

FPS Analysis

Reference:
Effective Date:
Type of Document:
Page:

12.30.07.80 03.05.2024/02 Formulaire 1/1

I. DESCRIPTION

Object:

Ce formulaire est un modèle utilisé pour traiter les incidents internes et externes

Il décrit la méthode utilisée pour éliminer les causes profondes de la non-conformité; il comprend les étapes suivantes :

1)№ constitution de l'équipe de résolution du problème.

2)≌a description du défaut

3) Eimplantation des actions immédiates

4) L'identification des causes racines du problème

5) Eidentification des actions correctives permanentes

6) I implantation des actions correctives

7) Elidentification des actions préventives

8) Eugement et observation relative au rapport 8D.

DOMAINE D'APPLICATION :

Problèmes qualité

UTILISÉ PAR :

Equipe qualité

DÉFINITION DES ANNOTATIONS

RAS

II. HISTORIQUE DU CHANGEMENT

DATE DE REVISION	VERSION	MODIFICATION	MODIFIÉ PAR
06.02.2024	01	1ère émission	Helmi Chebbi
03.05.2024	02	Ajout de la classification des incidents selon leurs criticités	Hazem Bououni

III. MATRICE D4APPROBATION

Nom	Département	Fonction		
Hazem Bououni	Qualité	Resp.Qualité Client		
Helmi Chebbi	Qualité	Chef Dépt. Qualité		
Mhamed Drira	Direction usine	Directeur d'usine		

DDO: 12-6620

IV. CLASSIFICATION DE CONFIDENTIALITÉ

Extrêmement	Confidentiel	Propriété/restreinte	х	Usage publique
confidentiel				

Ce document est la propriété du groupe COFICAB Il ne peut être transmis ou dupliqué par aucun moyen que ce soit sans son autorisation préalable.

	COFIC	AIG.	Coficab Plant		Claim Date		sponse Da	te:			
		FID	COF TN		09/02/2024	3I 8I					_
			8	D D	EPORT						
	601	NTACT CUSTOMER D		אט	EFORT	INFO	RMATION A	DOUT TH	COMPL	AINIT	
Custom		NTACT CUSTOMER D	ETAILS		ID Number	INFO	-	ABOUT TH	E COMPL	AINI	
From Functio					Reference Color						
Tel.					Rejected Quar	ntity (m)					
Fax E-mail					Received date Prod. Date	VBL					
	CUSTOMER CL.	AIM NUMBER	INTERNAL CLA	AIM NU	MBER		Pi	CTURE OF	THE PRO	DBLEM	
	-		-								
	Type of Incider	nt									
		Team Assembled									
		Establish a small gr technical disciplines	oup of people with the to solve the problem		ss/product l	cnowledge	e, allocated	l time, aut	hority and	d skill in the rec	quired
Depart	ment		Name	_			sponsabili				
-			-								
-			-			-					
-			-			-					
-			-								
-			-			-					
-			-			-					
-		Problem Description	-			-					
			it information, this wil	ll be vo	aar Problem i	Descriptio	ın.				
			, , , , , , , , , , , , , , , , , , , ,								
-											
	3	Containment Actions Temporary actions t	so contain the problem	and r	rotect the c	istomer f	om the fir	rther defec	ted parts		
		This action must be	fixed until the verifica	tion o	f the implem	ented per	manent co	rrective ac	tion.	Ctatus	
Localiz		Action take				Respor	ioiDie	Da		Status	
In COI	FICAB stock	-				-		-		-	
In proc	fuction	_								-	
In trar	sit	-				-		-		-	
	customer										
						-		-		-	
Other I	Actions (if applica	able)									
		Diagnose Root Caus	e								
			oot cause(s) with 5 Wh	ıys me	thod. Identif	y and veri	fy the Esc	ape Point.			
	Causes of creation	Why ?	Why ?			1?		Why ?		Why?	
욛	1	,	,							,	
Technical / Systemic Examination	2										
I / Sy	3										
ınica Exaı	Causes of non detection	Why ?	Why ?		Why	/ ?		Why ?		Why?	
Tecl	1										
	2										
	3										
Cla	im Decision :		Comment:								
	5	Identify Solutions, C	orrective Actions is and correct the root								
			d to be the best of all		ernatives.						
Action					Respon	sible	Date		Status		
_						-		-		-	
-						-		-		-	
-						-		-		-	
-						-		-		-	
	6	Validation of effective	eness late to ensure that cor	rective	action does	"what it:	s sunnose	d to do"			
		Detect any udesirah	le side effects								
	7	Prevention Determine what imp	rovements in system :	and pr	ocess would	prevent r	roblem fro	m reoccur	ing		
		Ensure that correcti	ive action remains in p	lace a	nd succesful						
		Review the following	documents / systems								
		Attach a copy of mo									
		Document	_	Modif	N/A	Resp	onsible		Planne	Date d Statu	s
	ement System M				IVA				T IUITIO	u otata	_
Flow C	harts	work Instructions		Ħ							
Contro	l Plans	•		П		-	•				
Risk A Forms	nalysis Table and	d lesson learned		Ħ							
. o. ms		Effectiveness measu	rement:		-1						
		Closed by: Closure Date:	-								
	Status definition to										
_		Realized at 339		66%	Real	ized at 10	ю% 🕕	Validat	ed and ef	ffective	
	Realized and n		Cancelled								
	Updating Date	Version									

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Claim Not Accepted COP EE 1 X
Claim Not Accepted COP MA 2
COP MAD 3
COP MAD 3
COP MAD 3
COP MAD 10 M

_							_			
1 /	COFIC	ID OI	Coficab Plant (1)	Clair	m Date (2)		ise Date: (3)		
- 1		10					3D 8D			
							U.D			
	CON	TACT CUSTOMER DE	TAILS (4)	8D F	REP		NEODMATI	ON ABOUT THE	COMPLAINT	(F)
Custor		IACT COSTOMER DE	1 ALS (4)		ID N	umber	NFORMATI	ON ABOUT THE	COMPLAINT	(5)
From					Refe	rence				
Function Tel.	on				Colo	r cted Quantity	u (m)			
Fax					Rece	eived date/BL				
E-mail						. Date		DIOTUDE OF	***** ********************************	HA (A)
	CUSTOMER CLAI	M NUMBER (6)	INTERNAL C	LAIM NU	MBEF	₹ (7)		PICTURE OF	THE PROBLE	:M (8)
	Type of Incident									
		Team Assembled (1								
		Establish a small gr technical discipline	s to solve the probl	i tne proc lem	ess/[roduct kno	owieuge, an	ocated time, au	tnonty and s	Kiii in the required
Depar	tment		Name				Respon	sability		
		Problem Description	(11)				_			
		Combine the relevan		s mill box		hablam Da	o ordentio m			
		Comonie the releval	it information, the	s will be y	our r	Toblem De	scription			
		Containment Action	s (12)							
		Temporary actions	to contain the prol	olem and	prote		omer from	the further defe	cted parts	
Local	zation	This action must be Action tak	e fixed until the ver	ification	of the	implement	ted perman Responsible	ent corrective a	ction. ate	Status
In CO	FICAB stock							_		
In pro	duction									
At the	customer									
Other	Actions (if applica	able)								
		Diagnose Root Caus	se (13)							
		Analyze problem's r	oot cause(s) with 5	Whys m	ethod	l. Identify a	nd verify th	e Escape Point		
	Causes of creation									
a P		Why ?	Why	?		Why ?	·	Why?		Why ?
echnical / Systemic Examination	1									
inical / Syster Examination	2									
E E	Causes of non detection	Why ?	Why	?		Why ?	,	Why ?		Why?
差面	1									
ě	2									
			Comment:		-					
Cla	im Decision :									
	5	Identify Solutions, C	orrective Actions (14)						
		Solutions that adre Solutions determine	ed to be the best of	all the a	ie. Iterna	tives.				
Action	1					Responsib	le [Date	Status	
-										
-										
		Validation of effective	veness (15)							
		Implement and valid Detect any udesiral	late to ensure that	correctiv		ion does "w	hat it is su	pposed to do".		
		Detect any udesiral	ne side ellects							
		Prevention (16)								
		Determine what imp	orovements in syst	em and n	moces	s would on	event nmbl	em from reoccu	ring	
		Determine what imp Ensure that correct	ive action remains	in place	and s	uccesful	•			
				44.00						
		Review the following								
		Attach a copy of mo	odified document(s). Mod						Date
		Document			N/A		Responsi	ble	Planned	Status
Mana	gement System M	anual work Instructions								
Flow (Charts	WOLK III SELECTIONS								
Contro	ol Plans									
	s Inalysis Table and	lesson learned			-					
Forms										
		Effectiveness measi Closed by:	urement (18)							
		Closed by: Closure Date:								
In the	Status definition to	use:								
		Realized at 33	K A Realisa	dat66∾	•	Realiza	dat 100°≤	Valida	ted and effor	tive
_		_	Cancelled	00%	-	- Nemil26		valida	eller	
8	Realized and no		cancelled							
L	Updating Date	Version								
	(19)	(20)								
-			•							10 20 07 26/15

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Claim Accepted COP EE 1 X
Claim Not Accepted COP NT 2
COP MAD 3
COP MAD 3
COP MAD 3
COP FT COP FT COP FT COP FT COP ST SCOP ST

Instructions de Travail pour le Traitement des Incidents Clients

1. Réception de l'Incident Client :

L'Ingénieur Qualité Client, l'IQC doit veiller à ce que toutes les informations pertinentes sur l'incident soient correctement documentées dans la base de suivi des incidents. Cela comprend :

- La date et l'heure de réception de l'incident.
- Les coordonnées du client (nom, entreprise, contact).
- Une description détaillée de l'incident, y compris les symptômes, les impacts et toute autre information pertinente.

2. Traitement de l'Incident :

L'IQC doit s'assurer que le fichier de suivi des étapes du 8D est correctement renseigné dès le début du processus

L'envoi d'un e-mail aux parties concernées doit contenir des informations claires sur l'incident et ses implications. Les pièces jointes, telles que l'onglet "D1-D2 / D3", doivent être clairement identifiées et accessibles.

3. Création du Dossier de Travail sur OneDrive :

L'IQC doit organiser le dossier OneDrive de manière logique et structurée, en créant des sous-dossiers pour chaque phase du traitement de l'incident.

Il est important de limiter l'accès au dossier OneDrive uniquement aux membres autorisés de l'équipe pour garantir la confidentialité et la sécurité des informations.

4. Sécurisation de l'Incident (Containment) :

L'IQC doit collaborer étroitement avec le responsable qualité de la zone et son équipe pour élaborer des actions de containment efficaces qui visent à stabiliser la situation et à prévenir tout impact supplémentaire sur le client ou les processus internes.

L'alerte qualité envoyée doit fournir des instructions claires sur les mesures de containment mises en place et les actions nécessaires à suivre.

5. Réunion de Traitement :

Après l'étape du containment, le responsable qualité de chaque zone doit :

- Participer activement au traitement de la non-conformité.
- Remplir les annexes D4-1, D4-2 et D4-3 pour obtenir toutes les informations relatives à la bobine réclamée, côté traçabilité et process.

La réunion de traitement doit être soigneusement préparée avec un ordre du jour détaillé, y compris la présentation des données sur l'incident et les résultats préliminaires de l'analyse.

L'IQC et le Responsable Qualité de zone doivent encourager la participation active de toutes les personnes concernées pour garantir une compréhension commune de l'incident et des mesures correctives à mettre en œuvre.

6. Mise à Jour et Suivi :

L'IQC doit documenter toutes les activités et les progrès réalisés dans le fichier 8D de manière claire et concise.

Les rappels aux personnes en retard dans l'exécution des actions doivent être effectués de manière proactive, en identifiant les obstacles et en fournissant un soutien supplémentaire si nécessaire.

7. Finalisation du Processus:

L'IQC doit s'assurer que toutes les actions préventives sont intégrées de manière appropriée dans les procédures et les processus existants.

La révision des documents qualité tels que les FMEA et les instructions de travail doit être menée avec rigueur pour garantir leur pertinence et leur efficacité.





8D Process Dashbord

8D Methodology	8D Methodology Steps Follow-up					
01 D1-D2		0,5				
02 D3-Containment		0,5				
03 D3-Alert&Awareness	03 D3-Alert&Awareness					
04 D4-Investigation Sheet	1					
05 D4-Roout Cause Analysis		1				
06 D5-Corrective Actions		0,5				
07 D6-Effectivness control		5				
08 D7-Prevention		0,5				
09 NC Spools Follow-up & NQ Cost		0,5				
	Global Progress	10				

Issue Date: 26/09/2023

Planning	Closing Date	Follow-Up	Progress
09/02/2024	05/02/2024	-4,5	100%
10/02/2024	-	-	0%
10/02/2024	-	-	0%
11/02/2024	-	-	0%
12/02/2024	-	-	0%
13/02/2024	-	-	0%
18/02/2024	-	-	0%
18/02/2024	-	-	0%
19/02/2024	-	-	0%
	2 1 "	4.5	
	Cumulation	-4,5	11%
	Overage Delay	-4,5	1 1 /0

COFICAB Powered by Passian	1D 2D		TEAM ASSEMB PROBLEM DESCR		N			Issue Da	te:	
Incident Pilote					gress Rate	1	00%	Closing [lato	05/02/2024
Name :	•			ΓΙΟ		one :	00%	Closing	Jale	03/02/2024
Name :					PII	one :				
Function:					Local	isatior	า:			
Incident Details	;									
Customer Incident Nbre:					Incide	nt Da	te	0	9/02/2	024
Incident Type		Claim			Cus	tomer				
Contact Customer D	etails	;			Informat	ion al	out th	e Incident		
Customer					ID N	umbe	r			
From					Refe	erence				
Function					С	olor				
Tel.					Rejected (Quanti	ity (m)			
Fax					Receive					
E-mail						l. Date				
					Pioc	. Date				
D1 Team Assem	blea						_			
Department			Name :				Fund			
Department			Name :				Fund			
Department			Name :				Fund			
Department			Name :				Fund	tion:		
Department			Name :				Func	tion:		
Department			Name :				Func	tion:		
Department			Name :				Fund	tion:		
Department			Name :				Func	tion:		
Department			Name :				Func	tion:		
Department			Name :				Func	tion:		
D2 Problem Desci	iptior	1								
Customer Descriptio	n	1								
Defect Samples :		Did we regione a cor	mple from Customer ?		Yes	No	<u> </u>	When		
Defect Confirmation :		Did we recieve a sai								
		Did we confirm the d	lelect ?		Yes	No	1	Not Yet	Ш	
COFICAB Description					Interr	al Cla	im Ref			
					Defect Na	ame				
					Defect Fa	mily				
What happened?							Photo	of the Probl	em	
Why is it a problem?										
When detected										
Who detected?										
Where detected?										
How detected?										
How many bad parts?										
Production Process ?										
In which Plant?										

Last Similar Problem?					
Incident criticality	Is the incident considered critical? Classification	<u>n :</u>	Н	M	
	Quality Manager Validation	Yes	✓ No □	When	21-sept23



Criticality of the customer incident

D2	Calculate the criticality of the incident

Evaluation

Incident type	Customer impact	Special characteristic	Number of impacted customers by the incident	Potential escalation
Claim	Direct customer process	1	1	Non
3	2	4	1	1

Matrix:

Special characteristic	Number of impacted customers by the incident	Customer impact	Result	Criticality classification
1			Н	
	More than 2		Н	
		Risk of Call recall	Н	
Different from 1	1-2	Different from "Risk of Call recall"	Total calculated points ≥20 H	
Different from 1	1-2	Different from "Risk of Call recall"	Total calculated points 10 <c<20< td=""><td></td></c<20<>	
Different from 1	1-2	Different from "Risk of Call recall"	Total calculated points ≤10 L	

Result:

Total calculated points "C"	Criticality classification
14	Н

Issue Date:	
26-sept	

Number of suspected spools	Financiai impact	Recurrence of the incident in the same year		
1-2	Less than 10000€	Non		
1	1	1		



Criticality of the customer incident

Criticality matrix of incident classification

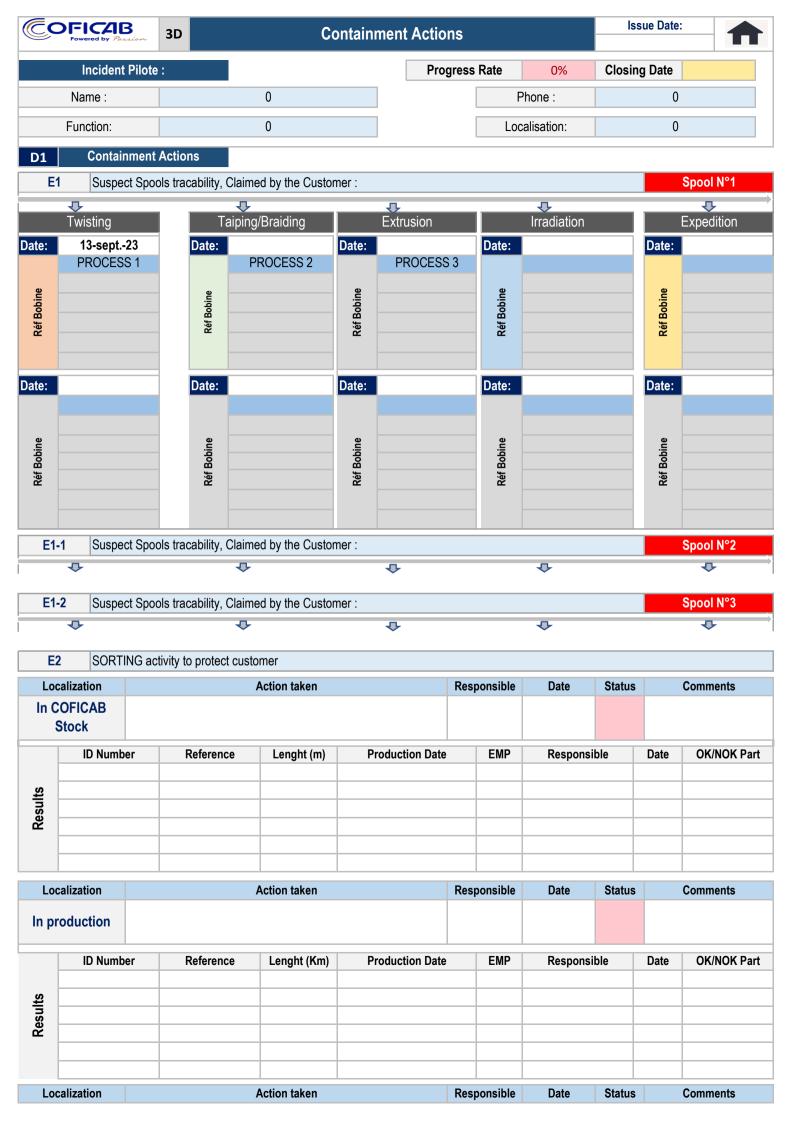
Classification criteria

D2

Incident type	Customer impact	Special characteristic	Number of impacted customers by the incident	Potential escalation
Notification	Incoming inspection of the direct customer	4	1	Non
Alert	Direct customer process	3	2	Oui
Claim	Final customer	2	More than 2	
	Risk of Call recall	1		

Issue Date:	
26-sept	

Number of suspected spools	Financial impact	Recurrence of the incident in the same year
1-2	Less than 10000€	Non
3-5	10000€-20000€	Oui
5-10	More than 20000€	
More than 10		



Results	ID Number 0 0	Reference	Lenght (Km)	Production Date	Color	Respons	ible	Date	OK/NOK Part
Loc In C	calization customer Stock		Action taken		Responsible	Date	Status		Comments
Results	ID Number	Reference	Lenght (Km)	Production Date	EMP	Respons	ible	Date	OK/NOK Part
S	orting Result	Nbr Of Ol	Spools	Nbr of NOK spools		esult was Cor		ed to the When	Customer?



E2-2 Sorting Activity Result To Protect Customer Data_Spools ID Line Serial Number Item Description Quantity Date

		-			-	
	E3 Urgent Replacement for the Customer					
	Spools_Data					
			Spoo	IS_Dala		
ID Line	Serial Number	Item	Description	Quantity	Date	

		Spools_Data						
	ID Line	Serial Number	Item	Description	Quantity	Date		
Ì								

Containment Actions

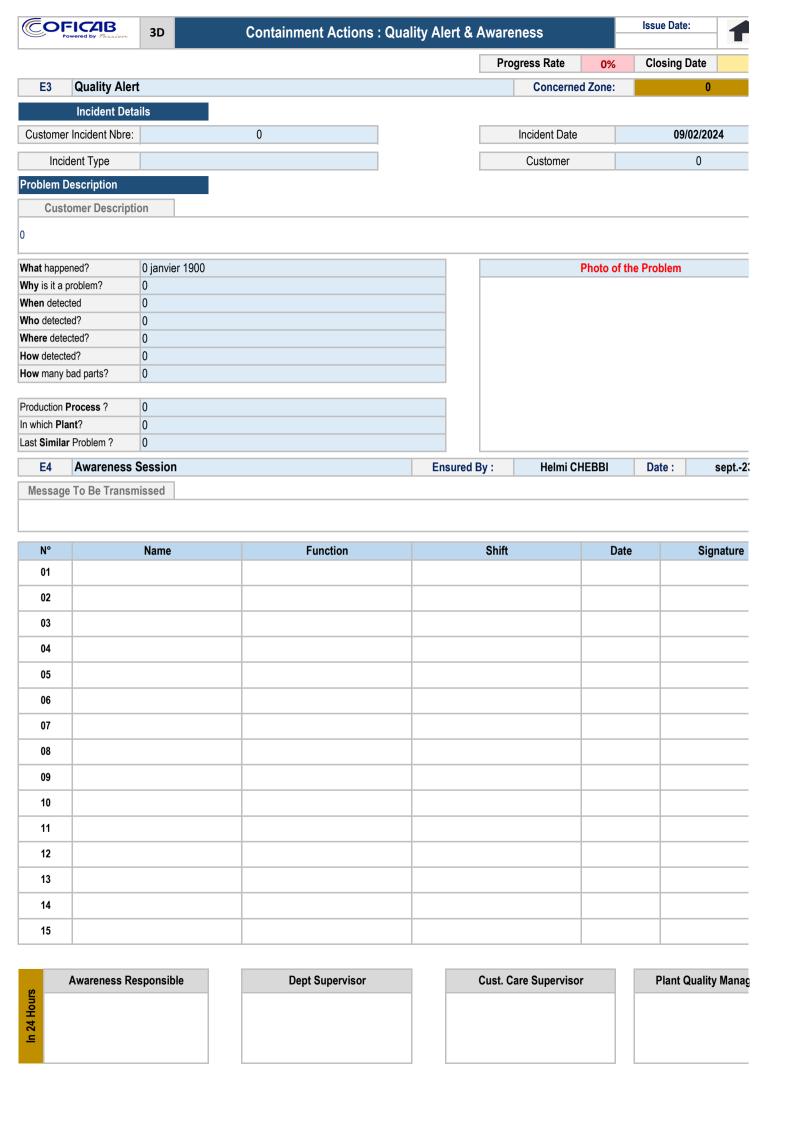
				Liste des Contrôle à effec			
Final Status	Туре	N° Longuer	Location	Adherance	Bull d'aire	Facteur A	

				Liste de	s Contrôle à (effectuer	
Final Status	Туре	N° Longuer	Adherance	Bull d'aire			



er	

Expedition_Data							
Delivery Date	Customer Feedback						





COFICAB Powered by Passing 4D	Diagı	าose Root Cause		ls	sue Date:	
D4 Diagnose Root Cause		Progre	ss Rate	0%	Closing Date	
E1 Investigation Sheet	Co	oncerned Zone Supervisor			Date	
What happen ?What is the difference between good a parts? The defect must be described as the deviation between a good part.		Bad Part			Good Part	
Was part produced in the standard process? Any product or process deviation or rework or operation done be qualified person must be taken in consideration	y non					
Who manufactured? These information are related to the person working at the stati responsible for the defect and the person in charge of the detect defect Name of the person and/or his registred number - Function of the person. qualification. status		Occurrence	e		Detection	
Where the defect is produced and in In which other ap or processes product is used ?	oplication					
How can we detected the defetct? are we capturing the when reinjecting product in normal process? refrer to the contrôle plan & (PAC/PEV) identifity the contrôle methis defect, reproduce the defect and reinject it without warning operator and see if we capturing the defect in the normal process.	ethod of the					
How many NOK Spool or meterage ? Did a similar pro happen previously at customer or internally ?	blem					
MACHINE SETTINGS&Tooling - is there any maintenance intervention recorded in the machine is the Poke Yoke Systeme or device implement and work properly? - Is the machines parameter (pressure , force,temperature, speed) and complient regarding the defined machine settings (Recette)? (Check the current machine settings and compare it regarding the clair report and the standard) - Complience of the Tool?						
Man -Is the person respensible for the defect or the detection of the trained to apply the involved instruction or standard? -Are the users able to explain the standard? -Are the users respecting the standard?	defect are					

METHOD & OPERATIONS Is the Work Instructions describing how: - to operate the workstation safely - to produce a part - to maintain the equipment (1 st maintenance level)	
QUALITY CONTROLS Is the defect existe in the contrôle activity (Pac , Pev,)? Is the control ensured by the operator or the quality agent ? What is the result of control if the tracebeality Data availbale?	
RAW Material Raw material lots and supllier complience ?	
PROJECT ACTIVITY Check Design Validation, Process Validation, Check the initial Prototypes and if design rules have been respected	
Customer Care Supervisor Validation	Yes V No When



Diagnose Root Cause

Issue Date:



P1 Process Parameters

Add the needed process parameters

@ 0	FICAB
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Diagnose Root Cause

Issue Date: 26-sept



E2-5 Raw Materials Investigation

Item :							
Inner Core Spools Nbre	RAW Material	Temperature Class	Batch Nbre	Color	Color Batcs	Date	Comments

Fournisseur	Code Article	Date Production	Date_Reception	Qte	Num Sac	Comments
	Fournisseur	Fournisseur Code Article	Fournisseur Code Article Date Production	Fournisseur Code Article Date Production Date_Reception	Fournisseur Code Article Date Production Date_Reception Qte	Fournisseur Code Article Date Production Date_Reception Qte Num Sac



Diagnose Root Cause

4D

Issue Date:

Diagnose Root Cause Progress Rate D4 Closing Date 0% E2 **Root Cause Analysis** Concerned Zone Supervisor 18/09/2023 H. CHEBBI Date Step1 List of all causes (Tools: Brain storming + Ishikawa) Machines/Equipement Methods/Process Manpower /People Ishikawa 0 Diagram Materials Environment Measuremants

			Materials		Liivii Oliilielit	Measuremants			
	5M	Process/Machine	Davametera	Potential causes / Factors	Selection	Argument / Validat	tion (Mandatory if ca	ause not retained)	
	SIVI	Process/wachine	Parameters	Potential causes / Factors	Selection	Action / Argument	Pilote	Deadline	Result
	Method - Process				Not Selected				OK
ø	Method - Process				Selected				OK
Occurrence					Not Selected				OK
ä					Not Selected				OK
ŏ					Not Selected				OK
					Not Selected				OK
_					Not Selected				OK
뜮					Not Selected				OK
Detection					Not Selected				OK
Non					Not Selected				OK
Ž					Not Selected				OK
					Not Selected				OK
.e					Not Selected				OK
Systemic					Not Selected				OK
Ŝ					Not Selected				OK
					Not Selected				OK

	Step 3	Potential Causes Validation	n & Defect Reproduction					
Trial N°	Causes		Trial Description	Waiting Result	Parameters	Tools	Pilote & Date	Result/Conclusion
1								
2								
3								
4								
5								
6								
7								
8								

Trial	ls Results with details	T 								
i	Step 2	Finding Root Causes (Tools: 5	5 Whys)							
	Potential cause		5 vviiys)	M/by/4	Wh	.0	1	M/hy/2	M/by/4	WhyE
	Potential cause	es .		Why1	Wh	yz		Why3	Why4	Why5
Occurrence										
Non Detection										
Systemic										
	Step 4	Selected Root Causes								
	ROOT CAUSES OF OCCURRENCE	0	OC1				OC2			
		0	DC3				OC4			
	DOOT CALIFFE OF NON DETECTION	N	ND1				ND2			
	ROOT CAUSES OF NON-DETECTION	N	ND3				ND4			
		s	SC1				SC2			
	SYSTEMIC ROOT CAUSES	S	SC3				CS4			
Custo	mer Care Supervisor Validation				Yes	No		When		

FICAB
Powered by Passion

Identify Solutions, Corrective Actions

Issue Date:

1

D5	Identify Solutions, Corrective Actions	Actions Plan Globlal Progress	#DIV/0!	Progress Rate	0%	Closing Date	
----	----------------------------------------	-------------------------------	---------	---------------	----	--------------	--

Root Cause		Actions	Pilote	Deadlin	пе	Follow-up				
Root Cause	N°	Intitulé	Pilote	Date	Week	Progress	Postpone	Comments & Progress		
OC					0					
SC					0					
					0					
					0					
					0					
					0					
					0					
					0					
					0					
					0					
					0					

Conclusion/Comments					
Customer Care Supervisor	Validation		Yes V No	When	

©	FICAB Powered by Passion	6D			Validation of effe	ectiven	ess						Issue Date:	
D6		idation of Ef						Prog	ress Rate		0%		Closing Date	
E1	Validatio	n of effective	veness method											
E2	Actions I	Implimentat	ion & Effective	ness Follow-up									■ Planed Action	Actions Done
	Actions Count	:		0	Week	1	2	3	4	5	6	7	8	
	Actions at 33% 0				Planed Actions	0	0	0	0	0	0	0	0	
	Actions at 66%													
	Actions at 100	%		0	Actions Done	0	0	0	0	0	0	0	0	
Report RI	ocage for progre	ess :											1 2 3 4	5 6 7 8
N° 1 2 3 4		Ac	tions Checked		From To From To From To From To From To					F	Result an	d Comm	nents	
5 6					From To									
E3	Process	/ Performar	ice Evolution		110111 10									
		tion Period			Performance / KPI	Before		After					Comments	
From:	Wxx-2023	To:	Wxx-2023	1										
From:		To:		2										
Follow Su	mmary													
Week	c Resu	lt T	arget	Arguments/C	omments			Phot	0				Evolution-Chart	
1													EVOLUTION AFTE	
2											15	50%	IMPROVEMENT	
3											10	00%		
4												200/		
						-					11 -	nn/		

5		
6		
Average		



= 4	A 1 1114	A 1 1						
E4 Proc	ess Capability	y Analysis						
E	/aluation Period	d]		Carateristic	Before	After	Comments
From: Wxx-2023	To:	Wxx-2023	1		CP			
From: Wxx-2023	To:	Wxx-2023	2		CPK			
			D	-14				0
			Kun	chart				Comments

E5

Conclusion

COFICAB POWERED BY Passion 7D				Prevent	ion				Issue Date:	
D7 Prevention E1 Preventive Actions						Progress Ra	ate	0%	Closing Date	
Actions					Respor	aciblo		Date	Status	
Actions					Respoi	ISIDIE		Date	Status	
E2 Review the following documents / system	ns									
Document	Υ	Modif.	N/A		Responsible			Date Planned Status		ntus
Management System Manual			14/11							
Process and inspection work Instructions										
Flow Charts										
Control Plans (PEV or PAC)										
Design/ Process FMEA										
Risk Analysis Table and lesson learned										
Forms										
E3 Lessons Learned & Next Steps										
1										
2										
3										
4										
D8 8D Closure										
Closed by:										
Closure Date:										

COFICAB Powered by Passion	8D+1	Suspe	ct Spools Fol	llow-up & N(Q Cost	Issue Date:	
D8+1	8D Accepta	nce		[Progress Rate (O% Closing Date	
Have the 8D been accept	ed by the Cu	stomer?			Yes 🗸 No	When	
If Not, Why							
Incident Deta	ils	 					
Customer Incident Nbre:		0		[Incident Date	45331	
Incident Type		Claim		[Customer	0	
Information about the	e Incident				0		
ID Number		0		[Rejected Quantity (m)	0	
Reference		0		[Received date/BL	00/01/1900)
Color		0		[Prod. Date	00/01/1900)
NC Spools Deci	sion						
Accepted	Na	me :		[Acceptance Date		
Rewinded	Na	me :		Г	Decision Date		
	Ne	w ID		j	Recovered Qte	120 Scrap	-120
Total Scrap	No	me :		Г	Decision Date		
Total Scrap		w ID		L [Scrap Date		
				L			
Non Quality Corrections Replacement Cost	ost	0,00€		Scrane	d Purchased Parts	0,00€	
Cost of Sorting		0,00 €		Test C		0,00 €	
Cost of Rework		0,00€		Overtin	ne Labor	0,00€	
Production Line Stopped		0,00€		Specia	l freights	0,00€	
Scraped Finished Goods		0,00€		Other (Costs	1 000,00 €	
To	otal Non Qual	ity Cost			1	000,00€	
Have the Costs of Non-Q	uality been a	ccepted by COFIC	AB TN?		Yes V No	When	
If Not, Why							
				-		w Non Quality Cost	
						000,00€	
Have the Credit Not been If Not, Why	Signed by C	OFICAB TN?			Yes 🗸 No	When	
ii Not, Wily							
CNQ Closur		<u> </u>					
Cust. Care Supervis	or		Dept Qity S	Supervisor		Plant Quality Mana	ger