

## FATIGUE INCIDENT REPORT FORM GUIDE

In our last installment on Fatigue we looked at developing a **Fatigue Risk Management System (FARM)**. As part of that system, drafting an incident report specifically for an incident involving fatigue may be helpful in getting to the root cause of the incident and implementing preventative measures so the event doesn't happen again.

If you are familiar with an incident report, it typically includes the following information:

1. Name.
2. Date.
3. Incident type (Injury/Illness/Close Call/Fire/Property Damage/Collision/Spill).
4. Location.
5. Position on the farm.
6. Level of Injury (First aid/Medical Aid/Modified Work/Lost Time/Fatality).
7. A detailed description of the scene including what led up to the incident.
8. Photos of the scene.
9. Immediate cause and underlying causes of the incident.
10. Recommendations for Preventative Measures.

What you may want to add to see if fatigue played a role in the incident:

1. The activity performed when first feeling fatigued.
2. Time of day.
3. When you last slept or had a break.
4. Working alone or with another person(s).
5. Specific details of how you were feeling at the time of the incident such as if you felt alert, somewhat alert, somewhat tired, extremely tired or complete exhausted.
6. Were you fatigued before starting work?
7. How long were you awake before you started feeling tired?
8. The amount of sleep in 24 and 72 hours?
9. Were you experiencing any stress?
10. Any actions you took to fight the fatigue?

You may be surprised with the answers to some of the questions above. You may have been working on the farm in this manner for years, even decades. Do we have to continue this way? It is worth exploring! If you don't have time to explore this, that could be another flag as to why this topic should be prioritized.

Adjusting your incident report form to include these details may help get to the root cause of the incident and how to adjust work on the farm to mitigate the risk of fatigue.

[FARM NAME] INCIDENT REPORT FORM

Receive & Control the Incident

\*Complete only Page 1 if this is a Close Call. Complete Pages 1 & 2 if this is a Loss-Type Incident\*

Incident type: [ ] Injury/Illness [ ] Property Damage [ ] Fire
[ ] Spill [ ] Vehicle Collision [ ] Close Call

Incident Date (dd/mm/yy): \_\_\_\_\_ Time: \_\_\_\_\_ (AM/PM) Time of Last Break: \_\_\_\_\_ (AM/PM)

Specific Location: \_\_\_\_\_

Name of Worker(s): \_\_\_\_\_ [ ] Working Alone?

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Experience: \_\_\_\_\_

[ ] First Aid [ ] Medical Aid [ ] Modified Work [ ] Lost Time [ ] Fatal [ ] N/A

[ ] Alert [ ] Somewhat Alert [ ] Somewhat Tired [ ] Extremely Tired [ ] Completely Tired

Fatigued before starting work? [ ] Yes [ ] No Amount of Sleep in last 24 hours? \_\_\_\_\_ 72 hours? \_\_\_\_\_

Object/Equipment/ Substance Inflicting Injury/Damage: \_\_\_\_\_

Witnesses: Names & Phone Numbers: \_\_\_\_\_

Investigate the Scene

Describe in detail events leading up to the incident, the incident itself, and results of the incident:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

{Diagram of Scene and Attach Photos}

[Empty box for diagram and photos]

What was the immediate cause of this incident? \_\_\_\_\_

What were the underlying causes of this incident, if any? \_\_\_\_\_

What training, instruction and cautions were given that may have prevented the incident? \_\_\_\_\_

Emergency Services Called: \_\_\_\_\_

(i.e. Police, Fire Dept, NSPI, Ambulance)

Time of Response by Emergency Service: \_\_\_\_\_

DISCLAIMER: This policy sheet example is provided by Farm Safety Nova Scotia as a general overview for information purposes only. Farmers are responsible for modifying the example to suit each individual farm.

Refer to section 5:1 of Farm Safety Nova Scotia's "A Guide to Your Farm Safety Plan".

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Emergency Services Member's Name & Badge # or copy of emergency services report: \_\_\_\_\_

\* First Aider: \_\_\_\_\_ Treatment Performed: \_\_\_\_\_

Was there any physical damage to the premises (Describe): \_\_\_\_\_

Were you fatigued before starting work?  Yes  No

How long were you awake before you started feeling tired? \_\_\_\_\_

Activity Performed when First Feeling Tired? \_\_\_\_\_

Any actions you took to fight the fatigue? \_\_\_\_\_

Were you experiencing any stress?  Yes  No If yes, explain: \_\_\_\_\_

### Post Incident Follow Up

Injured persons taken for emergency treatment to \_\_\_\_\_

Injured persons shuttled by: \_\_\_\_\_ Date/Time: \_\_\_\_\_ / \_\_\_\_\_

WCB Injury Report completed by: \_\_\_\_\_

WCB Injury Report submitted in (Date/Time): \_\_\_\_\_ / \_\_\_\_\_

Repairs to property damage authorized for completion: \_\_\_\_\_

Repairs to be completed by: \_\_\_\_\_ Date/Time: \_\_\_\_\_ / \_\_\_\_\_

Cost of repairs: \$ \_\_\_\_\_ P.O.# \_\_\_\_\_

Insurance Details: \_\_\_\_\_

Recommendations for preventative measures:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Supervisor on Duty at: \_\_\_\_\_ (time), on \_\_\_\_\_ (date).

### Review & Implementation

Recommendations Implemented by whom: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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