THE RURAL HITCH

A Quarterly Publication of the Lakes Region Mutual Fire Aid Association

Andover Fire Battles 1st Alarm House Fire

See Page 20

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From the Chief...

Jonathan M. Goldman, CPE

The first quarter of 2024 by all accounts seemed slower, but our team was as busy as ever. The beginning of the year starts some administrative work that needs to be done each year such as compiling the annual report, preparing for the yearly audit, and other once-per-year tasks that need to be done.

The team worked to continue to refine the Tyler CAD program. As we have become more used to it, we are able to continue to manage department-run cards and make changes as needed. LRMFA hosted an APCO International Public Safety Telecommunicator class that began on January 10th. This is a 40-hour program that was conducted each Wednesday over five weeks. The program was taught by Chief Jon Goldman, with Lt. Erin Hannafin assisting. Fifteen Police and Fire Dispatchers from all over NH participated as well as three of our own staff. The program had attendees from as close as LRMFA, to as far as Plaistow NH.

In February, we welcomed Dispatcher Dumka back full-time, and he picked right up where he left off. We are excited to have him back, and although he came back as a Dispatcher, he was previously a Lieutenant and can work as a Reserve Officer which helps to give us some flexibility when covering open Lieutenants shifts.

The Training Division took delivery of its new FIT Testing machine, and several of our staff were trained on its use. LRMFA has always been able to perform FIT Testing for our communities, but this new machine is smaller, self-contained, and does not need a laptop or printer for it to work. It was purchased with unexpended funds from the joint LRMFA/City of Franklin AFG grant.

We continue to work with the NH Department of Safety, and Division of Emergency Services and Communications on the architecture and design of the new facility.

The Rural Hitch

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Lakes Region Mutual Fire Aid Association

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Franklin Fire Department and Mutual Aid Rescue 3 from Icy River

On March 1 at approximately 4:07 PM NH9-1-1 and Lakes Region Mutual Fire Aid began fielding calls reporting three people in the water with an overturned canoe in the Winnipesaukee River behind Franklin City Hall. The callers were reporting someone screaming for help. Franklin Police arrived on the scene first located two children in the water, and reported their location to Franklin PD Dispatch. The officer humped into the cold water to rescue the two children. Fire companies arrived on the scene and assisted with removing the remaining victim from the water. A 1st alarm water rescue response had been requested with two additional ambulances and an air medical helicopter from DHART. The request automatically brings additional personnel and resources to the scene to aid in the water rescue efforts. Ultimately four patients were transported to Concord Hospital, Franklin. Three were in stable condition and one was in critical condition.

The children were wearing life jackets in a canoe with their father when the churning water from the outflow of the Eagle Creek Penstock pulled the canoe under and flipped it over. While the victims were still in the water an employee from Eagle Creek was driving by and saw the incident unfolding. He was able to shut down the water system which drastically improved the water flow conditions, helping rescuers rescue each of the victims. Franklin Fire Department Captain Jenkins stated “Thanks to the teamwork of all responding companies, the police officer who jumped in to stabilize the children until help arrived, and the fact the children were wearing PFDs, we were able to effect a rescue and hope for a positive outcome for all involved.” Departments assisting on the scene were Tilton-Northfield Fire and EMS, Sanbornton Fire, Belmont Fire, Tilton Police Department, Northfield Police Department, Merrimack County Sheriffs Office, NH State Police, NH Fish and Game, NH Marine Patrol, and Penacook Rescue Squad covered the Franklin Station with an ambulance.

Dr. Rix's EMS Pearl

Gunshot Wounds Mega Pearl – March 7, 2024

Gunshot Wounds (GSWs) are a huge topic to discuss but I felt like it was a worthy topic to tackle as I have seen quite a few in my earlier emergency medicine days in Chicago where penetrating violence is the daily norm, especially in the summer. My record while on the trauma service at Christ Memorial Hospital was 32 GSW victims over one warm 2007 Memorial Day weekend. That was a crazy number at the time but it's an even crazier statistic in retrospect given I haven't seen a GSW due to violence in years. Luckily in NH we are spared the intense gang violence some areas of the country are used to and overall we are much more likely to take care of the blunt trauma patient then someone with a penetrating injury. That being said, gun violence doesn't seem to be going away anytime soon and it's important to be prepared as GSWs are often accompanied by a high stress environment that can distract from the task at hand.

The Basics:

The size of the bullet is denoted as "caliber", which refers to the diameter of the bullet. A 45 cal bullet is .45 inches in diameter. It may also be described in millimeters, such as a 9mm. Obviously shotgun rounds are different than bullets as they have multiple smaller pellets rather than one larger bullet. Though the caliber of the weapon fired does have some importance when it comes to forensics, don't get too focused on figuring it out it as our goal is to treat the patient not the firearm type.

Rapid Transport:

When approaching the GSW patient, obviously scene safety is a priority. Once that's been checked off your list and your crew is safe, the priority is rapid transport. Though pre-hospital care and skillsets have obviously significantly advanced over the years, data suggest that penetrating trauma victims (blunt too for that matter) are not the patients you should "stay and play" with. Many of heard of the "golden hour" in trauma which is based off of data which shows a significant increase in morbidity and mortality past 60 minutes from the time of injury (penetrating or blunt). Data from the Pennsylvania trauma registry showed that mortality was the same in penetrating trauma patients who were transported by police compared to EMS, and The Eastern Association for the Surgery of Trauma (EAST) also looked at this in 1618 patients and showed there was no mortality difference in police vs ALS transport. The only

difference they did find however was that with police transport the patient got to the hospital in half the time it took for EMS to arrive. Bottom line: Load and go is the name of the game for GSW patients and all but the most immediately necessary life-saving interventions should be saved for the back of the ambulance en route to the hospital.

MARCH and Tourniquets:

Similar to most trauma patients, when initiating resuscitation consider following the MARCH mnemonic rather than traditional ABCs. Massive Hemorrhage, Airway, Respiration, Circulation, Hypothermia/Head injury = MARCH. Obviously direct pressure is your first line of defense against external hemorrhage. Focused pressure will control most heavy bleeders you'll run into. If you are dealing with extremity hemorrhage **that is unresponsive to direct pressure** you must place a tourniquet (TQ).

The following are some pearls to remember when using TQs:

- Always use a commercially available TQ whenever possible.

- Apply the TQ 2-3 inches above the wound, on bare skin, and never directly over the wound or a joint (elbow, wrist, knee, ankle).

- Placing the TQ "high and tight" (as high up on the extremity and as tight as possible) should be avoided unless the source of external bleeding cannot be identified.

- Before tightening the TQ windlass, ensure all slack is removed from the wrap so as to avoid bunching.

- Make sure to clearly record the time the TQ was placed. It is generally accepted that a TQ time of less than 2 hours is safe. Significant complications are almost universal once TQ time gets beyond 3 hours.

IVF:

Newsflash: patients bleed blood, not crystalloid therefore blood is what they need to replace lost volume due to bleeding. Obviously the vast majority of local EMS services in the country are not carrying blood these days so if you have a hypotensive GSW patient you should administer 500 ml to 1L of IV crystalloid (NS or LR). When considering a "goal" BP, the average GSW patient (usually on the younger spectrum of life) that is hypotensive due to suspected bleeding is the poster child for the concept of "permissive hypotension" and your goal should be a systolic BP of 90 (MAP of 50) vs the traditional 120 (MAP of 65). Permissive hypotension is the idea that you allow for a lower BP than is historically considered safe so as to prevent the dilution of clotting factors circulating within the blood with excessive IVF. Minimizing clotting factor dilution increases the likelihood of a clot forming over the wound damaged by the GSW/penetrating injury. Also, by keeping the blood pressure on the lower side, blood loss through any damaged vessels will be lower than if we were to pump the pressure up with crystalloid. This makes sense if you think about a hole in one of the pipes in your house. If you have higher pressure in the pipes you're going to increase the speed of water loss through that hole.

The only caveat to permissive hypotension would be a GSW to the head. This patient population should be resuscitated to a higher BP (130-180) to maintain cerebral perfusion pressure (CPP) as the injured brain does not take kindly to hypotension. The higher level thinker would see fit to administer vasopressors to a patient with an isolated GSW to the head who has a SBP under 120 as an attempt to maintain CPP.

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Airway:

The hypotensive GSW patient with a declining mental status is not the patient you should be rushing to RSI (GSW's to the head not included, see below). Often times the reason for the decline in mental status is because of under-resuscitation and administering RSI meds to these patients can lead to complete hemodynamic collapse. Rapid transport while employing basic airway maneuvers combined with continued resuscitation efforts and working to identify the source of hypotension should be your priority here.

Spinal immobilization?

Nope. Unless of course the patient suffered a significant fall of some sort after being shot, however recommendations (2018 EAST practice guideline) are clear that routine spinal immobilization for GSWs, including to the head or neck, are not necessary.

Exposure:

Super important to fully expose the GSW victim as bullet holes notoriously hide from plain view. Remember the mantra, "armpits, back, butt-cheeks, and sack" as a reminder of where else to look for wounds. I was schooled on this in training when I took care of an awake and alert teenager who came in via private vehicle with a GSW to his head. After he returned from CT scan with what was confirmed to be just a grazing head shot, we realized that we had missed the miniscule .22 cal wound in his right mid axillary region that put a not so miniscule hole in his IVC and he bled out and died shortly after.

EMS Hand-off:

As most of you know, Concord Hospital respects the "EMS time-out" on trauma patients arriving to our ED which calls for room silence to make sure the trauma team hears what EMS has to say about the patient and scene. This should be no more than 30-60 seconds of time with the more critical patients necessitating a shorter time out. In general the EMS report for a GSW patient should include timing of incident, number and location of wounds, blood loss on scene, vital signs, and treatments/interventions.

Injury Specific Treatment Considerations:

GSW to the Head

Obviously the GSW to the head patient often times has a much higher morbidity and mortality compared to other GSW locations on the body. For EMS services with RSI capabilities, unless the wound is superficial, most patients with a GSW to the head will require a definitive airway. The main goal when intubating a patient with a GSW to the head is to prevent a rise in intracranial pressure (ICP) as this is the leading cause of death for this patient population. There is some weak evidence that pre-medicating with high doses of fentanyl (3 mg/kg IV at least 3-5 minutes before the attempt) can help blunt rises in ICP. As far as induction agent choice goes, if the patient is hypertensive already, I would recommend using etomidate over ketamine. Though there is not data to suggest there is a mortality outcome, based on ketamine's pharmacologic properties (catecholamine stimulation), I'm of the opinion that it should

be avoided if there are other options available in the neurologically injured patient who is already hypertensive prior to RSI induction.

Additional maneuvers to combat rises in ICP include keeping the head of the bed elevated to at least 30 degrees, making sure post intubation sedation and analgesia are adequate, and avoiding c-collars. Not only are c-collars unnecessary but they can inhibit venous drainage from the head, leading to increased ICP. In the ED we might consider giving 3% saline or mannitol if there is concern for brainstem herniation through the skull base (often the ultimate cause of death in these patients). What all of these patient's really need however is a CT scan and a neurosurgeon ASAP so minimizing any unnecessary delays to the hospital is huge.

GSWs to the Neck:

I'll never forget what one of my attendings in training said to me when it came to penetrating injuries to the neck. It's complicated and hard to explain but I feel confident you all can handle it. He said, "You know Rob…there's a lot of important shit in the neck…" and I was like, "Whoa"…and he was like… "Yeah". But true to that statement, GSW's to the neck can be very scary injuries because there are indeed a lot of important structures in a very tight space. Typically anything more than a grazing GSW to the neck will require consideration of early airway intervention due to the risk of rapidly progressive edema and subsequent airway compromise. When we are considering whether a penetrating neck injury requires an airway and/or surgical intervention we typically think of what are known as "hard signs" of airway or vascular compromise. These include: AMS or neurologic deficits, respiratory distress, stridor, expanding hematoma, extensive subcutaneous emphysema, or severe anatomical disruption such as tracheal deviation.

Again, c-collars not recommended here either. Get these patients to the hospital fast.

GSWs to Chest, Abdomen, Pelvis:

Obviously a big geographic area encompassing a large spectrum of injuries however the immediate threats to life when there is a GSW to the chest, abdomen or pelvis (C/A/P) are fairly limited: Massive hemorrhage (intrathoracic or intra-abdominal), tension pneumothorax, and cardiac tamponade. Luckily, these 3 entities can usually be quickly discovered with a combination of clinical suspicion, physical exam, and the use of ultrasound should that tool be available to you. I'm not going to cover treatment of a tension pneumothorax in this pearl as I've already written about it a couple of times in the past and I'd be happy to pass on those older pearls if you're interested in a deeper dive on the topic so just let Craig or me know and we can email them to you.

When it comes to penetrating chest trauma, massive hemothorax is going to be more common than in the blunt trauma patient. This means you may have a hypotensive patient who has difficulty breathing and decreased breath sounds on one side and a needle chest decompression is not going to help them. Certainly this would be a patient who you would want to attempt decompression given the clinical findings are the same as you would find in a tension pneumothorax but if you're confident your decompression catheter reached and crossed the inner chest wall, repeat attempts at decompression

GILMANTON WELCOMES 9E3 TO THE FLEET

are probably not warranted as it's likely blood and not air causing the hypotension and decreased breath sounds.

Another important consideration when it comes to GSW's to the C/A/P is that bullets have crazy trajectories that are at times impossible to predict. A GSW wound to the abdomen can cause intrathoracic or cardiac injury and similarly, a GSW to the chest can cause intra-abdominal injury. Think about a person who is falling backwards away from the shooter when he or she is shot multiple times. You can imagine how that bullet can enter the abdomen at an angle and then traverse the diaphragm and cause intrathoracic injury as well. You may be focusing on strictly an intra-abdominal injury pattern when that bullet is actually causing a tension pneumothorax.

Pre-hospitally or without the use of ultrasound it is going to be difficult to accurately diagnose a pericardial effusion (def: blood around the heart within the pericardial sac) causing cardiac tamponade (def: excessive buildup of fluid/blood around the heart to the point it causes cardiac compression and decreased cardiac output leading to shock). Classically the clinical exam for a cardiac tamponade shows "Beck's Triad" or muffled heart sounds, distended neck veins, and hypotension. The reality is it's the rare patient where all 3 of these findings are present and noticeable. Without an ultrasound you should suspect cardiac tamponade in a patient with a GSW to the C/A/P who is tachycardic and has a narrowed pulse pressure. The pulse pressure is the difference between the systolic and the diastolic and should be at least 40. If your GSW patient is tachycardic and has a systolic of 100 and a diastolic of 80, that's too narrow and you should be very worried.

Documentation of Entry and Exit Wounds:

Obviously most GSW victims will have some legal considerations regarding their case therefore documentation is important. Do not document "entry" and "exit" wounds, rather just document "wound" and its location. It has been previously thought that entry wounds were small and circular and exit wounds were larger and irregular however studies have shown this to be unreliable. As noted above, specific determination of entry and exit wounds and bullet trajectory based on physical exam alone is not possible and these findings should not be documented.

I hope you were able to learn something from this GSW mega pearl. Fingers crossed we all only have to continue to deal with the singular sporadic GSW patient that seems to be an inevitable part of life these days and not the dreaded larger multi-casualty event which keeps many of us up at night.

Please feel free to reach out with questions or comments. We love hearing from you.

Rob

rrix@crhc.org

References for data above were from either Emergency Medicine Practice: "An Evidenced-Based Approach to Managing Gunshot Wounds in the Emergency Department" and via UpToDate.

LRMFA Hosts APCO Public Safety Telecommunicator Program

Over four Wednesdays in January and February LRMFA hosted a 40-hour APCO International Basic Public Safety Telecommunicator course (PST1).

The course culminates with coursework, lectures, and a 100-question final exam. These 15 students represent Police and Fire/EMS dispatch centers throughout NH. As an organization, we're proud to continue to develop not only our own staff but public safety dispatchers throughout NH.

Attending agencies were LRMFA, Tilton NH Police Department, Gilford Police Department, Salem Fire Department, Salem NH Police Department, Laconia Police Department, Portsmouth Police Department, Plaistow New Hampshire Police Department, Hampton Fire/Rescue, City of Portsmouth New Hampshire Fire Department, Plaistow Fire Department.

Gilmanton Fire Department Extinguishes 1st Alarm Building Fire

On January 27th Lt. Hannafin and Dispatcher Hanson began receiving 9-1-1 calls at approximately 0920 reporting a building fire in Gilmanton on Province Rd. Simultaneously with the dispatch of the call, Gilmanton Fire Chief Hempel, was driving by the address after a stop at the transfer station, arrived and confirmed smoke coming from the building, and requested a first alarm.

Chief Hempel cleared the building of occupants and when units arrived, they began an aggressive exterior and interior attack confining the fire to the first and second-floor living space. The fire appeared to have started as a chimney fire, extending into the partition and exterior walls. The fire was brought under control within 90 minutes leaving significant damage to the room of origin on the first and second floor and no injuries were reported. Mutual Aid for this incident was Alton Fire Rescue, Barnstead Fire Rescue, Belmont Fire Department, Laconia Fire Department, Loudon Fire Department, New Durham, and Tilton Fire Departments as well as the Gilmanton Police Department.

LRMFA Training Division Receives New FIT Testing Machine

Lakes Region Mutual Fire Aid and its Training and Education Division along with the City of Franklin Fire Department joined forces to apply for and then received a FEMA Federal Emergency Management Agency "Assistance to Firefighters" grant to conduct multiple training and certifications for our member communities. At the conclusion of the grant, not all the monies were spent.

The LRMFA Training and Education Division opted to replace the existing QuantiFit 1 equipment with the latest model, the QuantiFit 2. The new device is completely self-contained, and able to operate independently of a computer, or printer, and provides Quantitative testing of the proper fit of any SCBA mask or respirator. The total cost was a little over $10,000 and will serve our LRMFA member communities for years to come.
On February 20th Fire Tech & Safety delivered the equipment and trained some of our staff and Training and Education Division members to perform the Fit Testing with the new equipment. Contact Deputy Chief Steele if your department needs Fit Testing at fittesting@lrmfa.org

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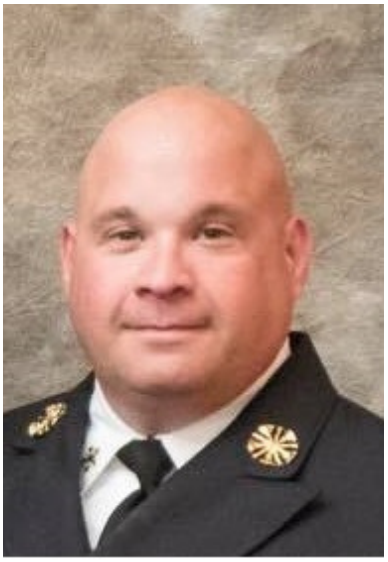

LRMFA
Chief Jonathan Goldman
7 Years

LRMFA
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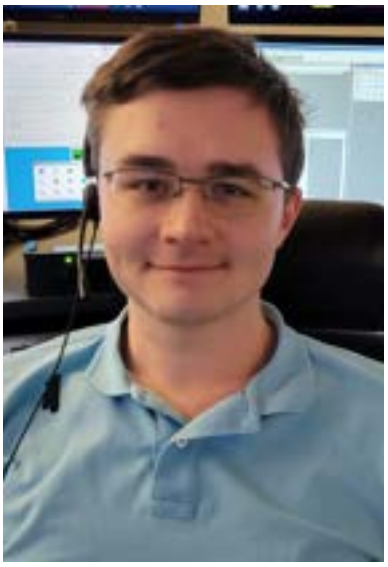
Nicholas Bridle
5 Years



LRMFA
Dispatcher Josh Hanson
1 Year

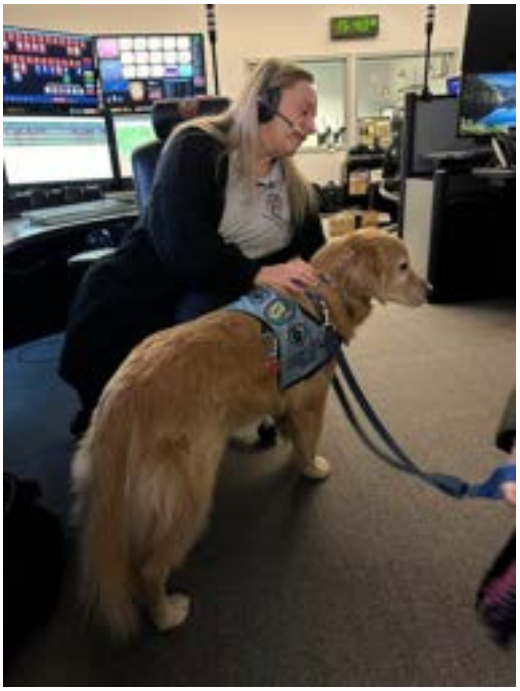
Promotions

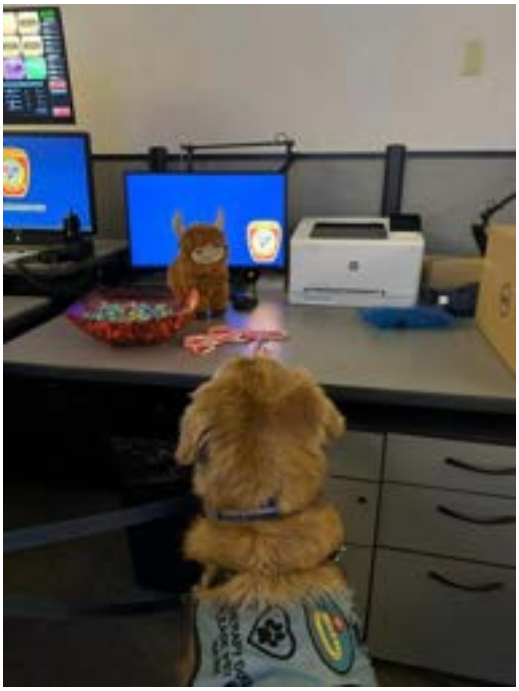
Center Harbor Fire
Lieutenant Nathan Manville
Promoted 01.04.2024

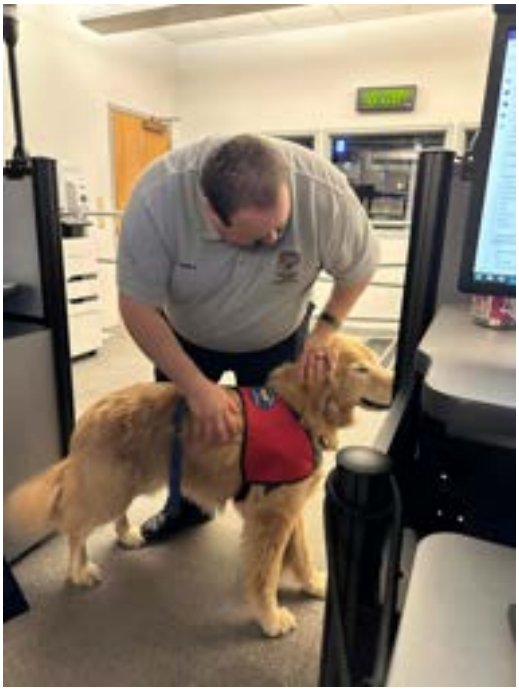
Please join the members of the Alton Fire Department in welcoming James Reinert as the town's new Fire Chief. Chief Reinert was officially sworn in at the select board meeting on February 27th. He joins Alton from the Farmington Fire Department just a short distance away and brings a breadth of professional and fire service experience. Welcome Chief!

We are pleased to welcome a new member to our Belmont Fire Department leadership team! Assistant Chief Pickowicz comes to us with 15+ years of experience in the Fire Service. You may find Assistant Chief Pickowicz out and about in the community conducting various business and residential inspections.

He may also assist our ambulance crews occasionally to become even more familiar with the Belmont community. Assistant Chief Pickowicz is native to New Hampshire and the Lakes Region and has worked closely with our Mutual Aid Agencies. Please welcome Assistant Chief Pickowicz to the Belmont Community and Fire Department Family!







Comfort Dog NASH visits the Communications Center

This past January 15th, the New Hampton Fire Department took a moment of Silence in remembrance of a member of their family who has made a great and lasting impression on the New Hampton Firemans Association. He was and will always be one of us.

For those of you who didn't know before COVID-19, we had the pleasure of having Brian as part of our Association. He was a pleasure to have around during our meetings, he often would be seen with a radio in hand waiting for the next call, and always trying to make you smile by cracking a joke or two. We will truly miss seeing you at our events. Our thoughts and prayers are with you and your family tonight Brian. You will be missed.

Andover Fire Battles 1st Alarm House Fire

On the morning of March 6th at 0110, Lt. Trempe and Dispatcher Dumka began receiving 9-1-1 calls reporting a house fire in Andover.

Andover Fire was quickly dispatched to the call with automatic aid. The first arriving reported fire coming from the chimney and smoke coming from the eves of the house. A first alarm was requested. This started as a chimney fire and extended into the ceiling and the attic. The fire was quickly knocked down and the overhaul began. Units cleared the scene around 3:15.

Andover received mutual aid from Franklin Fire, Wilmot Fire Department, New London NH Fire Department, New London EMS, Salisbury NH Fire Rescue, Tilton-Northfield Fire, Danbury, NH Fire Department, Hill Fire Department, Boscawen Fire Department, Lakes Region Mutual Fire Aid, and The Red Cross.

Gilmanton NH Fire Dept.

Alexis, Spartan Gladiator, Custom Pumper Tanker

TECHNICAL SPECFICTIONS

Alexis, Spartan Gladiator, Custom Pumper Tanker

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APS advanced seat belt system
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Two (2) Mattydale 1½" preconnects
Two (2) 2 ½" discharge(s) L/S
One (1) 2 ½" discharge(s) R/S
One (1) 3" discharge R/S
Two (2) 2½" preconnects Hose Bed
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"Tell me and I forget; Show me and I remember; Involve me and I understand...."

Camp Fully Involved is a physically challenging, aggressive hands-on, live-in week long summer camp directed towards young women between the ages of 14 (and having completed the 8th grade) and 20 who are interested in exploring the career of a firefighter. Cadets participate in numerous hands-on evolutions focused on firefighting career skills (SCBA drills, Engine & Truck company operations, forestry, to name a few), as well as developing leadership and teamwork skills. No previous fire service experience is necessary. Visit our website to download your application today!

For more information, please visit:
https://www.campfullyinvolved.com/

Franklin Fire Meets Cardiac Arrest Save Victim

Mike, a Franklin resident, came to the fire station on January 25, 2024, to thank the crew, and his daughter, for saving his life. He asked that we share his story with the public.

On December 30, 2023, at 05:19 in the morning, Mike experienced the worst day of his life. Mike went into cardiac arrest after exercising. Mike's daughter initiated quality CPR while the family called 911. NH911 began to provide pre-arrival CPR instructions to Mike's daughter, while simultaneously notifying Lakes Region Mutual Fire Aid. LRMFA Dispatcher Olisky processed the call and Dispatched the Franklin Fire Department within 60 seconds of receiving the call. The City of Franklin Fire Department, "A Shift", arrived and took over CPR. The crew shocked Mike one time with the defibrillator and continued CPR for 2 minutes. Mike started to exhibit signs of life almost immediately. He was then transported to Concord Hospital where he received additional care.

Mike is 53 years old and a Surgical Technologist, First Assistant at Concord Hospital – Laconia. He is also a Surgical Technologist Instructor at the Concord Hospital, Concord Campus. In attendance to give thanks today were his family: wife, daughter, son, his mother, and his mother-in-law. His students from the hospital also came to support Mike and his family. Concord Hospital presented the crew with a special life-saving recognition. Mike stated, "Franklin is a safer community because you're all watching over us, and personally, never more than on December 30th, 2023."

The on-scene crew consisted of Captain Tony Roberts, FF/AEMT Andrew Perkins, FF/AEMT David Sabo, and Captain Jason Jenkins. LRMFA Dispatchers: Lt. Erin Hannafin, and Dispatcher Jenn Olisky.

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Lakes Region Mutual Fire Aid Statistics

	Month	Admin	Emergency	Incidents
2024 First Quarter	January	1447	2462	2262
	February	1249	2311	2148
	March	1389	2382	2291
	Total for Quarter	*4085*	*7155*	*6701*
	Avg/Day	*44.89*	*78.63*	*73.64*
2024 Second Quarter	April			
	May			
	June			
	Total for Quarter	*0*	*0*	*0*
	Avg/Day	*0.00*	*0.00*	*0.00*
2024 Third Quarter	July			
	August			
	September			
	Total for Quarter	*0*	*0*	*0*
	Avg/Day	*0.00*	*0.00*	*0.00*
2024 Fourth Quarter	October			
	November			
	December			
	Total for Quarter	*0*	*0*	*0*
	Avg/Day	*0.00*	*0.00*	*0.00*
2024	*Month*	*Admin*	*Emergency*	*Incidents*
	Total for 2024	*4085*	*7155*	*6701*
	Avg/Day	*44.89*	*78.63*	*73.64*

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- How about a retirement? Let us thank them for their service to your community.
- Did you get a new piece of Apparatus? Send us a Picture or two, we love new trucks!
- Hosting a Training? Let us help you fill seats.

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