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We May Never Know Leaders' Responsibility in Gulf Disaster

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The last official report on the April 2010 explosion at the Deepwater Horizon rig was issued on September 16th. And yet the ultimate question remains: what responsibility did boards of directors and senior business leaders have for the catastrophe in the Gulf? We may never know. The report fails to address this fundamental question, just like all the other reports which have gone before.

As one of the most serious industrial accidents in history, the Gulf explosion should be a great case study for corporate leaders across the globe who are trying to manage risk in hazardous activities involving complex technology. Put simply, how did the directors, CEOs, top staff leaders and top business leaders at the companies involved — BP (owner of the Macondo Well), Transocean (rig owner), Haliburton (construction services), Cameron (manufacturer of the blow-out preventer) and other subcontractors — fail in establishing safety management, safety processes and safety cultures which would have prevented the accident or which would have led to more effective crisis response.

Because better risk management in the future turns on corporate behavior, not just more regulation, and because that risk management is going to be driven from the top of corporations, the answers to these questions of leadership responsibility and accountability for organizational action and culture are of critical importance. These leadership questions have special pertinence for BP and Transocean because both companies had important safety failures prior to Deepwater Horizon which would have caused their boards and CEOs to rethink safety and to take remedial steps — steps which failed in the Gulf and which other leaders in other companies need to understand.

Yet, this last major report on the disaster — from the Department of Interior's Bureau of Ocean Energy Management, Regulation and Enforcement — focuses intensively and narrowly on technical issues, and regulatory violations, relating to well design, cementing the well, escape of hydrocarbons, failures of detection and diversion of flammable materials from the rig and immediate causes of the explosion. It does not address issues of leadership, management and accountability above the level of immediate events on the rig, and above lower level operational managers.

In fact, all other reports on the Deepwater Horizon during the past 12 months have had similar, narrow scope in assessing the immediate causes of the explosion or immediate response and recovery actions. These include analyses from: the National Academy of Engineering, the Coast Guard, the National Commission on Deepwater Horizon, the National Commission's companion Chief Counsel's Report, and BP's and Transocean's own extensive (if self-serving) assessments. (See my earlier critique of the National Commission in this regard.)

But none of the reports step back to ask fundamental questions — much less develop information and analysis — about how the gulf explosion was caused by larger issues of corporate structure, policy and behavior. None ask what, in fact, was corporate leadership's role in the profound questions of promulgating, resourcing, implementing and monitoring appropriate and comprehensive safety management and safety processes? None ask what, in fact, was corporate leadership's role in defining and creating an appropriate and robust safety culture. None examine in any detail how the local organization on the rig fit into complex global organizations. None engaged in detailed comparisons with peer companies to assess whether this was a systemic industry issue or aberrant behavior by outlier companies. None therefore provide any insight, in fact, about how corporate leadership, not just leadership on the rig, was responsible and accountable for this catastrophic event.

Ironically, virtually all the reports recognize that larger questions of inadequate corporate safety culture, policy and practice were critical to the specific problems in the Gulf. For example, the recent Interior Department report notes that significant organizational problems were "contributing causes" to the Macondo blowout: absence of an effective "stop work" policy when dangerous conditions occurred; failure to follow risk assessment protocols when making important operational and personnel changes; taking steps to save time and money without considering safety implications; confusion in communication and accountability stemming importantly from BP's failure to oversee effectively all the subcontractors.

The National Commission states the importance of corporate safety management and culture "from the highest levels on down" but has no analysis of those highest levels. The Chief Counsel's subsequent, more detailed report explicitly addresses "The Overarching Failures of Management." That report raises such general issues as: failure to integrate important real-time information; poor education and training; ineffective oversight and integration of contractors; failure to assess risk properly; and lack of clarity on when cost and time savings improperly compromise safety. The Chief Counsels report concluded:

"To prevent an incident like Macondo from ever happening again, it will not be enough to add regulatory personnel... [or] issue new prescriptive regulations or write more voluminous safety manuals.... What the men and women who worked on Macondo lacked...was a culture of leadership responsibility."

Yet, remarkably, the report never follows its "failure of management" up the chain of command and never assesses the "culture of leadership responsibility" at the top of BP and its contractors.

Some might argue that the companies involved would not share the type of information I am discussing because they are involved in litigation, including derivative suits aimed at directors and top officers. But it is not clear that the various investigatory entities even tried. And, if they had and been rebuffed (lacking subpoena power), they should have made much more of this seminal issue of top leadership in their reports. Moreover, given the importance of the issue, a set of Congressional hearings, aided by subpoena power as necessary, could have addressed the role of top corporate management (think Goldman Sachs and collateralized debt obligations) and forced companies to come out from their litigation bunkers.

To be sure, since the explosion, many remedial proposals have emerged: BP has announced a new safety organization; the oil industry has raised a billion dollars to improve response to spills in the Gulf; the government is writing new regulations. But, unless companies get safety leadership, management and culture right these "paper" changes are not likely to prevent or mitigate the next problem. That is why the huge analytic hole about the role of top leadership in the gulf explosion is so important — for the oil and gas industry but also for so many other corporations trying to manage potentially catastrophic risk posed by high tech products and processes.

The inevitable settlements of litigation with government, with private parties or between BP and its contractors are highly unlikely to produce court papers which are illuminating. For example, the Justice Department's on-going review is, of course, focused on provable legal liability, not on broad questions of organizational responsibility. And future books or articles may have difficulty piercing the top levels of corporate leadership.

So, the manifest limitations of the last official report underscore the narrow inadequacies of all Deepwater Horizon inquiries into causes. The lessons of the Gulf catastrophe relating to failures of corporate leadership in managing complex technological risk may thus never be detailed, discussed and debated in public. And, if they are not known, those lessons can't be learned.

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