of death with the community stakeholders helps prevent additional deaths and contributes to overall public safety.

Public Health Surveillance: The Bingham County Coroner's Office collects and provides data on deaths within the jurisdiction of the Office. This is valuable information used for public health surveillance and identifies patterns of disease, trends in mortality rates, and emerging health threats. This information is used by the Idaho Department of Health and other related departments in the allocation of resources for public health intervention and educational programs.

Information and data are also imperative for understanding public health trends and risks. Acutely, diseases such as meningitis, tuberculosis, COVID-19, and even Creutzfeld-Jakob disease can be identified and reported as a public health threat. After the identification of such threats the coroner's office, working with our partners in public health, can prophylactically address the crisis and prevent further deaths.

Mental Health Surveillance: The Coroner's Office also monitors and reports on possible mental health crises. Most notable is that of the clustering of teen suicides. Upon identifying a potential crisis, the coroner will reach out to public health as well as the local school system to address the issue and employee mental health professionals in the community to prevent additional deaths.

Supporting and Partnering with Law Enforcement: Coroners work closely with law enforcement, even though our investigations are independent. These efforts help ensure that law enforcement's investigation is focused in the appropriate direction. Findings revealed in the coroner's scene investigation or revealed at autopsy could change the entire direction of law enforcement's investigations. Partnering with law enforcement in death scene investigations can provide and preserve crucial evidence in criminal investigations. These not only lead to the successful prosecution of criminals but also prevent unnecessary expense when no crime has been committed. This not only contributes to public safety but also helps conserve the taxpayer's dollars.

Organ & Tissue Donation: Organ donation saves lives. When a proper medicolegal death investigation is conducted not only can the decedent become an organ and/or tissue donor but a successful prosecution can proceed. The antiquated notion that organ donation will prevent a successful prosecution has been proven to be false nationally. In every instance when a coroner authorizes organ donation, lives are saved. This would not be possible without a proper medicolegal death investigation.

Additional Family and Public Services: In coroner jurisdiction cases, this Office works with grieving families to provide valuable services, such as answering general case questions, fulfilling records requests, and certifying cremations. Our teams handle grieving families with compassion and respect to provide valuable resources and information to help people in their times of need. The investigative information gathered by the coroner's office can be of the utmost importance to family of the decedent. The family's ability to settle an estate, submit for insurance benefits, receive other government benefits, and gain a sense of closure hinges on the timeliness of the coroner's investigations and case closures. All decedents are treated with professionalism, dignity, and compassion.

Child Fatality Review Committee: Jimmy Roberts, the Bingham County Coroner also participates in the Idaho Child Fatality Review Committee. This committee works to Identify patterns and trends in child deaths and improve the quality and comprehensiveness of child fatality data. Helping state agencies, law enforcement, and community organizations work to prevent and investigate child fatalities and recommend changes to policy, law, or practice to reduce preventable deaths to identify and address risks to children.

Professional Education:

Coroner Roberts also participates in the education of our future law enforcement, Fire Department, and EMS

providers, medicolegal, and medical professionals. By affiliation and precipitation with our local universities, future law enforcement officers, deputy coroners, and forensic science majors obtain a valuable education that will provide ongoing care for the citizens of Idaho. In 2024 Coroner Roberts guest lecturer in several classes at Idaho State University Pocatello campus and recruited two student interns to support the Coroner's Office in data research, legislative improvements, investigative methods, and fostering partnerships with community groups.

Infrastructure:

The Coroner's Office recently moved from the courthouse Basement to 490 N. Maple St. Suite B sharing the space with the Idaho Division of Vocational Rehabilitation. Our square footage increased from 144 sq ft to 225 sq ft. for the coroner and 4 investigators. However, the change in location does not satisfy the need for a facility that allows decedent exam and storage space. The office also secured a 2024 RAM 2500 for decedent transport. The procurement of this vehicle allows coroner staff to transport decedents that require autopsy at a savings of $700 per transport ($21,700 in 2023) it also provides coroner staff the ability to utilize the 24-bed mobile morgue that was obtained through a grant with FEMA in 2022. BY reducing the cost of decedent transport to autopsy the cost of the vehicle will be recovered in less than three years. This mobile morgue unit is intended for mass fatalities, and pandemics, and could also be used to ensure chain of custody of decedents in criminal cases once a secure facility is obtained for its use within the county.

Looking Forward:

By obtaining accreditation by the International Association of Coroners and Medical Examiners Bingham County Citizens and decision-makers can be ensured that the office is following the national standard in conducting death investigations to our citizens and visitors. The biggest hurdles that need to be overcome to achieve accreditation is having an office that allows for secure decedent exams and storage of the same to maintain an appropriate chain of custody. Together the Coroner and County Commissioners are exploring ways to overcome these challenges.

We extend our sincere gratitude to the Bingham County Board of Commissioners for their support of the Coroner's Office and the services we provide to the citizens of Bingham County.

Coroner's Office Staff & Contracted Forensic Pathology Agency

James Roberts, A.A., D-ABMDI
Bingham County Elected Coroner
Medicolegal Death Investigator

Flint Christensen
Chief Deputy Coroner/Medicolegal Death Investigator
Bingham County Coroner's Office

Lea Hartman
Deputy Coroner/Medicolegal Death Investigator
Bingham County Coroner's Office

Shante' Sanchez
Deputy Coroner/Medicolegal Death Investigator
Bingham County Coroner's Office

Samantha Unwin
Idaho State University Intern

Sophia Fehrenbacker
Idaho State University Intern

Kristin Langedyke
Volunteer Epidemiologist

Ada County Coroner Staff Available to the Bingham County Coroner's Office through our Forensic Pathology Contract:

Richard Riffle
Ada County Elected Coroner
Ada County Coroner's Office

Brett Harding
Chief Deputy Coroner
Ada County Coroner's Office

Garth Warren
Chief Forensic Pathologist
Ada County Coroner's Office

Christina Di Loreto
Forensic Pathologist
Ada County Coroner's Office

Ryan Belanger
Forensic Supervisor
Ada County Coroner's Office

Carolina Ramos
Senior Forensic Technician
Ada County Coroner's Office

Zackary Rushton
Forensic Technician
Ada County Coroner's Office

Collin Lapp
Forensic Technician
Ada County Coroner's Office

Sheila Silva
Administrative Specialist II
Ada County Coroner's Office

Jessica Macdonald
Emergency Preparedness Coordinator
Ada County Coroner's Office

Types of Deaths Reportable to the Office of the Coroner

Idaho Code § 19-4301. COUNTY CORONER TO INVESTIGATE DEATHS.

(1) When a county coroner is informed that a person has died, the county Coroner shall investigate the death if:

- The death occurred as a result of violence, whether apparently by homicide, suicide, or by accident.
- The death occurred under suspicion or unknown circumstances; or

(c) The death is of a stillborn child or any child if there is a reasonable articulable suspicion to believe that the death occurred without a known medical disease to account for the stillbirth or child's death.

The coroner has the authority under these Acts to order an autopsy at any time it is deemed necessary to determine or confirm the cause and manner of death.

Deaths Reportable to the Coroner:

- Violent death (e.g., strangulation, gunshot, stabbing, poisoning, etc.)
- Accidental deaths (e.g., falls, drowning, motor vehicle collisions, burns, overdose, etc.)
- Death of a prisoner (e.g., deaths in any county or city jail while imprisoned or in custody).
- Suspicious Circumstances (e.g., Unidentified Bodies or events surrounding death)
- Sudden and Unexpected deaths (e.g., all deaths during a surgical procedure, in recovery,
- anesthesia-related, unexpected natural death, occupational-related deaths) *
- Without medical attendance within 48 hours of death:
- In cases of chronic illness, the attending physician may sign the death certificate if s/he can be reasonably certain of the cause of death.
- Charred and or skeletal remains
- Death of a mother due to an abortion.
- Unexpected infant deaths

The coroner would generally determine a need for an autopsy for any of the reportable deaths listed above.

Trainings & Conferences Attended for Advanced Education

University of North Dakota Medicolegal Death Investigation Training
4BFFD Joint Training (April)
Arson Training with Detective Squad (April)
Homicide Investigators Course (May)
Blunt & Sharp Force Injuries Course (July)
Shelley QRU Training (July)
IACME Conference (July)
FH Suicide Coalition (August)
NMS DUI Webinar (September)
Donor Connect Virtual Symposium (September)
Advanced Forensic Science at ISU (September)
ISACC Conference (September)
MDI Myth: Talking with Decedent's Families is Simple and Routine (September)
NMS Navigating Testimonial Hearsay Training (September)
MDI Myth: Diversity in Medicolegal Death Investigation (September)
MDI Myth: Rapid Toxicology Screening Tools (October)
ISU Human vs Non-Human Remains Training (October)
Human vs Non-Human Remains Training recognition of osteology (November)
MDI Myth: Next-Of-Kin Notification (October)
Dead & Buried Course ISU (October)
Ada County Forensic Pathology, Autopsy & MDI Training (November)
SOMDI: Compassion fatigue & Resiliency (November)
SOMDI: Open-Source Intelligence (November)
International Homicide Investigators Association Conference Cold Case Conference (December)

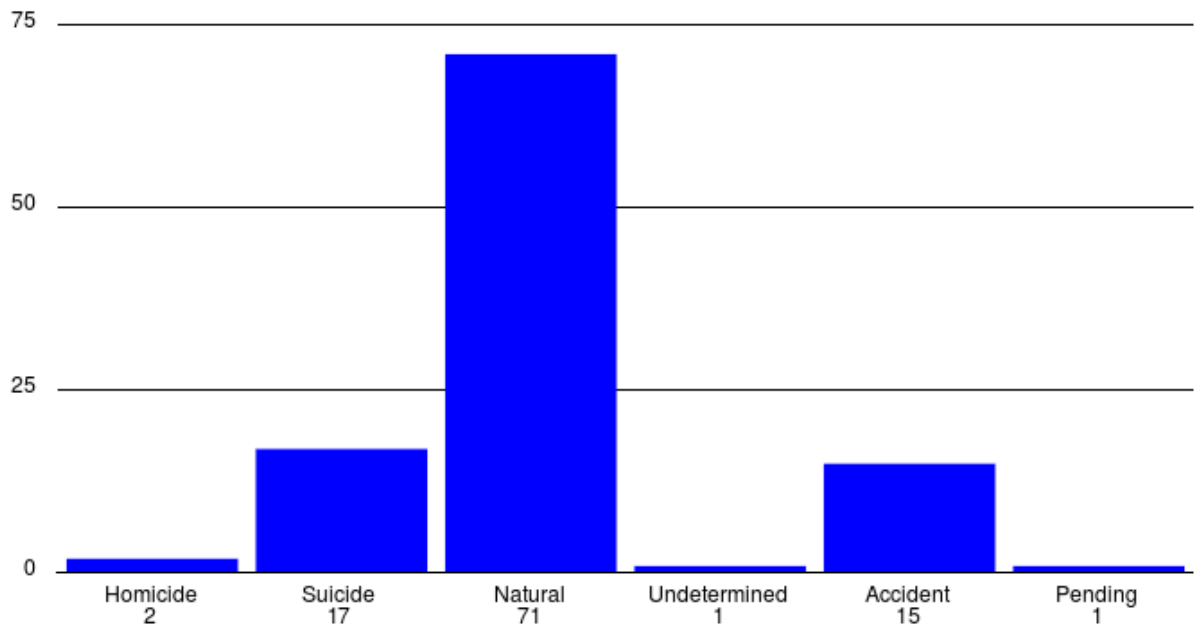
Bingham County Coroner Cases

	2023	2024
Population (Per 2024 Census)	47,992	50,395
Cases Reported to Coroner's Office	181	217
A. Case requiring some level of autopsy	31	21
1. Number of Coroner Cases with Complete Autopsy	27	21
2. Number of Coroner Cases with External Examination	2	0
3. Number of Cases with Limited Examination	2	1
B. Number of deaths certified with only medicolegal death investigator postmortem examination only.	73	91
C. Number of deaths not certified by Coroner's Office after investigation.	77	105

Definitions

Full Autopsy: A complete external and internal examination of a decedent
Limited Examination: An examination that is focused on a specific organ or region of the body, i.e., heart, and can be accomplished via images i.e. CT scan.
The limited examination also includes an external examination.
External Examination: An examination of the exterior of a decedent.

Manner of Death by Postmortem Examination



Reasons for Determining Manner of Death

Determining the manner of death was first implemented in the United States in 1910 when it was included as a box to fill out on the US Standard Certificate of Death . Generally, the contemporary purpose behind classifying a person's manner of death is for statistical purposes, and occasionally for legal cases as well. Interestingly, these classifications don't have to be concluded based on a preponderance of evidence, rather that they can be determined based on a coroner's reasonable certainty. This means that manner of death rulings can be adjusted should new or conflicting evidence come to light. The lack of evidentiary conclusions makes the manner of death a less viable legal tool than cause of death.

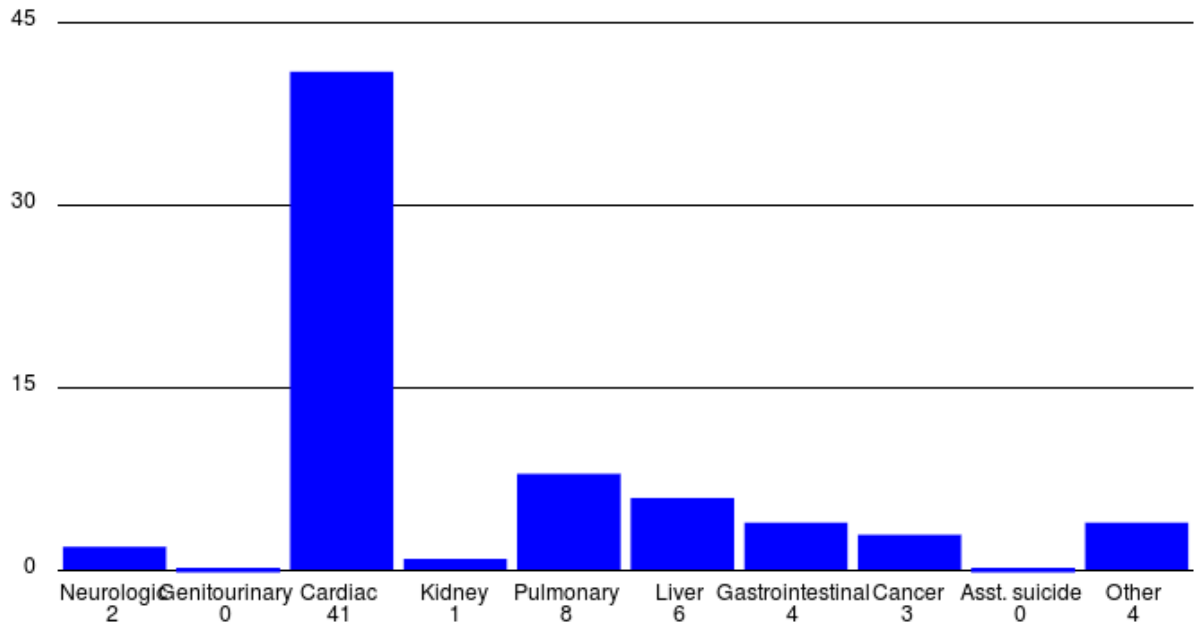
Five Manners of Death

Currently, there are five different manners of death: Natural, Accident, Suicide, Homicide, and Undetermined. In addition to these distinctions, there is an option to note a manner of death as pending. Normally this is only used when it's taking a while to determine the manner of death and is resolved once the final conclusions have been submitted.

Natural, Accident, Suicide, Homicide, Undetermined

Undetermined classifications are used when there isn't any single manner of death that a coroner or medical professional feels is more compelling than another. If more evidence comes to light, then this label can be changed on a person's death certificate in the future.

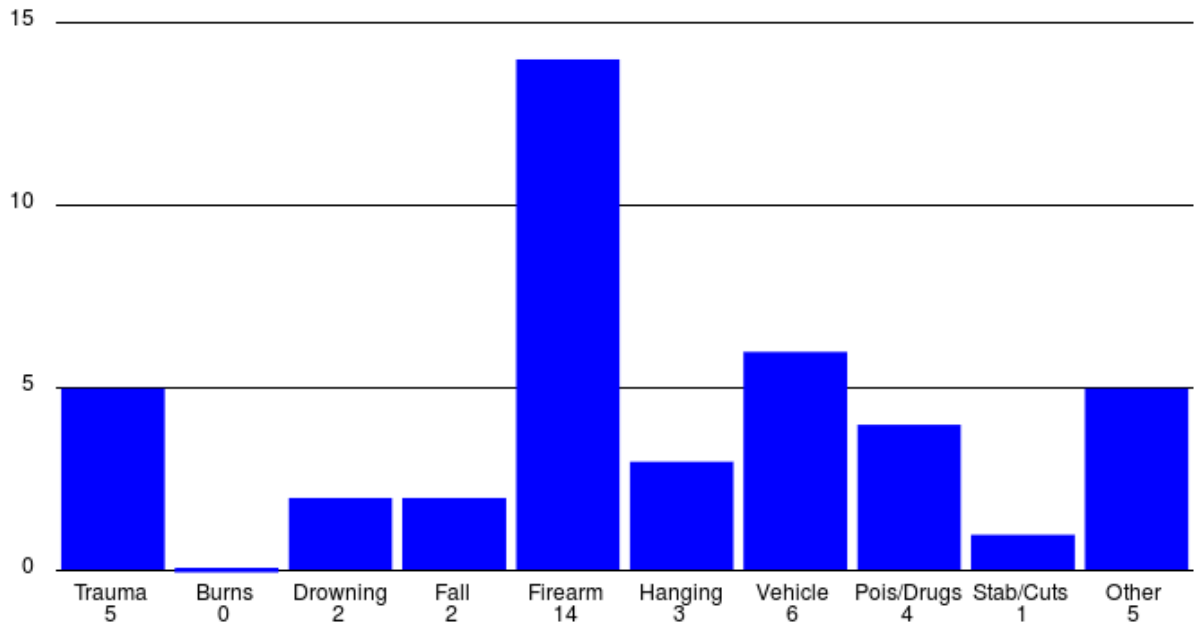
Data on Deaths by Natural Causes



Natural

Natural deaths result from natural means such as aging, illnesses, or disease. This label can be particularly difficult for people dealing with the untimely death of a loved one based on disease. Some feel like the natural label to the death of a child with cancer, for instance, is callous. However, it's important to note that this distinction isn't a reflection of the appropriateness of the death, but rather the nature of the death itself.

Data on Deaths by Unnatural Causes



Accident

Accidental deaths are unintentional deaths caused by an injury or poisoning. The important distinction here is that there isn't any actual evidence to prove that there was an intent to harm or cause a fatality. Things like falling down a flight of stairs and breaking your neck or driving off a cliff are examples of accidental deaths.

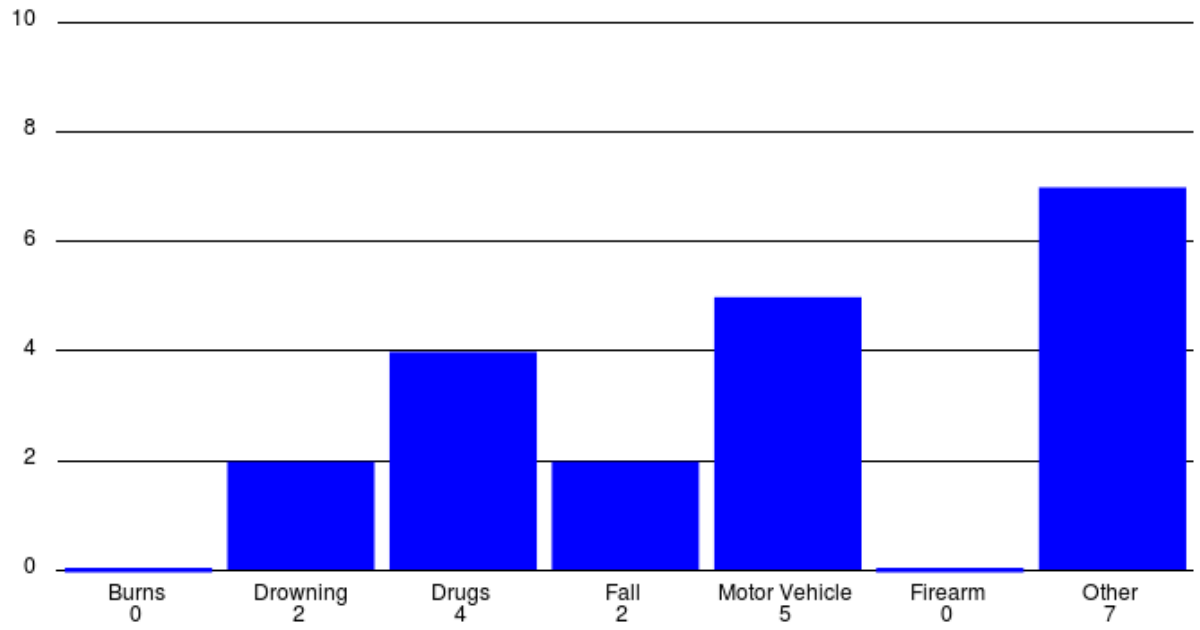
Suicide

Suicides differ from accidental deaths in that they result from a deliberate, self-initiated, intent to cause harm or fatality to oneself. These deaths can come from such self-inflicted injuries as poisoning, drug overdose, asphyxiation, and so on.

Homicide

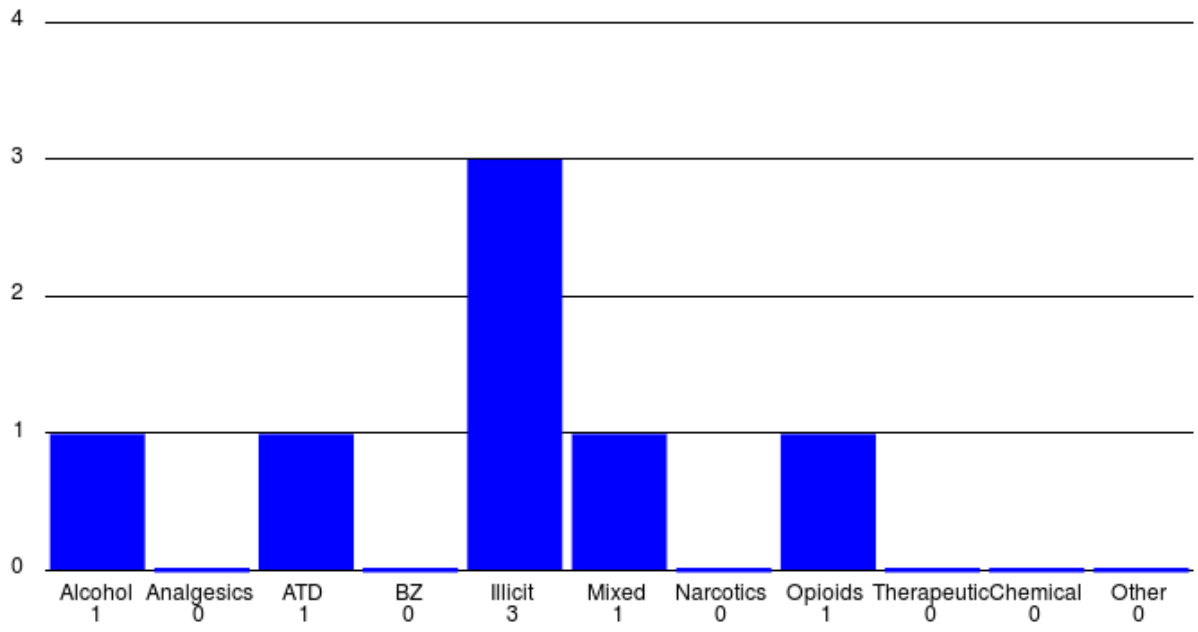
Homicides are determined to be deaths that have been caused by another person(s). Manner of death rulings that're ruled to be homicides are not criminal classifications in the sense that they don't seek to determine the exact cause of death or the motivations behind the homicide; rather, they just note that the person died because of another person, whomever that person(s) might be.

Data on Accidental Deaths by Type

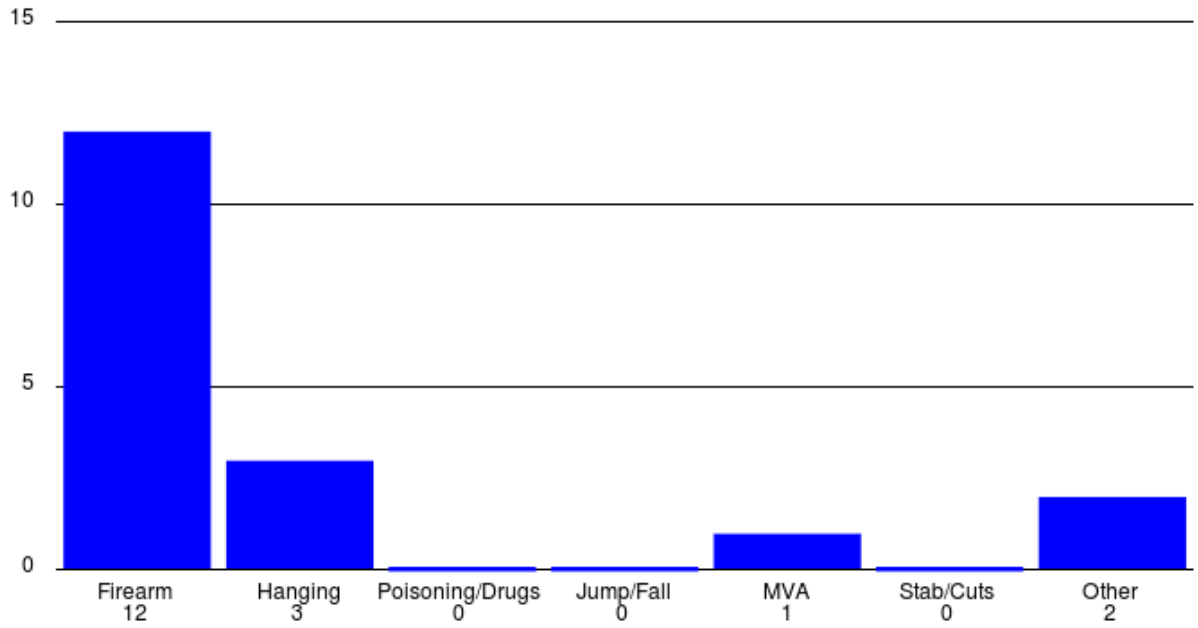


Breaking down the accidental manner of death into sub-sections allows fatality review teams and public health partners to identify risk factors, consumer product issues, and systemic issues that can be altered to prevent future deaths.

Data on Drugs Contributing to Causes of Death



Data on Suicide by Means



In 2024 we had a significant increase in the number of suicides in Bingham County from 2023 (11/18 respectively.) Coroner Roberts participates in a regional public health suicide prevention coalition as well as

the Fort Hall Suicide Prevention coalition working with partners within the community to identify risk factors and identify suicide prevention programs for our citizens and visitors.

Data on Deaths by Age Group