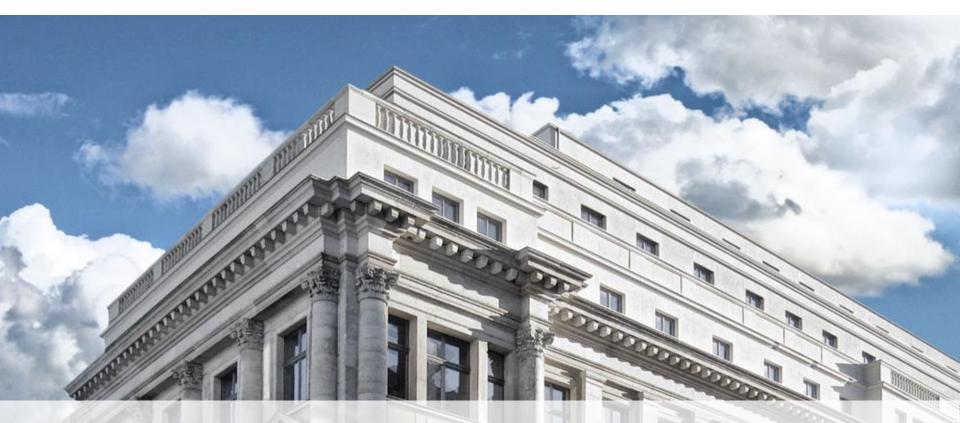




Qualitäts Management Center im Verband der Automobilindustrie





FMEA Alignment VDA and AIAG



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ALAG 2 Verband der Automobilindustrie Automotive Industry Action Group VDA

Failure Mode and Effects Analysis FMEA

Design FMEA and Process FMEA Handbook

Status October 2017

Alignment of FMEA handbooks **VDA and AIAG**

Project Leader: AIAG: Scott Gray VDA: Jochen Pfeufer

1st Edition 2017



Statement to the FMEA Presentation

The presentation is the current status of discussion of AIAG and VDA working group. This presentation status is not fixed and nonbinding.

A validation phase was held in <u>June/July 2017</u> with dedicated suppliers and evaluation of the results.

Release of Yellow Print <u>15th November 2017</u>

following a 90 days stakeholder review.

Release of final version scheduled End of April 2018

Publish May 2018

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Trainings to the new manual of FMEA in 2018 will be provided after release of the final manual (Red Print) VDA-QMC, AIAG and their licensees.

FMEA Alignment of VDA and AIAG

The AIAG FMEA manual is a supplement to SAE J1739 for suppliers. Now, again there is the opportunity for cooperation between SAE and AIAG as was done at the last update and now a possibility between SAE, AIAG and VDA - Wow!

You have been given this great opportunity to build bridges!

Currently suppliers providing products to both German and N.A. OEM's are required to assess their products' failure modes and effects differently, based on differences between the Severity, Occurrence, and Detection rating tables in the VDA and AIAG FMEA Manuals.

This causes confusion and adds complexity to the product development and product improvement activities of the suppliers.

A common set of FMEA requirements/expectations will enable suppliers to have a <u>single</u> FMEA business process and associated set of methods and tools to produce robust, accurate and complete FMEA's that would meet the needs and expectations of any of their customers.



Attendees

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AIAG Team

- OEM: Fiat Chrysler Automobiles, Ford Motor Company, General Motors Company*, Daimler Trucks North America*, Honda North America
- Supplier: Bendix Commercial Vehicle Systems, GKN Driveline, Lear Corporation, Nexteer Automotive*, ON Semiconductor, Visteon Corporation

* SAE Member

VDA Team

- OEM: Daimler AG, Ford Europe, Volkswagen AG, Opel Automobile GmbH, AUDI AG, BMW AG
- Supplier: Continental Automotive Systems, GKN Driveline International GmbH, Knorr Bremse, Robert Bosch GmbH, Schaeffler AG, ZF Friedrichshafen AG





Comparison of the FMEA Manual VDA and AIAG (Ford, GM, FCA)

Main focus of the project was the standardization of the criteria "severity", "occurrence" and "detection" within the ranking tables.

During the discussion of the issues in the industry the team members of VDA and AIAG agrees that would be a good opportunity to harmonize and standardize other parts of the manual in addition.

Embedding of the method in development process

- FMEA has to be worked out according the project plan and evaluated to the project mile stones according to the status of the analysis
- FMEA should be an integrated in design discussions and releases

APQP Phases	Plan and Define Program		Process Design and Development Verification	Product and Production Validation	Feedback Assessment and Corrective Action
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- > The process responsibility of the management is stressed
- Priority of FMEA, availability of resources and input dimensions
 => In practice often the biggest challenge
- Result communication and inspection
- Reviews with the management

	RG0	RG1	RG2	RG3	RG4	RG5	RG6	RG7
VDA Maturity Level	Innovation Approval for serial Development	Requirement Management for Procurement Extensive	Definition of the Supply Chain and Placing of Extensive	Approval of Technical Specification	Production Planning Done	Serial tools, Spare Parts and Serial Machines Available	Product and Process Approval	Project End, Responsibility Transfer to Serial Production, Start, Requalifikation

Projects meeting and face to face meetings (1/2)

- Since May 2015 regular (weekly / bi-weekly) conference calls to align content of the manual
- Three face to face meeting took place

- 1. Design FMEA main results Meeting in CW 07/2016 (AIAG)
- ✓ Review of VDA and AIAG approach
- ✓ Definition of 6 step approach
- ✓ Clarification of inputs and outputs of the 6 steps
- ✓ Review of Ranking Charts (S, O, and D)
- ✓ RPN is replaced by Action Priority (AP)
- ✓ DFMEA: Classification column special characteristics deleted

Projects meeting and face to face meetings (1/2)

- Three face to face meeting took place (duration 5 days)
 - 2. Process FMEA main results

- Meeting in CW 17/2016 (VDA)
- ✓ Chapter introduction in FMEA
- Clarification of inputs and outputs of the 6 steps
- ✓ Compare to D-FMEA with PFMEA 6 step approach
- ✓ Review of Ranking Charts (S, O, and D)
- Proceeded work on the templates
- ✓ PFMEA: Classification column special characteristics remains
- ✓ RPN is replaced by Action Priority (AP)

Projects meeting and face to face meetings (2/2)

- Three face to face meeting took place (duration 5 days)
 - 3. FMEA-MSR (Monitoring and System Response) main results Meeting in CW 04/2017 (AIAG)
 - Chapter "Supplemental FMEA for Monitoring and System Response (FMEA-MSR)" added
 - Included comments to the draft of the team members and their company colleagues
 - ✓ Detailing of the rank charts

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- ✓ Review of existing chapters and fine tuning of the wording
- > Next planned face to face meeting after yellow book phase



Six steps of FMEA

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	System Analysis		Failure	Analysis and Risk Mi	tigation
1 st Step Scope Definition	2 nd Step Structure Analysis	3 rd Step Function Analysis	4 th Step Failure Analysis	5 th Step Risk Analysis	6 th Step Optimization
×₽ ₽			378	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
Project identification	System structure for a product or elements of a process	Overview of the functionality of the product or process	Establishment of the failure chain (potential Failure Effects, Failure Modes, Failure Causes) for each product or process function (step)	Assignment of Prevention Controls (existing and/or planned) to the Failure Causes and Failure Modes	Identification of the actions necessary to reduce risks
Project plan	Visualization of the analysis scope using a structure tree or equivalent: block diagram, boundary diagram, digital model, physical parts, or process flow diagram	Visualization of product or process functions using a function tree (function net), function matrix parameter diagram or process flow diagram	Visualization of product or process failure relationships (failure nets and/or the FMEA worksheet)	Assignment of detection controls (existing and/or planned) to the Failure Causes and Failure Modes	Assignment of responsibilities and deadlines for action implementation
Analysis boundaries: What is included and excluded from the analysis	Identification of design interfaces, interactions, close clearances, or process steps	Association of requirements or characteristics to functions and functions to system or process elements	Creation of failure structures by linking the failures in the failure chain	Rating of Severity, Occurrence and Detection for each failure chain	Implementation and documentation of actions taken
Identification of baseline FMEA with lessons learned		Cascade of customer (external and internal) functions with associated requirements	Identification of product noise factors or process sources of variation (4M) using a fishbone diagram, parameter diagram, or failure network Collaboration between customer and supplier (Failure Effects)	Collaboration between customer and supplier (Severity)	Confirmation of the effectiveness of the implemented actions Assessment of risk after actions taken
Basis for the Structure Analysis step	Basis for the Function Analysis step	Basis for the Failure Analysis step	Basis for the record of failures in the FMEA form and the Risk Analysis step	Action Priority (AP) Basis for the product or process Optimization step	Continuous Improvement of the product and process Basis for refinement of the product and/or process requirements and prevention / detection controls







D1: DFMEA Rank Chart Severity

	Product General Evaluation Criteria Severity S	Corporate or Product Line Examples
SEV	Potential Failure Effects rated according to what the End User might experience	
10	Affects safe operation of the vehicle and/or other vehicles, the health of operator or passenger(s) or road users or pedestrians.	
9	Noncompliance with regulations.	
8	Loss of essential vehicle function necessary for normal driving during expected service life.	
7	Degradation of essential vehicle function necessary for normal driving during expected service life.	
6	Loss of convenience function.	
5	Degradation of convenience function.	
4	Perceived quality of appearance, sound or haptics unacceptable to most customers	
3	Perceived quality of appearance, sound or haptics unacceptable to many customers	
2	Perceived quality of appearance, sound or haptics unacceptable to some customers	
1	No discernible effect.	





D2: DFMEA Rank Chart Occurrence

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	Occurrence Potential O for the Product Design										
	Expected Failure Occurrence (Design Newness and Prevention Controls Best Fit)	Product Design Newness	Prevention Controls - Procedural	Prevention Controls - Analytical							
occ	Occurrence criteria for potential Failure Causes resulting in the Failure Mode, considering Prevention Controls, rated for the intended service life of the item (Qualitative rating)	Novelty of Design, Application or Use Case	Best Practices, Design rules, Company Standards, Lessons Learned, Industry Standards, Material Specifications, Government Regulations	Effectiveness of Prevention oriented analytical tools including Computer Aided Engineering, Math Modeling, Simulation Studies, and Tolerance Stacks							
10	Occurrence during intended service life cannot be determined at this time, no preventive controls, or occurrence during intended service life is extremely high.	First application of new technology anywhere without operating experience and / or under uncontrolled operating conditions. Use Case or operating conditions vary widely and cannot be reliably predicted.	Standards do not exist and best practices have not yet been determined.	Not able to predict field performance.							
9	Very high occurrence during intended service life.	First use of design with technical innovations or materials within the company. New use case, or change in duty cycle / operating conditions. Not previously	Newly developed for this design. First application of new standards with no experience.	Not targeted to identify performance to specific requirements.							
1	Possibility of failure is virtually eliminated through preventative control and history of failure-free series production.	Known system/ component with identical mature design. Same application, duty cycle, and operating conditions. Testing or field experience under	Design proven to conform to Standards and Best Practices, considering Lessons Learned, which effectively prevents the failure from occurring.	Capable of ensuring with high confidence, that the failure can not occur.							



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D3: DFMEA Rank Chart Detection

		Detection Potential D for the Validation of the Product Design
DET	Ability to Detect	Detection Criteria
10	Absolute uncertainty	No test or test procedure.
9	Very remote	Test procedure not designed to specifically detect the cause and/or failure mode.
8	Remote	Ability of detection control to detect the failure cause or failure mode is remote based on verification or validation procedure, sample size, mission profile, etc.
6	Low	Ability of detection control to detect the failure cause or failure mode is low based on verification or validation procedure, sample size, mission profile, etc.
4	Moderately high	Ability of detection control to detect the failure cause or failure mode is moderately high based on verification or validation procedure, sample size, mission profile, etc.
3	High	Ability of detection control to detect the failure cause or failure mode is high based on verification or validation procedure, sample size, mission profile, etc.
1	Almost certain	Design proven to conform to Standards and Best Practices, considering Lessons Learned and detection actions of previous generations, which effectively prevents the failure from occurring.



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P1: PFMEA Rank Chart Severity

	Process General Evaluation Criteria Severity S									
	Failure Effects rated for Manufacturing, Assembly, and End User as shown in PFMEA									
SEV	Your F	Process Ownership	End User (when known)							
		Your Plant	(when known) Ship to Plant	Customer						
10	(machine or	endanger operator assembly), Possible long- on health of production	Failure may endanger operator (machine or assembly), Possible long- term effects on health of production associates	Affects safe operation of the vehicle and/or other vehicles, the health of operator or passenger(s) or road users or pedestrians.						
9	Failure may r noncompliar	result in in-plant regulatory	Noncompliance with regulations.							
8	100% of proo be scrapped.	duct affected may have to	Line shutdown greater than full production shift. Stop shipment possible. Field repair or replacement required (Assembly to End User) other than for regulatory noncompliance.	Loss of essential vehicle function necessary for normal driving during expected service life.						
1	No discernib	le effect	Defective product triggers no reaction plan. Additional defective products not likely. Sort not required. Feedback to supplier not required.	No discernible effect.						





P2: PFMEA Rank Chart Occurrence

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	Occurrence Potential O for the Process								
	Expected Failure Occurrence	Process Maturity	Prevention Controls - Procedural	Prevention Controls -					
	(Considering Process Maturity			Analytical					
	and Prevention Controls)	Maturity of	Implementation of Best Practices	Effectiveness of Prevention					
	Occurrence criteria for	Process,	and Standard Instructions	oriented solutions					
осс	potential Failure Causes	Application or	(including work instructions, set-	(product or process design,					
	resulting in the Failure Mode	Use Case	up and calibration procedures,	fixture and tool design,					
	within the manufacturing or		preventive maintenance, error-	process sequence, error					
	assembly plant considering		proofing verification procedures,	proof, traceability,					
	Prevention Controls		and process monitoring	machine capability, and					
	(Qualitative rating)		verification checklists)	SPC charting)					
	Occurrence during	New process	Procedures do not exist and best	Not able to prevent failure.					
10	manufacturing or assembly	without	practices have not yet been						
	cannot be determined at this	experience	determined.						
	Very high occurrence during	Limited	Newly developed for this	Not targeted to specific					
9	manufacturing or assembly.	experience with	process. First application of new	failure cause					
		the process.	procedures with no experience.						
	Cause cannot occur because	Process proven to	Capable of ensuring with high	Possibility of failure is					
1	failure is eliminated through	conform to	confidence (error proof), that the	virtually eliminated through					
•	demonstrated preventative	procedures and	failure can not occur in series	preventative control and					
	control.	Best Practices,	production.	history of failure-free					

Note: A 10, 9, 8, 7 can drop based on process validation activities prior to start of series production.



P3: PFMEA Rank Chart Detection

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	Detection Potential D for the Validation of the Process Design
DET	Detection Controls rated according to the best fit for each detection activity. Frequency shall be established in the FMEA or control plan. Company/business unit non-conforming material handling procedures apply.
10	TYPE: Cannot detect failure or is not analyzed. DETECTION CAPABILITY: The malfunction or failure mechanism will not be proved. The failure will not or cannot be detected as no testing or inspection method has been established or is known.
9	TYPE: Failure is not easily detected. Random audits <100% of product. DETECTION CAPABILITY: It is unlikely that the testing or inspection method will detect a possible malfunction or fault mechanism.
8	TYPE: Defect (Failure Mode) detection downstream through visual, tactile or audible means. DETECTION CAPABILITY : The testing or inspection method is uncertain or the company/business unit has no experience with the defined testing or inspection method. The method relies on a human for verification and disposition.
\	
2	 TYPE: Error (Failure Cause) detection in-station through use of controls that will detect error and prevent discrepant product from being produced. DETECTION CAPABILITY: Proven testing or inspection method from identical processes under the same operating/boundary conditions (machines, material). Test/inspection/measuring equipment capability from identical processes confirmed through gauge repeatability and reproducibility evaluations. The required error proofing verification is performed.
1	PREVENTION CAPABILITY: Discrepant product cannot be physically produced due to design (part geometry) or process (fixture or tooling design). The effectiveness was demonstrated on this product.





DFMEA Spreadsheet

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Design Failure Mode and Effects Analysis (Design FMEA)

Company Name: Engineering Location: Customer Name: Model Year / Platform:			- - DF	Subject: DFMEA Start Date: DFMEA Revision Date:			-	DFMEA ID Number: Design Responsibility: Security Classification:					-		
S	TRUCTURE ANALYS	SIS	F	UNCTION ANALYS	IS		FA	ILURE ANALYSIS			R	SK ANALYSIS			
1. System (Item)	2. System Element / Interface	3. Component Element (Item/ Interface)	1. Function of System and Requirement or Intended Output	2. Function of System Element and Intended Performance Output	3. Function of Component Element and Requirement or Intended Output or Characteristic	1. Failure Effects (FE)	Severity (S) of FE	2. Failure Mode (FM)	3. Failure Cause (FC)	Current Prevention Control (PC) of FC	Occurrence (O) of FC	Current Detection Controls (DC) of FC or FM	Detection (D) of FC/FM	AP	Filter Code (Optional)
Window Lifter	Electrical Motor	Brush Card Base Body	Raise and lower window according to parameterization.	Commutation system transports the electrical current between coil pairs of the electro magnetic converter	Brush card body transports forces between spring and motor body to hold the brush spring system in x,y,z position (support commutating contact point)	Torque and rotating velocity of the window lifter motor too low	6	Commutation system intermittently connects the wrong coils (L1, 3 and 2 instead of L1, 2 and 3), resulting in angle deviation	brush, due to too low stiffness in	Simulation of dynamic forces on brush card body acc. FEM 6370		Sample test: measuring the elastics and plastic deformation effects of brush card body acc. test spec. MRJ82/60	2	L	





DFMEA Report

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STRUCTURE					7					
1. System (Item)		2. System Element / Inte	erfac	e	3. Component Element (Ite	em/In	terface)			
Window Lifter System		Electrical Motor			Brush Card Base Body					
FUNCTIONAL ANALYSIS		1								
1. Function of System a Requirement or Intende		2. Function of System E Performance Output	Elem	ent and Intended	3. Function of Component or Characteristic	Eler	nent and Requirement or In	tende	d Ou	itput
Convert electrical energy int mechanical energy (acc. cor signal)	rol	Commutation system trans coil pairs of the electro may		the electrical current between converter	Brush card body transports for suring system in x,y,z position (etween spring and motor body to ort commutating contact point)	hold t	he bru	sh
				FAILURE AND RISK A	ALYSIS					
1. Failure Effects (FE)	Severity (S) of FE	2. Failure Mode (FM)		3. Failure Cause (FC)	Current Prevention Control (PC) of FC Preventive Action (PA)	Occurrence (O) of F	Current Detection Controls (DC) of FC or FM Detection Action (DA)	Detection (D) of FC or FM	AP	Filter Code
				INITIAL STATE						
Torque and rotating velocity the window lifter motor too ow	of 6	Commutation system intermittently connects the wrong coils (L1, 3 and 2 inst of L1, 2 and 3), resulting in angle deviation	tead	Brush card body bends in contact area of the carbon brush, due to too low stiffness in carbon brush contact area	Simulation of dynamic forces on brush card body acc. FEM 6370	2	Sample test: measuring the elastic and plastic deformation effects of brush card body acc. test spec. MRJ82/60	2	L	
		Focus								



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FMEA Action Priority (AP)

Action Priority (AP)	Action Expectation						
High	The team must either identify an appropriate action to improve prevention and / or detection controls or justify and document why current controls are adequate.						
Medium	The team should identify appropriate actions to improve prevention and / or detection controls, or, at the discretion of the company, justify and document why controls are adequate.						
Low	The team could identify actions to improve prevention or detection controls.						
It is recommended that potential Severity 9-10 failure effects with Action Priority High and Medium, at a minimum, be reviewed by management including any actions that were taken.							

This is not the prioritization of High, Medium, or Low risk. It is the prioritization of the need for actions to reduce risk.



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Design FMEA Action Priority (AP)

S	0	D	ΑΡ	Justification for Action Priority - DFMEA
9-10	6-10	1-10	Н	High priority due to safety and/or regulatory effects that have a high or very high occurrence rating
9-10	4-5	7-10	Н	High priority due to safety and/or regulatory effects that have a moderate occurrence rating and high detection rating
5-8	4-5	5-6	Н	High priority due to the loss or degradation of an essential or convenience vehicle function that has a moderate occurrence rating and moderate detection rating
5-8	4-5	1-4	M	Medium priority due to the loss or degradation of an essential or convenience vehicle function that has a moderate occurrence and low detection rating
2-4	4-5	5-6	М	Medium priority due to perceived quality (appearance, sound, haptics) with a moderate occurrence and moderate detection rating
2-4	4-5	1-4	L	Low priority due to perceived quality (appearance, sound, haptics) with a moderate occurrence and low detection rating
1	1-10	1-10	L	Low priority due to no discernible effect







Process FMEA Action Priority (AP)

S	0	D	ΑΡ	Justification for Action Priority - PFMEA
9-10	6-10	2-10	Н	High priority due to safety and/or regulatory effects that have a high or very high occurrence rating
9-10	4-5	7-10	н	High priority due to safety and/or regulatory effects that have a moderate occurrence rating and high detection rating
5-8	4-5	5-6	н	High priority due to the loss or degradation of a primary or secondary vehicle function or a manufacturing disruption that has a moderate occurrence rating and moderate detection rating
5-8	4-5	2-4	М	Medium priority due to the loss or degradation of a primary or secondary vehicle function or a manufacturing disruption that has a moderate occurrence and low detection rating
2-4	4-5	2-4	L	Low priority due to perceived quality (appearance, sound, haptics) or a manufacturing disruption with a moderate occurrence and low detection rating
2-10	1	1	L	Low priority due to the failure being virtually eliminated through prevention controls
1	1-10	1-10	L	Low priority due to no discernible effect
2-10	1	2-10	Error	O=1 implausible without D=1
2-10	2-10	1	Error	D=1 implausible without O=1

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- Design FMEA contains information that is useful for Process FMEA
 - □ Failure Causes related to piece-to-piece

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- End User Failure Effects and Severity for the Failure Causes related to product characteristics
- Process FMEA contains information that needs alignment with the Design FMEA
 - Failure Effects and Severity for Failure Modes that are also shown in the Design FMEA
- Not all Failures Causes in a Design FMEA are Failure Modes in a Process FMEA.

Know-How Protection of the Design and Process FMEA

- The sharing of intellectual property between suppliers and customers is governed by legal agreements between suppliers and customers and is beyond the scope of this handbook.
- However, unless otherwise required by contractual agreement, for reasons of Intellectual Property (IP) protection the DFMEAs and PFMEAs prepared by suppliers for standard or "off the shelf" products should generally be considered proprietary information not given to the customers.
- > But may be shown by special arrangement when requested.



Validation Testing

Participants

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- □ Subdivision in design FMEA and process training FMEA
- ❑ Maximum 2 participants per supplier
- ❑ Maximum 12 participants per training
- "Homework"
 - Teams are asked to return to their organization, and using an existing product or process, develop a new FMEA.
 - The output will be evaluated by the team
 - o 3 weeks to 30 days are needed for this assignment
- No negative consequences for participants
 - Free training as "a recognition" and manuals
 - Confidential agreement
 - Nomination of the participants in the FMEA Handbook



Validation Testing

- Identify suppliers for the Validation Testing
 - Range of tiers, sizes, commodities, skill levels
 - □ Need to ensure we include small, Tier 2/3 suppliers
 - Volunteers and recommendation of suppliers by Ford/GM/FCA/Daimler Truck and QMA of VDA
- > Training

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- Explanation of the new methodology
 - Six Step Process
 - New S, O, D, Rating Tables
 - o AP Methodology
 - New Forms with new approach
- □ "Coaching" by the team members
- ❑ Complete subjective feedback survey





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Training in N.A.
 DFMEA 15th, 16th June 2017
 PFMEA 24th, 25th July 2017

Training in Germany

DFMEA 29th, 30th June 2017
 PFMEA 10th, 11th July 2017

Attendees DFMEA

Alpine Electronics, Aspöck Systems, Benteler Automobiltechnik, Dr. Schneider, EBK Krüger, Faurecia Automotive, Magna GETRAG, IMS Gear, WABCO

Attendees PFMEA

Alpine Electronics, Benteler Automobiltechnik, Dr. Schneider, EBK Krüger, Magna GETRAG, Heinrich Huhn, IMS Gear, Paul Craemer, PWO Progress-Werk, Wallstabe & Schneider



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Validation Results

	DFMEA				PFMEA				D&PFMEA			
	VDA			VDA			VDA					
Question	1	2	3	4	1	2	3	4	1	2	3	4
Introduction	0	0	0	10	0	0	0	12	0	0	0	22
Basis of FMEA	0	0	0	10	0	0	0	12	0	0	0	22
External and Internal Req	0	0	0	10	0	0	2	10	0	0	2	20
FMEA Team for Design &	0	0	0	10	0	0	2	10	0	0	2	20
Demand for Action & Tim	0	0	0	10	0	0	3	9	0	0	3	19
Definition and Description	0	0	0	10	0	0	1	11	0	0	1	21
1st Step: Scope Definition	ο	0	2	8	0	0	2	10	0	0	4	18
2nd Step: Structure Analysis	0	0	2	8	0	0	1	11	0	0	3	19
3rd Step: Function Analysis	0	0	4	6	0	ο	3	9	0	0	7	15
4th Step: Failure Analysis	0	ο	ο	10	0	0	0	12	Ο	0	0	22
5th Step: Risk Analysis	0	0	2	8	0	0	5	7	0	0	7	15
6th Step: Optimization	0	0	1	9	0	0	2	10	0	0	3	19
Annex	0	0	1	9	0	0	5	7	0	0	6	16
Rating Chart: Severity	0	0	1	9	0	0	2	10	0	0	3	19
Rating Chart: Occurrence	0	0	1	9	0	0	5	7	0	0	6	16
Rating Chart: Detection	0	0	0	10	0	1	3	7	0	1	3	17
FMEA Spreadsheet & Rep	0	0	1	9	0	0	3	8	0	0	4	17
Percentages	0%	0%	9%	91%	0%	0%	19%	80%	0%	0%	15%	85%
	I don't get it											

Question 2 I understand partially, but would need some help in application Question 3 I understand the major concepts, but have some questions on the details Question 4 pl:/get_it_citeisn/clebarations/fmea-alignment







Validation Results

	DFMEA			PFMEA				D&PFMEA				
	AIAG			AIAG				AIAG				
Question	1	2	3	4	1	2	3	4	1	2	3	4
Introduction	0	0	0	11	0	0	2	16	0	0	2	27
Basis of FMEA	0	0	0	11	0	0	1	17	0	0	1	28
External and Internal Req	0	1	2	7	0	0	3	15	0	1	5	22
FMEA Team for Design &	0	0	1	10	0	0	3	15	0	0	4	25
Demand for Action & Tim	0	0	2	10	0	0	2	15	0	0	4	25
Definition and Description	0	0	3	8	0	0	3	15	0	0	6	23
1st Step: Scope Definition	0	0	4	7	0	0	5	13	0	0	9	20
2nd Step: Structure Analysis	0	3	6	2	0	1	7	10	0	4	13	12
3rd Step: Function Analysis	0	5	5	1	0	7	8	3	0	12	13	4
4th Step: Failure Analysis	0	2	8	1	0	1	6	10	0	3	14	11
5th Step: Risk Analysis	0	1	5	4	0	1	3	13	0	2	8	17
6th Step: Optimization	0	1	5	4	0	1	1	15	0	2	6	19
Annex	0	0	1	3	1	1	2	11	1	1	3	14
Rating Chart: Severity	0	1	3	6	0	0	7	10	0	1	10	16
Rating Chart: Occurrence	0	1	3	6	0	0	8	9	0	1	11	15
Rating Chart: Detection	0	1	3	6	0	0	4	13	0	1	7	19
FMEA Spreadsheet & Rep	0	2	3	1	0	1	4	9	0	3	7	10
Percentages	s 0% 11% 32% 58% 0% 4% 24% 72% 0% 7% 27% 66%											
Question 1	I don't	t get it										
Question 2	l unde	rstand	partia	lly, but	t would	d need	some	help in	applic	ation		
Question 3	I understand the major concepts, but have some questions on the details											

Question 4 d./get-itciteisncleations/fmea-alignment





Validation Results

	D&PFMEA			D&PFMEA				D&PFMEA				
	VDA			AIAG				Overall				
Question	1	2	3	4	1	2	3	4	1	2	3	4
Introduction	0	0	0	22	0	0	2	27	0	0	2	49
Basis of FMEA	0	0	0	22	0	0	1	28	0	0	1	50
External and Internal Req	0	0	2	20	0	1	5	22	0	1	7	42
FMEA Team for Design &	0	0	2	20	0	0	4	25	0	0	6	45
Demand for Action & Tim	0	0	3	19	0	0	4	25	0	0	7	44
Definition and Description	0	0	1	21	0	0	6	23	0	0	7	44
1st Step: Scope Definition	ο	0	4	18	0	0	9	20	0	0	13	38
2nd Step: Structure Analysis	0	0	3	19	0	4	13	12	0	4	16	31
3rd Step: Function Analysis	0	0	7	15	0	12	13	4	О	12	20	19
4th Step: Failure Analysis	0	0	0	22	0	3	14	11	0	3	14	33
5th Step: Risk Analysis	0	0	7	15	0	2	8	17	0	2	15	32
6th Step: Optimization	0	0	3	19	0	2	6	19	0	2	9	38
Annex	0	0	6	16	1	1	3	14	1	1	9	30
Rating Chart: Severity	0	0	3	19	0	1	10	16	0	1	13	35
Rating Chart: Occurrence	0	0	6	16	0	1	11	15	0	1	17	31
Rating Chart: Detection	0	1	3	17	0	1	7	19	0	2	10	36
FMEA Spreadsheet & Rep	0	0	4	17	0	3	7	10	0	3	11	27
Percentages	0%	0%	15%	85%	0%	7%	27%	66%	0%	4%	21%	75%
	on 1 I don't get it											
Question 2			-	-				-				
Question 3	I understand the major concepts, but have some questions on the details											

Question 4 d. get it cite is pleastions/fmea-alignment

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Further actions

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- Weekly Meetings
 - ✓ Weekly Meetings for disposition of handbook
 - ✓ Align Design FMEA with Process FMEA
 - Align "Supplemental FMEA for Monitoring and System Response" (FMEA-MSR)
 - ✓ Discuss FMEA Review
- Evaluation of the results of the Validation Training and requested changes to handbook in progress
- Develop common training documents after start of Yellow Print phase with results of the Validation Training
- Trainings will be provided after release of the final manual (Red Print) in 2018 by VDA-QMC, AIAG and their licensees



High Level Project Plan and Timing (Draft October 2017)

Project Phases		Phase Description	Proposed Timing		
Pre - Plan		Conceptual Work, organization, identify participants	Jan. 2015 - May 2015		
Define		Kick off meeting, validate scope, define high level objectives and tasks, high level project schedule	5/28/15 to 07/16/15		
Analyze		Review current process, identify opportunities for improvement, refine/update future state model	07/16/15 to 10/15/15		
Build		Complete documentation, determine validation requirements/approach, disposition comments Editing/Translation AIAG/VDA	10/15/15 to 04/30/16 => End Oct. 2017* 01 st Nov. 2017*		
Validate		Validation with dedicated suppliers Start of formal stakeholder approval (90 days) End of stakeholder review Start Disposition Comments and Feedback	June/July 2017 15 th Nov. 2017 15 th Feb. 2018 08 th Jan. 2018*		
Release		Final release	End of Apr. 2018*		
Deploy		Create support materials (webinar, training) Publish Handbook	Feb. 2018* May 2018*		

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FMEA Introduction

Communication

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Accompanying communication from the yellow tape phase about various media

Events 2016/2017

\checkmark	26.09.2016	IAA Hannover Expert's F									
\checkmark	08./09.11.2016	1. European FMEA Cong									
\checkmark	07./08.12.2016	Audi forum Neckarsulm									
\checkmark	04./05.05.2017	VDA QMC QM Symposi									
\checkmark	15.09.2017	IAA Frankfurt Expert's Forum Licensee Meeting									
	07./09.11.2017 2. European FMEA Congress Vienna										
VD	VDA Regional Conferences International 2017										
\checkmark	17.02.2017	Stuttgart	\checkmark	25.08.20	17	Frankfurt					
\checkmark	24.03.2017	Dresden	\checkmark	06.10.20	17	Coventry/UK					
\checkmark	12.05.2017	Florence /Italy		17.10.20	17	Düsseldorf					
\checkmark	09.06.2017	Poznan/Poland		08.11.201	17	Hannover					
\checkmark	21.07.2017	Seoul/South Korea		08.12.20	17	München					
\checkmark	24.07.2017	Tokyo/Japan									







ALAG 2 Verband der Automobilindustrie Automotive Industry Action Group VDA

Failure Mode and Effects Analysis FMEA

Design FMEA and Process FMEA Handbook

Status October 2017

Alignment of FMEA handbooks **VDA and AIAG**

Project Leader: AIAG: Scott Gray VDA: Jochen Pfeufer

1st Edition 2017