



# KANEPACKAGE PHILIPPINE INC.

No. 5 Ring Road LISP II, Brgy. La Mesa, Calamba City, Laguna  
Telephone No. (049) 5457-7166 to 69  
Fax No. (049) 545-6302

## INVESTIGATION REPORT FORM (IRF)

Control No.:

Date Issued

0054

250205

Customer	SANYO DENKI PHILS INC.	Attention To	REXEL ALMARIO
Item Code	01015138-01	Department	PRODUCTION
Item Description	BOX PRINT SPECIFICATION	Date of Detection	250201
Job Order Number	JO25-M-00199-49	Section Detected	QA SCREENING

### ILLUSTRATION OF THE PROBLEM



Lot Quantity (pcs)	Reject Qty (pcs)	Reject %
150	50	33.33

Nature of Defect:

EXCESS PRINT

Requirement:

There should be no excess print

Actual

Excess print on the glue tab area

NO. OF OCCURENCE	DISPOSITION	AREA OF OCCURENCE / ORIGIN	CONTENT
<input checked="" type="checkbox"/> First <input type="checkbox"/> Recurrence No.: <u>1</u> Date.: <u>250201</u>	<input type="checkbox"/> Hold <input type="checkbox"/> Special Acceptance <input type="checkbox"/> For Rework <input checked="" type="checkbox"/> Reject / Disposal	<input type="checkbox"/> Slotter <input checked="" type="checkbox"/> EQOS <input type="checkbox"/> Diecut <input type="checkbox"/> Detaching <input type="checkbox"/> Gluing <input type="checkbox"/> Vertical <input type="checkbox"/> Others	<input type="checkbox"/> Material <input type="checkbox"/> Dimension <input type="checkbox"/> Appearance <input checked="" type="checkbox"/> Process / Method
Issued by	Checked by	Approved by	Received by (Receiving Section)
LESTER JOHN DIOSO   250205	CHARLENE JAN MARIE FLORES   250205	MICHAEL CASILLANO   250210	GERALD DE GUZMAN   250210

### I. INVESTIGATION / ANALYSIS

**DIRECT CAUSE: (Analyze the reason of occurrence, why it happened?)**

**System / Training**

**Design / Toolings**

**Process / Material**

WHY 1 : W1 Suteban mark hit during Diecut process. r nW2 Instillation of suteban near on the box dimension (within print tolerance). r nW3 No standard distance for the instillation of suteban in Eqos.

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**INVESTIGATION REPORT FORM (IRF)****INDIRECT CAUSE: (Analyze the reason of occurrence, why it leaked?)**

System / Training

Design / Toolings

Process / Material

**FINAL CONCLUSION**

**CORRECTIVE ACTION: (Actions to be done to ensure that the problem will not happen again)**

**WHO / WHEN**

Process / Material

WHY 1: Conduct awareness orientation during Production Assembly

Production Leader // 2025-02-06

WHY 2: Establish Guidelines for the Standard Distance of Suteban Installation

Production Leader // 2025-03-14

**IMMEDIATE ACTION: (Action to be done to contain/ temporary correct the problem found)**

A. Sorting Result

C. Reworking

	Location	Total Stock	NG	Total Good	Rework Quantity	n/a
RM	n/a	0	0	0	Total Good	n/a
WIP	n/a	0	0	0	Rework PPM (Good)	n/a
FG	n/a	0	0	0		

B. Orientation

Date	2025-02-06	Time	08:14
Title	Production Weekly Assembly Meeting		
Attendees	All Production		

Prepared By:

Approved By:

GERALD DE GUZMAN | 250304

REXEL ALMARIO | 250507

Department Head

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**INVESTIGATION REPORT FORM (IRF)****II. QA ROOTCAUSE VERIFICATION (To be filled out by QA In-charge)**

Date Conducted:	PIC:
Identified Rootcause	Recommendation

**III. CORRECTIVE ACTION VERIFICATION (To be filled out by QA In-charge)**

	Checked By:	Date	Implemented?	Running	JO Number	Date	NG Qty	Lot Qty
1st Verification of Action			[ ] Yes [ ] No	1st				
2nd Verification of Action			[ ] Yes [ ] No	2nd				
3rd Verification of Action			[ ] Yes [ ] No	3rd				
Effectiveness of Action			[ ] Yes [ ] No	4th				
Remarks:				5th				

**IV. CLOSURE**

Status	Remarks
Still Open	

Approved by:		Process Owner Acknowledgment: (Receiving Section)	
N/A	N/A	N/A	N/A
QA Head	Top Management	Line Leader	Department Head
Date: -	Date: -	Date: -	Date: -