Rev No.	Preparation Date	Description of Change	Prepared by
0	Dec. 11, 2017	Transition to the 2015 version of the ISO 9001 Standard	RGMD

CONTROLLED COPY

MASTER COPY

Prepared by:	Reviewed by:	Approved by:
Elvie C. Antenor Document Control Head	Rodolfo L. Velasco, Jr. Quality Management Representative	Rodolfo L. Velasco, Jr. Quality Management Representative

Rev #	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Issue #	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

OBJECTIVE:

To establish an internal management systems audit procedure capable of monitoring system implementation and process performance as well as engender continual improvements in the Bureau's Quality Management System.

SCOPE:

This procedure covers the following:

1. Internal audit

1.1 Organization of Internal Audit Team,
1.2 Planning and preparation for audit,
1.3 Conduct of audit,
1.4 Reporting of audit result,
1.5 Root cause analysis and corrective/preventive action
1.6 Verification of effectiveness of corrective action and
1.7 Recommendation for systems improvement as a result of the internal audit process.

2. External Audit

2.1 Second Party Audit
2.2 Third Party Audit

REFERENCE DOCUMENTS:

- ✓ Quality Management System Manual
- ✓ ISO 9001:2015
- ✓ ISO 19011:2011

DEFINITION OF TERMS:

Lead Auditor – Officer–In-Charge appointed by the Top Management to plan, organize and lead the Internal Audit process of the Bureau.

Auditors - Trained personnel tasked to audit the Quality Management System (QMS) to ensure consistent and effective implementation of the documented QMS.

Auditee – A representative of the Division being audited.

Major Non-Conformity – systemic deviation; accumulation of minor lapses in one area/department; repetitive or combined deviations that may cause damage to services being provided or failure to comply with clients' requirements; repetition of previously identified non-conformities; non-conformity to legal requirements that govern the operations of the company; deviations that may cause breakdown in the management system.

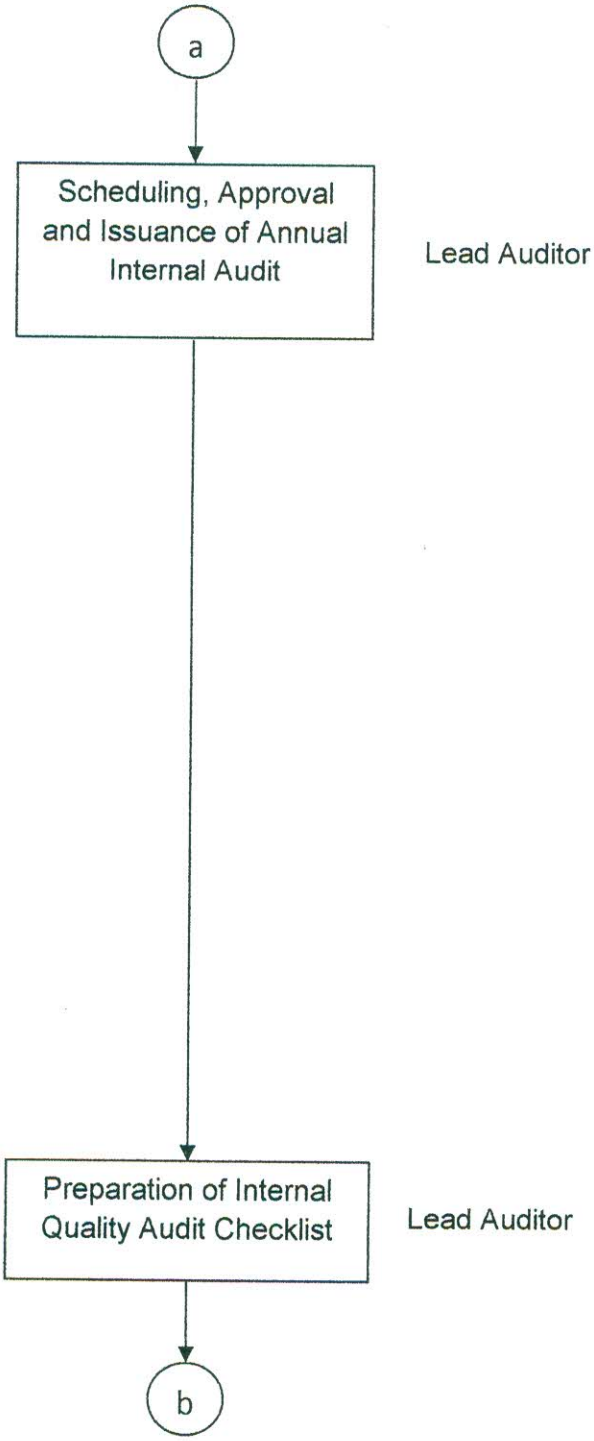
Minor Non-Conformity – is an isolated lapse in implementation that can easily be rectified and will not cause a serious breakdown in the system.

Observation - Statement of fact made during an audit and substantiated by objective evidence where such are likely to cause non - conformance in the future, an improvement or comment on the documented management system or its implementation.

Correction or Immediate Action – Action designed to eliminate an identified non-conformity or deviation. This is to be addressed and documented in accordance to the Corrective Action Procedure.

Corrective Action – Action designed to eliminate the root cause of the non-conformance or deviation so as to prevent its (non-conformity) recurrence. Similarly, this is to be addressed and documented in accordance to the Corrective Action Procedure.

Activities		Details/Remarks
1.0 Internal Audit Activities	**Responsible Person**	
Start		
Selection of Internal Audit Team members	Top Management, Quality Management Representative	Selected employees shall be provided with foundation courses on ISO 9001:2015 including Internal Quality Audit (IQA). The said employees shall form part of the IQA Team and implement this procedure to ensure effective implementation of the documented QMS. An employee must meet the following minimum qualifications to be considered as an Internal Auditor: 1.1 Employed with the Bureau 1.2 Can write and speak in English and Filipino 1.3 Can relate well with fellow employees and superiors 1.4 Has attended Internal Audit Training and/or conducted at least one guided Internal Audit.
Internal Audit Team Members Training	Top Management, Quality Management Representative	
Appointment of Lead Auditor	Quality Management Representative	One of the team members shall be appointed to be the Lead Auditor who shall plan, lead, organize and coordinate the activities of the internal audit team. Appointment shall be prepared and issued to all qualified auditors enumerating their responsibilities.
a		



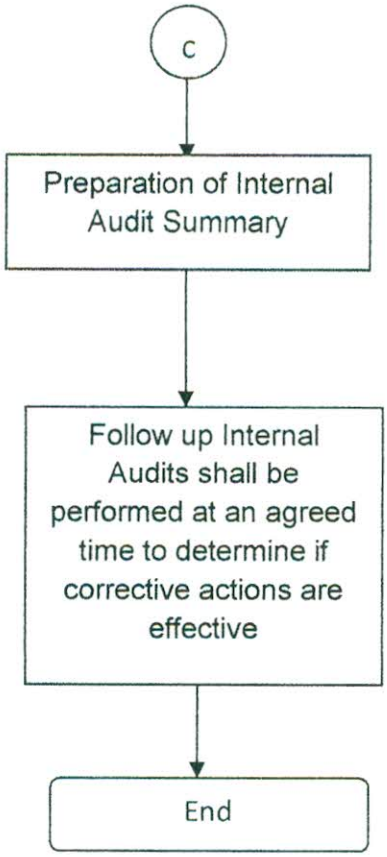
Regular internal audit shall be scheduled at least once a year. Additional audits shall be scheduled at least once a year for: 1) the Frontline Services as these are critical and the priority of the Bureau and 2) those areas whereby non-conformities were identified as a result of the previous internal audit or complaints raised by customers/stakeholders. The Lead Auditor shall prepare a Regular Annual Internal Audit Plan (FO-IA-01) and shall be submitted to the QMR for review and approval. The Lead Auditor shall include the following in the preparation of the Annual Internal Audit Plan:

1. Audit schedule,
2. Processes and areas to be audited,
3. Documents that will be covered by the audit,
4. QMS requirements related to the area that will be audited, &
5. Assignment of Auditors and Auditees - no Auditor is allowed to audit his/her own division/area to maintain the independence of the auditor and the integrity of the audit process

Upon approval, a copy of the Annual Internal Audit Plan shall be furnished to all Division Chiefs concerned, internal auditors and the Top Management, at least one (1) month before the IQA.

Prepare Internal Audit Checklist (FO-IA-02) based on the QMS manual, procedure(s), work instructions, regulatory/statutory/legal requirements and applicable ISO requirements to be audited as soon as the Internal Audit Schedule is received. This shall ensure that important aspects of the documented QMS are covered during the Internal Audit.

b		
Conduct of Opening Meeting	Lead Auditor	During the Opening Meeting, the Lead Auditor shall discuss the coverage, purpose, itinerary, methodology of the Internal Audit to the Division Chiefs and Process Owners concerned. Amendments to the Internal Audit schedules shall be mutually agreed upon by both parties.
Conduct of Internal Audit	Auditor	The following procedures shall be observed by the Internal Auditor: 1. Ask questions related the process 2. Gather records of implementation based on the defined processes 3. Record the evidences seen during the interview and gathering of data in the Internal Audit Checklist Form (FO-IA-02) 4. Classify identified lapse/s in the implementation as either major or minor non-conformances 5. Used CAR Form (FO-IA-03) in documenting the non-conformances 6. Verify the effectiveness of corrective action on the date committed
Conduct of Closing Meeting and Reporting of Internal Audit Result	Lead Auditor	Conduct a closing meeting to summarize the result of the Internal Audit process highlighting the good points, deviations and non-conformances, including unresolved issues, noted during the entire audit process.
c		



Collate all CARs at least five (5) days after the Internal Audit. All Auditees shall include root cause/ potential problem and corrective/preventive action plans. These shall be submitted to the Lead Auditor for review. Issue copy of the Internal Audit Summary to all Division Chiefs for their reference and corrective action follow up. (Note: Lead Auditor will present the same summary during the Management Review Meeting).

There shall be no undue delay in the implementation of corrections and corrective actions. In case of delay, the Division concerned shall be issued another CAR and be required to propose additional corrective actions.

Closure of CARs, shall be recommended by the Internal Auditor concerned and shall be subject to approval of the Quality Management Representative. Otherwise, the CAR shall be re-issued and will undergo the same procedure.

2.0 Records

2.1 Regular Annual Internal Audit Plan (FO-IA-01)
2.2 Opening / Closing Meeting Attendance
2.3 Corrective Action Report (FO-IA-03) with attached objective evidence – for internal and external
2.4 Audit Checklist (FO-IA-02)
2.5 Internal Quality Audit Report

Rev No.	Preparation Date	Description of Change	Prepared by
0	Dec. 11, 2017	Transition to the 2015 version of the ISO 9001 Standard	RGMD

CONTROLLED COPY

MASTER COPY

Prepared by:	Reviewed by:	Approved by:
Elvie C. Antenor Document Control Head	Rodolfo L. Velasco, Jr. Quality Management Representative	Rodolfo L. Velasco, Jr. Quality Management Representative

Rev #	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Issue #	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

OBJECTIVE:

To establish a system in analyzing, evaluating, establishing corrective actions and in implementating of such actions to eliminate the root causes of non-conformities in order to prevent their recurrence.

SCOPE:

This procedure consists of the following actions:

1. Review and analysis of non-conformities and root cause,
2. Determination of other potential non-conformities and their causes,
3. Evaluation of the need for action to prevent recurrence and occurrence of similar non-conformities in any aspect of the Bureau's QMS
4. Determination and implementation of action needed,
5. Recording of the result of action taken and
6. Review and follow up of action taken to establish its effectiveness.

REFERENCE DOCUMENTS:

Quality Management System Manual
ISO 9001:2015 Standard

DEFINITION OF TERMS:

Correction or Immediate Action – actions taken to eliminate an identified non-conformance or deviation.

Corrective Actions (C/A) – actions taken to eliminate the cause of non-conformities in order to prevent their recurrence/occurrence. These may come in the form of document revision, etc.

Non-conformity – deviation from a procedure or lapse in implementation. This includes as well all deviations causing adverse effects to the service rendered by MGB and customer complaints.

Minor Non-Conformity – is an isolated lapse in implementation that can easily be rectified and will not cause a serious breakdown in the system.

Major Non-Conformity – systemic deviation; accumulation of minor lapses in one area/department; repetitive or combined deviations that may cause damage to services being provided or failure to comply with clients' requirements; repetition of previously identified non-conformities; non-conformity to legal requirements that govern the operations of the company; deviations that may cause breakdown in the management system.

Observation - Statement of fact made during an audit and substantiated by objective evidence where such are likely to cause non-conformance in the future, an improvement, suggestion or comment on the documented management system or its implementation.

ACTIVITIES	RESPONSIBLE	DETAILS/REMARKS
A. Corrective Action		
Start		
Review and Analysis of Non-Conformities and Root Causes	Division Chief / Process Owner	Review and record non-conformities identified and analysis of the root cause and other facts related to the non-conformities in the Corrective Action Report Form. The auditor/personnel who identified the deviation shall classify it as either minor or major non-conformities. 1. Use of the Corrective Action Report form to record non-conformities, root cause analysis and corrective actions is mandatory. 2. In the event major non-conformity is identified, the Top Management shall be informed. The Division Chief concerned shall be involved in monitoring the rectifications to be applied. Note: These corrective actions may result from one, or a combination of the following: a) Non-Conforming items (including non-attainment of quality objectives); b) Internal and external audits; and c) Customer complaints.
Correction Measure of Non-Conformity	Division Chief / Process Owner/ Auditor	Undertake all the activities necessary to correct the observed non-conformities of the affected services, process or systems. Record the established activities and the persons or positions responsible for each of the activities in the Corrective Action Report form. Prepare written instruction as necessary. Instruct responsible personnel assigned to carry out the details of the remediation measure to be taken. Rectifications shall be submitted within the agreed upon time frame forged by the auditor and the concerned personnel (using the CAR Form).
a		

a		
Implementation of Correction Measure	Division Chief / Process Owner	Implement the required remediation measure according to instructions being the responsibility of the process owner. He/she shall review and record the results of such remediation measure to ensure that observed deviation have been eliminated.
Establishment of Corrective Action	Division Chief	Based on the root cause, the process owner shall establish the corrective action necessary to eliminate the causes of non-conformities in order to prevent recurrence. Division Chief shall assign personnel responsible for each activity and shall record corrective action in the CAR. Once the corrective actions are formulated, established activities shall commence accordingly. Should the course of action necessitate revisions in the affected documents, procedure for document management shall apply.
Monitoring of Effectiveness of Correction and Corrective Actions	Division Chief, Internal Auditor	Monitoring the progress/results of correction/ immediate measure and corrective actions, shall be recorded in the CAR (FO-IA-03) form. The auditee/process owner shall submit the results of correction measure/corrective actions to the auditor for verification or confirmation at the agreed time frame. The process owner shall attach supporting documents in the CAR (FO-IA-03) form as evidence of effective implementation of the correction/immediate measure and corrective actions as applicable.
Verification/Closure of Non-conformity	Internal Auditor	Verification activities may require one (1) or two (2) follow-up visits. If proven effective in eliminating the detected non-conformity, the designated auditor shall recommend the approval of its closure to the Quality Management Representative. Otherwise, the Corrective Action Report shall be re-issued and will undergo the same procedure.
End		

B. Updating the Risk Management Plan

Determine probable causes or sources of potential non-conformities. Each Division shall be responsible for updating its Risk Management Plan (RMP). This is to be spearheaded by the designated personnel indicated in the RMP. The Division Chief shall be responsible for its approval and shall ensure that the person in charge of the action plan observes the monitoring of timetables and/or deadlines and review if the said actions were indeed effective.

Copies of the RMP shall be given to all affected parties involved including other relevant data or information. The outcome of these monitoring and review activities shall be reported to the Top Management.

a ↓ Monitoring and Review of Implementation of Preventive Action ↓ End	Designated personnel in the RMP	Effectiveness of the action plan shall be monitored and reviewed depending on the approved timelines/deadlines. In the event the action plans were found to be insufficient to prevent the identified adverse impacts from occurring, the RMP shall be revised/ updated to incorporate additional or revised courses of action until these updated preventive measures are proven to be effective in addressing the risk.

2.0 Records

2.1 Corrective Action Report (FO-IA-03)
2.2 Risk Management Plan
2.3 Other Corrective Action records as required by the reference or appropriate procedure.
2.4 Minutes of the meeting during the analysis of root cause formulation stage as applicable.
2.5 Other supporting documents used to support the above documents.

Rev No.	Preparation Date	Description of Change	Prepared by
0	Dec. 11, 2017	Transition to the 2015 version of the ISO 9001 Standard	RGMD

Prepared by:	Reviewed by:	Approved by:
Elvie C. Antenor Document Control Head	Rodolfo L. Velasco, Jr. Quality Management Representative	Rodolfo L. Velasco, Jr. Quality Management Representative

Rev #	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Issue #	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

OBJECTIVE:

To establish controls with respect to managing lapses in the rendering of MGB's general services covered in the declared scope of MGB's ISO 9001:2015 certification.

SCOPE:

This shall cover all activities connected in the management of identified lapses in the processing of Exploration Permit applications by MTMD and approval of Environmental Protection and Enhancement Program (EPEP) and Final Mine Rehabilitation and/or Decommissioning Plan (FMR/DP) by MSESDD. This shall also cover controls related to identifieddeficiencies in the conduct and performance of laboratory servicesunder the jurisdiction of the MeTD and LGSD.

REFERENCE DOCUMENTS:

Quality Management System Manual
Division Quality Management System Procedure
ISO 9001:2015 Standard
Citizen's Charter

DEFINITION OF TERMS:

Non-Conforming Product – An output resulting from the execution of defined procedures that do not conform to specified requirements.

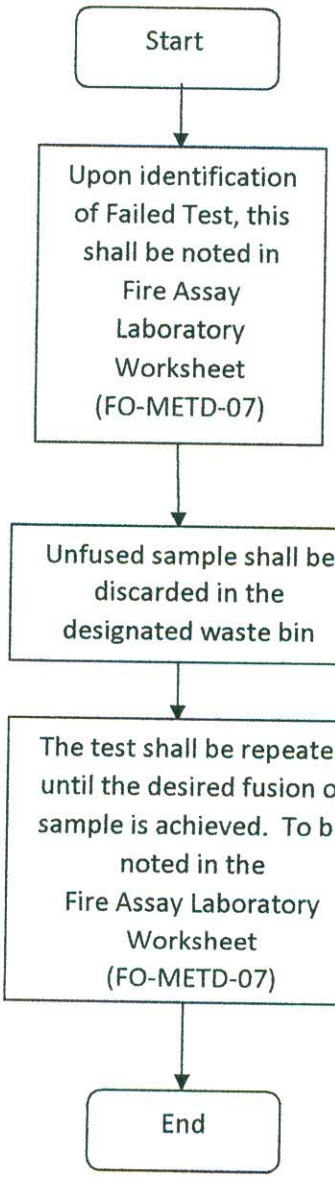
Failed test – a test that did not complete the required process i.e. incomplete fusion

1.0 Activities	Responsible Person	Details/Remarks
A.1. Control of Non-Conforming Products – Processing of Exploration Permit Applications and Approval of EPEP and FMR/DP		It is expected that from the initial review, lapses or deficiencies are determined from the start. Nonetheless, this procedure shall be defined so as to address any eventuality of lapses during the processing of applications.
Start		
Identification of deficiencies in the submitted documents – application shall be segregated	Division Representative	
Letter to applicants requiring them to provide necessary data	Division Representative	A formal letter shall be sent to the applicant.
Applicant submits completed documents		In the event the applicant issues a formal complaint, the employee concerned shall be issued a CAR form. The procedure for Corrective Action shall then apply.
Re-evaluate re-submitted documents	Division Representative	
Reprocessing of application	Division Representative	
End		

A.2 Control Of Non-Conforming Products – Release of Erroneous Exploration Permit Applications and Erroneous Approval of EPEP and FMR/DP

Start		
Identification of erroneously released Exploration Permit Application and erroneously approved EPEP and FMR/DP	Division Representative, Applicant	Note: Errors may be identified either by the applicant or by the Bureau.
Cancellation of Exploration Permit/Cancellation of Approved EPEP and FMR/DP Re-issuance of Exploration Permit/Re-issuance of Approved EPEP and FMR/DP	Office of the Director	Formal registered letters shall be sent to the companies concerned re: Cancellation/Re-issuance of Exploration Permit/Approved EPEP and FMR/DP stating the reason behind the Bureau's course of action.
End		

B.1 Control of Non-Conforming Products – Failed Test (MeTD and LGSD)



Metallurgical Engineer, Laboratory Technician

Laboratory Technician

Metallurgical Engineer, Laboratory Technician

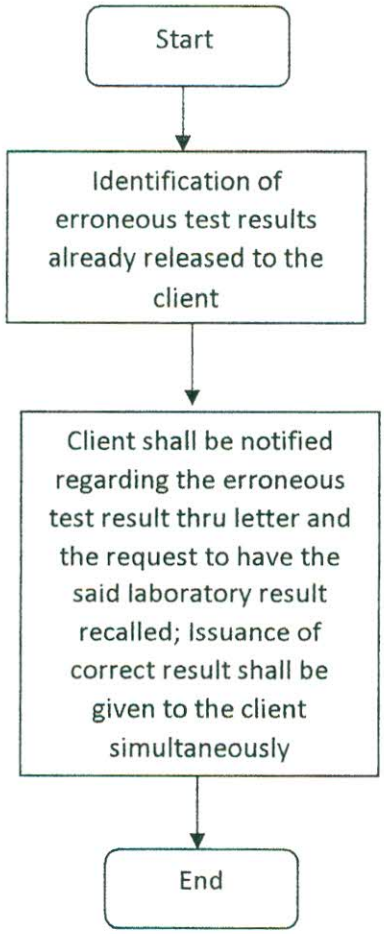
In reporting a Failed test, an asterisk (*) shall be used as mark on the appropriate item in the Fire Assay Laboratory Worksheet (FO-METD-07) in order to identify the said test.

A comparative analysis shall be performed to determine the cause of the failed test. Adjustments shall be incorporated in the succeeding tests and these shall be noted in the Fire Assay Laboratory Worksheet.

Succeeding tests that achieved desired fusion shall be re-verified to prove these satisfy pre-determined requirements.

Note:
Unfused test samples cannot be reworked. Rework shall be in the form of conducting re-tests from the remaining units for testing.

B.2 Control of Non-Conforming Products – Release of Erroneous Test Results (MeTD and LGSD)



Metallurgical Engineer, Laboratory Technician	The personnel involved in the test shall document the incident using the CAR form and, to that effect, shall implement the CAR procedure.
Metallurgical Engineer, Laboratory Technician	Formal registered letters shall be sent to the companies concerned re: erroneous laboratory result. This shall include an explanation as to why the error occurred.

2.0 Records

A. Control of Non-Conforming Products – Processing of Documents, Applications and Permits

2.1 Notification/Communication Letter
2.2 Documents pertaining to the processing of application
2.3 CAR report

B. Control of Non-Conforming Products – Conduct of Tests

2.4 Fire Assay Laboratory Worksheet (FO-METD-07)
2.5 Communication Letter
2.6 CAR report
2.7 Test result/report

Rev No.	Preparation Date	Description of Change	Prepared by
0	Dec. 11, 2017	Transition to the 2015 version of the ISO 9001 Standard	RGMD

OBJECTIVE:

To define the system in reviewing the effectiveness of the Quality Management System and the overall performance of Mines and Geosciences Bureau (MGB) Central Office to ensure the Quality Management Systems' continued suitability, adequacy and effectiveness.

To be able to pinpoint areas in the Quality Management System that needs improvement, changes, upgrading or management action, decision or support.

SCOPE:

This procedure covers all areas of the Bureau's operations, internal and external inputs, as well as the decisions and actions of the Top Management that affect the effective performance of the quality management system

REFERENCE DOCUMENTS:

Quality Management System Manual
Corrective Action Procedure
ISO 9001:2015 Standard

DEFINITION OF TERMS:

Quality Management Representative – shall be indicated "QMR" in this procedure; member of the organization and member of management; responsible in overseeing the effective implementation, maintenance and improvement of the Quality Management System

Activities	Details/Remarks
1.0 Management Review Activities **Responsible Person**	
Start	
Plan the schedule of Management Review and Prepare the agenda that will be discussed. — QMR	The Memorandum pertaining to the conduct of the Management Review shall be issued at least two weeks before the scheduled meeting to give ample time for all concerned to prepare the needed data. Those concerned includes Division Chiefs, ISO Team Leaders, BAC Head, HR Head and Administrative Head.
Issue Memo to all concerned regarding the Management Review and instruct them to collate needed information defined period of coverage — QMR	
In the conduct of the Management Review, all concerned are to report the performance of their respective areas, status of QMS implementation, problems and proposed solutions. — QMR	The minutes of the Management Review shall contain, at the minimum, the inputs stipulated in clause 9.3 of the ISO 9001:2015 Standard: a. status of actions from previous reviews b. changes in internal & external issues relevant to the QMS (context) c. information on QMS performance & effectiveness including trends in: 1.customer satisfaction & feedback from relevant interested parties 2. extent to which quality objectives have been met 3. process performance & conformity of products & services
Decisions and actions to be taken are discussed during the management review — QMR	
A	

A ↓ Records the proceedings of the Management ↓ In the event there are deviations from established targets, the Corrective Action Procedure shall apply. The corrective action shall be verified for effectiveness at a mutually agreed upon date. ↓ End	QMR QMR Lead Auditor Division Chief Concerned	4. nonconformities & corrective actions 5. monitoring & measurement results 6. audit results 7. performance of external providers d. adequacy of resources e. effectiveness of actions taken to address risks & opportunities f. opportunities for improvement (The Division Chiefs and ISO Team are to prepare information pertaining to their division's process performance and service conformity.) Outputs of the review shall include decisions and actions pertaining to: a. opportunities for improvement b. any need for changes to the QMS c. resource needs

2.0 Records

2.1 Management Review minutes
2.2 Reports of the MGB Division Chiefs
2.3 CAR for non-attainment of target
2.4 Evidence of CAR implementation
2.5 Reports regarding RMP results