

# RISK AND RESILIENCE BOOTCAMP





WORKFORCE  
DEVELOPMENT



# BUSINESS PROCESS MODELING

This module introduces and explores business process modeling and related areas

- BPMN
- Bottleneck Analysis
- RACI
- Control Weaknesses



# BUSINESS PROCESS MODELING (BPM)

- Why model business processes?
  - Organization manage risks from systems, controls and people
  - But often without a full picture of how work actually flows through the business
- BPM helps to visualize, analyze and improve workflows
  - Essential for revealing where risks lie
- In a risk and resilience context
  - Helps identify where inside the process might things go wrong
  - And what the resulting impacts would be

# BUSINESS PROCESS MODELING (BPM)

- Modeling a process provides
  - Clarity about inputs, outputs, flows, handoffs, decisions and system dependencies
  - Common vocabulary and visualization across business & IT stakeholders
  - Basis for identifying latent risks and control weaknesses
    - For example: rework loops, human manual steps, system dependencies
- A process map is not just a diagram of work
  - It is also a diagram of risk

# BPM IN RISK IDENTIFICATION

- Applying BPM with a risk lens can uncover
  - *Design risks*
    - Does the process design introduce delays, loops, unnecessary manual work or complexity?
  - *Execution risks*
    - Are there unmonitored manual handoffs, people acting without backup, or lack of system support?
  - *Dependency risks*
    - Does the process rely on a single system or person (single point of failure)?
    - Are there external suppliers or upstream/downstream processes that create risk?
  - *Control risks*
    - Where are the monitoring or control points?
    - Are they visible and documented?
    - Are there gaps or overlaps in ownership?

# BPM IN RISK IDENTIFICATION

- Applying BPM with a risk lens can uncover:
  - *Data/information risks*
    - How does data move?
    - Is there risk of data loss, corruption, incorrect handoff?
  - *Change risks*
    - If a process changes (e.g., new system, new regulatory requirement), how will the current flows adapt and what is the vulnerability during transition?
- Modeling shifts the risk lens
  - From: "*we hope nothing goes wrong*"
  - To: "*we can see where things can go wrong and can act*"

# MODELING TECHNIQUES AND TOOLS

- There are a number of standard toolsets used for business modeling
  - Business Process Model and Notation (BPMN) 2.0
    - The industry-standard notation for modelling complex business processes
    - Uses standard symbols (events, activities/tasks, gateways/decisions, flows) that both business and technical stakeholders can understand
    - Allows modeling from a “high-level overview” down to more detailed subprocesses, enabling the modeler to drill down to the risk source
    - Using BPMN for risk modelling: some researchers suggest enriching BPMN with risk information (likelihood/impact): e.g., in a “risk-annotated BPMN” model

# MODELING TECHNIQUES AND TOOLS

- Some tools are adaptations of older existing modeling techniques
  - Flowcharts, SIPOC diagrams, Value-Stream Maps
    - These are useful, especially in earlier or higher-level phases, or for less complex processes
  - Flowcharts
    - Simple, good for mapping steps, but may lack standardisation and clarity for cross-functional work
  - SIPOC (Supplier–Input–Process–Output–Customer) diagrams
    - Good for understanding the boundary/context of a process
    - Who supplies, what comes in, what goes out, who receives
  - Value-Stream Maps
    - Commonly used in Lean environments to show value-add vs non-value-add steps, handoffs, delays
    - Useful for spotting bottlenecks and waste, which are also risk indicators

# RISK IDENTIFICATION STEP BY STEP

- Select the process to model
  - Choose a process that is critical to business operations or IT-risk related
    - For example: customer onboarding, change-management, incident response, data access provisioning
- Map the “as-is” process
  - Use BPMN or other notation to capture how work actually flows today
  - Include start/end points, tasks, decision points, handoffs, system steps, manual steps, exceptions
  - Use swimlanes/partitions if different departments or systems are involved
  - Annotate where the process uses systems, where people operate manually, where there are delays or dependencies

# RISK IDENTIFICATION STEP BY STEP

- Overlay risk indicators on the model and ask:
  - Identify where are the handoffs occur
    - People to people
    - System to people, or vice versa
    - System to system
  - Identify manual steps or processes that could be automated or are error-prone
  - Identify loops or rework steps where there is a higher chance of delay or error
  - Is there a single person or system that if it fails, the process stops?
    - This is a single point of failure
  - Are the decision-points well documented, are there missing controls or lack of visibility?
  - How is data passed? Is it secure, accurate, validated?
  - What happens when exceptions occur? Are there contingency steps?

# RISK IDENTIFICATION STEP BY STEP

- Risk modeling approaches often follow the process
  - Model the process
  - Use the model to prompt risk identification.
  - By analyzing each activity of a business process you are more likely to identify risks than by relying solely on unstructured brainstorming

# RISK IDENTIFICATION STEP BY STEP

- Identify where control weaknesses exist
  - Highlight where controls are missing, ambiguous, redundant, or overlapping
  - For example
    - A manual approval step that has no logging or oversight
    - A task assigned to a person who also does approvals and execution (lack of segregation of duties)
    - A system dependency with no backup or no change control
- Prioritize risk areas
  - Based on the process model, prioritize:
    - Likelihood of failure/disruption
    - Impact of that failure (financial, regulatory, reputational, operational).
  - The visual depiction of the process is a way to justify your prioritization
    - For example, identifying a single point of failure at a critical step

# RISK IDENTIFICATION STEP BY STEP

- Design improvements
  - Once the model is overlaid with the identified risks
  - The process can be re-engineered by
    - Proposing controls
    - Identifying redundant paths
    - Identifying automation opportunities
    - Improving monitoring to enhance detective controls
  - The model becomes a communication tool with stakeholders

# FLOW OF RISK

- Traditional process modeling focuses on the flow of work
  - Adding a risk-aware lens, shifts focus to the flow of risk
  - How risk propagates through process steps, handoffs, and system interactions
  - For example:
    - If Task A feeds into Task B, and Task A is manual and error-prone
    - Then Task B can receive incorrect data
    - This is a risk flow because the risk flows from A to B
  - The process map visualizes the pathway of work *and* the pathway of potential failures, delays, rework, data leaks, control gaps
  - Visual modelling makes hidden dependencies visible
  - For example:
    - A system that triggers the next step but if it fails, the work stops
    - A manual check that is executed late or is incomplete
    - A hand-off between departments with unclear responsibility creating a risk blindspot

# INTEGRATING BPM INTO RISK ANALYSIS

- BPM can be included foundation activity
  - Identify critical processes, map them, overlay risk and dependencies, feed those into the risk register or assessment
  - Use the diagrams in workshops with stakeholders
    - The visual nature aids understanding, builds engagement, and supports communication across business/IT
  - Treat the process models as living artifacts
    - Update when process changes occur, when new systems are introduced, or when control environment shifts
    - Otherwise they become stale and lose analytic value.
  - Link the process models to control frameworks
    - Mapping where controls reside or should reside
    - Map to resilience procedures like the resilience plan for the failure of a key step
  - Use the models during incident response or root cause analysis
    - When something failed, revisit the process model to see where the breakdown occurred

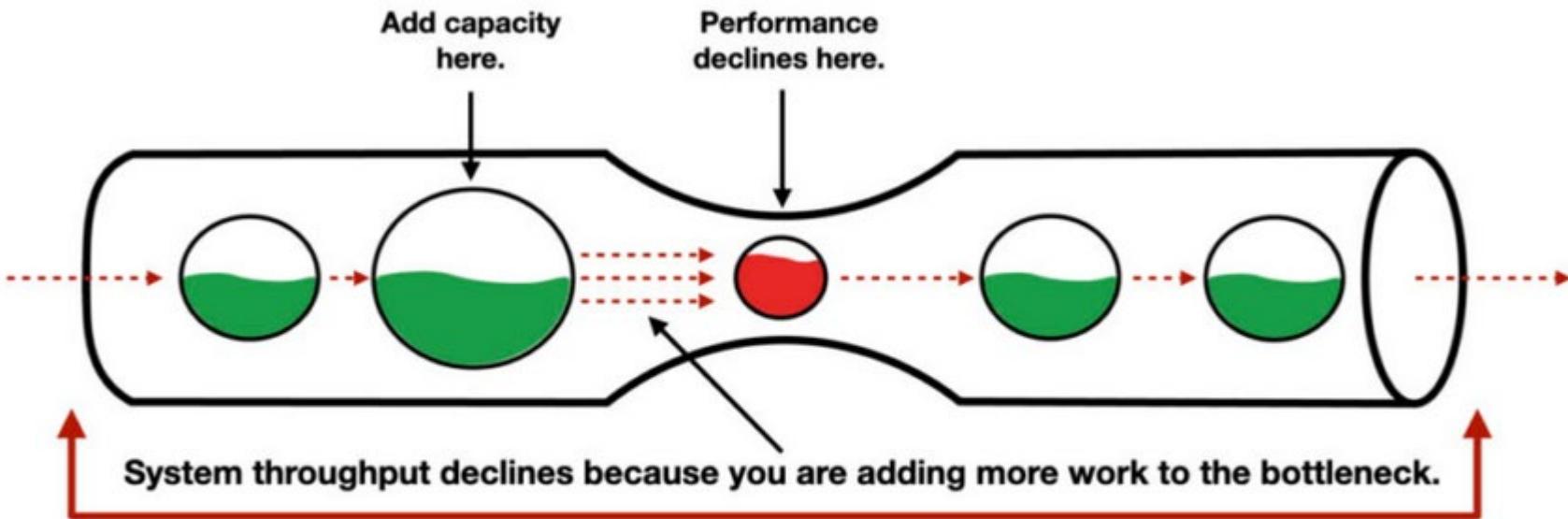
# BOTTLENECKS

- Once a process is mapped, it becomes possible to assess operational and systemic vulnerabilities
  - Bottlenecks
    - Stages where tasks accumulate due to resource constraints, approval delays, or inefficient handoffs
    - Indicators include high cycle time, queue buildup, or repeated rework.
  - Single points of failure (SPOFs)
    - Individuals, systems, or tools whose failure halts the entire process
  - Examples
    - A single IT administrator controlling access
    - A critical spreadsheet managed by one person

# BOTTLENECKS

- A place in a process where
  - The demand like work, tasks, information exceeds the capacity of that step like workers, system capacity, hand-offs or approvals
  - Slows down the overall flow.
- The rest of the process may be efficient
  - But the bottleneck effectively limits the throughput of the entire end-to-end chain
  - Analogous to the neck of a bottle limiting the flow of liquid.
  - Bottlenecks may be temporary (short-term) or structural/chronic (long-term)
  - Short-term could be a system outage or a person's absence
  - Long-term may be inherent capacity mismatch, workflow design fault, or outdated system

# BOTTLENECKS



The theory of constraints defines a constraint as:

**“Anything that limits the system from a higher level of performance.”** (Pretorius, 2014, p. 498)

# BOTTLENECKS IN RISK

- From a risk perspective, bottlenecks are critical because they
  - Increase cycle time and lead time, thereby delaying deliverables and reducing responsiveness
  - Create back-logs or work queues, which increase exposure to error, rework, and potential control failures
  - May indicate hidden single points of failure
    - For example, if one stage cannot scale or is highly dependent on a resource
  - Amplify the impact of other risks
    - For example, a bottleneck in a process may mean that when an upstream system fails, the backlog grows and uncontrolled work continues, increasing operational and compliance risk
  - Erode organizational resilience
    - If the bottleneck is not addressed, the system cannot adapt quickly to spikes in demand, external shocks, or changes in process

# COMMON TYPES OF BOTTLENECKS

- Capacity constraints:
  - A person, team, or system cannot process work as fast as it arrives.
  - For example: one expert reviewer approves all change requests and is overloaded
- Manual hand-offs or approvals
  - Tasks that require manual intervention, sign-off, or handover tend to be slower and more error-prone, introducing delay
- System performance or outdated technology
  - Legacy systems, slow response times, or batch processing can create bottlenecks

# COMMON TYPES OF BOTTLENECKS

- Handoff/transition delays across departments
  - When work moves from one team or system to another (especially across silos) delays often occur
- Redundant, unclear or overly complex workflows
  - Too many steps, rework loops, unnecessary approvals all slow the process
- Resource or role dependency (single person, single team):
  - When only one person or team performs a critical step, the process becomes fragile
- Variability and unpredictable demand
  - Large fluctuations in work volume without matching capacity produce bottlenecks

# HOW TO IDENTIFY BOTTLENECKS

- Step 1: Select the process scope
  - Choose a critical process
    - For example new-client onboarding, incident response escalation, change management
  - Define clear start and end points so you know what you're analyzing
- Step 2: Map the “as-is” workflow
  - Create a visual model (flowchart, BPMN, swimlane) showing steps, decision points, hand-offs, systems, manual tasks
  - Annotate
    - Where tasks queue
    - Where hand-offs happen
    - What systems are used
    - Who is responsible
  - Use data where possible
    - For example: cycle times, wait times, queue lengths.

# HOW TO IDENTIFY BOTTLENECKS

- Step 3: Collect data and observe metrics
  - Key metrics
    - *Lead time*: time from request to completion, also called transaction time
    - *Cycle time*: time taken at each step
    - *Throughput*: units processed per period
  - Work-in-progress (WIP) queues
    - A step where WIP accumulates or where lead time spikes suggests a bottleneck
  - Obtain feedback from staff:
    - Which steps repeatedly cause frustration or backlog?
    - Which persons are over-utilized?

# HOW TO IDENTIFY BOTTLENECKS

- Step 4: Identify the bottleneck(s)
  - Look for the step with the longest queue, highest utilization, longest processing time, or which restricts the entire process flow.
  - If this step were faster, would the overall process become faster?
    - If yes, than that step is a bottleneck.
  - Differentiate whether it is a constraint (systemic) or temporary overload

# HOW TO IDENTIFY BOTTLENECKS

- Step 5: Analyze root causes
  - For an identified bottleneck, ask
    - Why is the backlog forming?
    - Why is the capacity insufficient?
    - Are there manual approvals?
    - Are resources constrained?
    - Are hand-offs inefficient?
  - Use techniques such as 5 Whys, fish bone diagrams
  - Examine the interfaces between people, process, system
    - For example: maybe the system is fine but hand-off between teams is slow because roles are unclear

# HOW TO IDENTIFY BOTTLENECKS

- Step 6: Develop and implement solutions
  - Potential remediation
    - Redistributing workload
    - Adding capacity
    - Automating manual steps
    - Simplifying workflow
    - Eliminating redundant steps
    - Establishing backup resources
    - Improving hand-off protocols.
  - Prioritize by impact
    - Fix the bottleneck that will yield the most improvement in overall process flow
    - Improving non-bottleneck steps yields little gain

# HOW TO IDENTIFY BOTTLENECKS

- Step 7: Monitor and sustain
  - After implementing changes
  - Monitor metrics again to ensure the bottleneck is relieved
    - For example: lead time, cycle time, queue lengths
  - Bottlenecks may shift
    - Once one is removed, another may emerge elsewhere
    - Continuous monitoring is essential to identify emerging bottlenecks

# SINGLE POINTS OF FAILURE

- Bottlenecks are about capacity and throughput
- Single points of failure (SPOFs)
  - SPOF is a person, system, or step whose failure (unavailability, error, outage) will stop or severely impair the process
  - A redundancy gap means there is no backup, alternate path, or contingency for a critical process step, rendering it fragile
- From process modelling:
  - A step may appear fine in normal flow, but if the person responsible is absent, or the system fails, the process halts, that is a SPOF
  - Bottlenecks + SPOFs = elevated risk because when a bottleneck resource fails, the harm is much greater
  - Mitigation: design alternate paths, cross-train resources, ensure fail-over systems, incorporate contingency in process maps

# AUTOMATION ISSUES – PROCESS WEAKNESSES

- Automation issues are often linked to bottlenecks and SPOFs, automation plays an important role:
  - Manual tasks are often slower, error-prone, less visible, more susceptible to capacity constraints
  - These can become bottlenecks
  - Automation can improve throughput, consistency and reduce human dependency
  - But automation poorly designed or not maintained can itself become a bottleneck or failure point

# AUTOMATION ISSUES - PROCESS WEAKNESSES

- When modelling a process from a risk view
  - Annotate where manual work occurs
  - Where systems are used
  - Where automation might reduce delay and risk
  - Where automation is missing (gap), or outdated (risk of failure)
- Example:
  - A manual approval system via email becomes overloaded and delayed; automating approval or providing self-service may reduce that bottleneck and improve resilience.

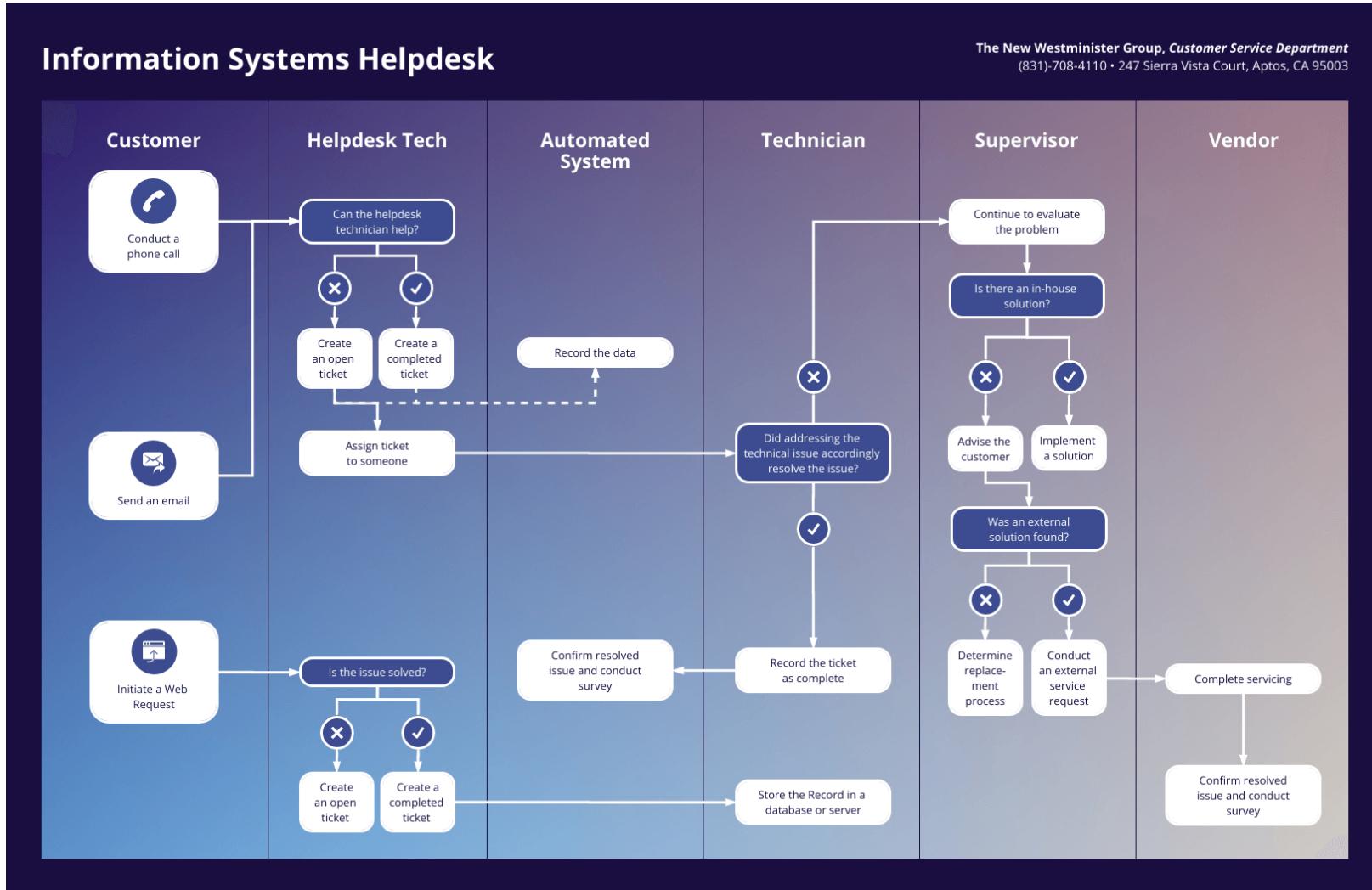
# SUMMARY

- To recap
  - Bottlenecks are systematic constraints in a process that limit throughput, slow flow, increase backlog and introduce risk
  - They may be due to people, process, or system issues (or combination thereof) and often highlight underlying fragility or resilience gaps
  - Identifying bottlenecks requires mapping the process, collecting data (lead time, cycle time, WIP), gathering feedback, and analyzing root causes
  - From a risk and resilience viewpoint, watch for single points of failure and lack of redundancy, as these amplify the impact of bottlenecks
  - Automation (or lack thereof) is a key factor: manual tasks increase bottleneck risk, but automation must be well-designed or it can itself be a fault
  - Regular monitoring is essential: once one bottleneck is relieved, another may emerge because the process needs to be a living risk-aware artifact

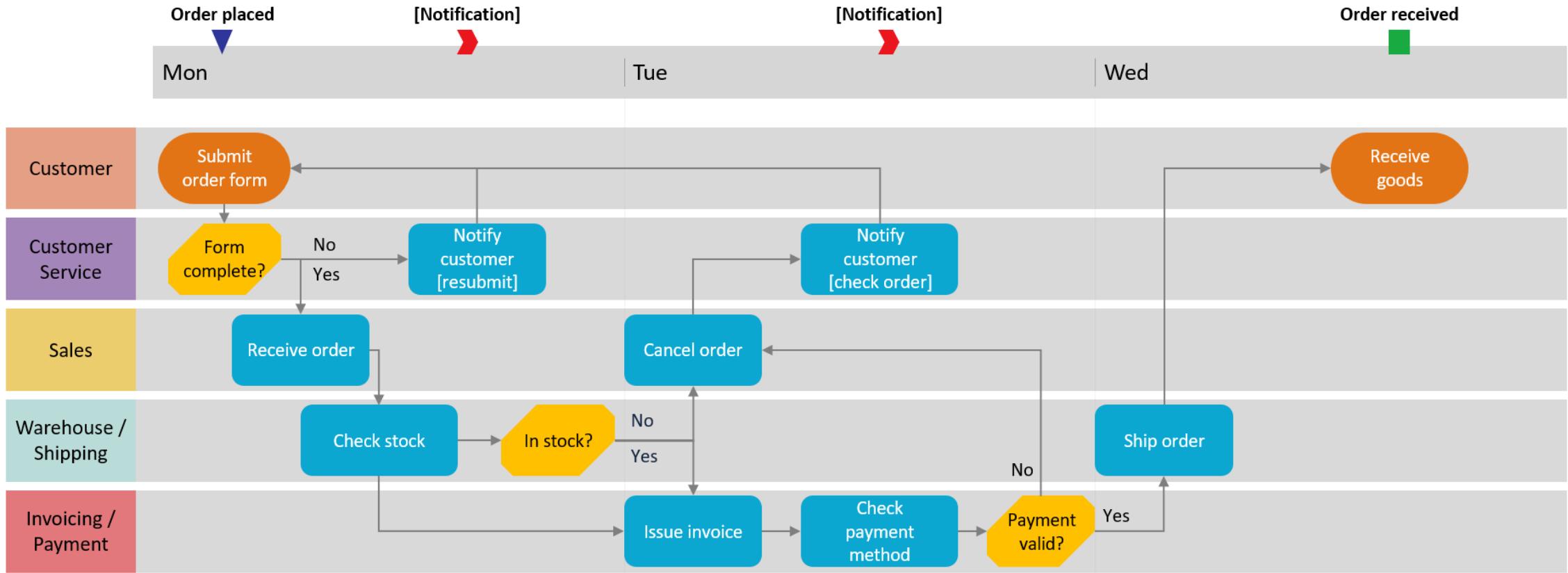
# SWIMLANE DIAGRAMS

- A type of process map
  - Divides the workflow into “lanes” representing different roles, departments, teams or systems
  - Then places tasks/activities inside those lanes according to who/what is responsible
  - Also called a cross-functional flowchart or role-activity diagram
  - These can be applied to any sort of diagram that maps out a flow
    - Data flow diagrams, business process models, flowcharts, etc.
- The visual metaphor
  - Like a swimming pool, where each lane is a different actor and the tasks “swim” across lanes
  - Unlike a diagram that just shows sequence, a swimlane diagram adds an extra dimension of responsibility/ownership, making “who does what” and “hand-offs” explicit
  - It is used especially when processes span multiple functions/teams or when hand-offs between teams/systems are common

# SWIMLANE DIAGRAMS



# SWIMLANE DIAGRAMS



# SWIMLANE DIAGRAMS

- In risk analysis, swimlane diagrams serve several important purposes
  - Visualize how work and information move across organizational boundaries
    - A risk often arises when there's a boundary crossing
    - Department to department, system to person, vendor to internal
    - Making that explicit helps highlight potential weak points
  - Clarify roles and responsibilities
    - If a task is shown in a lane labelled "IT Support"
    - But the subsequent decision appears under "Operations"
    - It is obvious who is accountable for what.
    - This helps uncover ambiguity in responsibilities, duplication of tasks, or gaps (no one assigned)

# STEP-BY-STEP

- Step 1: Define the scope
  - Choose the process to model
    - For example: change-management workflow, incident response, vendor onboarding
  - Identify start and end points; determine the high-level boundaries of the process
- Step 2: Identify the participants / roles / systems (Lanes)
  - List all the roles, departments, systems, external parties involved.
  - Decide how to organize lanes
    - For example: by department, by role, by system, or by both
  - Label each lane clearly
    - For example: "Business Unit", "IT Security", "Compliance", "Operations", "Vendor"

# STEP-BY-STEP

- Step 3: Map the steps/activities
  - For each step place it in the appropriate lane, depending on who/what executes it
  - Use arrows/flows to show how tasks move from lane to lane (hand offs), or loop back
  - Include decision points or gateways where relevant
  - Annotate if a system step, manual step, or external hand off
- Step 4: Highlight hand offs and dependencies
  - Identify where flows cross from one lane to another
  - Those are hand off points
  - Identify where activities depend on another role/system completing a task before proceeding
  - Mark these in the diagram and note possible risks

# STEP-BY-STEP

- Step 5: Review for role clarity and gap identification
- Once mapped, ask
  - Does every task have a clear owning lane?
  - Are there tasks that span lanes without a clear hand-over?
  - Are there “white-spaces” (steps with no lane/owner)?
  - Are there loops or back-and-forth between lanes?
    - These may indicate confusion or inefficient handoffs
- Ask also
  - Who is accountable (versus simply responsible) for each lane/task?
  - Where might someone think “it’s someone else’s job”?
  - Where might communication fail (between lanes/roles)?

# STEP-BY-STEP

- Step 6: Use the diagram to spot risks
  - Look for
    - Lanes with many incoming/outgoing flows → heavy hand-off load → higher risk of delay/communication error
    - Lanes that are lightly populated (few steps) but receive many inputs or send many outputs → potential bottleneck or dependency
    - Cross-lane arrows with no clearly annotated control or check step → risk of drop
    - External lane or vendor lane handoffs (less control visibility) → elevated risk
  - For each risk spot identify:
    - What if the lane fails (person absent, system down, vendor unresponsive)?
    - What is the impact and how many other lanes depend on it?

# STEP-BY-STEP

- Step 7: Communicate and maintain
  - Use the diagram in stakeholder workshops
    - It helps non-technical people like business executives visualize roles and dependencies
  - Treat it as a living artifact
    - When process or person roles change, update the diagram rather than leaving it stale
  - Link it to your risk register, controls library, or accountability frameworks
    - For example, connect a lane to a RACI chart

# CONSIDERATIONS

- Risk considerations
  - Within departments often there's clearer role definition, standard operating procedures, closer supervision
    - This usually means fewer surprises but it is still possible to overlook something
  - Boundaries or hand-offs between departments/roles often create risk because
    - It may be unclear who is responsible for the next step
    - Communication may be informal or undocumented
    - Systems may change across boundaries
    - There might be delays while waiting for another team.
    - The receiving team may not have full context or may assume something is already done

# RACI CHARTS

- A RACI chart (or matrix)
  - A responsibility assignment matrix (RAM) that maps tasks (or activities/decisions) against roles or stakeholders
  - It and assigns for each intersection one of the four RACI categories
    - Responsible (R)
    - Accountable (A)
    - Consulted ©
    - Informed (I).
  - In practice, the tasks are listed down the rows (left column)
  - Stakeholders/roles across the columns at the top
  - Then each cell is used to show each role's involvement in that task
  - The purpose is to ensure clarity of roles and avoid confusion, overlaps, omissions, or ambiguity in responsibility and decision-making

# RACI CHARTS

Areas of focus are the activities, deliverables, departments, or channels in the content process. These vary based on the content RACI type.

Area of focus	ROLES				
	Writer(s)	Translator(s)	Editor	Subject matter experts	Producer
Write content	R	C	C	C	A
Translate content	C	R	C	I	A
Content accuracy	R	R	C	A	I
Content completeness	R	R	A	C	I
Content quality	R	R	C	I	A
Tone and voice	R	R	C	I	A
Digital standards	R	R	C	I	A
Final approval	C	C	C	C	A/R

**R** Responsible

The people who actually do the work. One or more people can be responsible.

**A** Accountable

The Approver. The person who signs off on the work. Usually, only one person is accountable.

**C** Consulted

The subject matter experts who are consulted and sometimes contribute to creating content.

**I** Informed

The people who are informed when a deliverable is complete. Communication only goes one way.

# RACI ROLES

- Responsible (R):
  - The person or people who actually do the work to complete the task
  - The “doers”
  - Everyone doing the work should be identified
- Accountable (A):
  - The person who is ultimately answerable for the correct completion of the task, deliverable, or decision
  - They own the outcome, must approve/sign-off, and bear consequences for success/failure
  - Per best practice, each task should have exactly one Accountable person

# RACI ROLES

- Consulted (C):
  - People or roles whose opinions are sought
  - Typically subject-matter experts, stakeholders who must give input before the task/decision is done
  - They are engaged in a two-way communication
- Informed (I):
  - People or roles who need to be kept up-to-date on progress or results
  - They are not directly involved in doing the work or inputting decisions, but they need awareness
  - One-way communication.

# STEP-BY-STEP

- Step 1: Identify Activities / Tasks / Decisions
  - List the set of tasks or decision points for the process or system you are analyzing
  - For instance
    - Initiate change request
    - Review risk impact
    - Approve change
    - Implement change
    - Monitor change outcome
  - Decide on the level of granularity, you may want to limit to high-level tasks for clarity

# STEP-BY-STEP

- Step 2: Identify Roles / Stakeholders
  - Identify all relevant roles (not necessarily individual names) that will be involved
  - Example
    - Business Owner
    - IT Security Lead
    - Compliance Manager
    - Change Manager
    - Operations Team
  - Capture roles rather than always names, so the chart remains valid over time

# STEP-BY-STEP

- Step 3: Build the matrix structure
  - Create a table/spreadsheet with rows = tasks/activities, columns = roles
  - For each cell, assign R, A, C, or I as appropriate.
  - Ensure that there is at least one “R” per task and exactly one “A” per task
    - Consulted and Informed may have multiple assignments
- Step 4: Validate with stakeholders
  - Review the draft with relevant stakeholders to confirm the assignments
  - Lack of input from stakeholders may mean there are hidden gaps
  - Check for common problems:
    - No “A” assigned for a task
    - Too many “R” (means duplication or ambiguity)
    - Same person in multiple roles without clear justification

# STEP-BY-STEP

- Step 5: Risk identification and control mapping
  - Once the RACI chart is populated, analyze for risk
    - For example: tasks where "I" stakeholders are missing could mean decision makers aren't being informed, leading to lack of control oversight
  - Link tasks that have high risk or critical control to the "A" role
    - That person then owns risk acceptance for that control
  - Assign monitoring, assurance, escalation responsibilities via "R/A"
- Step 6: Maintain and update
  - The RACI chart becomes a living document
    - When processes change, roles evolve, or new tasks are added, updates are necessary
    - Otherwise it becomes stale and misaligned
  - Make it accessible and reference in governance meetings

# DIAGNOSTIC USES

- Use the RACI chart to identify potential problems with controls
  - No Accountable assigned or multiple people assigned to Accountable
    - When nobody or too many people own a task, decision-making stalls
  - Too many Responsible roles
    - Several people marked "R" for same task can create duplication, confusion and lack of clarity.
  - Excessive Consulted/Informed roles
    - Over-communication can slow processes
    - Too many "I" roles may add noise

# COMMON ERRORS

- Rigid/static chart
  - If not updated, the RACI chart becomes outdated and misleading
- Too granular
  - If every small step has a RACI assignment, the matrix becomes heavy and unwieldy
  - Apply suitable level of granularity
- Misalignment with process map
  - If tasks in process map and tasks in RACI chart don't correspond, then there is the potential for control gaps

# IDENTIFYING CONTROL WEAKNESSES

- Processes don't fail only because of technical or system flaws
  - Often the weakest link is people, communication, or organizational structure
  - Any shortcoming or gap in the design or operation of a control that increases the risk of error, fraud, or non-compliance
- Communication breakdowns often occur
  - Example: lack of timely, accurate information flowing between roles, teams, systems
  - These can turn what might be a minor issue into a major incident
  - Because necessary escalation, monitoring or remediation does not happen

# KEY DIAGNOSTIC ISSUES

- Role confusion
  - When duties overlap, when it is unclear who is supposed to perform or approve a task
  - Potential issues: duplicated work, missed work, or absence of control
    - For example: Two teams think the other will perform the hand-off check.
    - As a result none performs it resulting in a control gap
  - Possible design deficiency of control: lack of clarity as to who is responsible
  - Possible operational deficiency: control exists but how to execute it is unclear

# KEY DIAGNOSTIC ISSUES

- Lack of Accountability
  - Often when tasks are assigned to “everyone” or “anyone” then there is no clear owner of the outcome
  - Without an accountable person, no one drives it, no one maintains oversight, no one escalates when things go wrong
  - Absence of “Accountable” in the RACI or missing “A” for a task means that control is weak or ineffective
  - Frequently shows up in control testing as “no one signed off” or “no owner of the exception” when a failure occurs

# KEY DIAGNOSTIC ISSUES

- Communication Gaps
  - Key information not shared or delayed across teams, departments or levels
    - Example: A security vulnerability is discovered but is not communicated to the business until a change request is processed which results in the hand-off failing
  - Communication gaps are especially dangerous because they often don't show up in routine operations but when an incident or exception occurs
    - These are the situations where speed and clarity matter
  - Edge cases and outliers are often where communication breaks down
    - No one has done a walk through of rare event occurrences because they were overlooked
  - Missed exceptions are often handled by ad hoc initiatives
    - These have to be converted to SOPs and run books to update the controls

# KEY DIAGNOSTIC ISSUES

- Cultural Factors
  - If the organizational culture is a “blame culture”, employees may not escalate issues, near-misses or process deviations
    - They may hide or ignore them
    - This delays remediation, meaning control weaknesses persist
  - A risk-aware culture, encourages reporting, learning, escalation
    - Without this attitude, the “people” and “process” pieces of the risk triangle weaken
  - A well-designed process will still fail if people don’t feel safe to raise issues
    - Or if they lack clarity on roles and communication protocols

# STEP-BY-STEP

- Step 1
- Use process models and RACI charts as a baseline
  - These are the artifacts reviewed to check alignment
  - Are responsibilities clearly assigned?
  - Are hand-offs clear?
  - Where does communications between roles need to happen?

# STEP-BY-STEP

- Step 2
- Review control points and hand offs
  - On the process map, identify every control step: approvals, reviews, checks, data validations, hand-offs
  - For each control step, ask
    - Who is performing this? Do we have a clear owner?
    - What happens if this doesn't occur? Is there a backup?
    - Are there hand-offs (cross-team, cross-system)? If yes, is the receiving party clearly defined?
  - On the RACI chart, ask
    - Are tasks with controls assigned a clear "A" (Accountable)?
    - Are the "C" (Consulted) or "I" (Informed) roles too many (information overload) or missing?
    - Where are the overlaps or omissions?

# STEP-BY-STEP

- Step 3
- Survey and interview stakeholders
  - Speak with people doing the tasks; ask
    - Do you know your role clearly?
    - When you hand-off to another role/team, do you always follow the same procedures?
    - Have you ever waited on someone else to complete a task you thought you'd done?
    - Have you ever found you weren't aware of a change and you carried on in error because you weren't told?
  - Look for signals of communication breakdown
    - For example: repeated rework, tasks waiting on outside team, missing documentation, undocumented exceptions

# STEP-BY-STEP

- Step 4
- Analyze control effectiveness
  - For each control step, evaluate
    - *Design:* Is the control well explained, documented, and aligned with the risk it is intended to mitigate?
    - *Operation:* Is the control executed reliably, consistently? Are there exceptions, workarounds?
  - Use frameworks that control weaknesses into design vs operational vs administrative weaknesses
  - Identify communication weaknesses
    - For example, controls that rely on hand-written log entries, manual emails with no receipt, or informal verbal escalation

# STEP-BY-STEP

- Step 5
- Categorize, prioritize and document weaknesses
  - Create a table or register
  - Each row = identified weakness or communication gap
  - Columns (suggested)
    - Process step
    - Description of weakness
    - Risk impact
    - Root cause (people/process/system)
    - Proposed remediation
    - Priority
- Typical categories
  - Role confusion, missing accountability, unclear hand-off, un-documented escalation, culture/behaviour issue
- Prioritize on impact (how bad if fails) and likelihood (how likely based on current state)
  - Using the standard risk scoring used in the risk analysis

# STEP-BY-STEP

- Step 6
- Develop mitigation and remediation strategies
  - For each identified weakness, propose targeted actions
    - Clarify or rewrite task/role descriptions; update RACI and process map
    - Assign clear Accountable roles; eliminate “everyone’s job”
    - Formalize communication/handoff protocols (who informs whom, what format, timeline)
  - Conduct training and change management to shift culture (from blame to reporting)
  - Automate where possible to reduce hand-offs and manual communication
  - Add monitoring/controls to catch missed hand-offs or uninformed stakeholders
  - Embed review mechanism:
    - The control environment must be monitored and updated regularly
    - Continuous monitoring helps surface weaknesses early

# STEP-BY-STEP

- Step 7
- Monitor and sustain
  - After remediation, embed KPIs/metrics to monitor the effectiveness of the controls
    - For example: number of hand-off delays per month, number of un-approved tasks, number of escalations raised vs expected
  - Conduct periodic process walkthroughs with stakeholders
  - Review culture indicators
    - For example: number of risk/incident reports raised, near-miss reports, time to escalate
  - Use the process map + RACI + control register together as a living document
    - Revisit when process or organization changes

# Q&A AND OPEN DISCUSSION

