The General Motors Cobalt ignition failure case study – lessons learned

Stuart Weinstein
Coventry University
Charles Wild
University of Hertfordshire

1. Introduction

In 2014 General Motors (GM) recalled more than 2.6 million vehicles as a result of the ignition switch failure in which up to 90 people died in crashes linked to the faulty switch, with 163 sustaining injuries. The crisis shook the very foundations of GM causing major reforms into how safety issues are dealt with by automobile manufacturers as a whole. While the crisis had the potential to deal a 'fatal blow' to GM, under the right leader, CEO Mary Barra, GM has managed to turn the situation around and improve the organisation, its structures and most of all restore its credibility with the regulators and customers. Now the only question that remains is determining the full quantum of damages that GM has to pay as a decision in July 2016 by the United States Court of Appeals for the 2nd Circuit has raised the final bill that GM will face for the ignition failure.

2. Facts determined by an Independent Counsel and presented to the board of GM[1]

In autumn 2002, GM personnel made a decision with catastrophic consequences. A GM engineer chose to use an ignition switch in certain cars that was so below GM's own specifications that it failed to keep the car powered on in circumstances that drivers could encounter which resulted in moving stalls on highways as well as a loss of power on rough terrain a driver might encounter moments before a crash. Problems with the switch's ability to keep the car powered on were known within GM's engineering staff at the earliest stages of its production, although the circumstances in which the problems would occur were thought to be rare. From the switch's inception to about 2006, various engineering groups and committees considered ways to fix the problem. However, those individuals tasked with fixing the problem – sophisticated engineers with the responsibility of providing consumers with safe and reliable automobiles – did not understand one of the most fundamental consequences of the switch failing and the car stalling: the airbags

1 The facts as set forth here are excerpted from The Valukas Report: Anton R Valukas, Jenner & Block Lawyers, *Report to Board of Directors of General Motors Company Regarding Ignition Switch Recalls*, 29 May 2014, pp1–5, available at: www.beasleyallen.com/webfiles/valukas-report-on-gm-redacted.pdf (accessed 29 August 2016).

would not deploy. GM has identified at least 54 frontal-impact crashes involving the death of more than a dozen individuals in which the airbags did not deploy as a result of the faulty ignition switch.

The below-specification switch made its way into various GM vehicles including the Chevrolet Cobalt. Yet GM did not issue a recall for the Chevrolet Cobalt and other cars until 2014, and even then the initial recall was incomplete. GM personnel's inability to address the ignition switch problem for over 11 years reads as a history of failures. Although everyone had responsibility for fixing the problem, nobody took that responsibility.

A critical factor in GM personnel's initial delay in fixing the switch was their failure to understand, quite simply, how the car was built. GM has specifically designed the airbag system not to deploy, in most circumstances, in the event that the ignition switch was turned to OFF or ACCESSORY to prevent passengers from being injured by airbags being activated while parked. In 2004, however, GM engineers viewed the switch problem as a 'Customer convenience' issue – something annoying but not particularly problematic – as opposed to the safety defect that it was. Once so defined, the switch problem received less attention and efforts to fix it were impacted by cost considerations that would have been immaterial had the problem been properly categorised in the first instance.

From 2004–2006, not one of the various GM committees considering a fix for the switch ever reclassified the problem from one of customer convenience to one of safety or demonstrated any sense of urgency in their efforts to fix the switch. GM's Products Investigations Group, charged with identifying and remedying safety issues, made the same mistake, opening and closing an investigation in 2005 that lasted in total only one month in length – finding no issue to be remedied.

Interestingly, as the early committees failed to remedy the problem, accidents and fatalities in which the airbags did not deploy began coming to the attention of GM's personnel, including its in-house legal team and the engineers who worked with the in-house lawyers. Although those outside GM including research teams from Indiana University and a trooper from the Wisconsin Safety Patrol figured out the connection between the switch and airbag non-deployment, GM personnel did not make this connection.

From 2007 on, as years passed and fatalities mounted, engineers investigating the non-deployments and attempting to understand their cause were neither diligent nor incisive. The investigators failed to search for or obtain critical documents within GM's own files or publicly-available documents that would have made the connection between the switch and airbag non-deployment clear. Time and time again, investigators overlooked the obvious and simple explanation – that the switch that caused the cars to stall was turning the power off and disabling the airbags just as the cars were about to crash – in favour of more complex and exotic theories. Along the way, the investigators were misled by the GM engineer who approved the below-specification switch in the first place; he had actually changed the ignition switch to solve the problem in later model years of the Cobalt, but failed to document it, told no one, and claimed to remember nothing about the change. While stumped by the inability to determine why different year models of the Cobalt

performed differently, investigating engineers failed to take certain basic steps such as taking apart both functioning and non-functioning switches to compare the two. In 2013, an expert working for a plaintiff's attorney took apart two switches and quickly found the cause it took GM years to identify.

Throughout the entire 11-year journey, there was no demonstrated sense of urgency, right to the very end. The officials overseeing potential solutions did not set and adhere to prompt deadlines. Information left out of presentations such as the number of fatalities involved in respect of the Cobalts left the GM recall committee without adequate information to gauge the 'life and death' nature of the problems before it. All the while, while the issue of the ignition switch failure passed through numerous committees and made its way to the desks of different GM engineers and lawyers, it never percolated through to the 'C-level' suite – the highest levels of management at the company – who were best placed to take a broad view of the situation, demand solutions and see that they were implemented company wide.

3. Key conclusions to be drawn from the Valukas Report identified by GM

- GM personnel's inability to address the ignition switch problem, which persisted for more than 11 years, represents a history of failures.
- While everybody who was engaged on the ignition switch issue had the responsibility to fix it, nobody took responsibility.
- Throughout the entire 11-year history, there was no demonstrated sense of urgency, right to the very end.
- The ignition switch issue was touched on by numerous parties at GM – engineers, investigators, lawyers – but nobody raised the problem to the highest levels of the company.
- Overall, the report concludes that from start to finish the Cobalt saga was riddled with failures, which led to tragic results for many.

4. GM's response to the report by CEO Mary Barra[2]

Lesson 1: When faced with a significant legal risk problem of catastrophic proportions get the facts out honestly and without favour and share them with the regulator.

The Valukas Report when presented to the Board was also shared with the US automotive regulator the National Highway Safety Transportation Administration (NHTSA) who posted it on their website for the public to access. The Valukas Report team had complete independence in their activities and the investigation covered more than 350 interviews with over 230 individuals and more than 41 million documents. Mr Valukas and his investigators were provided with unlimited access to interview any GM employee and every request for an interview of a GM employee was granted. A number of former GM employees and third parties were also

2 GM Corporate Newsroom, GM CEO Mary Barra's Remarks to Employees on Valukas Report Findings, 5 June 2014, available at: http://media.gm.com/media/us/en/gm/news.detail.html/content/Pages/news/us/en/2014/Jun/060514-mary-remarks.html (accessed 29 August 2016).

interviewed as part of the investigation. Ms Barra said of the report that it is as the CEO states: "I can tell you the report is extremely thorough, brutally tough and deeply troubling."

Lesson 2: 'Own the problem', accept responsibility and do not hide behind the lawyers.

Mary Barra was keen to 'own the problem' and not evade the responsibility or hide behind lawyers: "First, we [must] do the right thing for those who were harmed; and, second, that we accept responsibility for our mistakes and commit to doing everything within our power to prevent this problem from ever happening again." She is to be praised for not minimising the problem: "I want it known that this recall issue isn't merely an engineering or manufacturing or legal problem, it represents a fundamental failure to meet the basic needs of these customers."

Lesson 3: Learn from your mistakes.

The 'top down' message from Mary Barra was clear that GM has to use the findings and recommendations from the Valukas Report as a template for strengthening GM.

At the heart of the problem was that "individuals failed to disclose critical pieces of information that could have fundamentally changed the lives of those impacted by a faulty ignition switch".

Mary Barra also noted that numerous individuals at GM did not accept any responsibility to drive GM to understand what was truly happening – it was clear that GM operated in silos, with a number of individuals seemingly looking for reasons not to act, instead of finding solutions.

While there was no evidence of a corporate conspiracy to cover up facts and investigators found no evidence that any employee made a trade-off between safety and cost, the investigation revealed that there was a pattern of management deficiencies and misjudgments – often based on incomplete data – that were passed off at the time as 'business as usual'.

Lesson 4: 'Own the solution' by taking broad remedial actions to address the problems

GM moved quickly to appoint a 'Safety Tsar' with responsibility for elevating and integrating safety processes under a single leader with a specialist 'flying squad' of safety investigators who will enable GM to troubleshoot issues quickly. Additionally, they introduced a Speak Up for Safety program encouraging employees to report potential safety issues quickly and created a new Global Product Integrity organisation that will enhance their overall safety and quality performance. Most of all, GM restructured its safety decision-making process to raise it to the highest levels of the company so that senior management is now going to be at the centre of these issues. The Valukas Report makes a series of recommendations in eight major areas GM has implemented.

Lesson 5: Take action against those employees who acted inappropriately

Fifteen individuals, determined to have acted inappropriately, were separated from

the company due to misconduct or incompetence or failure to take responsibility or act with any sense of urgency.

Lesson 6: Compensate the victims in an expedited manner
GM hired the September 11 mediator, Ken Feinberg, to develop and implement a compensation programme for those who have lost family members or who have suffered serious physical injuries as a result of an ignition switch failure.

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