C.C.P.C. Newsletter73. Spring 2002

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THANKS!!

Thanks must go out to Jim Shallcross, Jenny Drake and Matt for helping out with the DCRO Xmas pub collection. Assisted by Tim Webber  (SUSS) they collected over £200! The highlight of the evening was when Tim flagged down a police car whereupon the occupants, rather than arrest him put money in the tin!! The total for the evening came to £510.19p-not bad profit for a pub-crawl!!

CONGRATULATIONS!!

By the time you read this Kev n Bron should be well and truly hitched and those who flew out to NZ for the ceremony will be back in good old Blighty!! It seems a lifetime ago when Darren and I took Kev and this innocent looking Kiwi on a tour of the Alps!! Although my memory is a bit vague I think it all started at that party where I taught Bron how to jive (and she taught Darren, Kev and I how to drink!!-after giving us a thrashing on the Brighthorn earlier in the day!) but that's another story!!

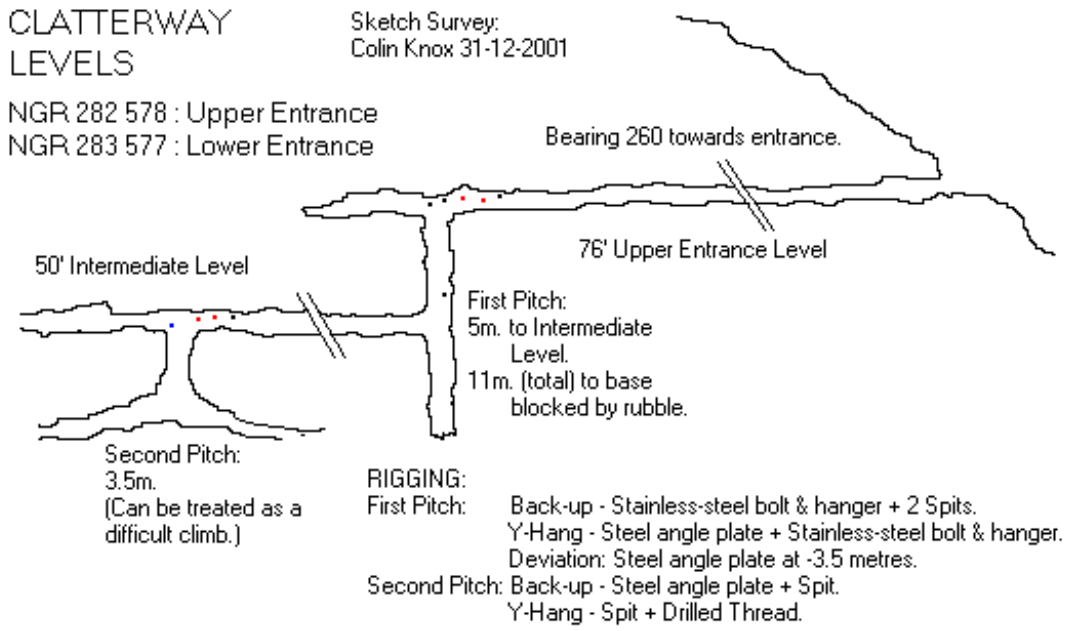
Thursday, 27th December 2001: Clatterway Levels,

Paul Nixon and I wanted something casual to fill in a snatched caving day between Christmas and New Year, so we decided to have a look at the rigging in Clatterway, prior to the planned Club trip (aimed at beginners) on Saturday, 12th January 2002.

Parking is easy; just up the hill from the Pig O' Lead pub (now closed) from the Via Gellia towards Bonsall village, there is a large lorry parking area with bottle-bank containers. Once changed, it is a short walk back down the road to the cluster of cottages around the tiny green on the left. Take the narrow footpath between the cottages, which leads uphill, until just beyond the last cottage on the left a pair of old gateposts marks the edge of the woodland. Sixty paces beyond, a very faint 'path' on the left leaves the main path and leads back uphill across the slope. Once clear of a clump of Holly trees, (near a small rock outcrop, with a short trial level, on the slope above and right) the 'path' drops steeply back towards a large tree immediately above one of the cottages. The tree marks the Upper Entrance to Clatterway Levels.

The entrance gives access to a horizontal passage which leads easily to the top of the first pitch after 76 feet (my tape is pre-metric), and continues a short distance beyond. The original explorers from Masson C.G. placed two spits at the pitch, but these are now supplemented by an initial stainless-steel bolt and hanger which can be used as a back-up with one or both spits, and another st.-steel bolt and

hanger with a st.-steel bolt and steel angle-plate hanger to give a good Y-hang over the pitch. A st.-steel bolt and steel angle-plate hanger can be used for a deviation 3.5 metres down. After 5 metres it is easy to step into the Intermediate Level, although the shaft continues down to rubble at 11 metres depth.
The Intermediate Level leads to the second pitch after 50 feet.



The second pitch is described in 'Caves of The Peak District' (page 113) as a free-climbable shaft, however it is awkward to descend safely without a rope, and desperate to get back up, so it seems sensible to treat it as a pitch and rig it properly. The passage walls in this area are highly mineralised and consequently provide few decent locations for anchors. There are two old Spits here, but these are now supplemented with an initial stainless-steel bolt with a steel angle-plate hanger which can be used with the first Spit as a back-up, then a newly drilled thread in the left wall which provides an acceptable Y-hang when used with the second Spit. The pitch is only 3.5 metres deep but a 10 metre rope would allow plenty of extra for rigging. Using a 20 metre rope on the First Pitch would allow a full descent before prussiking back up to the Intermediate Level.
For a more complete description of this little system, including the through trip, see CCPC Newsletter No.68, December 2000, pages 13 & 14.
Steve Knox.

<u>And now-a snippet from Tom Bailey's diary.</u>

It was a cold morning on 28th. October 1999 when John Shepherd and I met Ralph in the lay by at Perryfoot. John and I changed into our new Dragon caving suits, this was the first time I had worn a suit actually my size and complete with wet suit socks, wellies and gloves I seemed much more snug and comfortable than I had been on previous trips. Ralph helped us (myself in particular) sort out and put on our SRT equipment, very kindly loaned by DCRO. We tested our lights and sorted out a bag each and off we went.
Ralph pointed out marker pointers along the way, I asked what time he expected us to be back out, one o'clock he said unless something has gone wrong. We arrived at the entrance which was much more sheltered than the fields on the walk up. The entrance complete with its stream didn't seem as wet as the last time we came down, may be less rain or am I getting used to this wet environment bit.

We put our hoods up, I like these Dragon suites more all the time, Ralph pointed out the slippery bits and we entered without getting wet, Ralph leading the way.Both John and I were impressed by the level of comfort and warmth afforded by fitting suites and I remarked to John that I would feel better

when we came to go on a rescue with DCRO as my suite now looked a little used and would not proclaim " Hi new boy over here" to everyone on the scene, despite my actions and questions probably making it abundantly clear.

Since my last trip underground in Giants with Nichola, I have had long conversations with Dr Andrew Newton, Dr John Frankland and Dr Steve Raey. This trip I aimed to use their years of experience, advice, tips and observations to relook at the underground environment with a view to reassessing our medical goals aims and techniques, and to look at the places and positions the patient may finish up in and we could be looking at doing for them.

On this trip I had a small bag, with Nichola I had had a larger one and I found just having it made life so much harder and cumbersome than life had been on the training trips and sessions with DCRO, much harder work but valuable experience. One thing, the very first thing John Frankland had said was " keep your bag with you otherwise some fast young speed snake will have gone off with it when you want it" Well, I am sure he is right, but I think I will give it to some slightly older slow worm who will be happy to stay with me, should someone be kind enough and available. The speed snake can ferry the extra gear down from the surface that we find we need later on.

Having gloves made life much easier previously I have been aware of my hands being wet cold and feeling gritty sore and rough. I was surprised at how good the grip was that they provided on wet rock while climbing and how good the wellies gripped and it was ages before that cold-water feeling arrived at my feet but they soon warmed up and despite the soggy squelch were warm and fine.

We arrived at the first pitch and Ralph rigged it up for us, we had said that we would like to practice SRT in particular on this trip so he took a route with an extra abseil for us. He checked over our gear and attachment to the rope and over we went. John soon joined me at the bottom and we had a commiserating crutch rubbing session, each to his own I hasten to add, we are each of the opinion that the sooner our own harnesses arrive from Hitch & Hike the better, we promptly rearranged our tackle and tightened up the thigh straps on the right side.

We moved on taking the higher level route, the one used by our DCRO guides on my first trip in P8, after they had directed us into the waist high freezing water, then walking by over our heads saying "eh up what are you doing down there". This way was much better. Thanks Ralph.

We descended the 2 further pitches in much more comfort and went on to the sump. We opened my buttie box and assembled my wife's camera and took a few photos, ate one of the 4 for a £1 Lion bars I had bought the previous day. Learning point I will put them in a box next time and isn't chocolate hard underground.

We set off back and John prussicked up the first pitch with me tensioning the rope, I followed and immediately had trouble, it was several months since my training, so I sat back and thought about and soon realised that I had to pull the rope through the croll, I also experimented with putting both feet in to the loop and holding the rope between my feet this worked ok then again I stopped, I heard John shout down you have to let the rope fall back between lifts, pillock of course you do, went much better then but it seemed to have taken me ages to get up and I was surprised how out of practice I had become and how tiring it had been. I felt really glad that we have ordered some gear for the station to set up a practice pitch and a set of SRT equipment so everyone can keep the skills up.

I was a little concerned at how tired I felt with 2 more pitches to go, but on the next 2 my technique was much better and used hardly any energy at all and in no time we were back out on top.

Back at the cars Ralph was changed in no time and after our thanks for a really great morning that we had both got a lot out of was off on his way, the time 12.55

Tom Bailey 28-10-99

It now seems strange that since then John and I have done over 40 trips, many on our own including Oxlow and Maskhill, and others such as Nettle with Ralph, Matt, Dave Webb and other members from Crewe. Our gear has expanded exponentially over Christmas's and Birthdays but our greatest thanks go to all those who have helped us along with encouragement, advice, loaned equipment and most of all their time.

Thanks, **Tom Bailey,** John Shepherd and the other members of the EMASCRSU.

Stanley Moor. Buxton.

Been in Axe Hole lately? It's definitely worth a look. Plunge Hole could perhaps do with a little "chemical enlargement." Perseverance entrance is in need of repair.

Hypothermia in Cavers.

There is great potential for hypothermia in all UK caves with an ambient temperature of around 8 degrees C or less and the likely hood of the caver being wet. Even in modern protective clothing hypothermia must be planned for, looked for and treated correctly.

I am not advocating turning all cold, wet and demoralised cavers into stretcher cases. There are times when a brew, a Mars bar and 'encouragement' from some new faces will still do the job very well. But what must be recognised is that there are times when this can be a killer. This article is aimed at explaining why this can be, what to do about hypothermia in general and when it is necessary to treat someone as a stretcher case.

Hypothermia has three categories:-

Mild 35 to 32 oC Patient will be cold and shivering, arm and legs will be cold to the touch.

Moderate 32 to 26 oC Shivering has stopped.

Severe Below 26 oC Unconscious likely hood of cardiac arrest when moved.

So how do we sort out which is which and what do we do about it.

Firstly we do all we can as cavers to stop it happening in our party, then to stop it getting worse or at least to slow down its progression as much as possible.

Moderate hypothermia and beyond is the area that is of most concern to us.

Preventative measures.

When a caver appears different from their normal self provide warm drink, and food. Insulate and allow to rest.

As soon as possible after the caver becomes immobile:-

Insulate them from the ground, tackle bag, rope etc a lot of heat is sucked away by cold damp rock.

If appropriate move out of any draught.

Cover the patient, put in their survival bag

Wear appropriate clothing for caving especially important for first time cavers, leaders must ensure the trip is appropriate for the clothing and experience.

Finally there are respiratory heat losses. But as we can't stop them breathing there is nothing we can do about this in the early stages.

So assuming we do not have a thermometer how do we recognise moderate hypothermia?

The patient complains of feeling cold.

Shivers to start with, then it stops as they warm or as hypothermia progresses.

Drunken staggering movements. (*Not to be confused with walk to cave early on Sunday mornings.)*

Slurred speech Blank stare 'the lights are on but there is no one in'

Difficulty in concentrating, has problems with simple tasks, apathetic don't care attitude.

Tired, rests then tired again very quickly.

Anyone who has some of the above must stop and be insulated.

Anyone with a pulse below 65 and a respiratory rate below 15 and stiff limbs is in real trouble

Must stop, must insulate, must feed, if possible give warm sweet drinks, encourage and reassure, send for help.

As rescuers we should be able to measure core temperature. The traditional methods of a thermometer under the tongue or stuck in the arm pit are not appropriate when dealing with hypothermia, these areas are now colder than the blood in the body core. The blood vessels to the arm and legs are shut down to keep the core, the heart lungs and brain warm and the mouth has cold air passing through it. There is the good old rectal method, no I don't think so. Firstly it involves too much exposure of the patient and it's not for the squeamish and where do you put that thermometer after the first reading.

So it looks like tympanic membrane monitoring is the best bet for rescuers. Its quick, clean, simple and involves no exposure of the patient. A small infra red probe takes a reading off the eardrum and the blood here is the same blood that passes through the hypothalamus in the brain where temperature is controlled. So this is the method I intend to use in cave rescue. They are approx. fifty pounds and require some protection underground but this is not really a problem.

What happens to hypothermic patients?

As the temperature falls the patient shivers to create heat about 55kcal/hr, this is not very efficient. But this uses up glucose and the patient can then become hypoglycemic and dehydrated. Therefore food and drink are most important. Because shivering has stopped does not mean necessarily the patient is getting better i.e. warmer. How is the patient do they appear better? or has the temperature fallen to low to shiver or the glucose run out**.** Shivering stops around 30 oC. Cardiac arrest is likely at 28oC especially if the patient is bumped about.

Rescuers now face some major problems. So what are they and what can we do about them.

We have a cool central core and a load of cold blood in the arms and legs. Two things mix these and make the hypothermia worse. The first is movement under the patients own steam, i.e. pushing a moderately hypothermic patient on, the muscles work forcing cold blood out into the heart brain and lungs. The second is actually rewarming the patient. As the core warms up the blood supply to the arm and legs gets reopened and the core temperature can fall this is sometimes called the 'after drop'. The limbs having been shut down also contain acid products (similar to the crush injury patient) these combined with vasodilation caused by rewarming and dehydration can lead to sudden shock and possible death.

To combat this they need warm fluids intravenously (37oC) So we need to be able to transport warm fluids underground and keep them warm while infusing. (This may not be a difficult as it sounds but we need to do some trials to see)

Hypothermic patients are very susceptible to changes in position. Ideally they should be transported flat. To put them in a vertical position is likely to cause a fall in blood pressure to the brain and the brain becomes short of oxygen causing loss of consciousness and fitting.

Of course they are going to have to go vertical or die of old age while we blast Nettle wide enough to take a stretcher sideways. So prior to starting evacuation and hauling they need to be as warm as possible, well hydrated and well oxygenated, and the Little dragon used as soon as possible on all hypothermic patients to combat respiratory heat losses. The haul itself should be as slick and quick as possible.

Summary

The main aim from the outset is to stop further heat loss.
If they are not loosing heat they are getting warmer.
Secondary aim.
Use bivvi tent
Monitor vital signs including temperature.
No exertion if temp 32oC or less.
Caution if temp 35oC or less.
Use Little Dragon and oxygen. Especially on pitches.
Warm fluids to drink feed patient.

Warm fluids IV. (NO COLD FLUIDS IV)
Blood sugar keep within normal limits (food or IV glucose)
External heat pads to trunk abdomen and groin (caution localised burning)
Keep flat as possible.
Be as gentle as possible.
Bradycardia is to be expected with hypothermia i.e. very slow heart rate. Check pulse for a full minute before deciding there isn't one. DO NOT START CPR UNTIL IT CAN BE CONTINUED usually once out of the cave.
Remember rescuers are not immune from hypothermia.
Don't have nightmares, not all cavers are this hypothermic, look at all those who have been rescued before ok. But I hope this helps with some idea of the possibilities where they are pretty cold in real terms.
Tom Bailey.

The ladder on Robs Dig.

We've talked about this for ages! Thanks to Matt (who made ten trips through the Windpipe in a single day!) the ladder has been removed. Its likely location is The Bung in Speedwell-see below.

Speedwell

The trip was planned to measure up the ladder on The Bung. The day started badly when Paul H and Tom were unable to make it at the last minute. Things deteriorated when we found one of the bolts we inserted at The Bottomless Pit was loose (despite not being used!) followed by Matt snapping the key in the lock BEFORE we opened the gate. This meant we had to use the by-pass which is shown as blocked on the survey. It starts off like Colostomy crawl before becoming more like the Giants Windpipe! I don't recommend its use on a regular basis. We eventually arrived at The Whirlpool before doubling back to collect the bags left at the gate.
The Bung was WET but eventually Matt decided to go down and measure the ladder (5m) and deliver two bags of rope to the Bottom of Block Hall for a visit planned on 16th (see later) John Shep and I waited and shivered-anything was better than The Bung! Reunited we set off for JH and FSE (Matt managed to open the lock –with difficulty, without breaking the key! John hadn't been in Speedwell before so, following a discussion, my plans to visit Western Highway were abandoned (partly due to being forced to cave one-handed) and a visit to Salmons Chamber was decided on. Very impressive and well worth a visit. Not wishing to "miss the boat "and being pushed for time we decided to return –we still had the delights of the gate by-pass to look forward to!! Take my word for it –its worse coming out and the canal leading to Speedwell was squalid underfoot, making progress hard work.
A quick dash back to The Potteries, a shower-just in time to make the DCRO Training Session!
Ralph J.

Lower Long Churn mini-epic!

OK so the forecast **was** for heavy rain and the ground **was** waterlogged but having abandoned thoughts of a Diccan-LC exchange we assumed we would be OK in LLC. Gareth set off to rig LLC and the bottom of Alum while Matt and I set off with Lucy (a caver from S Wales now living in Sheffield and looking for a club to join) and Giles, a relative beginner from Manchester. Things went well as far as The Bridge when it was obvious that things were getting "aquatic". Gareth couldn't resist a quick trip down as far as the last pitch returning with some comments indicating that it was WET! We had rigged to "old" Dolly Tubs pitch with the "dry" traverse just for a change and although there was a little spray on the way down we found a fully-fledged waterfall on the way out-bordering on the dangerous. Giles and Lucy climbed the pitch while I did my best to hold Lucy out of the water, which was rising fast. (Giles was in a wet suit with oversuit)

Two lads from BPC came up after me held out of the water by Matt, they quickly packed their gear and set off out. Matt arrived and set off for the surface while I waited for Gareth to climb and derig

the pitch. The waterspout from the roof above the pitch (normally a trickle) was impressive. Gareth and I set off out deciding to take the short route via Diccan-no chance. As we arrived at the main Diccan streamway we saw a group rigging with rope-it was Matt. The two BPC members had abandoned thoughts of an exit and were awaiting the CRO! After a short discussion Matt set of for the surface rigging traverse lines as he went supported by Gareth. Being less heroic (a slip would have meant curtains I'm sure) I slit my bivvy bag, prepared a suitable shelter for myself, Lucy, Giles and the two BPC lads and settled down to wait. (I did take the opportunity to cuddle up to Lucy who is far prettier than Giles!)

Eventually Matt reappeared pronouncing the route passable with care. We modified the traverse line to make life easier (i.e. safer)-the worst step was the worst as Giles found out-luckily being saved by his cow's tails and Matt. Giles, Matt and the two from BPC set off while Matt and I re rigged the traverse so that we could recover the rope-I must confess I considered abandoning it! From then on things improved, we missed out the next stretch of streamway by taking a by-pass and Gareth was waiting near the entrance where the streamway had been rigged with a rope. An interesting day out that proved to me that even a benign little amble such as LLC, a popular haunt for novice parties, can become lethal at times. A couple more inches could have resulted in a very long stay, fortunately we had some survival equipment but I must emphasise again the need for everyone to carry a basic first aid kit, some spare food (which you only eat in emergency) and a bivvy bag. Dry gloves and a balaclava make life moderately pleasant. It weighs nowt and could save your life.

Ralph J.

Serious Injury Underground.

The likelihood of a caver suffering serious injury underground is actually quite small. The numbers seriously hurt compared to the projected number of caving trips taken annually reveals caving to be a very safe activity. However the potential for serious injury is obvious with loose rock and the possibility of a fall on a pitch etc.

In the ambulance service a fall of over 6 feet is considered a long fall and is automatically upgraded to a life threat. A fall from a sitting position on a stationary bicycle creates enough force to fracture your scull, so a rock hitting you on the head from the top of a pitch and the distances you can fall show the type of injuries that can be sustained and that you may be faced with sorting out.

From a fall or object impact various things happen to the human body.

Cavitation: - The body changes shape. Imagine a big car wash sponge, with an egg carefully encased in it. Now hit it hard with a baseball bat. The sponge will look ok, but it was crushed flat, stretched, lengthened, widened and the egg destroyed. Bits of shell are now stuck into the sponge and the egg yolk and white are slowly soaking into the inside. But the sponge is back to its normal shape and looking ok, the same thing happens to the human body, and you don't see the damage inside.

Falls cause sudden deceleration trauma just like car crashes and there are two impacts – body hits object (i.e. floor of cave) then the organs inside smash against walls of the body. Even if nothing has dug into the body (cavitation, remember the egg) such as rocks the deceleration can tear arteries in the brain – causing a stroke and brain damage – the aorta can be torn off the heart, the sack containing the heart can rupture, the lungs can be punctured, the liver can be cut in half by the ligament that holds it to the wall of the body and the spleen can burst open. (Hope you have not just had your tea.) Any of these things can cause instant death but not necessarily, in less severe impacts or sometimes in the 'larger' caver or where someone is just plain 'lucky' a vessel may be torn and leaking. The effects may not become apparent for quite some time, especially in a young previously fit person. They can be bleeding steadily internally, the only sign being a gradually rising pulse rate, they will be sat talking probably with some pain saying how lucky they have been to get away with that, then the body will reach a point where its compensatory mechanisms can no longer cope, the blood pressure suddenly falls and the situation has become critical.

Tip: - anyone who has suffered an event that should have damaged them probably has, also when asked how they feel, anyone replying "**I don't know but I don't feel right"** probably has something serious going on.

So how do we assess an injured patient?

Firstly if you didn't see it happen, gather the story of what's happened – were they hit by a rock, how far had it come, did they fall free – was it badly controlled decent, how far was the actual fall – i.e. 1st bolt change at top of pitch etc. Have they been unconscious? – What are they complaining off?

When you arrive at the casualty always consider DANGER then ABCDE always: -

Airway Breathing Circulation Disability Examine

The golden rule – whatever else happens stick to ABCDE.

If the patient is sat up talking then their airway is obviously all right. If the patient is unresponsive then you always start with their airway. – It's no good putting a nice bandage on a wound when no air is getting into the lungs.

So **AIRWAY –** to manage an airway simply pull the head back, chin up is an open airway position. Use the recovery position for all unconscious patients. Use the opportunity to roll them over onto some insulation. Or into a slit open survival bag and then tuck it all well in or tape it well closed, leave the neck open of course.

Breathing – Check for breathing – look for breath. Listen and feel for breathing if there's none, give 10 breaths check for a pulse. If there is a pulse but no breathing give a breath every 4 seconds. (If no pulse see Not Breathing Underground to be written shortly)

Circulation – Check at the wrist for a pulse the normal range is 60 to 80 , if you have just had a fall it will be higher but should settle down. Ideally 90 or less is good. It should settle back to normal limits when they calm down. A pulse at the wrist indicates a good blood pressure. If no wrist pulse can be felt try the inside surface of the elbow. (Hard in a caving suit so try the neck (at the side of the windpipe) if you get one at the neck shows a BP of 60. Pulse at the elbow shows BP of 70, pulse at the wrist shows BP of 80.)

High pulse rate and no wrist pulse is a sign of shock, the patient bleeding somewhere, probably internally.

All you can do to help with internal bleeding is raise feet up, head down – keep warm and reassure.

REMEMBER patients have backs as well as fronts, a caving suit is designed to keep water out, similarly it will keep a huge amount of blood in, there could be nothing to see outside the suit but several litres could be draining into their wellies from an unfound external wound.

Disability – AVPU Assesses level of consciousness.

Disability assesses the level of consciousness, We use the pneumonic AVPU (AvePoo) – what do they respond to, A= alert & talking V= voice answers when spoken to, opens their eyes. P= Pain respond when you squeeze finger or pinch the ear etc. U = Unconscious no response to any of the first three.)

Examine: – is look for injuries, its a head to toe systematic survey, its hard examine a caver in a caving suit and full SRT kit. Plus the exposure causes heat loss. So be quick – go over all of outside of suit very firmly look at face while you are feeling look for grimaces and listen for groans indicating pain. Feel for discontinuity of bones, bumps and lumps compare one inside with the other keep reassuring the patient. Look at anywhere there is pain see or feel the skin for bleeding or any unusual lumps.

If you find a wound to the chest that makes a sucking noise as the patient breathes this is serious and needs to be sealed. Cover the wound first with you or a helpers hand, then with a piece of plastic, use the bag the first aid kit is in, or cut a bit off the survival bag and tape or bandage it in place. You can cover it with a dressing as well if it helps.

Keep patient as warm as possible. Insulate, maintain the airway, more trauma patients die from closed airways and hence asphyxia than the injuries they have received. If their level of consciousness is reduced keep the head tipped back remember chin on chest is an airway shut position.

Bleeding: - Raise a bleeding arm or leg above the level of heart , lift it up prop on a rock and apply direct pressure to the site of bleeding . A pad from your first aid kit or a piece of under suit cut from a

person going out of the cave make good dressings for wounds, you need all yours to keep warm whilst waiting. (Plus who wants to cut up their own suit)
An increased pulse rate indicates that there is blood loss from somewhere, keep checking the pulse rate. 100 or more means they could be bleeding 60 or less they could be suffering from a head injury or it could be hypothermia. (see Hypothermia in Cavers. TBailey) You can't do much about internal bleeding, just keep insulated, keep as still as possible and elevate the legs to encourage blood from legs into body core, the brain, heart, lungs and liver need the blood not the toes.
Revisit ABCD regularly to determine changes in the patient's condition.
Broken bones:- very painful , if patient has pain they should have whatever pain killers are available provided they do not have an allergy to any of the constituent's, all cavers should carry their own propriety painkillers – i.e. Aspirin, paracetamol, etc.
A triangular bandage can be used as an arm sling as can tape slings and a tackle bag. One leg can be bandaged to the other as a splint, or the patient may well just get himself or herself into a relatively comfortable position and then want fractures to be left alone and this should be respected, as long as there is a pulse below the site of the break and the patient is not in a dangerous position.
Where there is bone sticking through the skin, cover it with a dressing, it can be helpful to cut a slit in a dressing and put it round the wound where the bone sticks through and then bandage it all up, always put something over the end of the bone though as this is a prime route for infection to get into the body.
You have to adopt a survival attitude, you have to put away your feelings of fear, guilt and denial and keep everything simple, your equipment is very limited the conditions are against you. If you keep an airway open, dress any wounds you have found, talk to the patient and get them insulated you have done well.

Summary

Danger to you – look, listen. Think then act.
Move in necessary –
Airway. Breathing. Circulation.
Disability Examine.
Deal with each in turn, sort each out before moving on to the next.
Cover any sucking chest wound.
Unconscious roll into recovery position.
Insulate –
Consider limb elevation if no fractures,
Reassure –
Revisit ABCDE –
Food & Drink
Write down your findings

First Aid Kit Contents

Plasters
Dressing Pad Large
Dressing Pad Small
Crepe bandage
Triangular Bandage
Pain Killers
Electrical Tape / Gaffer Tape
……
Other useful items you can use

Rope
Tape Slings
Knife
Tackle bag
Survival bag
Plastic bag the first aid kit is in

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China Syndrome.

By the time you read this Matt (lucky sod) will be "somewhere" in China. He is flying out just after Easter to join an expedition already in the field. He hopes to be there for around three months, as long as the authorities don't read his visa too closely, since no camping is allowed anywhere in China and visas are not granted for such frivolous activities as caving! I'm just hoping they require a video cameraman for a couple of weeks! I have informed him that we require regular reports!!

And now-what you've all been waiting for –MEETS.

April 6th. Little Hull Pot. An interesting (i.e. often wet!) SRT trip (Yorks) Not far from Sell Gill which is probably more suitable for novices.

April 14th. Devonshire. Straight forward horizontal system in Matlock Bath. Ideal for absolute beginners.

April 21st. Coniston Copper Mines. This fairly easy trip might well be combined with a walking weekend.

April 27th. DCRO AGM Bull I' th' Thorn 1430.

April 28th. Oxlow. If the ladder still there (unlikely)it needs bringing out. Otherwise a pleasant SRT trip even if it is an old lead mine!

May 11th. Craig y ffynnon. S.Wales. Just about possible in a day. Some might prefer to make a weekend of it. Horizontal in the main. Well decorated.

May 18th. Long Rake, Bradwell Moor. Possibly the best SRT trip in Derbyshire!

May 21st. DCRO Training 1930 The Railway, Buxton (but check nearer the time)

May 26th. Magnetometer. A hardish trip in Yorkshire.

June 1/2/3. Bank Holiday trip to Mendip. Excellent mainly horizontal caving. (and drinking!)

June 8th. If there is enough interest this will be the CCPC Xmas Do! Sat will be spent in Hillocks pumping out the sump/digging through to Cascade Cavern (while Matt's away!) Sat evening –a meal (Bulls Head?) camping in Monyash.

June 9th. Holme Bank Chert Mine (or Hillocks)

June 16th. Lancaster –Top Sink exchange. A classic Yorks trip with something for everyone.

June 22nd. Rowter Mine. Straightforward 60+m SRT trip. Volunteers will also be needed to help at Chelmorton Carnival (DCRO)

June 29th.Black Shiver. Deep/hard/wet Yorks SRT trip. If you've not done it –it's a must! Beginners could do Tatham Wife. (easy SRT trip-a classic)

July 7th. Odin. Muddy Derbyshire SRT trip. (beginners)

July 13th. DCRO 50th. Details later.

July20/21st. Nent Head Mines. Well worth a visit.

July 28th. Rumbling Hole. Excellent Yorks SRT trip. Short Drop Gavel could provide an alternative. for beginners, as could Lost Johns.

August 4th. DCRO Duck Race in Castleton. Help will be required. You can always go caving after and/or before!

As you can see our meets sec. has been really busy, if you're not getting your share you certainly can't blame John. So far this year meets have been really well attended. In addition to the above the CDCG (Coffin Dodgers Caving Group) are usually out once or twice a week (daytime) and often there is something happening on a Wed evening. Ring Ralph for the former, John for the latter.