

How the BP Commission Dropped the Ball

By Ben W. Heineman, Jr.

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What failures of the BP board of directors and its senior management led to the explosion of the Deepwater Horizon rig in the Gulf of Mexico?

Although the recent [report](http://www.oilspillcommission.gov/) of the [National Commission on the catastrophe](#) (http://www.oilspillcommission.gov/) purports to provide "thorough analysis and impartial judgment" on the "causes" of the explosion and "the lessons learned," one can read the 306 page report and the supporting staff papers and find barely a word — much less an assessment — about the board and senior management's role in the multiple failures of prevention, response and recovery.

Although the National Commission report emphasizes the importance of corporate safety culture and safety management "from the highest levels on down" as a necessary complement to regulatory reform, it never looks at the overall global organization of BP and never evaluates what board and business leaders did and did not do in furtherance of those goals.

Instead, the Commission's focus in the report is on the immediate causes of the explosion and on the individual and collective failures of BP (owner), Transocean (rig operator) and Haliburton (construction services) to assess and mitigate immediate risks — and to have effective crisis response plans. (It was not able to assess the failure of [Cameron's blow-out preventer](#).) From analysis of close-to-the-accident problems — why hydrocarbons penetrated the well; why people failed to see that; and why actions weren't taken to prevent the explosion — the report reaches sweeping conclusions: instead of a safety culture in the companies there was a "culture of complacency" that never subjected to risk assessments key design and operational decisions which led to less cost and to less time — and to the explosion.

Fine. But that conclusory language isn't very illuminating. We need a much broader and deeper understanding of the role of board and senior management in a large, complex corporation. BP and other companies in the oil and gas industry (as well as any corporation with potentially catastrophic operations) need to understand these larger governance and risk management lessons in meaningful detail in order to address

complicated risk across far-flung global firms more effectively. Time is of the essence because many of the public policy recommendations of the National Commission may get hung up in the new Congress, or because the reorganized Department of Interior oversight (even without legislation) is still plagued by lack of funds and expertise.

The Commission needed to ask larger questions in detail about BP governance, assessing board and senior management actions against at least three benchmarks:

- The Commission could have looked at the BP failings documented by three different inquiries after the **catastrophic explosion in March, 2005 at the Texas City refinery**: an internal review, a **Chemical Safety Board** study and the analysis of an independent commission headed by **former Secretary of State Jim Baker**. Among the BP failings identified were: lack of leadership consistency; lack of uniform safety culture; lack of consistent risk assessment; inadequate risk abatement; lack of effective early warning systems; lack of effective education and training; lack of employee voice when problems arose; inadequate dissemination of lessons learned; and inadequate senior management oversight. There is little question that both the BP board and the CEO (Tony Hayward) paid some attention to these issues, but it is critical to know why and how that attention failed to prevent the Deepwater explosion or prepare for the aftermath. Was there a plethora of paper and a dearth of reality? If so, why? What was their concept of forging a safety culture, and why did it fail?
- The Commission could have looked at the recommendations of **BP's own accident report** issued in September 2010. Although buried at the back of the document, they were a searing indictment of BP prior to the explosion. The recommendations called for: better, clearer standards for a range of safety-critical operations; for significantly improved education and training; for better audit processes on closing out deficiencies highlighted in safety reviews; for imposing much greater oversight on contractor's current practices; and for mandating that contractors create safety processes which BP could audit. The National Commission could have explored why the board and senior management had not created systems for identifying and implementing these obvious and fundamental steps which the BP report, by implication, says might well have prevented the accident.
- The Commission could have compared BP's leadership, systems, processes and culture to another oil company, **Exxon Mobile**, whose practices it singles out for praise. After its mind was "concentrated" by the **1989 Exxon Valdez spill**, the company instituted an **Operations Integrity Management System** in 1992 which has been evolving ever since. As the Commission noted, this

system, which applies to contractors as well as Exxon Mobile itself, "covers all aspects of safety, including management leadership and accountability, design, construction and maintenance of facilities; emergency preparedness; management of change; assessment of performance; and...thorough inquiries into accidents and incidents." (Exxon Mobile was not listed by the Commission as involved in any of the 79 Gulf of Mexico incidents of well dysfunction and uncontrolled flow of hydrocarbons reported between 1996 and 2009.)

With the Commission's emphasis on understanding "root causes" in order to prescribe both public and private remedies for the future, it is thus striking that it failed so completely to look at broader BP leadership and organizational failures. Such an assessment would have provided a concrete stimulus across the industry to ensure clear board and senior management accountability and responsibility for high priority substantive *issues* (like deepwater drilling), for essential safety management *processes* and, ultimately, for creating a safety *culture*. Such a culture, which a board can measure, truly puts avoidance of accidents first and prevents imprudent cutting of corners due to cost, time, or other pressures. Such an assessment would have exposed in detail the failure of leadership to take ultimate responsibility for oversight and management of subcontractors across the company, not just on the Deepwater Horizon. It would have highlighted how governance failures, not just on the rig but at the highest levels, can lead to catastrophe.

Ironically, BP's new CEO acknowledged the need for just such a broad analysis. When he succeeded **Tony Hayward**, in September 2010, **Bob Dudley** said: "There are lessons for us relating to the way we operate, the way we organize our company and the way we manage risk."

But, if BP has done a more comprehensive analysis of the leadership and organizational problems which led to the Gulf explosion than it revealed in its narrow September 2010 accident report, it has not made the details public. Moreover, such an analysis might have been conducted under attorney-client privilege because, even though the National Commission ignored the role of the BP board of directors and senior leaders, the plaintiffs bar has not. Derivative suits have been brought against BP directors and officers alleging violation of fiduciary duties, in among other things, failing to correct prior safety problems identified in other accidents, and in failing to carry out a settlement mandating governance changes in a prior derivative suit relating to a BP spill in Alaska. If those suits survive procedural hurdles, they may well be settled before extensive discovery and publicity about the workings of the BP board of directors and senior business leaders.

Thus, the National Commission has let the best opportunity to understand the broader governance and risk management issues behind the Gulf explosion slip away. Despite the pendency of the derivative suits, the Commission could have asked hard questions because many of its other lines of inquiry and factual findings implicate BP liability in other suits or regulatory proceedings (such as whether it was grossly negligent, thus multiplying potential fines).

In the foreword to the report, the National Commission said that findings on the immediate causes of the explosion sounded "recurring themes of missed warning signals, failure to share information, and a general lack of appreciation of the risks involved...these findings highlight the importance of organizational culture and a consistent commitment to safety by industry, from the highest management levels on down." Given the Commission's recognition of how important was the role of the board and senior management in the systemic failures of prevention, response, and recovery, its silence on that issue is baffling and leaves a major hole in the report on the core question of how boards and business leaders should manage catastrophic risk in complex global corporations.

Ben W. Heineman, Jr., GE's former Senior Vice President for Law and Public Affairs, is senior fellow at Harvard Law School's Program on the Legal Profession and Program on Corporate Governance and senior fellow at the Kennedy School's Belfer Center for Science and International Affairs. He is author of the book, [High Performance with High Integrity](#) (Harvard Business Press 2008).

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