ETHOS & Ethical Decision Making

The Cost of Silence

From Compliance to Culture

The Question Karyn's Session Left Open

Karyn gave you the rules of the road:
— what GD-OTS expects, how to report, your responsibility as a leader

But here is the question we are going to spend the next day and a half on:

What creates a culture where the rules rarely have to be invoked…
because people are already doing the right thing?

What a Well-Designed Ethics Framework Does

Psychological Safety
People know what is acceptable to raise — and that raising it is protected

Decision-Making Clarity
When pressure is high and the right answer is not obvious, values provide a framework

Trust
With customers, regulators, and your own teams **is** built through consistent behavior

Compliance tells you what you cannot do.

Values tell you who you are... And what you should do.

GD-OTS Mission–Vision – Values

Mission Arming the warfighter with a decisive advantage

Vision To enable security as the world's safest and most trusted solutions provider

Values Safety · Accountability · Excellence **-** ***WE ARE OTS***

THAT — A Leadership Lens, Not a Poster

Four values. One framework. One standard question

Am I living this in the ordinary moments?

T — Transparency
H — Honesty
A — Alignment
T — Trust

Trust is the output… The first three are the practice.

Transparency
What It Looks Like at GD-OTS

Definition

Operate with openness — share information, intentions, and challenges without concealment

Lived out

Surface problems before they become crises. Report accurately even when the news is bad.

What it sounds like

“Here is what I know, here is what I don’t know yet, and here is what I am doing about it.”

Its absence

The team finds out bad news from someone other than their manager

Honesty
What It Looks Like at GD-OTS

Definition

Tell the truth even when it is hard — accuracy in reporting, candor in feedback, courage to raise concerns

Lived out

Don't let schedule or budget pressure distort what you report up the chain

What it sounds like

"I am going to give you some feedback that may be hard to hear, because I think it will help you."

Its absence

Performance problems everyone knows about that no one has addressed

Alignment
What It Looks Like at GD-OTS

Definition

Connect individual actions to mission and strategy — daily decisions reinforce GD-OTS direction

Lived out

Safety commitments do not yield to schedule pressure. Mission drives decisions, not quarter-end metrics.

What it sounds like

“The reason we are prioritizing this is because of our mission to the warfighter.”

Its absence

Teams optimizing for their own metrics at the expense of the broader mission

Trust
What It Looks Like at GD-OTS

Definition

Earn and extend confidence through consistent behavior — Trust is the output of T, H, and A practiced over time

Lived out

Engineers know their concerns will be heard. Direct reports know their manager will back them up.

What it sounds like

“I am going to give you this responsibility because I believe you can handle it.”

Its absence

Micromanagement that signals the leader does not believe in their team

THAT and STAR® Manager

Accountability
Honesty and Transparency create the conditions for real accountability

Feedback
Honesty is the foundation of effective feedback — candid, specific, growth-oriented

High-performance environments
Trust and Transparency are the cultural conditions that make this possible

You have been building this…
THAT names what you are building

The Values Paradox
Poster vs. Actions

Boeing's Poster values

Safety · Quality · Integrity · People

VW's Poster values

Responsibility · Honesty · Respect · Sustainability

Both companies violated every single one at the exact moment those values mattered most, not because the policies were bad…

Because the culture made Institutional Pressure louder than the values

Two Kinds of Ethical Failure

Type 1 — Deliberate Misconduct

What it is

People knowingly violated values for gain or to avoid accountability

Examples

VW Dieselgate · Wells Fargo · Enron

The question

Did they know it was wrong?

Type 2 — Institutional Pressure

What it is

Good people whose judgment was overwhelmed by hierarchy, schedule, budget, or career risk

Examples

Challenger · Deepwater Horizon · I-35W Bridge

The question

Did the culture allow them to do the right thing?

The Most Dangerous Pattern — Boeing

Boeing began as Type 2

MCAS flagged by engineers — concerns minimized — FAA and pilots not fully informed

Boeing crossed to Type 1

concealment became deliberate, DOJ fraud settlement breach, 37% of manufacturing controls failed (2024 FAA finding)… **346 people killed**

When Type 2 silence becomes Type 1 concealment…
that is when catastrophe becomes inevitable

Which Failure Type Will Test You?

Most will never be asked to deliberately deceive a regulator, but…

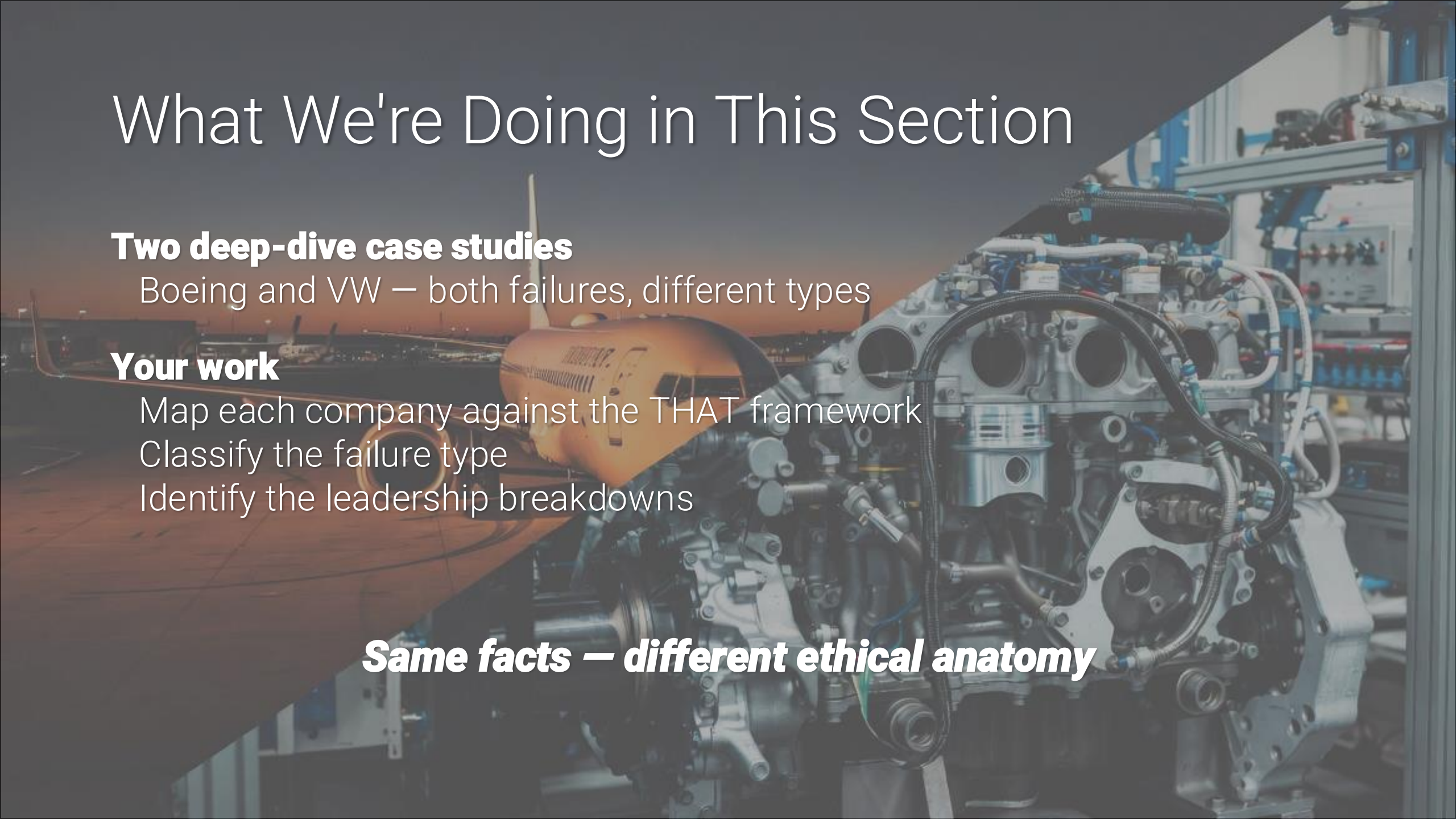
Every leader in this room will face a Type 2 moment

Type 2 does not feel like an ethics problem. It feels like
A schedule problem · A customer problem · A budget problem

The tell
when you notice yourself justifying why, just this once, the values can yield

That is what THAT is designed for

THAT Failure Analysis



What We're Doing in This Section

Two deep-dive case studies

Boeing and VW — both failures, different types

Your work

Map each company against the THAT framework
Classify the failure type
Identify the leadership breakdowns

Same facts — different ethical anatomy

Boeing
From Engineering Giant to Finance-First

Founded as an engineering-driven organization; led aviation for decades

1997 merger with McDonnell Douglas: management culture shift begins

"Run like a business rather than a great engineering firm"…
former MDD executive who became Boeing CEO

$43+ billion in stock buybacks in the decade before the MAX crashes

The question is not whether Boeing was a good company…
It is what happened to the culture.

The 737 MAX
What Pressure Looked Like

Internal warnings documented and dismissed

Engineers raised concerns about MCAS — overruled
Safety review timelines compressed under schedule pressure

What leaders communicated vs. what they knew

FAA kept in the dark on MCAS authority
Airlines and pilots not informed of the system's scope

The culture had made it normal…
to move fast and manage the narrative

MCAS
The Specific Turning Point

What MCAS was supposed to do

Prevent aerodynamic stall in specific high-angle flight conditions

What it actually did

Activated on bad sensor data — single point of failure

Pushed nose down repeatedly — crews had no documented procedure

The design choice that made it possible

Single sensor input, no redundancy — a known risk, accepted under schedule pressure

The Consequence

Lion Air 610 *(October 2018)*
… 189 lives lost

Ethiopian Airlines 302 *(March 2019)*
… 157 lives lost

The aftermath

346 deaths total
$20B+ in costs, fines, settlements
Criminal charges — multiple Boeing executives
737 MAX grounded worldwide for 20 months
Long-term reputation damage

The Pattern

Pressure
Schedule and competitive pressure overrode engineering judgment

Silence
Engineers who raised concerns were not heard; the culture made silence the rational choice

Concealment
MCAS risks not disclosed to FAA or pilots; post-crash responses shaped to minimize responsibility

Catastrophe
346 deaths, criminal investigations, $20+ billion in costs, reputational collapse

Did not begin as Type 1, it began as Type 2…
institutional pressure overwhelming engineering judgment.

Boeing THAT Mapping Teams 1 & 2

Teams 1 & 2 — 45 minutes

Using the THAT Failure Mapping worksheet

1. For each THAT value — where did Boeing fail?
2. What was the specific leadership decision or behavior?
3. At what point could a leader have changed the outcome?

Prepare to share your most critical finding

VW
The Clean Diesel Promise

Volkswagen's U.S. market strategy (2009–2015):
'Clean Diesel' — performance AND environmental responsibility

VW won environmental awards.
The brand built its American identity on this claim.

Their stated Group Essentials:
Responsibility · Honesty · Bravery · Diversity · Pride · Solidarity · Reliability

Their Code of Conduct explicitly named:
Customer Focus · Sustainability · Responsibility · Respect

All of it — built on a lie

The Defeat Device
What Was Engineered

A deliberate technical deception

Software detected steering, speed, and barometric patterns of EPA testing
Activated full emissions controls only during tests
Real-world driving: full performance, full pollution

The internal knowledge chain

Multiple engineering teams knew
Legal reviewed it
Leadership approved the go-to-market strategy

This was not an accident…
it was a product decision

The Culture That Made It Possible

CEO Martin Winterkorn's stated goal… make VW the world's largest automaker by volume

Autocratic leadership culture… disagreeing with leadership had consequences

Historical precedent:
VW engineers had used a similar defeat device in the 1970s — consequence was a $120,000 fine

Organizational rationalization
'We have done this before. The consequences were minimal. This is how it works.'

No internal whistleblower came forward. The defeat device was discovered by external researchers at West Virginia University.

The culture had foreclosed the honest path.

Scope and Consequence

11 million vehicles across the globe

$32+ billion in total fines, settlements, and legal costs

Criminal convictions
CEO indicted in the U.S.; multiple executives received prison sentences in Germany

6 years of sustained concealment across a global organization

Brand that had built decades of trust… permanently damaged

VW is Type 1
deliberate misconduct, knowingly chosen, systematically concealed

VW THAT Mapping Teams 3 & 4

Teams 3 & 4 — 45 minutes

Using the THAT Failure Mapping worksheet

1. For each THAT value — where did VW fail?
2. What specific decisions or behaviors drove each failure?
3. Where was the point of no return — and what preceded it?

Prepare to share your most critical finding

Breakout Session Description

- Table 1&2: Boeing
- Table 3&4: VW
- THAT Failure Mapping Worksheet
  - Analysis of Where each organization failed
  - What would THAT-aligned leadership have looked like

The Full Picture
Sorting by Failure Type

Boeing

Primary type: Type 2
Institutional pressure overwhelmed engineering judgment

Secondary: Type 1 elements emerged
Deliberate concealment of MCAS from FAA and pilots

Volkswagen

Primary type: Type 1
Deliberate misconduct — defeat device was a product decision

Leadership knew, legal reviewed, executives approved

Not pressure overcoming judgment — judgment was applied to deception

Type 2
When Good People Are Overwhelmed

The mechanism

Schedule, budget, career risk, hierarchy — these are real forces
Good people can make terrible decisions under sustained Institutional Pressure

What makes Type 2 so dangerous

The people often believe they are solving a problem, not creating one
Ethical erosion happens gradually — no single moment feels decisive

Culture determines whether institutional pressure produces Type 2 failures

Type 1
When Misconduct Is Chosen

The mechanism

People knowingly violate values — for gain, competitive advantage, or to avoid accountability

What makes Type 1 possible

Leadership that rewards outcomes without asking how
A culture that normalizes winning at all costs
Absence of accountability for the means, not just the ends

Type 1 failure is also a culture failure — it was allowed to happen

The Most Dangerous Pattern

Type 2 creates the conditions for Type 1

When pressure consistently overrides ethics, it signals to the organization

- Results matter more than methods
- Speaking up has a cost
- Compliance is negotiable when stakes are high enough

The trajectory

Type 2 culture → ethical numbness → Type 1 becomes thinkable

Boeing began as Type 2. The concealment of MCAS was Type 1

Discussion
Which Type Will Test You?

Individual reflection — 5 minutes, then discuss

In your current role, which type of failure is the greater risk?

What institutional pressures exist that could produce a Type 2 moment?

What would it take for you to recognize you were in one?

Not hypothetical — this is your operating environment

What We've Established

The anatomy of ethical failure

Both types trace back to culture — what leadership modeled and permitted

The THAT framework as a diagnostic

Transparency, Honesty, Alignment, and Trust — each has a failure mode

Real cases show how each value erodes under pressure

Coming next

What ethical courage looks like — the people who tried to stop it

Leadership Commitment

Leadership Commitment

- Performance Snapshot – share your experience
- Critical Conversation Reflections

STAR® Manager Progress Update

Program Midpoint

Four Domains of Leadership

Coaching:	**+71%**
Leading:	**+33%**
Managing:	**-39%**
Doing:	**-19%**

Management Competencies

+26%

STAR® Manager Progress Update

Business Impact

Success Value To-date

USD: $661,200
CAD: $ 30,300

TOTAL: $682,867 USD
ROI: 15.2x

Success Category

Engagement/Productivity	68.2%
Technical/Process	13.6%
Cost savings	9.1%
Operations	4.5%
Uncategorized	4.5%

Ethical Courage & Speaking Up

From Organizations to People

Yesterday

We analyzed what happened at Boeing and VW — the systems, the pressures, the decisions

Today

We start with who tried to stop it
The THAT framework is not abstract — it has faces

These are four people who saw what was coming…
said something, and paid for it

John Barnett
Boeing Quality Manager

32 years at Boeing — knew the 787 production line in Charleston the way most people know their own home

What he raised

Defective 787 parts fuselages; oxygen systems, electrical wiring, and door mechanisms not meeting specification… Workers pressured to skip quality checks to hit production schedule

What the system did

Transferred; Boeing filed a negative performance review. He filed an OSHA complaint in 2017 and fought them in court — alleging systematic retaliation

The outcome

March 9, 2024: found dead in a Charleston hotel room during his deposition testimony against Boeing

His concerns about the 787 were validated by subsequent FAA investigation

Ed Pierson
Senior Manager, Boeing Renton Plant

What he saw

Production chaos, exhausted workers, defects accumulating, parts installed incorrectly on the 737 MAX line

What he did

Went to his supervisor, then directly to CEO Dennis Muilenburg — given assurances, nothing changed
Went to the FAA and warned them specifically about the 737 MAX production line

What followed

October 2018: Lion Air Flight 610 — 189 killed. March 2019: Ethiopian Airlines Flight 302 — 157 killed
Pierson had raised the alarm before both crashes

He testified before Congress and has spent the years since advocating for aviation safety reform

Curtis Ewbank
Boeing Engineer

What he raised

Boeing's safety assessment process was fundamentally flawed
MCAS risk was being systematically underestimated in the analysis submitted to the FAA

What the system did

Management did not act. Ewbank left Boeing.

The outcome

Testified before Congress on the technical failures in Boeing's safety analysis
FAA's 2024 investigation confirmed the problems he had identified years earlier

His technical analysis was correct...
the culture did not allow it to reach a decision-maker in time

Sherron Watkins
VP of Corporate Development, Enron

What she saw

Enron's off-balance-sheet partnerships were fraudulent — she understood the structure

What she did

Wrote a direct memo to CEO Ken Lay — named the risk, named the people
'I am incredibly nervous that we will implode in a wave of accounting scandals'

What happened

Lay referred it back to the law firm already conflicted in the transactions
Enron collapsed. Lay and Skilling were convicted.

Her memo became Exhibit A in the Senate investigation

What These Four Had in Common

They used the channels available to them
None went public first — they escalated internally before going further

They documented
Memos, reports, audit trails — they created a record

They separated the issue from the person
The concern was about the decision, not an attack on individuals

They accepted the personal cost
All four paid a professional or personal price — none said it was easy

Team Discussion: All Four Questions — 20 Minutes

15 minutes — work through all four questions

1 — The Barriers: What prevents people from raising concerns at GD-OTS?

2 — What Makes It Possible: What has GD-OTS done — or could do — to lower the barriers?

3 — Your Decathlon Toolkit: Which framework gives you the most traction against the barrier you named?

4 — The Leader's Dilemma: What do you actually do when someone brings you inconvenient news?

Discussion Prompt Cards have all four questions — your assigned topic is what you'll facilitate

Bad News Doesn’t Get Better with Time

The compounding problem

Every delay in surfacing a concern gives it time to grow

What could have been a course correction, before it becomes a crisis?

Leaders who avoid bad news actually create

A team that learns to filter what they bring you

A version of reality that is increasingly optimistic and decreasingly accurate

If your team only brings you good news…
that is a warning sign, not a compliment

The STAR® Manager Connection

What STAR® Manager built

Accountability principles: creating environments where people perform at their best

What makes it real

You cannot create that environment if your team has learned that bad news is unwelcome
Transparency & Honesty are the cultural conditions STAR® Manager requires to function

What you built in STAR® Manager…
this is what makes it real under pressure

The Leadership Standard

Barnett, Pierson, Ewbank, and Watkins did what THAT requires…
and the system was not ready for them

Your job as a GD-OTS leader
To be the system that is ready
Not just to speak up yourself — to build the culture where your people can

"You are not just being asked to speak up…
You are being asked to build the culture where your people can."

ETHOS as Daily Leadership Practice

Our Next Step

Question we just asked: “Have I built a culture where my people can bring me the bad news?”

Next question: “What does it actually look like to live THAT — today, this week, in my next team meeting?”

The values are only as real as the decisions they produce

“We’ve started with the cost of failure. Now we spend the next hour on the practice of leadership.”

Transparency
"Surface It Early"

Sharing status that is uncomfortable — before someone asks

Naming a risk before it becomes a problem

Giving your team the context they need to do their jobs well

"I want to flag something before it gets to the VP."

"Our schedule is at risk. Here is what we know and what we don't know yet."

What it does NOT mean chaos: Transparency is calibrated…
the right information to the right people at the right time

Honesty
"Say What You Mean"

Reporting accurately — even when the number is bad

Giving feedback that is specific and true — not softened to uselessness

Telling your boss what is real, not what they want to hear

"The test results are not where we need them to be. Here is what the data actually shows."

"I want to give you feedback that will actually help you — and that means being direct."

Honest feedback, delivered with respect, is one of the most valuable things a leader can give

Alignment
"Hold the Mission"

Making decisions consistent with the mission — especially under pressure to take a shortcut

Connecting team decisions to the organization's purpose and values

Refusing to optimize for your function at the expense of the whole

"We're behind, but I need us to hold the quality standard. Here is how we recover without cutting that corner."

"Our mission is to arm the warfighter with a decisive advantage. That means this product has to work when it counts."

Alignment is hardest when the schedule is real, the pressure is real, and the shortcut is small

Trust
"Build the Conditions"

Creating an environment where your team knows concerns will be received — not punished

Following through on what you said you would do

Giving people the autonomy and information they need to do their best work

"I want you to bring me problems early — before they're disasters. That is what I need from you."

"I said I would follow up by Friday. It is Thursday — here is where we are."

Trust is built in small moments and destroyed in large ones — it compounds and erodes

THAT Leadership Scenarios Team Exercise

Each table has one scenario — 25 minutes

Your scenario tests one THAT value in a real GD-OTS leadership moment

Step 1: Name the value — which THAT principle is most directly tested?

Step 2: Describe the aligned response — what do you say, to whom, and when?

Step 3: Name the Type 2 failure path — what does the leader do when the pressure wins? What does that choice teach the team?

Share-out: 60 seconds per table…
one sentence on the aligned response, one on the failure path

THAT Leadership Language

Building a shared vocabulary

Each table: what does THAT-aligned leadership sound like — specifically?

Capture verbatim phrases on whiteboard under each value:

Transparency | Honesty | Alignment | Trust

15 Minutes

The ETHOS Standard
What GD-OTS Leaders Do

Transparency
Surface the problem before someone else discovers it

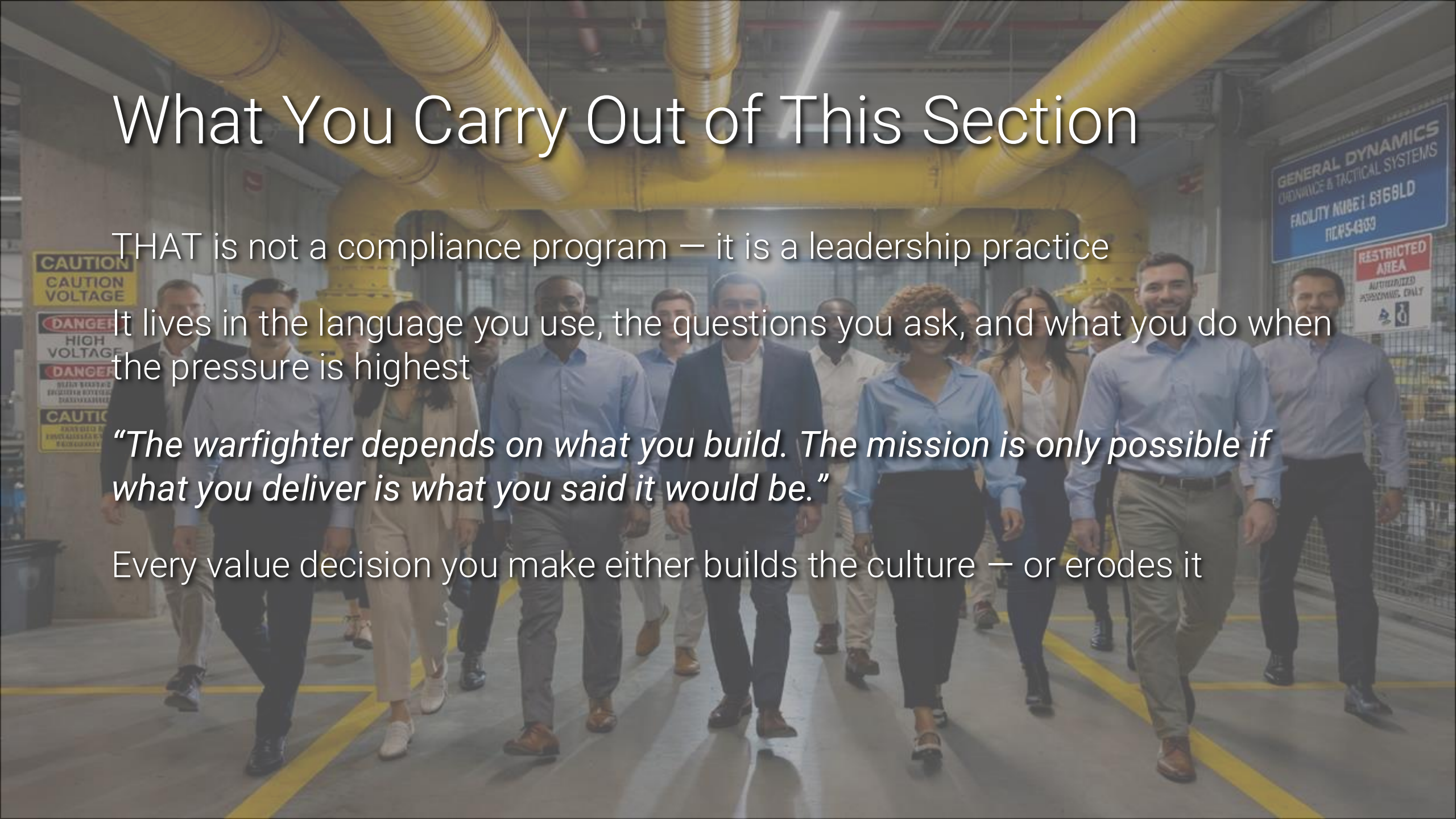
Honesty
Report what is true, not what is comfortable

Alignment
Make the decision the mission requires, not just the decision the schedule allows

Trust
Build the conditions where your team can perform — and where they can bring you the hard news

These are not aspirational. They are the standard.
This is what ETHOS requires of GD-OTS leaders.

What You Carry Out of This Section



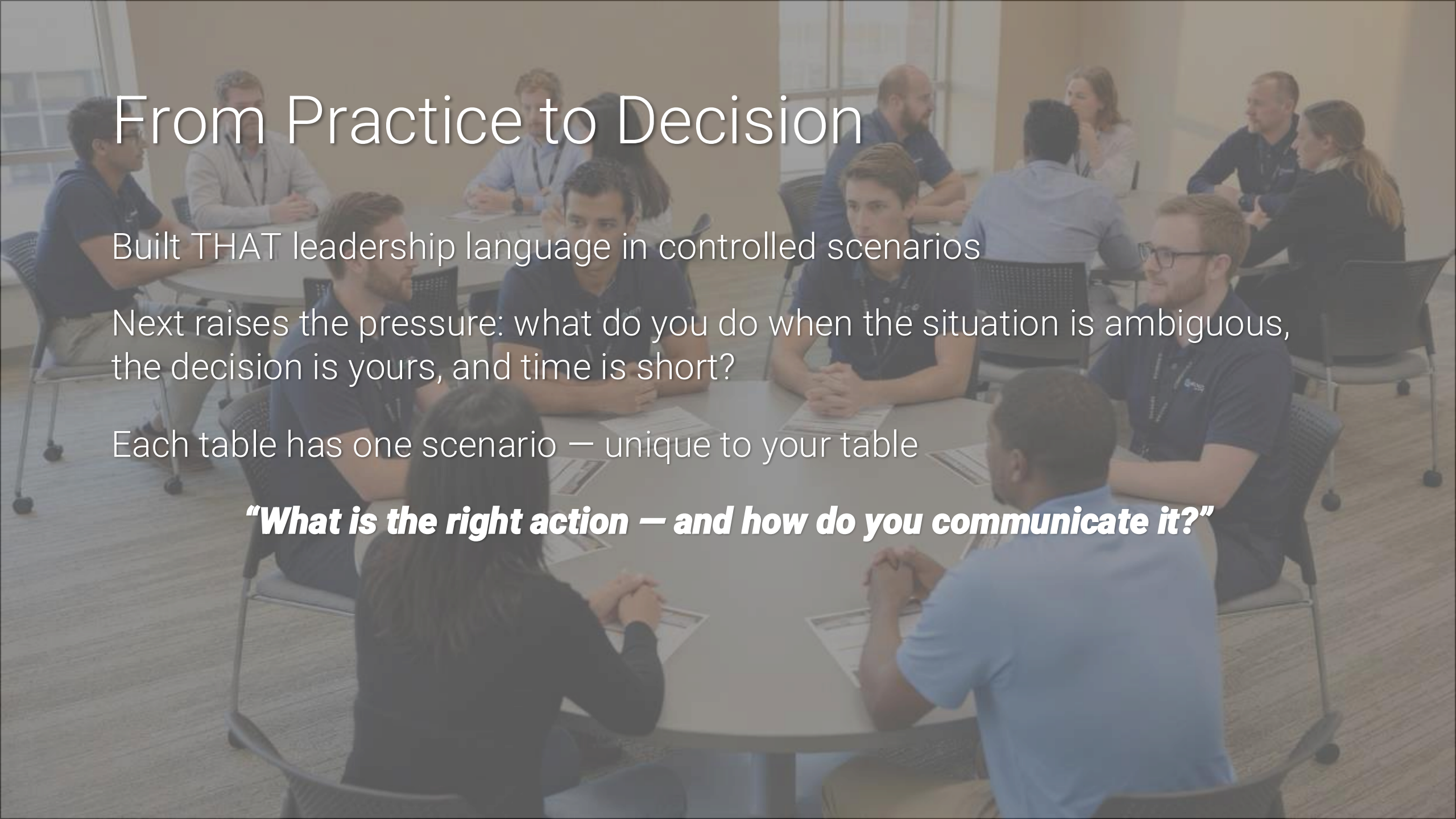
THAT is not a compliance program — it is a leadership practice

It lives in the language you use, the questions you ask, and what you do when the pressure is highest

“The warfighter depends on what you build. The mission is only possible if what you deliver is what you said it would be.”

Every value decision you make either builds the culture — or erodes it


Ethical Decision-Making Scenarios



From Practice to Decision

Built THAT leadership language in controlled scenarios

Next raises the pressure: what do you do when the situation is ambiguous, the decision is yours, and time is short?

Each table has one scenario — unique to your table

“What is the right action — and how do you communicate it?”

“What Would You Do?” Exercise Instructions

HANDOUT

Each table has one scenario — unique to your table. 20 minutes total.

For each scenario, answer four questions:

1. What type of failure is this? Which THAT values are at stake?
2. What is the right action? What do you do first — and what do you do next?
3. What GD-OTS resource or person do you engage? (Use what Karyn described)
4. How do you communicate the decision? What do you say — up, down, and sideways?

Debrief — The Type 2 Decision

What did your table decide — and how would you communicate it?

One table at a time: 2 minutes on the Type 2 scenario

Name

- the failure type
- the THAT values at stake
- the right action
- and who you told first

The Type 2 Tell

How to recognize when you are in a Type 2 moment

You are solving a constraint, not making an ethical decision

The pressure feels external — schedule, budget, leadership expectation

You are reasoning toward a predetermined outcome

You are aware that a different version of events is available to you

The question to ask yourself

Would I be comfortable if the people most affected by this decision could see exactly how I made it?

Using Your Resources
What Karyn Built

The ethics reporting infrastructure Karyn described is not a crisis tool… it is a Type 2 tool

LEOs exist for the moment before a concern becomes a formal complaint

The ethics hotline exists for the moment the chain of command is the problem

"You do not have to navigate a Type 2 moment alone. The infrastructure exists. Using it is what THAT requires."

From Decision to Culture

We have spent this session on what ETHOS looks like in failure — and in daily practice

This closes the loop how does ETHOS connect to the thing GD-OTS cares about most?

"Safety culture is not separate from ETHOS. It is what ETHOS produces."

ETHOS & Safety Culture: Closing the Loop

What GD-OTS Makes

GD-OTS builds products used in defense systems

The stakes of safety failure are not a recall or a fine…
they are lives, mission failure, national security

You know this. It is why you are here.

"Safety culture is not an add-on at GD-OTS…
It is what the mission requires."

When the Knowledge Existed Challenger

January 27, 1986 — the night before launch

Morton Thiokol engineers knew. Roger Boisjoly had warned about O-ring failure risk at low temperatures — in writing, 6 months earlier

The launch temperature was 29°F. Boisjoly recommended no-go below 53°F

A Thiokol manager told engineers to take off your engineering hat and put on your management hat

The engineers' concerns were overruled. The launch proceeded.

Seven crew members were killed.

"The knowledge existed…
The culture did not allow it to reach the decision-maker in time."

When the Knowledge Existed
Deepwater Horizon

April 20, 2010 — the Macondo well

BP engineers and rig personnel had flagged integrity concerns with the well casing and cement job in the weeks before the blowout

Schedule pressure and cost pressure were acute…
the well was 43 days behind and over budget

Concerns were raised. Risk assessments were revised in ways that reduced apparent severity. Several safeguards were bypassed.

Eleven workers were killed. 4.9 million barrels of oil released.

"Again: the knowledge existed…
What did not exist was a culture where that knowledge could survive the pressure to deliver."

What ETHOS Creates
The Safety Culture Connection

Transparency
Near-misses get reported — not buried

Honesty
Risk assessments reflect reality — not optimism

Alignment
Safety commitments are reflected in resource and scheduling decisions

Trust
Teams escalate concerns without fear of being labeled a problem

What breaks down without it

Near-misses become accidents

Risks become surprises

Commitments become slogans

Problems become crises before they surface

You Are the Culture Carriers

You are the next generation of GD-OTS leaders

In the organizations you lead, you will determine
- Whether a safety concern gets raised — or suppressed
- Whether a quality issue gets reported — or buried
- Whether the person who brings bad news gets protected — or managed out

That is not an abstraction. It is the outcome of every small cultural decision you make

"THAT is not what GD-OTS tells you to value…
It is how you lead when no one is watching and the pressure is real."

HANDOUT

Team Discussion
ETHOS & Safety Culture at GD-OTS

Teams — 25 minutes

Where do ETHOS values show up most clearly in your safety culture?

Where is the gap between stated safety values and operating reality?

What does a leader do — specifically — when they see that gap?

Be specific to your operating environment — not generic

Each Table Share One Insight ~ 5 minutes

What Do You Carry Forward?

5 minutes of quiet writing.

"What is one thing I will do differently as a leader to strengthen safety culture at GD-OTS?"

What specifically will I do?

In what context — what meeting, conversation, or moment?

What Type 2 pressure will make this hard?

What will I do when that pressure hits?

Keep this. You will use it in the Next Section

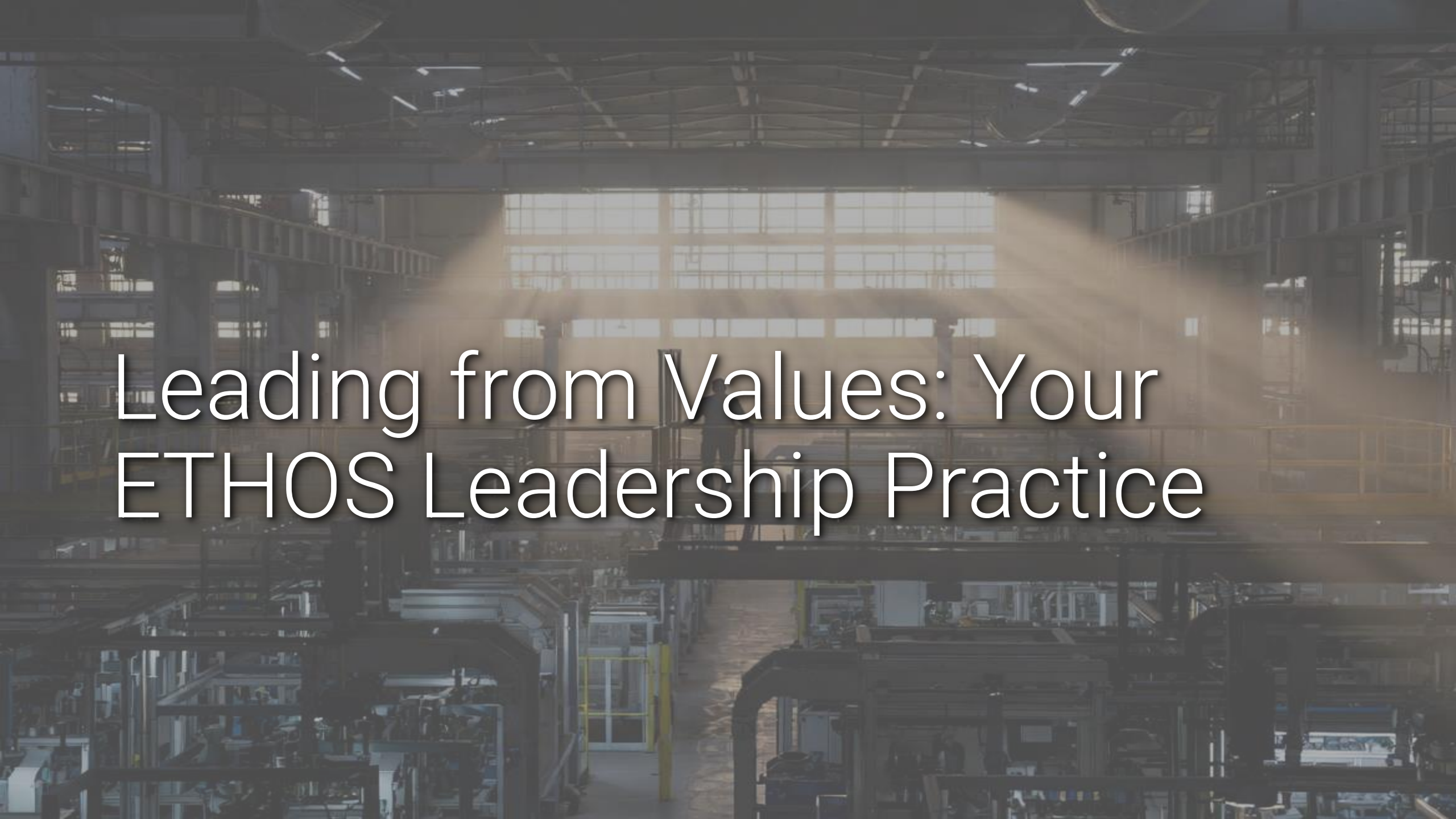
From Culture to Commitment

We have spent a day and a half on what ETHOS looks like…
in failure, in courage, in daily practice, in safety culture

Next is the last question: “What do I commit to doing differently?”

Not as an aspiration — as a specific, accountable leadership practice

“The work of this session does not end here. It starts here."



Leading from Values: Your ETHOS Leadership Practice

From Analysis to Commitment

A day and a half of case studies, frameworks, and conversation

> *Every one of those was asking the same question from a different angle: "what does it look like to lead with integrity when the pressure is real?"*

The answer — not in the abstract, but in your specific work, with your specific team, starting when you leave this room

> ***"The session ends today. The leadership practice doesn't."***

HANDOUT

Values-to-Behaviors — Team Exercise

What THAT looks like on your team. 20 minutes.

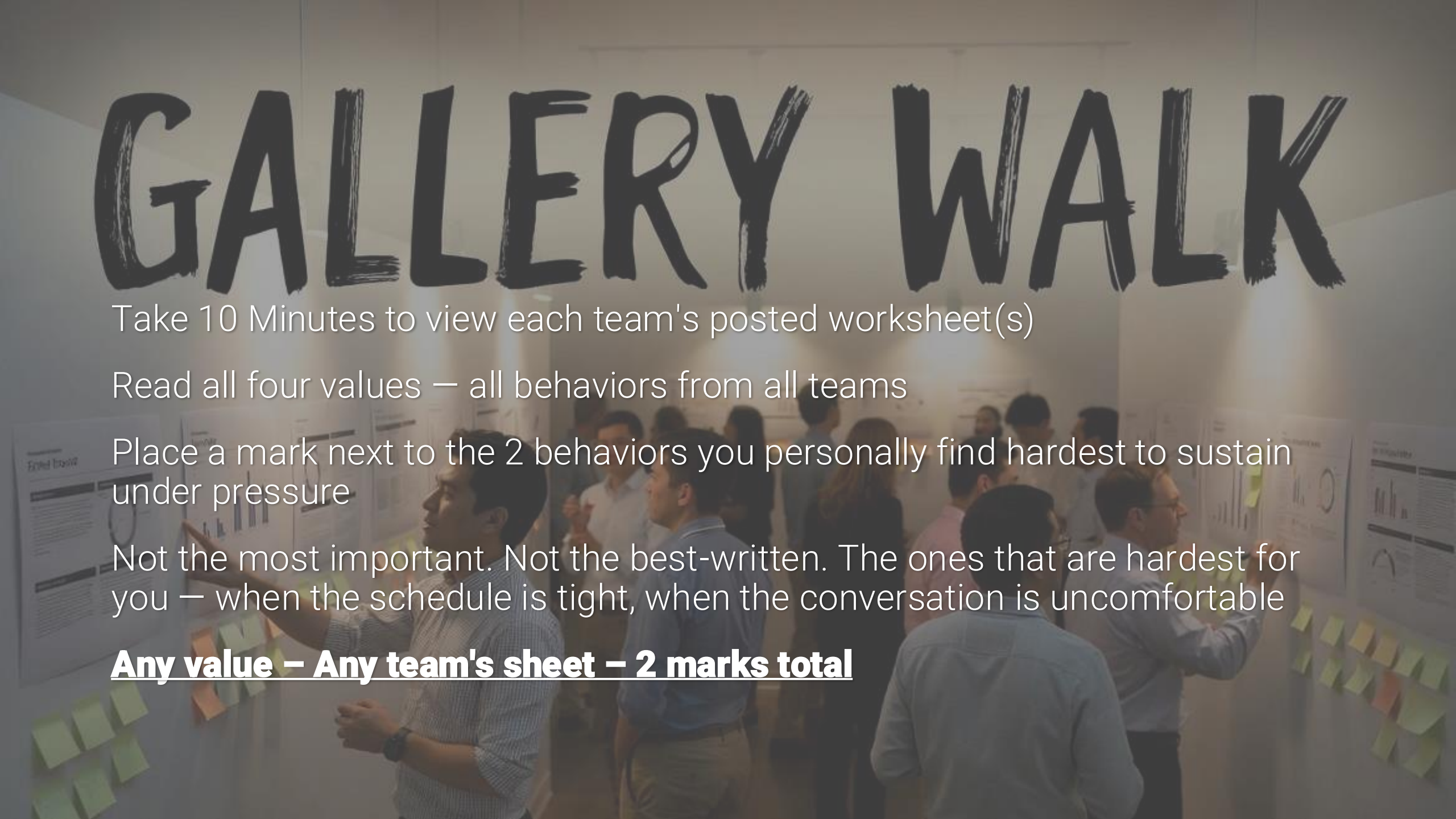
For each THAT value, your team identifies 2-3 specific, observable behaviors that a THAT-aligned leader on your team would demonstrate.

The standard for specific and observable: a direct report could describe the behavior to someone else — it is something you say or do

YES: "Tells the team what's uncertain…
not just what's decided — at the start of every program review"

NO: "Creates a culture of transparency"…
not a behavior; this is an outcome

Post on the wall when done.



Take 10 Minutes to view each team's posted worksheet(s)

Read all four values — all behaviors from all teams

Place a mark next to the 2 behaviors you personally find hardest to sustain under pressure

Not the most important. Not the best-written. The ones that are hardest for you — when the schedule is tight, when the conversation is uncomfortable

Any value – Any team's sheet – 2 marks total

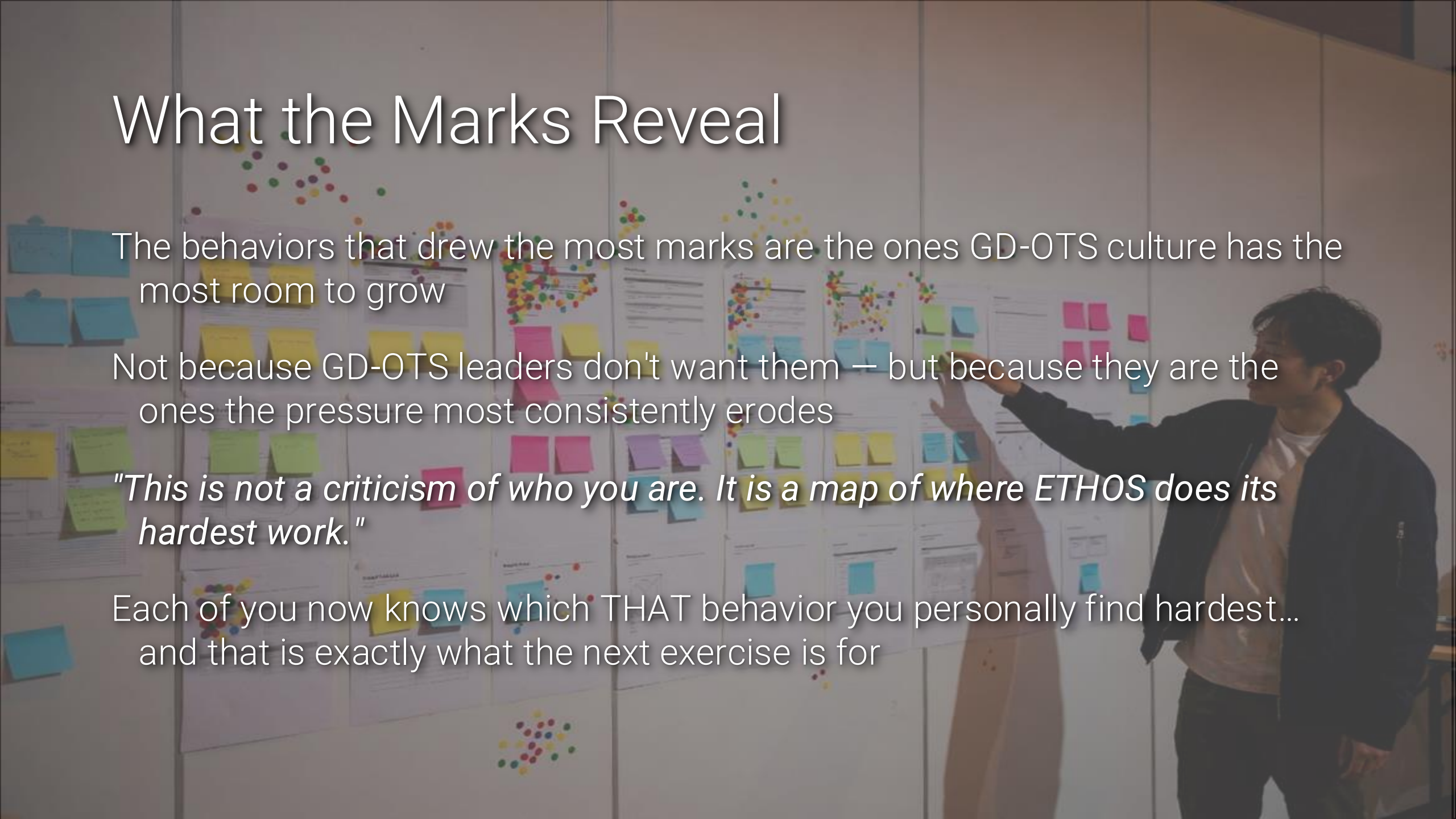
What the Marks Reveal

The behaviors that drew the most marks are the ones GD-OTS culture has the most room to grow

Not because GD-OTS leaders don't want them — but because they are the ones the pressure most consistently erodes

"This is not a criticism of who you are. It is a map of where ETHOS does its hardest work."

Each of you now knows which THAT behavior you personally find hardest… and that is exactly what the next exercise is for



HANDOUT

My ETHOS Leadership Practice
Individual written exercise. 15 minutes

For each THAT value, you will write one specific commitment:

1. What specifically will I do? The behavior — not the aspiration.
2. In what context? The meeting, the conversation, the moment.
3. What Type 2 pressure will make this hard?
   Name the specific force that will push against this.
4. What will I do when that pressure hits?

Start with the value that connects to the hardest behavior you marked in the gallery walk.

This is not a public document. Write for yourself — with enough specificity that you will still know what you meant 30 days from now.

Pair Share

With your accountability partner. 15 minutes direction.

1. Tell your partner the one commitment you are least confident you will keep. Read it or describe it — be specific.
2. Your partner listens. One clarifying question. One encouragement. Not advice — a question and a word.
3. Switch.

This is not a performance. It is a conversation between two people who will be accountable to each other for the next 90 days.

Peer Accountability Pairs

A 90-day accountability structure. Not a program — a relationship.

1. Exchange your single hardest ETHOS commitment. 2 minutes each. Say it plainly — not the whole worksheet, just the one.
2. Agree on a check-in date. 30 days from today. Write it down before you leave this room.
3. Decide on the format. A message. A call. A coffee. Whatever you will actually do.

Simple and real beats structured and abandoned.

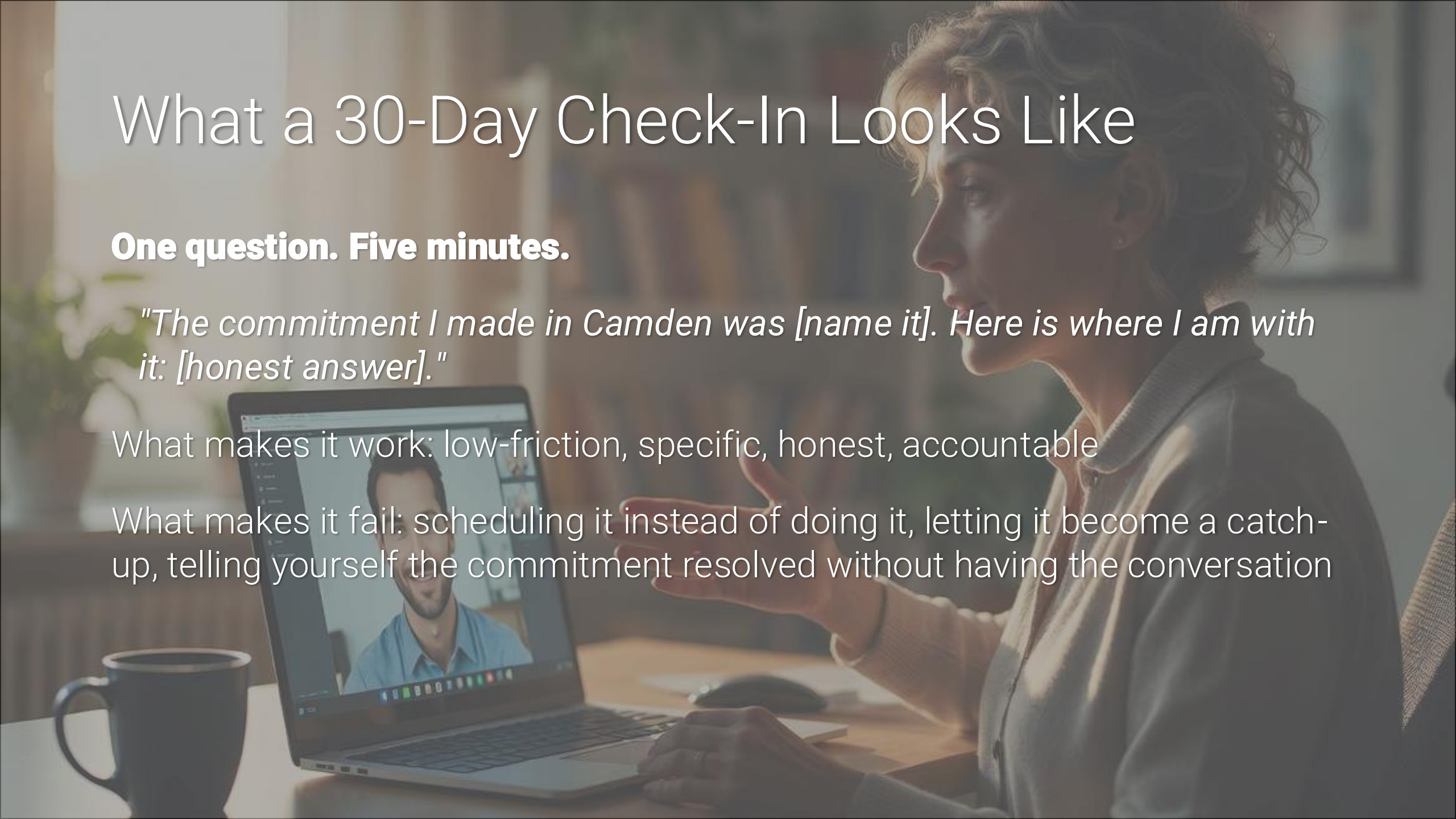
What a 30-Day Check-In Looks Like

One question. Five minutes.

> *"The commitment I made in Camden was [name it]. Here is where I am with it: [honest answer]."*

What makes it work: low-friction, specific, honest, accountable

What makes it fail: scheduling it instead of doing it, letting it become a catch-up, telling yourself the commitment resolved without having the conversation



The Leadership Standard You Carry Forward

ETHOS is not a training program you completed

It is a standard you are now accountable to — because you understand it, because you chose it, and because the people around you watched you choose it today

What you carry out of Camden is real: the framework, the case studies, the scenarios, the conversation with your accountability partner

"The warfighter carries what GD-OTS builds…
…You carry the culture that makes it worth carrying."

The Leadership Standard You Chose

You came to Camden with a job title

You are leaving with a clearer sense of the leadership standard that goes with it

What the last day and a half established

Ethics is not a compliance function — it is a leadership function
Culture is not what you declare — it is what you permit and model
ETHOS lives or dies in the daily decisions, not the big ones

The leaders in this room set the standard for GD-OTS…
not just for yourselves

Wrap Up

- **On-Going**
  - Time Management & Delegation
  - STAR® Manager – advance to finish by August 15
  - Project work

- **NEW:**
  - ETHOS Leadership commitment
  - Ensure your Skills Assessment recipients list is correct and their responses received by:

Decathlon V: Session 9 Feedback

Topics Covered:

DAY 1:

- Creating an ETHOS Culture
- Ethical Failure Case Studies

DAY 2:

- Ethical Courage
- ETHOS Leadership Practice
- Ethical Decision-Making
- ETHOS Safety Culture
- Leading from Values