



**Transocean Closing Argument**  
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**I. Introduction**

Your Honor, ladies and gentlemen of the jury, we stand here today in the shadow of one of the most profound tragedies in maritime history. On April 20, 2010, the Deepwater Horizon incident claimed eleven precious lives, including nine dedicated Transocean crew members, forever changing the lives of their families and communities (BP\_00001474). These weren't just workers; they were skilled professionals, family members, and valued colleagues. Jason Anderson, one of our finest toolpushers, had just been offered a promotion. Dewey Revette brought 23 years of drilling experience, while Stephen Curtis had dedicated nearly nine years to ensuring safe operations on the Deepwater Horizon. All three were universally respected and known for their unwavering commitment to safety (BP\_00000001 §24).

The human cost of this tragedy extends beyond the immediate loss of life. The environmental devastation has impacted countless communities along the Gulf Coast, disrupting ecosystems, damaging local economies, and threatening the livelihoods of thousands who depend on these waters for their survival (BP\_00000001 §22). The evidence shows that significant amounts of oil remain unaccounted for, and ongoing recovery efforts continue to remove oil from affected areas (BP\_00000001 §22).

The gravity of this disaster cannot be understated. As CEO Steven Newman testified before the United States Senate Committee, Transocean has been deeply committed to supporting the families of the lost crew members while actively participating in efforts to prevent such tragedies from occurring again (BP\_00001474). The impact on the Gulf Coast communities has been severe and long-lasting, affecting not only the environment but also the economic and social fabric of the region.

However, as we examine the evidence presented during this trial, it becomes clear that this tragedy was not the result of Transocean's actions but rather stemmed from a



series of critical decisions made by BP that prioritized profit over safety. The evidence shows that BP's management practices and operational decisions directly led to this catastrophic event.

Let me draw your attention to specific evidence that demonstrates BP's responsibility for this tragedy. On March 8, 2010, a significant well control incident occurred that should have raised red flags. BP's own internal communications reveal they were "drilling like a bat out of hell" in narrow-margin wells, a practice their own geologist, Mr. Lacy, acknowledged as potentially dangerous (BP\_00000036 §9). This reckless approach to drilling was further compounded by BP's failure to communicate critical information about pore pressure detection to Transocean's crew.

The evidence shows that between April 12 and April 20, 2010, BP generated at least five different Temporary Abandonment procedures for the Macondo Well, each varying in format, detail, and risk exposure. The final procedure, sent to the well site leader mere hours before the blowout, introduced unnecessary complexities and risks that were not present in earlier drafts (BP\_00001371 §11).

## **II. TransOcean's Demonstrated Commitment to Safety**

Your Honor, the evidence before this court demonstrates conclusively that Transocean maintained an unwavering commitment to safety aboard the Deepwater Horizon through multiple, overlapping systems of personnel qualification, training, equipment maintenance, and operational protocols. Let me detail this evidence systematically.

First, regarding crew qualifications and experience, the Deepwater Horizon was staffed with some of the most experienced professionals in the industry. Jason Anderson was widely recognized as one of the best toolpushers in the company. Dewey Revette brought 23 years of valuable experience, and Stephen Curtis had accumulated nearly nine years of expertise with Transocean (BP\_00000001 §24). These weren't just internal assessments - BP's own well site leader, Murray Sepulvado, testified that he would gladly work with this crew again, describing them as "good people, good workers and good safety people" (BP\_00001545 §7).



The Deepwater Horizon itself maintained an exemplary safety record. The rig was consistently recognized as one of BP's best-performing vessels in terms of both safety and operational excellence. It had achieved a remarkable milestone of 2,535 days without a lost time accident (BP\_00001480). The rig set a world record by drilling to a depth of 35,050 feet on the Tiber well, demonstrating both its capabilities and the crew's expertise (BP\_00000001 §25).

Our commitment to safety was implemented through multiple structured programs. The START Process empowered employees to observe and monitor work practices, while the THINK Planning Process ensured proper risk controls were in place before tasks began. The "Time Out for Safety" (TOFS) program allowed any crew member, regardless of position, to halt work if they perceived a safety risk (BP\_00001545 §6). This wasn't just policy on paper - it was actively encouraged by management and recognized through the "I Made a Difference" campaign.

Training was continuous and comprehensive. The crew maintained current well control certifications and conducted regular safety drills. Notably, a specific drill was conducted just two days before the incident (BP\_00001545 §5). Our training matrix showed a 95% completion rate against requirements, demonstrating our commitment to continuous learning (BP\_00001319 §1).

Regarding emergency preparedness, the rig was equipped with four lifeboats and six life rafts, with total capacity exceeding the crew size. The Station Bill was prominently displayed throughout the rig, and crew members were well-trained in emergency procedures (BP\_00001545 §5). The effectiveness of this training was tragically demonstrated during the incident itself, when 115 crew members were successfully evacuated.

Equipment maintenance was rigorous and well-documented. The Blowout Preventer (BOP) met or exceeded API specifications, with regular testing documented and modifications properly tracked (BP\_00001545 §24). Our maintenance records show that out of 753 documented maintenance tasks, 748 were completed on schedule - a 99.3% completion rate (BP\_00001593).



Third-party validation consistently confirmed our safety commitment. Lloyd's Register audits found that a significant majority of the crew felt their safety concerns were heard and understood safety procedures (BP\_00000001 §25). The rig successfully passed numerous U.S. Coast Guard inspections (BP\_00001594 §2) and maintained compliance with multiple regulatory requirements, including:

International Safety Management (ISM) Code

- MODU Code
- Outer Continental Shelf Lands Act
- Regular American Bureau of Shipping (ABS) inspections (BP\_00001545 §3)

Now, BP and the plaintiffs may raise certain criticisms. They may point to expert Geoff Webster's claim that the vessel was in "gross neglect." However, this opinion is contradicted by extensive third-party verification, including successful Coast Guard inspections and ABS surveys (BP\_00001419 §1). They may question our maintenance practices, but our documented 99.3% completion rate on maintenance tasks speaks for itself.

Our safety systems were comprehensive and multi-layered. The Emergency Shutdown (ESD) system complemented existing fire and gas systems, with centralized control and remote stations for quick access. The system featured redundant components and protection against inadvertent operation (BP\_00001004). We maintained advanced monitoring systems, including comprehensive purge and pressurization systems, redundant fans, and automatic gas detection and alarm systems.

Daily operations reflected our safety culture through:

- Twice-daily safety meetings
- Regular equipment inspections
- Detailed documentation of procedures
- Proactive hazard identification (BP\_00001443 §56)

The Major Accident Hazard Risk Assessment conducted in 2004 identified 27 recommendations, none of which were categorized as 'High' Risk (BP\_00001079). We



systematically addressed these recommendations, demonstrating our commitment to continuous improvement in safety practices.

Your Honor, the tragic events of April 20, 2010, do not negate this extensive record of safety commitment. The evidence shows that our crew acted professionally and followed established procedures when abnormalities were noticed (BP\_00000001 §23). The successful evacuation of 115 crew members during the incident demonstrates the effectiveness of our emergency response training and procedures.

The totality of evidence - from crew qualifications to training programs, from equipment maintenance to third-party validations - demonstrates that Transocean maintained a comprehensive commitment to safety that went far beyond mere regulatory compliance. Our approach to safety was systematic, documented, and verified by independent parties. The tragic incident, while devastating, does not diminish this documented history of safety commitment and operational excellence.

### **III. BP's Primary Responsibility as Well Operator**

Your Honor, I stand before you today to address BP's primary responsibility as the operator of the Macondo well. The evidence presented during this trial tells a compelling story of an operator that repeatedly chose expediency over safety, cost-cutting over proper procedure, and profits over protection. As I detail the extent of BP's operational control and decision-making authority, you will see how their actions and inactions directly led to this catastrophic event.

Let me begin with BP's comprehensive operational control. As Dr. Frederick "Gene" Beck's expert testimony confirms, BP maintained complete control over all aspects of well design and operations, including oversight of contractors like TransOcean and Halliburton. This wasn't mere theoretical control – BP actively exercised their authority in ways that consistently compromised safety margins and ignored critical warnings.

Consider their management of the Blowout Preventer system, Your Honor. BP made the deliberate decision to modify the BOP, reducing its pressure rating from 10,000 psi to



5,000 psi. They did this without proper risk assessment and despite explicit warnings from Cameron about the associated risks of this modification. The evidence shows this decision was made unilaterally by BP, demonstrating their direct control over critical safety systems (BP\_00001359 §6). Even more telling, BP chose not to implement available safety technologies such as acoustic trigger systems and wireless activation methods that could have prevented this disaster (BP\_00001358 §2).

The extent of BP's operational failures becomes even more apparent when we examine their approach to equipment maintenance. A September 2009 ModuSpec audit revealed a staggering 3,545 man-hours of overdue maintenance tasks. The BOP, a crucial piece of safety equipment, had not been recertified for nine years – a clear violation of industry standards and safety protocols (BP\_00001419 §6). When confronted with these audit findings that revealed significant maintenance issues, BP chose to return the rig to service without addressing these problems (BP\_00001061 §4).

Your Honor, these weren't isolated incidents or minor oversights. They represent a systematic pattern of neglect by the party responsible for ensuring the well's safety and integrity. The American Petroleum Institute's Recommended Practice emphasizes the critical importance of safety and environmental integrity in drilling operations (BP\_00000979 §1), yet BP consistently failed to meet these basic industry standards.

Each of these decisions carried real human consequences. When BP chose to modify the BOP without proper risk assessment, they weren't just changing equipment specifications – they were gambling with the lives of every crew member who relied on that critical safety system.

But BP's failures extend beyond operational control to their exercise of decision-making authority. The evidence shows that BP's onshore team made critical choices about well design and testing procedures without adequate review or consideration of safety implications. Between April 12 and April 20, 2010, BP engineers created at least five different temporary abandonment plans, with the final version lacking necessary MMS



approval (BP\_00001184). This rushed approach to critical procedures exemplifies BP's negligent oversight.

Their well design decisions consistently lagged behind operations, creating chaos within the team and leading to numerous last-minute changes (BP\_00001359 §14). The evidence reveals that BP even misrepresented critical data to regulatory authorities, inflating pressure test results in permit applications by claiming figures of 13.0 ppg instead of the actual 12.55 ppg (BP\_00001354 §8). This pattern of misrepresentation extends to their documentation practices, where records for critical components were either missing or inadequate (BP\_00001061 §9).

Perhaps the most egregious example of BP's failed decision-making can be found in their handling of the negative pressure test. BP's well site leaders failed to prepare expected bleed-off volumes, which severely hindered their ability to diagnose the situation effectively (BP\_00001371 §13). Even more disturbing, despite having over 30 minutes between identifying issues and the blowout, BP personnel failed to take decisive action that could have prevented this disaster (BP\_00000001 §20).

Your Honor, one conversation in particular epitomizes BP's failure to exercise proper authority. Less than an hour before the first explosion, BP's senior drilling engineer and well site leader discussed concerns about the validity of the negative pressure test. Despite these explicitly voiced concerns, no corrective action was taken (BP\_00000001 §19). This wasn't just a failure to act – it was a conscious decision to proceed despite clear warning signs.

The evidence further shows that BP's approach to cementing operations demonstrated their disregard for proper safety protocols. They chose to use leftover cement that contained incompatible materials (BP\_00001310 §7), and made the decision to use only six centralizers instead of the recommended twenty-one, despite clear warnings about increased risks of channeling and cement contamination (BP\_00001415 §15).



BP's final abandonment plan introduced unprecedented risks by requiring the displacement of drilling mud to an unusually deep level of 8,367 feet (BP\_00001184). This decision, made without proper review or risk assessment, removed critical safety barriers and contributed directly to the disaster. The Transocean Well Control Handbook emphasizes the critical nature of monitoring and managing pressure during drilling operations (BP\_00001455 §14), yet BP consistently failed to implement these essential safety protocols.

Your Honor, when we look at the totality of evidence, we see a clear pattern emerge. BP's operational control and decision-making authority weren't just poorly exercised – they were exercised in ways that consistently prioritized expediency over safety, cost savings over proper procedure, and production targets over protection of life and environment. They failed to maintain critical equipment, ignored audit findings, misrepresented data to regulators, and disregarded explicit warnings about safety risks.

As the well operator with ultimate authority, BP bears primary responsibility for these decisions and failures. The documentation and testimony presented in this trial paint a clear picture of an operator that repeatedly chose to ignore warnings, bypass safety procedures, and put production ahead of protection. These weren't just poor choices – they were conscious decisions made by BP in their capacity as well operator, decisions for which they must be held accountable.

The American Petroleum Institute's Recommended Practice emphasizes that the operator bears ultimate responsibility for ensuring safety and environmental integrity in drilling operations. BP not only failed to meet this responsibility – they actively undermined it through their decisions and actions. The evidence clearly shows that BP's exercise of operational control and decision-making authority directly led to this catastrophic event, and they must be held accountable for these failures.





#### **IV. BP's Critical Failures**

Your Honor, having established BP's position of ultimate authority and control over the Macondo well, we must now examine how their management philosophy and operational decisions created the conditions that made this disaster not merely possible, but inevitable. The evidence reveals not just isolated mistakes or unfortunate oversights, but rather a systematic pattern of negligence flowing directly from their position of authority and driven by a corporate culture that repeatedly and consistently prioritized cost-cutting over safety.

Let me begin with what the evidence shows about BP's corporate culture, because it is this culture that transformed their operational authority from a mechanism for ensuring safety into a tool for pursuing profits at any cost. Under CEO Tony Hayward's "Forward Agenda," BP aggressively pursued cost reductions while simultaneously reducing management layers, explicitly prioritizing production and risk-taking over safety culture (BP\_00001402 §13, BP\_00001419 §1).

The evidence paints a clear picture of systematic cost-cutting at the expense of safety. BP targeted an aggressive 20% cost reduction across their operations (BP\_00001402 §1, BP\_00001402 §19). This wasn't a gradual, carefully considered efficiency program. Instead, it created intense pressure throughout the organization to cut corners on crucial safety measures. The company implemented a bonus structure that explicitly encouraged rapid drilling (BP\_00001402 §3, BP\_00001402 §22), creating direct financial incentives to prioritize speed over safety.

We heard testimony that BP's management was under constant pressure to complete wells quickly (BP\_00000003 §19). This pressure wasn't abstract – it manifested in concrete decisions that compromised safety. Time and again, when faced with a choice between a safer, more expensive option and a riskier, cheaper alternative, BP consistently chose to prioritize cost savings over safety. As documented in their own records, BP's management made deliberate choices to proceed with operations despite known risks (BP\_00001402 §4).



Most troubling, Your Honor, is BP's pattern of willfully ignoring critical safety warnings. The evidence shows that expert recommendations for safety improvements were routinely dismissed or disregarded (BP\_00001402 §21, BP\_00001402 §14). Internal audits revealing serious safety deficiencies were left unaddressed (BP\_00001061 §4, BP\_00001123 §1). The ModuSpec audit specifically identified thousands of hours of overdue maintenance on essential safety systems (BP\_00001073 §10), yet BP chose to return equipment to service without addressing these problems.

Even more damning, BP had both the financial resources and the legal obligation to implement necessary safety measures (BP\_00000003 §19, BP\_00001402 §4). The American Petroleum Institute's Recommended Practice emphasizes the importance of safety and environmental integrity in drilling operations (BP\_00000979 §1), guidelines that BP consistently failed to follow. They made these choices not because they lacked the means to do better, but because they prioritized cost savings over safety at every turn.

This wasn't just poor management, Your Honor. This was a deliberate corporate strategy that created an environment where disasters like this became not just possible, but probable. The evidence shows that BP's corporate culture systematically undermined safety protocols (BP\_00001402 §4), ignored audit findings (BP\_00001061 §4), and created an environment where meeting cost and time targets took precedence over maintaining crucial safety standards.

Your Honor, this culture of cost-cutting and disregard for safety manifested itself in a series of critical technical and operational failures that directly led to this disaster. Let me walk you through the most egregious of these failures, documented in detail by the evidence before this court.

First, consider BP's failures in well design and construction. The evidence shows that BP proceeded with an inadequate well design that violated federal regulations (BP\_00001355 §6). Their own documents reveal that the well design consistently lagged behind operations, creating chaos on the rig and forcing numerous last-minute changes that compromised safety (BP\_00001266 §2, BP\_00001359 §14). They



continued drilling despite knowing that even slight changes in mud weight could lead to well control problems, showing a reckless disregard for basic safety protocols.

The cement job failures are particularly telling. In what can only be described as an unconscionable attempt to save money, BP chose to use leftover cement that contained incompatible materials (BP\_00001310 §7, BP\_00001422 §3). Even more disturbing, they made the deliberate decision to use only six centralizers instead of the recommended twenty-one, despite clear warnings about the increased risks of channeling and cement contamination (BP\_00001415 §15, BP\_00001251 §2).

The challenges of deepwater cementing operations required special consideration of temperature effects and proper mud displacement (BP\_00001104 §2). Yet BP's documentation shows they failed to properly maintain critical equipment and ignored essential safety protocols (BP\_00001514 §1). These weren't complex technical decisions requiring careful balancing of competing factors. These were clear examples of BP choosing the cheaper, riskier option over the safer alternative.

But perhaps the most shocking evidence concerns BP's maintenance failures, particularly regarding the Blowout Preventer – the last line of defense against exactly this type of disaster. The evidence shows that the BOP had not been recertified for nine years (BP\_00001419 §6). A September 2009 audit revealed significant maintenance deficiencies (BP\_00000859 §69), with documentation showing thousands of hours of overdue maintenance tasks (BP\_00000872 §14).

Even more alarming, BP modified the BOP system, reducing its pressure rating from 10,000 psi to 5,000 psi without proper risk assessment (BP\_00001359 §7). They failed to implement available safety technologies such as acoustic trigger systems and wireless activation methods (BP\_00001359 §8), technologies that could have prevented this disaster.

The ModuSpec audit findings paint a devastating picture of BP's maintenance practices. The audit revealed significant maintenance deficiencies, including overdue tasks and non-operational critical equipment (BP\_00001061 §1). BP's maintenance documentation for critical components was either missing entirely or woefully



inadequate (BP\_00001061 §9). They failed to implement proper inspection and testing protocols required by industry standards (BP\_00001312 §22).

But the most catastrophic failures occurred in BP's decision-making during the critical moments leading up to this disaster. The negative pressure test failures are particularly damning. BP's well site leaders failed to prepare expected bleed-off volumes (BP\_00001552 §21), which severely hindered their ability to diagnose problems. They misinterpreted critical test results and proceeded with operations despite clear pressure anomalies (BP\_00001418 §4).

Most troubling of all, less than an hour before the first explosion, BP's senior drilling engineer and well site leader had a crucial conversation raising concerns about the validity of the test results. Yet they took no corrective action (BP\_00000001 §19). Think about that, Your Honor – they recognized the danger signs but chose to proceed anyway.

The evidence shows that BP had over 30 minutes between identifying these issues and the blowout – more than enough time to take decisive action that could have prevented this disaster (BP\_00000001 §20). Instead, they proceeded with operations despite multiple pressure anomalies and clear indications of well integrity issues (BP\_00000859 §37, BP\_00000950 §38).

This pattern of technical and operational failures wasn't random or coincidental. It was the direct result of BP's systematic prioritization of cost savings over safety, speed over proper procedure, and financial goals over operational integrity. The evidence shows a company that repeatedly chose the expedient path over the safe one, with catastrophic consequences.

Your Honor, as we examine these technical failures in detail, let us remember that behind every pressure reading, behind every maintenance log, behind every rushed procedure was a fundamental choice by BP to prioritize speed and cost savings over human life and environmental safety.



Beyond these operational and technical failures, the evidence reveals a pattern of systematic disregard for regulatory requirements that is equally troubling. BP didn't just fail to follow regulations – they actively misrepresented crucial information to regulatory authorities.

Consider the evidence about pressure testing. BP inflated pressure test results in their permit applications, claiming figures of 13.0 ppg when the actual figure was 12.55 ppg (BP\_00000859 §4, BP\_00001354 §3). This wasn't a minor clerical error – it was a deliberate misrepresentation of critical safety data. Their own documentation shows that BP's well design calculations contained concerning omissions in pressure test load cases (BP\_00000859 §27).

The American Petroleum Institute's Recommended Practice emphasizes the importance of safety and environmental integrity in drilling operations (BP\_00000979 §1). Yet BP routinely bypassed these safety requirements through creative reclassification of procedures. The documents show that BP failed to maintain proper inspection and testing protocols as required by industry standards (BP\_00001139 §26). A comprehensive Major Accident Hazard Risk Assessment identified numerous safety issues that required attention (BP\_00001092 §1), yet BP failed to address these concerns.

The Transocean Well Control Handbook emphasizes the critical nature of monitoring and managing pressure during drilling operations (BP\_00001455 §14). However, BP failed to implement these essential safety protocols. Their oversight responsibility extended to ensuring proper cementing practices and wellbore stability management (BP\_00001140 §4), yet they consistently fell short of these obligations.

What makes these regulatory failures particularly egregious, Your Honor, is that they weren't isolated incidents. The ModuSpec assessment identified significant maintenance issues prior to the incident (BP\_00000872 §2), which BP failed to address despite their oversight responsibility. Their disregard for safety protocols is evidenced by missing or inadequate maintenance documentation for critical components (BP\_00000864 §11).



The cumulative effect of these failures created what can only be described as a perfect storm. A September 2009 audit revealed significant maintenance deficiencies, with the BOP not being recertified for extended periods (BP\_00000859 §69). The audit identified 3,545 man-hours of overdue maintenance (BP\_00000444), demonstrating systematic neglect of safety protocols.

Your Honor, this wasn't a storm that arose naturally. It was one of BP's own making. Their approach to well design and operational decisions consistently demonstrated a lack of adequate consideration for critical safety factors. The ModuSpec audit specifically revealed thousands of hours of overdue maintenance on critical equipment (BP\_00000864 §1), yet BP continued operations without addressing these serious safety concerns.

The evidence shows that BP failed to properly maintain the BOP system, with audit findings revealing significant maintenance issues that were ignored (BP\_00001162 §8). They failed to implement proper inspection and testing protocols as required by industry standards (BP\_00001139 §26). The documentation shows systematic failures in maintaining crucial safety equipment and following established safety procedures.

Let me be clear about what the evidence proves: BP's critical failures were not mere accidents or oversights. Their technical and operational failures, combined with their systematic disregard for safety warnings and regulatory requirements, created the conditions that made this disaster not just possible, but inevitable.

The law recognizes different levels of culpability, Your Honor. There's ordinary negligence – the failure to exercise reasonable care. There's gross negligence – a conscious disregard for the rights and safety of others. And then there's willful misconduct – the deliberate choice to proceed with actions despite knowing the risks.

The evidence presented in this trial shows that BP's conduct falls squarely within the most serious categories of culpability. The challenges of deepwater operations required special consideration and careful planning (BP\_00001104 §1), yet BP consistently chose to prioritize speed and cost savings over safety. They failed to maintain proper



oversight of cementing operations (BP\_00001139 §4) and ignored critical safety protocols (BP\_00001455 §21).

The consequences were catastrophic. Eleven lives were lost. An ecosystem was devastated. And a community was forever changed. These weren't the result of an unforeseen accident or an act of God. They were the direct, foreseeable, and inevitable consequence of BP's critical failures and conscious choices.

Justice demands that BP be held accountable for these failures. The evidence compels a finding that they bear primary responsibility for this disaster through their gross negligence and willful misconduct. Anything less would fail to acknowledge the overwhelming evidence of their culpability and would send the wrong message about corporate responsibility in matters of public safety and environmental protection.

#### **V. BP's Knowledge of Risks**

As we come to the conclusion of this trial, I urge you to reflect on the evidence presented regarding BP's actions and decisions leading up to the catastrophic events of April 20, 2010. It is clear that BP possessed a profound knowledge of the risks associated with their operations, yet they chose to ignore critical warnings and engage in reckless behavior that ultimately led to the Deepwater Horizon disaster.

First, let us consider BP's **knowledge of risks**. We heard from Professor Bea, an expert in process safety, who provided clear warnings about the inherent dangers of deepwater drilling. He emphasized the necessity for BP to prioritize safety measures and heed the lessons learned from past incidents. Despite these warnings, BP's management failed to implement the necessary changes to their operational protocols. This negligence is not merely a failure of oversight; it is a blatant disregard for the safety of their operations and the lives of those on the rig (Document BP\_00001402 §14).

Moreover, the evidence revealed a troubling history of accidents at BP facilities, including the Texas City refinery explosion and the Grangemouth incident. These past failures should have served as a wake-up call for BP to enhance their safety protocols and risk management practices. Instead, they continued to operate under the same



flawed systems, ignoring the lessons that should have been learned. This pattern of negligence illustrates a corporate culture that prioritized profit over safety, further supporting the argument that BP was fully aware of the risks yet chose to ignore them (Document BP\_00001402 §14).

Now, let us address BP's **deliberate risk-taking**. The evidence presented in this trial has shown that BP made a conscious decision to use an inadequate number of centralizers during the cementing process. Despite recommendations from Halliburton for a greater number, BP opted for only six centralizers, significantly increasing the risk of blowout. This decision was not made in a vacuum; it was a calculated risk that BP took, prioritizing cost savings over the safety of the operation (Document BP\_00000001 §12). This deliberate risk-taking behavior is a clear indication of BP's negligence and disregard for established safety practices.

Furthermore, BP's temporary abandonment procedures were executed hastily, without proper risk assessment or adherence to safety protocols. The decision to proceed with a single negative pressure test, rather than the two tests outlined in their own approved plan, exemplifies this negligence. This rush to complete operations without adequate safety checks directly contributed to the blowout and subsequent disaster (Document BP\_00001391 §20). BP's actions in this regard reflect a reckless approach to safety that cannot be overlooked.

In stark contrast to BP's actions, we must recognize **TransOcean's appropriate actions** during this crisis. The crew of the Deepwater Horizon acted in accordance with established emergency procedures. They were trained to monitor well conditions and respond to abnormalities, demonstrating their commitment to safety even in the face of chaos. The crew's adherence to these protocols highlights their professionalism and dedication to preventing disaster (Document BP\_00000001 §23).

Moreover, the crew's attempts to manage the situation effectively, including efforts to close the blowout preventer and monitor pressure changes, further illustrate their proactive approach to emergency response. This stands in sharp contrast to BP's negligence in risk management and decision-making (Document BP\_00000001 §23).





Following the blowout, TransOcean demonstrated a commitment to transparency and cooperation with investigations. They provided necessary documentation and support to authorities, showcasing their dedication to understanding the causes of the disaster and preventing future occurrences (Document BP\_00001474). This cooperation is a testament to TransOcean's responsible actions in the aftermath of the incident.

TransOcean's collaboration with various agencies and stakeholders post-incident further illustrates their responsible actions. They worked alongside BP and other parties to address the aftermath of the disaster, indicating a willingness to engage constructively in the recovery and investigation processes (Document BP\_00001474). This cooperation stands in stark contrast to BP's actions, which were characterized by attempts to deflect blame and minimize accountability.

In conclusion, the evidence presented throughout this trial has clearly demonstrated that BP was fully aware of the risks associated with their operations and chose to ignore critical warnings. Their deliberate risk-taking behavior, including the use of inadequate centralizers and rushed abandonment procedures, directly contributed to the Deepwater Horizon disaster. In contrast, TransOcean's crew acted responsibly, following established procedures and cooperating fully with investigations. It is essential to hold BP accountable for their actions and recognize the diligence and professionalism of TransOcean's crew in the face of this tragedy. Thank you.

## **VI. TransOcean's Appropriate Actions**

As we turn our attention to the actions taken by TransOcean during the events surrounding the Deepwater Horizon disaster, it is essential to recognize the professionalism and adherence to safety protocols demonstrated by the crew. The evidence presented throughout this trial clearly shows that TransOcean acted appropriately in the face of adversity, contrasting sharply with BP's negligence and reckless decision-making.



## **A. Emergency Response**

First, let us discuss the emergency response of TransOcean's crew. Throughout this trial, we have heard compelling testimony that underscores the commitment of TransOcean's crew to follow established safety procedures. The crew was trained to monitor well conditions and respond to any abnormalities, demonstrating their dedication to safety even amidst the chaos of the situation. For instance, the crew's actions to activate the blowout preventer and monitor pressure changes were consistent with industry standards and best practices (Document BP\_00000001 §23). This adherence to established procedures highlights the professionalism of TransOcean's personnel and their commitment to preventing disaster.

Moreover, the evidence has shown that TransOcean's crew made several attempts to manage the situation effectively. They acted promptly to close the blowout preventer and monitor well conditions, demonstrating a proactive approach to emergency response. This is further supported by the documentation of their actions during the incident, which illustrates their commitment to safety and adherence to established protocols (Document BP\_00000001 §23). The crew's efforts to address the well control issues reflect their training and preparedness, contrasting with BP's alleged negligence in risk management.

## **B. Post-Incident Cooperation**

Now, let us consider TransOcean's actions following the incident. After the blowout, TransOcean demonstrated a commitment to transparency and cooperation with investigations. They provided necessary documentation and support to authorities, showcasing their dedication to understanding the causes of the disaster and preventing future occurrences (Document BP\_00001474). This immediate response is a testament to TransOcean's responsible actions in the aftermath of the incident.

Furthermore, TransOcean's collaboration with various agencies and stakeholders after the incident further illustrates their responsible actions. They worked alongside BP and other parties to address the aftermath of the disaster, indicating a willingness to engage constructively in the recovery and investigation processes (Document BP\_00001474).



This cooperation stands in stark contrast to BP's actions, which were characterized by attempts to minimize accountability and deflect responsibility.

In conclusion, the evidence presented throughout this trial has clearly demonstrated that TransOcean acted responsibly and appropriately during the crisis. Their adherence to established procedures and their commitment to cooperation post-incident highlight the professionalism of their crew. In contrast, BP's actions reflect a pattern of negligence and deliberate risk-taking that directly contributed to the disaster. It is essential to recognize the diligence and professionalism of TransOcean's crew in the face of this tragedy and to hold BP accountable for their actions. Thank you.

## **V. Conclusion**

Ladies and gentlemen, as we conclude this trial, the evidence overwhelmingly demonstrates that BP's decisions and actions were the primary causes of this disaster. Let me outline the specific failures that led to this catastrophic event:

First, BP's management practices consistently prioritized speed and cost savings over safety. Dr. Frederick "Gene" Beck's expert testimony conclusively shows that BP's failure to wait 24-48 hours for proper cement curing was a critical error. This wasn't just a minor oversight - it was a fundamental violation of basic drilling safety protocols (BP\_00001391 §4).

Second, BP's decision-making process was fatally flawed. They repeatedly ignored warning signs and proceeded with risky operations despite clear indicators of danger. The evidence shows that BP misreported pressure integrity test results, stating figures of 12.6 ppg instead of the actual 12.55 ppg, creating a false impression of safer operating margins (BP\_00001354 §9).

Third, BP's well site leaders, Mr. Haffle and Mr. Vidrine, failed to act on critical information during the negative pressure test. Despite observing pressure anomalies that indicated potential well control issues, they proceeded with operations based on a flawed theory known as the "bladder effect," which BP's own \$10 million Bly Report later discredited (BP\_00000001 §19).



In contrast, Transocean's commitment to safety and proper procedures is well-documented. Our crew was highly trained and respected throughout the industry. Murray Sepulvado, a BP well site leader, testified that he never had safety issues with our crew members and would gladly work with them again. The Deepwater Horizon was considered one of the best rigs in the world, having passed numerous inspections by government agencies, including the Coast Guard (BP\_00000001 §24).

The evidence shows that our crew maintained proper monitoring and response protocols. When anomalies were detected, they followed established procedures. The tragic fact is that they were working with incomplete information, as BP had failed to communicate critical data about well conditions (BP\_00000001 §23).

BP's own internal documents reveal their culpability. Their Management of Change (MOC) form dated April 15, 2010, identified significant risks associated with their cementing operations, yet they proceeded without adequate safeguards (BP\_00000052 §26). They failed to conduct proper testing, ignored warning signs, and prioritized operational efficiency over safety.

The testimony of Adam Bourgoyne further supports our position. He confirmed that while the drilling phase was conducted safely and in line with industry practices, the temporary abandonment phase - which was under BP's direct control - was not executed safely. Had BP followed proper procedures during this critical phase, the well would not have blown out, and the rig would not have exploded and sunk (BP\_00000045 §15).

BP's failure to maintain proper drilling margins is particularly damning. They operated with margins as low as 0.25 ppg, well below the approved minimum of 0.5 ppg, creating dangerous conditions that contributed directly to the disaster (BP\_00001354 §9). This wasn't just a technical violation - it was a conscious decision to operate outside safe parameters.

Furthermore, BP's decision-making process regarding the cementing operation was deeply flawed. They chose to proceed without having received critical foam stability test results, and they failed to wait for proper cement curing times. These decisions, made



purely for operational expediency, compromised the integrity of the well (BP\_00000008 §28).

The evidence also shows that BP failed to properly document and report significant well control events. Their own wells team leader, Mr. Guide, admitted to not recording multiple serious incidents, including 6,000-barrel and 3,000-barrel losses, in violation of their own safety protocols (BP\_00000052 §24).

In contrast, Transocean's safety record speaks for itself. From 2005 to 2009, we worked on nearly 7,000 wells, maintaining strict well control standards. Our goal was to keep kicks under 20 barrels, and the evidence shows that most were detected within 10 barrels, demonstrating our crew's vigilance and competence (BP\_00000001 §25).

Ladies and gentlemen, the facts are clear: BP's management failures and reckless decisions were the primary cause of this tragedy. They ignored safety protocols, misreported critical data, failed to communicate vital information, and prioritized operational efficiency over human lives and environmental protection.

Transocean's crew, including the nine dedicated professionals we lost that day, were victims of BP's negligence. They were highly trained, safety-conscious professionals who relied on BP's guidance and decision-making. The evidence shows they followed industry standards, maintained their equipment properly, and responded appropriately to the information they had available.

In closing, I ask you to consider the overwhelming evidence that points to BP's responsibility for this disaster. Their decisions and actions directly led to the loss of eleven lives and caused unprecedented environmental damage. Transocean should not be held liable for BP's failures. Justice demands that BP be held accountable for their actions and their disregard for safety protocols that could have prevented this tragedy.

Thank you for your attention to these crucial matters. The families of our lost crew members, the affected communities, and the principle of corporate responsibility all demand that we assign liability where it truly belongs - with BP's failed management practices and their prioritization of profit over safety.