

Mintcake



January 2003

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Editor's Comments

Well, the New Year is now safely about us and things continue to be quiet, certainly in the south of the county. Even Langdale have had few major callouts but Keswick seems to be where it's all happening and they continue to have jobs at the rate they were getting them at the end of last year.

Congratulations to our own Dell Boy on gaining the highest mark in the recent MRC first aid exam!! (See John Hall's comments later in this issue).

This month sees an increase in the number of technical articles but all are items where either new guidelines have been issued or clarification of a particular subject has been sought. Our technical contributors all strive to keep their articles inside one A4 page. This is bound to exert constraints on what they would sometimes like to say. If anyone needs any further information on any of the subjects discussed in this issue, please contact the Team member who's name appears at the end of the relevant article.

Rob

Exercise Report

The exercise held at base on Wednesday 15th January was on defib training and assessment run by Eddie Harrison. As far as I am aware it was a first, in that the initial presentation made by Eddie and Winch was done with the aid of Power Point. The second part of the exercise was in practical training i.e. use of the training defibs and resusci Annie. Finally the last part of the exercise was individual assessment in the use of ADE. Overall the evening was very successful, generally everyone appeared to find the use of Power Point beneficial. It held interest, preparation was done in advance so that everything made sense and flowed easily. A further advantage was to be able to mix the use of slides diagrams & text. I personally think that this tech-

nology is the way forward for future exercises and presentations of all kinds. On the practical part of the evening some questions were raised on the recognised procedures. This has now been investigated and Eddie is going to publish the answers as supplied to us by the Resuscitation Council in this or a future edition of the newsletter.

Another positive note to the ex is that everybody fared very well in their personal assessment. Thanks to everyone involved in the ex - both helpers and attendees!

Steve Kelley (Deputy Team Leader)

The resuscitation article mentioned by Steve appears later in this edition - Ed

Tay River Journey

After weeks of crisp, burning-bright September weather, we arrived at the start of the River Tay as it leaves the Loch, to grey clouds and drizzle.



The river was painfully low with little rain for weeks. The ancient river-highway imperceptibly moved and changed; new shoals and banks were visible, sometimes not, and we often dragged or walked our canoes to channels of deeper water. Five hours we paddled, cold-camped, and head-down-journeyed on, river water muttering as we passed.

It was cold and wet, wearily wet and cold, wind blustery, moving the high-sided open canoes off-course. An eerie silence: a wind-in-the-trees, paddle-blades-cutting-the-water silence. Ahead, a salmon, disturbed by our alien passage silvered up from the deepness, and falling-back, thwacked the water, and then another. The sounds were rifle-shot angry and we felt intrusive, not belonging in this environment, late-comers, off-comers and not welcome.

The ancient highway up which generations of salmon had journeyed, drawn back to lay their eggs and perish, was too low for their progress. The dark rain slanted down to meet the curve and coils of the water. Trapped in the dark-deep eddying pools, dorsals cutting and arching the black surface, the combined heartbeats of frustrated ancient forces of fish and river, beat up through the bottom of the open canoe. Laboriously a Heron clambered away into the grey, rain-filled sky and settled solitarily down again to continue its vigil.

The deep river ran on. A flash of kingfisher fire through the gloom, and we too continued our separate journey.

Ray Green Kendal MRT January 2003

Dates For The Diary

Tuesday 18th February

Unfortunately Doug Scott's travel arrangements have been altered and he can no longer give the talk on 18th February. He has arranged for a friend Dr Jim Fotheringham to give a talk in his place. Jim Fotheringham is a dentist from Brampton; he is a friend of Dougs and Chris Bonnington and has climbed with both. His talk is entitled 'Big Mountains, Little Men' All other details as before. Tickets should be available from next week. From me and Kendal Tourist Information Office.

Kendal Town Hall 7.30 p.m. Tickets £6.50

Wednesday 19th February

Training - Round Robin

Team Winter Training - Scotland

Friday 28th February 2003



This year, in the Ben Nevis area, based at the Alte Cruinichidh bunk house at Roy Bridge.

Accommodation has been arranged from Thursday evening (27th Feb) until Saturday evening (1st March)

Those wanting to come along, add your names to the list in base.

(No complaints please, if the bunk-house spelling is wrong. I couldn't even begin to check it. I suggest that Team members traveling up, get a grid from Andy Bev, then you don't need to ask the locals and thus look a complete Sassenach pillock. Ed)

Wednesday February 26th

Equipment and Medical

Wednesday March 19th

Training - Search Skills

Wednesday March 26th

Equipment and Medical

Sunday March 29th/30th

Training - Overnight Mosdale Cottage

Wednesday ? April

Training - Downed Aircraft RAF

Sunday 27th April

Training - 1st Aid Scenarios

Wednesday April 30th

Equipment and Medical

Wednesday May 21st

Training - Rope Skills Refresher

Sunday May 25th

Training - Humphrey Head with Coast Guard

Wednesday May 28th

Equipment and Medical

Wednesday June 18th

Training - BaseOps / Cas site control

Wednesday June 25th

Equipment and Medical

Sunday June 29th

Training - Buckbarrow LWR

Wednesday July 16th

Training - Base Ops / Cas control

Sunday July 30th

Training - Cautley

Wednesday July 30th

Equipment and Medical

Callouts



After a very quiet start to 2003 year the team attended two call-outs on Sunday 26 January.

Call-out 1

The team headed for Hampsfell near Cartmel in response to a report of an elderly, slightly confused walker sitting in the Hospice and a subsequent call to the police by the wife of a 73-year-old diabetic who was overdue from a walk on Hampsfell. The occupants of Mobile 1 were first on the scene and headed for the Hospice on a mild evening, with occasional banks of mist blowing over the top. Calls were heard, and trainee search dog Kess, who was accompanying the group, went on 100 m ahead and gratifyingly did what she has been trained to do, i.e. she located the casualty and barked. The casualty had earlier started to walk off but had cramp in a leg and sensibly decided to stay put in the shelter of the Hospice. After ensuring that the casualty's blood sugar level was adequate and that he had suffered no other ill-effects, the team walked him off to the waiting vehicles where he was met by his wife.

Call-out 2

We then drove straight to Chapel House Wood, south of Gummers Howe, to search for a despondent man who had told police by phone that he had taken an overdose after a domestic incident. Duddon & Furness team were already deploying as we arrived. Line searches on difficult forest terrain in the area triangulated by a mobile phone company failed to find any sign of the man, and the team was stood down at about 11pm just as two search dogs from Langdale & Ambleside team were going into action. No news of the missing person was known at the time of going to press.

Les Telford (Kendal MRT/SARDA)

General Team News & Comment

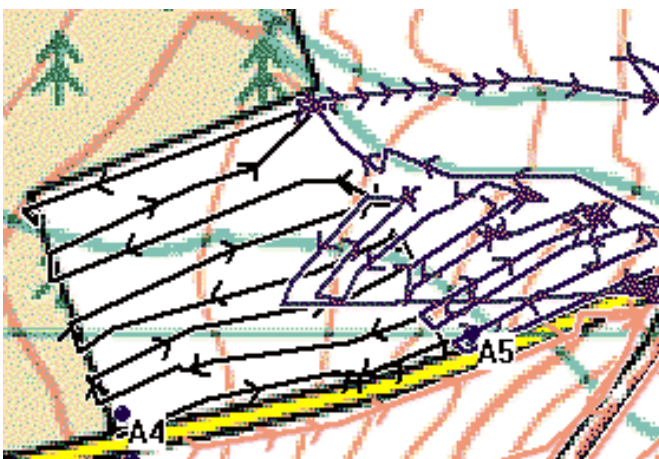
Dent Search

At the beginning of this month, a number of Team members attended a talk, at base, given by the PC's John Ellis and Martin Grime, of S. Yorkshire police. Those who were on the search carried out by Kendal and numerous other Teams, for a murder victim believed to have been buried in the Dent area, will remember these two officers as the cadaver dog handlers who eventually discovered the victim's remains in a densely wooded area close to Dent station. John works a Border Collie called Frankie and Martin, a Springer Spaniel called Eddie.

Based mainly around the video of a television documentary on the case, supplemented by police footage of the find area, this was an extremely interesting evening for those attending and went a long way towards shedding light onto the earlier parts of the case where we were not involved. We know *what* we did but now we have a better idea of *why* we did it.

Although our own SARDA dogs were also present on the search, MR dogs are trained more towards live casualties, where these particular police dogs specialise in finding the (often long,) dead.

From our own point of view, this was the first occasion where a heavy reliance was placed upon GPS logging of areas searched and an extensive computerised mapping system was set up, by us, in the Moorcock Inn at Garsdale. All information from the search teams on the hill, was loaded onto disks and transported to the control at Moorcock, here it was entered into the computers so allowing the police to see, at a glance, within a few metres, where the searches had been carried out. Part of the finished result appeared as shown in the diagram below;



This demonstrates the search pattern devised by Sue Brookes and the subsequent down-loads from two of the search party's GPS receivers. Specialist operators, Karl Hopwood from Langdale MRT and Paul Horder (*and Katherine!*) from Keswick volunteered their time over the entire weekend, to keep the system running and the job was a major success both for the police and for the mountain and cave rescue teams who took part. Well done all.

Rob Brookes, (Radio officer)

Medical Equipment Working Group

Naloxone



The naloxone (narcan) is now in the Medisacs. There is none in the Doctor's sack.

Naloxone is the antidote for opiate overdose.

Opiate (e.g. morphine or cyclimorph) overdose causes respiratory depression which may proceed to respiratory arrest. Because the morphine and cyclimorph are now kept in the Medisac and none is in the Doctor's sack, it is logical to have the antidote in the Medisac.

In a case of opiate overdose:

- 1). **Support of the patient's airway and administration of oxygen is indicated. Bag and mask** will probably be required to give **artificial respiration**, because the patient's own efforts of breathing are likely to be inadequate.
- 2). Continually monitor the patient's respiratory rate and oxygen saturation (pulse oximeter).
- 3). Naloxone is indicated to reverse the effects of the opiate. The preferred route of administration is intravenously (IV), as this will act the quickest. The MRC first aid qualification alone does not permit a Team member to give drugs IV. The British National Formulary (which is a main reference book for drug information used by doctors) states that when the Intravenous route is not feasible, naloxone can be given subcutaneously or intramuscularly (IM). The dose is the same as for the intravenous route, but the onset of action is slower.

Dave Allan, the former MRC Medical Officer (Dave has recently resigned and John Ellerton now holds the position) advised me today that in a case of opiate overdose **and if no one present is qualified to give naloxone IV, we should:**

- 1). **Support the patient's airway and administer oxygen using bag and mask.**
- 2). **Continually monitor the respiratory rate and oxygen saturation (pulse oximeter).**
- 3). **Phone a Doctor (e.g. Accident and Emergency) to ask advise on whether to administer naloxone IM.**

Naloxone can cause nausea and vomiting, tachycardia (rapid heart rate) and fibrillation. Serious adverse cardiovascular effects have occurred when administered to patient's receiving cardiotoxic drugs.

The recommended initial dose is 0.8 to 2mg.

Naloxone is short acting and so repeat doses are necessary at intervals of 2 to 3 minutes to a maximum of 10mg if respiratory function does not improve.

We currently carry only 0.8g (two ampoules containing 400mcg in each ampoule).

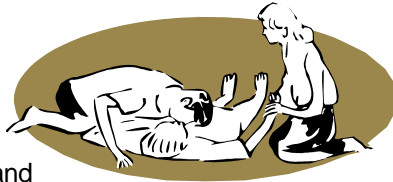
You will be reassured to learn Dave Allan said that in the history of mountain rescue no cases of opiate overdose have been reported to the MRC as a result of opiates administered by MR persons. We could of course be called out to rescue someone who had overdosed recreationally.

John C. Hall (Medical Equipment Officer).



Congratulations to our Team Leader Andy Dell for (not surprisingly!!) renewing his MRC 1st aid qualification. As many of you know the course is consuming in time and effort, and Andy attended last year's course in Kendal but was in hospital at the time of the exam. So he put twice the amount time and effort.

Resuscitation



There was some debate during the last exercise about when to go for help and the checking of pulse during dealing with resuscitation. The following guidelines from the Resuscitation Council is reproduced below and should answer all your queries, A copy of the full guidelines is available at base, please photocopy if required.

1. **Ensure safety of rescuer and victim**

2. **Check the victim and see if he responds:**

Gently shake his shoulders and ask loudly:
"Are you all right?"

3. **A. If he responds by answering or moving:**

- § Leave him in a position in which you find him (provided he is not in further danger), check his condition and get assistance if needed.
- § Reassess him regularly.

B. If he does not respond:

- § Shout for help
- § Unless you can assess him fully in the position you find him, turn the victim on to his back and then open the airway:
- § Place your hand on his forehead and gently tilt his head back keeping your thumb and index finger free to close his nose if rescue breathing is required
- § Remove any visible obstruction from the victims mouth, including dislodged dentures, but leave well fitting dentures in place
- § With your fingertips under the point of the victim's chin, lift the chin to open the airway.

Try to avoid head tilt if trauma(injury) to the neck is suspected.

4. **Keeping the airway open, look, listen and feel for Breathing (more than an occasional gasp or weak attempts at breathing):**

- § Look for chest movement
- § Listen at the victim's mouth for breath sounds
- § Feel for air on your cheek

Look, listen and feel for no more than **10 seconds** to determine if the victim is breathing normally.

5. **A. If he is breathing normally:**

- § Turn him into recovery position
- § Send or go for help
- § Check for continued breathing

B. If he is *not breathing* or is only making occasional gasps or weak attempts at breathing:

- § Send someone for help or, **if you are on your own, leave the victim and go for help**; return and start rescue breathing as below
- § Turn the victim onto his back if he is not already in that position
- § Give **2 slow, effective** rescue breaths, each of which makes the chest rise and fall:
- § Ensure head tilt and chin lift
- § Pinch the soft part of his nose closed with the index finger and thumb of your hand on his forehead
- § Open his mouth a little, but maintain chin lift
- § Take a deep breath to fill your lungs with oxygen, and place your lips around his mouth, making sure that you have a good seal
- § Blow steadily into his mouth whilst watching his chest; take about 2 seconds to make his chest rise as in normal breathing
- § Maintaining head tilt and chin lift, take your mouth away from the victim and watch for his chest to fall as air comes out
- § Take another breath and repeat the sequence as above to give 2 effective rescue breaths in all

If you have difficulty achieving an effective breath:

- § Recheck the victim's mouth and remove any obstruction
- § Recheck that there is adequate head tilt and chin lift
- § Make up to 5 attempts in all to achieve 2 effective breaths
- § Even if unsuccessful, move on to assessment of the circulation.

6 **Assess the victim for signs of circulation:**

- § Look, listen and feel for normal breathing, coughing or movement by the victim
- § **Only if you have been trained to do so, check the carotid pulse**
- § **Take no more than 10 seconds to do this**

7 **A If you are confident that you have detected signs of a circulation:**

- § Continue rescue breathing until the victim starts breathing on his own
- § About every 10 breaths (or about every minute) recheck for signs of a circulation; take no more than 10 seconds each time
- § If the victim starts to breath normally on his own but remains unconscious, turn him into the recovery position. Be ready to turn him on his back and restart rescue breathing if he stops breathing

B If there are no signs of a circulation, or you are at all unsure, start chest compressions:

- § With your hand that is nearest the victims feet, locate the lower half of the sternum (breastbone):
- § Using your index and middle fingers, identify the lower rib edge nearest to you. Keeping your fingers together, slide them upwards to the point where the ribs join the sternum. With your middle finger on this point, place your index finger on the sternum itself

- § Slide the heel of your other hand down the sternum until it reaches you index finger; this should be the middle of the lower half of the sternum.
- § Place the heel of the other hand on top of the first
- § Extend or interlock the fingers of both hands and lift them to ensure that pressure is not applied over the victim's ribs. Do not apply any pressure over the upper abdomen or bottom tip of sternum
- § Position yourself vertically above the victim's chest and, with you arms straight, press down on the sternum to depress it between 4-5cms
- § Release all the pressure without losing contact between the hand and sternum, then repeat at a rate of about 100 times a minute (a little less than 2 compressions a second); it may be helpful to count aloud. Compression and release should be equal amount of time.

Combine rescue breathing and chest compression:

- § After 15 compressions tilt the head, lift the chin, and give 2 effective breaths
- § Return your hands without delay to the correct position on the sternum and give 15 further compressions, continuing compressions and breaths in a ratio of **15:2**
- § Only stop to recheck for signs of a circulation if the victim makes a movement or takes a spontaneous breath; otherwise resuscitation should not be interrupted

8 Continue resuscitation until:

- § Qualified help arrives and takes over;
- § The victim shows signs of life;
- § You become exhausted

Eddie Harrison (Deputy Team Leader)

Base & Vehicles

**Wednesday 8 January 7 pm.
Main Committee Meeting.**



Firstly may I thank all who attended ,and for those who could not make it for what ever reason , you missed the opportunity to express your views on an evening of lively debate. Although many other worthy matters were discussed ,my main reason for being there was to present to our main committee the alternative solutions to the on going emotive issue of M2. To recap on the requirements and specification of M2. (from leader group 28/08/02)

Troop carrier (10 including driver and personal kit)

No stretcher carrying needed.

4x4 desirable but not essential.

To be driver friendly.

Size, to fit garage, narrow lanes and gates.

Running cost and insurance to be reasonable.

Maximum cost £30/40,000.

Summary of Mobile 2 presentation.

Due to conflicting opinions recently given on the condition of M2 , I thought I should get an independent appraisal from a V.W trained technician who is known to me and who's ability and opinion I respect. His findings make brief but interesting reading(a copy of which can be found on base notice board). Based on these findings I have been authorised to correct these faults with immediate effect so as to keep M2 safe ,reliable and in a state of readiness as what ever course is taken will take time.

When bought M2 expected life span was 15 years (2005).

Report shows vehicle sound.

M2 to be fully repaired and maintained. (Repairs completed)

M2 will, with care last at least another 2-3 years.

Should we keep M2. ????. Surely the answer must be "YES".

OPTION.....

RENUALT KANGOO (TREKKA)

- 5 seater.
- 1.9 diesel engine
- Hydraulic 4 WD.
- Sliding side doors.Tail gate
- Front air bags.
- Disc brakes .Power steering.
- 200mm (8 inch) ground clearance.
- Good carrying capacity, overhead lockers and shelf.
- Fold down rear seats.

OPTION.....

TOYOTA HIACE AUTOBUS .

- 12 seater.
- 2.4 diesel engine.
- Two wheel drive.
- One sliding side door, rear tailgate.
- Three point seat belts on all seats.
- Vinyl seat covers, at no cost, option.
- Wooden floor with non slip vinyl covering.
- 190mm (7.5 inch) ground clearance.
- Driver's air bag.
- Power steering.

OPTIONS.

- A. To keep M2 as is. (until when?)**
- B. M2 plus Kangoo . Total 15 seats**
- C. Two Ka ngoo. Total 10 seats**
- D. Toyota Hiace . Total 12 seats**

COSTS.

- A. Zero cost.**
- B. £11,000 plus conversion**
- C. £22,000 ———:———**
- D. £21,000 ———:———**

Option **B** and **C** may be subject to a lease hire agreement with a local company covering leasing costs.

The Debate, there appeared to be two to three different schools of thought and fur and feather was flying in many directions in what must be said was a good natured debate , questions from the floor ranged from ,”if M2 is in good condition then why replace? Kangoo to small with an image problem, Toyota HiAce not 4w.d . size, capacity, cost all these and the many more issues were fully debated and addressed by all who felt strongly about the subject.

To draw the session to a conclusion Three proposal's came from the floor from our very own astute team leader which were all approved.

1. To keep M2 for three more years, by which time it "will be replaced".
2. Investigate lease on Kangoo of three years duration if running costs about £1500 per year.
3. Fund raising to start immediately.

TO CLOSE.....

B & V hope that tonight you will have seen an alternative to ,or an addition to our fleet. The vehicle supplied tonight by D.S.G of Kendal certainly caused much interest .

2003 our anniversary year, an ideal time to make everybody aware of the large amounts of monies required for this and other projects by both news letter and the fund raising group.

Finally ,over the past twelve months or so a lot of time and effort and ,on occasions emotions and feelings vented and this only goes to show how passionately you care for the project and “The Team” (not a bad thing).

B & V thank every body involved and can only ask that when all the information is available to the committee ,collectively will instruct B & V promptly as to our next move ,also keeping mind how time has a habit of flying by.

John Everett (Vehicle Officer)

Communications

Team Computer.....

Some of you may have already noticed that the Team computer has recently undergone a number of upgrades. In addition to some low level alterations, there are a number of new devices on the system. These will, hopefully, improve it's ability to handle what might lie ahead once things like PowerPoint training presentations begin to see the light of day. As it stands, the machine has been upgraded as follows;

The addition of a CD burner replacing the existing CD ROM. This will allow Team members needing files that are bigger than the 1.4 MB limit of a floppy disk, to copy them from the machine. It will also allow PowerPoint presentations to be created on the base computer and stored on CD for use elsewhere.

An increase in the system RAM

The addition of a second hard drive which, for the time being, will run in tandem with the existing drive, until all software applications required by the Team have been tested against the new operating system installed on the new drive. Until this has been done, the computer will dual-boot into either Windows Millennium or Windows XP Professional. Users just need to select which one they want from the start-up menu.

Dudley will slowly be installing our current software onto the new drive so, at any time, you may or may not find your programs are available under Windows XP. Eventually, they all will be and we will then abandon Millennium if all is well.

We ask you to bear with us during this change-over.

Please bring any problems you encounter to Dudley's attention.

E-mails

If any Team member uses the Team's email address in order to have emails sent to them, could they make sure that their own address, if you have one, is in the Outlook Express address book on the base computer, so that we can forward emails on to you when they're received. Otherwise they just sit there.

New Radios

The production, by LDSAMRA, of a business plan, which hopes to convince Cumbria Police to continue to support us as they have done for many years, with the supply of MR radio equipment, is on-going and much work has been done by Gordon Starkie and his LDSAMRA Comms Sub Committee on which our Team is represented along with all others. Comments on the progress of this matter will appear under the communications heading as and when we have any news or developments.

Duddon & Furness MRT

As you will all be aware, the Millom and Furness's teams have now merged to form "Duddon and Furness Mountain Rescue Team". The new team has taken on Milloms old callsign "**MIKE**" and I am (for my sins) the radio officer. The callsign FURNESS is now no more.

This is how we propose to name the various stations:

MIKE BROUGHTON BASE (Formally MIKE FOXFIELD BASE)

This is our main base and is located between Broughton and Foxfield.

MIKE ULVERSTON BASE (Formally FURNESS BASE)

Located at Ulverston Police Station.

MIKE NEWFIELD BASE (Formally MIKE PARISH ROOMS)

Located at the parishrooms, Seathwaite up the Duddon valley.

The mobiles will be named:

MIKE MOBILE ONE (As before)

MIKE MOBILE TWO (Was FURNESS MOBILE 1)

MIKE MOBILE THREE (Was FURNESS MOBILE 2)

MIKE MOBILE FOUR (Was MIKE MOBILE 2)

Dave Binks, (Radio Officer, Duddon & Furness MRT)

For Sale

Salomon Super Mountain 8
Boots.

Worn 4 times only

Size 42 (8)

A bargain @ £50

Tel Eddie 01539 724410

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or

Editor's pigeon hole in base

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