The side path was estimated to 500 meters long and 250 meters vertical. The fracture zone was 120 meters wide by one m at its initiation point (an unseen pillow on the steeper west face of the bowl). However, most of the fracture wall was merely 20 to 30 cm high. The release was said to be "skier triggered from below."

Analysis
(1) Our test pit was dug on an aspect equivalent to what we skied, not that of the slope across the other side of the bowl. (2) We were skiing below a slope exceeding 30. (3) The euphoria of beautiful weather, scenery, and turns in perfect powder overshadowed caution after several runs. (4) Local advice and the avalanche forecast were weighted too heavily in the light of our field observation. (5) The prevailing wind had been northwest for several days, leaving the northwest facing bowl relatively safe. Apparently, a northeast eddy had windloaded a small, unnoticed area of slab on the far wall. (6) The victim was skiing with a heavy pack loaded with camera equipment. Possibly this reduced his mobility. (7) The skiers had too much separation to hear warning calls. (8) On our upclimb along the edge of the woods, "whoomp" sounds gave a strong indication of instability. (Source: Jed Eliades—53)

(Editor's Note: A fund in memory of Steve Gordon has been established by his friends. Contributions received are designated for the AAC Safety Committee.)

STRANDED, POOR COMMUNICATIONS, INEXPERIENCE, WEATHER
Colorado, Rocky Mountain National Park, Twin Owls
On June 9, 1992, at 1000, Brandon Latham (20) and Tom Anderson (19) began an ascent of Twin Owls via the East Ridge I (5.8). At 1200 Anderson was at the top of the second or final pitch, and he began to belay Latham. At this point, an intense thunderstorm had moved into the area, bringing with it loud thunder, bursts of lightning, and heavy rain. Anderson and Latham were unable to communicate with each other. Latham assumed Anderson would be rappelling down, so he untied himself from the rope. Anderson assumed Latham was climbing, and pulled in all of the slack rope until he found the untied rope end, minus Latham. Still unable to communicate with Latham, Anderson climbed over the top of Twin Owls and descended the "Bowells" to get help. Rangers Rick Guerrieri and Rik Henrikson responded by rappelling to Latham's location from the top. Latham was assessed for possible hypothermia and then lowered to the ground.

Analysis
Poor communications due to noisy environmental conditions is the cause of this incident, which could have evolved into something even worse. It is imperative that climbing partners agree on a set of silent signals, such as a series or rope tugs, before they ever start a pitch. In any case, the partner should never untie himself from the rope when communications are unclear, especially in the middle of a multiple-pitch climb. (Source: Jim Detterline, Longs Peak Supervisory Climbing Ranger, Rocky Mountain National Park)

AVALANCHE, LOSS OF CONTROL—GLISSADING, POOR ROUTE FINDING
Colorado, San Juan Mountains, Lookout Peak
I was mountain climbing with my husband, Edward W. Enlow, Jr. (38), when he had a fatal mountaineering accident on June 13, 1992. The following is a description of the accident.

We had decided to climb Lookout Peak, a 13,661 foot mountain in the San Juan mountain range near Ophir Pass in Colorado. We had read descriptions of the climb in various books, but we did not have a topographical map of the mountain. Soon after we started to climb, we were off trail and hiking up steep, snowy slopes toward a false summit. After we reached the false summit, we looked for a route to the true summit. That route led us over an exposed ridge with loose snow and then up a steep rock couloir on the north side of the mountain. We reached the summit at 1430, much later than we had anticipated when we started the climb. Since the skies were clear and sunny, Ed wasn't concerned about the late ascent.

When we started the descent at 1445, the snow was quite soft. We decided to try to descend by the "standard" route, which was most likely covered in snow, but we could not find an easy way down. After descending 100 feet of steep rock on the south side of the mountain, Ed decided to attempt a seated glissade down a steep snow chute. He had assumed that the chute would be snow covered all the way down to gentler terrain about 500 feet below. However, when he started his glissade, a small avalanche followed him into the chute. I yelled out to him to get out of the chute since he didn't see the avalanche behind him. He tried to self-arrest twice, without success, since he was caught in the swiftly moving snow. He then disappeared out of my sight.

I started to carefully descend down the same chute and saw exposed rocks below due to the avalanche having cleared away the loose snow. I also saw a cliff below me instead of a gradual slope. I had to find a different way down. Using extreme caution (while starting to go into shock at the unknown condition of my husband), I traversed across a couple of steep snow chutes, walked under a huge, cracked cornice, and descended a steep rock and snow gully. I saw his body below with his daypack about 20 feet away from his body. I reached his body about 30 minutes later. His arm was broken but there were no open wounds or external bleeding. There was no pulse or bleeding. The autopsy revealed that internal bleeding was the cause of death and that he had experienced a free fall which killed him instantly upon impact.

Analysis

Knowledge of dangerous snow conditions would help. Make sure the whole runout of a snow chute is visible before starting a glissade.

Climbers must never take a casual attitude toward mountains.... We always have to respect the dangers of mountaineering, even after having climbed successfully for many years. (Source: Regina Pasquale)

LIGHTNING, LATE START, INEXPERIENCE

Colorado, Rocky Mountain National Park, Hallett Peak

On June 28, 1992, at 2100, Glenn R. McDonald (31) was struck and killed by lightning near the summit of Hallett Peak after ascending Hallett Chimney II (5.6). McDonald and his partner Wayne Smart were attempting to summit when the incident occurred. Smart attempted CPR, but there was no response from McDonald.

Analysis

Smart had intermediate climbing skills, but McDonald was a beginner. They did not know each other prior to the climb. They had met through a "climbing partner wanted" ad on the bulletin board of a Boulder mountaineering shop. They had initially planned to do the Culp-Bossier Route III (5.8), but could not locate the start, so did Hallett Chim-