ASIC
Australian Securities & Investments Commission

Root cause analysis: Audit firm thematic review

Report 739 | October 2022

About this report

This report summarises thematic findings from our review of root cause analysis of negative audit quality findings performed by the largest six audit firms between 1 July 2020 and 31 December 2021 (review period). The report also outlines good practices we observed and better practice recommendations for audit firms performing root cause analysis.

This report will be of interest to all audit firms, auditors, audit committees, directors and preparers of financial reports.

Contents

About ASIC regulatory documents

In administering legislation ASIC issues the following types of regulatory documents: consultation papers, regulatory guides, information sheets and reports.

Disclaimer

This report does not constitute legal advice. We encourage you to seek your own professional advice to find out how the Corporations Act and other applicable laws apply to you, as it is your responsibility to determine your obligations. Examples in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

Executive summary

Our review focused on root cause analysis practices

We reviewed current root cause analysis practices across the largest six audit firms (firms). The review included a sample of 12 individual root cause analyses of audit files with negative quality findings carried out by the firms between 1 July 2020 and 31 December 2021. The samples showed how firms applied root cause analysis to negative quality findings.

Our review compared how the firms conduct root cause analysis and identified better practices across the firms in the areas of planning, conducting the root cause analysis and actions. For the 12 root cause analyses we reviewed, the two most common underlying root causes of audit deficiencies identified by the firms were inadequate skills of audit team members carrying out the work and application of professional scepticism and mindset. In contrast, supervision and review was identified as an underlying root cause in only 25% of the 12 root cause analyses.

Firms will soon need to comply with new auditing standard

Firms are currently voluntarily conducting root cause analysis. Auditing Standard ASQM 1 *Quality management for firms that perform audits or reviews of financial reports and other financial information, or other assurance or related services engagements* will mandate the conduct of root cause analysis from 15 December 2022.

Good practices we observed

We observed good root cause analysis practices across some of the firms. For example:

- including a wide range of audit files with negative quality findings for root cause analysis
- gathering audit quality indicators when performing root cause analyses
- involving senior leadership in the root cause analysis program
- well-structured methodology for conducting root cause analysis
- maintaining the independence of the root cause analysis team from the monitoring team
- appropriately documenting interviews
- question topics used as part of interviews
- timely remediation
- implementing actions and remediation that responded to the root cause analysis findings.

We have developed better practice recommendations

If not already doing so, firms should consider our better practice recommendations, such as:

- broadening the audit files on which root cause analysis is conducted (e.g. all regulator reviewed audits with findings and a sample of positive outcomes)

- interviewing all relevant audit team members, including specialists, experts and engagement quality control reviewers (EQCRs)
- better use of audit quality indicators and audit milestones data in concluding on the real root causes of quality findings
- establishing a root cause analysis team independent from internal monitoring teams
- conducting real-time reviews on future audits following root cause analysis
- exploring more comprehensive actions in addition to more training and communication.

More broadly, firms may also wish to consider wider behavioural and cultural actions, particularly in responding to a post COVID-19 environment, with audit teams adapting to hybrid remote working models. A wider perspective in considering possible remedial actions may also take into account factors such as audit partner portfolio mix, risk profiling of clients, resource mix and specialist skills (especially for complex audits) and communication with clients and audit committees.

For future root cause analyses, it is important that firms explore a wide range of underlying root causes in their root cause analysis programs on both negative quality findings and a sample of positive quality findings. This will ensure that the real underlying root causes are identified and actioned, including the robustness and adequacy of the professional scepticism and supervision and review that contribute to the findings.

Background and methodology for our review

On 15 December 2022, the new audit quality management standard ASQM 1 comes into effect. ASQM 1 requires audit firms to conduct root cause analysis on assurance files with identified deficiencies and to introduce remediation arising from root cause analysis findings. ASQM 1 also requires audit firms to conduct root cause analysis where there are deficiencies identified in their systems of quality control.

In advance of the implementation date of ASQM 1, we conducted a review of the largest six audit firms' existing voluntary root cause analysis practices. Most firms reviewed conduct a root cause analysis where they have negative quality findings from either their internal monitoring program, an external regulator review or a restatement of the existing audited entity's financial report.

We selected a sample of two individual root cause analyses from each of the firms. We reviewed how the root cause analysis was conducted and documented, the findings of the root cause analysis, and actions arising from the analysis. We selected a range of root cause analyses conducted during the period 1 July 2020 to 31 December 2021.

This review builds on an earlier review that we conducted in 2018, where we reviewed the root cause analysis policies, systems, processes and methodologies implemented by firms.

In this report, we identify good practices already adopted by the largest six firms in the areas of planning the analysis, conducting the root cause analysis, and actions following the analysis.

The intention of this report is to inform audit firms, auditors, audit committees, directors and preparers of financial reports of better practices that we have observed, to assist firms in their response to ASQM 1.

During recent periods of COVID-19 lockdowns in Australia, all six audit firms continued their root cause analysis programs, conducted voluntarily as part of their existing quality management systems.

Our observations: Planning the root cause analysis

Good practice observations

Some firms selected all of the following sources of audit files for a root cause analysis:

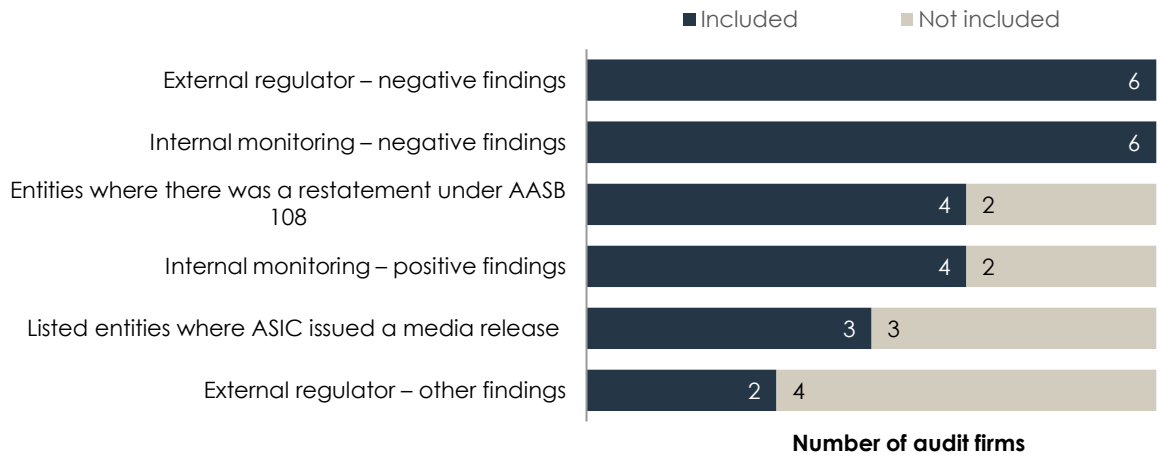
- audit files with either negative or positive ratings from internal monitoring activities
- all regulator-reviewed audits with findings
- audit files where existing listed clients had a restatement or an ASIC media release regarding a change in their financial information.

Some firms had a well-established policy, annual program and timetable for conducting root cause analyses. This enables actions arising from the root cause analysis to be implemented on a regular and timely basis.

All firms continued their root cause analysis programs during the COVID-19 lockdowns.

We reviewed the scope of the audit files each firm included for root cause analysis. We found that firms generally considered the audit file sources set out in Figure 1 for root cause analysis.

Figure 1: Audit file sources for root cause analysis



Note 1: See Table 1 for the data shown in this figure (accessible version).
Note 2: Restatements under Accounting Standard AASB 108 *Accounting policies, changes in accounting estimates and errors*, among other things.

Figure 1 shows that only two out of six firms included all of the better practice sources identified by ASIC for the audit files they selected for the root cause analyses conducted during the review period.

We observed that most firms have an established policy and criteria for the selection of audit files. This provides good root cause analysis coverage of audits conducted during an annual cycle.

Firms' internal monitoring programs were the primary driver for audit files to be included in a root cause analysis program. All six firms included audit files where there had been negative quality findings from their own internal monitoring programs. All six firms in Australia have been undertaking root cause analysis on findings from monitoring programs, as a voluntary component of their quality control systems, for a number of years. We also observed that four out of six firms

conducted root cause analysis on files that had been rated as satisfactory in their monitoring programs, to identify what 'makes a good audit'.

Most firms also included audit files for root cause analysis where files had been subject to a review by an external regulator and where the regulator had communicated negative findings. For negative findings identified by ASIC (where we were of the view that auditors did not obtain reasonable assurance that the financial report as a whole was free of material misstatement), all six firms included these audit files in their root cause analysis programs. However, we observed one firm conducted root cause analysis only when they agreed with a finding reported by an external regulator. We also noted that only two out of six firms included audit files where there were other findings reported by ASIC.

Three out of six firms conducted root cause analysis on an audit file where their listed audited entity had a financial reporting restatement or when ASIC had issued a media release on changes by the audited entity to their financial information following an ASIC inquiry.

Other good practices we observed in root cause analysis planning included the use of a timetable to support the completion of root cause analysis on a regular and timely basis. This enables firms to respond quickly to underlying causes of audit deficiencies.

During the review period the ability for some firms to conduct planned numbers of root cause analysis was impacted by COVID-19. However, most firms maintained a strong focus on performing root cause analysis and recognised the benefits to audit quality from an effective root cause analysis process.

Better practice recommendations

All audit firms should consider expanding their root cause analysis programs to include (if not already included) the following sources of audit files:

- a sample of audit files with positive quality findings from internal monitoring
- all files reviewed by an external regulator where there were findings
- listed entity audit files where there had been a restatement or an ASIC media release on a change in financial information.

Firm leadership should continue to support the root cause analysis process despite the impacts of COVID-19 and emphasise its importance to partners and staff.

Our observations: Conducting the root cause analysis

Good practice observations

We observed the following good practices at some firms:

- a well-structured methodology that included a framework of detailed root cause analysis processes
- individual interviews of engagement team members who worked on the area of the audit with a negative quality finding
- inclusion of the EQCR in the root cause analysis interview process
- sufficient documentation to capture the root cause analysis process and its findings, while still encouraging the identification of the real underlying root causes
- relevant audit quality indicators gathered as part of the root cause analysis process
- senior leadership of the root cause analysis program to emphasise the importance of the program's contribution to audit quality
- independence of the root cause analysis team, with designated responsibilities separate from internal monitoring teams and the assurance practice.

Primary root causes identified by the firms

Firms typically identified multiple primary root causes for each root cause analysis. For the 12 root cause analyses we reviewed, the most common underlying root causes of negative quality findings identified were:

- inadequate skills of audit team members carrying out the work, and
- the professional scepticism and mindset of engagement team members.

In contrast, supervision and review was identified as an underlying root cause in only 25% of the 12 root cause analyses we reviewed. In our view, a robust and thorough supervision and review process is an important 'first line of defence' to ensure a quality audit.

In three of the 12 root cause analyses we reviewed, firms identified as root causes of negative quality findings:

- the adequacy of documentation on the engagement file
- the appropriate use of experts on engagements
- the nature and extent of complex issues on the audit.

In two cases, the adequacy and mix of resources on the engagement team were noted as a root cause of the negative quality findings. Staff motivation and commitment, and instances where the firm policies and guidance were not followed, were identified in one of the 12 root cause analyses reviewed.

We also noted instances where firms may not have identified a primary root cause and/or identified a symptom of a root cause rather than the root cause itself. For example, one root cause analysis identified insufficient documentation as a root cause. However, the audit quality finding and firm's documentation reviewed by ASIC indicated that the primary root causes could include supervision and review, knowledge and skills of individuals, and the level of professional scepticism exercised by the engagement team.

Figure 2 shows that a broad range of root causes were identified by the firms. Knowledge and skills of individual audit staff was identified most often as the primary root cause, being selected in 58% of root cause analyses reviewed by ASIC.

Figure 2: Primary root causes identified by the firms

Note: See Table 2 for the data shown in this figure (accessible version).

Carrying out the root cause analysis

We observed that all six firms used a range of root cause analysis methods when carrying out the analysis. The methods applied were mostly developed by the global firm, but in some cases involved additional processes developed by the Australian firm. Some examples of the techniques used by the firms to conduct root cause analysis were:

- various problem-solving methodologies (e.g. 'Five Whys' and 'Fishbone')
- a range of interview techniques, including facilitated group discussions and individual interviews
- questionnaires and/or tailored agendas
- comprehensive root cause lists to help determine and classify possible root causes
- analysis of audit quality indicators
- mapping of root causes to auditing standard requirements.

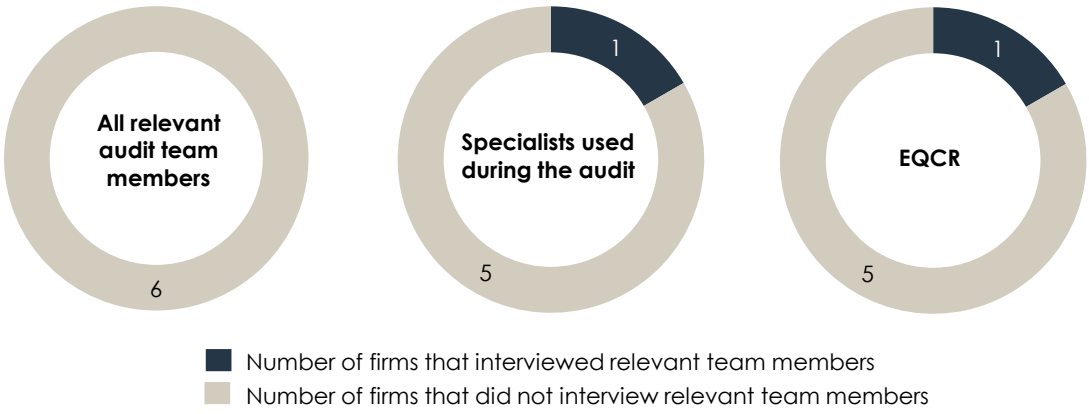
We encourage firms to use a wide range of techniques to identify the real root causes of negative quality findings.

To record the root cause analysis findings, firms relied on internally designed tools and templates. However, no firm had an integrated system that combined the planning, conduct and reporting of root cause analyses. Some firms also used lists of potential root causes to help them identify and report root causes.

We observed that some firms provided training for conducting root cause analysis, including training for conducting interviews.

From the 12 root cause analyses reviewed across the six firms, Figure 3 shows that firms often did not interview all relevant engagement team members, specialists and the EQCR who worked in the area of the audit file where there was a negative quality finding.

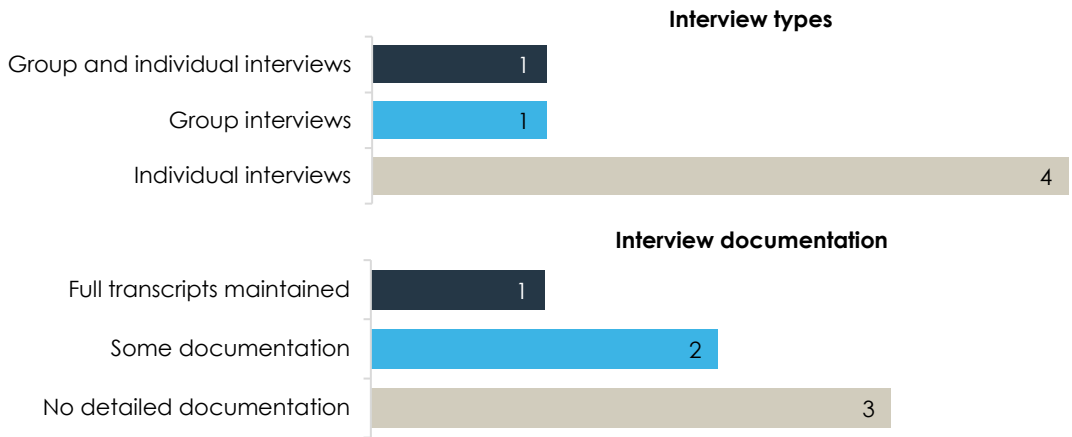
Figure 3: Engagement team members interviewed by the firms



Note: See Table 3 for the data shown in this figure (accessible version).

Figure 4 shows that most firms conducted individual interviews of audit team members as part of their root cause analysis process. One of the six firms used group interview techniques and one firm used both group and individual interviews. There was also a range of documentation maintained to evidence the root cause analysis interviews.

Figure 4: Firm conduct and documentation of interviews



Note: See Table 4 for the data shown in this figure (accessible version).

Interviews are an important tool in identifying the real root causes of negative quality findings. For the 12 root cause analyses we reviewed, firms conducted interviews predominantly with the audit partners and managers and did not include the whole audit team that worked on the area of the

negative quality finding. The reasons for not interviewing these audit team members were also not documented. In most of the 12 root cause analyses, the firm had not interviewed the EQCR as part of the root cause analysis process. EQCRs play an important role in quality control of an audit and must review areas of significant judgement.

One of the six firms interviewed specialists used on the audit as part of the root cause analysis to understand how their work contributed to the area where there was a finding. Not all of the audit files for the root cause analyses we reviewed had specialist involvement. 'Specialist involvement' can include a wide range of specialists used to gather audit evidence (e.g. valuation, actuarial, information technology, taxation, controls and data analytics specialists).

Some firms included a tailored agenda or detailed interview questions to facilitate productive discussions, while some firms preferred to have an unstructured approach to encourage open discussion. There were varying levels of documentation for the root cause analysis interviews.

Audit quality indicators

Some of the firms gathered audit quality indicators as part of the root cause analysis process, to assess whether this gave additional insights into primary root causes of either negative or positive quality findings. Some firms used audit quality indicators to plan which audit files would be selected for root cause analysis, while most other firms gathered those indicators to understand the underlying root causes.

Listed below are some examples of audit quality indicators collected by the firms. Where indicators are tracked, further analysis can be conducted to help understand and identify the root causes of findings. Examples of audit quality indicators and milestone data used by some audit firms are set out below.

Examples of audit quality indicators and milestone data used by some audit firms

- Total actual engagement hours compared to budget for lead audit partners, EQCR and the audit team
- Industry and geography alignment of lead audit partners, EQCR and senior staff
- Years on engagement of lead audit partner, EQCR and senior audit staff, identifying experience on the audit engagement as a strength as well as any potential familiarity threat
- Occurrence and timing of specialists used and technical consultations requested
- Engagement hours spent before and after the balance date, such as EQCR approvals, partner and manager first review, timing of planning, review and completion approvals—that is, milestone data
- Assessment of the client portfolios and concentration of audited entity year-ends for the lead audit partner and EQCR
- Whether the lead audit partner is an EQCR on other engagements
- Internal performance ratings for the lead audit partner, EQCR and manager (e.g. non-compliant in prior two years)
- Mandatory training records of audit partners and staff
- Audit fees, budget and recovery rate on the engagement

In the 12 root cause analyses we reviewed, we did not see many instances where the actual root causes identified and concluded on, considered the audit quality indicator data collated by the root cause analysis teams.

Milestone data used for project management of audits may be used as an audit quality indicator to provide further insights into primary root causes for quality occurrences.

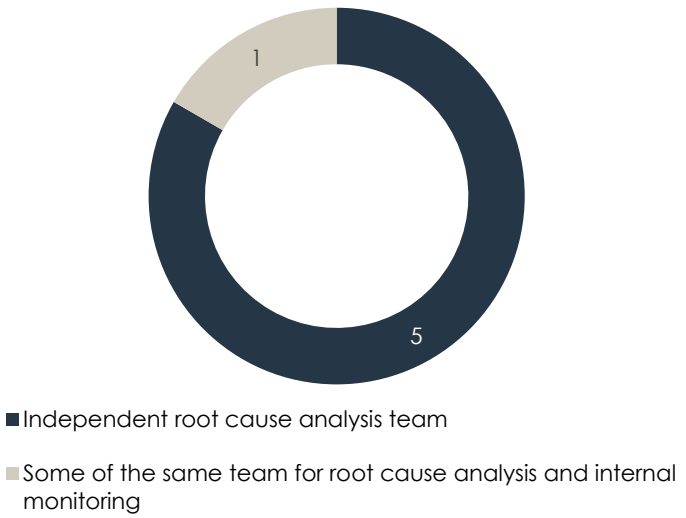
Leadership and independence of the root cause analysis team

Senior leadership involvement in the oversight of the root cause analysis process was evident in most firms. This highlighted the importance of the root cause analysis program.

Most firms established a root cause analysis team independent from the internal monitoring program and lead audit partners.

Figure 5 shows that most firms have a root cause analysis team that is independent of the teams carrying out internal monitoring. In one firm the root cause analysis discussions were led by the lead audit partner, and the internal monitoring team had involvement in facilitating the root cause analysis interviews.

Figure 5: Independence of the root cause analysis team



Note: See Table 5 for the data shown in this figure (accessible version).

Better practice recommendations

Where they haven't already, all audit firms should consider implementing the following practices when conducting root cause analysis:

- documenting a firm-wide standalone root cause analysis policy that brings together all the requirements and tools and templates of the firm's root cause analysis program
- implementing an integrated system that captures the root cause analysis process of planning, conduct (including interviews with audit team members) and reporting in a more structured manner

- conducting the root cause analysis process in a timely manner—where audit team members are available and matters are fresh in their minds—to ensure more accurate identification of root causes
- interviewing all audit team members, including experts, specialists and EQCR who worked on the area of the audit that is subject to the negative quality finding
- although group facilitation can be a useful tool, conducting individual interviews to encourage open responses and full exploration of underlying root causes
- using meeting agendas with possible topics to explore to facilitate and encourage open discussion
- keeping sufficient records of root cause analysis interviews, while still encouraging the identification of the real underlying root causes
- obtaining insights from exit interviews to understand the reasons for staff departing the firms if linked to a negative quality finding
- facilitating the independence of the root cause analysis team (e.g. from the internal monitoring team and audit engagement team) to lead the process and conduct discussions and interviews thoroughly and objectively
- reviewing and updating common root cause lists on an ongoing basis to populate with new or emerging root causes
- using audit quality indicators, including milestone data (where available), more effectively to identify real root causes of positive or negative quality findings
- establishing time codes for capturing time spent on root cause analysis and reporting to firm leadership
- conducting root cause analysis training annually to develop best methods and practices for the root cause analysis team that supports continual refinement and improvement to the process
- exploring a range of other underlying root causes and related remedial actions—such as project management, supervision and review and resourcing—to ensure that the real root causes are identified and actioned.

Our observations: Actions from root cause analysis

Good practice observations

We observed the following good practices at some firms:

- identified deficiencies remediated in a timely manner
- remedial actions appropriately designed and implemented to respond to the root cause analysis findings
- a range of actions implemented to address the root cause analysis findings, on either a thematic basis or to address isolated findings
- increased training and communications to address identified deficiencies.

Firm actions from root cause analysis

From the introduction of ASQM 1, firms will be required to implement remediation for underlying root causes identified. In our review of the 12 root cause analyses, we observed firms generally implemented the following types of remedial actions:

- individual audit file remediation
- real-time reviews for subsequent audits
- more skilled resources to be involved in audits
- changes to the audit plan for subsequent audits
- improvements in audit procedures for future audits
- training and communications in technical accounting and auditing skills
- improvement in tools and templates for use in audits.

We observed that firms responded to identified root causes using a thematic approach or to address isolated findings. The thematic approach is where the root cause is included in a thematic action (e.g. development of technical skills could be matched with a number of audit files where the root cause was found to be poor technical knowledge of an accounting standard). For isolated findings, individual remedial actions were developed for the audit engagement.

The most common outcome implemented by firms was improvements in training and communications to audit practice staff. Where regular training and communication updates are embedded as a regular feature in firms' audit quality or remediation plans, it is also important to consider wider possible actions to address the underlying root causes identified. Intrinsically linked with this is whether the root cause analysis has uncovered the appropriate root cause(s) and, therefore, whether the identified remedial actions are responsive.

In five of the 12 root cause analyses we reviewed, the firm carried out remediation on the audit file. In seven root cause analyses, the firm changed their audit plan for subsequent audits and/or improved audit procedures in the subsequent audit, to address the underlying root causes identified. An example of a change in an audit plan was improvement in risk assessments and scope regarding a component auditor.

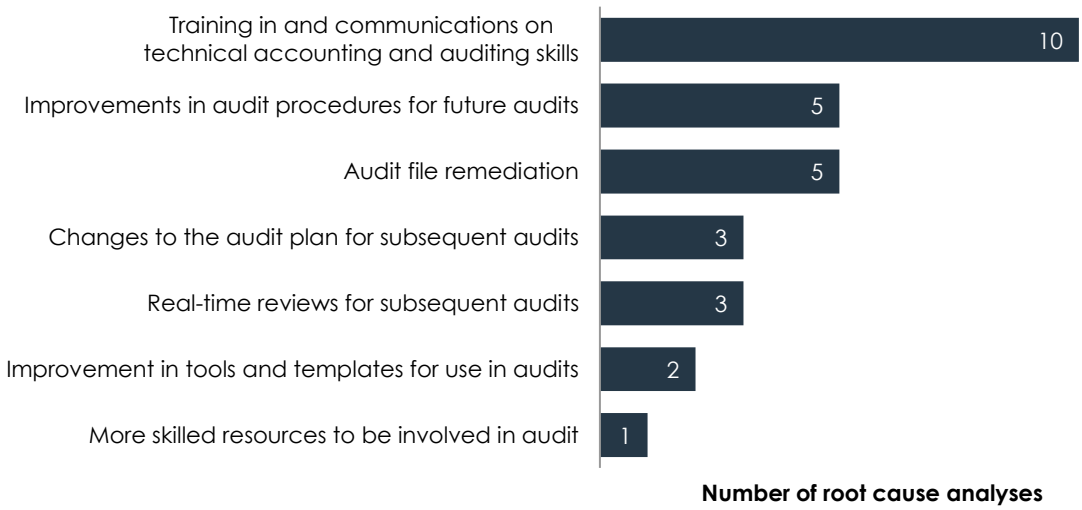
We emphasise the importance of performing real-time reviews and/or coaching for the subsequent period to confirm that the remedial actions are effective in improving audit quality. We noted that in three out of the 12 root cause analyses reviewed, real-time reviews or coaching were conducted in subsequent audits.

In two out of the 12 root cause analyses reviewed, firms improved tools and templates to help audit teams apply the firm's methodology correctly in future audits. In one of the 12 root cause analyses, the firm responded to the findings by improving the skill mix and resources for the subsequent audit.

We encourage firms to think broadly when adopting actions and remediation plans to address the underlying root causes identified from audit quality findings.

Figure 6 shows that for 10 out of the 12 root cause analyses reviewed, the firms took action to implement training and communications in technical and auditing skills.

Figure 6: Actions taken in response to root cause analysis



Note: See Table 6 for the data shown in this figure (accessible version).

Better practice recommendations

Audit firms should consider other, more comprehensive, actions that can be taken, especially where the key action taken was to increase training and communication. They should also consider the following better practices when responding to root cause analysis and in developing remediation plans:

- conducting more real-time reviews and coaching to ensure matters arising from a root cause analysis are appropriately addressed in subsequent audits
- considering wider behavioural and cultural actions, particularly in responding to a post COVID-19 environment, with audit teams adapting to hybrid remote working models
- considering more broadly whether the 'right' mix of skill sets and resources is planned for audits, and that audit fees are appropriately negotiated for the complexity of the work required (which may require more involvement of specialists and experts)
- improving communication strategies with audit clients and audit committees to address significant and complex issues in a timely manner

- improving audit engagement project management, which may be better informed by the monitoring of milestones
- focusing on and considering supervision and review processes and training that are most effective to facilitate quality audits
- reviewing audit partner client portfolios, other responsibilities and workloads
- risk profiling to inform acceptance and continuance of audits
- appropriate use of specialists and experts, and the timing and resources allowed for technical consultation.

Appendix: Accessible versions of figures

This appendix is for people with visual or other impairments. It provides the underlying data for the figures in this report.

Table 1: Audit file sources for root cause analysis

Audit file source	Included	Not included
External regulator – negative findings	6	0
Internal monitoring – negative findings	6	0
Entities where there was a restatement under AASB 108	4	2
Internal monitoring – positive findings	4	2
Listed entities where ASIC issued a media release	3	3
External regulator – other findings	2	4

Note: This is the data shown in Figure 1.

Table 2: Primary root causes identified by the firms

Root causes	Number
Knowledge and skills of individual staff	7
Professional scepticism and mindset	5
Insufficient documentation	3
Use of specialists and experts	3
High number of complex issues	3
Supervision and review	3
Project management and resourcing	2
Motivation and commitment	1
Firm's policies, procedures and guidance not used	1

Note: This is the data shown in Figure 2.

Table 3: Engagement team members interviewed by the firms

Engagement team members	Number of firms that interviewed relevant team members	Number of firms that did not interview relevant team members
All relevant audit team members	0	6
Specialists used during the audit	1	5
EQCR	1	5

Note: This is the data shown in Figure 3.

Table 4: Firm conduct and documentation of interviews

Interview types and documentation	Number
Group and individual interviews	1
Group interviews	1
Individual interviews	4
Full transcripts maintained	1
Some documentation	2
No detailed documentation	3

Note: This is the data shown in Figure 4.

Table 5: Independence of the root cause analysis team

Root cause analysis team composition	Number
Independent root cause analysis team	5
Some of the same team for root cause analysis and internal monitoring	1

Note: This is the data shown in Figure 5.

Table 6: Actions taken in response to root cause analysis

Actions	Number
Training in and communications on technical accounting and auditing skills	10
Improvements in audit procedures for future audits	5
Audit file remediation	5
Changes to the audit plan for subsequent audits	3
Real-time reviews for subsequent audits	3
Improvement in tools and templates for use in audits	2
More skilled resources to be involved in audit	1

Note: This is the data shown in Figure 6.

Key terms

accounting standards	Standards issued by the Australian Accounting Standards Board under section 334 of the Corporations Act
ASIC	Australian Securities and Investments Commission
ASQM 1	ASQM1 *Quality management for firms that perform audits or reviews of financial reports and other financial information, or other assurance or related services engagements* (ASQM 1) effective 15 December 2022
auditing standards	Standards issued by the Auditing and Assurance Standards Board under section 336 of the Corporations Act
Corporations Act	*Corporations Act 2001*, including regulations made for the purposes of that Act
EQCR	Engagement Quality Control Reviewer
largest six firms	Large firms that audit listed entities with the largest aggregate market capitalisation. These firms may operate through national partnerships, an authorised audit company or a national network of firms. They are the BDO firms in Australia, Deloitte Touche Tohmatsu Australia, Ernst & Young Australia, Grant Thornton Australia Limited, KPMG Australia and PricewaterhouseCoopers Australia
negative findings	Where in our view auditors did not obtain reasonable assurance that the financial report as a whole was free of material misstatement
negative quality finding	Findings from a firm internal monitoring review or regulator review that relates to negative findings (see above) or other findings that are non-compliant with the requirements of auditing standards
other findings	Regulator findings that are reported to firms to improve audit quality and are not classified as a negative finding
positive quality finding	Findings from a firm internal monitoring review that are satisfactory and where there are no negative findings