NON-CONFORMITY MANAGEMENT

PR	WHQ_IMS_PR009	WHQ	IMS	05	02/10/2018	EN
Type	Code	Site	Process	Revision	Issue date	Language

WITTUR

SCOPE

This procedure define and standardize the criteria and the process to put in place in case of a system, process, product non-conformity or HSE related issues (Property Damage, Reportable Injuries, First Aid & Near Miss) by including the tools and actions explanation.

APPLICATION

All Wittur Group Sites & Processes (included products).
Exceptions: safety components, lift components that caused an accident or that potentially can cause it are managed by another document:
[WHQ_IMS_PR014] Wittur Product Safety Risk Management

RESPONSIBILITY

PROCESS OWNER

Global HSEQ Director

CORPORATE

HSEQ Corporate Team shall:

- verify the correct application of the procedure
- approve the containment and corrective actions for critical non-conformities
- manage the meetings to root causes analysis like 8D calls

LOCAL NEEDS

HSEQ Local coordinates the activities related to:
Containment and corrective actions of non-conformity generated internally.
In particular it:

- Applies the rules established by Corporate for the management of NC's;
- Properly records data of the non-conformity;
- Inform, set & attend the 8D meetings to discuss and present root cause analysis.

REFERENCE DOCUMENTS

NORMS	ISO 9001:2015 ISO 14001:2015 ISO 45001:2018
PROCEDURES	[WHQ_IMS_PR014] Wittur Product Safety Risk Management [WHQ_SQD_MAN001] Supplier Quality Manual
INSTRUCTIONS	IN001[WHQ_IMS_PR009] SharePoint HSEQ website
FORMS	FR003 [WHQ_IMS_PR009] Wittur 8D Tool

DATE	REV.	DESCRIPTION OF CHANGE	EDITOR	VERIFIER	APPROVERS
2017-07-25	00		Cadei M.	/	Verri P.
2018-01-29	01	Addition of category types (Annex 1)	Scarpellini M.	/	Lolli A.
2018-02-27	02	8D Forms Revised NC Rules Revised	Scarpellini / Lolli (HSEQ Systems)	Lolli (HSEQ Systems Manager)	Uzunkavak E. (Quality Corp. Manager) Sevincli A. (HSE Corp. Manager)
2018-07-30	03	New procedure form, flow chart included, NC rules reviewed with problem solving tools related.	''	''	''
2018-08-02	04	Changed Par. 3 - "NC MANAGEMENT TIMELINE" HSE	''	''	''
2018-10-02	05	Changes Par. 3 - "NC MANAGEMENT TIMELINE" Rev.5	Scarpellini / Lolli (HSEQ Systems)	Lolli (HSEQ Systems Manager)	''

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0. TERMS AND DEFINITIONS

Acronyms

(CC) Customer Claim: complaint from the customer.
(IN) Internal non conformity: all the issues quality related detected before the shipment to the customer.
(FAI): First Aid Injury.
(RI): Reportable Injury.
(PD): Property damage.
(NC) Non-conformity: non-fulfilment of a requirement that affect the customer and Wittur satisfaction. It could be related to quality (CC, IN, Suppliers), HSE (near misses, FAIs, RI, PD) or to others dept.
(CT) Containment action: action to eliminate a detected non-conformity.
(RC) Root Cause: origin of the issue inside the analysed process.
(CA) Corrective action: action to eliminate the cause of a non-conformity and to prevent recurrence.
(SMART): Specific, Measurable, Achievable, Relevant, Time-bound.
(HSEQ): Health, Safety, Environment, Quality.
(LQM): Local HSEQ Manager

Standard Terms

Requirement: need or expectation that is stated, generally implied or obligatory.
Process: set of interrelated or interacting activities that use inputs to deliver an intended result.
Output: outgoing info by a process.
Stakeholders: Wittur sites and corporate functions, Customers, Suppliers, other interested parties.
FAI: Are defined as any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor work related injuries, which do not ordinarily require treatment by a medical professional (even if at the moment are made by medical professional). After the medical treatment, the operator can returns to work (on the same day).
RI: reportable injury is any work related injury or illness which requires treatment from a medical professional.
PD: Any intentional damage and not property of Wittur Group such as damage or breakage of: products, machinery, means of transport and work, real estate, roads, processing plants, tools etc.

Tool

Traffic lights: visual communication to all employees and visitors showing actual Safety, Quality and Delivery performance status.

Products

Safety components: all the components included in the LD 2014/33/EU, EMC 2014/30/EU, LVD 2014/35/EU and to which the NC are managed with the procedure reference: [WHQ_IMS_PR014] Wittur Product Safety Risk Management:

LD 2014/33/EU	EMC 2014/30/EU	LVD 2014/35/EU
▪ Safety components (which need to be CE marked) ▪ Landing door locks ▪ Over-speed governors ▪ Hydraulic safety valves (Rupture valves) ▪ Buffers (Energy accumulation/dissipation type buffer) ▪ Safety gears ▪ UCM devices	▪ Door drive ▪ Light Sensor System ▪ EOS ▪ Electric drives ▪ Inverter ▪ Controller/E-Pack	▪ Electric drives ▪ Brakes ▪ Encoder ▪ Hydraulic drive ▪ Switches

1. FOREWORD

This procedure defines how to manage a non-conformity (CC or IN) in accordance with ISO 9001:2015, ISO 14001:2015 and 45001:2018. It set out actions to be taken to:

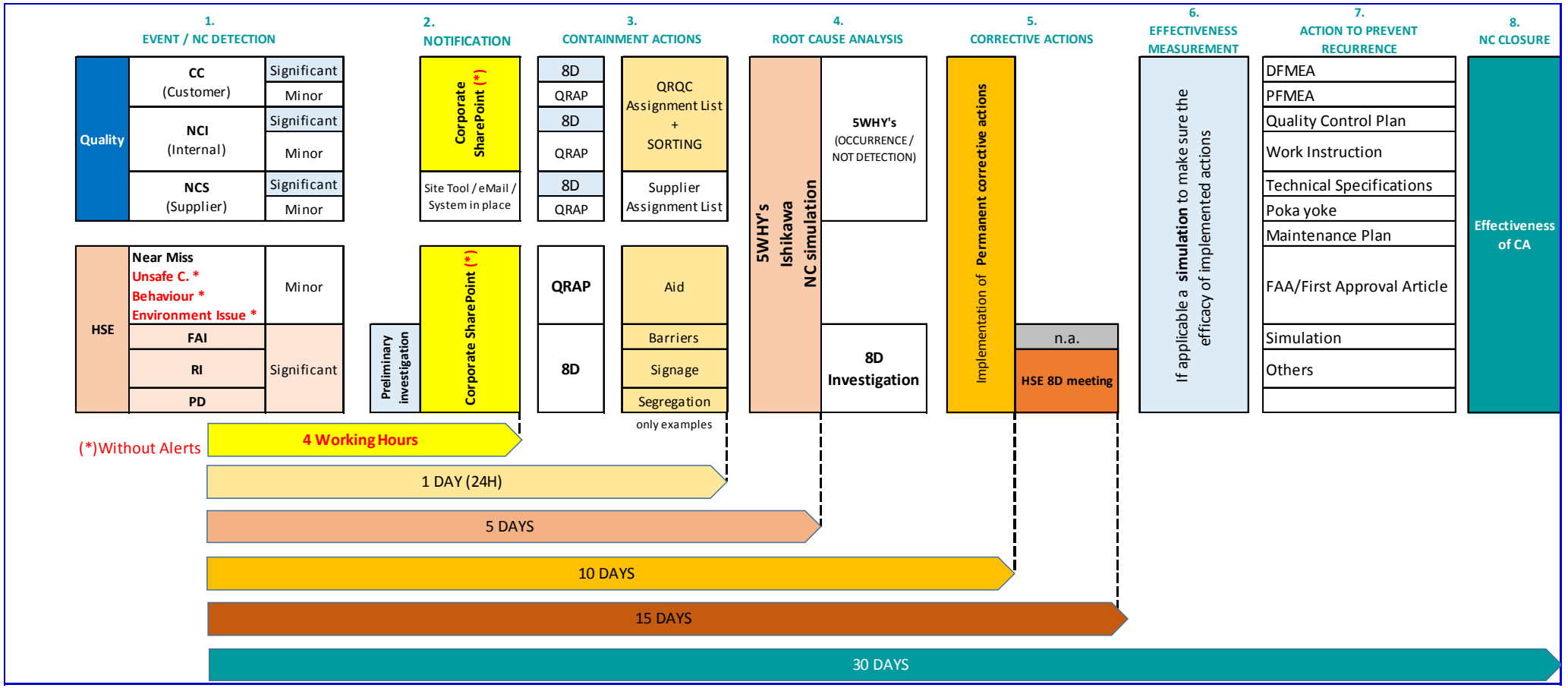
- ✓ React to the non-conformity, and as applicable:
  - take action to control and contain it.
- ✓ Evaluate the need for action to eliminate the root causes, in order that it does not recur or occur elsewhere, by:
  - reviewing and analysing the non-conformity;
  - determining the causes of the non-conformity;
  - determining if similar non conformities exist, or could potentially occur;
  - Implement any corrective action evaluated and needed.
- ✓ Review the effectiveness of any correctives actions taken;
- ✓ Share the best practices with the other Plants.

2. RESPONSIBILITY, INPUT, OUTPUT

ACTIVITY	RESPONSIBLE	SUPPORT
1. EVENT OCCURRING / NC DETECTING / CLAIM RECEIVING	Who detect the NC	LQM
2. NC ALERT	LQM	HSEQ Team
3. PROBLEM DESCRIPTION	Working team	LQM
4. CONTAINMENT ACTION	Working team	Key people in the entire supply chain
5. ROOT CAUSE ANALYSIS	Working team	LQM + Depts. involved
6. PERMANENT CORRECTIVE ACTIONS	Dept. where NC was imputed	LQM + Depts. involved
7. EFFECTIVENESS OF PERMANENT CORRECTIVE ACTIONS	Working team	LQM
8. ACTION TO PREVENT RECURRENCE	Working team	LQM + Depts. involved
9. TEAM RECOGNITION AND 8D CLOSURE	Plant Manager	Working team

3. NC MANAGEMENT TIMELINE (Rev. 5)

NC Management timeline.xlsx



3.1. EVENT OCCURRING / NC DETECTING / CLAIM RECEIVING

DIRECT RESPONSIBILITY	Who detect the NC				
SUPPORT FUNCTION	LQM				
INPUT	▪ product and manufacturing requirements ▪ potential non-conformity				
ACTIVITY DESCRIPTION	A potential quality non-conformity can be found by local functions, corporate functions, customer, national authorities and supplier during the main following cases: ▪ during material incoming inspection; ▪ measuring/testing of products; ▪ during an audit; ▪ receiving a customer claim or a notification; ▪ Others. Who detect it shall to notify the HSEQ team in order to form a proper working team for investigation and root cause analysis. After verification about an effective deviation all the countermeasures will be taken and the workflow goes ahead. Otherwise the working team will reject the notification and close the case. For HSE incidents and near misses, all the witnesses and key people in the event's area must be involved to investigate the event occurred.				
OUTPUT	NC declaration				
REFERENCE DOC	FR002_[WHQ_IMS_PR010] QRAP				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐ 🖹
	QRAP opening	LQM	LQM	5 years	☐

3.2. NC ALERT (Rev. 5)

DIRECT RESPONSIBILITY	LQM				
SUPPORT FUNCTION	HSEQ Team				
INPUT	Data collection				
ACTIVITY DESCRIPTION	The HSEQ Team shall evaluate the non-conformity severity through the association of traffic lights criteria. After the collection of the minimum info requested for alert sending, the identified responsible person will upload and save the NC into HSEQ SharePoint website. An email will be automatically sent to all interested parties after saving. Time for alert sending: **within 4 hours from the detection**[1]**.** *Non conformities detected during performing an Audit must be categorized in compliance with the respective checklist and are not included inside the alert system.*				
OUTPUT	▪ NC records in SharePoint ▪ HSEQ Alerts				
REFERENCE DOC	IN001[WHQ_IMS_PR009]_SharePoint HSEQ website				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐ 🖹
	/	HSEQ Team	SharePoint	5 years	☐

3.3. PROBLEM DESCRIPTION

DIRECT RESPONSIBILITY	Working team
SUPPORT FUNCTION	LQM
INPUT	Data collection
ACTIVITY DESCRIPTION	The working team previously stated shall fulfil the sections **D1** and **D2** of the 8D Tool through 5W2H methodology. The task involves the usage of two different tools depending on the ambit on which the NC raised: ▪ Quality NC -> FR002_[WHQ_IMS_PR010] QRAP ▪ HSE NC -> Safety Investigation Afterwards diagrams or pictures about comparison between bad and good parts must be attached to better illustrate the NC defect/type. For HSE is enough to show with pictures the dynamic of the incident/PD occurred and the related body part injured.
OUTPUT	D1 and D2 Section:

[1] In case the issue is detected at the "end of the shift" or at the end of the working day it shall be transmitted within the first 2 hours of the following working day shift.

	▪ Working Team with in charge the analysis ▪ Problem description (5W2H)				
REFERENCE DOC	FR002_[WHQ_IMS_PR010] QRAP FR003_[WHQ_IMS_PR009] 8D Tool				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐ 🖹
	QRAP D1 + D2 of 8D Tool	Working team	LQM	5 years	☐

3.4. CONTAINMENT ACTION

DIRECT RESPONSIBILITY	Working team				
SUPPORT FUNCTION	Key people in the entire supply chain				
INPUT	D2 Section ▪ Problem description through two points of view: Customer/operator and Wittur ▪ Bad/good part (quality) ▪ Incident area/Body part injured (HSE)				
ACTIVITY DESCRIPTION	Non-conformed parts must be identified and treated belonging all the supply chain. Relative section to be fulfilled for containment actions is **D3** of the 8D tool. Time for closing: **Mandatory within 1 day (24 hrs)** Sorting activity is always mandatory for quality issues both minor as critical and must be weighted basing on the severity of the NC detected. Afterwards the both Learning lesson sections (sorting and final) are fulfilled to learn which have been the weaknesses that lead to the NC. ⚠ It is mandatory to set the 8D call meeting by Skype within 15 days after reportable injury or property damage occurred.				
OUTPUT	D3 Section: ▪ Lesson learned ▪ Reassured customer				
REFERENCE DOC	FR003_[WHQ_IMS_PR009] 8D Tool				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐ 🖹
	D3 of 8D Tool	Working team	LQM	5 years	☐

3.5. ROOT CAUSE ANALYSIS

DIRECT RESPONSIBILITY	Working team				
SUPPORT FUNCTION	LQM + Depts. involved				
INPUT	▪ Problem description (D2) ▪ Containment actions and lesson learned (D3)				
ACTIVITY DESCRIPTION	NC root cause analysis is addressed in section **D4** of the 8D tool and must be performed through a strong methodology such as: 5 WHYs and Ishikawa Fishbone Diagram. The purpose is to identify the root cause(s) to be eliminated in order to avoid the recurrence of same NC or happening of similar cases. Time for root causes identification: **5 days since NC detection.** If needed, a simulation of the NC could help to make sure that the identified cause is the real one. This involves a reproduction of the situation to observe all the factors that affected the part/process compromised.				
OUTPUT	Root causes identified				
REFERENCE DOC	FR002_[WHQ_IMS_PR010] QRAP FR003 [WHQ_IMS_PR009] 8D Tool				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐ 🖹
	D4 of 8D Tool	Working team	LQM	5 years	☐

3.6. PERMANENT CORRECTIVE ACTIONS

DIRECT RESPONSIBILITY	Dept. where the NC was imputed
SUPPORT FUNCTION	LQM + Depts. involved
INPUT	Root causes (D4)

ACTIVITY DESCRIPTION	The working team has to set an action plan to fix and monitor all the improvements and corrections deemed necessaries to completely eliminate the root causes previously identified. Each actions' responsible is the guarantor of the actions' success. The section to be fulfilled for permanent corrective action plan is the **D5** of the 8D tool. The goals to be achieved must be based on the SMART concept. Time for implementation: **10 days since NC detection.**				
OUTPUT	Action plan				
REFERENCE DOC	FR003 [WHQ_IMS_PR009] 8D Tool				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐ 🖹
	D5 of 8D Tool	Working team	LQM	5 years	☐

3.7. EFFECTIVENESS OF PERMANENT CORRECTIVE ACTIONS

DIRECT RESPONSIBILITY	Working team				
SUPPORT FUNCTION	LQM				
INPUT	▪ Goals set (SMART) ▪ Criteria for success ▪ Action plan (D5) ▪ Evidences (Before/After)				
ACTIVITY DESCRIPTION	The working team shall verifies the effectiveness of the corrective actions through a prefixed criteria by compiling the section **D6** of 8D tool. If the obtained results have met the expectations, HSEQ Team confirms the effectiveness of the realized actions; otherwise it describes the reasons of a negative outcomes and define a new action plan. The LQM (or a deputy), in case of RI and PD, shall: ▪ Set a call to discuss the corrective actions implemented within 15 working days; ▪ Upload the compiled 8D report in SharePoint as attachment of the respective accident alerted, at least two days before the meeting. Time to realize the HSE 8D meeting: **15 days since NC detection.** *Structure of the 8D Call:* ▪ ***Participants of 8D call**: Corporate HSEQ Director, Corporate HSE Manager, Corporate Quality Data analyst & Reporting, Plant Manager and Managing Director (if available), Local HSE Manager, Related Dept. Manager, Supervisor of the area and operator (if available), Human Resources Regional reference, area supervisor and Head of dept.* ▪ ***Roles and responsibilities**: Local HSE Manager is the support function to start investigation and to lead root cause analysis. During the call related department is responsible to describe what happened during the accident and what are the agreed actions that department is going to take and follow.* ▪ *LQM has a disposition 30 days by the incident occurred to **track the actions completion and verification**. After all process completion LQM will share 8D with plant manager for his/her signature.*				
OUTPUT	▪ Score ✓ Successful ✓ Unsuccessful (Action plan to be reviewed for new implementation – come back 3.5-3.6)				
REFERENCE DOC	FR003 [WHQ_IMS_PR009] 8D Tool.				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐ 🖹
	D6 of 8D Tool	Working team	LQM	5 years	☐

3.8. ACTION TO PREVENT RECURRENCE

DIRECT RESPONSIBILITY	Working team				
SUPPORT FUNCTION	LQM + Depts. involved				
INPUT	▪ Corrective actions realized with evidences of effectiveness (D5+D6) ▪ Input on similar cases and situations (place, process, product etc.)				
ACTIVITY DESCRIPTION	The working team has to ensure to avoid the repetition of the same or similar NC by putting in place the opportune studies and countermeasures. Shall be taken into account all the similar situations / scenarios that lead to recurrence. Different techniques and methodologies shall be applied for the deep analysis and process Verification: ▪ DFMEA ▪ PFMEA ▪ Quality Control Plan ▪ Work Instruction ▪ Technical Specs ▪ Poka yoke ▪ Maintenance Plan ▪ FAA/First Approval Article ▪ Training ▪ Other Afterwards further training and corrective actions extension to other or similar products/process/areas must be recorded inside the final part of **7D** section of the 8D tool.				
OUTPUT	▪ Preventive actions plan ▪ Trainings scheduling				
REFERENCE DOC	FR003 [WHQ_IMS_PR009] 8D Tool				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐
	D7 of 8D Tool	Working team	LQM	5 years	☐

3.9. TEAM RECOGNITION AND 8D CLOSURE

DIRECT RESPONSIBILITY	Plant Manager				
SUPPORT FUNCTION	Working team				
INPUT	8D fulfilled				
ACTIVITY DESCRIPTION	The 8D report has to be signed by the Plant Manager to be considered closed. Time for closing: **30 days since NC detection**. HSE 8D once signed shall be saved in SharePoint and marked like “Close”.				
OUTPUT	▪ 8D closed ▪ Eventual best practices				
REFERENCE DOC	▪ FR003 [WHQ_IMS_PR009] 8D Tool ▪ IN001[WHQ_IMS_PR009] SharePoint HSEQ website				
RECORDS	**DOCUMENT**	**FILLED BY**	**CATALOGUED BY**	**PERIOD OF STORAGE**	☐
	▪ Report closed and signed off	PM	LQM	5 years	☐

ANNEX 1: LISTS TO BE USED FOR NC CLASSIFICATION AND RECORDS

DEPARTMENT List	CODE
Supplier Quality Development	**SQD**
Special Projects & Estimation Office	**SPE**
Steel Work Competence Center	**SCC**
Sales	**SAL**
Research and Development	**RD**
Health Safety Environmental and Quality	**HSEQ**
Purchasing	**PUR**
Process & Tools	**PT**
Spare Parts Office	**SP**
Parts & Service EU	**PSEU**
Production	**PROD**
Project Management Office	**PMO**
Product Management	**PM**
Planning Engineering Department	**PED**
Patents, IPR	**PAIPR**
Marketing	**MKT**
Lift & Norms	**LN**
Logistics	**LOG**
Legal Department	**LD**
Key Account Manager	**KAM**
Industrial Engineering	**INDU**
Information Technology	**ICT**
Health, Safety and Environmental	**HSE**
Human Resources	**HR**
Finance	**FIN**
Facility	**FAC**
Certification	**CT**
Application Engineering	**AE**

PROCESS List	CODE
Acceptance and Incoming Controls	**INC**
Picking & Line Procurement	**PICK**
Cutting	**CUT**
Punching	**PUN**
Bending	**BEN**
Welding	**WLDS**
Painting	**PAINT**
Assembly	**ASSY**
Cladding & Finiture	**CLD**
Kit-Preparation	**KIT**
Packaging	**PKG**
Warehouse	**WHR**
Shipment	**SHP**
Offices	**OFF**

NON CONFORMITY LIST
Component not work (only for electronics parts)
Damaged
Defective Dimension
Defective material
Missing components
Defective packaging

Wrong component
Manufacturing defect
Label not legible

ROOT CAUSE LIST
Failure In Design
External-Environmental Conditions
Lack of Training
Not Procedure or Process defined
Not Fulfilment of procedure/process
Manual Data Entry
Configuration Failure
Machine Failure

CONTAINMENT ACTION LIST
Sort
Rework
Use as is (only in case previously agreed with Customer)
Scrap

ANNEX 2: TRAFFIC LIGHTS AND PROBLEM SOLVING TOOL USE (Rev. 05)

TRAFFIC LIGHTS		MINOR		SIGNIFICANT
		GREEN	YELLOW	RED
SIGNIFICANT CUSTOMER CLAIM (Accepted)	• SAFETY-Related (characteristics) • CTQ-Related (characteristics) • FUNCTIONAL IMPACT • (installation/product usage/first handover issues)	No relevant or *significant* issue detected	-	**x**
	• UNSOLVED REPETITIVE ISSUES		Equal or Less than **3 times in 3 months** with the same problem type description	More than **3 times in 3 months** with the same problem type description
SIGNIFICANT INTERNAL NC	• SAFETY-RELATED • PRODUCTION STOP • ADDITIONAL QUALITY CHECKS • REPETITIVE INTERNAL PROCESS NC	No relevant or *significant* issue detected	**x**	Decision upon Plant Manager request (based on *significant** cost evaluation)
SIGNIFICANT SUPPLIER NC	• CUSTOMER Related • SAFETY-Related (characteristics) • PRODUCTION STOP	No relevant or *significant* issue detected	-	**x**
	• UNSOLVED REPETITIVE ISSUES	Local Management	Equal or Less than **3 times in 3 months** with the same problem type description	More than **3 times in 3 months** with the same problem type description
	• CTQ-Related (characteristics) • FUNCTIONAL IMPACT	-	**x**	-
HSE	NEAR MISS	-	**x**	-
	FIRST AID INJURY**		**x**	-
	REPORTABLE INJURY **		-	**x**
	PROPERTY DAMAGE **		-	**x**
DELIVERY	DELAYED ORDERS	No delays (on time ship)	Equal or Less than **5 days**	More than **5 days**
	Rules for plants with weekly confirmation: (Counter of records is also done in days)	All shipments on-time in the confirmed week	Equal or Less than 1 week delay	More than 1 week delay to Customer Order
LOCAL / SITE PROBLEM SOLVING TOOL (TO BE USED BY THE DESIGNATED RESPONSIBLE CHOOSEN BY PLANT MNG)			Quick Response & Action plan : 5W2H **FR002_[WHQ_IMS_PR010_QRAP]** - **Only for First Aid follow the 8D**	Wittur 8D Tool: **[FR003_WHQ_IMS_PR009_8D]**

**Significance determined by Quality/Logistic/HSE or Plant Management*
*** Preliminary Investigation should be fulfilled immediately after the accident occurs.*