MOUNTAIN RESCUE 2008

David Allan, FRCS

David Allan was appointed general surgeon to Furness General Hospital in 1975 and almost immediately was drawn into the Duddon and Furness Mountain Rescue Team. In subsequent years, he became medical officer to the national body and then the chairman. Since retirement in 2004, involvement with mountain rescue has continued, but sailing now rivals climbing for leisure time.

This year, 2008, is the 75th anniversary of mountain and cave rescue in the British Isles. There have been enormous changes in both the incidents dealt with and the way in which rescues are carried out; but one thing remains unchanged, the service is entirely voluntary at all levels from the team members on the hill to those responsible for administration of the service at regional and national level. There is also no statutory or official funding of mountain and cave rescue. All the income arises from fund raising efforts by the people within the ranks.

HISTORY

During the first 25 years, mountain rescue was largely dealing with accidents to seasoned mountaineers. The number of incidents was small and a strong ethos of self-sufficiency and self-help was present amongst the hill-going bodies. Almost all the call outs at this time were to people who had sustained injury and were unable to get off the hill without help. The rescue teams comprised other mountaineers supplemented by local farmers, forestry workers, police officers etc.

During the 1950s, more organisation of teams with enough members to be self-sufficient in carrying out rescues emerged. The first recorded teams were in Conistone and Keswick and others steadily followed to the current level of 52 teams in England and Wales. At the same time, mountain rescue in Scotland became a separate organisation, as did cave rescue. There are now 26 teams in Scotland and some

20 cave rescue teams across the whole country. A number of teams have a dual role dealing with incidents above and below ground.

The following 25 years witnessed an enormous leap in the numbers going into the hills. A change of emphasis occurred with the fell walkers rapidly outnumbering the traditional all-round mountaineers and climbers. The production of guide books, such as the Wainwright series, encouraged more people to explore the fells. During the same period, enthusiasm for outdoor education blossomed. In addition to the Duke of Edinburgh expeditions there were numerous

MOUNTAIN RESCUE ORGANISATION

The coordination of search and rescue in the UK is undertaken by the police under common law, with the oath of a constable, to protect life and property. Incidents on sea cliffs are coordinated by HM Coastguard, although in some areas joint arrangements are in place.

Mountain Rescue Teams are members of regional organisations. These regional organisations have a role coordinating operations involving multiple teams and other organisations such as the police, the RAF and Royal Navy helicopters. They also organise a considerable amount of training on a regional basis.

The regional organisations are all members of the Mountain Rescue Council of England and Wales (the MRC), the national coordinating body for mountain rescue in England and Wales (in Scotland this role is played by the Mountain Rescue Committee of Scotland). Other members of the MRC include: the British Cave Rescue Council, the Search and Rescue Dog Associations, the Association of Chief Police Officers, HM Coastguard, RAF Search and Rescue, Ofcom, the Fire Service Inspectorate, The Sports Council and the Association of Chief Ambulance Officers.

The MRC is a voluntary body and a registered charity. Its main function is to liaise on behalf of the teams with the various government departments in the running of mountain and cave rescue and to arrange such items as the provision of communications, stretchers and first-aid equipment.

other bodies taking young people into the mountains. All of this led to a marked increase in the number of incidents. The pattern also changed with exhaustion/hypothermia, lost and overdue becoming as common as incidents involving injury.

Teams responded with better organisation, more team members and more intensive training schedules. Communications also improved during this period allowing much better use of manpower on the hill. Search and rescue dogs established their value during this period and gradually reached the point where dogs became available to all teams across the country.

During the last 25 years, more wide-reaching changes have occurred. The numbers visiting the hills has continued to rise but there has also been a departure from the traditional walking and climbing. Mountain biking, para-gliding and other new activities have presented different challenges to mountain rescue. At the same time, the average age of hill walkers has significantly increased. No longer do people hang up their boots at retirement age and casualties well into their eighties are regularly encountered. Alongside a more liberal approach to illness and activity at all ages this has meant that medical problems in the mountains rank highly with trauma. Indeed, during some years the commonest cause of death on the Lake District hills has been myocardial infarction.

Mountain rescue teams have always made their services available to local communities, for example carrying out animal rescues. The skills and training have, however, now been recognised as a valuable resource in much wider terms. Their search skills have been put to good effect to look for people, particularly children and the elderly, away from the mountains. Teams have been deployed to work alongside other emergency services in numerous major incidents. The recent floods up and down the country and locally the Grayrigg train incident are some examples. Whilst the service is more than willing to be involved with these episodes it does place more pressure on resources, time and training.

Not everybody is as well equipped as this group for the conditions

Photo: Hugh Stewart

MOUNTAIN RESCUE NOW

The primacy for search and rescue on land rests with the police and, therefore, mountain rescue works essentially on their behalf. The degree of actual police involvement is variable. Often with an accident on the hills they simply notify a rescue team, or teams, and await the outcome. There are a number of occasions when teams turn out to support the

ambulance service, usually at times of severe weather interference with the transport of patients.

The police give some support to the running of the service in contributing to the insurance of team members and assisting with the provision of radio links. There is an allowance from the Department of Health (DoH) toward the provision of consumable first-aid materials and after that everything has to be raised by public donation.

Most teams have some 30 to 40 active members who are available for the call-out list. There are usually a number of supporting members, often those who have come off the call-out list because of reduced fitness etc, who carry out vital roles operating base radios during incidents and taking responsibility for many of the routine tasks around the base and vehicles.

Mountain rescue does not teach mountaineering or hill-going skills. The time and resources are not available to do this. There is, therefore, a requirement that those joining teams will be active walkers and climbers who have already gained experience of mountains in all weathers.

People are enrolled as probationary members for a period averaging 12 months. During this time they are expected to attend a prescribed number of practice sessions and demonstrate an ability to fit in with the team. Thereafter, training log books are the norm and these must be kept up to date to retain a place on the call-out list.

In the past, most teams had waiting lists of would-be members but for many teams this has changed. In some areas there are serious concerns about recruitment and there is a notable and steady rise in the average age of the team. There are probably several reasons for this. Mountain rescue is not unique, as the Royal National Lifeboat Institution is actually advertising for crew in some areas of the country, a situation unthought of in the past. Across the country as a whole the ethos of voluntary work seems to have been replaced by a 'get lost' attitude, especially when the voluntary commitment is of an open-ended nature. It is common to encounter astonishment amongst those rescued that the rescuers are unpaid volunteers. Employers have a less liberal approach to people disappearing from work, or indeed turning up tired after a long night on the fells. In some areas there are actually fewer people living and working in the vicinity of the hills.

At present, these concerns have not compromised the ability to respond to incidents. In many instances teams now recruit the assistance of other teams to supplement numbers at busy periods. Each team has a nominal area for which it is responsible but boundary regions are shared and teams practice and work together. Local knowledge is very important, particularly when incidents involve parties who are lost or overdue.

Training now covers a wide range of skills. In addition to the traditional areas of search patterns, navigation in adverse conditions, first aid, crag and steep ground rescue, and radio procedure there are now additional topics such as global positioning system (GPS) mapping, water rescue and blue light driver training to be mastered.

Mountain rescue has always had the support of RAF helicopters and more recently air ambulances in most regions. Learning to work with both of these is a regular feature on the training calendar.

Nick Owen, Team Leader of the Langdale/Ambleside Mountain Rescue Team, is looking for volunteers to strengthen mountain rescue teams in the Lake District

Super fit, more medical qualifications than you can point a stick at and all the time in the world? Nice thought, but not real life!

The reality of mountain rescue is that we are a disparate bunch of volunteers, made up from various sectors of the community, who enjoy helping those in trouble in the hills. The one thing we share is dedication. We have a few medically qualified people amongst us, but most of us are just dedicated amateurs. We use the word amateur in its true sense, ie, derived from love and passion.

So can you help? Team members are available and willing. Training covers all aspects of rescue work from the medical stuff, driving, on and off road, technical aspects of rope access, navigation etc. Team members are encouraged to study for and pass the Mountain Rescue casualty care exam every three years. There are also a number of members who are approved to response drive on blue lights, plus swiftwater rescue technicians and those experienced in rope access. We also train in bereavement, legal aspects, crime scene preservation, triage and a myriad of other things.

Training covers all aspects of rescue work

You can help us if you have some time to spare. You actually don't need many medical qualifications, but if you have some, we'll pick your brains dry, especially if you are in the field of trauma or A&E. You need to be reasonably

fit, but not necessarily youthful! Team members range from mid 20s to well beyond retirement age. You also need to be able to look after yourself on the far side of Crinkle Crag, in the dark, in the snow, on the wildest night you can imagine! So not the world's greatest rock climber, or Himalayan mountaineer, but just a competent all-year-round hill-goer.

Prompt immobilisation and evacuation made the difference between saving and losing a leg. One year and many operations later, he is continuing to make progress.

X-ray courtesy of Cumberland Infirmary, Carlisle

In addition, you need to be able to get on with the aforementioned disparate bunch! Not too weird! The other essential is that you live within our area of operation.

The Langdale/Ambleside team attends around 100 rescues a year. Many involve no serious injury. An increasing number of people are just getting lost and need talking down, or retrieving. They went up a mountain that they never had any realistic chance of getting back down again. So patience is useful! Occasionally we encounter serious injuries. In 2007, we attended a depressed skull fracture, fitting, two pelvic fractures, a near-leg amputation and the Grayrigg train crash.

There are ten mountain rescue teams in the Lake District, plus the Search and Rescue Dogs Association and the Cumbria Ore Mines Rescue Unit, covering the National Park and beyond. If we're not the nearest, then there will be another nearby.

For more information on the team's work, go to www.lamrt.org.uk, or contact admin@lamrt.org.uk

For other teams' contact details go to www.mountain.rescue.org.uk/links/teamlinks.php

See you in the hills.

Most teams have purpose-built or adapted bases along with at least a couple of customised vehicles, and most of the work that these generate is dealt with in-house, an area where supporting members are invaluable. It is also very useful for teams to have the services of a supporting cast to deal with issues such as accounting, insurance, VAT and fund raising.

The frequency of call outs for each team is very different, largely related to the number of people roaming through their patch. The busiest teams have been responding to in excess of 100 incidents over 12 months, with the less busy dealing with 20-30 incidents. The time demanded by an incident is also very variable. Recovering a casualty with a straightforward problem from a known location can be accomplished within a couple of hours, although there is always the cleaning, drying and repacking of kit to follow. Searching for missing persons with scanty information may take several hours, occasionally running into days.

Mobile phones have had a significant impact. There are numerous stories of misuse with people asking for bus times and availability of accommodation but largely they are now used sensibly and have speeded up the time for a rescue and sometimes enabled lost parties to be 'talked off the hill'. There is a current trend for over reliance on mobile phones, with some parties taking a phone as a replacement for a map and compass, but hopefully this will become an exceptional event.

Mountain rescue has always had an ethos of refraining from censure and criticism. After all, most accidents are simply the result of bad luck and most rescuers have been there or close at some time. We would, therefore, not welcome any moves to legislate or restrict the freedom of people in the hills.

MEDICAL MATTERS

Medical care of the injured has been a major part of mountain rescue from the outset. Doctors from many disciplines have been closely involved throughout its history. The chair of the national body has exclusively been held by Manchester-trained doctors: three surgeons and a general practitioner.

In 1948, Wilson Hey, surgeon at Manchester Royal Infirmary, persuaded the government to allow team members to carry and administer morphine. This decision followed a court action in which Hey faced the possibility of a sojourn in prison. Remarkably, the Scottish Mountaineering Club offered to pay his legal expenses!

As teams developed they sought the support and help of local doctors. In the early years, there was pressure to take the doctor on the hill because first-aid training of team members was sketchy. When the doctor had some climbing experience this was successful, but in other instances less so and there were interesting episodes when the rescue required getting the doctor off the mountain as well as the casualty.

First-aid training was initially provided by outside bodies such as the Red Cross. In 1979, it was apparent that we needed training customised to working in difficult conditions and adverse weather, often for long periods. The injuries sustained in mountaineering accidents are not unique but leaving the field of play is exceedingly difficult. Mountain rescue, therefore, established its own casualty care syllabus,

training schedule and system of examinations. The process has been honed and improved over the years and now provides a robust means of ensuring that casualties can expect a high standard of care measured against a national yardstick. Team members are required to retake the examination every three years and to complete a regular number of training sessions in the intervening period.

... casualties can expect a high standard of care measured against a national yardstick

Maintaining this system places heavy demands on the medical and paramedical people in the service. We have been fortunate to date in securing the help of people who, if not on an active call-out list, do have experience and understanding of the environment in which we work. There are, however, clear worries in some districts that this support is looking less certain. We have also been fortunate to have specialist medical opinion available within the ranks and this is also looking vulnerable.

In the early years, it was sufficient for team members to be well versed in the management of fractures and hypothermia. Now, there is a likelihood that they will encounter illness as well as trauma and thus the training has undergone extension. There are greater challenges in teaching the management of conditions such as asthma and epilepsy than that of handling a fracture of the leg. A drug list beyond the provision of analgesia has been developed and the means to treat asthma, epilepsy, diabetes and, of course, myocardial infarction are now provided. In 2005, the DoH granted team members a 'Casualty Care Certificate' to administer these drugs in their own right.

The production of a text 'Casualty Care in Mountain Rescue', now in its second edition, has been a great step forward. This book has been edited by Dr John Ellerton, team doctor with Patterdale Mountain Rescue Team and general

... away from the comforts of a hospital or surgery

practitioner in Penrith, with contributions from other doctors in mountain rescue.

The number of call outs when a doctor is present is very variable. Some teams reach 60% but the figure is much lower for most and in some cases it does not happen at all. This illustrates the importance of securing good training for the lay team members. Better communications do, however, mean that it is sometimes possible for a doctor in the valley or at work to be consulted in the event of a difficult situation on the hill.

The changes in the pattern of incidents dealt with do suggest that the medical challenges are likely to increase.

The ideal mountain rescue doctor would not only qualify as a team member in respect of hill-going skills but would also have some experience of dealing with casualties away from the comforts of a hospital or surgery. We recognise, however, that there is a very important role for supporting medical staff in respect of teaching, undertaking examinations and offering advice to teams.

This is but a brief synopsis of mountain rescue as it stands. More information can be gained from the further reading section and if you have any interest in becoming involved

your local team will welcome a call.

FURTHER READING

Mountain and Cave Rescue Handbook. The Mountain Rescue Council; 2006

Ellerton J. Casualty Care in Mountain Rescue. 2nd Ed. Mountain Rescue Council; 2006

Sharp R, Whiteside J. Mountain Rescue. Kirkby Stephen, Cumbria: Hayloft Publishing; 2005

And for a light-hearted review:

Whiteside J, Allan D. So you want to join Mountain Rescue? Kirkby Stephen, Cumbria: Hayloft Publishing; 2006

There is also a National Supporters' Group for Mountain Rescue England and Wales, called BaseCamp. See the Mountain Rescue website for details:

www.mountain.rescue.org.uk/basecamp/

All photographs by Nick Owen unless otherwise attributed.

Annual Scientific Meeting

Thursday 15th and Friday 16th May, 2008

Centre For Life
Times Square, Newcastle upon Tyne
NE1 4EP

'THE OLDER SURGICAL PATIENT: NEW CHALLENGES'

Topics for discussion include:

Incapacity dilemmas in the elderly

Early recovery after surgery (ERAS) programme: achievable in the elderly?

Proactive care of older people undergoing surgery ('POPS')

The National Hip Fracture Audit

Ethical case scenarios with audience participation

Free paper and poster presentations

This 1.5 days multidisciplinary meeting is designed for all healthcare professionals involved in the perioperative care of the older surgical patient. Trainees presenting papers are eligible for the AAA Trainee Prize.

Dateline for free paper and poster submission: 15th April 2008

Registration: £150 (AAA member)
£170 (non-members but includes one year membership)
£80 (nurses and allied healthcare professionals)

For further details and application forms
visit: www.aaa-online.org.uk or email secretary@aaa-online.org.uk