

## Defect Details

<b>NC No.</b>	8000853856
<b>NC Date</b>	05/12/2023
<b>NC Submission Date</b>	
<b>Part No.</b>	S2HT52107B
<b>Part Name</b>	OUTER SPRING K0PG
<b>Supplier Name &amp; Code</b>	101236-SUMA SPRINGS PRIVATE LIMITED
<b>ETL Plant</b>	1146-ETL Suspension Narasapura
<b>Defect Details</b>	MIX UP OTHER MODEL-NOT USING K0PG MODEL MIX UP AT SUMA END

## 1. Problem Description

<b>Defect Description</b>	wrong part supplied not using K0PG rear model ( Mix up at supplier end )
<b>Detection Stage</b>	Inprocess
<b>Problem Severity</b>	Fitment
<b>NG Quantity</b>	1
<b>Is Defect Repeatative?</b>	Yes
<b>Defect Sketch / Photo</b>	<a href="#">sfiqcryk235brvcvwblawhc.gif</a>

## Supplier Communication Details

<b>Quality Head Email ID</b>	qc@sumasprings.com
<b>Plant Head/CEO Email ID</b>	vp@sumasprings.com
<b>MD Email ID</b>	

## 2. Stock Details &amp; action taken for NG parts

Location	ETL End	Warehouse	Transit	Supplier FG	Supplier WIP	Total
<b>Total Qty</b>	100	0	0	0	0	100
<b>Check Qty</b>	100	0	0	0	0	100
<b>NG Qty</b>	1	0	0	0	0	1

## Action taken on NG part

<b>Scrap</b>	1
<b>Rework</b>	0
<b>Under Deviation</b>	0

## Containment Action

Awareness created to the packing team, Segregated at Customer end as well as Suma End

## 3. Process Flow

**Process Flow Description**

COILING+TEMP1+GRINDING+SHOTPEENING+TEMPERING2+SCRAGGING +BEND CHECK AND OILING+PDI+PACKING AND DESPATCH

## 4. Process Details

<b>Process / Operation</b>	Packing
<b>Outsource</b>	No
<b>Machine / Cell</b>	Manual
<b>Machine / Cell No.</b>	Manual

## 5. Problem Analysis

Type	Possible Cause	Fact Verification	Jud
Method	.During Packing left over parts of similar parts mixup	verified leftover parts kept in packing stage	O

## 6. Inspection Method Analysis (Current)

<b>Inspection Method</b>	Other
<b>Other Inspection Method</b>	visual & tag identify
<b>Check Point at Final Inspection</b>	Yes
<b>Checking Freq.</b>	Sampling
<b>Sampling</b>	No
<b>Sample Size</b>	IS2500-2k

## 7. Root Cause Analysis (Occurance)

<b>Why 1</b>	Similar part mix-up
<b>Why 2</b>	mix up during packing
<b>Why 3</b>	during Packing left over parts of similar parts mix-up
<b>Why 4</b>	
<b>Why 5</b>	
<b>Root Cause (Occurance)</b>	During Packing left over parts of similar parts mix-up

## Root Cause Analysis (Outflow)

<b>Why 1</b>	Similar part mix-up
<b>Why 2</b>	Ineffective awareness for packing personnel
<b>Why 3</b>	
<b>Why 4</b>	
<b>Why 5</b>	
<b>Root Cause (Outflow)</b>	During Packing left over parts of similar parts mix-up

## 8. Countermeasure ( Occurrence , Outflow &amp; System side Actions )

Type	Countermeasure Details	Responsibility	Target Date	Actual Date	Status
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Occurance	During Packing left over parts of similar model will be identified and to be return back to storage area	CHANDRAN	07/12/2023	07/12/2023	Completed
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## 9. Inspection Method After Customer Complaint

<b>Change In Inspection System</b>	No
<b>Change Details</b>	Nil
<b>Inspection Method</b>	Other
<b>Other Inspection Method</b>	visual & Tag System
<b>Check Point at Final Inspection</b>	Yes
<b>Checking Freq.</b>	Sampling
<b>Sampling</b>	No
<b>Sample Size</b>	IS2500 2K

## 10. Evidence of Countermeasure

<b>Occurance (Before)</b>	During Packing left over parts kept in the packing area <a href="#">605_Occurance_Before.pdf</a>
<b>Occurance (After)</b>	During Packing left over parts of similar model will be identified and to be return back to storage area <a href="#">605_Occurance_After.pdf</a>
<b>Outflow (Before)</b>	Ineffective awareness for packing personnel <a href="#">605_Outflow_Before.jpeg</a>
<b>Outflow (After)</b>	Awareness created to the packing personnel and impact of part mix up explained <a href="#">605_Outflow_After.jpeg</a>

## 11. Horizontal Deployment

<b>Horizontal Deployment Required</b>	Yes
<b>Applicable Machine / Model / Plant</b>	F1GN01102

## 12. Document Review

<b>Documents</b>	
<b>Specify Other Document</b>	QALERT & AWARENES,

## 13. Effectiveness Of Action

<b>Reviewed Quantity</b>	
<b>Reason for submission</b>	