August 6, 2025

Company name: Nikkiso Co., Ltd.
Representative: Koichi Kato,
Representative Director, President & CEO
(Code No. 6376, TSE Prime Market)
Contact: Masaharu Murakami,
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(Updated) Notice Regarding Receipt of the Investigation Report from a Special Investigation Committee

It has been discovered that some of the pumps manufactured by Nikkiso Co., Ltd. (the "Company") had not undergone part of the internal inspection (pressure resistance test) based on the quality plan established by the company's internal regulations before shipping (hereinafter referred to as the "Incident"), as previously announced in "Regarding the establishment of a special investigation committee" dated February 28, 2025.

The Company has established a special investigation committee consisting mainly of external experts in order to conduct the investigation for further fact-finding and cause analysis, and has cooperated with the investigation by the special investigation committee, aiming to identify the facts and ensure early completion of accounting-related procedures.

The Company has now received the investigation report from the special investigation committee and hereby reports as follows.

The Company deeply apologizes for the great concern and inconvenience caused to our shareholders, investors, our customers, and everyone else concerned. The Company seriously takes the investigation results from the committee and will devote full efforts to restoring trust and preventing recurrence.

1. Investigation results from the special investigation committee

Please refer to the attached "investigation report (summary)" for the findings of the special investigation committee. Please note that the investigation report has been partially simplified and subject to non-disclosure measures from the perspectives of personal information protection and confidential information protection.

2. Impact on consolidated financial performance

According to the investigation report, the impact of the incident on the group's consolidated financial results for the fiscal year ending December 31, 2025, will be negligible, and there are no revisions to the full-year financial forecasts.

3. Responding to the incident

(1) Recurrence prevention measures

The investigation report from the special investigation committee contains recommendations for recurrence prevention measures.

The Company sincerely accepts the investigation results from the special investigation committee and will formulate specific recurrence prevention measures in accordance with the recommendations for preventing future recurrence, and will devote its full efforts to their implementation. The Company will announce specific recurrence prevention measures in a timely manner.

(2) Clarifying the responsibilities

The Company's executives take the incident seriously and there were offers to voluntarily return a portion of compensation at the Board of Directors as follows.

Representative Director, President & CEO Koichi Kato	voluntarily return 30% of monthly remuneration for a period of one month
Chairman and Director Toshihiko Kai	voluntarily return 20% of monthly remuneration for a period of one month
Director, Executive Officer Yoshihiko Kinoshita	voluntarily return 10% of monthly remuneration for a period of one month

Also, certain employees involved in the incident will be subject to disciplinary actions based on the internal regulations.

Investigation Report

Summary Version

31 July 2025

Special Investigation Committee

For Nikkiso Co., Ltd.

To: Nikkiso Co., Ltd.

Special Investigation Committee

For Nikkiso Co., Ltd.

Committee Chairperson	Naoyuki Kishimi
Committee Member	Yuta Kakura
Committee Member	Motohiro Takeuchi

Chapter 1. Overview of the Investigation

I. Background of the Investigation and Establishment of the Special Committee

In October 2024, while reviewing the manufacturing processes at the Industrial Plant of the Industrial Division of Nikkiso Co., Ltd. (hereinafter sometimes referred to as the "Division" or the "Company"), it was discovered that certain pump products had not undergone some portions of the internal pressure resistance tests required by internal inspection procedures[1].

An internal investigation revealed that, for certain products of the Canned Motor Pump (hereinafter referred to as the "NonSeal Pump") and the Reciprocating Pump (hereinafter referred to as the "Milflo Pump") manufactured by the Company, water pressure tests had not been performed, yet test result certificates stated that the water pressure tests had been conducted and were submitted to customers (hereinafter referred to as the "Incident").

Determining that it was necessary to ascertain the facts of the Incident discovered within the Division and to identify whether similar incidents existed, the Company established a Special Investigation Committee (hereinafter referred to as the "Committee") on February 28, 2025, including external experts, and entrusted it with the investigating the Incident and related matters.

II. Composition of the Committee

The Committee is composed as follows:

- Chairperson: Naoyuki Kishimi (Attorney-at-law, City-Yuwa Partners)
- Member: Yuta Kakura (Attorney-at-law, City-Yuwa Partners)
- Member: Motohiro Takeuchi (Full-time Corporate Auditor of the Company)

In addition, eight attorneys from City-Yuwa Partners participated in the investigation as supporting members.

III. Purpose of the Committee

The purposes of the Committee are:

1. Fact-finding regarding the Incident;
2. Determining whether similar incidents exist; and
3. Analyzing the causes of the Incident and recommending measures to prevent recurrence.

[1] The Company conducts two types of pressure resistance tests: one using water for pressurization and the other using gas (nitrogen) for pressurization. In this report, the test using water is referred to as the "water pressure test," and the test using gas is referred to as the "airtightness test" to distinguish between them.

Chapter 2. Overview of Investigation Procedures and Methods

I. Basic Policy of the Investigation

To verify the implementation status of the water pressure tests for the Pumps, the Committee decided to conduct interviews primarily with individuals associated with Miyazaki Nikkiso Co., Ltd. (hereinafter referred to as "Miyazaki Nikkiso"), the manufacturing site for the Pumps.

In addition to clarifying the facts of the Incident, the Committee determined to investigate whether similar incidents had occurred within the Company, analyze the causes leading to the Incident, and consider effective measures for preventing recurrence. The investigation covered the period retroactive to January 1, 2015.

To uncover the full scope of the Incident, the Committee closely examined materials at the Company and Miyazaki Nikkiso and conducted digital forensic investigations on computers loaned to relevant individuals and data stored on servers. Furthermore, for the purpose of identifying similar or related incidents, a questionnaire survey was conducted among officers and employees of the Company's Industrial Division.

II. Investigation Period

The period required by the Committee to conduct the investigation relating to the Incident was from February 28, 2025, to July 28, 2025.

III. Subject Period of Investigation

The investigation target period concerning the Incident was from January 1, 2015 (approximately ten years retroactive from the discovery of the Incident in October 2024) to October 31, 2024 (the end of the month in which the Company recognized the Incident).

Given that the depreciation period for the Company's products is seven years, the investigation period was extended by several additional years as a buffer period, also taking into account the replacement period for the Company's products.

IV. Investigation Methods

The Committee's investigation of the Incident and similar cases (hereinafter referred to as the "Investigation") was primarily conducted using the following methods:

1. Interviews with officers and employees;
2. Review of transaction-related materials and analysis of transaction data;
3. Digital forensics;
4. Questionnaire survey; and
5. Operation of an interim reporting hotline.

V. Premises and Limitations of the Investigation

This report summarizes the results of investigations and analyses conducted to the extent considered reasonably appropriate, based on the voluntary cooperation of Company-related persons and business partners and the materials and information thus obtained. However, since the investigators lacked any legally enforceable investigative authority, the investigation had inherent

limitations. If it is later revealed that important information was not disclosed or provided, the factual findings and evaluations contained in this report may be subject to change.

Chapter 3.

(Omitted)

Chapter 4. Facts Identified Regarding the Incident

I. Overview of the Investigation Triggered by the Discovery of Partial Omission of Water Pressure Tests

The Committee initiated its investigation in October 2024, when it was discovered that certain Pumps manufactured by the Company had not undergone the required water pressure tests. Subsequently, it was also determined that a portion of airtightness tests had likewise not been conducted. As a result, the scope of the investigation was also expanded to include the airtightness tests, with the objective of investigating the root cause of the partial omission of both tests.

II. Water Pressure Tests and Airtightness Tests for the NonSeal Pump

(1) Overview and Purpose of Both Tests

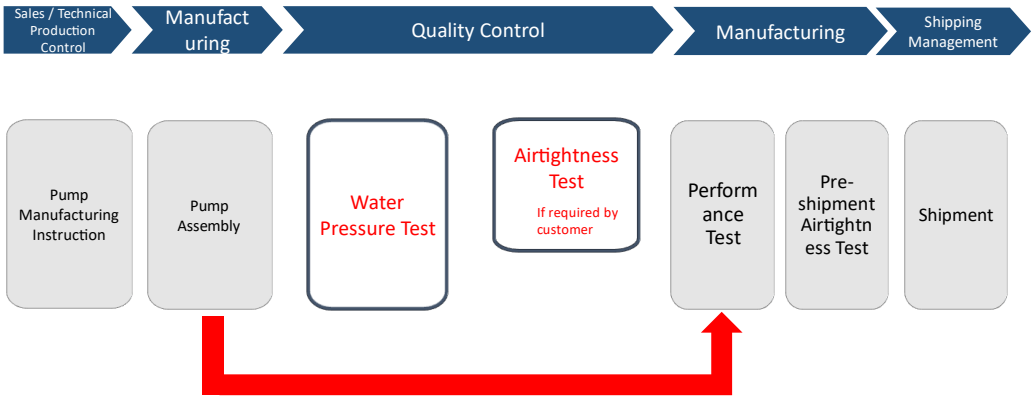
The purpose of conducting water pressure tests and airtightness tests on the NonSeal Pump is to apply pressure higher than the design pressure to the pump and to check for leaks (caused by the use of nonconforming parts or operational errors) and abnormal deformation of the pressure-retaining parts. This is to detect nonconformities such as casting voids or welding defects and thereby screening for initial product defects.

Under the Company's internal regulations, water pressure tests are required to be conducted on all units, whereas airtightness tests are not required to be performed on all units, except where their execution is mandated under the High-Pressure Gas Safety Act. Apart from such statutory requirements, airtightness tests were to be performed only when the contract with the customer explicitly required them.

Furthermore, at the time of delivery or after delivery of pumps to customers, the Company submitted to the customers inspection procedure documents describing what tests had been performed on the delivered pumps and summaries of such tests, along with test reports containing the specific test results.

(2) Standard Workflow

The process flow for conducting the water pressure test and the airtightness test within the standard workflow and manufacturing process for NonSeal Pumps at the Company is shown in the figure below.



(3) Partial Omission of Water Pressure Tests

(A) Timing and Background of Commencement

Since the NonSeal Pump was manufactured at the Higashimurayama Plant, it was required under internal company regulations that water pressure tests be conducted on all units.

However, beginning no later than the 1970s, the Company started shipping certain NonSeal Pump products to customers without performing water pressure tests, and this practice continued until March 2021, when fundamental corrective measures were implemented.

(B) Department Responsible for the Decision Not to Perform Water Pressure Tests

When the manufacturing base for the NonSeal Pump was located at the Higashimurayama Plant, the water pressure tests for the pump were conducted in the pressure testing facility of the Quality Control Department[2] (referred to internally as the "pressure test site" or "water pressure site"). Accordingly, after the pump assembly had been completed, the personnel in charge of the Manufacturing Department's Final Assembly Section would bring the pumps to the pressure testing facility.

However, based on certain criteria, assembly team personnel brought only some pumps to the pressure testing facility, and the remaining pumps were passed directly to the next process within

[2] Because the pressure resistance test applies relatively high pressure to the pump, the pressure test area is surrounded by concrete walls, and warning lights are installed to prevent third parties from entering the area during the test.

the Manufacturing Department—namely, the performance testing team—without undergoing water pressure tests and were then shipped.

(C) Criteria for Determining Whether to Perform Water Pressure Tests

The Committee interviewed long-serving employees of the Manufacturing Department and determined that personnel of the Manufacturing Department's Final Assembly Section generally applied the following criteria in deciding whether to conduct water pressure tests:

1. Pumps for which customer attendance at the water pressure test was required.

2. Pumps subject to the High-Pressure Gas Safety Act.

3. Pumps to be delivered to nuclear-related facilities (pumps designed to transfer liquids containing radioactive substances).
   Water pressure tests were conducted for these pumps, and additionally, 4. There was a tendency to perform water pressure tests on pumps with high design pressure (maximum allowable pressure).

In contrast, for pumps of standard design pressure not falling within categories 1 to 4 above, the pumps were not brought to the pressure testing facility at all, and were moved directly to the next process (performance testing team) within the Manufacturing Department, and were shipped without undergoing water pressure tests.

(D) Handling by the Manufacturing Department When Water Pressure Tests Were Not Performed

To visualize the status of each manufacturing step and prevent omissions in the processes, the Company had adopted a practice of affixing a Process Check Sheet to the cart transporting each pump during manufacturing, moving it along with the pump, and having each operator mark and sign off when their respective process was completed.

However, even in cases where water pressure tests were not performed, manufacturing personnel wrote numerical test pressure values in the "pressure marking" column of the Process Check Sheet. As a result, from the entries on that sheet alone, it was impossible to distinguish whether water pressure tests had been performed, and consequently, certain pumps were shipped without undergoing water pressure tests.

Although cross-sectional process management between operators and departments using the Process Check Sheet was implemented within the Manufacturing Department, due to the mistaken understanding that omission of water pressure tests did not pose any particular problem, management using the Process Check Sheet was not thoroughly enforced.

(E) Response of Other Departments Regarding Partial Omission of Water Pressure Tests

The Inspection Group of the Quality Control Department performed all tests on pumps brought to it by the Manufacturing Department. However, it did not go so far as to instruct the Manufacturing Department to bring all pumps for testing, nor did it take corrective measures.

In this regard, among current employees, including the employee with the longest service period as a water pressure test operator (from 2013 to 2024 in the Quality Control Department Inspection

Group), at least some were aware of the partial omission of water pressure tests. Nevertheless, because sufficient personnel had not been allocated to handle testing all units, the Quality Control Department had not built a system to supervise or monitor the Manufacturing Department to ensure full-unit testing.

The Production Management Department (currently the SCM Department's Production Management Group), except for pumps scheduled for water pressure tests with customer attendance, did not manage the schedule of which pumps would undergo water pressure tests and when those tests would be conducted. Other than pumps requiring customer-attended water pressure tests, all scheduling for tests was entrusted entirely to the Manufacturing Department. As a result, there was no opportunity for Production Management personnel to recognize that water pressure tests were being partially omitted, and the monitoring function of the Production Management Department was effectively compromised.

(F) Status of the Number and Rate of Unperformed Water Pressure Tests

In this manner, the partial omission of water pressure tests on NonSeal Pumps continued from around the 1970s until corrective measures were implemented in or around March 2021.

The transition in the implementation status of water pressure tests for NonSeal Pumps by year of shipment for the past ten years is shown in the figure below. Although there were still a few pumps identified as untested even after the corrective measures in 2021, these were regarded as likely unintentional errors. Furthermore, under the decision-making flow for determining whether tests were performed, some pumps lacked definitive evidence to prove the test had been carried out and thus were classified as untested.

Transition in the Implementation of Water Pressure Tests for NonSeal Pumps (by Year of Shipment)

(G) Failure of Corrective Measures

The Investigation revealed that, in the case of NonSeal Pumps, although as of 2020 both the Manufacturing Department and the Quality Assurance Department had recognized the partial omission of water pressure tests as a problem and had reported it up to the plant manager level, no corrective measures were subsequently implemented until much later.

Meanwhile, the Company, led mainly by the Manufacturing Department and the Quality Control Department (renamed the Quality Assurance Department from April 2020), had considered the fabrication of jigs to perform water pressure tests more efficiently. Although test trials using prototype jigs were conducted, no further jig fabrication followed, and consequently, full-unit testing was not achieved.

The failure of these corrective measures appears to have been primarily caused by staff in the Quality Control Department and the Manufacturing Department being preoccupied with immediate customer responses. As a result, the omission of water pressure tests, which affected the pumps, was treated as an issue only within the limited scope necessary for specific customer explanations, narrowing the analysis of root causes and the consideration of preventive measures.

Even though the Industrial Plant Manager and department-level managers were aware of the partial omission of water pressure tests, no fundamental measures beyond customer responses were implemented, nor were issues reported to the Quality Assurance Committee or mentioned in weekly reports. Consequently, senior management, including directors, was not made aware of the situation, and corrective measures were not implemented.

(H) Corrective Measures Implemented by the Company

At the Company's Industrial Plant, in preparation for the start of operations at the Miyazaki Plant in January 2021 and the transfer of NonSeal Pump production to the Miyazaki Plant in June of the same year, a working group was established to consider corrective measures aimed at resolving workflow issues observed at the former Higashimurayama Plant so that such problems would not be carried over to the Miyazaki Plant.

As part of these considerations, during an internal meeting held on February 9, 2021, concerning the implementation of water pressure tests for pump components, it was pointed out that full-unit testing of NonSeal Pumps was not being conducted as required by internal regulations. Consequently, it was decided that, for shipments from March 15, 2021, onward, water pressure tests would be conducted on all NonSeal Pumps produced by the Company.

Subsequently, on June 1, 2021, the manufacturing base for NonSeal Pumps was transferred to the Miyazaki Plant, where a space for performing water pressure tests was established within the Manufacturing Department. At the time of the Investigation, this practice had been confirmed to be maintained and continued. As noted above regarding the transition in the implementation status of water pressure tests for NonSeal Pumps, the above corrective measures were effective, as evidenced by a sharp decline in the number of partially unperformed water pressure tests after 2021.

(I) Automated Test Result Printing Program

As a structural issue that enabled the partial non-performance of water pressure tests and airtightness tests for NonSeal Pumps to continue for many years, the Quality Control Department used an automated test result printing program (hereinafter referred to as the "Automated Printing Program") incorporated into AS400 (the core system used by the Industrial Division; hereinafter referred to as "AS400"). This program created a situation in which test result records could be automatically generated for pumps even when water pressure tests (or airtightness tests) had not actually been performed.

After the introduction of this Automated Printing Program, when it was necessary to submit pressure test records to customers, personnel of the Quality Control Group of the Quality Control Department ran the Automated Printing Program to output pressure test records without verifying whether the water pressure tests had actually been performed. Subsequently, water pressure test personnel of the Quality Control Department's Inspection Group affixed their seals in the inspector column of those records, thereby creating pressure test records for submission to customers.

In February 2020, concerns were raised by personnel of the Quality Control Department that this Automated Printing Program enabled the creation of pressure test records even when water pressure tests had not been performed, and the Head of the Higashimurayama Plant instructed improvements. However, the Quality Control Department Manager and other related personnel did not hold discussions towards corrective action, nor did they take any specific measures, resulting in the continued creation of pressure test records using the Automated Printing Program. In order to prevent recurrence, the Automated Printing Program has been rendered completely unusable.

(J) Awareness of Non-Performance of Tests by Officers

The Committee reviewed emails related to the reporting line to the General Manager of the Industrial Division, including successive Plant Managers, Production Center Managers, Quality Assurance Department Managers, and Quality Control Department Managers, but found no facts indicating that officers were aware of the non-performance of tests. In addition, interviews conducted with successive General Managers of the Industrial Division revealed no facts indicating awareness or involvement in such non-performance.

(4) Partial Non-Performance of Airtightness Tests

The personnel in charge of the NonSeal Pump's assembly group could not accurately determine when an airtightness test was required based on customer specifications. Even when they could identify that an airtightness test was required, they could not correctly determine the test conditions and therefore could not perform tests under the customer-specified conditions.

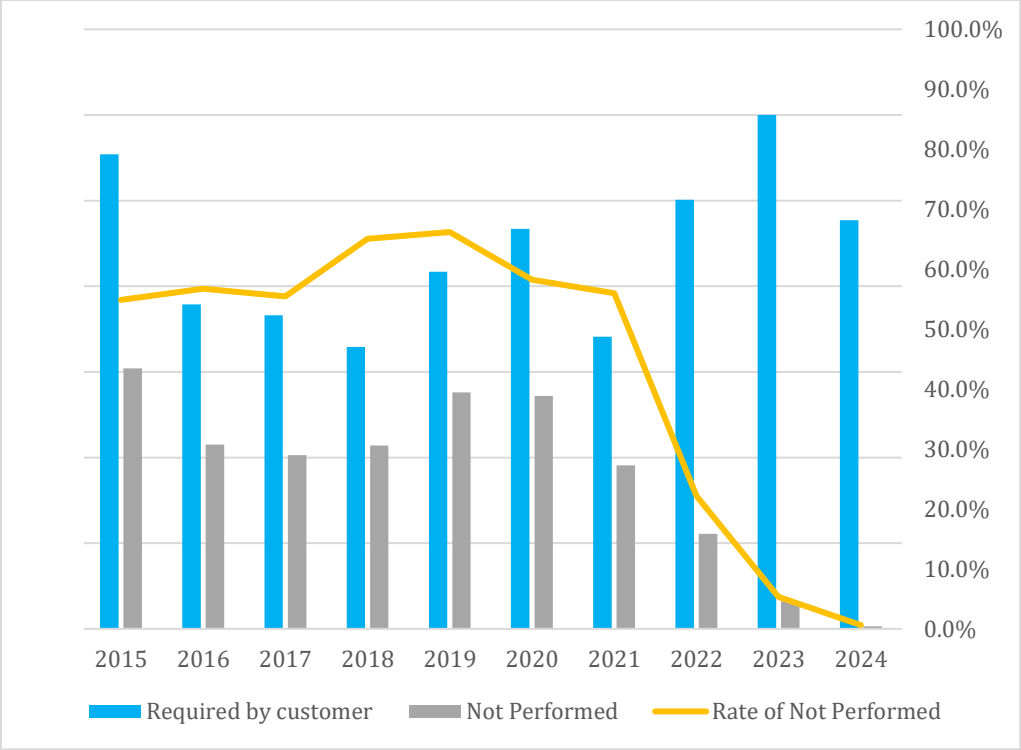
It should be noted that there is a test similar to the airtightness test at the Company, namely, the pre-shipment airtightness test performed prior to shipment on all NonSeal Pumps produced by the Company. While both tests use the same method of applying pressure to the pump with nitrogen or plant air, they differ in whether the test is customer-specified and in the magnitude of the pressure applied during testing[3].

[3] The differences between pre-shipment airtightness test and airtightness test are as follows:

The non-performance of airtightness tests continued until around 2021; however, the personnel in charge of the pre-shipment airtightness section of the Manufacturing Department at that time considered the procedures handed down from their predecessors to be error prone. From the perspective of improving operational efficiency, they adopted a method of determining the testing conditions for each pump based on the inspection work item list available on the Company's internal website. Between the second half of 2021 and 2022, work instructions related to this operation were created.

As a result of these efforts, from 2021 onward, the number of cases of partial non-performance of airtightness tests has significantly decreased.

Transition in the Implementation of Airtightness Tests for NonSeal Pumps (by Year of Shipment)



	Test Conditions	Test Pressure	Holding Time
Pre-Shipment Airtightness Test	Performed on all units	Low pressure (0.6 MPa or 2 MPa, depending on design pressure *)	3 minutes
Airtightness Test	Only when required by the customer	Pressure specified by the customer	Time specified by the customer

* If the pump's design pressure is less than 2 MPa, the test pressure is 0.6 MPa; if 2 MPa or higher, the test pressure is 2 MPa(according to the NonSeal Pump Pre-Shipment Airtightness Test Procedure prior to shipment).

It should be noted that even after 2022, a certain percentage of airtightness tests continued to be partially omitted. From 2022 to 2023, the above-mentioned method for determining testing requirements was not thoroughly communicated, and in cases where other Manufacturing Department employees conducted the pre-shipment airtightness test in the absence of the regular pre-shipment airtightness test personnel, they could not accurately interpret whether customer-specific airtightness tests were required or determine the correct test conditions. These omissions were determined not to be intentional deviations.

The Committee conducted an email review targeting successive Plant Managers, Production Center Managers, and Quality Control Department Managers who were in the reporting line to the General Manager of the Industrial Division regarding airtightness testing, and also conducted interviews with successive General Managers of the Industrial Division. As a result, no evidence was found that they were aware of or involved in incidents of partial non-performance of airtightness tests.

(5) Relevant Laws and Customer Contracts

With respect to water pressure tests and airtightness tests for NonSeal Pumps, the High-Pressure Gas Safety Act is cited as a relevant law for some pumps. However, for pumps subject to this Act, both the water pressure test and the airtightness test were performed, and thus no violation of law was identified.

On the other hand, there were cases where customers were informed that water pressure tests would be performed, and airtightness tests were performed upon customer request, with test records being provided when requested. Accordingly, contractual issues with customers could potentially arise. Nevertheless, because the purpose of both tests is to screen for initial product defects, and as described in Section IV.5 below, reports of defects from customers have been very few, the impact of not performing these tests is considered to have been limited.

III. Water Pressure and Airtightness Tests for Milflo Pumps

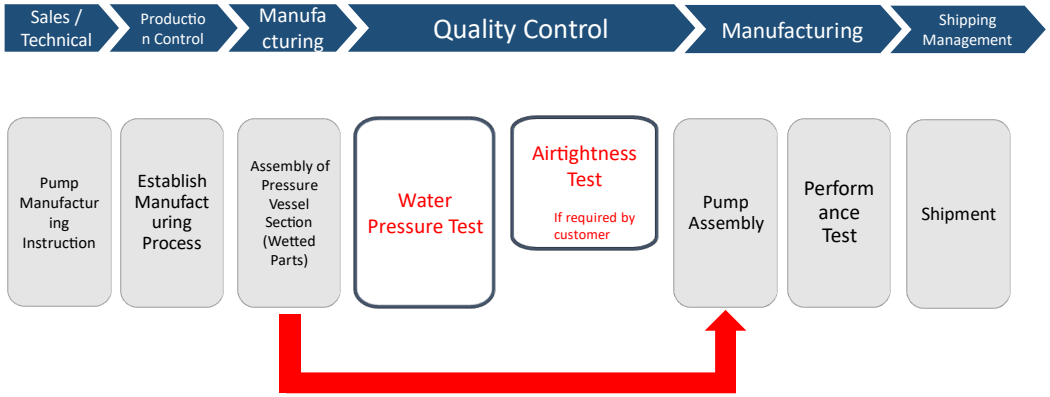
(1) Overview of Tests

The primary purpose of water pressure tests and airtightness tests for Milflo Pumps is the same as for NonSeal Pumps: by applying pressure higher than the design pressure to the pump's pressure-containing components (also called wetted parts), confirm the absence of leaks or abnormal deformation caused by the use of non-compliant parts or assembly errors, and detect non-conformities such as casting voids and welding defects, and thereby screening for initial product defects.

Under the Company's internal regulations, water pressure tests are required to be performed on all units. In contrast, airtightness tests are not required for all units and are only performed where mandated under the High-Pressure Gas Safety Act or when contractually agreed with the customer.

(2) Standard Workflow

The process flow for conducting the water pressure test and the airtightness test within the standard manufacturing process for Milflo Pumps at the Company is shown in the figure below. In cases where these tests were not performed, as indicated by the red arrows in the figure, the pumps were not brought to the Quality Control Department after the assembly of the pressure vessel section (wetted parts) by the Manufacturing Department, but instead proceeded directly to the next process, pump assembly, which was conducted by the Manufacturing Department.



(3) Partial Omission of Water Pressure Tests

(A) Commencement Period and Background

Since at least the 1970s, the Company began shipping certain Milflo Pumps to customers without conducting water pressure tests, and this practice continued even after the relocation of the manufacturing base to the Miyazaki Plant, persisting until around October 2024 when this matter came to light.

(B) Department Responsible for Determining Omission of Water Pressure Tests

The partial omission of water pressure tests for Milflo Pumps began no later than the 1970s and continued for a long period until October 2024. It was recognized that the Production Management Department consistently made determinations on whether to conduct water pressure tests, and this did not change even after the manufacturing base was relocated from the Higashimurayama Plant to the Miyazaki Plant.

(C) Criteria for Determining Whether to Conduct Water Pressure Tests

The Committee investigated the criteria used by production management personnel in deciding whether or not to conduct water pressure tests and found that such determinations were generally made based on the following criteria:

1. When customer attendance at the water pressure test was required.

2. When the specifications of the pump to be manufactured were Grade 2 or higher.

3. When the specifications of the pump to be manufactured were Grade 1 and, in addition.
   i. subject to the High-Pressure Gas Safety Act;
   ii. destined for nuclear-related facilities; or
   iii. subject to the Fire Service Act.

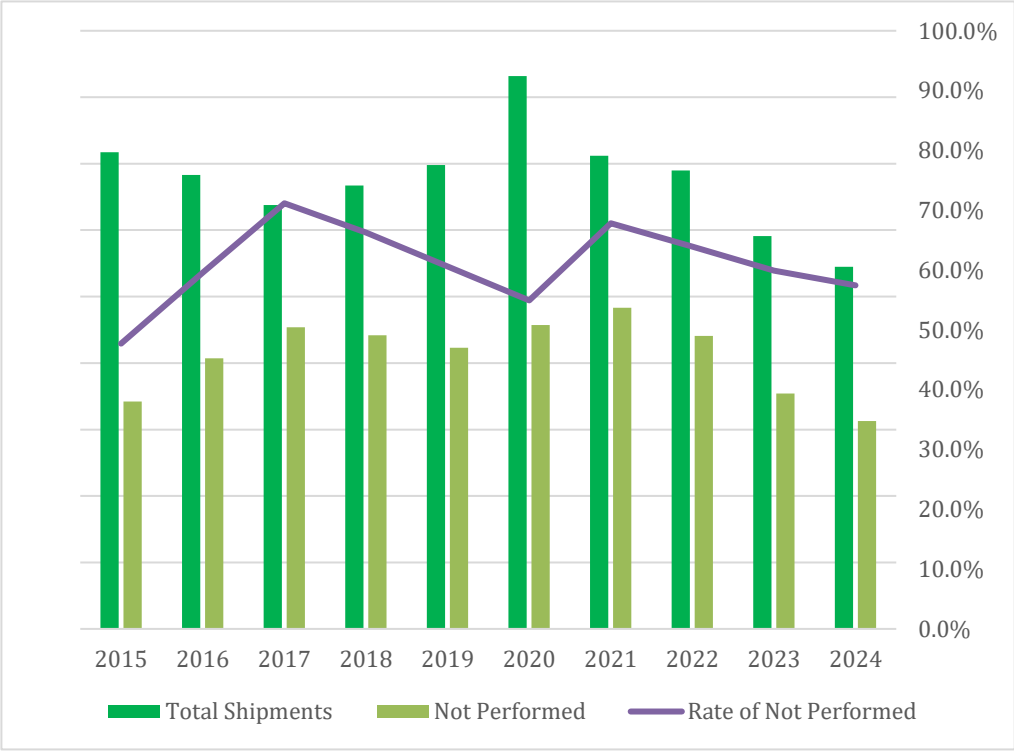
Water pressure tests were conducted in these cases. However, for pumps not falling under any of the above categories 1. through 3., based on these criteria, decisions were made on whether to conduct water pressure tests, and the manufacturing process was planned accordingly.

(D) Numbers and Rates of Unperformed Water Pressure Tests

Thus, from around the 1970s through October 2024, at both the Higashimurayama Plant and the Miyazaki Plant, despite the awareness by the Production Management Department, the Manufacturing Department, and the Quality Control Department—all of which were actually involved in the pump manufacturing process—that some water pressure tests were not being performed, the omission of water pressure tests continued.

The transition in the implementation status of water pressure tests for Milflo Pumps over the past ten years, by year of shipment, is shown in the figure below.

Transition of Water Pressure Testing Implementation for Milflo Pumps (by Shipment Year)



(E) Failure of Corrective Measures

With regard to the Milflo Pumps, although corrective measures were considered in February 2020 following the discovery of partial omissions in water pressure testing for NonSeal Pumps, no corrective measures were implemented to ensure full testing.

While water pressure tests for NonSeal Pumps were, in principle, fully implemented for shipments on or after March 15, 2021, ahead of the relocation to the Miyazaki Plant, no specific corrective measures were implemented to ensure full testing of Milflo Pumps. In this regard, the leader of the SCM Department Production Management Group considered it more practical to adopt an operational pressure-resistance testing method (a method of performing water pressure testing in conjunction with operational testing after pump assembly) to avoid the complicated current method that required temporary assembly of the pressure vessel section[4]. The leader consulted with the technical department on the feasibility of changing the testing method and revising the internal regulations accordingly, but received a response that such changes were difficult to implement.

Subsequently, the SCM Department Production Management Group became preoccupied with preparations for the relocation of the production base to the Miyazaki Plant in June of the same year, and discussions on implementing full water pressure testing were abandoned. Even after the relocation to the Miyazaki Plant, discussions on implementing full water pressure testing were not resumed because priority was given to addressing disruptions in the manufacturing site caused by the relocation, delays in delivery schedules, and related issues. As a result, partial omissions in water pressure testing continued without resolution, and the number and rate of untested pumps did not decrease after 2021, continuing until the Incident was discovered in October 2024.

(F) Awareness of Test Omission by Officers

The Committee reviewed emails involving successive Plant Managers, Production Center Managers, Quality Assurance Department Managers, and Quality Control Department Managers who reported to the General Manager of the Industrial Division concerning the implementation of water pressure testing. However, no facts were found indicating that any officers were aware of the partial omission of tests. In addition, interviews conducted with successive General Managers of the Industrial Division revealed no facts suggesting that they had been aware of or involved in the partial omission of tests.

(4) Partial Omission of Airtightness Tests

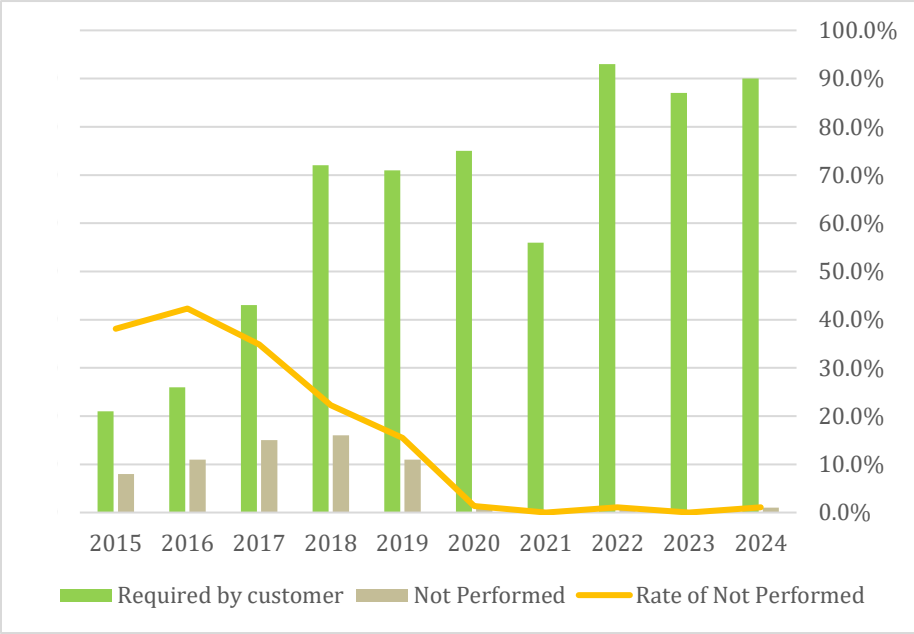
Interviews with successive production management personnel in charge of Milflo Pumps revealed that all personnel believed airtightness tests had been fully implemented. Even in the Investigation, it was not possible to determine when the partial omission of airtightness tests began, or the circumstances and decision criteria behind it.

In this regard, the only difference between the water pressure test and the airtightness test is whether water or gas (nitrogen) is used to apply pressure. However, it is possible that some production management personnel mistakenly assumed that airtightness tests should be determined based on the same criteria as water pressure tests, and therefore prepared manufacturing processes

[4] The reciprocating pumps of LEWA GmbH (Germany), represented by the Company, adopt the operational pressure resistance testing method.

that omitted airtightness tests for certain pumps requiring them, leading to the partial omission of airtightness tests.

Transition of Airtightness Test Implementation Status for Milflo Pumps (by Shipment Year)



The number of omitted airtightness tests for Milflo Pumps has remained very low since 2020 and is generally considered to have improved. Following the Investigation, a mechanism was introduced requiring employees from the Manufacturing Department, the Quality Control Department, and the Production Management Department to secure time each morning to share manufacturing progress, discuss production control, and mutually confirm whether pumps under production require airtightness testing as requested by customers, to prevent any omissions of airtightness testing, including human error.

The Committee, as with water pressure tests, conducted an email review of successive Plant Managers, Production Center Managers, Quality Assurance Department Managers, and Quality Control Department Managers who reported to the General Manager of the Industrial Division, and conducted interviews with successive General Managers of the Industrial Division. No facts were found indicating awareness or involvement in the partial omission of airtightness tests.

(5) Relevant Laws and Customer Contracts

As with NonSeal Pumps, some Milflo Pumps are subject to the High-Pressure Gas Safety Act as a relevant law for water pressure and airtightness tests. However, because water pressure and airtightness tests were performed on pumps subject to this law, no legal violations were identified.

On the other hand, there were cases where customers were informed that water pressure tests would be conducted, and airtightness tests were performed upon customer request, with inspection records submitted when requested. Therefore, there is potential for contractual issues with customers. However, given that the purpose of both tests is to screen for initial product defects, and as described in Chapter IV.5 below, since no defect reports from customers were confirmed, the impact of not conducting these tests is considered limited.

IV. Divergence in Timing of Corrective Actions for Water Pressure Testing between NonSeal Pumps and Milflo Pumps

While corrective action for NonSeal Pumps resulted in water pressure tests being conducted on all products shipped on or after March 15, 2021, Milflo Pumps continued to have untested products, and partial omission of testing persisted until the Incident was discovered in October 2024.

Although both pumps were manufactured within the Manufacturing Department, and the partial omission of water pressure testing for both pumps was recognized in an internal meeting on February 9, 2021, corrective action was limited to NonSeal Pumps, resulting in more than three years' difference in timing.

According to the Committee interviews, within the Manufacturing Department, Quality Control Department, and Production Management Department for Milflo Pumps, even after the implementation of full testing for NonSeal Pumps, no particular concerns or attempts at improvement were observed regarding the difference in corrective actions between the two pumps.

This can be attributed to the fact that although both pumps were produced within the same Manufacturing Department, they had separate production lines, with little personnel exchange due to the specialized nature of pump manufacturing tasks. Furthermore, in the Production Management Department[5], separate personnel were assigned for each pump line, with little operational interaction between them. Consequently, the difference in corrective actions for the two pumps was not considered problematic, and the follow-through of the February 9, 2021, internal meeting decision to implement corrective actions was left to individual personnel.

Additionally, although the Quality Control Department, which was responsible for water pressure testing of both pumps, was in a position to take necessary measures to ensure full testing, it was confirmed that corrective measures were only partially implemented by some employees, limited to the introduction of booster pumps for NonSeal Pumps. No evidence was found that the Quality Control Department as a whole had encouraged the Manufacturing Department or the Production Control Department to take corrective measures.

In conclusion, for Milflo Pumps, corrective measures were left to individual personnel in the Production Management Department, which was involved in deciding whether or not to conduct water pressure tests, and no corrective measures were taken by the Quality Control Department. As a result, differences in corrective action arose between the two pumps, and partial omission of testing persisted until the Incident was discovered in October 2024.

V. Impact on Safety Due to Omission of Tests for the Pumps

(1) NonSeal Pumps

The NonSeal Pumps manufactured by the Company have been standardized from the design stage to have strength equivalent to that of pressure vessels and are compliant not only with Japanese Industrial Standards (hereinafter "JIS Standards") but also with the High-Pressure Gas Safety Act. Therefore, they can be evaluated as being designed to ensure sufficient safety.

The purpose of conducting water pressure tests on NonSeal Pumps is to check for leaks and deformations in pressure-bearing parts caused by the use of nonconforming parts or operational

[5] The name at that time in 2021 was the SCM Department Production Management Group.

errors, and to detect defects such as casting voids and welding failures. These tests serve to screen for initial product defects by detecting leaks present at the time of inspection.

In addition, before shipping, the Company conducts a pre-shipment airtightness test on all products. This pre-shipment airtightness test can be regarded as having a similar screening function to the water pressure test because it applies an air pressure of 0.6 MPa or 2.0 MPa (depending on the design pressure) for three minutes to detect leaks.

From the complaint data covering all customer claims received by the Company[6], defects reported for NonSeal Pumps were extracted and examined. The defects that were expected to be detected by conducting water pressure tests—specifically casting voids and welding failures—were found in only two units out of a total of 28,405 shipped between January 2015 and June 2021, including the period when some water pressure tests were not performed, representing an incidence rate of 0.007%. Moreover, for the period after July 2021, when water pressure tests were performed on all NonSeal Pumps, no defects that could have been detected by water pressure testing were reported. Even when the review period is extended to cover January 2015 to October 2024, only two such defects were identified among a total of 43,755 units shipped, representing an incidence rate of 0.005%.

(2) Milflo Pumps

Similarly, the Milflo Pumps manufactured by the Company have been standardized from the design stage to have strength equivalent to that of pressure vessels and are compliant with both JIS Standards and the High-Pressure Gas Safety Act, and therefore can be evaluated as being designed to ensure sufficient safety.

The purpose of conducting water pressure tests on Milflo Pumps is the same as for NonSeal Pumps: to check for leaks and deformations in pressure-bearing parts caused by the use of nonconforming parts or operational errors, and to detect defects such as casting voids and welding failures. These tests serve to screen for initial product defects by detecting leaks present at the time of inspection.

In addition, prior to shipment, the Company conducts a performance test on all products, in which water is used to apply the customer-specified discharge pressure while verifying discharge at or above the rated flow rate. This test is considered to have a function similar to water pressure tests in terms of verifying leak detection.

From the complaint data covering all customer claims received by the Company, defects reported for Milflo Pumps were extracted and examined[7]. For the period from January 2015 to October 2024, there were no reported cases of casting voids or welding failures, which are the types of defects that water pressure tests are designed to detect, among the total of 6,773 units shipped. No defects that could have been detected by water pressure testing were reported.

[6] In the Company, customer complaints are shared with the Quality Assurance Department through the responsible sales representative, and all complaints are registered in the complaint database.

[7] The extraction method was the same as that used for the NonSeal Pumps described above.

Chapter 5. Facts Revealed by Investigations Outside the Incident

I. Cable Bending Test for Cryogenic Pumps

(1) Background of Investigating the Cable Bending Test

In a questionnaire survey conducted by the Committee, responses were received indicating that cable bending tests (hereinafter referred to as the "Cable Bending Test") for cryogenic pumps had not been performed. Based on these responses, the Committee conducted interviews with personnel from the Quality Control Department Inspection Group who were in charge of the Cable Bending Test and confirmed that, as indicated in the questionnaire survey responses, the Cable Bending Test had indeed not been performed.

(2) Overview of the Cryogenic Pump and the Cable Bending Test

A cryogenic pump refers to a submersible motor pump used for transferring low-temperature liquefied gases such as LNG (liquefied natural gas) and LPG (liquefied petroleum gas) and is a general term for specialized pumps handling cryogenic liquids. Because such pumps are directly immersed in LNG storage tanks, taking advantage of LNG's non-conductive properties, their power cables (hereinafter referred to as "Cryogenic Cables") are also intended for use in cryogenic environments.

The Company outsources the manufacturing of Cryogenic Cables to external suppliers. Around 1999, the Company received a request from customers to verify in advance, through testing, that the insulation would not crack even when the Cryogenic Cable, cooled to cryogenic temperatures, was repeatedly bent and stretched as might occur during maintenance. In response, the Company introduced the Cable Bending Test.

(3) Background and Status of Test Omission

Since the introduction of the Cable Bending Test in 1999, the frequency of implementation has been relatively low—at most once or twice a month, and as infrequent as once every six months at times. During that period, the Cable Bending Test appears to have been conducted whenever requested by customers.

However, according to interviews conducted by the Committee, although the exact starting time and circumstances are unclear, the Cable Bending Test had ceased to be performed by around 2017 at the latest and the Cable Bending Test had not been carried out except when required under customer attendance testing.

(4) Impact of Cable Bending Test Omission on Product Quality and Safety

The Cable Bending Test is performed upon customer request and is intended to confirm that insulation does not crack when cables are repeatedly bent and stretched under low-temperature conditions similar to those encountered during actual use. The Company enforces strict 4M change management for suppliers manufacturing the cables and screens for initial defects through standard electrical testing for initial failures.

Moreover, the Cable Bending Test does not need to be conducted for every cable; it is performed on sample cables from the same lot rather than on cables actually shipped. Since there have been

no reported defects attributable to the absence of the Cable Bending Test, it was concluded that the impact on product quality and safety was negligible.

(5) Awareness by Officers of Test Omission

The Committee also investigated whether the Company's officers were aware of the omission of the Cable Bending Test and found no evidence suggesting that the officers had such awareness.

II. Partial Omission of Calibration and Verification

(1) Background and Scope of the Investigation of Calibration and Verification

In the questionnaire survey conducted by the Committee, responses were received indicating that there had been periods up to around 2021 during which thread gauge calibration[8] and verification[9] (hereinafter collectively referred to as "Calibration Tests") had not been performed. Interviews were conducted with a former employee of the Industrial Plant Quality Control Department, Quality Control Group (hereinafter "Former Calibration Test Responsible Employee"), who had been solely responsible for Calibration Tests between around 2016 and 2021. This individual admitted to not performing measurements of effective diameter for Calibration Tests of the thread gauge, prompting the Committee to recognize the need to investigate this issue as a separate area of concern.

The investigation also covered Calibration Tests for pressure gauges and other measurement instruments used in water pressure tests and related procedures.

(2) Status of Calibration Tests for Measurement Instruments

With respect to the thread gauges, given the Former Calibration Test Responsible Employee's admission of non-performance of Calibration Tests and the fact that no calibration failures ("calibration dropouts") were recorded between 2016 and 2020—but that after all thread gauges were switched to external calibration in December 2021, 155 out of 633 gauges failed calibration—it was determined that Calibration Tests had not been performed prior to December 2021.

It was confirmed that calibration tests had been performed for pressure gauges and nine other types of measuring instruments, while five types of measuring instruments had not undergone calibration tests, and two types were identified for which calibration tests had not been performed in accordance with prescribed procedures.

(3) Impact of Calibration Test Omission on Product Quality and Safety

Among the measurement instruments for which omission of Calibration Tests was confirmed by the investigation of the Committee, the thread gauges might have exceeded allowable tolerances

[8] To determine the deviation and other values between the reference instrument and the measuring instrument. Specifically, this is done by measuring the reference instrument (also referred to as the primary calibration instrument) with the measuring instrument and calculating the difference (instrument error) between the value that should be measured by the reference instrument and the value measured by the measuring instrument.

[9] To verify whether the deviation and other values meet the required standards.

due to wear. However, even if worn the thread gauges were used in production, the resulting threaded connections would have tended to be tighter rather than looser, meaning that there was no risk of dangerous looseness.

For analog measurement instruments, the structural characteristics make it unlikely that significant measurement errors would occur. Furthermore, digital instruments are used for critical safety-related measurements. Therefore, even where Calibration Tests were not performed, the impact on product quality and safety was determined to be extremely small.

(4) Awareness by Officers of Test Omission

During the course of the Committee's investigation, no documents, emails, or other evidence were found indicating that officers were aware of partial omissions of Calibration Tests, nor was there any evidence suggesting that the officers had instructed employees not to perform Calibration Tests or otherwise condoned such omissions.

Chapter 6. Accounting Impact and Analysis

I. Accounting Impact of the Incident

The consideration for water pressure tests of NonSeal Pumps and Milflo Pumps was not separately stated as an additional charge in estimates provided to customers, and no cases were identified where costs related specifically to water pressure tests were itemized and invoiced.

However, among the Pumps identified in the Investigation as having omitted water pressure tests, while costs related to such tests were not explicitly indicated, an estimated amount including testing costs under items such as "Comprehensive Testing Costs" had been added to quotations for 145 units of NonSeal Pumps and 3 units of Milflo Pumps.

For these Pumps, although the Company does not believe there is a need to replace products already delivered, it calculated potential refund amounts based on test grade and pump size in anticipation of possible refund requests from customers for the costs corresponding to the unperformed water pressure tests and recorded these amounts as the financial impact of the Incident.

On the other hand, airtightness tests are performed only when requested by the customer. Among the Pumps identified in the Investigation as having omitted airtightness tests, 44 units of NonSeal Pumps had explicitly stated amounts for airtightness tests, and 357 units of NonSeal Pumps and 6 Milflo Pumps had received orders with estimated amounts including test costs under items such as "Comprehensive Testing Costs," even though such costs were not separately specified.

For these Pumps, the Company calculated potential refund amounts based on the additional costs for airtightness tests and recorded these as the financial impact of the Incident.

While it is difficult to completely eliminate the possibility of liability for damages arising from unperformed tests, product defects directly attributable to such omissions are extremely rare, and aside from the refund amounts above, it is difficult to identify any damage resulting from these omissions. Additionally, while there is a possibility that sales activities with certain customers could temporarily slow down and orders may decline, the Company anticipates that the accounting impact will be minor. The Company also does not expect any administrative surcharges to be imposed in connection with the Incident.

(Thousand Yen)

①	Impact amount related to unperformed water pressure tests	6,373
②	Impact amount related to unperformed airtightness tests	11,192
③	Total	17,565

II. Impact of Similar Incidents

Neither the Cable Bending Test nor the Calibration Tests for Cryogenic Cables were specified in estimates, nor were additional testing fees charged separately, and therefore no accounting impact was recognized for these items.

Chapter 7. Analysis of the Causes of the Incident

The investigation by the Committee revealed that although the starting point of certain unperformed inspections could not be precisely determined, in some cases, the practices continued for an extended period even after the production base was relocated from the Higashimurayama Plant to the Miyazaki Plant, without any corrective actions.

These inspection omissions inevitably reflect a disregard for the expectations of customers and other stakeholders who relied on the Company and the quality of its products.

Underlying causes included overconfidence in product quality, adherence to outdated rules without review, a diminished awareness of compliance with quality assurance protocols, and the absence of a governance framework capable of exercising mutual oversight. Together, these factors allowed improper practices to persist over many years.

I. Overconfidence in Product Quality and Declining Commitment to Customer Engagement

The partial omission of inspections, including water pressure tests, was known at the level of successive quality assurance personnel. However, as these omissions did not result in customer complaints, it was complacently assumed that there would be no quality or safety issues. Consequently, the seriousness of the matter was not widely recognized.

In February 2021, just before the relocation to the Miyazaki Plant, there was an opportunity to rectify omissions for both NonSeal Pumps and Milflo Pumps. While corrective action was implemented for NonSeal Pumps, only a review was conducted for Milflo Pumps, and the omissions continued.

This occurred because some employees prioritized immediate problem-solving and refrained from conducting a full review or initiating improvement efforts. As a result, no transition to operations that emphasized quality assurance took place.

Many of the Company's customers are manufacturers handling industrial products. The Company lacked a clear recognition of its critical role in the overall supply chain, including final users. Employees did not adequately acknowledge their responsibilities related to product safety. Frontline managers, despite some success in identifying problems, showed little initiative in solving them and delegated resolutions back to frontline workers.

This diminished awareness of compliance with quality rules was not limited to the Quality Control Department but was also evident in the Manufacturing Department, leading to a lack of a sense of resistance to breaches of customer agreements.

II. Diminished Awareness of Process and Workflow Deviations

Partial omissions of water pressure and airtightness tests were ultimately caused by erroneous judgments by the Manufacturing Department's Final Assembly Section or production control personnel, resulting in pumps not being delivered to the Quality Control Department for testing.

One root cause behind the continuation of the Incident was that, while deviations from processes were recognized at the worker level, they were not seen as critical enough to warrant immediate corrective action. Behind this was hesitation to break with entrenched practices and a dulled awareness of deviations from proper workflows.

Such improper practices had been passed down for years and had become ingrained, creating an environment resistant to change and beyond the capacity of frontline workers to resolve fundamentally.

In addition, because the Company's products were produced in small quantities with a wide variety of types, gathering components often took time. Since inspections were usually performed late in the production process, inspectors often lacked sufficient time, leading them, in some cases, to bypass processes and workflows to meet delivery deadlines.

III. Ambiguous Responsibilities and Inadequate Evidence Retention

Responsibility for product quality and safety primarily rested with the Miyazaki Nikkiso Quality Control Department, which handled testing, and the Head Office Quality Assurance Department, which oversaw product safety and quality. In principle, these departments should have cooperated and shared responsibility for quality assurance. However, the scope of the Quality Assurance Department's duties was not clearly defined in internal rules, and its responsibilities were unclear. Moreover, it was not explicitly stated in the Quality Assurance Regulations whether the Miyazaki Nikkiso production site was treated as an outsourced facility, resulting in ambiguity regarding accountability for quality control and quality assurance.

As a result, the Head Office Quality Assurance Department, which remained at the Higashimurayama Plant, did not properly review inspection operations performed by the Quality Control Department, and its failure to engage appropriately led to the hollowing out of inspection operations.

Furthermore, the Quality Control Department's Inspection Group, which handled preparation of inspection records, repeatedly created documents that implied inspections had been performed even when they had not, submitting these to customers as official inspection records.

This was possible because the automated printing program (AS400) introduced for efficiency in NonSeal Pump inspections was misused, allowing inspection records to be generated without reflecting actual inspection results and without verification by anyone other than the inspector.

Although some workers kept personal notes, these were individual efforts without standardized procedures. Consequently, not all process records were preserved, leading to omissions in inspections.

IV. Personalization of Work, Weakness in Quality Assurance Systems, and Monitoring Deficiencies

Not only inspection tasks but operations in general had become overly dependent on individuals, with no system for visualizing workflows or tracking tasks even within the same department. With personnel assignments remaining static for long periods, problem detection was delayed.

Departments operated in isolation, lacking mechanisms for mutual oversight or checks and balances. The Company had no shared documentation or systems for overall process management, making it difficult to detect deviations from production schedules. Because independent reviews rarely occurred, it was possible to advance products to subsequent processes without inspections, and the organizational structure made such deviations hard to detect, revealing weaknesses in internal controls.

V. Dysfunction in Reporting Lines

The issues uncovered in the Investigation, in the first place, should have been reported through normal reporting lines from the shop floor through management and up to the executive level, where appropriate responses could have been considered. However, due to inadequate compliance awareness among managers who were aware of the problems, the issues were mistakenly regarded as matters to be addressed at the shop floor level, or there was hesitation to report to executives.

Although the Company had mechanisms such as weekly reports and Quality Assurance Committee meetings to escalate issues, no constructive reviews or solutions were implemented, resulting in dysfunctional reporting lines.

VI. Infrequent Review of Procedures and Reliance on Oral Instruction

Although the Company had established various procedures to support quality assurance, these had not been reviewed for decades, gradually diverging from actual shop floor operations, and no subsequent corrective actions were taken. Even when there were signs of review, bridging the gap between outdated procedures and actual practices required substantial effort and was abandoned.

Combined with the personalization of tasks, employees exercised wide discretion in operational methods and relied heavily on oral instruction during handovers. As a result, some workers were unaware of formal procedures for their assigned processes, leading to serious operational deficiencies.

Chapter 8. Recommendations for Preventing Recurrence

The development of measures to prevent recurrence should be carefully considered by the Company's Board of Directors, considering the Incident. However, based on the facts identified during the Committee's investigation, this chapter presents recommendations that can be considered at this stage.

I. Reform of Awareness Concerning Product Safety and Quality Assurance

The partial omission of inspections identified during the Committee's investigation persisted over a long period and revealed a low level of awareness of quality assurance. However, most employees neither participated in nor were aware of these issues, and there is no evidence of a corporate culture that deliberately disregarded product quality and safety.

While overconfidence in product quality appears to have been one reason for the omission of inspections, there is no indication that costs were deliberately reduced to increase profits, and historically the frequency of defective products was very low.

Nevertheless, given the occurrence and long-term continuation of these issues, there is a need to return to the fundamental principle of thoroughly ensuring product quality assurance and to instill this awareness consistently among all employees. Above all, product quality and safety must be treated as matters of professional pride in manufacturing, avoiding any justification of unsafe behavior and firmly embedding this mindset.

II. Review and Ongoing Maintenance of Quality Assurance Workflows

The inspection omissions identified in the Investigation represent deviations from established quality assurance workflows. Going forward, the Company must clarify the risks it should control and reconstruct workflows that are genuinely necessary for quality assurance.

The Investigation revealed that even when inspections were performed, internal procedures were not consistently followed, and the shared understanding of workflows was vague. It is essential to establish workflows to which all employees must adhere and to make continuous efforts to prevent deviations.

Once workflows are established, any areas requiring improvement should be reported promptly to supervisors, and regular reviews should be conducted to prevent divergence between actual practices and documented procedures.

III. Clarification of Responsibilities and Establishment of Rules for Preserving Evidence

The Company's internal rules on division of duties were unclear, resulting in ambiguity regarding accountability for quality control and assurance, resulting in the Quality Assurance Department failing to become involved in a timely and appropriate manner and leading to the hollowing out of inspection operations in practice. These rules should be revised as soon as possible to clearly define responsibilities for quality assurance and control, the position of Miyazaki Nikkiso, and the division of roles between the Quality Assurance Department and the Quality Control Department.

Furthermore, the lack of objective evidence of process execution allowed inspection omissions to persist. The Company should implement measures to record and store evidence of operations of

the Manufacturing Department, the Quality Control Department, and the Quality Assurance Department in databases or similar systems so that post-event verification is possible.

IV. Transformation into an Organization Capable of Exercising Oversight Functions

The Incident was rooted in harmful practices that persisted mainly within the Quality Control Department. From the perspective of preventing recurrence, verifying processes and workflows must be thoroughly enforced. While internal department checks alone may have limited effectiveness, awareness of internal verification itself has some deterrent effect.

Rather than placing the blame for the Incident solely on a specific department, the Company should also review its organization from a company-wide perspective to ensure external oversight of individual departments, such as by having other departments conduct periodic monitoring of quality control and quality assurance functions. For example, one possible measure would be to have other departments conduct regular monitoring audits of the Quality Control and Quality Assurance Departments.

In addition, the long-term placement of employees within the Quality Control Department created an environment where problems were easily overlooked. While specialization has advantages, fixed personnel arrangements can foster closed relationships and minimize problem recognition. Personnel policies should be reviewed to rotate employees periodically or reassign duties based on aptitude, thereby eliminating the overreliance on individuals.

V. Strengthening Governance and Internal Controls

In 2020 and 2021, there were opportunities to correct inspection omissions for certain pumps, yet corrective actions were not taken. This highlights the need to instill awareness of the importance of internal controls. Efforts must be made to eliminate tolerance of improper practices, even at the risk of being seen as overreactive. Quality Control and Quality Assurance Departments that are independent from the Manufacturing and Inspection Departments must be established.

It is also necessary to define and communicate manufacturing and inspection processes, establish feasible production plans, and monitor progress to prevent deviations. Where problems arise, realistic corrective measures should be promptly implemented, including feedback from on-site supervisors.

Managers must actively identify workload and problems, prioritize them appropriately, and resolve them in a timely manner. Reporting rules must be clarified to ensure that issues are reported promptly and appropriately via proper reporting lines.

Furthermore, the internal whistleblowing system must be enhanced to allow early detection and investigation of misconduct, ensuring the system functions effectively.

VI. Cultivating Quality Assurance Awareness and Providing Training and Guidance

The issues underlying the Incident and similar ones were recognized at the operational level long before the transfer of production to the Miyazaki Plant. While some efforts were made to address divergences between documented procedures and actual operations, they ultimately failed, indicating insufficient awareness of quality assurance.

Although the Company has periodically conducted training for officers and employees to raise awareness of quality assurance, it has not provided training specifically focused on product

inspections. Specific training programs should be introduced to prevent the occurrence of the Incident, and continuous training should be provided to foster a culture of quality assurance and emphasize that improper practices will be strictly punished.

Additionally, the Company should establish an integrated system for managing processes across departments (sales, design, and manufacturing), enabling shared, real-time data entry and eliminating reliance on oral instruction, thereby building a sustainable organization capable of ensuring quality and safety based on a shared understanding.

End of report