February 19, 2026
CHEMIPAZ Corporation

Overview of Investigation Findings by External Investigation Committee Regarding Quality and Other Misconduct in The CHEMIPAZ Group and Recurrence Prevention Measures

CHEMIPAZ Corporation (Headquarters: Nihonbashi-Honcho, Chuo-ku, Tokyo; Representative Director and President: Katsuhisa Yuda; the "**Company**") disclosed on September 8, 2025 "Regarding the falsification of test result reports and the false statement on the safety data sheets of paper making chemical products for the Japanese market, implemented corrective actions and future preventive measures" (hereinafter the "**Previous Disclosure**").

Subsequently, on September 26, 2025, the Company established an investigation committee comprised of attorneys from Nishimura & Asahi (the "**Committee**"), which has no advisory contract with the Company, to conduct a comprehensive and reliable third-party investigation into quality-related misconduct at the Company and its consolidated subsidiaries (the "**Group**"), analyze root causes, and develop preventive measures.

On February 3, 2026, the Company received the investigation report from the Committee. The following sets out an overview of the findings in the investigation report and establishment of recurrence prevention measures, which were approved by the Board of Directors on February 16, 2026.

1. Overview of Committee Investigation Report (Details in Appendix)

(1) The Committee reviewed and verified the findings and related materials from the Company's internal investigation team (the "**Internal Investigation Team**") that had been conducting a comprehensive investigation of misconduct within the Group since September 2025. The Committee ensured sufficiency and thoroughness by directing the Internal Investigation Team to conduct additional investigations as needed, interviewing officers and employees involved in quality and other misconduct (the "**Misconduct**") and performing forensic investigations including email data review. Additionally, an emergency questionnaire was distributed to all officers and employees regarding the Misconduct, with follow-up investigations conducted on newly discovered cases.

(2) The main findings of the Misconduct confirmed by the Committee are as follows. Misconduct that had not been identified in the Previous Disclosure was subsequently identified. In addition, the Misconduct related to items (i) and (ii) below was found to be widespread across multiple business units. No facts that would affect product safety have been confirmed.

(i) Testing misconduct (including cases disclosed in the Previous Disclosure; all cases corrected,

or correction initiated);

(ii) SDS/label display deficiencies (all cases corrected, or correction initiated); and

(iii) Violations of laws and regulations (regarding hazardous materials management, chemical substance management, factory wastewater management, and local exhaust ventilation; all cases reported or in the process of reporting to relevant authorities; all cases corrected, or correction initiated).

(3) The Committee identified eight (8) root causes of the Misconduct, which are insufficient understanding of the essence of quality assurance and lack of compliance awareness, weak quality assurance and management systems, inadequate establishment and communication of rules, weak regulatory management system, poor quality documentation management, insufficient checks and balances system such as audit, inadequate specification setting processes and interdepartmental coordination, and underutilized internal reporting system.

(4) The Committee recommended the following recurrence prevention measures: continuous messaging from top management, regular training implementation, establishment of a quality assurance department that is organizationally independent of business units and systematic quality management system ("**QMS**"), comprehensive development of related rules and procedures, clarification of the compliance framework and authority, redesign of document management, strengthened auditing involving in-depth review of quality data (including ISO 9001-based internal and external audits), improved manufacturing-sales-technical coordination and clarification of specification change processes, and re-communication of internal reporting system with clarified scope thereof.

2. Establishment of Recurrence Prevention Measures in the Group

In light of the investigation report, the Company will, pursuant to its internal rules and policies, take necessary actions, including clarifying the accountability of employees involved in the Misconduct, and will implement corrective measures to improve its organizational management.

Since September 2025, Katsuhisa Yuda, who served as Executive Vice President and COO and is currently Representative Director, President and CEO (the "**President**"), has led internal discussions on fundamental reforms to the Company's compliance framework, including quality assurance. The Company has implemented, or is in the process of implementing, the measures described below and has begun explaining their status to its customers.

These measures implemented or initiated by the Company fully address all recommendations for recurrence prevention measures in the investigation report. Rebuilding the Group-wide quality assurance system and establishing and embedding QMS are expected to take about one to two years,

including deployment and operational stabilization of those systems. In the meantime, the Company will prioritize strengthening operations and driving improvements in high-risk areas, rebuild a corporate culture that prioritizes quality through continuous verification and corrective actions, and work diligently to restore trust from customers, stakeholders, and society.

(1) Since September 2025, the President has been explaining to all employees the series of misconduct cases within the Group and has been communicating and will continue to communicate the message that "compliance is at the core of management." This message was also explicitly stated in the new Medium-Term Management Plan 2030, finalized in late January 2026.

(2) At the Board Meeting held in November 2025, decisions were made to establish the Quality Assurance Division Group that is organizationally independent of business units and hire external talent with extensive experience in quality assurance system development. The Division Group was launched on January 1, 2026. The President serves as the Executive Officer in charge of quality assurance, with the recruited external talent appointed as Director of Quality Assurance Division Group. The Company has begun building quality assurance systems and frameworks with the goal of initiating ISO 9001 certification process in 2028.

(3) At the Board Meeting in December 2025, it was decided to establish the Compliance Committee directly under the President. The Compliance Committee was launched effective January 1, 2026, and has been convened since January 2026. The Committee is responsible for overseeing the development and operation of the Group's compliance governance system, identifying key risks and prioritizing response measures, determining policies for the establishment, revision, and abolition of the Compliance Code of Conduct and related policies and procedures and deliberating on their contents, and setting policies for compliance education and training and monitoring their implementation. While the meeting is basically held quarterly, considering the response to the Misconduct, the committee will meet monthly in FY2026 to expedite reconstruction of the Group's compliance framework.

We sincerely apologize again for the significant inconvenience and concern caused to our customers and stakeholders. Under the President's responsibility, the Group will continuously implement the measures determined based on the investigation report's recommendations, verify operational status, and make ongoing improvements. We will place compliance at the core of management and work as one to thoroughly implement preventive measures and restore trust.

Contact Information:
CHEMIPAZ Corporation
Email: QM2026@chemipaz.co.jp

Appendix

1. Committee Investigation Details

(1) The Committee was composed of attorneys from Nishimura & Asahi, including Mr. Satoru Hirao and Mr. Satoshi Miyamoto.

(2) The Committee examined and verified the investigation results and materials relating to the Misconduct received from the Internal Investigation Team. The Committee validated the appropriateness of the Internal Investigation Team's investigation methods and analysis and directed the Internal Investigation Team to conduct additional investigations as needed, thereby ensuring thoroughness and comprehensiveness of the investigation. Furthermore, the Committee conducted interviews with officers and employees relevant to the subject matter to clarify investigation results by the Internal Investigation Team and the causes and background thereof.

(3) To comprehensively identify any Misconduct beyond those discovered by the Internal Investigation Team, the Committee conducted an emergency survey questionnaire on quality and safety compliance targeting all 782 officers and employees of the Group, receiving 732 responses. For new cases identified through the questionnaire, the Committee conducted necessary investigations, including interviews with responding officers and employees.

(4) For significant cases where interviews with key persons were not possible due to their resignation, the Committee engaged external forensic experts to review email data of such persons stored on email servers.

2. Overview of Committee Investigation Findings

The Misconduct identified by the Committee's investigation is outlined below, including that was not recognized at the time of the previous disclosure, and as for the testing misconduct and SDS/label display deficiencies, widespread Misconduct is identified across multiple business units. No facts that would affect product safety have been confirmed.

Regarding shipments of products related to the Misconduct, the Company is discussing appropriate and proper measures with its customers.

(1) Testing Misconduct

The following four (4) kinds of Misconduct were identified, including those in the Previous Disclosure. All cases corrected or correction initiated.

(i) Data tampering

(ii) Test condition changes

(iii) Test omissions

(iv) Reporting date manipulation

(2) SDS/Label Display Deficiencies

The following four (4) kinds of Misconduct were identified, including those in the Previous Disclosure. All cases corrected or correction initiated.

(i) Understated content amounts in SDS

(ii) Missing label information

(iii) SDS not created or updated

(iv) Inconsistencies between SDS and label information

(3) Violations of Laws and Regulations

The following four (4) kinds of violations were identified. All cases reported or in the process of reporting to relevant authorities; all cases corrected or correction initiated.

(i) Violations related to hazardous materials management in hazardous materials storage facilities

(ii) Violations related to chemical substance management

(iii) Violations related to factory wastewater management

(iv) Violations related to local exhaust ventilation system installation

3. Committee's Root Cause Analysis and Preventive Measure Recommendations

The Committee provided root cause analysis and preventive measure recommendations for the following eight (8) areas:

(1) Insufficient Understanding of Essence of Quality Assurance and Lack of Compliance Awareness

Root Causes:

- Justification that "it is fine as long as there are no quality issues"
- Desensitization due to normalized rule violations since pre-2000s
- Many facilities lacking ISO 9001 certification
- Insufficient company-wide, continuous compliance training

Recommendations:

- Continuous messaging from top management
- Regular compliance/quality training
- ISO 9001 certification at all facilities

(2) Weak Quality Assurance and Management Systems

Root Causes:

- Lack of comprehensive and systematic QMS
- Understaffed company-wide quality oversight and supervision organization (only 1-2 people)
- Quality activities dependent on factory

- Many facilities without ISO 9001 certification and therefore lacking audits

Recommendations:

- Establishment of quality assurance department that is organizationally independent of business units
- Building systematic QMS
- ISO 9001 certification at all facilities

(3) Inadequate Establishment and Communication of Rules

Root Causes:

- Missing or underdeveloped operational rules and procedures
- Existing rules insufficiently communicated and not followed

Recommendations:

- Comprehensive development, revision, and abolition of rules and procedures aligned with actual operations
- Establishment of system enabling all staff to access operational rules

(4) Weak Regulatory Management System

Root Causes:

- Insufficient mechanisms for regulatory compliance checks
- Insufficient system for maintaining compliance

Recommendations:

- Establishment of regulatory management system
- Clarification and review of roles and authorities

(5) Poor Quality Documentation Management

Root Causes:

- Missing quality-related documents
- Failure to update delivery specifications

Recommendations:

- Review of quality documentation management system

(6) Insufficient Checks and Balances System such as Audit

Root Causes:

- Quality audits limited to operational confirmation
- No verification of test data accuracy

Recommendations:

- Internal audits from QA perspective by other departments
- Strengthened audits (including sample verification delving into data)

- Implementation of ISO 9001-based internal and external audits

(7) Inadequate Specification Setting Process and Interdepartmental Coordination

Root Causes:

- No discussion process such as design review for specification creation
- Lack of interdepartmental coordination and customer consultation when the specifications become difficult to maintain

Recommendations:

- Strengthened manufacturing-sales-technical coordination and regular issue sharing
- Clarification of specification determination and change processes

(8) Underutilized Internal Reporting System

Root Causes:

- Ineffective internal reporting system; new Misconduct discovered through emergency questionnaire
- Possible insufficient communication about quality-related reporting being within scope of the internal reporting system and reporter protection

Recommendations:

- Re-communication of the internal reporting system
- Clarification that quality misconduct is within the reporting scope