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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.: 259

Date Issued: 20 08 03

Customer: MITSUMI PHILS. INC.

Item Code: 19-Y338A DRT-J583

Item Description: CARTON BOX R

Job Order Number: WO-SO-IPD-1108-2.1

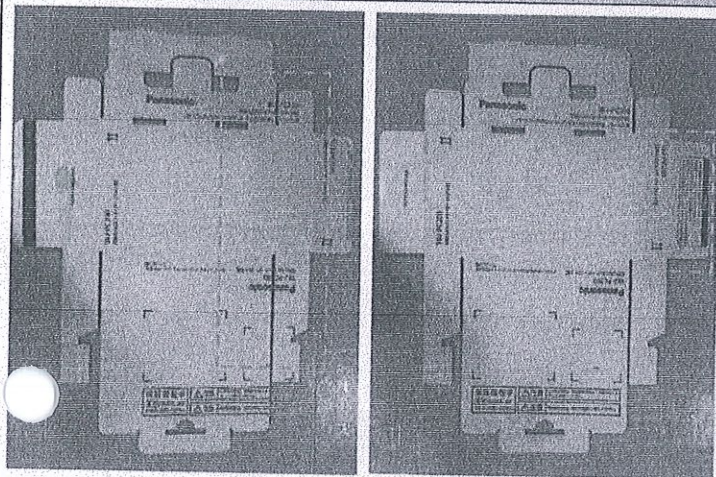
Attention To: Mr. Gerald De Guzman / Ms. Weena Apalla

Department: PRODUCTION

Date of Detection: 20 07 31

Section Detected: QA - SCREENING

ILLUSTRATION OF THE PROBLEM


☒ Major

☐ Minor

Lot Quantity (pcs.): 502

Reject Quantity (pcs.): 118

Reject Percentage: 23.51%

Nature of Defect:

MISALIGN PRINT

Requirement:

Print location tolerance $\pm 3\text{mm}$

Actual:

>7mm printing movement

NO. OF OCCURRENCE

☒ First

☐ Recurrence

No.: _____

Date: _____

DISPOSITION

☐ Hold

☐ Special Acceptance

☐ For Rework

☒ Reject / Disposal

AREA OF OCCURRENCE / ORIGIN

☐ Slotter

☐ Gluing

☒ EQOS

☐ Vertical

☒ Diecut

☐ Others: _____

☐ Detaching

CONTENT

☐ Material

☒ Dimension

☐ Appearance

☐ Process / Method

Issued by

Checked by

Approved by

Received by

Adrian Vergara
QA-IE Staff

Ms. Noemi Cepeda
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

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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FINAL CONCLUSION

OCCURRENCE ROOTCAUSE

- WRONG MACHINE SETTING

OUTFLOW ROOTCAUSE

- MISALIGN PRINT IS HARD TO NOTICE VISUALLY BECAUSE THE ITEMS IS NOT YET DIE-CUTTED

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

B. Orientation

Date	20 08 06	Time	14:50 ~ 15:00
Title	ORIENTATION REGARDING MISALIGN PRINT OF MITSUMI 19-Y338A DRT-J683 CARTON BOX R		
Issues	EQDS & SLITTER OPERATORS		

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 08 05

PIC: A. Vergara

Identified Rootcause

Recommendation

>The material slipped inside the printing machine due to wrong feedgate setup.
>The materials length deviation is ± 3 mm

1. Slitter operator should cut the boards for diecut items w/ 1mm deviation only
2. Printing operator should double check if the material fluke in the drawing & in the machine are tally

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 06	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	C.A. is implemented
2nd Verification of Action			<input type="checkbox"/> Yes <input type="checkbox"/> No	
3rd Verification of Action			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Effectiveness of Action	A. Vergara	21 03 05	<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)
CLOSED	QA Supervisor	Line Leader
Still Open	QA Ass. Manager	Department Head
Re-Issue IRF	Date: 21 04 14	Date: 21 04 14

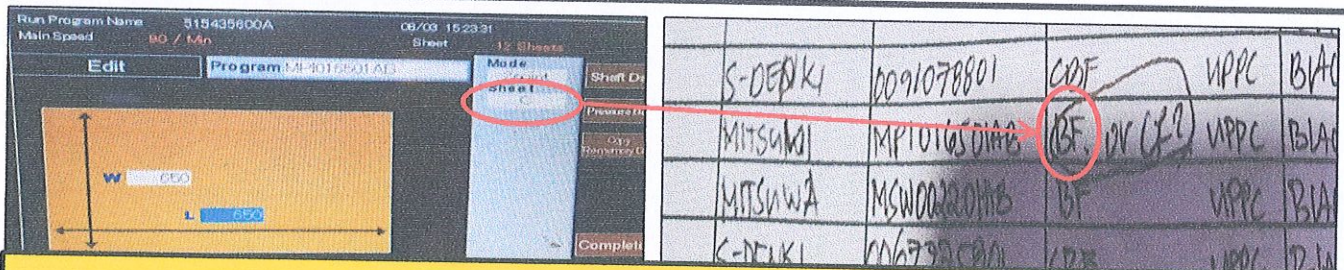
DATE AND SIGNATURE

21 04 14

INVESTIGATION REPORT FOR MISALIN PRINT OF MITSUMI 19-Y338 A DRT-J583 CARTON BOR R

DIRECT CAUSE PROCESS/MATERIAL	W1- Misalign Print occurs because Eqos operator forgot to change the Feed Gate to B-flute.
	W2- Feed gate set to C-Flute instead of B-Flute (actual item).
	W1- Another factor is uneven cut of corrugated board.
	W2- Slotter operator didn't consider that the item have print, why there is 3mm uneven cut in corrugated board.

Note:	During diecut process operator notice the print movement and some uneven board, why the operator immediate inform to Leaders in-charge that time.
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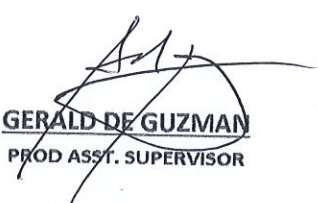
Sir Suzuki notice and question the operator, because the record of Eqos operator is B-flute but the Register in monitor is C-flute

INDIRECT CAUSE PROCESS/MATERIAL	W1- Operator proceed to mass production.
	W2- Trial run approved by QA Patrol.
	W3- Eqos operator didn't notice the uneven board and print movement because according to them during sampling the print is within tolerance and misalign print is hard to notice visually because the items is not die-cutted yet.

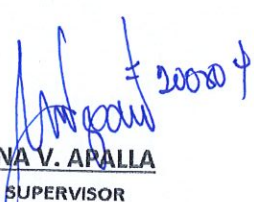
CORRECTIVE ACTION

Orient the Slotter operator once the die-cutted box have print the cutting accuracy of corrugated board is within ± 1 mm dimension tolerance only if possible.			
PIC:	PRODUCTION	TARGET DATE:	200806
Orient the Eqos operator to double check the actual materials flute use vs drawing vs. the flute register in Eqos monitor before proceed to trial run.			
PIC:	PRODUCTION	TARGET DATE:	200806

PREPARED BY:


GERALD DE GUZMAN
 PROD ASST. SUPERVISOR

APPROVED BY:


WEENA V. APALLA
 SR. SUPERVISOR