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What Lessons Can We Learn From This Fiasco?

FROM THE PRESIDENT

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On Independence Day in 2004, 37-year-old Shara Lynn Towne was driving alone in her new 2004 Saturn Ion in Visalia, California. Described by one of her five children as the "light switch in any room," Towne was headed to Fresno when her car left the roadway, jumped a curb, and struck a utility pole, killing her instantly. The police investigating the collision could not determine conclusively the cause of the accident, as there were no eyewitnesses and the autopsy showed no evidence of drugs or alcohol usage. The police observed that her air bag failed to deploy, however. Years later, it would be determined that Towne was the first fatality involving a defective ignition switch causing certain General Motors vehicles to stall while in operation, disabling the air bag systems designed to protect front seat passengers.

In February 2014, GM issued its first recall of vehicles equipped with the defective ignition switch, eleven years after it first learned of problems with the switch. The following month, it ordered an internal investigation, led by former U.S. Attorney Anton R. Valukas, to "determine how and why it took so long for GM to recall" vehicles with the defective switch. On May 29, 2014, Valukas issued a 276-page report of the investigation.

The early delays were attributed to ineptitude. When GM engineers began to receive reports about cars stalling because of the movement of the key switch from the Run position into the Accessory position, they were not overly concerned because the cars could still be steered. They classified the issue as one of "customer convenience" rather than safety, as if stalling at highway speeds was a mere inconvenience. In doing so, they failed to consider that losing power meant the driver and front seat passenger also lost air bag protection. As years went by, though, "accidents and fatalities in which airbags did not deploy began coming to GM personnel's attention, including GM's in-house counsel and the engineers who worked with them."

In 2007, a Wisconsin State Police investigator issued a written report on an accident involving a 2005 Chevrolet Cobalt that veered off the road and hit trees, killing 15-year-old Amy Rademaker and 18-year-old Natasha Weigel. The investigator noted that the airbags had failed to deploy, that the ignition switch was in the Accessory position at impact, that federal regulators had publicly-available reports of similar incidents, and that in 2006 GM issued a technical service bulletin to dealers discussing the movement of the ignition switch position from Run to Accessory "due to low key cylinder torque/effect." He concluded correctly that the airbag non-deployment was related to the ignition switch position, a conclusion reached the same year by Indiana University researchers independently researching the same accident. That year, the GM Legal Department received a copy of the Wisconsin State Police report, yet no one at GM would recall reviewing it until 2014.

Also in 2007, the GM engineer responsible for the ignition switch, Raymond DeGiorgio, directed changes to the switch involving an improved plunger. Although DeGiorgio solved the problem for cars built in model year 2008 and thereafter, he told no one at GM of the change, did not document it with a new part number in contravention of GM policy, and thereafter claimed to remember nothing about the change. In 2010, as the accidents, injuries, and lawsuits mounted while GM continued to investigate the problem, an investigation determined to be neither diligent nor incisive, GM received the first of several warnings from outside counsel that it was risking punitive damage awards for repeated instances of airbag non-deployment.

In April 2013, during a deposition of DeGiorgio in an action against GM, DeGiorgio was confronted with what GM's outside counsel described as "bombshell evidence" developed by a plaintiff's expert who took apart both an early switch and a later switch, discovered the improved plunger, "and quickly found the cause it took GM years to determine." Ten months later, after a series of internal meetings, GM finally concluded a recall was necessary.

To date, 30 fatalities and hundreds of injuries have been attributed to the ignition switch defect. Upon the issuance of the Valukas report, 15 GM employees were fired, including three senior in-house attorneys. The Valukas report shows that GM's in-house attorneys were at the center of the ineptitude, settling cases confidentially while failing to raise the continuing air bag non-deployment problem to the General Counsel, resulting in substantial harm to GM and to the public.

What lessons can we learn from this fiasco? Some suggest we ban confidentially provisions in settlement agreements involving unsafe products, which seems sensible even though it might discourage some settlements. Yet, it is not clear from the Valukas report that such a ban would have led to an earlier recall. Rather, we need to consider whether something broader is required where lawyers have unique knowledge of threats to public safety, as no one reading the Valukas report can take comfort in the actions of the GM lawyers. While a client may rightfully demand vigorous representation, it cannot correspondingly expect complicity in malfeasance. Hopefully, the GM ignition switch debacle will spark a discussion on the proper role and duties of lawyers where inaction presents a continuing threat to public safety.