



Risk Assessment & Action Strategy

Plant Description	Games in hall	Date of Assessment: Reviewed January 2012
Location	In Main hall	Assessor/s

<input type="checkbox"/> Camp Wilkin	<input type="checkbox"/> Burnside Camp	<input checked="" type="checkbox"/> Halls Gap	(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
<input type="checkbox"/> Other	Name	<input type="checkbox"/> Other	

HAZARD TYPE	HAZARD		INITIAL HAZARD LEVEL	INITIAL COMMENTS	ACTION/STRATEGY IMPLEMENTED	FINAL HAZARD LEVEL
	Yes	No				
Entanglement/Entrapment ie -loose clothing	<input checked="" type="checkbox"/>		16	Clothing caught on furniture, games props	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"/>	8
Crushing ie rollover, press or vice		<input checked="" type="checkbox"/>			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		<input checked="" type="checkbox"/>			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"/>	
Stabbing Shearing Puncture		<input checked="" type="checkbox"/>			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"/>	
Confined Space/Suffocation ie vessels pits tanks		<input checked="" type="checkbox"/>			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	<input checked="" type="checkbox"/>		12	Carpet burn	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"/>	8
Striking ie Impact injuries	<input checked="" type="checkbox"/>		16	Tunning into walls. equipment, each other	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"/>	8
High Pressure liquid/fluid ie gas bottles, hydraulic lines, fuel lines		<input checked="" type="checkbox"/>			A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/> C YES <input type="checkbox"/> NO <input type="checkbox"/>	
Electrical ie power-points, cables, plugs,leads		<input checked="" type="checkbox"/>			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		<input checked="" type="checkbox"/>			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				Trip on equipment, loose	A YES <input type="checkbox"/> NO <input type="checkbox"/> B YES <input type="checkbox"/> NO <input type="checkbox"/>	8

ie from heights and ladders	X		16	balance, slide on carpet	C	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	sliding	8
Manual Handling/ Ergonomics ie sitting height, standing distance repetitive actions	X		12	Lifting equipment	A	YES <input type="checkbox"/> NO <input type="checkbox"/>	Use correct lifting techniques	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				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"/>		
Thermal Comfort ie (hot cold)	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"/>		
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					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 - Equipment approved for use	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	Position	Name	Signature	Date	/ / /
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