Root Cause Analysis (RCA) The Five Whys Method

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Introduction

Incidents, near misses and system failures happen for a reason. Understanding the contributing factors and root cause, then implementing countermeasures or process improvements is the key to preventing future incidents and possible losses. Losses materialise in many forms including property damage, personal injury, lost income, missed opportunities and damage to reputation. The process described below adopts the “Five Whys” approach to determine the root cause of an incident.

Five Whys Tool for Root Cause Analysis

Sakichi Toyoda, one of the fathers of the Japanese industrial revolution, developed the technique in the 1930s. He was an industrialist, inventor and founder of Toyota Industries. His method became popular in the 1970s, and Toyota still uses it to solve problems today. The architect of the Toyota Production System, Taiichi Ohno, described the 5 Whys method as "the basis of Toyota's scientific approach by repeating why five times, the nature of the problem as well as its solution becomes clear."

Step by Step Process

Step 1 Select a group of stakeholders to participate in the process. Ideally, people who were involved in the incident should participate in the root cause analysis as well as those with specific knowledge of the processes and systems involved. Further, the process is more effective if the group is facilitated.

Step 2 Select a facilitator

Step 3 Develop the problem statement. Be as clear and specific about the problem as possible.

Step 4 The facilitator asks why the problem happened and records the group response. To determine if the response is the root cause of the problem, the facilitator asks the group to consider “If the most recent response were corrected, is it likely the problem would recur?” If the answer is yes, it is likely this is a contributing factor, not a root cause.

Step 5 If the answer provided is a contributing factor to the problem, the group keeps asking “Why?” until there is agreement from the team that the root cause has been identified.

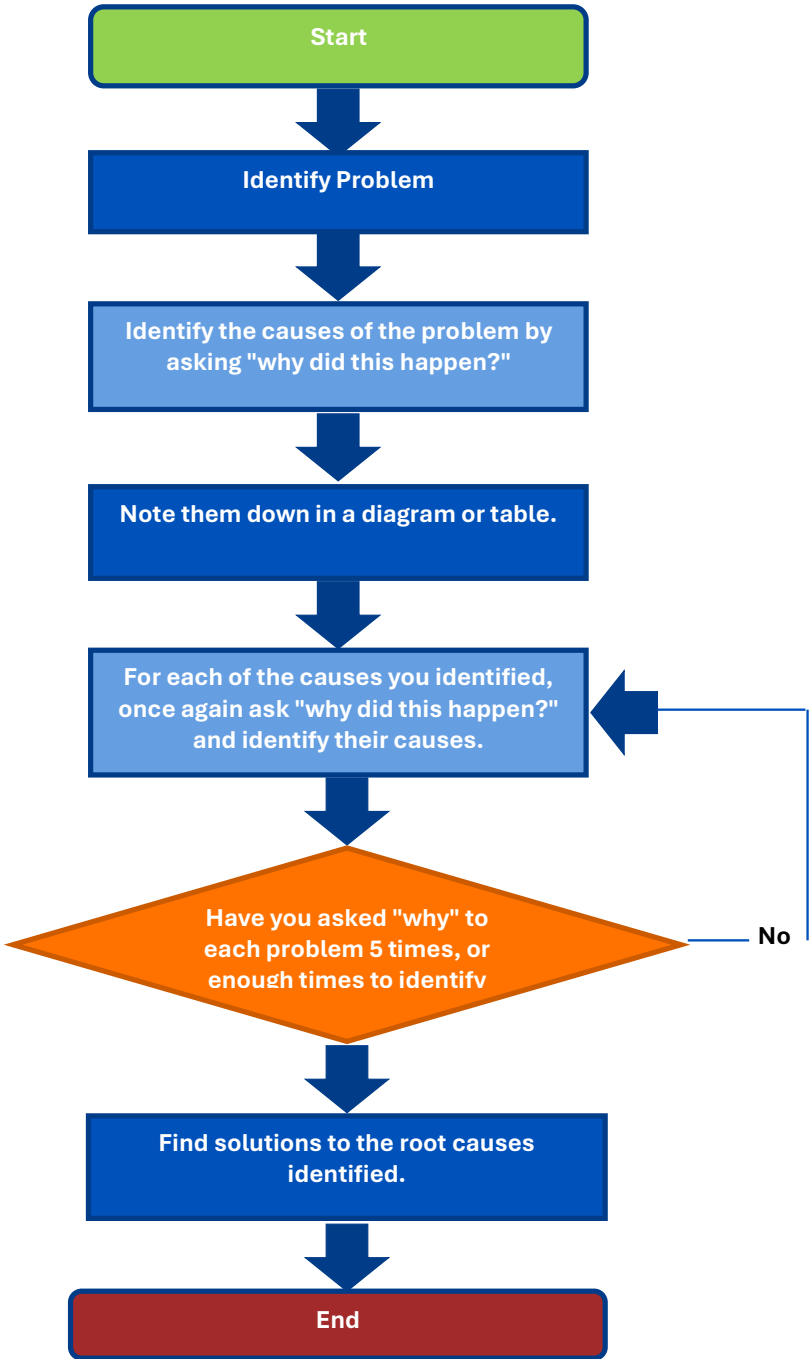
It often takes three to five whys, but it can take more than five! It is important to keep going until the team agrees the root cause has been identified. Be aware that in some cases there may be more than one line of enquiry. The Three Legged 5 Why includes additional paths to determine what control or process was not in place or not effective enough to detect the failure prior to the incident. Systemic or management processes either not in place or that could have contributed to the incident should also reviewed.

Caution must be observed to assure that the “Whys” follow a logical path. One method to check if the progression follows a logical path is to read the causes in reverse order. When you read the causes or “Whys” in reverse order, they should follow a logical progression to the problem statement or failure mode.

Use the table below to record the outcomes of the process.

Problem Statement		
Why →		Contributing Factor (where applicable)
Why →		Contributing Factor (where applicable)
Why →		Contributing Factor (where applicable)
Why →		Contributing Factor (where applicable)
Why →		Contributing Factor (where applicable)
Root Cause(s)	1. 2. 3.	

5-Why Process Flowchart



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