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April 30, 2025

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(Progress of Disclosed Matters) Notice of Inappropriate Conduct in Businesses
Other than the Marine Engine Business of Kanadevia Group

Kanadevia Corporation (hereinafter the “Company”) has established a Special Investigation Committee consisting of external experts independent of the Company Group on July 17, 2024, in response to the inappropriate conduct announced in the “Notice of Inappropriate Conduct in the Marine Engine Business of Hitachi Zosen Group” dated July 5, 2024. The Special Investigation Committee has investigated the inappropriate conduct in the marine engine business and other businesses. Among the results of the investigations by the Special Investigation Committee and its recommendations for measures to prevent recurrence, etc. (hereinafter the “Investigation Results, etc.”), the Investigation Results, etc. for the marine engine business were reported in the “(Progress of Disclosed Matters) Notice of Inappropriate Conduct in the Marine Engine Business of Kanadevia Group” dated March 25, 2025 (only in Japanese and amended on March 27, 2025) .

Today, we received from the Special Investigation Committee the Investigation Results, etc. for businesses other than the marine engine business, and have summarized them ourselves. Please refer to the attached material for those Investigation Results, etc. The Company Group's measures to prevent recurrence are as announced in the “ (Progress of Disclosed Matters) Notice of the Measures to Prevent Recurrence for Inappropriate Conduct in Businesses Other than the Marine Engine Business)” dated today.

With regard to the series of inappropriate conduct announced above in businesses other than the marine engine business, whose specific descriptions are provided in the reference material at the end of this document, we have reported to the customers concerned and are taking action to address these issues. The Company has determined that those series of inappropriate conduct do not have an immediate and material impact on the safety of the Company's products, which include the inappropriate conduct announced in the

“Inadequate Qualifications of Welding Operators in the Production of Bridges and Other Structures at Our Mukaishima Works” dated February 21, 2025 (replaced on February 27, 2025 and amended on March 4, 2025) and the “(Progress of Disclosed Matters) Notice of Inappropriate Conduct in the Marine Engine Business of Kanadevia Group” dated March 25, 2025 (only in Japanese and amended on March 27, 2025), and other inappropriate conduct newly identified through subsequent investigations by the Special Investigation Committee.

We would like to express our sincere apologies once again to all of our stakeholders for the significant loss of trust and for causing considerable inconvenience and concern due to the series of inappropriate conduct by our group. We will steadily implement measures to prevent a recurrence of the same inappropriate conduct and will do our utmost to restore the trust of our customers and all other stakeholders.

The impact of the series of inappropriate conduct on our financial results has not yet been determined. We will promptly announce any matters that should be disclosed in the future.

[Attached material]

April 30, 2025 Investigation Report (Abridged version) *

* The English version is an abridged translation of the original Japanese document disclosed on April 30, 2025.

[Reference material]

Businesses other than marine engine business.

Business Description
Manufacturing of steel structures, mainly bridges, etc.
Manufacturing of surface plates of special equipment as casting products and other related parts, etc.
Operation and maintenance of water treatment facilities, etc.
Operation of waste incineration and recycling facilities
Development and Manufacturing of Special valves and other products, etc.

End

(Abridged version)

April 30, 2025

Investigation Report

Kanadevia Corporation

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Chapter 1 Overview of the Investigation

1 Background of the Investigation

On March 25, 2025, Kanadevia Corporation (hereinafter referred to as “**Kanadevia**”) received the investigation findings and recommendations for recurrence prevention measures from the Special Investigation Committee (established by Kanadevia on July 17, 2024; the investigation by this Committee is hereinafter referred to as the “**Investigation**”) regarding the case of inappropriate conduct including the falsification of measurement results concerning fuel consumption and exhaust gas component concentrations, etc. in marine engines (hereinafter referred to as the “**Marine Engine Case**”) at Kanadevia’s consolidated subsidiaries, Hitachi Zosen Marine Engine Co., Ltd. and IMEX Co., Ltd. On the same day, Kanadevia published a report summarizing these findings from the perspective of Kanadevia (hereinafter referred to as the “**Marine Engine Case Investigation Report**”).¹

On April 30, 2025, Kanadevia received from the Special Investigation Committee the investigation findings and recommendations for recurrence prevention measures concerning cases which the Committee deemed appropriate for it to investigate in light of its investigative purpose (hereinafter referred to as “**additional cases**”²), among the cases of suspected inappropriate conduct (hereinafter referred to as the “**inappropriate conduct**”) at a total of five sites: Kanadevia’s Mukaishima Works and Wakasa Works as well as Ataka Asano Co., Ltd. (hereinafter “**ATAKA ASANO**”), Kanadevia Environment Service Company Limited (hereinafter “**KVES**”), and V TEX Corporation (hereinafter “**V-TEX**”), all of which belong to Kanadevia and its group companies (hereinafter collectively referred to as the “**Kanadevia Group**”). This report summarizes these matters from the perspective of Kanadevia.

It should be noted that the purpose of the Special Investigation Committee’s investigation,³ the composition of the Special Investigation Committee and the crisis management/investigative framework,⁴ the positioning of this report, and the reservations regarding the limitations of the

¹ See “(Progress of Disclosed Matters) Notice of Inappropriate Conduct in the Marine Engine Business of Kanadevia Group” published by Kanadevia on March 25, 2025 (<https://www.kanadevia.com/newsroom/news/assets/pdf/FY2024-136.pdf>) (Only in Japanese).

² The additional cases include the inappropriate conduct described in “Inadequate Qualifications of Welding Operators in the Production of Bridges and Other Structures at Our Mukaishima Works” published by Kanadevia on February 21, 2025 (<https://www.kanadevia.com/newsroom/news/release/assets/pdf/FY2024-122.pdf>), as well as other inappropriate conduct except for the matters related to Marine Engine Business described in “(Progress of Disclosed Matters) Notice of Inappropriate Conduct in the Marine Engine Business of Kanadevia Group,” published by Kanadevia on March 25, 2025 (<https://www.kanadevia.com/newsroom/news/assets/pdf/FY2024-136.pdf>) (Only in Japanese).

³ Technical verification of whether and to what extent the inappropriate conduct has affected the safety of the relevant products and services is not included in the scope of the Investigation.

⁴ The Special Investigation Committee appointed two technical advisors for the investigation of the marine engine case, but did not appoint any technical advisors for the investigation of the additional cases.

investigation⁵ are as stated in Chapter 1, Sections 2, 3, and 6 of the Marine Engine Case Investigation Report.⁶

2 Period of the Investigation

The period of the Investigation was from July 17, 2024 to April 27, 2025.

3 Investigation Method

The investigation methods used by the Special Investigation Committee for the additional cases were, in principle, the same as those employed in the investigation of the Marine Engine Case; however, the matters specific to the additional cases were as follows. In addition to the investigation methods listed below, the Special Investigation Committee, in conducting the investigation of the additional cases, also carried out analysis and examination of relevant documents, analysis and examination of electronic data, and on-site investigations, as was done in the investigation of the Marine Engine Case.

(1) Consistency Investigation

To investigate, based on objective materials, whether inappropriate conduct similar to that of the Marine Engine Case occurred, the Special Investigation Committee proposed to Kanadevia the implementation of an investigation to verify the consistency between the raw data and the documents submitted to customers, etc. (hereinafter referred to as the “**consistency investigation**”). In response, Kanadevia conducted the consistency investigation based on the instructions of the Special Investigation Committee regarding investigation methods, with verification and support provided by the Special Investigation Committee and Ernst & Young ShinNihon LLC, and reported the results to the Special Investigation Committee.

The details of the consistency investigation (such as the investigation target sites and investigation methods used) are as stated in Chapter 2, Section 4 of the Marine Engine Case Investigation Report. Note that, at some Kanadevia Group sites, intentional obstruction of the consistency investigation by certain employees was confirmed, which gave rise to doubts regarding the validity and appropriateness of the investigation results. Accordingly, the Special Investigation Committee conducted an additional investigation.⁷

⁵ The Investigation was conducted under certain time constraints and based on the voluntary cooperation of the Kanadevia Group and its related parties, without any legal compulsion. It was not intended to detect all potential instances of inappropriate conduct within the Kanadevia Group, nor to conduct a comprehensive investigation into all such instances. Furthermore, the findings of the Special Investigation Committee are based on materials provided by the Kanadevia Group and its related parties, as well as interviews conducted with officers and employees (hereinafter referred to as “**officers and employees**”) of the Kanadevia Group. In addition, the Special Investigation Committee, in conducting investigations into individual cases, in some instances carried out investigations on a sampling basis, in consideration of time constraints and other factors. The findings of the Investigation are limited by such constraints, and the descriptions in this report may, in some cases, be rendered abstract or otherwise modified out of consideration for the privacy of the individuals involved.

⁶ With respect to matters already described in the Marine Engine Case Investigation Report, this report shall refer to the relevant sections of that report and shall not repeat the same content herein.

⁷ Specifically, additional investigations into the occurrence of inappropriate conduct at those investigation target sites were conducted by means such as implementing a separate questionnaire survey in addition to focused interviews and the Survey (see (2) below).

The details of the inappropriate conduct confirmed as a result of the consistency investigation are described in Chapter 3.⁸

(2) Questionnaire Survey and Establishment of Hotline Contact Point

The Special Investigation Committee conducted a questionnaire survey (hereinafter referred to as the “**Survey**”) and established a hotline contact (hereinafter referred to as the “**Hotline**”) with the primary purpose of gathering information regarding the inappropriate conduct within the Kanadevia Group. The specific details of the Survey and the Hotline (such as the sites surveyed and the methods of implementation) are as stated in Chapter 2, Section 3 of the Marine Engine Case Investigation Report.

Among the cases of inappropriate conduct reported through the Survey and the Hotline, the Special Investigation Committee selected certain cases for further review in light of the content of the reports and other relevant factors, and conducted initial fact-finding through interviews. As a result of these interviews, cases involving inappropriate conduct related to quality or the environment that were deemed particularly serious were designated as investigation targets by the Special Investigation Committee. (The results of such investigations are described in Chapter 3.⁹)

In addition, as described in (1) above, with respect to certain sites within the Kanadevia Group where obstruction of the Consistency Investigation by some employees was identified, the Special Investigation Committee conducted an additional investigation regarding the occurrence of inappropriate conduct. To this end, with the cooperation of Kanadevia and an external law firm engaged by Kanadevia, the Committee conducted a separate questionnaire survey—distinct from the Survey—targeting officers and employees at those sites in order to assess their awareness of the inappropriate conduct (hereinafter referred to as the “**Additional Survey**”).¹⁰

(3) Interviews with Relevant Parties

In connection with the investigation of the additional cases, the Special Investigation Committee conducted interviews (approximately 420 in total) with about 280 individuals, including current

⁸ Even where inconsistencies with customer specifications identified through the consistency investigation were considered not to constitute inappropriate conduct (for the concept, see Section 4 below), the Special Investigation Committee reported a separate summary of such inconsistencies to Kanadevia, recognizing the need for such inconsistencies to be corrected and with the aim of utilizing them in future improvement activities within the Kanadevia Group.

⁹ On the other hand, in light of the relevance to the objectives of the Special Investigation Committee and the effective use of its investigative resources, the Committee excluded from its investigation scope those cases of inappropriate conduct related to quality or the environment that were considered to be of relatively limited seriousness, as well as cases not related to quality or the environment. For such cases, the Committee shared an overview with Kanadevia and, based on the details and nature of each case, requested that Kanadevia take appropriate investigative action or other actions as necessary.

¹⁰ The cases reported through the Additional Survey were, even assuming that inappropriate conduct was confirmed in such cases, considered to have characteristics that were almost identical to or similar in nature to the cases of inappropriate conduct already under investigation by the Special Investigation Committee at the time of the Additional Survey (hereinafter referred to as the “**previously investigated cases**”). Given the high likelihood that the results of the root cause analysis and the content of the proposed recurrence prevention measures for such cases would overlap with or be similar to those of the previously investigated cases, the Special Investigation Committee requested the external law firm to conduct an initial investigation into those cases. The results of the initial investigation were also shared with Kanadevia. Regarding those cases, since Kanadevia plans to conduct a detailed investigation with the support of the external law firm, the details of such cases are not included in this report.

and former officers and employees of the Kanadevia Group, who were deemed necessary to be interviewed for the purposes of the Investigation.¹¹

4 Overview of the Inappropriate Conduct

With respect to the various acts identified in the Investigation, the Special Investigation Committee classified such acts as inappropriate conduct in cases in which (a) the acts were deemed to potentially constitute violations of laws and regulations related to the quality or labeling of products or services, or (b) the acts involved intentional breaches of agreements with customers regarding the quality or labeling of products or services. Given that the Kanadevia Group has numerous stakeholders, such acts are considered to require particularly strong measures to prevent recurrence from the standpoint of compliance and corporate social responsibility.¹²

As a result of the Investigation, the total number of cases of inappropriate conduct identified within the Kanadevia Group¹³ was 35, and the number of cases by site is as shown in Table 1.

Table 1. Number of Cases of Inappropriate Conduct by Site

Number of Cases of Inappropriate Conduct by Site	
Mukaishima Works	7
Wakasa Works	7
ATAKA ASANO	10
KVES	9
V-TEX	2
Total	35

The inappropriate conduct identified at each of these sites involved various forms of misconduct. In addition, since the products handled at each site within the Kanadevia Group differ significantly—and because the sites also differ in terms of their histories, business scale, major customers, and organizational structures—the Special Investigation Committee pointed out that it is necessary to fully recognize both the issues common to the entire Group and those unique to each site, and to consider and implement specific responses accordingly.

¹¹ This refers solely to the hearings conducted by the Special Investigation Committee for the purpose of fact-finding and root cause analysis regarding the inappropriate conduct (excluding preliminary sessions, progress review sessions, and other meetings held to implement the consistency investigation, as well as initial hearings related to the Survey and the Hotline cases).

¹² On the other hand, for example, cases such as clerical errors resulting from misreading during transcription of inspection results, or instances in which inspection items specified in customer specifications were not reflected in internal inspection instructions due to transcription mistakes when preparing such instructions based on customer specifications, resulting in an inspection being carried out without the officers and employees recognizing it to be a breach of agreement with a customer, are not included in the inappropriate conduct.

¹³ The number of instances of inappropriate conduct has, in principle, been counted as one case per type of conduct at each site, meaning that even if multiple product types or customers were affected, such cases were still counted as a single instance of inappropriate conduct. However, it is difficult to establish a uniform standard for what constitutes the “same type of conduct,” and the counting has not necessarily been applied in a completely consistent manner across the various sites. Therefore, the figures presented in this report are provided for reference only.

Accordingly, Chapter 2 describes the matters reported by the Special Investigation Committee as issues of group governance common to the entire Group, while Chapter 3 describes, in addition to the details of the inappropriate conduct identified at each site, the results of the analysis of the causes of such inappropriate conduct at each site as well as the matters reported and recommended by the Special Investigation Committee as potential recurrence prevention measures.¹⁴

Chapter 2 Issues in Group Governance Identified as a Result of the Investigation

1 General

Within the Kanadevia Group, in addition to the many years of inappropriate conduct related to marine engines at the Ariake Works and IMEX, it was also found, as will be detailed in Chapter 3, that inappropriate conduct continued for periods ranging from several years to more than a decade at multiple sites and subsidiaries. Kanadevia received from the Special Investigation Committee both a list of governance issues concerning Kanadevia's sites and subsidiaries (see Section 2 below)¹⁵ and recommendations for improvement based on those issues.

In response, Kanadevia has stated that it intends to consider and implement effective recurrence prevention measures as outlined below (see Section 3).

2 Governance Issues Concerning Sites and Subsidiaries

(1) Issues in the Analysis and Assessment of Quality Compliance Risks¹⁶

In order for Kanadevia to consider which content is appropriate for its compliance program,¹⁷ it is first necessary to have a framework and initiatives in place for identifying, analyzing, and assessing the compliance risks that it faces. Furthermore, as Kanadevia has multiple businesses and subsidiaries that are responsible for such businesses, it is necessary to establish a risk management system at the group level. Specifically, it is necessary to gather information on the compliance risks anticipated at each site and each subsidiary as well as the actual status of the management of such risks, to appropriately assess related risks, and to reflect the results of such assessments in the operation of the risk management system and related systems.

With respect to the management of sites and subsidiaries within Kanadevia, each business headquarters is responsible not only for managing the sites (such as business offices and works) under its jurisdiction, but for overseeing the formulation and promotion of management strategies for subsidiaries closely related to its business, as well as for profit management, supervision,

¹⁴ Unless otherwise specified, the names of departments, positions, committees, documents, and inspections used within each section of Chapter 3 describing the inappropriate conduct shall refer to those specific to the relevant site.

¹⁵ As of the date of this report, Kanadevia has already begun to implement organizational and rule changes aimed at preventing recurrence. However, from the perspective of analyzing the circumstances at the time that the inappropriate conduct occurred, the Special Investigation Committee has based its list of issues and related comments on the conditions prior to the discovery of the inappropriate conduct (in principle, as of April 2024, although information from earlier or later periods is also included as necessary).

¹⁶ In this report (Chapter 2), the term "quality compliance" is used not just in the context of product quality in manufacturing but to encompass broader issues concerning service quality, such as the inappropriate conduct related to the management of waste incineration facilities (KVES) and the falsification of reports in the operation and maintenance of water treatment facilities (ATAKA ASANO), as revealed in the course of the Investigation.

¹⁷ In this report, the term "compliance program" refers to the internal processes and structures of a company designed to ensure that its business activities and the conduct of its officers and employees are aligned with applicable laws, internal rules, and other relevant standards.

auditing, and risk management of those subsidiaries. In addition, as described in b. below, according to the division of duties, the Corporate Planning Section of the Corporate Planning Department, the Legal Department, and the Quality Assurance Department are responsible for overseeing subsidiary management from their respective perspectives.

On the other hand, with respect to risk management within the Kanadevia Group, a company-wide risk management framework under which business risks in general would be uniformly (e.g. by a specific department or organizational unit) identified, analyzed, and assessed, and then addressed in order of priority, had not been established.¹⁸ Instead, it was assumed that each responsible department would continuously assess and monitor risks by type, and carry out training and give guidance accordingly. However, risk assessments by the responsible departments were, at least with regard to quality compliance risks, insufficient.

a. Risk Assessment by Each Business Headquarters of Kanadevia

Among the sites and subsidiaries where the inappropriate conduct was found in this case, the Mukaishima Works, Wakasa Works, and V-TEX were under the jurisdiction of the Machinery & Infrastructure Business Headquarters, while ATAKA ASANO and KVES were under the jurisdiction of the Environment Business Headquarters. However, both headquarters' management focused primarily on performance and numerical control of business activities, and did not include efforts such as specifically analyzing and assessing in advance the quality compliance risks of the respective sites and subsidiaries or considering and reviewing compliance programs according to risk.¹⁹

b. Risk Assessment by Kanadevia's Head Office Administrative Departments

At Kanadevia, with respect to quality compliance risks, both the Legal Department, which oversees compliance in general, and the Quality Assurance Department, which oversees quality assurance in general, are organizationally positioned to serve as responsible departments according to the division of duties. However, to date, sufficient communication has not occurred to clarify which of the two should assume primary responsibility for management, and neither department has proactively assessed the quality compliance risks faced by the Kanadevia Group, nor considered or reviewed compliance programs based on the magnitude of such risks.

For example, the Legal Department is, according to the division of duties, responsible for "planning, formulating, and promoting various initiatives to advance group compliance management (including compliance with laws and corporate ethics)." Although the Compliance

¹⁸ With regard to risk management related to the profitability of individual projects, the Project Risk Management Department has jurisdiction and has established specific risk management processes. However, in the course of risk identification and assessment, no efforts were made to identify and evaluate compliance risks and other issues beyond what was specific to individual projects, nor had corresponding response policies been determined.

¹⁹ Specifically, within the Machinery & Infrastructure Business Headquarters, the Administration Department was responsible for "internal control operations" and "management of affiliated companies," while within the Environment Business Headquarters, the Administration Department was responsible for "compliance risk management." However, these departments were primarily responsible for carrying out compliance activities as required by the Head Office Legal Department, managing risks related to individual order projects and business investment projects as mandated at the company-wide level, and conducting sales compliance activities to ensure adherence to competition laws. They were not engaged in activities involving the analysis and evaluation of individual quality compliance risks that focused on the products or services of individual sites or subsidiaries.

Committee, of which the Legal Department serves as the secretariat, once took the lead in conducting a survey aimed at identifying compliance risks (including “fraudulent inspections and data falsification”) at group companies, this survey did not lead to an effective assessment of quality compliance risks due to its methodology and insufficient follow-up. In addition, no subsequent requests were made for reports concerning information or evaluations related to quality compliance risks such as data falsification. The Quality Assurance Department, under the Rules on the Division of Duties, was tasked with “company-wide quality assurance operations.” However, the department focused primarily on activities explicitly stated in the rules, such as collecting information on defect-related costs and disseminating information on current conditions, countermeasures, and policies from the perspective of preventing defects and issues for the purpose of quality improvement, and its main role was to support the quality assurance departments within each business headquarters. As a result, efforts to assess in advance quality compliance risks, to consider quality assurance structures and policies in accordance with the assessed risks, and to periodically review such assessed risks were not implemented.²⁰

Although many similar cases of quality compliance violations by other companies in the manufacturing industry had already been publicly disclosed, Kanadevia did not take specific actions to evaluate the occurrence or extent of similar risks at each site and subsidiary of the Kanadevia Group based on the lessons learned from such cases. Such an evaluation could have included an assessment of the potential for similar misconduct to occur, taking into account the contributing factors, environment, and status of countermeasures at each site. Furthermore, Kanadevia had not utilized such insight for a periodic review of risk assessments. Had Kanadevia conducted a sufficient and specific risk assessment based on past similar cases at other companies, along with objective monitoring based on such an assessment, it is highly likely that the inappropriate conduct could have been detected and corrected at an earlier stage.

(2) Issues in the Group Compliance System and Quality Assurance System

a. Issues concerning the group compliance system and initiatives

The Kanadevia Group’s compliance system is centered around the Compliance Committee, with the President of Kanadevia serving as the chief officer responsible for compliance. Under this system, the head of each business site is designated as the person responsible for promoting compliance at the respective site, while the president of each group company is designated as the person responsible for promoting compliance within the respective group company. These individuals are tasked with implementing and promoting compliance initiatives.

However, due to (a) the lack of risk assessment (as described in (1) above), information regarding the group-wide quality compliance risk assessment was not shared within the Compliance Committee, and discussions were not conducted from the perspective of risk-based measures and initiatives. Additionally, (b) although the members of the Compliance Committee included external experts (lawyers) who provided meaningful opinions from an external perspective, based on the state of group management and examples from other companies, with

²⁰ In addition, while the Corporate Planning Section within the Corporate Planning Department was, according to its division of duties, in charge of managing group companies, including subsidiaries, and following up on their medium-term management plans, these activities did not involve discussion of quality compliance risks. The section did not request that its subsidiaries identify, analyze, or evaluate such risks.

regard to quality compliance, the committee met only once a year, and such meetings were limited to approximately 2 hours per session. Furthermore, reflection methods of such opinions in concrete actions after the meeting, such as incorporating them into compliance risk assessments or utilizing them in organizational initiatives, was left to the discretion of each participant or organization. As a result, with respect to the quality compliance issues raised in this case, the system centered around the Compliance Committee did not sufficiently ensure that its activities are reflected to actual operational processes including risk assessments and consideration of countermeasures; this is a challenge for the current compliance framework.

Kanadevia's Legal Department and Quality Assurance Department were not entirely unaware of quality compliance risks; in fact, training programs and employee guidance materials included content related to quality compliance.²¹ However, the countermeasures taken by each department were considered and implemented individually and primarily within the scope of their respective resources and authority.

In this way, from the perspective of implementing efficient and effective measures, various challenges remain regarding interdepartmental cooperation and coordination aimed at achieving quality compliance across the Kanadevia Group as a whole.

b. Fragility of the supervisory function in the group quality assurance system

Under Kanadevia's quality assurance system, (a) the executive officer in charge of quality assurance serves as the chief officer; (b) the Quality Assurance Department at the head office is responsible for "company-wide quality assurance operations"; and (c) the quality assurance departments of each business headquarters are responsible for "quality assurance operations related to the respective business headquarters."

Although the Quality Assurance Department is responsible for "company-wide quality assurance operations," the quality assurance departments of each business headquarters and works were, from an organizational standpoint, under the supervision of the respective heads of the business headquarters or works and were not under the supervision of the Quality Assurance Department at the head office. In addition, the Quality Assurance Department regularly held Quality Assurance Department Heads Meetings, in which subsidiaries' quality assurance department heads also participated. However, these meetings primarily focused on issues such as defect rates and quality troubles, serving as a forum for participants to share information about the statuses of their respective departments, which is only a venue for information sharing among the quality assurance department heads. As a result, the Quality Assurance Department basically did not take an active role in managing the quality assurance systems of the various departments and sites, nor did it provide specific instructions aimed at implementing countermeasures or improvements.

Each business headquarters had established (i) Management Units, (ii) Business Units, and (iii) a Quality Assurance Department not affiliated with any works or business site (hereinafter

²¹ The Legal Department introduced cases of quality misconduct at other companies during compliance training for new employees and in compliance e-learning programs. The Quality Assurance Department also addressed quality misconduct in its quality-related e-learning materials. In addition, the Compliance Handbook prepared by the Legal Department and distributed to group companies, including subsidiaries, included Q&A sections on topics such as the Water Pollution Control Act and the Air Pollution Control Act as well as Q&A on quality-related breaches of contract and falsification of inspection results.

referred to as the “**Headquarters QA**”). In addition, a separate Quality Assurance Department (hereinafter referred to as the “**Works QA**”) had also been established within each works belonging to the same business headquarters. However, the Headquarters QA was, in principle, not in a supervisory position over the Works QA with respect to the duties under its jurisdiction.

As for the sites belonging to Kanadevia where inappropriate conduct was identified in the present case, at the Mukaishima Works, only the head of the Works QA concurrently held a position in the Headquarters QA (the Mukaishima Section), which was the second-line department. At the Wakasa Works, where there is no Works QA on-site, one of the sections (the Materials Section) comprising the Headquarters QA, which was the second-line department, assumed the role of providing the function as the Works QA. However, in practice, all personnel responsible for quality assurance operations at the works were stationed on-site at the respective facilities (see Figure 1). Moreover, given the physical distance from the business headquarters, oversight by the second-line departments (Headquarters QA) over the quality assurance operations at the works was not functioning effectively in reality.

Furthermore, with respect to the Mukaishima Works, personnel evaluations were also heavily influenced by the Mukaishima Works General Manager and those under the manager's supervision. (Oversight of the Head of the Works QA by the business headquarters, which was the second-line department, was not functioning effectively.)

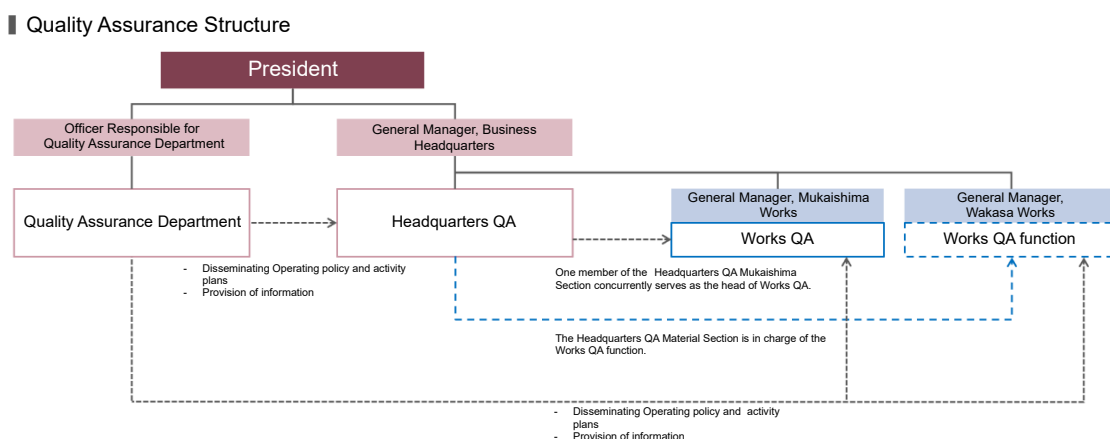


Figure 1: Kanadevia's Quality Assurance Structure

Thus, those responsible for quality assurance operations at Kanadevia's Mukaishima Works and Wakasa Works were not under the supervision of the Quality Assurance Department at the head office and were, in effect, independent from the Headquarters QA overseeing them. Accordingly, with respect to the Mukaishima Works and Wakasa Works, where the inappropriate conduct was confirmed, there was effectively no oversight from the second-line departments at the head office level in two respects.²²

²² In fact, the Headquarters QA and the Quality Assurance Department at the head office were completely unaware of the reality that, at the Mukaishima Works and Wakasa Works, the personnel in charge of the Works QA were themselves involved in the inappropriate conduct, and that quality assurance was not functioning.

Not only within Kanadevia itself but also within the Kanadevia Group-wide quality assurance system, the Quality Assurance Department at the head office did not possess strong authority to oversee or control the quality assurance departments of Group companies. Given that each subsidiary manufactures or provides different products and services with various characteristics, the response to quality compliance risks was essentially left to the discretion of individual subsidiaries' quality assurance departments.

(3) Challenges in Monitoring Sites and Subsidiaries

a. Inadequate oversight and supervision of sites and subsidiaries

Each business headquarters, site, and subsidiary of the Kanadevia Group engages in diverse business operations. The sites and subsidiaries where the inappropriate conduct was discovered—namely, the Mukaishima Works, Wakasa Works, ATAKA ASANO, KVES, and V-TEX—differ significantly in the types and nature of the products and services that they manufacture or provide.

Furthermore, with regard to the Mukaishima Works and Wakasa Works, in addition to the uniqueness of their products and differences in business operations, there were several factors that contributed to organizational insularity: the geographical distance between the headquarters and each site; the fact that employees belonging to the sites below a certain level of seniority were generally hired locally; the limited personnel exchanges between sites and with head office departments; and the insufficient oversight by the head office and the business headquarters. As a result, a closed tendency was observed among employees to feel a stronger sense of belonging and loyalty to their respective sites than to Kanadevia as a whole.

Furthermore, with respect to the subsidiaries where the inappropriate conduct was identified—ATAKA ASANO, KVES, and V-TEX—oversight from a compliance risk perspective proved to be insufficient. This was due not only to the differences in their products and services but to factors such as the varying histories of these companies, the timing and circumstances under which they became part of the Kanadevia Group, and the fact that Kanadevia's oversight focused primarily on numerical and financial control. In fact, during the course of the Investigation, although Kanadevia's top management explicitly requested full cooperation with the investigation conducted by the Special Investigation Committee, and the Executive Officer in charge of Quality Assurance together with the General Manager of the Quality Assurance Department explained the purpose and scope of the consistency investigation at meetings attended by the heads of quality assurance departments from various sites and subsidiaries, requesting their cooperation, such requests and instructions were not thoroughly implemented at some sites and subsidiaries. As a result, during the consistency investigation, obstruction such as intentional destruction of evidence by some employees was confirmed. These circumstances suggest that each organization within the Group had developed its own distinct organizational culture (subculture). It is possible that as a result of such cultures having been fostered in an unhealthy manner, compliance-related measures or related requests issued by the head office were interpreted in ways that deviated from their original intent, leading to situations in which those measures failed to function effectively.

b. Challenges in monitoring by the head office administrative departments

From the perspective of monitoring by Kanadevia's head office administrative departments (the Legal Department or the Quality Assurance Department), at least it is necessary to establish mechanisms and activities that enable the department responsible for the relevant risk to promptly obtain the necessary information in the event of a quality compliance violation occurring at a site or group company.²³

Since 2017, Kanadevia's Legal Department, which is responsible for compliance management of group companies, has made efforts that are positioned as monitoring activities, including confirming the status of compliance initiatives through regular submission of compliance reports²⁴ from subsidiaries and holding regular information exchanges with compliance officers at each group company. However, these efforts remained merely instances of information sharing and exchange, and they were not utilized for discussions or information gathering concerning the evaluation of quality compliance risks or response measures. Furthermore, the head office administrative departments did not go so far as to conduct monitoring activities aimed at actively confirming whether information related to quality compliance risks or instances of non-compliance was properly reported (i.e., whether such information was being grasped on the head office side).

Furthermore, it is difficult to say that the head office Legal Department and the Quality Assurance Department had sufficient resources to fulfill their roles as the departments responsible for quality compliance risks, including providing support to and monitoring the sites and subsidiaries. Since no dedicated compliance departments are established in each business headquarters, site, or subsidiary, it is important for the head office administrative departments to provide education, support, and supervision to each business headquarters, subsidiary, and so forth. However, the only department responsible for compliance-related operations as the entire Kanadevia Group is the Legal & Compliance Section of the Legal Department, which consists of six members. Given the scope of responsibilities assigned to the section, these six members are not in a position to devote themselves exclusively to compliance-related duties.

c. Issues related to data storage at sites and subsidiaries

To ensure the feasibility of and to enhance the possibility of monitoring activities by the department responsible for quality compliance, including investigations into cases of suspected compliance violations, it is necessary to require each site and subsidiary to store raw data (e.g., inspection results) necessary for retrospectively verifying the appropriateness of operations, and to establish a system whereby the department responsible for compliance can access such data as needed. At the very least, it is important to require the storage of raw data, even if only for a

²³ With respect to quality compliance violations, a rule is in place that applies to Kanadevia and seven major domestic affiliated companies (IMEX, ATAKA ASANO, H&F, Kanadevia Engineering, Kanadevia E&E, HZME, and V-TEX). This rule requires that a report be made to designated recipients when a "serious technical issue," including a legal or regulatory violation, occurs. However, for subsidiaries not included among the seven companies, such as KVES, no comparable specific rule has been established.

²⁴ As part of Kanadevia's monitoring framework, since fiscal year 2016, compliance promotion officers at domestic and overseas group companies have been required to report to the Compliance Committee twice a year—once every 6 months—on whether any compliance issues have occurred and the effectiveness of preventive measures being implemented.

certain period, at sites or subsidiaries with quality compliance risks (e.g., falsification of inspection results). This is also meaningful as a form of psychological deterrent for on-site employees, in the sense that they will be aware that falsification may later be detected by the department responsible.

However, within the Kanadevia Group, there were no uniform rules regarding data retention at each manufacturing site. The consistency investigation revealed that, among the sites subject to the Investigation, there were several cases in which the raw data necessary for reconciliation checks had not been retained at all, or in which such data was not stored and managed in a standardized manner, leading to differences in retention methods depending on the department or person in charge. Furthermore, it was confirmed that, in some cases, at the Mukaishima Works and ATAKA ASANO, the permissibility of discarding raw data was one of the factors that contributed to the inappropriate conduct.

d. Issues related to response to past quality compliance violations when they occurred

The inappropriate conduct at KVES had, in part, already come to light previously as similar instances of misconduct had been identified within KVES, and the results of the investigation conducted at the time had been reported to Kanadevia.

However, the Investigation revealed that some instances of the inappropriate conduct were already occurring at that time and continued without being rectified due to several factors: (a) the lack of clarity regarding which department at the head office was responsible for addressing the risk; (b) insufficient coordination among departments, resulting in none of them instructing KVES to conduct further investigations into similar cases and to assess the associated risks, or following up on improvement efforts; and (c) the absence of initiatives to reassess the evaluation of quality compliance risks in light of the incident.

Had an adequate internal investigation, consideration and implementation of preventive measures, and monitoring by Kanadevia been conducted at the time, it is highly likely that some of the instances of inappropriate conduct at KVES identified in the current investigation could have been detected and rectified at an earlier stage.

e. Lack of internal audits of quality compliance risks

At Kanadevia, internal audits of the Group are conducted by the Internal Audit Section of the Internal Auditing Department. The Internal Auditing Department had conducted audits under the theme of “quality control” with the primary objective of preventing increases in defect-related costs, which was considered to be an important issue. On the other hand, audits adopting a risk-based approach that anticipated quality compliance risks were not conducted in terms of scope, frequency, or content. For example, no sampling inspections were carried out for the purpose of checking for falsified inspection results. Furthermore, even in circumstances in which quality-related misconduct at other companies had become a social issue, no focused internal audits were conducted from the perspective of verifying whether such misconduct had occurred.

As detailed in Chapter 3, many of the acts of inappropriate conduct identified in the Investigation continued for a period of several years to more than a decade. However, none of these acts were uncovered through past internal audits. In light of these circumstances, it must be

concluded that effective internal audits adopting a risk-based approach, conducted after appropriately identifying and assessing quality compliance risks, were not carried out.

3 For Future Improvement

As detailed in Chapter 3, the Investigation revealed that, among some of the officers and employees working on-site at Kanadevia's sites (the Mukaishima Works and Wakasa Works) and its subsidiaries (ATAKA ASANO, KVES, and V-TEX), the inappropriate conduct had become entrenched to the extent that it was regarded as almost routine behavior.

To fundamentally address these issues and to build an organization in which the Kanadevia Value and the associated code of conduct are thoroughly instilled in everyone from senior management to the officers and employees at each site and subsidiary, it is essential to recognize the circumstances revealed by the Investigation as indicative of an organizational culture problem—namely, the entrenchment of unhealthy values and behavioral norms at the operational level of each site and subsidiary. Based on such an understanding, it is necessary to transform the entrenched unhealthy state into the desired state by mitigating or eliminating the various factors that contributed to the formation and persistence of such unhealthy conditions.

From this perspective—namely, the importance of prioritizing quality compliance—the framework and viewpoints of the recurrence prevention measures outlined in Chapter 7 of the Marine Engine Case Investigation Report are equally applicable to the issues identified in the additional cases. Furthermore, based on the governance issues concerning the Group's sites and subsidiaries described in Section 2 above, the Special Investigation Committee has given Kanadevia recommendations for future improvements. In response, Kanadevia intends to consider and implement effective measures for improvement as outlined in items (1) through (5) below.

(1) Establishment and Implementation of a Framework for Evaluating Quality Compliance Risks

As a corporate group, at a minimum, Kanadevia needs to undertake initiatives to evaluate the magnitude of quality compliance risks in advance by considering their likelihood of occurrence and potential impacts, and examine based on this evaluation whether the current compliance program is appropriately aligned with the assessed level of risk. There are various possible mechanisms and approaches for evaluating quality compliance risks. One such example is for Kanadevia to clearly identify the department responsible for managing quality compliance risks, and to consider introducing a system whereby that department, ideally in collaboration with any department responsible for company-wide risk management processes, takes the lead in collecting and assessing information related to quality compliance risks. This system would involve regularly reviewing the Group's overall risk assessment and sharing the results with senior management.

In addition, from the perspective of conducting risk assessments at the Group level, it is essential that each organizational unit (e.g., the business headquarters, individual sites, and subsidiaries) actively participates in the process. Kanadevia should consider providing the departments or personnel in each organizational unit who are tasked with identifying and assessing risks with: (a) guidance and support on the appropriate methods and criteria for identifying and assessing compliance risks, and (b) reviewing of risk assessments by the department responsible for risks as necessary. Additionally, when considering a risk-based approach to the Group-wide risk

management framework, it is also important to strengthen oversight functions by enhancing the involvement of the head office administrative departments or business headquarters, particularly in the case of subsidiaries which do not have internal audit departments, such as ATAKA ASANO and KVES.

(2) Strengthening of the Group's Compliance and Quality Assurance Systems

As for quality compliance risks within Kanadevia, no department had previously conducted sufficient consideration of the systems and initiatives necessary for quality compliance across the entire Group. Going forward, given that the Quality Assurance Unit has been established, Kanadevia will examine this issue, develop an appropriate framework, and formulate necessary measures. In parallel, Kanadevia will assess the resources and authority available to each department and subsidiary to implement such measures, and where deficiencies are identified, take steps to address them.

In addition, to implement more efficient and effective measures to achieve quality compliance across the entire Kanadevia Group—namely, to instill the desired code of conduct—it is essential to ensure not only the quality assurance department responsible for managing such risks but also the compliance department, human resources department, internal audit department, and business departments functioning as the first, second, and third lines of defense collaborate and coordinate. Kanadevia must undertake discussions and initiatives to enable these departments to jointly formulate and implement relevant measures.

Furthermore, the Kanadevia Group has lacked a centralized function for quality assurance, including at its sites and subsidiaries, which has resulted in insufficient support for and oversight of the quality assurance departments of individual business sites and subsidiaries. Going forward, it is essential that the newly established Quality Assurance Unit, which consolidates the quality assurance functions of each business headquarters, takes responsibility for overseeing the Group's overall quality assurance functions. This includes the management of quality compliance risks as well as the clarification and development of the skills and experience required for personnel engaged in quality assurance operations.

In addition, from the perspective of strengthening the functions of the Compliance Committee, it is necessary to ensure that the opinions and proposals of committee members, including external members, do not end up as one-off remarks. For example, the secretariat could take the lead in reviewing, after each meeting, whether the Group should reflect such opinions and proposals in its initiatives or risk assessments. If deemed necessary, the secretariat could request each compliance officer to respond appropriately and provide feedback to the committee. This type of operational framework should be considered going forward.

With regard to the development of departments and personnel responsible for compliance functions at each subsidiary, it is important to collaborate with the Legal Department at the head office, which enhances its training and support activities with strengthened resources for such efforts. Such initiatives aim to improve the skill levels of the personnel responsible for compliance at each subsidiary.

(3) Enhancement of the Effectiveness of Monitoring of Sites and Subsidiaries

It is important for Kanadevia to conduct risk-based audits of its sites and subsidiaries, including their frontline operations and second-line functions, based on compliance risk assessments derived from the newly implemented risk management framework. In particular, for subsidiaries which do not have their own internal audit departments, such as ATAKA ASANO and KVES, Kanadevia's Quality Assurance Department or Audit Department should consider including such subsidiaries as audit targets from the perspective of quality compliance. This may involve verifying the risk of misconduct (e.g., data falsification) through sampling-based investigations and audits.

In addition, taking into account monitoring by the departments responsible for risks and subsequent internal audits, it is important to review and revise data retention rules and practices in a somewhat standardized manner—at least at sites where the risk of misconduct (e.g., falsification of inspection results) cannot be ruled out—to ensure that raw data is not discarded immediately after collection.

Furthermore, regarding the response when a quality compliance violation is discovered at a site or group company, at present no rules or procedures have been clearly established, except in cases in which the Kanadevia Helpline (the Group's internal whistleblowing hotline) is used, concerning the department responsible for investigation, investigation procedures, systems for developing and implementing recurrence prevention measures, and follow-up frameworks. In light of past issues in which appropriate investigations, formulation and implementation of preventive measures, and monitoring by the head office were not carried out after compliance violations were uncovered at sites or group companies, going forward, it is essential for Kanadevia to clarify and formalize the procedures and methods for conducting internal investigations and other responses in the event that a compliance violation, including those related to quality compliance, is discovered, and to ensure the thorough dissemination of such procedures and methods within the Group. It is also important to allocate the necessary resources and authority to the responsible departments to implement such responses.

(4) Establishment and Dissemination of a Code of Conduct to Be Shared Across the Kanadevia Group

In light of the organizational closedness and unique subcultures observed at certain sites and subsidiaries, the Kanadevia Group must, at a minimum, clearly define the code of conduct it expects its officers and employees to abide by with respect to quality compliance. Furthermore, it is necessary to consider and take both soft and hard approaches to promote the dissemination of this code of conduct, taking into account the differences among sites and subsidiaries (for details, see Chapter 7, Section 2 of the Marine Engine Case Investigation Report).

For example, consider the following. (a) In appointing site managers, presidents of subsidiaries, and executive officers, Kanadevia should incorporate elements of the aforementioned code of conduct into the selection criteria, which have not been clear. A framework should be developed to appoint individuals who possess the capability and mindset to demonstrate a strong commitment to compliance, and such leadership candidates should be cultivated accordingly. (b) Even after appointment as a site manager or subsidiary president, regular communication and training should be conducted to ensure continued commitment to the Group's code of conduct. (c) Consideration should be given to how accountability is assigned to subsidiary president, executive officers and

employees through personnel evaluations, disciplinary action, and compensation should a compliance violation occur—and such consideration should include mitigating consequences for those who conducts expected actions, such as proactively identifying violations and implementing corrective and improvement measures promptly.

(5) Periodic Improvement of the Compliance Program Based on Lessons Learned from Kanadevia or Other Companies

It is important for the Kanadevia Group to not only improve its compliance program based on the lessons learned from the inappropriate conduct uncovered in this case and the issues identified through the Investigation, but to continue making ongoing efforts to reassess and refine its compliance program. Specifically, when quality compliance violations occur within the Group or at other companies, Kanadevia should conduct investigations that include root cause analysis, review risk assessments based on the lessons learned, and reexamine the weaknesses of its own compliance program accordingly.

To do so, it is essential to: (a) designate a responsible department and person in charge who will primarily oversee the design, implementation, and improvement of the compliance program from a quality compliance perspective, and provide this department and person with the necessary resources and authority; (b) ensure cross-functional collaboration among departments; and (3) secure the commitment of senior management to support and enable these efforts.

Chapter 3 Facts Identified, etc. Regarding the Inappropriate Conduct

1. Mukaishima Works

At the Mukaishima Works, seven instances of inappropriate conduct were identified in connection with order-based fabrication of steel structures, primarily steel bridges, which are the site's main products: (a) the involvement in welding work of individuals without welding skills qualifications; (b) falsification of repair records in ultrasonic testing; (c) inappropriate practices concerning the timing of ultrasonic testing; (d) falsification of repair records in magnetic particle testing; (e) substitution of steel materials without the customer's approval during trial assembly inspections; (f) fabrication of measurement values in each phase (undercoat/intermediate coat) in film thickness testing; and (g) falsification of final measurement values in film thickness testing.

(1) Main Business Activities

The Mukaishima Works engages in the fabrication of steel structures, with a primary focus on bridges. Bridge fabrication accounts for approximately 80 to 90 percent of the factory's total operations, while it also manufactures steel chimneys and marine structures.

(2) Overview of the Inappropriate Conduct

a. The involvement in welding work of individuals without welding skills qualifications

In the fabrication of bridges, marine structures, and chimneys, individuals without welding skills qualifications engaged in welding operations. These individuals included foreign technical intern trainees as well as Japanese welders from partner companies who performed welding work without possessing the required qualifications.

b. Falsification of repair records in ultrasonic testing

During the fabrication processes of bridges, marine structures, and chimneys, inspection reports were created in which areas that had been deemed defective and requiring repair based on the results of ultrasonic testing were falsely marked as having “passed” in the inspection result section from the outset.

c. Inappropriate practices concerning the timing of ultrasonic testing

Ultrasonic testing, which was required to be conducted at least 24 hours after the completion of welding, was carried out before such 24-hour period had elapsed. This was done by blowing air onto the surface near the repaired area to bring it to a temperature suitable for contact with the inspection device.

d. Falsification of repair records in magnetic particle testing

During the fabrication processes of bridges, marine structures, and chimneys, reports were created in which areas that had failed magnetic particle testing were falsely recorded as having “passed.”

e. Substitution of steel materials without the customer’s approval during trial assembly inspections

During trial assembly inspections, temporary splices were fabricated using steel materials of a lower grade than what had been specified by the customer. These splices were then used in trial assembly inspections conducted in the presence of the customer.

f. Fabrication of measurement values in each phase (undercoat/intermediate coat) in film thickness testing

During the painting process for bridges, when coating thickness measurements were not recorded at each painting stage, inspection results were falsified by inputting values into the coating thickness Excel file that had been fabricated based on the final measurement values, in a manner that would not appear unnatural.

g. Falsification of final measurement values in film thickness testing

To meet the standard film thickness specified in the painting specifications, coating thickness measurement values at each location were falsified and submitted to the customer.

(3) Causes of the Inappropriate Conduct at the Mukaishima Works

a. Existence of an environment in which inappropriate conduct was easily committed and monitoring was difficult

At the Mukaishima Works, an environment existed in which inappropriate conduct such as falsification could easily be committed with respect to inspection results, which are intended to serve as the foundation for quality control and quality assurance. For example, some inspection

data could be modified retroactively, and there were no internal rules prohibiting the disposal of raw inspection data after completion inspections. As a result, in many cases, raw inspection data was not retained.

b. Establishment of a mindset and behavioral patterns that downplayed compliance with laws and customer agreements

A mindset and behavioral pattern that prioritized maintaining the status quo—achieved through inappropriate conduct—over compliance with laws and customer agreements had become entrenched among employees. This was due to a lax attitude that it would be acceptable so long as there were no serious issues in terms of quality and safety.

c. Failure of the quality assurance department to fulfill its role, and lack of awareness in the department of such role

Fundamentally, the quality assurance department is expected to function as a second line of defense by providing a check on the manufacturing department through inspection and quality assurance operations. However, at the Mukaishima Works, the quality assurance department failed to fulfill this role.

d. Insufficient measures to establish and instill norms for employees that emphasize “No quality without compliance”

At the Mukaishima Works, when employees were faced with conflicting demands in their daily work, such as the pressure to meet delivery deadlines versus the need to do work carefully and thoroughly, there were insufficient efforts to clearly establish and instill the guiding principle that employees must comply with. This principle is that “there can be no pride in high quality or trust in our products without compliance.”

e. Existence of a closed organizational culture and inward-looking sense of solidarity unique to the Mukaishima Works

At the Mukaishima Works, employees tended to adopt an insular mindset, fostering a workplace culture that was inward-looking and isolated. There was a notable tendency for employee loyalty to be directed not toward the company as a whole, but solely toward the Mukaishima Works.

f. Challenges in maintaining a high level of technical skills due to a workforce skewed toward less experienced workers

In the mid-2010s, a large number of veteran employees retired from the Mukaishima Works; however, the factory was unable to secure new workers with equivalent technical skills to fill the gap. As a result, the workforce has come to be composed predominantly of relatively young and inexperienced workers.

(4) Recurrence Prevention Measures for the Inappropriate Conduct at the Mukaishima Works

a. Establishment of an environment and operations that do not tolerate misconduct

It is essential to create and thoroughly implement mechanisms that minimize the opportunities for misconduct and prevent its occurrence altogether. For example, it is necessary to revise the rules and operational procedures regarding the recording and preservation of raw inspection data, as well as to reassess fundamental quality control processes.

b. Restoration and strengthening of the oversight function of the Quality Assurance Department

Measures should be implemented to restore and strengthen the oversight function of the Quality Assurance Department. For example, it is necessary to increase the number of personnel responsible for quality assurance functions and to ensure they are dedicated to inspection and quality assurance tasks.

c. Centralized legal management and effective compliance education to foster personal ownership of compliance

It is essential to ensure that each employee at the Mukaishima Works perceives compliance as their personal responsibility and is equipped with guiding principles when faced with uncertainty in daily operations. To achieve this, accurate and up-to-date legal requirements must be centrally managed, and compliance education must be conducted based on a precise understanding of on-site conditions.

d. Enhancement of technical capabilities and reformation of the organizational culture from a medium- and long-term perspective

In light of the failure to effectively accumulate and transfer technical expertise, it is crucial to make continuous efforts to enhance technical capabilities from a medium- and long-term perspective. Also, it is necessary to break down the insular organizational culture at the Mukaishima Works and to eliminate the overly familiar interpersonal dynamics that have developed internally.

2. Wakasa Works

At the Wakasa Works, the following instances of inappropriate conduct were identified during the manufacturing processes of casting products as main products—surface plates for special-purpose equipment—and related components.

(1) Main Business Activities

The Wakasa Works engages in the manufacture of surface plates for special-purpose equipment and related components. These surface plates, made of cast metal, are used for polishing industrial substrates such as specialty substrates and glass substrates. The related components are used to

maintain the flatness of the surface plates and to condition their surfaces. These products are made to order, and delivery specifications and manufacturing drawings are exchanged with customers.

(2) Overview of the Inappropriate Conduct

a. Manufacturing of special equipment surface plates using material specifications different from those agreed upon with the customer

At the Wakasa Works, the materials used in the production of castings, including surface plates for special-purpose equipment, are generally categorized into two representative material specifications: the Standard series and the Sieve series. The specific material specification used was determined through agreement with the customer. However, there were instances in which special equipment surface plates were manufactured and shipped using material specifications that differed from what was agreed upon with the customer. In particular, for surface plates with a diameter of 1,000 mm or more, even when the Standard series was the agreed-upon specification, the products were manufactured using the Sieve series method.

b. Failure to submit a 4M change request for the Optical Emission Spectrometer (OES)

At the Wakasa Works, a violation of the agreed procedures with a customer was identified regarding changes to the OES, a component used in optical emission spectroscopy equipment. Specifically, a new manufacturer's OES was used without submitting the required 4M change request, despite such submission being stipulated in the agreement with the customer.

c. Omission of annealing for related components

Certain related components delivered to specific customers were not subjected to annealing, despite the fabrication drawings clearly indicating that annealing should be performed. Although residual stress was removed by cooling the components within the mold and no annealing had been planned to be carried out in practice, insufficient verification led to the continued inclusion of annealing instructions in the fabrication drawings.

d. Inappropriate re-inspection practices in dimensional inspections of special equipment surface plates and related components

When dimensional inspection results fell outside the specified tolerances, inspectors changed the measurement angles and positions to obtain values within the specified tolerances and recorded those values as the inspection results.

e. Falsification of various inspection results for special equipment surface plates, machine component surface plates, and auxiliary parts

Various inspection results were falsified by selectively recording only those values that fell within the specified tolerances. These altered results were used to prepare inspection certificates, which were then submitted to customers.

f. Shipment of products outside the tolerances for special equipment surface plates, related parts, and machine component surface plates

Even when measurement values fell outside the specified tolerances, only values within the tolerances were recorded on the inspection certificates based on the prescribed format. As a result, products that did not meet the required tolerances were shipped.

g. Inappropriate conduct in hardness testing of special equipment surface plates

The HS values measured using a Shore hardness tester were converted into HB values and recorded on the inspection certificates submitted to customers.

h. Impact of the inappropriate conduct on product quality

Reports from customers using the products subjected to the inappropriate conduct indicate that no quality issues have occurred.

(3) Causes of the Inappropriate Conduct at the Wakasa Works

a. Closed environment resulting from fixed personnel and inadequate oversight by the head office

At the Wakasa Works, fixed personnel by a lack of personnel rotation and insufficient management by the head office contributed to the formation of a closed environment isolated from the head office. This made it difficult for the head office to effectively perform monitoring and oversight.

b. Environment in which it was difficult to challenge the policies of the General Manager

The General Manager held significant influence, creating an environment in which employees found it difficult to raise objections to or challenge the policies set forth by the General Manager.

c. Environment conducive to the falsification of inspection results and a fragile quality assurance system

An environment existed in which falsification of inspection results could be carried out with relative ease. Moreover, the quality assurance system was insufficiently robust.

d. Insufficient initiatives to foster sufficient awareness of quality compliance

Initiatives aimed at fostering awareness of quality compliance were insufficient.

e. Failure to review delivery specifications and manufacturing drawings

The delivery specifications and manufacturing drawings exchanged with customers did not reflect the actual management and operational practices at the Wakasa Works.

f. Disregard and hollowing out of internal regulations and QC documents

Internal regulations and manufacturing drawings were disregarded, and in some cases, the rules had become mere formalities.

(4) Recurrence Prevention Measures for the Inappropriate Conduct at the Wakasa Works

a. Introduction of external oversight to the Wakasa Works

If deciding to retain the current General Manager, it is necessary to establish a supervisory structure from the head office to appropriately manage risks. In addition, it is necessary to promote managerial personnel exchanges with the head office or other sites, and to implement regular personnel rotations.

b. Introduction of systems to prevent falsification of inspection results

It is important to introduce a system in which inspection results are automatically transferred and recorded to prevent falsification. In addition, it is necessary to conduct effective internal audits and to have the check mechanism by the head office function properly.

c. Strengthening of the structure of the Materials Section within the Quality Assurance Department

It is necessary to reinforce the workforce of the Materials Section within the Quality Assurance Department and to establish a structure capable of conducting quality inspection operations.

d. Education on quality compliance

It is important to conduct renewed education and training on quality-related misconduct issues and to have the top management continue to communicate messages concerning quality.

e. Review of delivery specifications and manufacturing drawings

It is necessary to revise the delivery specifications and manufacturing drawings through negotiations with customers to ensure that their content is necessary, sufficient, and realistic and that compliance is feasible.

3. ATAKA ASANO

(1) Main Business Activities

ATAKA ASANO is a wholly owned subsidiary of Kanadevia that primarily engages in the operation and maintenance of water treatment facilities. At each business site, based on contracts with its customers, which are municipal governments, the company provides services such as purifying sewage and sludge, and discharging treated water into public bodies of water or public sewer systems. In this process, water quality tests are conducted on the treated water each operating day or every few days.

(2) Overview of the Inappropriate Conduct

a. Inappropriate conduct at Site A

At Site A of ATAKA ASANO, voluntary water quality testing was conducted at a sewage treatment facility installed by the customer, in addition to statutory water quality testing. However, the results of the voluntary tests were falsified. Specifically, the test results for T-N were altered from values that deviated from the customer's water quality standards to values that fell within the standards, and these falsified results were submitted to the customer. In addition, the test results for coliform group counts were also falsified.

b. Inappropriate conduct at Site B

At Site B, voluntary water quality test results for $\text{NH}_4\text{-N}$, $\text{NO}_2\text{-N}$, and $\text{NO}_3\text{-N}$ were falsified. Specifically, test results that deviated from statutory water quality standards were altered to values that fell within the standards and submitted to customers.

c. Inappropriate conduct at Site C

At Site C, voluntary water quality test results for T-P and pH were falsified. In addition, inappropriate water samples were provided for statutory water quality testing.

d. Inappropriate conduct at Site D

At Site D, during statutory water quality testing, water samples were taken from the piping immediately before inflow into the activated carbon treatment tank located upstream of the effluent tank, and these samples were submitted to an external testing agency.

e. Inappropriate conduct at Site E

At Site E, during statutory water quality testing, water samples were taken from the piping downstream of the sterilization device only while the sterilization device was not in operation, and these samples were submitted to an external testing agency.

(3) Causes of the Inappropriate Conduct at ATAKA ASANO

a. Sites and branches

ATAKA ASANO's business sites and branches were unable to report or consult with customers regarding technical issues related to water quality management. In addition, the results of voluntary water quality inspections were easily falsified, and there was a lack of awareness and understanding regarding compliance with customer agreements and the legal requirements related to water quality management.

b. Head office departments

At ATAKA ASANO's head office, the establishment and operation of supervisory and guidance systems related to water quality management were inadequate. Furthermore, the compliance

department failed to act appropriately in consideration of water quality management risks. Also, the monitoring system based on water quality management risks was insufficient.

c. Top management

The company-wide risk management approach of ATAKA ASANO's top management was insufficiently aware of water quality management risks. Internal communication was not smooth, and there were no systems in place for effectively transmitting and sharing risk-related information within the company.

(4) Proposals for Recurrence Prevention Measures for the Inappropriate Conduct at ATAKA ASANO

a. Sites and branches

At ATAKA ASANO's sites and branches, it is necessary to revise the relationships among the sites and branches with respect to water quality management, as well as the flow for reporting to and consulting customers. It is also necessary to review the flow for inspection and recording related to voluntary water quality testing, and to foster awareness and understanding regarding compliance with agreements with customers and laws and regulations related to water quality management.

b. Head office departments

At ATAKA ASANO's head office, it is necessary to review the governance system, compliance system, and monitoring system with respect to water quality management risks.

c. Top management

For ATAKA ASANO's top management, it is necessary to establish company-wide risk management systems and processes, to improve smooth communication and information-sharing systems, and to strengthen awareness and commitment regarding risks and compliance related to water quality management.

4. KVES

(1) Main Business Activities of the KVES Group

The KVES Group companies primarily engage in the operation of waste incineration facilities and recycling facilities. As of April 1, 2025, the KVES Group has 107 branches nationwide, and inappropriate conduct was identified at seven of those branches.

(2) Overview of the Inappropriate Conduct

a. Improper measurement of waste incineration volumes at Branch A

At Branch A, improper measurement practices were conducted by manipulating of opening and closing the crane buckets—specifically, performing “empty measurements” in which no actual waste was loaded but the act was recorded as if waste had been input, and “reverse empty

measurements” in which the actual input was not recorded. These improper measurements had been carried out since at the latest around 2003 and were uncovered in July 2024.

b. Improper measurement of waste incineration volumes at Branch B

At Branch B, improper measurements were conducted by using reverse empty measurements and “tare weight adjustments,” which resulted in underreporting of waste input volumes. These improper measurements had been carried out since at the latest February 2001 and continued until October 2024.

c. Improper measurement of waste incineration volumes at Branch C

At Branch C, improper measurements were conducted using reverse empty measurements, which resulted in underreporting of waste input volumes. These improper measurements had been carried out since around 2018 and continued until December 2024.

d. Improper measurement of waste incineration volumes at Branch D

At Branch D, improper measurements were conducted using both empty measurements and reverse empty measurements, which resulted in either overreporting or underreporting of waste input volumes. These improper measurements were carried out continuously from around 1996 until December 14, 2024.

e. Improper measurement of waste incineration volumes and falsification of flue gas measurement values at Branch E

At Branch E, in addition to conducting empty measurements and reverse empty measurements, inappropriate conduct was also carried out in flue gas inspections. Specifically, actual measurement values were falsified using the “low-cut function” and “calibration function” of the DCS. This inappropriate conduct was carried out from around 2007 until August 2024.

f. Exceedance of standard values and falsification related to flue gas and furnace temperatures at Branch F

At Branch F, measurement values for flue gas and furnace temperatures were falsified. These improper measurements continued from April 3, 2016 until July 26, 2023.

g. Improper operation of the flue gas analyzer at Branch G

At Branch G, the flue gas analyzer was set to inspection or maintenance mode to prevent recording of actual measurement values. This inappropriate conduct continued from around 2015 until March 25, 2025.

(3) Causes of the Inappropriate Conduct at KVES

a. Branches

At the branches where the inappropriate conduct occurred, an appropriate framework to manage operational risks had not been established, resulting in operations being carried out without giving due consideration to such risks. The specific causes were a lack of consultation regarding operational risks either within the branches or with customers, the existence of an environment in which inappropriate conduct could be easily committed, and the absence of efforts to foster awareness and understanding of the importance of compliance with customer agreements and relevant laws.

b. Head office departments

The head office departments of both KVES and Kanadevia failed to establish appropriate frameworks to manage operational risks, resulting in operations being carried out without giving due consideration to such risks. The specific causes were an inadequate supervisory structure within the business headquarters, the administrative departments not engaging in appropriate activities based on operational risk considerations, and the insufficiency of the audit system.

c. Management

The management of both KVES and Kanadevia failed to adequately implement company-wide risk management that takes operational risks into account, and did not establish the necessary frameworks to address such risks. The specific causes include the lack of a company-wide system to eliminate identified issues and the insufficient monitoring of the implementation statuses of recurrence prevention measures.

(4) Proposals for Recurrence Prevention Measures by the Special Investigation Committee

a. Branches

It is important to establish an open and candid environment for discussion, consultation, and reporting within each branch; to review relationships with customers in connection with operational management; to reassess inspection and recording processes in which operational risks exist; and to implement initiatives to foster awareness and understanding of compliance with customer agreements and laws related to operational management.

b. Head office departments

It is important to clarify the roles and responsibilities of the business headquarters of both KVES and Kanadevia, to rebuild cooperative relationships between these business headquarters and the branch offices with respect to operational management, and to review the compliance and audit systems.

c. Management

It is important to establish a company-wide risk management and crisis management system, and to reform management's mindset and initiatives regarding operational risks and compliance.

5. V-TEX

(1) Main Business Activities

V-TEX is a wholly owned subsidiary of Kanadevia that engages in development, manufacturing, and sales of special valves used in manufacturing equipment for precision machinery as well as components that function as safety devices in various plants and pressure vessels. These products are made to order, with specifications determined individually for each customer based on their orders.

(2) Overview of the Inappropriate Conduct

a. Inaccurate reporting of operation cycles in development phase evaluation tests

Development of special valves at V-TEX is begun either in response to a customer request and requirements or as part of in-house development. Each development project is led by a design engineer assigned by the Design Department, and upon completion of the design and prototype fabrication, evaluation testing is conducted. While the evaluation test results are reported to customers, there were confirmed cases in which regular tests in durability tests were conducted before the specified number of operation cycles had been reached or after the specified number had been exceeded, and the results of those tests were falsely presented as if they had been measured at the specified number of cycles.

b. Implementation of 4M changes without customer approval

At V-TEX, when making 4M changes (e.g., changes to equipment, work conditions/processes, specifications, components, and subcontractors) related to products, customer approval is required. However, if the General Manager of the Quality Assurance Department determined that submitting a 4M change request to the customer was unnecessary, such changes were implemented without that request to the customer. There were also instances in which changes were made before customer approval was obtained.

(3) Causes of the Inappropriate Conduct at V-TEX

a. Inaccurate reporting of operation cycles in development phase evaluation tests

The causes included misunderstandings within the Design Department regarding the terms agreed upon with customers and a lack of awareness of the problematic nature of the inappropriate conduct. Within the Design Department, it was believed that there was no substantial impact on product quality or performance, which led to a diminished sense of concern and allowed the issue to persist for a long period. Additionally, insufficient scheduling and the absence of any checks from other departments contributed to the problem.

b. Implementation of 4M changes without customer approval

The causes included insufficient management of contractual terms with customers within the Quality Assurance Department, which led to a failure to accurately grasp the actual statuses of unapproved 4M changes. In addition, although customers required very strict 4M change

management, V-TEX's internal management, operational framework, and actual business practices were not fully aligned with those expectations.

(4) Recurrence Prevention Measures for the Inappropriate Conduct at V-TEX

a. Inaccurate reporting of operation cycles in development phase evaluation tests

As measures to prevent recurrence, it is necessary to implement initiatives within the Design Department to enhance legal literacy and to raise awareness of the importance of complying with agreements made with customers. Specifically, regular compliance training focused on preventing quality misconduct should be conducted, along with leadership training for managers and regular dialogues between management and supervisory staff regarding compliance. Furthermore, it is important for senior management to clearly articulate and demonstrate the company's values and stance.

b. Implementation of 4M changes without customer approval

As measures to prevent recurrence, the Quality Assurance Department must review and consolidate all contractual provisions related to 4M changes across all customers and establish a framework that enables contractual requirements for 4M change management to be accurately and comprehensively understood on a per-customer basis. In addition, in relationships with customers, it is necessary to align the requirements related to 4M change management at a level that allows for reasonable and practical operation.