

# Nexteer Supplier 3L5Y Training

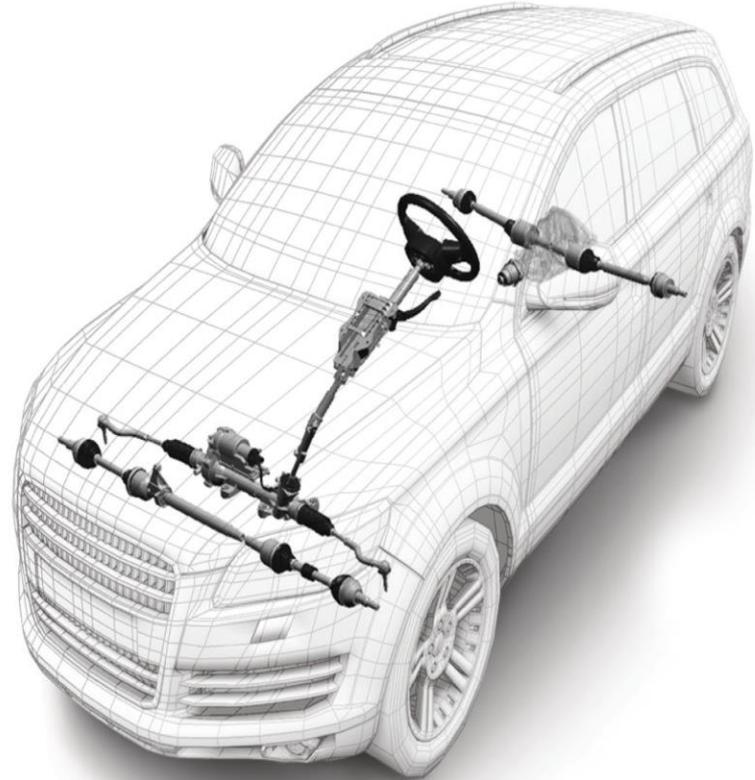
What is a 3L5Y &  
How to fill out  
Nexteer's Excel  
Form



*a leader in intuitive motion control*

Last Updated:

September 17, 2018



ELECTRIC  
POWER  
STEERING

COLUMNS &  
INTERMEDIATE  
SHAFTS

DRIVELINE  
SYSTEMS

HYDRAULIC  
POWER  
STEERING

ADAS &  
AUTONOMOUS  
TECHNOLOGIES

# 3L5Y Learning Objectives

## **Part A – 3L5Y (3 Legged 5 Why) basic concepts**

- What is a 3 legged 5 Why?
- When to use the 3L5Y ?
- Leg #1 – Specific Problem
- Leg #2 - Detection
- Leg #3 – Systemic
- Corrective Actions, Lessons learned, Look Across
- Ford, GM & FCA requirements

## **Part B – How to fill out Nexteer’s 3L5Y Excel Form**

- Where to find the Excel form
- What is in each Excel Worksheet tab
- 1 page summary “cheat sheet”
- Leg #1 – Specific Problem - Containment & Corrective Actions
- Leg #2 – Detection – Corrective Actions
- Leg #3 - Systemic – Corrective Actions
- Other items to fill out on Excel form

# A Core “Problem Solving” Tool at Nexteer

## What is a 3 Legged 5 Why:

- 5 Why is a problem solving tool
  - Effectively finds the Root Cause by analyzing cause and effect relationships
  - A Focused approach to solving chronic and / or systemic problems
  - For more complex problems, a 5 why can be combined with other problem solving tools such as Shainin Red X, Fast X, or Six Sigma.
- Can be used with various problem solving formats
  - Nexteer’s 3L5Y, or, 5 Phase process
  - GM’s Drill Deep
  - Ford’s 8 D problem solving
  - FCA’s “8 Step” problem solving

# When to Use 5 Why:

- Customer Issues
  - Required for all WFCCs (Worldwide Formal Customer Complaint) and warranty issues
  
- Supplier Issues
  - Must used by suppliers for all problem reports
  
- Internal Issues
  - Informal complaints including Field Engineer Incident reports
  - Quality system audit issues
  - First Time Quality (FTQ)
  - Fast Response Internal Quality Issues

# Nexteer 3L5Y Definitions

- **3L5Y** – 3 Legged 5 Why- A problem solving tool to find root cause. It systematically drills down to the real root cause.
- **Root Cause** – the fundamental reason for the occurrence of a problem.
- **Containment** – all suspect material is contained from usage including – WIP<sub>(work In Process)</sub>, finished good, in-transit, at customer.
- **FCC** – Formal Customer Complaint from a OEM.
- **RPN** – Risk Priority Number -used in PFMEA to create a summary value per AIAG requirements.
- **PSCC** – Product Safety Compliance Committee –Typically issue associated with a severity of 9 or 10. See procedure G1789 for details.

## Takata Airbag Recall

- Vehicles made by 19 different automakers have been recalled to replace frontal airbags.
- NHTSA stated "**the largest and most complex safety recall in U.S. history.**"
- The airbag's inflator, is a metal cartridge loaded with propellant wafers.
- If inflator housing ruptures in a crash, metal shards can be sprayed throughout the passenger area.

**Root Cause:** airbags that use ammonium nitrate-based propellant without a chemical drying agent.



# WHY - 3L5Y Problem Solving is Needed

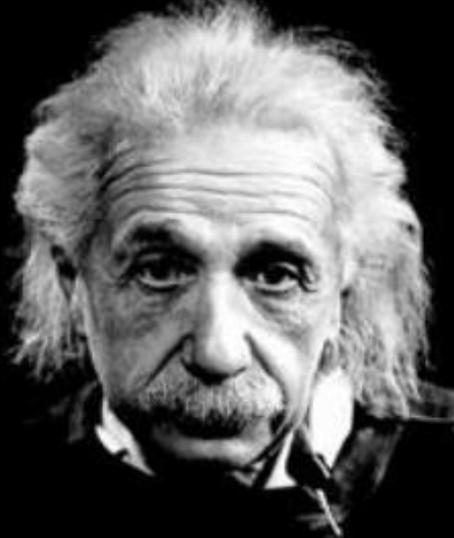
## Why use a 3 Legged 5 Why:

- What does it mean for Nexteer if we use **bad** parts?
  - Customer dissatisfaction
  - Uncompetitive / nonconforming performance
  - Uncompetitive costs
  - Potential loss of business, or recalls
- Why use the 3 legged 5 Why?
  - Provides a **road map** to a permanent corrective action.
  - Stops the problem from happening again, both safety and quality issues.
  - Increases employee and customer satisfaction.
  - Increases quality, profitability, and market share.

# WHY - 3L5Y Problem Solving is Needed

**“The problems that  
exist in the world  
cannot be solved by the  
level of thinking that  
created them.”**

*- Albert Einstein*



Einstein and Deming's thoughts on **WHY** problem solving is needed.....

**“85% of the reasons for  
failure to meet customer  
expectations are related  
to deficiencies in systems  
and processes... rather  
than the employee.”**

*- Dr. W. Edwards Deming*



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# History of 5 Why Problem Solving



## History –

- The technique was developed by the Toyota Motor Corporation during the evolution of its manufacturing methodologies.
- The "5" in the name derives from an anecdotal observation on the “typical” number of iterations needed to resolve the problem.

## 5 Why Example

The vehicle will not start. (the problem)

1. *Why?* - The battery is dead. (First why)
2. *Why?* - The alternator is not functioning. (Second why)
3. *Why?* - The alternator belt has broken. (Third why)
4. *Why?* - The alternator belt was well beyond its useful service life and not replaced. (Fourth why)
5. *Why?* - The vehicle was not maintained according to the recommended service schedule. (Fifth why, a root cause)

# How - Planning and Preparing to do a 3L5Y

- Planning/Preparing
  - A cross-functional team **must** be used to problem solve
    - Include Operations, Engineers, Quality, PC&L, etc.
    - Need knowledge, opinions, and observations of different people
    - People with process and product knowledge and authority to correct the problem
    - Empowered to “think outside the box” and “change the rules”

# How - Planning and Preparing to do a 3L5Y

## ■ Planning/Preparing

- To solve problems we have to overcome our normal pattern of thinking which occurs due to our past experiences. Think outside the box. (AIAG Problem Solving Guideline)
- Often a problem is solved from someone who does not have knowledge of the history of the problem because they can see it from a different perspective.
- Don't jump to conclusions, or, assume the answer is obvious
  - Same issue may be due to a different cause
  - Previous corrective actions may have corrected only a symptom

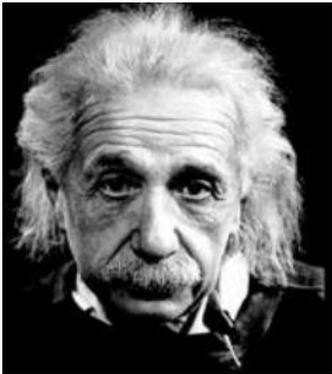


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# How - Planning and Preparing to do a 3L5Y

## ■ Planning/Preparing

- **MUST** Include pictures (photos, graphics)
  - Keeps team focused on issue
  - Helps customer/others understand corrective action and apply lessons learned
  - Walk the process – do not try to solve problem from your desk.
- **Must** include test data and facts to show you can turn root cause off and on.



*“Imagination is more important than knowledge”*

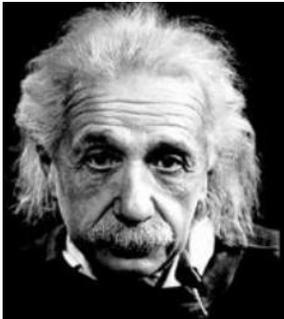
– *Albert Einstein*

# 3L5Y - Problem Definition – *Most Important thing you do!*

- **Define the Problem**

- The Problem statement **must be** clear and accurate
- Define problem as the customer sees it
- Include
  - Who found it?
  - When was it identified?
  - How was it detected?
  - How many? Frequency?

- Do **not** add “**causes**” into the problem statement



“A Problem Well-Defined is Half Solved”

- Albert Einstein

# 3L5Y - Problem Definition – Good and Bad Examples

## • Are the Problem Definitions below good??

*Was the problem definer an Einstein, or, a Poor Problem Solver?*

(1). Noisy pump

(2). Nexteer Saginaw Plant 6 was notified by first shift supervisor John Smith, that he found three rake brackets, part #28271777, with broken mounting pads, that prevented the columns from being assembled correctly. John Smith found them at 8AM, on August 17, 2018, in plant 6, department 23.

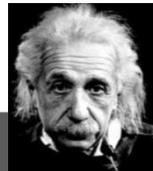
(3). REPS gear has broken casting.

(4). Drawing G datum out of spec

(5). On June 5<sup>th</sup>, at 10 AM, during a GM Lansing assembly plant audit, GM quality engineer Matt Anderson, detected a thumping noise on a Nexteer half-shaft. Only one half-shaft was found, part # 26076778, with part label indicating it was built by Nexteer's plant 5, dept. 37, on May 9th.

No Causes!!

- Hint – did they Include:
  - Who found it?
  - When was it identified?
  - How was it detected?
  - How many? Frequency?



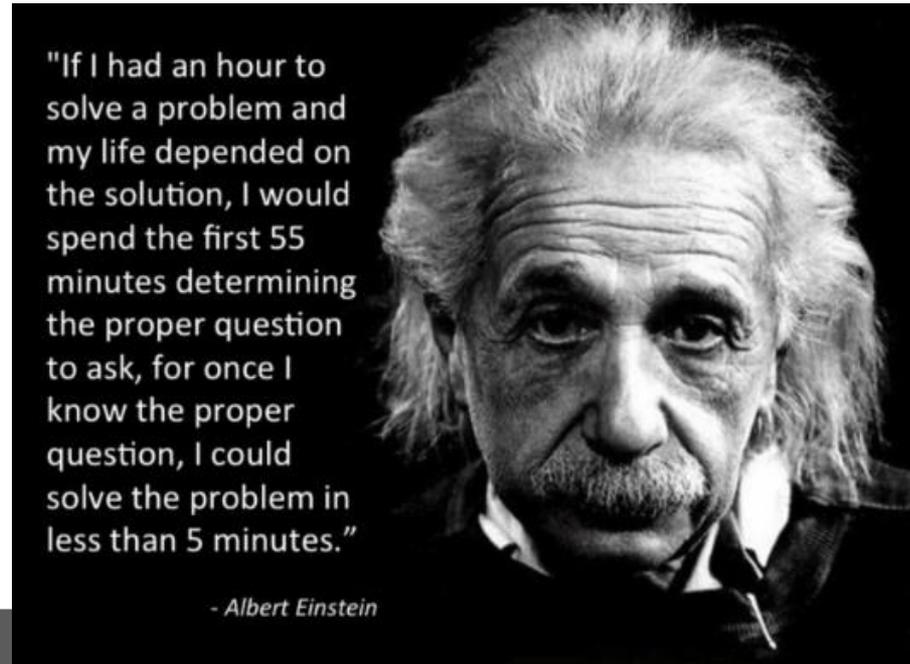
"A Problem Well-Defined is Half Solved"

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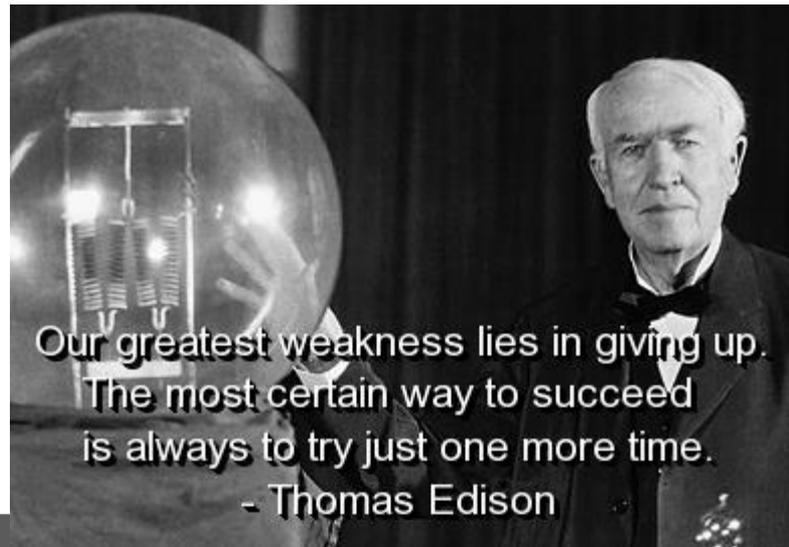
# 3L5Y – “Why” Guidelines

- How many Why’s should you ask??
  - Ask “Why” until the root cause is uncovered
    - May be more than 5 Whys or less than 5 Whys
    - If you don’t ask enough “Whys”, you may end up correcting a “symptom” and not “root cause”
    - A root cause is usually a process, policy, design, or a person. There can be more than one root cause.



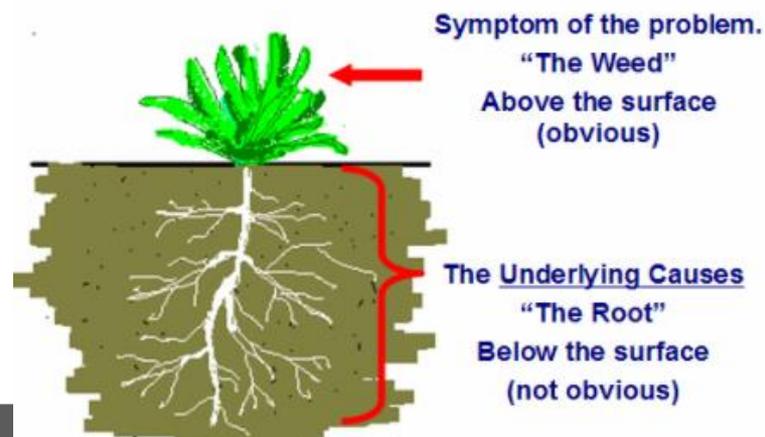
# 3L5Y – “Root Cause” Guidelines

- Root cause can be turned “on” and “off” with the corrective action.
  - Will addressing / correcting the “cause” prevent recurrence?
  - If not what is the next level of cause?
- Walking from the cause back to the problem should make sense when read in reverse using “therefore”



# 3L5Y – Finding the “Root Cause”

- 5 Why is Interrogative technique used to explore the cause and effect relationships for a particular problem.
- By repeating the question “Why”, each answer forms the basis for the next question.
- The final Why is the Root Cause. Ask “WHY” as many times as needed until you find the root cause.
  - Do not stop until you reach a process, policy, or person that seems to be the root cause.
  - You should be able to turn the problem on and off, using the root cause.



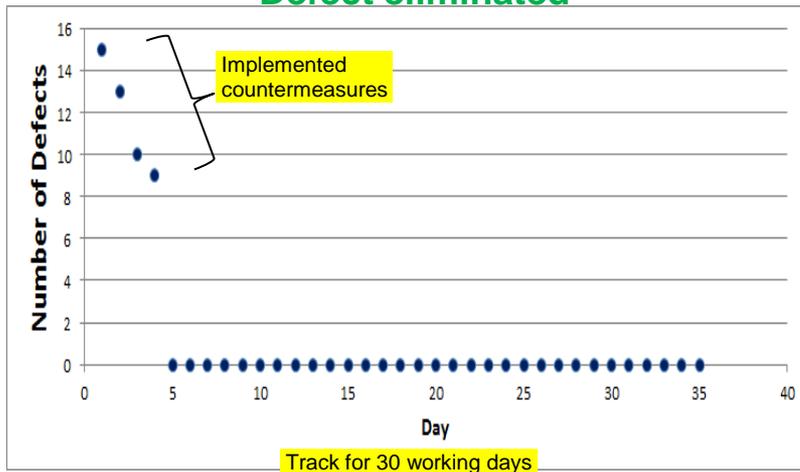
# 3L5Y – Finding “**Root Cause**” and knowing you are in control

*How do I know I have identified the root cause?*

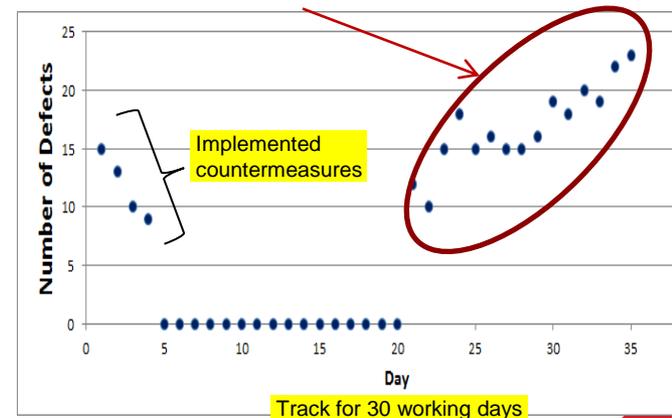
Ask:

“If I eliminate the Root Cause, will the Problem and all the symptoms disappear?”

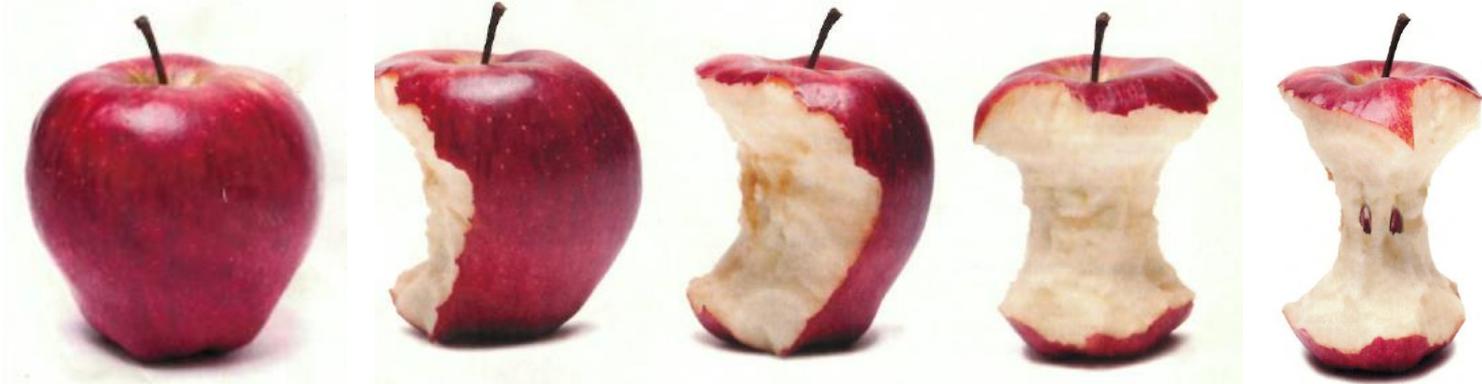
**Root Cause Found**  
– Defect eliminated



**Root Cause Not Found**, or, solution went out of control, process not stable, etc..



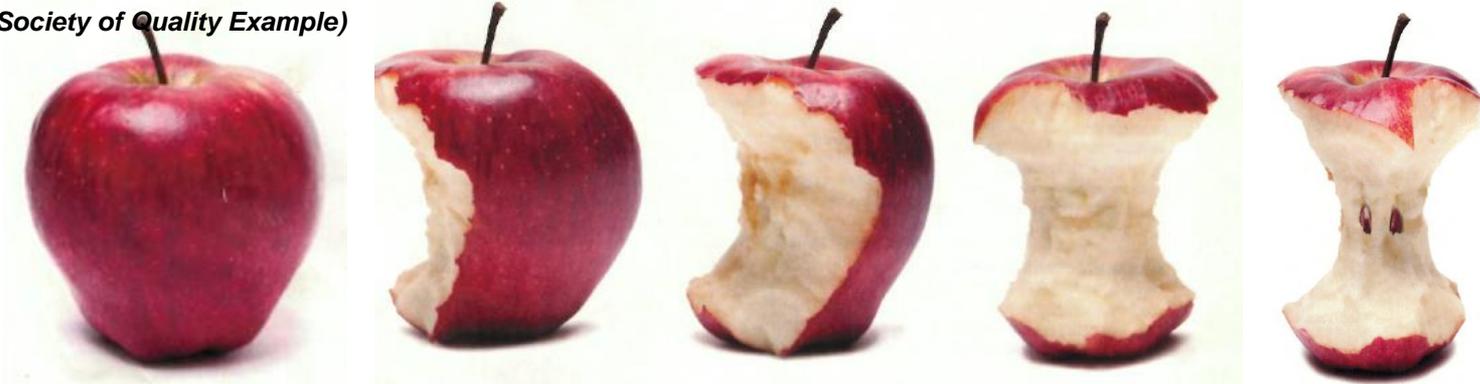
# 3L5Y – “**Root Cause**” – Get at the Core (American Society of Quality Example)



- In manufacturing defect investigations, **human error often is incorrectly identified** as the **root cause** of the defect.
- **Human error** is an inadequate “Root Cause”, because it does not address the true reason the failure occurred.
- Retraining employees is often the corrective action. This does **NOT** solve the actual root cause!!! The defect occurs again, because the True Root Cause manufacturing issue was **NOT** found. They did not get to CORE of the Root Cause!
- Ask “Why did the Human error?”, to help you identify the true root cause.
  - Humans will always error – no one is perfect.
  - How can you make the manufacturing system more robust to prevent this error?
  - For example, Human visual inspection is only 85% accurate.

# 3L5Y – “A better Root Cause” – Than Human Error

(American Society of Quality Example)



- After asking “**Why did the Human error?**” you may discover:
- 1. **Confusing Procedure:** Poorly written or vague work instructions
- 2. **Internal (personal) distractions:** Personal life, illness, injury, disability
- 3. **External Distractions:** Poor layout or workflow –frequent interruptions, noisy
- 4. **Unaware of Procedure:** Hard for employees to access, poor communication
- 5. **Procedural Updates:** Occur too often, to many revisions. Cant keep up.
- 6. **Willful Misconduct:** Employee disgruntled or dissatisfied.
- 7. **Inadequate Controls:** Unauthorized workarounds, another employees login used. Pages missing from work instructions.
- 8. **Missed Step:** Instructions unclear, poor training, poor error proofing
- 9. **Assembly line Robustness:** Need better fixture, tool, vision system.

# 3L5Y – The “3 Legs” of the 5 Why

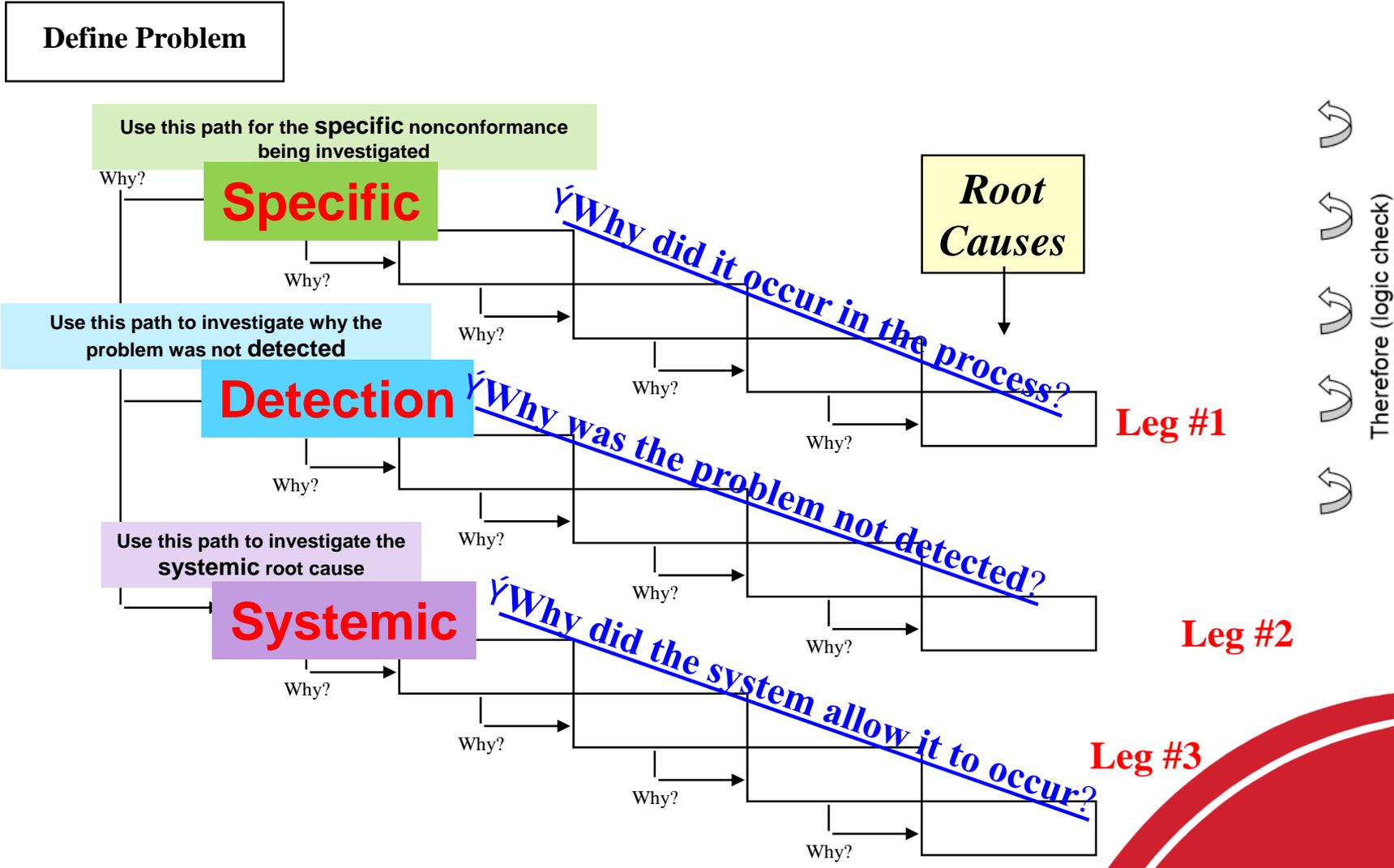
- Nexteer 5 Why includes 3 legs or questions that need to be addressed

(1). Specific Problem “leg #1” – why did the specific problem happen?

(2). Detection “leg #2” – why did we not detect the specific problem?

(3). Systemic Problem “leg #3” – what was the system breakdown that allowed the specific problem to occur?

# 3L5Y – Three Legs – How they fit in the problem solving process



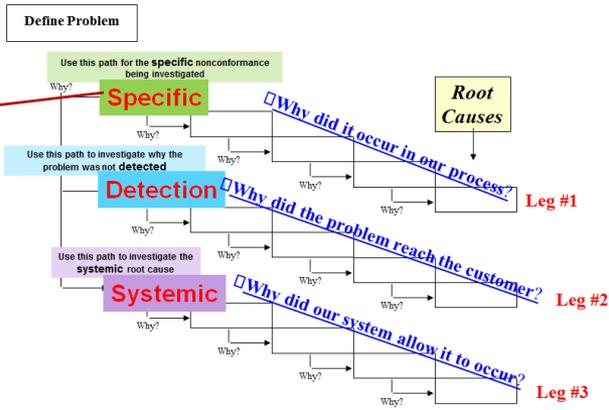
# 3L5Y – Three Legs – Shown in Nexteer’s Excel Form

Nexteer Plant	Part Number	Part Name and for Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	OEM Customer	FCC Qty of Pcs in the complaint	Date 3LSY Submitted
Intelex # (if applicable)		Detailed Problem Definition:						
PFMEA Summary	Severity #	Occurrence #	Detection #	RPN #	PFMEA Background information			
Before:				0				
After:				0				
3 Legged 5 Why		Picture and Description of Current State		Containment /QA Alert/ Owner / Target Date		Picture and Description of Corrected State		
SPECIFIC Leg #1 – Why did it occur in our process?	Problem Statement:							
	Why did it occur:							
	Why did it occur:		Corrective Actions / Owner / Target Date					
	Why did it occur:		<p><b>Specific Leg# 1</b> – Why did it occur in our process?</p>					
	Why did it occur:							
	Why did it occur:							
Why did it occur:								
DETECTION Leg #2 – Why did problem reach customer?	Why was it not detected:		Corrective Actions / Owner / Target Date					
	Why not detected:							
	Why not detected:		<p><b>Detection Leg# 2</b> – Why did problem reach the customer?</p>					
	Why not detected:							
	Why not detected:							
	Why not detected:							
SYSTEMIC LEG #3 – Why did system allow problem to occur?	Why did the system allow the problem to occur (what was the weakness in the system):		Corrective Actions / Owner / Target Date					
	Why:							
	Why:		<p><b>Systemic Leg# 3</b> – Why did our system allow it to occur?</p>					
	Why:							
	Why:							
	Why:							
OEM Customer Complaint Number (If applicable)		Affected OEM Customer Locations:		Supplier Name/Location:		Nexteer and / or Supplier Contact Name:		
Supplier Look Across #	Lessons Learned:							



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# 3L5Y – Specific Problem “leg #1”



- **SPECIFIC** Problem “leg #1”

- Why did we have the specific non-conformance?
- How was the defective part or non-conformance created?
- Root cause is typically related to operations or dimensional issues. For Example:
  - Tooling wear/breaking
  - Set-up incorrect
  - Processing parameters incorrect



# 3L5Y – **Specific** Problem “leg #1” - Questions to Ask??

## – **Process** related questions to ask:

- Was the correct process used?
- Was standardized work followed?
- Was the person performing the work trained?
- Has anything changed recently in the process?

## – **Product / part** related questions:

- Was correct part used?
- Has there been a product change?
- Are parts handled and stored correctly?

## – **Tooling** related questions:

- Was correct tooling used?
- Is tool change/maintenance being followed?
- Are tools in good working condition?

## 3L5Y – **Specific** Problem “leg #1” - **FMEA**

- Is failure mode identified on the FMEA (Failure Mode Effects Analysis)?
  - Failure mode should not be confused with symptom
  - Failure mode is manner in which process fails to meet requirement
  - Information on the FMEA may provide leads on the specific problem leg (occurrence failure modes) and the detection leg (controls)



“If you fail to plan, you are planning to fail!”

– Benjamin Franklin

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# 3L5Y – **Specific Problem – Root Cause** Examples

- **Specific Problem – Leg #1**

- Root Cause Examples

- Parts damaged by shipping – dropped or stacked incorrectly
- Operator error – poorly trained or did not use proper tools
- Operator error – performed job in wrong sequence
- Changeover occurred – wrong parts used
- Processing parameters changed
- Excessive tool wear/breakage
- Machine fault – machine stopped mid-cycle

# 3L5Y – Specific Problem – Root Cause Examples

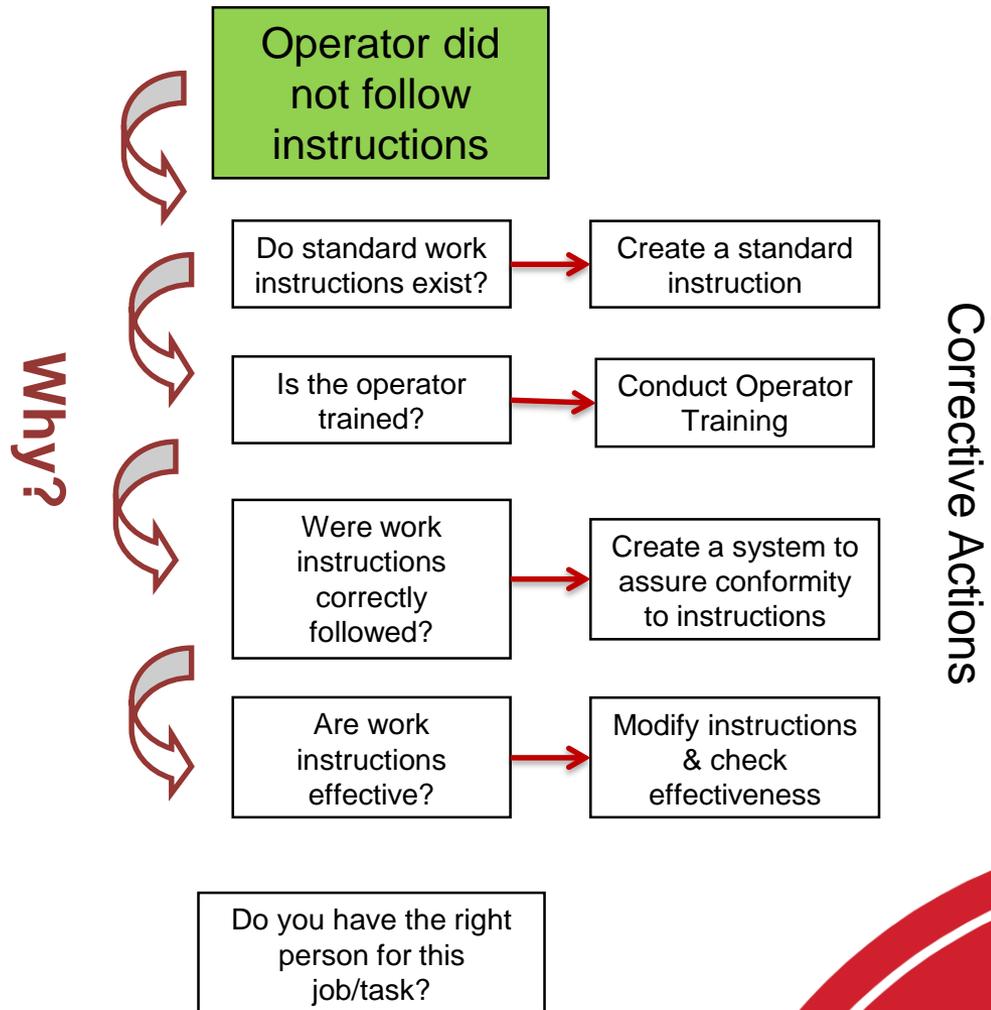
What if root cause is?

Operator did not  
follow  
instructions

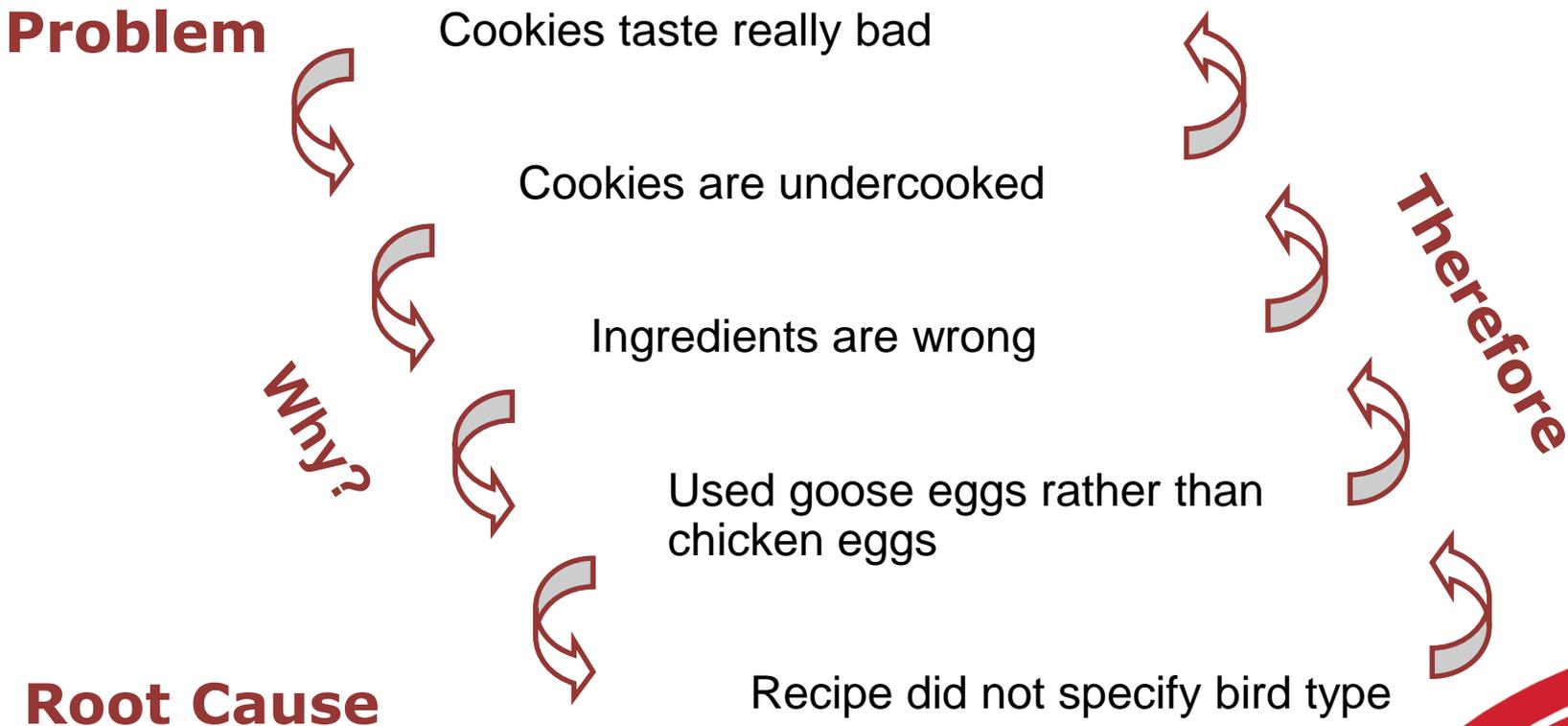
Do we stop here?

# 3L5Y – Specific Problem – Root Cause Examples

Or do we attempt to find the “real” root cause?



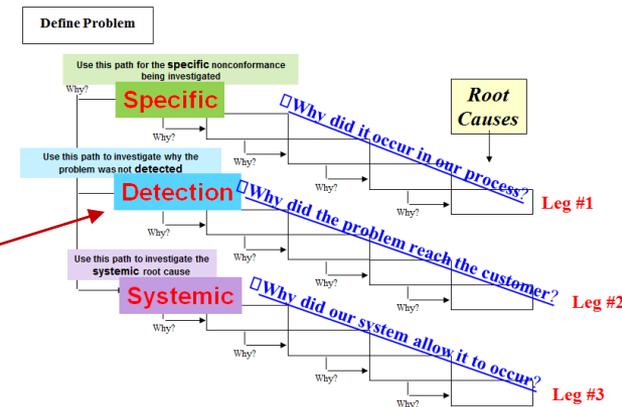
# 3L5Y – A simple example – **Specific** Leg #1



# 3L5Y – DETECTION “leg #2”

## ■ DETECTION “leg #2”:

- Why did the problem reach the customer?
- Why did we not detect the problem?
  - As noted by the customer or
  - Specific non-conformance
- How did the controls fail?
- Root Cause typically related to the inspection system
  - Error-proofing not effective
  - No inspection/quality gate
  - Measurement system issues
  - Detection system or logic changes
  - Parts too dirty



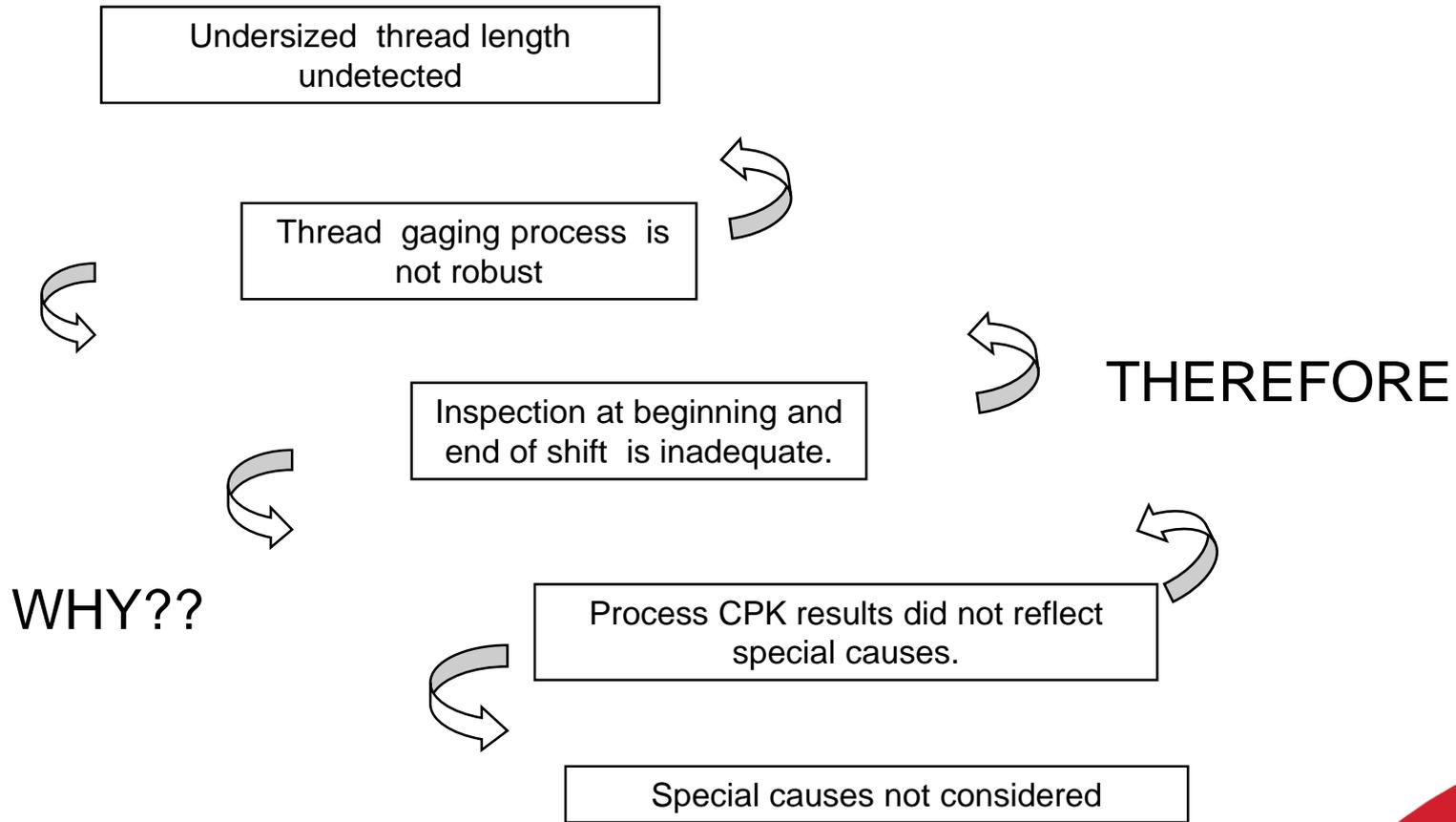
# 3L5Y – DETECTION “leg #2”

## • DETECTION

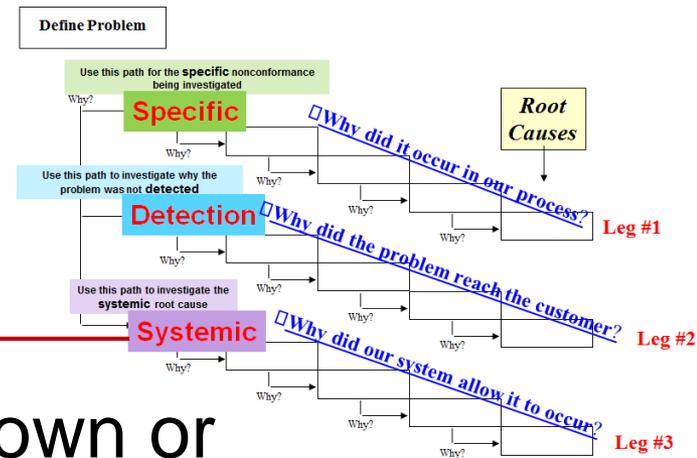
### – Example **Root Causes**

- No detection process in place – cannot be detected in our plant
- Defect occurs during shipping
- Detection method failed – sample size and frequency inadequate
- Error proofing not working or bypassed
- Gage not calibrated
- Master was worn out
- PPAP was not properly done.
- Parts labeled incorrectly

# 3L5Y – A Nexteer example – DETECTION Leg #2



# 3L5Y – SYSTEMIC - Leg # 3



- **SYSTEMIC “Leg #3”**

- What was the systemic breakdown or weakness in the process that allowed the cause of specific non-conformance to occur?
- Why did the possibility exist for this failure to happen?
- Typically traceable to, or, controllable by, support people
  - Management, Quality, Engineering, etc.

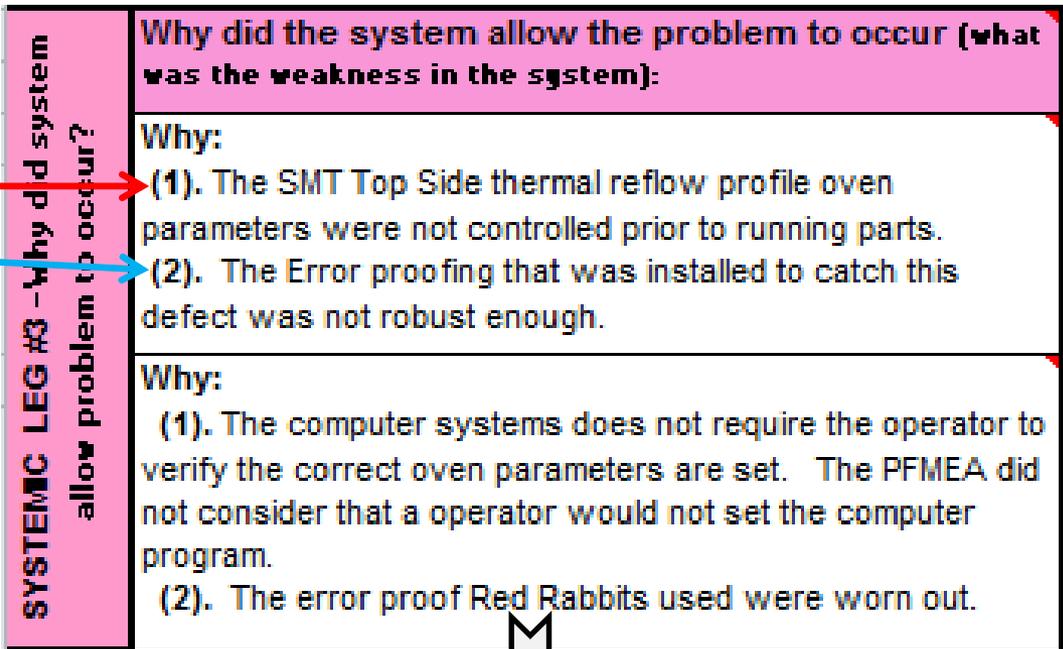
# 3L5Y – SYSTEMIC - Leg # 3

- Questions to consider on **Systemic** Leg #3
  - Was the failure mode identified in PFMEA?
  - Was new product/process planning process followed?
  - Was risk of failure mode occurring predicted properly?
  - Was risk of not detecting the failure mode predicted properly?
  - Is the design of the product robust as it relates to failure modes of root causes?

# 3L5Y – SYSTEMIC - Leg # 3 – First Why

- The **first WHY** of the **SYSTEMIC** leg #3, **is** the Root Cause from the **SPECIFIC** problem leg #1.
- **In Addition**, if a detection or containment system was in place but it failed in **DETECTION** leg #2, you should include a **second WHY** in **SYSTEMIC** leg #3.
- *The example below shows a situation where you use both Root Causes from the Specific leg #1, and Detection leg #2, for the first WHY's in Systemic leg #3.*

**Example:**  
 Root Cause from both the **Specific** legs and **Detection** legs.  
 Are used for **first Why** in the Systemic leg: numbered -> 1 and 2.



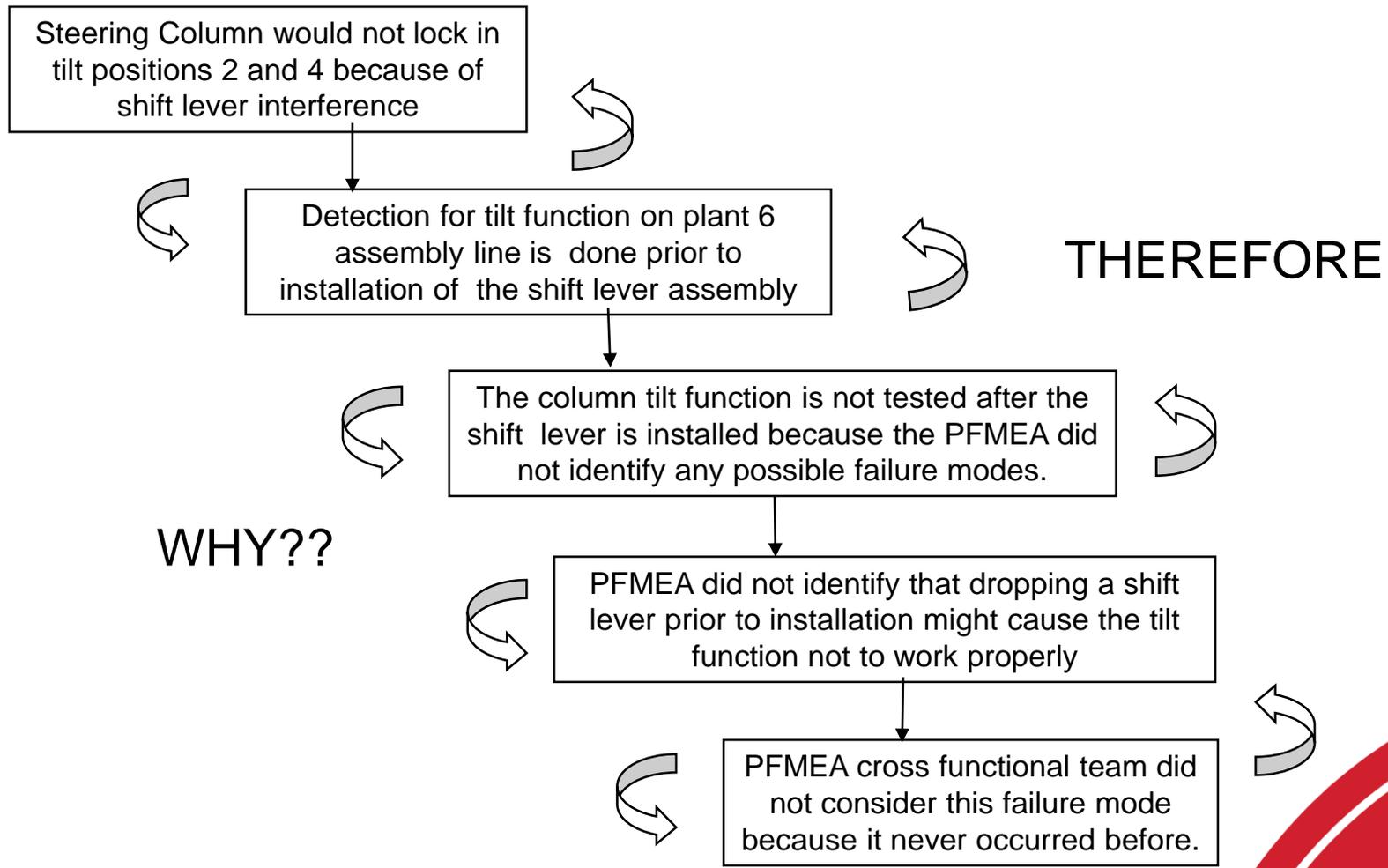
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# 3L5Y – **SYSTEMIC** - Leg # 3 – Root Cause Examples

- **SYSTEMIC** Root Cause Examples:
  - Failure mode not on PFMEA
    - Believed failure mode had zero potential for occurrence
    - Failure mode not considered
  - New process not properly evaluated
  - Process was changed creating a new failure mode
  - Quality planning issues or quality system failures
    - Rework/repair not considered in process design
    - Lack of effective Preventive Maintenance system
    - Process planning – all failure modes not considered
    - Not identified during APQP

# 3L5Y – A Nexteer example – SYSTEMIC Leg #3

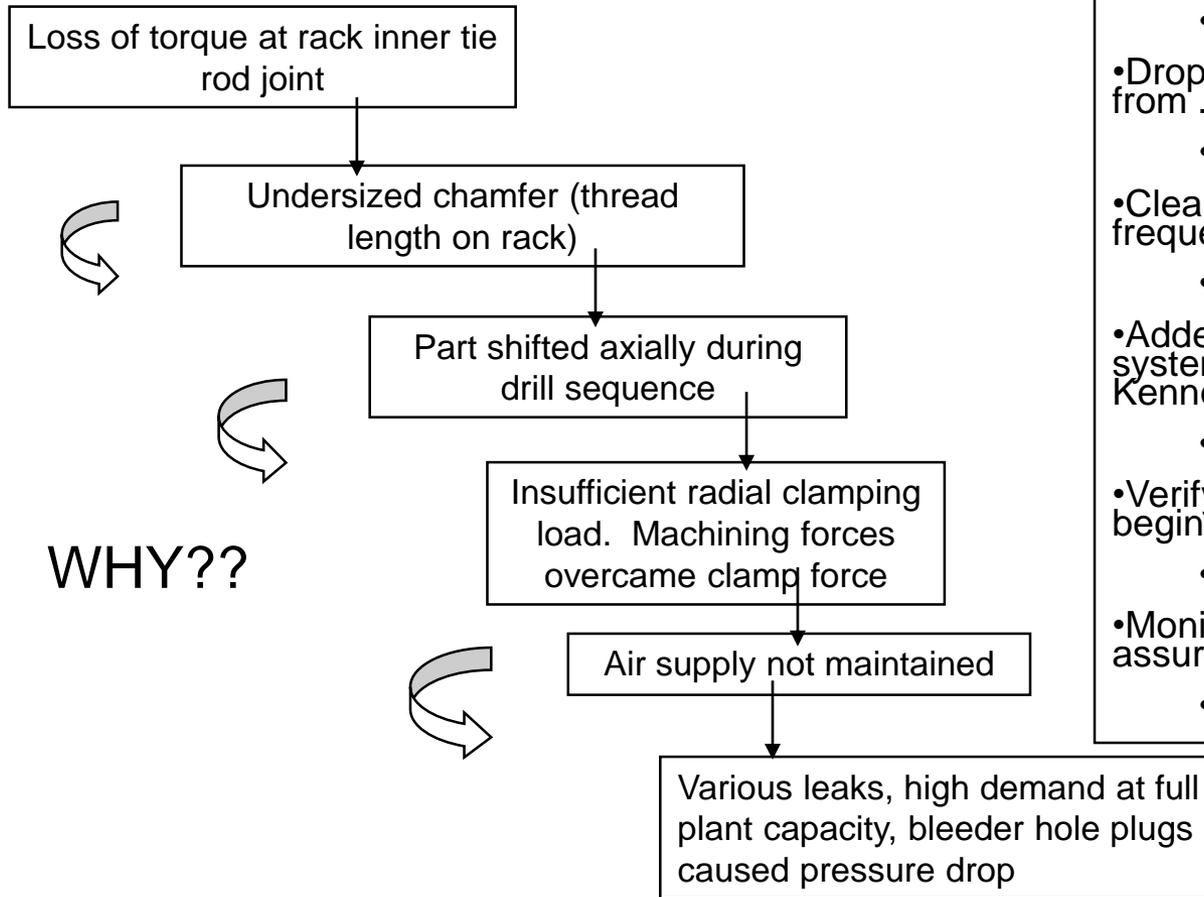


# 3L5Y – CORRECTIVE ACTIONS

- Corrective action identified for each root cause
- Corrective actions must be feasible, within span of control
- **MUST** Include owner/person responsible and implementation date
- Consider and include documentation updates and training as appropriate
  - **Note: Customer approval may be required for implementation of corrective action if it results in a process change**

# 3L5Y – Specific Problem **CORRECTIVE ACTIONS** example

## Specific

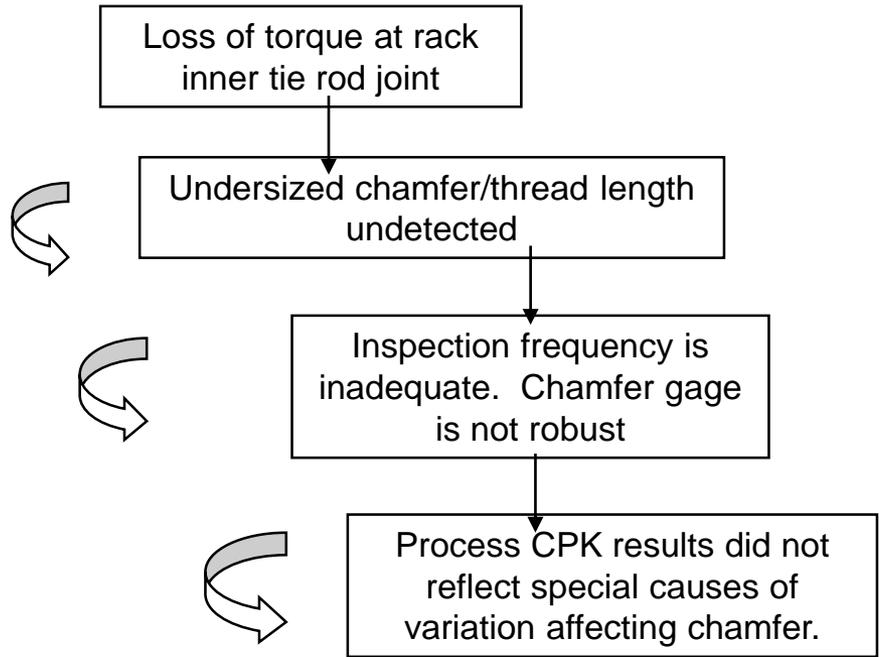


### Corrective Action:

- Reset alarm limits to sound if <90 PSI.
  - Smith 10/12/17
- Disable machine if <90 PSI.
  - Jones 9/28/17
- Dropped feed on drill cycle to .0058 from .008.
  - Davis 10/10/17
- Clean collets on Kennefec @ PM frequency
  - Smith 10/12/17
- Added dedicated accumulator (air) for system or compressor for each Kennefec
  - Smith 10/12/17
- Verify system pressure at machines at beginning, middle, and end of shift
  - Smith 10/12/17
- Monitor air pressure for 30 days to assure corrective actions effective.
  - Fitzko 11/12/17

# 3L5Y – Detection CORRECTIVE ACTIONS example

## Detection



WHY??

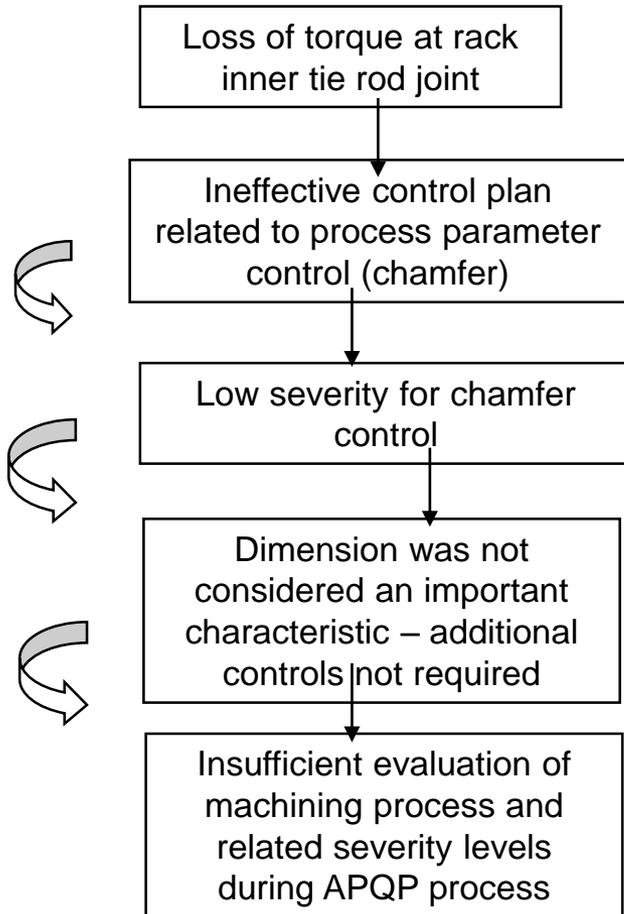
### Corrective Action:

- Implement 100% sort for chamfer length and thread depth.
  - Smith 9/26/17
- Create & maintain inspection sheet log to validate
  - Davis 8/22/17
- Redesign chamfer gage to make more effective
  - Jones 11/30/17
- Increase inspection frequency at machine from 2X per shift to 2X per hour
  - Johnson 10/14/17
- Review audit sheets to record data from both ends on an hourly basis
  - Davis 10/4/17
- Conduct machine capability studies on thread depth
  - Jones 9/22/17
- Perform capability studies on chamfer diameters
  - Ancel 10/14/17
- Repair/replace auto thread checking unit to include thread length. \*Ancel 10/14/17



# 3L5Y – Systemic CORRECTIVE ACTIONS example

## Systemic



### Corrective Action:

- Design record, FMEA, and Control Plan to be reviewed/upgraded by Quality, Manufacturing Engineering. R. Smith 12/3/17
- Update control plan to reflect 100% inspection of feature. R. Jones 12/5/17
- PM machine controls all utility/power/pressure. D. Ancel 12/10/17
- Implement layered audit schedule by Management for robustness/compliance to standardized work. F. Bolger 12/16/17

### Lessons Learned:

- PFMEA severity should focus on affect to subsequent internal process (immediate customer) as well as final customer
- Measurement system and gage design standard should be robust and supported by R & R studies
- Evaluate the affect of utility interruptions to all machine processed (air/electric/gas)

WHY??

Nexteer Supplier Quality: “We drive continuous improvement in everything we touch and do”

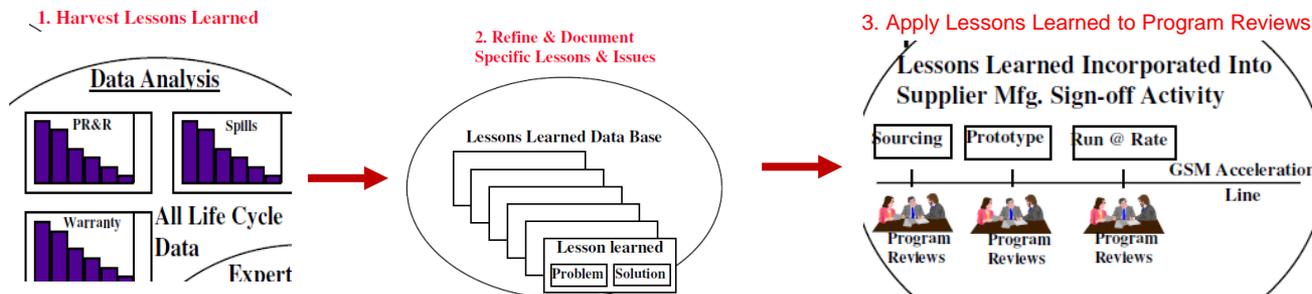
# 3L5Y – Lessons Learned

## ■ Lessons Learned

- What information should be shared with other plants, departments, products, or processes?
- Consider similar/same products, processes, and equipment
- State lessons learned in a manner that would make sense to someone not familiar with the specific cause or issue
- Should be specific, and avoid being too general.

# 3L5Y – Lessons Learned - Examples

- **Lessons Learned examples:**
  - Welding operations – boundary samples of what is acceptable and what is not are needed
  - Operation of critical machine controls (i.e. diverters) must be verified at an appropriate frequency
  - Operator work instructions must include steps to be taken after machine wreck/smash-up



## 3L5Y – Look Across

- Nexteer Suppliers **MUST** have a “Look Across” process in place.
  - Ensure lessons learned are shared across all supplier’s plants and with external suppliers.
  - Incorporate lessons learned into a common BOP (Bill Of Process) and BOD (Bill of Design). Include in PFMEA’s.
  - New and previous Lessons learned records should be stored in a database. Have a number tracking system.
  - Should have a Look Across procedure.

# 3L5Y – Summary of Key Points

- When do you use it? –Use for formal, informal, and internal issues.
- Use a cross-functional team
- Never jump to conclusions
- Ask “WHY” until you can turn problem off (*you found the root cause*).
- Use the “therefore” test for reverse path
- Strong problem definition as the customer sees it
- **Specific Leg** – Typically applies to people doing the work in operations
- **Detection Leg** – Typically applies to poor detection and controls
- **Systemic Leg** - Typically applies to management, quality, engineering
  - Remember, start with root cause from the specific leg
- Corrective actions must have the due date and owner
- Documents lessons learned and look across
- Supports fast response

**Specific** - Why did it occur in our process?

**Systemic** - Why did our system allow it to occur?

**Detection** - Why did the problem reach the customer?

# 3L5Y – Group Exercise Example

## Group Exercise

### Review a 5 Why using what you have learned

- Has probable root cause been determined for:
  - Specific issue
  - Lack of detection
  - Systemic issue
- If not, what questions would you ask?
- Do corrective actions address root cause?
- Have Lessons Learned been noted? Can another plant learn from this?
- If any above answers are “no”, what recommendations would you make to the team working on the 5 Why?

*\*\* See page 68 in the section B training, for a “Bad” example 3L5Y, and, a corrected “Good” version of the same 3L5Y.*



# **Part B Training – How to fill out Nexteer’s 3L5Y Excel Form**

# Part B – How to Fill Out Nexteer’s 3L5Y Excel Form:

## Why did Nexteer Update the 3L5Y Excel form?

- The purpose of the 3L5Y Excel worksheet training is to standardize a global procedure and method for filling out 3L5Y Excel forms correctly.
- In the past, many 3L5Y’s were filled out incorrectly, or, missing information. This resulted in 2 or 3 iterations before getting it correct.
- The new 3L5Y Excel form has “Pop-Ups” that guide the user as they are filling out the form.

## Contents–

- Where to find the Excel form
- What is in each Excel Worksheet tab
- 1 page summary “cheat sheet”
- Leg #1 – Specific Problem - Containment & Corrective Actions
- Leg #2 – Detection – Corrective Actions
- Leg #3 - Systemic – Corrective Actions
- Other items to fill out on Excel form



# 3L5Y Excel File located on Nexteer.com under Suppliers



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## QUALITY PROCESSES

For all of us to be successful, we need to build perfect quality. As Nexteer's Quality Policy states, "Take Action for Quality; it's everyone's job." Suppliers shall have a commitment to total quality, with subsequent planning and actions that drive for perfection. Contained herein are the documents that will assist in meeting our quality requirements.

### APOP AND CURRENT PRODUCTION CYCLE DOCUMENTS

- 5 Why Form
- Application Form of Material Substitution
- QCL/DSS 101 for Suppliers



Nexteer Supplier Quality: "We drive continuous improvement in everything we touch and do"

# 3L5Y Excel File – Contains 11 Worksheets

➤ This Training will review the **5 added** Worksheet tabs in Nexteer's Excel 3L5Y

**Worksheet #1 added**

**Worksheet #2 added**

**Worksheet #3 added**

**Worksheet #4 added**

**Worksheet #5 added**

Old worksheets describing the PFMEA

**3L5Y: Leg 1 - Specific Problem**

Corrective Actions - What we are looking for:

**CONTAMINANT ACTIONS**

- Quality Alerts issued
- Containment checklist
- Suspect window quantity
- Final Quantity sorted
- Final Quantity defective
- Location of suspect parts & segregation
- Date & quantity of first certified shipment
- Document identification marks used on "Certified" parts
- Picture of verification marks and packaging labels
- Run chart showing break point effectiveness

**CORRECTIVE ACTIONS (Specific Problem)** Update documents for this issue including:

- Standard Work Instructions (good & bad visuals)
- Early Production Containment (EPC)
- Set-up procedures
- Drawing updates
- Part ID
- Line Side Reviews
- Data audits and verification needed
- Revison control
- Tooling issues updates
- Containment control
- Recreate Defect - how run on & off?

**3L5Y: Leg 2 - Detection**

Corrective Actions - What we are looking for:

**CORRECTIVE ACTIONS (Detection)** Update documents for this issue including:

- Error proofing masters (Red Rubber added)
- Daily error proofing checks in control plan?
- Detection method documented in PFMEA?
- Reject chute tied to machine logic to count bad parts?
- Reject/gate reconciliation added to workbook?
- Can reject chute be deflated?
- Is a gate release needed?
- Reject alarm limits
- Logic changes
- Mis-handling of reject parts
- Unapproved Rework Procedures
- Rework
- Added Gages & frequency used
- Gage drawing updates
- Gage Calibration Instructions
- Control Plan (Inspection frequency)
- Process sheet
- Traceability

**3L5Y: Leg 3 - Systemic**

Corrective Actions - What we are looking for:

**CORRECTIVE ACTIONS (Systemic)** Update documents for this issue including:

- PFMEA (severity, occurrence, missed failure modes)
- Process Flow
- Control plan
- Control charts & process monitoring
- Preventive Maintenance increase?
- Layred audits
- Compliance to standardized work
- APQP/Launch process changes
- Change Management & Change control
- Setup, Changeover & Repair instructions
- Policy & Procedures
- System changes
- Training
- Core Design
- Core Process
- PPAP
- Submit a SCR (process/product change required)

\*Note: Updates to be made by Quality and Mfg Engineering. 3L5Y to be audited by Supplier Senior Mgt.



# 3L5Y Excel File -> 1 pg. summary "Cheat Sheet" (Worksheet #1)

Nexteer Plant	Part Number	Part Name and for Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	OEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted
See the Detection, Severity, and Occurrence worksheet tabs below, in this Excel file to fill out this section.		<b>Detailed Problem Definition:</b>	A complete and clear problem description. Do not have "causes" in it. State where the problem occurred, on what part number, and what is wrong with part?					
<b>Severity</b>		<b>Occurrence</b>	<b>Detection</b>	<b>RPN</b>	<b>PFMEA Background information</b>			
<b>Before:</b>		<b>Specific Leg #1 - problem non conformance path.</b> should tie back to issues such as design, operations, supplier issues, etc. Typically applies to people doing the work.						
<b>After:</b>		A problem statement is a clear description of what is wrong with the part -> broken handle, missing weld, wrong heat treat, etc.						
<b>3 Leg</b>		<b>Description of Current State</b>			<b>CONTAINMENT ACTIONS:</b>			
<b>Problem Statement:</b>					(1). Quality Alerts issued, (2). Containment checklist (3). Suspect window quantity, (4). Final Quantity sorted, (5). Final Quantity defective, (6). Location of suspect parts & segregation, (7). Date breakpoint established, (8). Date & quantity of first certified shipment, (9). Document identification marks used on "Certified" parts, (10). Picture of certification marks and packaging labels, (11). Run chart showing break point effectiveness			
<b>Why did it occur:</b>		One or 2 sentences for each Why. One concept per Why. If using words like "because" or "due to" move on to next Why. No leaps in logic. Use as many whys as needed.			<b>Corrective Actions / Owner / Target Date</b>			
<b>Why did it occur:</b>		SPECIFIC problem: Why did we have problem? How was problem created? Ex. Tool broke, set up bad, machine fault, bad design, process parameters changed, change over, parts damaged by shipping.			<b>CORRECTIVE ACTIONS (Specific Problem):</b> Update documents for this issue including: (1). Standard Work Instructions (good & bad visuals), (2). Early Production Containment (EPC), (3). Set-up procedures, (4). Drawing updates, (5). Part ID, (6). Line Side Reviews, (7). Daily audits and verification needed, (8). Revision control, (9). Tooling issues/updates, (10). Contamination control, (11). Process Parameter control, (12). Recreate Defect - How turn on & off?			
<b>Why did it occur:</b>		Can you turn the Root cause on and off? If not, you did <u>not</u> find real root cause.			<b>Corrective Actions / Owner / Target Date</b>			
<b>Why was it not detected:</b>		Therefore - Read each why in reverse from cause to cause -> use <b>THEREFORE</b> , instead of WHY.			<b>CORRECTIVE ACTIONS (Detection):</b> Update documents for this issue including: (1). Error proofing /masters /Red Rabbit added, (2) Daily error proofing checks in control plan?, (3). Detection method documented in PFMEA?, (4). Reject chute tied to machine logic to count bad parts?, (5). Reject part reconciliation added to toolbox?, (6). Can reject chute be defeated?, (7). Is a gate release needed?, (8). Reject alarm limits, (9). Logic changes, (10). Mis-handling of reject parts, (11). Unapproved Rework Procedures, (12). Rework, (13). Added Gages & frequency used, (14). Gage drawing updates, (15). Gage / Calibration instructions, (16). Control Plan (inspection frequency), (17). Process sheet, (18). Traceability			
<b>Why not detected:</b>		Detection path should tieback to issues such as control plans, error-proofing, etc. Typically applies to people doing the work.						
<b>Why not detected:</b>		Why did the problem reach the customer? Why did we not detect the problem? How did the controls fail? Error-proofing not effective? No inspection/quality gate? Measurement system issues?			<b>Pictures:</b> You need a picture of the problem, and the corrective action. A picture says 1000 words. The more pictures the better.			
<b>Why not detected:</b>					<b>Corrective Actions / Owner / Target Date</b>			
<b>Why did the system allow the problem to occur (what was the weakness in the system):</b>		Restate the last SPECIFIC leg final Root Cause, if possible.			<b>CORRECTIVE ACTIONS (Systemic):</b> Update documents for this issue including: (1). PFMEA (severity, occurrence, missed failure modes), (2). Process Flow, (3). Control plan, (4). Control charts & process monitoring, (5). Preventive Maintenance increased?, (6). Layered audits, (7). Compliance to standardized work, (8). APQP/Launch process changes, (9). Change Management & Change control			
<b>Why:</b>		Ask why manufacturing System broke for each systemic question. eg. Failure mode not on PFMEA, a process change made, ect.			(10). Setup, Changeover & Repair instructions, (11). Policy & Procedures, (12). System changes, (13). Training, (14). Core Design, (15). Core Process, (16). PPAP, (17). Submit a SCR if process/product change required. ** Note: Updates to be made by Quality and Mfg Engineering, 3L5Y to be audited by Supplier Senior Mgt.			
<b>Why:</b>		Systemic path should tie back to management systems/issues such as change management, preventive maintenance, control plans, etc Typically applies to management issues.			<b>For each CORRECTIVE ACTION:</b> (1). List action items (2). Owner of corrective action item (3). due date & timing.			
<b>Why:</b>								
<b>Why:</b>								
<b>Why:</b>								
<b>OEM Customer Complaint Number (If applicable)</b>		<b>Affected OEM Customer Locations:</b>		<b>Supplier Name/Location:</b>		<b>Nexteer and / or Supplier Contact Name:</b>		
<b>Supplier Look Across #</b>		<b>Lessons Learned:</b> Document what should be communicated as Lessons Learned, Within the plant, Across plants, At the supplier, At the Customer.						

Leg #1

Leg #2

Leg #3

- This is a 1 page summary showing how to fill out a 3L5Y.
- The next few pages will show an enlargement of each of the "corrective action" sections, and how to fill them out.



# Why Do We Need a "Cheat Sheet"?

## Bad 3L5Y Example

Poor problem statement, and many items not filled out.

Plant	Part Number	Product/Process Name	Date of Occurrence	Look Across #	Type of Look Across (Warranty or WFOD):	Customer	Plant Tracking number	Date 3L5Y Written
7	38003523		2/15/2016		Customer Complaint	Watsville		
<b>Problem Definition:</b> Bolts loose								
<b>CN #, If Applicable:</b> CN401277 CN403325		<b>PFMEA Summary</b> Before:	<b>Severity #</b> 7	<b>Occurrence #</b> 3	<b>Detection #</b> 3	<b>RPN #</b> 63		
		After:						
<b>3 Legged 5 Why</b>			<b>Picture of Current State</b>	<b>Corrective Actions / Owner / Target Date</b>		<b>Picture of corrected state</b>		
<b>Problem Statement:</b> Vehicle Assembly received a 680... with loose valve cover bolts.				<b>Containment Actions</b> Revisi/Alert: 2/15/16 Posted for operator awareness and containment certification. Complete Date: 2/15/16 & 2/14/16 Y. Pruitt				
<b>Why did it occur:</b> The bolts were not torqued.				<b>Containment Worksheet</b> <b>Corrective Actions / Owner / Target Date</b>				
<b>Why was it not detected:</b> Gear returned for loose bolts.				<b>Lessons/Learnings</b> Updated LA for GLTL/GE <b>Complete Date:</b> 6.3.16 Y. Pruitt				
<b>Why not detected:</b> A rejected gear was allowed to enter the valved station.				Added Photo Eye with back check detection to prevent any type of reject from being sent around the line. <b>Complete Date:</b> 6-3-16 C. Camera				
<b>Why not detected:</b>								
<b>Why not detected:</b>								
<b>Systemic root cause:</b> Gear returned for loose bolts.				<b>DCP:24400128</b> Updated DCP with new documents <b>Complete Date:</b> 6.13.16 C. Camera				
<b>Systemic root cause:</b> Downstream pallet tracking switch was faulted in "good" position.								
<b>Systemic root cause:</b>								
<b>Systemic root cause:</b>								
<b>Customer Problem Case Number</b> N/A		<b>Affected Customer Locations:</b> Watsville Assembly		<b>Supplier Location:</b> Nexteer Plant 7		<b>Contact Name:</b> Yolanda Pruitt		
<b>Lessons Learned</b> Follow Teardown Procedure								

The "After" Risk Priority Number (RPN) missing

Poor Containment, and, not enough Corrective actions

3L5Y's did not dig deep enough. Stopped half way.

Not enough pictures. No after pictures

# 3L5Y Excel File – Pop Up Instructions on New 3L5Y Blank Master

Nexteer Plant	Part Number	Part Name and /or Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	OEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted
Intelect # (if applicable)		Detailed Problem Definition:						
PFMEA Summary		Severity #	Occurrence #	Detection #	RPN #	PFMEA Background information		
Before:					0			
After:					0			
3 Legged 5 Why		Picture and Description of Current State		Containment /QA Alert/ Owner / Target Date		Picture and Description of Corrected State		
SPECIFIC Leg #1 - Why did it occur in our process?	Problem Statement:		<p>Remember the <b>Problem Definition</b> should <b>not</b> have any <b>causes</b> in it!!!                      ** Do <b>NOT</b> use any <b>Acronyms!!!</b> You may know what it means, but no one else does.</p> <p><b>The Problem Definition should include:</b></p> <p><b>(1). Who found it?</b>  <i>Example</i> - Nexteer plant 7, dept 31, on 2nd shift by line assembler Mike Jones. <i>Example</i> - GM's Lordstown assembly plant quality control dept.</p> <p><b>(2). When was it identified?</b>  <i>Example:</i> On October 21, 2016, at 10 AM, a cracked steering column was found by Ford's Lansing asm plant's quality manager, during a routine test drive.</p> <p><b>(3). How was it detected?</b>  <i>Example:</i> GM's quality department found 3 Nexteer steering columns that would not tilt and tele at Oshawa plant 5, assembly line 2.</p> <p><b>(4). How many? Frequency?</b>  <i>Example:</i> 23 cracked rake brackets, part number 26039212, were found in one box. The box has serial number 29234 written on it, and is from Continental castings.</p> <p><b>Good EXAMPLE with WHO, WHEN, HOW combined:</b>                      ** On March 21st, Nexteer plant 6, dept. 23, on 2nd shift, found three rake brackets, part #28271777, with broken mounting pads, that prevented the columns from being assembled correctly.</p>					
	Why did it occur:							
	Why did it occur:							
	Why did it occur:							
	Why did it occur:							
DETECTION Leg #2 - Why did problem reach customer?	Why was it not detected:							
	Why not detected:							
	Why not detected:							
	Why not detected:							
	Why not detected:							
SYSTEMIC LEG #3 - Why did system allow problem to occur?	Why did the system allow the problem to occur (what was the weakness in the system):							
	Why:							
	Why:							
	Why:							
	Why:							
OEM Customer Complaint Number (If applicable)		Affected OEM	***NOTE: Your PC WILL BE REJECTED if you have a poor problem statement!!				Contact Name:	
Supplier Look Across #		Lessons Learned:						
		**Note #2: The wording does not have to be exactly like the OEM customers description.						

- Example “Pop-Up” Instruction
- Hover over any box in the 3L5Y “Blank Master” and instructions on how to fill out that box will “pop up”



# 3L5Y Excel File → Leg 1 –Containment Actions (Worksheet #2)

## CONTAINMENT ACTIONS:

- (1). Quality Alerts issued
- (2). Containment checksheet (send copy to Nexteer)
- (3). Suspect window quantity
- (4). Final Quantity sorted
- (5). Final Quantity defective
- (6). Location of suspect parts & segregation
- (7). Date breakpoint established
- (8). Date & quantity of first certified shipment
- (9). Document identification marks used on "Certified" parts
- (10). Picture of certification marks and packaging labels
- (11). Run chart showing break point effectiveness

Nexteer Plant	Part Number	Part Name and Its Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	DEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted
Intelex # (if applicable)		Detailed Problem Definition:						
PFMEA Summary		Severity #	Occurrence #	Detection #	FPN #	PFMEA Background information		
Before:					0			
After:					0			
3 Legged 5 Why			Picture and Description of Current State		Containment: RGA Alert Owner / Target Date		Picture and Description of Corrected State	
Problem Statement:								
SPECIFIC LEG #1 - Why did it occur?	Why did it occur:							
	Why did it occur:							
	Why did it occur:							
	Why did it occur:							
	Why did it occur:							
Why was it not detected:				Corrective Actions / Owner / Target Date				
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why did the system allow the problem to occur (what was the weakness in the system):								
Why:								
Why:								
Why:								
Why:								
Why:								
DEM Customer Complaint Number (if applicable)		Affected DEM Customer Locations:		Supplier Name/Location:		Nexteer and / or Supplier Contact Name:		
Supplier Look Across #		Lessons Learned:						

Leg #1 - Specific

## ➤ For LEG 1 – Specific Problem - CONTAINMENT:

- Document that you did all 11 items shown in the chart above, if they apply to your problem
- Expand the 3L5Y to 2 or 3 pages if needed, or add a worksheet tab

# 3L5Y Excel File – CONTAINMENT Worksheet Example

CONTAINMENT WORKSHEET - NONCONFORMING PRODUCT					
Date:		Name Responsible Person Containing:			
Location where Concern was Discovered:					
Defect Description (including part number/part description):					
Sort Method / Sort Criteria:		Hand Gage:	CMM:	Visual:	Mating Part:
ID (Marking) Method for sorted conforming parts:					
ID (Marking) Method for sorted "BAD" Non conforming parts:					
<b>Total Quantity Defective Parts found at:</b>		<b>(1). Parts @ OEM</b> Customer = _____ parts		<b>(2). At Nexteer:</b> (a). Nexteer Incoming _____ parts, (b). Partially Asm Nexteer _____ parts, (c). Final Asm Nexteer _____ parts	
<b>Total Qty non-conforming parts returned to supplier:</b>		<b>Total Qty non-conforming parts scrapped at Nexteer:</b>			
<b>Total Qty of Good + Bad parts returned to supplier</b>		<b>Total Qty of Good + Bad parts scrapped at Nexteer</b>			
Breakpoints (when were first and last non-conforming part produced)?					
Total Qty Sorted:		Engineering permit # (if necessary):		Hold Tag #s:	
Notifications (Email or Other):					
Operators/ Team Leaders		Production Mgr		Supplier Quality	
Supervisor/Group Leader		Operations Mgr		PC&L	
Quality Engineer		Metallurgist		Customer Quality Contacts	
Purchased Parts Administration					
PRODUCT CONTAINMENT: IDENTIFY ALL AREAS WHERE SUSPECT PRODUCT COULD BE LOCATED					
LOCATION	POTENTIAL SUSPECT QTY.	QUANTITY SORTED	NON - CONFORMING QTY FOUND?	Comments	
In Manufacturing Cells:					
In Process containers, loaders, trays					
In Shipping:					
In Receiving:					
Outside Processing (plating, etc)					
WIP Storage Area					
Laboratory					
Engineers Desks					
Scrap bins or Scrap areas					
Rework Areas					
Shipping Dock					
In Transit:					
At Heat Treater or Painter					
Induction Hardeners					
Staging Areas (Incoming / Outgoing)					
Service Parts Operations					
Repair or teardown area					
Pilot Build Areas					
Containment / Hold Areas					
Between Departments					
Between Plants					
At warehouse or Distribution center					
At Service Parts					
At Suppliers or sequencers					
At Nexteer					
At OEM Customer					
GP-12 Area					
Teardown					
Update Documents:		Post Quality Alert <input type="checkbox"/>		Layered Process Audit Sheets necessary <input type="checkbox"/>	
List other departments or plants that are possibly at risk and include who was notified?					
Signatures: Originator		Manufacturing Supervisor		Quality Engineer	

Nexteer Plant	Part Number	Part Name and Its Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	OEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted
Inteles # (if applicable)		Detailed Problem Definition:		Before:		After:		
PFMEA Summary		Severity #	Occurrence #	Detection #	RPN #	PFMEA Background information		
3 Legged 5 Why		Picture and Description of Current State		Containment / QA Alert Owner / Target Date		Picture and Description of Corrected State		
Problem Statement:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why was it not detected:				Corrective Actions / Owner / Target Date				
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why did the system allow the problem to occur (what was the weakness in the system):		Corrective Actions / Owner / Target Date						
Why:								
Why:								
Why:								
Why:								
OEM Customer Complaint Number (if applicable)		Affected OEM Customer Locations:		Supplier Name/Location:		Nexteer and / or Supplier Contact Name:		
Supplier Look Across #		Lessons Learned:						

➤ Attach a Containment Worksheet similar to the one above.

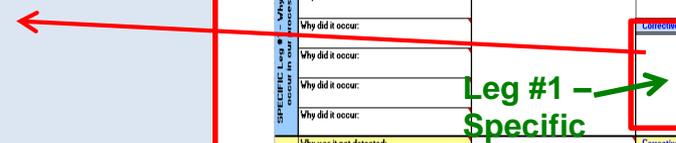
# 3L5Y Excel File → Leg 1 –Corrective Actions (Worksheet #2)

## CORRECTIVE ACTIONS (Specific Problem): Update

documents for this issue including:

- (1). Standard Work Instructions (good & bad visuals)
- (2). Early Production Containment (EPC)
- (3). Set-up procedures
- (4). Drawing updates
- (5). Part ID
- (6). Line Side Reviews
- (7). Daily audits and verification needed.
- (8). Revision control
- (9). Tooling issues/ updates
- (10). Contamination control
- (11). Process Parameter control
- (12). Recreate Defect - How turn on & off?

Nexteer Plant	Part Number	Part Name and Its Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	DEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted
Intelex # (if applicable)		Detailed Problem Definition:						
PFMEA Summary		Severity #	Occurrence #	Detection #	RPN #	PFMEA Background information		
Before:					0			
After:					0			
3 Legged 5 Why		Picture and Description of Current State		Containment / QA Alert Owner / Target Date		Picture and Description of Corrected State		
Problem Statement:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why was it not detected:		Corrective Actions / Owner / Target Date						
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why did the system allow the problem to occur (what was the weakness in the system):		Corrective Actions / Owner / Target Date						
Why:								
Why:								
Why:								
Why:								
DEM Customer Complaint Number (if applicable)		Affected DEM Customer Locations:		Supplier Name/Location:		Nexteer and / or Supplier Contact Name:		
Supplier Look Across #		Lessons Learned:						



Leg #1 - Specific

### ➤ For LEG 1 – Specific Problem – CORRECTIVE ACTIONS:

- Document that you did all 12 items shown in the chart above, if they apply to your problem.
- Expand the 3L5Y to 2 or 3 pages if needed, or, add a worksheet tab.
- For each **CORRECTIVE ACTION:** (1). List action items (2). Owner of corrective action item (3). due date & timing.





# 3L5Y Excel File → Leg 3 – SYSTEMIC Corrective Actions (Worksheet #2)

**CORRECTIVE ACTIONS (Systemic):** Update documents for this issue including:

- (1). PFMEA (severity, occurrence, missed failure modes)
- (2). Process Flow
- (3). Control plan
- (4). Control charts & process monitoring
- (5). Preventive Maintenance increased?
- (6). Layered audits
- (7). Compliance to standardized work
- (8). APQP/Launch process changes
- (9). Change Management & Change control
- (10). Setup, Changeover & Repair instructions
- (11). Policy & Procedures
- (12). System changes
- (13). Training
- (14). Core Design
- (15). Core Process
- (16). PPAP
- (17). Submit a SCR if process/product change required.

**\*\* Note:** Updates to be made by Quality and Mfg Engineering, 3L5Y to be audited by Supplier Senior Mgt.

Nexteer Plant	Part Number	Part Name and Its Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	OEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted
Intellex # (if applicable)		Detailed Problem Definition:						
PFMEA Summary		Severity #	Occurrence #	Detection #	SPN #	PFMEA Background information		
Before:					0			
After:					0			
3 Legged 5 Why		Picture and Description of Current State		Containment	RCA Alert Owner / Target Date	Picture and Description of Corrected State		
Problem Statement:								
Why did it occur:						Corrective Actions / Owner / Target Date		
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why was it not detected:						Corrective Actions / Owner / Target Date		
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why did the system allow the problem to occur (what was the weakness in the system):						Corrective Actions / Owner / Target Date		
Why:								
Why:								
Why:								
Why:								
Why:								
OEM Customer Complaint Number (if applicable)		Affected OEM Customer Locations:		Supplier Sales Offices:		Nexteer and / or Supplier Contact Name:		
Supplier Look Across #		Lessons Learned:						

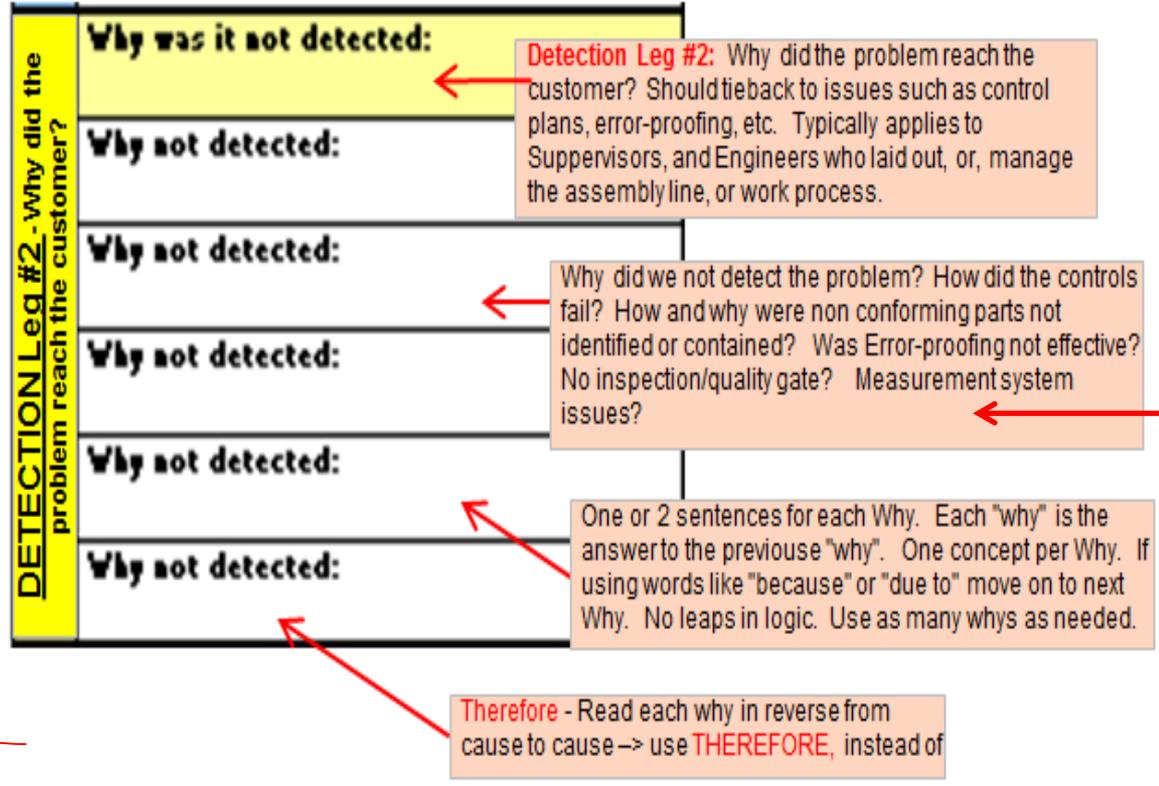
**Leg #3 -Systemic**  
What failed in quality system to allow this to occur?

➤ **For LEG #3 - the SYSTEMIC leg, Corrective Actions:**

- Document that you did all 17 items shown in the chart above if they apply
- Expand the 3L5Y to 2 or 3 pages if needed, or add a worksheet tab
- For each **CORRECTIVE ACTION:** (1). List action items (2). Owner of corrective action item (3). due date & timing.



# 3L5Y Excel File – Leg #2 Cheat Sheet Summary – Detection Leg



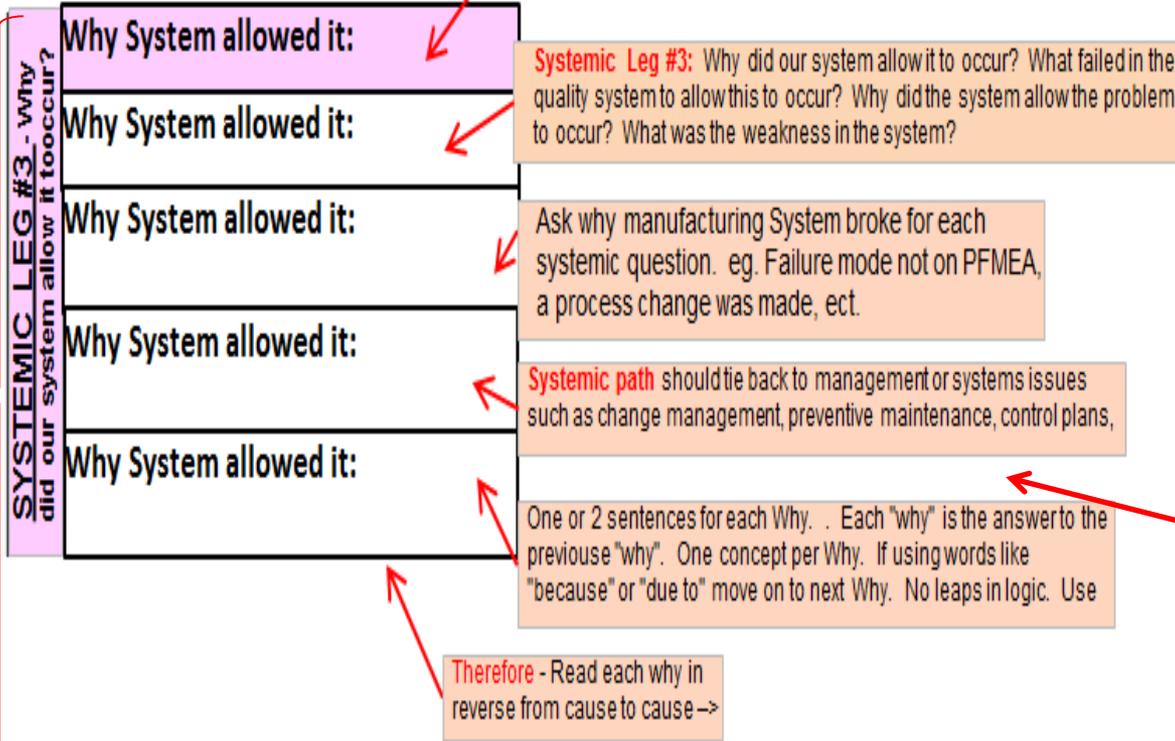
Nexteer Plant	Part Number	Part Name and lot Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	OEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted
Inlets # (if applicable)	Detailed Problem Definition:							
PPMCA Summary	Severity #	Occurrence #	Detection #	RPN #	PPMCA Background information			
Before:				0				
After:				0				
3 Legged 5 Why		Picture and Description of Current State		Containment / QA Alert / Owner / Target Date		Picture and Description of Corrected State		
Problem Statement:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Why did it occur:								
Corrective Actions / Owner / Target Date								
Why was it not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Why not detected:								
Corrective Actions / Owner / Target Date								
Why did the system allow the problem to occur (what was the weakness in the system):								
Why:								
Why:								
Why:								
Why:								
Why:								
Why:								
OEM Customer Complaint Number (if applicable)								
Affected OEM Customer Locations:			Supplier Name/Location:			Nexteer and / or Supplier Contact Name:		
Supplier Look Across #		Lessons Learned:						

**Leg #2 -Detection**  
How and why were non conforming parts not identified or contained?

- The Detection Leg #2 of the 3L5Y should have good flow, and, can be read forewords and backwards.
- Concentrate on why the problem was not detected. Did controls fail, poor error proofing, poor measurement systems?

# 3L5Y Excel File – Leg #3 Cheat Sheet Summary – Systemic Leg

Restate the final root cause from **SPECIFIC leg #1**



Nexteer Plant	Part Number	Part Name and Its Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Nexteer Plant Tracking Number	DEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted						
Intelex # (if applicable)		Detailed Problem Definition:		PFMEA Summary		Severity #	Occurrence #	Detection #	SPN #	PFMEA Background information				
Before:				0										
After:				0										
3 Legged 5 Why			Picture and Description of Current State			Containment			RGA Alert Owner / Target Date			Picture and Description of Corrected State		
Problem Statement:														
Why did it occur:														
Why did it occur:														
Why did it occur:														
Why did it occur:														
Why did it occur:														
Why was it not detected:														
Why not detected:														
Why not detected:														
Why not detected:														
Why not detected:														
Why not detected:														
Why did the system allow the problem to occur (what was the weakness in the system):														
Why:														
Why:														
Why:														
Why:														
Why:														
Why:														
Affected DEM Customer Locations:														
Supplier Name/Location:														
Nexteer and / or Supplier Contact Name:														
Supplier Look Across #														
Lessons Learned:														

**Leg #3 - Systemic**  
What failed in quality system to allow this to occur?

- The Systemic Leg #3 of the 3L5Y should have good flow, and, can be read forewards and backwards.
- Concentrate on how the system broke down – failure mode not on PFMEA, unauthorized change made, preventive maintenance inadequate, ect. Typically a management issue.

# 3L5Y Excel File – How to Handle problems with Multiple Root Causes

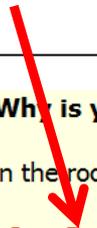
- The Pop Ups below explain how to handle problems with multiple root causes, and corresponding corrective actions.
- The next page will give an example of a multiple root cause numbering method – use if at one site.
- Use multiple 3L5Y's if problem is at multiple sites.

**The Corrective Actions "Specific" should include all the following that apply to your 3L5Y:**

- List all Actions taken to fix the problem
  - Each action should have the owners name and target completion date.
- Please look at the **"Cheat Sheet Details"** worksheet tab to make sure you did everything that apply to your 3L5Y listed under **"Corrective Actions - Specific"**
- List everything you updated - work instructions, drawings, etc.
- The corrective actions must be irreversible and implemented in a timely manner.
- Note:** If your problem has more than one root cause, with each root cause numbered, then the **corrective action numbering system** should match the root cause numbering system. See Nexteer's training for example of **multiple root cause** and corresponding **corrective action** numbering system.

Nexteer Plant	Part Number	Part Name and for Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council	Next Tr N
Intelix # (if applicable)	Detailed Problem Definition:				
PFMEA Summary	Severity #	Occurrence #	Detection #	RPN #	
Before:				0	
After:				0	
3 Legged 5 Why		Picture and Description of Current State		Containment / QA Alert / Owner / T	
Problem Statement:					
Why did it occur:					
Why did it occur:				Corrective Actions / Owner / Target Date	

SPECIFIC Leg #1 - Why did it process?



- The last 5Why is your ROOT CAUSE.**
- Can you turn the root cause on and off? If not, you did not find the real root cause.
- More than One Root Cause?** If you have multiple root causes **all at Nexteer**, then you can number the root causes, and only fill out one 3L5Y. See Nexteer training manual for handling multiple root causes within Nexteer.
- If you have multiple root causes, that have occurred across different organizations**, then multiple 3L5Y's are needed. See Nexteer training manual.
  - Create a 3L5Y Excel worksheet tab for each Root Cause.
  - Label the worksheet tabs "3L5Y Nexteer", and "3L5Y Supplier #1". Ask the Nexteer Quality Engineers, or, SQE's for advice if you have any questions.



# 3L5Y Excel File – Problems with Multiple Root Causes - Numbering Example

Nexteer Plant	Part Number	Part Name and/or Process Name	Date of Occurrence	Formal Customer Complaint (FCC), and/or, Product Safety & Compliance Council (PSCC)	Nexteer Plant Tracking Number	OEM Customer	FCC Qty Pcs found at OEM	Date 3L5Y Submitted
Nexteer Plant 8- Saginaw, MI	38202929	I-Shaft Yoke Asm / Yoke Stake Operation	1/22/2016	32455	FCC	Ford - Lansing Asm	1	06Jun2016
<b>InteleX # / eQMS CA #</b>	<b>Problem Definition:</b> On March 30, 2016, Ford's Lansing Assembly plant 2, on second shift, found one Bronco steering column with a missing stake on the I-shaft yoke. The I-shaft felt loose to the Ford assembly line operator, and almost came apart in his hands. The I-shaft asm was returned to Nexteer's Plant 8, in Saginaw, MI, along with a formal complaint.							
1234567								
<b>CN #, if applicable</b>	<b>PFMEA Summary</b>	<b>Severity #</b>	<b>Occurrence #</b>	<b>Detection #</b>	<b>RPN #</b>	<b>PFMEA Background information</b>		
NA	<b>Before:</b>	9	3	3	81	The PFMEA has been reviewed and updated by a cross functional team involving both Nexteer and Ford personnel.		
	<b>After:</b>	9	4	4	144			
<b>3 Legged 5 Why</b>		<b>Picture and Description of Current State</b>		<b>Containment / QA Alert/ Owner / Target Date</b>		<b>Picture and Description of Corrected State</b>		
DETECTION Leg #2 -Why did problem reach customer?	<b>Why was it not detected:</b> OP10 T21 missed the yoke staking			<b>Corrective Actions / Owner / Target Date</b>				
	<b>Why was it not detected:</b> 1. There was no detection in place to detect miss operation or missing stake 2. Operator running visual check on GP12 didn't detect missing stake on this part							
	<b>Why not detected:</b> 1. The Chery T21 shaft has paint coat and the standard traceability via label could not be used, and the CCD (camera) was not implemented on this application 2. Records show that the Operator was caught being distracted during his work. Additionally, it was noticed that the light intensity was not optimum at the GP12 station.							
	<b>Why not detected:</b> 2. Team leader didn't take actions when the operator was first found not performing his job adequately							

**Example:** multiple Root Causes numbered -> 1 and 2.

**Example:** corresponding corrective actions numbered 1.1, 1.2, AND 2.1, 2.2.



# 3L5Y Excel File – PFMEA Summary & Lessons Learned

PFMEA Summary	Severity #	Occurrence #	Detection #	RPN #	PFMEA Background information
Before:	See the Detection, Severity, and Occurrence worksheet tabs below, in this Excel file to fill out this section.			0	
After:				0	

3L5Y - Blank Master	1 Pg - Cheat Sheet	Cheat Sheet Details	Containment Worksheet	Supporting Documents	Detection	Severity	Occurrence	Product Severity Rank	Revision tracker
---------------------	--------------------	---------------------	-----------------------	----------------------	-----------	----------	------------	-----------------------	------------------

OEM Customer Complaint Number (If applicable)	Affected OEM Customer Locations:	Supplier Name/Location:	Nexteer and / or Supplier Contact Name:
Supplier Look Across #	<b>Lessons Learned:</b> Document what should be communicated as Lessons Learned, Within the plant, Across plants, At the supplier, At the Customer.		

Nexteer Plant	Part Number	Part Name and / or Process Name	Date of Occurrence	Formal Customer Complaint (PCO, webto, Product Safety & Compliance Council)	Nexteer Plant Tracking Number	OEM Customer	FCC Qty of Pcs in the complaint	Date 3L5Y Submitted
		Detailed Problem Definition:						
		PFMEA Summary	Severity #	Occurrence #	Detection #	RPN #	PFMEA Background information	
		Before:				0		
		After:				0		
		3 Logged Why	Picture and Description of Current State		Customer: Ask Nexteer (Target Date)	Picture and Description of Corrected State		
		Why did it occur:						
		Why did it occur:						
		Why did it occur:						
		Why did it occur:						
		Why did it occur:						
		Why was it not detected:						
		Why not detected:						
		Why not detected:						
		Why not detected:						
		Why not detected:						
		Why not detected:						
		Why did the system allow the problem to occur (what was the weakness in the system):						
		Why:						
		Why:						
		Why:						
		Why:						
		Why:						
		Why:						
		OEM Customer Complaint Number (If applicable)	Affected OEM Customer Locations:	Supplier Name/Location:	Nexteer and / or Supplier Contact Name:			
		Supplier Look Across #	Lessons Learned:					

- PFMEA Summary values should meet AIAG requirements and a Risk Priority Number (RPN) should be calculated (see PFMEA Worksheet tabs).
- Write a logical Lessons Learned statement for the issue. For Nexteer users, your lessons learned may be updated by a APQP and placed into Nexteer’s eQMS system.



# 3L5Y Excel File – Pop Up’s – Problem Definition vs Problem Statement

- Both the Problem Definition, and, the Problem Statement, should be filled out by the complaint issuer. If not, please contact the complaint issuer to help you fill them out. Regardless of who fills them out, they must meet Nexteer guidelines, or your 3L5Y will be rejected.

Remember the **Problem Definition** should **not** have any **causes** in it!!!  
 \*\* Do **NOT** use any **Acronyms!!!** You may know what it means, but no one else does.

**The Problem Definition should include:**

**(1). Who found it?**  
*Example* - Nexteer plant 7, dept 31, on 2nd shift by line assembler Mike Jones. *Example* - GM's Lordstown assembly plant quality control dept.

**(2). When was it identified?**  
*Example:* On October 21, 2016, at 10 AM, a cracked steering column was found by Ford's Lansing asm plant's quality manager, during a routine test drive.

**(3). How was it detected?**  
*Example:* GM's quality department found 3 Nexteer steering columns that would not tilt and tele at Oshawa plant 5, assembly line 2.

**(4). How many? Frequency?**  
*Example:* 23 cracked rake brackets, part number 26039212, were found in one box. The box has serial number 29234 written on it, and is from Continental castings.

**Good EXAMPLE with WHO, WHEN, HOW combined:**  
 \*\* On March 21st, Nexteer plant 6, dept. 23, on 2nd shift, found three rake brackets, part #28271777, with broken mounting pads, that prevented the columns from being assembled correctly.  
 \*\*\*NOTE: **Your PC WILL BE REJECTED if you have a poor problem statement!!**  
 \*\*Note #2: The wording does not have to be exactly like the OEM customers description.

Intelix # (if applicable)	Detailed Problem Definition:				
	Severity #	Occurrence #	Detection #	RPN #	PFMEA Background information
PFMEA Summary					
Before:				0	
After:				0	
3 Legged 5 Why		Picture and Description of Current State		Containment / QA Alert/ Owner / Target Date	Picture and Description of Corrected State
SPECIFIC LEG #1 – Why did it occur in our process?	Problem Statement:				
	Why did it occur:				
	Why did it occur:				
	Why did it occur:				
	Why did it occur:				
	Why did it occur:				
DETECTION LEG #2 – Why did problem reach customer?	Why was it not detected:				
	Why not detected:				
	Why not detected:				
	Why not detected:				
	Why not detected:				
	Why not detected:				
SYSTEMIC LEG #3 – Why did system allow problem to occur?	Why did the system allow the problem to occur (what was the weakness in the system):				
	Why:				

**Problem Statement MUST be completed by Complaint Issuer:**

**(1).** A problem statement is the description of an issue currently existing that needs to be addressed. It should answer "what is the problem", and, have enough detail to establish why it is important.

**(2).** Describe a part defect with as much detail as possible -> a broken feature, a diameter issue, a surface imperfection, hardness out of specification, missing weld, etc.

**(3).** Remember to include a **picture** of the **Problem Statement**, in the "Picture and Description of current state".

**Examples:**

(a). Nexteer received 100 heat treated halfshafts with a core hardness of 40 Rc, however, the max allowable is 30 Rc.

(b). Nexteer found three rake brackets, part #28271777, with broken mounting pads.





# Results of using Cheat Sheet -> A Good 3L5Y

## Bad 3L5Y Example

## Good 3L5Y Example

Poor problem statement, and many items not filled out.

The "After" Risk Priority Number (RPN) missing

Poor Containment and not enough Corrective actions

3L5Y's did not dig deep enough. Stopped half way.

Not enough pictures. No after pictures

Plant	Part Number	Product/Process Name	Date of Occurrence	Look Across #	Type of Look Across (Warranty or WFOC)	Customer	Plant Tracking number	Date 3L5Y Written
7	38009529		2/15/2016		Customer Complaint	Wheatville		
<b>Problem Definition:</b> Bolts loose								
<b>CH #, If Applicable:</b>	<b>PFMEA Summary</b>	<b>Severity #</b>	<b>Occurrence #</b>	<b>Detection #</b>	<b>RPN #</b>			
CN 409277	Before:	7	3	3	63			
CN 403325	After:							
<b>3 Legged 5 Why</b>		<b>Picture of Current State</b>	<b>Corrective Actions / Owner / Target Date</b>			<b>Picture of corrected state</b>		
<b>Problem Statement:</b> Wheatville Assembly received a 680 gear assembly with loose valve cover bolts.			<b>Containment Actions:</b> Quality Alert 7-18-162 Posted for operator awareness and containment certification. Complete Date: 2/15/16 @ 3/4/16 Y. Pruitt					
<b>Why did it occur:</b> The bolts were not torqued.			<b>Containment Worklist:</b>					
<b>Why was it not detected:</b> Gear returned for loose bolts.			<b>Corrective Actions / Owner / Target Date:</b>					
<b>Why not detected:</b> Rejected gear was allowed to enter the unload station.			<b>Lessons/Learned:</b> Updated LA for GLTLDE Complete Date: 6.3.16 Y. Pruitt					
<b>Why not detected:</b>			Added Photo Eye with back check detection to prevent any type of reject from being sent around the line. Complete Date: 6-3-16 C. Cameron					
<b>Why not detected:</b>								
<b>Why not detected:</b>								
<b>Systemic root cause:</b> Gear returned for loose bolts			<b>OCPS14400126</b> Updated OCP with new documents Complete Date: 6.13.16 C. Cameron					
<b>Systemic root cause:</b> Downstream pallet tracking switch was faulted in "good" position.								
<b>Systemic root cause:</b>								
<b>Systemic root cause:</b>								
<b>Systemic root cause:</b>								
<b>Customer Problem Case Number:</b> N/A		<b>Affected Customer Locations:</b> Wheatville Assembly	<b>Supplier Location:</b> Nestor Plant 7	<b>Contact Name:</b> Yolanda Pruitt				
<b>Lessons Learned:</b> Follow Teardown Procedure								

Everything filled out

PFMEA updated, after RPN# lower than before RPN#

Good Containment and Corrective actions

Good whys on all 3 legs

Good Pictures before and after

Plant	Part Number	Product/Process Name	Date of Occurrence	Look Across #	Type of Look Across (Warranty or WFOC)	Customer	Plant Tracking number	Date 3L5Y Written
7	38009529	680 Integral Gear	2/15/2016		Customer Complaint	Wheatville	7-61198	2/22/2016
<b>Problem Definition:</b> Customer received a 680 gear assembly with loose bolts on valve housing								
<b>CH #, If Applicable:</b>	<b>PFMEA Summary</b>	<b>Severity #</b>	<b>Occurrence #</b>	<b>Detection #</b>	<b>RPN #</b>			
CN 409277	Before:	7	3	3	63	Updated to include mis-routed pallet as a potential cause of loose bolts.		
CN 403325	After:	8	2	2	32			
<b>3 Legged 5 Why</b>		<b>Picture of Current State</b>	<b>Corrective Actions / Owner / Target Date</b>			<b>Picture of corrected state</b>		
<b>Problem Statement:</b> Wheatville Assembly received a 680 gear with loose valve cover bolts.			<b>Containment Actions:</b> Quality Alert 7-18-162 Posted for operator awareness and containment certification. Complete Date: 2/15/16 @ 3/4/16 Y. Pruitt					
<b>Why did it occur:</b> The bolts were not torqued.			<b>Containment Worklist:</b>					
<b>Why did it occur:</b> A gear was correctly routed to the reject loop for a bolt torque failure. However, was manually routed by an operator to the wrong station. (Operator pushed the wrong button in the reject loop)			<b>Corrective Actions / Owner / Target Date:</b> Maintenance replaced defective pallet from RFID reader. Complete Date: 5.31.16					
<b>Why did it occur:</b> Controls failed allowing a mis-routed part to go to the unload.			<b>Document Created:</b> Create Standard Work Instructions for Teardown Loop Complete Date: 6.13.16 M. J. Popper, Chris H.					
<b>Why was it not detected:</b> Gear returned for loose bolts.			<b>Lessons/Learned:</b> Updated LA for GLTLDE Complete Date: 6.13.16 Y. Pruitt					
<b>Why not detected:</b> A rejected gear was allowed to enter the unload station.			Added Photo Eye with back check detection to prevent any type of reject from being sent around the line. Complete Date: 6-3-16 C. Cameron					
<b>Why not detected:</b> Reject loop had no method to detect faulty controls, which verify proper pallet tracking.			<b>AUMS14400014</b> Enhanced Final Inspection Instructions Complete Date: 3.4.16 Y. Pruitt					
<b>Why not detected:</b>								
<b>Why not detected:</b>								
<b>Systemic root cause:</b> Gear returned for loose bolts			<b>OCPS14400126</b> Updated OCP with new documents Complete Date: 6.13.16 C. Cameron					
<b>Systemic root cause:</b> Downstream pallet tracking switch was faulted in "good" position.								
<b>Systemic root cause:</b> There was no EP defined to verify controls and pallet tracking.								
<b>Systemic root cause:</b>								
<b>Systemic root cause:</b>								
<b>Systemic root cause:</b>								
<b>Customer Problem Case Number:</b> N/A		<b>Affected Customer Locations:</b> Wheatville Assembly	<b>Supplier Location:</b> Nestor Plant 7	<b>Contact Name:</b> Yolanda Pruitt				
<b>Lessons Learned:</b> Follow Teardown Procedure inside Loop to prevent suspect parts from escaping our process								



# Summary of New Items on the updated 3L5Y Excel File

- A one page 3L5Y “Cheat Sheet”, that will be a fast easy reference sheet to make sure you filled everything out. Pop up comments added to the 3L5Y Excel sheet will also help users to fill it out correctly.
- A worksheet tab called “Containment Worksheet”. Users can use this generic form, or, replace it with the form they used for containment.
- A worksheet tab called “Supporting Documents”, that the user may want to include to support your problem solving efforts.
  - Additional Pictures of corrections made, DOE’s, Component Swap results, Error proofing added, Die Changes made, etc, etc.
- You can contact Nexteer’s Quality, I&CIM, or GSM departments if you have any questions about filling out the 3L5Y



# 3L5Y – Resources and References

- Procedure G1738 – Corrective and Preventive Action
  - Describes the Nexteer Problem Solving Process requirements
  - Guidelines for when to use 5 Why Analysis
  - 5 Why Training material
  - Flow diagram of Look Across process
- Nexteer Business System Manual
  - Section 5 – Problem Solving
- Nexteer’s Look Across process is described in:
  - Process Map 15-1-3-7 Lessons Learned & Look
- Global Supply Management – Supplier Quality – F1043
  - Nexteer.com Supplier portal -Training Material for 5 Why Analysis
- Customer sites (Problem Solving Training)
  - Fiat Chrysler eConnect Supplier Portal
  - Ford – Covisint Portal
  - General Motors – Covisint Portal
- AIAG Problem Solving Guide
- ASQ - American Society of Quality

# **APPENDIX –**

## **ADDITIONAL 5 WHY EXAMPLE**

# 3L5Y – Finding the “Root Cause”

A good example:

Thomas Jefferson Memorial – Washington, DC, USA



- The National Park Service noticed the Thomas Jefferson Memorial in Washington, D.C., was deteriorating faster than other monuments.
- Park service rangers investigated the problem using a **5 Why** and formed the following chain of causes.

**nexteer**  
AUTOMOTIVE

## • Thomas Jefferson Memorial Example

- Why does the memorial deteriorate faster?
  - Because it gets washed more frequently
- Why is it washed more frequently?
  - Because it receives more bird droppings
- Why are there more bird droppings?
  - Because more birds are attracted to the monument

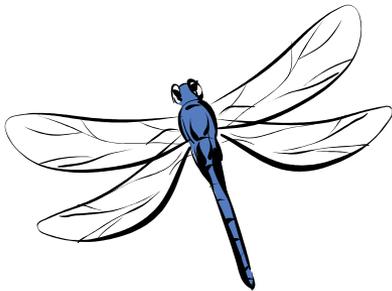


## • Thomas Jefferson Memorial Example

- Why are more birds attracted to the monument?
  - Because there are more fat spiders in and around the monument
- Why are there more spiders in and around the monument?
  - Because there are more tiny insects flying in and around the monument during evening hours
- Why are there more insects?
  - Because the monument illumination attracts more insects.

## ■ Thomas Jefferson Memorial Example

- The causes could be expanded. They could try to determine why illumination attracts insects. But could a solution to that be within their control?



Probably not

## ■ Thomas Jefferson Memorial example

- So why couldn't they stop and consider one of the previous causes as the root cause and address with corrective action?
  - Bird droppings – coat monument with water resistant substance to allow frequent wash
  - Spiders – use pesticides to remove or experiment with different lighting that is less attractive to insects
- So why not consider these? Would these be feasible?

Possibly – but there are other causes/actions that should be considered

## • Thomas Jefferson Memorial Example

- Park service rangers decided to address the monument illumination as root cause
  - Monument illumination attracts more insects
- Corrective action
  - Turn on lighting one hour later in the evening
- Measure of effectiveness
  - Bird dropping problem reduced by 90%!

