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

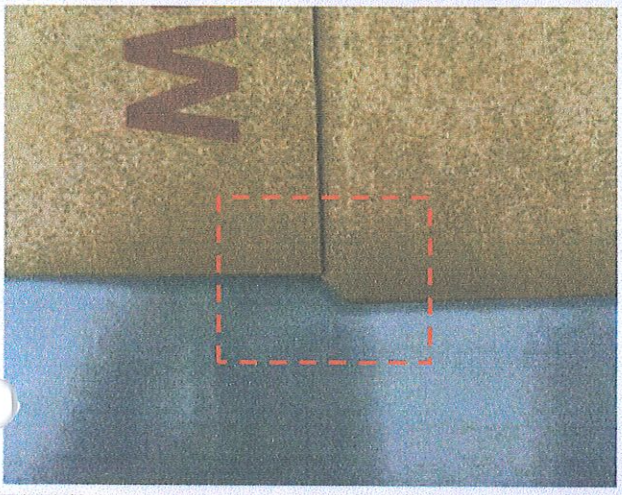
INVESTIGATION REPORT FORM (IRF)

■ Inhouse Detection ☐ Customer Claim

Control No.: 322 Date Issued: 20 11 10

Customer	EMORI	Attention To	Mr. Gerald De Guzman
Item Code	HP01D2200C	Department	PRODUCTION
Item Description	CARTON BOX	Date of Detection	20 11 09
Job Order Number	WO-DRS-20-M-01558-4	Section Detected	QA - IN LINE

ILLUSTRATION OF THE PROBLEM



☐ Major ■ Minor

Lot Quantity (pcs.)	Reject Quantity (pcs.)	Reject Percentage
2,620	58	2.21%

Nature of Defect:

MISALIGN GLUING

Requirement:

Bottom creasing should be even

Actual:

Bottom creasing is not even

NO. OF OCCURRENCE	DISPOSITION	AREA OF OCCURRENCE / ORIGIN	CONTENT
☐ First	☐ Hold	☐ Slotter ■ Gluing	☐ Material
■ Recurrence	☐ Special Acceptance	☐ EQOS ☐ Vertical	■ Dimension
No.: 4	☐ For Rework	☐ Diecut ☐ Others:	■ Appearance
Date: 20 11 09	■ Reject / Disposal	☐ Detaching	☐ Process / Method

Issued by	Checked by	Approved by	Received by (Receiving Section)
Adrian Vergara QA-IE Staff	Ms. Noemi Cepeda QA Supervisor	Mr. Rexel Almario QA Asst. Manager	Mr. Gerald De Guzman 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
-THICK APPLICATION OF GLUE THAT CAUSE SLIDE DURING FEEDING IN CONVEYOR.	- OPERATOR DID NOT NOTICE THE OUTFLOW BECAUSE POSSIBLE IT WAS HAPPEN RANDOMLY

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	N/A			

B. Orientation

Date	20 11 16	Time	09:29 - 09:36 A.M.
Title	Re-orientation regarding proper/right application of glue		
Attendees	GLUING OPERATORS		

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 11 16 PIC: A. Vergara

Identified Rootcause	Recommendation
The side panel slides from the glue tab since the gluing operator applied too much glue on the glue tab.	

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

	Checked by	Date	Implemented?	Remarks
1st Verification of Action	A. Vergara	20 11 16	[✓] Yes [ ] No	C.A is implemented
2nd Verification of Action			[ ] Yes [ ] No	
3rd Verification of Action			[ ] Yes [ ] No	
Effectiveness of Action	A. Vergara	20 12 03	[✓] Yes [ ] 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

Status: Remarks:
[✓] Closed
[ ] Still Open
[ ] Re-issue IRF

QUALITY ASSURANCE DEPARTMENT
CLOSED
DATE AND SIGNATURE 210414

Approved by:		Process Owner Acknowledgment: (Receiving Section)	
QA Supervisor	QA Asst. Manager	Line Leader	Department Head
Date: 210414	Date: 210414	Date: 210414	Date: 210414

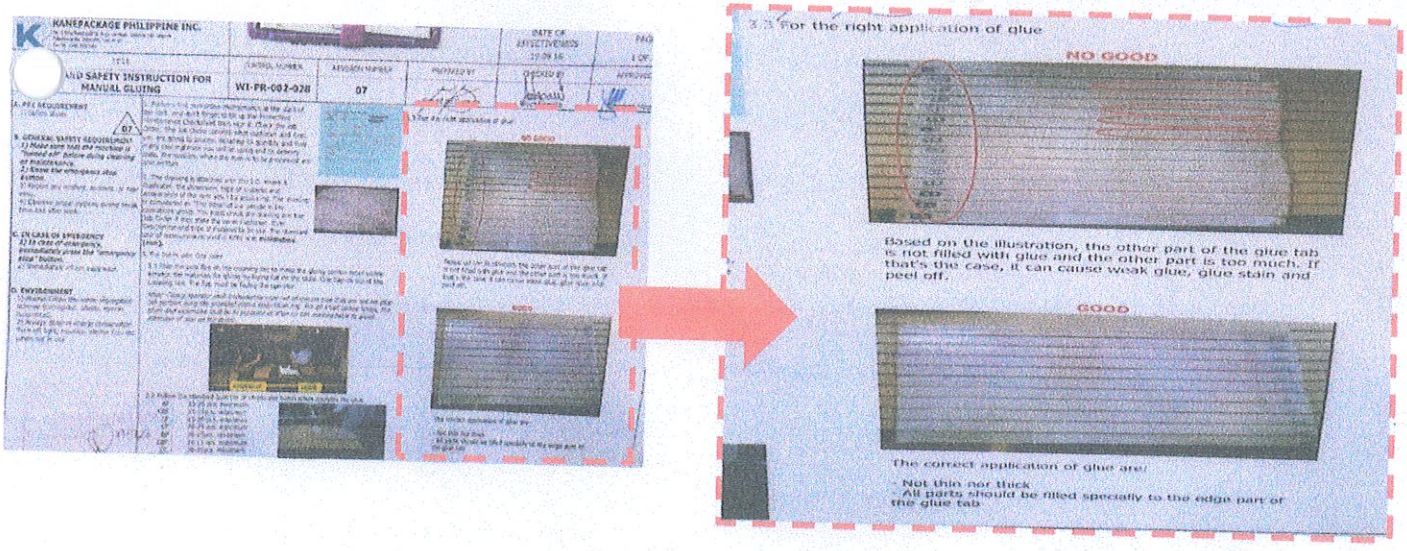
INVESTIGATION REPORT FOR MISALIGN GLUING OF EMORI HP01D2200C CARTON BOX

DIRECT CAUSE **PROCESS/MATERIAL**	**W1**- According to operator possible that during feeding of items, it was accidentally slide.
	W2- If the application of glue is too much, possible the item will slide during feeding in conveyor that cause misalign glue.

INDIRECT CAUSE (OUTFLOW) **PROCESS/MATERIAL**	**W1**- Once the operator trap the misalign he will rework the affected item immediately.
	W2- Operator did not notice the outflow because possible it was happen randomly.

PRODUCTION CORRECTIVE ACTION

Re-orient the operator regarding section 3.3 of Work and Safety Instruction for Manual Gluing (WI-PR-002-028), for the right application of glue.			
PIC:	**PRODUCTION**	**TARGET DATE:**	**201112**



PREPARED BY:

20111

GERALD DE GUZMAN
PROD ASST. SUPERVISOR

APPROVED BY:

20111

WEENA V. APALLA
SR. SUPERVISOR