

Teaching undergraduates to analyze major incidents as failures in risk management systems

Case Study: Rogers 2022 Outage

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CSCHE Process Safety Management Division (PSMD)

26 May 2026



David and Joan Lynch School
of Engineering Safety and
Risk Management

LIVE AERIAL VIEW CALIFORNIA CHEMICAL LEAK

GKN Aerospace in
Garden Grove with
7,000 gallons of
methyl methacrylate

50,000 residents
evacuated



California Chemical Leak LIVE Updates | Aerial View
of California Plant With Failing Chemical Tank

Watch >

Uploaded: May 23, 2026 · 40 Likes

Officials ordered tens of thousands of people to evacuate their homes in...

More ▾



"We Sincerely apologize for the significant disruption... We are working tirelessly with all relevant experts to resolve this situation as safely as possible and in a timely manner."

GKN Aerospace

CLASS ACTION LAWSUIT FILED OVER CHEMICAL TANK DANGER



FOR MORE INFORMATION CALL 714-741-5444   CREWS BATTLE FIRE AT PALLET YARD IN POMONA

7:06 57°

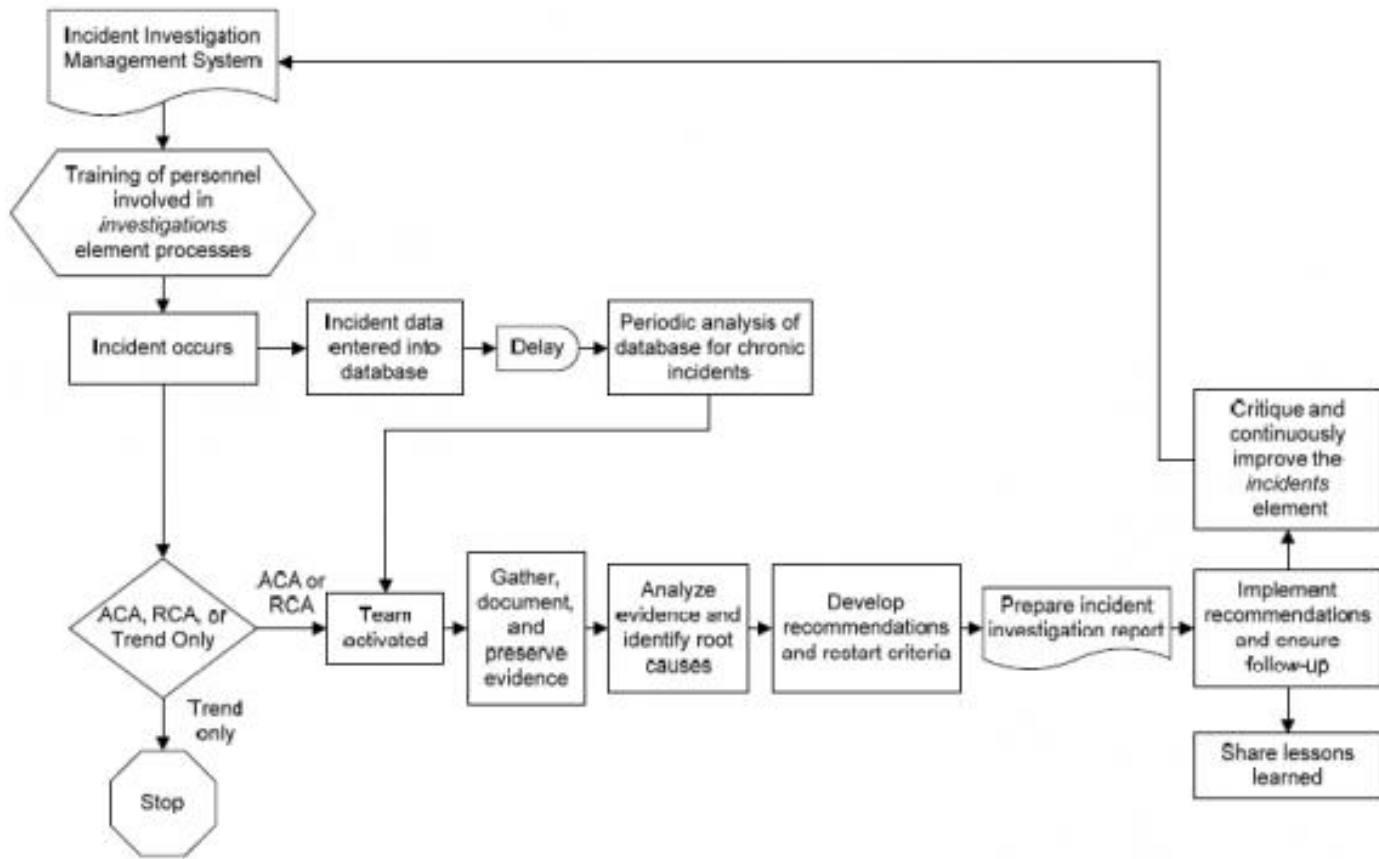


FIGURE 19.1. Incident Investigation Flowchart

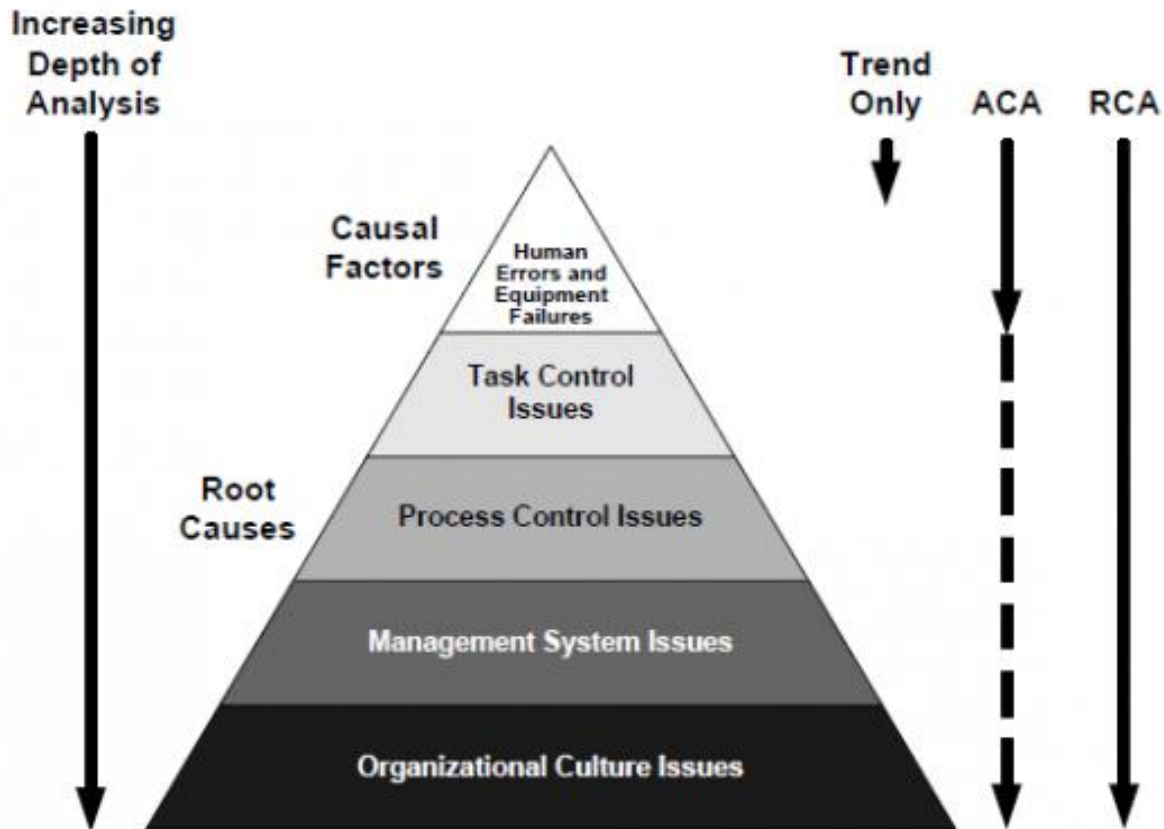
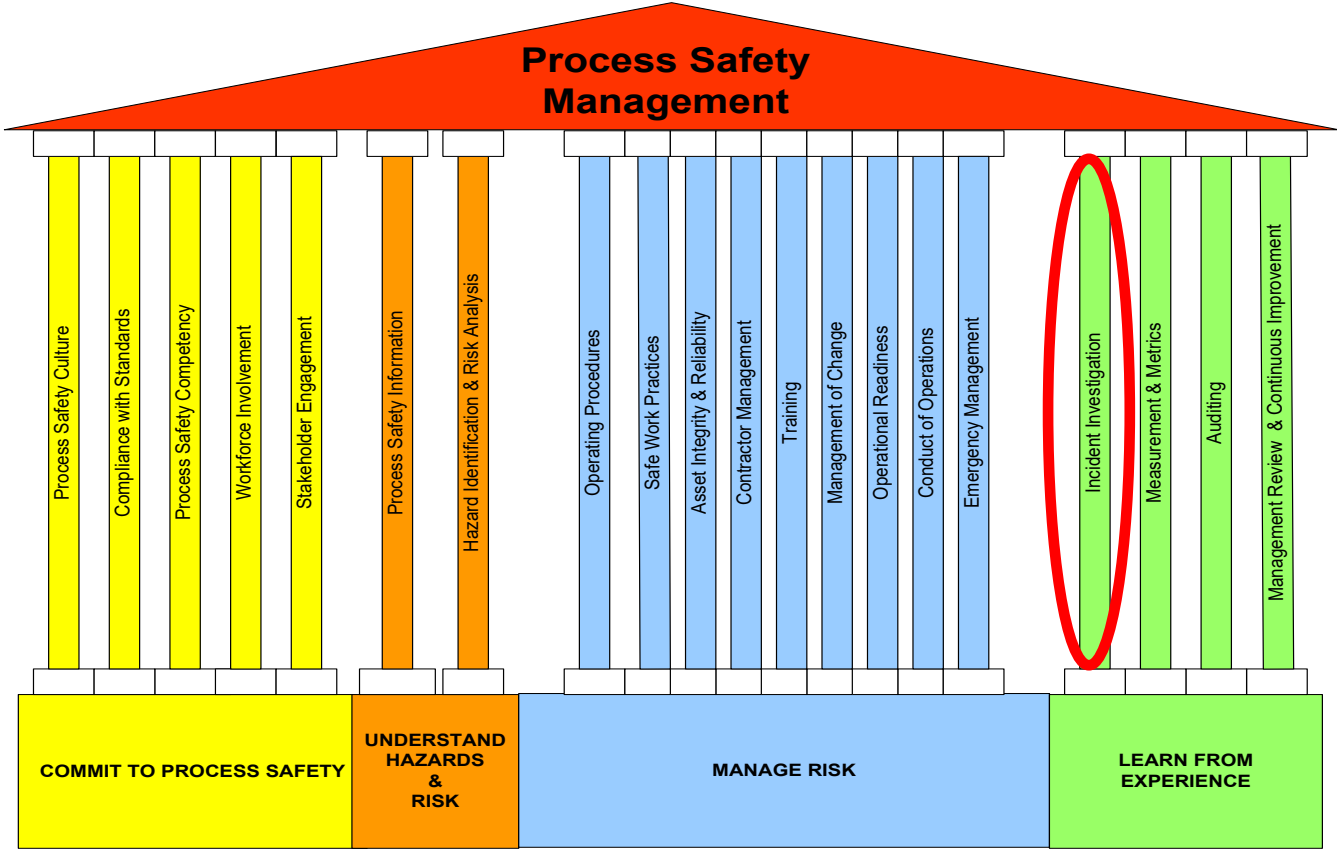


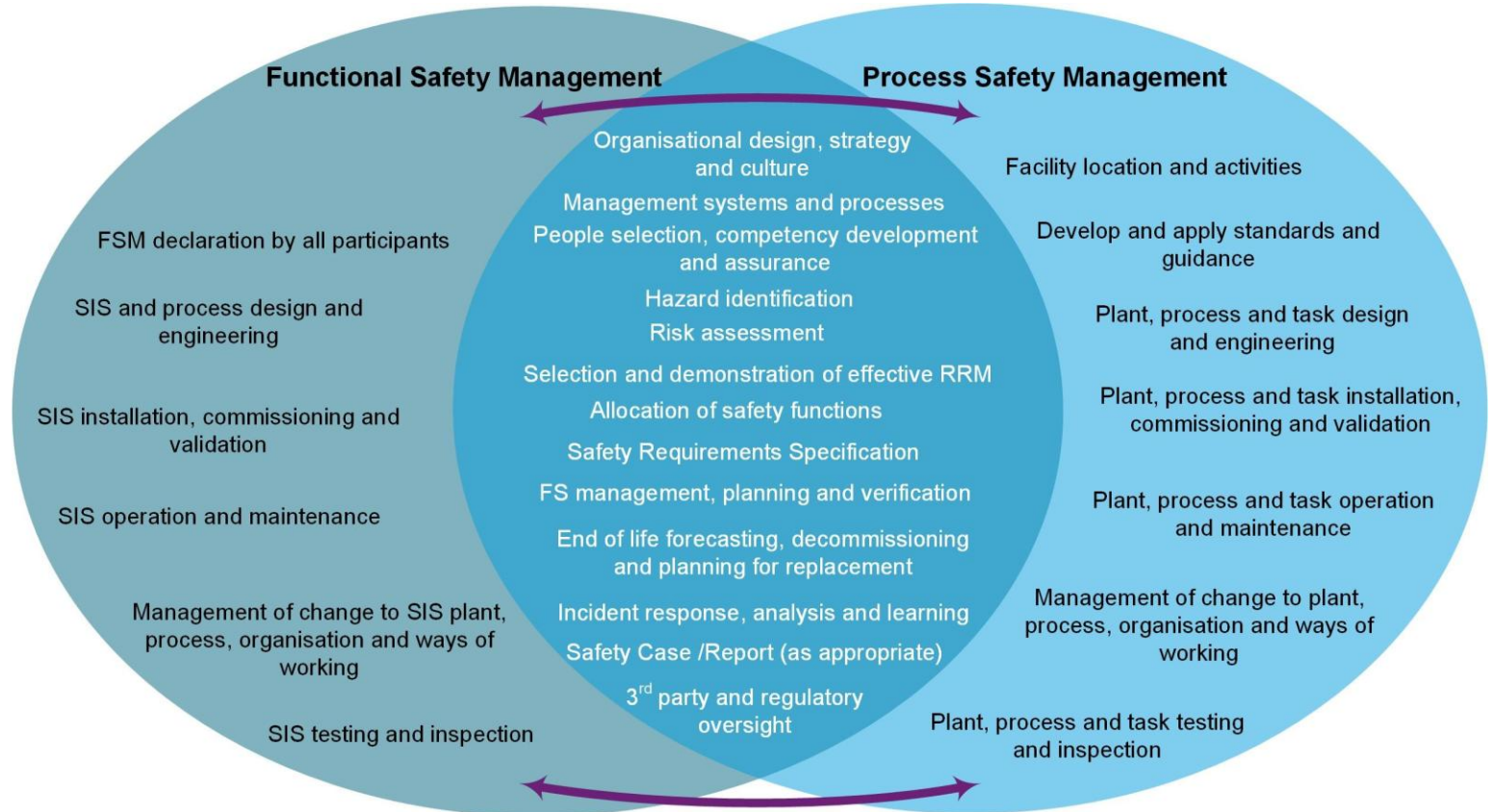
FIGURE 19.2. Incident Investigation Levels of Analysis

CCPS's SAFETY MANAGEMENT SYSTEM



20 Safety Management System Elements

IChemE FUNCTIONAL AND PROCESS SAFETY MANAGEMENT SYSTEM



IChemE (2022) Learning from Major Incidents

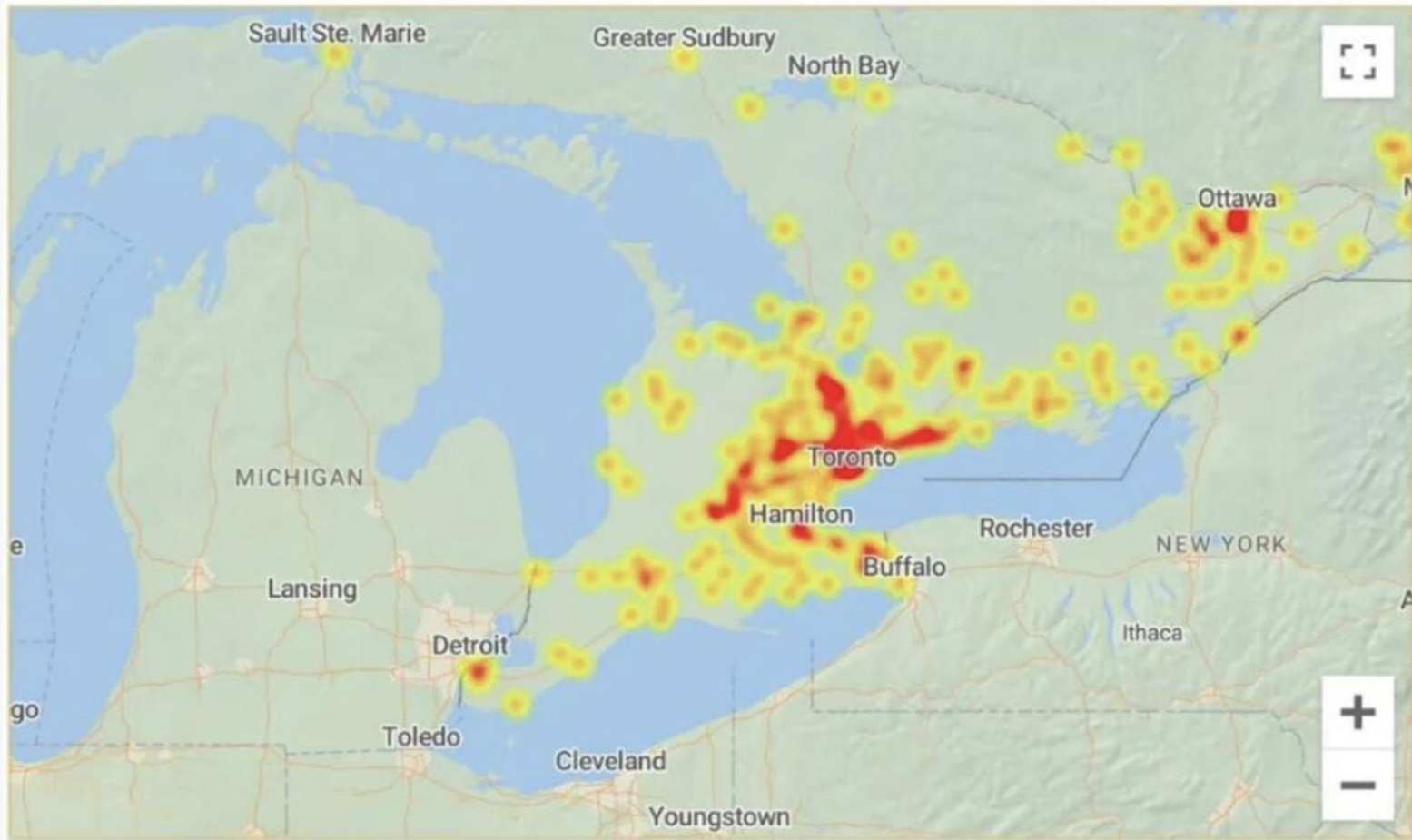
Major Process Safety Incident vs Root Cause Map
(Quick Reference Guide)

	"Natech" Triggers										Root Causes																																					
Abnormal Operations	Escalation Potential	Earthquake	Tsunami	Flood	Cyclone/Hurricane	Extreme Cold/Ice	Hazard Identification	Process Design	Equipment/Piping Design	Materials of Construction	Instrumentation	Safety Instrumented Systems	Protective Systems	Plant Layout	Occupied Buildings	Process Monitoring	Process Control	Cyber Security Breach	Alarm Management	Creeping Change	Hazard Awareness	Operations Risk Assessment	Preventative Maintenance	Inspection	Material Degradation	Work Planning	Maintenance Risk Assessment	Energy Isolation	Control of Work	Housekeeping	Human Factors	Role Clarity	Personal Protective Equipment	Communication	Procedures	Training	Supervision/Leadership	Contractor Selection	Production over Safety	Normalisation of Deviance	Quality Assurance/Control	Management of Change	Failure to Learn	Emergency Preparedness	Process Safety Management	Design Standards	Land Use Planning	Regulatory Compliance Audits
Context	Natural Hazards					Design Factors					Operations Factors					Maintenance Factors					Personal		Competency			Culture				Regulator																		

IChemE (2022) Learning from Major Incidents

Sector	Date	Event	Country	Type	
Oil & Gas	Upstream	06-Jul-88	Piper Alpha	UK	Explosion
		27-Jul-05	Mumbai High North	India	Explosion
		20-Apr-10	Macondo	USA	Explosion
	LNG	11-Feb-15	Camariupim	Brazil	Explosion
		19-Jan-04	Skikda	Algeria	Explosion
		25-Sep-98	Longford	Australia	Explosion
	GPP	24-Mar-89	Valdez	USA	Fire
		06-Jul-13	Lac Mégantic	Canada	Pollution
	Ship	04-Jan-66	Feyzin	France	Fire
		04-Jan-66	Feyzin	France	BLEVE
Rail	23-Jul-84	Romeville	USA	Explosion	
	22-Mar-87	Grangemouth	UK	Explosion	
Downstream	24-Jul-94	Milford Haven	UK	Explosion	
	23-Feb-99	Avon	USA	Explosion	
	17-Aug-99	Izmit	Turkey	Fire	
	16-Apr-01	Humber	UK	Explosion	
	23-Mar-05	Texas City	USA	Explosion	
	05-Nov-05	Delaware City	USA	Explosion	
	16-Feb-07	Mckee	USA	Asphyxiation	
	02-Apr-10	Anacortes	USA	Fire	
	11-Mar-11	Chiba	Japan	BLEVE	
	06-Aug-12	Richmond	USA	Fire	
Terminal	18-Feb-15	Terrance	USA	Explosion	
	19-Nov-84	San Juan Ixhuatepec	Mexico	BLEVE	
	11-Dec-05	Buncefield	UK	Explosion	
	23-Oct-09	Bayamon	Puerto Rico	Explosion	
	Coal	28-Mar-79	Three Mile Island	USA	Near Miss
		26-Apr-86	Chernobyl	Russia	Explosion
	Nuclear	11-Mar-11	Fukushima Daiichi	Japan	Explosion
		08-Apr-99	Gannon	USA	Explosion
	Petrochemical	10-Nov-07	Dallman	USA	Explosion
		01-Jun-74	Elizborough	UK	Explosion
23-Oct-89		Passadena	USA	Explosion	
21-Sep-92		Castelford	UK	Explosion	
01-Feb-94		Ellesmere Port	UK	Fire	
27-Mar-98		Hahnville	USA	Asphyxiation	
13-Jun-13		Geismar	USA	BLEVE	
03-Jun-14		Moerdijk	Netherlands	Explosion	
31-Aug-17		Crosby	USA	Explosion	
Agrochemical		10-Jul-76	Seveso	Italy	Decomposition
	03-Dec-84	Bhopal	India	Toxic Release	
	21-Sep-01	Toulouse	France	Toxic Release	
	15-Nov-14	La Porte	USA	Toxic Release	
	17-Apr-13	West	USA	Explosion	
Pharma	04-Jan-92	Grimsby	UK	Runaway	
	29-Jan-03	Kinston	USA	Explosion	
	28-Apr-08	Cork	Ireland	Runaway	
	23-May-84	Abbeystead	UK	Explosion	
	06-Jul-88	Camelford	UK	Pollution	
Water	05-Apr-93	Milwaukee	USA	Disease	
	03-Sep-91	Hanlet	USA	Fire	
	11-Apr-03	Louisville	USA	Explosion	
Food	07-Feb-08	Port Wentworth	USA	Explosion	

ROGERS OUTAGE 2022



Cause-effect model to latency (weaknesses in management system elements)

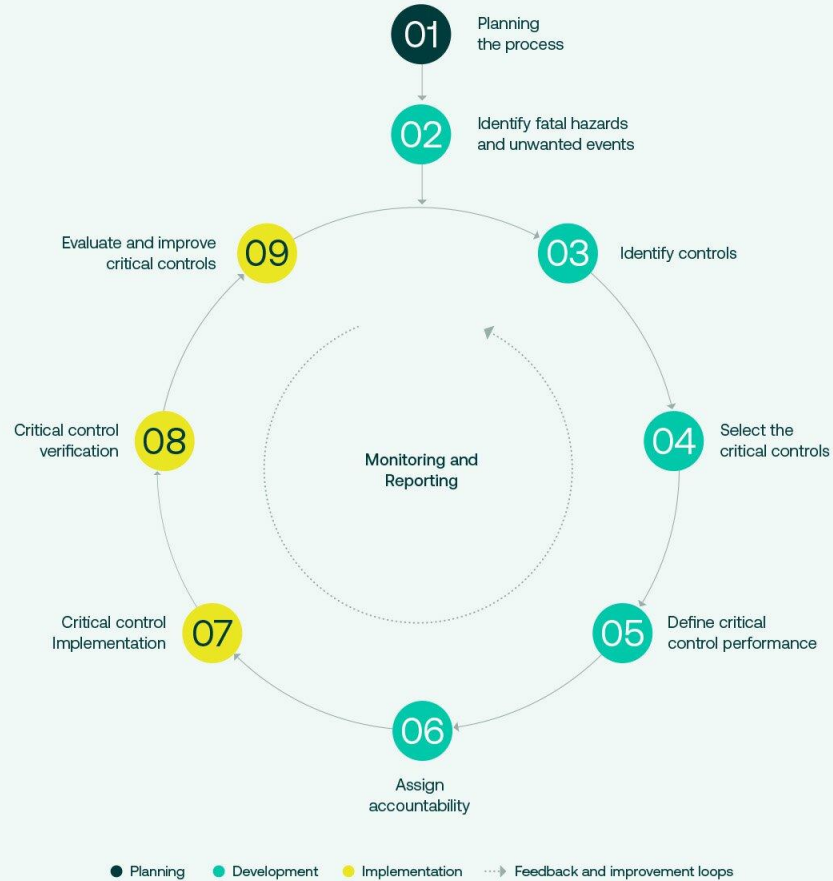
Detailed Cause and Effect Model:						
Losses Type	Incident Type	Immediate Causes Type	Basic Causes Type	Latent Causes		
				Weaknesses in System Elements		
				P	S	C
Injury / Illness	Body Motion:	Substandard Work Practices	Engineering & Design Factors:	1) Management Leadership, Commitment and Accountability.		
First Aid	Struck against	Use of Protective Defenses (assumes in place)	inadequate technical design	2) Risk Assessment and Management of Risks.		
Medical Treatment	Struck by	Use of Tools or Equipment (good equipment available)	inadequate ergonomic design	3) Community Awareness and Emergency Preparedness.		
Lost Time	Fall to lower level	Following Procedures General: (assumes sound & exist)	inadequate assessment of loss exposures	4) Management of Change.		
Fatality	Fall on same level	Following Procedures Specific: (assumes sound & exist)	inadequate standards, specifications and/or design criteria	5) Incident Reporting, Investigation, Analysis and Actions.		
	Caught in	Inattention / Lack of Awareness (not focused)	inadequate monitoring of construction	6) Program Evaluation and Continuous Improvement.		
Environment	Caught on		inadequate assessment of operational readiness	7) Design, Construction and Start-up.		
spill / release <25 kg, no adverse impact	Caught between	Substandard Conditions	inadequate monitoring of initial operation	8) Operations and Maintenance.		
spill / release >25 kg, no adverse impact	Overexertion	Hardware	inadequate evaluation and/or documentation of change	9) Employee Competency and Training.		
spill / release >25 kg, adverse impact	Overstress	Condition of Safeguards	Job Factors:	10) Contractor Competency and Integration.		
regulatory exceedance		Process Exposure	Inadequate maintenance	11) Operations and Facilities Information and Documentation.		
off-plant adverse impact	Contact with:	Workspace Hazards	Inadequate job procedures			
	Environmental Heat		Error-inducing conditions			
Assets	Environmental Cold		Organizational factors			
Minor <\$5,000	Hot surface		Incompatible goals			
Serious \$5,000-\$50,000	Cold surface		Inadequate training			
Major \$50,000-\$500,000	Fire		Inadequate communication			
Catastrophic >\$500,000	Electricity					
	Chemical - corrosive		Personal Factors:			
Business Interruption *	Chemical - toxic		Inadequate physical / physiological state / capability to do the work.			
Minor <\$5,000	Noise		Perceived inadequate mental / psychological state / capability to do the work.			
Serious \$5,000-\$50,000	Pressure		Physical or physiological stress.			
Major \$50,000-\$500,000	Radiation		Perceived mental or psychological stress.			
Catastrophic >\$500,000			Improper risk taking / improper motivation			
			Lack of knowledge / lack of skill.			
* measured as conversion cost of lost production plus any wasted / lost materials				Categories of Latent Causes: P = inadequate program S = inadequate standards C = inadequate compliance		



RISK MANAGEMENT SYSTEM ELEMENTS (APEGA)

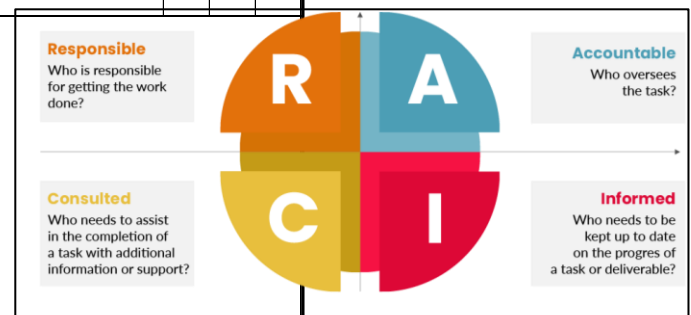
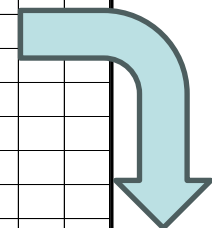
- 1) Management Leadership, Commitment and Accountability.
- 2) Risk Assessment and Management of Risks.
- 3) Community Awareness and Emergency Preparedness.
- 4) Management of Change.
- 5) Incident Reporting, Investigation, Analysis and Actions.
- 6) Program Evaluation and Continuous Improvement.
- 7) Design, Construction and Start-up.
- 8) Operations and Maintenance.
- 9) Employee Competency and Training.
- 10) Contractor Competency and Integration.
- 11) Operations and Facilities Information and Documentation.

ICMM THE CRITICAL CONTROL MANAGEMENT PROCESS



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Categories of Latent Causes:

P = inadequate program

S = inadequate standards

C = inadequate compliance

* measured as conversion cost of lost production plus any wasted / lost materials
 This model is based on a model developed by Bird Jr., F.E. and Germain, G.L. (1992). Practical Loss Control Leadership. Loss Control Management. Det Norske Veritas Inc. Adapted by ESRM Program at The U of Alberta, including the APEGA Model for Management System Elements.

APPLICATION THREAT MODELING ACTIVITIES per STAGE	BU/Product Groups						Corporate Functions							3rd Party	
	MGT	PMO	BA	ARC	SWE	QA	SYS	SOC	RL	PC	SA	EA	CTO	VA	PT
STAGE 1 - DEFINE BUSINESS OBJECTIVES - Est. New TM = 2-4 hours Est. Repeat TM = < 1 hour	A	R	R	A	I	I	I	-	I	R	I	I	R	-	-
Obtain business objectives for product or application	A	I	R	A	I	I	I	-	I	-	-	I	I	-	-
Identify regulatory compliance obligations	A	I	I	A	I	I	I	-	I	R	-	I	I	-	-
Define a risk profile or business criticality level for the application	A	I	I	A	I	I	I	-	I	C	I	I	R	-	-
Identify the key business use cases for the application/product	A	R	R	A	I	I	I	-	I	-	-	I	I	-	-
STAGE 2 - TECHNICAL SCOPE - Est. New TM = 3-4 hours Est. Repeat TM = 1-3 hours	I	I	C	A	R/A	C	I	-	I	-	I	C	I	-	-
Enumerate software applications/database in support of product/application	I	I	C	A	R/A	C	I	-	-	-	-	C	I	-	-
Identify any client-side technologies (Flash, HTML5, etc.)	I	I	C	A	R/A	C	I	-	-	-	I	C	I	-	-
Enumerate system platforms that support product/application	I	I	C	A	R/A	C	I	-	-	-	I	C	I	-	-
Identify all application/product actors	I	I	C	A	R/A	C	I	-	-	-	I	C	I	-	-
Enumerate services needed for application/product use & management	I	I	C	A	R/A	C	I	-	-	-	I	C	I	-	-
Enumerate 3rd party COTS needed for solution	I	I	C	A	R/A	C	I	-	-	-	I	C	I	-	-
Identify 3rd party infrastructures, cloud solutions, hosted networks, mobile devices	I	I	C	A	R/A	C	I	-	-	-	I	C	I	-	-
Obtain business objectives for product or application	I	I	C	A	R/A	C	I	-	I	-	I	C	I	-	-
STAGE 3 - APPLICATION DECOMPOSITION - Est. New TM = 8 hours Est. Repeat TM = 4 hours	I	I	I	A	R	C	C	-	I	-	-	C	-	-	-
Perform data flow diagram of application environment	I	I	I	A	R	I	C	-	-	-	-	C	-	-	-
Define application trust boundaries/trust models	I	I	I	A	R	C	C	-	-	-	-	C	-	-	-
Enumerate application actors	I	I	I	A	R	C	C	-	-	-	-	C	-	-	-
Identify any stored procedures/batch processing	I	I	I	A	R	C	C	-	-	-	-	C	-	-	-
Enumerate all application use cases (ex: login, account update, delete users, etc.)	I	I	I	A	R	C	C	-	-	-	-	C	-	-	-
STAGE 4 - THREAT ANALYSIS - Est. New TM = 8 hours Est. Repeat TM = 2 hours	I	I	R/A	A	R/A	R/A	C	C	-	-	-	I	-	-	-
Gather/correlate relevant threat intel from internal/external threat groups	I	I	R/A	A	C	I	C	C	-	-	-	C	-	-	-
Review recent log data around application environment for heightened security alerts	-	-	I	A	R	R/A	I	C	-	-	-	C	-	-	-
Gather audit reports around access control violations	-	-	I	A	R	C	I	C	-	-	-	C	-	-	-
Identify probable threat motives, attack vectors & misuse cases	I	I	I	A	R/A	C	I	C	-	-	-	C	-	-	-
STAGE 5 - VULNERABILITY ASSESSMENT - Est. New TM = 12 hours Est. Repeat TM = 8 hours	I	I	I	A	R	C	I	C	I	-	-	I	-	R/A	R
Conduct targeted vulnerability scans based upon threat analysis	-	-	-	A	R	C	I	C	I	-	-	I	-	R	R
Identify weak design patterns in architecture	-	-	-	A	R	C	I	-	-	-	-	C	-	R	C
Review/correlate existing vulnerability data	I	I	I	A	R	I	I	C	-	-	-	I	-	R/A	I
Map vulnerabilities to attack tree	-	-	I	A	R	I	I	-	-	-	-	C	-	C	I
STAGE 6 - ATTACK ENUMERATION - Est. New TM = 10 hours Est. Repeat TM = 5 hours	I	I	I	A	R	R	-	-	I	-	-	C	I	I	R/A
Enumerate all inherent and targeted attacks for product/application	I	I	I	A	R	C	-	-	I	-	-	C	I	I	R/A
Map attack patterns to attack tree vulnerability branches (attack tree finalization)	-	-	-	A	R	C	-	-	I	-	-	C	-	I	A
Conduct targeted attacks to determine probability level of attack patterns	-	-	-	A	C	R	-	-	I	-	-	C	-	I	R/A
Reform threat analysis based upon exploitation results	I	I	I	A	R	C	-	-	I	-	-	C	I	I	C
STAGE 7 - RESIDUAL RISK ANALYSIS - Est. New & Repeat TM = 5 days (inc. countermeasure dev.)	C	I	I	A	R	C	C	C	I	I	C	C	I	I	R
Review application/product risk analysis based upon completed threat analysis	I	I	I	A	R	C	I	C	I	I	C	C	I	I	R
List recommended countermeasures for residual risk reduction	I	I	I	A	R	C	C	C	I	I	C	C	I	I	R
Re-evaluate overall application risk profile and report.	C	I	I	A	R	C	I	I	I	C	C	C	I	I	I

- MGT** Product Mgmt
- PMO** Project Mgmt
- BA** Business Analyst
- ARC** Architect
- SWE** Software Engineer
- QA** Quality Assurance
- SYS** SysAdmin
- SOC** Security Operations
- RL** IT Risk Leader
- PC** Product Compliance
- SA** Software Assurance
- EA** Enterprise Architect
- CTO** Administration
- VA** Vuln Assessor
- PT** Pen Tester

Corporate Functions

- Office of the CTO
- Compliance
- Security (ISRM)

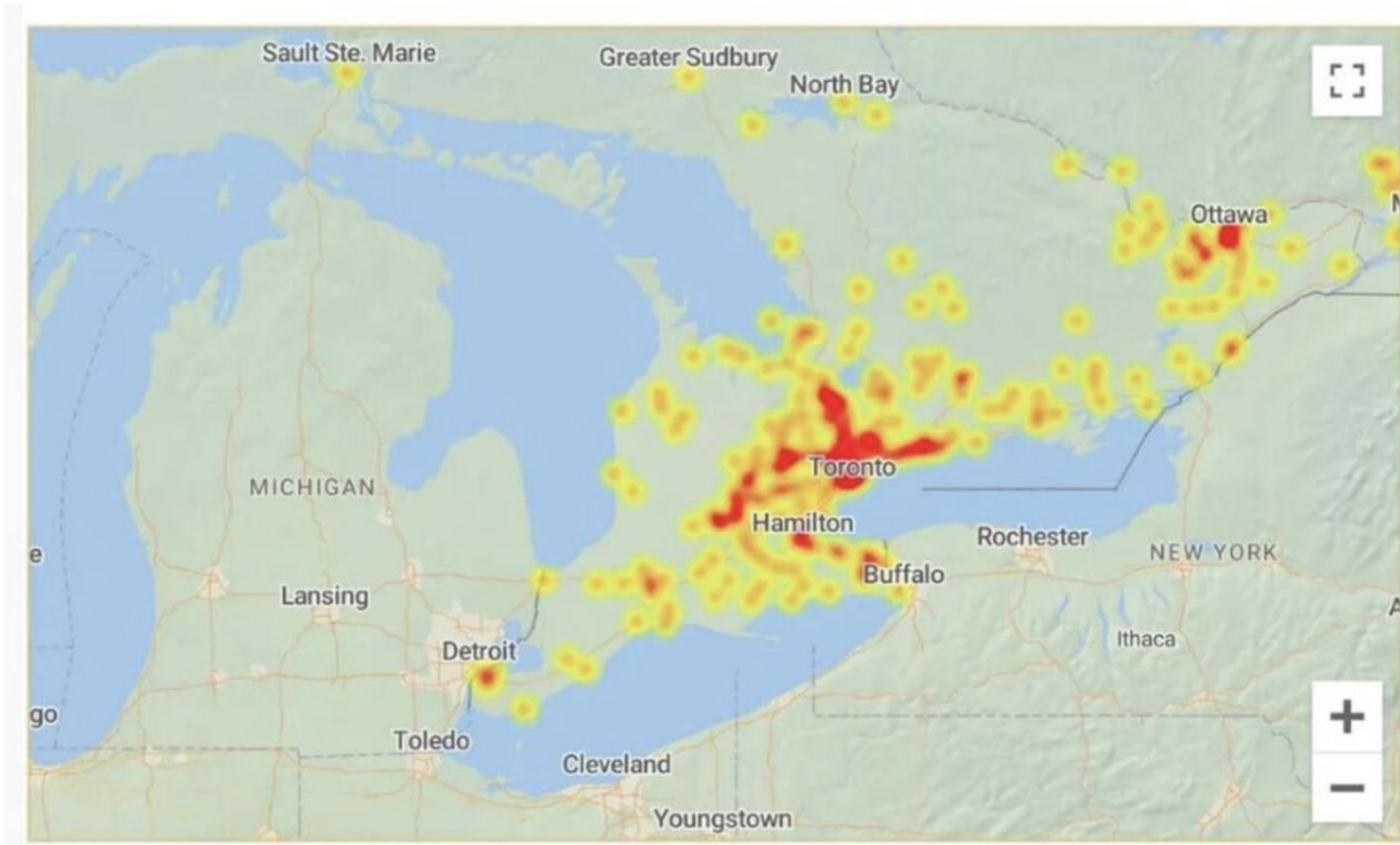
RACI Legend

- R Responsible
- A Accountable
- C Consulted (2 way)
- I Informed (1 way)



VerSprite's Process for Attack, Simulation and Threat Analysis (PASTA) benefits stakeholders by assessing threats to your application environment by designing secure applications and deciding how to mitigate risks by applying risk mitigation strategies. Examples include Architects, Developers, Security Testers, Project Managers, Business Managers, and Information Risk Officers. [Learn more >>](#)

ROGERS OUTAGE 2022



ROGERS OUTAGE 2022

The July 8, 2022 Rogers network outage was caused by a routing error during a system upgrade when Rogers staff inadvertently removed an Access Control List (ACL) policy filter from distribution routers. This missing ACL allowed a flood of IP routing data to crash the core network.

This critical network failure, which impacted roughly 12 million customers:

The Root Cause: Removing the ACL filter caused routing information to flood the core network routers. This triggered a massive system crash within minutes.

Flawed Risk Assessment: The configuration change was the sixth phase of a seven-phase network upgrade. Because earlier phases went smoothly, Rogers' algorithm downgraded the change to "Low risk," bypassing crucial laboratory testing and higher levels of approval.

Outage Impact: The combined wireless and wireline networks shared this common IP core. This resulted in a near-total blackout of internet, wireless, and 911 services, and completely disabled the Interac payment network across Canada.

Delayed Recovery: Incident management was hampered because staff lost access to error logs and lacked backup communication channels (Rogers staff even had to send SIM cards from rival network operators to communicate). Following the subsequent investigations by the Canadian Radio-television and Telecommunications Commission (CRTC), Rogers was ordered to implement router overload protection, separate data networks from network management layers, and use third-party backup systems.

What is an ACL?



An Access Control List (ACL) is used to control the traffic flowing through a network by defining which packets are permitted or denied.

Standard ACL: Controls traffic using source IP addresses

Extended ACL: Controls traffic using both source and destination IP addresses, along protocols and port numbers

IPv6 ACL: Filter traffic on IPv6 networks

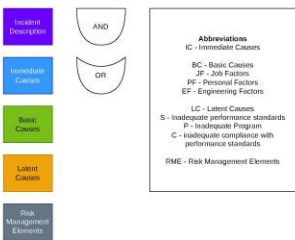
Named ACL: Create ACLs that are defined with a name, instead of a number



Pranuthi V ✓ · 3rd

Network Security Engineer | Firewall Operations | Network Monitoring | DNS/IPAM | F5 | Incident Response | Security Policy Management |

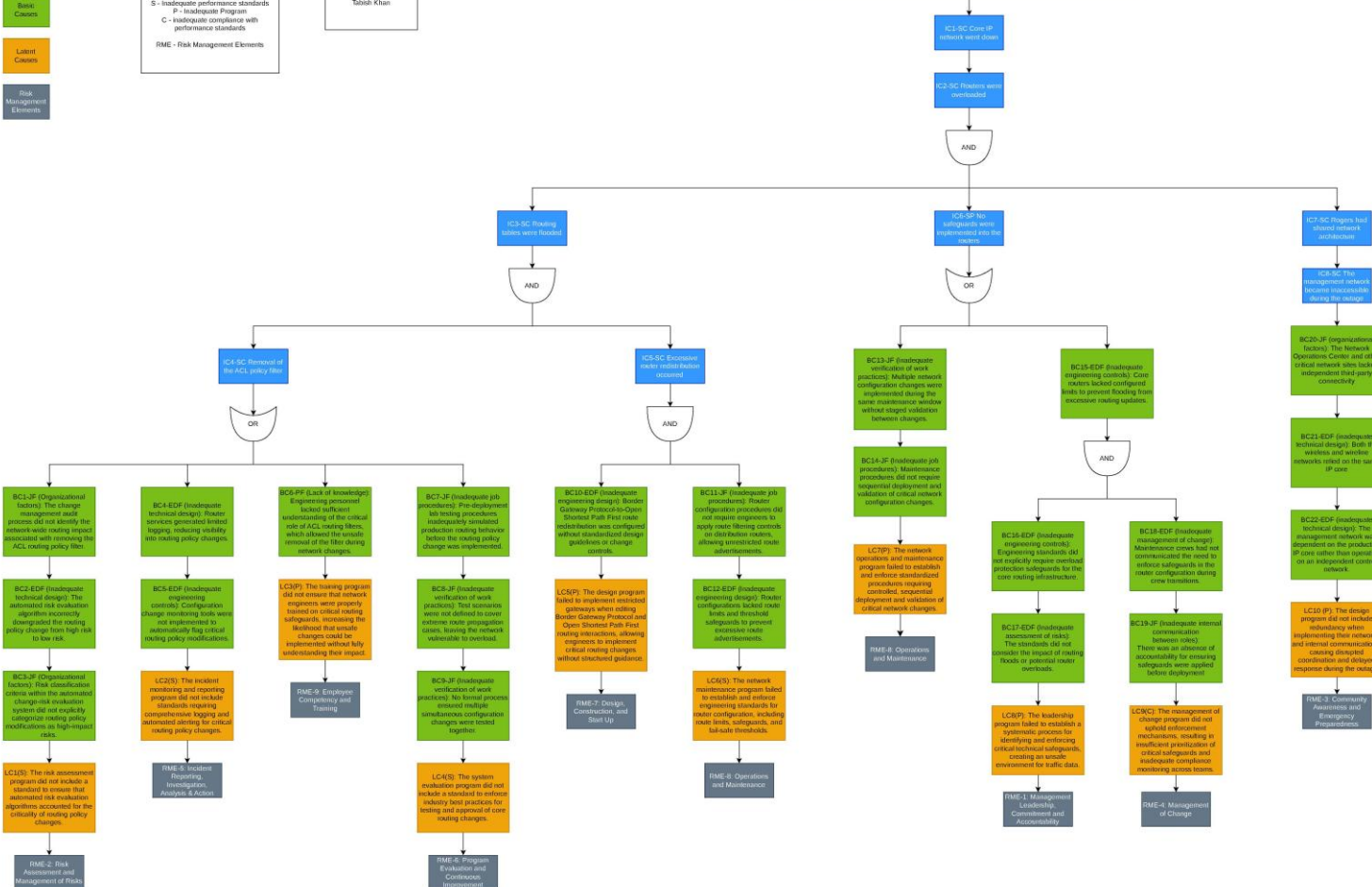
Hyderabad, Telangana, India · [Contact info](#)



March 11, 2026

ENG 404 Team 002
 Final RCA Chart
 Team Members:
 Dhruv Bhatia
 John Alwan
 Kavin Ma
 Michael Gao
 Tabish Khan

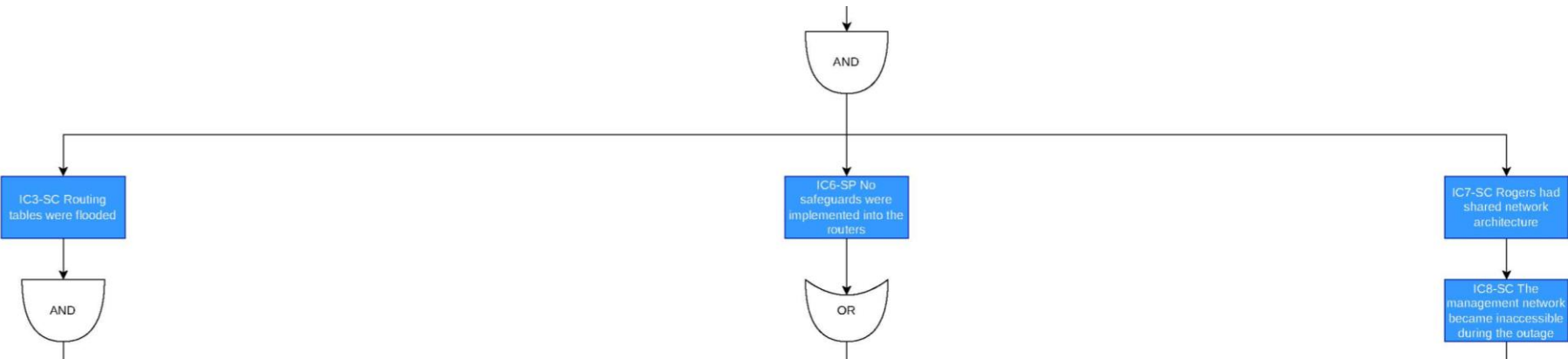
On July 8-9, 2025, Rogers Communications experienced a nationwide outage lasting approximately 26 hours, affecting between 10 to 22 million customers across Canada. The incident caused significant loss to customers such as people being affected through 911 access disruptions and healthcare service interruptions. The cause assessment is based between 3:00-2:00 (initial) by Rogers. An environmental impact was reported leading to negligible monetary losses. Asset losses included substantial reputational damage and loss of customer trust, and including the need to split physical and virtual lines resulting in \$25 million loss for Rogers. Productivity impact included widespread banking, transit, and business disruptions. The outage resulted in estimated economic losses exceeding \$142 million across affected sectors.



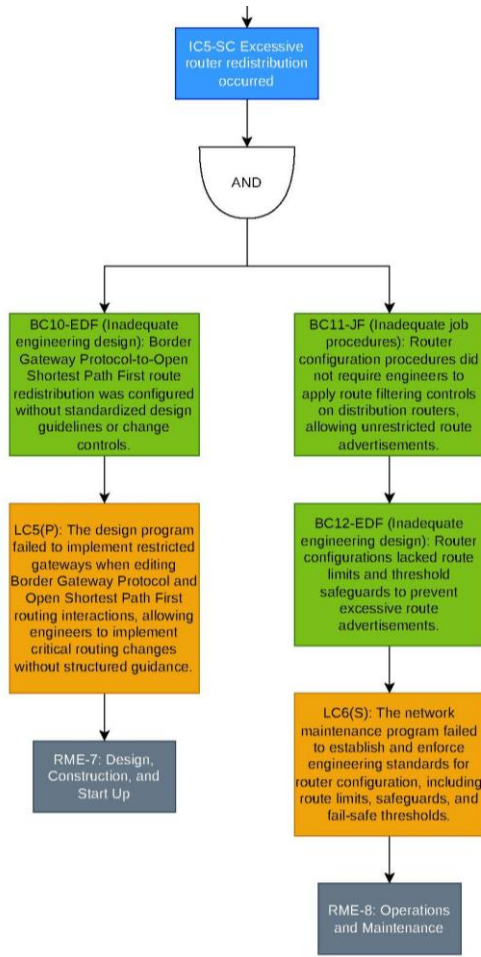
On July 8-9, 2022, Rogers Communications experienced a nationwide outage lasting approximately 26 hours, disrupting services for over 12 million customers across Canada. The incident caused significant loss for customers such as people being affected through 911 access disruptions and healthcare service interruptions, the value assessed to be between \$180-220 million by Rogers. No environmental impacts were reported, leading to negligible monetary losses. Asset losses included substantial reputational damage and loss of customer trust, and including the need to split physical and wireless lines resulted a \$261 million loss for Rogers. Productivity impacts included widespread banking, transit, and business disruptions. The outage resulted in estimated economic losses exceeding \$142 million across affected sectors.

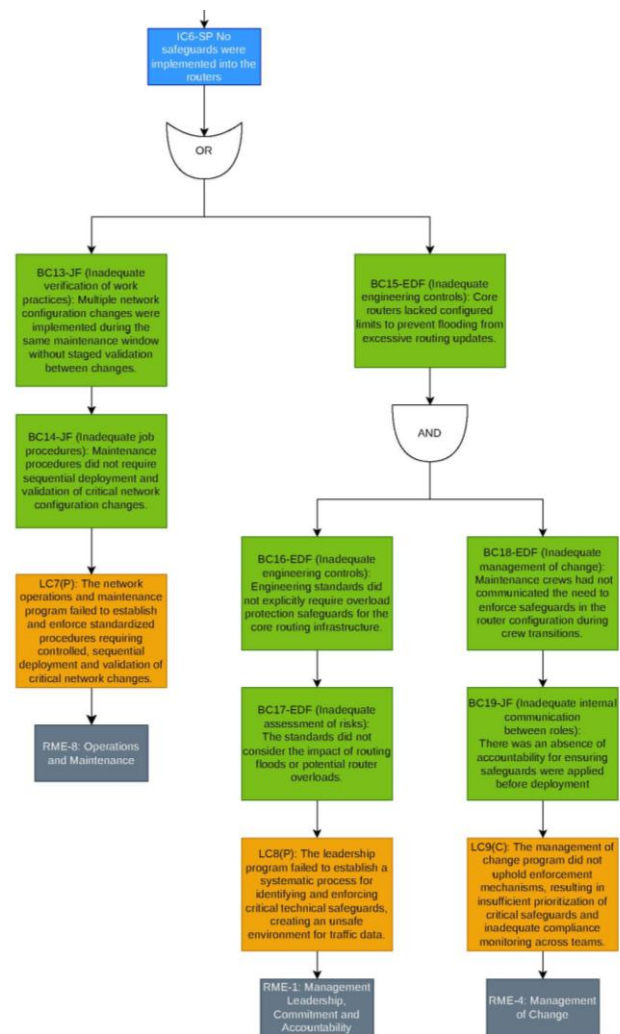
IC1-SC Core IP
network went down

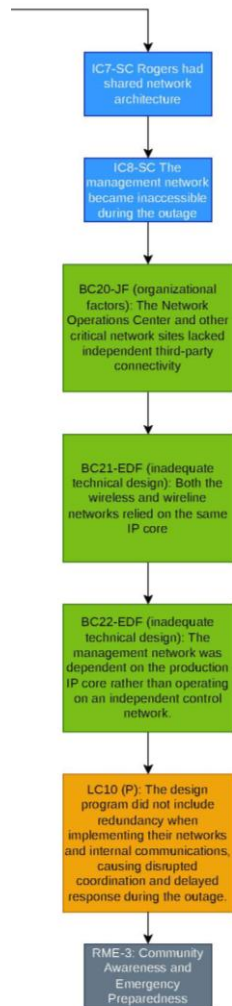
IC2-SC Routers were
overloaded

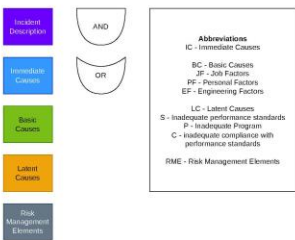








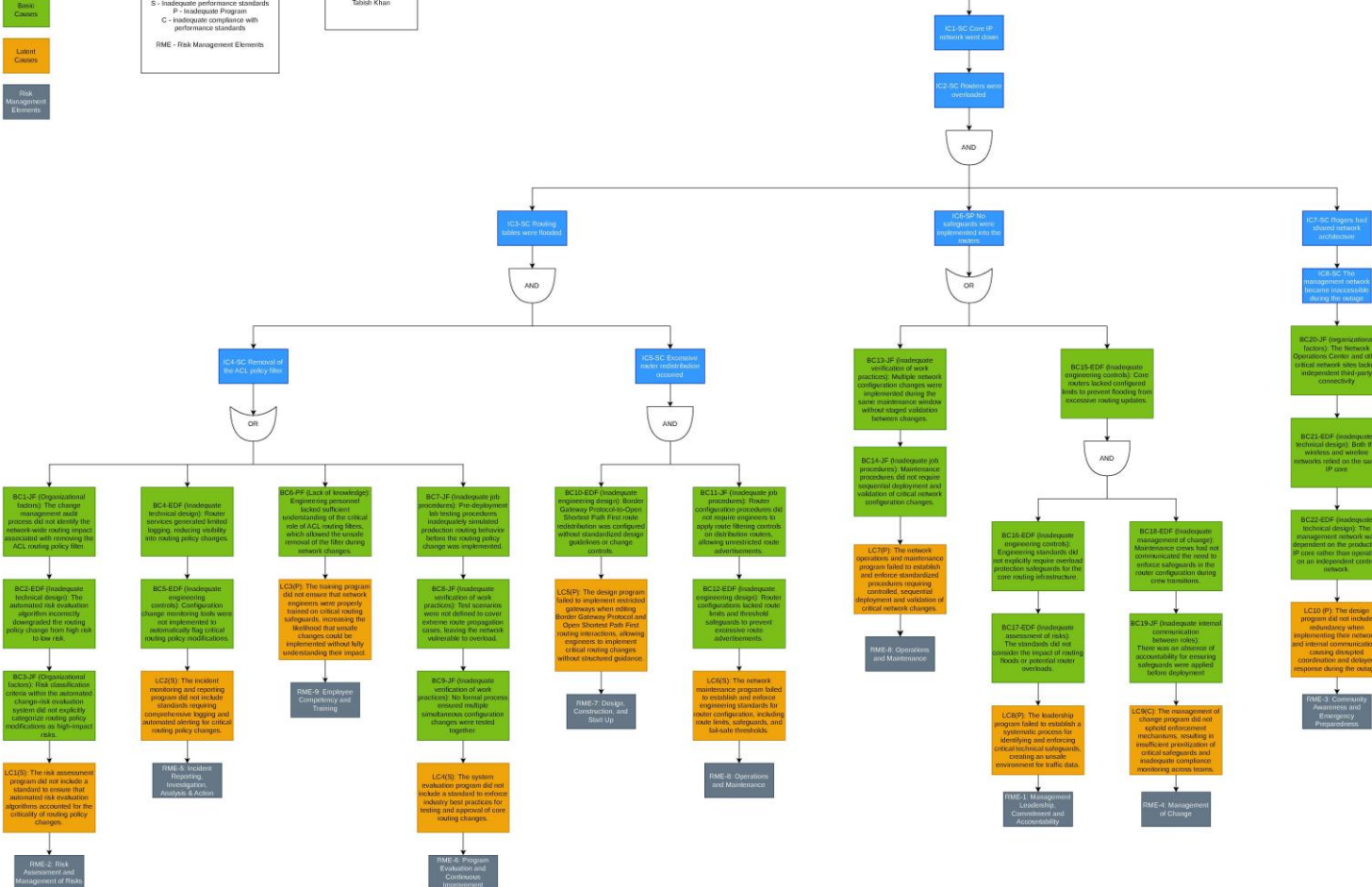




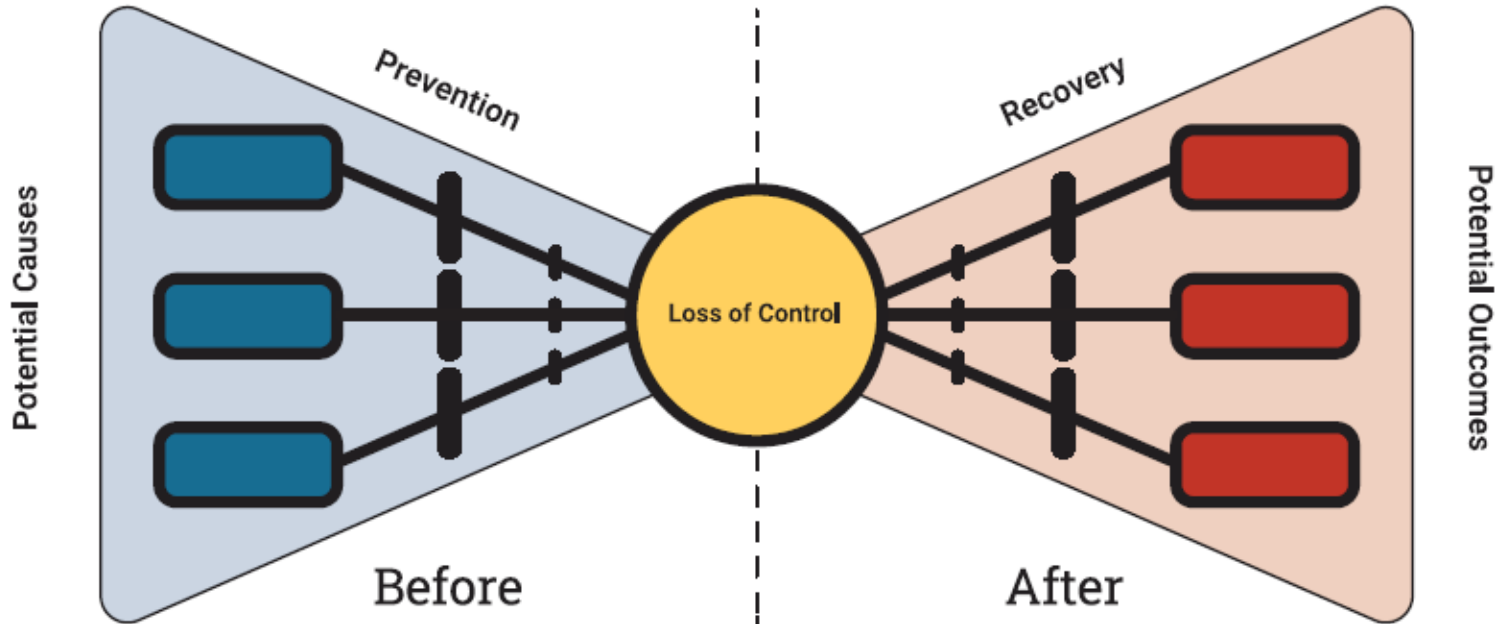
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 Michael Gao
 Tabish Khan

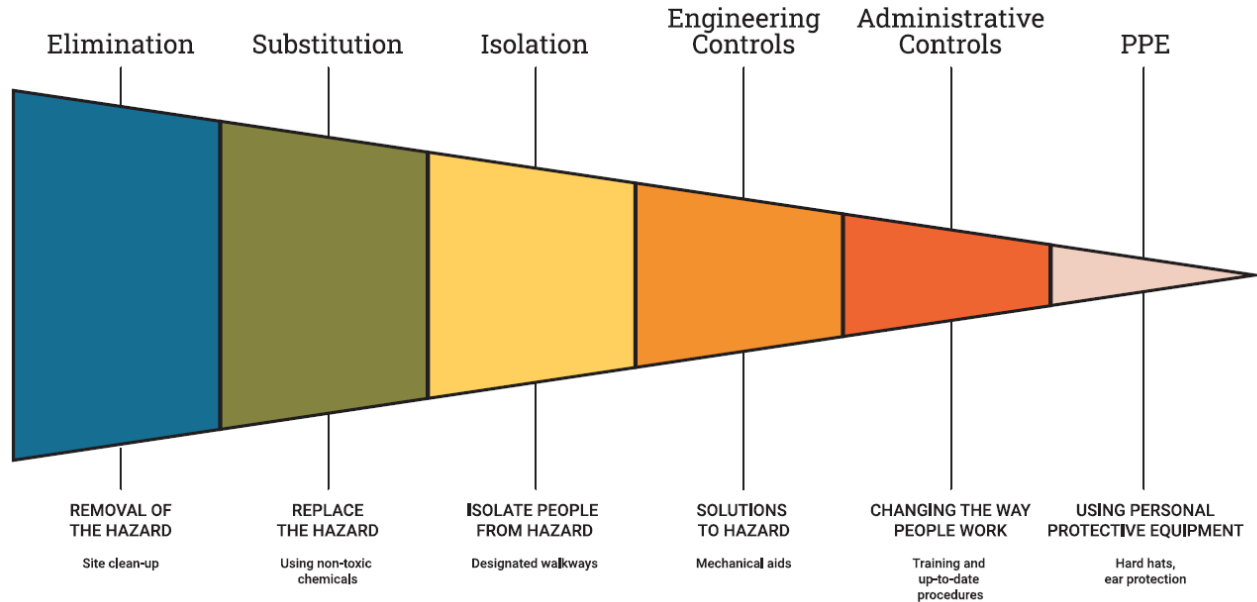
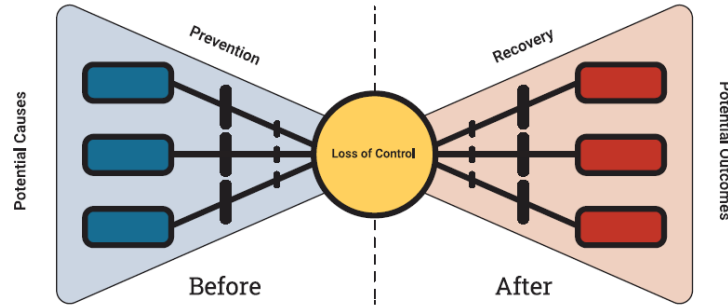
On July 8-9, 2022, Rogers Communications experienced a nationwide outage lasting approximately 26 hours, affecting between 10 to 22 million customers across Canada. The incident caused significant loss to customers such as people being affected through 911 access disruptions and healthcare service interruptions. The cause assessment is based between 3:00-2:00 indicated by Rogers. An environmental impact was created leading to negligible monetary losses. Asset losses included substantial reputational damage and loss of customer trust, and including the need to split physical and virtual lines resulting in \$22.1 million loss for Rogers. Productivity impact included widespread banking, transit, and business disruptions. The outage resulted in estimated economic losses exceeding \$142 million across affected sectors.



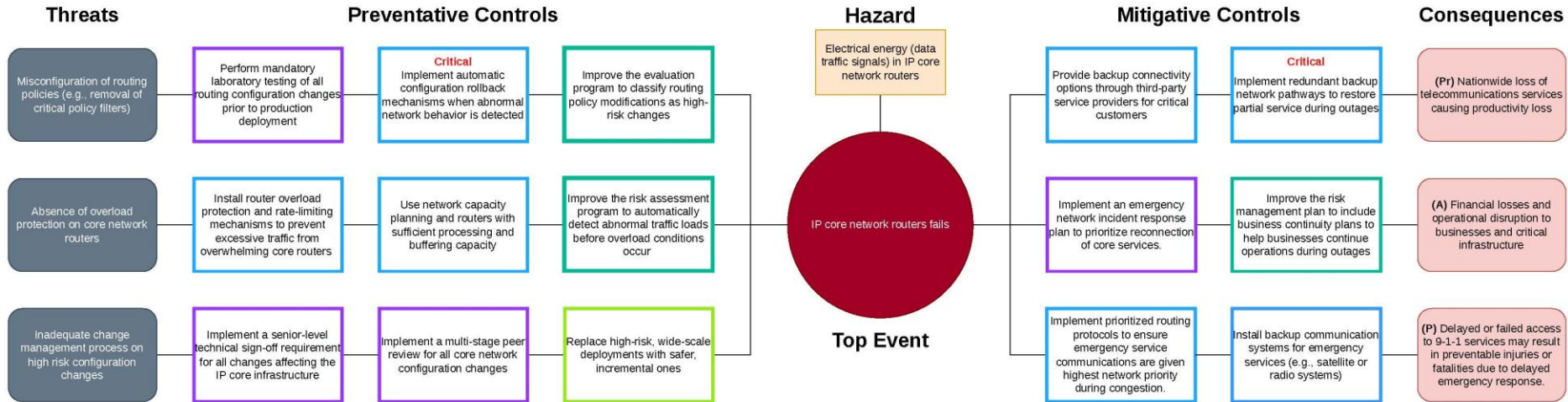
Use Bowties to examine causes for loss of control, outcomes, preventions, and recovery/mitigations



Bowties show that safety is the presence of layers of controls, so we are more likely to fail safely than fail lucky



Team #202
 Michael Gao
 Kevin Ma
 Tabish Khan
 Dhruv Bhatia
 John Alvaro



Legend



In sum:

- Process safety techniques – root cause analysis, risk management element failures, bowties are supremely helpful for examining non-chemical/process safety incidents
- Linking root causes to failures in risk management elements generates very specific recommendations for improvements
- Tying these to RACI supports organizational learning and change
- Bowties also demonstrate that a “layers of protection” approach ensures organizational fail safely and not ‘fail lucky’ or, worse, unlucky
- We teach this to 1000+ engineering undergraduates/year



Thank you!



“Bowtie Primer”



“Using Key Risk Indicators”



“What is the Value of Risk Management”



“Why is the Value of Risk Management so Difficult to Measure?”

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