

**Title: Black out due to wrong operation made on a Fleet vessel.**

## What happened

Vessel at sea.

Engineer on duty, received the generator room starboard bilge high level alarm.

The alarm was related to a cooling water leakage from LT thermostatic valve of DG 3.

The thermostatic valve of DG 3 was found with pin stud detached out of valve body and water was leaking from the valve cover.

After repair of the thermostatic valve, manual valves in/out cooling for LT and HT system were opened to refill preheating line with water.

After initial positive results, suddenly the cooling pressure drop down again and soon all three DG shut down and black out occurred.

## Investigation of root causes/contributory factors

After repair the thermostatic valve, manual valves in/out cooling for LT and HT system were quickly opened instead to proceed slowly.

Engineer in charge did not vent all the air from the system, consequently this wrong operation cause the remaining air not properly purged into the empty circuit of DG 3, to flow into the others common generators that caused the black out.

## Proposed Corrective/Preventive Actions

### The Vessel:

- It is reminded that the operation of the refilling cooling system must be done slowly, step by step in order to be sure that all air was vented, in order to avoid a possible blackout.

### All Managed Vessels:

- Ch. Eng. must ensure that, the work where may imply propulsion, is always supervised by a person with a higher level of knowledge.
- The Case Study should be discussed during the Safety Meeting and bring to the attention of all Engine Officers and engine crew.

### The Company:

- Case Study to circulate fleet wide
- The Officers experience should be better evaluated

Completed