

## MONTHLY SAFETY SCENARIO

AUGUST 2023

# Blackout caused grounding

The vessel was sailing in a river under pilotage towards the discharge port. It was being manually steered and the weather was intermittently rainy, but visibility was good, and the wind was light.

There had been a detailed pilot exchange between the pilot and Master. The pilot was given a pilot card describing manoeuvring characteristics and he checked to confirm there was an anchor watch forward, which was a requirement.

Normally the Third Engineer was stationed in the emergency generator area during manoeuvres, but for this river transit he and the Second Engineer had changed watch positions so the Third Engineer could gain more experience in another area of the engine room. The Third Engineer was carrying out his rounds on the fuel treatment area when he noticed excessive differential pressure on the fuel filter. Without consulting anyone he decided to carry out a manual back flush after switching from one

fuel filter to another. He moved the switch-over lever only part of the way, which resulted in the fuel flow to the main engine and auxiliary engines being interrupted and leading to a total blackout.

The Chief Engineer and the rest of the engine room watch acted immediately but they were restricted by the fact that it usually takes 10 - 15 minutes to recover from a blackout. At the time of the blackout the vessel was altering course to port for a major turn of almost 90 degrees. There were no other vessels underway in the area.

The Master ordered full astern, but nothing happened due to the blackout. He realised that he had no engine control, the main engine revs were falling, and there was no steering control. The vessel still had some port rudder and was moving at about ten knots. In front of the vessel there were some smaller vessels moored at the quay. The pilot ordered starboard anchor to be dropped





but it had no effect. The pilot ordered the fog signal to be sounded. He also called the berthed vessels on the VHF and the VTS and he ordered the port anchor to be dropped.

Both anchors were dropped, and the vessel began to slow down. Shortly afterwards the vessel made contact with the quay at approximately 7 knots and continued alongside, hitting one of the berthed vessels before proceeding out into the river again. The vessel finally grounded on the opposite riverbed.

## Questions

When discussing this case please consider that the actions taken at the time made sense for all involved. Do not only judge but also ask why you think these actions were taken and could this happen on your vessel?

1. What were the immediate causes of this accident?
2. Is there a risk that this kind of accident could happen on our vessel?
3. How are crew members trained for new duties?
4. Do we have sufficient procedures?
5. What are our procedures for carrying out a manual back flush or similar job?
6. Do we have a career plan for all officers?
7. If not, would it be useful?
8. Do we have a risk assessment on board that addresses these risks?

9. How could this accident have been prevented?
10. What sections of our SMS would have been breached if any?
11. Is our SMS sufficient to prevent this kind of accident?
12. If procedures were breached, why do you think this was the case?