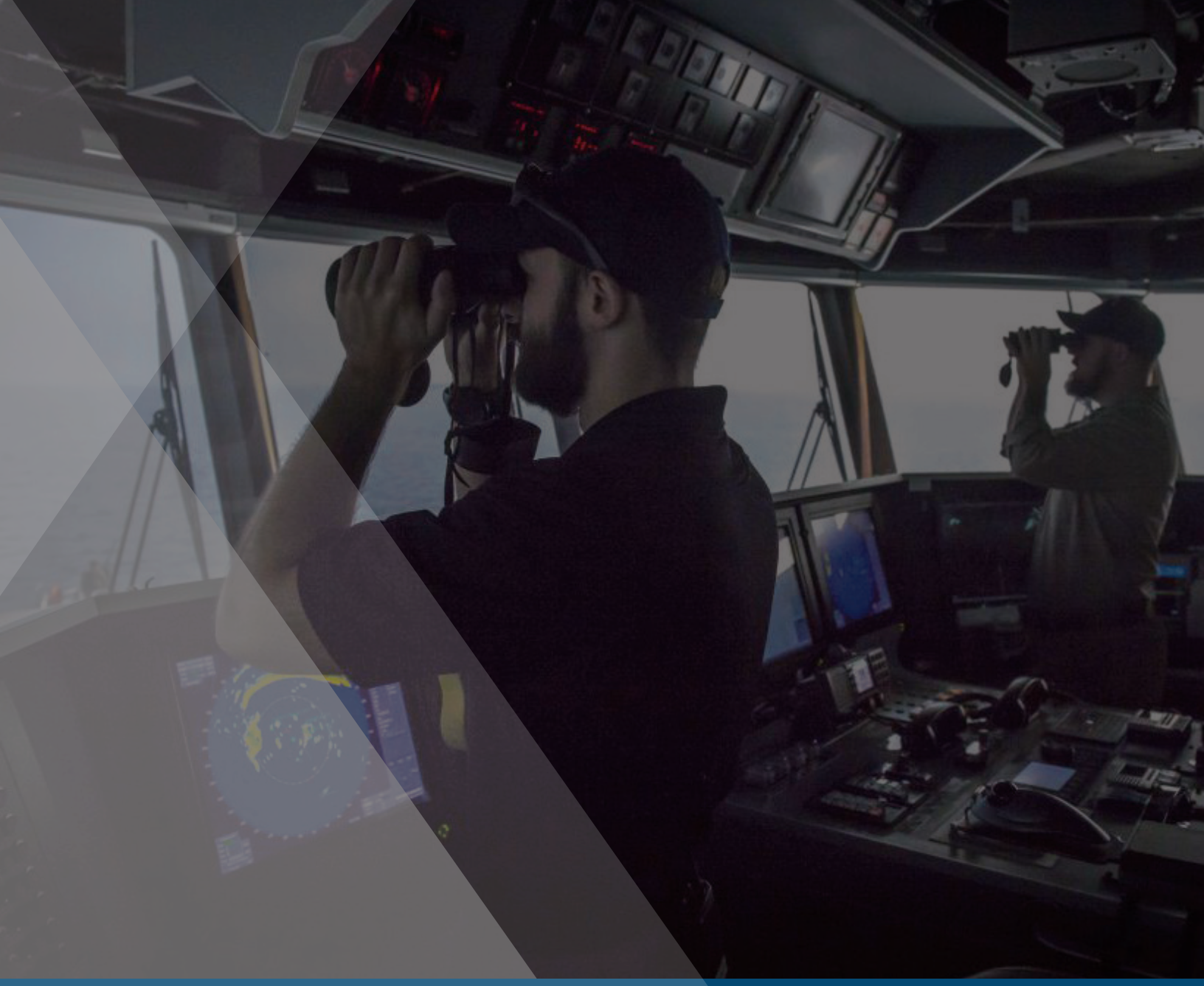

PARTICIPANT WORKBOOK

ETHICAL DECISION-MAKING

DECATHLON

KMP Consultants

MindWire®

From Compliance to Culture

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
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*

NOTES:

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

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

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

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

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.

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?

NOTES:

Two Failure Types — Reference Card

Keep this card with you through Day 2. You will use it in every block.

The Core Distinction

	Type 1 — Deliberate Misconduct	Type 2 — Institutional Pressure
What it is	People knowingly violated stated values for gain or to avoid accountability	Good people whose judgment was overwhelmed by hierarchy, schedule, budget, or career risk
The question	Did they know it was wrong? (Yes)	Did the culture allow them to do the right thing? (No)
Who is responsible	The individuals who chose it	The culture that made the wrong choice rational
How it feels	Like a clear ethical line being crossed	Like a schedule problem, a customer problem, a budget problem
The tell	"I knew this was wrong and did it anyway"	"I justified why, just this once, the values could yield"

Case Examples

Type 1 — Deliberate Misconduct

VW Dieselgate — Engineers built software specifically designed to deceive emissions regulators. Eleven million vehicles. Sustained over six years. People at multiple levels knew.

Wells Fargo — Employees opened 3.5 million fraudulent accounts without customer knowledge to hit sales targets. Systematic misconduct driven by a high-pressure sales culture.

Enron — Accounting fraud sustained for years with deliberate concealment from regulators and shareholders. Executives knew.

Type 2 — Institutional Pressure

Space Shuttle Challenger — Engineers at Morton Thiokol flagged O-ring failure risk the night before launch. Management overruled them under schedule pressure. Seven crew members killed. The engineering knowledge to prevent the disaster existed.

Deepwater Horizon — Known well integrity issues were deprioritized against production pressure. Warning signs ignored at multiple decision points. Eleven workers killed; Gulf of America permanently damaged.

I-35W Bridge, Minneapolis — Structural concerns flagged by inspectors in regular reviews. Remediation delayed by budget pressure. Thirteen killed when the bridge collapsed, August 2007.

The Intersection — Most Dangerous Pattern

Boeing 737 MAX — Began as Type 2: schedule pressure overriding engineering judgment, engineers silenced by culture. Crossed into Type 1 as concealment became deliberate. Three hundred forty-six killed.

Type 2 is the gateway to Type 1.

Why Type 2 Is the One to Prepare For

Most leaders will never be asked to deliberately deceive a regulator.

Every leader will face a Type 2 moment. It will not announce itself as an ethics problem. It will feel like:

- A program review where the news is bad and you feel the pressure to present it better than it is
- A direct report who brings a safety concern on a Friday before a Monday ship date
- A shortcut that would hit the schedule but bypass one step of the quality review process
- A peer who is cutting corners because the customer is screaming

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

THAT as the Type 2 Defense

THAT Value	What It Does in a Type 2 Moment
Transparency	Surface the problem before pressure turns it into concealment
Honesty	Report accurately — especially when the news is bad and the pressure to shade it is high
Alignment	Hold the mission constant when competitive, schedule, or financial pressure pushes against it
Trust	Build a culture where people bring you the bad news, before it becomes a crisis

The Leadership Question

It is not: "Would I do the right thing in an obvious ethical crisis?"

It is:

"Have I built a culture where my people can bring me the bad news — before it becomes a crisis?"

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

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

It did not begin as Type 1, it began as Type 2:
institutional pressure overwhelming engineering judgment.

EXERCISE 

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

NOTES:

The Culture that Made it Possible

CEO Martin Winterkorn's stated goal: to make VW the world's largest automaker by volume.

Autocratic leadership culture meant disagreeing with leadership had consequences.

Historical precedent:
VW engineers had used a similar defeat device in the 1970s — the 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.

EXERCISE

VW THAT Mapping - Teams 3 & 4

Teams 1 & 2 — 45 minutes

Using the THAT Failure Mapping worksheet:

1. For each THAT value — where did VW 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

NOTES:

THAT Failure Mapping Worksheet

Team Exercise | 20 minutes

Your team has been assigned one case: **Boeing 737 MAX** (Teams 1 & 2) or **VW Dieselgate** (Teams 3 & 4).

For each THAT value, identify a specific decision point where that value failed — and describe what THAT-aligned leadership would have looked like at that moment.

Be specific. *"Boeing wasn't transparent" is not an answer. "Boeing did not disclose MCAS's full operational authority to the FAA during certification" is an answer.*

Team Number: _____ **Case Assigned:** ☐ Boeing 737 MAX ☐ VW Dieselgate

Team Members: _____

T — Transparency

Where did this value fail?

Identify a specific decision, moment, or action where Transparency was absent.

Decision point or moment:

Who was involved? What was not disclosed, and to whom?

What would THAT-aligned leadership have looked like?

Describe the specific action a leader should have taken. Be concrete — what would they have said or done?

H – Honesty

Where did this value fail?

Identify a specific decision, moment, or action where Honesty was absent.

Decision point or moment:

What was the dishonesty? Was it active misrepresentation or silence when truth was required?

What would THAT-aligned leadership have looked like?

Describe the specific action a leader should have taken. Be concrete — what would they have said or done?

A – Alignment

Where did this value fail?

Identify a specific decision, moment, or action where Alignment — between the organization's stated mission and its actual decisions — broke down.

Decision point or moment:

What pressure overrode the mission? Schedule? Competitive threat? Financial metric? Career risk?

What would THAT-aligned leadership have looked like?

Describe how a leader aligned to the organization's mission would have responded to that pressure.

T – Trust

Where did this value fail?

Identify the point at which Trust — between leadership and the people who held critical knowledge — broke down.

Decision point or moment:

What was the signal the culture sent to people who tried to speak up? What happened to them?

What would THAT-aligned leadership have looked like?

Describe what a leader would need to do — consistently, over time — to build a culture where people with critical knowledge felt safe to bring it forward.

Your Team's Strongest Finding

For the two-minute share-out: what is the single most important THAT failure your team identified?

The value: _____

The specific moment:

What THAT-aligned leadership would have looked like:

Failure Type Classification

Based on your analysis, how would you classify this case?

- ☐ **Type 1 — Deliberate Misconduct:** People knowingly violated stated values for gain or to avoid accountability.
- ☐ **Type 2 — Institutional Pressure:** Good people whose judgment was overwhelmed by hierarchy, schedule, budget, or career risk.
- ☐ **Both — It Crossed Over:** Started as Type 2; became Type 1 as concealment became deliberate.

What tipped the classification for your team?

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 accountabilit

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 — two 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?

This is not hypothetical — it is your operating environment.

NOTES:

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.

NOTES:

STAR® Manager Progress Update

Leadership commitment

Ethical Courage & Speaking Up

The People Who Tried to Stop It

Four Stories of Ethical Courage

> ***These are not cautionary tales. They are accounts of people who understood the THAT values better than the organizations they worked for — and who paid a price for it. Their stories are not meant to produce despair. They are meant to answer the question: what does it actually look like to do the right thing when the pressure is real?***

John Barnett — *Boeing Quality Manager*

John Barnett spent 23 years at Boeing. He started on the factory floor and worked his way to Quality Manager at the 787 Dreamliner production facility in North Charleston, South Carolina. He was the kind of person Boeing's values documents said it wanted: technically precise, committed to quality, willing to speak up when something was wrong.

Starting around 2010, Barnett began raising concerns through internal channels. What he was seeing on the 787 production line troubled him: defective parts were being installed in aircraft fuselages because the production schedule did not allow time to wait for proper replacements. Oxygen systems, electrical wiring, door mechanisms — components where a failure would not be an inconvenience but a catastrophe. Workers, he said, were under pressure to keep the line moving. Quality checks that should have been performed were being deferred or skipped.

Barnett documented what he saw. He raised it with supervisors. He raised it with Boeing's internal ethics channels. He filed a complaint with OSHA in 2017. When he was later transferred to a new position, Boeing filed a negative performance review against him — the kind of review that appears, to those paying attention, to be a signal about the cost of speaking up.

He retired from Boeing in 2017 and continued to pursue his legal case against the company — a lawsuit alleging systematic retaliation for his whistleblowing. The case dragged on for years. By early 2024, he was in Charleston to give deposition testimony.

On the weekend between deposition sessions — March 9, 2024 — John Barnett was found dead of a self-inflicted gunshot wound in his car outside his hotel. He was 62.

In the months after his death, the FAA completed an investigation into the Boeing 787 production facility in Charleston. They found that 37% of Boeing's manufacturing controls had failed. The problems John Barnett had been documenting for more than a decade were real.

> ***He was right. He paid for being right with everything he had.***

Ed Pierson — *Senior Manager, Boeing Renton Plant*

Ed Pierson was a decorated Navy veteran and senior manager at Boeing's Renton, Washington facility — the plant where the 737 MAX was built. He had spent years in high-pressure operational environments. He was not someone who raised concerns without thinking through the consequences.

In 2018, Pierson began observing what he described as production chaos on the 737 MAX line. Workers were burning out under intense schedule pressure. Defects were accumulating. Parts were being installed incorrectly. The pressure to deliver aircraft — driven by Boeing's competitive battle with Airbus and the commitments it had made to airline customers — was overriding the quality controls the production process required.

Pierson went to his direct supervisor. The conversation did not produce change. He escalated. He secured a meeting with Boeing's CEO, Dennis Muilenburg, in 2018 and told him directly that he was worried about what was happening in Renton. Muilenburg assured him the situation would be addressed. It was not.

Pierson then took an extraordinary step: he contacted the FAA. He warned regulators specifically that the 737 MAX production line was not in a condition he felt confident about.

Lion Air Flight 610 crashed in October 2018. Ethiopian Airlines Flight 302 crashed in March 2019. Three hundred forty-six people were killed across the two crashes.

Ed Pierson had raised his concerns before both. He has spent the years since testifying before Congress, speaking to investigators, and advocating publicly for aviation safety reform.

> ***"I was willing to stand up for safety and quality. Boeing management was more concerned with cost and schedule."***

Curtis Ewbank — *Boeing Engineer*

Curtis Ewbank was a Boeing engineer who worked directly on the 737 MAX safety systems. His concerns were technical and specific: he believed that Boeing's safety assessment process — the analysis that the company submitted to the FAA to demonstrate the aircraft was airworthy — was fundamentally flawed.

The specific issue was MCAS. Ewbank believed that Boeing's analysis was systematically underestimating the risk posed by MCAS failures and that the assumptions built into the safety analysis did not accurately reflect how the system would behave in actual operation.

He raised these concerns internally. Management did not act on them.

Ewbank left Boeing. He later testified before Congress, describing in technical detail why he believed the safety assessment process had failed. The FAA's own 2024 investigation confirmed what Ewbank had described — the problems he had documented and raised years before the crashes were real and had persisted.

> ***He did not stop the crashes. But his testimony changed how Boeing's safety systems are certified and overseen.***

Sherron Watkins — *VP of Corporate Development, Enron*

In August 2001, Sherron Watkins sat down and wrote a seven-page memo to Kenneth Lay, the Chairman and CEO of Enron Corporation. The company was, at that moment, one of the most celebrated corporations in America. Its stock had traded above $90 per share.

Watkins was Enron's Vice President of Corporate Development. Her memo was not vague. It named the specific financial vehicles — off-balance-sheet partnerships — that Enron had been using to conceal billions of dollars in losses. It predicted, in explicit terms, that the company would "implode in a wave of accounting scandals" if the situation was not addressed.

She signed her name to it and sent it to the CEO.

Lay did not act on her warning. Instead, he had Enron's law firm review whether Watkins could be terminated for writing the memo. The firm concluded she could be. She was not fired — but nothing she warned about was addressed.

Three months later, in October 2001, Enron began its collapse. By December, the company had filed the largest corporate bankruptcy in U.S. history at that time. Tens of thousands of employees lost their retirement savings. Executives were indicted.

Watkins testified before Congress in February 2002. She was named Time's Person of the Year. Her courage — and the catastrophic scale of what happened when her warning was ignored — helped produce the Sarbanes-Oxley Act of 2002: the most significant corporate governance legislation in American history.

> ***She could not save Enron. But what she did changed the rules for every organization that came after.***

What Their Stories Carry

These four people were not heroes in the popular sense — not fearless, not certain they were right, not immune to what speaking up would cost them. They were professionals who understood the risk, chose to act anyway, and lived with the consequences.

None of them stopped the disasters they warned about. All of them were vindicated after the fact. Three of them changed what came after.

The question their stories leave for you is not:

> ***"Would I have done what they did?"***

It is:

> ***"Have I built a team where someone in their position wouldn't have to fight as hard to be heard?"***

Discussion Prompts

INSTRUCTIONS
You have 15 minutes to work through all 4 questions at your table. Each table is assigned one topic to facilitate for the full group. When we come back together, your table will lead a 3–5 minute discussion on that topic.

QUESTION 1 — THE BARRIERS

What barriers prevent people from raising concerns at GD-OTS? Name them specifically.

Don't stay at the level of "fear" or "culture." Get specific.

- Is it the relationship with a particular manager? The way performance reviews work?
- Is it how past concerns were handled — and what happened to the person who raised them?
- Is it the pace of the work — that there is never a good time?
- Is it ambiguity about where to go and who to tell?
- Is it the belief that raising it won't change anything?

Your goal: Leave this discussion with 3–5 specific, named barriers that are real in your experience at GD-OTS — not generic barriers from a textbook.|

When you facilitate:
"The most significant barrier we identified, and why it's hard to solve, is..."

Discussion Prompts

INSTRUCTIONS
You have 15 minutes to work through all 4 questions at your table. Each table is assigned one topic to facilitate for the full group. When we come back together, your table will lead a 3–5 minute discussion on that topic.

QUESTION 2 — WHAT MAKES IT POSSIBLE

What makes it easier to speak up? What has GD-OTS done — or could do — to lower the barriers?

Start with what already exists. What has worked — even once — that made someone feel safe enough to raise a concern?

- Was it a specific manager who responded well?
- Was it a process (the ethics hotline, a LEO, a skip-level conversation)?
- Was it a moment where someone who spoke up was visibly protected rather than penalized?

Then think forward: what is one specific thing a leader on your team could do —starting next week — that would lower the cost of speaking up?

Your goal: Leave this discussion with at least 1 real example of what made it work, and 1 specific action a GD-OTS leader can take.

When you facilitate:
"One thing that actually makes speaking up easier at GD-OTS is... and one thing a leader could do starting now is..."

Discussion Prompts

INSTRUCTIONS
You have 15 minutes to work through all 4 questions at your table. Each table is assigned one topic to facilitate for the full group. When we come back together, your table will lead a 3–5 minute discussion on that topic.

QUESTION 3 — YOUR DECATHLON TOOLKIT AND SPEAKING UP

Which framework/concept from your Decathlon learning gives you the most traction against the barrier your table named? Scan the full toolkit and explain why.

This is a synthesis question. You've built real frameworks across this program. Use them.

- **THAT**: Which of the four values — Transparency, Honesty, Alignment, Trust — is most directly implicated in the barrier you identified? What does acting on it look like in practice?
- **Two Failure Types**: Is the barrier your table named a Type 2 pattern — good people staying quiet under pressure? If so, what specifically breaks that pattern?
- **STAR® Manager**: What does the accountability and feedback practice from STAR® tell you about how to build the conditions where concerns surface early?
- **PI Profile**: Does your own behavioral style make it easier or harder to overcome this specific barrier? What does that mean for how you lead?

Your goal: Name one framework or concept from your Decathlon learning that gives you a concrete path through the barrier. Be specific — not the concept, the actual move.

When you facilitate:
"Name one framework or concept from your Decathlon learning that gives you a concrete path through the barrier. Be specific — not the concept, the actual move."

Discussion Prompts

INSTRUCTIONS
You have 15 minutes to work through all 4 questions at your table. Each table is assigned one topic to facilitate for the full group. When we come back together, your table will lead a 3–5 minute discussion on that topic.

QUESTION 4 — THE LEADER'S DILEMMA

As a leader: what do you actually do when a direct report brings you a concern that is inconvenient — one that will create problems for you, for your project, for your schedule?

Be honest. This is the hardest version of the question.

You have a program review tomorrow. A direct report comes to you today with a quality concern that, if it's real, means you cannot deliver on time. You do not know yet if it's real. Your instinct is to investigate quietly, manage the situation, and not surface it until you know what you're dealing with.

- Is that Transparency?
- Is that what you would want your own manager to do if the situation were reversed?
- What does your response in that moment communicate to your direct report — and to everyone who is watching?

The whistleblowers in the profiles all went through their direct manager first. Barnett went through internal channels for years. Pierson went to his supervisor before escalating. The culture they encountered in those first conversations was the one that determined what happened next.

You are that first conversation for your team.

Your goal: Leave this discussion with at least one real example of what made it work, and one specific action a GD-OTS leader can take.

When you facilitate:
"The hardest part of being the leader in that moment is... and a THAT-aligned response sounds like..."

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 became 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 and 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

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 uselessn

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 s

“I want to give you feedback that will actually help you — and that means being direc

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.

EXERCISE

THAT Leadership Scenarios

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 and one on the failure path.

NOTES:

Ethical Decision-Making Scenarios

EXERCISE

"What Would You Do?"

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

For the scenario, answer four questions:

What type of failure is this? Which THAT values are at stake?

What is the right action? What do you do first — and what do you do next?

What GD-OTS resource or person do you engage?

How do you communicate the decision? What do you say — up, down, and sideways?

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

The ethics reporting infrastructure described is not a crisis tool … 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."

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."

EXERCISE

"What Would You Do?"

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

NOTES:

INDIVIDUAL REFLECTION

ETHOS & Safety Culture

Session 9 — ETHOS & Ethics | KMP Consultants | GD-OTS

Over the past day and a half, you have examined how ETHOS values either hold or fail when pressure is applied — in organizations, in teams, and in individual moments of leadership. This reflection is yours. It is not shared, not graded, and not submitted. It is the bridge between what you learned here and what you do when you return to GD-OTS.

Take 5 minutes. Write honestly.

THE QUESTION

As a leader, what is one thing you will do differently to strengthen safety culture on your team at GD-OTS?

Not an aspiration. A behavior — something a member of your team could observe and describe.

WHAT SPECIFICALLY WILL I DO?

Name the behavior — not the intention. What will someone see or hear?

IN WHAT CONTEXT?

Staff meeting? One-on-one? Program review? When a concern is raised?

WHICH THAT VALUE DOES THIS MOST DIRECTLY SERVE?

☐ **Transparency** ☐ **Honesty** ☐ **Alignment** ☐ **Trust**

Why this one?

WHAT IS THE TYPE 2 PRESSURE THAT WILL MAKE THIS HARD?

Schedule? Hierarchy? A difficult customer? A bad week? Name the specific force that will push against this commitment.

WHAT WILL I DO WHEN THAT PRESSURE HITS?

Not a general principle — a specific, concrete action or decision rule.

THE ONE COMMITMENT I AM LEAST CONFIDENT I WILL KEEP:

(You will share this with your accountability partner.)

"The organizations where safety culture is strongest are not the ones with the best policies. They are the ones where the leader who receives bad news on a Friday afternoon before a Monday ship date responds in a way that makes the next person bring bad news sooner."

Leading from Values:

Your ETHOS Leadership Practice

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."

ETHOS in Action

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.

What You Carry Out of Camden

The THAT framework — and the case studies that show why it matters

The behaviors your cohort named as hardest to sustain — and the map of where GD-OTS culture has room to grow

Your personal ETHOS leadership practice — four commitments written in your hand, in your words

Your accountability partner — and a date

The session ends here. The leadership practice starts now.