FOR IMMEDIATE RELEASE

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Released on September 4, 2026, in Kyoto, Japan

Disclosure of Investigation Report and Nidec's Actions in Response to It

As announced in the press release, "Notice Regarding Nidec Corporation's Receipt of the Investigation Committee's Report" dated September 2, 2026, Nidec Corporation (TSE: 6594; OTC US: NJDCY) ("Nidec," the "Company," or "we") received an investigation report (the "Investigation Report" or the "Report") from an investigation committee comprising outside experts (the "Investigation Committee" or the "Committee") on the same day. This release is to announce that the Company discloses the Investigation Report as attached today, as the examination of confidentiality measures necessary to protect the trade secrets of the Nidec Group and our business partners, customer information, individual privacy, and other information is completed. We sincerely apologize for any concern or inconvenience experienced by our customers, shareholders, investors, and other stakeholders. Going forward, the Company's executives and other employees will be committed to making concerted efforts to steadily reform our corporate culture, systems, and processes. Your continued support will be greatly appreciated.

1. Disclosure of the Investigation Committee's investigation report

Please see the attachment for the Summary Report of the Investigation Committee.

2. Nidec's understanding based on the Investigation Report

As part of the efforts to reform its internal management system by Nidec Corporate Reform Committee (established on October 30, 2025), Nidec launched on January 8, 2026 a quality inspection for all of the Nidec Group's production and development bases. This inspection revealed suspected cases of misconduct at multiple bases, prompting us to establish the aforementioned Investigation Committee comprising outside experts. Since then, we have fully cooperated with the Committee's investigation.

The Investigation Report identifies a series of quality-related issues, including 4M change rule violations, falsification and fabrication of testing and inspection results, violation of inspection and manufacturing conditions, use and shipment of substandard and unauthorized items, and violation of preparation and management rules of component- and material-related records, and misconducts related to products' country-of-origin data (hereinafter collectively referred to as the "quality-related issues").

The Report also points out other issues such as: (i) while the management system was unable to keep up with the growth of the Company, employees were strongly required to achieve short-term business targets and reduce cost beyond the actual business conditions; (ii) in individual businesses, the understanding, evaluation, and monitoring of quality-related risks, and the management of transition of business succession and production transfer, were both inefficient; and (iii) amid strong pressure to reduce cost, Nidec could not secure enough human and other resources for quality assurance, while the Company's quality assurance department could not fully exercise its independent check functions. These issues, intertwined, led to the generation and continuation of the aforementioned series of misconduct. We sincerely acknowledge these issues, which the Report states caused an "unhealthy state" to be formed and continue to exist in Nidec.

With respect to the excessive pressure to achieve business targets, the voice-suppressing corporate culture, other issues and problems that the previously established Third-Party Committee revealed (https://www.nidec.com/files/user/www-nidec-com/corporate/news/2026/0303-01/260303-01en.pdf) caused the series of inappropriate accounting practices, and other issues common to them related to Nidec's management attitude and corporate culture, we regard them not as individual phenomena but as fundamental tasks that we should face in rebuilding Nidec. To solve these issues, we will continue to steadily improve and promote measures to create a better corporate culture.

Nidec also realizes issues with its systems and processes uniquely to quality assurance as well. By addressing these issues together, we will be reborn as a company that carries high ethical standards and always prioritizes "Do things right."

Specifically, Nidec will continue its cultural reform measures implemented after the discovery of inappropriate accounting practices, while sending out the top executive's messages of becoming a proud manufacturer with a quality- and customer-first policy, and holding quality compliance training for all executives and other employees.

As part of the system and process reform to improve its quality assurance organization's authority and functions, Nidec will revise its Global Quality Assurance Regulations to inform all concerned that individual Business Units' and Nidec Group companies' quality assurance managers have the authority to suspend product shipment. In addition, the Company's Global Quality Management Division will launch quality audits and check the status of our compliance with the regulations continuously. Further, we have installed opinion collection boxes permanently and revised the report lines to the quality assurance managers of individual Business Units, Nidec Group companies, and their subsidiaries, to rebuild a system where the Nidec Group's quality compliance-related information will be reported to the head office promptly, and appropriate actions will be implemented.

3. Facing customers

With respect to customers related to Nidec products found with the aforementioned quality-related misconducts and other issues, we are in the process of providing them with explanations, responding to issues individually. We will continue to face each customer with sincerity and address issues responsibly.

4. Impact on Nidec's financial statements for past fiscal years

So far, Nidec's evaluation of individual matters' financial impact has revealed no issue with any material impact on the Company's consolidated and other financial statements of past fiscal years. Nidec plans to correct its securities reports and other documents of past fiscal years and submit its securities report for the fiscal year ended March 2026 at the earliest possible date.

5. Disciplinary actions based on the Investigation Report

Going forward, based on facts to be revealed in the Investigation Committee's investigation, we will launch appropriate disciplinary actions on personnel.

6. Actions going forward to rebuild Nidec

Quality is equivalent to a promise that Nidec makes with its customers and society, and a basis to support trust in Nidec and its corporate value. By deeply reflecting on the issues we have caused, we will return to the basics of *monozukuri* (manufacturing, with a deep philosophy of craftsmanship, pride, skill, and a continuous drive for perfection) and shift toward a quality-centered management.

At the same time, seriously taking to heart the fact that it will never be easy to recover lost trust, and accepting the Investigation Committee's suggestions sincerely, all executives and other employees will be committed to reforming our corporate culture, systems, and processes drastically.

Through these actions, Nidec will dedicate all its strength to regain the spirit as a proud manufacturer with a quality- and customer-first spirit and regain our customers' and society's trust as soon as possible. Please continue to support us as we go forward.

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September 2, 2026

To: Nidec Corporation

Investigation Report (Summary)

Investigation Committee

Chairperson: Toshihiko Itami

Member: Hideo Makuta

Member: Kenji Kawai

1 Overview of the Investigation

(1) Background and Purpose of the Investigation

Nidec Corporation (hereinafter referred to as "**Nidec**") established a Third-Party Committee on September 3, 2025, in response to allegations of improper accounting at Nidec and its group companies (hereinafter collectively referred to as the "**Nidec Group**"). Concurrently, with the aim of restoring stakeholder trust and strengthening its internal control systems, Nidec established the Nidec Reform Committee on October 30, 2025, and began an internal investigation of the Nidec Group's production and development sites (hereinafter referred to as the "**Comprehensive Quality Inspection**") on January 8, 2026.

In the course of conducting the Comprehensive Quality Inspection, Nidec identified potential quality assurance issues at multiple Nidec Group sites (hereinafter referred to as the "**Quality Assurance Issues**")[1] and potential issues related to product country-of-origin labeling, etc. (hereinafter referred to as the "**Country-of-Origin Labeling Issues**"[2]; collectively referred to as the "**Quality Assurance-Related Issues**" when combined with the Quality Assurance Issues). Consequently, Nidec determined that an objective investigation by external experts was necessary and, at a Board of Directors meeting held on May 13, 2026, established an Investigation Committee

[1] The "Quality Assurance Issues" refers to any act (including omission) related to the design and development, manufacturing and change management, testing and inspection, shipping, customer service, or other processes of Nidec Group products that may violate or deviate from the requirements under applicable laws, regulations, rules, standards, or certification (hereinafter referred to as "**Laws and Certifications**"), contracts with customers or other agreements (hereinafter referred to as "**Customer Agreements**"), or Nidec Group internal standards or internal criteria (hereinafter referred to as "**Internal Standards**").

[2] The "Country-of-Origin Labeling Issues" refers to acts (including omission) that may violate or deviate from applicable laws, regulations, or rules regarding the labeling, description, or certification of the country of origin of Nidec Group products; declarations to customs authorities made in connection with import or export; or the preparation, submission, or use of invoices or other documents related to these matters.

(hereinafter referred to as the "**Committee**") composed of external experts.

The Committee conducted an investigation (hereinafter referred to as the "**Investigation**") from that date through September 2, 2026, for the purposes of: (1) clarifying the facts regarding the Quality Assurance-Related Issues; (2) analyzing the causes and proposing corrective measures; and (3) examining matters deemed necessary by the Committee.

(2) Investigation into Quality Assurance Issues

A. Scope and Methods of the Investigation

In the Investigation, the scope and methods were determined through the following procedures: (i) identifying cases for investigation; (ii) conducting supplementary investigations; (iii) selecting cases to be investigated; and (iv) determining who would conduct the investigations and the depth of the investigations.

(a) Identification of Cases for Investigation

The Committee identified the following cases for investigation: (a) cases reported by each Business Unit (BU) or sites[3] through interviews and self-checks conducted as part of the Comprehensive Quality Inspection[4]; (b) cases reported to the Quality Feedback Channel that the Committee took over from Nidec; (c) cases reported to Nidec's employee reporting hotline that the Committee took over due to alleged Quality Assurance-Related Issues; and (d) cases identified through site visits to key sites conducted by Nidec's Global Quality Management Division (hereinafter referred to as "**GQM**").

(b) Supplementary Investigations

In order to broadly identify cases not captured through the channels described in (a) above and to verify whether there were any discrepancies between the information provided by Business Units (BUs), sites, employee reporters, and others and the actual circumstances, the Committee conducted a questionnaire survey, an AI avatar survey[5], and a forensic investigation.

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[3] "BU" refers to each business unit of the Nidec Group and group companies managed by Nidec's Group Company Business Management Department; "site" refers to the production and development sites belonging to each BU. The same applies hereinafter.

[4] The Comprehensive Quality Inspection was conducted primarily through interviews with executives and employees at the Nidec Group's production and development sites; by cross-checking records of process changes, design changes, and other matters against the history of reports to customers; and by establishing a contact point (hereinafter referred to as the "**Quality Feedback Channel**") to receive information regarding the Quality Assurance-Related Issues and other related matters from all Nidec Group executives and employees.

[5] The AI avatar survey was carried out mainly by Nidec at the request of the Committee.

The questionnaire survey was conducted among all 97,663 executives and employees assigned to 305 production and development sites, and responses were received from 89,973 individuals (a response rate of 92.1%). Among these, responses reporting specific instances of Quality Assurance-Related Issues and other issues were scrutinized for their content and severity, and cases deemed to require investigation were added to the scope of the Investigation[6].

In addition, the AI avatar survey involves an AI avatar displayed on a dedicated system—acting in place of a human interviewer—asking questions regarding awareness of Quality Assurance-Related Issues, the actual state of quality control, and organizational culture, among other topics, to which respondents answer via voice or text input. This survey was conducted at 16 locations[7]. As a result, two new cases suspected of Quality Assurance Issues were identified and added to the scope of the Investigation.

The forensic investigation was conducted primarily to verify whether any Nidec directors or executive officers (hereinafter collectively referred to as "**Officers**") had instructed or been involved in Quality Assurance-Related Issues. To this end, electronic data—including emails—from 31 current and former Officers was preserved, narrowed down through keyword searches, and reviewed. The forensic investigation did not identify any new cases involving suspected Quality Assurance Issues, nor did it identify any emails or other communications clearly indicating that any Officer had specifically instructed or tacitly approved any Quality Assurance-Related Issues.

(c) Selection of Cases for Investigation

Of the cases identified through the above processes, the Committee excluded those that (i) consisted solely of violations or deviations from Internal Standards, with no evidence of potential violations of Customer Agreements or Laws and Certifications, and (ii) cases related to violations of 4M change procedures[8] where the details of the change were subsequently explained to the customer and the customer's approval for the change was obtained; and (iii) cases where,

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[6] From the responses indicating awareness of Quality Assurance-Related Issues, the Committee excluded those that contained no specific details in the section for summarizing such incidents—limiting themselves to abstract responses—or those that described matters clearly outside the scope of the Investigation and identified relevant responses from 1,999 individuals.

[7] In selecting the target sites, the Committee took into account the reporting status of Quality Assurance-Related Issues, the possibility that pressure related to performance targets and other factors may have affected quality control, and quality risks in light of product characteristics and other factors.

[8] Violations of 4M change procedures refer to instances where a change is made to "Man", "Machine", "Materials", or "Methods used in the manufacture, testing, or inspection of a product without following prescribed procedures (such as submitting a prior application to the customer, obtaining the customer's approval, or other prescribed procedures), even though those procedures are required under Customer Agreements.

although the product or customer differed, the conduct was carried out in the same or substantially the same manner as in other cases within the same BU and site, and were therefore consolidated with those other cases. Cases found after the Investigation began to fall under any of these categories were also excluded from the scope of the Investigation[9] .

(d) Investigating Body and Depth of the Investigation

For each case subject to the Investigation, the Committee determined the investigating body and the depth of the investigation, based on the source of the information, the progress of Nidec's internal investigation, the potential for the case to fall under the "**Critical Quality Criteria**" defined in B. below, and other factors related to the nature and severity of the cases.

Specifically, for cases highly likely to meet the Critical Quality Criteria, the Committee took the lead in scrutinizing objective documentation, conducting interviews with relevant individuals or posing questions via email, and, where necessary, visiting sites to conduct on-site investigations and verify records. For other cases, Nidec investigated the facts based on the Committee's instructions, and the Committee reviewed the investigation results and related materials, requesting the submission of additional materials, verification of facts, or supplementary investigations as necessary.

B. Classification of Cases Based on Investigation Results

For cases in which the Quality Assurance Issues were identified through the above investigation, the Committee classified them into "**Significant Quality Assurance Cases**" and "**Non-Significant Quality Assurance Cases**" by comprehensively considering the nature and form of the conduct, its duration and frequency, the affected products and their applications, the nature and scope of customers, the positions and scope of those involved, legal and technical risks, potential impact on customers and consumers, business and financial impacts, and the necessity and nature of responses to customers and other relevant parties, among other factors.

(a) Significant Quality Assurance Cases

The Committee classified the following cases as a Significant Quality Assurance Case: (a) cases involving an officer or site manager of the Nidec Group; (b) cases where the final product

[9] Cases that fall under (i) and (ii) were excluded because it was determined that the likelihood of customer response or cost burden arising from them was relatively low. Furthermore, cases that fall under (c) were consolidated because it is highly likely that the individuals involved, the causes, or the structural issues are common, and it is reasonable to investigate and analyze them as a single case.

is intended for overseas public agencies; (c) cases where there is suspicion of a potential violation of laws, regulations, or certifications; (d) cases assessed by a BU, a site, or a reporter as having the potential for a recall of the relevant product; and (e) cases assessed by a BU, a site, or a reporter as involving a high level of technical risk (a risk affecting product safety) related to the relevant product (hereinafter, the items (a) through (e) are referred to as the "**Critical Quality Criteria**"). However, with regard to (d) and (e), verifying the validity of these assessments is not included in the scope of the Investigation, and the Committee has not determined the validity of such assessments.

(b) Non-Significant Quality Assurance Cases

Cases in which a Quality Assurance Issue was identified but were not determined to fall under any of the categories listed above were classified as Non-Significant Quality Assurance Cases. Non-Significant Quality Assurance Cases were classified as having relatively lower severity compared to Significant Quality Assurance Cases, to the extent that the Investigation did not confirm their meeting the Critical Quality Criteria; however, this does not necessarily mean that the identified Quality Assurance Issues are minor or that no additional action is required.

(3) Scope and Methods of Investigation Regarding Country-of-Origin Labeling Issues

With regard to the Country-of-Origin Labeling Issues, it was necessary to verify not only the terms of agreement with each relevant customer but also compliance with the laws and regulations of the country or region of export or import, as well as the potential necessity for corrective declarations to overseas authorities or other corrective actions. Since the verification items and necessary responses differ from those for the Quality Assurance Issues, these were investigated as a separate category of cases.

The cases subject to investigation were those identified by Nidec through its Comprehensive Quality Inspection, as well as those identified by the Committee through supplementary investigations and other means. However, within the Nidec Group, investigations into the Country-of-Origin Labeling Issues—identified through the Comprehensive Quality Inspection—had been underway by Nidec or external law firms retained by Nidec even before the establishment of the Committee. Therefore, for cases in which investigations by Nidec or the external law firms had been completed by the time the Committee was established, the Committee received the investigation results and verified that there were no significantly unreasonable aspects in the

findings. On the other hand, for cases in which investigations had not been completed by that time, as well as cases newly identified through supplementary investigations and other means, the Committee took the lead in conducting investigations by scrutinizing objective evidence, interviewing relevant individuals, and reviewing email data, among other measures.

2 Summary of Investigation Findings

(1) Cases Involving Quality Assurance Issues

A. Overview

A total of 844 cases of Quality Assurance Issues were identified in the Investigation[10] (60 Significant Quality Assurance Cases and 784 Non-Significant Quality Assurance Cases), and their distribution by BU is as follows.

Business Unit	Significant Quality Assurance Issues	Non-Significant Quality Assurance Issues	Total
Nidec Instruments Co., Ltd. (NIST)	18	567	585
Nidec Mobility Co., Ltd. (NMOJ)	8	117	125
Nidec Techno Motor Co., Ltd. (NTMC)	7	50	57
Small Motor Business Division (SPMS)	10	14	24
Home Appliance Industry Division (ACIM)	2	17	19
Automotive Existing Business Division (AMEC Organic)	10	5	15
Motion & Energy Business Division (MOEN)	0	6	6
Nidec Components Co., Ltd. (NCCC)	0	4	4
Nidec Drive Technology Co., Ltd. (NDTC)	3	1	4
Automotive Business Division (AMEC)	0	3	3
Nidec Powertrain Systems Co., Ltd. (NPSC)	1	0	1
Nidec Precision Co., Ltd. (NPCJ)	1	0	1
Total	**60**	**784**	**844**

[10] In its May 13, 2026, statement titled "Toward Nidec Reform," Nidec announced that, as of that date, it had identified "more than 1,000 potential inappropriate conducts." However, this figure represents information regarding potential Quality Assurance-Related Issues identified through Nidec's Comprehensive Quality Inspection and other means that Nidec compiled; it has not undergone the Committee's selection of investigation targets, case categorization, or determination of facts. In contrast, as described in Section 1 B. above, the figure in this section was calculated by excluding certain cases from the scope of the Investigation, consolidating related cases of the same or substantially the same nature into a single case, and then counting only those cases in which a Quality Assurance Issue was confirmed. Since the two figures differ in terms of the entity conducting the tally, the timing, the scope, and the unit of measurement, they cannot be compared directly.

As shown above, the number of cases was concentrated in the three BUs—NIST, NMOJ, and NTMC—which together accounted for approximately 90.9% of the total [11]. Furthermore, in terms of types of violations, there were 805 cases of violations of 4M change procedures without prior notification or approval from the customers, accounting for approximately 95.4% of the total. In addition, 22 cases (2.6%) of falsification or fabrication of test and inspection results, 11 cases (1.3%) of violations of inspection and manufacturing conditions, four cases (0.5%) involving the use or shipment of non-conforming or unapproved products, and two cases (0.2%) of violations in the creation or management of records relating to parts and materials, were identified. On the other hand, among the 60 Significant Quality Assurance Cases, in addition to violations of 4M change procedures, the proportions of falsification or fabrication of test and inspection results, violations of inspection and manufacturing conditions, and the use or shipment of non-conforming or unapproved products were relatively high[12].

B. Examples of Significant Quality Assurance Cases

Among the Significant Quality Assurance Cases, there were cases where the company prioritized business requirements—such as cost reduction and ensuring production volume—or continued to implement exceptional operating practices without the customer's consent, even without fundamentally resolving process capability issues. For example, at AMEC Organic, prior to the transition to mass production, technical feasibility, process capability, and the necessary production system were not sufficiently verified or secured. With defective products piling up, rework practices—such as the reuse of parts—were carried out for an extended period without customer approval in order to meet production volume targets and reduce scrap costs. At SPMS, while the manufacturing process was unable to consistently meet customer specifications, the company relaxed its internal judgment criteria without customer approval and continued for an extended period to alter inspection results submitted to customers to values different from the actual measured values. After the relevant departments at SPMS recognized the problem, they failed to report it to

[11] However, the proportion of Significant Quality Assurance Cases out of all confirmed cases varies greatly by Business Unit (BU). For this reason, it is not appropriate to assess the severity of quality risks or issues in each BU based solely on the total number of cases.

[12] While violations of 4M change procedures accounted for 99.1% of Non-Significant Quality Assurance Cases, among the 60 Significant Quality Assurance Cases, 28 cases (46.7%) involved violations of the 4M change procedures; 22 cases (36.7%) involved the falsification or fabrication of test and inspection results; five cases (8.3%) involved violations of inspection and manufacturing conditions; three cases (5.0%) involved the use or shipment of non-conforming or unapproved products; and two cases (3.3%) involved violations in the creation or management of records relating to parts and materials.

the customer or implement permanent process improvements; instead, they established internal rules permitting data modification under certain conditions.

In addition, there were cases where, after violations of Customer Agreements and other requirements were discovered, the company prioritized internal technical evaluations over reporting to customers, as well as cases where compliance with customer requirements was determined without obtaining or verifying the necessary information. At NMOJ, in an effort to reduce costs, materials prohibited by customer agreements were used without customer approval; after this was discovered, the company determined that the quality risk was low based on internal verification tests and did not immediately report the issue to the customer. At NTMC, during process changes associated with a production transfer, the company notified the customer that compliance with requirements had been confirmed without first obtaining or verifying the necessary information on chemical substances contained in the products, and proceeded to manufacture and ship the products.

Furthermore, there were cases where previous business practices with potential issues were not reviewed during business succession or production transfers and were passed on to the transferee. For example, at NIST, the practice continued for recording standard values that met specification requirements as actual measured values for inspections that had not been performed, and submitting inspection reports to customers indicating that the inspections had been completed. The head of the quality assurance department was also aware before the transfer, that at least some inspections were not being conducted at the prescribed frequency; however, after the transfer, he did not verify the implementation status and approved inspection reports that simply transcribed the values from the in-process inspection records.

(2) Cases Involving Country-of-Origin Labeling Issues

As a result of the Investigation, six cases of Country-of-Origin Labeling Issues were identified. Of these, two cases were verified retrospectively by the Committee based on existing investigation results from an external law firm, and three cases were investigated by the Committee. The remaining case was newly identified through a questionnaire survey and other investigations.

Cases involving Country-of-Origin Labeling Issues included instances where the required country-of-origin determination was not reviewed after changes to the manufacturing process or location, resulting in a country of origin whose accuracy is in question being stated on product labels, customs clearance documents, or certificates of origin; and instances where the customs declared value was set incorrectly. The underlying causes varied: some cases resulted from a lack of

knowledge regarding country of origin and customs procedures, unclear division of responsibilities among departments, the absence of written, uniform standards for determining and labeling the country of origin, or the lack of a workflow linking changes in manufacturing processes to the verification of country-of-origin determinations and customs clearance procedures.

3 Analysis of Structural Problems—Reasons for the Formation and Entrenchment of Unsound State

(1) The "Unsound State" at Issue

The Quality Assurance-Related Issues confirmed in the Investigation varied widely in terms of the nature of the acts, the circumstances under which they occurred, the duration of their occurrence, and the scope of those involved; consequently, their causes were not uniform. However, in most cases, these issues were not committed by executives or employees to gain direct personal benefit; rather, they persisted as a result of a series of decisions made under pressure from various business processes, including performance targets, cost reduction, and delivery deadlines.

Such conduct cannot be rectified simply by attributing the cause solely to the knowledge, experience, or sense of ethical standards of individuals and disciplining those individuals. A company is a system in which people collaborate within a complex interplay of organizations, systems, and processes; therefore, the risk of misconduct must be analyzed and addressed as a risk of the system as a whole. Therefore, the Committee characterized the state of the organization—which influenced the judgment and actions of executives and employees and permitted the occurrence and continuation of the issues—as an "unsound state." Furthermore, the Committee identified the business operations, organizational structure, management, and various systems that led to the formation and entrenchment of this state as "structural problems," and analyzed the mechanisms by which these structural problems created and entrenched the unsound state.

The "unsound state" identified in the Investigation was a situation at the BU and site levels where, under pressure to achieve performance targets, reduce costs, meet delivery deadlines, and ensure continuous supply, compliance with Customer Agreements or Laws and Certifications and customer requirements and certain aspects of the quality assurance process took a back seat to business imperatives. As a result, the Quality Assurance-Related Issues were regarded by officers and employees in manufacturing and quality assurance functions as "unavoidable for achieving performance targets or reducing costs" and as "not problematic if limited to this extent." Coupled with diminished transparency, the Quality Assurance-Related Issues became embedded as part of

routine operations, repeated and continued over time, and in some instances, were passed on to successors or entities to which responsibilities were transferred.

On the other hand, despite the fact that transparency across the entire group had declined as the scope of the business expanded, and that BUs and sites were under intense pressure to deliver results and strict cost controls, Nidec's corporate departments did not fully grasp the actual status of order intake, manufacturing, and quality assurance at each business unit and site because an adequate organizational structure commensurate with the business expansion was not sufficiently established. Consequently, the mechanisms designed to detect signs of Quality Assurance-Related Issues and specific risks at an early stage, monitor them according to their nature and severity, and reflect the monitoring results in the strengthening of the quality assurance system and the improvement of risk management processes were not functioning properly.

This situation has been formed and entrenched by the attitude of management, which did not establish a management structure commensurate with the Group's rapid expansion and continued to place strong emphasis on achieving short-term performance targets and reducing costs. Management maintained a management structure centered on micromanagement by Mr. Nagamori and, without sufficiently establishing a system to ensure transparency necessary for effective governance and grasp the actual state of each BU and site, imposed the impractical demands and contradictions of top-down targets on the BUs and sites.

Below, we will organize the structural problems that led to the formation and entrenchment of this "unsound state" by dividing them into the management layer, the corporate layer, and the business unit and site layers.

(2) Structural Problems That Led to Formation and Entrenchment of Unsound State

A. Management Level—Management Practices Unsuitable for Scaling Up and Performance Targets Disproportionate to Actual Capabilities

The Nidec Group rapidly expanded through M&A to a scale comprising 354 group companies (as of the end of September 2025) and 305 production and development sites across 31 countries (as of June 2026). Consequently, the burden of collecting, aggregating, analyzing, and verifying the information necessary for management decisions (information costs) increased significantly. However, efforts to strengthen the governance structure to match the Group's expanding scale and complexity, design an organizational structure that took management span into account, and

integrate quality assurance processes did not progress sufficiently. After the Group's expansion, the management system—based on the concentration of authority in Mr. Nagamori and micromanagement—persisted, making it difficult to ensure the transparency needed to grasp the actual state of the businesses and on-site operations.

In the business plans, in addition to the target figures submitted by each BU based on market conditions and their operational capabilities, guidelines were set based on the profit levels the consolidated group as a whole was required to achieve, and BUs were expected to bridge the gap between these figures. Despite differences in the profit structures across businesses, uniform profit margins or improvement targets were imposed; when BUs expressed concerns that these targets were difficult to meet, such feedback was not adequately reflected. Targets were broken down into monthly and even daily targets; for BUs expected to fall short, strict performance management—involving frequent meetings that sometimes lasted into the late hours of the night and severe reprimands—was implemented. In the questionnaire survey conducted by the Committee, 31.9% of all respondents cited "internal pressure regarding delivery deadlines, sales, profits, or cost reductions" as a cause of Quality Assurance-Related Issues; this figure rose to 37.8% among those who acknowledged the existence of Quality Assurance-Related Issues.

The Investigation did not confirm that Mr. Nagamori or other members of management directly instructed or were involved in specific instances of Quality Assurance-Related Issues intended to achieve performance targets; nor did the aforementioned management practices serve as the direct cause of all such issues. However, in at least some BUs and sites, high performance targets and short-cycle performance management, while promoting rationalization and cost-cutting, also led to constraining the time, personnel, and equipment necessary for change procedures, inspections, customer responses, and the correction of Quality Assurance Issues. If frontline staff find it difficult to candidly communicate the unrealistic nature of targets or negative information, management cannot accurately grasp the actual performance of the business and the quality-related risks involved, thereby missing opportunities to review targets or resource allocation. This interaction contributed to the formation and entrenchment of the unsound state.

B. Corporate Level—Lack of Integration, Monitoring, and Horizontal Rollout of Quality Governance

At the Nidec Group, following M&A transactions, while performance management systems and

initiatives such as 3Q6S[13] were rolled out to acquired companies, at least in some BUs, the allocation of responsibilities and procedures uniformly applied within the BU—regarding the identification and implementation of Customer Agreements and Laws and Certifications, determining the necessity of 4M change requests, and the inspection, recording, and reporting of quality-related issues—were not sufficiently established. Furthermore, during business succession and production transfers, transition management—which involves taking stock of not only equipment and personnel but also Customer Agreements and Laws and Certifications, change histories, inspection methods, country-of-origin determinations, unresolved issues, as well as previous operational practices, and re-verifying their appropriateness—was insufficient. As a result, instances occurred where inspection practices with issues were carried over to the recipient organization, mass production continued without resolving insufficient process capability, and country-of-origin labeling issues were continued at the recipient organization.

Although efforts to establish Group-wide quality regulations and reporting systems progressed following the establishment of GQM in 2023, the mechanisms for systematically evaluating quality compliance risks at each BU and site and monitoring them through quality information and audits were insufficient. When customer responses, disciplinary actions, training, or dissemination of regulations were implemented for individual cases, there were instances where this did not sufficiently lead to a horizontal rollout—that is, identifying the root causes and control weaknesses, inspecting other BUs and sites with similar risks using common methods and audit trails, and verifying the effectiveness of those measures. The ability of GQM, the internal audit department, and other relevant departments to identify operational practices within BUs and sites that were not being corrected and to halt their continuation was also insufficient.

C. BU and Site Level—Insufficient Quality Assurance Resources and Functions, and Justification of Inappropriate Actions

In at least some BUs and sites, the shortfall between performance targets and actual performance was allocated to numerous rationalization and cost-cutting measures, including material costs, fixed costs, labor costs, F costs, productivity, and capital expenditures. As changes to materials, parts, suppliers, equipment, process conditions, or manufacturing locations increased, the workload

[13] "3Q6S" refers to the Nidec Group's on-site improvement initiative, which combines the "3Q" (Quality Worker, Quality Company, and Quality Products) with the "6S" (Sort, Set in Order, Shine, Standardize, Sustain, and Self-Discipline).

associated with notifying and obtaining approval from customers, identifying affected products, conducting inspections, and managing records continued to grow; however, indirect personnel—including those in the quality assurance department—capital expenditures, and working hours were all subject to cuts. As a result, sufficient resources could not be secured for the increasing quality assurance workload, creating a situation where customer procedures and fundamental corrective actions were deprioritized.

Furthermore, in some business units and sites, priority was placed on securing orders and production volumes, leading to a transition to mass production without a sufficient assessment of technical feasibility, process capability, or the necessary personnel, equipment, and inspection systems. Consequently, defects or process capability deficiencies that became apparent after mass production began were addressed through rework without customer approval, internal special acceptance, or other in-house measures. Furthermore, internal assessments—such as the conclusion that modified materials or processes were technically equivalent or that there were no immediate issues with product functionality or safety—were used as justification for omitting notifications to customers, requests for approval, inspections, or accurate reporting.

The quality assurance department is, in principle, independent of the business departments and is responsible for verifying compliance with Customer Agreements and Laws and Certifications, suspending manufacturing and shipping as necessary, and reporting to higher-level management. However, in some cases, the quality assurance department was involved in data alterations, the entry of fictitious figures, or the failure to report to customers, thereby validating the business department's decisions. This was due, in part, to the fact that at some BUs and sites, while the quality assurance department was placed under the direction and supervision of the site manager or business head, mechanisms for higher-level quality departments to independently verify quality judgments made at the site, as well as direct reporting channels to those departments, were not sufficiently established. Furthermore, the perception that reporting a problem would necessitate the suspension of production and shipping, product disposal, additional investment, customer responses, and the recognition of losses—and that this would result in severe reprimands or accountability from senior executives responsible for performance management, as well as the expectation that the reporter would be tasked with resolving the issue—also contributed to executives and employees hesitating to report such issues.

(3) Analysis Based on the Characteristics of Each Business Unit

The structural problems described above did not exist uniformly across all BUs; rather, they manifested in different forms depending on each BU's business environment and organizational characteristics, and their severity also varied.

First, in some BUs, business demands took priority, and problems were handled within individual sites without the cross-organizational functions that are needed to resolve issues related to process capability or mass production systems functioning adequately. For example, at SPMS, each site was required to achieve performance targets as a profit center; however, the technical and quality functions that are needed to resolve process capability issues or discrepancies with customer specifications—which could not be resolved within individual sites—did not function sufficiently at the SPMS-wide level. Furthermore, at AMEC Organic, despite the automotive industry's strict quality and change management requirements, some overseas sites prioritized securing orders and production volumes as well as reducing scrap costs. Consequently, rework and other activities were carried out without customer approval, even though verification of process feasibility during the transition to mass production and the necessary technical and quality support were insufficient.

Furthermore, at some BUs, mechanisms for reviewing the underlying assumptions and previous operational practices—and re-verifying their appropriateness—in conjunction with standard revisions, business succession, or production transfers were not functioning adequately. For example, at NDTC, there was a lack of mechanisms to update standards, product specifications, and other operational assumptions in response to standard revisions, production transfers, or the transfer of sales rights, and to verify them across departments. Furthermore, at NIST, while the company was engaged in a diverse range of businesses and faced overlapping business succession and production transfers, numerous rationalization measures and changes were implemented to achieve performance targets. However, there was a lack of functions to verify, on a cross-functional basis, customer-specific change procedures, actual materials, processes, source records, and inherited operational practices; as a result, issues were carried over even after the transfer.

In addition, some BUs were found to lack adequate mechanisms for accurately reflecting Customer Agreements and Laws and Certifications and other factors in their operations and for the quality assurance department to independently verify compliance. For example, at NMOJ, while mechanisms for cross-departmental review and early reporting regarding major design changes and similar matters functioned to a certain extent, the same level of control did not extend to process changes, replacement parts, and some overseas sites, and independent verification by the quality

assurance department was insufficient. Furthermore, at NTMC, with a large number of products and customers and an increasing number of changes resulting from rationalization efforts, the identification and implementation of change requirements for each customer depended on the knowledge of individual staff members or ad hoc management, and quality assurance resources were unable to keep pace with these demands.

(4) Summary

As described above, the manifestation of structural problems and the extent of their impact varied depending on the business environment and organizational characteristics of each BU and site. However, the "unsound state" identified in the Investigation did not arise solely from circumstances specific to each BU or site. At the management level, while the establishment of a management structure commensurate with the company's expansion was delayed, there was strong pressure to achieve short-term performance targets and reduce costs. Furthermore, at the corporate level, there was insufficient understanding, monitoring, and cross-organizational dissemination of on-site conditions and quality-related risks; at the BU and site level, the technical and quality personnel necessary for quality assurance, as well as independent oversight functions, were not sufficiently secured. The overlap of these issues led to the formation and entrenchment of the "unsound state."

As a result, discrepancies with Customer Agreements or Laws and Certifications, as well as problems related to process capability, were not resolved at the organizational level but were instead handled through exceptional practices at individual sites. Furthermore, decisions that prioritized business demands over compliance with Customer Agreements and Laws and Certifications and other aspects of the quality assurance process were tolerated, leading to inappropriate practices being repeated as part of daily operations and passed down through the organization.

4 Proposed Improvement Measures—Transitioning from an "Unsound State" to the "Desired State"

(1) Basic Approach

To address the structural issues outlined in 3 above, it is necessary to go beyond merely correcting and resolving individual cases; rather, the company must comprehensively reform management, the organization, systems, and operational practices to transform the "unsound state" into the "desired state". The "desired state" refers to a situation in which: (i) senior management shares the organization's direction (goals) and key values (principles), including quality, from a medium- to

long-term perspective, and makes high-quality decisions as a team while prioritizing organizational learning; (ii) corporate departments support and provide checks and balances on business units from a cross-functional perspective, without falling into departmentalism or local optimization; and (iii) BUs and sites understand their roles within the entire Group and continue to take sound risks while ensuring the necessary transparency.

To realize this "desired state," it is necessary to implement, in parallel and in a mutually consistent manner, or to continue implementing where already being done, "soft" measures that influence the values, judgments, and behaviors of executives and employees, alongside "hard" measures that improve management control, organizational structure, authority, procedures, information infrastructure, monitoring, and auditing. These two approaches are not mutually exclusive and should be designed and implemented as an integrated whole, in accordance with the roles of each layer. Furthermore, the effectiveness of these measures must be evaluated not only based on the introduction of systems or the conduct of training, but also on whether the judgment and day-to-day operational practices of executives and employees have actually changed.

(2) Realizing the "Desired State" at the Management Level

The "desired state" at Nidec's management level is a state in which **management, taking not only a short-term view but also a medium- to long-term perspective, redefines the ideal organization's structure and the direction it should pursue (goals), shares important values (principles), including a commitment to quality, prioritizes continuous organizational learning, and makes high-quality decisions as a team rather than as individuals**.

A. Soft Measures

- **Articulating Long-Term Vision and Direction (Goals), and Key Values (Principles)**

Management must take a long-term perspective, set out the Nidec Group's way of being and the direction it should pursue (goals), and personally share and practice the key values (principles) derived from that direction. We expect the "Re-Definition" Declaration and the formulation of Nidec's Purpose to continue to be promoted as initiatives aligned with this direction.

- **Discussions on How to Approach and Understand "Quality"**

Senior executives must clearly demonstrate, in specific situations, that the leadership team supports any necessary quality-related suspension measures, reporting, or customer response. The

Chief Quality Officer (CQO) must consistently communicate that, in cases where customer approval cannot be obtained in time for mass production schedules, inspection results fall outside specifications, or non-compliance with Laws and Certifications is suspected, the facts and original records must be preserved, and necessary actions—such as suspension measures, internal reporting, and responses to customers—must be taken. Senior executives and managers must align their statements with actual decisions and conduct. They must demonstrate support decisions to take appropriate quality-related suspension measures, internal reporting, or respond to customers, and provide the necessary resources. Senior executives and managers should also share concrete examples of such decisions and cases requiring improvements. Furthermore, it is desirable to verify whether management's responses, post-reporting support, and the treatment of reporters have actually improved.

- **Emphasizing Organizational Learning**

Management must treat problems as "seeds for learning" and make clear that it will promote early recognition and early sharing of problems rather than reprimanding or immediately holding accountable those who report problems. To that end, management must ensure psychological safety in meetings and other communications, welcome unconventional or negative information, and improve management's listening skills. Senior executives must accept reports even when the facts or impact remain uncertain, take ownership of post-reporting responses as an organization—including providing necessary support through relevant departments—and ensure through concrete experience that executives and employees can trust that sharing a problem will advance organizational learning. The responses of managers receiving reports, post-reporting support, and treatment of reporters must also be monitored continuously; where conduct that causes individuals to withhold problems or unfavorable treatment is identified, it must be appropriately reflected in guidance, evaluations, and disciplinary action. In addition, the company should secure diversity of cognitive assets and establish mechanisms for incorporating perspectives from different positions and areas of expertise into decision-making. GQM, the Legal and Compliance Department, and the Human Resources Department must continue case-based training using the Quality Assurance-Related Issues identified in the Investigation and cases arising at sites that may cause uncertainty in judgment. It is also worth considering assessing whether the content of such training is reflected in actual conduct. It is necessary to strengthen dialogue between management and the front lines to restore trust with the business divisions.

B. Hard Measures

- **Formulation of Performance Targets Grounded in Business Environment and Capabilities, and Continuous Review of Business Portfolio**

Performance targets must be formulated after verifying the basis for the targets, means of achievement, responsible entities, necessary resources, and quality risks; it is essential not to mechanically allocate cost-reduction targets to individual expense categories without a clear means of achieving them. The new medium-term business plan must incorporate a mechanism whereby each BU and group company formulates plans backed by their operational capabilities and quality risks, and the headquarters verify their feasibility and the necessary resources and provide support. Where there are deficiencies in planning capabilities or support functions, it is expected that the necessary personnel will be assigned and developed, or that external experts will be utilized. At the same time, it is necessary to reconsider the organizational structure, including the business portfolio and the number of manageable subsidiaries and sites.

- **Revision of Performance Targets and Business Plans in Response to Changes in Operational Assumptions**

The company must avoid raising performance targets mid-period without verifying the means of achievement and necessary resources; when operational assumptions change due to sudden shifts in demand, production transfers, delays in customer approval, or serious quality issues, performance targets, delivery dates, order plans, and key performance indicators (hereinafter referred to as "**KPIs**") must be reviewed in a timely manner. Losses resulting from quality-related suspension measures or corrective actions must not be treated mechanically as shortfalls against targets; rather, it is necessary to reflect such losses in planning in light of their causes and appropriateness of the response. Performance review meetings and metrics such as F-costs should be used to identify and resolve issues, rather than for assigning blame or implementing across-the-board cuts; it is necessary to verify that improvements in these figures are not due to an underestimation of defects or delays in reporting or recognizing losses.

- **Transforming Performance Meetings to Facilitate Problem Identification and Resolution**

In some performance meetings, there was an excessive focus on accountability for target shortfalls and the accumulation of additional measures, without sufficient discussion of the structural causes of shortfalls or the necessary resources. Going forward, performance meetings must be managed as forums for analyzing the causes of variances from plans and linking them to

the correction of targets and KPIs, decisions to add resources, or the revision of business plans. Furthermore, daily and weekly information should be utilized for early detection of problems and the provision of necessary support and decision-making; conduct that inhibits reporting and consultation must not be tolerated, and it is necessary to continuously verify that previous behavioral patterns are not being reproduced.

- **Appropriate Use of F-Costs and Other Management Indicators**

It is necessary to continuously verify that indicators such as profit margins, F-costs, inventory, and delivery schedules are not causing delays in the recognition or reporting of quality issues or losses. In particular, regarding F-costs, rather than demanding across-the-board reductions, their definitions and calculation methods should be established, and they should be utilized as management information for identifying quality issues and process weaknesses and linking them to necessary improvements; it is necessary not to unfavorably evaluate costs that become apparent through early detection and reporting of problems.

- **Alignment of Responsibilities, Authority, and KPIs, and Consideration of Cost-Center Model**

Which organization should be assigned profit responsibility needs to be considered from the standpoint of management control. As an option to correct inconsistencies in the responsibilities, authority, and KPIs, it is worth considering a cost-center model in which business divisions are held accountable for consolidated revenue, while plants and sales companies are held accountable for their respective operational responsibilities. If adopted, authority, resources, and KPIs corresponding to each organization's responsibilities must be redesigned as an integrated whole; the independent decision-making authority of the quality assurance department must be secured with respect to quality-related judgments; and a mechanism must be established whereby the CQO and GQM can provide opinions independent of revenue responsibilities. Through limited pilot tests, transfer of profit pressure to other indicators and approval backlogs caused by the concentration of decision-making must be verified and corrected, and it is necessary for the internal audit department to evaluate these matters independently.

- **Reporting to Management and Business Responses Relating to Material Quality Risks**

The CQO and GQM must clarify the standards, deadlines, and required information for reporting to management on significant quality risks. Senior management must promptly make decisions regarding necessary responses; designate responsible parties, set deadlines and completion criteria;

and ensure the necessary support and verification of effectiveness. Furthermore, where multiple group companies are involved, it is desirable to designate a cross-group coordination officer and contact point as necessary. GQM must record the progress from reporting through completion of corrective actions for serious incidents, and report to senior management and the Board of Directors on a regular basis. Furthermore, senior management should allocate resources in light of each BU's and site's assessment of necessary resources, as well as the second line's assessment of quality compliance risks. Where that is not possible, performance targets and the scope of the business should be reconsidered. In addition, for businesses in which material quality risks cannot be resolved, consideration should be given to measures including additional investment, restrictions on accepting orders, or exit from the business.

- **Evaluation of Senior Management and Oversight and Auditing by the Board of Directors, etc.**

The evaluation of senior management and BU heads must reflect compliance with Customer Agreements and Laws and Certifications, early reporting of issues, appropriate suspension measures, responses to customers, completion of corrective actions, and the development of human resources and business infrastructure. Such treatment must favorably reflect appropriate quality-related decisions, while appropriately reflecting inappropriate conduct or supervision in treatment and other consequences. The Board of Directors must receive reports from the CQO and GQM on significant quality risks, unresolved issues, recurring incidents of the same nature, delays in corrective action, and resource shortages, and reports from the internal audit department on independent assessment of the management system of the first line and second line. The Board of Directors must oversee targets, business plans, resource allocation, and responses to serious incidents; the Audit and Supervisory Committee must audit the execution of duties by directors, including internal controls related to quality.

(3) Realizing the "Desired State" at the Corporate Level

Nidec's "desired state" for the corporate level is **a state in which the corporate divisions, while sharing the direction to be taken (goals) and key values (principles)—including quality—with management and the corporate level, proactively supports business divisions across departmental boundaries to achieve overall optimization rather than succumbing to departmentalism or local optimization**.

A. Soft Measures

- **Sharing Values That Emphasize Overall Optimization**

The Quality Assurance-Related Issues must be viewed not merely as problems within the quality assurance process, but as manifestations of strains and contradictions in the Group's overall governance that have surfaced in the quality domain. Each corporate department must share values that prioritize overall optimization and assume the role of understanding the actual state of business operations, providing specialized support, and exercising risk-based oversight.

- **Clarification of the Roles of the Second and Third Lines and Coordination**

The CQO, as well as the departments comprising the second and third lines of defense, must clarify their respective responsibilities, authorities, points of coordination, and reporting lines, and ensure they possess the necessary expertise. Second-line departments must share information regarding signs of quality-related issues, consultations and reports, customer complaints, investigation cases, and the status of corrective actions; they must clarify their roles for each case and reflect on their own support and oversight activities. While necessary information must be shared with the internal audit department, the internal audit department must not be involved in determining response policies for individual cases and must maintain its independence.

B. Hard Measures

- **Cross-Departmental Collaboration, Independence, and Resource Allocation**

It is strongly expected that mechanisms for evaluation, consultation, and information-sharing that promote cross-departmental collaboration be established. Furthermore, it is necessary to ensure that the second and third lines of defense have the necessary independence, authority, direct reporting channels, personnel, budget, and expertise. It is also necessary to establish specialized personnel and regional support and oversight functions commensurate with quality risk and workload. When utilizing regional quality functions, it is desirable to ensure knowledge of the regions, a functional reporting relationship with GQM, and independence from business divisions.

- **Centralized Management of Quality Information and Establishment of Reporting Channels**

GQM must establish internal reporting standards, reporting items, and deadlines for serious incidents, and visualize the reporting pathways from all BUs and sites to GQM. A distinction must

be made between internal reporting and decisions regarding responses to customers; the latter must be determined based on the contractual and legal responsibilities borne by each entity. Quality-related incidents must be centrally managed on a case-by-case basis and tracked through investigation, customer response, corrective action, and verification of effectiveness. Additionally, it is necessary to ensure the availability of consultation and reporting channels that bypass standard reporting channels, as well as anonymity, protection against retaliation, and opportunities to provide feedback to reporters.

- **Investigation, Corrective Action, Rollout, and Reflection in Awareness-Raising and Education**

In cases of suspected Quality Assurance-Related Issues, an investigative framework appropriate to the nature and significance of the case must be established, and an independent internal team or external experts must be engaged as necessary. As a general rule, the internal audit department should not serve as the lead investigator; if it is involved on an exceptional basis, the division of roles with respect to the subsequent independent evaluation must be clearly defined. Following an investigation, based on the causes and control weaknesses identified, similar risks must be reviewed comprehensively using audit trails; operations must be monitored for a certain period thereafter; and the lessons learned must be incorporated into standard operating procedures, audits, quality meetings, and training.

- **Risk Assessment and Internal Audits**

Quality compliance risks for each BU and site must be assessed periodically, taking into account product and customer characteristics, Laws and Certifications, frequency of changes, approval backlogs, past incidents, M&A and production transfers, the quality assurance system, and resource shortages. The priorities for support and oversight must be determined based on the level of risk. A low number of incidents should not automatically be interpreted as low risk; it is important to take into account factors such as reporting delays, an unnaturally low number of consultations, the prolonged implementation of provisional measures, and the recurrence of similar incidents. The internal audit department must independently evaluate first- and second-line controls by verifying source records, actual processes, and logs in systems.

- **Quality Integration in M&A, Business Succession, and Production Transfer**

In M&A, quality, technology, and compliance must be considered from preliminary investigation through post-integration verification, and matters that cannot be verified prior to the acquisition

must be managed as residual risks. In the event of business succession and production transfer, it is also necessary to verify Customer Agreements, Laws and Certifications, certification status, change history, inspection methods, labeling and commercial decisions, unresolved issues, as well as previous operational practices. Furthermore, GQM must re-examine the post-transfer management status, and the internal audit department must independently verify the company-wide integration process.

(4) Realizing the "Desired State" at the Business Unit and Site Levels

The "desired state" to be realized at the BU and site levels is **a state whereby each executive and employee shares key values (principles), including quality; understands the importance of their own position in relation to the direction (goals) to be pursued and the transparency necessary for effective governance; and continues to take sound challenges toward achieving high goals**.

A. Soft Measures

- **Integrating Goals and Principles into Daily Operations**

Each BU and site must instill the goals, principles, and attitude and approach toward quality in their executives and employees. "Quality" should not be treated as a matter solely for the quality assurance departments; rather, each department must reflect it in its own operations and specify the decision-making process and reporting chain in situations where quality requirements conflict with delivery deadlines, costs, or production continuity. Furthermore, site managers and supervisors must embody this through their own actions, direct the necessary initial response even when facts or impacts are uncertain, and not leave the response to the reporter but take ownership of the problem as an organization.

- **Training and Organizational Learning Tailored to Roles and Risks**

Training must incorporate case-based discussions using the cases identified in the Investigation: for frontline employees, record retention and reporting; for personnel in sales, design/development, procurement, and production engineering, the verification of Customer Agreements and Laws and Certifications, as well as change procedures; for quality assurance personnel, independent suspension of operations and escalation; and for managers, initial responses after receiving a report and support for the reporter. Furthermore, training content must be continuously updated in light

of new incidents, and its reflection in actual reporting and consultation behavior must be confirmed. Quality meetings must also serve as organizational learning opportunities to share information on escalated incidents, root cause analyses, and the success or failure of corrective actions.

B. Hard Measures

- **Identification, Update, and Implementation of Customer Agreements, etc., into Operations**

  It is necessary for persons responsible for overseeing each BU and site to designate individuals responsible for identifying and updating Customer Agreements and Laws and Certifications for each product and customer, and to ensure that the basis, scope of application, revision date, and approval history can be tracked. Furthermore, requirements should be mapped to design, bills of materials (BOMs), parts and suppliers, manufacturing sites, processes, inspections, labeling, and trade documents, and disseminated to relevant departments, and their alignment with actual operations should be continuously reviewed in response to changes.

- **Verification During Order Acceptance, Development, Transition to Mass Production, and Business Succession**

  Cross-departmental reviews must be conducted at each stage from order receipt to the start of production to verify Customer Agreements and Laws and Certifications, technical feasibility, process capability, inspection methods, necessary resources, as well as any unresolved issues, and establish a mechanism to prevent advancement to the next stage when necessary conditions are not met. Even in the case of a conditional transition, the responsible persons, deadlines, provisional measures, and the status of discussions with the customer must be clearly defined. Even during business succession and production transfers, it is necessary to conduct a comprehensive review of Customer Agreements and Laws and Certifications, change history, inspection methods, unresolved issues, and previous operational practices to reconfirm their compliance and feasibility.

- **Change and Exception Management and Data Integrity Relating to Testing and Quality**

  Roles and approval authorities must be articulated for 4M changes, special approvals, rework, retesting, and production transfers; the quality assurance department must independently verify whether customer procedures are required. Mass production or shipment of modified products must not proceed until the necessary customer approvals are obtained, and provisional measures must be centrally managed, including their expiration dates and permanent countermeasures; where provisional measures are repeated or renewed, they must be linked to permanent countermeasures

or discussions with the customer. Furthermore, inspection results and source records must be accurately retained; the quality assurance department must periodically verify that inspections were actually performed and confirm the reasons for and authority behind any remeasurements, transcriptions, and corrections. Additionally, for high-risk processes, it is desirable to implement measures such as automatic data acquisition, restrictions on manual data entry, and the retention of change histories.

- **Initial Response, Reporting, and Customer Responses Following the Discovery of a Non-conformity**

Upon identifying a non-conformity or a suspected non-conformity with Customer Agreements and Laws and Certifications, the actual measurement values, source records, and the affected products must be preserved, and initial necessary measures must be carried out. Relevant departments must determine how to respond to customers, document that process, and must not substitute internal technical evaluations for the procedures required in relation to customers. After initial measures have been taken, it is necessary to establish a mechanism where the scope of impact, root cause analysis, corrective actions, and improvement measures are managed with clearly defined persons responsible, deadlines, and completion criteria, and where repeated occurrences of similar cases or delays in implementing permanent corrective measures are automatically escalated to higher-level organizations.

- **Independence of the Quality Assurance Department and Securing Necessary Resources**

The quality assurance managers must be granted independence and authority to suspend mass production, implement suspension measures regarding manufacturing and shipping, isolate products, and report directly to higher-level quality organizations. Furthermore, the resources required for quality assurance, engineering, regulatory compliance and certification, trade and information systems must be periodically evaluated, taking into account the number of changes, the number of customers and products, and the complexity of Laws and Certifications and processes. For technical issues that cannot be resolved within a site, it is desirable for the BU headquarters or corporate headquarters to provide support; if the necessary resources cannot be secured, the matter must be escalated to management for their decision on whether to consider order volume, delivery schedules, production allocation, or the scope of operations. In addition, Nidec's senior management and the CQO should assess the effectiveness of the current framework and determine the entities for which a direct reporting line to the CQO and GQM is to be established, as well as

the scope and manner of GQM's involvement in the appointment, evaluation, and transfer of quality assurance managers.

- **Performance Evaluations and Disciplinary Actions Which Supports Reporting and Corrective Actions**

Performance evaluations must reflect actions such as the early reporting of issues, appropriate suspension measures and escalation, responses to customers, completion of corrective actions, and support for subordinates' reporting, and must not unfavorably evaluate short-term performance deterioration resulting from appropriate quality-related decisions. Regarding disciplinary action, common principles must be established that take into account whether and to what extent the person was aware of Quality Assurance-Related Issues, the circumstances of the conduct, its impact, position and supervisory responsibility, self-reporting and cooperation with investigations, obstruction of reporting or investigations, and retaliation, among other factors; these principles must also apply to tacit approval, failure to report, or serious supervisory negligence on the part of managers.

(5) Management of the Implementation of All Improvement Measures and Verification of Their Effectiveness

- **Clarification of Overall Plan and Implementation Responsibilities**

The unsound state arose from the interplay of performance targets, resource allocation, management of Customer Agreements and Laws and Certifications, the independence of the quality assurance department, internal reporting, and quality governance. Therefore, rather than implementing each improvement measure individually, it is necessary to align soft and hard measures and implement them in an integrated and parallel manner, taking into account short-, medium-, and long-term timeframes. In addition, management needs to lead the overall improvement efforts, establish a person with overall responsibility and a secretariat, and continue to demonstrate a commitment to driving the reform program.

- **Verification of Effectiveness Based on Changes in Operational Practices**

The effectiveness of improvement measures must be evaluated not only based on the volume of activities—such as the establishment of regulations, training, and audits—but also on changes in the judgment of executives and employees and in business operations. An increase in consultations or reports should not be immediately interpreted as a deterioration in the situation; rather, the

content of consultations or reports, initial responses, and corrective actions must be assessed. Furthermore, where new issues are identified through monitoring, GQM and the secretariat should analyze their content and determine whether additional measures or revisions to existing improvement measures are necessary.

- **Independent Evaluation and Continuous Review**

Nidec must continuously assess, while obtaining feedback from independent external third parties, the effectiveness of the improvement measures for achieving the “desired state”, including whether it has succeeded in establishing an environment where issues are identified and reported at an early stage; necessary suspension measures, responses to customers, and fundamental corrective actions are chosen at the organizational level; and lessons learned are shared and applied to other products and sites.

End