Idaho Criminal Justice Commission Coroner Subcommittee Meeting

Date: June 3, 2025

Time: 2:30 pm MT

Present: Kelli Brassfield, Bernie LaSarte, Josh Hall, Torey Danner, Will Carson, Brett Harding, Matthew Gamette, Sheriff Quayle, Kirt Gaston, Scott Carver, Melissa Wintrow

Subgroup Assignments: Each subgroup will review the needs we discussed and use the grid below to brainstorm creative ideas/solutions. At this stage there are no bad ideas.

Each subgroup will also have an **additional focus listed** with their group to do a little additional brainstorming on.

Subgroup 1: Bernie, Josh, Kirt, Scott, Kelli (confidentiality)

Subgroup 2: Matthew, Torrey, Sheriff Quayle, (infrastructure, resources)

Subgroup 3: Brett, Will (accreditation)

Meeting Outcomes:

- Review of OPE report and survey of needs
- As a group share the key areas from reports that stood out as problematic
- Assign work groups and schedule next meeting

Framework for Problem Solving: As we work toward positive change, building on S1101, we want to

- 1) Review the current landscape (documented in OPE reports): what exists currently, what's missing, what are gaps...
- 2) Why do some of these challenges exist? Is it funding structures, statutory or constitutional issues, education, etc.
- 3) What do we see as optimal solutions to challenges? This is where creative thinking comes that aligns with our values.
- 4) What is our strategy to address challenges?

What Drives Our Work? The Purpose and Reasons?

Ensuring public safety for our communities including justice, peace of mind, and closure for victims and their families is a driving force to our work. This commitment compels us to conduct professional and thorough investigations and collaborate with other partners for the best possible outcomes and closure for victims and their families.

Key Areas and Challenges in the System: in reviewing the OPE reports we identified some key areas and challenges to address.

• Systems/System Design: thorough review and development of strong systems and

- designs are required.
- **Oversight:** Enhanced oversight mechanisms are essential to ensure accountability and proper functioning.
- **Finance and Equipment:** Securing adequate funding and providing necessary equipment are critical priorities.
- Lack of Respondents: Not all the coroners responded to the survey conducted by OPE; addressing the issue of low participation rates and ensuring complete data collection is vital.
- Office Space: Adequate office space is required to support operations in a professional and secure manner.
- **Privacy of Individuals:** Appropriate Individual privacy protections should be put in place.
- Standards: Establishing clear standards for various processes and requirements
- **Record Management:** Developing protocols for record storage, retrieval, security, and usage is important.
- Record Users and Accessibility: Identifying and addressing the needs of those who require access to records; determining who gets records
- **Inconsistencies:** Rectifying inconsistencies in education, evidence, qualifications, and wages is very important.
- **Transportation:** Ensuring reliable transportation for necessary work like transporting descendants.
- **Certification and Accreditation:** Overcoming the lack of funds and infrastructure to achieve certification or accreditation.
- Regional Resources: Developing regional resource centers to avoid fund shortages could be considered.
- Accreditation Standards: Utilizing accreditation standards as a guide for building resource solutions and reaching national standards
- Education and Standardization: Establishing educational standards and developing processes to standardize and provide oversight.
- **Enforcement and Accountability:** Strengthening enforcement mechanisms and ensuring accountability.
- **Child Deaths:** Addressing the issue of unanswered questions regarding child deaths and increasing resource availability and funding for autopsies is critical.
- **Citizen Support:** Providing answers and support to citizens who are suffering is a core responsibility.
- Resource Access to things that exists: there are some resources that exist that
 coroners may not know about; get information to them on how to access resources
- Resource Distribution: Implementing innovative solutions for quick and efficient resource distribution to counties
- **Public Education:** Educating the public and stakeholders is essential for transparency and awareness.

Initial Brainstorm of Things to Address:

Funding Sources: Identify and secure diverse sources of funding.

- State Support: Advocate for increased state support and resources.
- **Autopsies:** Prioritize funding and accessibility for autopsies to provide answers and gather critical information.

Use the Grid Below as a guide. Please add your thoughts when you meet in teams.

Challenge Identified	Specific Problem and what has caused the problem? Why it important to address	Creative Solutions	Why is th
Systems/System Design			
Oversight			
Records (sharing, storage, security, policies)			
Office Space			
Access to Necessary Resources			
General Infrastructure (lab to conduct autopsies, cold storage, access to vehicle/transports)	Counties vary in population, which impacts budget and resources.	Create a mechanism to distribute funding to counties who need more help and have fewer resources. - Form nn Advisory Board of relevant stakeholders to make decisions about how grant funding is distributed to counties to support coroner's public safety obligations	
	There are not enough facilities to conduct autopsies. Ada County	Create a model to share space with a hospital or ISP forensics lab (Pocatello)	

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	Autopsies are being done inconsistently across the state. Should there be "automatic" deaths that would require an autopsy, like for child deaths?	that has facility and capability to conduct autopsy. This may offer a way to build out a facility at the same time. This would require - a pathologist - An agreement between entities (ISP or local hospital) - additional funding - If ISP, their accreditation already requires operational independence; policies to separate entity of scientific side of the house and law enforcement; - Model to pay for autopsy when the counties are smaller with smaller budget - Could create a reimbursement model for smaller counties so the board/entity could be like EMS is done as a pass through grant) - ISP is equipped to manage grants like it manages grants for US Attorney Project Safe; ISP manages the grant and the stakeholder group then makes the decisions - Nurture existing relationship between medical fellow who may be interested in such a position upon graduation: Brett has been building relationships and may have found an interested party	
Professionalization of the Position (wages, training/education,ac countability to position duties)		Reduces liability because you are doing the work in accordance with established standards; would also help with prosecution; teaches the best investigation practices; some fed grants will only go to accreditation	

OAdd more cells as you see fit!

Tab 2

Idaho Criminal Justice Commission - Coroner Subcommittee Meeting Minutes

Date: June 17, 2025

Time: 3:00 PM - 4:15 PM Mountain Time

Facilitators: Senator Melissa Wintrow and Kelli Brassfield (IAC) - Note: Kelli Brassfield on

vacation

Attendees

- Senator Melissa Wintrow, JLOC Co-chair
- Ryan Langrill, Director, Office of Performance Evaluations
- Sydney Norsk, OPE Intern (taking notes)
- Sheriff Bart Quayle, Fremont County
- Matthew Gamette, ISP Forensic Services
- Bernie LaSarte, Coeur d'Alene Tribe
- Will Carson, Twin Falls County Coroner
- Torey Danner, Bannock County Coroner
- Joshua Hall, Nez Perce County Coroner
- John Fudenberg, Executive Director, International Association of Coroners and Medical Examiners (new participant)
- Brett Harding, Ada County Chief Deputy Coroner (joined briefly)

Subgroup Report: General Infrastructure Primary Problems Identified:

- 1. Inconsistencies in autopsy practices across the state
- 2. Lack of adequate resources for autopsies
- 3. Need for additional pathology facilities beyond Ada County
- 4. Inconsistent resource distribution across counties of varying sizes

Solutions Discussed:

Advisory Board Structure

- Proposed composition: Coroners, sheriffs, police chiefs, prosecutors, law enforcement, and other stakeholders
- Purpose: Create communication channels and make funding distribution decisions
- Analogous models: Idaho POST Council, Idaho Brand Board, Idaho Racing Commission
- Function: Provide stakeholder governance for resource distribution rather than topdown state control

Reimbursement Program for Autopsies

• Target: Smaller counties lacking adequate autopsy funding

- **Priority focus:** Child autopsies (where Idaho ranks last nationally)
- **Structure**: Similar to EMS grant system examining county needs and distributing funding accordingly
- Administration: ISP would manage the grant; stakeholder advisory board would make distribution decisions

East Idaho Pathology Facility Development

- **Immediate opportunity:** Young pathologist completing fellowship next year and interested in Idaho
- Starting location: Potential partnership with existing facilities in Bonneville or Pocatello
- **Independence requirement:** Must maintain operational independence from Idaho State Police (per accreditation standards)
- Precedent: Montana runs forensic pathology through state lab with proper independence structure
- Next steps: Begin scoping facility requirements, partnerships, and funding mechanisms

Low-Hanging Fruit Solutions

- Matthew Gamette's observation: Many counties lack basic supplies (gloves, PPE, body bags)
- Proposed solution: State-level purchasing and distribution system for basic supplies
- Implementation: Relatively simple for state agencies with purchasing contract access

Standardization of Autopsy Requirements Current Problem:

- Inconsistency in when autopsies are performed
- Point of contention between law enforcement and coroners often centers on autopsy decisions
- Law enforcement may bypass coroner by having prosecutor order autopsy (comes from coroner's budget)

Proposed Solution:

- Legislation requiring "automatic" autopsies for specific case types
- Priority cases identified: Child deaths, homicides, suspicious deaths
- Caveat: Must ensure adequate facility capacity before mandating increased autopsy volume

Accreditation Discussion (John Fudenberg) Key Finding:

Counties can obtain IACME accreditation without their own autopsy facility if they
use an already-accredited facility

Benefits of Accreditation:

- 1. Reduced county liability by demonstrating adherence to national standards
- Public trust and transparency shows highest standard of service
- 3. Staff training requirements improve investigation quality
- 4. Federal funding opportunities some grants only available to accredited offices
- 5. **Legal credibility** important for court testimony and prosecution

Current Status:

- Tory Danner's perspective: Accreditation is "the best way to explain to the public that we are operating at the highest bar"
- **Standard clarification:** Accreditation represents "bare minimum standards" rather than best practice, making it achievable

Action Items

- Senator Wintrow and Ryan Langrill: Meet to discuss mapping out identified issues and solutions
- 2. All subcommittee members: Continue brainstorming on the grid worksheet
 - Include considerations for office space and other resource needs
- 3. Senator Wintrow: Contact prosecutor Matt Fredback to join subcommittee
 - o Note: This was identified as a missed action item from previous meeting
- 4. Confidentiality subgroup follow-up: Address records confidentiality issue
 - Status: July 1 meeting proposed for confidentiality subgroup
- 5. Future exploration: Define specific cases that should constitute "automatic" autopsies

Tab 3

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	There are not enough facilities to conduct autopsies. Ada County is the only game in town.	Create a model to share space with a hospital or ISP forensics lab (Pocatello) that has facility and capability to conduct autopsy. This may offer a way to build out a facility at the same time.

	Autopsies are being done inconsistently across the state. Should there be "automatic" deaths that would require an autopsy, like for child deaths?	This would require
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