



Risk Assessment & Action Strategy

Plant Description	Games during- day	Date of Assessment: Reviewed January 2012
Location	Assessor/s	Geoff Caldwell

<input type="checkbox"/> Camp Wilkin <input type="checkbox"/> Burnside Camp <input checked="" type="checkbox"/> Halls Gap <input type="checkbox"/> OtherName <input type="checkbox"/> Other Name	(A) This equipment MUST only be used by externally certified personnel. (Extensive proven prior experience/learning may be acceptable) (B) Formal in-house training is required before using this equipment (C) Safe Operating Procedures (SOP's) must be read, adhered to by all users of this equipment
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HAZARD TYPE	HAZARD		INITIAL HAZARD LEVEL	INITIAL COMMENTS	ACTION/STRATEGY IMPLEMENTED	FINAL HAZARD LEVEL
	Yes	No				
Entanglement/Entrapment ie -loose clothing		X			A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/> C YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Crushing ie rollover, press or vice		X			A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/> C YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Cutting	X		8	Falling over, someone throwing something, running into each other, tripping on logs etc.	Check area beforehand, provide adequate light, provide proper supervision instruction.	4
Stabbing Shearing Puncture	X		8	Falling over, someone throwing something, running into each other, tripping on logs etc.	Check area beforehand, provide proper supervision instruction.	4
Confined Space/Suffocation ie vessels pits tanks		X			A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/> C YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Friction		X			A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/> C YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Striking ie Impact injuries		X			A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/> C YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
High Pressure liquid/fluid ie gas bottles, hydraulic lines, fuel lines		X			A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/> C YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Electrical ie power-points, cables, plugs,leads		X			A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/> C YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Radiation Exposure ie UV rays welding etc	X		16	Sunburn.	Slip, slop, slap.	8
Slip - Trip - Fall ie from heights and ladders	X		16	Falling over, someone throwing something, running	Check area beforehand, provide adequate light, provide proper supervision instruction.	8

				into each other, tripping on logs etc.	C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Manual Handling/ Ergonomics ie sitting height, standing distance repetitive actions	X		16	Carrying camp equipment could get hurt.	A	YES <input type="checkbox"/> NO <input type="checkbox"/>	Do not lift heavy things, don't carry too much, and use Ute to transport.	8
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Biological ie Heb B, Aids Blood		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Flora and Fauna Hazards	X		16	Snakes/spiders/ants/bees.	A	YES <input type="checkbox"/> NO <input type="checkbox"/>	Reduction by instruction, no touch, appropriate first aid management if bitten.	8
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Thermal Comfort ie (hot cold)	X		16	Exposure to elements.	A	YES <input type="checkbox"/> NO <input type="checkbox"/>	Wear appropriate clothing.	8
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Drowning/ Near Drowning		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Chemical ie hazardous goods/liquid spills		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Mist Dust Vapour Fumes		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Mechanical Breakdown		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Structural Failure ie metal fatigued		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Gas Escape ie punctured lines, refrigeration, services, pilot-light. Faulty thermocouple		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
House keeping ie clear dry, workspace		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Other		X			A	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

Further Requirements	By When	By Who	Completed	Signed
Centre1 - Equipment approved for use YES <input type="checkbox"/> NO <input type="checkbox"/> Position _____	Name _____	Signature _____	Date / /	
Centre 2 - Equipment approved for use YES <input type="checkbox"/> NO <input type="checkbox"/> Position _____	Name _____	Signature _____	Date / /	