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**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.: 242

Date Issued: 20 07 09

Customer	KOYAMA	Attention To	Mr. Gerald De Guzman / Ms. Weena Apalla
Item Code	PKC505B-A	Department	PRODUCTION
Item Description	INNER BOX	Date of Detection	20 07 08
Job Order Number	WO-20-M-00901-30	Section Detected	QA - SCREENING

**ILLUSTRATION OF THE PROBLEM**
☒ Major

☐ Minor

Lot Quantity (pcs.)

Reject Quantity (pcs.)

Reject Percentage

4,080

55

1.34%

Nature of Defect:

BLOTTED PRINT

Requirement:

Letters should be readable

Actual:

The text on the item has no holes

**NO. OF OCCURRENCE**
**DISPOSITION**
**AREA OF OCCURRENCE / ORIGIN**
**CONTENT**
☒ First  
☐ Recurrence

No.: \_\_\_\_\_

Date: \_\_\_\_\_

☐ Hold  
☐ Special Acceptance  
☐ For Rework  
☒ Reject / Disposal

☐ Slotter  
☒ EQOS  
☐ Diecut  
☐ Detaching

☐ Gluing  
☐ Vertical  
☐ Others: \_\_\_\_\_

☐ Material  
☐ Dimension  
☒ Appearance  
☐ Process / Method

Issued by

Checked by

Approved by

Received by

(Receiving Section)

 Adrian Vergara  
 QA-IE Staff

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:  
 Why 4:  
 Why 5:

N/A

Design / Toolings

 Why 1:  
 Why 2:  
 Why 3:  
 Why 4:  
 Why 5:

N/A

Process / Material

 Why 1:  
 Why 2:  
 Why 3:  
 Why 4:  
 Why 5:

PLS. SEE ATTACHED

 Why 1:  
 Why 2:  
 Why 3:  
 Why 4:  
 Why 5:

N/A

 Why 1:  
 Why 2:  
 Why 3:  
 Why 4:  
 Why 5:

N/A

 Why 1:  
 Why 2:  
 Why 3:  
 Why 4:  
 Why 5:

PLS. SEE ATTACHED



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## INVESTIGATION REPORT FORM (IRF)

### FINAL CONCLUSION

#### OCCURRENCE ROOTCAUSE

#### OUTFLOW ROOTCAUSE

- SHALLOW DISTANCE AND HOLE  
IN CYREL

- BLOTTED PRINT DIDNT NOTICE DURING  
SKIPPING DUE TO RANDOMLY OCCURENCE

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

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

#### A. Sorting Result

#### Actions to be done to eliminate recurrence

Who / When

	Location	Total Stock	NG	Total Good
RM	N/A			
WIP	N/A			
FG	N/A			

System

N/A

#### B. Orientation

Date	N/A	Time	N/A
Title	N/A		
Att. us	N/A		

Design /  
Tools

N/A

#### C. Reworking

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

Process

PLS. SEE ATTACHED

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

Date Conducted: 20 07 10

PIC: A. Vergara

Identified Rootcause

Recommendation

~ The ink accumulates on the rubber die that  
causes to fill the canals

~ Clean the rubber die immediate once detected  
blotted print using rags / brush

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

	Checked by	Date	Implemented?	Remarks
1st Verification of Action	A. Vergara	20 07 10	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	C.A. is implemented
2nd Verification of Action	A. Vergara	20 07 13	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2nd C.A. will not be pursue
3rd Verification of Action			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Effectiveness of Action	A. Vergara	20 09 16	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	C.A. is implemented

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

QUALITY ASSURANCE DEPARTMENT

Approved by:

Process Owner Acknowledgment: (Receiving Section)

Sta

Closed

Still Open

Re-Issue

**CLOSED**

QA Supervisor

QA Asst. Manager

Line Leader

Department Head

Date:

20 07 11

Date:

21 01 11

Date:

21 01 11

Date:

21 01 11

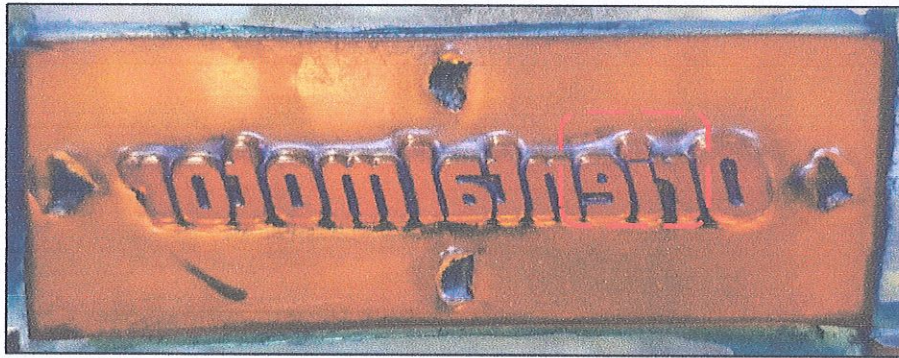
DATE AND  
SIGNATURE

21 01 09



## INVESTIGATION REPORT FOR BLOTTED PRINT OF KOYAMA PKC505B-A INNER BOX.

<b>DIRECT CAUSE PROCESS/MATERIAL</b>	<b>W1-</b> During investigation in actual affected item, we notice that the affected of blotted print in Koyama Orientalmotor box is always in the same portion from the previous blotted occurrence.
	<b>W2-</b> During checking of the cyrel we notice that Orientalmotor logo distance between letter r & i is very shallow and the hole of Letter e is too small and shallow why this portion is prone to blotted print even the other area is good.
	<b>W2-</b> Due to Shallow distance and hole in cyrel the ink was easy to clogged on that portion.




<b>INDIRECT CAUSE PROCESS/MATERIAL</b>	<b>W1-</b> Operator proceed to mass production.
	<b>W2 -</b> Trial run approved by QA Patrol.
	<b>W3 -</b> Operator didn't notice the blotted print during sampling because the occurrence are randomly.

## CORRECTIVE ACTION

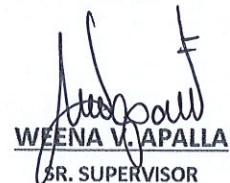
Orient the operator to include this portion in their critical check point for Koyama Orientalmotor and once they encounter blotted print immediate clean the cyrel using brush, rags & water.			
<b>PIC:</b>	<b>PRODUCTION</b>	<b>TARGET DATE:</b>	<b>200713</b>

Possible improvement in logo character if applicable.			
<b>PIC:</b>	<b>DESIGN</b>	<b>TARGET DATE:</b>	

PREPARED BY:

  
**GERALD DE GUZMAN**  
 PROD ASST. SUPERVISOR

APPROVED BY:

  
**WEENA V. APALLA**  
 SR. SUPERVISOR