

2176



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

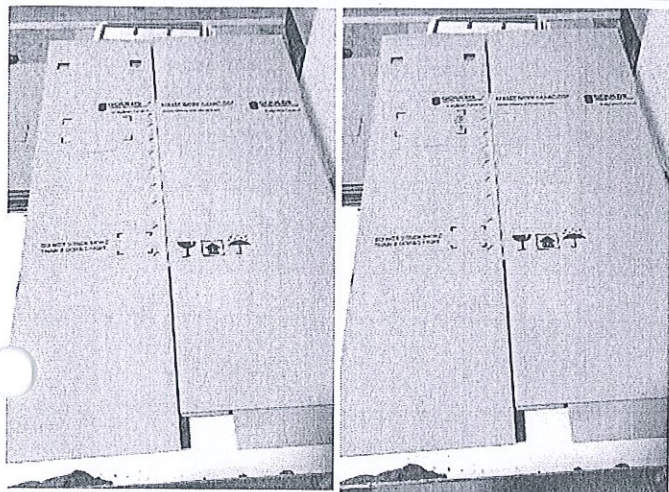
Control No.: 250

Date Issued: 20 07 16

Customer	SUPERFLEX	Attention To	Mr. Gerald De Guzman & Mr. Rexel Almario
Item Code	839N	Department	PRODUCTION & QA
Item Description	OUTER BOX	Date of Detection	20 07 15
Job Order Number	WO-20-M-00451-2A.2	Section Detected	CUSTOMER - SFLI

ILLUSTRATION OF THE PROBLEM

☒ Major

☐ Minor


Lot Quantity (pcs.)	Reject Quantity (pcs.)	Reject Percentage
65	1	1.54%

Nature of Defect:

DOUBLE PANEL

Requirement:

No Double Panel

Actual:

Same Panel B

NO. OF OCCURRENCE		DISPOSITION		AREA OF OCCURRENCE / ORIGIN		CONTENT	
<input checked="" type="checkbox"/> First		<input type="checkbox"/> Hold		<input type="checkbox"/> Slotter	<input type="checkbox"/> Gluing	<input type="checkbox"/> Material	
<input type="checkbox"/> Recurrence		<input type="checkbox"/> Special Acceptance		<input type="checkbox"/> EQOS	<input type="checkbox"/> Vertical	<input type="checkbox"/> Dimension	
No.: _____		<input type="checkbox"/> For Rework		<input type="checkbox"/> Diecut	<input checked="" type="checkbox"/> Others:	<input checked="" type="checkbox"/> Appearance	
Date: _____		<input checked="" type="checkbox"/> Reject / Disposal		<input type="checkbox"/> Detaching	_____ Stitching _____	<input type="checkbox"/> 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 & Mr. Rexel Almario 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	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	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:	PLS. SEE ATTACHED

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INVESTIGATION REPORT FORM (IRF)**FINAL CONCLUSION****OCCURRENCE ROOTCAUSE**

— OPERATOR AND ASSIST PERSON DIDNT NOTICE THEY ARE GOT PANEL/PART IN THE SAME PALLET (PALLET OF PANEL-B)

OUTFLOW ROOTCAUSE

— LACK OF COORDINATION BETWEEN TABLE STITCHING OPERATOR AND ASSIST PERSON BECAUSE NO STANDARD ROUTINE

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

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

Actions to be done to eliminate recurrence**Who / When**

System

N/A

Design / Tools

N/A

Process

PLS. SEE ATTACHED

B. Orientation

Date	N/A	Time	N/A
Title	N/A		
Issues	N/A		

C. Reworking

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

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

Date Conducted: 20 07 20

PIC: A. Vergara

Identified Rootcause**Recommendation**

Wrong attachment of panels because both operators get the same panel is same pallet because there were no assign operator for getting panel A & panel B.

Make a guideline to standardize the routine in table stitching

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

	Checked by	Date	Implemented?	Remarks
1st Verification of Action	A. Vergara	20 08 03	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	C.A. is implemented
2nd Verification of Action	A. Vergara	20 09 07	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Stitching process transfer to supplier
3rd Verification of Action			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Effectiveness of Action	A. Vergara	20 09 01	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	C.A. is effective

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)	
<input checked="" type="checkbox"/> Closed	CLOSED				
<input type="checkbox"/> Still Open		QA Supervisor	QA Asst. Manager	Line Leader	Department Head
<input type="checkbox"/> Re-issued IRF		Date: 21 04 14	Date: 21 04 14	Date: 21 04 14	Date: 21 04 14

DATE AND SIGNATURE

21 04 14

INVESTIGATION REPORT FOR DOUBLE PANEL OF SUPER FLEX 893N OUTER BOX

DIRECT CAUSE PROCESS/MATERIAL	W1- Operator mislook and combine both Panel-B during Table Stitching.
	W2- Even the Panel-A and Panel-B have Pokayoke mark and separate pallet, the Table Stitching operator and the assist person didn't notice that they are got Panel/Part in the same pallet (Pallet of Panel-B).

INDIRECT CAUSE PROCESS/MATERIAL	W1- Lack of coordination between Table Stitching operator and assist person.
	W2- No standard routine.

CORRECTIVE ACTION

Make a guideline for Standard routine in Table Stitching, for well coordination between Table Stitching operator and assist person:

example:

Process of two Joint boxes with different Panel

Table Stitching operator > in-charge to get Panel-A

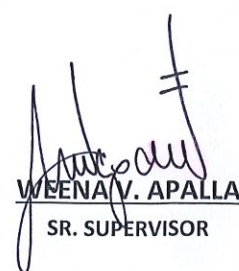
Assist Person > in-charge to get Panel-B

PIC:	PRODUCTION	TARGET DATE:	200724
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PREPARED BY:


GERALD DE GUZMAN
PROD ASST. SUPERVISOR

APPROVED BY:


WEENA V. APALLA
SR. SUPERVISOR