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Guidance on completing PSC Inspection or RightShip Inspection Closeout Submissions

This document provides reasoning and guidance related to the development of closeout submissions for Port State Control (PSC) Inspection deficiencies and RightShip Inspection findings, but it can also apply to any vessel inspection or audit observations.

Why are Closeout Submissions important?

Good quality closeout submissions are important for several operational, safety, regulatory, and reputational reasons. The following provides details on why they matter:

1. Demonstrates Commitment to Safety and Compliance

- Good quality closeout submissions show that the vessel operator and crew take all deficiencies and findings seriously.
- It reflects a proactive safety culture and adherence to international standards (e.g., ISM Code, MARPOL, SOLAS).

2. Provides Transparency and Accountability

- Clear documentation of what went wrong, why it happened, how it was fixed and what has been done to prevent recurrence builds trust with regulators, charterers, owners, vetting organisations, and employees.
- Assigning responsibility and tracking status ensures accountability.

3. Enables Learning and Continuous Improvement

- Effective Root Cause Analysis (RCA) helps identify systemic issues, not just symptoms.
- Preventive actions can be applied fleet-wide, reducing the risk of recurrence on other vessels.

4. Reduces Risk of Repeat Findings or Detentions

- Poor or vague closeouts lead to repeat deficiencies in future inspections.
- Effective closeouts help avoid reputational damage, operational delays, and financial penalties.

5. Supports Data-Driven Decision Making

- High-quality submissions contribute to internal safety databases and trend analysis.
- They help vessel operators prioritise training, maintenance, and procedural updates.

6. Strengthens Collaboration Between Ship and Shore

- Closeouts require joint input from the vessel leadership team and the operator.
- Fosters shared ownership of safety and operational excellence.

7. Aligns with Human Factors and Modern Inspection Standards

- Good closeouts reflect consideration of fatigue, stress, communication, equipment design, and procedural design.

8. Enhances Reputation with Stakeholders

- Regulators, charterers, owners, and vetting organisations view detailed closeouts as a sign of professionalism.
- Can positively influence vetting and inspection outcomes and ensure there are no concerns, time consuming follow-up queries or delays during vetting reviews.

Composition of a Closeout Submission

PSC Inspection deficiency or RightShip Inspection finding closeout submissions should be presented in a clear, well-structured format. This approach assists those responsible for preparing the submissions but also facilitates a more efficient review and understanding of the content. Vessel operators are expected to provide a defined format for closeout submissions.

Good quality closeout submissions are typically organised in accordance with the following 8 sections:

1. Information Header

Each closeout submission should have an information header section which contains key details such as vessel's name, IMO Number, date of inspection, port of inspection, inspection type and inspecting authority/company.

2. Deficiency / Finding Details

The closeout submission should record each exact deficiency or finding as it was recorded by the inspector, along with the Deficiency Code and Initial Inspection Action Code for PSC Inspections and specific RISQ reference number and criteria for RightShip Inspections.

Within this section the vessel operator may also elect to record specific categories from a pre-determined list to support trend analysis. These categories could include relevant section within the operator's SMS, a category that corresponds with a finding (e.g. Navigational Safety, Emergency Preparedness, Security, Machinery and System Maintenance, Hull/Deck Maintenance, Cargo System), applicable TMSA Element/DryBMS Section or reference the applicable standard/regulation.

3. Explanation

The explanation section should include a factual and clear summary in relation to the deficiency or finding – The information provided must be free of ambiguity.

Explanations can often be well supported with the inclusion of a photograph the shows the deficiency/finding as reported.

4. Immediate Cause(s)

Immediate Cause(s) are the direct, observable reason(s) why something happened.

For trend analysis it may be appropriate for a vessel operator to also assign specific categories that relate to Immediate Cause(s).

5. Root Cause Analysis (RCA)

A Root Cause is an underlying, systemic reason that allowed the Immediate Cause(s) to exist or go unaddressed.

RCA is the output of the review process that identifies the Root Cause(s) that are linked to the Immediate Cause(s).

During RCA for PSC Inspection deficiencies and RightShip Inspection findings consideration should be given to Human, Management and Organisational causes.

When developing PSC Inspection deficiency or RightShip Inspection closeout submissions the RCA process followed can be proportional to the severity and risk of the specific deficiency or finding.

Higher risk deficiencies or findings should use a recognised RCA methodology such as '5 Whys', Fishbone Diagram, Fault Tree Analysis or a structured RCA framework (e.g., ABS MaRCAT, DNV M-SCAT, Lloyd's Maritime Institute RCA). For low-risk items, a brief explanation may suffice.

Human factors such as fatigue, communication breakdowns, and inadequate training must be considered within RCA (see below section on Human Factors).

Effective RCA identifies systemic issues and not just surface-level symptoms. Generic statements such as 'human error' or 'lack of training' should be avoided without further elaboration.

For trend analysis it may be appropriate for a vessel operator to also assign specific categories that relate to RCA.

Further detail in respect to RCA can be found in RightShip's Safety Insights Paper – Root Causes and Preventive Actions but simply put:

RCA that meets expectations:	Clearly and precisely addresses the recorded deficiency/finding.
	Provides an explanation in simple and clear language.
	Uses the system they have control over to operate the ship and identifies the cause and its effect relationship within their system.
	Identifies opportunities to reduce risk.
	Avoids blame and focuses on effective Preventative Measures.
	Aims to achieve the criteria against which the shipboard operation was measured.
	Uses one of the recognized RCA techniques within the maritime industry.

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RCA that partially meets expectations:	An RCA that lacks detail, depth, or clear connections between the elements, leading to a less effective solution.
RCA that does not meet expectations:	An RCA that is vague, poorly written and/or incomplete, failing to address key elements in a meaningful way. This oversight frequently results in recurring findings/deficiencies.

6. Corrective Actions

Corrective Actions address the immediate issue. Actions must be specific, measurable, and aligned with ISM Code Section 9.

When developing Corrective Actions, it is important to think about:

- What immediate steps were taken to mitigate any risks associated with the deficiency/finding?
- Why were the immediate steps taken?
- How can you verify that the corrective action has effectively resolved the deficiency/finding?
- Is there any other immediate action that could or has been taken?

There will be cases where there is more than one Corrective Action for a single deficiency or finding. Each Corrective Action should therefore:

a) Be individually identifiable
b) Include supporting evidence
c) Include a due date/status
d) Clearly identify the responsible person/rank.

7. Preventative Measures

Preventive Measures must aim to eliminate the root cause and prevent recurrence. Measures must be specific, measurable, and aligned with ISM Code Section 9. Preventive Measures should also be considered for applicability across the vessel operator's entire fleet.

When developing Preventative Measures, it is important to think about:

- What can be done to prevent the problem from happening again?
- How will the solution be implemented?
- Who will be responsible for it and how will success be measured?
- What are the risks of implementing the solution, and how will they be managed?

It is important to appreciate that it is common for there to be more than one single Preventative Measure for a single deficiency or finding, but it is appreciated that the same Preventative Measure can apply to multiple deficiencies or findings.

Within a closeout submission, each Preventative Measure should:

a) Be individually identifiable and linked to an identified root cause of the deficiency or finding.
b) Include supporting evidence

c) Include a due date/status
d) Clearly identify the responsible person/rank.

8. Review and Approval Record

The vessel management team (onboard and ashore) must collaborate to ensure corrective actions are appropriate and preventive measures are both enduring and realistic. There should be clear evidence that all closeout submissions have been reviewed and agreed by the vessel operator.

Explanatory Notes

i) For higher risk deficiencies/findings (including those which result in a PSC Detention) it is typical that the closeout submission should be more comprehensive.

ii) It is essential that persons involved in the development and review of closeout submissions have had training in RCA and development of closeout submissions. Such training may be internal or external and is often covered within incident investigation training courses.

iii) At the end of the process the person(s) reviewing the closeout submission must always consider if the preventive measures taken/proposed will be effective in preventing reoccurrence.

iv) Human factors must be considered within closeout reviews.

v) Operators should always consider the use of productivity tools to help with things like maintaining consistency, improving RCA standard, recording closeout for historical reference/data analysis and/or overcoming any language challenges.

Productivity tools can be as simple as having specific drop-down menus within electronic forms or having forms incorporated into an electronic Safety Management System (SMS) but more advanced productivity tools can be used to support the RCA process or suggest Preventative Measures that should be considered. It is however important for any advanced productivity tools to be used in a support function only, with personnel from the vessel operator always involved in the review process and for there to be evidence that Corrective Actions and Preventative measures have been implemented.

vi) Responsibility for actions shall always be assigned to specific personnel or onboard positions – This allows for clear accountability, enables effective tracking/follow-up, improves ownership/engagement, reduces the risk of oversight and strengthens collaboration. For the above reasons, assigning responsibility for actions to groups (such as HSEQ, Technical or Vessel) should be avoided.

vii) Analysis should identify if the deficiency or finding is a repeat onboard the vessel or within the operator's fleet.

viii) Operators are encouraged to incorporate guidance related to completion of closeout submissions within their SMS, either as part of the specific reporting form used, with a specific section of their SMS or both. Such guidance may include specific examples that outline what an acceptable standard of submission looks like.

RightShip Specific:

ix) Where it is clear that closeout submissions have been developed with little or no involvement from the vessel's operator they will not be accepted.

x) It is highly preferable for closeout submissions to:
- Have each deficiency or finding addressed individually in the order of the PSC Inspection Report Form B or the RightShip Inspection Report.
- Include appropriate reference numbers.
- Be contained within the same PDF document and not part of a series of documents/files.
- Incorporate photos or screenshots of Corrective Actions and Preventative Measure supporting evidence for each deficiency or finding within the same PDF document (see below section related to supporting evidence).

xi) For incidents - RightShip already provide guidance on the Desirable Content of an Incident Investigation - https://help.rightship.com/en/articles/5447079-desirable-content-of-an-incident-investigation. Other comprehensive incident investigation guidance, utilising well-established and proven methodologies, are also provided within various industry publications and supported by a multitude of accredited training options.

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Additional Considerations

Supporting Evidence:
Below are examples of **evidence** that might be expected to support **Corrective Actions** and **Preventive Measures** within any closeout submission. Such evidence helps demonstrate that actions have been taken, are effective, and are sustainable. Good supporting evidence is a key part of any comprehensive closeout submission.

Corrective Action(s) Evidence

Type of Evidence	Description	Examples
Photographic Evidence	Before-and-after photos clearly showing rectification of the deficiency/finding.	One photo showing the defective fire door not able to close and a second photo showing the repaired fire door and how it can now be closed properly.
Maintenance Records	PMS Work orders, job completion reports, or logbook entries.	Signed work order for replacement of expired lifebuoy light.
Testing Reports	Results from functional tests or inspections.	Generator load test report from service technician showing operational status.
Confirmation Statements	Written confirmation from officer(s) verifying completion of corrective action(s).	Statement from Chief Engineer confirming repair has been completed and verified.
Inspection Checklists	Updated checklists showing inclusion of previously missed items.	Revised pre-departure checklist including navigation light checks.
Attendance Report	Class Surveyor or Service Company Attendance Report.	Class Surveyor Attendance Report that provides class agreement that the defective echo sounder has been repaired to their satisfaction and the Condition of Class has been deleted.

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Preventive Measure(s) Evidence

Type of Evidence	Description	Examples
Training Records	Attendance sheets, training materials, or certificates. Onboard or ashore.	Training record signed by crew. Drill training record. CBT Course completion certificate. Participation in Bridge Team Management Training Course.
Procedural Updates	Revised procedures or manuals.	Updated SMS procedure for inventory expiry tracking.
Audit Reports	Internal or external audit findings confirming implementation.	Safety audit confirming checks are now part of an established routine. Navigation Audit report. Several different options available (e.g. Internal or External, Live or VDR). See LINK.
Fleet-wide Communication	Notices or circulars sent to other vessels in the fleet.	Fleet memo instructing all vessels to update lifebuoy expiry tracking.
Management Review Minutes	Meeting records showing operator review and approval.	Minutes from operator's safety committee confirming closeout acceptance.
System Configuration Evidence	Screenshots or logs showing system changes.	Screenshot of inventory system with expiry alert feature enabled.

Collaborative Closeout Process:

It is important that closeout development and execution takes a collaborative approach between ship and shore. There is a joint responsibility to ensure that closeout submissions are accurate/comprehensive and that actions are not only reactive but also proactive and enduring.

- **Vessel Leadership Team**: Investigates deficiencies, determines root causes, and proposes corrective actions and preventative measures.
- **Vessel Operator**: Reviews investigation and proposed actions, ensures fleet-wide applicability, and formally approves the closeout.

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Human Factors:

All good RCA includes analysis of factors which related to human performance, such as:

1. **Equipment Issues**
   - Poor design, malfunction, or lack of usability.
   - Examples: Control panel layout poorly labelled and causing confusion. Supply of poor-quality parts.

2. **Task Design**
   - Complexity, unclear procedures, or unrealistic expectations.
   - Examples: Checklists either too long or too generic. Procedures don't clearly reflect the task.

3. **Familiarity**
   - Lack of experience or recent exposure to the task.
   - Examples: Crew member unfamiliar with updated procedures due to training gaps. Missing handover notes.

4. **Nervousness or Stress**
   - Psychological pressure, anxiety, or performance stress.
   - Examples: Crew under pressure during port operations. Personnel experience heightened emotional anxiety or worry during questioning.

5. **Fatigue**
   - Physical or mental exhaustion due to long hours or poor rest.
   - Examples: Watchkeeper missing checklist items due to sleep deprivation, Crew Hours of Work/Rest showing excessive hours.

6. **Time Constraints**
   - Rushed operations or insufficient time to complete tasks properly.
   - Examples: Pre-departure checks skipped due to tight schedule. Proper tool not used because it takes time to go and get it.

7. **Unawareness of Changed Approach**
   - Not informed of procedural updates or changes in expectations.
   - Examples: Crew unaware of revised ballast handling procedure. New equipment provided without adequate Management of Change.

8. **Leadership and Culture**
   - Influence of onboard leadership, communication, and safety culture.
   - Examples: Lack of encouragement to report near misses. Poor culture of secondary checks by supervisors. Limited shore management engagement.