

M. H. remained conscious and complained of tingling and numbness in his legs and tenderness in his spine. He was back-boarded and carried out to a waiting helicopter. He was diagnosed as having three cracked vertebrae and small pieces of bone floating around the spinal column. He was operated on in Johnson City, TN, where he himself is an ER physician.

Analysis

Climber should have taken advantage of the numerous opportunities to place gear on this route rather than relying on a single piece. The lead climber should be aware of the belayer's abilities. Belaying the leader requires practice catching and holding a falling leader. Credit is due to the seven-year-old who ran out for help! (Source: Aram Attarian)

FALL ON ROCK, FAILURE TO FOLLOW ROUTE, INADEQUATE BELAY AND PROTECTION, NO HARD HAT, POOR POSITION

Oregon, Smith Rocks

Bill Pesklak (39) and his partner Brian Boshart (25) were working on Titanium Jag, a 5.10b, assigned two stars, an average quality route, by Alan Watts, author of *Climber's Guide to Smith Rock*. Both men had attained a small ledge about 80 feet up the route. With Boshart belaying, Pesklak climbed an estimated 20 feet above the ledge, slipped off, fell on his belayer, tipped off the ledge, fell again striking his head, then slid the remaining 60 feet to rocks below. Pesklak died from massive head injuries. Boshart, with a concussion, back muscle injuries and belay rope burns around his leg, was lowered from the rock six hours after the fall by rescue personnel, hospitalized and released.

Analysis

Titanium Jag has some fixed anchors. Traditional protection gear going up to two inches is suggested. Climbers familiar with the route suggest that Bill Pesklak may have been off line. He had placed one piece about ten feet above his belayer and was working on a second piece when he fell. Brian Boshart was clove hitched with the climbing rope into a two-bolt anchor. He belayed directly to the climber from his harness with an ATC. Both men had discussed his belay position. Boshart stated that he had unclipped his runner from the anchor to move laterally several feet to a position under Bill because of rock fall concern. Brian was able to watch Bill climb. He had locked off the ATC with the rope around his leg as the leader worked on the second piece. Bill fell feet-first onto his belayer, knocking him off the ledge and into a 15-foot pendulum to a point 10 feet below the anchor. Control of the belay was lost; the climber had tipped off the ledge, falling head first then sliding to a stop at the bottom of the climb. Brian remembers the rope playing out through the protection point, which remained on the rock.

Above a belay ledge, experience tells us that the rope should be clipped to a second anchor just above the belayer's head or to the belay anchor, thereby adding friction to the system and pulling the belayer's body weight into the anchor above the ledge while holding a leader fall.

Smith Rock is a highly developed sport climbing area and most routes have

been artfully bolted and cleaned of natural debris. Most climbers at Smith Rock do not use helmets on top roped routes. The use of helmets on less developed routes should be a mark of advanced ability and could have saved a life in this instance. The use of a belay device such as the Gri-Gri is a way to stop a fall, uncontrolled by a belayer. Brian believes that use of a Gri-Gri and a helmet might have save Bill's life. (Source: Robert Speik)

AVALANCHE, POOR POSITION

Oregon, Mount Hood, West Crater Rim

The incident took place on Sunday May 31 at 10:05 PDT at the 10,700 foot level on the West Crater Rim route. The occasion was a graduation climb for The Mazamas Basic Climbing Education program.

The party was caught in a large slab avalanche. The fracture occurred about 200 vertical feet below the westernmost summit ridge near the 10,800 foot level. One rope team of three people were caught and swept down a 45–50 degree slope—through the Hot Rocks area and then the gully between Crater Rock and Castle Crags. One person was killed by trauma during the fall, a second person received a fractured pelvis possibly due to the rope breaking between her and the person killed, and a third person on the rope team experienced a fractured ankle. The leader was also briefly caught in the avalanche and experienced an ankle and a shoulder injury.

The avalanche was classified as SS-A0-3 (medium in size relative to its potential path). The crown was 300 feet wide, two feet average depth varying from one to five feet. The slope faced southeast and the slide ran from 10,800 feet to the 9,550 foot level, or 1250 vertical feet. The slope angle at the fracture line was 40 degrees. The climbers were engulfed at the 10,700 foot level while traversing a 25–30 degree “ramp.”

Stormy, cool weather during much of the preceding week had produced one to two feet of new snow at higher elevations on Mount Hood. Clearing late Saturday allowed sun and rising freezing levels to produce surface snow melt of the upper one to two inches of wind packed snow. Radiation cooling overnight helped briefly stabilize the surface crust. At the time of the accident sun had been warming the slope for about four hours and the air and snow temperatures were rising rapidly. The freezing level was around 10,000 feet. Earlier parties summited climbing predominantly on the firm crust. However, by mid-morning climbing parties reported knee depth post-holing down to an old crust.

When the group left Timberline Lodge, they observed a hand-written sign, posted in the Forest Service Climbers' Register, stating “HIGH AVALANCHE HAZARD!” The sign had been updated Saturday, May 30 at 8 p.m. by the USFS climbing ranger, only hours before the group set out. It was unusual for such signs to be posted. In fact, this was only the second such sign in seven years.

The leader and other party members observed the sign. The wording of the sign caused questions from and confusion among various party members, some of whom who believed it might have been placed the prior week.