Naval Safety Command

Risk Awareness: What Every Team Should Know

Mid-level leaders play a key role in shaping the safety environment across our commands. This handout is designed to help you open a conversation with your teams and encourage awareness around the unseen factors that can lead to mishaps. These talking points can be used during team meetings, safety stand-downs, or informal walk-arounds.

BLUF

As mid-level leaders, your influence shapes how risk is recognized, discussed, and managed on the deckplates. By fostering open conversations and identifying small, systemic issues early, you help prevent mishaps before they happen — even when the problems aren't obvious.

What Are Latent Failures?

- They're the "hidden hazards" in our systems, proccesses, or environments.
- Think of them as problems that are baked into our routines - like missed inspections, outdated checklists, or unclear responsibilites.
- They may sit unnoticed for weeks or months, until they set the stage for something to go wrong.
- Team Talk Prompt: What are some small issues we've "learned to live with" that could become a bigger problem down the line?"
- Here are some real world examples of latent failures._

Awareness in Action

- **Conduct informal pulse checks - not everything needs to wait for an inspection.**
- **Encourage people to share workarounds or unofficial processes - they often point to system gaps.**
- **Remind teams that noticing and sharing small issues is part of operational excellence, not micromanaging.**

V31 executes EOTG TRAP course

Culture Matters

A safety culture isn't just about following rules - it's about being aware, speaking up and fixing the small stuff before it grows.

- When feedback is ignored or people are afraid to speak up, those small cracks turn into real risks.
- Mid-level managers set the tone. People notice when you listen, follow up and prioritize safety.

Team Talk Prompt: Do you feel comfortable flagging something that seems off, even if it's not "in our lane"? What makes that hard?

Looking Past the Obvious

Most mishaps don't start with a single bad decision. They build over time. Active failures (like pressing the wrong button) are often the last link in the chain of deeper problems.

- The real cause of a mishap might be a policy that hasn't been reviewed, a missing resource, or unclear tasking.
- Identifying these upstream issues is how we prevent repeat events.

Team Talk Prompt: Have we had a close call recently? What might've set it up in the first place?

Helpful Tip: The DoD Human Factors (HFACS) Analysis Classification Guide lists 37 supervisory and organizational influences that can contribute to mishaps. It's a great reference to help identify hidden latent factors before they appear in a mishap. The HFACS is also built into the Risk Management Information (RMI) system for reporting mishaps.

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