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.: 269 Date Issued: 20 08 12

Customer	EPSON IJP	Attention To	Mr. Gerald De Guzman / Mr. Rexel Almario
Item Code	5150864-01	Department	PRODUCTION
Item Description	INDIVIDUAL BOX	Date of Detection	20 08 11
Job Order Number	L-0068-26.1, 29, 30, 31	Section Detected	QA - IN LINE

ILLUSTRATION OF THE PROBLEM

■ Major. ☐ Minor

Lot Quantity (pcs.)	Reject Quantity (pcs.)	Reject Percentage
12,700	1,325	10.43%

Nature of Defect:

EXTRA IMAGE

Requirement:

No extra image

Actual:

W/ extra image

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	Ms. Noemi Cepeda	Mr. Rexel Almario	Mr. Gerald De Guzman / Mr. Rexel Almario
QA-IE Staff	QA Supervisor	QA Asst. Manager	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: N/A Why 4: Why 5:	Why 1: Why 2: Why 3: N/A Why 4: Why 5:
Design / Toolings	Why 1: Why 2: Why 3: N/A Why 4: Why 5:	Why 1: Why 2: Why 3: N/A 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
- EXCESS CYREL ACCIDENTALLY STICK IN THE MYLAR	- DIDN'T NOTICE BY OPERATOR BECAUSE ITEM 1 IS NOT DIECUTTED YET

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	SEMI-AUTO GLUING	7,400	4,946	2,454
FG	KP - LIMA	4,000	4	3,996

B. Orientation

Date	N/A	Time	N/A
Title	N/A		
A[illegible]es	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 08 12 PIC: A. Vergara

Identified Rootcause	Recommendation
PRD: > The tooling custodian accidentally place the damage rubber die on the mylar because it was not dispose immediately QA: > The in-process QA did not conduct detailed checking	PRD: > Include on the existing procedure for proper disposal of damage rubber die > Include in EQOS W.I to check 1 by 1 the print characters QA: > Conduct proof checking on the sample produce

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 12	[✓] Yes	[ ] No	C.A. is implemented
2nd Verification of Action			[ ] Yes	[ ] No	
3rd Verification of Action			[ ] Yes	[ ] No	
Effectiveness of Action	A. Vergara	20 09 09	[✓] Yes	[ ] No	C.A. is effective

QUALITY ASSURANCE DEPARTMENT
CLOSED
DATE AND SIGNATURE 20 10 12

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 occurrence as per monitoring	QA Supervisor Date: 20 10 12	QA Asst. Manager Date: 20 10 12	Line Leader Date: 20 10 12	Department Head Date: 20 10 12

INVESTIGATION REPORT FOR THE EXTRA IMAGE OF EPSON IJP 5150864-01 INDIVIDUAL BOX

DIRECT CAUSE PROCESS/MATERIAL	W1- Night shift tooling custodian replaced the damage cyrel (Care Mark Sign), and endorse the mylar together with the damage cyrel to day shift tooling custodian.
	W2- Day shift tooling custodian did not disposed the damage cyrel.
	W3- Tooling Custodian accidentally left the damage cyrel in the mylar and due to double sided attached in the damage cyrel it was stick in the mylar.
	W4- Tooling Custodian put back the mylar in the Cyrel rack and forgot the damage cyrel stick in the mylar.
	W4- Mylar issue again in Eqos last August 11, 2020 without knowing that the damage cyrel was stick in the mylar.

INDIRECT CAUSE **PROCESS/MATERIAL**	**W1**- Eqos operator used the mylar where the damage cyrel stick.
	W2- Operator didn't notice during trial run that there is excess character, because excess character is almost align to other character and during fitting of Pattern Jig they just get the alignment reference of print and because this item is fast running they didn't expect the excess character.
	W3 - QA patrol approved the trial run why they proceed to mass production.
	W4 - Excess character not so visible during sampling, because the items is 2outs and not yet die-cutted.

CORRECTIVE ACTION

Include in Tooling procedure that after the damage cyrel will replaced the existing damage cyrel will immediately dispose			
PIC:	**PRODUCTION**	**TARGET DATE:**	**200817**

Include in Eqos Work Instruction that the operator need to check one by one the Print character during trial run, and they need to put check mark to all print character in the drawing as evidence that they conduct checking.			
PIC:	**PRODUCTION**	**TARGET DATE:**	**200817**

PREPARED BY:

GERALD DE GUZMAN
PROD ASST. SUPERVISOR

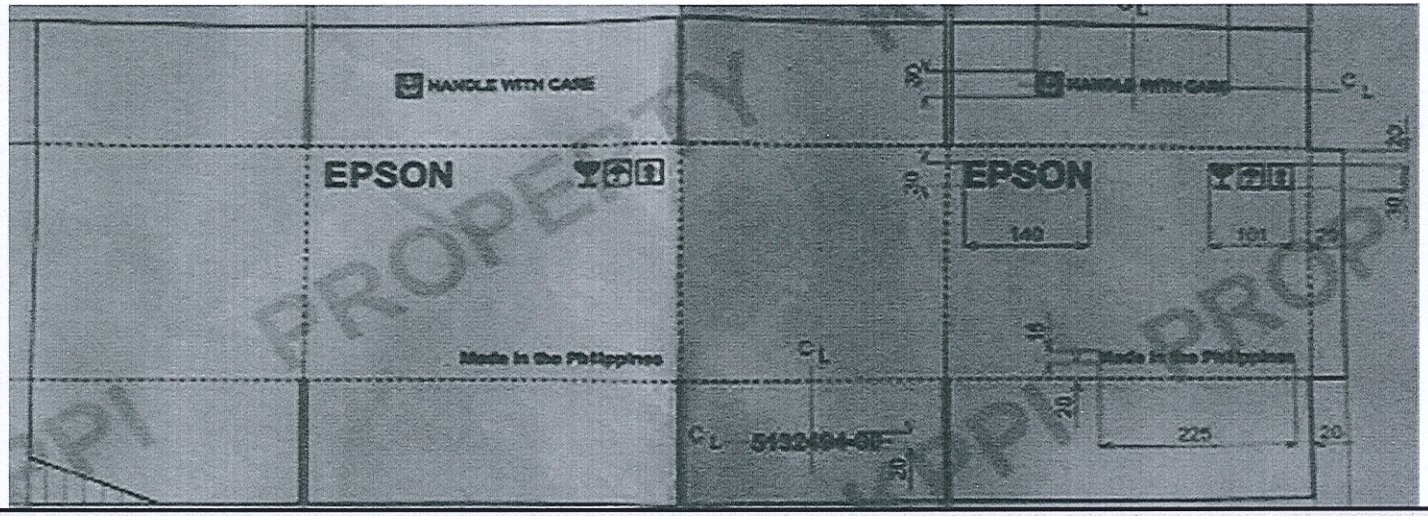
APPROVED BY:

WEENA V. APALLA
SR. SUPERVISOR

ROOTCAUSE ANALYSIS:

QA SIDE:

1. Comparing drawing vs. actual checking was not performed properly for images
2. Because the In-process QA did not verify each details indicated on the drawing.
3. Putting of checkmarks was not indicated on the reference procedures (as evidence if detailed checking was conducted)



EXISTING DRAWING CONDITION AFTER IN-PROCESS CHECKING

>No checkmarks on each characters of the item

PROCEDURE CHECKING (PM-QA-024):

5.4 Conduct VISUAL and DIMENSIONAL inspection on the initial output sample based on the item drawing & customer's approved sample (if applicable).

>The existing procedure lacking of instruction

CORRECTIVE ACTION:

1. *Put Checkmarks on the images of Initial Run and Keep the trial run for Leader's checking*
***(PIC:** In-Process QA**, Target Date:** August 12, 2020)*

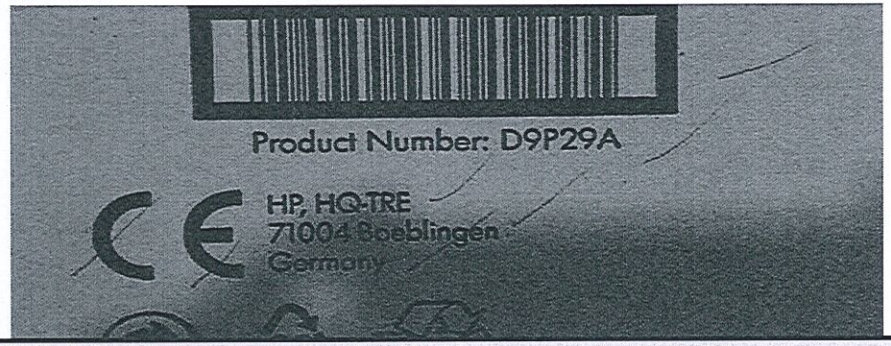


ILLUSTRATION OF CORRECTIVE ACTION

2. *Sub-Leader and Above will put checkmarks on the drawing to verify if the approved initial run of In-Process QA and the drawing is tally.*
***(PIC:** QA Leaders**, Target Date:** August 12, 2020)*

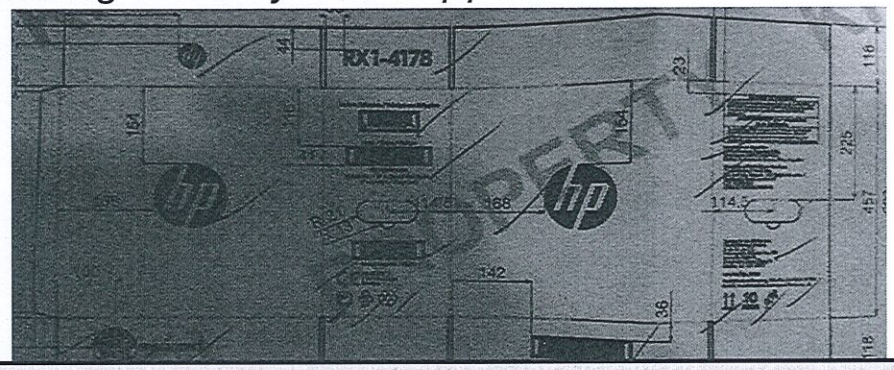


ILLUSTRATION OF CORRECTIVE ACTION

3. *Revision of In-Process QA Procedure. Indicate additional Instructions; Putting of checkmarks on the Initial Run; QA Head or Sub-Leader will check the initial run approved and put checkmarks on the Drawing (**PIC:** QA Supervisor, **Target Date:** August 17, 2020)*