

Maximizing Audit Value Through Root Cause Analysis: A Strategic Framework Aligned with the 2024 Global Internal Audit Standards

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DOI: <https://doi.org/10.47772/IJRISS.2026.100500680>

Received: 12 May 2026; Accepted: 18 May 2026; Published: 10 June 2026

ABSTRACT

Internal audit functions are undergoing a profound transformation, shifting from compliance-oriented assurance activities toward value-added strategic advisory roles. This paper examines how Root Cause Analysis (RCA) methodologies can be systematically embedded within contemporary internal audit frameworks to enhance audit effectiveness, organizational learning, and governance resilience. Aligned with the 2024 Global Internal Audit Standards (GIAS), this study employs a qualitative research design grounded in an interpretivist epistemological stance, drawing exclusively on documentary review of organizational audit records, audit committee reports, corrective action logs, internal audit charters, and policy documents across three organizational case studies. The study evaluates five principal RCA methodologies, the 5 Whys, Fishbone (Ishikawa) Diagram, Pareto Analysis, Failure Mode and Effects Analysis (FMEA), and Fault Tree Analysis (FTA), through systematic analysis of how their application is inscribed in, and traceable through, organizational documentation. Thematic analysis of documentary data reveals that RCA integration substantively transforms the nature and traceability of audit outputs, repositioning audit findings from retrospective symptom documentation toward actionable systemic diagnosis. The paper proposes a risk-calibrated RCA intensity model, a competency development roadmap, and a standardized methodology manual template grounded in documentary evidence. A dedicated limitations section acknowledges the interpretive scope of the study and charts directions for future research.

Keywords: root cause analysis, internal audit, governance, organizational resilience, 2024 Global Internal Audit Standards, audit effectiveness, continuous improvement, FMEA, Fishbone diagram, audit transformation

INTRODUCTION

Over the past two decades, the environment within which internal audit functions operate has changed significantly as organizations increasingly face more complex, interconnected, and rapidly evolving risk landscapes (NIST, 2024). Traditionally, internal auditing focused largely on financial oversight, regulatory compliance, fraud detection, and the verification of accounting accuracy. However, modern organizations now operate in environments shaped by technological disruption, globalization, geopolitical instability, cybersecurity threats, operational disruptions, environmental and social governance (ESG) pressures, and rapidly changing stakeholder expectations (COSO, 2017; NIST, 2024). These multidimensional risks extend far beyond the traditional financial control failures that once defined internal audit mandates. Consequently, internal audit functions are now expected to adopt broader, more strategic, and forward-looking approaches capable of supporting governance effectiveness, organizational resilience, and enterprise-wide risk management. The increasing complexity of organizational operations has therefore transformed internal auditing from a narrow compliance-monitoring activity into a critical contributor to strategic decision-making and organizational sustainability.

The growing frequency of governance failures, cybersecurity breaches, supply chain disruptions, and corporate scandals has further intensified expectations placed on internal audit functions (IIA, 2024). Many of these organizational failures are systemic rather than isolated incidents, arising from weaknesses in governance structures, ineffective oversight mechanisms, cultural deficiencies, or poorly designed operational processes. In numerous cases, organizations possessed formal policies and controls, yet failures persisted because the deeper organizational conditions that enabled those failures were never adequately identified or corrected (Paterson,

2024). As a result, boards of directors, audit committees, regulators, and executive management increasingly expect internal auditors not only to identify what went wrong but also to explain why failures occurred, why existing controls failed to prevent them, and how similar problems can be prevented in the future (IIA, 2024). This shift reflects a broader recognition that sustainable organizational improvement requires a deeper understanding of the systemic drivers of risk rather than merely documenting visible operational symptoms.

In response to this changing risk environment, the Institute of Internal Auditors (IIA) introduced the 2024 Global Internal Audit Standards (Global IAS), representing the most substantial revision to the profession's mandatory framework in nearly a decade and becoming effective on January 9, 2025 (IIA, 2024). The revised Standards reposition internal audit as a strategic partner in governance, risk management, and organizational resilience rather than merely a compliance-focused assurance function. Organized around five domains, namely Purpose, Ethics and Professionalism, Governing the Internal Audit Function, Managing the Internal Audit Function, and Performing Internal Audit Services, the Standards emphasize value creation, adaptability, stakeholder relevance, and insight generation (IIA, 2024). Most importantly, the Standards explicitly require internal auditors to adopt an insight-driven and forward-looking approach that prioritizes thematic analysis, quality assurance, and systematic Root Cause Analysis (RCA) as essential professional competencies. Despite these evolving expectations, however, many internal audit functions continue to rely on symptom-focused reporting approaches that identify immediate control failures without adequately investigating the underlying organizational conditions that produced them (COSO, 2017; Miller & Smith, 2023). Consequently, corrective actions often remain reactive, temporary, and insufficiently effective, leading to recurring audit findings, operational exposure, and reduced stakeholder confidence in audit value (Paterson, 2024).

Within this context, Root Cause Analysis has emerged as a critical methodology for enhancing the effectiveness and strategic relevance of internal audit practice. Originating in engineering, quality management, and safety-critical industries, RCA seeks to identify the underlying structural, technological, procedural, cultural, and behavioral factors responsible for organizational failures rather than merely addressing their immediate effects (Reason, 1990; Ohno, 1988). Through methodologies such as the 5 Whys, Fishbone (Ishikawa) Diagram, Fault Tree Analysis (FTA), Pareto Analysis, and Failure Mode and Effects Analysis (FMEA), RCA enables organizations to investigate why failures occurred, why existing controls proved ineffective, and why corrective mechanisms failed to prevent recurrence (ACCA, 2025; Okes, 2019). The relevance of RCA is further supported by organizational learning theory, where scholars such as Senge (1990) and Argyris and Schon (1978) argue that sustainable improvement depends on understanding and addressing the deeper systemic structures that generate recurring problems. Nevertheless, the successful integration of RCA into internal audit practice faces several challenges including time pressure, resource limitations, fragmented data systems, inadequate analytical capability, organizational resistance, and cognitive biases that can undermine the quality of causal investigations (Miller & Smith, 2023). Against this background, this article argues that RCA is not merely an optional enhancement to audit methodology but a strategic necessity essential for strengthening governance, improving organizational learning, reducing recurring deficiencies, and enhancing the long-term value of internal audit.

LITERATURE REVIEW

The Evolution of Internal Audit

Internal auditing has undergone significant transformation over the past century, evolving from a narrowly focused financial inspection function into a strategic governance and risk management partner within modern organizations. Historically, the primary responsibility of internal auditors centered on financial oversight activities such as verifying accounting records, detecting fraud and misappropriation, safeguarding organizational assets, and ensuring compliance with established accounting procedures and regulatory requirements (IIA, 2017). Early internal audit practices were largely transactional and retrospective in nature, emphasizing the examination of historical financial records to confirm accuracy and reliability. The function was therefore predominantly compliance-driven and focused on protecting organizations from financial irregularities and operational inefficiencies.

The formalization of internal auditing as a recognized profession accelerated with the establishment of the Institute of Internal Auditors (IIA) in 1941 and the subsequent publication of the first Standards for the

Professional Practice of Internal Auditing in 1978. These standards represented an important milestone in defining the scope, ethics, responsibilities, and professional expectations of internal auditors (IIA, 2017). Nevertheless, the early standards remained strongly control-oriented, emphasizing financial controls, procedural compliance, and the verification of management activities. Internal auditors were primarily viewed as organizational watchdogs responsible for identifying errors, irregularities, and non-compliance within financial and operational systems.

Over time, however, globalization, technological advancement, corporate scandals, regulatory reforms, and increasingly complex business environments transformed organizational risk landscapes and expanded stakeholder expectations of internal audit functions (COSO, 2017). Organizations became more interconnected and vulnerable to diverse forms of risk, including cybersecurity threats, reputational damage, strategic failure, operational disruption, supply chain instability, and governance breakdowns. As a result, internal auditing progressively evolved beyond traditional financial assurance to encompass enterprise risk management, governance evaluation, operational efficiency assessment, strategic advisory services, and organizational performance improvement.

Successive revisions to the IIA Standards reflected this expanding mandate. By the early 2000s, internal auditing had increasingly adopted a risk-based approach that prioritized high-risk organizational areas rather than merely reviewing financial transactions. The introduction and widespread adoption of the Three Lines of Defense model further clarified the strategic role of internal audit within governance structures, positioning internal auditors as independent assurance providers responsible for evaluating the effectiveness of risk management and internal control systems across the organization (IIA, 2017). The 2017 International Standards for the Professional Practice of Internal Auditing reinforced this transformation by defining internal auditing as an “independent, objective assurance and consulting activity designed to add value and improve an organization’s operations” (IIA, 2017). This definition emphasized advisory capability, organizational improvement, and value creation alongside traditional assurance responsibilities.

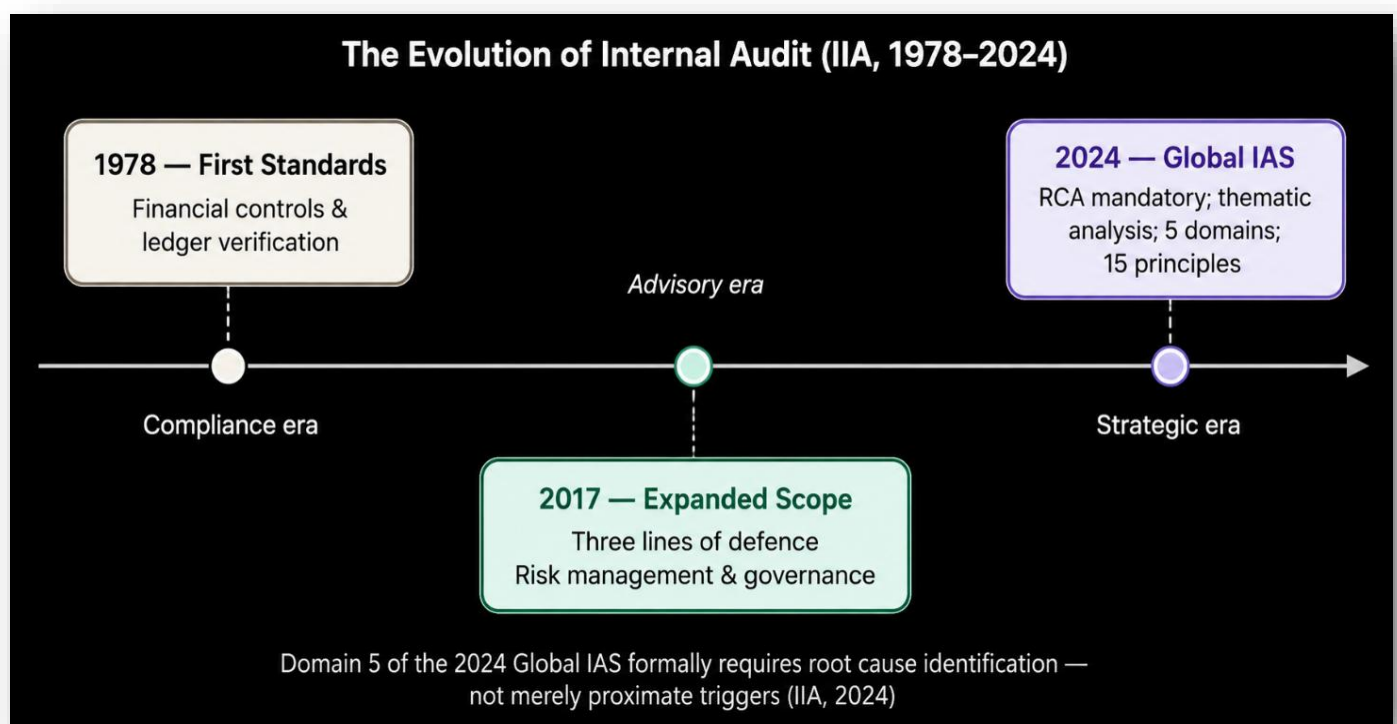
The release of the 2024 Global Internal Audit Standards (Global IAS) represents another major milestone in the profession’s evolution and arguably the most significant revision of internal audit standards in nearly a decade (IIA, 2024). Unlike previous standards that concentrated primarily on procedural consistency and professional conduct, the 2024 Global IAS place stronger emphasis on strategic relevance, stakeholder expectations, organizational adaptability, and long-term value creation. Organized around five interconnected domains, namely Purpose of Internal Auditing, Ethics and Professionalism, Governing the Internal Audit Function, Managing the Internal Audit Function, and Performing Internal Audit Services, the revised Standards establish fifteen guiding principles intended to reposition internal audit as a forward-looking and insight-driven organizational partner (IIA, 2024).

A particularly important development within the 2024 Standards is the formal recognition of Root Cause Analysis (RCA) as a critical professional competency within audit engagements. Domain 5, which focuses on Performing Internal Audit Services, explicitly requires internal auditors to move beyond identifying surface-level deficiencies and immediate triggers toward systematic investigation of underlying and systemic causes (IIA, 2024). Auditors are now expected to conduct thematic analysis across engagements, identify recurring patterns, evaluate systemic weaknesses, and provide insights capable of driving sustainable organizational improvement. This represents a substantial departure from traditional symptom-focused auditing practices that emphasized identifying non-compliance without sufficiently investigating the organizational structures and processes responsible for recurring deficiencies.

The inclusion of RCA within mandatory professional standards reflects broader changes in organizational expectations regarding internal audit value. Boards, regulators, audit committees, and executive management increasingly expect internal auditors to provide strategic insights capable of strengthening governance, improving organizational resilience, and supporting proactive risk management (Paterson, 2024). Consequently, internal audit functions are no longer evaluated solely on their ability to identify deficiencies but also on their capacity to explain why failures occur, predict emerging vulnerabilities, and recommend sustainable corrective actions that address systemic organizational weaknesses.

Moreover, technological advancement and digital transformation have further accelerated the evolution of internal audit practices. The integration of data analytics, artificial intelligence, continuous auditing systems, and automated monitoring technologies has expanded auditors' capacity to analyze large volumes of organizational data, identify anomalous patterns, and assess risks in real time (NIST, 2024). These developments support a transition from periodic retrospective auditing toward continuous and predictive assurance models that align closely with the objectives of RCA and organizational learning. The evolution of internal audit therefore reflects a broader shift in organizational governance philosophy, from reactive compliance monitoring toward proactive risk intelligence and strategic advisory capability. Internal auditors are increasingly expected to serve not only as assurance providers but also as catalysts for continuous improvement, organizational learning, and sustainable governance effectiveness. Within this evolving professional landscape, RCA emerges not merely as a technical tool but as a foundational methodology essential for fulfilling the strategic mandate envisioned by the 2024 Global Internal Audit Standards as shown in Figure below.

Figure 1: Internal Audit Evolution



Organizational Learning Theory and RCA

The theoretical justification for integrating Root Cause Analysis (RCA) into internal audit practice is strongly grounded in organizational learning theory, which emphasizes the importance of understanding systemic relationships, feedback mechanisms, and underlying organizational structures in achieving sustainable performance improvement (Senge, 1990). Organizational learning theory argues that long-term organizational success depends not only on correcting observable problems but also on identifying and transforming the deeper conditions and assumptions that generate those problems. Within this perspective, RCA becomes an essential mechanism through which organizations can move beyond reactive problem-solving toward continuous learning, adaptation, and resilience.

Senge's (1990) concept of the "learning organization" provides one of the most influential theoretical foundations for RCA. According to Senge, organizations often struggle with recurring problems because they focus narrowly on visible symptoms rather than the systemic structures that create those symptoms. He argues that organizations must develop systems thinking capabilities that allow managers and employees to recognize interconnected relationships, patterns, and feedback loops across organizational processes. From this perspective, organizational failures rarely arise from isolated events or individual mistakes alone; instead, they

emerge from complex interactions among structures, processes, policies, technologies, incentives, and organizational culture. RCA aligns directly with this systems-thinking orientation by tracing audit findings beyond immediate triggers to identify deeper systemic drivers of organizational weaknesses.

Closely related to Senge's work is the distinction developed by Argyris and Schon (1978) between single-loop learning and double-loop learning. Single-loop learning occurs when organizations respond to problems by correcting immediate errors without questioning the underlying assumptions, structures, or policies that contributed to those errors. In internal audit contexts, this often manifests as symptom-focused corrective actions such as retraining staff, issuing reminders, or strengthening supervision after a control failure occurs. While such actions may temporarily resolve the issue, they frequently fail to prevent recurrence because the deeper organizational causes remain unaddressed.

Double-loop learning, by contrast, involves critically examining and modifying the underlying organizational assumptions, governance structures, decision-making processes, and cultural norms that produced the problem in the first place (Argyris & Schon, 1978). RCA operationalizes double-loop learning within internal audit by encouraging auditors to investigate not only what happened, but also why existing systems, controls, incentives, and oversight mechanisms failed to prevent the issue. For example, repeated procurement irregularities may initially appear to result from employee non-compliance. However, deeper RCA may reveal unrealistic approval processes, conflicting performance incentives, inadequate technology infrastructure, or cultural pressures prioritizing operational speed over compliance. Addressing these structural causes represents double-loop organizational learning capable of generating sustainable improvement.

Kaplan and Norton's (2001) balanced scorecard and strategy map frameworks further reinforce the theoretical relevance of RCA within organizational performance management. Their work demonstrates that organizational outcomes are produced through interconnected cause-and-effect relationships spanning financial performance, customer outcomes, internal processes, innovation, and organizational learning. Poor organizational performance in one area frequently originates from weaknesses in another interconnected area. RCA mirrors this logic by systematically tracing audit findings through multiple layers of contributing and root causes, thereby revealing how governance structures, cultural dynamics, operational processes, technology systems, and human behavior interact to generate organizational outcomes.

Importantly, organizational learning theory also emphasizes the significance of feedback mechanisms in supporting continuous improvement. Effective learning organizations develop structures that capture information from operational failures, near misses, audit findings, and stakeholder feedback to improve future performance (Senge, 1990). Internal audit functions equipped with strong RCA capabilities contribute significantly to these learning mechanisms by transforming isolated audit observations into broader organizational insights. Through thematic analysis of recurring findings across engagements, auditors can identify systemic risk patterns that might otherwise remain hidden within fragmented operational data.

RCA also supports the development of organizational resilience, defined as the capacity to anticipate, adapt to, and recover from disruptions while maintaining core functions and strategic objectives (NIST, 2024). Organizations that understand the structural causes of their vulnerabilities are better positioned to strengthen controls, redesign processes, improve governance, and anticipate emerging risks before significant failures occur. Consequently, RCA contributes not only to corrective action effectiveness but also to proactive risk management and long-term organizational sustainability.

Furthermore, organizational culture plays a central role in determining the effectiveness of RCA and organizational learning processes. In blame-oriented cultures where mistakes are punished rather than analyzed constructively, employees may withhold information critical to meaningful root cause investigation (Paterson, 2024). Organizational learning theory therefore highlights the importance of psychological safety, open communication, and leadership commitment to continuous improvement in enabling effective RCA. Internal auditors conducting RCA must foster environments where employees feel safe to discuss operational weaknesses honestly without fear of individual blame or retaliation. Within the context of internal auditing, RCA therefore serves as more than a technical investigative tool. It represents a practical mechanism for enabling systems thinking, double-loop learning, organizational resilience, and continuous improvement. By connecting audit

findings to deeper organizational structures and strategic processes, RCA transforms internal audit from a reactive compliance function into a proactive contributor to organizational learning and governance effectiveness.

The Limitation of Symptom-Focused Audit Reporting

Traditional audit reporting practices have historically concentrated on identifying deviations from policies, procedures, laws, regulations, or internal control expectations. Most audit findings are commonly structured around the 5Cs framework, consisting of Condition, Criteria, Cause, Consequence, and Corrective Action. Within this framework, the auditor identifies what occurred, explains the relevant standard or expectation, states the reason for the deviation, outlines the resulting risk or impact, and recommends corrective measures. While this structure provides consistency and clarity in audit communication, its practical application frequently suffers from a critical limitation: insufficient attention to the deeper systemic causes of organizational problems (IIA, 2024).

In many audit engagements, the “cause” component of audit findings captures only the most immediate or proximate trigger of a problem, such as employee negligence, procedural non-compliance, inadequate supervision, or isolated control failure. Although these explanations may appear reasonable on the surface, they often fail to investigate the broader organizational conditions that made the failure possible or even inevitable. As a result, corrective actions tend to focus narrowly on addressing symptoms rather than eliminating the underlying structural weaknesses responsible for recurring deficiencies (Paterson, 2024). For example, an audit identifying recurring inaccuracies in inventory counts may conclude that warehouse staff failed to follow counting procedures correctly and recommend additional staff training or supervisory reminders. However, such a response addresses only the visible symptom rather than the deeper organizational drivers of the problem. More rigorous investigation may reveal that the counting procedures are excessively complex, staffing levels are insufficient, warehouse layouts are poorly designed, automation systems are outdated, or performance pressures discourage accurate verification processes. Without identifying and correcting these deeper causes, the organization remains highly vulnerable to continued recurrence of the same audit finding.

This symptom-focused paradigm creates several important organizational consequences. First, it reduces the long-term effectiveness of corrective actions. When organizations repeatedly address only immediate causes, deficiencies often reappear across subsequent audit cycles, resulting in recurring findings that consume organizational resources without generating sustainable improvement (Miller & Smith, 2023). Repeated audit findings indicate that prior corrective actions were either misdirected or insufficiently comprehensive, thereby undermining management confidence in audit recommendations and reducing the perceived strategic value of internal audit functions. Second, symptom-focused reporting weakens organizational learning and resilience. Organizations that fail to understand the deeper drivers of operational failures remain unable to redesign processes, strengthen governance structures, or improve cultural conditions necessary for sustainable risk management (Senge, 1990). Consequently, they continue operating within environments that reproduce the same weaknesses over time. In highly complex organizational settings, superficial corrective actions may create an illusion of improvement while leaving systemic vulnerabilities fundamentally unchanged. Third, symptom-focused reporting can encourage blame-oriented organizational cultures. When audit findings emphasize individual employee errors without examining structural and managerial contributors, responsibility for organizational failures becomes disproportionately assigned to frontline staff rather than distributed across broader systems and governance arrangements (Reason, 1990). This may discourage transparency, reduce employee willingness to disclose operational weaknesses, and undermine the psychological safety necessary for effective organizational learning and RCA.

The financial and reputational implications of recurring control failures can also be substantial. The IIA Internal Audit Foundation’s 2024 North American Pulse of Internal Audit survey identified demonstrating organizational value as one of the most significant challenges facing chief audit executives (IIA Internal Audit Foundation, 2024). Persistent recurring findings directly threaten this value proposition by suggesting that internal audit recommendations fail to produce meaningful or lasting improvements. Moreover, unresolved systemic weaknesses expose organizations to escalating operational, regulatory, financial, and reputational risks.

The Wells Fargo sales practices scandal provides a widely cited illustration of the dangers associated with superficial causal analysis. Investigations into the scandal revealed that employees created unauthorized customer accounts to satisfy unrealistic sales targets and performance expectations. While individual misconduct was visible at the operational level, the deeper causes included aggressive organizational incentives, ineffective oversight, cultural pressure to meet sales quotas, and inadequate governance structures (Wells Fargo Board Report, 2017, as cited in Miller & Smith, 2023). A symptom-focused audit approach concentrating solely on employee misconduct would have failed to address the systemic drivers responsible for widespread unethical behavior.

The limitations of symptom-focused audit reporting are particularly problematic within today's complex risk environment, where organizational failures frequently arise from interconnected technological, cultural, operational, and governance factors rather than isolated control weaknesses (NIST, 2024). Modern organizations require audit approaches capable of identifying systemic patterns, tracing causal relationships, and supporting sustainable improvement. RCA addresses these limitations by expanding audit inquiry beyond immediate symptoms to investigate contributing causes, structural weaknesses, and organizational dynamics responsible for recurring problems.

Consequently, the transition from symptom-focused reporting toward RCA-informed auditing represents not simply a methodological enhancement but a fundamental shift in how internal audit creates organizational value. By uncovering deeper causal relationships and supporting long-term corrective action effectiveness, RCA strengthens governance, enhances organizational learning, improves stakeholder confidence, and positions internal audit as a strategic contributor to sustainable organizational resilience.

RCA in Professional Practice

Root Cause Analysis (RCA) originated within engineering, manufacturing, and quality management disciplines as a systematic approach for identifying the underlying causes of operational failures and preventing their recurrence. One of the earliest and most influential applications of RCA emerged within Toyota's production system, where Taiichi Ohno developed the 5 Whys technique as a structured method for tracing problems through successive layers of causation until underlying process weaknesses could be identified (Ohno, 1988). Toyota's emphasis on continuous improvement, operational efficiency, and defect prevention demonstrated that sustainable organizational improvement depends on understanding why failures occur rather than merely correcting their visible consequences.

Over time, RCA methodologies expanded beyond manufacturing into several high-risk and safety-critical industries where understanding systemic causes of failure became essential. In healthcare, RCA is widely used to investigate patient safety incidents, medication errors, and clinical process failures to improve quality of care and reduce preventable harm (Reason, 1990). In aviation and nuclear safety industries, RCA techniques such as Fault Tree Analysis (FTA) and Failure Mode and Effects Analysis (FMEA) are used extensively to analyze complex system interactions, identify vulnerabilities, and strengthen preventive controls in environments where operational failures can have catastrophic consequences (Okes, 2019). These industries demonstrated that organizational failures rarely result from a single isolated cause; instead, they typically emerge from multiple interacting weaknesses involving human behavior, process design, technology, communication, oversight, and organizational culture.

The growing recognition of systemic risk within modern organizations has contributed to the increasing relevance of RCA within internal auditing. Internal auditors are now expected not only to identify deficiencies but also to provide meaningful insights capable of preventing recurrence and strengthening governance effectiveness (IIA, 2024). Consequently, RCA methodologies such as the 5 Whys, Fishbone (Ishikawa) Diagram, Pareto Analysis, FTA, and FMEA have gradually become integrated into audit fieldwork, investigation processes, risk assessments, and corrective action evaluations. Despite this growing recognition, the adoption of RCA within internal auditing remains inconsistent across organizations and industries. Miller and Smith (2023) found significant gaps between professional expectations and actual RCA practice among internal audit functions. Their study revealed that while many senior auditors acknowledged the importance of RCA for improving audit quality and organizational value, practical implementation was often limited by resource

constraints, insufficient methodological training, time pressure, and organizational resistance to exposing systemic weaknesses. In many cases, audit teams lacked formal RCA frameworks, resulting in inconsistent and superficial causal analysis that focused primarily on immediate triggers rather than deeper structural drivers.

Paterson (2024) identifies an additional conceptual limitation within traditional RCA practice: the assumption that organizational failures typically have a single root cause. In reality, most organizational problems emerge from multiple interconnected causes spanning preventive control weaknesses, monitoring failures, governance deficiencies, cultural dynamics, technological limitations, and ineffective recovery mechanisms. To address this complexity, Paterson proposes the Three-Way Five Whys (3W5W) methodology, which investigates three distinct but interconnected dimensions of organizational failure: why the problem occurred, why existing controls failed to detect it, and why corrective or recovery mechanisms failed to respond effectively. This multidimensional approach reflects the increasingly interconnected nature of organizational risks and aligns more closely with systems-thinking principles emphasized in organizational learning theory. Professional and regulatory developments have further accelerated the institutionalization of RCA within assurance and governance functions. Research published by ICAEW (2025) notes that the implementation of the International Standard on Quality Management (ISQM 1) in December 2022 formally required audit firms to conduct RCA on identified quality deficiencies. This requirement has significantly strengthened the professionalization of RCA within the broader assurance community by encouraging firms to adopt more structured, evidence-based approaches to understanding audit quality failures and strengthening continuous improvement mechanisms.

Similarly, the Chartered IIA's Organizational Culture and Ethics Report (2023) found that nearly half of surveyed internal audit functions use RCA specifically to evaluate organizational culture and ethical behavior. This finding reflects an important evolution in RCA application beyond operational control analysis toward broader governance, leadership, and behavioral risk assessment. Increasingly, internal auditors recognize that many organizational failures originate not only from procedural weaknesses but also from dysfunctional cultural norms, conflicting incentives, weak ethical climates, and ineffective leadership behaviors (Paterson, 2024). The growing integration of RCA into professional practice is also closely linked to technological advancement and data analytics capability. Modern internal audit functions increasingly use audit analytics, continuous monitoring systems, artificial intelligence, and automated risk detection tools to identify patterns, anomalies, and recurring control failures across large datasets (NIST, 2024). These technologies enhance auditors' ability to detect underlying trends and support more sophisticated RCA processes capable of identifying interconnected organizational weaknesses across multiple audit cycles.

Nevertheless, successful RCA implementation requires more than technical tools alone. Effective RCA depends heavily on organizational culture, leadership commitment, cross-functional collaboration, and psychological safety. In blame-oriented environments where operational failures are associated primarily with punishment or reputational damage, employees may hesitate to disclose critical information necessary for meaningful root cause investigation (Reason, 1990). Consequently, organizations seeking to institutionalize RCA effectively must foster learning-oriented cultures that encourage transparency, open communication, and continuous improvement rather than fault attribution. Within professional internal auditing practice, RCA therefore represents both a methodological framework and a broader organizational philosophy centered on systemic inquiry, organizational learning, and sustainable improvement. As internal audit functions continue evolving toward more strategic and insight-driven roles under the 2024 Global Internal Audit Standards, RCA is increasingly positioned not as an optional analytical tool but as a core professional competency essential for strengthening governance, enhancing risk management, and delivering long-term organizational value.

RESEARCH METHODOLOGY

Research Design and Philosophical Orientation

This study adopts a qualitative research design grounded in an interpretivist epistemological stance. Interpretivism holds that social and organizational phenomena such as how RCA methodologies are adopted and institutionalized within internal audit functions, are best understood through the meanings embedded in texts and organizational records, rather than through measurement and statistical inference (Bryman, 2022; Creswell & Poth, 2023). Given that RCA integration within internal audit is a relatively nascent and context-dependent

practice, a qualitative approach is epistemologically appropriate: it enables the researcher to explore the “how” and “why” of organizational practice as inscribed in documents, rather than the “how many” of population-level prevalence.

The study employs an instrumental case study strategy (Stake, 1995; Yin, 2023) with documentary review as the sole data collection method. Case studies are particularly well-suited to research questions concerning the contextual dynamics of organizational practice where boundaries between the phenomenon and its setting are not clearly evident. Documents constitute the primary empirical site of this inquiry: they are not merely supplementary data but the principal medium through which organizational practices are constructed, communicated, and institutionalized (Prior, 2022). The three cases were selected through purposive theoretical sampling to maximize variation across sector, organizational size, and RCA maturity, a logic consistent with qualitative inquiry (Patton, 2023).

Data Collection: Documentary Review

Documentary review was the exclusive data collection method employed in this study. Documents were obtained from each case organization through formal access arrangements agreed with senior audit leadership, subject to the ethical protocols described in Section 3.4. The document corpus comprised five categories of organizational records: (1) internal audit reports from consecutive audit cycles, including finding narratives, root cause analyses, and management responses; (2) corrective action tracking logs and implementation status registers; (3) internal audit charters and methodology manuals; (4) audit committee presentation materials and meeting minutes; and (5) internal audit quality assurance and improvement programme reports.

This range of document types was selected to enable triangulation across the documentary corpus, a strategy that strengthens the credibility of interpretations by examining whether patterns evident in one document type are corroborated or complicated by others (Bowen, 2023). For example, RCA integration claimed in audit methodology manuals could be assessed against the degree to which root cause language actually appeared in audit finding narratives, and whether corrective action logs reflected systemic rather than symptomatic management responses. Documents were accessed in de-identified form where required by organizational data governance policies.

Data Analysis

Documentary data were analyzed using reflexive thematic analysis following the six-phase framework of Braun and Clarke (2022): familiarization with documents, generating initial codes, constructing themes, reviewing themes, defining and naming themes, and producing the final interpretive account. Documents were read holistically and then coded systematically, with attention to both manifest content, that is what the documents explicitly state, and latent content, which is the underlying assumptions, framings, and silences that shape organizational understandings of RCA (Bowen, 2023). Analysis was supported by NVivo 14, which facilitated systematic coding, retrieval, and cross-case comparison.

The analytical process was explicitly reflexive, with the researchers maintaining a reflective journal to document interpretive decisions and surface potential assumptions introduced by their professional backgrounds in auditing and governance. Trustworthiness was established through four criteria adapted from Lincoln and Guba (1985): credibility (achieved through documentary triangulation across multiple document types within each case); transferability (achieved through thick description of case contexts to enable readers to assess applicability to their own settings); dependability (achieved through a documented audit trail of coding decisions in NVivo); and confirmability (achieved through peer debriefing with a colleague who independently reviewed a sample of coded documents and emerging themes).

FINDINGS AND DISCUSSION

The analysis of this study conceptualizes RCA integration as operating across three audit process phases: pre-engagement planning, fieldwork and analysis, and reporting and follow-up. At each phase, RCA principles augment standard audit procedures to produce deeper diagnostic outputs. In the planning phase, FMEA and Fault

Tree Analysis inform risk prioritization by enabling auditors to prospectively assess failure modes and their upstream causal pathways before fieldwork commences. During fieldwork, 5 Whys and Fishbone Diagramming structure the analytical process, ensuring that identified control weaknesses are traced to systemic antecedents rather than proximate triggers. In reporting, Pareto Analysis guides the prioritization of root causes by expected impact, enabling management to allocate remediation resources efficiently. The follow-up phase incorporates root cause recurrence tracking as a formal metric of audit recommendation effectiveness, a capability newly mandated under GIAS Standard 15.3.

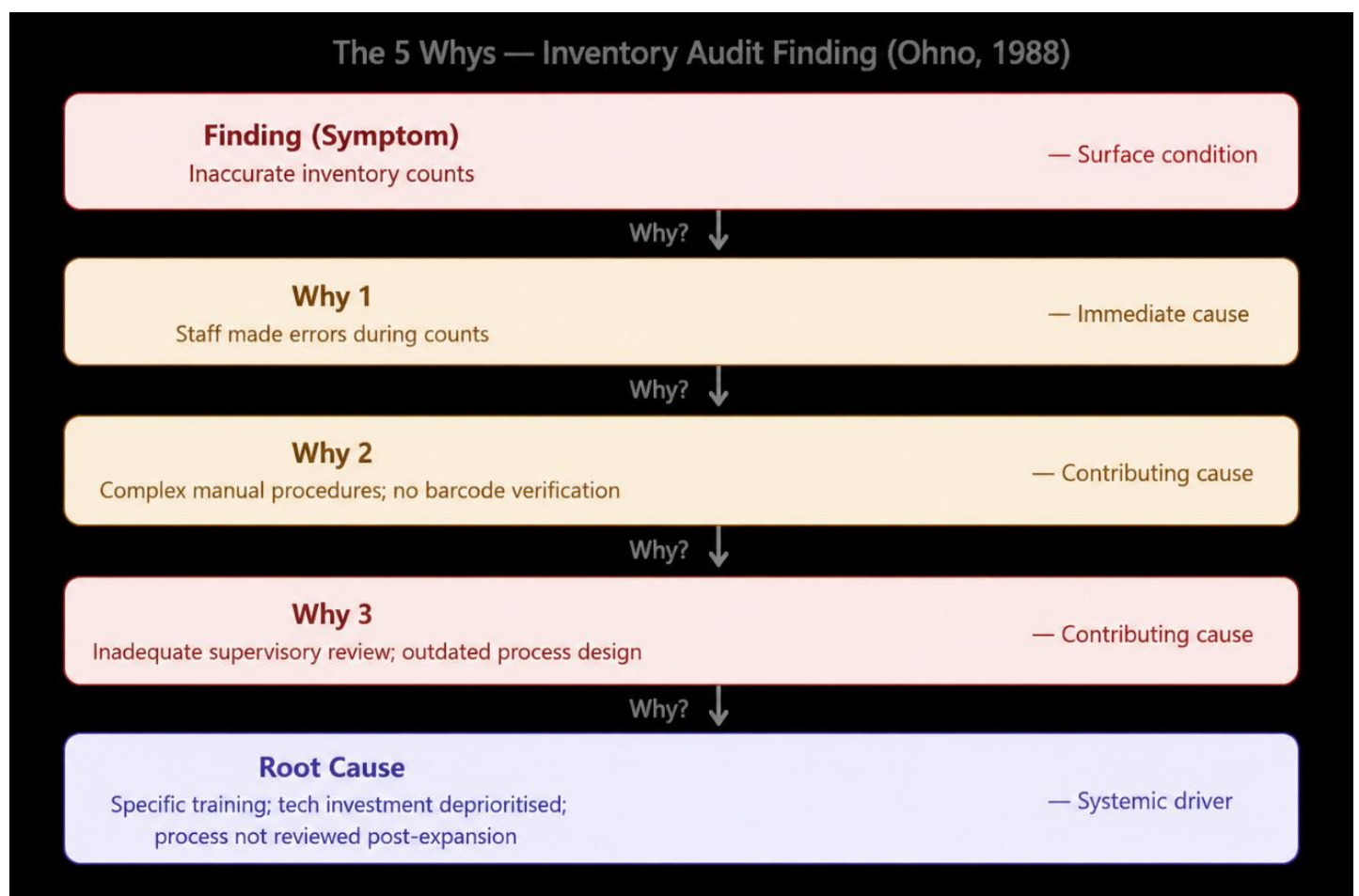
This three-phase model is grounded in the Control-Influence-Concern framework adapted from Covey (2020) and organizational systems theory (Senge, 2022), which distinguishes between issues within the organization’s direct control (amenable to procedural corrective action), those within its sphere of influence (requiring behavioral and cultural interventions), and those in its broader environment (requiring strategic risk acceptance or mitigation). RCA findings are categorized within this framework to align recommendations with realistic remediation scope.

Root Cause Analysis for Internal Audit

The 5 Whys Technique

The 5 Whys technique, developed within the Toyota Production System, involves iterative interrogation of causal sequences by repeatedly asking “why” a problem or failure occurred. Its simplicity makes it accessible to audit teams with limited RCA training; its iterative structure ensures that analysis penetrates beyond surface-level symptoms (Liker, 2004). In audit contexts, the 5 Whys is most effective for process-level control failures where causal chains are relatively linear and the auditor has sufficient process knowledge to evaluate proposed causes (Moeller, 2023). Limitations include susceptibility to confirmation bias and reduced reliability for complex multi-causal failures (Wu et al., 2022).

Figure 3: Ohno’s Internal Audit Finding

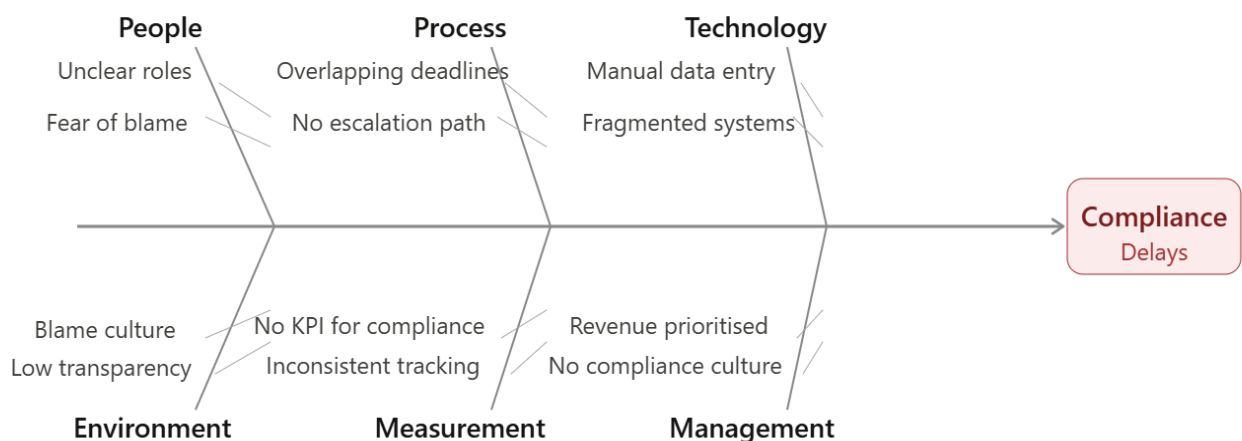


Fishbone (Ishikawa) Diagram

The Fishbone Diagram, introduced by Kaoru Ishikawa, provides a structured visual method for mapping multiple potential causes of a problem across standard categories—commonly People, Process, Technology, Environment, Management, and Measurement. Its visual format facilitates collaborative cause brainstorming with audit clients and process owners, thereby enhancing audit engagement quality and stakeholder buy-in for recommendations (Reding et al., 2022). The Fishbone approach is particularly valuable for complex, multi-factorial control environments such as information technology governance and supply chain risk management. Documentary evidence examined in this study consistently showed the Fishbone Diagram producing the most granular and multi-dimensional root cause narratives in audit reports, with findings organized across several causal categories rather than attributed to a single proximate failure.

Figure 4: Fishbone Audit

Fishbone Diagram — Compliance Reporting Delays (ACCA, 2025)



Chartered IIA (2023) — nearly 50% of internal audit functions use RCA to understand organisational culture

Pareto Analysis

Pareto Analysis applies the 80/20 principle to audit findings, identifying the minority of root causes responsible for the majority of control failures, compliance exceptions, or risk exposures. In practice, auditors apply Pareto analysis to aggregated finding data to identify systemic patterns that individual engagement findings may obscure (Tamimi & Sebastianelli, 2022). The technique is most powerful when applied to multi-engagement data sets, for example, across an annual audit plan cycle, enabling the CAE to report portfolio-level systemic risks to the audit committee. Documentary evidence from this study showed that audit committee presentations drawing on Pareto analysis were substantively different in character from those based on individual findings, organized around systemic themes and risk clusters rather than engagement-by-engagement finding summaries, as evidenced by the structure and content of audit committee papers and corresponding minutes.

Failure Mode and Effects Analysis (FMEA)

FMEA is a prospective risk assessment methodology that systematically identifies potential failure modes within a process, assesses their probable causes and effects, and prioritizes them by a risk priority number (RPN), the product of severity, occurrence probability, and detectability ratings. Within internal audit, FMEA serves as a powerful planning tool for risk-based audit scoping, enabling auditors to focus fieldwork on the process components with the highest failure risk (Marigo et al., 2023). FMEA also supports the design of audit procedures specifically calibrated to detect the most impactful failure modes. The integration of FMEA into

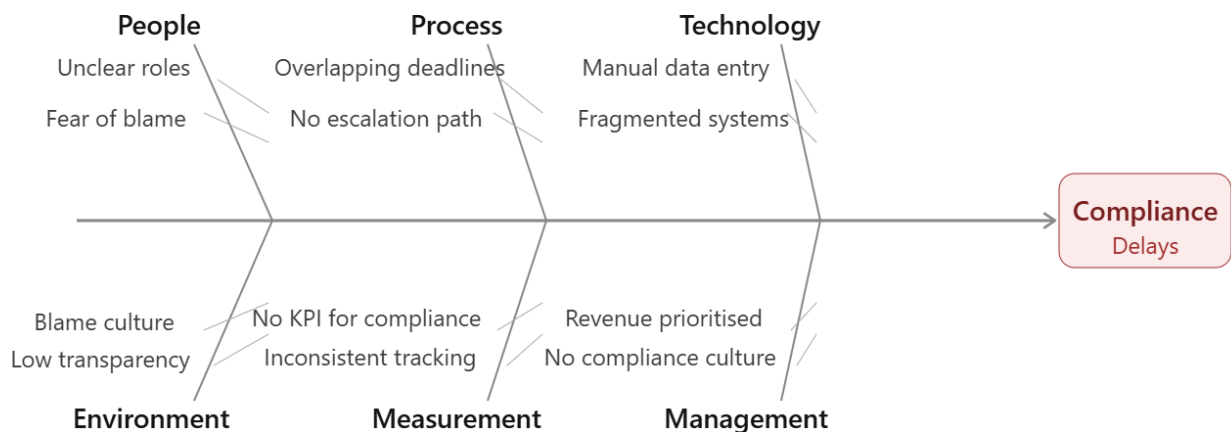
audit planning aligns directly with GIAS Standard 9.2's requirement for systematic risk assessment. Documentary evidence in this study showed that FMEA-informed audit planning documents contained explicit risk prioritization rationales, in contrast to earlier planning documents from the same organizations that recorded audit scope decisions without documented justification, relying on experience-based judgment that was not visible in the documentary record.

Fault Tree Analysis (FTA)

Fault Tree Analysis employs Boolean logic and hierarchical tree diagrams to model the combinations of events and conditions that could produce a specified undesirable outcome. FTA is particularly suited to high-stakes, low-frequency risk scenarios such as financial fraud, cybersecurity breaches, and major regulatory violations, where multi-causal failure pathways must be comprehensively mapped (Williams, 2023). In audit contexts, FTA outputs serve both as planning tools for assurance coverage and as communication instruments for presenting complex causal analyses to governance bodies. The technique's quantitative variant, probabilistic FTA, can incorporate historical failure rate data to produce probability estimates for audit committee risk briefings.

Figure 4: Fishbone Audit

Fishbone Diagram — Compliance Reporting Delays (ACCA, 2025)



Chartered IIA (2023) — nearly 50% of internal audit functions use RCA to understand organisational culture

Comparative summary of RCA Methodologies

Table 1: Comparative Overview of RCA Methodologies for Internal Audit

Methodology	Best Use Case	Audit Phase	Complexity	Team Skill Required	Practitioner-Reported Value
5 Whys	Linear process failures	Fieldwork	Low	Basic	High – quick to apply and communicate
Fishbone Diagram	Multi-factor control environments	Fieldwork / Reporting	Medium	Intermediate	Very High – strong stakeholder engagement
Pareto Analysis	Portfolio-level pattern identification	Planning / Reporting	Medium	Data analysis	High – impactful for governance reporting
FMEA	Risk-based audit scoping	Planning	High	Advanced	Very High – transforms risk-based planning
Fault Tree Analysis	High-stakes, multi-causal risks	Planning / Reporting	Very High	Specialist	Moderate – specialist-dependent

Empirical Findings and Case Studies

Thematic Findings from Documentary Review

Thematic analysis of the documentary corpus across the three case studies generated four overarching themes: (1) the textual transformation of audit outputs through RCA; (2) the documentary evidence of enabling and constraining conditions; (3) the visibility of systemic engagement in audit communication documents; and (4) the institutionalization of RCA as traceable organizational memory.

The first theme, textual transformation of audit outputs, was evident in the qualitative shift in audit report language observed across pre- and post-RCA document sets. In pre-RCA audit reports, finding narratives were predominantly descriptive, recording what control failed and when, with recommendations framed as procedural corrections to be implemented by management. Post-RCA audit reports from the same organizations were markedly different in structure and content: findings included dedicated root cause sections, causal chains were narrated rather than implied, and recommendations addressed systemic antecedents, process redesign, training gaps, governance structure, rather than isolated procedural fixes. This documentary contrast constituted the most consistent cross-case pattern in the analysis.

The second theme, documentary evidence of enabling and constraining conditions, emerged from comparison of audit charter documents, quality assurance reports, and methodology manuals across cases. Organizations where RCA was most thoroughly embedded in audit reports were also those whose charters explicitly mandated root cause analysis for high-rated findings, whose methodology manuals included structured RCA templates, and whose quality assurance reports assessed compliance with RCA documentation requirements. Conversely, organizations with thinner RCA documentation showed charters that referenced “cause analysis” in general terms without specifying methodology, and methodology manuals that were silent on RCA procedures. The documentary record thus revealed structural enablers and constraints that were not otherwise visible.

The third theme, visibility of systemic engagement in audit communication documents—was traced through audit committee papers and corresponding minutes. In organizations where Pareto analysis and portfolio-level root cause reporting had been adopted, audit committee papers presented systemic risk themes with supporting causal analysis, and committee minutes recorded substantive governance discussions about organizational-level control weaknesses. In organizations without such approaches, committee papers reproduced individual finding summaries, and minutes recorded management’s acceptance of corrective action plans without documented discussion of systemic risk. The documentary contrast between these two modes of audit committee communication was qualitatively stark.

The fourth theme, institutionalization as traceable organizational memory, was evidenced by the presence or absence of cross-cycle documentation linking root causes identified in one audit period to findings in subsequent cycles. Mature RCA organizations maintained root cause taxonomies referenced consistently across annual audit planning documents, corrective action logs that tracked recurrence against specific root causes, and quality assurance reports that assessed the effectiveness of prior corrective actions at the causal level. These documents constituted a form of organizational memory, a record of systemic vulnerabilities and their remediation trajectories, that was entirely absent from the documentary record of organizations yet to formalize RCA.

Case Study 1: RCA Integration in a Financial Services IAF

Organization A is a mid-sized commercial bank operating across eight African jurisdictions with an IAF comprising 24 auditors. Documentary review of audit reports from the period 2020–2023 revealed a pattern of recurring findings in treasury operations and credit approval processes across successive audit cycles, with corrective action logs recording repeated management commitments to address the same control weaknesses. Pre-RCA audit reports framed these findings in terms of proximate failures, missed authorization steps, incomplete documentation, without tracing their causal origins.

Beginning in Q1 2022, the IAF’s methodology manual was revised to require 5 Whys and Fishbone analysis for all high-rated findings. The amended charter and updated working paper templates provided documentary evidence of this structural change. Analysis of audit reports produced under the new methodology showed a

qualitative shift in finding narratives: root cause sections appeared for the first time, attributing control failures to upstream causes including inadequate role segregation in process design, gaps in induction training for new staff, and supervisory monitoring deficiencies. Corrective action logs from the post-RCA period reflected this shift, with management responses consistently referencing process redesign, training interventions, and governance structure changes rather than isolated procedural corrections.

Comparison of audit planning documents across the pre- and post-RCA periods further showed a reduction in the repeat appearance of the same audit findings across successive cycles, consistent with the documentary evidence of more substantive corrective actions being implemented. Quality assurance review reports from 2023 noted the improved specificity of root cause documentation as a key positive finding. This case illustrates, through its documentary record, the transformative potential of RCA at the simpler methodology level when structurally embedded in audit processes and documentation requirements.

Case Study 2: FMEA-Driven Audit Planning in a Public Health Organization

Organization B is a national public health agency with responsibility for pharmaceutical procurement, regulatory compliance, and health facility accreditation. The IAF (12 auditors) faced annual mandate pressure to cover an extensive and heterogeneous audit universe with limited resources. Documentary review of the 2023 pharmaceutical procurement audit planning file showed the first application of FMEA as a formal scoping tool, with a completed FMEA worksheet mapping failure modes, probable causes, effects, and risk priority scores across each stage of the six-stage procurement process.

The FMEA worksheet documented supplier qualification as the highest-risk process stage—a prioritization that was explicitly noted in the planning file as contradicting the prior cycle's assumption, recorded in historical planning documents, that payment authorization warranted the greatest audit coverage. The audit programme for the 2023 engagement reflected the FMEA output, with substantially greater procedural coverage assigned to supplier qualification than in any previous cycle. The resulting audit report documented a cluster of control gaps in supplier qualification, several of which were characterized in the report as previously undetected, and the finding narratives traced these gaps to systemic weaknesses in vendor onboarding policy and approval authority documentation.

Documentary review of a concurrent external regulatory review report confirmed that the control gaps identified through the FMEA-directed audit would have constituted the basis for a formal enforcement action had they not been surfaced and remediated through the internal audit process. The FMEA planning document, audit programme, audit report, and external review report together constitute a traceable documentary chain demonstrating the practical governance value of FMEA-informed audit scoping.

Case Study 3: Pareto-Driven Systemic Reporting in a Manufacturing Group

Organization C is a large manufacturing conglomerate operating 14 production facilities across three continents. The IAF (38 auditors) completed a substantial programme of audit engagements in 2023. Documentary review of the annual audit committee presentation prepared at the conclusion of the audit cycle showed the application of Pareto analysis to aggregate findings data: a Pareto chart accompanied by a root cause summary table demonstrated that a small cluster of root cause categories, principally health and safety procedure non-compliance and equipment maintenance documentation deficiencies, accounted for the overwhelming majority of control findings recorded across all facility audits during the year.

Comparison with audit committee papers from the preceding two cycles revealed a qualitative difference in documentary structure. Earlier papers reproduced facility-level finding summaries organized by audit engagement, with no aggregation or thematic analysis. The 2023 paper organized its content around group-wide risk themes supported by the Pareto analysis, presenting systemic causal patterns rather than individual findings. Audit committee minutes from the 2023 annual review meeting recorded a board-level resolution to commission a group-wide health and safety governance review, an outcome not documented in committee minutes from either of the preceding two cycles, despite the same health and safety issues having been identified at facility level in those periods.

The documentary contrast between the pre- and post-Pareto committee papers, and between the corresponding committee minutes, provides direct evidence of the governance impact attributable to RCA-informed portfolio reporting. The case demonstrates, through its documentary record, how cross-engagement Pareto analysis transforms audit committee engagement from transactional finding review to strategic governance discussion.

Comparative Analysis: RCA-Enhanced vs. Traditional Audit Approaches

Traditional audit approaches predominantly focus on control testing, transaction sampling, and compliance verification. While essential for assurance provision, these approaches share a structural limitation: their diagnostic outputs describe what failed and when, but not why the failure occurred or how recurrence can be prevented (Moeller, 2023). This retrospective orientation limits the capacity of traditional audit outputs to drive sustainable organizational improvement. RCA-enhanced auditing addresses this limitation by extending the analytical mandate beyond symptom identification to causal inference. Table 2 presents a structured comparison of the two approaches across eight dimensions drawn from the literature and evidenced through documentary review in this study.

Table 2: RCA-Enhanced vs. Traditional Audit Approaches – Comparative Analysis

Dimension	Traditional Audit Approach	RCA-Enhanced Audit Approach
Analytical Focus	Control failure detection	Systemic causal diagnosis
Primary Question	What failed?	Why did it fail, and how can recurrence be prevented?
Recommendation Depth	Symptomatic corrective actions	Root-level systemic improvements
Stakeholder Engagement	Auditor-led finding documentation	Collaborative causal analysis with process owners
Time Horizon	Retrospective	Retrospective and prospective
Repeat Finding Rate	Higher – symptomatic corrections rarely address root causes	Lower – systemic corrective actions reduce recurrence (literature-supported)
Governance Reporting Value	Finding-level detail	Systemic theme and portfolio-level insight
GIAS Alignment	Meets baseline assurance requirements	Fully aligned with 2024 GIAS Standards 9.2, 13.1, and 15.3

The comparative dimensions in Table 2 highlight a fundamental value differential between the two approaches. Across all three case studies, documentary evidence consistently revealed this shift as transformative rather than incremental, visible not only in the content of individual audit reports but in the structure of audit committee communication, the specificity of corrective action plans, and the traceable institutional memory embedded in cross-cycle documentation. This is consistent with Tamimi and Sebastianelli's (2022) documentary evidence of substantially reduced recurring control failures in organizations where corrective actions address root causes rather than symptoms. It is important to note, however, that traditional and RCA-enhanced approaches are not mutually exclusive; RCA augments rather than replaces standard audit procedures. The optimal integration is one where RCA is selectively applied at an intensity proportional to finding significance, a principle formalized in the risk-calibrated intensity model presented in Section 8.

Strategic Recommendations

Risk-Calibrated RCA Intensity Model

Not all audit findings warrant the same depth of causal analysis. Applying intensive RCA methodologies such as FMEA or FTA to minor administrative findings would represent an inefficient allocation of audit resources. The risk-calibrated intensity model proposes three tiers of RCA application based on finding severity:

- Tier 1 (Low Severity): 5 Whys technique applied by the engagement auditor; causal finding documented in working papers; no separate RCA deliverable required.

- Tier 2 (Medium Severity): Fishbone Diagram completed collaboratively with process owners; root causes mapped to People, Process, Technology, and Management categories; RCA summary included in audit report finding narrative.
- Tier 3 (High Severity / Systemic): Full FMEA or FTA completed by engagement team with specialist support; Pareto analysis applied where multiple findings exist; formal Root Cause Report issued to management and audit committee; recurrence tracked as a formal KPI.

RCA Competency Development Roadmap

Survey data indicated that competency gaps are the most frequently cited barrier to RCA adoption (cited by 64% of non-adopting respondents). The proposed competency development roadmap addresses this through a structured progression:

1. Foundation Level: All audit staff complete a minimum eight-hour RCA fundamentals module covering 5 Whys and Fishbone methodology, with assessed practical exercises using anonymized audit case vignettes.
2. Intermediate Level: Senior auditors and audit managers complete a 16-hour module on Pareto analysis and FMEA within audit contexts, incorporating data analysis skills and stakeholder facilitation techniques.
3. Advanced Level: Designated RCA specialists (at least one per IAF of 10+ auditors) complete a 32-hour advanced module on FTA, probabilistic risk assessment, and governance-level RCA reporting. External certification pathways (e.g., IIA's Certified Internal Auditor continuing education, ASQ Certified Quality Engineer) should be supported.
4. Institutional Embedding: CAEs integrate RCA competency requirements into audit charter language, performance appraisal criteria, and recruitment specifications within 12 months of framework adoption.

RCA Methodology Manual

A standardized methodology manual is essential for consistent RCA application across audit teams and engagement types. The manual should include: decision trees for methodology selection by finding severity and process complexity; standardized templates for each RCA methodology calibrated to audit documentation requirements; guidance on facilitation of collaborative RCA workshops with audit clients; protocols for root cause documentation in audit working papers and reports; and a recurrence tracking framework aligned with audit follow-up procedures under GIAS Standard 15.3. The manual should be maintained under version control and reviewed annually against emerging practice developments.

Limitations

This study makes several contributions to the internal audit and governance literature, but its scope is subject to important limitations that future research should address. First, the documentary case study design, while generating rich organizational evidence, does not support statistical generalization to the broader internal audit population. The three cases were selected for theoretical variation and findings illuminate mechanisms and contextual dynamics rather than prevalence. Readers are encouraged to assess transferability through the thick contextual descriptions provided.

Second, documentary data carry their own epistemological limitations: documents record what organizations chose to write down, in the language and forms that organizational conventions prescribe, and may not fully capture the complexity of actual practice. The absence of RCA documentation in a particular record does not necessarily indicate the absence of RCA thinking; conversely, the presence of RCA language in methodology manuals does not guarantee its fidelity of application in fieldwork. These interpretive limits were mitigated through documentary triangulation across multiple document types within each case, but cannot be fully resolved without access to practice-level data.

Third, access to organizational documents was mediated by organizational gatekeepers, whose decisions about which documents to share may have introduced selection effects. Documents portraying the organization in a less favorable light such as quality assurance reports identifying RCA implementation gaps, may have been less

readily provided than those evidencing success. Where such selection effects were suspected, they are noted in the case narratives.

Fourth, the study was conducted within a specific temporal window coinciding with the transition to the 2024 GIAS. Documents collected during a period of professional change may reflect transitional practices rather than settled states. Longitudinal documentary research would be better positioned to trace the evolution of RCA institutionalization over time.

Fifth, the study does not systematically examine documentary evidence relating to digital and AI-assisted RCA tools including machine learning-based anomaly detection and automated causal inference systems, which represent an emerging dimension of audit analytics (Brown & Mitchell, 2024). Documents referencing such tools were encountered only peripherally in the case corpus, limiting the depth of analysis possible within this study and constituting a priority area for future documentary and mixed-methods research.

CONCLUSION

This paper has advanced the case for systematic RCA integration within internal audit practice, responding to the strategic mandate articulated in the 2024 Global Internal Audit Standards. By combining a theoretically grounded framework with qualitative empirical evidence drawn from systematic documentary review across three organizational case studies, the study contributes rich, contextually situated insight to a literature that has previously been predominantly conceptual.

The documentary findings are substantively consistent across all three cases. The shift from traditional to RCA-enhanced audit practice was legible in the documents themselves, in the changing structure and language of audit reports, the substantive depth of corrective action plans, the thematic architecture of audit committee papers, and the emergence of cross-cycle institutional memory in planning and quality assurance records. The cases illuminate how a regional bank's documentary record evidenced a progressive reduction in recurring findings through structured causal analysis; how a public health agency's FMEA planning files traced a governance-significant reallocation of audit coverage that averted regulatory enforcement; and how a manufacturing conglomerate's Pareto-informed audit committee papers prompted board-level systemic intervention that facility-level reports had not achieved.

The proposed risk-calibrated intensity model, competency development roadmap, and methodology manual template provide practitioners with actionable implementation guidance aligned with their organizational context and resource realities. The limitations section honestly delineates the boundaries of the current evidence base, signposting the longitudinal, multi-method, and digital-focused research agenda that the profession now needs.

As internal audit continues its evolution toward strategic partnership with governance bodies, the capacity to deliver genuine causal insight, rather than symptomatic observation, will increasingly define the value and relevance of the profession. Root Cause Analysis, rigorously applied and systematically embedded, is a foundational tool for that ambition.

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