Naval Safety Command

Defining Risk Awareness

The majority of mishaps throughout the Naval Enterprise are attributed to human factors and failure to properly manage risk. Effective risk management enables organizations to anticipate, respond and manage potential threats and opportunities. This approach ensures resilience, sustainability and long-term viability while also protecting the warfighter and the mission.

BLUF Exercising a well-rounded risk management process is key to a culture of safety and must be continuously taught and mentored. The risk management framework provides a standardized approach for evaluating, managing and communicating risk, therefore enabling leaders to make informed decisions.

Latent Failures

Latent failures are hazardous conditions that exist within the chain of command or within the organization itself that affect the tragic sequence of events leading to an active failure. Often latent failures are those less-obvious influences that create an environment where small errors can escalate into major incidents. These failures can go unnoticed for weeks, months, or even years before manifesting in a mishap.

The 5 Whys?

One useful method for identifying deeper issues is the "5 Whys" technique — a root cause analysis tool that helps teams move beyond surface-level symptoms. By asking "why" repeatedly (typically five times), teams can peel back the layers of a problem to uncover the underlying cause. This simple yet powerful approach is especially effective in revealing latent failures, which are often hidden or not immediately obvious.

For example, consider a case of improper tag-out procedures.

- Why did this occur? Because equipment was tagged out incorrectly.
- Why was it tagged out incorrectly? Because the person performing the procedure wasn't properly trained.
- Why weren't they properly trained? Because the required training hadn't been scheduled.
- Why wasn't the training scheduled? Because the command hadn't reviewed or updated its training cycle.
- Why wasn't the cycle reviewed? Because there was no process in place for recurring evaluation.

By using the 5 Whys, the issue is no longer just "improper tag-out" — it becomes a discussion about systemic gaps in training oversight and program management. Identifying that root cause allows leadership to correct the condition, not just the error.

Organizational Culture and Management

Latent failures can arise from systematic issues in an organization, such as poor leadership, lack of accountability, ineffective communiction or failure to prioritize safety. A weak safety culture can contribute to the persistence of latent failures, as they may go unnoticed or unaddressed by management.

Proactive measures like regular safety audits, continuous improvement initiatives and open channels for feedback can help identify latent failures before they cause harm. Organizations should focus on creating systems that foster transparency, learning and responsiveness to potential hazards.

What is the root cause of a mishap?

Latent failures often serve as the root cause of accidents or mishaps. While active failures (e.g., a human error or equipment malfunction) are the immediate triggers. Latent failures are typically the systemic problems that set the stage for the incident.

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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