Extracting learning from operational risk loss events and root cause analysis

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Chief Executive, ORIC International
Today’s agenda

- An introduction to ORIC International
- Risk consciousness
- Creating value from risk events
- Conclusions
- Questions
An introduction to ORIC International
Who are we and what do we do

• We are the leading operational risk consortium for the (re)insurance and asset management sector globally

• We are an industry led solution, owned by our members, providing a trusted platform to share operational risk intelligence within our community, including:
  – Risk event data
  – Scenario benchmarks
  – Capital benchmarks
  – Best practice

• We are using our collective experience to advance operational risk management and measurement

• We are deeply involved in the formulation of best practice for the sector
Our member firms
Creating shared value

- Consortium data service: 6,000+ risk events from our member firms
- Scaled consortium data service: Risk events scaled to the size of your organisation
- Public data service: 15,000+ risk events sourced from the public domain
- Scenario and capital benchmarks for our member firms
- Analytics
- Scenario Library service: 400+ detailed scenarios
- KRI Library service: 2,500+ detailed key risk indicators
- Collective learning & collaboration: Development of operational risk frameworks, services and best practice
Risk consciousness
“Human beings, who are almost unique in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so”

Douglas Adams, *The Hitchhiker’s Guide to the Galaxy*
Is this true for your firm?

- People speak openly about near misses and loss events
- Operational risk events are seen as an opportunity to improve
- When a risk event happens, root cause analysis is performed
- Root cause analysis is used to determine the most appropriate response to the risk event
- Key information and learnings from root cause analysis are shared with other parts of the business that could have an exposure
- Internal and external risk event data is used to continuously improve organisational controls and increase operational resilience
Operational risk happens...

- ING Insurance: Australia’s 2nd largest fraud
- 40 year old Rajina Subramaniam worked for ING Insurance in Sydney for 20 years as an accountant
- Embezzled AUD 45 Million between 2004 and 2010 by transferring suspense account balances and unclaimed client money to personal accounts
- Became known throughout Sydney for her lunch hour shopping sprees, in 2009 alone:
  - Chanel: AUD 98,452
  - Bulgari: AUD 3,300,300
  - Paspaley Jewellers: AUD 7,600,000 (over and above AUD 16,000,000 in previous years)
- Reason for the fraud – not valued and respected, Manager delegated everything to her
Even to Swiss firms…

- Zurich Insurance: £2.3m fine for customer data loss
- UK operation of Zurich Insurance fined by the FSA (Financial Services Authority) for losing the personal details of 46,000 customers
- It was the highest fine levied on a single firm for data security failings
- Data (including bank account/credit card details) went missing in transit to a data storage centre in South Africa in August 2008
- However the loss wasn’t uncovered until a year later
- Agreed to settle at an early stage in the investigation, which reduced the fine by 30%
And often too…

**Actual Losses - Frequency & Severity**

**Full Dataset**

<table>
<thead>
<tr>
<th>Year</th>
<th>Gross Loss (GBP) (£m)</th>
<th>No. of Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>100</td>
<td>50</td>
</tr>
<tr>
<td>2006</td>
<td>300</td>
<td>200</td>
</tr>
<tr>
<td>2007</td>
<td>200</td>
<td>150</td>
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<tr>
<td>2008</td>
<td>250</td>
<td>180</td>
</tr>
<tr>
<td>2009</td>
<td>300</td>
<td>200</td>
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<tr>
<td>2010</td>
<td>350</td>
<td>250</td>
</tr>
<tr>
<td>2011</td>
<td>400</td>
<td>300</td>
</tr>
<tr>
<td>2012</td>
<td>450</td>
<td>300</td>
</tr>
<tr>
<td>2013</td>
<td>500</td>
<td>350</td>
</tr>
</tbody>
</table>
Sources of risk event information

• Internal information:
  – Risk assessment (ORSA) and scenario assessment data
  – Internal incidents, or loss event data
  – Complaints, audit findings, control breaches and near misses

• External information:
  – Public sources, such as the press and the internet
  – Commercial vendors of public information
  – Consortium data, derived from participants pooling their internal data and sharing it
And how do you respond to this?

3 typical responses:

- Don’t know about it
- Don’t want to know about it
- That would never happen here
- We are different
- What if?
- Could it?
- How would we react?
- How badly could it hurt us?
Creating value from risk events
‘Creating value from risk events’ study

• ORIC commissioned Oliver Wyman in 2013 to conduct a study into how member firms are/can create value from risk events

• The aim of the study was to identify best practice approaches focusing on four main areas that organisation need to get right:
  – Creating an open culture that encourages reporting
  – Event investigation and analysis, including impact assessment
  – Managing actions
  – Learning and continous improvement

• 28 ORIC members were interviewed alongside 4 asset intensive companies for comparison

• The final report was endorsed by both the IRM & IOR
Objectives of our study

- To identify leading practice in operational risk event, reporting, analysis and management
- Understand more about the role of behaviours and culture
- Develop a maturity model to help organisations benchmark their current performance
- Create a practical reference guide, which contains turn-key approaches
- To identify strengths and opportunities for improvement
Major Findings

• Wide range of operational risk event management practices
• Different levels of maturity – even between companies of a similar scale and in the same business line
• Companies with strong risk management approaches systematically address leadership, staff capability and awareness, governance, systems and reporting
• Maturity linked to behaviours and culture, leadership has a vital role
• Opportunities for other sectors to learn from how we classify, quantify and assess loss events and near misses
• Identified approaches from other sectors to improve near miss capture and root cause analysis
Open environment that encourages reporting

**Good Practice Characteristics**

- Staff feel valued and respected when reporting
- Reporting process is simple
- All staff are clear on what risks are and their role in reporting
- Staff see the value of reporting
- Reporting of an event is timely

**Good Practice Examples**

- **Continual leadership:**
  - Openly recognise staff in meetings or corporate communications
  - Visits / asking questions on visits
  - Continual messaging about the importance of risk reporting
  - Following up on non-reporting

- **Relentless staff engagement:**
  - Annual training (for all staff)
  - Situational training (role playing events)
  - At a minimum, strong risk focal points in each business area

- **Simple process and focus on near misses:**
  - No filter on size of what is reported
  - One page form on the intranet to complete

- **Outsourced operations on the same platform:**
  - A large insurer has placed its outsourced operations on the same risk platform

Leadership support and drive is the most important lever in creating an open reporting environment.
Event investigation and impact analysis

**Good Practice Characteristics**

- Clear thresholds for when to conduct deep root cause analysis (RCA)
- Staff understand how to do RCA
- RCA considers all aspects of the operating model (including behaviours and culture)
- Consistent and robust tools used
- All events have an associated financial and/or non-financial impact
- Trend analysis of events is conducted to identify systemic issues

**Good Practice Examples**

- **Linking it back to the process:**
  - Appointing risk owners for key processes – similar to a process improvement team (LEAN)
- **Peer reviews:**
  - Invite peers for a different part of the business to review their RCA to get challenge and also support sharing of knowledge across the business
  - Set up a RCA forum to review incidents and challenge robustness of the findings and prepare messaging for governance
- **Using RCA as an engagement tool and to identify true root causes:**
  - Use of visual techniques such as fishbone diagrams and bow-ties

Many organisations delegate investigations to internal or external auditors, this results in loss of learnings within the business.
Root cause analysis tools

<table>
<thead>
<tr>
<th>Suggested RCA tools</th>
<th>Good Practice Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Five Whys:</strong></td>
<td><strong>1. Why?</strong></td>
</tr>
<tr>
<td>– Getting to the deep root cause of simple linear events.</td>
<td>A: The pricing system produced the wrong number.</td>
</tr>
<tr>
<td></td>
<td><strong>2. Why?</strong></td>
</tr>
<tr>
<td></td>
<td>A: The data used by the system was incorrect.</td>
</tr>
<tr>
<td></td>
<td><strong>3. Why?</strong></td>
</tr>
<tr>
<td></td>
<td>A: The pricing model producing the data contained a calculation error.</td>
</tr>
<tr>
<td></td>
<td><strong>4. Why?</strong></td>
</tr>
<tr>
<td></td>
<td>A: The pricing model was not quality checked after it was developed three years ago.</td>
</tr>
<tr>
<td><strong>Fishbone/Ishikawa diagram:</strong></td>
<td><strong>5. Why? (a root cause)</strong></td>
</tr>
<tr>
<td>– A simple but robust approach for investigating relatively simple events</td>
<td>A: No policy is in place to ensure pricing tools are audited after pricing updates.</td>
</tr>
<tr>
<td><strong>Bow Tie:</strong></td>
<td><strong>6. Why? (optional)</strong></td>
</tr>
<tr>
<td>– A more sophisticated tool which can be used across scenario planning, investigation, decision making and communication</td>
<td>A: Each pricing model is manually built and developed differently, making creation of a single policy challenging</td>
</tr>
</tbody>
</table>
Managing actions

**Good Practice Characteristics**

- Transparency of the progress of all critical actions
- Clear KPIs and targets
- Robust governance and oversight
- Prioritisation against a defined risk appetite

**Good Practice Examples**

- **Targeting action closure:**
  - One organisation has a target of no more than 10% of actions overdue – if exceed that, committee will investigate and chase

- **Managing with resource constraints:**
  - Due to a large number of actions a global insurer prioritises them based in impact
  - For low priorities, the business agrees that these are ‘acceptable risks’ and removes them from the log
  - Greater focus on the critical action items

- **Single platform to manage actions:**
  - Leading organisations have one platform to capture and manage all actions
  - Teams can drive greater action management discipline as a result of this transparency

A robust governance structure will ensure actions are correctly reported, reviewed, prioritised and unblocked.
Continuous improvement

<table>
<thead>
<tr>
<th>Good Practice Characteristics</th>
<th>Good Practice Examples</th>
</tr>
</thead>
</table>
| • Set targets to reduce annual operational risk exposure | • Capturing and communicating learnings  
  – An insurer creates a monthly pack of internal and external risk events and share with the risk focal points  
  – Staff are expected to discuss one or two each month, testing if the business has the right barriers in place  
  – Key events are shared in the company magazine to ensure all staff are aware  |
| • Captures learnings from internal and external risk events | • Could it happen to us?  
  – A risk function sends out an email to the relevant business asking ‘could this happen to you’ and requests evidence of barriers or actions to close them  |
| • Communicate and engage the appropriate staff in these learnings | • Establishing targets  
  – A large insurer places a target each year to reduce the capital allocated to operational risk  
  – The business uses scenario analysis to evidence how barriers have been strengthened to reduce the probability of key events |
| • Continuous improvement culture exists where the business is in a state of ‘unease’ |  |

Leadership support and drive is the most important lever in creating an open reporting environment.
## Maturity diagnostic

<table>
<thead>
<tr>
<th>Risk Event analysis, investigation and impact assessment</th>
<th>Action management</th>
<th>Learning and continuous improvement</th>
<th>Open environment for reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reactive</strong></td>
<td><strong>Compliant</strong></td>
<td><strong>Proactive</strong></td>
<td><strong>High reliability</strong></td>
</tr>
<tr>
<td>- Only significant risk events are reported</td>
<td>- Coherent process for people to report events</td>
<td>- Everyone feel encouraged to report events</td>
<td>- Single, simple approach to capture enterprise-wide risks</td>
</tr>
<tr>
<td>- Lack of leadership involvement</td>
<td>- Most events reported</td>
<td>- Simple standardised company-wide approach to reporting</td>
<td>- Everyone understand current and potential risks they face</td>
</tr>
<tr>
<td>- Inconsistent reporting processes</td>
<td>- Key people are risk aware</td>
<td>- Ownership of reporting at 1st line</td>
<td>- Everyone understands the need to report risk events and does so directly</td>
</tr>
<tr>
<td>- Fear of blame/ reprimand impedes reporting</td>
<td>- Key people understand how to report a risk event</td>
<td>- Selected staff at 1st line of defence staff are focused on risk</td>
<td>- Open, learning culture sees events as an opportunity to improve</td>
</tr>
<tr>
<td>- People are unsure what to report and why</td>
<td>- Little focus on near miss reporting</td>
<td>- Staff understand the need to report near misses, &gt;50% are reported</td>
<td>- Near misses actively reported in order to reduce frequency of loss events</td>
</tr>
<tr>
<td>- Reporting delegated to the 2nd line</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Near misses not reported</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deep Root Cause Analysis (RCA) for key events and major near misses</strong></td>
<td><strong>Action management process integrated into company-wide continuous improvement approach</strong></td>
<td><strong>Learnings from loss events and near misses used to deliver year on year reductions in risk exposure</strong></td>
<td><strong>Coherent process for people to report events</strong></td>
</tr>
<tr>
<td>- Focus on addressing recovery from loss events</td>
<td>- Root Cause Analysis (RCA) conducted for priority events</td>
<td>- Processes in place to prioritise and share learnings across the company from internal risk events</td>
<td><strong>Simple standardised company-wide approach to reporting</strong></td>
</tr>
<tr>
<td>- Leadership seek to identify responsibility and blame</td>
<td>- Focus on controls, processes and systems – not behaviours</td>
<td>- Actions derived to make a difference</td>
<td>- Ownership of reporting at 1st line</td>
</tr>
<tr>
<td>- Root cause analysis (RCA) not conducted</td>
<td>- Ad hoc and inconsistent approach to RCA - few standard tools</td>
<td>- Actions are prioritised based on resources available and risk appetite</td>
<td>- Selected staff at 1st line of defence staff are focused on risk</td>
</tr>
<tr>
<td>- Clear thresholds for Root Cause Analysis (RCA)</td>
<td>- Little trained investigative capability</td>
<td>- Actions clearly tracked and only closed on evidence</td>
<td>- Staff understand the need to report near misses, &gt;50% are reported</td>
</tr>
<tr>
<td>- Top leadership reviews causes of major events</td>
<td></td>
<td>- Top leadership review actions for major events</td>
<td>- Near misses actively reported in order to reduce frequency of loss events</td>
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<tr>
<td><strong>Actions for most loss events are not monitored or followed up</strong></td>
<td><strong>Actions are managed, monitored and closed</strong></td>
<td><strong>Processes in place to prioritise and share learnings across the company from internal risk events</strong></td>
<td><strong>Deep Root Cause Analysis (RCA) for key events and major near misses</strong></td>
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<td>- Follow-up for major events is on ad hoc basis</td>
<td><strong>Approach and tools for action management are not consistent across company</strong></td>
<td><strong>Actions are derived from external risk events</strong></td>
<td><strong>Analysis identifies trends and causes from volume lesser events</strong></td>
</tr>
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<td><strong>Changes to policies and procedures occur in response to significant internal risk events</strong></td>
<td><strong>Actions are managed, monitored and closed</strong></td>
<td><strong>Appropriate ORIC data shared with 1st line</strong></td>
<td><strong>All leaders are seen to engage in RCA</strong></td>
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<td><strong>Processes in place to prioritise and share learnings across the company from internal risk events</strong></td>
<td><strong>Approach and tools for action management are not consistent across company</strong></td>
<td><strong>Multiple channels used to engage staff in learnings</strong></td>
<td><strong>Focus on behaviours (why people acted that way)</strong></td>
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<td><strong>Learnings not always shared across all relevant parts of the company</strong></td>
<td><strong>Actions are managed, monitored and closed</strong></td>
<td><strong>The 3rd line review learning effectiveness</strong></td>
<td><strong>Leadership, behavioural and cultural issues confronted</strong></td>
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<td><strong>Review of major external risk events is not systematic</strong></td>
<td><strong>Actions are managed, monitored and closed</strong></td>
<td><strong>Learnings are derived from external risk events</strong></td>
<td><strong>Quality assurance of investigations through peer and 3rd line review</strong></td>
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<td><strong>Learnings tend to be ad hoc and rely often on informal networks</strong></td>
<td><strong>Actions are managed, monitored and closed</strong></td>
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- **Open environment for reporting**
  - Only significant risk events are reported
  - Lack of leadership involvement
  - Inconsistent reporting processes
  - Fear of blame/ reprimand impedes reporting
  - People are unsure what to report and why
  - Reporting delegated to the 2nd line
  - Near misses not reported

- **Risk Event analysis, investigation and impact assessment**
  - Focus on addressing recovery from loss events
  - Leadership seek to identify responsibility and blame
  - Root cause analysis (RCA) not conducted

- **Action management**
  - Actions for most loss events are not monitored or followed up
  - Follow-up for major events is on ad hoc basis

- **Learning and continuous improvement**
  - No systematic approach in place to learn from internal or external risk events
  - Learnings tend to be ad hoc and rely often on informal networks
Where is your firm now?

Where is your firm now?

Reactive
“Cost of doing business”

Compliant
“Do what it takes to comply”

Proactive
“Lets improve how we do things”

High Reliability
“Continuous improvement is in our DNA”

Moving from Reactive
Compelling benefits case
Leadership support
Staff awareness

Moving from Compliant
Near miss management
Behaviours, culture and capability
Root cause analysis
Learning organisation

There is a significant financial and reputational prize for organisations who make the shift
Conclusions

1. **Reduce operational risk losses by placing a strong focus on risk event reporting, analysis, learning and sharing**

2. Focus on near misses as well as loss events to reduce the number of loss events

3. Put clear thresholds in place for performing a deeper root cause analysis (RCA)

4. The root cause analysis of any risk event should consider behavioural aspects and evaluate culture

5. A systems and process based solution to risk event management won’t work without strong leadership and staff engagement

6. Become a learning organisation, heighten your organisations risk ‘consciousness’

7. Strengthen the learning process to ensure that the business can improve itself
Questions?
Powering risk intelligence