



# Safety Alert

From the International Association of Drilling Contractors

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ALERT 00-12

## PIPE RACKING SYSTEM (PRS) MAINTENANCE INCIDENT

### WHAT HAPPENED:

A crewman was changing the rubber stops on the forward Pipe Racking System (PRS) Track at the 144' (43.9m) level of the derrick. He was wearing a safety harness and had his safety lanyard tied off to the PRS track and was working from the PRS. During this task, the driller moved the PRS along the track at the request of the PRS programmer. This moved the unit out from underneath the man working aloft. The man aloft felt the movement and arrested his fall by grabbing onto his lanyard. He then lowered himself the full length of the lanyard and hung suspended from the PRS track. The driller was alerted to the situation, and stopped the movement of the PRS. A personnel workbasket was sent up and the man lowered to the floor with no injuries sustained.

### WHAT CAUSED IT:

Two maintenance tasks were going on at the same time without adequate communication between the serviceman, driller and crewman working aloft. Lock-Out / Tag-Out procedures were not in use.

### CORRECTIVE ACTIONS:

1. Fully implement Lock-Out /Tag-Out program and Permit to Work system for tasks such as replacing PRS rubber stops.
2. Tasks such as replacing rubber stops in the derrick should have a hazard assessment and Job Safety Analysis (JSA) conducted prior to beginning the task. For more on conducting JSAs, consult the *IADC Accident Prevention Reference Guide*.
3. Communications between service personnel, driller and rig crewmen needs to be carried out to ensure that all personnel are aware of employees working aloft. As part of the Work Permit, a sign should be posted on the PRS controls - "Personnel in the Derrick".
4. Simultaneous Operations Procedures should be developed with a matrix that describes which operations cannot be done at the same time, regardless of Simultaneous Operations Procedures.

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**The Corrective Actions stated in this alert are one company's attempts to address the incident, and do not necessarily reflect the position of IADC or the IADC HSE Committee.**

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Issued April 2000