



AAC Publications

Ground Fall from Anchor – Miscommunication

Vermont, Lower West Bolton

AT APPROXIMATELY 6 p.m. on September 16, I responded to the report of a fatal rock climbing accident at the Lower West Bolton climbing area. I was directed to an ambulance where the two subjects who had been climbing with the deceased (20-year-old Rebecca Ryan, “RR”) were waiting. I briefly interviewed LK (19) to get her version of the events before I went to the scene of the accident. The other partner (IH, 21) was present but said very little.

LK indicated that RR was top-roping a route (later determined to be Harvest Moon, 5.7+) while belayed from the bottom of the climb. The climb is approximately 80 feet high, and the top is not visible from the bottom. LK said that RR completed the climb and gave the command “off belay” to indicate that she had secured her-self to the anchor at the top. LK was under the impression that RR was going to rappel down the route, and she removed her harness to await RR’s descent. LK then heard RR yell down, “Are you ready?” She then realized that RR may have been expecting her to lower her down the route, and she yelled up that she was not ready and scrambled to put her harness back on. (IH later remembered the events in a very similar way.) Before she could don her harness, LK observed RR free-fall down the cliff, landing at the bottom.

I asked if they had discussed before the climb what method RR was going to use to descend, but she was not clear on that point. I then examined the scene and found the following:

RR was tied into one end of the rope in a configuration (Figure 8 follow-through knot properly tied through her harness) that would be consistent with climbing the route and being lowered back down to the bottom by her partner. If she was planning on rappelling, the rope would not have been tied in to her harness. RR did not have a rappel device on her harness, which would indicate that she did not have an easy way of rappelling down the route. Her options would have been to be lowered by LK or walk off the route around the top of the cliff. RR was not wearing a helmet. It was lying on the ground near her pack at the base of the climb. At the top of the climb the rope was threaded through the two-bolt anchor, consistent with RR’s expectation that she would be lowered from the top.

Five days after the accident, a state police detective and I met with LK and IH to review the sequence of events that led up to the accident. We learned that RR was the most experienced of the climbers, and LK and IH had looked to her as the “leader” of the group, though her outdoor experience was limited. LK said she had just bought her first rope, and this was her first outing using it.

The pattern of climbing throughout the day, prior to the accident, had been for the belayer to lower the climber. At no point during the day had anybody rappelled. Nevertheless, both LK and IH remember RR indicating that her intent was to rappel down their final route (where the accident occurred) after cleaning the anchor. (Source: Neil Van Dyke, Department of Public Safety.)

ANALYSIS

This incident strongly reinforces the importance of a climber and belayer clearly communicating a plan for descending from each anchor, especially when the anchor is out of sight (and possibly out of clear hearing range) from the ground. In some cases, a climber may need to change the descent plan en route. In this case, RR had stated that she planned to rappel but had no device on her harness or the rope when she fell, suggesting she may have forgotten to carry it and thus was forced to change plans once she reached the anchor. Whenever there is such a change of plans, the climber should

communicate the new plan as clearly and loudly as possible and wait for acknowledgment from the belayer. Then, the climber should test the lowering system before unclipping from the anchor, making sure the belayer is holding his or her weight. (Source: The Editors.)

Images

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