Lessons Learned from a Short Roping Incident

by the Lessons Learned Group

Leader and Clients Died whilst Short Roping

Six clients were taking part in a three day crossing of a pass in the New Zealand Alps with two leaders: an aspirant guide who had done the crossing fifty times before and an experienced mountaineer with no qualifications who had done it eighty times. The weather on the second day had severely limited the opportunity to teach the use of crampons and axes but the leaders felt that they had seen enough to proceed over the col on day three. The group all had axes and crampons and the clients also had helmets.

The leaders judged two of the group to be sufficiently competent to not require a rope for the descent from the pass and split the remaining members between them. The descent involved hard snow slopes up to 30° over a vertical descent of 300m. The aspirant guide tied two clients on separate tails of rope (3m and 3.5m respectively) joined to a hand loop, with the remainder of her 50m x 6mm (Spectra) rope stored in her pack. After a short distance she stopped, possibly to coach her clients in aspects of walking in crampons or short roping. She was seen to be less than 2m from her clients waving her arms and with slack rope between herself and the clients. One client slipped over and although he quickly self arrested the second client also fell and pulled the other two after him. The leader was pulled down the slope headfirst on her back and it would appear that she was unable to recover from this position because the rope in her pack effectively was pulling at her shoulder. The trio went over a small bluff, then down a second snow slope before hitting a second rock outcrop and stopping. All three were killed.

The Coroner recorded a verdict of accidental death.

Lessons Learned

1 The hazards of intermediate ground must never be underestimated and short roping must be regularly examined and understood

2 Leaders must take particular care to accurately assess the hazards of familiar and routine ground

3 Strategies to minimise the risk such as cutting a 'step line' or relaying clients one at a time should be considered

4 Confidence roping, where the rope is not necessarily fixed to the guide, is purely for situations where if everyone fell over they would stop i.e. the technique provides psychological support but physical security is unnecessary.

5 Novice clients need exacting training in crampon and ice axe movement skills as well as in self arrest.

6 Anyone short roping should attach the rope to their waist via a harness or improvised equivalent.

6 Even when the party is stationary a short rope can only be effective if kept under tension

8 While a helmet would not have saved the leader from the final impact it is possible that it would have cushioned her from the initial head first slide and allowed more control of the situation. ■

CONFIDENCE ROPING used to safeguard one individual in a hill walking group to boost confidence in an apparently exposed situation. The individual is tied to a short length of rope that is held by the leader. The instructor may not even tie into the rope. Both move at the same time, thereby not slowing the group as a whole. Confidence roping is used where a fall or slip will not have serious consequences.

SHORT ROPING used to safeguard up to two individuals on terrain that is exposed and where a slip could have serious consequences. Clients move over difficult ground at the same time, tied a few feet apart the instructor using direct belay methods or a braced stance with a body belay. The whole party will move at the same time between sections of difficulty and in less exposed situations.

Shortened from MLTUK Mountain Instructor scheme handbook

The Lessons Learned Group is a small group of professionals and enthusiasts in adventure activities, brought together by a common aim to incorporate any lessons that can be learned from accidents into ongoing good practice.

Our intention is to present an objective summary of an incident together with possible lessons. We do not aim to allocate blame or responsibility and our report represents the views of the individual members of LLG and not of any official body.

Information not currently available to us may render our comments inaccurate and the lessons identified may or may not have influenced the actual outcome. Any report published has been agreed by at least four individuals within the Group as meeting these aims.

www.lessonslearned.org.uk