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# Guano Happens

**Guano Happens** is a regular column of the PTGA's Brash Talk newsletter that seeks to enlighten and educate guides on field safety, risk management, situational awareness, and decision-making topics. We learned in our 2019 member survey that Guano Happens is the most popular and well-read section of the newsletter; that guides greatly value sharing and learning via narratives from the field. This document represents a compilation of all Guano Happens reviews, and more reviews will be added with each new addition of Brash Talk.

We want you to learn from the experience of others. PTGA believes that incident and near-miss reporting is a very important area of development in the industry. There is incontrovertible value to learning about and discussing events related to risk-management in a no-blame environment, with the explicit goal of preventing future mishaps industry-wide.

Reading through the collection below is time well spent. As you read, is important to be mindful of several things:

1. Understanding the language of review, and how to replicate it in the field/work environment
2. Understanding the sequence of decisions and actions that occurred (or didn't occur)
3. Understanding the concept of casual factors; that every big incident is often pre-cursed by smaller events or decisions that are more consequential than they appear
4. Understanding that incidents and near-misses provide clues to knowledge, skills, and judgement deficits that can be overcome with additional training or experience

You are invited to contribute to the Guano Happens forum. Use our **Anonymous Incident and Near-Miss Report Form** to share your story. Our mission is simply to educate and encourage guides to make sound risk management and safety decisions in the field. When reporting, please do not use names of people, company/organization names, or use any other identifying labels. Learning from these near misses and being able to discuss them without fear of judgement or punishment is critical. Please share whatever you are comfortable with. No matter how old or new your story is, we would love to hear from you.

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# Driver overboard with engine still running.

*The individual who shared this has given full permission knowing that sharing the incident is far more useful than burying it. We have provided the narrative then our summation of the causal factors that precipitated the incident.*

This guide had retrieved some kayaks and the end of an excursion and takes up the story:

*I had retrieved 2 kayaks from the water and positioned them across the pontoons. I waited for the call to go alongside, retrieve the hook and prepare for the lifting aboard.*

*On receiving the call, I engaged the drive and swung the zodiac around to starboard to come alongside (I'd removed my kill-cord to prepare the zodiac and kayaks for crane ops). As I started this manoeuvre, the bow of the Zodiac lifted up on some sea ice which caused the kayaks to slide backward toward the stern of the zodiac. I was temporarily unbalanced as the kayaks struck me and pushed me to the stern of the zodiac. I reached for the tiller for some assistance to retain my balance. When I grabbed the tiller I rotated the drive slightly and then lost whatever balance I had and fell backwards into the water.*

*The accelerator sleeve did not self-return and so remained stuck in full throttle instead of returning to neutral/idle. Thus, the zodiac careened off at speed shedding its cargo of kayaks and looped around a circuit and I was in its path. I was aware of what was happening and was able to avoid being runover by ducking my head and moving my body away from the course of the zodiac.*

*I was in the water for probably less than 2 minutes as I swam toward another zodiac which was standing by. I had some difficulty in retrieving the rescue throw line as the hood of my float jacket kept falling over my face. I had zipped up my float coat, but this is not sufficient unless the waist clip is fastened tightly also. When being retrieved from the water the rescuer may pull on the jacket and unless the waist band clip is fastened the jacket could be pulled over the head of the person being hauled from the water. Eventually I was hauled aboard and taken back to the gangway to find comfort in a warm shower. I was back on duty within an hour.*

## Causal Factors

- **Not being aware of the ice under the zodiac bow when taking off** – any professional guide should have constant situational awareness. In this case the unknown ice under the zodiac was the issue that ignited the sequence of events.
- **Kill-cord was not being worn when the driver went into the water** – kill-cords are a critical safety item regardless of your perception of your own skills/experience. This was the biggest causal factor in this incident and turned it from a simple embarrassing plop into the water into a critical near miss.
- **Throttle control was sticking/malfunctioning** – guides/drivers should be fully aware of any deficiencies with equipment they are expected to use, their role in reporting deficiencies, requesting repair or undertaking it themselves if they are competent.
- **Float coat was not worn as per manufacturer recommendations** – waist belts are critical to the functioning of any flotation device to assist the victim to stay in it and/or to be used as a means of hoisting.

Positive note: **The rescue was quick and efficient** – all guides should have practical experience of rescuing a MOB with the challenges and solutions a zodiac offers.

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# Driver overboard under gangway with inflatable life jacket.

This incident is a few years old and shared by a senior guide but had an interesting sequence of events and lessons.

*I was returning from driving a landing on the Antarctic Peninsula. Winds were over 30 knots and there was a big swell but I felt comfortable enough with the conditions that I tied my Zodiac up at the gangway without waiting for help and hooked it up to the crane. The ship then swung at anchor and the swell became much bigger; a particularly big set had the crane cable coiling in the bottom of the boat before it fell again into the troughs, jolting hard each time the cable came taut. The motion was too violent for me to stand and eventually I was thrown overboard between the aft of the Zodiac and the ship.*

*I hung onto the Zodiac's pontoon, trying to hold myself high enough out of the water to stop my lifejacket from getting soaked through as I knew I wouldn't be able to maneuver with it inflated.*

*Eventually I realized I couldn't climb out over the pontoon and I wasn't willing to risk climbing over the transom in the heavy swell, so I let go and swam for the gangway. My lifejacket inflated, and on arrival at the gangway I sat on a crossbrace underneath to make a plan for getting out of the water without being crushed between the gangway and Zodiac, which was still rising and falling on the swell and slamming against the gangway. Unfortunately, the swell then washed me in under the gangway, and I was pinned face up by my lifejacket on the underside of the floor grate around 50cm below the surface of the water. When the wave passed I was left floating beneath the grating, and I took the opportunity to climb out and up the side and onto the gangway. The chief officer was informed by the crane operator and he arrived as I was climbing out of the water. Other staff had looked out during the minute I was in the water but had seen only the boat tied up and not noticed me. I was dressed in offshore sailing waterproofs and Muck boots. I was wet but the clothing acted like a wetsuit so I was warm enough that I simply towelled down and put on dry clothes afterwards.*

## Causal Factors

- **Operating at a rough gangway without a spotter** – This guide made the decision to tie up to and operate at the gangway without a spotter or assistance. In any rough conditions 'transition zones' are largely, and predictably, where accidents are going to occur (getting in/out of zodiacs, going from one state of doing something to another). A set of eyes or a spotter could have halted the incident process in the early stages. For many companies these days this is a mandatory requirement and standard operating procedure.
  - **Loss of the ships lee** – It isn't always possible, and often difficult to hold, but the loss of a lee (shelter) at the gangway was a major contributing factor to the events that transpired. Without a spotter if the guide had communicated with the Bridge and disclosed that they were attaching to the crane in riskier conditions it could have mitigated the issue.
  - **Choice of flotation device** – The use of an inflatable lifejacket was very nearly the final straw that might have turned this brief incident into a tragedy. The guide involved now says they only ever use a PFD when driving because of this event and the general difficulty they have seen during a number of practice drills with MOB and zodiac drivers trying to self-rescue (or not) with inflatable lifejackets vs PFDs. Inflatable lifejackets are very effective at keeping someone afloat but are very difficult to manoeuvre in or climb over a pontoon or ledge in or, in this case, duck below the water if needed to avoid being hit or to escape (zodiac or gangway).
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# Trapped at Brown Bluff with moving ice.

This guide shared a story that is perhaps more common than is probably reported.

*I was ELing and we had a spot at Brown Bluff. Weather was great with little breeze but forecast to rise a little through the morning. The 'ashore' landing was a breeze and a group went off hiking around to the glacier while others dispersed to the colony/beach areas to enjoy penguins. We are a smaller operation so we had plenty of time. I had walked to the penguin colony to help out and hang out. After an hour or so the breeze set up from the east but not enough to be a problem, it was just colder. Some pax decided to go back to the ship so a driver was doing shuttles. The driver reported an increase in ice at about the same time as the hike group (via the bridge radio intermediary as reception from around the corner is not good) leader called to say they could see a large amount of big ice moving our way. I immediately called the landing to a halt and communicated this to staff who, without alarming people, started moving them back to the beach and into pfd's. Drivers managed to get all the beach walking and colony people off the beach and back to the vessel. By the time the hikers returned all zodiacs were off the beach, one was stuck in the ice (the driver walked to an open side and was picked up by another driver) but 18 people were stuck on shore.*

*We had our shore bags with water and shelters (amongst other things) and the breeze was cold and without movement people were chilling quickly. We put groups of 6 into the group shelters and settled in to wait.*

*After 4 hours the ice field had moved west enough that we could get a zodiac to shore (drivers had managed to rescue the stuck one). We packed up our beach camp and got everyone back to the vessel without further incident. While some people were uncomfortable (from sitting in the emergency shelter) and a little anxious no one was in any danger. If we'd had to stay longer/overnight we had some rations and other survival gear in the shore bags. In the end it made for a good story and we continued our trip with no follow up issues. I checked in with all pax at re-cap and talked through what happened, how we managed it and checked if anyone had any lingering concerns or issues. There were none.*

## Causal Factors

It is difficult to isolate one causal factor out of this event. The closest seems a familiarity trap where this site might have been visited a number of times before without incident and perhaps the EL's guard was dropped. Back up plans all seemed to go well and shore bags were there and shelter was available. We all know Brown Bluff can be a very cold place with the wind blowing so this contingency planning was critical.

Fast moving pack and floe ice is a known phenomenon along this coast and through Antarctic Sound. In this day and age with the information we have available and healthy numbers of close calls it seems almost inconceivable that someone would get caught out. But – it continues to happen. Something to consider is a briefing for bridge officers or placing

a staff member on the Bridge as a high look-out. This would mitigate this ever happening almost completely. But – if a group of hikers are a long way out and even if the bridge/spotter person sees the ice coming it can be traveling easily at 1-4 kts (I've measured drift through the channel between Andersson Is and the end of the Peninsula there at 5 kts) it is still possible to catch a small group out. This is where quality shore kit and knowledge of how to use it can stop a 4-5hour shore stranding turning from an interesting inconvenience into a possible epic or tragedy.

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## Communication issues in deteriorating weather:

This Communications incident was shared and is worth considering. It points to the need to be situationally aware of when to switch to the formal VHF call and response protocols that get dropped for most easy operations.

*We had an instance where, while it remained relatively calm onshore, a katabatic sprung up in the outer bay where the ship was anchored, and rapidly increased in force to a point that Captain called back everyone on shore while he dealt with the ship dragging anchor.*

*The katabatic was blowing 55kts when Zodiac-A delivered their group to the ship. While still at the gangway, Zodiac-A requested that one of the passengers remain in the Zodiac as ballast as the zodiac was probably needed back onshore. At the gangway, Zodiac-A radioed ashore to Staff-1 to confirm that they were needed to return to shore to collect more passengers. Communications were difficult at the ship end with the wind but Zodiac A received the transmission from Staff-1, 'No, you are not needed.' Zodiac-A responded "Copy that", slipped the radio back into its holster and moved away from the relative protection of the gangway, readying to get the Zodiac on the hook.*

*Unbeknownst to Zodiac-A, seconds after those communications, Staff-2, who was also ashore, called on the radio, "We do need you back on shore," but with the wind, the transmission was not heard and Zodiac A went up on the hook.*

*The katabatic became stronger – it was blowing 65 knots by the time the 4th of 5 Zodiacs got back to the ship to offload passengers at the gangway. The 5th Zodiac was by this stage also on its way to the ship with passengers. The ship received a call from shore to say that one more Zodiac was needed to return to shore to collect final passengers and staff. The 4th Zodiac (with an extra staff member for ballast), was now free, so returned to shore in worsening conditions, collected a full load and inched back to the ship in 65-70 knot winds in hazardous wave conditions. They had strong, capable staff aboard and managed well at the gangway then got the Zodiac back onto the hook.*

*It all ended well but being out in those conditions was hazardous. Had radio communications been effective, Zodiac operations would have been completed by Zodiac-A 45 minutes sooner, in safer conditions for both Zodiacs and for the ship which was struggling to hold position until all Zodiacs returned.*

*We debriefed the event afterward. Staff-1 acknowledged that they'd made a mistake in saying Zodiac-A was not needed; however, they assumed Zodiac-A had heard the instructions from Staff-2 to come back to shore." Staff-2 said, "Sorry, but at the same time as I radioed I was dealing with a situation near shore and was busy with that." We also acknowledged that a central point of comms control and logistics would have been a good idea.*

## Causal Factors

1. **Lack of situational awareness – communications.** We all (mostly) know what 'formal' radio protocol is. The reason it is in any number of SOPs is that VHF communications in marginal conditions are marginal and there are procedures for checks and balances so that important messages get through and are understood. Guides should always be conscious of this when environmental or geographical conditions are such that they need to shift to formal comms procedures even if day-to-day operations drop the formality.
2. **Lack of central control in marginal conditions.** This team identified in review that as conditions got more marginal having someone (shore or ship)

in the role of central communications person is a good idea. There is a solid reason why all critical incident teams (fire, ambulance, police etc) have command control protocol when dealing with rapidly changing and complex situations. This became one of them!

3. **Familiarity trap.** There could be an argument that this tight knit team familiar with working with each other may have suffered some Familiarity trap as most of their operations work smoothly doing what they always did – they were very familiar with standard, and even non-standard operations. This particular event seems to have gone beyond even non-standard.

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## Walrus incident, a cautionary tale.

This is an interesting experience and rather than having any causal factors to review it is a cautionary tale and registered incident so is worthy of sharing and being reminded that walrus are unpredictable, powerful and armed with anti-zodiac swords. This incident also reinforces the value of operating with a partner (if you can) when out in ambiguous conditions.

*I was EL and driver during a Zodiac cruise in eastern Svalbard. There were swimming walrus with calves thinly spread across the whole area of the excursion so I was regularly warning staff to maintain a safe distance from them. Winds were approximately 15-20 knots and the water was murky with sediment.*

*As I was returning to the ship I was at full throttle with the intention of getting up on plane when three adult walrus surfaced simultaneously on my port side, almost touching the Zodiac. They were swimming in the same direction as me and at the same speed. All three rolled onto their sides to face the boat and raked their tusks through the port tubes before fleeing. The whole event took about 3-4 seconds. The whole port side of the zodiac collapsed instantly and the passengers on that side threw themselves forward onto the floor. My 'buddy boat' came alongside immediately and took all ten passengers before redistributing to other boats who were arriving.*

*I was able to drive back to the ship unassisted with a pronounced list, the floor awash and the helm hard over to counter the drag of the empty tubes! When the boat was lifted onto the ship, five individual tears of up to 50cm in length were found across two chambers*

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# Ice floe landing incident.

This incident happened in the NW Passage while landing on an ice floe.

*I'd been out zodiac cruising near Banks Island at the western end of the NW Passage. I'd radioed my partner and said I'd found a great floe and wanted to get my zodiac out for a walk on the floe. My partner wasn't keen but said they would stand by and back me up with a zodiac in the water.*

*I ran my zodiac up onto the floe and was nicely perched. I grabbed a paddle from the zodiac as a probe and jumped out onto the ice for a look around. I poked around a bit and everything seemed solid. I went back and explained what we were going to have a short walk on an ice floe in the NW Passage and also said if anyone was not happy with the idea they could stay in the zodiac. All my guests were keen. I began unloading and told them to have a look around, not go near the edge and not too far away. I'd nearly finished getting people out when there was a cry and a gentleman was knees deep in a slush pool of soft ice having broken through the surface. He was flailing around and panicking which was making matters worse. His rubber boots were full of freezing cold water and he clearly believed he was going to go right through and into the sea. I grabbed my spare paddle and rushed over. He had walked into a mushy melt-pool area I hadn't seen on my quick look around. I offered the paddle but he was just out of reach so I used the paddle as a walking stick and waded into the pond to steady him and escort him out. He was quite shaken and had cold feet. I rallied my group back into the zodiac and offered him my spare socks in my pack and explained we could get back to the ship in less than 10 mins. He had settled by this stage and said he would be okay but wanted to go straight to the ship. We emptied the water from his boots and drove back to the ship. His story was the biggest news in the bar that night.*

This guide did a lot of things right and we thank them for sharing. This isn't a major incident and as always there are still some things we can all learn.

## Causal factors for the incident in the slushy pond

- **Insufficient scouting** – if operating an ice walk a guide should scout an area as thoroughly as they can. Having an ice probe, paddle or ice axe is useful to really poke at suspect surfaces without having to step in them.
- **Lack of clear boundaries for the guests** – if a guide is going to let people wander freely there should be very clear boundaries. Items from a zodiac or your guide pack can make useful boundary markers if needed.

## Further issues for consideration

- Carrying a throw bag or rope at all times – it is unknown if the guide had a rope on them at all

times but the PTGA recommends having a personal rope or throw bag with the guide at all times during an ice walk or any extended journey on sea ice.

- We don't know exactly from this report but if someone was through the NW Passage it was likely to be later season with warmer temperatures. This might indicate that even once a guide decides to run an ice walk they should be on high alert because any ice floes are likely to be degrading with a high likelihood of surface melt pools.

Ice landings are a lot of fun and often a highlight for many guests. They also have a lot of potential for things to go badly wrong and with significant consequence. In the tourism industry there aren't any established guidelines or practises (there are some resources and SOPs for Govt Science operations and heavy vehicle operations on ice) so this makes it difficult for people to learn and for a lot of polar tourism industry guides hand-me-down training is as good as it gets. If you ever run into a guide who has extensive experience working on sea ice it is a golden opportunity to grill her/him and learn as much as you can.

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## Near-miss incident highlighting why sharing and learning is important.

This story was shared and didn't happen to the guide but they got to observe a near-miss unfold which highlighted the reasons why knowledge and reporting of 'near-miss events' across the industry should be systematic and a mandatory part of a company's operating system coupled with an anonymised way to share. This incident highlights all the standard reasons for skill development, ensuring minimum competencies are in place before a guide takes charge or at very least are identified and strategies put in place to account for them. It also reaffirms for all of us just how quickly things can turn from an unsettling/amusing incident to a tragedy because of the polar environment.

*It was the end of the day and the excursion was wrapping up. The vessel was anchored but some ice had been moving through the area. Experienced drivers had been pushing ice away from the bow of the vessel and keeping things clear but these people were no longer available. There was a large low ice berg bearing down on the vessel. The only person available was inexperienced polar driver who was doing some practise driving and had some other non-expedition staff in the zodiac.*

*They attempted to 'drive on' and move the berg as they had seen others doing. The piece of ice was massive and in strong tide current. They didn't stand a chance. With about 10 feet to go before the berg hit the vessel the driver drove the zodiac between the berg and the ship to try and stop any impact. The berg continued its journey and began to crush the (taco) the zodiac which then popped up and began to tip. The three people in the zodiac were able to scramble onto the ice berg (it was fairly low profile with flat sections luckily). There was no other zodiac handy for a rescue if anyone had fallen in the water. The Bridge managed to pull the vessel back to allow the berg to carry on its way unhindered and the zodiac sat flat again. The driver had managed to hang on to a rope to the zodiac and once clear of the vessel they managed to jump back into the zodiac, get it started then pick up the other two people and continue wrap up operations.*

*We debriefed the event afterward. Staff-1 acknowledged that they'd made a mistake in saying Zodiac-A was not needed; however, they assumed Zodiac-A had heard the instructions from Staff-2 to come back to shore." Staff-2 said, "Sorry, but at the same time as I radioed I was dealing with a situation near shore and was busy with that." We also acknowledged that a central point of comms control and logistics would have been a good idea.*

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# Zodiac Operations near-miss and GroupThink warning and lessons.

The story below was shared with us, describing how a near-miss unfolded during a zodiac operation. This incident reminds us that the polar environment is fickle and what you see is not always what you get. While we all want to provide our guests with a memorable experience, it's not worth risking anyone's personal safety.

It also reaffirms the need for well-trained, experienced and competent leaders who allow a psychologically safe space where team members can question decisions that are being made.

*This episode occurred during a zodiac operation from a small ship. We were at Spert Island in the Antarctic Peninsula and there was a planned zodiac cruising operation for two rounds of six groups. There is usually a good swell there, as was the case on this day, and proximity to the rocky shoreline requires vigilance, but the conditions were suitable for cruising. The plan was for the six boats to generally stick together and always be visible to at least one other craft, however there was no designated leader; we were going out to explore.*

*This was my first time to the site and I was relying on the others to show me around. First, we entered the tight passages that the area is renowned for, losing visibility and comms to the ship as we transited from the south to the north side of the island group. After exiting the passages, the lead zodiac turned into a narrow cove containing three large icebergs, exposed to the swell. The interior of the cove is characterized by a very steep amphitheater-like wall that plunge directly into the sea. Seals could be seen on the far end and drew the attention of the lead zodiac. One after another each of the zodiacs entered the cove. I was fifth in line and hesitated. I recognized the potential hazard from the three icebergs; if one was to roll, we'd quickly be met with waves pushing us toward the rock walls. I signaled to the driver behind me, indicating that I was uneasy. A shoulder shrug was the response. I reluctantly continued, thinking perhaps we just need to quickly pass the bergs and then it would open up. After several minutes within the cove, the lead zodiac turned to the icebergs and steered right into the middle of the three. It turns out that the only way out of the cove was either doubling-back or passing between the icebergs. Again, the string of zodiacs followed. I turned a corner to see what was transpiring. Not only did I not like the icy passage, but to my surprise, two of the boats had stopped to admire the bergs, floating between them. The boats were six meters away and each of the icebergs was ten meters tall or more. I powered up and turned out of there and continued to a significant distance away. Two other zodiacs did the same. One remained floating in the middle and offered pictures to guests. After a few minutes, all the boats were safely away from the icebergs.*

*Flash-forward to the second round of cruising, about an hour and a half later. Again, all six zodiacs were in line and as we approached the same cove for the second time, we were met with lots of brash ice. Turning the corner, we could see that the entire amphitheater now contained ice and it was basically unnavigable. The three huge icebergs had all rolled since we had left them just over an hour ago, and one had broken up. Had that happened during the earlier cruise it most certainly would have been a catastrophe.*

## Causal Factors and Probable Heuristics

- Risk shift
- Familiarity
- Expert Halo heuristic
- Social Facilitation heuristic

The critical balance point between near miss and tragedy was simply lucky timing. The real risk posed by the three large icebergs was significant. One or even several zodiacs were exposed to that risk at any given time. The swell and tight geography of the cove, combined with steep rock walls would have further complicated a Man Overboard (MOB) situation. Furthermore, there were no direct comms to the ship and it was a significant distance away.

This is a very complex but common scenario for group based excursions into terrain/areas that can change character at an unknowable time but when they do it happens in an instant. The nature of this particular scenario was very much like a group of skiers in avalanche terrain so we will review it using some common tools and concepts from that industry.

The biggest factor involved here is what's called **Risk Shift**. It is a known and studied social aspect of risk taking which states that a group will make riskier decisions than the individuals that comprise that group. You can see in this narrative the contributor felt uncomfortable with a lot of the excursion but went along because the group was all doing it and there was no organized channel of communication to break this flow of action. The accountability for the risk had 'shifted' to the group in the absence of leadership, hence the term Risk Shift. Put this in your guide tool box, understand it, be able to identify it so you can say something about it, and know it is natural to want to follow the group and to feel pressure to perform like your peers. However, if poor choices are being made, then you must fall back on your own level of comfort. That may mean prioritizing the safety of your guests and taking action that is personally acceptable to you.

It is clear there was some familiarity trap involved and I [author of this analysis] have seen exactly the same scenario played out in the same place. **Familiarity** was the sole driver of the rationale as to why we were doing this. Clearly this won't sit well with a coroner when a berg does collapse, one day when someone is in there.

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There is no indication in the narrative but we might assume at some stage that a lead driver or someone had decided this was an acceptable idea given the circumstances. Be aware of the **Expert Halo heuristic** where someone with expertise (perceived, real or false) may make a decision and others will simply follow without active participation or ability to participate because of environmental conditions or the perception that this person 'knows' what is going on. It is similar to Risk Shift but to an individual instead of a group. One way to avoid this is to build into your expedition team culture an agreement to discuss with your fellow guides or zodiac drivers to come up with a shared and accepted understanding of what the purpose of the excursion is. Had the drivers got together on the water and had a quick chat some of these concerns that the driver was internalizing may have come out then with acknowledgment of 'transition'. In this case, moving from open water to a confined space with increased risk exposure. This transition might have been a good place to pause, regroup, and check quickly to see that the shared plan is still agreed and has anything changed.

Regardless of how these particular situation turned out, the hope would be that there was an effective review of the excursion after the fact, examining concepts and decisions (not personalities) so that the expedition team might learn from what happened and be better as a team next time. Safety or risk management depends upon the **ability** to be safe (training/education), the **opportunity** to be safe (technology), and most importantly the **desire** to be safe (motivation). A key part of our job as professional guides is to make sure we have the knowledge, tools and support to be the best we can.

Thankfully, the incident described above was just a near-miss, and we can all learn something from it.

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# Crevasse Incident at Danco Island.

This iteration of Guano Happens is a story that might be more common than we realize.

*I was with a large group on a walk to the top of Danco Island (editors note – this guide had a formal qualification as a mountain leader and had been in charge of this hike multiple times before). Conditions were fine and clear and quite warm. There were other staff on the hike but they were spread out on the ascent. Some of the guests had seen bum-slide trails on the lower slopes and were asking about sliding down the slope. I said we would get to the top first and see how conditions were when we got back down.*

*Guests had been coming and going from the summit with other staff stationed at various positions and some descending helping those less able. All people had received a warning about staying in the summit area when they first arrived. A number of guests were still sitting around on the summit and taking pictures etc and had been there for some time. I wandered a short distance to look down the descent to see how things were going.*

*There was shouting from the summit and I rushed back and people were yelling that someone had fallen in a crevasse. It turns out while I was away and facing away, a gentleman had seen the sliding trails far below and thought the slope looked good from the summit down to them so started off down. The man bum-slid about 60metres from the summit (never fast or out of control people confirmed) and fell into a crevasse. The person was unhurt and standing on a soft snow ledge with their head sticking out of the crevasse. They couldn't get enough purchase on the uphill side wall to get out themselves (the downhill side would have been easier but I would have to have left the group on the summit to find a route to safety. I couldn't tell if this was a snow bridge or the base but decided it was safe for me to help. I kicked out a solid foot placement and used a sling I was carrying as a hand line (I had a throw-bag as well.) I helped the guest out and onto the slope. I did a quick informal survey and found they had a sore bum from hitting a harder block of snow and that was all. We walked back to the summit.*

*I gathered the people remaining and talked through what had happened and warned them again about only going where allowed and that any small incident could impact the trip for the whole vessel. Some people thought the whole thing was hilarious, some were freaked out. Word got around the ship but the EL managed it by revisiting the incident and providing information about what happened and how it related to everyone on board – this was really positive and gave people a lot to think about.*

*We reviewed it as an expedition team and learnt what we could from it. I outlined what I thought had gone wrong and that was: I hadn't done a specific 'do-not-move' disclosure to the remaining people on the summit before leaving them alone, I could have used my throw bag (as I have done before) to mark a limit of movement allowed in the area and I thought if I had kept another staff member on top I would have had more freedom to move around and see how others were doing. On top of this I just didn't think it would ever happen! Lesson learned – never assume!*

## Causal Factors and Incident Review

*PTGA note: there is a bergschrund type crevasse ringing the summit of Danco Island on all aspects except the northern hike approach. We don't have clear, useable data on its depth apart from the fact that the Danco summit snow dome is not particularly thick. Any planned excursions into this terrain need a suitably qualified guide (and equipment) capable of judging crevasse hazard and performing an extraction if required.*

Without much more detail it seems the guide had a good summation of the causal factors that led to the incident. It's worth mentioning that the guide's preparedness in terms of possessing slings and a throw bag were key to a quick and uneventful solve for extracting the client.

The fact that the guide left the summit without very clearly and specifically instructing the clients regarding expectations (in this case, to NOT go somewhere) was one of the key contributing factors. Effective communication is probably more important than using markers to physically create a boundary, but the two together would have been considered sound practise.

It's worth considering that the Familiarity trap was in play here as the guide had been here many times before and disclosed that they just never thought

someone would take-off like that. It is worth stating time and time again – people can do the weirdest things and constant vigilance or mass control systems are critical skills in this kind of tourism. It's possible the guide was overtasked and perhaps they didn't have sufficient staff supporting their role, but I don't feel we have enough information to make that judgment in full.

It is very positive that the EL got out in front of the issue and dealt with it before it became something it wasn't, and the team discussion and accurate reflection is a very positive forum to deal with it and move on.