KANEPACKAGE PHILIPPINE INC.

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

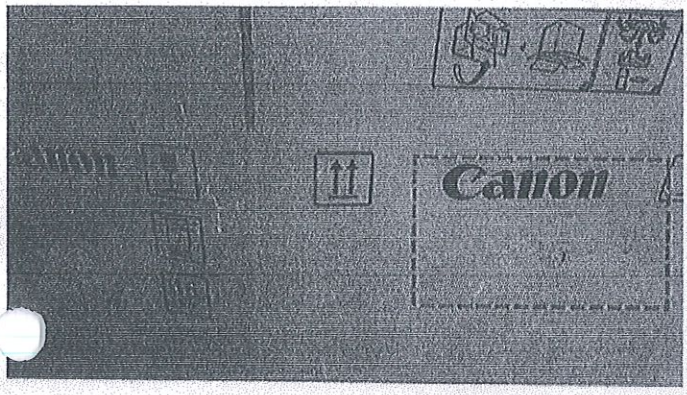
INVESTIGATION REPORT FORM (IRF)

■ Inhouse Detection ☐ Customer Claim

Control No.: 194 Date Issued: 20 02 28

Customer	CANON	Attention To	Mr. Gerald De Guzman / Ms. Weena Apalla
Item Code	RX1-4518-000	Department	PRODUCTION
Item Description	Z10_CARTON	Date of Detection	20 02 27
Job Order Number	WO-F-20-016-16	Section Detected	QA - SCREENING

ILLUSTRATION OF THE PROBLEM



■ Major ☐ Minor

Lot Quantity (pcs.)	Reject Quantity (pcs.)	Reject Percentage
157	157	100.00%

Nature of Defect:

WRONG DIECUT BLADE

Requirement:

Diecut blade to be used should be RX1-4517-000 (No slot)

Actual:

Diecut blade used is RX1-4508-000 (With slot)

NO. OF OCCURRENCE	DISPOSITION	AREA OF OCCURRENCE / ORIGIN	CONTENT
■ First	☐ Hold	☐ Slotter ☐ Gluing	☐ Material
☐ Recurrence	☐ Special Acceptance	☐ EQOS ☐ Vertical	☐ Dimension
No.:_____	☐ For Rework	■ Diecut ☐ Others:	■ Appearance
Date:_____	■ Reject / Disposal	☐ Detaching _____	☐ Process / Method

Issued by	Checked by	Approved by	Received by (Receiving Section)
Adrian Vergara QA-IE Staff	Mr. Roderick Ramos QA Supervisor	Mr. Rexel Almario QA Asst. Manager	Mr. Gerald De Guzman / Ms. Weena Apalla Head/ Supervisor

I. INVESTIGATION / ANALYSIS

	DIRECT CAUSE: (Analyze the reason of occurrence, why it happened?)	INDIRECT CAUSE: (Analyze the reason of occurrence, why it leaked?)
System / Training	Why 1: Why 2: Why 3: NOT A FACTOR Why 4: Why 5:	Why 1: Why 2: Why 3: NOT A FACTOR Why 4: Why 5:
Design / Toolings	Why 1: Why 2: Why 3: NOT A FACTOR Why 4: Why 5:	Why 1: Why 2: Why 3: NOT A FACTOR Why 4: Why 5:
Process / Material	Why 1: Why 2: Why 3: PLS. SEE ATTACHED Why 4: Why 5:	Why 1: Why 2: Why 3: PLS. SEE ATTACHED Why 4: Why 5:

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FINAL CONCLUSION

OCCURRENCE ROOTCAUSE	OUTFLOW ROOTCAUSE
- OPERATOR DIDN'T NOTICE THAT THE MOTHER BLADE FOR PART-A & PART-B ARE DIFFERENT	- OPERATOR DIDN'T NOTICE THAT THE BLADE HE USED WAS WRONG, BECAUSE THE DIMENSION ARE SAME IN THE DRAWING.

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

A. Sorting Result

	Location	Total Stock	NG	Total Good
RM	N/A			
WIP	N/A			
FG	QA - IN LINE	157	157	0

B. Orientation

Date	N/A	Time	N/A
Title	N/A		
Attendees	N/A		

C. Reworking

Rework Quantity	N/A
Total Good	N/A
Rework Percentage (Good)	N/A

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

	Actions to be done to eliminate recurrence	Who / When
System	N/A	
Design / Tools	N/A	
Process	PLS. SEE ATTACHED	

II. QA ROOTCAUSE VERIFICATION (To be filled out by QA In-charge)

Date Conducted: 20 03 03 PIC: A. Vergara

Identified Rootcause	Recommendation
~ The operator retrieve the blade on the "fast moving" rack since the said rack is very accessible to S1400 & S1700 ~ The operator skipped the instruction indicated on the diecut blade issuance & initial running approval under PM-PR-003	~ Revised the Procedure - Additional instruction where both Production Operator & Tooling custodian will check simultaneously ~ Highlight the diecut blade to be used for similar/ common items

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

	Checked by	Date	Implemented?	Remarks
1st Verification of Action	A. Vergara	20 03 03	[ ] Yes [✓] No	- CA is already implemented - Recommendation 1st CA is not yet implement. 2nd CA is implemented
2nd Verification of Action	A. Vergara	20 03 16	[✓] Yes [ ] No	- Already Implemented
3rd Verification of Action			[ ] Yes [ ] No	
Effectiveness of Action	A. Vergara	20 07 28	[✓] Yes [ ] No	- CA & Recommendation is effective

QUALITY ASSURANCE DEPARTMENT
CLOSED
DATE
SIGNATURE

Note: If no same defects / problems occurs for 5 consecutive deliveries, corrective action is considered effective / closed. If the same problem occurs within 5 consecutive deliveries or 3rd verification of action still not yet implemented, Investigation Report shall be re-issued to the affected department to provide new improvement action.

IV. CLOSURE

Status:	Remarks:	Approved by:		Process Owner Acknowledgment: (Receiving Section)	
[✓] Closed [ ] Still Open [ ] Re-Issue IRF	No occurred of wrong diecut blade	NOEMI V. CEPEDA QA Supervisor Date: 200805	QA Asst. Manager Date: 20 08 05	KRISHAMAY L. ESTAREJA Line Leader Date: 200825	Department Head Date: 200825

INVESTIGATION REPORT FOR WRONG DIECUT BLADE USED FOR CBMP RX1-4518-000 Z10_CARTON

DIRECT CAUSE **PROCESS/MATERIAL**	**W1-** Operator prepared the diecut blade of RXI-4508 Part-A & Part-B (mother blade) for the process of RX1-4518 and not the tooling custodian.
	W3- Blade location is in the fast moving items Rack beside the machine, that's why the operator is the one who prepared the tooling.
	W2- He didn't notice that the mother blade needed for Part-A is different (RX1-4517).

INDIRECT CAUSE **PROCESS/MATERIAL**	**W1** - Upon Trial Run opertor check only the dimension and cutting condition as requirement.
	W2- He didn't notice that the blade he used was Wrong, because the dimension are same in the Drawing.

CORRECTIVE ACTION

> Pull-out all diecut blades in the Rack beside the machine and the responsibility for the issuance of diecut blade for fast moving items will still be on the tooling custodian.

PIC: Production / Tooling Target Date: 200303

> Used pattern jig in diecut, for easy visual checking of cutting and print detail.

PIC: Production & Design Target Date: Next Running