

Failure Mode Effect Analysis

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ASME, Takata Airbags, Galaxy 7

- <https://www.flickr.com/photos/michaeljy/3682379207/>
- <http://i1-news.softpedia-static.com/images/news2/samsung-galaxy-s7-catches-fire-in-a-busy-coffee-shop-508251-2.jpg>
- <https://www.lawyersandsettlements.com/images/articles2/Takata-deployed-airbags-article.jpg>

From Mech 223

FMEA Process

- For a part/process, determine risk priority number (RPN):
 - Severity of effect
 - Chance of cause occurring
 - Chance of detection using a control

Failure Mode	Severity		Occurrence		Detection		RPN	Recommended Action
	Effect	S	Cause(s)	O	Control	D		
Hose leaks	- loss of performance - fluid spill - uses up fluid	5	hose cut during assembly	6	None	10	300	inspect units after assembly

From Mech 223 Cont'd

FMEA Process (con't)

- Next steps:
 - Implement recommended actions for failure modes with high RPN
 - Iterate -> recompute RPN

RPN	Recommended Action	Action	S	O	D	RPN
300	inspect units after assembly	- visually inspect 100% of units - pressure test 10% of units	5	6	3	90

← continues

How FMEA Fits in the Design Process

- A comprehensive FMEA starts with individual parts, then considers sub assemblies and finally the full assembly.
 1. Identify the part
 2. Identify the part's function(s)
 3. For each function, identify failure modes
 4. Determine the potential severity of each failure mode
 5. Determine the cause of each failure mode (often more than one)
 6. Determine the probability that the failure will happen in the current state of the part.
 7. Identify the controls in place that are intended to detect the onset of failure and respond in time to prevent the effect.
 8. Determine the probability of success of the controls

How FMEA Fits in the Design Process

9. Calculate the RPN
10. Recommend actions to address failures, beginning with the highest RPN failures
11. Calculate the expected RPN
12. Assign actions
13. Carry out the actions and cross reference the actions to the FMEA
14. Monitor the status of each action
15. Update when a part, subassembly or assembly changes
16. At the end of the project, identify any remaining high RPN failures where actions are not complete

Failure Mode

- **Failure Mode?**

- Think of it as how something fails to meet expected performance values.

- **Failure as defined in 223 textbook** – “noticed by end-user” *This is too simple!*

- “serious unintended negative effect on some stakeholder(s)” more appropriate.

Severity, Occurrence, Detection

- **Severity**- how bad is the potential outcome?
- **Occurrence** – what is the chance the failure will happen for the part/system in its current form?
- **Detection**- what is the chance that the design process/implementation of a procedure will identify and effectively keep the failure from occurring?
- Ratings based on scales from 1-10 used to quantify
- Scales are not really standardized (designer has some freedom to choose; definitions for each rating and consistent application are critical)
 - generally accepted practice is to e.g. assign severity rating of 10 for serious injury or death

Effects, Causes and Controls

- **Effect** – potential ultimate consequence
 - May be multiple effects. Focus on the worst case first
- **Cause** – underlying reason(s) for the failure
 - May be multiple causes.
 - May take some digging to work down to the root cause
 - Understanding cause is needed to allow designer to take corrective action.
- **Control** – features already incorporated in the design, implementation procedure, etc. that reduces the chance the failure will occur in implementation
 - At early stages in the design, there may not be much in this category

Recommended Action(s)

- Address highest RPN value first
- For early design sizing, this is your analysis “to-do” list
- Calculate the expected new RPN to gauge the effectiveness of the proposed action
- Assign action to the appropriate team member
- Monitor the status of each action
- Cross reference FMEA action to supporting analysis, (e.g. Appendix F, p F-12).

Guidelines when Recommending Action(s)

- Consider making your design inherently safe.
- Take care to avoid “solving” problems through the use of warnings and disclaimers in the user manual.
- Beware of the temptation to over-analyze and run out of time - It may be better to be conservative with sizing, allow costs to rise and performance to suffer to make a safer design (net benefit). Apply ***Hooley's Theorem*** (Roy Hooley UBC'47 Civil prof 1952-1996. Pioneer of FEM and Old Port Mann bridge designer)
 - Will fail
 - Won't fail
 - Might fail – effort required

Additional General Guidelines

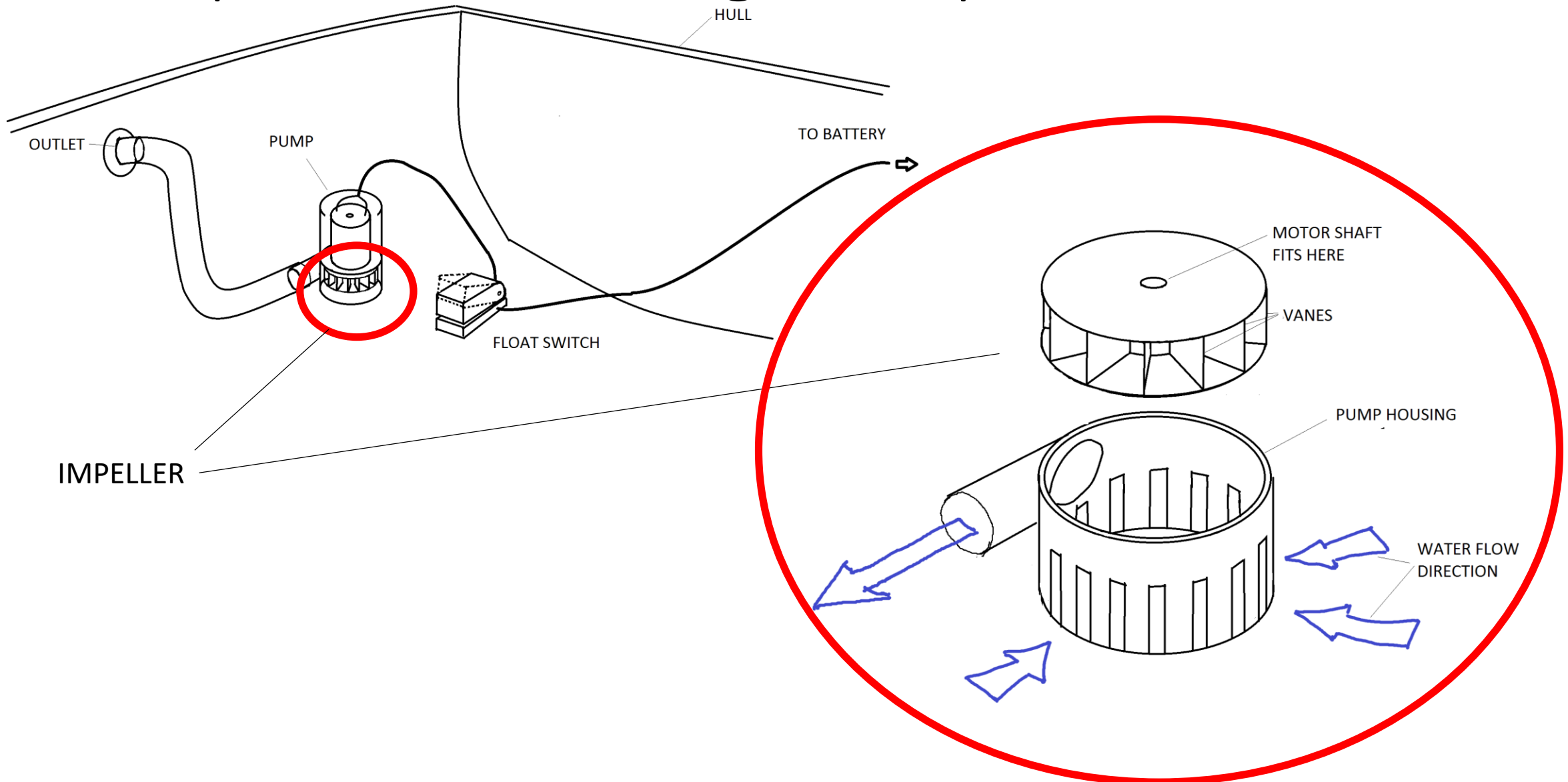
- For a Design FMEA focus on the specification and assume that
 - All parts will be made to your specifications, including custom and off the shelf parts
 - Parts are handled and assembled correctly during manufacturing and delivery (intact delivery to end user)
- If you are designing a custom part, you have to determine the actual performance
- Off the shelf parts and assemblies – trust the manufacturer's specifications for performance but beware of caveats in applications notes. You are ultimately responsible to ensure that the component's specifications meet your design's requirements – no need to do FMEA on the individual parts of an off the shelf motor, but consider failure modes of the motor assembly based on your implementation

Expectations for Mech 328 (D)FMEA

1. Every team member should take on at least one part or assembly and perform the FMEA for that item
2. Focus on what seem likely high RPN items
3. You don't have time to do this comprehensively – suggest stopping at 4 failure modes per item, 4 causes per FM
4. We want to see a history – early, mid and final FMEA with increasing rigour.

Thinking about failure is a chance to think creatively😊

Example: FMEA on Bilge Pump



[illegible]

Failure Modes and Effects Analysis

Revision:

Part	Function(s)	Failure Mode	Severity		Occurrence		Detection		RPN	Recommended Action	Assigned To	Expected results of action				Status of Action	
			Effect(s)	S	Cause	O	Control	D				S'	O'	D'	RPN'	C=Completed P= In-Progress N=Not Addressed	Cross Reference Appendix Page Number
bilge pump system	remove excess water faster than it comes into boat	no flow	boat fills with water and potentially sinks	10	intake blocked by debris	5	Intake screened and regular cleaning required	5	250	pick up point is raised slightly off bottom of boat to allow dense debris to collect away from input and float switch is set to allow floating debris to float above intake.	Mengus Farkler	10	5		0		
					output blocked				0						0		
					pump rotor jammed by debris				0						0		
					pump failure				0						0		
					float switch motion blocked by debris				0						0		

Exercise:

1. Use existing or download as templates *FMEA Example Bilge Pump Impeller*, *FMEA Example Bilge Pump System* (Failure, Risk and Safety Resources under Templates on Canvas)
2. Work in team to brainstorm and identify failure modes for parts of your microplastics sampling solution.
3. Take time to identify/argue the possible outcomes (severity and causes) for each failure mode.
4. Identify the occurrence and calculate RPNs
5. Prepare to be called to the front to present and discuss