

**14 November 2008**  
**Issue Number 0608**

## **Man Roland Lithoman Press – Engineer Fatality**

### **The Incident**

On Monday 6th October, a maintenance engineer and Unite member at web printer St Ives, Peterborough was involved in a fatal accident while working on a folding unit/merge unit on a Man Roland Lithoman press. While it is very unlikely that this exact type of machine is used in any of our sectors. The circumstances surrounding the fatality could be applicable to all, and emphasize the importance of total isolation, taking into account the possibility of stored 'residual energy'

After consultation with St Ives, Peterborough, Unite issued the following statement. It should be stressed that this represents the current position, based on the knowledge that is available of this event at this time.

*"On the night Monday 6th October, a maintenance engineer and Unite member at web printer St Ives, Peterborough was involved in a fatal accident while working on folding unit/merge unit on a Man Roland Lithoman press.*

*The unit involved in the incident is described by Man Roland as a folding unit with upper swivelling A4 delivery fan. The unit is interlocked such that it cannot operate when accessed, and cannot return to operation without resetting. Additionally, local procedures would also require a stop button on the unit to be activated. The entire delivery fan cartridge can be swivelled upwards into the maintenance position. In this position the cartridge is secured against swivelling downwards both by two pneumatic cylinders and by an additional mechanical locking device.*

*The accident is still under investigation by the Health and Safety Executive, and by St Ives, with the involvement of the machine suppliers, Man Roland, in order to identify the root cause of this tragic event.*

*The exact circumstances of the accident are as yet unknown. However, the basic circumstances of the accident are believed to be as follows. Operational problems with the unit resulted in the unit stopping in mid cycle. The exact status of the fan unit immediately prior to the incident is unknown. Whilst the engineer was attempting to investigate and repair the fault, the A4 delivery fan moved to its operating position, crushing the engineer in the process.*

*As a consequence of their investigation into the accident the Health and Safety Executive has suggested that stored energy in the rams operating the delivery fan cartridge might have been a contributory factor in the incident.*

*Man Roland have advised that if any indication relating to a malfunction of the swivelling of the upper delivery fan is displayed, it is not safe to enter the unit as there may be uncontrolled movement of the delivery fan. If after advice from Man Roland and in very exceptional circumstances it is necessary to enter the danger zone, the delivery fan must be secured against uncontrolled movement e.g. by securing it from above by suitable ropes or chains.*

*Companies with these units should have already received advice direct from Man Roland.*

*Other companies with similar configurations of folding units need to ensure that all safeguards are in place, that units are fully interlocked and operating correctly, and that additional measures are used to secure fan cartridges from uncontrolled motion during repair work relating to malfunction of the swivelling A4 delivery fan operations.*

*It is good industry practice for all companies to ensure risk assessments of their folder/merge operations take place after an accident like this and in particular, to establish that:*

- *All parts of the merge unit are properly guarded*
- *All necessary isolations are in place during maintenance operations. This should include ensuring that:
  1. *The equipment has either been isolated from the power.*
  2. *There is no residual pressure in the system likely to cause any part of the equipment to move in such a way as to cause harm*
  3. *Moving parts such as rams, rotor arms etc. have been secured as appropriate in order to prevent them from moving**
- *Safe Systems of Work are in place*
- *Any manual interventions are strictly governed by agreed Standard Operating Procedures*
- *All personnel are competent.”*

### **Important Safety Reminders**

The paper industry has experienced similar incidents whereby equipment has either fallen under gravity, or through leakage of the hydraulic system. Members are strongly advised to review their isolation procedures for both routine and non-routine tasks (when things go wrong) against the advice given.

Further information on 'Isolation and lock-off guidance' and 'The dissipation of residual energy' is available on the CPI website

<http://www.paper.org.uk/members/healthsafety/machinery.asp>