

Risk Assessment & Action Strategy

Plant Description	Games at night	Date of Assessment:	January 2012
Location	Around the property	Assessor/s	Geoff Caldwell

Camp Wilkin
 Burnside Camp
 X Halls gap
 OtherName
 OtherName

(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

HAZARD TYPE	HAZARD		INITIAL HAZARD LEVEL	INITIAL COMMENTS	ACTION/STRATEGY IMPLEMENTED			FINAL HAZARD LEVEL
	Yes	No			A	B	C	
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.	A	YES <input type="checkbox"/> NO <input type="checkbox"/>	Check area beforehand, provide adequate light, and provide proper supervision instruction.	4
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Stabbing Shearing Puncture	X		8	Falling over, someone throwing something, running into each other, tripping on logs etc.	A	YES <input type="checkbox"/> NO <input type="checkbox"/>	Check area beforehand, provide adequate light, and provide proper supervision instruction.	4
					B	YES <input type="checkbox"/> NO <input type="checkbox"/>		
					C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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			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"/>		
Slip - Trip - Fall	X		16	Falling over, someone	A	YES <input type="checkbox"/> NO <input type="checkbox"/>	Check area beforehand, provide adequate light, and provide proper supervision	8

ie from heights and ladders				throwing something, running into each other, tripping on logs etc.	B YES <input type="checkbox"/> NO <input type="checkbox"/>	instruction.	
					C YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Manual Handling/ Ergonomics ie sitting height, standing distance repetitive actions	X		16	Carrying 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
Centre 1 - 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	/ / /