



## AAC Publications

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### **Lowering Error – Rope Too Short, No Stopper Knot**

Idaho, Castle Rocks State Park, Castle Rock, Southwest Face

**On July 21, Dan and Carolyn Morgan were climbing with a group of friends on the southwest face of Castle Rock. The pair were experienced climbers, she with 20 years and he with more than six years of experience.** The two were staging an informal climbing and rappelling clinic for their friends. Dan began ascending Red Rib (5.10a), a route that is 190 feet high, with the goal of setting up a top-rope, and Carolyn led Slab Happy (5.9), just left of Red Rib, to set up a practice rappel for the others.

At around 10:10 a.m., Carolyn heard Dan call “take!” and then “lower” to his belayer. She then heard him shout with alarm and watched him free-fall approximately 130 feet to the ground. According to witnesses, the single line used to lower Dan slipped through the belayer’s device, causing the uncontrolled fall. No knot was tied in the rope end. Dan fell to a ledge about 20 feet above the base of the climb, and was immediately tended by Carolyn and a friend, who were able to rappel down Slab Happy and traverse over to reach him. Dan was initially found semiconscious with labored breathing, but soon passed away due to multiple traumatic blunt force injuries. (Sources: Carolyn Morgan, Sarah Carpenter, and Stephen King, ranger at Castle Rocks.)

### **ANALYSIS**

This incident occurred through a series of overlapping errors. Perhaps most importantly, an atmosphere of relaxed complacency existed within the team of climbers, which may have contributed to errors in judgment, lack of awareness of the scale of the climb, and a clear plan for how the climbers would ascend and descend the route.

**Rope too Short.** This accident could have been avoided by assessing the height of the climb and the length of the rope or ropes needed to complete it. A review of the guidebook (and careful assessment of the cliff itself) would have alerted the climbers that the 70-meter rope they were using was not sufficient for lowering or rappelling directly from the top of Red Rib (190 feet or roughly 58 meters high). A second rope or multiple rappels is required to descend from this climb.

Belay system was not closed, and belayer failed to track the end of the rope. The inexperienced belayer complied with the request to lower and continued until the end of the rope slipped through her Grigri. Had either climber affixed a knot to the end of the rope, the accident would have been prevented. The belayer, whose experience was mainly in gym settings, was unaccustomed to using the entire length of a rope and unquestioningly trusted the more experienced climber to make all the decisions. With more instruction, the belayer would have known to monitor the center of the rope and to alert her climber when the rope was running short.

Lack of clear planning and situational awareness. This incident highlights the importance of the climber clearly communicating a plan with the belayer prior to leaving the ground. The climber was reasonably experienced, but he misinterpreted the height of the route. The goal of climbing Red Rib was to set up a top-rope for others, yet the single 70-meter rope he was using would have been much too short to reach the ground. He then asked to be lowered from the top of the pitch, despite having already climbed nearly 60 meters. (Sources: Carolyn Morgan, Sarah Carpenter, and the Editors.)

**Images**

## Article Details

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