

CORRECTED Activity Start Date	CORRECTED Activity Category	CORRECTED Activity	CORRECTED Incident Type	CORRECTED Incident Category	ADDED Incident specifics	ADDED Injury/Illness Location	ADDED Injury/Illness	CORRECTED Terrain	Notes	CLEANED Incident report	CLEANED lessons-learned
3/Jul/2020	Trip	Climbing	Near Miss	Slip, Fall, Capsize	Ice axe arrest needed / attempted			Snow - steep, ice axe, poles recommended		Incident occurred during descent from climb of North Face of Kangaroo Temple. There was more snow cover than anticipated by the trip leader. Steep sections were navigated slowly but safely during ascent. During descent, all the participants were tired as this was first climb of the year for many. Coming down from Kangaroo Pass towards SR20, participant lost his footing on a snow section, slipped and fell some distance (10-20 feet), unable to arrest with his ice axe. He was able to stop next to the rocks. He declined medical examination and was able to hike out with everyone.	As trip leader, I should have had the team members bring crampon or micro spikes. I was asked at the start and offered my opinion that it won't be necessary. They may have prevented the slip and fall. Fortunately, I had loaned my ice axe to SB for descent, which hopefully helped in other instances on descent. The participants, including the person who slipped, were not in best physical shape, given the abbreviated start to the season. Basic graduates do not have the same physical readiness requirement as current students. Leader kept the pace measured for the approach and descent, but 13-hour day did take its toll towards the end when this occurred.
10/Mar/2020	Field trip	Climbing	Near Miss	Slip, Fall, Capsize	fall (travel a distance)			Rock - technical, rope & protection needed		Leader cleaned the anchor on South wall and was ready to lower. Belayer took all the slack from the system and started lowering. Suddenly there was significant slack in the system allowing climber to get lowered at a pace equivalent to free falling and out of control. Unclear on what was the root cause. Belayer kept an eye on rope to make sure it wasn't tangled around a hold to get untangled on lower. Some investigation might avoid similar future incidents.	
22/Feb/2020	Trip	Climbing	Near Miss	Slip, Fall, Capsize	fall (travel a distance)			Ice - technical	fell 30 ft	On the final approach, I made a mental note make sure we didn't down climb too far after the final rappel to save having to climb back up to our stowed gear. We had stowed gear much higher than normal because of the amount of snow allowed us to snowshoe up past the trees that are at the top of the saddle (clear up by the base of the climb). The climb was running far later than anticipated because of problems with 1. slow climbing. Though we were on top at 2:30 we did have plenty of time to get back to the gear. 2. Then on the rappels, we had a very slow first rappelling (Megajul issues). 3. After the first rappel, the rope got stuck and I had to climb the gully and free the rope, then downclimb the gully. 4. We had trouble setting up an extension (clipping both sides of the knot causing binding the carabiner, and the Megajul again). The above issues did not cause the fall below, they were only ancillary issues that had an impact on the outcome of the trip. By this time, it was close to the end of dusk and we were losing light, we had finished the final rappel and started down climbing the gully. The two other climbers had their headlamps attached while I pulled the rope. They had both took out. I didn't have my headlamp out and mentioned to the climber calling the rope that we needed to hurry and that I didn't want to take the time to get mine. I only had one tool out because I was comfortable with the deeper snow conditions of that part of the climb (similar to a TS scramble). Thinking back to my mental note above, I wanted to make sure we cut across just below the rock line (like you see in most of the pictures. What I didn't know was the rock line I was referencing was much higher on this side of the wall than where the climb started, the snow conditions were far different than in most pictures and the low light conditions didn't flag me of this. I was trying to move fast and at the same time not wanting to push the others past their comfort climbing speed. As I moved across the hill the snow became far more solid and much steeper than it should have if we were on the right route. The clouds cleared just enough for me to catch a glimpse of the trees at the top of the saddle and I was way, way too high and knew I needed to climb further down because there was a rock band in my way and if I continued I would have been about three quarters up the variation of the first pitch (see option #2 on Summitpost.com). The snow was so firm now that it was front pointing, but the snow would not allow for a good tool placement (just pull through). I decided to go back to better conditions and when it hit a section of was I felt was decent snow I looked down and it appeared that I could downclimb for when I was at back to the real route. I climbed down about twenty-five feet and went to kick in my left foot and when it hit the snow. Knees bent I was on, broke away and I began to fall. At first, I thought I had started an avalanche. My first instinct was to bring my tool up for arrest, but there wasn't any snow around me and then my crampons caught in the ice below and sent me flipping end over end. My tool was hurled from my grasp on the third or fourth impact. I continued the rise cycle, landing on my face, back, head and legs for what I felt like never ending. I finally came to rest on my back; still in steep snow (about 100 feet below the correct route). The two other climbers called down to see if I was "ok". I said: "I don't know yet". After slowly moving all my body parts everything seemed to be intact and functioning. Though I felt like someone had hit me in the face with a frying pan a few times and my ankles felt like they had been run over by a truck, I was able to stand and was coherent. I yelled up for them to get back the way they came and completely downclimb the gully. It took what seemed like twenty to thirty minutes for them to reach me. I felt what looks to be about 300 feet. The other two collected the snowshoes and they helped me slowly hike out. Left the trailhead at 7:00 am, Return to the cars and 11:00 pm	Know the route, even if you think you know the route. Be as careful on the descent as you do on the climb. Spend the time to figure out the route when conditions deteriorate, don't rush to beat the light. Make sure all in the party have a voice and are expected to speak up if something doesn't look or seem right. Ask if everyone is comfortable with the decisions made.
8/Feb/2020	Field trip	Climbing	Safety Concern	Slip, Fall, Capsize	fall (travel a distance)			Gym, artificial climbing walls,	Loose hold on climbing feature	I was just climbing the south wall and tried to grab a hand hold and it was loose so it spun and I swung a little. It wasn't a big deal but it should probably be tightened.	
2/Feb/2020	Trip	Climbing	Major	Hit, Struck, Cut	hit/out - natural object	face, eye, nose, mouth	injury - laceration, abrasion, puncture	Ice - technical	Went to hospital	A participant, was struck by falling ice, which cut his lower lip, resulting in stitches. Leader Report: Morning of Feb 7th a group was top roping at Haffner Creek (British Columbia) highway 935. They were all warming up and on their first few laps of the day. The ice was a touch brittle from cool temps over night. One participant was half way or so up the ice route. When he swung into the ice and a "sinner plate" became dislodged. He was able to mostly duck his head and get out of the way, but a small chunk hit his lip, resulting in a couple stitches. We did a field cleaning, bandaged and sent him to the hospital. Subject Report: Incident account by participant: On my second lap of an ice pitch at Haffner Creek on top rope, I dislodged a football-sized hunk of ice while swinging my tool. The hunk of ice struck me in the face, slightly left of center between my chin and lip. The impact caused a 1cm cut that bled profusely and also caused me to bite the inside of my mouth. This was around 11AM. I asked belayer to lower me, and once off belay, he provided some immediate first aid in the form of wound cleaning and a gauze pad to apply pressure. Other party members looked at the wound and concluded that it might require stitches. We discussed a plan and determined that another participant would drive me back to Canmore and that I would then drive myself to the hospital. The driver and I hiked out quickly, and after about a 45 minute drive, the driver dropped me off as planned. I drove myself to the emergency room at Canmore General Hospital. I was seen quickly, and the doctor determined that the face wound and mouth wound were not connected and that only the facial wound required stitches. He administered a local anesthetic and applied two sutures. The doctor determined that there was no brain or other head trauma but gave me a sheet on warning signs to take away. I left the hospital by 2:00.	From leader: Falling ice both natural and human produced is a normal hazard mitigated from tucking head down, wearing a helmet, swinging into concave features and not staring directly at the ice when you swing, however ice still fly's and produces a hazard. Not much could have been differently other than tucking his head faster and perhaps not swinging at convex ice feature.
18/Jan/2020	Clinic	Climbing	Near Miss	Logistics, equipment issues, party issues	lack of skill, preparation, conditioning, fatigue			Ice - technical	Improper anchor setup	We were nearing the end of our last ice climbing day in Hyalite Canyon, MT. Participants in my group had each led their first (and some their second) WI3 climbs. We relocated to Fat Chance WI3 and I asked the group in any participant wanted to lead the climb. One offered to lead it and this climb was fully within this participant's ability level. At the top of the climb is a large tree with a sling for rappelling and this participant affixed the rope to this anchor (which is what other parties do, too). After being lowered the other group leader and I asked the participant what was used for anchoring the rope. The answer was that this participant had clipped the rope to the tat with a quick draw and then used a locking carabiner. A few participants climbed the lower, steeper section and lowered off. The last participant climbed up to the tree to clean the gear and lower off. When he got up there he yelled out something to the effect of having been top roping on a single non-locking carabiner. When all people were back on the ground we asked the individual that lead the climb what exactly was used in the anchor. This participant had used a quick draw and a locking carabiner, but evidently put the locker on one side of the quickdraw locking it to the tat and clipped the rope with a non-locking carabiner. This surprised us because this participant has climbed for several years and built two perfect anchors with screws, cord, and locking carabiners on the two prior leads. We had a lengthy discussion about the risk that the other climbers were subjected to and that it is never, ever appropriate to make a top rope anchor with only one non-locking carabiner attaching the rope to the anchor (and I explained how this could become unclipped and how climbers have fallen in the past).	We could have asked for an exact description of the anchor this participant created. Then we would have had a clearer understanding instead of interpreting the original explanation as a quickdraw as well as a locking carabiner. This situation did not end poorly because we were not flipping the rope multiple times to get it on a different fall line, which kept the rope away from the carabiner gate and therefore did not unclip itself when weighted. Long story short, this could have ended very poorly for a participant, also all participants learned (and relearned) that this was not an acceptable anchor set up and that they will never ever do this again.
18/Jan/2020	Clinic	Climbing	Safety Concern	OTHER	lack of skill, preparation, conditioning			Ice - technical	Improper anchor setup	A student led an ice route and set up a top rope anchor. The anchor was a quick draw that was attached to webbing on a tree. The draw had a locker on the webbing and a single non-locker attached to the rope. Three students climbed on this set up.	
11/Jan/2020	Trip	Climbing	Significant	Slip, Fall, Capsize	Slip not resulting in a fall	foot/ankle	injury - sprain, strain, tear	Trail		After a successful short hike and skills practice of mock top rope belay practice we hiked back to the cars. One participant who has experienced minor ankle sprains in the past rolled their ankle. Their pain was immediate and the team quickly responded. Our first aid lead for the day evaluated the injury while they rested in a seated position. While our injured participant rested the rest of the party divided up our injured participants gear. After some water and anti-buprenorphin our hiker tested their ankle. With the assistance of two trekking poles it was determined that they could walk out slowly on their own. Thank fully what remained of our hike out was a manageable 200ft of elevation loss and less than a 1/4 mile. Under my advisement the injured participant followed up with a doctors visit on Monday. X-rays determined that there were no fractures. A brace/boot was prescribed along with some physical therapy in the subsequent weeks.	Given the moderate terrain and favorable weather I allowed participants to hike out at their own pace with myself and an assistant leader as a sweep. The participant was moving at a faster pace than most. Had I potentially modulated the pace of the hike out, this injury may have been avoided. Our team did however respond quickly and avoided exacerbating incident with the potential for exposure.
22/Sep/2019	Field trip	Climbing	Significant	Slip, Fall, Capsize	fall (travel a distance)	back	injury - sprain, strain, tear	Gym, artificial climbing walls, sports area		Participant was practicing falling while in the gym on overhanging walls. Climber fell and was not caught as softly as one could expect and did not assume a more relaxed falling position. The climber said they were fine and continued to climb throughout that evening. Found out a week later that they had went to the doctor the day after the incident because of pain near their lower back and hip the following morning. The individual noted that they were not sure if it had to do with the falling practice or not. Subsequently, the individual was only allowed to top-rope the following workshop session, which they were able to do without issue, and will only be allowed to top-rope on the "final" field trip.	More instruction was giving and demonstrations were given before asking students to practice this skill. Small falls (top rope falls) were practiced in order to build up to actual smaller leader falls. Falling correctly in an outside scenario start with practice in the gym and lots of it folks need. Continue to re-evaluate course curriculum and speak with the climbing.
14/Sep/2019	Trip	Climbing	Significant	Slip, Fall, Capsize	Slip not resulting in a fall	foot/ankle	injury - fracture	Rock - talus, boulders, scree	doc visit	On approach to base of The Tooth/South Face, crossing a boulder field, Annie slipped on rock and injured her right foot. She continued on, thinking it was a minor issue since it was not obviously painful. We discussed it briefly on base of the climb, and she decided to push to the summit as it was not painful at that point. Pain started to settle in during the descent, she made it back to car without any help, although on last part of the hike out (about last 2 miles) she had to deliberately place her foot to minimize pain. Next day she visited urgent care and xray showed fractured 3rd metatarsal in her right foot.	Question self diagnosis, lie pause and take appropriate actions to confirm if this is indeed nothing major. Lesson learned for me, is to step back a bit and cross check participant condition. Don't underestimate the non technical terrain! There were plenty of unstable rocks, this could have easily happened to other people. This can be actionable as part of the discussion with group prior to start.
21/Aug/2019	Trip	Climbing	Near Miss	Slip, Fall, Capsize	route conditions, routefinding,			Snow - technical, glacier, rope needed	fall into crevasse when snow bridge collapsed	Party member fell into a crevasse when the snow bridge being crossed collapsed. Member was able to self-extricate. Rope team members followed training: provided team arrest, set initial and secondary anchor. No injuries besides some minor bruises.	Team might have avoided crossing snow bridges in the afternoon. Team executed proper crevasse fall procedures to stop the fall and allow member to climb out under own power.
25/Jul/2019	Trip	Climbing	Near Miss	Slip, Fall, Capsize	Ice axe arrest needed / attempted			Snow - steep, ice axe, poles recommended		After climbing Mt. Cruiser, we were coming down a steep snowfield heading toward the main trail. The next to last climber to come down slipped and was unable to self arrest in the soft snow. Luckily, he slid into gravel area in the talus field below the snow and narrowly missed two climbers on the edge of the talus field. He popped right up relatively unscathed and was able to walk out without any sign of injury.	This is a tough question. We had some climbers rappel down the snow field and some walked down. The fallen climber pulled the rappel ropes and was down climbing the final 60 meters. One of us had to walk down after pulling the ropes. I think this is just one of the hazards of climbing. Possibly, better steps could have been kicked and everybody could have followed them.
20/Jul/2019	Trip	Climbing	Safety Concern	Other	rock fall, rock movement			Rock - talus, boulders, scree		Party of 4 was returning to Itsood Ridge camp late in the night after a 20 hour day spent climbing Sinister and Dome. Around 11 pm, one participant was aware of some loose rocks on a slab but somehow she still did slip and triggered a rock slide which took her down for about 15 feet. Luckily no injuries occurred.	Extra caution and a working headlamp could mitigate it. The headlamp rechargeable battery died about an hour before the near miss happened and the participant was forced to use the phone flash light and rely on some other participants headlamps lights. The participant slid until she stopped.
13/Jul/2019	Trip	Climbing	Safety Concern	Other	avalanche			Snow - technical, glacier, rope needed		We had two roped parties ascending the mild Dark Glacier to the col from where we would scramble to the summit of Dark Peak. Weather was partly cloudy with occasional sun. We stopped for a short break (water, clothing adjustment), heard a noise behind us, and saw an avalanche of meter-sized and smaller ice blocks appear from behind a rock rib and cover about 30 feet of the path some of our party had been on about 5 minutes earlier. We did not see the point of origin of the ice fall, but it appears to have been some ice resting on rock several hundred feet above which had broken free. On the return, it was not very obvious where it had come from. In hindsight we realized there had been runnels in the glacier there, and therefore probably some previous activity. I had a chance to read a draft of participant's report on the incident and thought it was accurate and thoughtful.	Nothing obvious I would have done differently; I don't think there were options for a better route, given the restrictions between rock above and crevasses some ways below, and there was no obvious objective hazard. If a rope team had been in the way of the slide, it is quite possible that the one person in the path could have escaped misfortune if he/she kept his/her wits, because the speed of the ice fall was not too great and the width was narrow. I suppose going much earlier in the morning might have lowered the risk, but it was not a hot sunny day.
12/Jul/2019	Trip	Climbing	Significant	Hit, Struck, Cut	hit/out - equipment, tool	leg	injury - laceration, abrasion, puncture	Snow - technical, glacier, rope needed	cut by crampon	One of our participants cut himself on his calf with the other's leg crampon. Since he was only wearing thin pants and no gaiters, the crampon caused a pretty good cut. This was one of his first steps on the glacier and we were almost all still at the base of the glacier so we stopped and attended the injury from a comfortable spot. We cleaned the wound with alcohol swabs and then applied steri-strips to close it and a compressed gauze to keep to absorb excess bleeding and keep it together. Andrea felt fine continuing and we checked periodically on bleeding and feeling. He kept reassuring us it was ok to continue. Back at camp in the evening, we cleaned the wound again and applied antibiotic ointment and more steri-strips and new gauze and bandage. The day after the climb the participant visited the doctor's office and had his leg examined. They were impressed on how well we treated the cut which was clean and did not need real stitches. A good reminder to wear gators when using crampons and to have an up-to-date first aid kit. Mine had been recently re-stocked and was handy in one of the external pockets of my pack when the incident occurred. We also had a near-miss when a football size rock was dislodged in a chossy area near the summit scramble ridge and flew past my head. Had it hit me, it is very likely I would have fallen and since exposure was great in that spot, this could have been fatal.	As for the rock fall, we were slightly off-route at that time and we ended up in a chossy section of rock. We later found the correct spot to transition from snow to rock which would have kept us on the crest of the ridge and more solid rock. Due to low snow it was hard to transition there but had we known about the hazards on the other side, we may have tried harder to join the ridge from climber's right rather than climber's left.
11/Jul/2019	Trip	Climbing	Significant	Slip, Fall, Capsize	Slip not resulting in a fall	hand/wrist	injury - fracture	off-trail, cross-country	climber trail	After a successful summit of Mt Rainier via the Emmons Glacier, a participant was descending from Camp Schurman to the White River Campground with two other members of our party. On the climber's trail between the lower part of the Inter-glacier and Glacier Basin, he slipped on loose rocks and took a fall. He caught the fall with his right hand, causing his wrist to fracture. One of his teammates administered first aid and they were able to proceed to Glacier Basin where a park ranger provided additional assistance. He and the other two team members were able to hike on their own back to the trailhead where they were parked. He went to the hospital where they confirmed his wrist was broken and administered definitive care.	The part of the climber's trail where the participant fell has very loose rock and it's an easy place to lose your footing. He didn't have trekking poles on this trip and said afterward that if he'd been using them, it might have helped prevent the fall and/or his broken wrist.
29/Jun/2019	Field trip	Climbing	Near Miss	Logistics, Equipment issues, Party issues	party issues - conflict, misunderstandings, organization			Rock - technical, rope & protection needed		A leader was instructing my partner team. While I was on top rope, mock leading a diagonal 5.9 crack, she gave direction to my belayer to keep slack out. I asked my belayer to pull in slack, because there was a puddle of rope at my lap. The leader wanted me to feel like I was leading it, but she didn't get my consent to do this before I started climbing...or at all. I talked to my belayer, Jocelyn Huang, after the climb. We were both confused. I was taught, and continue to practice, to follow the instructors of the climber. My partner apologized for not taking in more slack. She was trying to help by doing what I asked, but another participant was holding the rope at the anchor and not allowing her to belay me on top rope. I don't think this is an appropriate method for teaching in The Mountaineers. I need to be able to trust the people I'm climbing with. With too much slack in my top rope, I could get tangled or trip on the extra rope. If I were climbing, thinking my top rope belayer had me, I'd climb in a different manner, not considering the ledge I might hit when taking a fall.	The leader could have asked me to lead the climb, so I understood what was going on from the beginning. The leader and assistant could have let my belayer take in slack, and I could have continued to mock lead. I could have been more firm with Lani, telling her more boldly to let me instruct my belayer as I see fit.
22/Jun/2019	Trip	Climbing	Safety Concern	Other	rock fall, rock movement			off-trail, cross-country		On approach of The Castle from Pinnacle-Plummer saddle (approach.png, green arrows), our group decided to scramble up a short 4th class gully to cross the southeast ridge at "G200" (approach.png, red arrow). This gully consists of large blocky steps, scattered with loose rock, some of which are of considerable size. One participant at the front of the group triggered a rock fall (4th_class_gully.jpg, red rectangle shows suspected origin) that narrowly missed other participants below. I did not observe the origination or the rock fall itself, given my position hidden below a steep rocky step (which provided adequate shelter for myself). Account from participant that triggered the rock fall: ...I've been scrambling for a long time, long before I joined the mountaineers, and this happened to me many times with small rocks, but never with a rock of this size... It all happened very quickly so I'm not sure how exactly it happened, but I believe actually triggered it with my hand - I remember trying to stop the rock with my boots but wasn't able to. It was a really scary moment and I don't think I'll ever forget about it...	From participant that triggered the rock fall: ...As the first climber, I should have told everyone that some of the big rocks are loose and not let people climb right below me. I was aware of that but didn't call it out - which was clearly a bad decision considering the risks.
14/Jun/2019	Trip	Climbing	Safety Concern	Other	rock fall, rock movement			rock - talus, boulders, scree		Party-induced rockfall. Route took us up 2000 vertical feet of talus, rock and scree. Team did a good job of spreading out to stay out of the fall line of other climbers. However there were several times where climbers needed to move to avoid potential rockfall. I would not call these near misses but required all team members to be vigilant.	No suggestions. Common objective hazard for this type of terrain. All climbers wore helmets.
9/Jun/2019	Field trip	Climbing	Near Miss	Slip, Fall, Capsize	fall (travel a distance)			Snow - steep, ice axe, poles recommended	ice axe still on back	We were traversing a short but steep snow slope, an old avy chute about 20-30 feet wide, when a MAC member slipped and slid about 10 feet and landed in a moat. He was uninjured and was able to climb out without issue. I stopped the group, and made those who had already started across the snow back track a few feet back to the trail. We put on helmets and got out ice axes, and the rest of us crossed without incident.	We definitely should have had ice axes out. At this point there were a couple MAC students in the front of the group, but I normally have myself or another adult in front. We had had some route-finding issues through a short scramble section, and I had stopped to help coach others through it. The trail was narrow, so I had let the students go ahead of me while I was stopped. We had been crossing snow all day with just poles, so I think our guard was probably down. In hindsight, I should have had the students all wait in a safe place, or direct one of the adults to go in the lead. I think the adults would have had the judgment that the snow slope required ice axes for safety.

CORRECTED Activity Start Date	CORRECTED Activity Category	CORRECTED Activity	CORRECTED Incident Type	CORRECTED Incident Category	ADDED Incident specifics	ADDED Injury/Illness Location	ADDED Injury/Illness	CORRECTED Terrain	Notes	CLEANED incident report	CLEANED lessons-learned
1/Jun/2019	Field trip	Climbing	Near Miss	Logistics, Equipment Issues, Party Issues	equipment issues			Snow - technical, glacier, rope needed	knot came undone on webbing	During crevasse rescue z-pulley practice at Mt Baker, one student was lowered into a crevasse approximately 15 feet. The two students up top began to set up their z-pulley by first building two anchors using pre-set deadman anchors and their own webbing and carabiners. The student setting up the anchor used webbing tied with a water knot. The students did not set up the anchor correctly, and before instructors could correct this error the water knot failed. The student was caught by the backup belay and held until instructors could instruct on proper anchor setup.	This near miss is being reported because we feel that we should put more emphasis on dressing and stressing knots. We show students how to tie and dress knots throughout the course, however water knots can loosen through just hanging on your harness all season. Knots should be reevaluated and stressed before climbs and use. Don't take for granted that a knot you tied in February is still the same knot by June.
1/Jun/2019	Trip	Climbing	Near Miss	Logistics, Equipment Issues, Party Issues	route conditions, routefinding, lost, overdue			Snow - steep, ice axe, poles recommended		During our trip outward, we needed to traverse underneath a snowy and icy ledge below Pyramid Peak a few hundred feet above, with a cliff band and waterfall a few hundred feet below, while also crossing a snow bridge over a stream. We received beta via walkie-talkie from a party crossing a few hours earlier that they experienced a near-miss in that stretch, with a large rock landing a few feet from a party member. We discussed the need to traverse quickly. During the traversal, the group split. Three party members in front were significantly faster than three behind, with the trip leaders also split. One party member was having difficulty traversing while using an ice axe in their non-dominant hand, slowing the two people behind them and taking a much longer time to traverse. The snow was soft and the footing relatively good. While approaching the edge of the danger area, a loud crack was heard. Ice and rock began falling, appearing to be headed toward the rear party. The shouted warnings and noise of falling debris induced the rear party to run. Ice and rock crossed the path behind the rear party. It became apparent that it likely would have missed them, but not by much, and the volume, character, and velocity of the ice and rock was such that it certainly would have caused serious injury. There were no injuries; there was much relief. The two most important contributing factors to the incident are: the decision to cross underneath such an unstable area in such weather while ample evidence of rockfall was present, and the reduced speed of the trailing party.	It is difficult to assess the risk of rockfall impacting any given traverse. We did discuss the need to traverse quickly. However, one or more party members were unable or unwilling to do so. We should have assessed the practical ability of our party to actually traverse quickly. Given our advance knowledge of the danger, we should have discussed whether it would be appropriate to delay our exit until either nightfall or early the next morning. We did not have this discussion. On the way in on the day previously, we could also have assessed the likelihood of facing an elevated danger the next day. The other climbing party chose to camp prior to this slope; I'd be interested to know their thoughts (and trip co-leader Rob Busack knows one of the members well). This party also started and finished their summit bid significantly earlier. Possibly we should have, as well. When facing a traverse like this, under danger of rock and icefall, the entire party should be confident of their ability to traverse quickly in both directions. This need underscores the need for more practice traversing with an ice axe on steep slopes during Basic and prior to such a climb. We should also advertise the potential dangers on the trip page (https://www.mountainers.org/activities/routes-places/snowfield-peak-nine-glacier) so that good decisions can be made prior to the start of the trip. See attached a picture of the area in question. Debris is evident from the slide under discussion and past slides.
19/May/2019	Field trip	Climbing	Near Miss	Logistics, Equipment Issues, Party Issues	rappel			Rock - technical, rope & protection needed	harness issue	This near miss occurred at the rappel station of our Rock 2 field trip for Basic Climbing. Student was practicing his first of three rappels using belay device. He tied into a backup belay and went through gear and setup safety checks with the backup belay, checking that each were tied in properly and gear was properly secured. He was then belayed to the rappel anchor to tie in with a personal anchor system. He and the instructor evaluated the rappel anchor for any concerns. Anchor passing inspection, Ross then set up his belay device rappel properly. After safety checks - checking carabiners locked and autoblock functions properly - Student began to rappel. Nearly halfway down the approximately 200 foot rappel, he called up "Uh oh, I have a problem here." We called down for clarification and he reported that his harness leg loop had "snapped". Ross was wearing a Black Diamond Couloir Harness, which is an ultralight harness. Ross called up that he felt he could carefully and slowly continue the rappel and make it safely to the ground. I notified course leader of the issue so that she could meet Ross at the bottom of the rappel to evaluate the situation. The course leader met the student at the bottom of the rappel and confirmed that he was safely on the ground. Student felt okay afterward and completed his last two required rappels borrowing an instructor's rock climbing harness.	Student had known this was not an ideal harness for rock climbing and had mentioned before the rappel that his rock climbing harness is on it's way, "in the mail."
12/May/2019	Trip	Climbing	Significant	Hit, Struck, Cut	rock fall, rock movement	foot/ankle	injury - bruises, contusions	Rock - technical, rope & protection needed		ASSISTANT LEADER We were setting up our final rappel out of the gully below yellow jacket. I was sitting above and next to a triangular "refrigerator sized" Boulder. It became evident that the boulder was loose as another climber approached so I told the party and stayed where I was to keep other climbers away. I am unsure how it happened - perhaps the sand below was destabilized in some way - but the boulder began to roll down and then over towards my legs. I moved out of the way but not in time to have my foot partially crushed by the boulder as it settled. I was able to quickly remove my foot and get away but it was clear I had injured it. My shirt and pants were torn where the boulder brushed past me. The party cleared the area around the boulder significantly and I rappelled out and walked the descent down. I went to the Leavenworth ER after confirming the party got down and learned that the foot only has a crushing injury and is not broken. PARTICIPANT As we were descending the sandy gully above the checkstone to our final rappel station we noticed significant rockfall. When we reached the rappel station, we noticed a small boulder shift in the sand. The boulder had a disk shape and was perhaps 4 feet in diameter. It was about ten feet above and to the climber's right of the rappel station. We started setting up the rappel. I was flaking rope and the next thing I knew the boulder was moving again, one participant did his best to get out of the way and direct it away from the group. He was unharmed. another participant was sitting near the boulder and it rolled into her arm, leg and foot. To my knowledge her arm was unharmed, leg had scrapes and bruising and foot/toes had significant bruising and swelling. Luckily, this participant was able to get out of the way before she got stuck or suffered more significant injuries. She was able to descend under her own power before going to urgent care in Leavenworth, where she fortunately learned that she had no broken bones.	ASSISTANT LEADER We could have moved further away from the boulder earlier. Honestly the whole gully is a bowling alley though. The party was aware it was loose but we didn't realize the extent. PARTICIPANT Once we first noticed the boulder move, we should have all gotten a safe distance away from it. Perhaps we could have considered an alternative rappel station away from the hazard, but I am unsure in any other viable rappel stations existed. Finally, we were not expecting such significant rockfall hazards given the climber's rating and description (rockfall is only mentioned in connection with goats)-updating this information accordingly would benefit future climbers.
20/Apr/2019	Field trip	Climbing	Near Miss	Hit, Struck, Cut	rock fall, rock movement			off-trail, cross-country		As the first group of the field trip was on the scramble leaving the new Everett hill site, a rock larger than a head fell from the highest students straight down the line of students. The students at the top shouted ROCK with more and more urgency until the rock passed the last person (within a few feet). It was moving fast and would have hit someone if they hadn't been shouting warnings, and could have caused a serious injury because of the size and speed.	Reminder of the importance of shouting rock. It was the first group on a new site and it was spring time, so rock fall might be more likely than it would normally be. The group had finished climbing and had taken off their helmets. This is an opportunity to teach scrambling awareness in the climbing courses. It is also an opportunity to determine a rule of thumb for when helmets are required on a scramble. On snow it is whenever ice axes are out. On rock it is when you need to use your hands?
13/Apr/2019	Field trip	Climbing	Significant	Slip, Fall, Capsize	ice axe arrest needed / attempted	foot/ankle	injury - sprain, strain, tear	Snow - steep, ice axe, poles recommended	team ice axe arrest	Events/Diagnosis: During crevasse rescue practice, a participant injured her right ankle while attempting to stop a simulated fall as the middle person on the 3 person rope team around 2PM that day. As the MOFA lead, I was called over and began to assess the extent of the injury. Her history included a past injury (torn ligaments) to the same ankle. She said she felt a 8Kzapppp sensation. No breaks that I could detect as she was able to move her foot back and forth against stress with slight pain. Side to side movement induced sharp pain. Determined that it could be a bad sprain or possibly ligament damage. Decided to keep her boot on so it would keep it compressed and act like a splint. She was able to walk/limp with my help to an area by our packs and I had her sit down and put on extra clothing to keep warm. She was not going to be able to continue 8E" she was able to contact someone to come and get her. She was still cold so I assisted her down to the cars where she waited in another participant's van for her ride. Recommended that she seek a professional follow up if her condition does not improve. Results: Her ride arrived, and she was able to go. She contacted me later that evening with an ER diagnosis of a sprained/possible torn ligament in her ankle. Field Trip results: She was able to complete 8X% of the days events.	
30/Mar/2019	Trip	Climbing	Near Miss	Logistics, Equipment Issues, Party Issues, organization	party issues - conflict, misunderstandin gs, organization			Rock - technical, rope & protection needed		While leading a cragging trip at the Sunshine Wall in Vantage we had a "near miss" incident involving a couple of our participants and the establishment of a top-rope belay. One participant had led "Ship 'em or Clip 'em" and had setup a top-rope. After lowering off she swapped ends and her follower tied-in. There was, apparently, some confusion during the establishment of the belay, and rather than putting the rope through her belay device, she instead just started pulling the rope in hand-over-hand. The climber started climbing, and she continued this way for some time. This was noticed by an adjacent climber who helped her re-establish the belay. I was climbing a route nearby and heard some of the exchange, but because I was on lead and focused on what I was doing, I did not witness the event. I heard about it after I got down and immediately went to talk with the party involved. We talked about the need to go through all of the steps when putting someone on belay, the climbing commands, checking each other out, etc. We then continued to climb the rest of the day. However, I am filing this report because I think this qualifies as a "near miss". The consequences of what would have happened had her follower fell while "top roping" the route are unthinkable. I am also attaching a much more thorough report of the incident another participant, who was belaying a climber himself only a few feet away and witnessed most of what happened.	Hopefully the lesson learned here is that no matter how experienced you become, you must never skip steps in establishing a viable belay. Your mind must not wander, you must not become careless or distracted. Obviously, it is up to both parties to go through the sequence of checking each other out. Is my harness on correctly? Am I tied in correctly? Is the rope through the belay device properly? Is it attached correctly to the belayer's harness? Am I on belay? Ok, "on belay", "your belay is on", "climbing!", "climb on!"
17/Mar/2019	Trip	Climbing	Assistance Given	Slip, Fall, Capsize	fall (travel a distance)			Snow - technical, glacier, rope	no injury reported	Mountaineers assisted rescue of a non-Mountaineer / private climber who fell into a fumarole hole.	Pay attention where you're walking; be prepared for all the chaos that can occur on a popular route on a good weather day.
25/Feb/2019	Field trip	Climbing	OTHER	Safety Concern	equipment issues			gym, artificial climbing walls, sports area		Last Monday (2/18) at skills night I was checking the Locking carabiners on the upper ledge in Goodman C and both lockers on the west side top rope were unlocked and one of the two on the east side was unlocked. With those odds, I figured the others that were unreachable to be suspect but didn't check. I tightened all the lockers I could reach. Tonight (2/25) one of the west side lockers was unlocked again! Obviously, something is going wrong here and the way they are situated make them unscraw.	Maybe we need to invest in auto lockers?
23/Feb/2019	Field trip	Climbing	Significant	Illness or Personal issues (conditioning, lack of skill)	injury/ illness - pre-existing condition	GENERAL - usually for illness, describe in narrative	illness - general, nausea, vertigo, flu	Inside a building or structure		Everett Basic Climbing Course - Fundamentals Field Trip on 23 February 2019 An older male student began exhibiting dizziness and physical weakness at the beginning of the field trip. The male student told me, the field trip leader, he had taken (unknown) medication and had experienced vertigo before driving to the field trip. I told the student if he continued to feel sick or weakness to stop further activity and contact me. The student said he felt fine and continued field trip activity (knot tying at that time). I continued to observe the male student as time progressed. Approximately three hours later, the male student's physical condition had declined further. The ill male student had stopped all field trip activity and was asked to walk and sit on the couch in the lobby of the Program Center. An Everett branch member attending the field trip with SAH medical training was contacted to conduct an interview with the ill male student to determine his condition. Subsequently a Basic Course student, a Nurse Practitioner, also evaluated the ill male student. Both individuals concluded the ill male student should seek immediate medical attention. After three vomiting episodes in the men's restroom the ill male student stated he was feeling OK so no call was made to 911. Instead the ill male student provided the name of his medical insurance provider and it was determined the nearest hospital/urgent care clinic was on Capital Hill, Seattle. However, the male student stated he wanted to go to his medical insurance provider's hospital/urgent care clinic in south Everett, near where the male student lived, so his vehicle was closer to his residence. A male instructor agreed to drive the ill male student to the south Everett hospital/urgent care clinic location using the ill male student's vehicle. The ill male student's emergency contact person on file with The Mountaineers was contacted and advised of the ill male student's condition and of the intent to transport him in his personal vehicle to the hospital/urgent care clinic in south Everett. It was later confirmed the male instructor did arrive at the south Everett hospital/urgent care clinic with the ill male student to seek further medical attention. At the time of this report submittal, the ill male student did obtain medical assistance and is fine.	The student should have recognized if he was experiencing vertigo before driving himself from Everett to the Program Center, he should not have driven himself to Seattle. Based on the transpired events on the morning of 23 February 2019, there does not appear to be anything that could have been done differently to avoid the incident or mitigated the outcome.
18/Aug/2018	Trip	Climbing	Near Miss	Logistics, Equipment Issues, Party Issues, misunderstanding	party issues - conflict, misunderstanding or reservation			Rock - technical, rope & protection needed	NOT CERTAIN THIS SHOULD BE COUNTED	One of the students was scrambling/ down climbing a 5.6+ class of rock without ropes, where the student had no prior rock exposure. With a significant drop below. Also another student had a huge rock kicked below (by another group) at him on the way down, which was more than 2 feet long and heavy	
12/Aug/2018	Trip	Climbing	Major	Slip, Fall, Capsize	fall (travel a distance)	MULTIPLE - usually for injury, describe in narrative	injury - fracture	Rock - technical, rope & protection needed		40-50 ft leader fall. Report from doctor: Broken ribs, sternum, and wrist. Air in the chest. We were climbing the South Face of Concord. A participant was anchored at the base of the 4c-shark fin on the South side. Another participant was leading the third (final) pitch, and was ascending the 4c-8c awkward flaring crack. 8c. He was out of view from the rest of the party. According to him, he was attempting to pull onto the summit of Concord Tower, when the alpine draw from his last piece of protection clipped onto his leg loop preventing further upward progress. While attempting to unclip this carabiner from his leg loop he fell, pulling with him the protection piece (pink tricam). He had placed another tricam into the same horizontal crack to aid with, but he did not secure his rope to this piece. As Ryan fell, he screamed loudly enough that the whole team heard. As he screamed, the belayer moved backward as much as his tether to the anchor would allow, and braced for the catch. We believe the climber fell approximately 20 feet to the ledge at which his last piece of protection (after the pink tricam pulled out) was located (this piece was a slung tree). It is here that we believe the climber landed on his wrist and back, then continued to fall/slide/fall down slabby ramps another 20-30 feet until his rope became taut. The time was approximately 3 PM. After the belayer completed fall arrest, he pulled rope through his belay device while progressing to the crest of the shark fin. He called to climber to ask if he was ok. Climber said he had broken his wrist. A party across from the route, on Liberty Bell called over and said that climber had landed on his back. Belayer acknowledged climber's probable broken wrist and asked about any other injuries he believed he might have sustained. Climber seemed lucid and is a trained EMT. At this time, belayer could not see climber. Climber requested to be lowered a few feet so that we was resting on a ledge, belayer lowered him. The party on Liberty Bell asked if they should call 911; climber responded to them and declined their offer. Belayer asked climber if he provided a fixed line, would be able to ascend. He said he would be unable. Belayer descended from the shark fin on the South side back towards his anchor and called to second rope team who were still approaching on the second pitch. After a few minutes, second team arrived, they had heard climber's scream but were otherwise unaware of any situational details. Belayer described the situation as was known and the three formulated a plan of action. Second team climb together frequently and work together fluidly, for this reason belayer and another exchanged places, the other taking over belay (easy as there was some slack in the system with climber sitting on the ledge). Other two prepared to climb to the base of the summit block. One called down to climber letting him know they would be there within ten minutes. Another led out along the shark fin, she arrived at the base of the summit block slinging a tree for an anchor (the same tree that had become climber's last piece). Another followed the short pitch. A pair fixed one end of their rope to the anchor and another rappelled down to climber. Once he reached climber, attendant checked climber's torso and back for injuries. Climber complained of some pain in his ribs and had many abrasions on his back, but no deep wounds or bruising, and his spine seemed to be unaffected by the fall. Climber said he did not believe he hit his head during the fall. His helmet appeared untouched. At climber's request, attendant pulled a jacket from his pack, and a cordelette, and created a sling for climber's arm. Attendant told climber about the plan to haul him up to the anchor, and rappelled down the South face of Concord, and once again asked climber if he wanted a professional rescue, he declined. Climber declined an offer for a jacket for warmth. Climber accepted an offer for a splint, so attendant made a crude splint using two chock-pick tools and a length of perlon.	Attendant clipped a loop of rope to climber's belay loop and ascended to the anchor. At the anchor, Daniel and Jill created a 6:1 drop-loop haul system and began pulling climber to the anchor. Climber was able to stand and keep his feet in front/under him during the haul, though it was clear that he was in a lot of pain and could only move very slowly. One, still managing climber's belay with the other rope, took in slack as climber was brought higher. Once climber was brought to the anchor, he was secured to the anchor and given a jacket for warmth (now in the shade). A tandem rappel was necessary to get climber off the route. Not wanting to trust the current (small tree) anchor with the task, and knowing there were bolts on the summit, team belayed up the short pitch to the summit block. While one was setting up the rappel, another belayed third over to the current anchor. One rappelled off the summit block, back to tree anchor and began setting up the tandem rappel system. Another ascended the rappel ropes to the summit block, trailing the rope he was still tied into. Once climber was secured to the rappel system, team untied climber's rope from his harness. Attendant and climber were ready to rappel. Because they were not directly under the bolted anchor on the summit, we knew that a swing was inevitable. In order to control this as much as possible, the tail of the second rope was clove hitched with a locking carabiner to tandem's extended rappel loop, and run through another's belay device (who was anchored to the tree anchor). As attendant and climber stepped off the ledge onto the South face, third slowly let out rope to get them to a neutral hanging position. Once a neutral position was achieved, attendant removed the clove hitch and continued the rappel as third pulled the second rope back up. Third tied into the second rope, broke down the tree anchor, and fourth belayed him to the summit. At this time, because of the indirect routing of the rappel rope, tandem (attendant and climber) were nearly out of rope and could not reach the next rappel station. Attendant yelled up to the summit indicating such. Top team set up a second rappel with the second rope on a second pair of bolts, and third rappelled down to tandem team. A second tandem rappel system was created and climber's weight was transferred from attendant's rappel to third's rappel. Third and climber rappelled down to the next rappel station and secured themselves to the anchor chains. Prior attendant was able to stand on a flake and unweight her rope enough so that top, on the summit, could flick the rope to the correct orientation so that she could reach the rappel station. Once top arrived at the rappel station and was secured to the anchor, she pulled her rappel rope while a party member ran it through the chains to setup the next rappel. Once the rope was setup, top again setup her tandem rappel system. After safety checks, in order to lower climber onto the rappel (at a position below top), he was connected via a cordelette to his belay loop to a munter hitch on the anchor and slowly lowered until he was hanging on top's rappel system. New tandem (top and climber) began rappelling to the base of the tower. Participant rappelled down to next, they pulled the first rappel rope, and then both rappelled to the base of the tower. The time was approximately 5:30 PM. Climber took some Bupropfen and Tylenol, while top assisted him with changing his shoes and getting ready for the hike out. Another created a better splint for climber's wrist using a foam sit-pad. Climber started down the gully as the team stowed gear and then joined him shortly. Progress down the gully was slow at first, but quickened as the Bupropfen/Tylenol took effect, and the terrain eased. The team got to the trailhead parking lot at approximately 8 PM. Several had carpooled to the climb, so they all drove to Overlake hospital in Bellevue at climber's request. Two were lower at the hospital, around 11:30 PM after confirmation that his girlfriend would be meeting him there shortly. Climber could have placed more protection (better protecting the crux), which would have mitigated the fall.
14/Jul/2018	Trip	Climbing	Near Miss	Logistics, Equipment Issues, Party Issues	equipment issues			off-trail, cross-country		On day one of our three day trip, one participant did not secure her backpack and allowed it to roll of a moraine near White Pass. We were about to descend toward the base of White Chuck Glacier. The participant held onto an ice axe and helmet. The pack rolled off the cliff in the general direction of our travels so a decision was made to continue toward our first night's camp but send a two person team behind us about 300 yards and look for the pack. This team remained in our sight at all times. Though they did find the pack, the tent poles were missing. This was not noted until we had reached our camping area after a long day hiking in the heat. Due to the time of day and how tired the team was feeling my decision was to not go back and look for the tent poles. With the help of various team members and lots of gear, we made a frame for their tent that survived for the two days we camped at this location. On the way out we passed close to the packs fall location and a second team found the tent poles stuck in the rocks slightly higher than where the pack was located. The pack rolled about 200 feet total and not visible until we came off the ridge.	The participant learned critical importance of securing one's pack in an area where it may roll or slide. Team learned how to build a tent with just rope and hiking poles. Total loss of the pack may have required the group to turn around or at a minimum, leave this participant in camp on summit day due to a lack of required gear.

CORRECTED Activity Start Date	CORRECTED Activity Category	CORRECTED Activity	CORRECTED Incident Type	CORRECTED Incident Category	ADDED Incident specifics	ADDED Injury/Illness Location	ADDED Injury/Illness	CORRECTED Terrain	Notes	CLEANED incident report	CLEANED lessons-learned
13/Jul/2018	Trip	Climbing	Safety Concern	Other	rock fall, rock movement			off-trail, cross-country		During the ascent to the base of the Banded Glacier, a natural choke point forced the party to the center of the fall line for a few minutes. At this point a boulder from the rock band above spontaneously detached, and rolled down the fall line, narrowly missing the closely spaced party. Fortunately, it was spotted by a party member early, and we had sufficient time to take evasive action. The boulder was variously described by party members as 'cow sized' and 'like a smart car'. Personally, I estimated it to be a compact dorm sized refrigerator. It probably weighed 100-200kg and was moving pretty fast by the time it reached our level.	Lessons learned: my experience has been that spontaneous rockfall such as this is often induced when sun first hits the area concerned. Had we been able to make our original launch time of 0430, this area would still have been in shade and the situation avoided. Also, when in a choke point such as this, keeping a good lookout should be paramount. If we had not been able to avoid the rockfall, this would have turned into a major incident with a helo evacuation. We did have a PLB, but it was good not to have to use it.
26/Jun/2018	Trip	Climbing	Significant	Slip, Fall, Capsize	hit/cut - equipment, tool	head/neck	injury - laceration, abrasion, puncture	off-trail, cross-country		Scrambling through a wooded patch between snow routes, so ice ax was out, and climber mate slipped on wet log, causing the shaft of the ice ax to hit her forehead, which in turn caused the top layer skin to split open (a verticle line about an inch long), and some bruising. We cleaned and dressed the wound, and the climber opted to finish the climb, which we did. Upon returning home, I took her to an urgent care (I'm her boyfriend), and they cleaned the wound more thoroughly, and applied some glue to encourage wound sealing. They agreed that it was a pretty minor wound. Though, it could have been a lot more serious (the shaft of an ice ax is kinda the least dangerous part).	It can be hard to know when to put away the ice ax, like when scrambling through small breaks in a snow route, it can seem more fluid and efficient to simply keep the ax in hand. However, were the ice ax not in hand (it certainly wasn't needed for this small patch of wooded scrambling), the injury would not have occurred. So perhaps being more aggressive on temporarily stowing the ax between snow routes would minimize this kind of risk/injury. However, such an incident could easily happen on the snow as well, where the ice ax is needed.
24/Jun/2018	Trip	Climbing	Near Miss	Slip, Fall, Capsize	Slip not resulting in a fall			Snow - technical, glacier, rope needed	partial fall into crevasse	A climber fell waist-deep into a crevasse. The crevasse was fully hidden by snow and not detected until the climber punched through. He was caught by the crevasse itself and his ice axe. Helped out by the next rope team lead with no injury. Crevasse flagged with wands.	N/A - it was undetectable with no visible signs from the outside.
19/Jun/2018	Field trip	Climbing	Safety Concern	Other	party issues - conflict, misunderstandings, organization			NOT CERTAIN THIS SHOULD BE COUNTED		I witnessed a student belayer using a strange action, taking the brake hand off of the line, not consistent with Full-Brake-Under-Slide. I approached the belayer, and pointed this out, to which the belayer responded that his instructor climber was off belay, as the climber was setting up a top-rope anchor and was currently tied in from above. We had a short discussion, where I mentioned that using the same motions when on belay or off is possibly appropriate. It is possible that the climber heard our discussion and heard "on belay" to assume he was on belay. However if went, the climber began descending as though being lowered without the belayer being aware the climber was doing so, and without the belay having a hand on the brake line. We both heard the climber shout "Slower! Slower!", looked up, and saw the climber descending rapidly. The belayer put his hand on the brake line and caught the climber, who then entered a controlled descent. Had the belayer not caught the climber, the climber would have impacted the ground at a speed sure to cause injury.	The climber and belayer should absolutely use names during climbing command exchanges. The explicit use of names would have prevented this incident. Use of the word "on belay" should be solely between the climber and belayer if possible. This may or may not have prevented the incident. While a climber is above, a belayer might continue to assume the climber may need the belayer's assistance, up to and including holding the rope in the brake hand, despite knowledge that the climber has called "off belay". Having a discussion with a belayer might distract the belayer at a critical time. However, pointing out immediate apparent safety issues should still be encouraged.
16/Jun/2018	Trip	Climbing	Near Miss	Slip, Fall, Capsize	Slip not resulting in a fall			Snow - technical, glacier, rope	leg in crevasse	Participant had one leg inside a crevasse after slipping, she climbed over it by herself	
16/Jun/2018	Trip	Climbing	Major	Slip, Fall, Capsize	fall (travel a distance)	ankle	injury - sprain, strain, tear	Snow - technical, glacier, rope needed	severe sprain, extraction	We climbed Snowfield as a two day trip, with each day taking a little longer than the route description's estimated time window because of the lack of endurance and lack of comfort traversing steep snow or finding good footing on rock by one member of the party. We relieved him of group gear within the first hour of the hike in, and then I also carried his piolet and ice axe because he was falling far behind the rest of the group and taking frequent little breaks. He informed me that he hadn't been hiking the last couple of months because he'd hurt his knee in a fall descending since it couldn't land there, and then fly up the ridge to a spot to land and move everyone inside before flying to the Marblemount Ranger Station. I then hiked out, drove to Marblemount and debriefed with kevork before driving home. Participant's friend had already picked him up in Marblemount and they drove to a medical facility and determined that his ankle was sprained with a recovery of six weeks. There are many things I would have done differently in hindsight. I did screen my climbers for fitness for this climb, and participant's list of his hikes looked adequate but he didn't tell me that his conditioning had ended a couple of months previously. Upon learning of that and observing his pace on the hike to camp I should have insisted that he stay at camp instead of summiting with us. He did actually fall once on the snow traverse into Colonial Basin and failed to arrest immediately. We were doing alright on the snow when we made sure he had the Snowfield summit pyramid, but then the scrambling took more time because there were two other parties, and I could have turned us around then. Once we went back down on the trail we also made steady progress back to camp until the 10 Pyramid ridge. Participant showed down significantly, in fear, taking about 35 minutes while everyone else took about 20. I coached him through it and we talked about his lack of experience on snow as we walked back to camp. I should have made sure he had his ax out when we left camp though, considering that we still had more than 500' of elevation to drop in slushy snow with very tired climbers. It didn't occur to me at this point to ask everyone if they wanted to camp another night instead of hiking out. I knew everyone was running low on food and were expected to work the next day. This would have been a good option to consider though, as I could tell everyone was pretty tired and the trail down is a fairly technical climber's trail even below the snow. After they left us, the other four didn't get reach the cars for another four hours because of fatigue, and one of them could easily have gotten hurt too. All in all, I think this was a bad combination of a very strenuous trip where everyone was carrying heavy packs, including distributing participant's group gear, we didn't get as early of a start Sunday as we should have, and also the length added to each day by waiting for participant, with his lack of endurance, and comfort in his footing on snow or rock contributing to his exhaustion and fall.	By 9 am with no contact from SAR we started to contemplate moving slowly down the trail again, when at 9:15 I heard the helicopter. We got back into the open, got the attention of the helicopter and it circled us for 5 minutes. It then flew back up the ridge, and about 20 minutes later a couple of rangers (kevork and Christina) reached us. They did a health assessment of participant, splinted his leg, and we helped him move back up 30 feet to an open area. The helicopter then came to extract participant on a 200' long line with the rangers since it couldn't land there, and then fly up the ridge to a spot to land and move everyone inside before flying to the Marblemount Ranger Station. I then hiked out, drove to Marblemount and debriefed with kevork before driving home. Participant's friend had already picked him up in Marblemount and they drove to a medical facility and determined that his ankle was sprained with a recovery of six weeks. There are many things I would have done differently in hindsight. I did screen my climbers for fitness for this climb, and participant's list of his hikes looked adequate but he didn't tell me that his conditioning had ended a couple of months previously. Upon learning of that and observing his pace on the hike to camp I should have insisted that he stay at camp instead of summiting with us. He did actually fall once on the snow traverse into Colonial Basin and failed to arrest immediately. We were doing alright on the snow when we made sure he had the Snowfield summit pyramid, but then the scrambling took more time because there were two other parties, and I could have turned us around then. Once we went back down on the trail we also made steady progress back to camp until the 10 Pyramid ridge. Participant showed down significantly, in fear, taking about 35 minutes while everyone else took about 20. I coached him through it and we talked about his lack of experience on snow as we walked back to camp. I should have made sure he had his ax out when we left camp though, considering that we still had more than 500' of elevation to drop in slushy snow with very tired climbers. It didn't occur to me at this point to ask everyone if they wanted to camp another night instead of hiking out. I knew everyone was running low on food and were expected to work the next day. This would have been a good option to consider though, as I could tell everyone was pretty tired and the trail down is a fairly technical climber's trail even below the snow. After they left us, the other four didn't get reach the cars for another four hours because of fatigue, and one of them could easily have gotten hurt too. All in all, I think this was a bad combination of a very strenuous trip where everyone was carrying heavy packs, including distributing participant's group gear, we didn't get as early of a start Sunday as we should have, and also the length added to each day by waiting for participant, with his lack of endurance, and comfort in his footing on snow or rock contributing to his exhaustion and fall.
12/Jun/2018	Trip	Climbing	Near Miss	Slip, Fall, Capsize	fall (travel a distance)			Snow - steep, ice ax, poles recommended		One climber slipped when snow step collapsed while descending from Pandora's Box. Climber was able control the slide and stopped at the edge of the snow after sliding about 10-15 feet. Climber was uninjured. Contributing factors: late morning softening snow, due to E/SE exposure.	This was climber's first climb after completing basic climbing field trips. Perhaps a reminder about improving snow steps when downclimbing could have been reviewed prior to attempting this portion of the climb. We did discuss what our approach would be for this section of the climb. Climb leader was the first to descend in order to ensure that there were good steps available for the rest of the team.
2/Jun/2018	Field trip	Climbing	Near Miss	Slip, Fall, Capsize	equipment issues			Snow - technical, glacier, rope needed		INSTRUCTOR 1 Our group set up 2 teams for 2-Pulley crevasse rescue. On our first run I wanted to set up an abbreviated scenario removing some of the steps of crevasse rescue, specifically not having a middle student hold the fall and instead start by capturing the climber rope and build the Z-Pulley off the pre built anchor while I held the "victim" on belay from separate anchor with a belay rope. After we lowered our students into the crevasse we each began our versions of the scenarios. My group immediately captured the climbing rope with a prusik from the anchor and began building the Z-Pulley. We both prusiked down our munter belay lines to the crevasse edge to communicate with the students as her team began the scenario. Her group realized that they had a problem and we both ascended up our lines. The middle climber had "fallen" below the pre built anchor instead of above to hold the "fall" of the victim in their scenario. Participant was now holding the weight of another but his team was unable to build a Z-pulley in this position. Leader offered the solution of using cordelettes to extend the pre built anchor below participant to create a new anchor to build from while he remained in arrest. This seemed like a good solution to me and leader began to assist her group in this adjustment. I could not see what was happening with too many people between myself and other leader's anchor so I returned back down my line to the edge of the crevasse to communicate with my student. About 30 seconds later I saw the climbing line with a prusik attached from other leader's group falling and accelerating through the snow and realized her student in the crevasse was falling. He came to a stop near the bottom hitting his back against the wall of the crevasse as leader's belay caught him. I would estimate a fall of 15'. Even though the lip of the crevasse had been padded with an ax and cleared snow as much as possible leader's belay line had cut through the snow and become trapped or frozen in the snow so she didn't know that she was no longer holding Nathan on tight belay as he had begun to prusik up the climbing line. Student out climbed his belay from leader or there couldn't have been so much slack. At this point leader cleared the belay rope and her team built their Z-pulley system. Her team hauled without incident although it was very difficult work due to the rope cutting into the snow and required an extra helper. After my teams first run we switched to doing the full scenario since we knew we had the bugs worked out. There were no further incidents and student continued the rest of the field trip without pain or injury. I do not know what the actual cause of the failure was in leader's set up. I was too far away to see and none of the explanations given seem to fully explain the failure witnessed. INSTRUCTOR 2 I do think that multiple issues compounded to create the fall. A lot going on and we did make changes afterwards but unfortunately failed to catch the (multiple) red flags that lead up to the event. Setting up for the first Z-Pulley Scenario of the afternoon, the student was on belay from two dead men on the (blue belay rope), and two deadmen anchors had been set for the Z-pulley rope team on the (black main rope). The student (fallen climber position) was safety checked by Myself (belay instructor), and the rope team (middle and third climber) safety checked each other. The student was lowered down into the crevasse. The middle climber was attached to the black rope w/ a butterfly to a locking carabiner, and a prusik (to a swivel/auto locker?) to his harness?? I am unsure of this as the two climbers safety checked each other, then got into position. After lowering the fallen climber, there was too much slack in the system between the middle climber and the climber in the crevasse. We took the slack from the top, using the prusik on the middle climber's harness, I asked the middle climber "Is the prusik locked into your belay loop on your harness?" he responded with a "yes" I could not see what was happening with too many people between myself and other leader's anchor so I returned back down my line to the edge of the crevasse to communicate with my student. About 30 seconds later I saw the climbing line with a prusik attached from other leader's group falling and accelerating through the snow and realized her student in the crevasse also could have used his prusiks to take up all of the slack, from the bottom of the rope. Either of these would have been a safer situation and mitigated the risk, unless the climber's prusik/Carabiner had failed. I transferred the weight to the middle climber and the "fallen climber" began to start prusiking up the main rope. In lowering the climber on the belay line, the blue belay rope cut through the edge by about 5-6 feet below and to an angle from where our edge pro (two ice axe's had been placed to try to protect the edge, about a 12-18 inches from the edge) This created so much friction that I thought I still had the load and could not feel any slack in the belay line. The middle climber had positioned himself below the Z-pulley rescue anchors instead of above, and now had the weight of the climber on his harness (and the single prusik on a swivel/auto lock?) carabiner, with the student's body weight on top, possibly cross loaded??? of the slack between the prusik and his initial butterfly (I guess we should have retied the butterfly to the correct length for the scenario, so the main rope was locked into the harness). The End (3rd climber on the rope) was extending the anchor to mitigate for this and was taking longer to transfer the load from the middle climber to the anchor when the incident happened. The middle climber may have been twisting to look at the third climber, somehow the prusik under load became unattached from the climber (came out of the carabiner auto locking twist carabiner???) and the student whom had prusiked beyond the blue belay rope which was caught, fell about 10 feet? hitting the ledge of ice where the crevasse started to narrow. This fall was created by the length of the slack between the prusik and the original butterfly knot to the middle climber AND the length of the slack in the blue belay rope caught in the edge. I would guess that all of this happened in about 5-6 min from the time the climber was lowered down. PARTICIPANT 1 During the Z-pulley rescue, the "fallen climber" fell about 10 ft while prusiking up the green rope. I was the "middle climber", arresting the "fall" and holding fallen climber's weight until Z-pulley was in place. Nathan had started to prusik up, then suddenly my seat prusik on the green rope snagged out of my harness, and Nathan fell for real for about 10 ft. WHAT? "THINK" HAPPENED: My seat prusik snagged, but the prusik person itself was intact (no knots undone, not cut). I don't think I would have slid out of my carabiner either. That leads me to believe I had just tucked the seat prusik into my leg loop of the harness***, as opposed to connecting it to a carabiner. In addition, I positioned myself downhill of the two deadman anchors, which was incorrect. So in between the moment when Nathan started to climb up and the rescuer (Alwar) came downhill to place the Z-pulley, it must have been my feet and prusik bearing Nathan's weight. Finally, Nathan must have taken the fall because the slack on the blue belay rope wasn't pulled in (either miscommunication and/or MAJster hitch	failure). ***I think I was instructed to do this (not sure, can't remember), but I think the idea was that I would be uphill from the deadman anchors, rather than downhill, so my seat prusik wouldn't have taken the load and where it was positioned wouldn't have mattered anyway. Contributing factors: - my seat prusik wasn't hooked to a biner (again, I am speculating) - I "arrested" below the anchor - the slack in the blue belay rope wasn't taken in PARTICIPANT 2 On Saturday 6/2 my group were going to conduct crevasse lowering and practice z-pulley rescue. I volunteered to be lowered first into the crevasse. I was lowered in by my leader who had me on anchored belay with a munter hitch. My "climbing" team was simulating my "fall" into the crevasse, as if it was a three person team. Once I was lowered about 30 feet into the crevasse, I called out that was good enough. I then lowered my pack and began setting up my tenax prusiks. I climbed up my climbing rope with the prusiks and climbed up about 10-12 feet. When I stopped into my foot harness to raise myself, the rope I was on went completely loose and I fell the 10-12 feet to a little below or around where I started. My back did hit the side of the ice/crevasse pretty hard, but I had no injuries. There was a little bit of a ledge for me to stand on until it was confirmed that I was safe. One of the leaders came quickly to ask if I was okay, in which I responded "Yes". I'm not sure what happened above with the Z-pulley, but per the leader, the backup belay rope failed because there was too much slack in the system because of the rope cutting into the lip of the crevasse. The team then re-established the Z-pulley system and the belay, and raised me out with no further complications. INSTRUCTOR 1 1- I believe doing a "dry run" or abbreviated scenario is a good way to get students dialed in to the set up before setting up the full scenario. 2- Do not lower student to within 10-15 feet of the bottom of the crevasse. Hopefully this will mitigate any problems with the belay and prevent anybody from decking if the Z-Pulley set up fails. INSTRUCTOR 2 Lessons learned Multiple red flags - we failed to recognize between the belay instructor (myself), the edge instructor, and the lowered climber that the belay line was as slack as it was (or failing to move on my part), had we recognized this we could have mitigated for it having the student stop prusiking up the main rope or even lower back down to a more even distribution 50/50 between black and blue ropes, after the event we took about 8 minutes to dig out a 6 foot deep diagonal trench to where the blue line had been caught and moved the two ice axes another 8-10 inches closer to the edge. We failed to back up the slack that the prusik on the middle climber had taken up with a solid tie-in, to the middle climber's harness before transferring the load to the climber in arrest position, could this have failed through the carabiner also? If this tie-in and the prusik were in separate carabiners then in separate carabiners that would have been redundant safety. We failed to recognize that the carabiner to the prusik may not perform well under a loaded and twisting condition of laying on top of it. The student failed to recognize that he was out-climbing his belay or to call for "Lig Roped!" (belay instructor) was sucked into helping the 3rd climber extend the anchor and distracted from the larger scenario, and failed to register that the climber below the lip had prusiked as far as he had with no slack left in the belay line, and that there was an issue. We were able to identify all of these issues after the fall happened and safely belay/raise the fallen climber back to the top of the glacier, but these issues should have been caught before the incident happened. Overall, the whole situation made me feel really bad, that the students had had a negative and potentially unsafe and dangerous experience under my watch. I am so thankful that the student who fell claimed to be uninjured, and was okay to complete the rest of the weekend. I hope that that is still the case. It was scary to have something like this happen under my watch, and it makes me think about all the moving parts and things that observationally I missed, under what should have been a positive, confidence-building weekend and experience for the students. I think that the crevasse rescue scenarios are an invaluable experience that we are able to offer to the students, but it must be done in a safe manner. PARTICIPANT 2 In the future, I should have been informed to ensure that the belay rope is taut and to call "up rope" as needed. I was not paying attention to this line as I was focused on the prusiking up and out of the crevasse. It seems that there should have been another instructor monitoring the Z-pulley setup, as Laurel had to mind her belay as well as monitor the setup of the Z-pulley, Rose was monitoring the climber in the crevasse and relaying information.
30/May/2018	Trip	Climbing	Significant	Illness or Personal issues (conditioning, lack of skill)	injury/illness - sudden onset	GENERAL - usually for illness describe	illness - MAJOR lungs, heart, abdomen	Snow - steep, ice ax, poles recommended	unexplained shortness of breath	After about 40 minutes into the trip participant had shortness of breath. After checking her out, her heart rate remained high. I determine that the complete climbing party should turn around. Her pack gear was carry out by other members of the party and she walked out. She seem ok at the turnaround. As she drove one of the other members of her carpool drove. She did see her doctor later that day.	
20/May/2018	Trip	Climbing	Near Miss	Hit, Struck, Cut	hit/cut - natural object			Rock - technical, rope & protection needed		On the descent at the base of the gully at the final rap station. A party of 5 was at the top of the gully setting up their rappel and knocked a basketball size boulder loose. Everyone was yelling "rock" and had time to duck and cover around a corner of rock. A piece of rock ricocheted into the corner I was tucked into and hit my helmet hard enough to leave a piece of rock embedded through the shell. It was a glancing blow, I didn't feel the impact but heard it. No harm done but would count it as a near miss. Not much could have been done to prevent it. We had started out at 5am to avoid crowds which did work out. But faster parties did catch up to us on the rappel. A fair amount of rocks landed at the base of the climb but nobody was hit.	I would make clearer in the future of the potential for rockfall and make sure people didn't linger at the base as well after the final rap as a precaution.
19/May/2018	Field trip	Climbing	Significant	Illness or Personal issues (conditioning, lack of skill)	rappel	leg	injury - sprain, strain, tear	Rock - technical, rope & protection needed	no attachments provided by leaders are available	INSTRUCTOR First, this is not about safety arrangements. All stations were prepared in a very safe way and instructors/leaders were very serious about it. On 5/19, one student was getting ready to begin rappelling and suddenly something snapped in his right calf. He could not continue rappelling. He was at the very top, so he was dragged back to the flat area (by instructors, in a safe manner for all parties). He was in pain and could not walk, although the injured calf did not look different from the other one. Since he could not make a step, it was decided to escort him down (using the trail) to the car and take to emergency. A group of 5 was assigned to proceed with the plan. After bringing him to the parking, two climbers from the party took him to the emergency care he got help. The whole situation was NOT life-threatening. All groups were able to continue as planned. From the patient report: 50 yr old male. Lower right leg injury. Suspected torn ligament. 1 pm. Witnessed. No loc. A+4. Patient took 400 mg Ibuprofen at 1:20 pm. Treated with cold pack RICES. Pulses above and below injury site. Evacuated to car and transported to Quincy Med at 2:30. PARTICIPANT During my first rappel when I was all roped in and started to walk down the wall I heard a loud pop come from my right calf. When I tried to put any weight on it my pain level went from a 0 to a 9 immediately. I was close enough to the top of the cliff that I grabbed onto the ledge and instructor pulled me up. I screamed and writhed in pain, and then they carried me to the medical tent. After some discussion it was decided to carry me out to the cars and drive me to the medical center in Quincy. Five different volunteers took turns carrying me in various positions until we made it out, about 2 miles, to the cars. Two volunteers drove me to the hospital where I received pain medication, crutches and an ace bandage on my calf, with instructions to rest and see my doctor on Monday. The volunteers then drove me back to the Field Trip site where I could meet up with my other classmates and my ride back to Olympia.	INSTRUCTOR Incidents like this are extremely hard to predict. The person was in a good physical shape and did not do anything wrong while working through the course. He confessed that he was training a lot recently. Potentially, and this is only a guess, it may be an over-training issue. PARTICIPANT There was no way to predict or avoid the torn calf muscle. I did not do anything wrong. It just gave out. The best part was the response of the MOFA team, the volunteers and the caring attitude of all of my fellow students. Everyone was genuinely concerned about me.
14/Apr/2018	Field trip	Climbing	Near Miss	Slip, Fall, Capsize	fall (travel a distance)			Rock - technical, rope & protection		I witnessed an instructor take a long leader fall. There was no significant injury. The fall was in my opinion longer than it should have been, partially due to the fact that the climber was considerably heavier than the belayer and the belayer was not anchored. Ideally, the climber would have placed additional pro to shorten any possible fall, but in fairness to the climber and belayer the fall was a surprise, unexpected type of fall.	Anchor the belayer. Place pro more often prior to a sketchy section with higher risk of falling. Communicate with the belayer #AtWatch Main! Before sections with more difficult moves, when possible. In this case the fall was a surprise to the climber, belayer and onlookers alike and hence I doubt that it could have been anticipated. Increase awareness that a one pitch trad climb is not a one pitch sport climb. The risks are higher on trad routes. In this case the top piece held, but had it failed this could have been an injurious ground fall. While sport routes are commonly climbed without an anchored belayer, it is usually prudent to anchor the belayer on a one pitch trad climb.

CORRECTED Activity Start Date	CORRECTED Activity Category	CORRECTED Activity	CORRECTED Incident Type	CORRECTED Incident Category	ADDED Incident specifics	ADDED Injury/Illness Location	ADDED Injury/Illness	CORRECTED Terrain	Notes	CLEANED incident report	CLEANED lessons-learned
14/Apr/2018	Field trip	Climbing	Safety Concern	Other	rappe			Rock - technical, rope & protection needed	?? Could just as easily happen with screw locker	INSTRUCTOR The incident happened at Barney's Rubble on the overhang rappe. This report is in addition to the report submitted by the student who experienced the incident. I was running a station this weekend that included sit and spin rappe on an overhang. We are using extended rappels with autoblock. In the process of transition from sitting to facing the wall, the autolocking carabiner on the student's rappe device was twisted the 1/4 turn necessary to unlock it and, at the same time, opened. The carabiner was stuck, open and cross-loaded, on the edge of the overhang. The student was dangling with no footholds and unable to get back up. Since we use an autoblock on the belay loop, it is a weight-bearing backup. Despite appearing to be a very unsafe situation, the student was still safely attached to the rope via the engaged autoblock. I used a prusik to attach to the rope for my safety. I attached one of my prusik prusiks to his hard points. His autoblock was engaged and attached to the belay loop but I figured a backup anchor would make him feel better. I attached my second prusik to the rope above his rappe carabiner and maneuvered his foot into the loop. I had him stand up, unweighting rope enough to close the gate. His rappe carabiner was still stuck on the lip so I had him put his feet as high up on the rock as he could and keep his legs straight, while I created a mini high directional by standing up with my prusik attached to the rope (13" hollowblock attached to my belay loop via carabiner), thus allowing his carabiner to be free from the rope (since I was now using my prusik for the high directional, I added a second backup using another prusik). This got him past the lip and he finished the rappe. At no point did I feel he was in danger of falling since his autoblock was engaged and holding but he was pretty freaked out and uncomfortable so I moved swiftly and communicated with him throughout. It wasn't a perfect rescue but it was quick and safe. The student did nothing wrong and was calm and cooperative throughout the rescue. PARTICIPANT This is a summary of an incident that occurred during Rock 2, at Barney's Rubble. I was practicing a sit and spin rappe on an overhang. When I did the sit and spin maneuver, my belay device and attached self-locking carabiner in my rappe system got caught on the rock above the lip of the overhang; my lower body was under the ledge and I could touch my toes but not completely plant my feet against the rock. I started shifting around to see what I could do to get the belay device and carabiner over the edge so I could complete my rappe. While doing so, I saw that the gate of the self-locking carabiner had opened, and was pinching against the end of the belay device loop, which together with the rock was preventing the carabiner from closing. I immediately called out to the instructor overseeing the rappe station to let him know what had happened. He ran to get assistance, while I held my position steady and tried to move as little as possible. Very quickly the lead instructor at the station returned together with the first instructor, and after anchoring in built an additional anchor from the rope to connect with my harness, then a foot prusik for my right foot. I observed that a third instructor was standing below and ready to hold me in a freeman belay if needed. The lead instructor pointed out that the autoblock in my rappe system would hold me. Using the foot prusik I stood up, at which point the lead instructor was able to safely close my self-locking carabiner, and get both the carabiner and belay device over the edge of the rock. At this point, the lead instructor said that they could bring me back above the ledge if I would like, or that I could complete the rappe. After the rescue anchors were removed, I chose to continue the rappe, with the instructors observing both from above and below until I completed the rappe.	INSTRUCTOR I would recommend discouraging the use of the 'dual lock' auto-lockers on extended rappels for Basic Climbing students. I love the weight-bearing trait of the autoblock on the extended rappe. I felt very fortunate to have taken and assisted instructing at our Self Rescue Course but the high directional is something out of a non-Mountaineers Mountain Rescue Rigging course (maybe we should add it to our course). I easily could have solved all the problems by just using the high directional (lifting up the rope) from the beginning. But even still it was a pretty quick rescue. This is from our lead Rigging for Rescue instructor (John Morton) after I shared the story with him: "The carabiner event you saw is called "dynamic rollout". It is attributed or suspected in several incidents and accidents, including some fatalities. This includes technical/mountain rescue, helo, and rope access professionals. There are some scary, almost Houdini-like youtube videos on the topic, though all the ones I have seen are contrived "what is possible" shots. Dynamic rollout is usually Reason #1 when someone is trashing talking auto-lock carabiners." PARTICIPANT One takeaway is not to use self-locking carabiners in a rappe system. I will replace my self-locking carabiners with manual screw-gate carabiners, in order to eliminate or at least mitigate the risk of this happening again. I don't think I would have encountered this problem doing a regular rappe over this particular ledge. In the sit and spin, I have thought about whether had I gotten my feet higher up and closer to the edge, I would have had more success in getting the belay device safety over the edge. Because at least one other student also had their belay device catch on the edge, I wonder whether there are better locations at Barney's Rubble to practice the sit and spin rappe technique where there is less risk of something like this happening.
17/Mar/2018	Field trip	Climbing	Safety Concern	Other	driving issues (including personal vehicles)			road		Highway 900 is a very busy road and nearly impossible to get across from the tiny parking lot at the cougar crags (dry tooling). An accident could happen fairly easily with six cars trying to back out onto the road.	I think that paying attention to the forecast and making decisions for a new location/to go or not based on the conditions are vital for safety outdoors. This is talked about but as a new member I'm concerned that it isn't taken into account.
17/Mar/2018	Field trip	Climbing	OTHER	Logistics, Equipment Issues, Party Issues	party issues - conflict, misunderstandings, organization			developed spaces, campgrounds, fields		I was really impressed with our trip leaders who had to call me to task for a serious infraction of an agreement made as a participant with the mountaineers. It wasn't obvious how serious my actions were in the moment, earlier in the day, mainly because I'd been accustomed to sliding into that frame of mind while out enjoying the wilderness on my own adventures alone and with friends... They were both very professional in addressing it with me. Waiting until after the trip had finished, and not making it a scene in front of other mountaineers. They addressed the infraction and I confirmed that I was in violation of my agreement during the Saturday exercises. And then the full weight of my actions started to set in! Thankfully no one was hurt/injured by my poor decision, but I became present to the impact that it could have had, and the potential repercussions to the organization as a result. Thank you again for the review, support and hard work volunteering to help others to learn and love the outdoors, along with the highest emphasis placed on safety and preparedness for all the incredible adventures just out our door!	I know that my actions had the potential to impact others on the trip adversely because of affected judgement, and looking back, I know it was a serious infraction of the agreement I made as a part of the Mountaineers. Regardless of the decision on my standing in the organization I'm committed to not only be more aware of my own safety and decision making process in heightened awareness situations, but to also be a champion to help others recognize their own binders and perceived risk as well. By my being safer I can hold space and help others accept and see the need to elevate their attention to safety also. At the end of the day, that's all that really matters. Everyone coming home in the same condition we left in... As this infraction is reviewed with the committee I hope my contrition and reaffirmed commitment to ensuring mine and others safety can keep me in good standing with the organization going forward.
17/Mar/2018	Field trip	Climbing	Assistance Given	Slip, Fall, Capsize fall (travel a distance)	arm/ elbow/ shoulder	injury - dislocation	Snow - non-technical	injury is best guess		Our group had set up basecamp near treeline just off the Worm Flows route of St. Helen's. A snowboarder (not in our party) crashed and injured his arm or shoulder about 100 yards from our base camp. It was getting late in the day, probably around 6:30pm. We did not realize he was injured until his partner walked over to our camp for help. He said his friend had torn his rotator cuff and was in a lot of pain. One of my adult volunteers, one of my MAC kids, and myself hiked over to check him out. My other adult volunteer had more advanced first aid training than the rest of us, so he assessed the shoulder injury. The injured snowboarder, Komar, was lucid and coherent, but would shriek in pain anytime he was moved at all. Jeff made attempts to move his arm into a position where we could sling (swathe) it, but it was too much pain for Komar to bear. He seemed to need his arm to be held up and bent, and couldn't fold it in against his chest. W We removed his snowboard, and my MAC kid, carried it back down to camp. Adult volunteer and I worked to get snowshoes on his feet so he could walk back to our camp (the snow was soft from afternoon sun). As we were working with Komar, one of the other parent volunteers shouted to us that they had brought a SPOT beacon. Initially, I thought that since it was an upper body injury, Komar might be able to walk out under his own power. As we worked with him, I realized that any movement caused a lot of pain for Komar, and walking out would be long, cold, and painful, as night was falling soon. I shouted back for them to activate the SPOT. It was probably around 7pm at this time. MAC kid and volunteer adult supported Komar as they slowly walked back to camp. I went ahead to kick down a flat path. Komar was not really able to support his own weight. It was a lot of work for us to get him down, but they did it without falling. Back at camp, we got Komar into a more comfortable position at our snow table. We put pads down and got extra layers, and he was able to get comfortable laying on his side. We offered food, but he wasn't hungry, but took some water. I was able to get a call out to 911 and tell them the situation and our location. We gave them our GPS coordinates, but the call was dropped, and I'm not sure they received the full coordinates. Neither Komar, nor his partner, were carrying much in the way of gear. They had small backpacks with food and water. They had one headlamp, but I didn't have batteries. We gave them one of our headlamps (one of the MAC kids was carrying an extra) and one of our radios, and he headed back to the trailhead to assist with Search and Rescue efforts when they arrived. As it was getting dark, we moved Komar into the tent that was nearest to the trail. He stayed in the tent with one of the adult volunteers, and his daughter moved into another tent. He got settled into a fairly comfortable position and was stable. As a group, we decided that if rescue had not arrived by 6am the next morning, two of our parent instructors would remain with Komar while the rest of us carried on with our summit attempt. We all headed to the tents by 8pm. A rescue party arrived very quickly, by 9:30pm. They had been training on St. Helen's earlier that day, so where very close by. In fact, one of the rescuers had stopped by our camp and chatted with us for several minutes earlier in the afternoon, so he probably had a very good idea of where Komar was. They assessed his injuries, and were able to get him to walk out of camp about a half mile to where he could be pulled out on a sled.	Komar was extremely lucky in a few ways. First of all, his accident happened very close to our well-established and large camp. They were the last group we saw descending that day. If we hadn't been there, they would have been alone in the dark, in the cold. It was a cold, windy, and snowy night. His friend alone would not have been able to assist him back to the trailhead in the state he was in. Our group was large enough and well-prepared enough (12 of us, and we are a youth program, so lots of safety gear!) that we could scrape together extra food, clothing, and tent space for him, as well as an extra headlamp and radio for his friend. The SPOT beacon came in extremely handy, as well as a cell phone with coverage in the wilderness (Verizon is worth the money!!!) A one day snowboard trip up and down St. Helens can seem pretty casual. But one bad fall, too late in the day, and things get hairy pretty quick. In short - he and his friend were not prepared for anything to go wrong, but we were. He is very fortunate we were there.
15/Mar/2018	Trip	Climbing	Major	Slip, Fall, Capsize fall (travel a distance)	head/neck	MULTIPLE	Rock - technical, rope & protection needed			We had a leader fall on this trip. The accident happened on Hemingway Butress on "Dung Fu" (5.7). A climb leader from Tacoma, was our third rope gun on the trip. I have climbed with him a number of times before, including on Crimson Crystals (5.8+) in Red Rocks. I know Marty as a solid 5.8 leader. On the day of the incident, we started out in an area called Mindless Mound. We had both led a 5.7 route, and another led a 5.8. I did not see subject lead the 5.7 because I was leading "Rainy Day Woman" at that same time. Subject later led Rainy Day Woman (the route I had first set up), and I saw him take a small leader fall (the pro was at his waste so it was no big deal). However, I got the impression he was a bit rusty, and he later told me that he had not been climbing since last September (including indoor climbing). Subject wanted to lead the 5.8 but other leader had led but I talked him out of it. The 5.8 had a big ledge underneath a roof, and there was a longish no fall zone. Based what I saw on Rainy Day Woman I was concerned that the 5.8 was over his head. Note that most routes in Joshua Tree are pretty sandbagged. We then went to Hemingway Butress. I was going to lead White Lightning (5.7), and other was going to lead Feltonian Physics (5.8). Subject was adamant that he wanted to lead something. I did not want him to lead either of these two routes as I had done them before and new how sandbagged they are. There was another route nearby "Dung Fu". Dung Fu requires bigger gear which we did not have with us, so I told him that if he wanted to lead it he would need to go back to the car and get 2 more #4's and a #5. He agreed so I gave him the keys to our car. At this point I took off and led White Lightning. The route is longer than 35m so one needs to belay from the top. This meant I stayed on top and did not see any of the events that unfolded. From what others told me, subject got the gear and started leading Dung Fu. Others said he was struggling on the lower part but made it ok to the ledge at the bottom of a chimney. Subject said he had difficulties in the chimney - from what he told me I conclude that he stuffed himself too deep into the chimney and then could not move. He said he placed one nut in the chimney above the ledge but other participant said that he did not see a nut placed and it was not on the rope. So it is unclear if subject in fact did place a nut and forgot to clip it, or if it pulled and got lost in the chaos later. In any case, other participant (who finished the route later to retrieve the gear) said there was gear above the ledge in the chimney but no nut. Subject must have fallen from approximately 10-15 above the ledge, and he landed on the ledge. Another participant, who was belaying him, said it was at first not clear if he fell. The rope went tight, and then nothing happened. A participant called to subject, and he replied that he was ok. Participant then asked if he wanted to come back down, and after a few minutes subject replied yes. He then built a three piece anchor where he his last piece was and was lowered to the ground. A participant on the trip, is a doctor and she did the physical examination. They found a deep round puncture wound on his right butt cheek, and he was ADL times 2 or 3 - he did not recall what led up to the incident and had difficulties remembering what day of the week it was. Participant cleaned the wound and applied a gauze pad. Subject was able to walk so participants walked him back to the car and took him to the ER. They did a CAT scan of the ER, took care of his wounds and released him later that same evening. In addition to the wound they told him he likely had a mild concussion. The subject stayed with us in Joshua Tree for the next few days, but did not climb. The first few days he appeared as if he had taken drugs - he was slow and sluggish mentally and physically, but the symptoms got better with each day. We last saw him on Wednesday - five days after the accident - and he appeared normal. He was supposed to take part in my Red Rocks trip, but he cancelled and is now driving home.	When I saw subject leading that morning I felt a bit uneasy. He looked rusty - as if he had not climbed in a while which was in fact the case (but I did not know it at the time). After I saw him take the small leader fall I did not want him to lead anything hard, and I talked him out of the 5.8 route on Mindless Mound, and out of White Lightning on Hemminway Butress. However, he was adamant that he wanted to lead the route that I had not led myself and therefore did not have much beta. Given my uneasy feelings that morning I now feel that I should have at least suggested that he top rope any route first before attempting to lead it. However, subject is a climb leader with Tacoma and has climbed for a long time. He was fairly insistent that he wanted to lead, and he was after all, our third rope gun on the trip. The risk of taking a leader fall is inherent in lead climbing, and within reasonable limitations participants must be allowed to make their own decisions. I feel I should have raised the option to top rope first, but ultimately it was his decision.
11/Mar/2018	Trip	Climbing	OTHER	Informational	driving issues (including personal vehicle)			road	MVI	Incurred a motor vehicle accident enroute. Vehicle transporting the leader and another participant was rear-ended while in stop-and-go traffic on I-5; it was a 3-car accident that occurred in Fife, WA. No injuries incurred in any of the vehicles. - Due to the wait for State Patrol response delaying the approach as well as concern of all participants being in the appropriate 'mental mindset' we opted to turn around and try for this summit on another day.	
10/Mar/2018	Field trip	Climbing	Significant	Slip, Fall, Capsize fall (travel a distance)	hand/wrist	injury - fracture	rock - talus, boulders, scree			I slipped on rock and subtly fractured the distal end of my radius bone at the wrist by way of a "FOOSH" - Fall On Outstretched Hand. I'll be getting a wrist cast for 4-6 weeks. We were on the Sunshine Wall at Vantage in the morning of Sunday March 11. I was going back and forth at the base to help different teams locate and set up routes for students to practice climbing skills. As I scrambled up toward Vantage Point on the basal "steps", my right foot slipped out. I began to fall leftward and put out my arm. It must have landed pretty solidly on the base of my palm near my thumb and jammed the radius bone pretty hard. I also took a tumble and landed in the trail. Initially, I felt a scratch on my elbow and below my knee and didn't really feel wrist pain until later in the day. But by evening as I got home, it was swelling and needed attention. The doctor needed second opinion on the X-Ray, and the radiologist said there could be a subtle fracture on the end of the radius.	I know I was "hurrying" to distribute gear and help people get set up at multiple locations and the complex terrain was definitely not the place to be hurrying. It could have been much worse, I'm sure. Slips and Falls are the most common incident. I had even mentioned the scree and such as an objective hazard for the day.
10/Mar/2018	Field trip	Climbing	Near Miss	Logistics, Equipment Issues, Party Issues	rappe		Rock - technical, rope & protection needed	rope not properly centered by instructors		LEADER I was running the Basic Rock Field Trip on a gorgeous Sunday afternoon on the Friction Slab wall in the Mt. Erie climbing area. We had 4 instructors on the top of the crag manning 3 top-rope stations and a dedicated rappe station. The other 4 instructors, including myself, were on the ground doing other instructional stations including belay. We had set up a handline to reach an easier start to the pitch of one of the climbs and have students practice prusiking up and clipping into a hand line. Belayes were happening on the ground with the students transferring with the help from an instructor to the rope (the ledge was about 15 feet off the ground). Towards the end of the day, this pitch was converted by the instructors at the top of the crag into a rappe station as well. I was belaying a student when I looked up and saw another student on that newly converted rap station and saw the rope was uneven...one of the ends of her rope was on the ground with a stopper knot and the other was a few feet from running through the belay device, no knot on the end of the rope. I yelled at her to stop rappelling (they all were rapping with autoblocks) and she came to a stop. I had another instructor run to the handline to assist and instructor 3 came up from helping with belay escape to assist as well. The student was in a good spot on a friction slab so we had her stand up on the slab (keeping hand on the break/try to take her weight off the rappe) to move the autoblock uprope, which would enable her to try and feed one strand of the rope uprope so we could have the instructor from above try to equalize the rope so we would be able to lengthen the short end so student could reach the rope from the handline. This worked and student tied a knot in the end of the rope and we had her clip into the handline, which we extended with a runner and had student clip to her harness. We were then able to have her take enough of the rope to equalize the strands from above and she was safely lowered to the handline ledge, then to the ground. PARTICIPANT Student was rappelling at a crag, but the rope was not centred on the anchor leading to different length strands. The issue was caught well in advance of reaching the short end and multiple instructors worked together in a very efficient manner to safely anchor the student and fix the situation so that she could safely complete the rappe. Following this, trip leader interviewed everyone involved, debriefed all participants, and instituted protocol to avoid the same issue from occurring again.	LEADER The instructor above didn't see the midpoint on the rope when turned into a rappe from a toprope. This should ALWAYS be checked. At the beginning of the day, all ropes had knots tied into the ends and these were checked throughout the day. Since we only had one rappe station the entire day, there were always knots in the ends of the rope without a problem. Apparently, someone who had been climbing on the newly converted rope had removed one of the knots, perhaps when untying from a belay, and it wasn't checked or asked to be checked when it was converted into a rappe. Complacency was a learning lesson here, the instructors at the top assumed that the knot was still in the rope and assumed that the other end was on the ground, instead of lying on the shelf, and no one from above yelled down to check if that was the case. DOUBLE AND TRIPLE CHECK EVERYTHING. The students learned a few very valuable lessons. After I gathered everyone who was below to debrief them on the possible consequences, other alternatives we could have taken (there was also a bolt nearby, she could have clipped a runner to that bolt, but we had the handline with an anchor there so that was the option we used to clip her in) and what to do to keep something like this from happening in the future (make sure you always find the midpoint, that both rope ends reach the ground and that there are always stopper knots in the end of the rope, that rappelling with an autoblock is important for a backup!) finished by saying that no instructor or leader or other student is going to be put out if a someone (even a new student) notices something is or could be wrong, or just doesn't look quite right. Speak up if there is any concern or question and we can all stay safe! PARTICIPANT * Better communication about whether rope ends reached the ground * Fireman belay * Further instruction on risks of rappelling (All of these were instituted immediately after the near miss)
17/Feb/2018	Field trip	Climbing	Near Miss	Logistics, Equipment Issues, Party Issues	fall (travel a distance)			gym, artificial climbing walls, sports area		Friction slab rappe station: Students were instructed to start the rappe from the small ledge near the top of the friction slabs. The anchors for at least two of the rappe routes were too long so that students who tried to rappe slipped on the vertical surface and fell or stumbled a couple of feet to the flat area below the ledge - where the angled friction slabs start. I leaned back to rappe and fell backwards to the flat surface. I'd call this a near miss because I landed on my hip and did not hit my head, possibly because the anchor was finally weighted and I didn't let go of my rappe brake hand. The instructors moved the start of the rappe to below the ledge after several people slipped/fell.	The anchor placement could have been checked more thoroughly before students started rappelling. We were the first group of the day. The anchors were constructed from a rope wrapped around the large tower at the top of the friction slabs. I also could have noticed that the anchors were too long to start the rappe where we did.
10/Feb/2018	Field trip	Climbing	OTHER	Safety Concern	OTHER			Inside a building or structure	Complaint re: storage issues in basement	Follow up on FT2. The lumber rubbish storage next to the belay stations in the basement is not good. Not only does it block access to some of the stations, it is so close to the action that it becomes a safety issue. It is a real shame that both field trips and Monday night sessions are affected by this. We know that the lumber will be removed later this year. By that time Basic won't need the space any more for the year.	
10/Feb/2018	Field trip	Climbing	Safety Concern	Other				Inside a building or structure		We had a potentially dangerous situation with the stairs and the access ramp at the Kitsap cabin. Both were quite slick, resulting in several slips by various people early in the morning. Three people scrubbed the moss/growth off of the stairs and ramp, which helped, but did not eliminate the problem. Some tree bark was spread on the stairs treads, which did a better short term job of correcting the problem.	There needs to be some thorough cleaning of the stairs and ramp at the cabin. The growth will recur soon unless something is done about it - chemical cleaning or similar.
8/Oct/2017	Field trip	Climbing	Assistance given	Safety Concern	lack of skill, preparation, conditioning, fatigue			Rock - technical, rope & protection needed		We were on a non-Mountaineer climb on Midway when two young men struggled to communicate. We used our radios to communicate their needs about climbing and belaying and anchor status. They made a safe climb to the summit and were grateful for our radio communication assistance. After this climb, we went over to R&D. There were two Mountaineer groups that just finished the route and we were heading up and could see two climbers at the chimney. We caught up to them. One of us waited for the 2nd woman to start climbing from the bottom of the 3rd pitch. She mentioned how her friend leading the route was tired. One of us created an anchor and the other climbed. The following lady was still on the 5.5 crack when I arrived and we waited about 8 minutes before climbing. I lead the next pitch to the end, but just above the crack the ladies were mingling and trying to decide what to do. They said they were going to try and rap down, but couldn't find a safe place. I recommended they did not and that they could trail a rope behind my friend and we could haul them up the remaining part of the route. The rope lead said she could not finish the route if it was like the crack and I said it was easier and she could do it. I again recommended they follow my friend. They said for us to pass them. We did and I radioed my friend to ask them for help when he reached them. He did but they did not want help. My friend arrived to the summit of R&D and we chose to wait until they reached the summit. The leader made it. We helped her pull the other climber to the top because they could not communicate with each other and she said she was too tired. It started raining, hailing, and strong winds of 20-30 MPH. They were grateful for the help and noted they did not know how to get off the summit. We called their rope and lead them down from the summit and to the vehicles. Everyone made it safe without any injuries or incidents. Even though the troubled party were not mountaineers, field trip organizers suggested a report could still be beneficial.	It was beneficial to wait for this group to complete the climb and finish the route. It could have also helped if my friend and I took rope leads for each of the women and lead them to the summit, but only if the situation was worse than it was or they asked for help.

CORRECTED Activity Start Date	CORRECTED Activity Category	CORRECTED Activity	CORRECTED Incident Type	CORRECTED Incident Category	ADDED Incident specifics	ADDED Injury/Illness Location	ADDED Injury/Illness	CORRECTED Terrain	Notes	CLEANED incident report	CLEANED lessons-learned
24/Sep/2017	Field trip	Climbing	Significant	Slip, Fall, Capsize	fall (travel a distance)	foot/ankle	injury - sprain, strain, tear	gym, artificial climbing walls, sports area		<p>LEADER</p> <p>A student was climbing on an artificial outdoor climbing wall during a sport climbing course activity. The individual was lead climbing. The goal for the day was learning how to fall on lead cleanly/correctly. The individual purposefully took a lead fall and when coming back to the wall their ankle impacted the wall resulting in an ambulatory injury to their ankle. The individual completed the remainder of the day doing ground practice and belaying.</p> <p>STUDENT</p> <p>On September 24, 2017, I was a student in the "Introduction to Leading on Bolted Routes Workshop - Mountaineers Tacoma Program Center." While we were in Tacoma, I was in a class of Olympia Mountaineers. I got injured, initially did not check "safety incident" on the feed back form (won't explain my thinking on that), but wrote about it in a different spot on that form. The Olympia climbing chair suggested I do this and let the leaders review it.</p> <p>So here's what happened: We were practicing falls while leading a route on the outside walls at the Tacoma Center. I had climbed and clipped in on two previous one to do lower falls, and successfully "took" a fall twice at a lower level. The instructors guided me up for my third fall, wanted me a body length above my last clip, and directed me to the spot to drop, with my feet next to the clip (maybe a little higher, can't remember for sure). I was obviously worried about it and hesitated a lot, and had the leaders advising how to get in the frame of mind and stating it would be safe, to not grab the rope as I go, etc.</p> <p>When I dropped, my right ankle and foot got hurt, somehow jammed harder than the other, and it began swelling up. I couldn't put much weight on it, when I did it hurt. I could hobble around. I went to the doctor the next day, and it was swollen and sprained, with bruising on the right side off ankle and left bottom of foot. X-ray did not show any fractures.</p> <p>I got prescription for a month of physical therapy. In the second week, they were concerned it didn't seem to be clearing up as well as expected, I went to the doctor again, who then scheduled me for a podiatrist this Friday. It's been 16 days and I still have considerable pain when crunching the ankle or extending the foot, pointing the toes all the way out), especially going down steps and down hill, with pain across the top of the foot and where the top of the foot meets the ankle. I had crutches for a couple of days, but general flat walking is fine.</p>	<p>LEADER</p> <p>Climbing on lead is inherently dangerous. Climbing a more overhanging route could have mitigated the impact taken on the fall due to falling into space. On the other side of that is, can the student climb an overhanging route? If not, this skill is prudent to safe sport climbing and falling still remains a hazard and is more hazardous on non-overhanging routes.</p> <p>STUDENT</p> <p>On the accident itself, I clearly wasn't prepared and practiced enough. If this highest drop is to remain part of the class, to prevent it happening again, I would recommend more practice at a lower level and putting emphasis on bending the knees as the student is coming back to the wall to absorb some of the impact (my doctor said most people my age are avoiding sudden impacts to their skeletal structure, not volunteering for them! I'm 65).</p> <p>I wonder, too, if the highest drop is necessary to get the concepts of falling, and whether or not repeated practice on lower drops could do it, or if the highest drop could be only for volunteers but not an expectation of the class. I'm not sure how critical it is to the class to drop from as high as I did.</p>
24/Sep/2017	Field trip	Climbing	Safety Concern	Other	equipment issues			gym, artificial climbing walls, sports area trail		<p>Some of the bolt hangers are loose at the top of the South Wall at the Program Center. There were also some loose holds. We tightened up some of the holds. Is there a maintenance plan for keeping these things in good shape. Who is responsible for this. We could have tightened the nuts on the bolt hangers but we were concerned that we were not supposed to do this because we did not have a good knowledge about what is backing up the bolts and were concerned about tightening them up too much.</p>	
10/Sep/2017	Trip	Climbing	OTHER	Informational	OTHER					<p>We encountered an abandoned or lost, aggressive dog about 1.5 miles up the Snow Lake Trail. The dog had on a leash and a backpack - clearly belonged to someone, but there was no owner in sight. We looked around the area and shouted to see if the owner was nearby, worrying that perhaps the owner had stepped off the trail to go to the bathroom and had fallen down to the creek. We were unable to find anyone or any signs of a person. The dog didn't appear to be seriously injured, but was obviously upset. It barked and growled aggressively and didn't let us near it. We called 911 to report the dog, and they said they would send a ranger or someone from animal control. We then left the scene, feeling that there was nothing more we could really do. The dog was gone when we returned from the climb that evening. I later read on the facebook "Washington Hikers and Climbers" group that someone had been able to walk the dog back out. I don't know if the owner was found though.</p>	<p>I feel we handled the situation appropriately. I think it would have been dangerous to try to approach the dog, but I'm glad we were able to at least contact authorities.</p>
26/Aug/2017	Trip	Climbing	Significant	Slip, Fall, Capsize	fall (travel a distance)	knee	injury - sprain, strain, tear	off-trail, cross-country		<p>When attempting to obtain our permit for the Thunder Basin camp there were no fire closures listed in the area but the rangers said the area was closed for fire. This forced us to choose our backup climb of Cosho/Kimtah.</p> <p>We decided to camp at the Ragged Ridge camp to avoid losing several thousand feet of elevation from Easy Pass. This requires a reported 1.5 miles of cross country side hill travel, mostly class 2 with very short class 3 steps on traverse. Time estimate from Easy Pass to camp is 1.5 hours. Several members of the team were struggling with side hiking and it took us 5.5 hours to reach camp. Upon reaching camp and assessing the condition of the team, while knowing that we had a longer more exposed traverse ahead of us to the Col between Cosho and Kimtah, I told the team that I was cancelling the climb and that our only objective for the second day would be to get back to the main trail and home safely. There was no dissent from the group. After a leisurely breakfast the next morning (08/27/17) we packed up and headed out around 8:30AM.</p> <p>With nobody wanting to endure the side hiking back to Easy Pass, I opted (based on Summitpost beta and GPS Topo Map) to take a different scramble route down to the main trail from camp. Finding our way out while never exceeding class 2 terrain was going well and it was much better than the side hiking option, but there were sections of steep vegetated terrain with many Marmot holes. Having been in similar situations I warned the group to be extra cautious of these holes as they sometimes can't be seen in the vegetation. Around 9:45AM as we reached the final short vegetated slope before our rock field exit, (student) stepped on the top of a marmot hole. As the top half of the hole collapsed she had no friction on the hill and slid 6-8 feet down the hill the top of the rock field. I saw the fall, but the reason why it occurred is based on student's description.</p> <p>I asked if she was OK and after the third repeat question she said "I felt my knee pop" but was able to immediately stand and walk over to me. After some short discussion with her about the pain level and stability of her knee, we decided to keep moving. Shortly after the fall we reached a flat area where student used an ace bandage to wrap her knee, no swelling was noticeable but she said that it was sensitive and that she had taken ibuprofen. The group took a large portion of her gear to lighten her load and we continued down to the main trail without further incident. Student was able to hike about 6 miles (1500' gain, 2800' loss) back to the Easy Pass trail head by 2:45PM and the group went for early dinner in Marblemount. After dinner student was noticeably limping and said she would go to a Walk In Clinic the next morning.</p> <p>Student did notify me today (08/28/17) that she has been to the doctor and that it was diagnosed as a knee sprain. She was told to rest for 1 week.</p>	<p>1 : Calling the ranger station ahead of time may have allowed time to research more backup climb options, but I do not know when the fire closure went into affect as it's still not listed.</p> <p>2 : While the terrain chosen was within the ability of the group it was tedious, and fatigue certainly played a role in the incident.</p>
19/Aug/2017	Field trip	Climbing	Assistance given	Safety Concern	water incident - capsiz, immersion			water - stream, creek, river		<p>Upon exiting the lower Coleman camp, the water was running as high as I have ever seen it. The water looked brown, the color of hot chocolate with soil and sediment churning. The regular crossing was impassable, so we hiked up stream to the base of a waterfall where we waded across a broader pool. The water was still running fairly fast, but the depth was only knee high. A young family with 3 small children was trapped and following behind us. My guess is their ages were 4 - 10. After crossing, I tossed my pack on the bank and waded back to assist. One participant placed himself down stream, in a position to render assistance if any got swept off their feet. The father was attempting to cross with the youngest child riding piggy back. He was about to cross the narrowest section thinking it would be easier, but I warned him it would be deeper and likely to sweep him off his feet. I managed to reason with him and instructed him to cross where we did. I stood mid-stream and spotted them as each made their way across.</p> <p>All in all, we assisted another party and nobody got hurt.</p>	<p>In hind sight, that water crossing was the riskiest part of the day, and no doubt other hikers were still caught on the other side behind us. Someone had earlier tied a fixed 6-7 mm hand line across the regular crossing, which was clearly dangerous to cross at this point. When we descended back to that point to get back onto the trail, there were a half dozen late day hikers milling around the bank, likely contemplating crossing. What little swift water training IAT™ we had has taught me that hand lines like this provide a false sense of security and are very dangerous to clip to. IMO, that was an accident waiting to happen, and I regret not taking the hand line down. We went in knowing that swift water would be running higher in the afternoon when we crossed to exit. That was an accepted risk for us, and we were well equipped and experienced for this. I doubt the family and others trapped on the other side went in eyes wide open about the water hazard and harms way they were placing themselves in when they crossed the stream earlier in the day.</p>
19/Aug/2017	Field trip	Climbing	Assistance given	Safety Concern	water incident - capsiz, immersion			water - stream, creek, river		<p>Upon exiting the lower Coleman camp, the water was running as high as I have ever seen it. The water looked brown, the color of hot chocolate with soil and sediment churning. The regular crossing was impassable, so we hiked up stream to the base of a waterfall where we waded across a broader pool. The water was still running fairly fast, but the depth was only knee high. A young family with 3 small children was trapped and following behind us. My guess is their ages were 4 - 10. After crossing, I tossed my pack on the bank and waded back to assist. One of us placed himself down stream, in a position to render assistance if any got swept off their feet. The father was attempting to cross with the youngest child riding piggy back. He was about to cross the narrowest section thinking it would be easier, but I warned him it would be deeper and likely to sweep him off his feet. I managed to reason with him and instructed him to cross where we did. I stood mid-stream and spotted them as each made their way across.</p> <p>All in all, we assisted another party and nobody got hurt.</p>	<p>In hind sight, that water crossing was the riskiest part of the day, and no doubt other hikers were still caught on the other side behind us. Someone had earlier tied a fixed 6-7 mm hand line across the regular crossing, which was clearly dangerous to cross at this point. When we descended back to that point to get back onto the trail, there were a half dozen late day hikers milling around the bank, likely contemplating crossing. What little swift water training IAT™ we had has taught me that hand lines like this provide a false sense of security and are very dangerous to clip to. IMO, that was an accident waiting to happen, and I regret not taking the hand line down. We went in knowing that swift water would be running higher in the afternoon when we crossed to exit. That was an accepted risk for us, and we were well equipped and experienced for this. I doubt the family and others trapped on the other side went in eyes wide open about the water hazard and harms way they were placing themselves in when they crossed the stream earlier in the day.</p>
11/Aug/2017	Trip	Climbing	Major	Slip, Fall, Capsize	ice axe arrest needed / attempted	MULTIPLE - usually for injury, describe in narrative	injury - laceration, abrasion, puncture	Snow - technical, ER visit, CT scan		<p>LEADER</p> <p>Our Shukan/Fisher Chimney climb was going to be a three day climb. We obtained a permit to camp two nights up at high camp located just before getting on the Curtis Glacier. However, there was significant weather coming in on our third day and we decided to summit, return to camp pack up and head down either to camp at Lake Ann or out to the TH depending on how tired we were. We did not want to climb in the rain. We all made the summit and got back to camp around 2:30 - 3:00 which was much later than I expected, but we all packed up and started down. We got down through the first two chimneys and everyone stated they were still feeling good. We got to our first snowfield to cross. We had to climb up onto the snowfield and maybe take 10 or 15 steps to cross an area that was steep but it quickly became flat. I had everyone get their ice ax out and wanted to check the conditions to see if it has become icy or hard. One member got up on the snowfield and stated it was still soft and looks good. Another member got up on the snowfield next, took one step and slipped and fell. She tried to arrest but because of her backpack she wasn't able to roll over. She slid down the snowfield about 150 feet. It was still very soft snow. However, when she hit the talus field she rolled about 3 times on the rocks. Her backpack hit the talus field first which took the brunt force. She laid there for a second before moving. I immediately grabbed my backpack and crossed the snowfield and headed down to her. I told her to just sit there and not move I will be right there. By the time I got to her she was standing and walking in my direction. I had her sit on a rock, took her backpack off and did a full assessment. She was alert and oriented, able to move all extremities. She had multiple scratches on her hands, arms, left side of her face, and one large laceration on her left knee. She was able to bend her knee and bear weight on that leg. No numbness or loss of feeling in her legs or arms. No difficulty in breathing no signs of head trauma. We placed band-aids on some of her wounds on her hands. I bandaged up her knee with a Adv. kexlix roll and an ace bandage to give her support. She was answering all my questions appropriately and she started she was able to keep hiking out. We took weight out of her backpack and shared it with the rest of the group. We decided to keep hiking out as long as she still feels like she can. She is very tough, despite her injuries she still wanted to keep moving. We hiked the entire way back to the TH arriving around 11:30pm. We all kept checking in on her and reassessing her condition. I was worried about any internal injuries and most of all head injury, but no signs of either one. Once out we drove back towards Seattle, however, we had to stop and sleep a couple of hours in the car. We all were way too tired to continue to drive. I took her to Evergreen Hospital Emergency Department to be assessed. By this time it is about 12 hours after she had fallen. This fall is considered Trauma so she needed to have a full assessment done. Evergreen Hospital perform CT scan on her head and x-ray of her left knee, which all came back normal. They cleaned her wound and she ended up having 13 stitches. She was started on antibiotics because the wound was large and had been open which increase the chance of an infection. Besides her laceration on her knee the only other complaint was her neck due to the whiplash. I have been in contact with her that last two days and she is feeling much better. Neck pain has diminished and her knee is healing fine.</p> <p>Participant</p> <p>This happened when we were descending the Fisher Chimneys. We stopped at the bottom of the second chimney. We did not have crampons on, because we have just finished down climbing. Below us was a moderately steep snow slope and after it a rocky slope. There was a moat between the bottom of the chimney where we stood and the snow slope. There was an easy way to climb up from the moat to the snow. One of our climbers climbed up on the snow and said that she can see the path. She went a little further on that path on the snow. Our assistant leader also climbed up from the moat onto the snow to look. She had her backpack on and her snow axe. The bit of snow near the moat was steeper than the overall slope. She slipped on it and slid down the slope for about 15 meters, until she reached a rocky slope. She rolled on the rocks several times. I did not see how she slipped & the top of the snow above the moat was not visible for people standing close to the moat on the rocks. After she slid I stepped up a little on the snow and saw her slide on the snow and roll on the rocks.</p> <p>Also, I have seen many extended rappels done improperly, including attaching the personal anchor to the harness belay loop instead of two hard points, and attaching the prussik for the autobloc to the leg portion of the harness, not the belay loop. The students are telling me there is great variation on how to do it, depending upon who the course instructor is.</p>	<p>LEADER</p> <p>I was very impressed with this whole group. They all were very strong and we worked well as a team. I believe one reason she fell was because we were tired from summiting that day and we knew we had a long way to go. I should have required everyone to put on crampons, but we all crossed it on the way up without crampons and no one had any difficulties. I should have been the first person up on the snowfield to assess it. I believe we all felt it was such a short distance and the snow was soft that we wouldn't have any problems crossing it.</p> <p>There was one more snowfield and a moat to cross but we were able to skirt around both of them and not put ourselves in a situation that could result in another fall. We all were very cautious and continued to assist each other in the harder sections.</p> <p>Every time I go out I always have lessons to learn. My insight here is that with any basic group I need to be extra cautious and just put on my crampons, set up extra belays just because you never know. Subject is an intermediate climber and I have climbed with her many times. I wasn't worried about her at all, but it doesn't matter how good you are accidents can still happen.</p> <p>Spending the extra night would have been better. We all would have been well rested, but with the weather coming in it would have made it more difficult to get down.</p>
30/Jul/2017	Trip	Climbing	Safety Concern	Other	rappel			Rock - technical, rope & protection needed	1 of 2 reports	<p>This leader is concerned with how basic students have used the extended rappel with autobloc on this climb and other climbs. Some students are rappelling with just one hand only (on the autobloc). This seems to be potentially unsafe if the climber slips/trips/whatever, because the natural instinct could be to grab onto the autobloc, and if you are only rappelling with one hand only, then you won't stop quickly and could "fall". The basic students have told me that they were taught to only use one hand.</p> <p>Also, I have seen many extended rappels done improperly, including attaching the personal anchor to the harness belay loop instead of two hard points, and attaching the prussik for the autobloc to the leg portion of the harness, not the belay loop. The students are telling me there is great variation on how to do it, depending upon who the course instructor is.</p>	<p>Consistent teaching in the course of how to use the extended rappel with autobloc. I recommend having two hands on the rope.</p>
29/Jul/2017	Trip	Climbing	Significant	Slip, Fall, Capsize	Slip not resulting in a fall	foot/ankle	injury - sprain, strain, tear	trail	1 of 3 reports	<p>1) Short... Participant sprained ankle on trail at very beginning of trip, they turned around and went home. They went to see a doctor, it was just a sprain.</p> <p>Long... At the very beginning of the trip one of the participants twisted her ankle on the trail, about 5 minutes from the cars. It was before sunrise with headlamps. She wasn't paying attention and the trail had a few dips which were hard to see. She stepped into one, twisted her ankle, then fell lower off the trail. She tried continuing for a couple minutes but had to turn around. Her husband was on the trip and he went back with her.</p>	
29/Jul/2017	Trip	Climbing	Significant	Slip, Fall, Capsize	Slip not resulting in a fall	knee	injury - bruises, contusions	off-trail, cross-country	2 of 3 reports	<p>2) Basic Glacier climb Sahale Peak TH</p> <p>I slipped on a wet rock slab and hit a knee on the rock. It didn't start to hurt until almost back at the cars. It didn't impact the trip outcome at all. I got an x-ray after I got home and the bones were fine, just a lot of swelling in the knee.</p>	
29/Jul/2017	Trip	Climbing	Significant	Hit, Struck, Cut	rock fall, rock movement	foot/ankle	injury - bruises, contusions	off-trail, cross-country	3 of 3 reports	<p>3) LEADER Short... A person in our group knocked a small rock and it fell about 15 feet then hit my leg. No visible issues at the time. It didn't impact the trip outcome at all. I got an x-ray after I got home and the bones were fine, just some swelling and a bone bruise.</p> <p>Long... On the descent, right after the rappel, a person above me knocked a small-ish rock down and it hit my leg. She yelled "rock" but I couldn't get out of the way fast enough. It hurt a LOT for a minute or so, then felt better. There was no blood or visible issues, so I continued. A few hours later at the cars after I took off my sock, there was a 1" diameter bloody scab, and there was a lot of swelling. I got an x-ray after I got home and the bones were fine, just a bone bruise.</p> <p>PARTICIPANT</p> <p>I accidentally kicked a rock down on the descent and it hit a participant in the ankle. He said he was okay after we stopped and assessed his condition. He had some bruising around the area when the rock impacted, but he was in overall good shape when we reached the cars.</p>	<p>PARTICIPANT</p> <p>We could have stayed a bit closer together so that we could have shortened the distance the rock rolled before hitting participant.</p>
25/Jul/2017	Trip	Climbing	Near miss	Slip, Fall, Capsize	rappel			Rock - technical, rope & protection needed		<p>a basic climbing student, was finishing his last rappel. He was near to the ground (within a foot), but slipped/lost his balance. It looked like he took a small pendulum into the rock next to him when off balance. He was unhurt.</p>	<p>I think person who kicked rock was tired, and relaxed his guard as he reached the ground. Next time, I would encourage a student to maintain vigilance, even when the rappel is virtually over.</p>
22/Jul/2017	Trip	Climbing	Significant	Hit, Struck, Cut	hit/cut - natural object	knee	injury - laceration, abrasion,	Snow - non-technical		<p>Student punched through the snow near rocks and hit his knee. The impact split his knee open.</p>	<p>Try to avoid crossings snowfields where rocks are showing through.</p>
21/Jul/2017	Trip	Climbing	Critical	Slip, Fall, Capsize	rappel	MULTIPLE - usually for injury, describe in narrative	MULTIPLE	Rock - technical, rope & protection needed	Fatality	<p>While descending the west ridge of Forbidden after successfully summiting, an experienced Mountaineers climber performed a diagonal rappel to one side of the natural fall line. She lost her footing and a large pendulum resulted in blunt force trauma that caused her to lose consciousness, and without an autobloc or knots in the ends of the rappel rope, she slipped down the rope and off the end.</p> <p>Based on the information from a thorough investigation, the primary cause of this fatality incident was the pendulum caused by rappelling well off of the fall line and the secondary cause was not employing backup systems to protect from sliding off the end of the rope (e.g., placing knots in the rope ends or using an autobloc).</p>	<p>There are clear opportunities for sharing key lessons learned with The Mountaineers climbing community. Mountaineers climb programs have an opportunity to train for:</p> <ul style="list-style-type: none"> * risks associated with increasing potential energy when leaving a rappel fall line; increased lateral forces on footing; the potential for larger and more forceful than expected pendulums. * further reinforce intermediate-level alternative rappel techniques—requiring a higher level of climbing skill and experience—such as the saddle bag rope carrying technique to prevent ropes with knots in the ends from becoming stuck when on rappel. * increased repetition of the use of autoblocks to ensure they can be accomplished with a smooth rappel. * even more clearly guard against allowing the halo effect to prevent speaking up about risk management concerns and techniques. <p>Bottom line, if choosing to rappel, one should always rappel on closed system, employ an autobloc or other suitable backup friction hitch, and/or rappel the fall line.</p>
18/Jul/2017	Trip	Climbing	Safety Concern	Other	rock fall, rock movement			Rock - non-technical, scramble skills needed		<p>A climber descending a gully knocked at large rock, about two feet across (see picture), loose and toward the climbers waiting below. Initially the rock appeared to be going down the fall line and directly toward the climbers. Realizing this, two of them sprinted climber's right to avoid the rock. About the same time the rock decided to bounce climber's right right toward them again. It bounced back toward the fall line and suddenly came to a stop feet in front of where they were originally standing.</p>	<p>Although I was repeating loose rock warnings often, it might of been beneficial for me to have descended first and directly overseen group movement directing waiting climbers to find a safer spot and to tell descending climbers not to be directly over other climbers. Another thing I would have done differently is made the least sure footed individual descend first. The gully was at the bottom of a rappel and they rappelled in order of who was ready first. Also, it was not until later I found out the individual that knocked the rock down had some severe foot pain from an activity they did earlier in the week. This may have contributed to knocking the rock loose. If I were to do this again I would reduce the number of participants to no more than four because of the rock fall hazard and I would keep the group together tighter on loose rock. I will also do a better job of getting participants to disclose any type of injury that might affect their performance.</p>

CORRECTED Activity Start Date	CORRECTED Activity Category	CORRECTED Activity	CORRECTED Incident Type	CORRECTED Incident Category	ADDED Incident specifics	ADDED Injury/Illness Location	ADDED Injury/Illness	CORRECTED Terrain	Notes	CLEANED Incident report	CLEANED lessons-learned
15/Jul/2017	Trip	Climbing	Safety Concern	Other	lack of skill, preparation, conditioning, fatigue			Rock - technical, rope & protection needed		<p>There was a general lack of ability and safe operation on the part of the trip leader. Fortunately, this did not result in any injuries.</p> <p>Below is a copy of the trip feedback I left that summarizes most of my safety concerns.</p> <p>The leader was highly fearful of exposure and froze numerous times during the climb. The problem was so bad that the trip leader was unable to lead the first pitch of the climb. The first pitch is a short 5.5, however, before even reaching the crux move the leader declared that she couldn't do it and after much hesitation, staring and stopping, she down climbed. The trip leader then allowed the other climb leader to lead the pitch and second her up on top rope.</p> <p>The problems only got worse from here. In another instance the trip leader insisted that we set up a rappel for her so that she would not have to descend a short low fourth class scramble. The trip leader chose to rappel first and did so without the use of an auto block. Upon reaching the bottom of the rappel, trip leader began working on her own equipment and either forgotten or ignored the participants request for a fireman's belay.</p> <p>The leader also showed signs of what I would describe as mental instability. She alternated between extremes of pessimistically apologizing for her own timidity/ absent mindedness and snapping at others for perceived affronts to her leadership. The leader was also constantly vocal in her own personal fretting and worrying. The leader routinely expressed a lack of familiarity for a route she climbed to have climbed several times.</p> <p>As a result of this poor leadership, a climb that should have taken a competent party 6-8 hours took us nearly 12 hours.</p>	<p>In the future I plan to do my own vetting before signing up for a trip with a leader that I do not know.</p> <p>Just because someone is listed as a trip leader does not mean that they are competent to lead a trip.</p>
8/Jul/2017	Trip	Climbing	Major	Slip, Fall, Capsize	ice axe arrest needed / attempted	MULTIPLE - usually for injury, describe in narrative	MULTIPLE	Snow - steep, ice helioprotraxion poles, recommended		<p>we had just completed a successful summit of Little Tahoma and broke camp at 4:30 p.m. and began the hike back to the trailhead when a member slipped and fell (5 p.m.) on a moderate snow slope and failed to arrest. It was a very slow, long slide and the climber almost came to a complete stop twice before speeding back up again. In total the climber slid 400 vertical feet down the snow slope before rolling across a 6 foot section of exposed rock and moat and coming to a stop in a flat area. We immediately contacted emergency services via an inreach GPS device and via cell phone and a helicopter was immediately dispatched. The climber never lost consciousness and immediately communicated that he was injured and needed help. The first two members of the party reached the climber within a couple of minutes of the fall and immediately went to work to stop the bleeding on a puncture wound on the climber's left forearm that he said was caused by his ice ax. The climber also reported a leg injury, he believed that the leg was broken but it was just sprained. The climber was alert and in good spirits when I arrived to assist. I bandaged the puncture wound on his forearm and removed the tourniquet that had been initially applied and the bleeding stopped. The climber was placed in a sleeping bag and cared for while we waited for the emergency response. One hour after the accident a helicopter dropped a medic who did a full assessment of the injured climber and he determined that the climber would be air lifted to a nearby ambulance and transported to a hospital for treatment. At 6:30 p.m. the injured climber was flown out and transported to the emergency room at Good Sam Hospital in Puyallup, WA. We were able to contact the injured climber's wife and he was able to speak to her while we were waiting for the helicopter to arrive. The incident was also reported to the Mountaineers emergency line. I hiked out with the rest of the climbing party and drove to Good Sam to take the climber's gear and personal effects to his wife who was at the hospital with him when I arrived. The climber was in still in good spirits and stable condition with no life threatening injuries but the doctors had at that time discovered that he had broken a disk in the lumbar region on his back (L4) but that no spinal damage had occurred and that they expected him to make a full recover from his injuries. The climber reports that the spinal injury is minor enough that no surgery will be required just some physical therapy and a back brace while it heals. The climber had crampons on. He also had a heavy pack, we had just broke camp and were traveling down a snowfield just below the high camp when the climber slipped and fell.</p> <p>[Participant 1] This is an intermediate level climb, not a Basic climb. At least the way it was led. I think none of us realized quite the extent of the challenges in this climb, including our leader - but after we learned of the challenges, we should have stopped and addressed them; instead we proceeded.</p> <p>[Participant 2] Fallen climber was not adequately prepared for /confident in/ experienced at snow travel and not able to self arrest with ice ax and crampons when sliding on snow field. There were two segments of the trip that felt high-risk for safety, and in which multiple Basic students expressed a lot of fear. In the second dangerous segment, one Basic student nearly died. The first instance was a very icy early AM start, traversing a glacier at a steep incline (up to 45 degrees), immediately above deep crevasses, on snow that we could only get our ice axes an inch into at maximum per plunge, even if throwing body weight into the plunge several times. Our leader was prepared and knew that the freezing level was supposed to be thousands of feet above us, so a 2am start should be okay. Although the party who went up the day before us advised not starting before 5am to wait for the snow to soften, we did not change our plan. When we started our climb hitting glacier at about 3am, the ice was frozen. The three students on my rope all expressed to each other that we did not feel like we could successfully self arrest on that ice. I was roped directly to two people who weighed 1.5-2 times as much as me, and either of them failed to self-arrest. I think I would have had very little chance of holding their weight on top of my own. (Note one of them did in fact fail to self arrest later in the day.) One of the students on my team is an intermediate student and soft-spoken, and a friend of the leaders, so even though he told me repeatedly that he did not feel safe in those conditions, that we should not be crossing the glacier at that time or at least have pickets in, he did not verbally express it. I stopped the group and expressed my fear of inability to self-arrest to the leader, and while it was acknowledged in a sympathetic way, I was still told basically "this is how it goes." For our climb out from camp, we took the standard climb route, which was different from our way in. We were running several hours behind and everyone was exhausted. While at camp getting ready to leave, before we saw the climb route out, leader asked us to remove harnesses and coil ropes; we would not need safety equipment from here out. Ice axes were needed and crampons were recommended for the hike out now. We all wore crampon-caps on slope with soft snow, and several hundred feet long. Two of the three intermediate students hurried down, while one took more time, carefully stamping out each side step. Three Basic students, held behind a little bit, and subject verbally expressed that he felt hesitant about the route. One student was confused about why we were not in a safety set-up, and pointed to a steep drop-off in snow at the bottom of the hill and said to James "that almost looks like a glacier." James said "it is." As we continued down the hill, at least three of the Basic students started to get scared. A student was quietly angry that we were taking such a risk and was in the back of the pack, carefully plunging his ice axe and stomping out each step. The snow was soft and crampon-ers were probably not helping us. A student was near the front of the group but slowing down, and verbalized "I'm freaking out. Why are we not roped up. This is not okay." She and two other students were about halfway down the hill at this point, and subject and another student were about 1/3 down. About a minute later subject was sliding down the slope, attempting and failing to self arrest. I did not see how he slipped. He ice axe was near his head, and as far as I could see he was not digging in his feet, but trying to arrest with the axe. Below him was a segment of rocks to one side, and what looked to be a crevasse (pointed out by leaders earlier). I would guess he fell 200-300 feet. Fortunately at the bottom he hit a part of snow with neither rocks nor crevasse (what turned out later to be steep snow fall-off into a moat with rocks several feet below). He continued forward to a stop then started yelling for help and that he was bleeding. The two intermediate students at the bottom, made their way toward subject and attended to him. Intermediate leader made his way down as well. People rallied for help, and a helicopter came to get subject. He had only minor injuries - a 5cm laceration in his arm with muscle damage, a vertebral fracture, and an ankle sprain.</p> <p>Party Induced Rockfall. After finishing rappel off Boston Peak member cleared to the side to leave the fall line below the rappel route. As last member was getting ready to rappel several rocks fell. Member was struck by a small rock in the upper left arm that did not require any treatment.</p> <p>Assessment. Boston Peak is known for having loose rock so rockfall was a known risk factor. All climbers were wearing helmets. Party had utilized a double-rope rappel (60m) to reduce the number of rappels that would be needed to descend (there were 3 established rap stations but the party only needed to make one rappel). Party was sized to four climbers to reduce the risk of rockfall. Party cleared the bottom of the rappel path immediately after finishing the rappel.</p>	<p>Participant 3 A participant slipped descending a moderately steep snow slope, failed to self belay, failed to self-arrest, and slid approximately 200 ft down the slope. Luckily, the victim gained speed and hit a bump which allowed him to fly over a moat. I did not observe the initial slip, but did observe the victim descending head first on his back and his flight over the moat. Once he had stopped as a result of the slope run out, the victim yelled in pain. The victim lacerated his arm badly with his ice axe and thought his leg might be broken. The victim stated his pack was too heavy for him to self-arrest. The victim fell many times on our way down from the summit in our rope team. Despite efforts to discuss proper crampon and ice axe techniques, the victim attributed his difficulties to the size of his feet. This should not have been a problem plunge stepping down soft snow.</p> <p>The climber was a basic student who had struggled off and on with snow travel skills throughout the day. I had placed pickets the whole way down from the summit until we reached the gentle slopes of the lower Whitman and Frying Pan Glacier because all of the students on the climb were struggling with the steep upper slopes of Little Tahoma. The climber has size 15 boots and complained several times that he was not able to use the steps that were being kicked by other climbers because his feet are too big. The accident itself happened on a moderate snow slope that was soft and in great condition for both plunge stepping and self arrest (see attached photos). The accident could have been prevented by proper self belay technique or proper self arrest technique after the fall occurred (I slipped and fell shortly before the injured climber did and arrested immediately without any difficulty). During the long slow slide the injured climber never was able to get on top of his ice ax. The ice ax was extended out in front of him above his head during the entire incident. Both myself and my rope leaders where yelling at him to get on top of his ax as he slowly slid down the slope. When I asked him why he didn't get on top of his ice ax he said that his heavy pack prevented him from doing so. The only thing I could have done differently and will do in the future is spend more time vetting the basic climbers that I allow to come on my trips. I had 2 basic students on the climb that where not skilled enough for a climb as challenging as Little Tahoma. They did well on the way up to the summit but struggled on the way down (I hadn't climbed with either student prior). Going forward I will require all members of my climbing party to have gone on one of my snow scrambles or easier climbs prior to signing up for anything that is technical 3 or above so that I can have the opportunity to assess their mountaineering skills prior to taking them on a difficult climb.</p> <p>[Participant] Glacier groups should not go on ice on which participants do not feel that they can safely self-arrest. If snow is not soft enough for self-arrest, the group should wait in safety until it softens before proceeding if it is absolutely necessary to.</p> <p>[Participant 2] I would ask for leaders to have a better way of being able to vet student competencies and skill level before a climb to improve safety and success of climbs. This will promote optimal leadership within the mountaineers. This was a technical and strenuous climb, and 3 out of 4 students were not able to do this climb with competence, confidence, and the snow/glacier skill required.</p> <p>[Participant 3] I don't believe the club has students arrest with fully loaded overnight packs during any of the field trips as an official requirement. If this is the case, the club may want to include that as a requirement. The leader stressed the importance of good ice axe placement for self-belay to avoid the need to self-arrest. The snow was soft enough to enable good plunge stepping. I think the only thing that could have prevented this incident to better preparation on the part of the participant.</p>
7/Jul/2017	Trip	Climbing	Near miss	Hit, Struck, Cut	rock fall, rock movement			Rock - technical, rope & protection needed		<p>Party Induced Rockfall. After finishing rappel off Boston Peak member cleared to the side to leave the fall line below the rappel route. As last member was getting ready to rappel several rocks fell. Member was struck by a small rock in the upper left arm that did not require any treatment.</p> <p>Assessment. Boston Peak is known for having loose rock so rockfall was a known risk factor. All climbers were wearing helmets. Party had utilized a double-rope rappel (60m) to reduce the number of rappels that would be needed to descend (there were 3 established rap stations but the party only needed to make one rappel). Party was sized to four climbers to reduce the risk of rockfall. Party cleared the bottom of the rappel path immediately after finishing the rappel.</p>	<p>Reasonable precautions were taken, such as choosing full length ropes, wearing helmets and limiting party size to four climbers.</p>
6/Jul/2017	Trip	Climbing	Near miss	Hit, Struck, Cut	rock fall, rock movement			Rock - technical, rope & protection needed		<p>While descending the Tooth, a basic student on rappel dislodged a large rock. It fell 10-15 feet and pinched one strand of the rope below, severing it clean through. Rope leader and a basic student were secured to the next anchor at the bottom of the rappel and spotted the now-cut tail at the bottom of the rappel and they alerted the rappeller to stop immediately. He stopped 6-8 feet above the cut end of the strand and about another 8-10 feet above the ledge where we were waiting. At this time trip leader asked the rappeller to knot the two strands together below his autoblock as a "disaster knot" and climb back up to a ledge just above his location (bringing his belay device and autoblock up as he went). I rappelled down to the ledge and anchored to a cordalette around a tree, eventually scrambling down to the rappel anchor that the others were at. Like a sharp knife cutting with ease, the rope was severed. It's the only incident that I have ever encountered while rappelling that caused me great concern. I have never witnessed anything like it before. Without the climbers below notifying the rappeller, high might have kept rappelling without looking at his rope and slipped through. The team really came together to ensure the safety of the group. Everyone made it back to the TR safely and without further incident.</p> <p>[Participant] A climber on rappel dislodged a piece of rock the size of a small computer or a VCR. It fell 10-15' and pinched one strand of the rappel rope against a thin ledge on the second to last rappel on the descent, severing it clean through. Rob Busack and I were secured to the next anchor at the bottom of the rappel and spotted the flaccid tail at the bottom of the rappel and the cut end below the rappeller, and we alerted the rappeller to stop immediately. He stopped 6-8 feet above the cut end of the strand and about another 8-10 feet above the ledge where Rob and I were waiting. He was able to knot the two strands together below his autoblock as a stopper, climb back up to a ledge just above his location (bringing his belay device and autoblock up as he went). The remaining two climbers rappelled down to the ledge and anchored to a cordalette around a sturdy tree, eventually scrambling down to the rappel anchor that Rob and I were at. Everyone made it down safely thanks to quick action and clear decisions from the leaders.</p>	<p>[Participant] In the event of rockfall below you on a rappel, inspect the ropes below you (both visually and by flicking the strands with your brake hand to see if they move together) and enlist the aid of parties with a better view, if any. Repeat the inspection if any portions of the rope were out of view.</p>
24/Jun/2017	Youth activity	Climbing	Near miss	Logistics, Equipment Issues, Party Issues	party split			off-trail, cross-country		<p>On June 24th as part of a joint Leavenworth trip for Seattle and Tacoma branch youth programs (Pioneers, Explorers and MAC), one group of Pioneers and MAC went to Roto Wall for the day.</p> <p>The group parked at the Mad Meadows parking lot and hiked over to Roto Wall, where a participant set up ropes. The kids practiced climbing and belaying for a while 4E" it was a 90+ degree day but we were cool in the shade which everyone appreciated. At one point I saw students bouldering around on the rocks directly to the right of Roto Wall, and when I asked what they were doing, someone answered "Kercock Hoopings." This was a perfectly acceptable thing for them to do while waiting for another route since no one was needing them to belay. I walked over to help one of the kids on the far left side of the wall. About 5-10 minutes later, I walked back over to check on them and to see if they wanted to get a rope, and they were out of sight. I asked a participant where they went and he said "they went up. I doubt you'll find them." A participant and I exchanged glances and I told him I was going to scramble up and call them back down. I scrambled up to the top of the first rock band and did not see them. I decided to move right, and continued to scramble uphill and right (towards domestic dome and the mad meadows parking lot). It was extremely hot and I was aware that I did not have water with me. After about 20 minutes looking for them, I scrambled down the far side of Domestic Dome and ran back via the road to Roto Wall. When I returned to Roto Wall, two people were getting kitted up to start a search. They were pleased to see me and we regrouped. An added minor component was that there was also a small guided group at Roto Wall, and we made an effort to help the emergency away from them. One participant is on Mountain Rescue, and he and another participant had a plan to leave a walkie talkie with a third participant who was comfortable manning the crag. They took a rope and 3L of water each, and a first aid kit. They made a plan to go left, since I had gone right. They would not go on terrain they needed more than a hand line for, and they would be gone for 60 minutes, returning by 2:30 at the latest. If the two youth were not found by 2:30 we would call search and rescue. We knew that one student was a very experienced and fit scrambler, so we weren't too worried about their technical skills. Another student is much younger and has a history of seizures, and we were very concerned about her getting heat exhaustion. We knew they did not have water with them. Because of the extreme heat, we made the decision that 2:30 would be our Search and Rescue call time.</p> <p>While participants were out searching, I would go to Playground Point, where another group of ours was climbing, to let two other staff members know what was happening. I told a participant I would also be back by 2:30 at the latest. Knowing a participant had some service at Playground Point, I texted him to meet me at the trailhead if possible, since I was pretty tired from my preliminary search. He met me at Mad Meadows, and I shared with him what was going on, and asked him to relay that information to staff, which he ran up to do. He is one of our physically strongest leaders, and so knowing that the Playground Point group was okay without him, he returned to come with me to help with whatever was needed. We had time before 2:30 so drove up and down Ickle Road, checking 8-mile camground which was our destination for the night. Without finding the two students, we returned to Roto Wall, where they had shown up around 1:50. When the two students had returned, a participant had been able to radio another participant that he and the other searcher could turn around. Fortunately, they did not have to search for long in the heat. I had a conversation with the students asking them about the rules, asking them to discuss their judgment and planning and letting them know the impact their decisions had on others. That night at the campfire, we had a discussion with all of the youth about the reason for the rules and the importance of staying with the group.</p>	
23/Jun/2017	Trip	Climbing	Safety Concern	Other	route conditions, routefinding, lost, overdue			Snow - technical, 2 of 2 reports glacier, rope needed		<p>2. Snow bridge collapse. On the ascent the bergschrund on a snow bridge. On the descent two of the party members had recrossed the snow bridge when the block of snow that was providing the bridge collapsed and fell down the mountain. Remaining party members were able to find a section of the bergschrund that was filled with snow debris. The debris was crossable and all remaining members were safely belayed across. The day was the hottest day of the year so far and there was significant snowmelt across the entire ridge. Climbing route was predominantly with southeast aspect so afternoon sun was expected.</p>	<p>Lessons learned: constantly reevaluate the changing mountain environment as the day progresses.</p>
17/Jun/2017	Trip	Climbing	Major	Slip, Fall, Capsize	fall (travel a distance)	leg in a fall	injury - fracture	trail helioprotraxion		<p>On the way out from a Snowfield Peak attempt at 5:30 p.m. Sunday June 18, 2017 Assistant Leader slipped on a log that had was lying across the trail and fell awkwardly breaking her fibula just above the ankle. Search and rescue was immediately notified via an In Reach GPS device. The ankle was rapped by members of the climbing party and later splinted by search and rescue.</p> <p>The remaining two intermediate students and two basic students hiked the remaining two miles to the Pyramid Lake trailhead to meet with search and rescue. I remained with the subject at Pyramid Lake the sight of the accident. At 6:30 p.m. a search and rescue helicopter appeared over the lake and I walked out on a log in the lake and signaled to them. They returned shortly after 9 p.m. and lowered two rescuers into a very small opening in the forest. I met the rescuers and led them to subject's location on the other side of the lake. They did a quick medical assessment and then asked me if I could get her to the extraction sight. I put subject over my shoulder and hiked to the extraction sight. Subject was placed into a screamer suit and extracted via helicopter.</p> <p>I gathered subject's gear and mine and hiked to the trailhead and met with the rest of my climbing party at 10:30 p.m. The helicopter had dropped subject off a short distance from the trailhead and the other members of the climbing party had already picked her up. I then drove subject to the Swedish Hospital emergency room in Seattle. Where she received treatment and was picked up and transported home by her husband.</p> <p>[Participant] Group member slipped on a wet, decomposed log and broke their leg as a result.</p>	<p>This was simple a case of fatigue and bad luck. Subject attempt to step on the low lying log itself instead of stepping over it. The kind of log crossing that is experienced on almost every hike and climb. The fall was very short (no more than 16 inches).</p> <p>[Participant] Avoid stepping on wet, decomposing logs.</p>
17/Jun/2017	Trip	Climbing	Major	Slip, Fall, Capsize	fall (travel a distance)	foot/ankle	injury - fracture	Snow - technical, 1 of 2 reports glacier, rope needed		<p>We were roped and belaying with pickets across a steep snow slope on the south side of Sloan Peak near 7200' at about 3pm (past the glacier, on the Corkscrew section) when one of the climbers fell. He describes that his foot stuck into the snow and stuck, and his fall wrenched it. He ended up breaking an ankle bone and is now splinted with crutches. Our team members helped him hobble over to a rocky spot on the ridge south of the glacier where we could wait for rescue on dry ground. I activated my PLB and we gathered some group gear, and then I sent the other two rope teams back down the route while the three of us on our rope stayed with the subject awaiting help. The helicopter buzzed us about 7 pm but couldn't locate us in the cloud cover so we spent the night (subject on a pad and in a full body with extra clothes), SAR rescuers arrived about 8:30 am Sunday to transport him on a litter across the glacier and down to the saddle between Bedal and Sloan where the helicopter was able to pick him up at about 6pm. I'm sorry about the injury and the rescue required. Thankfully our 10 day with ropes belaying, and group cooperation made the situation as good as possible. Please contact me with any questions, thank you.</p> <p>[Participant] on the decent one member, on a steep and thin snow field, appeared to slipped back a few feet over a thin area and broke through to rocks below, severely injuring his leg when it struck rocks in the hollow under the snow. It was painful enough that he could not put any weight on it, and could not negotiate the steep and difficult terrain. He was assisted while on belay over to an area suitable for bivouac, off the snow, and plans were made for two team members to spend the night with him in an emergency bivouac. The trip leader triggered an emergency beacon to request an evacuation. There was adequate cold weather gear, extra food and supplies for an over night stay, the remaining two rope teams were to descend and reach a place with a phone signal and make contact with the rescue authorities and our emergency contact, and to give details and affirmation that assistance was necessary. I had witnessed the incident, but could not see the lower part of the person from my vantage point. We had been belaying people across several steep snow fields with exposure, the surface snow as soft and wet, making positive foot holds difficult to kick in deep enough for a reliable footing, and crampons were often balling up with the wet surface snow making it difficult for the spikes to penetrate deep enough into the underlying firm snow. minor slips were common on the afternoon snow fields and on the glacier. Most of the members of the group has successfully navigated across this thin section of snow field. The thin area could be seen since it was at the edge of the snowfields, everyone, including the injured person, has avoided stepping on the thin part of the snow, but appeared to slip back a few feet when above this area and broke through, injuring his lower leg on the exposed rocks in the hollow below. He was on belay, but the slip was not long enough for the rope to stop him from sliding down a few feet onto the thin snow. The injuries did not appear life threatening, nor at any time was any one exposed to life threatening conditions.</p>	<p>The best prevention for subject's fall would have been waiting a month to do the trip when the trail along the steep heather slopes was fully melted out. Thankfully we were roped and using pickets to belay teams or his fall might have continued down to a heather bench or over the cliffs below. However we had the gear to call for rescue and for three of us to unexpectedly spend the night fairly easily and send the rest of the team on safely.</p> <p>[Participant 1] This just looks like bad luck. Other than avoiding the thin snow cover (not always possible) I do not know of any piece of equipment or change in procedure that might have prevented the injury. Shin guards like those used in soccer come to mind, but not sure that would have worked.</p> <p>cautionary lessons:</p> <ol style="list-style-type: none"> even relatively minor slips or incidences could result in injuries severe enough to cause a group on a day trip to spend a cold bivouac in deteriorating weather conditions before rescue can occur. Despite the desire to go "light", there should always be enough gear and extra food to keep you warm in the worst weather you might encounter. In this case they spent a night on an exposed ridge, in winds during a snow storm, in mid June. remaining group members should be extra cautious when trying to hurry out, to avoid further injuries, so another emergency is not created, and possibly delaying getting word out to rescue authorities. the emergency beacon summoned a sheriff's helicopter in only a few hours, though the weather conditions at the bivouac site did not allow for an evacuation. It would have been useful to have a way of communicating with the helicopter or other rescue personnel, for they had no way of knowing the extent of the injuries nor the level of assistance needed. There was no phone signal anywhere along this particular route, only after returning to Darrington could a phone call be made. attached photo is approx location of where the injury occurred. Bivouac site is in background where large boulders are present where the team in waiting for the remaining members to cross the last snow field before the glacier <p>[Participant 2] For subject's accident, perhaps I could have put in more pickets.</p>

CORRECTED Activity Start Date	CORRECTED Activity Category	CORRECTED Activity	CORRECTED Incident Type	CORRECTED Incident Category	ADDED Incident specifics	ADDED Injury/Illness Location	ADDED Injury/Illness	CORRECTED Terrain	Notes	CLEANED incident report	CLEANED lessons-learned
17/Jun/2017	Trip	Climbing	Major	Slip, Fall, Capsize	injury/ illness - self inflicted, caused by movement	foot/ankle	injury - fracture	water - stream, creek, river	2 of 2 reports	<p>Another of our climbers broke his fibula near his ankle hustling down the trail to help SAR on Saturday evening. He was enroute below the saddle and about 1500' and a couple miles above the Bedal Creek Trail when his foot got wedged in some rocks and he was moving too fast and broke his ankle. He hobbled out to the trail head with the aid of trekking poles and our other climbers. He is scheduled for surgery but should be fully mobile in a month. I'm sorry about the injuries and the rescue required. Thankfully our 10 essentials, roped belaying, and group cooperation made the situation as good as possible. Please contact me with any questions, thank you.</p> <p>[Participant 1] On the descent of the six that left the bivouac site to return to the trailhead, while hurrying down steep decent in rough terrain, another member injured his ankle. He was able to continue, slowly and with assistance, to the trail head and sought medical attention once we returned to town. Near the trail head, those of us that descended met with emergency responders, we filled them in on the condition of the injured person, their bivouac location, food and supplies on hand, etc. and gave them detailed instructions on ascending to the glacier, since there was no obvious trail, marks or boot tracks up the west side of Sloan from the Bedal creek trailhead. they planned an early morning approach since the helicopter could not reach the bivouac site because of high winds and low clouds. the rescue personnel did manage to reach the bivouac site on foot late the next morning, relieving the two team members who stayed with the injured person overnight. The two team members descended after they arrived. the emergency responders prepared to sled the injured person down lower on the mountain to where the helicopter could reach them.</p> <p>[Participant 2] Here's what I can offer: 1. I feel lucky to have climbed Dragontail and now Sloan with a particular climb leader. She is awesome. Technically she is so competent and she is always making sure every one is learning. Just so thankful for her. 2. My Accident: I wanted to make sure that the new students got full value so just when they thought their day couldn't get any more intense, I decided it would be good to break my leg so they'd have to pull it together at their most exhausted point, 3 miles and 1500 vertical ft from the trailhead. It was a clean break so it didn't hurt too much. The snapping sound of a leg bone is pretty unmistakable so I knew I'd done my job well. I got up, got my ice axe out and started moving right away. Walking on a fibula broken in three pieces is painful (3-11 out of 10 on the pain scale) but possible (Surgery this Thursday morning). A participant and I were ahead of the others trying to keep the pace up but I couldn't quite stay ahead of the students without broken legs and they eventually caught me after about a quarter mile. I asked for trekking poles to replace the ice axe but kept moving and I heard him say to another participant that he couldn't catch up to give me the poles so of course I tried to go even faster to enhance the learning experience. As well, after crawling under a couple of logs, I crawled further than really necessary on my belly in order to dramatize the basics just what it takes to be a rope lead on an Everett Mountaineers climb!</p> <p>I trail run a lot, recently ran down the old sl trail in 35 minutes from the rocks to the parking lot. I make good and a few bad foot placements and I pretty much always know exactly why a foot placement went bad even before it's gone bad. This time though, nothing. I wasn't reckless or in anyway doing anything even remotely close to what I do in training. I was walking at a good clip and suddenly I was going down hard. As I was falling I saw my boot locked behind the rock that was perpendicular to the trail and it stayed locked behind the rock such that after falling I had to extract it by prying myself up and moving backwards. As it happened, I felt an impact to the sole of the boot like when you kick in a step on hard snow and then I was falling. I think what happened is that my boot ricocheted off something like a rock or root in the shadows at the edge of the trail, twisted enough for the rock trap to grab it, and then forward momentum drove the boot into place behind the rock that was about ankle height. It was at the time of day just before it was dark enough for headlamps but light enough to render them ineffective. Conclusions: A) consider slowing down. B) Mountaineering boots suck in the majority of cases, consider including approach shoes in our rack. I have been using them regularly but because of the relatively short snow approach decided to boot it - never again, carry the boots and lightweight approach shoes will be my method!</p> <p>Potential takeaways from this climb: A. Screening of climbers should be a thing. Even with subject's injury we should have had our two rope teams down, in good light, two hours before I bit the dust. The reason we were so long in descending is the same reason we were so long in getting to our turn around point shortly before subject's fall and possibly a contributing factor to subject's injury: another participant. He should never have signed up for this climb but people aren't always honest with themselves so we need to screen people perhaps. Over the course of the day he caused us to lose about 6 hours of time (compared to the next slowest person), after always lagging behind he was always the last to be ready to go after a break, was incompetent in knots, belaying, and glacier rope travel, was dangerous in walking on steep snow (for example, he was unable to follow the established boot track on the slope where subject fell - shortly before subject's traverse of the slope, other participant destroyed the steps exactly where the fall occurred. Unfortunately he had destroyed them before I had time to yell at him to stop wrecking the fragile steps AND thank goodness, our picket placements were good because he fell on them repeatedly). He was largely unable to clear built up snow from his crampons and repeatedly fell on our descent (like every 3 steps! Ultimately, I figured that he was more dangerous with them on then off so I had him take them off and he was way better). He was unable to descend more than 10 steps on soft snow without stopping for rest (downhill, never mind the glacial pace of going uphill). He showed no sense of urgency to descend the</p>	<p>mountain with our climbers bivouing above even going so far as to insist that we stop while descending the snow field so he could urinate knowing full well that in five minutes we'd be unroping. 5 minutes later, again, with the climbers above, now stuck on the mountain with the helicopter unable to extract Honorio, as we unroped, he announced that he was going into the woods to take his second crap of the day, we waited yet again. We still had thousands of feet to bushwack down to the trail and his knees were now bothering him and his pace slowed even more. A rope lead and I kept the party together and we repeatedly waited for the other participant to catch up. When we finally reached the trail it was time to get moving in case SAR was at the trailhead and we needed to contact Pie. After I fell and I stopped to get the trekking poles, the other participant just passed through from the back of the group without saying anything and proceeded down the trail. When I made it to the trail he was sitting in the passenger seat of my truck. I got into a Subaru and layed down and someone else drove my truck to the junction of 4096 and Mtn Loop Hwy. SAR asked a participant to stay and in an instant, without a word, the other participant drove away in my truck. When we made it back to his house the truck was there, the other participant was in his house and never came out. We left for the hospital. This individual was a danger on the climb and cared not one shred for anyone else on it. He showed no sense of urgency toward our people on the mountain. I think he exaggerated his knowledge of the mountain and his expertise with the trail he claimed to have done extensive work on (I saw no real evidence of work on any part of the lower trail and the upper part before the snow was all bushwack). He did exhibit an amazing summit fever though. I don't pretend to be some great mountaineer but I've never seen anyone as incompetent as him on a climb.</p> <p>B. No photos when climbing is happening. Hey, when you're stopped taking a break, fine. When you're sitting at the top, fine. Throughout the day, and this happens on most climbs, people would hold up the group to snap an action photo of people on rope teams or whatever, costing valuable time. A participant and I actually both got very insistent with one individual who kept taking pictures when we needed to be moving post leaving our people behind.</p> <p>C. Emergency gear - Each rope team should specifically have to have, in the possession of the rope lead, a PLB and, I'd suggest, a radio. On climbs where snow/glacier travel is happening, at minimum two stoves with two sets of primary and back up fuel.</p> <p>Conclusions: A. The troubling participant should be screened I suggest that you contact another leader for another perspective on him. The troubling participant and I were on the same rope so I experienced his behavior more directly.</p> <p>B. If there isn't already something in place, we should have a more effective way of handling up front and in the field screening. Some people just aren't ready for a climb.</p> <p>C. Consider limiting the distraction of photos on basic climbs. This probably cost us 20-30 minutes over the course of the day.</p> <p>D. Consider setting additional minimums for certain gear on snow/glacier climbs. I'm very sorry about subject's injury, but the Bedal Creek approach is pretty rugged with no trail for the 2-3 miles and 2000' of gain between the Bedal Creek trail and the saddle. A rope leader was trying to move quickly because we'd been held back in speed most of the day by the pace of one of the climbers, and he was trying to rush to the trail head to help SAR locate us. In hindsight I shouldn't have let the slower climber on the trip, but it was hard to know his conditioning before the trip.</p> <p>For me, slowing down or perhaps switching to approach shoes.</p>
3/Jun/2017	Field trip	Climbing	Safety Concern	Other	lack of skill, preparation, conditioning, fatigue			Snow - technical, glacier, rope needed		<p>Student presented some issues with belaying and generally not paying attention to the rope team. While performing a backup safety belay for a "fallen" climber during crevasse rescue practice field trip, student dropped his brake hand so the "fallen" climber was no longer on belay and he could take pictures and do other things on his phone. I talked with the climber being belayed after the field trip and she said she was very uncomfortable and had reminded herself that the crevasse rescue team had her secured. I talked with the fallen climber and told her she should have communicated with her belayer that she was uncomfortable and to put her back on belay or leader tie-off.) Student didn't have the safety of his team in mind when he was belaying and practicing his skills. Understanding that student has had issues with being on his phone when he should be watching his teammates or performing other skills during field trips, his lack of focus on the rest of the team presents a significant safety issue should he do this while on a real climb. No injury happened this time.</p>	
29/May/2017	Trip	Climbing	Safety Concern	Other	lack of skill, preparation, conditioning, fatigue			Rock - technical, rope & protection needed		<p>Two basic climbers on this climb are very nervous climbers on Rock or scrambling. Another student is very, very slow, nervously talks the whole time while rock climbing (and even before starting the climb the rock climb), is often unfocused, was nervous on each rappel (even after stating that was one of her strengths) and slowed the climb down significantly! However, she was strong on the approach and on snow.</p> <p>Another student's rock climbing skills are ok when rope up but he was very nervous and occasionally froze on class 3 & 4 rock scrambles. However, his navigation skills were very strong and he helped with approach route-finding significantly.</p> <p>They both made it to the summit with the skills, patience and coaching from their climb leaders, but it was an exhausting and stressful climb for all participants. We nearly had to descend in the dark due to the slowness of these two climbers. They both made it to the summit so I gave them credit for the climb, but I thought I should write something that has a warning that both students should have more practice climbing at the Gym, and outside in a controlled environment to improve their speed and skills before attempting another rock climb.</p>	
28/May/2017	Trip	Climbing	Safety Concern	Other	lack of skill, preparation,			Snow - technical, glacier, rope		<p>This climbing leader doesn't know how to properly set up an anchor, and needs remedial skills training.</p>	
20/May/2017	Trip	Climbing	Major	Hit, Struck, Cut	hit/cut - natural object	back	injury - fracture	Rock - technical, rope & protection needed	Upgraded to Major Reported as Field Trip	<p>We were a party of 6 climbing the West Face of Guye Peak, 3 leaders, 3 students. I told everyone to put their helmets on at the end of the small snowfield when we were about to begin the loose rock gully approach. After scrambling the loose rock gully towards the base of the ramp that leads to the base of the climb, we encountered snow. Finding the normal entrance to where you gain access to the ramp, there was a cascading waterfall (knownwell), we opted to stay right of the gully and continue up to the top of the snow finger. There was a short scramble up to where we could access the ramp and so we conferred and one of the students climbed up to set up a hand line for the students. I advised the students and other instructor to hug the right side of the fall line. Once the other instructor got to the top of the scramble section he called to have his pack raised to him. I clipped it to the rope and he pulled it up, then yelled to us he was going to move further back to set up the line on a tree further back. I was flaking the rope as it had been caught on rocks to the bottom right, away from the fall line when we heard "rock!" (not the first time we had heard that this day). We all ducked, covered our helmeted heads and apparently I was struck in the upper back/shoulder area by a rock the size of a men's shotgun. I didn't know where it hit me but I knew I had been hit as I instinctively rolled right as I was thrown to the ground, landing with my right shoulder and head in the snow finger bank. My fingers and toes tingled and I asked everyone not to move me, that I was experiencing some type of shock and to give me a minute. My other instructor, who is also part of King County Search and Rescue, was immediately by my side and asked if I could move. I told her to wait a moment as the shock wore off then tried moving my extremities, all good. I sat where I was, and she asked where I had been hit. I didn't know and one of the students said my upper back/shoulder area. She performed an initial assessment while another student got me a jacket. We told the other instructor who had now anchored in the handline to stay put as there was an injury and after about 5 minutes I was able to collect myself and move. My instructor checked my neck and back and I asked her to palpate an area that hurt, she found a huge swollen bruise and contusion between the right of my spine and my shoulder. We sheltered in place for about an additional 20 minutes and formulated a plan of exit. The snow we had just ascended was pretty steep and I didn't know if I was going to be able to make it down. One of the students had a microtraxion so we decided to climb up to the other instructor to see if there was a more feasible way down from the base of the ramp. When we got up there, he scouted around and couldn't find anything, and the rock we were to climb was dripping wet (even if there wasn't an injury, we would have turned around at this point). We decided to get some food, water and rappel down. Luckily with some gain I was able to rappel onto a safe spot on the snow. We then rigged a 2-rope rappel to the base of the snow and a student kept me on a fireman's belay for that, very slow going but much safer than trying to descend the steep snow. We all regrouped in a safe spot and continued the descent slowly down the approach, back to the cars. I went to Meadowbrook Urgent Care in North Bend and the doctor sent me to Snoqualmie Hospital Outpatient to get C-Spine xrays. I have a broken spinous process at the C-7 which will require healing on it's own, thankfully, no surgery and nothing more serious.</p>	<p>Not a lesson learned, but a lesson for others...MAKE SURE you're wearing helmets, especially when there is loose rock, potential for rockfall, etc.. EVEN if it's on the approach, better safe than sorry.</p>
13/May/2017	Youth activity	Climbing	Safety Concern	Other	lack of skill, preparation, conditioning, fatigue			Rock - technical, rope & protection needed		<p>While we were climbing on the south side of the Feathers, one of the instructors, noticed that the party climbing next to us had a strange anchor set up for their toprope. On closer look, we realized that their anchor was a non-locking carabiner at the end of each chain, with single webbing loop going through both non-locking carabiners, and the rope was running directly through the webbing loop. After a bit of consideration and pointing out to some of the kids on leadership, Joe decided to chat with the couple, explaining that the rope will melt through the webbing and he would highly recommend having a piece of hardware in between webbing and rope. When the climber got to the top, he cleaned the anchor and commented that yes, our instructor was right - it was beginning to melt through the webbing.</p> <p>Back at camp that evening, we shared the story with the entire group as an opportunity to teach about assessing anchors, and how to respectfully help other parties without sounding like a know-it-all. At that point, one of the youth, said "Oh my gosh I climbed on their rope. They were so nice and they seemed like they knew what they were doing!"</p> <p>We then discussed the need to assess other parties' systems and ensure one of the leaders has confidence in their system before climbing on someone else's rope.</p>	<p>We generally try to role model camaraderie as part of our crag ethic. We pull ropes when not in use, we offer other parties to use our rope if we're climbing in the same area, and we encourage sharing ropes to create a positive climbing environment. The lesson here is that kids (and people in general) don't know what they don't know. This could have been avoided if we had been clear and specific that we only share ropes with parties whose skill and systems have been assessed by one of our staff or volunteer leaders.</p> <p>This story ended well with no one getting hurt, and great teaching moments for all involved, including the other climbing party. But had it not ended well, it could have been hugely traumatic for everyone. Evidence that reporting and learning from near misses needs to be a critical part of our risk management practices.</p>
18/Mar/2017	Field trip	Climbing	Near miss	Slip, Fall, Capsize	ice axe arrest needed / attempted			Snow - steep, ice axe, poles recommended	Seattle teaches to use feet with crampons	<p>Our group was practicing sitting glissade. The slope we were on was not particularly steep. The snow was deep, soft and very wet from rain. While demonstrating technique an instructor casually used his heels to maneuver and reduce his speed. His leg appeared to get sucked into the snow and got stuck there. His momentum carried the rest of his body downhill, twisting the stuck foot, ankle and leg beneath him. Thankfully he came to a stop. He carefully called to the rest of us for assistance, stating very clearly that he needed to be pulled uphill. We go up there quickly and did so. It took several minutes to extricate his leg and foot from the snow. The snow had somehow solidified into a concrete like state around his limb. We dug his foot and leg out with hands and gingerly with ice axes. I was amazed how firmly compacted the snow had become around his leg, and how difficult it was to get his foot out. Our group MOA lead worked with the victim to ensure there was no injury, and thankfully there was not. Close call, could have had a serious knee injury had the slope been steeper or if he had been moving faster. We modified instruction at that point ensuring that we did not dig our heels into the snow. We did all self arrest practice "heels up" simulating wearing crampons, instead of what we normally do, which is dig in with our feet as part of the arrest.</p>	<p>When instructing snow travel highlight the risk of hyper extension as a mechanism of injury. Discuss evaluating the snow and method of travel and keeping speed under control to prevent hyper extension.</p> <p>We modified instruction at that point ensuring that we did not dig our heels into the snow. We did all self arrest practice "heels up" simulating wearing crampons, instead of what we normally do, which is dig in with our feet as part of the arrest.</p>
18/Mar/2017	Field trip	Climbing	Safety Concern	Other	party issues - conflict, misunderstanding, organization			Inside a building or structure		<p>The following was already sent over in a private email correspondence.</p> <p>I was at the 'belay from above' station with an instructor and my climbing partner. I top rope the climb up to the belay station, to the anchor and clip my PA. At this point I know I am anchored to the belay station. I call off BELAY. I look over the edge to try and get visuals on whether my climbing partner has me off belay so I can start taking up rope.</p> <p>My climbing partner me off belay AND then unclips his own clove hitch from the ground anchor system. In the same step, I do not remember if my climb partner removes the PA. I instantly call down to climb partner to stop but he's already out of the system. Instructor inquires why I am yelling to my climb partner. I indicate that I do not have my climb partner on belay AT ALL - I have not taken up any rope, I have not set up my munter, nothing. My only call to my climb partner, the only thing he knows about my system, is that I would like to be off belay and am safe at the chains. The instructor indicates that they have not been checking for this step. I do not mention this to make a dig. I mention this to corroborate my safety concern. I have no concerns about the instructor's judgment of the situation.</p> <p>I proceed with taking up rope and put my climb partner on a munter belay. My climb partner is unable to complete the climb to the belay ledge after multiple attempts. My climb partner puts me back on belay off an ATC and I am lowered as I have completed my portion of the exercise. I am hard-pressed to consider the practice of unclipping from the anchor a valid step BEFORE knowing you are on belay (in this case, as the 2nd climber). If this were a multi-pitch situation, then that is undeniably and unmistakably a real safety concern. I was treating the exercise as a multipitch scenario, given that was I was belaying from above.</p> <p>If this were a situation where the 2nd was still on the ground, about to start P1 of a climb, I do not necessarily believe the 2nd would be anchored in at all! And even so, best practice is STILL to stay anchored until you know your belayer has you on belay before starting a climb. I know these safety assessments are situational. But staying tied into the anchors, or using lockers to set up an anchor are just best practice things. If given the two options, one is always the superior (and safer) decision.</p>	<p>Presenting such skills test within the context of real-life situation might prove useful in the future.</p> <p>Am I following the leader, or belaying from above, as if it were a multipitch climb? If so, am I operating as if this were ground to P1, or something like a P2 ledge up to P3?</p> <p>And I still believe best practice emphasis should be given to using lockers at anchor stations and always staying tied into the anchors until you know you are safe in the hands of the belayer. We do this check on the ground before starting our first climb. Why would we ever change that safety check?</p>
5/Mar/2017	Field trip	Climbing	Near miss	Logistics, Equipment Issues, Party Issues	equipment issues			developed spaces, campgrounds, fields		<p>[Instructor] The Texas Prusik station hangs from cargo straps between large Doug Fir trees. This year a new group of people was assigned to setup the station and the straps weren't properly wrapped around the trees. In the past they were wrapped once around the tree at the ratchet end to distribute the load better between the strap and the tree. This resulted in the ratchet buckle releasing and dropping 4 students to the ground from 3 to 4 feet up. No injuries were reported.</p> <p>[Leader] I as the primary ratchet for this event and two other individuals did the logistical work and put it together. I did not see the incident happen, but was the first there after it happened. Four students had fallen from our prusik station due to, what appeared to be an equipment failure. The students said they fell less than 2 feet and all were startled but not hurt. I checked in with each of them. I shut down the station immediately and photos were taken of the ratchet system. I have asked the two instructors at the station and the two group leaders to submit an incident report. A station instructor and group leader tried, but ran into errors while completing it. A group leader he writes "This appears to be an equipment failure incident.</p> <p>Four students in team 6 were all prusiked to the ropes and just beginning their climb up the ropes. The three closest to me were a few inches off the ground. I am not sure how far one student was off the ground, but understand she was a little further up the rope. I believe all were hanging freely at the time, but just prior two had stepped of the table (but not at the same time) at the direction of the instructor and then settled with their feet already in the leg prusiks. At some point there was a loud sound, like a snap, and the team all fell to the ground, and my first impulse was that the device was coming down. I had been standing next to one tree right below the device, and I left that spot, thinking it might come down on me. As it was, after the snap, nothing else seemed to be moving, the instructors checked with the students, and all were untied and left the rope. As people looked for what was wrong, I heard someone say one of the devices meant to wench the cable hold the ropes tight had opened (not sure of terminology) and given way to a degree."</p> <p>The station attendant and helped set-up the station writes: "We were helping run the prusik station. After running approximately 7 groups through, the 8th group of 4 were on the climbing ropes approximately a foot off the ground. When the winch slipped and released the strap about a foot and was held by the strap wrapped around the ratchet handle. Fortunately no one got hurt."</p> <p>I was also there for the set-up the day prior to the event. The same people who had put up the station in previous years were on-site and two volunteers did the actual set-up.</p> <p>For first rappel off roof, when checking anchor, found carabiner attached to wall unlocked. Don't know if the instructor did that so I would catch it...I did not notice him doing that, as I was standing there.</p> <p>Also, not a safety issue, but why were some students allowed to bring DOGS to this event?! You let one person do it, and everyone else wants to do it. Pets are a distraction to stuff going on. They jump at people and charge them. They are curious and want to smell everyone's packs. Please do not allow pets to these events.</p>	<p>You need to have carry over with the setup crew from year to year. Its OK to add new people but make sure they have had experience with the setup in the past. Replace straps and equipment at intervals.</p> <p>[Leader] Redundancy is taught in all of our anchors. This one was not backed-up. The logistic leader and I had just talked about the age of the equipment and look at making a request to replace it.</p> <p>You need a stated pet policy about bringing pets to field trips or mountaineer events where students are learning. Instructors leave their pets at home.</p>
21/Jan/2017	Seminar	Climbing	Safety Concern	Other	equipment issues			Inside a building or structure	Also, complaint pet on trip	<p>I was also there for the set-up the day prior to the event. The same people who had put up the station in previous years were on-site and two volunteers did the actual set-up.</p> <p>For first rappel off roof, when checking anchor, found carabiner attached to wall unlocked. Don't know if the instructor did that so I would catch it...I did not notice him doing that, as I was standing there.</p> <p>Also, not a safety issue, but why were some students allowed to bring DOGS to this event?! You let one person do it, and everyone else wants to do it. Pets are a distraction to stuff going on. They jump at people and charge them. They are curious and want to smell everyone's packs. Please do not allow pets to these events.</p>	<p>You need a stated pet policy about bringing pets to field trips or mountaineer events where students are learning. Instructors leave their pets at home.</p>