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ETHICAL CULTURE AND LEGAL LIABILITY: THE GM SWITCH CRISIS AND LESSONS IN GOVERNANCE

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During 2014 news stories emerged that eventually revealed and caused General Motors (GM) to admit that the corporation took more than ten years to recall millions of vehicles because of an elaborate cover-up related to defects in its engine ignition switches. Beyond the tragedy of at least 100 deaths attributed to the ignition switch failures, the company’s internal failure to address and timely disclose what was a material event evident in the earliest stages of the use of the switch and clear evidence of the company’s awareness of the defects is appalling. Within the past fifteen years there have been significant examples of ethical lapses, all with the common factor that the evolution of the lapses within the companies took place over a period of time with many in the organization aware of the growing problems. The ignition switch problem at GM follows this same pattern. The purpose of this article is to examine the GM ignition switch debacle in light of its culture and past practices and search for insights to aid other companies in how to detect these material events and decisions in their early stages. First, we discuss what went wrong at GM, including findings from the report conducted by attorney Anton Valukas at the request of GM’s board. Second, we explore GM’s several appearances before Congress due to this ignition switch safety issue. Third, we look at what GM has done so far. Fourth, we provide thoughts about what GM needs to do in the future. Next, we discuss lessons learned from this ethical crisis. Finally, we conclude and offer
advice. We believe this paper offers a recital of the facts surrounding an egregious lapse in U.S. corporate ethical conduct as it provides constructive thoughts about future prevention of the causal management conduct, failure of corporate governance and regulatory oversight. The GM experience offers many lessons about the importance of organizational integrity, “truth telling” at all levels within large corporations, and the costs and issues that result when there are failures in corporate governance.

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I. OVERVIEW

“There are only two types of companies. Those who have experienced an ethical lapse and those who are not aware that they are in the development stage for one.”1

During 2014 news stories emerged that eventually revealed and caused General Motors (GM) to admit that the corporation took more than ten years to recall millions of vehicles because of an elaborate cover-up related to defects in its engine ignition switches.2 Beyond the tragedy of at least 100 deaths attributed to the ignition switch failures,3 the company’s internal failure to address and timely disclose what was a material event, even in the earliest stages of the use of the switch and clear evidence of the company’s awareness of the defects became clear. Within the past fifteen years there have been multiple significant examples of corporate ethical lapses.4 All these ethical crises evolved over a

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1 Marianne M. Jennings, paraphrasing FBI Director James Comey in his description of cyber attacks, “There are two kinds of big companies in the United States. There are those who’ve been hacked . . . and those who don’t know they’ve been hacked.” Riley Walters, Persistent Cyberattacks of U.S. Companies on the Rise, WASHINGTON TIMES (Nov. 3, 2014), http://www.washingtontimes.com/news/2014/nov/3/riley-walters-persistent-cyberattacks-on-us-compan/ [https://perma.cc/9SLR-BQPK].

2 Jeff Bennett, U.S. Fines GM for Missing Deadline, WALL ST. J., Apr. 9, 2014, at B1 (reporting that GM has failed to answer about one-third of the 107 questions asked by the National Highway Traffic Safety Administration a month earlier). When we make reference to GM prior to July 10, 2009, our reference is to General Motors Corporation. General Motors Corporation filed a Chapter 11 bankruptcy petition in the United States Bankruptcy Court for the Southern District of New York on June 1, 2009. The sale of all of the assets of General Motors Corporation to an entity that became known as General Motors Company received court approval on July 5, 2009, with subsequent sale closing on July 10, 2009. Accordingly, when we reference GM from and after July 10, 2009, we are referring to the purchaser of the assets, General Motors Company. See also General Motors Company, Filing with SEC of Amendment No. 8 to Form S-1 Registration Statement, About this Prospectus, i (Nov. 16, 2010).

3 Christopher M. Matthews & Mike Spector, GM Likely to Face Criminal Charges, WALL ST. J., May 26, 2015, at B1.

4 For a full discussion of the evolving issues at companies such as Enron, WorldCom, and Adelphia and the resulting federal regulation, see Marianne M. Jennings, A Primer on Enron: Lessons From A Perfect Storm of Financial Reporting, Corporate Governance and Ethical Culture Failures, 39 CAL. W. L. REV. 163 (2003), and for details on WorldCom and Tyco, see Marianne M. Jennings, Restoring Ethical Gumption in the Corporation: A Federalist Paper on Corporate Governance – Restoration of Active Virtue in the Corporate Structure to Curb the “Yeehaw Culture” in Organizations, 3 WYO. L. REV. 387 (2003).
prolonged period of time, with many within the organization aware of the growing problems. The ignition switch issue at GM follows the same pattern. The purpose of this article is to examine the GM ignition switch debacle in light of GM’s culture and past practices and search for insights to aid other companies in how to detect these material events and decisions in their early stages.

First, we discuss what went wrong at GM, including findings from the report conducted by attorney Anton Valukas at the request of GM’s board. Second, we explore GM’s several appearances before Congress due to this ignition switch safety issue. Third, we look at what GM is reported to have done so far. Fourth, we provide thoughts about what GM needs to do in the future. Next, we discuss lessons learned from this ethical crisis. Finally, we conclude and offer advice. We believe this paper offers a recital of the facts surrounding an egregious lapse in U.S. corporate ethical conduct and provides constructive thoughts about future prevention of the causal management conduct, failure of corporate governance and regulatory oversight. The GM experience offers many lessons about the importance of organizational integrity, “truth telling” at all levels within large corporations, and the costs and issues that result when there are failures in corporate governance.

II. WHAT WENT WRONG AT GENERAL MOTORS?

By the summer of 2015, deaths attributed to GM’s faulty ignition switch problem had risen to more than 100. On September 17, 2015, criminal charges were announced against GM that resulted in a deferred prosecution agreement and a $900 million forfeiture. In announcing the agreement with GM, the head of the Manhattan U.S. Attorney’s Office, Preet Bharara, explained why criminal charges were necessary for GM and other companies: “The first line of defense is self-policing within the company. The second is regulators. . . . ‘When all those things have failed, prosecutors come along with the blunt hammer. That does get some attention in the Board room.’” The criminal charges and deferred prosecution for GM were a long time in coming and an examination of GM’s history indicates why the first line of defense failed.

A. Historical Importance of General Motors

General Motors was founded in Flint, Michigan on September 16, 1908 by William “Billy” Durant. GM’s worldwide sales of 9.9 million vehicles for the

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5 See Matthews & Spector, supra note 3, at B1.
7 Matthews & Spector, supra note 3, at B5.
8 The Editors of Encyclopedia Britannica, General Motors (GM) American Company. in ENCYCLOPEDIA BRITANNICA, [http://www.britannica.com/topic/General-Motors-Corporation
year ended December 31, 2014, mean that GM’s market share is the largest estimated “market share in North America and South America, the number six market share in Europe and the number two market share in the Asia Pacific, Middle East and Africa region.” During this same period, the Asia Pacific, Middle East and Africa regions accounted for 44.1% of GM’s global retail vehicle sales. Because of its market presence and now worldwide brand, GM President Charles Wilson, during his 1953 confirmation hearings to become secretary of defense, reportedly said he believed “‘what was good for the country was good for General Motors and vice versa.’ (Soon that would be simplified to: ‘What’s good for General Motors is good for the country.’)” Mr. Wilson was prescient and his statement has gone through iterations to a description of GM’s role in the U.S. economy: as GM goes, so goes the nation. GM was suffering in 2008 when U.S. financial markets collapsed. Both the financial markets and GM recovered through combinations of bankruptcy reorganization and government assistance.

Sales of automobiles have constituted one of the historical engines powering job creation and economic growth in the United States. Perhaps GM’s role in the foundation of the U.S. economy and increasingly intertwined relationship with the federal government has provided cover for an ethical culture that has grown sloppy and dysfunctional over the years. Because the global financial melt-down and credit crisis of 2008-09 resulted in GM’s critical shortage of operating cash, it “received a bridge loan from the U.S. Treasury, under the conditions that the company further accelerate a tough restructuring of its [U.S.] operations that had been underway for several years.” Corporate turnaround expert Jay Alix observes, “By the time the company closed its books on 2008 it would be in the red by a staggering $30.9 billion.”


10 GM Form 10-K, supra note 10. at 10.


14 Id.

15 Jay Alix, How General Motors Was Really Saved: The Untold True Story of The Most
III. THE SAFETY HISTORY AT GM

A. GM’s History of Problem Cars

1. The Corvair

The GM ignition problem is not, as the saying goes, GM’s “first rodeo” when it comes to safety issues with its vehicle design. Ralph Nader began his career as a consumer advocate with his book, Unsafe at Any Speed, which documented the safety and design issues with GM’s rear-engine Corvair.\(^1\)\(^\text{16}\) The Corvair was first sold in 1959, with questions about the car’s stability arising almost immediately as drivers lost control of their cars, spinning off roadways backwards, crashes which often ended in rollover accidents.\(^2\)\(^\text{17}\) EMPI, an accessory company, began selling stability packages for Corvairs almost immediately after the first Corvair sales began.\(^3\)\(^\text{18}\) By October 1965, GM was facing over 100 lawsuits that alleged that the instability of the Corvair had resulted in accidents.\(^4\)\(^\text{19}\) In that era of cat-and-mouse discovery, GM was able to withhold the data about the car’s testing and/or settle the cases so as to preserve the GM brand.\(^5\)\(^\text{20}\) GM defended itself, claiming “it’s all about the nut behind the wheel,” and at least two juries believed that the crashes were attributable to driver negligence and did not hold GM liable.\(^6\)\(^\text{21}\) GM also had the benefit of time on its side.\(^7\)\(^\text{22}\) With each passing year, there were fewer and fewer Corvairs on the road with fewer opportunities for drivers to explore causation through litigation.\(^8\)\(^\text{23}\) Each year also brought more public disclosures and analysis of the car’s safety. In 1963, sports car racer and writer, Denise McCluggage, wrote about the “handling idiosyncrasies” of the Corvair and number of accidents.\(^9\)\(^\text{24}\) She also noted that Corvairs involved in accidents were likely to have back-end damage with no evidence of the cars traveling in reverse gear or being hit from behind.\(^10\)\(^\text{25}\) Also in 1963, EMPI’s stability package was praised in a Sports Illustrated article

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\(^1\) RALPH NADER, UNSAFE AT ANY SPEED: THE DESIGNED-IN DANGERS OF THE AMERICAN AUTOMOBILE (1965).
for its ability “to reduce oversteer and smooth out the unstable rear-end breakaway.” Mr. Nader concluded that the GM engineers “did not have the professional stamina to defend their engineering principles from the predatory clutches of the cost-cutters and stylists.” By 1963, GM had received hundreds of complaints about the Corvair and the problems from the rear-end axle swing. The problem was one an engineering professor said could be solved by any engineering student, but the company, while taking action to correct the problem for its 1964-65 models, did not issue a recall, notify existing owners, or offer a disclosure about the issue.

Dr. Seymour Charles, a GM shareholder and founder of Physicians for Automotive Safety, raised questions about the Corvair to both GM’s chairman and president. In his pleading he urged GM to consider a recall for the Corvairs still on the highway. Even Motor Trends’ technical editor had noted the number of Corvairs in the wrecking yards. Yet, the president of GM, John F. Gordon, seemed to be unaware of the problem despite the litigation and despite his presiding, since 1958, over GM’s introduction of this novel vehicle design. Evidently Mr. Gordon had not reviewed or followed the Corvair’s introduction, engineering policy approval, or subsequent sales, complaints, and accidents. The president of GM somehow remained ignorant of the ongoing objections and analysis of the Corvair’s problems in everything from Sports Illustrated to Motor Trends.

This pattern of design issues, the failure to self-correct, the complaints, the eventual public exposure, and resulting litigation would be repeated many times within the GM culture. With each repeat performance the refrain was always, “Who knew?”

2. The Chevrolet Malibu

On July 9, 1999, a Los Angeles jury awarded Patricia Anderson, her four children, and her friend, Jo Tigner, $107 million in actual damages and $4.8 billion in punitive damages in a lawsuit the six brought against GM because they were trapped and burned in their Chevrolet Malibu when it exploded on impact following a rear-end collision. Jury foreman Coleman Thorton, in explaining the large verdict, said, “GM has no regard for the people in their cars, and they

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26 Id. at 11.
27 Id. at 28.
28 Id. at 36.
29 Id.
30 Id. at 37-38.
31 Id.
32 Id. at 38.
33 Id. at 38-39.
34 Id. at 37-39.
should be held responsible for it.”Richard Shapiro, an attorney for GM, said, “We’re very disappointed, . . . This was a very sympathetic case. The people who were injured were innocent in this matter. They were the victims of a drunk driver.”

The accident occurred on Christmas Eve 1993 and was the result of a drunk driver striking the Andersons’ Malibu at 70 miles per hour. The driver’s blood alcohol level was .20, but the defense lawyers noted they were not permitted to disclose to the jury that the driver of the auto that struck the Malibu was drunk. The discovery process in the case uncovered a 1973 internal “value analysis” memo on “post-collision fuel-tank fires” written by a low-level GM engineer, Edward C. Ivey, in which he calculated the value of preventing fuel-fed fires. Mr. Ivey used a figure of $200,000 for the cost of a fatality, noted that 500 fatalities occur per year in GM auto-fuel fire accidents, and that the cost of these explosions to GM would be $2.40 per car. After an in-house lawyer discovered the memo in 1981, he wrote, “Obviously Ivey is not an individual whom we would ever, in any conceivable situation, want identified to the plaintiffs in a post-collision fuel-fed fire case, and the documents he generated are undoubtedly some of the potentially most harmful and most damaging were they ever to be produced.”

In the initial cases brought against GM, the company’s defense was that the engineer’s thinking was his own and did not reflect company policy. However, when the in-house lawyer’s commentary was revealed during discovery in a Florida case in 1998, GM lost that line of defense. In the Florida case, a 13-year-old boy was burned to death in a 1983 Oldsmobile Cutlass station wagon, and the jury awarded his family $33 million.

These two documents became the center of each case. Judge Ernest G. Williams of Los Angeles Superior Court, who upheld the verdict in the $4.9 billion Los Angeles case but reduced the damages, wrote in his opinion, “The court finds that clear and convincing evidence demonstrated that defendants’ fuel tank was placed behind the axle of the automobiles of the make and model here in

36 Id. at A2.
37 Id.
38 Id.
39 Id.
40 Id.
41 Id.
42 Id.
44 Id.
45 Id.
46 Id.
order to maximize profits—to the disregard of public safety.”

On appeal, the Los Angeles verdict was reduced from $4.9 billion to about $1.2 billion.

The class action lawsuits were still being resolved around the country through 2006. The suits centered on GM’s midsize “A-cars,” which include the Malibu, Buick Century, Oldsmobile Cutlass, and Pontiac Grand Prix. Approximately 7.5 million cars were equipped with this gas-tank design.

3. The Cobalt Ignition Switch

In 1999, as GM was developing several new smaller model cars (including the Cobalt and Impala), its test drivers reported problems with the ignition on the cars. If the keys were bumped, the cars experienced a sudden shut down. The shut down not only resulted in the car stopping from full speed to zero speed, thus making it difficult to control, it also caused the airbags to fail, thus making any crashes that resulted more likely to be fatal. GM took no action to change the ignition switch, and in 2002 test drivers reported the same problems. In 2004, two years before GM would finish its litigation over the Malibu, GM received the first reports from customers about engines shutting down in Chevrolet Cobalts. By 2005, GM received its first reports of an ignition failure and the failure of the airbag to deploy, events that resulted in the death of Amber Marie Rose, age 16. During 2005, a GM engineer proposed redesigning the key head on the ignition, but management rejected his proposal. Also in 2005, a GM employee who drove one of the Cobalt-like models, sent the following e-mail to several engineers and managers in the company:

“I think this is a serious safety problem . . .” “I’m thinking big recall. I was driving 45 mph when I hit the pothole and the car shut off, and I had a car driving behind me that swerved around me. I don’t like to imagine a customer driving their kids in the back seat, on I-75, and hitting a pothole

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47 Id.
51 Id.
53 Id.
54 Id.
55 Id.
57 Id.
in rush hour traffic.”

Raymond DiGiorgio, then a senior engineer at GM, began to refer to the ignition switch on the cars as “the switch from hell.” At the end of 2005, GM issued a service bulletin to its dealers that alerted them to the ignition problem, but GM did not issue a recall. During this time period, as the ignition issues continued to evolve, GM was experiencing financial pressures. In fact, GM’s financial problems continued to mount during all of the periods that involved these safety issues. In 1991, GM closed 25 plants and laid off 74,000 workers. In 2006, GM shed 47,600 GM and Delphi workers through early retirement or buyout offers. By 2008, the financial market collapse took its toll on GM in the form of Chapter 11 bankruptcy.

The accidents and notifications related to ignition failures continued through 2006. GM took no further action except to switch out the part for the ignition. The part number was not changed as required by federal regulations. If a part number is not changed, there is no requirement that the National Highway Traffic Safety Administration (NHTSA) be notified. In a series of e-mails, GM’s supplier, Delphi, pushed back on the failure to change the part number, but proceeded with the change and the resulting sales. One Delphi employee had observed earlier in a June 2005 e-mail, “Cobalt is blowing up in their faces.” But GM engineers observed at the time, “What we are dealing with here is an issue

59 Bennett & Hughes, supra note 52, at B1.
60 Vlasic, supra note 58.
63 As one analyst phrased it, “This is a big, big hunk of ballast over the side.” James P. Womack, The Chatter, N.Y. TIMES, July 2, 2006, at B2.
65 Vlasic, supra note 58.
66 Id.
68 Id.
69 Id.
70 Id.
of ‘customer convenience,’ not safety.”71

On the regulatory end, NHTSA did not inform GM of the Rose accident until 2007, and NHTSA did not open an investigation.72 GM did, however, in response to the NHTSA disclosure, begin to follow the ignition accidents in 2007.73 Despite the notification, awareness, and increasing reports, GM did not take any further public steps on the ignition issue until 2010.74 There was, however, below-the-radar litigation related to the switches, including suits by the family members of those who died in ignition failure cases.75

By the summer of 2010, GM halted production of the Cobalt, and by December 2013, GM determined that there had been 31 accidents caused by ignition failure and that 13 of those crashes had resulted in deaths.76 The Freidman Research Corporation determined that the problem crossed models and classified 303 deaths as related to the ignition switch problem.77 In February 2014, GM recalled 619,000 vehicles,78 a recall that would slowly be expanded as problems across models emerged to 16.5 million vehicles, including the 2005-07 Chevrolet Cobalts, the 2003-07 Saturn Ions, the 2006-07 Chevrolet HHR, the 2007 Saturn Sky, and the 2006-07 Pontiac Solstice.79 The recall included a warning for owners not to drive with any objects on the key chain because the weight of the key chain seemed to be a factor in causing the switch failure.80

Unfortunately, the recall was not done quickly enough to prevent additional deaths. Lara Gass, a third-year law student, received an e-mail from her father that her car, a 2006 Saturn ION, was just issued another recall and that GM

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71 VALUKAS REPORT, supra note 61, at 2.
73 Id.
74 VALUKAS REPORT, supra note 61, at 139.
75 Id. at 103–199.
would be sending her a letter.\textsuperscript{81} Her father signed the e-mail, “FYI Love, Dad.”\textsuperscript{82} Ms. Gass responded, “Oh, great, one thing after another with that car. Thanks for the heads up! See you in a couple of days! Love you, Lara.”\textsuperscript{83} Unfortunately, her ignition turned off when she was on the way to her internship for a federal judge and she was killed when the car hit a tractor-trailer in front of her and the air bag did not deploy.\textsuperscript{84} It is unclear if she had followed her father’s warning about taking all the other keys off of her keychain and using her ignition key separately.\textsuperscript{85}

Reflecting on the common factors in these three GM situations, spread over a period of nearly 50 years, patterns emerge. When the design issues with the cars first came to light, the response within GM was not one of immediate concern and action. In all three situations, the safety issue was researched, revisited, and suppressed. In all three safety and design issues, the outcomes were costly, in both actual dollar amounts as well as in reputation. The way these moral dilemmas were processed at GM was an inherent part of GM’s culture.

\textbf{B. Moral Dilemma of Safety at General Motors}

Early on, the Committee on Energy and Commerce of the U.S. House of Representatives reported that senior GM executives were aware of defective ignition switches for at least three years before starting the limited recalls.\textsuperscript{86} By 2014, GM was admitting that it had actually known of stalling and power loss problems for almost a decade before ordering the February 2014 faulty ignition switch recall.\textsuperscript{87} As noted earlier, the issue arose for the first time in 1999 with test drivers. As the rest of the story began to percolate into the media, GM announced the departure of its global head of engineering.\textsuperscript{88}

Surprisingly, sales did not appear to decline in the face of growing negative publicity.\textsuperscript{89} GM still appeared to operate and handle public relations issues as if the ignition problem was the work of a single engineer and perhaps some staff

\begin{flushleft}
\textsuperscript{81} Id.
\textsuperscript{82} Id.
\textsuperscript{83} Id.
\textsuperscript{84} Id.
\textsuperscript{85} Id.
\textsuperscript{87} Jeff Bennett, \textit{GM Chief Can’t Shake Recall Furor}, WALL ST. J., Apr. 16, 2014, at B3 (observing that the company had known of problems with many of its smaller car brands for many years before ordering a recall).
\end{flushleft}
members but assured that there were not cultural issues at the company.\textsuperscript{90} GM’s early story was that “work on defective ignition switches was limited to a handful of midlevel employees.”\textsuperscript{91} However, \textit{New York Times} reporter Bill Vlasic notes “a review of internal documents, emails and interviews paint a different picture, showing that high-ranking officials, particularly in GM’s legal department, led by general counsel Michael P. Millikin, acted with increasing urgency in the last 12 months to grapple with the spreading impact of the ignition problem.”\textsuperscript{92}

By mid-2014, because all of the facts surrounding the GM recall were not known it was still too early in the saga to have clarity as to the extent of damages. However, by mid-2014, twenty-nine separate recalls had been announced, covering almost 15.4 million vehicles globally between January 1 and May 21, 2014.\textsuperscript{93} By June 2014, GM’s exposure for the Cobalt ignition switch crisis involved independent estimates “to compensate victims, legal fees and any settlements or judgments rang[ed] from less than $5 billion to as much as $7 billion.”\textsuperscript{94}

\textit{C. The “Recall”}

The GM recall involves a pattern of numerous expansions of scope and activities. To begin, GM informed the NHTSA of the defective ignition switch in the 2005-2007 model year Chevrolet Cobalt and 2007 Pontiac G5 automobiles on February 7, 2014.\textsuperscript{95} GM’s explanation to the NHTSA at the time was that:

The “ignition switch torque performance” may not meet GM’s specifications. If the torque performance is not to specification, and the key ring is carrying added weight or the vehicle goes off road or experiences some


\textsuperscript{92} \textit{Id.}


\textsuperscript{94} Jeff Bennett, \textit{GM to Offer Estimate Of Recall Costs Soon}, \textit{Wall St. J.}, June 11, 2014, at B5 (observing that “[i]t is unclear if GM will immediately share that figure or wait until its second-quarter results are released July 24 [,2014]. The company will begin accepting claims from victims on Aug. 1[, 2014].”). See also Jeff Bennett, \textit{GM Holders Question Recall Costs}, \textit{Wall St. J.}, June 10, 2014, at B2.

\textsuperscript{95} Memorandum from The Comm. on Energy and Commerce to the Subcomm.on Oversight and Investigations (June 16, 2014), \url{http://docs.house.gov/meetings/IF/IF02/20140618/102345/HHRG-113-IF02-20140618-SD002.pdf} (hereinafter “GM February 7, 2014, Letter to NHTSA”).
other jarring event, the ignition switch may inadvertently be moved out of the run position.

GM explained that, depending on the time the ignition moved out of the “Run” position, the airbags of the affected vehicles would not deploy. . . In its recall notices, GM stated that it is “very important that customers remove all items from their key rings, leaving only the vehicle key. The key fob . . . should also be removed from the key ring.” In a March 17, 2014, notice to GM dealers, GM stated that they expected the initial supply of new ignition switch parts would be available on April 7, 2014.

On March 28, 2014, GM again expanded the ignition switch recall. . . GM state[d] that its reason for expanding the recall was that faulty switches may have been used as service parts in these later models. GM stated that it [was] “unaware of any reports of fatalities with this group of vehicles where a frontal impact occurred, the front air bags did not deploy and the ignition is in the ‘accessory’ or ‘off’ position.” The second expansion of the ignition switch recall cover[ed] an additional 823,788 vehicles in the U.S., bringing the number of recalled vehicles to 2,191,934.

In addition, with regard to questions about whether removing the key fob and other items from the key ring would prevent the key from moving out of the “Run” position until the recall could be performed, Secretary of Transportation Anthony R. Foxx declined to advise owners of the recalled GM vehicles to cease driving their cars until the ignition switch was replaced, stating that such a warning was “not necessary.” In reaching this conclusion, Secretary Foxx stated that NHTSA had “thoroughly evaluated” GM’s interim guidance and testing and NHTSA’s own engineers had examined the “geometry and physics” of the ignition key, switch, and steering column in the recalled vehicles.

NHTSA opened a “Timeliness Query” on March 4, 2014, “to evaluate the timing of GM’s defect decision-making and reporting of the safety defect to NHTSA.” On May 16, 2014, NHTSA announced a settlement of the Timeliness Query, stating that GM had “agreed to pay a record $35 million civil penalty and to take part in unprecedented oversight requirements as a result of findings from NHTSA’s timeliness investigation regarding the Chevrolet Cobalt and the automaker’s failure to report a safety defect in the vehicle to the federal government in a timely manner.” GM admitted in the Consent Order that it had failed to notify NHTSA of a safety-related defect within five working days as required by the Safety Act. Pursuant to the Consent Order, GM agreed to have monthly meetings with NHTSA for one year following the date of the Consent Order to discuss its implementation of recommendations resulting from the GM internal investigation conducted by Mr. Valukas. GM also agreed to establish improved internal reporting procedures for safety-related defects; improve employee training;
and strengthen processes for identifying safety defects.96

D. Valukas Report and GM Internal Investigation

Prompted by the identification of at least fifty-four frontal-impact crashes,97 involving more than a dozen fatalities, the GM board of directors hired law firm Jenner & Block on March 10, 2014 to discover why the Cobalt recall took so long to accomplish.98 Written by former United States Attorney Anton R. Valukas, The Valukas Report, dated May 29, 2014, states, in relevant part, that:

GM personnel’s inability to address the ignition switch problem for over 11 years is a history of failures. While GM heard over and over from various quarters – including customers, dealers, the press, and their own employees – that the car’s ignition switch led to moving stalls, group after group and committee after committee within GM that reviewed the issue failed to take action or acted too slowly. Although everyone had responsibility to fix the problem, nobody took responsibility.99

The Valukas Report includes several prominent and recurring themes regarding GM’s failure in leadership and culture. The first such failure was the apparent tone deafness at the top of GM regarding the continuous tension between the two goals of safety and cost containment. However, the Report focuses on a more pervasive problem in GM’s culture – that of nurturing a reluctance among employees to speak, disclose, and/or tell the truth when it comes to issues that involved issues of cost vs. safety.100 The GM “tone at the top regarding safety,” according to the Valukas Report, as is true in most company cultures, did not consist of a specific management directive that could be tied to the decisions made related to the ignition switch.101 Rather, the report concluded that there was a general atmosphere that affected the decision process when cost-containment goals were in conflict with correct, but expensive, fixes in vehicles:

It is impossible to catalog all possible directives and management actions that might generally have influenced how GM employees viewed their roles and responsibilities. It is even more difficult to ascertain how the general tone set by senior leadership affected specific decisions made by individuals. Where individuals referenced specific management directives as the cause of their actions, we have identified them. In most circumstances, however, we could not ascribe a particular management action or policy

96 Id. at 1-3 (internal citations omitted).
97 VALUKAS REPORT, supra note 61 at 1.
98 Id. at 5; see also Jeff Bennett, GM Report To Address Missteps, WALL ST. J., June 2, 2014, at B1; Bill Vlasic, G.M. Inquiry Cites Years of Neglect Over Fatal Defect, N.Y. TIMES (June 5, 2014), http://www.nytimes.com/2014/06/06/business/gm-ignition-switch-internal-recall-investigation-report.html?_r=0 [http://perma.cc/SA5H-5WQC].
99 VALUKAS REPORT, supra note 61 at 2.
100 Id. at 252.
101 Id. at 248-49.
directive from a senior executive as the reason for any specific action.\textsuperscript{102}

However, the employees did repeat mantras during the course of the Valukas investigation that seem contradictory: “Repeated throughout the interview process we heard from GM personnel two somewhat different directives – ‘when safety is at issue, cost is irrelevant’ and ‘cost is everything.’ It is worth examining how those two messages collided.”\textsuperscript{103}

Prior to the release of the report, GM CEO Mary Barra had acknowledged that there was a cultural problem at GM.\textsuperscript{104} Ms. Barra, at the time of the recalls, issued a statement that included, “Something went very wrong in our processes in this instance, and terrible things happened.”\textsuperscript{105} In her congressional testimony, Ms. Barra said that GM had been operating under a “cost culture,” but that it was now changing to a “customer culture.”\textsuperscript{106} The Valukas report documents both a safety culture and a cost culture:

GM personnel were quite consistent in saying that they understood that safety was a critical priority and that, if they identified a safety problem, cost should not be a factor in deciding whether and how to address the safety problem. For example, a senior manager in Accessories Engineering said that safety is the top pillar at GM. Training material and directives that have been located for FPE process for reviewing safety issues, make no references to cost-benefit analyses.\textsuperscript{107}

Despite the seeming on paper clarity on the concepts of safety controls, the actions GM actually took on safety were counterintuitive. The key to understanding the duplicity in the culture was another aspect of GM operations: a longstanding inability to have safety and design issues raised from lower levels in the organization when there was concern or a dispute in order to obtain proper resolution.\textsuperscript{108} At the time of the recalls, Ms. Barra set up an internal probe into how the company failed to issue a recall until 10 years after the first e-mail indicated a problem with the ignition.\textsuperscript{109} “I asked our team to redouble efforts on

\textsuperscript{102} Id.
\textsuperscript{103} Id. at 249.
\textsuperscript{104} See Examining the GM Recall and NHTSA’S Defect Investigation Process: Hearing Before the Subcomm. On Consumer Protection, Product Safety, and Insurance of the S. Comm. on Commerce, Science, and Transportation, 113th Cong. (2014) (statement of Mary Barra, Chief Executive Officer, General Motors) (observing that “we have done several things since the bankruptcy to create a new culture at General Motors).
\textsuperscript{106} Id.
\textsuperscript{107} Valukas Report, supra note 61, at 249.
\textsuperscript{108} Id. at 252.
pending product reviews, bring them forward, and resolve them quickly.”110 In a press conference she added, “‘Clearly this took too long.’ . . . ‘We will fix our process.’”111 However, the fix had eluded the auto giant for decades. Even 25 years ago when Ross Perot served on the GM board, he observed, 

If you see a snake, you kill it. At GM, if you see a snake, the first thing you do is go hire a consultant on snakes. Then you get a committee on snakes, and then you discuss it for a couple of years. The most likely course of action is—nothing. You figure, the snake hasn’t bitten anybody yet, so you just let him crawl around on the factory floor. We need to build an environment where the first guy who sees the snake kills it.112

The Valukas Report even documents the desperate pleas of those within GM to get employees to raise issues. In a May 2004 ‘FPE Sensitivity and TREAD Training’ presentation by Kevin Williams, GM North America Vice President of Quality, employees were told:

The harsh reality is—we are competing in a new world, one that demands a culture where there is no tolerance for defects at any point during in [sic] the vehicle development and manufacturing process. Because the marketplace has zero tolerance for defects, this organization will have no tolerance for defects. If I sound alarmed, I am . . . . You must also become gatekeepers of quality. Consider every issue a potential defect and risk to the customer. I like to say “stand in front of the train”. Stop the problems from flowing downstream! If, despite your best efforts, you cannot stop a problem, your next action is to . . . escalate the issue up to someone who can. We have escalation systems in place for this very reason so don’t hesitate to use them.113

The ignition switch was an illustration that the efforts to get information from employees who were aware of problems to those who could and would do something were not taking hold. Ms. Barra has been with GM since she was 18 (1979) and climbed the ranks to the CEO position.114 She has consistently maintained that she knew nothing about the switch problem until December 2013 or January 2014 and took swift action once she was aware of the issue.115 Yet the issue was writhing and percolating in the lower ranks of the company. Following an internal investigation, Ray DiGiorgio, the engineer who approved the parts switch without changes and notification, was placed on unpaid leave and was ultimately

111 Healy, supra note 109.
113 Valukas Report, supra note 61, at 249.
114 Cong. Hearings, supra note 104.
fired in June 2014. An anonymous executive described DiGiorgio as a “tiny cog in a massive machine,” further describing the cog-culture as one where “You stay in your box and you do your job. And you don’t let anyone else into your box.” Likewise, following the Valukas investigation, other engineers were terminated because of awareness of the problem: Jim Federico, chief engineer for small cars and electric vehicles, retired after thirty-six years at GM, and John Calabrese, head of the product development division, retired after thirty-three years at the company.

The top executive team has been referred to as “insulated from many of the company’s inner workings, including active safety reviews.” The report also indicates that this insular atmosphere was possible because of the creation of so many committees within the company. There was a recall committee, a safety committee, a design committee, and a host of other groups that dealt with inter-division issues after divisions had dealt with them. The end result was a slow-moving culture caught up in processes. GM’s internal report indicated that GM knew enough about the switches to issue a recall years before one was actually issued. Ironically, however, the perspective of the employees was that by withholding information they were doing their jobs. In one of his post-employment interviews, Mr. DiGiorgio justified his actions in a way that reflects the appropriateness of his decisions, “All I can say is that I did my job. I didn’t lie, cheat, or steal. I did my job the best I could.”

Financial Times reporter Gillian Tett contends that “Many large organizations are divided, and then subdivided into numerous different departments, which often fail to talk to each other – let alone collaborate. People often live in separate mental and social ‘ghettos’ talking and coexisting only with [highly similar] people.” Tett describes this widely observed organizational fragmentation by using a “silo” metaphor by observing that “Silos breed tribalism. But they can

116 Vlasic, supra note 58.
117 Id. at B2.
118 Id. at B1.
119 Bennett, supra note 115, at B3.
120 Bill Vlasic, G.M. Recall, and a Decade of Inaction, Present an Early Trial for Its New Chief, N.Y. TIMES, Mar. 8, 2014, B1, B2.
121 Id.
122 See generally VALUKAS REPORT, supra note 61.
124 See Vlasic, supra note 58.
125 Id. (Mr. DiGiorgio denied in a 2013 deposition that he authorized the 2006 switch change. E-mails contradict that assertion. He had, however, asked the GM safety committee in 2005 to change the switch, but the request was denied).
also go hand in hand with tunnel vision.”

In addition to the cultural practice of keeping information within “your box,” there was, at the time of the evolving ignition switch issues, a culture of cost-cutting. The Valukas report describes the cost culture in detail:

. . . [T]he 2000s was a time of extraordinary cost-cutting at GM. The messages from top leadership at GM – both to employees and to the outside world – as well as their actions were focused on the need to control costs. We heard repeatedly from GM personnel about the focus on cost-cutting and the problems it caused. For example, an engineer stated that an emphasis on cost control at GM “permeates the fabric of the whole culture.”

Cost-cutting impacted all aspects of the business. Keeping projects on time – because of the impact on cost – became a paramount concern. One witness expressed concern that the cost- and time-cutting principles known as the ‘Big Four’ emphasized timing over quality. Those principles were introduced to GM in the early 2000s.

Those responsible for a vehicle were responsible for its cost, but if they wanted to make a change that incurred cost and affected other vehicles, they also became responsible for the costs incurred in the other vehicles.

Reductions in staff, especially in Engineering, meant that employees were forced to do more with less. In the time leading up to the bankruptcy, one cost-cutting measure was to decrease the Engineering headcount by adding to the responsibilities of the Design Release Engineer. . . . Witnesses stated that the reduction in force created a difficult environment in which people were overworked and the quality of work suffered.

The cost-cutting naturally flowed through to suppliers. One cost-cutting measure in the time leading up to GM’s bankruptcy was to source parts routinely to the lowest bidder, even if they were not the highest quality parts.

As is the case in most culture reports by attorneys, the conclusion reached is one of ‘no direct evidence.’ Both management and the board tend to relax when such reports come in, ignoring the findings and the need to address the cultural issues that are uncovered that do not result in legal liability. With class-action liability issues pending, the conclusions of the report are not surprising, but they are also not instructive. Legal investigations commissioned by companies do not reach conclusions as explicit as “employees made an explicit trade-off between safety and cost.” However, what legal reports miss in their zeal to reach the “no intentional misconduct here” conclusion is the impact of cost pressures and low-level silence on issues arising or being debated. The result of the cost and silence

127 Id.
128 VALUKAS REPORT, supra note 61, at 249-51.
129 Id.
pressures within any organization is not an intentional choice between cost and safety.\textsuperscript{130} Rather, the effect is based in psychological tendencies.\textsuperscript{131} There is an introduction of error into the decision process that may be unwitting, but is real. Pressures such as cost and silence result in a diagnosis bias.\textsuperscript{132} Diagnosis bias is an unintentional psychological force that causes engineers and others to minimize situational risk.\textsuperscript{133} For example, the Valukas report includes the following observation:

To be sure, the Cobalt engineers working in the 2004-2006 time frame rejected various fixes to the moving stall issue because there was “no acceptable business case,” but those engineers’ error was that they failed to understand the connection to airbags and the safety issue that they were facing. Having wrongly identified the issue as a customer convenience issue, cost considerations that would otherwise have been immaterial became part of their calculus.

That noted, we cannot conclude that the atmosphere of cost-cutting had no impact on the failure of GM to resolve these issues earlier . . . GM was under tremendous cost pressure . . . . Engineers did not believe that they had extra funds to spend on product improvements. Staff was cut dramatically. . . .

When belts are tightened, most functions are impacted in some way, and we cannot assume that safety was immune.\textsuperscript{134} The GM switch issue is not the first time diagnosis bias has impacted the ability of those within an organization to see the risks and impact of their decisions. For example, in 2007, Toyota did an internal presentation in which it announced that it had saved $100 million by negotiating an equipment recall of floor mats with its regulator, the NHTSA, as a solution for what was causing what customers were describing as a “sudden acceleration” problem.\textsuperscript{135} The information was presented as “Wins for Toyota.”\textsuperscript{136} Four days later, there was another accident and the floor mats had been recently removed from the car.\textsuperscript{137} Toyota’s goal was to ‘solve’ the problem, even if the root cause had not truly been identified. The zeal to put the issue behind induces diagnosis bias, a false feeling of euphoria characterized by statements such as, \textit{I think we have this...}
solved now. The operative word is think because the desire is to have it solved. The character of the internal Toyota document illustrates how diagnosis bias controls in cost and pressure cultures: “The document cites millions of dollars in other savings by delaying safety regulations, avoiding defect investigations and slowing down other industry requirements.”

Legal analyses of cultures touch briefly on the decision-making process, but fail to recognize the impact of the cultural forces on the efficacy of that process. For example, those involved in these decisions ignore or discount the possibility that the public will find out. The question that is not asked is, What would the reaction be if this decision and the reasons for it were made public?

Also, in these decision-processes in cultures of pressure, diagnosis bias does not allow for accurate assessment of costs and collective outcomes. When E.F. Hutton managers made the decision to engage in check-kiting in order to increase the amount of funds under management they were thinking of incentives, goals, and performance. They were not thinking of the non-Excel spreadsheet types of costs such as the loss of reputation.

Psychologically, humans respond to the pressures and pain in the present, not the future and non-quantifiable costs that accompany poor risk decisions. When Volkswagen engineers made the decision to install emissions test defeating software in the company’s diesel vehicles, they were responding to several pressures. The overarching pressure was the goal of the then-CEO to be the number one car company in the world.

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139 Messick & Bazerman, supra note 130, at 10.


142 Messick & Bazerman, supra note 132, at 11.

goal is set, the pressure to produce and sell cars sets in and affects judgment. In making the decision to simply get the fuel-efficient and “clean” diesel cars out there, the engineers missed the non-quantifiable costs not as obvious to those responding to pressure. For Volkswagen, the discovery of the emissions defeating devices has resulted in the following costs: 1) VW having to offer significant discounts and incentives to entice buyers post-emissions scandal;\(^\text{144}\) 2) a drop of 34% in the share price;\(^\text{145}\) and 3) a set-aside of over $7 billion to cover the expected cost of bringing current vehicles into compliance.\(^\text{146}\)

In addition to the impact of diagnosis bias in cultures affected by pressure and silence, there is the additional issue of self-deception caused by the way issues are framed. If an issue is framed in terms of shutting down plants and losing jobs, those involved are likely to undertake more risks.\(^\text{147}\) In this case, remaining silent seems to be the correct decision, or at least the palatable one at that pressure point.\(^\text{148}\) The logic we can survive a delay in a new design does not percolate into the thought processes. Nor does the reality but we can’t survive the recall of millions of vehicles, multi-billion dollar penalties for EPA violations, and loss of sales creep into the picture. Those under organizational pressure underestimate negative outcomes and they self-assure, It will be fine in the name of serving the organization, to wit, “I did my job.”

The GM congressional hearings revealed problems with both the framing of issues as well as diagnosis bias in the ignition switch issues. Those problems in analysis along with the box atmosphere meant that full understanding of the scope of the ignition problems and their potential costs were not present at GM. Fred Upton, Chairman of the House Committee on Energy and Commerce noted during the GM switch hearings:

Our investigation tracks with the findings of the report: a maddening and deadly breakdown over a decade plagued by missed opportunities and disconnects. Engineers didn’t comprehend how their cars operated or how vehicle systems were linked together. The company believed a car that stalled


\(^{147}\) See Messick & Bazerman, supra note 132, at 13-14.

\(^{148}\) Id.
while driving wasn’t necessarily a safety concern. Investigators let investigations drift for years despite having proof right before their eyes that an airbag system wasn’t deploying when it should have. And all of this existed in a bureaucratic culture where employees avoided taking responsibility with a nod of the head.149

In cultures such as GM, intellectual curiosity departs with pressure, and the search for facts, the questioning attitude, and communication suffer because keeping the issue below the radar is the goal and perceived desire of the culture. In business ethics, the saying, “The first whale to the surface always gets harpooned” is a summary of a culture such as GM’s. Employees never want to be the bearers of bad news. For example, the congressional hearings served to connect the dots of failures of curiosity and questioning attitude. Despite customer complaints and reports from GM’s own engineers, it took GM until 2009 to realize that the airbags had any connection to the power mode status of the car.150 The company would take yet another four years to link that finding to the ignition switch, one of the components that determines the power mode.151 The source of this discovery was not internal.152 Rather, the information came to light during the course of a lawsuit brought by the family of a young woman who died because of an ignition failure in her Cobalt.153 “An investigator for the family simply took two ignition switches apart and compared them – something that GM failed to do during the over seven years of investigations into the mystery of Cobalt airbag non-deployments.”154

In these cultures, the decision-making process simply does not see the potential costs of the risks that are being discounted, ignored, or postponed through a non-questioning attitude. GM is not the first company to experience the consequences of cultural context resulting in poor decisions that are made by employees who believe that they are making good ones. For example, BP is still grappling with the costs and clean-up from the explosion of its Deepwater Horizon

[https://perma.cc/MZ2K-FBQJ].
151 Id.
152 Id.
153 Id.
154 Id.
rig in the Gulf of Mexico. Who would have made the decision to undertake billions in cost and years of clean-up?\textsuperscript{155} Given BP’s culture at the time, that decision is not surprising.

There were critical points in BP’s construction of Deepwater Horizon where decisions were made on the basis of quicker, faster, and cheaper rather than on the basis of safety, long-term production, and industry standards.\textsuperscript{156} For example, BP chose the far riskier single line for Deepwater Horizon, a decision that others in the industry have testified was not appropriate for a well that deep.\textsuperscript{157} The risk was far too great in terms of its failure rate as well as the accumulation of gas around such a single line.\textsuperscript{158} The design posed a safety risk for those who worked on the rig.\textsuperscript{159} E-mails uncovered for BP’s congressional hearings reveal that engineers who requested 10 additional critical path hours to install 21 centralizers instead of just six were dismissed by the lead engineer with “I do not like this.”\textsuperscript{160} Once the well was in operation, the decisions workers made exacerbated the design problems. For example, on the day of the explosion the employees focused on keeping the well going, not on the risk that continued operations posed.\textsuperscript{161} BP employees framed the issue in the context of the importance of keeping the well going.\textsuperscript{162}

GM followed a similar process in a living-in-denial mode despite increasing evidence of problems. As the earlier history recounted, evidence continued to mount that there were problems with the ignition. Yet, decisions were made to continue production, substitute switches, and keep it all silent. By late May 2014, GM knew of a certainty that there were at least 13 who had died as a result of an


\textsuperscript{156} See Ben Casselman & Russell Gold, Unusual Decisions Set Stage for BP Disaster, WALL ST. J., May 27, 2010 at A1, A6 (telling the story of the practices and decisions at BP that lead to the Deepwater Horizon crisis).

\textsuperscript{157} Id.

\textsuperscript{158} Id.

\textsuperscript{159} Id.


\textsuperscript{162} Id.
apparent cover-up of a defect, known to exist for over a decade. What was not realized, as yet, by leadership at GM, was who knew what, when, and the extent to which management and the board of a great American enterprise may have been complicit. Who makes a decision to risk 80 civil lawsuits related to GM’s ignition switch failure that seek alleged “economic damages, such as repair costs and declines in resale value on about 2.6 million cars recalled since February” 2014? These decisions were made at GM and BP (and other companies) because of employee perceptions about priorities in their leadership teams.

IV. CONFRONTATION WITH CONGRESS

As observed previously, the automotive industry and highway safety has been the subject of various legislation and numerous Congressional hearings over the years. On April 1, 2014, the U.S. House Energy & Commerce Committee heard GM’s Mary Barra and David Friedman, Acting Administrator of the NHTSA, testify on the subject “The GM Ignition Switch Recall: Why Did It Take So Long?” Mary Barra appeared again, this time with Attorney Anton Valukas, before the U.S. House Energy & Commerce Committee’s hearings titled “The GM Ignition Switch Recall: Investigation Update” on June 18, 2014. During 2014, the Senate Committee on Commerce, Science, and Transportation “held two hearings to examine the GM ignition switch recalls (on April 163 Mike Ramsey & Jeff Bennett, *GM Death Toll Likely to Rise*, WALL ST. J., May 28, 2014, at B2.


V. WHAT GM HAS DONE

A. The GM Code of Ethics: General Content

GM epitomizes what is known as a dashboard company. Every best-practice-shoe-box governance tool is present, including a code of ethics. Recall from our previous discussion that the Valukas Report found a prominent and recurring theme of GM’s failure of leadership and culture. GM’s most recent proxy statement details that the Company has “adopted a code of ethics that applies to [its] directors, officers, and employees, including the CEO, the Executive Vice President and Chief Financial Officer, the Vice President, Controller and Chief Accounting Officer, and any other persons performing similar functions.”


169 See generally VALUKAS REPORT, supra note 61.


171 Id.

172 See Valukas Report, supra note 61.

Guidelines for Employee Conduct (Code of Ethics), does not lend itself to reproduction in full, here is an account of major issues addressed. Following a transmittal letter from CEO Mary Barra, Winning with Integrity notes that this code of conduct “applies to all staffs, divisions, and subsidiaries of GM . . . in which GM, directly or indirectly, owns more than 50 percent of the equity interest or which GM otherwise controls . . . [and] applies to consultants, agents, sales representatives, distributors, independent contractors, and contract workers . . . when they act on behalf of GM.”174 The GM Code of Ethics emphasizes key concepts such as “Personal Integrity,” by stating, “[n]othing is more fundamental to Winning with Integrity than taking personal responsibility for our actions. It is imperative that we all comply with the legal obligations and policies described in GM’s Code of Conduct.”175

The code makes the mistakes of a novice. The code is labeled a “code of ethics” and then switches to the term “integrity” and all without definitions to explain the difference. In addition, the quote from the previous paragraph indicates the intent to “comply . . . with legal obligations and policies . . . in [the] Code.” Given that this is a company that has just been through a national shock wave and paid a $900 million criminal fine, some introductory words about intent and purpose might be helpful.176 Peter Drucker’s classic, primum non nocere (roughly translated as, don’t hurt anybody) would be a good starting point before diving into the legal compliance.177

B. GM’s Code Addressing “Speaking Up”

One of GM’s goals in its code is to emphasize the importance of employees speaking up when they see misconduct, ironically expanding on the general notion of integrity:

174 GENERAL MOTORS COMPANY, WINNING WITH INTEGRITY: OUR VALUES AND GUIDELINES FOR EMPLOYEE CONDUCT, GUIDELINES FOR EMPLOYEE CONDUCT 4 (2015), http://www.gm.com/content/dam/gmcom/COMPANY/Investors/Corporate_Governance/PDFs/WWI.pdf [https://perma.cc/B7ET-HZLZ]. See also Reyes Calderón, Ignacio Ferrero & Dulce Redin, Ethical Codes and Corporate Responsibility of the Most Admired Companies of the World: Toward a Third Generation Ethics?, 14 BERKLEY BUS. & POL. 1 (2012) (suggesting that the codes of ethics of the 2009 Most Admired Companies of the World are still governed by traditional norms related to immediate economic success, normative compliance, internal management and the pressing effects of their sector and that the philosophy of corporate responsibility, CSR, is scarcely found in the codes of those companies thought to be most reputable).

175 See WINNING WITH INTEGRITY, supra note 174, at 5.

176 See id.

177 See MARIANNE JENNINGS, BUSINESS ETHICS: CASE STUDIES AND SELECTED READINGS 29 (7th ed. 2012); see also Drucker Institute, Above All, Do No Harm, DRUCKER INSTITUTE (Oct. 31, 2010), http://www.druckerinstitute.com/link/above-all-do-no-harm/ [https://perma.cc/TP2J-WN2Y].
It is also important to voice concerns when we believe the law, or GM policies, are not being observed. General Motors is committed to maintaining a culture that promotes the prevention, detection and resolution of misconduct. Each employee has an obligation to report potential misconduct. Examples of misconduct may include fraud, theft, workplace violence, discrimination, harassment, misuse of company resources, conflicts of interest, information breaches, improper accounting controls or purchasing arrangements, and other unethical behaviors. In cases where an individual is uncomfortable reporting through established internal channels, reports can be made using the Awareline.178

One of the important things to note about the content of GM’s language regarding speaking up is that the focus is on employee conduct, not employee decisions or safety processes. Would the addition of “safety” have helped to emphasize that decisions that affected safety mattered as much to GM as its focus on harassment or discrimination? Ironically, GM had specific policies on speaking up—it explicit protections for those who raise issues.179 The problem is that it was not clear from either the list of misconduct or the following non-retaliation policy that employees were protected when they raised questions about products and product designs and safety.

Speak Up!, GM’s Non-Retaliation Policy, is intended to protect GM employees from retaliation as a result of raising concerns in good faith. If you believe that you have been retaliated against or witnessed retaliation against another in violation of this policy, you should immediately report such concerns to your supervisor, HR contact, Legal Staff contact, or local leadership.180

The GM Code of Ethics addressed the types of generic ethical issues that can occur in all companies, a state-of-the-art inclusiveness in covering all possibilities of misconduct, save one; process and product decisions were not taking safety and customer harm into account. The segments of the code on safety are divided. There is a small segment of the code that provides, “Always observe safety protocols.”181 There is then this more detailed portion of the code on safety, included in the code after the recalls, penalties, and investigations:

Speak Up for Safety

At General Motors, we have an obligation to provide a safe work environment for every employee, contractor and visitor at every GM location. We live values that are designed to return people home safely—every person, every site, every day. Each day thousands of men and women leave

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178 See WINNING WITH INTEGRITY, supra note 174, at 5.
179 Id.
180 Id.
181 Id. at 6.
their families to do their best work for GM, and to create vehicles that people love.

Additionally, all over the world, millions of people drive or ride in our vehicles and they deserve the highest quality and safety when doing so.

No one function within GM owns safety – rather, safety is the responsibility of every one of us.

. . .

Vehicle Safety

In addition to workplace safety, it is our job, every day, to produce high-quality, safe vehicles for our customers. We all must be personally responsible for safety and integrity in all that we do.

GM is rapidly strengthening its approach to vehicle safety, such as an increased focus on system interactions and improvements in our analysis and decision making processes. But process and analytics are not enough – producing the safest cars for our customers requires active dialogue within GM, with our suppliers, our dealers, our employees and management. Identification, communication and escalation of potential safety issues are required. Safety matters most. Always.182

The language in this new code indicates that GM has attempted to emphasize process safety. But the language used is the same language that appeared previously that the investigations found in spades, but does not combine this emphasis with a discussion of the reality of the costs pressures that employees reported. The platitudes of vehicle safety in isolation do not address the reality of a culture that has, since 1958, allowed cost pressures to prevent fixes and avoid public disclosure. What GM faces at this point with this newly detailed section of its code of ethics is a credibility crisis. Many have said similar things at the company for decades, but still the Corvair, the Malibu, and the Cobalt happened. Neither the code nor its non-retaliation policy address consequences or what failures in process safety looks like. In addition, the code does not address the impact of poor decisions in terms of costs, recalls, possible criminal charges, and reputation damage. Those who had the power to influence the outcome would have been protected had they protested or voiced concern. However, they failed to take action for over a decade. The following sections of the code are indicative of a written philosophy committed to getting employees to speak up, ask questions, and seek guidance:

Understanding the Rules

Because laws are complex and changing, good intentions are not always enough to assure compliance. Every employee whose work is directly affected by particular laws must understand the legal rules well enough to spot problems and know when to get advice. Contact GM Legal with any

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182 Id. at 6-7.
questions about legal obligations that may affect your role.

*Acting With Integrity When the Rules Seem Unclear*

Not all situations are clear-cut, so good judgment is essential. Be alert to warning signs: if a questionable proposal is defended as “doing whatever it takes” or because “our competition does it” or “no one will ever know,” chances are it needs to be reconsidered.

When in doubt about the right choice, ask yourself:

- Is it legal?
- Is it consistent with our values and policies?
- Would you be willing to be accountable for your actions?

**DO**

- Take personal responsibility for performing assignments consistently with GM policies and all applicable laws and regulations.
- Know the rules. Seek guidance from the Legal Staff or other subject matter experts about laws and regulations relating to your work.
- Notify your leadership or the Legal Staff if you have any doubts about whether an action is legal or violates GM policies.

**DON’T**

- Assume it’s acceptable to follow instructions that violate the law or GM policy.
- Assume someone else will correct a problem.
- Assume a questionable practice is legal just because it has been done by someone else.¹⁸³

If you place these code sections in juxtaposition with the timeline of events in the switch case, you can understand how employees at GM were perhaps affected with a cynicism about the company’s devotion to ethics as they were witnessing a failure of response, action, or report on all of the events leading to the recalls and suits. The simple exercise of putting yourself in the shoes of the early test drivers offers some feeling of how employees perceived the disconnect.

While the GM efforts on its code of ethics are necessary and admirable, codes of ethics do not change culture. Codes of ethics are necessary, but they must be read in the context of actual behavior. Drawing on BP once again, the company had a culture in which on-the-surface observations presented a puzzling scenario of ubiquitous safety messages surrounded by contradictory behaviors. All BP facilities had reminders for employees to hold the banister whilst using stairs, walk only in marked areas, and never walk with hot coffee.¹⁸⁴ Employees who

¹⁸³ *Id.* at 5.

drove on the job had to take defensive driving courses. Further, all employees were reminded of their CEO’s singular message, “Safety is our first priority.” Indeed, at the time of the Deepwater Horizon explosion, BP was receiving safety awards.

BP developed a blind adherence to the standard type of industrial and occupational safety programs. BP had bench-marked its safety program, right down to the banisters and hot-coffee precautions. BP not only implemented the safety program, but it was also measuring the impact of its safety program with the usual forms of data tracking; reportable injuries, missed-work-day injuries, etc. BP’s data on these factors marked them as a stellar performer. In fact, Deepwater Horizon had been presented with an award by the U.S. government for its safety record. BP was entitled to recognition for meeting their safety goals, but there are problems with blind adherence to these dashboard types of programs and measures of safety. These forms of safety programs and monitoring do not provide managers with the information about far more risky safety issues. BP was not measuring risk accurately. It was only measuring safety events.

VI. WHAT GM NEEDS TO DO

Culture controls ethics. GM still faces the monumental task of having its communication (through incentives, evaluations, bonuses, and promotions) become consistent with the values stated in its code of ethics. Regardless of what happens with the criminal investigation in the ignition switch matter, withholding information about defects in your cars and products from regulators and customers is not a close ethical call. Yet, as the facts emerge, we know now that many at GM, including engineers, lawyers, and suppliers, agreed to remain silent about the problem. How did so many people all willingly go along with something that we look at today and wonder, What were they thinking? A company can have employees with strong ethical principles and unassailable integrity, but put them in a culture of costs or numbers, and we lose them, and, along with them, the company.

185 Id.
186 Id.
190 Id.
The House Committee on Energy and Commerce, Subcommittee on Oversight and Investigation’s majority memorandum preceding its meeting of June 18, 2014 noted that one of the primary issues to be examined at the hearing is “How did the culture and systemic problems that are identified in the Valukas report develop at GM? What must be done to address these problems and when will GM know if they have been successfully fixed?”

Congressman Tim Murphy expounded on the GM culture as a necessary area of focus going forward:

Even when a good law . . . is in place it requires people to use common sense, value a moral code, and have a motivation driven by compassion for it to be effective. Here the key people at GM seemed to lack all of these in a way that underscores that we cannot legislate common sense, mandate morality, nor litigate compassion. At some point, it’s up to the culture of the company that has to go beyond paperwork and rules.

The failures at GM were ones of accountability and culture. If employees do not have the moral fiber to do the right thing, and do not have the awareness to recognize when mistakes are being made, then the answer must be to change the people or change the culture.

Press reports point to the potential for rapid change in management culture at GM, brought on by Congressional inquiry, lawsuits and substantial recall and litigation expenses. The crisis seems to have allowed CEO Barra to “quickly put her own stamp on management” by “naming new executives for engineering, safety and communications.”

Professors Erika Hayes James and Lynn Perry Wooten warn that

[m]any organizational leaders have a laissez faire attitude toward the possibility of a crisis happening in their firm, despite the high probability that every business leader and every organization will experience a crisis of some significance. Consequently, leaders are underprepared not only for “managing” crisis situations when they occur, but also – and more important – for leading organizations in turbulent times with a vision or expectation that they and their organizations can be positively transformed by the experience.

It appears that a new approach at GM of addressing issues in a straightforward manner (if this proves to be the case) “represents a change at the top of GM – a

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192 Memorandum from the U.S. House Committee on Energy and Commerce Majority Staff to the Members of the Subcommittee on Oversight and Investigations (June 16, 2014), http://docs.house.gov/meetings/IF/IF02/20140618/102345/HHRG-113-IF02-20140618-SD002.pdf [https://perma.cc/2NZV-5HAU].
193 Statement of Hon. Tim Murphy, supra note 150.
195 Id.
company that for years minimized the depth of its troubles. In 2008, then-CEO Rick Wagoner repeatedly said a bankruptcy wouldn’t happen, up until he was ousted and GM was ushered into a restructuring by the federal government.”

CEO Barra has indicated that her intent is to recast GM’s corporate culture, one that she characterizes as responsible for “a ‘pattern of incompetence and neglect’ in the auto maker’s 11-year failure to recall cars equipped with a defective ignition switch.”

Norman Bishara and Cindy Schipani observe that “[c]orruption, by its nature, is secretive and, the costs of corruption are often hidden from plain view and difficult to measure.” While we can hope that the press adulations are accurate, culture change is neither as easy nor as rapid as the press would lead us to believe. There are three simple facts about CEOs and senior leadership in their companies: (1) the perception they have of their culture is usually not accurate; (2) the information that they need to know about culture is not getting to them; and (3) they could fix the culture if they realized both (1) and (2).

A. Pervasive Culture of Problem Denial/Avoidance

GM begins with deficits in Fact #2 (the information that CEOs and boards need to know about culture is not getting to them). Unlike a cultural environment that encourages and rewards employees for identifying problems and bringing them to the attention of management quickly, the GM work environment apparently offers “resistance or reluctance to raise issues or concerns.”

The Valukas Report notes “if an employee tried to raise a safety issue five years ago, the employee would get pushback. Mary Barra explained that problems occurred during a prior vehicle launch as a result of engineers being unwilling to identify issues out of concern that it would delay the launch.” GM employee concerns about “speaking up” and “fear of retaliation” are revealed by a survey administered during 2013. The Valukas Report mentions that

While the survey comments were unconnected to safety questions, issues of culture cannot be easily confined. Some witnesses provided examples where culture, atmosphere, and the response of supervisors may have discouraged individuals from raising safety concerns, including, in a different context than the Cobalt, supervisors warning employees to “never put anything above the company” and “never put the company at risk.”

\[197\] Bennett, supra note 194, at B1.
\[200\] VALUKAS REPORT, supra note 61, at 252.
\[201\] Id.
\[202\] Id.
former Cobalt Brand Quality Manager said that he felt that GM “pushed back” on describing something as a safety issue during a relevant time period.

Whether general “cultural” issues are to blame is difficult to ascertain, but the story of the Cobalt is one in which GM personnel failed to raise significant issues to key decision-makers. Senior attorneys did not elevate the issue within the Legal chain of command to the General Counsel – even after receiving the [ ] evaluation in the summer of 2013 that warned of the risk of punitive damages because of a “compelling[ ]” argument that GM had “essentially . . . done nothing to correct the problem for the last nine years.” Engineers, too, failed to elevate the issue. Starting in mid-2012, there were three high-level managers brought in as “champions” . . . . The very reason they were brought in was to help resolve an unexplained pattern of airbag non-deployments in an expeditious manner. But they did not elevate the issue to their superiors, and the common thread was to hold more meetings and refer the matter to additional groups or committees.203

B. “Don’t Take Notes” & Careful What You Write

The Valukas Report documents not only a culture of silence, but also a culture of concealment. The report reveals that “a number of GM employees reported that they did not take notes at all at critical safety meetings because they believed GM lawyers did not want such notes taken.”204 The tendency was documented above in the discussion of the Malibu design, but also emerged in the Jenner & Block investigation:

No witness was able to identify a lawyer who gave such an instruction, no lawyer reported having given such an instruction, and we have found no documents or e-mails reflecting such an instruction. The no-notes direction, however reached the status of an urban myth that was followed, an instruction passed from GM employee to GM employee over the years. Thus, as we learned in our investigation, for many meetings – of GM’s many committees – there are no clear records of attendance or of what was discussed or decided.205

The dangerous aversion to creating discoverable notes was exacerbated by a practice of “GM employees receiv[ing] formal training as to how to write about safety issues.”206 During 2008, GM employees were warned “to ‘write smart,’ and not to use ‘judgmental adjectives and speculation.’”207 Employees were given a number of words to avoid, with suggested replacements:

203 Id. at 252-53 (internal citations omitted).
204 Id. at 254.
205 Id. at 254-55.
206 Id. at 253.
207 Id. at 253-54.
Employees were also given examples of sentences not to use, including “Dangerous . . . almost caused accident” and “This is a safety and security issue . . . .” And they were told, in what the author described as an attempt at humor, not to use phrases such as “Kevorkianesque,” “tomblike,” or “maniacal,” or “rolling sarcophagus.” The “actual examples” provided in the presentation described how a plaintiff’s lawyer had used a memo from a senior manager at another automaker warning that a risk of conducting a survey about a problem was that it could provide “product liability evidence to a hypothesis we have long ignored.”

C. The GM Structural Barriers

The Valukas Report documents “[a] cultural issue repeatedly described to us and borne out by the evidence is a proliferation of committees and a lack of accountability.” These structural barriers were astonishing in the Cobalt history:

The Cobalt Ignition Switch issue passed through an astonishing number of committees. We repeatedly heard from witness that they flagged the issue, proposed a solution, and the solution died in a committee or with some other ad hoc group exploring the issue. But determining the identity of any actual decision-maker was impenetrable. No single person owned any decision. Indeed, it was often difficult to determine who sat on the committees or what they considered, as there are rarely minutes of meetings.

One witness described the GM phenomenon of avoiding responsibility as the “GM salute,” a crossing of the arms and pointing outwards toward others, indicating that the responsibility belongs to someone else, not me. It is this same cabining of responsibility, the sense that someone else is responsible, that permeated the Cobalt investigation for years.

Similarly, Mary Barra described a phenomenon known as the “GM nod.” The GM nod, Barra described, is when everyone nods in agreement to a proposed plan of action, but then leaves the room with no intention to follow through, and the nod is an empty gesture. It is an idiomatic recognition of a culture . . . that does not move issues forward quickly, as the story of the Cobalt demonstrates.

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208 Id. at 254 (internal citations omitted).
209 Id. at 255.
210 Id. (internal citations omitted); see also Jeff Bennett, GM Report to Cite Cultural Failings, WALL ST. J., June 5, 2014, at B1, B7; Gretchen Morgenson, A Vow to End Hollow Nods and Salutes, N.Y. TIMES, June 8, 2014, at BU1, BU7N.
D. Possible Motivations for the Cobalt Behaviors

Cultural reforms cannot be done in isolation. HR issues such as compensation, bonuses, incentives, and discipline are part and parcel of the culture and are a means of communication. No one may have ever said, *Keep costs down, Safety be damned*, but if employees witnessed managers and engineers being rewarded for doing so, their assumptions create a culture of complicity. For example, Wall Street Journal columnist Holman W. Jenkins, Jr. faults the Valukas Report, contending that Mr. Valukas “chooses to explain only the part of the Cobalt story that it suits GM, its regulators and its political overseers to explain.”²¹¹ Jenkins contends that cultural signal motivated the behavior:

Engineer Ray DeGiorgio, after struggling to design an ignition switch that met complicated requirements, ended up with a switch that performed the necessary functions but didn’t meet GM’s torque spec. He waived it through. Why? One plausible answer (Mr. Valukas offers none) is that he was under pressure to deliver the part as cheaply as possible since every additional dollar, even a dollar spent increasing customer satisfaction, would add to the losses GM had to bear on a car built to meet fuel-economy mandates.²¹²

The examination of other factors is also critical at all levels of the organization. Did executive compensation contribute to the diagnosis bias and issue framing that clouds risk judgment during decision processes? With executive compensation tied to reported profitability, the pressures may have influenced the decision not to take prompt action once the switch malfunction problem was known. What has become clear is that there was no rogue engineer acting alone on the switch. The problems could not have lingered for as long as they did and as extensively as they did without more than one person involved.

E. Fear and Silence: The Institutional Failure to Share Knowledge

One of the major lessons to be learned from the GM crisis is that the organizational dysfunction may have caused or may have been the result of organizational communication failures and insufficient knowledge at the levels of the organization where change could have been implemented. The Valukas Report observes, “Repeatedly, over a decade, GM personnel failed to search for, share or gather knowledge, and that failure had serious consequences. There are multiple components to these failures, involving individual mistakes, organizational dysfunction, and systems inaccessible to some and impenetrable to many.”²¹³ The report continues:

In 2004 and 2005, when complaints of moving stalls came in, the engineers

²¹² Id.
²¹³ VALUKAS REPORT, supra note 61, at 256.
who considered the issue did not know that the vehicle was designed so that the airbags would not deploy when the ignition switch was in Accessory. As a consequence, the engineers failed to recognize the stalls as a safety issue and resolve the problem quickly. Even the committees . . . that were designed to have cross-disciplinary members did not connect the dots.214

The discussion of the timeline earlier indicates that as various facts were uncovered in different areas that they were not shared. The change of the faulty part by Mr. DiGiorgio and his failure to disclose the change resulted in engineers investigating the matter being misled about the role of the Ignition Switch in the airbag non-deployments. The following additional events illustrate how much the right hand and the left hand were completely separate within the GM organization:

- In 2007, when Sprague was directed to start tracking airbag non-deployments, no one shared with him (and he did not find) all of GM’s prior work on the Cobalt moving stall issue . . . As a consequence, he did not have an opportunity to connect the non-deployments with the problem of low torque in the Ignition Switch.
- From 2007 on, GM employees failed to find publicly available materials. This included the Indiana University study, which a plaintiff’s expert reportedly found on the NHTSA website. It also included GM’s own TSBs [Technical Service Bulletins], which were available both internally and publicly.
- In 2011, Stouffer failed to check the TREAD [“Transportation Recall Enhancement, Accountability and Documentation” Act] database correctly, and thus did not obtain all of the information available on it. As a consequence, he missed the Ion and HHR fatalities, which were not discovered until February 2014 – after the first recall.
- From 2011 on, the fact that the Cobalt accidents led to fatalities was not shared with all relevant decision-makers. These individuals say that, as a consequence, they lacked a sense of urgency.215

It appears that even GM’s legal counsel, as in the Malibu case, often got in the way of resolving the Cobalt issue properly.216 Plaintiffs in an amended class action allege “it is ‘inconceivable’ that individuals in General Motors Co.’s general counsel’s office didn’t know about the now-infamous ignition switch defect
when the company filed for bankruptcy in 2009.”

Kira Lerner writes that the complaint alleges that the acting director of NHTSA has stated that “GM executives ‘all the way up’ the company’s reporting structure knew of the defect earlier than this year, despite testimony made by GM’s chief . . . and general counsel . . . that they only learned of the defect this year.”

As GM works to revise its culture, it must do so on a company-wide basis—no employee is immune. There are cultural issues in the way legal counsel handles litigation and any other matters for the company. The response of corporate counsel who has knowledge of a violation of law sends a message to the company’s employees. The employees’ perception would be that if the lawyer is comfortable with the violation, then what they are doing must be okay. The cultural change must encompass compliance with all legal and professional rules so that those who work with employees throughout the company (legal counsel, auditors) must also follow their own profession’s code of ethics as well as any statutory requirements.

F. The Information and Cultural Silo Problem

GM’s organizational information silo problem is certainly a major contributing factor to the ignition switch crisis. Gillian Tett observes that “[a]bove all else, silos can create tunnel vision, or mental blindness, which causes people to do stupid things.” In describing what may be termed the kindest possible explanation for GM’s ignition switch conduct, Tett contends that the defective switch information “sat in one tiny, bureaucratic silo. Worse still, the engineers who handled the switches had minimal contact with the legal team that was worrying about reputational risk. General Motors . . . was riddled with silos—. . . where staff had little internal incentive to collaborate in a proactive way.”

G. Criminal Probe Begins

Professor Rena Steinzor argues that auto producers like GM “have grown so complacent that they view billions of dollars in civil penalties and tort damages as unfortunate but routine costs of doing business . . . [T]he legal system fails to instill the wariness in top executives that is essential if senior and mid-level managers are to make consumer safety their top priority.” Federal and state prosecutors have started investigations into the faulty GM ignition switches.

217 Id.
218 Id.
219 See Tett, supra note 126 at 14.
220 Id. at 15.
News reports cite that “GM has turned over reams of documents to the government including thousands of emails between company officials relating to the ignition switch defect.” In separate probes, “a group of state attorneys general, including New York Attorney General Eric Schneiderman and Florida Attorney General Pam Bondi, is investigating the delayed GM recalls . . . .” Legal experts believe that Anton R. Valukas, himself a former federal prosecutor, has given prosecutors a substantial head start in their investigation, identifying key GM decision makers at critical points in the saga, providing thoroughly footnoted accounts by some of those decision makers, and laying out a general framework of what transpired inside the company since the faulty ignition switch first came to light.

**H. Focus on Legal Ethics**

While noting “[t]he actions of GM’s lawyers clearly raise significant legal ethics ramifications,” Professor Michele Benedeto Neitz says, “[t]he Michigan State Bar, legal ethicists, and in-house counsel should take note of potential violations” of ethics rules. Professor Neitz writes that these potential rules violations include:

1. **Perjury**

   . . . During his deposition testimony in the Melton case, GM engineer Raymond DeGiorgio testified that he had never approved any modifications to the design switch. Documents later revealed that Mr. DeGiorgio had in fact personally signed off on the changes to the switch in 2006. . . .

2. **Conflict of Interest**

   As the cover-up scandal reached a crescendo, GM hired Anton Valukas to co-direct an internal investigation with GM Michael Milliken. . . . the existing relationship between the [law] firms and GM raised questions about whether this internal investigation was credibly independent. . . . The report cleared the top officers, including the CEO and General Counsel, of any wrongdoing. Senator Richard Blumenthal called the report “the best money can buy,” noting that it “absolves upper management, denies deliberate wrongdoing, and dismisses corporate responsibility.” Whether an actual conflict exists, the appearance of a conflict is overwhelming and caused more bad press for General Motors.

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223 Id.
224 Id.
225 Id.
The parallels to the Enron case are obvious: Corporate officials are lying about the company’s actions. In-house attorneys are staying mute about corporate wrongdoing. A law firm with a potential conflict of interest is conducting an internal investigation. With these resemblances, General Motors’ shareholders should hope the end result is not an Enron-style collapse.227

I. Implied Motives: What About Compensation?

So, what possible motivation could there be for failing to promptly issue a recall for the approximately 2.6 million vehicles so far recalled for this ignition switch problem?228 Why does it appear that bad news does not quickly percolate to the top and become urgently reported? Could it be that a hit to reported corporate earnings threatens the compensation of key managerial decision makers? Norman Bishara and Cindy Schipani, building off the work of Dunfee and others about corruption, observe that “[a] corporate culture that facilitates an executive’s unethical impulse to put personal interests ahead of the interests of the firm may be as corrupt as one that promotes the payment of bribes to government officials.”229 Bishara and Schipani contend that “[i]n both instances, the offending parties are acting without integrity and attempting to secure private gain at the expense of the trust placed in them by their constituents.”230 James Brickley and Clifford W. Smith contend “[i]f the compensation plan sometimes rewards unethical behavior then unethical behavior is what the company will get. . . . Corporations develop ethics programs in an effort to persuade employees to put

227 Id.; See also Keith Leavitt & David M. Sluss, Lying for Who We Are: An Identity-Based Model of Workplace Dishonesty, 40 ACAD. MGMT. REV. 587 (2015) (observing that “[s]ome have argued that organizational members rely on accurate and timely information not only to make effective decisions but to effectively coordinate and implement those decisions such that when information is incorrect, inaccurate, or timed inappropriately because of lying, the organization and its members will suffer.”); see generally SISSELLA BOK, LYING: MORAL CHOICE IN PUBLIC AND PRIVATE LIFE (2d ed. 1999); STUART P. GREENE, LYING, CHEATING, AND STEALING: A MORAL THEORY OF WHITE COLLAR CRIME (2006); Blake E. Ashforth & Vikas Anand, The Normalization of Corruption in Organizations, 25 RESEARCH ORG. BEHAV. 1 (2003); Scott J. Reynolds, The Non-Conscious Aspects of Ethical Behavior: Not Everything in the “Good” Organization is Deliberate and Intentional, 51 AM. CRIM. L. REV. 245 (2014); Ann E. Tenbrunsel, Misrepresentation and Expectations of Misrepresentation in an Ethical Dilemma: The Role of Incentives and Temptation, 41 ACAD. MGMT. J. 330 (1998); Linda K. Treviño et. al, (Un)ethical Behavior in Organizations, 65 ANN. REV. PSYCHOL. 635 (2014); Linda K. Treviño et. al, Behavioral Ethics in Organizations: A Review, 32 J. MGMT. 951 (2006).

228 See Mike Spector & Christopher M. Matthews, GM Admits to Criminal Wrongdoing, WALL ST. J., Sept. 18, 2015, at B1.

229 See Bishara & Schipani, supra note 199, at 4.

230 Id.
the interests of the organization or its customers ahead of their own.”

On July 1, 2015 the Securities and Exchange Commission proposed rules requiring companies listed on national securities exchanges, “to develop and enforce recovery policies that in the event of an accounting restatement, ‘claw back’ from current and former executive officers incentive-based compensation they would not have received based on the restatement. Recovery would be required without regard for fault.” The proposed rules, among other requirements, will “apply to incentive-based compensation that is tied to accounting-related metrics, stock price or total shareholder return. Recovery would apply to excess incentive-based compensation received by executive officers in the three fiscal years preceding the date a listed company is required to prepare an accounting restatement.” Such rules can be adapted and expanded to apply to production and manufacturing companies in a way that allows clawbacks in the events of safety recalls of cars from which sales and earnings were obtained.

J. Failure of Information Flow to the GM Board

The Valukas report indicated that the GM board did not receive information regarding the faulty ignition switch. As a result, the Board hired the New York law firm of Wachtell, Lipton, Rosen & Katz to conduct an independent investigation of facts surrounding the failure of corporate governance. Before Wachtel Lipton’s report became available, the Valukas Report had the following observations regarding the GM board’s serving during the relevant periods.

The Audit Committee, in addition to its core function overseeing GM’s financial reporting process and systems of disclosure and internal controls, was also responsible for oversight of GM’s external and internal auditors, and its risk management process.

...[T]he Audit Committee oversaw GM’s risk management process, including reviewing the ‘risk factors’ described in GM’s public disclosures, and meeting regularly with the Chief Risk Officer in the years his work was overseen by the Committee.

Before 2014, none of the written reports to the Board included any information concerning the Ignition Switch.

A director’s duty of care encompasses the responsibility to inquire and to be


233 Id.

234 VALUKAS REPORT, supra note 61, at 244.


236 See VALUKAS REPORT, supra note 61, at 242-44.
informed. Willful or contrived ignorance is no defense. Observing that “[t]he most obvious motivation for unethical decision making in the executive suite, is simply, greed[,]” Bishara and Schipani suggest that, “it may be useful for firms to envision the board and particularly the board’s ethics committee, as an active gatekeeper, rather than as a passive panel which only addresses issues brought to its attention.”

Moreover, examples of traditional gatekeepers include lawyers and accountants who are needed to certify accounts and who would not permit falsification by a corrupt executive. . . .

[A] corporation’s ethics committee could be tasked with a new level of proactive oversight by initiating inquiries into the executive compensation structure as a check on the activities of the firm’s compensation committee. In this way the ethics committee could also employ outside expertise to remain informed of potential ways in which executive corruption is arising at other firms . . .

The goal is to have an ethics committee that is designed to anticipate ethical pitfalls and loopholes that are ripe for exploitation by corrupt executives . . .

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240 Bishara & Schipani, supra note 199, at 22.
VII. CRIMINAL CHARGES AND THE SETTLEMENT

On September 17, 2015 the Department of Justice announced charges against GM of “concealing a potentially deadly safety defect from its U.S. regulator, NHTSA, from the spring of 2012 through February 2014, and, in the process, misleading consumers concerning the safety of certain of GM’s cars.”

The DOJ announcement states:

Rather than move swiftly and efficiently toward recall of at least the population of cars known to be affected by the safety defect . . . GM personnel took affirmative steps to keep the company’s internal investigation into airbag non-deployment caused by the defective switch . . . outside of GM’s regular recall process.

U.S. Department of Transportation Secretary Anthony Foxx observed that GM “not only failed to disclose this deadly defect, but as the Department of Justice investigation shows, it actively concealed the truth from NHTSA and the public.”

According to U.S. Attorney Preet Bharara of the Southern District of New York, “[b]y doing so, GM put its customers and the driving public at serious risk. Justice requires the filing of criminal charges, detailed admissions, a significant penalty, and the appointment of a federal monitor. These measures are designed to make sure that this never happens again.”

Goldsmith Romero, Special Inspector General, observes, “[t]he worst part about this tragedy is that it was entirely avoidable. GM could have significantly reduced the risk of this deadly defect by improving the key design for less than one dollar per vehicle but GM chose not to because of the cost.”

Historically, this type of cost-based decision was a part of GM’s culture. For example, with the Corvair, one of the fixes that was added too late were instructions inserted in the owner’s manual on the importance of proper rear-end tire inflation as well as guidance on steering in the event the rear wheels of the Corvair happened to turn under due to under-inflation of those tires.

U.S. Attorney Preet Bharara announced that GM had entered into a deferred prosecution agreement “under which the company admits that it failed to disclose a safety defect to NHTSA and misled U.S. con-

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242 Id.

243 Id.

244 Id.

245 Id.

246 NADER, supra note 16, at 23.
sumers . . . . The admissions are contained in a detailed statement of facts attached to the agreement.”247 The terms of the agreement require GM to “cooperate with the federal government and establish an independent monitor to review and assess the company’s policies and procedures in certain discrete areas relating to safety issues and recalls.”248 GM’s announcement also states:

[T]he government’s decision to defer prosecution was based on the actions GM has taken to “demonstrate acceptance and acknowledgement of responsibility for its conduct,” including:

- Conducting a swift and robust internal investigation
- Furnishing investigators with information and a continuous flow of unvarnished facts
- Providing timely and meaningful cooperation more generally in the government’s investigation
- Terminating wrongdoers
- Establishing a full and independent victim compensation program that is expected to pay out more than $600 million in awards249

On the same date, GM announced resolution of certain civil actions brought against the company: a shareholder class action (Eastern District of Michigan); and the reaching of a memorandum of understanding “potentially covering approximately 1,380 individual death and personal injury claimants.”250 Because of these settlements, GM “will record a charge of $575 million in the third quarter [2015].”251

Following announcement of GM’s deferred prosecution agreement, law Professor David Uhlmann observes, “[a]ll charges against GM will be dropped if it complies with the deferred prosecution agreement, and no company officials have been charged with crimes based on GM’s deadly concealment scheme. . . . underscore[ing] how badly the federal government has lost its way in the prosecution of corporate crime.”252 Professor Uhlmann writes “G.M. will not be required to plead guilty to any criminal charges for misleading safety regulators and the American public. . . . But lower fines and perhaps reduced charges are the right way to credit cooperation, not the dismissal of all.

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247 See DOJ Press release, supra note 241.
249 Id.
251 Id.
charges when corporate deception claimed so many lives.\textsuperscript{253}

Uhlmann contends:

The best way to combat corporate crime is to bring criminal charges against corporations and culpable individuals within those companies – and to insist that defendants plead guilty or go to trial. Charging and convicting corporations addresses the flawed corporate cultures and misplaced priorities that encourage criminal behavior; holding individuals accountable is the best way to deter future wrongdoing and promote law-abiding behavior.

Instead, in case after case over the last decade, the Justice Department has treated the worst corporate criminals like first-time drug offenders, agreeing to dismiss or not bring charges if the companies clean up their acts. G.M. is just the latest example. The department also agreed to a deferred prosecution for similar misconduct by Toyota, in the huge money-laundering case involving HSBC, and with JPMorgan Chase after the Bernard Madoff scandal. In an overwhelming majority of these cases, no corporate officials were charged.

A glaring oversight in the Justice Department’s new policies on corporate crime is the lack of any limits on the use of deferred prosecution and nonprosecution agreements. It is long past time for the department to amend its policies to make clear that criminal convictions must be sought in egregious instances of corporate crime like the G.M. case. If the department is serious about corporate crime, it needs to stop sending the mixed message that corporations can avoid criminal liability by admitting they were wrong and promising not to do it again. . . .

\textit{[W]e need to do a better job of holding [corporations] responsible for their crimes.}\textsuperscript{254}

\section*{VIII. Lessons Learned}

Both those with practical experience (including CEOs and consultants) and academics agree on this proposition: Negative information struggles to find its way to the top of a large organization.\textsuperscript{255} It is a tall order to ask employees to raise issues that will cause a halt in production for products or will result in a recall. Some simple questions leaders could ask to determine whether they are getting accurate information: When was the last time someone told you, \textit{No, that can’t be done}? When was the last time someone told you that a project or product

\textsuperscript{253} Id.


was not going well? When was the last time you learned about a mistake someone in the organization made? Bad news coming to senior leaders early means that there is a better chance issues can be fixed before you reach a GM-level public relations nightmare.

Professors James and Wooten report on the findings of Max Bazerman and Michael D. Watkins, who contend that organizations fail to learn in four basic ways:

- **Scanning failures**: as a result of arrogance, a lack of resources, or simple inattention, leadership fails to pay attention to internal or external warning signs that a potential problem is imminent.
- **Integration failures**: failure to understand how seemingly disparate pieces of information (e.g. data, evidence) fit together to provide lessons for crisis avoidance.
- **Incentive failures**: failure to provide adequate rewards or reinforcement for people who bring potential problems to the attention of others. Likewise, punishing people for surfacing such information is also a form of incentive failure.
- **Learning failures**: failure to draw the appropriate lessons from prior crises and to preserve those lessons in the organization’s memory.

Mary Barra is not the only CEO to be “shocked, shocked” that bad things are going on in a company. When news of Duke Energy’s ash spill into a North Carolina river got to CEO Lynn Good, she explained, “[t]his is not who we are.”

Well, yes, for now, this is who Duke is, and the job of the CEO becomes one of finding out not just how it happened, but why. The questions most CEOs try to answer in situations in which they are blind-sided by actions of employees are, *Who did this?* and *Who needs to go?* Future problems cannot be prevented unless and until this question is answered, *Why would employees think this behavior is acceptable in this company?* Often, terminating those whose hands are on the debacle makes matters worse. Employees understand why those terminated did what they did, and the culture is not changed. Only those who left their fingerprints on the events are gone. Those who sent the unwitting signals are assigning blame without wondering, *Is there something I did or said, directly or indirectly, that contributed to these events?*

Every leader wants to believe that their organizations are ethical. They spend the money needed for compliance, audits, and codes of ethics. However, those are the dashboard kinds of measures and actions that may not be able to coun-

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256 ERIKA HAYES JAMES & LYNN PERRY WOOTEN, ORIENTATIONS OF POSITIVE LEADERSHIP IN TIMES OF CRISIS, HANDBOOK ON POSITIVE ORGANIZATIONAL SCHOLARSHIP 9 (Kim Cameron, Gretchen Spreitzer, eds., 2010).

term and the signals that are given to employees about acceptable behavior, results, and getting rewarded for keeping things quiet as much as you can for as long as you can. These behaviors lead us to the second issue.

A. Information Leaders Need to Know About Their Culture Is Not Getting to Them

The lack of communication from the bottom up may be the result of the communication flowing down from the top. Communications and miscommunications issues run both ways. Those at the top of the organization often fail to recognize the messages they send by indirect communication. Indirect communication can result from emphasis. If your focus, discussions, and interactions with employees emphasize schedules, results, and performance, then you will find employees focused on those issues and not on the code of ethics or even the wisdom of their cost-saving decisions. Employees aim to please their leadership.

Lack of communication from the bottom up may also be the result of indirect communication. Indirect communication is information leaders cannot control, in terms of its disbursement through the organization or its perception by employees. These are the stories about the senior management, which can include everything from how a CEO took an employee to task in public for a mistake to discussions about executives’ affairs. These stories, however exaggerated or, in some cases false, formulate employee perceptions of CEOs and other senior leaders. If employees hear the urban legends about CEOs aggressive behavior with managers not meeting goals or making mistakes, then the lines of communication will be shut down.

There are also the unknowns – the communication that gets out there without awareness on the part of the CEO and senior management. Employees take signals from every word, sign, or deed. For example, John Rowe, the former CEO of Exelon, said that in his first CEO job, a young woman who worked for him told him, “Do you know that the gossip in the office is that the way for a woman to get ahead is to wear frilly spring dresses?” When he asked where that information had come from she explained, “Well, you said, ‘pretty dress’ to four women who happened to be dressed that way. And so now it’s considered policy.” Mr. Rowe explained, “Well, it’s the furthest thing in the world from policy. I was just trying to be pleasant in the elevator.” Correcting those indirect disbursements of company folklore requires something more than quarterly meetings and e-mails.

258 See Marianne M. Jennings, This Is Not Our Culture: OH, But It Is, and Has Been For Some Time, 19 CORP. FIN. REV. 37 (2014).
260 Id.
261 Id.
Sometimes employees receive indirect communication by choices their leaders make about which supervisors and employees stay in place. A failure to root out the employees who make decisions to say nothing is a powerful signal to their direct reports and many others down the chain to also say nothing. For example, when Barclays acquired Lehman Brothers, it also acquired a tough-as-nails culture, the culture that took risk to new levels in the lead-up to Lehman’s bankruptcy and subsequent acquisition by Barclays. Barclays’ CEO understood that by allowing the Lehman troops to remain that he was sending a signal, however unwitting, that their approach to banking was acceptable at Barclays.

So, the CEO recently showed many Lehman leaders the door in order to establish a culture that he wanted of less risk and less debt.

If leaders communicate, however unwittingly or indirectly, that they want good news, they will get good news. Good news is not omnipresent in most organizations. Bad news comes from competition, mistakes, and other human events that abound when humans are at work. If leaders have not heard bad news in a while, they have their signal that something is amiss. For example, at General Motors, the fact that the company went for over a decade with a slew of new models being introduced without recalls and issues should have been a dire warning. Senior GM leaders should have known that the flow of information was not getting to them.

B. Fixing the Culture: Understanding CEO Perception, and Information Needs

If employees are unwilling to communicate bad news, then leaders need to make a point of requesting bad news. Here are a list of questions that could be asked in meetings in order to encourage front-line managers and employees to raise those points of contention, bad news, or just concern.

1. Is there anything about this project/product/assignment that I have not heard?
2. Is there anything we have not covered about this project/product assignment that I need to know?
3. Is there anything about this project/product/assignment that keeps you up at night?
4. Is there any bad news about this project/product/assignment that I don’t know about?
5. If you could change one thing about this project/product/assignment what would it be?

And if stories communicate the attitudes and receptiveness of senior leaders, then the CEO and senior managers need to let the stories fly. Alan Mulally, the

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263 Id.
264 Id.
recently retired CEO of Ford Motor Company, turned around a culture (and, as a result, a company) in which no one ever passed along negative information about their projects.\footnote{Chris Woodyard & James R. Healy, \textit{Mulally Flew in from Boeing and Ford Took Off}, \textit{USA TODAY} (Apr. 21, 2014, 8:32 PM) http://www.usatoday.com/story/money/cars/2014/04/21/ford-alan-mulally/4008171/ [https://perma.cc/5779-BPPS].} He did so by asking his direct reports to always talk about their problems in meetings.\footnote{Id.} He then took a team approach to helping them solve those problems.\footnote{Id.} He also sent a powerful message through the culture by rewarding those who brought problems forward to him and punishing those who hid their problems.\footnote{Id.} The first time one of Mr. Mulally’s senior leaders brought negative information to a meeting, the room became silent until Mr. Mulally broke that silence by clapping, signaling such news, even though it wasn’t “warm and fuzzy”, was welcome.\footnote{Id.} Also, the first man who broke the silence was promoted shortly thereafter.\footnote{Auriemma, supra note 255, at B1.} That man, Mark Fields, recently assumed the CEO position at Ford, following Mr. Mulally’s retirement.\footnote{Id.}

The goal needs to be changed from \textit{all is well} in reporting to \textit{we don’t want any minefields and no one should be blind-sided}. Some industries, such as the nuclear industry hold challenge meetings, where anyone involved in a project has the right to disagree with the project, plan, process, or progress and have that concern be heard by senior leaders and other involved. The formal process for airing concerns takes the painful sting out of being the first whale to the surface that gets harpooned. All the whales are protected, especially when they come to the surface first.

A final fix is for senior leaders to be out and about in organizations. Following a crisis, CEOs tend to travel around and interact with employees informally in order to be sure that they have received the message about the changed culture. Again, research shows that leaders who are out, about, and accessible to employees because they are interacting with the front line are less likely to be blind-sided.\footnote{Detert & Treviño, supra note 255, Table 4 at 260.} The things employees might not speak up about may become obvious as leaders travel the company, visit production lines, and interact with designers and engineers because they are witnessing the front line at work. Regular interaction with the front-line employees will give leaders the real story they may not be getting from their direct reports and other managers and leaders. Professors James and Wooten contend that “leaders who have a mindset for 1) learning and adapting to rapidly changing circumstances; 2) seeing possibilities amid the tragic circumstances of a crisis; and 3) expecting trust and trustworthiness will
be more inclined to identify positive outcomes in crisis situations."^{273}

IX. CONCLUSION AND ADVICE

Jamie Dimon, the head of Chase, famously discussed how often he spoke to employees and leaders in his bank and emphasized doing the right thing and the importance of the bank’s reputation.^{274} "I sat in those meetings myself and said: Believe that the Pope is over here and the chairman of the securities commission is over here, what is the right thing to do? And that’s what we are going to do.’ And no, ‘There was no hiding, there was no lying, there’s no bull—ing period, okay?’^{275}

Still, Chase’s London Whale problem arose, along with $6 billion in losses and more in fines for all the subsequent problems uncovered and investigations that resulted.^{276} Mr. Dimon seems puzzled, This is not the Chase I told them to be. But there was a real Chase and his assumed Chase. The real Chase got him into what he has described as the worst year of his professional life as he worked to navigate the regulatory maze that Chase found itself in, all from one whale.^{277} Mr. Dimon will continue to be perplexed because he has not yet asked the question that all CEOs who believe that what happened is not their culture must ask and answer, Why would they think this kind of behavior is acceptable in this organization?

The introspection of unwitting communication, through stories, statements, emphasis, incentives, rewards, promotions, and a host of other factors are necessary in order to solve the culture problem. Just one last warning and lesson. Mr. Dimon acknowledged that there was an e-mail from a trader who indicated that there may be a problem with the London trading desk.^{278} That e-mail was not taken seriously because, as Mr. Dimon noted, “it was a $300 million problem, okay, not a $6 billion problem.”^{279} But, it was a problem, and large enough for a trader to muster the courage to offer the tiniest bit of bad news. There was an opportunity to seize the moment. When the culture speaks, listen and act. And ask, "Why would they think a $300 million problem in trading is okay?" The amount is not the issue initially. At first, GM had thirteen fatalities, a number

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^{273} JAMES & WOOTEN, supra note 256, at 2.
^{275} Matthias Rieker, What Not To Ask Jamie Dimon, WALL ST. J. (June 11, 2013, 4:00 PM) http://blogs.wsj.com/moneybeat/2013/06/11/what-not-to-ask-jamie-dimon/ [https://perma.cc/7XQY-7RRX].
^{277} Id.
^{278} Id.
^{279} Id.
that has now grown to at least 124.\textsuperscript{280} But, behind those thirteen fatalities were ten years of employees and managers suppressing of bad news. Finding what’s hidden means understanding the patterns of history and thereby learning and understanding what an organization’s culture really looks like.

\textsuperscript{280} Spector & Matthews, supra note 228, at B1.