

RISK AND RESILIENCE BOOTCAMP

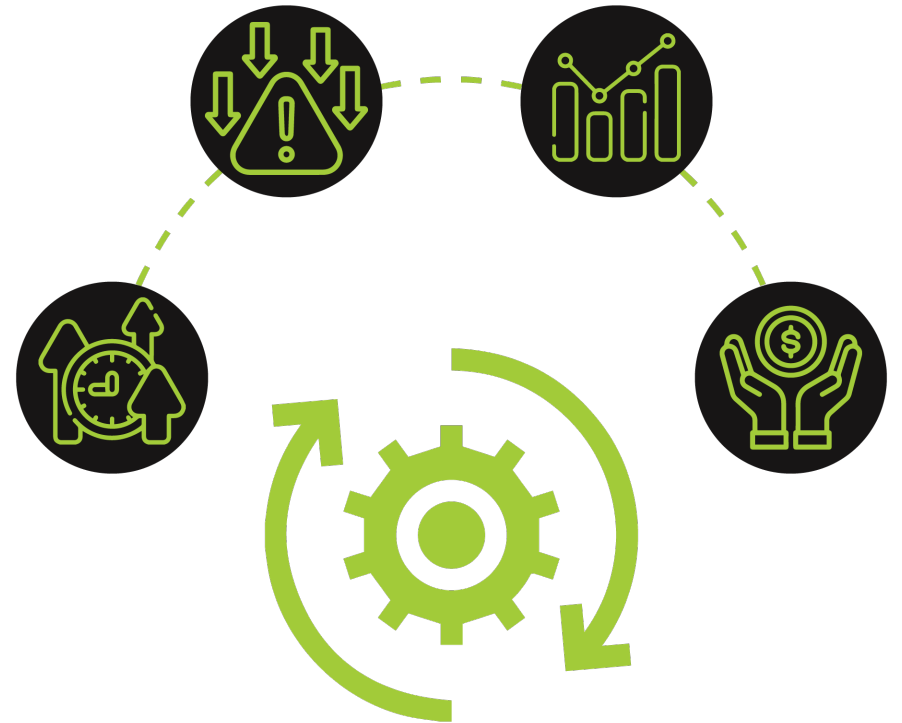




BUSINESS PROCESS MODELING

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

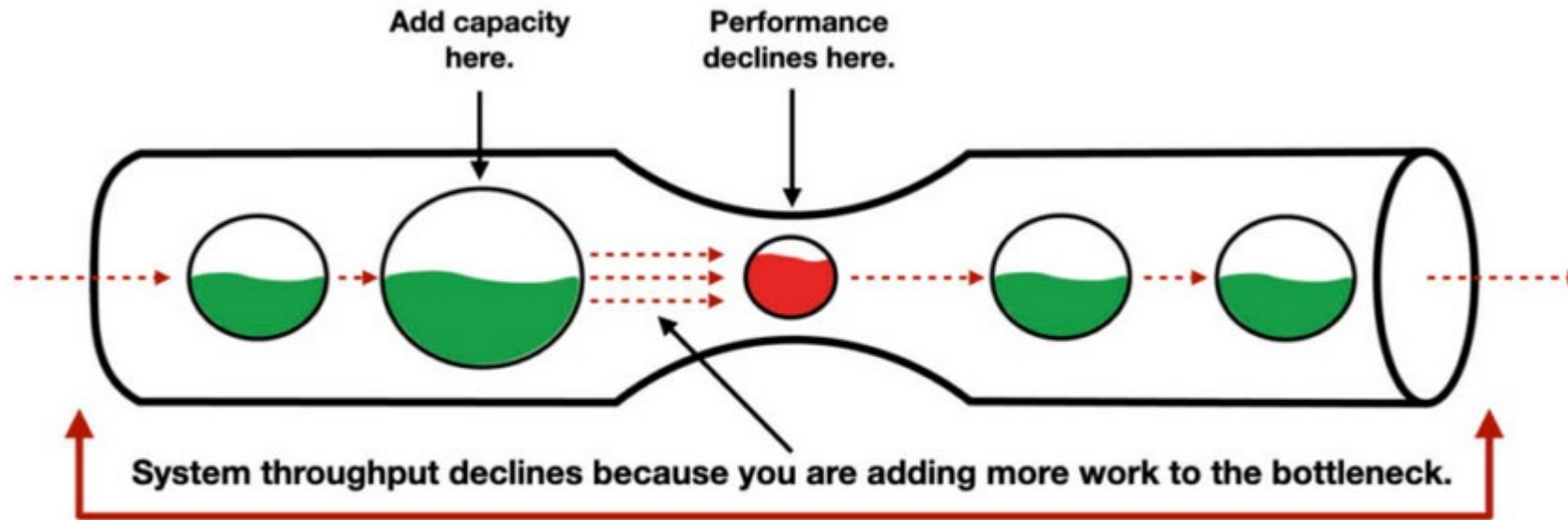
BOTTLENECKS

- 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, then 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.

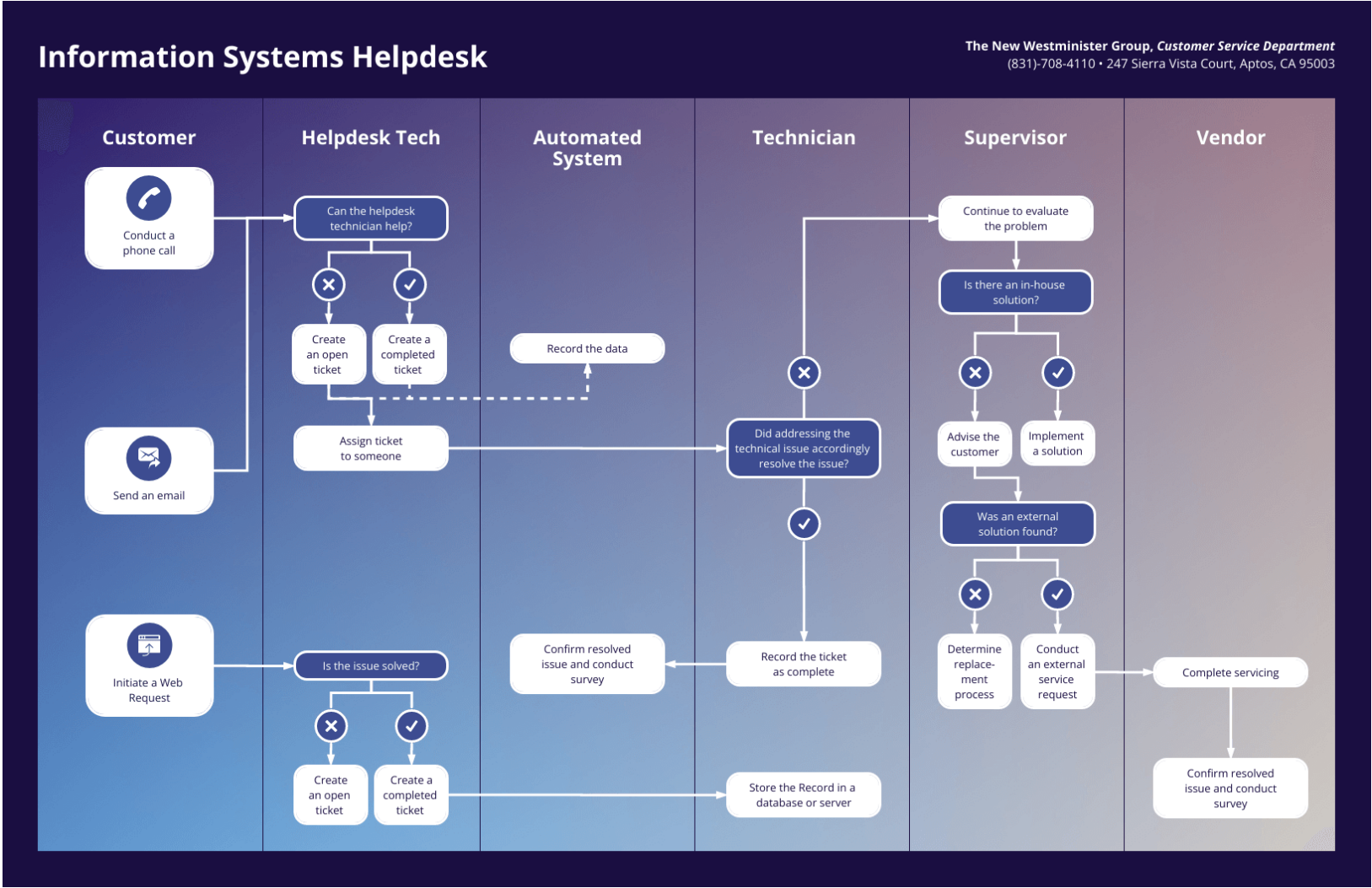
SUMMARY

- 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

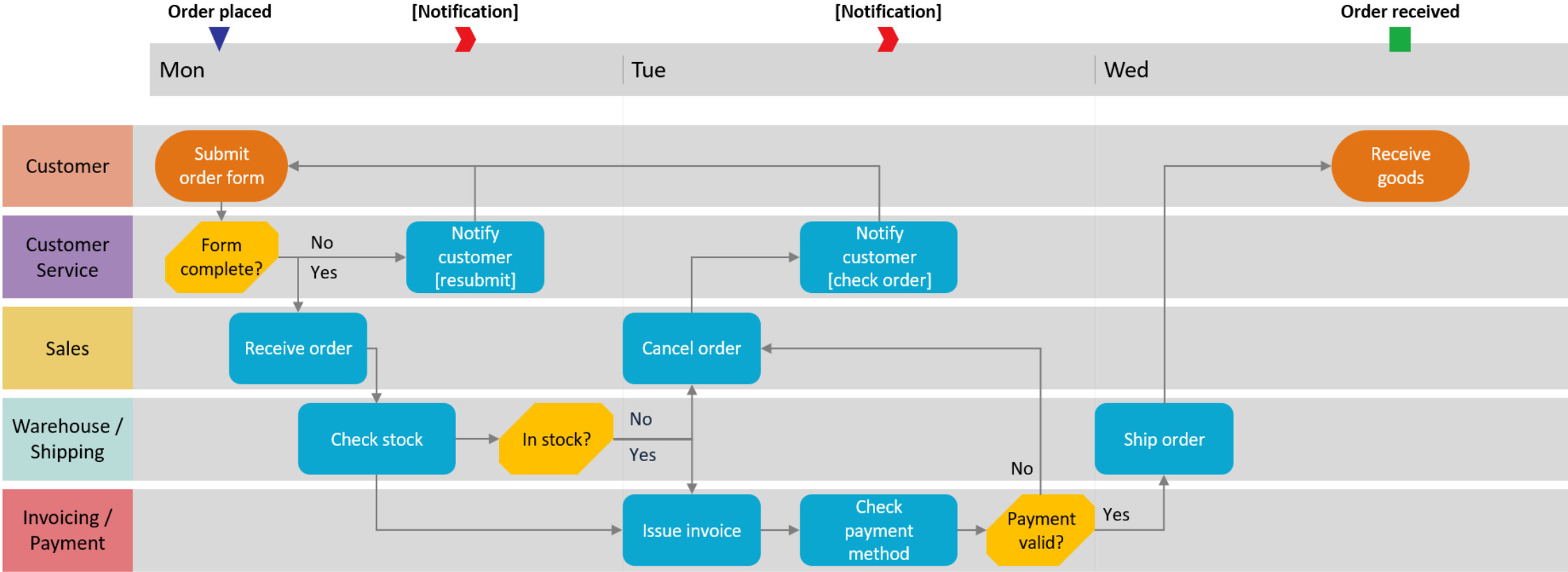
SWIMLANE DIAGRAMS

- 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

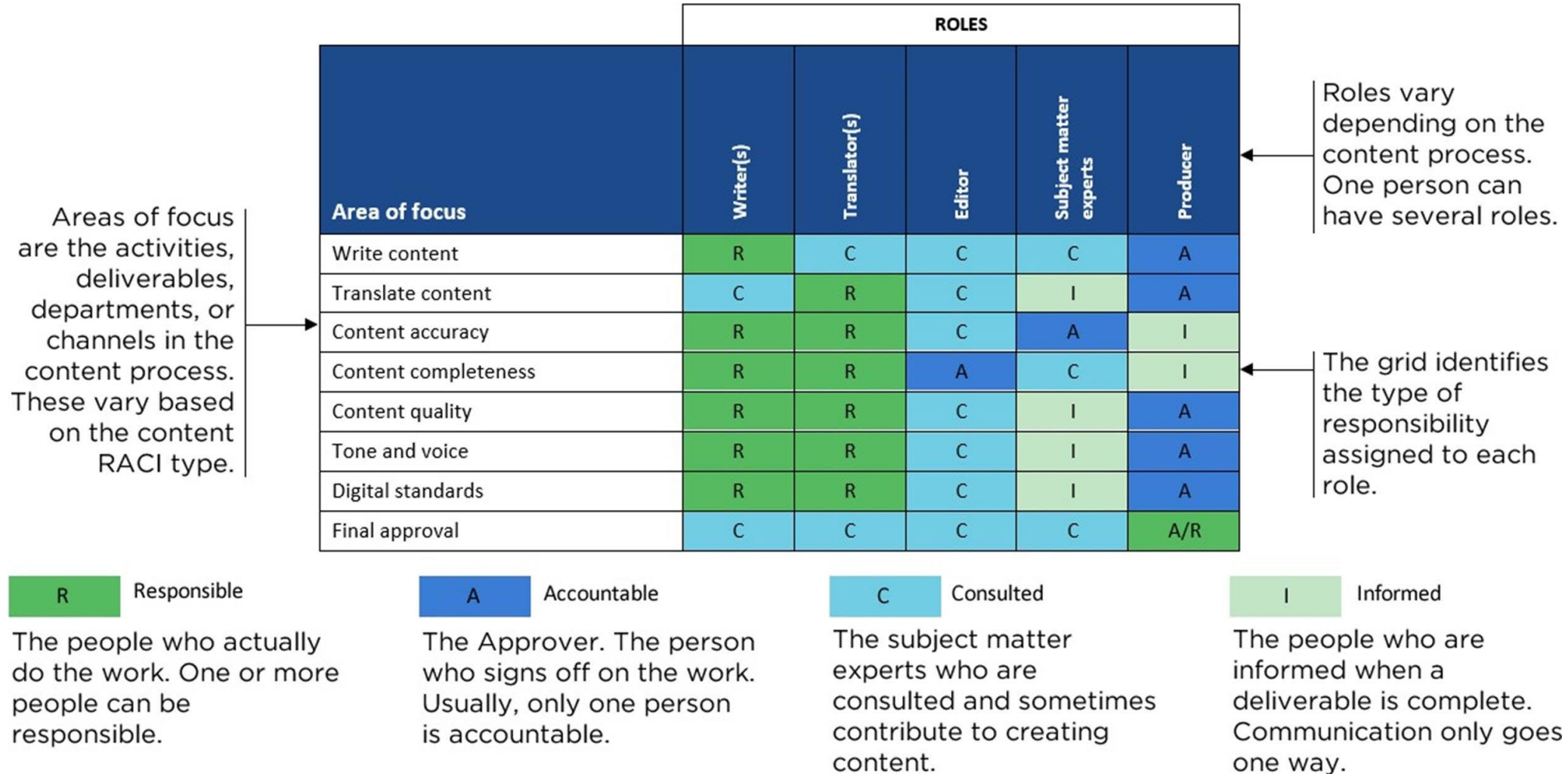
CONSIDERATIONS

- 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



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

