

**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.: IRF-08-0004

Date Issued: 15-Aug-22

Customer	EPPI	Attention To	JAYSON SEGUENZA / MICHAEL CASILLANO
Item Code	516182300	Department	ME DEPARTMENT
Item Description	LINUS FAL ASIA	Date of Detection	11-Aug-22
Job Order Number	19788	Section Detected	INLINE QA

**ILLUSTRATION OF THE PROBLEM**☐ Major☒ Minor

Lot Quantity (pcs.)	Reject Quantity (pcs.)	Reject Percentage
398	20	5.03%

**Nature of Defect:****MISALIGNED CUT****Requirement:**


ITEM SHOULD BE IN GOOD CONDITION; NO OCCURRENCE OF MISALIGNED CUT

**Actual:**MISALIGNED CUT OCCURRED ON THE GLUE TAB PORTION;  
DUE TO SHORT BLEEDING

NO. OF OCCURRENCE	DISPOSITION	AREA OF OCCURRENCE / ORIGIN		CONTENT
<input checked="" type="checkbox"/> First	<input type="checkbox"/> Hold	<input type="checkbox"/> Slotter	<input checked="" 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 type="checkbox"/> Others:	<input type="checkbox"/> Appearance
Date: _____	<input type="checkbox"/> Reject / Disposal	<input type="checkbox"/> Detaching		<input checked="" type="checkbox"/> Process / Method
Issued by	Checked by	Approved by	Received by (Receiving Section)	
C. Arevalo QA-IE Staff	G. Magsino QA Supervisor	QA Asst. Manager	N. Royales 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: Newly hired graphic artist	Why 1:	No actual measurement on bleeding
	Why 2: Not aware with the standard work instruction for additional bleeding	Why 2:	Rely only in using die cut film.
	Why 3:	Why 3:	
	Why 4:	Why 4:	
	Why 5:	Why 5:	
Design / Toolings	Why 1:	Why 1:	
	Why 2:	Why 2:	
	Why 3:	Why 3:	
	Why 4:	Why 4:	
	Why 5:	Why 5:	
Process / Material	Why 1: No standard checking during plate making	Why 1:	
	Why 2:	Why 2:	
	Why 3:	Why 3:	
	Why 4:	Why 4:	
	Why 5:	Why 5:	

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<b>FINAL CONCLUSION</b>									
OCCURRENCE ROOTCAUSE					OUTFLOW ROOTCAUSE				
Newly hire graphic artist is not aware of the established WORK INSTRUCTION for standard bleeding size.  No checking during plate making at supplier.					ME.ONSITE staff did not measure the bleeding of both sides.He only used die cut film during checking and anticipate that there is a 6mm bleeding already				
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	System	Revision of onsite inspection report ( <b>BLEEDING SIZE indicated on pre site inspection report</b> )			Roneth/ 220816
RM									
WIP									
FG									
B. Orientation					Design / Tools				
Date		Time							
Title									
Attendees									
C. Reworking					Process	Reorientation on graphic artist awareness.And to follow standard work instruction for the bleeding requirements.			Roneth/ 220825
Rework Quantity									
Total Good									
Rework Percentage (Good)									
<b>II. QA ROOTCAUSE VERIFICATION (To be filled out by QA In-charge)</b>					Date Conducted:_____ PIC:_____				
Identified Rootcause					Recommendation				
<b>III. CORRECTIVE ACTION VERIFICATION (To be filled out by QA In-charge)</b>									
	Checked by	Date	Implemented?		Remarks				
1st Verification of Action			[ ] Yes [ ] No						
2nd Verification of Action			[ ] Yes [ ] No						
3rd Verification of Action			[ ] Yes [ ] No						
Effectiveness of Action			[ ] Yes [ ] No						
<i>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.</i>									
<b>IV. CLOSURE</b>									
Status:	Remarks:	Approved by:			Process Owner Acknowledgment: (Receiving Section)				
<input type="checkbox"/> Closed		QA Supervisor		QA Asst. Manager	Line Leader		Department Head		
<input type="checkbox"/> Still Open									
<input type="checkbox"/> Re-Issue IRF		Date:	Date:	Date:	Date:				