1	UNITED STATES DISTRICT COURT
2	EASTERN DISTRICT OF LOUISIANA
3	
4	*****************
5	IN RE: OIL SPILL BY THE OIL
6	RIG DEEPWATER HORIZON IN THE GULF OF MEXICO ON APRIL 20,
7	2010
8	CIVIL ACTION NO. 10-MD-2179 "J" NEW ORLEANS, LOUISIANA
9	MONDAY, FEBRUARY 25, 2013
10	THIS DOCUMENT RELATES TO:
11	CASE NO. 2:10-CV-02771,
12	IN RE: THE COMPLAINT AND PETITION OF TRITON ASSET
13	LEASING GmbH, ET AL
14	CASE NO. 2:10-CV-4536, UNITED STATES OF AMERICA V.
15	BP EXPLORATION & PRODUCTION, INC., ET AL
16	INC., ET AL
17	******************
18	
19	DAY 1 MORNING SESSION
20	
21	TRANSCRIPT OF NONJURY TRIAL PROCEEDINGS
22	HEARD BEFORE THE HONORABLE CARL J. BARBIER
23	UNITED STATES DISTRICT JUDGE
24	
25	

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1 P-R-O-C-E-E-D-I-N-G-S 2 MONDAY, FEBRUARY 25, 2013 3 MORNING SESSION (COURT CALLED TO ORDER) 4 5 07:22AM 08:02AM 6 THE DEPUTY CLERK: All rise. 7 08:02AM THE COURT: All right. Good morning, everyone. 8 08:02AM VOICES: Good morning, Your Honor. 9 08:02AM THE COURT: Be seated. 08:02AM 10 All right, Stephanie, you may call the case, 08:02AM 11 08:02AM 12 please. THE DEPUTY CLERK: Multidistrict Litigation 10-2179, In 08:03AM 13 08:03AM 14 re: Oil spill by the oil rig Deepwater Horizon in the Gulf of Mexico on April 20, 2010; Civil Action 10-2771, In re: 08:03AM 15 The Complaint and Petition of Triton Asset Leasing GmbH, et al.; 08:03AM 16 Civil Action 10-4536, United States of America versus 08:03AM 17 08:03AM 18 BP Exploration and Production, Incorporated, et al. 08:03AM 19 THE COURT: All right. Counsel, I would like to have 08:03AM 20 those counsel who will be appearing during the trial to make an 08:03AM 21 appearance on the record right now, please. 08:03AM 22 MR. ROY: Your Honor, Jim Roy, good morning, PSC 08:03AM 23 coliaison. 08:03AM 24 MR. CUNNINGHAM: Your Honor, Robert Cunningham, PSC. 08:03AM 25 MR. WILLIAMS: Good morning, Your Honor.

08:03AM	1	Williams, PSC.
08:03AM	2	MR. IRPINO: Anthony Irpino on behalf of the PSC.
08:03AM	3	MR. DEGRAVELLES: John DeGravelles, PSC.
08:04AM	4	MR. STERBCOW: Paul Sterbcow, Your Honor, PSC.
08:04AM	5	MR. HERMAN: Good morning, Your Honor. Steve Herman
08:04AM	6	for the plaintiff.
08:04AM	7	MR. LEGER: Walter Leger, Counsel for the PSC.
08:04AM	8	MR. WILLIAMSON: Jimmy Williamson, PSC.
08:04AM	9	MR. WATTS: Mikal Watts, PSC.
08:04AM	10	MR. THORNHILL: Good morning, Your Honor. Tom.
08:04AM	11	Thornhill, PSC.
08:04AM	12	MR. CERNICH: Scott Cernich, the United States.
08:04AM	13	MR. CALDWELL: Buddy Caldwell, Attorney General for the
08:04AM	14	State of Louisiana.
08:04AM	15	MR. STRANGE: Luther Strange, Attorney General, State
08:04AM	16	of Alabama.
08:04AM	17	MR. O'ROURKE: Steve O'Rourke for the United States.
08:04AM	18	MR. UNDERHILL: Good morning, Your Honor.
08:04AM	19	Mike Underhill on behalf of the United States of America.
08:04AM	20	MR. BREIT: Jeffrey Breit on behalf of the PSC,
08:04AM	21	Your Honor.
08:04AM	22	MR. KANNER: Allan Kanner for the State of Louisiana.
08:04AM	23	MR. MAZE: Corey Maze for the State of Alabama.
08:04AM	24	THE COURT: Anyone else on the plaintiffs' side?
08:04AM	25	Let's move to the defendants.

08:04AM	1	MR. BROCK: Mike Brock for BP.
08:04AM	2	MR. REGAN: Matthew Regan for BP, Your Honor.
08:05AM	3	MS KARIS: Hariklia Karis on behalf of BP.
08:05AM	4	MR. LANGAN: Andy Langan for BP.
08:05AM	5	MR. HAYCRAFT: Don Haycraft, BP.
08:05AM	6	MR. BECK: David Beck for Cameron.
08:05AM	7	MR. ROBERTS: Steve Roberts, Transocean.
08:05AM	8	MR. MILLER: Kerry Miller, Transocean.
08:05AM	9	MR. BRIAN: Brad Brian, Transocean.
08:05AM	10	MR. DOYEN: Michael Doyen, Transocean.
08:05AM	11	MR. Li: Luis Lee, Transocean.
08:05AM	12	MS. CLINGMAN: Rachel Clingman, Transocean.
08:05AM	13	MR. HYMEL: Richard Hymel, Transocean.
08:05AM	14	MR. GODWIN: Don Godwin, Halliburton.
08:05AM	15	MR. YORK: Alan York, also for Halliburton.
08:05AM	16	MR. HILL: Gavin Hill, also form Halliburton.
08:05AM	17	MR.: Floyd Hartley for Halliburton.
08:05AM	18	MR. VON STERNBERG: Jerry Von Sternberg, Halliburton.
08:05AM	19	MR. TANNER: Hugh Tanner for M-I.
08:05AM	20	MS. SCOFIELD: Denise Scofield for M-I.
08:05AM	21	MR. FUNDERBURK: John Funderburk, for M-I.
08:05AM	22	THE COURT: I'm sorry, what's your name, sir? I don't
08:05AM	23	have you on my list. What's your name?
08:05AM	24	MR. FUNDERBURK: John Funderburk.
08:05AM	25	THE COURT: Funderburk?

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MR. FUNDERBURK: Yes, sir.

THE COURT: Okay, thank you.

MR. WITTMANN: Phil Wittmann, Cameron.

MR. JONES: David Jones for Cameron.

MR. GANNAWAY: Geoff Gannaway for Cameron.

MR. ROBERTS: Alan Roberts for Cameron.

MR. KINCHEN: John Kinchen for Transocean.

THE COURT: All right. Does that cover everyone?

All right. In a few moments, we will begin what are called *opening statements* by counsel for the parties. It's anticipated that these opening statements will take up the rest of today.

These statements, of course, are not part of the evidence in this trial, but are an opportunity for counsel for each party to give us an overview or a preview of what they believe the evidence will show.

At the conclusion of the opening statements today, we will recess the trial and resume in the morning with the first live witness.

Before counsel begin their opening statements, however, I want to address a few matters regarding courtroom conduct and, also, explain some other things about the trial itself.

This is the first phase of what is expected to be a multiphase trial. The parties have estimated that this first

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phase will take approximately three months to complete.

Ordinarily, we will hold trial Monday through Thursday beginning at 8:00 a.m. and recessing not later than 6:00 p.m.

This is a bench trial. As everyone can see, we have no jury, which is customary in admiralty cases such as this.

At this time, I ask everyone to make sure that your cell phones, laptops, iPads, tablets or any other electronic devices are either turned off or placed on silent mode. If you need to use your phone, please step into the hall and away from the courtroom doors to do so.

I also expect that proper decorum will be maintained at all times during this lengthy trial. We, of course, cannot have any sorts of verbal commenting or outbursts during the trial or during a witness's testimony, so please heed this caution.

No food or drinks are allowed in the courtroom.

An exception is that counsel for the parties may have water at their tables.

I also remind everyone that the taking of any type of photographs or video anywhere in the federal courthouse complex is strictly prohibited. Any recording, broadcasting or transmitting any part of a trial in a federal courthouse is prohibited. These are not simply my rules. It is the policy

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of the judicial conference of the United States.

Anyone who violates these rules may be subjected to sanctions, including fines, seizure of the camera, phone or other device, and possible ejection from the courtroom and courthouse.

These rules and other matters regarding public access to the trial are set forth in the Court's Order of January 18, 2013, which is Record Document 8291. It's also posted on the Court's public website on that date, and I strongly encourage everyone to read this article.

Also, we have several overflow courtrooms where there are audio feeds and evidence presentation screens. So those of you who cannot get into the courtroom will nonetheless be able to hear the live testimony, what is occurring in this courtroom, and you'll be able to see whatever is on the evidence presentation screens at the same time.

The same rules about what is prohibited in the courthouse and in the courtroom apply to these overflow courtrooms as well.

Now, I would like to give some brief context to this trial, primarily to help the press and public understand the nature of the current proceedings.

These comments are provided merely to establish background and do not constitute rulings or findings by the Court. So, for example, if my description of a particular

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statement is not binding.

As you are all probably aware, this trial

party's role is not entirely accurate or complete, that

As you are all probably aware, this trial concerns the April 20, 2010 blowout, explosion and fire on the mobile offshore drilling unit *Deepwater Horizon* as it was preparing to temporarily abandon the Macondo well, an exploratory well drilled in Block 252, Mississippi Canyon, on the Outer Continental Shelf, approximately 50 miles south of Louisiana.

That catastrophe took the lives of eleven men and injured many others.

On April 22, after burning for two days, the rig sank into the Gulf of Mexico. For roughly the next three months, oil continuously discharged into the Gulf before the well could be capped. Later, the well was permanently sealed via a relief well.

There are a number of parties participating in this Phase One of the trial. For example, the plaintiffs, or claimants, include, among others, the United States of America, the States of Louisiana and Alabama, and numerous private individuals, businesses or other entities who have filed claims in Transocean's limitation action.

There are also multiple defendants. BP was the operator and leased the Macondo prospect site from the federal government.

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Transocean owned the *Deepwater Horizon* and was contracted by BP to drill the Macondo well.

Halliburton was contracted by BP to provide cement and related services for the Macondo well.

Cameron manufactured and sold to Transocean the Deepwater Horizon's BOP, or blowout preventer, which was installed near the wellhead.

M-I was contracted by BP to provide certain drilling fluids, among other services and materials.

In August of 2010, numerous individual lawsuits stemming from these events were consolidated before this Court in what is called a multidistrict litigation, or commonly called an MDL.

This Phase One trial concerns two of the cases within this MDL: Case number 10-2771, which is the Transocean entities limitation action, under what is known as the Shipowners' Limitation of Liability Act, which I will further discuss in a moment; also, Case Number 10-4536, the United States' action for certain damages under the Oil Pollution Act of 1990, or also called OPA, and for civil penalties under Section 311 of the Clean Water Act.

Both of these cases are before the Court for all purposes including trial, as opposed to some of the other cases that were transferred here for pretrial purposes only under the MDL statute.

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The Shipowners' Limitation of Liability Act is an 1851 federal statute which permits a vessel owner to file a complaint in federal court seeking exoneration from liability or, alternatively, limitation of liability equal to the post-casualty value of the vessel, plus any pending freight.

If the vessel owner complies with certain requirements, claims against the vessel owner pending in other courts are stayed, and the claims instead must be brought in the limitation proceeding.

In this manner, all claims are marshaled together in what is called a concursus. The vessel owner may also join third parties it believes are liable to the plaintiffs, who may likewise crossclaim against one another and/or counterclaim against the vessel owner.

This is what happened here. Transocean filed a limitation complaint. Claims were filed in the limitation proceeding. Transocean brought third-party claims against BP, Halliburton, Cameron, M-I and others, who then cross-claimed against one another and counterclaimed against Transocean.

A vessel owner may limit its liability only if it shows that the fault causing the loss occurred without its privity or knowledge. Thus, the Court must determine what acts of negligence or unseaworthiness caused the casualty and whether the vessel owner had knowledge or privity of these acts.

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The burden of proving negligence or unseaworthiness is on the claimants. The burden will then shift to the vessel owner to prove lack of privity or knowledge.

It should be noted that even if Transocean is entitled to limit its liability, there would be unresolved questions about what claims are subject to the limitation, particularly with respect to claims under OPA.

Although Transocean is technically the plaintiff in the limitation action, to simplify matters during this trial, I will typically refer to the United States, the States and the private plaintiffs as the plaintiffs, and I will refer to Transocean and BP, Halliburton, Cameron and M-I as the defendants.

As mentioned, the United States' action brings claims under OPA and the Clean Water Act. This action is being tried with Transocean's limitation action because there are some overlapping issues, particularly whether BP or Transocean acted with gross negligence or willful misconduct.

This is because the Clean Water Act imposes a civil penalty for harmful discharge of oil, the maximum value of which is determined primarily by two factors, how much oil was discharged, and whether or not the discharger acted with gross negligence or willful misconduct.

Phase One of this trial will address fault

determination and allocation relating to the loss of well 08:15AM 1 2 control or blowout, the ensuing fire and explosion, capsizing 08:15AM 3 and sinking of the Deepwater Horizon, and the initiation of the 08:15AM release of oil from the well. 4

> Phase One will also include issues related to Transocean's exoneration, limitation and liability defenses, as well as the issues relating to various crossclaims, counterclaims, etcetera, between the various defendants.

> It is important to understand that the particular losses or damages suffered by any one plaintiff will not be determined in this phase, nor will the Court determine the amount of any civil fines or penalties in this phase of the trial.

> Also, the Court will not hear evidence relating to or decide in this phase issues regarding the response efforts following the spill or the quantity of oil that escaped before the well was capped. Those issues will be subjects of a later Phase Two trial.

Now, the Court has previously allocated time for opening statements and assigned the order in which they will occur.

The private claimants represented here today by the Plaintiffs' Steering Committee will have 75 minutes of opening statements. The United States will then follow for The States of Louisiana and Alabama have a total

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of 20 minutes. Transocean then has 60 minutes, Halliburton 60 minutes, BP 90 minutes, Cameron 10 minutes, and M-I 10 minutes. If my math is correct, that's a total of 370 minutes, or a little over six hours.

During the trial, the order of proof, the order will generally go as follows: First, the PSC, the United States and the States will present evidence in support of their claims against all defendants.

Second, Transocean will present evidence on its exoneration, limitation and liability defenses, as well as any counter, cross or third-party claims against other defendants.

Third, the remaining defendants shall present their evidence in support of their defenses in counter, cross and third-party claims.

And fourth, the PSC, USA and States shall present any rebuttal evidence.

Finally, a few notes regarding evidence presentation. The parties deposed many, many witnesses prior to trial. This means that witnesses were questioned by counsel outside of court under oath, and those examinations were recorded. Transcripts of these depositions have been submitted to the Court in advance of trial.

During the trial, a witness's deposition transcript may be introduced into evidence in lieu of having that witness appear in person to testify live.

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shorter video clips from certain depositions.

The parties have also prepared numerous exhibits that will be submitted as the trial progresses.

In addition, the parties may at times play

The plan is to have Magistrate

Judge Sally Shushan assist the Court and the parties each

Thursday afternoon in marshalling the materials which were used or introduced during that week.

All of the depositions and exhibits are in electronic format and will be made available for the press and public as follows.

During each week of the trial, the report and résumé of each expert who testifies will be introduced into evidence. The report will be a part of the expert's trial testimony on direct examination.

At the first marshalling conference, the PSC will tender for filing into the record fact witness deposition transcripts and exhibits. Those will be proffered subject to objections which have been lodged by various parties. That procedure will continue through the course of the trial.

Let me provide the press and the public, particularly, a caveat here about this. Because of the sheer volume of evidence that the Court has already seen and will see during the course of this trial, some of the testimony and exhibits that will be admitted during the trial will be

admitted subject to certain objections. That means that the Court may later exclude some of this evidence and not take it into consideration in reaching its decisions in this case.

So I would just caution the press and public that just because something is mentioned in testimony or an exhibit is introduced at trial, if it is subject to an objection, that does not preclude the possibility of it being excluded at a later date.

This is being done as an accommodation, again, because of the sheer volume of evidence that the parties and the Court are working with in this case.

All right. Again, the plan is that all deposition transcripts, related exhibits, expert reports and résumés, and the exhibits that are marshalled each week will be made available and posted each week on a public FTP Internet website, which is www.MDL2179trialdocs.com. The link to that will be posted on the Court's public website.

That is not a court-maintained website, however, but it is a website where all of this information will be posted weekly and will be available to the public or press.

So if anyone has any further questions about public access to trial materials, you should refer to the recent Order of the Court issued February 22nd, 2013, which will be available on the Court's public website. The Court's website, by the way, for the benefit of those who do not know,

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is www.laed.uscourts.gov.

If you go there, that's the Court's home page, there is a link to MDL 2179.

Please do not, do not call the Court or contact the Court staff about this. All information you should have is posted at the Court's website. There's really nothing else we can tell you, so please do not call or contact the Court staff with these questions.

I should also note that the parties have made available to the Court and to the court reporters a glossary of certain terms and acronyms that may be used from time to time during the trial.

The oil and gas industry is a specialized and highly technical industry, and there are a lot of acronyms that will be used. I'm going to ask the parties and the attorneys to try to avoid using acronyms as much as they can during the trial; but, so that the press and the public can understand what's going on, we do have a glossary that can be made available that would be helpful.

With regard to the press corps, you will note that we have two benches in the courtroom reserved for members of the credentialed media.

In addition, at least for this first week, we have arranged, in addition to the three normal overflow courtrooms which we should have for the length of the trial,

just for the week of C-224, which is Jude 18:23AM 2 C-224, which is Jude 18:23AM 3 hall from my courtre 20:23AM 4 proceeding that she 20:23AM 5 courtroom to allow 19:23AM 6 This is 18:23AM 7 there are courtrooms

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just for the week only, we've arranged for the use of Courtroom C-224, which is Judge Milazzo's courtroom directly across the hall from my courtroom. She's been kind enough to move one proceeding that she had scheduled this week to another courtroom to allow us to use that courtroom.

This is going to be a week-to-week thing. If there are courtrooms available, I'll try to make another district court courtroom available.

In that courtroom, it's a no lawyer zone. We figured out or counted that the lawyers have enough room between taking up most of this courtroom and three other courtrooms that we needed space reserved for the press and public.

So if there are any members of the press who could not get in this courtroom and/or would just like a more convenient place to work, we have five tables reserved for use by the press across the hall. The rest of the seating in there is for the public.

All right. And again, that courtroom, like the other overflow rooms, will have a live audio feed and evidence screens for you to follow what's going on in this courtroom.

One more thing before we begin opening statements. I want to announce to the lawyers and to everyone else that I've looked at the calendar. We had already announced that we would not work -- this trial, as I said, is

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expected to last three months. We've already announced that we would not work or hold court on the Thursday and Friday immediately preceding Easter weekend.

And in thinking about it and looking at the calendar, since a lot of the attorneys and parties in this case are from out of town, to accommodate them, I've decided that we would also not work on the Monday right after Easter, which I think is April 1, so that way you all can make travel plans so you don't have to travel back -- so those of you out of town don't have to travel back on Sunday, if you care to stay home for that weekend.

Okay. Does anybody have any other preliminary matters before we begin opening statements?

All right. Who is going to make opening statements? Mr. Roy?

OPENING STATEMENTS

BY MR. ROY:

Good morning, Your Honor. I'm Jim Roy for the Plaintiffs' Steering Committee.

Why did this terrible tragedy happen? That's why we're gathered. Let's begin with Transocean, the owner and the operator of the *Deepwater Horizon*. They seek limitation of their liability. The evidence is going to show Transocean failed to discover a major gas kick and shut in the well on April 20, 2010.

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A critical part of the temporary abandonment procedure from Macondo was a negative pressure test. This was a shared responsibility between BP and Transocean. The test was misinterpreted. This led to the mistaken belief that the well was secure and that it was safe to go forward with displacement of the heavy drill mud with much lighter seawater.

Richard Heenan, an expert petroleum engineer, will describe the failure to interpret this test correctly as a gross and extreme departure from the standards of good oilfield practice.

Transocean's own standards state that a kick that is over 20 barrels is code red and critical. The Macondo kick is described as off the chart and unprecedented, exceeding not 20 barrels, but exceeding 700 barrels, and consuming 50 minutes of time before the kick was detected and unsuccessful efforts made to shut it in.

The evidence will show Transocean's failure to discover this giant gas kick and to shut in the well was a result of the willful failure of Transocean management to give its *Deepwater Horizon* crew, and other crews on other rigs, adequate training.

The evidence shows that despite a wealth of information showing that this well was flowing, this Transocean crew, BP and Halliburton Sperry logger totally missed the kick on April 20, 2010, that according to BP's own expert,

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Robert Grace, my dad would have caught.

The evidence will show the ultimate responsibility at Transocean for this gross and extreme departure from good oilfield practically rests with the management of Transocean.

Transocean never specifically trained any member of the drill crew, including the offshore installation manager, the driller, the assistant driller or the toolpusher on how to interpret a negative pressure test. Amazingly neither Transocean's formal training, its training materials, nor its well control handbook cover or even discuss negative pressure tests.

The catastrophic failure of the *Deepwater Horizon* crew and BP and Halliburton on April 20, 2010, to catch the riser unloading, the kick, was no isolated event. The evidence will show that Transocean had known for years that its rig personnel were not adequately trained to recognize and shut in gas kicks, especially riser unloading events like that involved on the *Deepwater Horizon* disaster.

Transocean's investigation of an incident as far back as 2004 on another semisubmersible concluded procedures were not set up to effectively detect kicks. The team did not heed warnings in the drill program. The team did not use disciplined, coordinated procedures to monitor for well influxes, and prophetically, alarms were turned off.

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By March of 2008, the situation had deteriorated such that Larry McMahon, Transocean's vice-president of performance, wrote an e-mail to management teams about a series of recent loss-of-control-type events, including, as an example, loss of well control.

This is what he said, among other things, "We cannot ignore what has happened in the area of loss of control. This is very concerning to me. The problem is that we are having events at a rate that is overwhelming. We would be better off investing that time in the prevention side and more effective risk assessment, as well as adherents to proceed."

And then McMahon prophetically concluded, "If we do not change the way we operate, we will continue to have these train wrecks."

That's in 2008. A year later, in March of 2009, following yet another riser unloading incident in February of '09, on a Transocean rig, Transocean determined, there was no task risk assessment performed; that Management of Change was not adequately addressed; well control training and the well control manual does not adequately cover the procedures for closing in a well during a blowout situation; also, the use of the diverter is not adequately covered.

The report also found that there had been no specific training given for handling a kick in the riser and a lack of explanation about the proper use of the diverter. It

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also recommended well control reference material and training should adequately cover the use of the diverter and what to do in the case of the riser unloading. And rig management should use Management of Change procedures to ensure adequate risk assessments are performed.

Transocean management refused to act on these recommendations until the April 20th catastrophe.

Again, in late July of 2009, another well control event on another Transocean rig, once again, demonstrated the inadequacy of crew training problems to management. It involved multiple failures to shut in the well when influxes were clearly detected, and not shutting in the well during an influx. Just five months before this disaster.

In December of 2009, another well control incident occurred aboard the Transocean Sedco 711, involving an uncontrolled release of hydrocarbons on the drill floor due to Transocean crews failure to notice kick indicators.

The Transocean investigation of this incident prophetically revealed that Transocean's mind-set is certainly less vigilant regarding well control preparedness during the completion phase as compared to the drilling phase.

Although the investigation again made the recommendation that Transocean's well control handbook add a section on performing fluid displacements, this was not done until after the *Deepwater Horizon* catastrophe.

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Randy Ezell, Transocean's senior toolpusher aboard the *Deepwater Horizon*, will recall several declared well control events on the *Deepwater Horizon* before this one where hydrocarbons made it past the blowout preventer and to the bottom of the rotary table thousands of feet up above on the drill floor, and had the potential to endanger life in the environment.

In fact, on March 8th of 2010, just a month before this disaster, the Transocean crew on the Deepwater Horizon failed to catch a gas kick for some 35 to 40 minutes. Once again, demonstrating a pattern that had reflected itself over years, that lack of training in kick detection and well control was no isolated incident with Transocean rigs, but rather was a chronic problem, allowed by Transocean management to go uncorrected.

The BP well team leader at the time, in March of 2010, in fact, commented, Transocean's drill crew had screwed up by not catching it.

In its annual well control report for 2009,

Transocean management itself recognized the following: "The increasing trend seen in 2009 of drilling risers being either partially or completely evacuated or unloaded."

Again, from December of 2008 until year end 2009, this type of event, that's riser unloading, occurred six times on Transocean rigs.

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"It is particularly hazard," it went on, "due to the uncontrolled release of mud and gas through the rotary table and the potential for ignition. Riser unloading events can be avoided through the application of fundamental well control practices, such as treating every positive indicator as a kick, shutting in quickly, and taking returns through the choke whenever in any doubt, any doubt whatsoever."

Transocean management knew about the widespread nature of well control problems on its vessels, and that the time spent on well control events had increased in 2009.

The failure of Transocean drill crews to know and follow basic well monitoring kick detection and shut-in procedures was well known to upper level management at Transocean and continued unabated and uncorrected, despite their knowledge, up to and including this tragedy.

The fateful April 20th, 2010, riser unloading was at least the seventh that a Transocean rig had experienced in just the previous 17 months. This chronic problem ultimately led to the disaster of April 20th, 2010, which Larry McMahon, Transocean's own vice-president operations and performance, agreed was a train wreck of the largest magnitude.

The evidence is also going to show that Transocean willfully failed to adequately train its crew in other safety critical functions. There was no competence assurance system in place aboard the *Deepwater Horizon*.

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In fact, Lloyd's Register, an entity trusted by drillers across the world to tell them what their problems are, Lloyd's Register issued a report covering an assessment from March 9th to 26th of 2010, just weeks before this catastrophe, in which it discussed Transocean's safety management and safety culture.

Among the supervisors' comments recounted in the report were the following ominous indications of training failures: "The workforce was not always aware of the hazards they were exposed to, relating to both their job and to other jobs in the same/adjoining work areas."

"The risk posed by identified hazards were not fully understood, and the subsequent control measures were not always appropriate. They don't know what they don't know."

The report concluded this section with the comment, "This clearly demands attention, as frontline crews are potentially working with a mind-set that they are fully aware of all the hazards when it's highly likely that they are not."

The International Safety Management Code, ISM for short, required Transocean to appoint a designated person ashore who has responsibility for safety on a given rig, and has access to the highest levels of management.

Gerald Canducci was Transocean's designated person ashore for the *Deepwater Horizon*.

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Jeff Webster, a marine expert testifying on behalf of the PSC, will testify that Mr. Canducci was not even minimally competent for this job. His training consisted of a three-day course. Amazingly Mr. Canducci had never been on board the Deepwater Horizon. And this is the man with the responsibility for safety that management had entrusted to that job.

The captain of the Deepwater Horizon,

Carl [verbatim] Kutcha, was also woefully under trained. Good guy, good captain, but under trained in the safety management system of the vessel, despite the ISM requirement that he, no one else, he be in charge of implementing it, and he had never been trained in it adequately. He had never been trained in the operation of the vessel's emergency disconnect system either.

Compounding this problem was the Deepwater Horizon's dual command structure, which prevented Captain Kutcha, the captain of the vessel, from activating the emergency disconnect system until Jimmy Harold, the offshore installation manager arrived.

The evidence will show that if Captain Kutcha had been given the requisite training and authority by Transocean management, earlier activation of this emergency disconnect system could have averted much of the catastrophe, either altogether or at the very least mitigating it by reducing loss

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of life, injuries, the vessel, and pollution.

Amazingly, the offshore installation manager,

Jimmy Harold's certificate did not allow him to be the OIM and
the person in charge on this vessel.

Senior dynamic positioning officer, DPO,
Yancy Keplinger had no training on the safety equipment on the
bridge of the vessel where he acted as senior watch keeping
officer and held no proper license for the job he was
performing. Neither he nor dynamic positioning officer
Andrea Fleytas had ever received training on a scenario like
the one which occurred on the day of this fateful disaster
where there was a contemporaneous activation of numerous gas
detection alarms.

The evidence will establish that this overarching Transocean management failure to adequately train this crew directly contributed to the events leading to the blowout explosion, deaths, the loss of *Deepwater Horizon*, and the ensuing pollution.

The evidence will also show that Transocean's crew recklessly misused equipment by diverting the blowout through the mud-gas separator, instead of the rig's diverter system.

The mud-gas separator is a low-pressure system,

Judge, used to separate small amounts of gas coming up in the

mud returns and taking them out. It's not designed or intended

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to handle large amounts of gas or gas under high pressure in an emergency.

Transocean's policy on this thing did dictate that the gas diverter system, not the mud-gas separator, be used in the event of a well control event requiring diversion of large amounts of gas.

The evidence will show that when the poorly trained crew of the *Deepwater Horizon* failed to divert the kick through the emergency diverter system, the mud-gas separator was quickly overwhelmed by the high volume of gas and pressure and the entire vessel was engulfed in flammable gas.

The evidence will show had the emergency diverter system be used instead of the mud-gas separator, the Deepwater Horizon crew would likely have survived without casualty and the vessel not been destroyed.

This lack of adequate training in the proper use of the diverter system was once again evidence of a chronic problem known to senior management in failure to train but which remained uncorrected for years.

The evidence will also show Transocean willfully overrode several automatic functions of the integrated alarm and control system. In the course of this trial, Judge, you may have people refer to that as the I-A-C-S or IACS or the Kongsberg system. It's one in the same.

By overriding the automatic functions, it

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required human intervention to activate the shutdown system. Specifically, the integrated alarm and control system was designed to control a number of safety critical functions automatically upon the detection of combustible gas, including the sounding of a general alarm, and the activation of an emergency shutdown system, and activation of a fire and gas safety system.

The emergency shutdown system, or ESD, as some call it, would in turn stop gas from entering the engine room, which was the major potential source of gas ignition on this rig, by closing dampers that allowed -- stopped air from entering the room itself where the engines were, sounding audible alarms and actually shutting down the over-speeding engines to deny an ignition source to all the natural gas that had set the alarms off to begin with.

By Transocean's inhibiting these alarms in this alarm and control system and requiring human intervention to activate the shutdown system, while the alarm signalling the influx of gas would be reported to the bridge, it would no longer automatically activate these other safety critical functions. And this meant a lot when time was of the essence on the fateful day of April 20th of 2010.

In addition, many of the centers which served as the origination point for signalling an influx of gas amazingly had either been set into passive mode or otherwise had their

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sensors set basically into what is functionally a passive mode and removed from service.

This inhibition of the integrated alarm and control system was Transocean company policy. Why? Transocean chief electronics technician, Mike Williams, will testify in this courtroom that inhibiting the alarms was done to avoid waking people up at night.

Transocean personnel failed to activate the emergency shutdown system fast enough to do any good. Why?

Even with the automatic function inhibited, the crew could have activated the emergency shutdown system, but why didn't they?

Because after the blowout there was chaos and mayhem on the bridge, shouts, directions being yelled that weren't being enacted. Captain Kutcha had a deer-in-the-headlights look, was overwhelmed, dazed and confused.

Even after the second explosion, it took three requests from Chris Pleasant, another crewmember, to the captain to allow him to activate the emergency disconnect system before the captain finally authorized him to do it.

During this critical time when the captain could have activated the emergency disconnect system, but under the then existing dual command structure, he was prevented from doing so until the offshore installation manager, Jimmy Harold, arrived and gave his approval.

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Had this been done promptly, the vessel probably would have been saved and pollution minimized. But because of the dysfunctional dual command structure and lack of adequate training, the emergency disconnect system was not even activated manually. Certainly not timely.

The evidence will show the master of the Deepwater Horizon, in other words, did not have overriding authority and responsibility from Transocean management to take the decisive action he needed to take to protect the crew, the vessel, and the environment. This constituted a major nonconformity with the ISM code and contributed significantly to the magnitude of the disaster.

Transocean executive management had been warned about this problem. They had been warned about this since the first days of the *Deepwater Horizon*'s operation nine years earlier.

In the initial ISM certification by an organization called Det Norske Veritas or DNV, an international respected organization that does inspections for vessel and owners, for compliance. They identified that the authority and responsibilities of the master and OIM were in conflict.

DNV raised this ISM code nonconformity issue, requiring action to be taken by August of 2002. Seven years later, in 2009, DNV again cautioned Transocean management about this problem. The company was requested to address it.

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For seven years before this tragedy, this critical problem had been known to Transocean executive management but Transocean still had not corrected the situation as of April 20th, 2010.

Other key members of the Transocean bridge team were poorly trained and failed to act in a timely manner. When the cascading alarms did sound, in fact, dynamic positioning officer Andrea Fleytas failed to announce, "This is not a drill," because she was too nervous.

Even worse, the more senior DPO, dynamic positioning officer, Yancy Keplinger failed to intervene and allowed this to happen. Indeed, Keplinger agrees that he had never received training for a scenario where there was a contemporaneous activation of numerous detections and alarms going off.

Transocean's design involvement and willful refusal to upgrade and maintain the *Deepwater Horizon* blowout preventer was also a major cause of this disaster. The blowout preventer or BOP, is a safety critical piece of *Deepwater Horizon* vessel equipment, owned by Transocean.

And the evidence will establish that because it's the main barrier protecting human life, equipment and the environment, it must function without fail. BOPs are viewed in the field as the last line of defense to a blowout.

Transocean participated with BP and Cameron in

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the original design of the Deepwater Horizon blowout preventer and the selection and configuration of the component parts. Under the drilling contract, Transocean was to furnish the blowout preventer and ensure that it was adequately maintained in such a condition as to permit its continuous and efficient operation.

As stated by Transocean's CEO, Steve Newman, "The BOP on the Deepwater Horizon is a piece of Transocean equipment, and we are responsible for the maintenance of that piece of equipment."

Multiple audits warned BP and Transocean that the BOP was out of certification and in violation of industry standards.

Transocean's well control handbook required the BOP to be able to handle the maximum pressure and temperature conditions for any well where it was to be used. evidence will show that this BOP could not.

If Transocean concluded that the BOP was unfit for a particular well, it, Transocean, was obligated to either change the BOP or not drill the well.

Now, the converse is true, too, Your Honor. evidence will also show that if BP realized that the equipment of the rig was not fit for the well it wanted the rig to drill, then BP, too, had the obligation not to take that rig but to get another or make them change it.

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Transocean knew that drilling crews frequently confronted situations where the blind shear rams on the BOP would encounter off-center piping. Yet Transocean chose not to upgrade the blind shear rams with better cutting blades even those they were cheap, easily available and easily installed.

Transocean knew as early as 2001, that a single blind shear ram represented a single point of failure, and knew that double-blind shear rams were available and becoming more common in 2009 and 2010, yet Transocean chose to continue with the single ram.

Transocean knew of the potential for the BOP failure under dynamic flow conditions. Dynamic flow conditions, oil, gas, high-pressure liquids or distillate actually flowing rapidly through it and you try to close it. That's a dynamic condition versus a static condition, it's already closed and it's just holding the pressure back.

Transocean knew of the potential for BOP failure under these dynamic flow conditions and knew that blind shear rams had not been tested under dynamic flow conditions, and willfully chose not to do that testing itself to see if they would work and under what dynamic flow conditions. For that matter, there was no BOP shear testing at all.

Transocean management knew that the batteries on the pods of the BOP could not be monitored, checked or charged while the BOP was 5000 feet underwater on the sea floor, and

knew that its maintenance and recordkeeping system regarding 08:55AM 1 2 the batteries was seriously flawed such that one could not tell 08:55AM 3 when the batteries had been changed. Yet Transocean did not 08:55AM change its recordkeeping system. 4 08:55AM Transocean knew the potential danger of running 08:55AM 5 08:55AM 6

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Transocean knew the potential danger of running the cables, they are called MUX cables, that powered and controlled it and give feedback to the surface and vice versa, Transocean knew that by running the MUX cable through the Moonpool, the hole in the rig, that it created a single failure point if there was an explosion that could knock out both redundant cables from the same explosion. It chose not to take steps to correct that. It also failed to add an acoustic trigger system to the blowout preventer activation, which Transocean, in fact, utilized on other rigs in other places in the world.

In violation of the ISM code, the Deepwater Horizon had not been in for drydocking inspections and repair during its entire nine years of existence. PSC expert Geoff Webster says that was reckless and inexcusable.

Furthermore, Transocean had a reactive, rather than a proactive, condition-based maintenance system, which, from the view of Transocean Chief Mechanic Doug Brown, translated to a run it till it breaks philosophy.

Yet, barely six months before this disaster,

Paul Johnson, the Transocean Rig Manager - Performance, when

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asked about one of the Deepwater Horizon's -- when asked about its readiness to commence operations, he told BP, Transocean is satisfied we can start up operations safely.

Less than a month after making that safe to start up representation to BP, he was telling his own team that he understood why the Deepwater Horizon was in its current bad condition, a condition that Steve Bertone, the Deepwater Horizon Maintenance Supervisor, had just told the same Mr. Johnson the day before. "The issue that the Deepwater Horizon is currently experiencing, in my opinion, is a lack of proper maintenance on the equipment for many years The drive behind this has been from a performance induced standpoint."

"When the rig does receive maintenance time, that time is generally taken up by repairing the equipment that was broke."

"Once again, limping along with equipment failures."

He goes on, "There is just too much equipment in need of repairs or maintenance performed and not enough personnel or time to do it" -- "to throw at it."

"The rig has an overloaded amount of work that could not be completed even by doubling the amount of workers on the rig."

"The engineering department has been going down

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for some time now due to lack of knowledge, motivation and supervision."

Yet, Transocean said it was safe to start up operations in the fall of 2009.

Transocean's condition-based maintenance system had been audited on multiple occasions and found to be seriously deficient, yet Transocean never corrected the deficiencies, at least not many of the substantial ones.

The evidence will show one significant casualty of its broken maintenance system was the blowout preventer. Inspections following the disaster found that it had multiple deficiencies which contributed to the blowout preventer not properly functioning on the day of the explosion and in the days that followed. Both Transocean and BP knew of many of these deficiencies before April 20 and did not act on them.

The Deepwater Horizon BOP was not the best available and safest technology. Transocean, BP, and Cameron knew this.

In fact, the BOP was out of certification. Inspections in 2008, '9 and spring of 2010 clearly made Transocean and BP aware of this.

Transocean willfully continued to lease the Deepwater Horizon, making over a half million dollars a day, instead of bringing the vessel into a shipyard for repairs of the BOP and other critical equipment.

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No one disputes that the blowout preventer was ship's equipment on the *Deepwater Horizon* essential to fulfill its mission, and that Transocean had a responsibility to have it working properly at all times in order the maintain a seaworthy vessel. It did not.

By the way, BP knew about the design and maintenance problems of the *Deepwater Horizon*, and especially the BOP. BP knew all of this and still, in late 2009, chartered the *Deepwater Horizon* to finish the Macondo well.

Every time BP chartered the *Deepwater Horizon* to drill a well, the evidence will show BP had the primary duty to determine whether that vessel was adequate to drill that well, including the adequacy of the operational -- or, rather, the operational requirements of the BOP for a particular well, pressure, temperature, the competence of the crews and management systems such as safety management.

BP alone knew what unique risks awaited in terms of pore pressures, fracture gradients and temperatures.

The evidence will show that a longstanding failed safety culture at Transocean was a substantial cause of this disaster.

Following four fatalities of four different
Transocean rigs, on October 21 of 2009, Transocean's top
executives, CEO Steve Newman and Bob Long, sent a news bulletin
out to employees of Transocean. This is what they said, among

other things: "Something's not right. We're clearly not
executing our safety processes as well as we once thought -and we need to find out why."

"It is vital that we learn from these recent

"It is vital that we learn from these recent experiences so that no one else is injured or killed."

"We must learn why we cannot seem to operate without serious incidents and injury to our people."

A couple of months later, a December 2009

Transocean Engineering PowerPoint put it even more bluntly.

"We have lost our safety culture."

"There is no quick fix; we have to rebuild it."

Transocean's maintenance system had been audited on multiple occasions and found to be woefully deficient. The evidence will show that the maintenance processes and systems within Transocean were by no means the best in the class, yet Transocean never corrected the major deficiencies.

Their May 1, 2009 Asset Reliability Project was brutally candid. Personnel at a division level stated that:

"We often have such a focus on saving money in the short term that it affects the philosophy of looking after our equipment and following our policies."

The lost safety culture of Transocean was clearly not a recent thing. Transocean's Director of the Performance Group summed it up well in 2009, when he recognized the difficulties Transocean had experienced with task planning and

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risk management in 2004, and observed that the 2009 09:03AM 1 company-wide Offshore Installation Manager's survey on the same 2 09:03AM 3 subjects resonated to be many of the same results noted in 09:03AM 2005. 4 09:03AM 09:03AM 5 His conclusion: "The definition of insanity, doing the same things over and over and expecting a different 09:04AM 6 result." 7 09:04AM In August of 2009, a BP audit of Transocean's 8 09:04AM Health Safety, Security and Environment management systems was 9 09:04AM so poor that Transocean was only conditionally approved to work 09:04AM 10 09:04AM 11 for BP's Gulf of Mexico Strategic Performance Unit. The unfortunate reality is that since the 09:04AM 12 09:04AM 13 Deepwater Horizon was first put into service in 2001, the 09:04AM 14 evidence is going to show it had never, ever been to port for 09:04AM 15 maintenance, repairs, refitting. Not one single time; nine 09:04AM 16 years. 09:04AM 17 Transocean's safety culture was broken, and the 09:04AM 18 evidence will show that management's willful refusal to fix it 09:04AM 19 led directly to the Deepwater Horizon disaster. 09:04AM 20 The Deepwater Horizon kept drilling, and BP kept 09:05AM 21 hiring. Now, let's turn to Cameron and its blowout 09:05AM 22 09:05AM 23 preventer. 09:05AM 24 In 2007, Melvin Whitby, as Cameron's Director of

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Engineering, drilling, said: "In all cases, however, when the

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BOP is called on to function in an emergency situation, it is the main barrier protecting human life, capital equipment and the environment. Therefore, it must function without fail."

The evidence will show this blowout preventer failed partly due to the serious neglect of Transocean with knowledge of BP, but also due to willful decisions of Cameron.

Cameron will blame the men on the drill floor who died for not trying close the BOP shear rams fast enough because they will say the blowout preventer rams were not designed to close after the flow begins to go up into the riser.

Well, in any of the BOP materials of Cameron, that admonition is not given.

The evidence will show that BP, Transocean and Halliburton personnel clearly missed the fact that a blowout was beginning, but the evidence will also show that Transocean personnel ultimately did try to use the blowout preventer shear rams — to no avail in either saving their lives or stopping millions of gallons of oil from entering the Gulf.

The BOP, in other words, did not function without fail as Cameron's Director of Engineering said it must.

There are four primary problems with Cameron's BOP other than Transocean's neglect of it.

First, the blind shear ram cutting blades did not cover the entire wellbore. Cameron knew that its BOP would

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likely not be able to shear and seal drill pipe if it was off center in the wellbore, a common occurrence and completely foreseeable situation.

The evidence will show Cameron had no idea whether the blind shear rams it sold would seal under dynamic flow conditions, yet Cameron sold it as a preventer.

Cameron did not know and never even tried to find out whether its blowout preventer blind shear rams would successfully shear pipe and fully seal a well against -- and this is the key phrase, Your Honor -- against a high pressure dynamic flow plus an off center pipe, neither one, even though both were known foreseeable environment conditions the BOP could be called upon to function in.

The third problem, Cameron knew rig personnel could not monitor the batteries to see if they were charged or dead.

Cameron's signal light system was powered from the surface, 5000 feet above it. That's the power that ran the controls that indicated to the operators on the drill floor that the automatic emergency BOP functions were armed and therefore available; but, if that power was on all the time, it wouldn't tell whether or not the batteries were dead, and it couldn't function.

In other words, the driller could be getting a green, everything is okay light, and yet his batteries be

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totally dead, that he's showing it's armed.

The result on April 20 was the battery in the Blue Pod was dead, and nobody knew it was dead.

The fourth issue, the multiple BOP emergency systems were not separate emergency systems because all of them would fail if a single component, the blind shear rams, failed.

Cameron knew of this single point failure hazard, yet willfully chose to ignore it in design and instructions.

Now, in fairness, Transocean requested that design, and Cameron cooperated. Whether they should or shouldn't have is going to be up to Your Honor.

Now, what about Halliburton's conduct?

As the self-described world leader in cementing services, what were Halliburton's obligations?

The evidence will show that Halliburton was contractually responsible to BP for the design, testing, and execution of cementing the production casing, and to provide mud pit monitoring through its Sperry division for signs of a kick or blowout.

Halliburton recommended the type of cement to be used for each casing string and the volumes and spacers to be used.

BP did not tell Halliburton which cement to use.

Halliburton's contractual obligations included

sole responsibility for pressure testing and pumping the cement

09:10AM 1 as well as a safety leadership role. The contract between BP 2 and Halliburton required Halliburton to create a lightweight 09:10AM slurry mixture with very specific characteristics. 09:10AM 3

> Halliburton was required to provide BP and Halliburton management the final cement slurry details at least 24 hours prior to BP running the production casing. not.

Indeed, Halliburton's Jesse Gagliano never even checked the cement test results before the blowout, despite being notified they were ready the day before.

The evidence will show that the gas flowed prematurely at Macondo due to a failure of the Halliburton cement.

In connection with its obligations to BP, Halliburton assigned cement engineer Jesse Gagliano to be embedded in BP's Houston offices as BP's what will be described as in-house cementing expert.

The evidence will show that prior to April 20 of 2010, both Halliburton and Gagliano had histories of problems with BP as far as modeling inputs and timeliness were concerned.

Indeed, in the weeks leading up to the blowout, BP engineers voiced serious concerns -- questions about his competency as it affected the timeliness and quality of his reports to BP.

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In fact, BP Drilling Engineer Team Leader Greg Walz believed that the decision had already been made to fire Gagliano from his embedded position with BP in its Houston office.

Halliburton compounded the problem by refusing to provide technical supervision of Gagliano, thus leaving the inadequacies of his work undetected.

Yet, Mr. Gagliano, in Houston, was virtually the final word on what Halliburton did or did not do regarding the Macondo cement job; yet he had no supervision.

In fact, Ronnie Faul, Gagliano's immediate supervisor, did not even know what Mr. Gagliano was doing, much less that there was a critical cementing job about to take place in Macondo.

The evidence will show that Halliburton created cement that was poorly designed, not properly tested, and was unstable.

Cement in a well like Macondo should have provided a barrier to hydrocarbon flow that was high pressure, high temperature. Halliburton did not provide that barrier.

The cement used at Macondo was a foam cement which is known to present risks and potential complications not found with conventional cement, thus requiring additional expertise and care.

The evidence will show that every investigation

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which has considered the question, except Halliburton's, and every expert, except Halliburton's, who has opined about it, has concluded that the Halliburton cement was poorly designed and did not seal the well.

In designing the cement for Macondo, Halliburton used the cement from another well, Judge, the Kodiak well.

That blend had been on the *Deepwater Horizon* since November of 2009, and had aged at least five months since the *Deepwater Horizon* had left the Kodiak and come and been working on the Macondo.

More significantly, Kodiak cement contained a Halliburton proprietary additive called D-Air 3000, a defoamer, emphasis, defoamer that destabilizes and is incompatible with foam cement.

Halliburton's own expert, David Bolado, in fact, will admit that the slurry Halliburton used at Macondo would not have included a defoamer agent, as the Kodiak did, if Halliburton had designed the cement from scratch.

So why would Halliburton risk using this leftover Kodiak cement on Macondo well and try to convert it to a foam cement when it had defoamer in it? The evidence will show Halliburton was able to save time and save money by doing so.

BP was not charged for extra testing, regardless of the amount of testing.

Halliburton also had already given BP about

\$100,000, in fact, \$139,000 credit, for that Kodiak cement that 09:15AM 1 2 went unused at the Kodiak well that was still sitting on the 3 Deepwater Horizon, so Halliburton had a monetary incentive to use that stuff, to then charge BP and get paid some of what it 4 09:15AM already on hand without incurring the cost of shipping new 09:15AM 5 stuff out there, mixing new stuff and so forth, much less 09:15AM 6 hauling off the leftover Kodiak. 7 The evidence will show that Halliburton's 8 09:15AM

employees also admit that Halliburton failed to run many required tests and did not have a single successful stability test on the actual slurry pumped down the Macondo before it was Their lab was overworked, understaffed and undersupervised.

The evidence will also show the testing performed by Halliburton was essentially useless because all those tests failed except one that was manipulated to not mimic Macondo's downhole condition.

Halliburton performed fewer than the full suite of tests required by the American Petroleum Institute, BP, Halliburton itself, and the BP-Halliburton contract, and failed to utilize standard testing protocols.

In fact, Halliburton's own expert, Dr. Sam Louis, will admit the fluid loss and static gel strength development tests were indeed important for this job, and Halliburton failed to perform either test.

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The evidence will show Halliburton's Sperry Sun division mudloggers were not adequately trained and missed the kick that blew up the *Deepwater Horizon*.

In October of 2009, while the *Marianas* drilling vessel had started on the Macondo, BP told Halliburton that one of its mudloggers was not getting the job done and was not getting the basics right. Halliburton pulled him from the job.

Prior to the Macondo, because BP felt
Halliburton's Sperry Sun's performance was so poor, the
evidence will show BP was considering pulling its business.

The March 8, 2010, kick on this well went undetected for 33 minutes by the Halliburton Sperry mudlogger on duty.

Following that go kick, Halliburton-Sperry did no lesson learned investigation and did not provide its mudloggers with any additional training.

The evidence will show that on April 20 of 2010, the Halliburton Sperry mudlogger ignored signs the well was flowing.

The Halliburton Sperry-Sun mudlogger testified that the first time he realized there was a kick was when mud started raining down on the mudlogger's shack.

Why? The evidence will show that the Halliburton Sperry mudlogger, Joe Keith, left his mudlogger's monitoring pit unmanned while he took a 30-minute smoke break just as the

well began to give clear signs that it was flowing, signs he would have seen if he had been paying attention and not recklessly abandoned his post.

Halliburton had a contractual obligation under its 2009 contract with BP to provide, in connection with its cement work, a complete safety analysis in writing called a Basis of Design.

The April 2009 BP/Halliburton contract required Halliburton to, among other things, continuously, emphasis, continuously reassess and update these risk assessments on an ongoing basis. They didn't do it.

When David King, Halliburton's Division

President, signed that contract on April 16 of 2009, the

evidence will show that Halliburton knew it had no way of

complying with this contract provision because no such process

safety system was in place that would have been required to

fulfill this ongoing contractual requirement.

The evidence will show that between April of 2009 and April 20 of 2010, Halliburton did not have a formal Basis of Design standard, nor did it have a formal Management of Change standard, both of which are essential to timely identification of process safety risk effectively required to be recognized on an ongoing basis under the contract.

The evidence will establish that at the time of the Macondo well blowout, Halliburton had failed to comply with

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this express contractual requirement to have in place and provide complete continuing process risk analysis to BP.

The evidence will show that if Halliburton had updated the Basis of Design as required by its contract, it would, of necessity, have identified the catastrophic risk of using Kodiak blend.

Let's now turn our attention to BP.

Financial pressure drove BP to rush the completion of the Macondo well.

Because BP's production was down in 2010, BP did not have the cash to fund its commitment to pay dividends to its shareholders. The evidence will show BP calculated Exploration and Production Division portion of the amount needed to pay the dividend to be about \$7 billion.

In order to raise this \$7 billion and meet its 4 to 5 percent profit growth commitment to shareholders, BP Exploration and Production was under pressure to raise these dollars by driving efficiency in a year where production was lower.

It chose to do so by spending fewer days in the drilling of its wells.

According to BP, without major project startups, 2010 was expected to be "a year where every barrel counts and every dollars counts."

Macondo was more than \$50 million over budget and

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behind schedule. The *Deepwater Horizon* was committed to drill two more wells for BP within a short time, and it had to get one right away started or BP risked losing an expensive Gulf lease.

The evidence will show BP executive management placed huge financial pressure on BP rig management to cut costs by cutting corners and to rush the job.

The Macondo well bottom was under 5000 feet of water and then another about 13,000 feet of earth below that, total of around 18,000 feet, in a formation known to BP for being high pressure, high temperature, and, most importantly, an unstable, no-salt formation.

As Jonathan Bellow, a BP Operations Geologist for Deepwater Exploration at BP, confirms, wells without a thick sequence of salt require more casing for a given depth than those that do penetrate salt.

The drilling window between the pore pressure and the frac gradient is generally narrower in no-salt wells which requires more casing.

BP had drilled wells with no salt previously before Macondo, but, as he says, "it had just been a few wells."

So, with the rush of financial urgency combined with BP concerns about the Macondo well situation, how did BP proceed with its Macondo well?

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Petroleum engineering expert David Pritchard says: "BP repeatedly chose speed over safety."

When asked for feedback following the March 8th Macondo kick, BP Tiger Team member Kate Paine says: "I'm not sure it was a lack of communication nor awareness as much as a 'we can get away with this' attitude."

Dr. Allen Huffman, a geophysicist, will testify that BP failed to disclose information to MMS that it was required to disclose on an ongoing basis. The evidence will show that on multiple occasions BP falsely reported its fracture gradients and pressure integrity test results to the MMS by drilling ahead without a safe drilling margin and without seeking prior MMS approval.

Macondo was described variously by BP personnel as the "well from hell," a "nightmare" well, and a "crazy" well. In the months preceding the disaster, there were four kicks and ten incidents of lost returns resulting in the loss of 668,000 gallons of mud.

The push to complete the "nightmare" well caused so many last-minute changes to the temporary abandonment procedure plan that BP's John Guide told David Sims just three days before the disaster, "David, over the past four days, there has been so many last-minute changes to the operation, that the well site leaders have finally come to their wits' end." The quote is, "Flying by the seat of our

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pants."

"Everybody wants to do the right thing, but this huge level of paranoia from engineering leadership is driving chaos. This operation is not *Thunder Horse*. Brian has called me numerous times trying to make sense of all the insanity."

And then later he concludes, "The operation is not going to succeed if we continue in this manner."

Now, put that into context, March 29th -- excuse me -- just 22 days before the Macondo disaster Robert Bodek, the BP operations geologist -- March 27th, Robert Bodek, a BP operations geologist told his boss that, "If BP continued to total depth on Macondo, it will all be in God's hands."

Two days later, just 22 days before the Macondo disaster, Bodek again told his boss that, "If they really believe that the poor pressure can be as high as projected, we need to start having some serious discussions about pulling the plug early."

The evidence will show that during BP's rush to temporarily abandon this well, BP made a series of decisions to save time and money but substantially increased risk and reduced safety. Here are some examples:

BP used a long string casing rather than a liner with a tieback, which it was originally designed to be until about a month before the disaster, to save time and at least seven to \$10 million and seven to ten days in time.

BP failed to perform a bottoms up circulation 09:28AM 1 2 test prior to allowing Halliburton to pump its cement. 09:28AM 3 Third, BP refused to use the recommended and 09:28AM originally planned -- and originally planned 21 centralizers, 4 09:28AM ended up using many less. 5 09:28AM BP failed to wait for the completion of the foam 09:28AM 6 stability test before pouring -- or allowing to pour the 7 09:29AM cement. 09:29AM 8 Fifth, BP began its positive pressure test just 9 09:29AM 12 hours after the cementing operation and refused to wait for 09:29AM 10 09:29AM 11 the cement to fully cure. Six, BP displaced the riser before setting a real 09:29AM 12 09:29AM 13 barrier, the cement plug. 09:29AM 14 Seventh, BP displaced the riser over 3,000 feet below the surface. 09:29AM 15 BP used a untried experimental spacer from 09:29AM 16 leftover lost circulation materials. 09:29AM 17 09:29AM 18 BP ran the safety critical negative pressure test 09:29AM 19 without a written procedure and with personnel who had never been given formal training in how to perform the test. 09:29AM 20 09:29AM 21 Tenth, BP refused to run a cement bond log to 09:30AM 22 confirm the success or failure of the cement job despite the 09:30AM 23 presence of a Schlumberger crew they had on the rig ready to 09:30AM 24 run it. Once again, BP did this to save time and money.

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Finally, BP conducted simultaneous operations

during the displacement without doing the required risk 09:30AM 1 assessment, which significantly impaired the ability to 2 09:30AM recognize that a kick, a serious kick was happening. 3

> The evidence will show the actions of BP executive management were a substantial cause of the disaster. BP will place great reliance on its Bly Report to try to diminish its culpability. Yet the evidence will show that the Bly Report was not as thorough as represented by BP to be.

BP's CEO Tony Hayward claimed BP conducted an open, complete and transparent investigation that would cover everything. Rather, contrary to BP's standard protocol for investigating serious accidents, and certainly no one will contest that this wasn't a serious accident, BP's investigation of the Macondo disaster, the Bly Report failed to investigate systemic management causes.

The evidence will show BP's executive management directly controlled BP's Worldwide Risk Management and encouraged a culture which placed profit and production over safety and protection.

Process safety and risk engineering expert Professor Bob Bea will make it clear, starting tomorrow when he takes the stand, that effective process safety only happens if a company creates a safety culture that reflects the seriousness with which that company attempts to manage risks.

Effective process safety is reflected by what a

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company actually does, not what it says. It's also reflected 09:32AM 1 2 by its commitment to learn lessons from past events. 09:32AM commitment is critical, because in the words of Dr. Bea, "It 09:32AM 3 has a major effect on how the company balances between 4 09:32AM production and protection." 09:32AM 5 Dr. Bea will explain how BP knew from previous 09:32AM 6 disasters to place relatively high emphasis on short-term 7 09:32AM

Dr. Bea will explain how BP knew from previous disasters to place relatively high emphasis on short-term benefits of cost and speed could cause major loss of life and property. And that cost cutting, failure to invest, and production pressures from BP executive managers, impairs process safety performance.

Nonetheless, the evidence will show that in 2010 for Macondo, BP was still putting production over protection, profits over safety.

In 2007, BP's CEO Tony Hayward acknowledged that he had two years to turn the company's financial performance around. The evidence will show BP's executive management issued directives to cut billions and billions of dollars from the costs of BP operations.

From 2008 to 2009, BP management slashed costs by \$4 billion, with plans for another 1.4 billion in 2010. This resulted in massive layoffs, 20 percent of BP's entire worldwide force.

Former BP vice-president of drilling and completions Kevin Lacy, will describe for the Gulf of Mexico

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ompletions Kevin Lacy, will

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operating unit, incredibly pressured with respect to cost production during 2008 and 2009.

Beginning in 2008, Lacy received directives from BP's senior vice-president global projects, Neil Shaw, and CEO of BP Exploration and Production, Andy Inglis, to cut the costs.

One of Shaw's first decisions was to eliminate the safety and technical director, 290 BP personnel, 93 contractors. After eliminating the safety and technical director, there was no one person in the Gulf of Mexico unit whose sole job was administer or oversee process safety.

In 2009, BP cut between 250 and 350 million from the Gulf of Mexico Drilling & Completion organization with further cost cutting directed for 2010. Many key safety personnel lost their jobs -- or rather, saw their jobs eliminated.

Cost cutting was further incentivized but did not include incentives for effective measurable process safety.

BP's safety culture will be shown by the evidence, according to BP's Kate Payne, to be a "we can get away with this" attitude.

According to Dr. Bea, a culture of entrepreneurial risk taking and a culture of production over protection.

Even Halliburton process safety expert

Patrick Hudson will testify that BP was a highly risk tolerant culture and an opportunistic and speed-driven culture and a

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culture of being loss averse rather than risk averse.

In other words, the evidence will show that BP management incentivized a culture of cost cutting, profits over safety, and taking high risk with a conscious disregard for dire potential risks.

The evidence will show BP executive management intentionally refused to change its past behavior and instead willfully exclude its process safety requirements, its OMS program, from leased vessels like the *Deepwater Horizon*.

At BP's invitation -- let's give some context to this. At BP's own invitation, renowned process safety and risk engineering expert, Dr. Bob Bea himself, was retained directly and advised BP on three separate occasions, in 2001, 2002, and 2005, what it was doing wrong with process safety and what needed to be done to correct it. Dr. Bea will explain how BP did not listen and how that was a substantial cause of the Macondo disaster.

Dr. Bea will also explain how the organizational and systemic causes of previous disasters, major accidents, are virtually identical to the systemic and organizational causes of the Macondo blowout.

BP's then head of safety, John Mogford, predicted in 2006, that if BP did not improve its process safety, it was going to have another disaster every 10 to 15 years. In fact, it only took four.

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Long before the *Deepwater Horizon* disaster, BP was aware of specific recommendations of how it could fix its process safety problem in order to avoid future disasters.

In an effort to improve its process safety, BP executive management in London implemented the operations management system, or OMS, which was indeed a comprehensive management system that integrates and improves existing management systems and provides the framework to achieve safe and reliable operations across its worldwide operations.

But the evidence will show that in willfully failing to extend its OMS program to its leased drilling vessels, like the *Deepwater Horizon*, BP failed to keep the following factors present in previous disasters from playing a role in Macondo: Ignoring process safety risks, failing to perform effective audits, engaging in mindless, pointless and counterproductive organizational restructuring, and failing to maintain safety critical equipment.

Prior to the Macondo disaster, BP executive management promised to change, to learn lessons. The evidence will show that for BP's leased vessels in the Gulf of Mexico, like the *Deepwater Horizon*, BP's culture regarding safety remained the same.

The evidence will show that when BP's Gulf of Mexico drilling engineering manager, Jonathan Sprague, in fact, received an e-mail from a lower level BP employee regarding

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process safety, lessons learned, he passed it off as clutter.

In late 2009, BP conducted a rig safety audit of the *Deepwater Horizon* and discovered an astounding 390 outstanding maintenance issues requiring 3,545 man-hours to repair, some of which had been outstanding since another 2008 audit by BP.

But the evidence will show that BP kept chartering and using the *Deepwater Horizon* year in and year out despite actual knowledge of many problems with the vessel, keeping it at sea, driving it hard, when BP knew it should have been taken to a shipyard for repairs.

BP Tiger Team member Kate Payne, who being requested to participate in a "lessons learned" inquiry in a March 8th kick, 2010, said, "I don't think this is going to be a lesson learned. I'm sorry to push back on the lessoned learned. I know you've got to get something out there to make it look like we won't do this again. I don't see us really learning."

Commenting on apartments, Deepwater Horizon repair cost concerns, in September 2009, BP Houston operations engineer, Brett Cocales responded internally, "Don't worry about this small stuff. We're not going to tear anything else apart unless absolutely necessary and we are ready to kick some serious ass. Don't worry, be happy."

BP Drilling Engineer, Nicholas Lirette replied

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saying, prophetically, "This rig is not in appropriate condition to start a well." But of course, it did.

Just five days before the blowout, BP Houston engineer, Brett Cocales, sent 15 extra centralizers to the Deepwater Horizon in addition to the six already on board. And the extra centralizers were intended to reduce cement channeling and thus reduce the risk of a blowout.

The next day BP's John Guide's boss demanded that the extra centralizers not be used. Why? The evidence will show to save time and money for BP.

Cocales succumbed to Guide's demand and e-mailed another BP Houston engineer, "But who cares, it's done. story. We'll probably be fine."

Dr. Bea will explain how the failure of BP to implement OMS on its riskiest enterprise, deepwater drilling in the Gulf of Mexico, played a substantial role in the disaster at Macondo.

Whatever benefit the system might have brought was lost. At the time of the blowout there was no individual in charge of process safety of the Macondo well.

THE COURT: Mr. Roy, you need to bring it to a close. Your time is about up.

MR. ROY: I have one-and-a-half pages, Your Honor.

THE COURT: Go ahead.

MR. ROY: Dr. Bea will explain that the Macondo

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Drilling Team was blind to major process safety risks because of the lack of OMS.

Ironically, BP board member Sir William Castell denies knowing the high risk of drilling in the Gulf of Mexico prior to the Macondo disaster. But he testifies, "If I had known the risk in the Gulf of Mexico, we would have never drilled that well in the Gulf of Mexico."

Kevin Lacy, the former vice-president of Drilling & Completions summed up the Macondo disaster best when he said, "It was entirely preventable."

In conclusion, Your Honor, we respectfully suggest that the evidence will prove the Deepwater Horizon was unseaworthy on April 20th of 2010, and had been for many months, if not years, before. And Transocean and BP both knew it.

It will also prove the negligence -- the evidence will also prove the negligence of BP, Transocean, Halliburton and Cameron.

And finally, the evidence will prove the defendants' gross negligence and willful and reckless conduct.

The limitation should be denied. The evidence in this trial will demonstrate to Your Honor why this tragedy occurred and who is responsible.

Thank you.

THE COURT: All right. I was planning on taking a

break after the United States' presentation, but we are going 09:44AM 1 to do it right now because we have a technical problem, I 2 09:44AM 3 understand. 09:44AM They still have that going on, Stephanie? 4 09:44AM 09:44AM 5 THE DEPUTY CLERK: Yes, sir. In one of the overflow courtrooms, there is 09:44AM 6 THE COURT: a problem with the sound, and someone needs to come here and 7 09:44AM fix something. 09:45AM 8 So we're going to take about a 15-minute recess 9 09:45AM right now. 09:45AM 10 THE DEPUTY CLERK: All rise. 09:45AM 11 (WHEREUPON, at 9:45 a.m. the Court took a recess.) 09:45AM 12 10:03AM 13 THE COURT: All right. I think they tell me we have 10:03AM 14 our technical problem in one of the other courtrooms repaired, so we're ready to proceed. 10:03AM 15 Mr. Underhill. 10:03AM 16 10:03AM 17 OPENING STATEMENTS 10:03AM 18 BY MR. UNDERHILL: 10:03AM 19 Thank you, Your Honor. Good morning. 10:03AM 20 Your Honor, before I start, my good friend, Mr. Roy, asked me to say that he made a mistake that he would 10:03AM 21 10:03AM 22 like me to correct, and I certainly agree to do that. 10:03AM 23 He indicated that Mr. Keith, the Sperry-Sun

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mudlogger took a 30-minute smoke break or whatever kind of

break, and Mr. Roy indicated it should have been 10 minutes.

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He didn't want to mislead the Court or any of the parties.

So is that good, Jim? Thank you.

THE COURT: Okay.

MR. UNDERHILL: Your Honor, good morning.

This was the *Deepwater Horizon* on April 22, two days after the Macondo well blew out. The job of the parties in this courtroom today, myself, my colleagues from both the plaintiff and defense side, is to try to give the evidence to the Court so you can decide how this tragedy happened, why it happened, and who caused it to happen.

The evidence in this trial will show that, despite BP's attempts to shift blame to other parties in this lawsuit, by far and away, the primary fault for this disaster lies with BP.

BP was the owner of the Macondo well. It designed the Macondo well. It was the operator of the Macondo well.

The evidence will show that critical decisions that caused the blowout and disaster up on that screen, decisions about narrow and dangerous drilling margins, about cement design and placement, the all critical negative pressure test you'll hear a great deal about in this case, about well monitoring and well control, about the BOP, those decisions, Your Honor, were made by BP.

We will show that a long series of missteps and

reckless decisions made by BP taken together demonstrate 10:05AM 1 willful misconduct. 2 10:05AM THE COURT: Stop, I'm sorry, one second. Did something 3 10:05AM happen to the sound? I can still hear you, but I'm not sure 4 10:05AM everyone else can. Excuse me. 10:05AM 5 Is your Lavalier mic not working? Is that what 10:05AM 6 7 it is? Is that not working? 10:05AM 8 MR. GODWIN: It's your battery. 10:05AM MR. UNDERHILL: There might be another one right there 10:05AM 9 10:05AM 10 next to you. There is a backup. 10:05AM 11 THE COURT: See if the other one works. MR. UNDERHILL: Certainly, Your Honor. 10:05AM 12 10:05AM 13 THE COURT: Isn't technology wonderful, as long as it 10:05AM 14 works. 10:06AM 15 That sounds like it's working. 10:06AM 16 MR. UNDERHILL: How are we doing? 10:06AM 17 THE COURT: That's better. 10:06AM 18 Thank you very much, Your Honor. MR. UNDERHILL: 10:06AM 19 THE COURT: Thank you. 10:06AM 20 MR. UNDERHILL: We will show that a long series of missteps and reckless decisions by BP taken together 10:06AM 21 demonstrate willful misconduct. We will show that individual 10:06AM 22 10:06AM 23 decisions made by BP standing alone constitute gross 10:07AM 24 negligence.

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Especially among those individual decisions was

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the incomprehensible decision to declare the negative pressure test a success only two hours before the first of the explosions that wracked the rig.

The evidence will show that at 8:52 p.m., on April 20, less than an hour before oil and gas exploded in a fireball aboard that rig that was up on the screen a moment ago, BP Senior Drilling Engineer in Houston, Mark Hafle, and its Senior Well Site Leader on the rig, Don Vidrine, had a telephone conversation. Both men subsequently took the Fifth Amendment in this case.

That conversation, we will show, should have prevented the tragedy, the need for any of us to be in this courtroom today and for the next three months.

They had a conversation that could have saved eleven lives, saved the Gulf, saved the people of the Gulf from a catastrophe, despite all of the BP failures that had happened before that day on API 20 and in the days before.

The evidence will show that when those two men hung up the phone at 9:02 p.m., eleven men, eleven souls, had 47 minutes to live the rest of their lives, 47 minutes in which BP failed to take any action that could have prevented that tragedy that's on the screen and our need to be here today.

The evidence and testimony will show that with as little as a ten-second phone call from Mr. Vidrine to the toolpusher or the driller, as little as a 30=second walk down

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to the rig floor to those two men, the toolpusher, the driller, we could have avoided all of this, all of this.

The evidence will show, Your Honor, that BP's failure to take that action, that simple action, that act alone constituted willful misconduct.

In an opening like this, and with the volume of the record that we have, Your Honor, the best we can do as attorneys is present a snapshot of the evidence to the Court; but, if we're looking for a snapshot that shows how and why BP is the primary cause for this disaster, we point to evidence of a corporate culture of disregard for safety that laid the foundation for all that happened on April 20 on that rig.

The evidence will show that BP made John Guide the well team leader for the Macondo well. It will show that the well site leaders, Mr. Vidrine and Mr. Kaluza, reported directly to Mr. Guide in Houston.

The evidence will show that the well team leader, Guide, reported to David Sims, his boss at BP headquarters in Houston.

It will show that on April 17, 2010, only three days before the blowout, Guide sent Sims an extraordinary document that explains as much as any single piece of evidence in this entire case that Your Honor will hear why eleven men needlessly lost their lives and why this catastrophe of an oil spill began.

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Mr. Roy mentioned this e-mail. I'll very briefly going through it. On April 17, Guide told Sims that the BP well site leaders had finally come to their wits end, that BP well site leaders were flying by the seat of their pants.

Guide described a huge level of paranoia that was driving chaos. He talked about another BP Macondo engineer trying to make sense of all the insanity. In a sentence that within three days became literal prophecy, Guide finished, "the operation is not going to succeed if we continue in this manner."

The evidence will show that the same day, Sims, Guide's boss, responded to Guide by telling him that he had to go to dance practice in a few minutes. It will show that Sims told him that the engineer who used the word "insanity" to describe this operation needed to be reminded that, quote, it was a great learning opportunity. It will be over soon. That the same issues or worse exist anywhere else.

He finished by telling Guide, I'll be back soon, and we can talk. We are dancing to the Village People.

Well, the operation, as we know, Your Honor, didn't succeed. The evidence will show through the sworn testimony of BP's own witnesses that BP should have shut down the Macondo operation at the moment, that moment, when Guide sent the e-mail to Sims.

The evidence will show in Sims's own testimony

that he didn't shut down the operation either after dance
practice or before the well blew out, even in response to words
like paranoia, chaos and insanity.

In fact, Sims's testimony will show that he refused to give a straight answer in deposition to the simple question of whether he and Guide, the Macondo well team leader, had more responsibility for safety aboard the *Deepwater Horizon* than the rig's cook or its bed maker.

But the evidence will show that a BP operation that was, to use their words, flying by the seat of the pants, had far deeper problems, that stopping the operation was not the BP way.

The evidence will show that BP put profits before people, profits before safety, and profits before the environment. It will show that the BP way, the way that BP drove its people, was, as Mr. Roy mentioned, time is money, and every dollars counts.

The story that will be told by this evidence will be that time is money, and every dollars counts were the bludgeons that sacrificed safety, the weapons that drove people to save money at the cost of people's lives.

If we want to grasp this culture of profit over safety and what drove people to use words like "chaos" and "insanity" to describe this high hazard, high risk BP operation, the easiest example is the Macondo well itself.

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The evidence will show that BP was tens of millions, 50 million according to Mr. Roy, over its budget of one hundred million dollars to drill the Macondo well, and that it was spending nearly a million dollars a day for every day the rig stayed onsite.

So a safety corner cut, a day saved was a million dollars saved for BP. 10 days, 10 million. 20 days, 20 million.

Decisions that any safety minded company would have made during the last days of the rig, such as those dealing with the cement job, with the float collar, with the negative pressure test, with the Guide/Sims e-mail, the evidence will show that those decisions were not made because they would have caused delayed and, most importantly to BP, money.

BP's own words: "The evidence that we'll see in this trial make the point about profit over safety better than anyone in this courtroom ever can or ever could."

As an example, and I stress this is only an example, one example of the culture that pervaded BP's operation of the Macondo, the evidence will show that Mark Hafle, the same BP engineer in Houston who talked to the rig in its last and final hour, Hafle knew before the disaster, quote, the cement design was on the ragged edge, closed quote -- and pardon the language, Your Honor -- that he knew that, quote, we

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are going to get a shitty cement job, closed quote. That's Mr. Hafle.

The evidence will show that to BP that wasn't an alarm ringing down the halls of BP headquarters, not even close.

The evidence will show that doing it right and redoing it with a new cement job could have cost delays worth millions of dollars to BP.

Instead, the evidence will show that only days before the blowout and eleven deaths, another BP engineer in Houston, Brett Cocales -- e-mail is up on the screen -- made the infamous, unforgiveable statement that by the end of this trial will stand as the summation of BP's safety culture at Macondo: "But who cares, it's done, end of story, will probably be fine, and we'll get a good cement job."

But it wasn't only millions of dollars that BP was concerned about. The evidence will also show, through the testimony of Dr. Allen Huffman, that BP violated mandatory federal regulations and critical safety practices over the course of drilling the Macondo well, regulations and safety procedures that require operators to maintain what is called a safe drilling margin.

Dr. Huffman will explain what drilling margin means in terms of fundamental drilling and safety issues; but what will become apparent through the evidence is that BP

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drilled and pushed this well beyond safe drilling margin limits, in violation of law, all because it feared that if it told the MMS what it was doing on this well, MMS could shut down the operation, and BP would stand to lose not only the one hundred million or whatever the amount is plus that it had already spent drilling Macondo, but it could loose the potential of billions, that's billions with a B, billions of dollars of profit from the production well they hoped to get.

Now, no plaintiff here in this courtroom will ever begrudge BP or anyone from wanting to make a profit.

That's not an issue in the case, not even remotely.

Instead, what the evidence and the testimony will show is that reckless actions amounting to gross negligence and the willful misconduct were tolerated by BP, sometimes encouraged by BP to squeeze extra profit out of every decision, out of every well, including this well.

That repeated multiple times in the operation of this well, and especially in the final days and hours of the Deepwater Horizon, the evidence will show that at every fork in the road, BP chose time and money over safety in the operation of what the rig crew called this "well from hell."

Witnesses will testify in this courtroom that BP needed to do have the integrity and the responsibility to own up to the ongoing dangers and its own mistakes, just like Hafle and Vidrine needed to do in the last hour of the rig.

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But it will show that BP, from company men in the well to senior managers ashore, refused to deviate from a course of a corporate culture of recklessness that was chartered in board rooms in Houston and London.

As people BP's men continued on that course, the evidence will show that their actions spoke louder than words and demonstrated the same reckless behavior that's shown in the words, "who cares, it's done, probably be fine," written on that screen and the Guide/Sims e-mails and in Hafle's and Vidrine's abdication of responsibility in the last hour.

During the course of this trial, Your Honor will find that BP put people in charge of the Macondo well that weren't functionaries. They weren't guys pumping gas and changing oil at the BP corner service station. They headed the BP operation, deepwater drilling of a well like Macondo that had the destructive power to do exactly what we've seen in this case, deaths, injuries, a rig at the bottom of the Gulf of Mexico, economic and environmental devastation, along the swath of Gulf Coast states and communities, and the power to cause an oil spill that even has its own name.

But the tragedy of this case, Your Honor, the tragedy of this case, and as the evidence will show, is that the explosions, the death, everything that followed, could be explained as being caused by some of the simple, easiest to understand things imaginable that we'll understand in this

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happened, that with even a simple amount of care should never

10:21AM 3 have happened.

At worst, the evidence will show that the amount of money saved to execute so many of the cost cutters, the cost savings, the short cuts, didn't even amount to pocket change in the operation of this magnitude with this many millions of dollars.

Now, BP published its internal investigation and put out its story of why this strategy happened. The Bly Report, as Mr. Roy pointed out, that will be Exhibit 1 in this trial. It consists of 190 pages and another 569 pages of appendices.

But, Your Honor, if you read every page of that exhibit, all 769 of them, all the footnotes and all the fine print, you won't find a mention, not a whisper, not a hint, of the deeper systemic and corporate management causes, BP culture of corporate recklessness like we see in the Guide/Sims e-mails, the Cocales e-mail and the ones like it.

Much of this trial, the evidence will look at events that happened on the rig during its last few days and hours. As for the immediate rig-based causes, the evidence will show that when BP declared the negative pressure test a success, it was wrong, recklessly and grossly wrong. But that one failed test isn't even close to being the only cause of the

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1 Deepwater Horizon tragedy.

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This evidence up on the screen, Your Honor, is 3 taken from BP's own internal investigation, the Bly Report, which claimed to trace the causes of the Deepwater Horizon 4

tragedy to a series of interrelated causes, when taken

together, caused the accident.

For example, the failure of cement, which isn't coming up, but it's the far left slice; the failure of the float collar, the second from the left; the failed negative test; the failure to monitor and control the well; all the way to the far right, the failure of the BOP to close in the well.

Now, according to BP's own accident model, which you see on the screen, each causation slice lined up in an unbroken sequence and created a chain of causation, a direct line through all of these holes that led to the disaster.

According to BP's own model, this evidence on the screen, and according to the testimony you'll hear from the Bly Report's namesake, if even one of the causation holes hadn't -or slices hadn't lined up, then the Gulf oil spill never would have happened.

For example, if the negative pressure test had been interpreted correctly by BP and it was discovered the cement job had failed, BP's own highly respected drilling expert, Dr. Azar, and BP's own cement expert, Mr. Calvert, will testify that this blowout and all that followed never would

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have happened. Your Honor, this is what BP's expert witnesses will say.

We'll come back to the negative pressure test because it, more than any one single reason, was the immediate rig-based cause of this tragedy.

Leaving aside the model's emission of the systemic corporate and management causes that allowed the separate mechanical failures to happen, the evidence will also prove BP's liability for willful misconduct.

United States, as Your Honor has pointed out, has sued BP for simple penalties under the Clean Water Act, which is consequences for willful misconduct as well as gross negligence.

If we think of the factual evidence and the legal standards as two pieces of a jigsaw puzzle, the evidence that we'll present at trial and BP's own accident model, this model, fit the law of willful misconduct under the Clean Water Act is perfectly matched pieces.

When we present this evidence during the trial, Your Honor, we ask that the Court examine each piece of evidence against the Clean Water Act's legal standard of willful misconduct, which says that an accumulation of acts, a chain of circumstances that were contributing causes, like those we see in BP's own Bly Report and this model, this accumulation of acts constitute willful misconduct even if no

single one of those causes was the immediate cause, and even if
no single one of them standing alone would rise to the level of
willful misconduct.

This legal standard of the chain of causation and

This legal standard of the chain of causation and willful misconduct under the Clean Water Act is describing BP's own accident model.

Now, in the limited time for this opening, we can only skim the surface of the evidence that will establish BP's ownership of each of these interrelated pieces of the willful misconduct chain of liability.

I don't think my arrow is working. There we go.

The first, on the left, Your Honor, is BP's representation of the first causal chain in their model, which is cement.

BP was in the process of temporarily abandoning the well until a production rig would later come and start pumping oil. The purpose of the cement job, as we'll hear during trial, is to prevent oil and gas from pressuring into the casing and causing a blowout during the temporary abandonment.

Now, BP will attempt to shift blame to others by focusing on the cement job. I'll suggest that that attempt is disingenuous, at best.

The evidence will show that it's simply a fact that cement jobs sometimes are unsuccessful, but a bad cement

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job doesn't equal a blowout.

Before safe operators rely upon a cement job to provide a barrier to hydrocarbons, they test it. They test it with a negative pressure test. BP tested the Macondo cement with a negative pressure test and botched the test.

The evidence will show that BP took multiple risks that compromised the cement job and that it ignored warnings from Halliburton and its own in-house BP cement expert. BP's attitude was epitomized in the callous "who cares, it's done, probably be fine" e-mail. It acknowledged the risk as running fewer centralizers that had been recommended by Halliburton.

Considering the risks that BP had undertaken to that point, particularly on the cement job, witnesses will testify that BP should have put the rig crew on heightened alert before the negative pressure test; that BP should have warned them, had the duty, the obligation, the responsibility to warn them before the negative pressure test of BP's own concerns about the cement job. The evidence will show they did not do that.

BP also bears responsibility for the flow collar. Again, my pointer doesn't work. It's this second slice from the left is the flow collar, Your Honor.

The flow collar was supposed to keep the cement in place and prevent it from flowing back into the casing while

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the cement set up and formed a barrier to hydrocarbons.

As the witnesses will explain, BP had severe problems in what is called *converting* the flow collar and making it work. Nine different attempts were made to convert the device. Each of those attempts involved applying increasing amounts of pressure to the flow collar.

But one of the design limitations of the equipment was that a critical component could fail at 1,300 pounds per square inch. As a point of reference, when we go to the service station, fill the tires in our car, call it 32, 40 pounds. 1,300 pounds was the design limitation.

BP applied 3,142 pounds of pressure. Over 1,800 pounds of pressure above the 1,300-pound design limitation.

Testimony will show that at that point, one of BP's well site leaders, Mr. Kaluza, told people aboard the rig, quote, I was afraid something had blown, close quote. His words.

The evidence will show that yet another BP engineer, Brian Morel, who was also on the rig and who has also taken the Fifth Amendment, stated, as we see, quote, Yeah, we blew it at 3,140. Still not sure what we blew yet, close quote. That's Mr. Morel.

The evidence will show that despite BP's own concerns, as we've just seen, about having blown something, to

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use their words, BP did not standdown the operation and take the time to see what they had blown.

Dick Heenan, the United States' drilling expert, will testify about BP's responsibility for the negative pressure test, well monitoring and well response; third, fourth and fifth slices of the causal chain until BP's accident model.

For now it's enough to come back and point out the central and obvious evidence. Oil and gas traveled three nautical miles, from the bottom of the well up to the rig, 18,000 feet. Point of reference, roughly the distance from here to City Park in New Orleans. Up 13,000 feet of well casing through 5,000 feet of ocean and marine riser, and finally blew out on to the *Deepwater Horizon* before either of BP's well site leaders were aware of the blowout.

Despite, despite the mandate of a federal regulation 30 C.F.R. 250.401, which required BP, required BP to take all necessary precautions to keep the well under control at all times.

The evidence will show that a kick less than 40 barrels of oil is considered a major kick that must be discovered in time to take action to prevent an uncontrolled blowout.

The evidence will show that BP has admitted that by the moment the rig exploded a kick had become a blowout of approximately 2,000 barrels, 84,000 gallons, 50 times more than

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a 40-barrel kick they considered to be a major well control event.

We'll hear other evidence concerning BP's responsibility for other causation slices, including the BOP's failure to shut in the well.

Since my pointer isn't working, I'll use this, Your Honor. The BOP on BP's accident model is that last and final slice.

In an emergency, as Mr. Roy has pointed out already, the BOP is the last barrier to protect human life in the environment. So it has to function, has to function without fail. Precisely for that reason, BP was required by federal regulation as the operator of the Macondo well to, quote, Maintain your BOP system to ensure that the equipment function properly, close quote.

Now, BOP -- pardon me, BP will attempt to blame Transocean for the BOP, but the evidence will establish that for five years, stemming from rig audits in 2005, 2008, and 2009, BP believed and understood that it had significant maintenance problems with the BOP. Yet, despite knowing it was drilling the "well from hell," in an area with no kick tolerance and little to no room for mistakes, BP barreled ahead and gambled with a piece of major equipment that was the last line of defense to protect against an uncontrolled blowout.

But of all the evidence the Court will hear, and

all the different slices of the causal chain of failures in

BP's own accident model, the evidence will show that none was

critical and none was so thoroughly and grossly botched as

the negative pressure test.

As even BP's own witnesses will testify, if this one test had been the done right, this one simple test, it would have prevented the blowout, the deaths, and everything else that followed, despite the things that had already gone wrong, like the cement job.

8:00 p.m. on April 20th, BP and Transocean completed the negative pressure test of the Macondo well's casing. The negative pressure test was a safety critical test. The last safety critical test to determine whether the cement pumped into the bottom of the hole less than 18 hours before would stop oil and gas from pressuring into the casing, and if unchecked, create an uncontrolled blowout.

The Court will hear a great deal about the negative pressure test, and there is simply not enough time now to describe the different tests and all that occurred. For our purposes now, the evidence will show that all BP needed to know is what's on the right-hand side of this slide.

Once the test was set up, there should have been:

One, no flow out of the well when it was opened up during the

test; or, two, no pressure buildup when the well was closed in.

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As witnesses will explain, this test is exceedingly simple and is pass/fail. It's not multiple choice. It's not an essay exam. If either of those elements are present, flow or pressure buildup, the test is a failure.

The evidence will show that the final negative pressure test monitored pressures on two pipes: The drill pipe and the kill line.

Using the example here, Your Honor, the drill pipe is the center of the casing going up, and on this right-hand slide has an pressure reading of zero. There are other lines here that we aren't going to be going through for the negative test.

The kill line, which they are also monitoring, finally, is this other one here on the very right-hand side, that on the right-hand side of the slide also has a zero pressure reading.

To have a successful test when it was lined up like this, the evidence will show that all BP needed to know was that the pressure on both pipes had to be zero; repeat, zero.

The evidence will show that if one pipe read zero and the other pipe had pressure, like the graphic on the left-hand side of the slide, then the test was a failure. Because pressure potentially meant that oil and gas were pressuring into the well and threatening to blow it out, which

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is exactly what happened.

Every fact witness who will testify in this courtroom, Your Honor, every expert witness who will testify in this courtroom, every investigative report that is admitted into evidence by Your Honor in this trial, and every witness who was asked the question in deposition, testified that you can't have a successful negative pressure test if both pressures aren't zero.

BP's own drilling expert, Dr. Azar, testified that this is something he would expect his first-year students to understand. But instead of pressure, zero pressure on both lines, as in the graphic on the right, the evidence will show that BP saw 1,400 pounds of pressure on the drill pipe and zero on the kill line, what's up there on the left-hand side of the slide. That meant, without any doubt, that the test could not be considered a success and that the well could be flowing.

Instead, the evidence will be undisputed that BP's two company men, well site leaders Kaluza and Vidrine, disregarded the differential pressure and approved the test based upon a nonexistent theory called the *bladder effect*.

Now, we expect BP to claim that the theory was proposed by Transocean crewmen. But whatever the source of this nonexistence phenomenon, BP's two well site leaders bought into it lock, stock and barrel.

As the experts and the percipient witnesses will

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testify, without any exception, the theory is incomprehensible and makes absolutely no sense from engineering, drilling or even common sense perspectives.

As we'll show, BP's Bly Report admits, without equivocation, that no such phenomenon could be discovered. In fact, Mr. Bly himself is expected to testify that his investigation spent approximately \$10 million and used approximately 50 people, yet still could find no evidence, no evidence whatsoever, of the bladder effect, and that BP's well site leaders, what they had used to justify to turn out, turned out to be a deadly decision.

As BP's own report explained, the investigation team could find no evidence this phenomenon is possible, leaving the 1,400 psi unexplained unless it was caused by pressure from the reservoir.

One BP executive, who is expected to testify in this case, looked at well site leader Kaluza's attempt to explain the nonexistent bladder effect and summed it up here, eloquently, with nothing but question marks, 560 of them.

The evidence will show that BP's well site leaders, who had the final authority to approve the test or reject it, called it successful. They declared the test a success despite the 1,400 on the drill pipe.

And the evidence will then show that BP proceeded with its next decision, which displaced mud in the riser to

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lighter seawater and severely underbalanced the well and allowed it to flow. The action that set in motion the blowout and explosions and set the rig afire like a Roman candle.

The evidence will establish that this approval by BP of the negative pressure test under these circumstances was so far outside the bounds of any reasonable judgment to be constituted gross negligence, but the evidence against BP will, in fact, show far, far more.

Documents and testimony will show that at 8:52 p.m., less than an hour after the approval of the negative pressure test, and less than an hour before the first explosion on the rig, Hafle and Vidrine had a telephone conversation that should have stopped the chain of events, prevented the need for this trial. Instead, both men, armed with knowledge that could save 11 lives and prevent the Gulf oil spill, did absolutely nothing.

At 8:52, at almost the exact same moment the two men began their call, the evidence will show and BP's Bly Report admits, that high pressure oil began flowing into the well approximately three miles below the rig floor on the Deepwater Horizon.

At that same moment, according to what BP's own documents will show, the BP man in Houston, Hafle, called the well site leader on the rig, Vidrine, and the two men talked for ten full minutes.

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The evidence will show that Vidrine talked to
Hafle about the negative pressure tests; that Vidrine told
Hafle that the crew had zero pressure on the kill line, but
that they still had pressure on the drill pipe. Hafle told
Vidrine that he couldn't have pressure on the drill pipe and
zero pressure on the kill line in a test that's properly lined
up.

This exchange between these two BP men and other evidence concerning the actions and inactions of BP's well site leaders, the senior drilling engineer in Houston, in that final hour of the rig, will be among the clearest, most irrefutable pieces of evidence in this trial that show BP's primary responsibility for the blowout and everything that followed.

The evidence will show that BP's man in Houston, Hafle, understood the obvious and correctly told the well site leader on the rig that the negative pressure test that BP had approved only an hour before couldn't be considered a success.

But the evidence will show that Hafle did absolutely nothing to countermand the well site leader's disastrous conclusion that, quote, He was fully satisfied that the rig crew had performed a successful negative test.

The evidence will show that Hafle, who already believed that the cement design was on the ragged edge and had used a swear word to describe the cement job that the negative pressure test was supposed to be testing. It will show that

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Hafle didn't tell Vidrine the obvious: Full stop. Shut it in. Do it again.

The evidence will show that Hafle did nothing like that.

Now, what about well site leader Vidrine? The evidence will show that he already knew that the final negative pressure test had 1,400 on the drill pipe and zero on the kill line, and he had just been told by one of BP's senior men in Houston that that can't be.

In other words, the evidence will establish that BP's well site leader flunked the all-critical safety test when he approved it shortly before 8:00 p.m.; but, worse, he was given the right answer, the right answer by Hafle an hour later, and he was given a chance to undo the previous disastrous mistake he had already made.

So did BP's well site leader get off the phone and immediately order the test be rerun? The evidence will show that he didn't. Did he protect the rig and the crew by ordering the well shut in while he investigated what it was doing? The evidence, Your Honor, will be that he didn't.

Did he warn the driller? Did he warn the toolpusher? Did he warn anybody on the rig floor? Anybody on the rig anywhere? The evidence will show that he didn't.

In fact, there won't be a scrap of evidence, no testimony, any document at all to show that Vidrine did

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anything at all in that last hour after hanging up the phone with Vidrine -- with Hafle, to take any action to reverse the deadly blowout that was already underway miles below the floor of the rig.

In a case that is already filled with tragedy, the evidence will show that the greatest tragedy, the saddest tragedy and the tragic irony is the fact that if Hafle had ordered Vidrine immediately to find the reason for the failed negative test, or if Vidrine had done it on his own as he was supposed to, the very actions that would have been taken would have saved the rig, the men's lives and the oil spill, prevented the oil spill.

And the reason for that is, the evidence will show, that in order to re-perform the negative pressure test, the BOP would have been shut in, just as it had been during the earlier negative pressure test. That would have shut in the well before oil and gas passed above the BOP stack and barreled up the riser like an explosive time bomb counting down to zero, which is exactly what the well had become.

Make no mistake, the evidence will show that if BP's two men, or either one of them had done their jobs, simple jobs, jobs that were their responsibility, *Deepwater Horizon* tragedy and an environmental disaster we call the *Gulf Oil Spill* would never have happened.

The blowout would have stopped right here at the

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end of the negative pressure test, on this slice of BP's own accident model. Instead BP did nothing.

The evidence will show that Hafle and Vidrine ended their call at 9:02 p.m., ten minutes after the well began to flow. The evidence, such as BP's Bly Report, will show that the explosive mass of oil and gas didn't pass the BOP and enter the riser until approximately 9:38 p.m.

Witnesses will testify that that means both BP and the rig crew would have had over a full half hour after the conclusion of the phone call between BP Houston and its well site leader to close in the well through normal operation of the BOP.

The evidence will show that when BP's two men hung up the phone at 9:02 p.m., the people on the rig, the rig itself, and the Gulf and its people had 47 minutes before oil and gas exploded out of the riser and changed, in some cases ended, lives.

The evidence will show that those actions we've just described weren't the result of an accident, or mere negligence or even gross negligence, which it was, but it was the result of willful misconduct, for not only was it within BP's power to prevent the tragedy, it was its responsibility.

Now, to be sure, BP will argue that the blowout was the fault of the Transocean crewmen, who worked under BP's well site leaders and followed their orders during the negative

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pressure test that went so horribly wrong. But the evidence will show, it will be proved that if even some of those Transocean crewmen bore responsibility for what happened, they paid for those mistakes with their lives. And other men, some employed by Transocean, some not, had nothing to do with the negative pressure test and made no mistakes for which they could ever be held to pay.

But the point is that none of them, not a single one of those men should have paid for any mistake with their lives when the evidence will show, without a sliver or a shadow of a doubt, that BP could have saved them, could have saved every plaintiff in this courtroom, every defendant in this courtroom, the Gulf from this disaster, with something as short as a ten-second phone call to the rig floor, to the driller, Dewey Rivette; the toolpusher, Jason Anderson, saying something as simple as: Shut it in. We're doing the test again.

We don't use words like gross negligence and willful misconduct lightly, Your Honor. We understand the seriousness of those allegations. But the fact that remains is 11 people died as a result of multiple interconnected faults of BP and others.

As a further consequence, many tens of thousands of people across the Gulf States suffered injuries to their livelihood. The Gulf and the environment upon which tens of millions of people depend, directly and indirectly, for their

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food, their livelihoods, and their recreation, as well as the birds, the fish, the marine and shoreline organisms, which sustains the Gulf's complex ecosystem, sustain damage and injuries which are still being measured, and will be tried in later phases of this trial. These damages, and not least the deaths to the people aboard the Deepwater Horizon, were caused by actions on and prior to April 20th, that cannot be seen as anything but utterly inexcusable behavior.

We look forward to putting on this evidence, Your And by the end of the phases of trial, securing answers for the benefit of the families of the men who were killed, justice for the people of the Gulf and for the money to help heal and restore the precious environment that sustains this Crescent City and the states, the cities, and the communities all across the Gulf of Mexico.

Thank you very much.

THE COURT: All right. Thank you.

Alabama.

OPENING STATEMENTS

BY MR. STRANGE:

May it please the Court, Your Honor. Luther Strange, the Attorney General of the State of Alabama and the liaison counsel for the Gulf States in this historic litigation. It's my privilege to stand before you today on

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behalf of Alabama and its nearly five million citizens.

In due course, Your Honor, I'll have the opportunity to detail the lingering economic and environmental devastation the defendants inflicted on Alabama. I'll have a great deal to say about those damages at the appropriate time, for they are indeed great.

But today I'll be brief. In this phase one we address just one issue, who was at fault for the explosion and spill that caused such unprecedented and catastrophic damages to the Gulf Coast?

On this issue, Alabama's interests align perfectly with the interest of the United States and the private plaintiffs. Alabama, therefore, supports and affirms the descriptions of facts and laws so well outlined by Mr. Roy and Mr. Underhill, and I don't plan to duplicate their efforts this morning.

Instead, I offer two points that summarize our collective case against BP: One, the spill was both predictable and preventable. Two, BP's culture of corporate callousness towards the Gulf caused the spill.

On this first point, the evidence will show that BP knew that the risks of a deep-water blowout in the Gulf of Mexico was great. In fact, it was nine times greater than in the North Sea.

BP also knew, and certainly should have known before the blowout, that the centralizers would not centralize, the cement

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will not cement, the controllers will not control, and the blowout preventer would not prevent. We'll show that BP knew all of this, but BP was blinded by their bottom line.

Which leads me, Judge, to my second point, the spill was tragically inevitable due to BP's corporate culture.

The evidence will show that at BP money mattered most. Money mattered more than the environment. Money mattered more than the thousands of jobs and businesses that were destroyed all along the Gulf Coast. Money even mattered more than the lives of the 11 workers who lost their lives on the *Horizon* rig. Money mattered more to BP than the Gulf, much more.

Your Honor, the evidence will be clear and unmistakable, greed devastated the Gulf.

Finally, Your Honor, I agree with Mr. Roy, that in the coming weeks we will prove that BP acted with gross negligence and willful misconduct, and that we'll prove the same level of fault against two of BP's partners, Transocean and Halliburton.

For that reason, we'll ask the Court at the end of this trial to rule that all three, BP, Transocean, and Halliburton are liable for punitive damages to the State of Alabama.

Again, Your Honor, it's a privilege to stand here on behalf of the victims of the Gulf disaster as this historic case gets underway.

Thank you.

THE COURT: All right. Thank you, Mr. Strange.

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Mr. Caldwell. Louisiana.

OPENING STATEMENTS

BY MR. CALDWELL:

Your Honor, Judge Barbier, if it please the Court, I want to thank you and Magistrate Shushan and your staff for consuming and exhaustive efforts in bringing this landmark case to trial. The courtroom staff, the law clerks, and those involved are all part of an effort for your entire hard-working team.

But I would also like to thank Special Master
McGovern and the parties for handling their clients' interests
in a professional manner, but after all, none of the lawyers so
far, as I know, were witnesses to this event. And everybody
here has a job to do. And having said that, I want to thank my
own counsel and staff. And we're here to do justice.

Trials are important. This court has stated for the benefit of the press and those who are watching, that we're having a trial and it's important for the general public to understand what we're doing.

All citizens and workers should feel confident, as far as we're concerned, that our oil companies -- and Louisiana is an oil and gas state -- that our companies are conducting business in the safest possible manner. When they don't do that, then it's our job as Attorney General Luther Strange, myself, and the other lawyers, too, do what

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we're supposed to do so that they have to answer.

I have personally been executing my responsibility as Attorney General from a couple of days out when this rig happened, along with the other Attorney Generals from the Gulf States; and with the help, I should say, of BP. Mr. Jack Lynch is in the courtroom today from Texas.

We worked together to try to solve what everybody knows, and in retrospect and in hindsight, is a tragic, horrible event.

But this case is really about the cost of doing business, not just in the Gulf of Mexico, but in the world.

The second thing about this case is the gross underestimating the cost of doing that business.

For example, on the application to drill, BP told Louisiana, this was a no risk proposition for any oil to reach Louisiana shores 48 miles away.

The disaster has damaged Louisiana's people, its economy, and its ecology. I think that's clear. But most importantly, this disaster continues in various forms, including continued pollution, higher unemployment, and the need for increased social service. And today, less than 30 miles from the door of this courthouse, Your Honor, over 212 miles of Louisiana coast are being polluted and continue to be oiled, and in Gulf waters, especially Barataria Bay and Breton Sound. We continue to be adversely affected.

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Our culture, of course, we know is unique in our reliance on the Gulf; but, the other states, to a certain extent, as well, our natural resources, our livelihood and recreation.

This trial can't bring back the 11 workers, and it can't restore the ecosystem; but this trial can and will show that BP and its contractors, all of them, all of the contractors bear some responsibility. They acted in a grossly negligent manner.

This disaster was totally and wholly avoidable, as we heard Mr. Roy, Mr. Underhill state.

We've heard a lot about the problem of BP's culture, but the law doesn't penalize culture, it penalizes gross negligence. The culture, of course, causes an atmosphere of negligence.

It recognizes that elevated risks warrant elevated care.

BP has admitted liability under OPA and waived OPA's limitation of liability, and certainly we appreciate that. Nevertheless, the evidence in this case is going to show the willful and wanton misconduct, and that this imposition of punitive damages should be in the highest amount allowed by law.

We want the Court to focus on, and we know it will, the chaos that was BP's planning process and operations,

and including the botched negative pressure test that we know is central, a central feature, the cement job disaster, and the failed control and the well response.

What about Transocean? Well, you've heard a lot about that, especially in detail from Mr. Roy. I won't go into that much, just that show that Transocean is liable under OPA jointly and severally.

Transocean, the owner of the *Deepwater Horizon*, failed to operate the vessel safely and to protect personnel onboard and the marine environment.

Transocean oil was the first oil to reach

Louisiana. The first oil may be the worst oil. It wasn't

burned off, and no attempt was made to capture this oil.

Transocean must also be held accountable for its failure to monitor the well, to control the well, and for its conduct, along with BP's, in the negative pressure test.

BP and Transocean worked together to botch the negative pressure test. Prior to that, they botched the September 2009 rig audit, which documented 390 jobs of overdue and inadequate maintenance equaling 3,545 overdue hours of maintenance that Mr. Roy referred to. Deepwater Horizon was not even seaworthy.

A final word about Transocean, almost every deposition, Transocean asked its witnesses if its employees would really act so as to endanger themselves. Well, that's

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the wrong question. The right question is did the employees do 1 11:04AM the best with what Transocean made available to them, and was 2 11:04AM what Transocean made available enough? 11:04AM 3 The evidence will show these deaths and economic 4 11:04AM and ecological disaster could have been avoided as well by 11:04AM 5 So we've got BP and Transocean. 11:04AM 6 Transocean. What about Anadarko? Nobody said much about 7 11:04AM them, if anything at all. Evidence will show that they're 8 11:04AM strictly, jointly and severally liable under OPA. Anadarko is 9 11:04AM a 25 percent owner of the --11:04AM 10 11:04AM 11 THE COURT:

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THE COURT: Mr. Caldwell, excuse me, Anadarko is not a party to this phase of the trial, so you might want to talk about another party, okay.

MR. CALDWELL: All right, Your Honor.

Halliburton. Halliburton was grossly negligent, as we've seen and has been referred to, using leftover rig blend from a prior job that contained a defoaming agent incompatible with the slurry.

It failed to run critical safety tests to confirm the cement stability, and without the results of that test that showed that the slurry was also unstable.

The evidence will show Halliburton failed to perform the production casing cement job in accordance with the industry accepted recommendations was another but for cause.

Each one of these things on their own could be deemed to have

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caused this disaster.

Cameron redesigned the BOP, and it was grossly negligent. The emergency battery system for Transocean and BP, it designed that for them, but did not install rechargeable batteries.

More troubling is Cameron's system erroneously led the operator to believe that the automatic emergency BOP function was armed, even when the batteries were dead, and could not function.

M-I Swaco was also grossly negligent. It had a displacement procedure that was improper. It did not use normal spacer procedure.

BP and each of every one of its contractors violated their duties, as Mr. Underhill has stated, under 30 CFR 250.401 to take all necessary precautions to keep the well under control at all times.

Management for each of these defendants ignored the critical warning signs and failed to take precautions that would have delayed the completion of the well, but also would have averted this entire environmental disaster.

BP's team goal was to save money, and to heck with the consequences. Macondo was behind schedule and some \$50 million over budget. Corners were not cut, they were ignored.

Your Honor, finally, I would like to say that

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Louisiana has been ground zero for this disaster.

Based on an inspection of one-half of Louisiana shoreline -- BP refused to inspect the other half -- we've got 660 miles of marsh and shoreline oiled in Louisiana. One million barrels of oil are unaccounted for. 28 new oil mats have been discovered and removed in 2012 from Louisiana's shore. Since January 1, 2013, 93 percent of all oil removed in 2012 was from Louisiana's shores.

60 percent of all Gulf oiling occurred in the State of Louisiana, in our waters. The number is even higher, nearly one hundred percent, when you look at heavy and moderate oiling.

To date, retrievable, visible oil is recovered weekly from Louisiana's shores and beaches in the form of oil balls and oil mats.

In 2011, operations crews removed over one million pounds of oily material from subsurface mats on Elmer's Island. 2.1 million pounds of oil material has been removed in Louisiana since 2012; but, over 9 million pounds of oil and material collected have been removed since June of 2011 through December 2012. Post-Hurricane Isaac, between September 7th and November 21st of 2012, 1,720,000 pounds have been recovered.

58 percent of all wildlife injured and collected in state identifiable waters were recovered in Louisiana.

Your Honor, finally, I know the Court has lived

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and breathed this case. I would like to say that if we could take every lawyer in this courtroom and every person that wanted to out to Louisiana oil and drop them off, we'd see what a 10W90 smog would look like. The point is this a continuing tragedy to this very day and tomorrow.

It's crucial for this Court to keep an open mind and to judge the case on live witness testimony, not just wholesale reference as well to depositions and documents. sure the lawyers are going to produce that for the Court; but, the direct and cross-examination has got to be critically assessed by the Court in the event that there is some change in what the Court expects.

Because it's the Court's responsibility to determine the real truth in this case, that is, what happened, why, who is responsible, and to what degree and who is still responsible for the continuous oiling. In short, this Court is the one to separate the chaff from the grain and apply the law accordingly.

We need to get to the proof, Your Honor. The whole world is watching what we're doing.

Again, I want to thank Your Honor for the opportunity to address the Court.

> THE COURT: All right. Thank you, Mr. Caldwell. All right. Transocean.

MR. BRIAN: Your Honor, I'm going to put up an exhibit

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THE COURT: Sure.

With all the technology we have here, Mr. Brian, you're going to use a pad, low tech. Okay. Haven't seen this in a while in court, but that's okay.

May Mr. Miller approach and readjust the easel?

MR. BRIAN: Mr. Roy told me he was low tech, and I told him I could out low tech him, Your Honor.

OPENING STATEMENTS

BY MR. BRIAN:

Your Honor, Brad Brian for Transocean.

At 8:52 p.m. on April 20, 2010, a conversation took place on the *Deepwater Horizon* that explains virtually everything you need to know about what happened on the rig that night.

There was a conversation between Don Vidrine, BP's onsite well site leader, and Mark Hafle, their onshore engineer.

Mr. Vidrine had supervised the negative pressure test. He had declared the negative pressure test a success, but he thought the results were squirrelly. So he called Mr. Hafle, who called him back at 8:52 p.m., before the gas had gotten above the BOP, and early enough that if they had shut down the job then, none of us would be here today.

Who was Mr. Hafle? Mr. Hafle was one of three onshore engineers, part of the BP team. Mr. Hafle knew better

than anybody how problematic this well had been and the risks 11:13AM 1 that BP had taken. 2 11:13AM

> Mr. Hafle understood better than anybody what a negative pressure test is and what it should show. He listened to Mr. Vidrine, and he knew immediately that there was a problem.

He told Mr. Vidrine that you could not have the test results that Mr. Vidrine had explained if the test had been done right.

Mark Hafle told Don Vidrine that you can't have pressure on the drill pipe and zero pressure on the kill line in a test that's properly lined up.

So what did they do? Your Honor, the PSC's expert, the DOJ's expert, just about everybody's expert believes that that should have shut in the well, then, shut down the job. If they had done that, we wouldn't be here.

But Hafle did not do that. Instead, Mark Hafle did what he and the other engineers at BP had been doing for two months in the face of risk; he did nothing.

Mr. Vidrine did worse. Mr. Vidrine got off the phone and walked to the drill floor. He walked into the drill shack, and he talked to the three men on Transocean's crew. told them to proceed with the displacement, to remove from the well the drilling mud, the only thing that was at that point standing in the way between those men and a blowout.

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He left them alone in the drill shack to face those risks. He never saw them alive again.

Transocean's drill crew followed those They did it attentively. They were not instructions. complacent. Twice during the next 30 minutes they shut down the pumps when they saw abnormalities.

They spent crucial minutes trying to figure out what Mr. Hafle already knew, that you can't have pressure on the drill pipe and zero pressure on the kill line in a test that's properly lined up.

These men on the drill crew made the mistake of putting too much trust in BP, and they paid for that trust with their lives.

Under these facts, Your Honor, BP's continuing effort to shift the blame to the Transocean drill crew and to avoid its indemnity obligation is shameful.

Your Honor knows that both BP and Transocean have entered guilty pleas as a result of some of the conduct on April 20, 2010, but that's where the comparison ends.

BP pled guilty to eleven counts of seamen's manslaughter for not only causing the largest oil spill in history, but for causing the deaths of eleven people, including nine of our crewmen.

Transocean Deepwater, Inc., the employer of the men offshore, pled guilty to one ordinary negligence

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misdemeanor count for discharging oil into the Gulf.

We have admitted, Your Honor, that our crew should have investigated more in response to Mr. Vidrine's instruction, and we pled guilty for that; but they put their trust into BP, and they were betrayed.

Your Honor, it's my privilege to represent the Transocean defendants in this case. I'm honored and humbled to be working alongside some of the best lawyers I've ever had the privilege to work with, Kerry Miller, Steve Roberts, Rachel Clingman, Richard Hymel; my own colleagues, Mike Doyen and Luis LI and, back in the courtroom somewhere, John Kinchen.

I've tried to organize my opening remarks around the two questions Your Honor will have to decide with respect to Transocean in, I think, Phase One of the trial: Was the drill crew or the company that employed them so consciously indifferent to danger that their conduct can be deemed to be grossly negligent; and, was the conduct of those men or the company so deliberately deviant such that Transocean is deemed to have committed a core breach of conduct that might conceivably void BP's unambiguous indemnity obligation?

I would submit that the answer to both of those questions is no.

The evidence will show at this trial that the crew and Transocean were not consciously indifferent to danger. Their conduct does not come close to the sort of deliberate

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misconduct that has to be shown to establish a core breach of contract.

I would submit that that 8:52 p.m. call lies at the heart of the facts that Your Honor must wrestle with in answering both of those questions. In many ways, it's a microcosm of what BP did wrong on this well and why we believe that Transocean and our crewmen truly are victims of that misconduct.

When the BP onshore engineer and the BP well site leader had that conversation, and they realized that the test was no good, their instructing the crew to proceed with displacement of the well was in utter disregard to the facts. Nothing remotely similar was done by Transocean.

Did the crew make a mistake in thinking the test was good and relying on Mr. Vidrine? Yes. We've admitted that. In hindsight, everybody knows they made a mistake.

But did they know the test was wrong, as Mr. Hafle indicated in those notes of his interview? No.

Mr. Hafle had an eight-minute conversation with Mr. Vidrine, immediately saw a problem, and then stayed safely onshore. The Transocean crew, by contrast, worked hard for several hours for the sole purpose of getting that negative pressure test right. They didn't get it right, but it wasn't for lack of trying, and it was not for indifference.

We don't know, and we'll never know, Your Honor,

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precisely what that crew was thinking because they are not here to tell us. But what we do know is they had no interest in putting themselves and their crew mates at risk.

I would submit that it's wrong as a matter of fact and law, as Mr. Caldwell just tried to do, to equate the conduct of the Transocean crew to the conduct of Mark Hafle, who knew it was wrong and did nothing, or the conduct of Don Vidrine, who was told by Mark Hafle it was wrong, and yet told the crew to proceed.

The Transocean crew did not go home to safety,
Your Honor. They did not ignore their duty. They did their
duty. They died doing their duty. They died fighting the
well.

From 6:00 p.m. that night on April 20 until the end, the Transocean drill crew, Revette, Stephen Curtis, and Jason Anderson, were in the drill shack.

This was a great crew, experienced, well trained, universally admired by everyone. The overwhelming evidence shows that Transocean worked long and hard to provide this drill crew with the training and the equipment that they needed to do their job safely and return home. They died not because they weren't trained properly; they died because critical information was withheld from them.

Who were these three men? Jason Anderson had been on the *Deepwater Horizon* almost 10 years, since its maiden

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Shortly before April 20, he was offered a promotion precisely because he was one of the best toolpushers in the company.

Dewey Revette, the driller, had 23 years of experience with the company. He had been on the Deepwater Horizon almost as long as Mr. Anderson.

Stephen Curtis, the assistant driller, had worked for Transocean for almost nine years, all but a few months of which were on the Deepwater Horizon.

These men were universally respected. depositions in this case, Your Honor, we asked virtually everyone what they thought of these men. The answer, they were safety conscious people, the kinds of men you would gladly entrust yourself, your lives to.

Here is what Murray Sepulvado, one of the highest ranked BP well site leaders, said in his deposition:

(WHEREUPON, at this point in the proceedings, a video clip was played.)

- Ο. "Did you ever have any problems with any of these individuals we just talked about in terms of their safety consciousness while you work as a well site leader on the Deepwater Horizon?
- "Never had it. Α.
- "If you could turn back the clock, and if you could work Q. on a rig with these guys again, would you have any problem

11:23AM 1 working on a rig with these guys?

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A. "It would be my pleasure."

(WHEREUPON, at this point in the proceedings, the video clip ended.)

MR. BRIAN: The *Deepwater Horizon*, Your Honor, was one of the best rigs in the world. It drilled some of the most challenging wells in the world.

In 2009, it dug a well over 35000 feet, a record in the world at its time, twice what the Macondo well was.

The rig was inspected hundreds of times by government agencies and neutral third parties. One of the officials at the government, the MMS, testified that from his experience, they're one of the best.

When the Coast Guard inspected the rig in 2009, they said they found the rig, the overall rig in excellent condition. BP agreed.

The Deepwater Horizon had been built for BP and worked exclusively for BP. It was regarded by BP as one of the best rigs in the fleet.

You're going to hear testimony at the trial about a tour on April 20 of the *Deepwater Horizon* by some senior BP people, including a man named Pat O'Bryan. Here is what he had to say about it.

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At his deposition, he said, "It was the best performing rig from a safety and a drilling performance

performing rig from a safety an

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He went out on the tour because he wanted to see what good looks like.

This crew didn't just meet industry standard.

This rig, Your Honor, was what the industry standard should be.

As of April 20, 2010, that was the view of BP, the MMS, the Coast Guard. The problem here wasn't with the rig or the crew. The problem was the well and the way BP managed or mismanaged it.

It was not an accident that Transocean had its best rig and a fine, well-trained crew on the Macondo well, Your Honor. Transocean has only two assets, its people and its equipment. We don't own oil and gas leases. We don't risk our people or our equipment on the hope that we'll make zillions of dollars by striking oil. When we send our people out to a rig, we want them to come back to their homes and their families.

Transocean gave its people state of the art training. All three of the men in the drill shack that night, Jason Anderson, Dewey Revette and Stephen Curtis, were up to date on their well control training courses.

Those courses were audited and certified by the IADC, which sets standards and has certified well control training programs in companies like Exxon Mobil, Chevron, Noble Drilling and others.

Many, many experts have reviewed our training

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The bottom line is our training was top notch, Your Honor.

You're not going to find a single expert report saying that our training was below the standard of care in the industry at that time.

Now, it is, of course, proper after an accident to ask whether we could have done something different and We've all done that. Transocean has always done that when it had accidents and incidents in the past. They have reported on them. They've instituted studied them. new procedures. They've updated their training control manual.

We all hope that lessons will be learned from But in the world before Macondo, I would submit that the evidence in this case will show that Transocean's training was far above the standard of care in the industry.

Our training programs were reinforced constantly by drills on the rig. Some of them weekly, others ad hoc.

For example, this is the drill report from April 18, 2010, on the Deepwater Horizon, just two days before the incident. In this drill, they discussed the roles and responsibilities of the crew, and they discussed the possibility of kicks during cement jobs. The crew was reminded that wells have been lost due to improperly designed cement slurries and spacers.

You heard Mr. Roy talk about the Sedco 711

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incident that took place in the North Sea in late 2009. suggested, and I expect to hear argument at trial, that somehow, because of that incident, and because a written advisory somehow didn't get to the Deepwater Horizon because somebody was on vacation, that the crew somehow was complacent to the fact that barriers like cement can fail.

Your Honor, that is precisely what the crew was told on April 18, 2010, two days before the incident.

Who was present? Jason Anderson, Stephen Curtis, Dewey Revette, Don Vidrine. In fact, nine of the 11 men who perished on April 20 were there.

That drill on April 18, Your Honor, is just an example of how training at Transocean works. To join a crew, the Transocean crewmen must attend well control school, get classroom training and receive on-the-job training that is tailored to their specific job responsibilities.

Once they make it to a crew, they keep on training. They go back to the well control school every two years. They learn on the job by teaching others and, probably most of all, by drilling.

Your Honor, these men know and knew how to do They knew what to look for, and they weren't their jobs. looking for the right stuff on April 20.

They knew the fundamentals. They were preached into them when they took the job, and that became their trade,

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and they relived them and relearned them repeatedly.

Now, Mr. Roy talked about some other well control events and suggested that that somehow shows that Transocean as a company was grossly negligent, that somehow we had -- our safety culture was deficient. With respect to my friend Mr. Roy, they show nothing of the sort, Your Honor.

Transocean is justifiably proud of its record on well control. Kicks are part of the business.

From 2005 through 2009, that five-year period,

Transocean worked on almost 7,000 wells worldwide. Our goal -
kicks are a part of the business, Your Honor, and our goal is

to keep the kicks under 20 barrels.

This is a report that came out in 2009, well control events report, and you'll see what it tracks. It tracks how the company or how the rig crews do in detecting kicks.

What you see clustered in the lower left-hand corner is that the majority of the kicks are detected within 10 barrels, the vast majority within 20, and only a small sliver exceed 30 barrels.

The plaintiffs' efforts to use a handful, I think Mr. Roy referred to six, of well control events to suggest that somehow the company was grossly negligent or the crew was grossly negligent on April 20 is unfair to the evidence, it's unfair to the company, and it's unfair to the crew.

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Now, when a drill crew does not meet that goal, which happens, the company goes out, and it investigates it, it reports on it, and it takes corrective action.

For an example, let's look at this 2004 event on the *Cunningham* that Mr. Roy referred to. First of all, that took place nine years ago, in 2004, six years before the Macondo event. It took place off the coast of Egypt, in an entirely different division of the company.

But, more fundamentally, Your Honor, the reason that Mr. Roy is able to stand up and talk about these events is because the company doesn't sweep them under the rug. The company investigations them and creates written reports and takes action.

Here is the action that took place as a result of -- oops, I went the wrong way.

This is a letter that was written to the night toolpusher, that's the -- a letter that says his conduct -- that he was complacent, and his conduct was grossly negligent. It was recommended that he will be terminated from the company immediately.

In every single one of the incidents that Mr. Roy will talk about at trial, the company investigated those events and took action. That's what a safety process system is.

Now, Mr. Roy referred an e-mail by Larry McMahan, in which he said -- talked about train wrecks. You'll seal

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that document. He's talking almost entirely, by the way -- he uses the phrase "loss of control," and Mr. McMahan will tell you that virtually all of those are loss of control of objects, things falling, heavy equipment falling. I think there are one or two well control events that are referred to in there.

But the point is that these are not e-mails from some whistleblower who feels like he's not being heard by his superiors at the company. This is a document by Larry McMahan, the company's most senior executive in charge of training worldwide.

His responsibility was to point out problems. When he felt that people were not living up to that — to the high standards that the company set, he took action. He did it with the kind of language that Mr. Roy indicated. At Transocean, that is encouraged.

Steven Newman, the company's CEO, who, like Mr. McMahan, will testify at this trial, totally supported Mr. McMahan's effort.

Mr. Newman personally got involved in connection with some problems you'll hear about involving a rig that they call the $Arctic\ I$ with Shell.

Before that, in the Fall of 2009, because three or four people had actually been killed, not in well control events, but on accidents on the rigs, he commissioned a worldwide survey of the company. Because that was going to

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take a while, he actually ordered an immediate worldwide shutdown of the fleet to reemphasize the basics of safety.

Transocean does not put profit over safety.

Now, Mr. Roy mentioned a March 8th kick, 2010, on the *Deepwater Horizon*. He said that the Transocean drill crew detected that kick late, and that it was criticized by John Guide.

John Guide has said that. His testimony on that is contradicted by every other piece of evidence. In fact, the evidence will be that the kick was detected within 10 to 12 barrels. It was not shut in until slightly more than 30 barrels because the crew was investigating whether the movement of a crane on the rig could affect the pit volumes, which it can do.

So we asked Murray Sepulvado, again, who was the BP well site leader at the time, what he thought about the crew's performance on March 8th. This is what he said.

(WHEREUPON, at this point in the proceedings, a video clip was played.)

- Q. "Because of the circumstances where the crane was in use and the driller saw something that he had concerns about and took the time to shut the crane down and then look to see if there was really the crane or something else going on --
- A. "Right.
- Q. " -- did you consider his response to what he was seeing

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- appropriate?
- A. "Yes.
- Q. "Do you believe that anybody there on the rig screwed up, as Mr. John Guide is quoted as having said here in this interview, in terms of the March 8 kick?
- A. "Well, I was there, and I thought they done a pretty good job myself.
- Q. "They being the TO folks?
- A. "The TO folks and Halliburton."

(WHEREUPON, at this point in the proceedings, the video clip ended.)

MR. BRIAN: Mr. Roy also talked about this Lloyd's audit that took place also in 2010, and said there were some problems. Well, I actually didn't think he was going to mention it, so I didn't have it to put it up. So I'll read to you a few of the findings by Lloyd's audit.

They found that 97.6 percent of the Deepwater Horizon crew members surveyed believed that line managers listened and acted on the crew's safety concern.

They believe that 100 percent of the Deepwater Horizon crew members surveyed felt they understand the safety procedures and hazards associated with their jobs because of the degree of training and support they have received, and they found the Deepwater rig safety culture to be robust.

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So, Your Honor, if we had this great rig and this well-trained crew, why did the blowout take place? There are, in the end, only two reasons for that.

First, BP took a series of unconscionable risks with an exceptionally difficult well.

Second, instead of warning the crew that the cement likely would fail and that the test, the negative pressure test, to determine whether the cement job was good had, in fact, failed, they did not give those warnings.

Now, Mr. Underhill described some of the risks that BP took with the not doing the bottoms-up circulation, using the long string instead of a liner, using the lower number of centralizers. All of these decisions were made in the context of a well they described as one of the wells from hell, or a "nightmare" well.

The risk that they took made the integrity of the bottom hole cement critical. Nevertheless, the evidence will show that BP did not comply with its own requirements to make sure they had a good cement job.

Others in this trial will spend more time on cement than I will, Your Honor, but one of the critical variables in cement is how long it takes to set, to harden.

The evidence here will show that compressive strength tests were performed at the wrong temperature, contrary to BP and industry standards. Other tests showed that

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the cement would not set in 24 hours.

Despite that, BP shortened the time between the pouring of the cement and the time that displacement was started. Rather than waiting, let's say, 24 to 48 hours, they ordered the crew to proceed with displacement within 16 hours of the pouring of the cement.

Now, I expect that BP's lawyer will blame this on Halliburton; but, one thing is absolutely clear, that by April 20, BP had lost faith in the Halliburton cement team.

They referred in these documents to

Jesse Gagliano, who was their interface at Halliburton. They
said that Jessie isn't cutting it anymore. There is no excuse
for this. Jesse still waited until the last minute.

In another document, in their handwritten notes, they said he showed a lack of understanding of the modeling. The lab results came in at the last minute. They had to QC.

Whoever is to blame, Your Honor, for the cement job, whether it's Halliburton, BP, or both, some facts are absolutely clear: One, the cement job failed; two, they went forward with the cement job without accurate test results; three, they went forward without waiting for the test to harden.

To make matters worse, they decided not to do a cement bond log. Why? Because it would cost more money.

The men who made these decisions had days to

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think about what they were doing. This is very different from the Transocean rig crew whose conduct over the course of minutes is at issue in this case.

You've already heard about BP flip-flopping on the number of centralizers, even though they'd received a report from Halliburton on April 18 warning them of a severe gas flow problem if they didn't use the number of centralizers that BP wanted. The head of BP's onshore team, Greg Walz, admitted that he had a conversation with Mr. Gagliano on April 19, in which Mr. Gagliano told him about this document, and yet they did nothing.

That takes us to one of the most famous e-mails in the case, Brett Cocales' e-mail where he says, who cares, it's done, end of story, it will probably be fine.

There is an lot of arrogance in that e-mail; but,

I think the second, the next sentence, Your Honor, is in some
ways more telling. "I would rather have to squeeze than get
stuck above the wellhead."

What he's saying is, I would rather take the risk of getting it wrong and then having just to fix it, than taking the additional time to get it right in the first place.

That attitude has been widely condemned; but, whatever you think of its merit, that risky approach that BP took, if you're going to take those risks, you have to tell the people sitting on top of the well, the guys who are going to

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have to deal with it in the event of a failure.

BP's view at the time seemed to be that since this is a risky business, and since the drill crew knew that cement can fail, there is no need to tell them about the extraordinary risks they were taking.

Now, this is not -- I'm not the only one saying this, Your Honor. The PSC's expert, Professor Bea, in his report says, and I quote, BP's onshore well team refused to communicate key risks of the operation to Transocean.

The PSC now stands up and says that both BP and Transocean were grossly negligent on a negative pressure test. Your Honor, I just would point out, you certainly can't prove that from our guilty plea because in our guilty plea, while we've admitted ordinary negligence, we have not admitted gross negligence. There is nothing in there that establishes.

The truth is that BP was responsible for the test from the beginning to end, and they botched it up. They botched it in the planning, in the design, in interrupting the crew, and interpreting its results.

In the weeks leading up to April 20, Your Honor, BP changed its mind five or six times about how to do a negative pressure test, how many to do, when to do them. First, they were going to do one. Then they were going to do two. Then they were going to do one.

By the way, in the middle, and you'll see that

the yellow says -- the one that's below says, monitor for 11:43AM 1 2 30 minutes. I suspect BP might argue that they never planned 3 to do two tests; but, in fact, their own documents make clear that that was in reference to a second negative pressure test, 4 11:44AM 11:44AM 5 because this an e-mail from Brian Morel, April 18, where he says, the plan is to do a negative test with base oil on the 11:44AM 6 bottom plug. Then we will displace, and a second negative test 7 11:44AM will be done. 11:44AM 8

In addition to all this confusion, they then monkeyed with the test. You see, they had 400 barrels of unused lost circulation materials on the rig. Under the law, they were going to have to ship that back to shore and dispose of it as hazardous waste.

They didn't want to do that because it would cost money. So somebody at BP had this bright idea that if they pumped it through the BOP in the system, they could refer to it as circulation material, call it spacer, and then they could just dump it overboard into the Gulf of Mexico.

Well, this stuff had been used to patch cracks in the formation. As far as we know, it had never been used to displace a well.

You know, people have been studying what the effect of that was, and there's all these theories about whether it clogged the kill line and stopped the flow; but, at a minimum, it confused the negative pressure test.

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All of these last minute changes by the engineering people at BP had the operations people at wits end. This is the e-mail you saw earlier from John Guide, where he says there is so many last minute changes that they had finally come to their wits end. The quote is, "flying by the seat of our pants." Then he made his prophetic prediction, the operation is not going to succeed.

He sent that to his boss, David Sims. What did David Sims do about it? Nothing. He didn't do anything. He didn't call a time-out. He didn't say, let's talk about it. Instead, he sent back this e-mail in which he said, if we had more time to plan this casing job, I think all of this would have been worked out before it got to the rig.

They actually considered an alternative, plug the well and abandon it, but that would have cost over \$10 million.

Your Honor, they had the time, they just didn't want to spend the money.

The crew set up the negative pressure test on the drill pipe, as was their practice when Murray Sepulvado had been the well site leader, and they detected the abnormal pressure on the drill pipe.

They were in the middle of investigating and analyzing what that pressure meant when there was a change in shifts of the two well site leaders at BP. Don Vidrine replaced Bob Kaluza.

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Don Vidrine insisted that they start the test over and do it down the kill line because that's what their permit had said, and instructed the crew to do it down the kill line and to check for flow.

The crew followed that instruction, and they watched it for 30 minutes. There was no flow.

Mr. Vidrine declared it a successful negative test monitored on the kill line, as reflected in a document he and Mr. Kaluza signed shortly after the incident.

Now, some people have said, well, this is very simple, that it's like two straws going down a glass. see a different pressure, automatically it's a failure.

It's not so simple because the two straws here, one killed the kill line, went down 5,000 feet, the drill pipe went down 3,000 more feet, and they are in different fluids with different pressures.

So it's not unusual to have different pressure on the kill line and the drill pipe. The question is why do you have that different pressure? That's the issue. And that's what the -- the crew didn't miss the fact that they had different pressure. They were trying to analyze that, but Mr. Vidrine told them to look for flow on the kill line, and that was the mistake the crew made. They should not have listened to that instruction.

After Vidrine finished his call at 8:52 p.m. with

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Mr. Hafle and came to the drill pipe -- to the drill shack, there were subtle signs that, with hindsight, experts now say indicated a kick around 9 o'clock, slightly after 9 o'clock.

No one knows exactly how those signs appeared on the screens that were available to Transocean, BP and Halliburton; but, one thing we know for sure is that those subtle signs of a kick were missed by a number of people between around 9:08 and 9:14, 9:15.

They were missed by the driller at Transocean.

They were missed by the mudlogger, Joseph Keith, who did take a break, a 10-minute break that Mr. Roy indicated, and then came back to the drill shack and checked the screen and didn't notice that.

They were missed by Don Vidrine, who visited the drill floor during this time period to look at a sheen test and check the screens.

They were missed by Mark Hafle, who testified -- who said in his interview that he had the screens up during his conversation with Mr. Hafle between 8:52 and about 9 o'clock.

After Mr. Vidrine left the drill shack between 9:15, the crew then monitored the well.

As I said earlier, we will never know exactly what they were thinking and exactly why they did what they did because they are not here to tell us. But we do have the data, Your Honor, the Sperry-Sun data.

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The right four-fifths of that is the actual actually Sperry-Sun data. We changed the column on the left to make it easier.

This is what shows you what's happening, what they are watching between 9:14 and 9:49. What you see is that the crew was far from being complacent.

At about 9:18, you see that blue spike. The crew noticed that, and they shut down three pumps to investigate. They determined the problem was a popped pressure valve, so they turned the pumps back on and the pressure rose.

The drill pipe is the red at the bottom, and the kill line is the blue, Your Honor.

They continued to monitor. Then, about shortly before 9:30, they see that the kill line and the drill pipe are acting different, that the kill line goes up and then starts to go down, and the drill pipe is doing something different.

So they shut off the pumps again. You see that at the top, when it goes down to the bottom.

They continued to monitor. At about 9:36, they actually released the pressure on the drill pipe. You can see it dip down as a result of that. That's because they were monitoring what was going on.

Then right around 9:40, before, about 9:39, you see the pressure on the drill pipe goes up, and then it turns back down. That's an indication of a kick.

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The crew noticed that, and they did a flow check. They saw that the well was flowing, so they closed the annular. The flow was too strong, so closing the annular did not seal the well.

As they were trained to do, they diverted the flow into the diverter system.

Now, consistent with BP and Transocean policy at that time, the diverter system was set by default to divert to the mud-gas separator. The reason for that is environmental. You don't want to just automatically divert hazardous stuff into the sea.

Ultimately, as Mr. Roy indicated, the mud-gas separator became overwhelmed. There is going to be evidence in this case, we don't know exactly when, but there will be evidence in this case that the crude did, in fact, then begin to divert overboard; but, of course, by then, it was too late.

At about 9:46 or 9:47, they closed the variable For a moment, the well was successfully shut in, but bore ram. the force was just too great.

My point, Your Honor, is in a case where the issue is were they consciously indifferent, were they grossly negligent, this crew was attentive in taking responsive actions at every step of the way in response to the indications that they saw.

In addition to activating the BOP, closing the

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annular, activating the variable bore rams, the crew did their duty to alert others. They called the bridge, they called Mr. Vidrine, and they called the senior toolpusher, Randy Ezell.

This is Randy Ezell's testimony about his conversation with Steve Curtis: Steve said the well is coming in. We got mud blowing to the crown. I remember thinking, oh, my God, and I asked did they have it shut in. Curtis told me that Jason -- that's Jason Anderson -- was shutting it in. He said, Jason is shutting it in now. Then he made the remark that, we can't see out of our windows. Randy, we need your help.

Ezell ran to put on his coveralls and his boots and to help them, but he was blown back by the tremendous explosion that then happened.

None of this had to happen, Your Honor. It happened because BP was behind schedule and was rushing to get this well done.

Some people have accused Transocean, and you're going to hear evidence in the trial, of accusations that the crew did not act quickly or decisively enough. I would submit, Your Honor, that that's unfair. They took action, they were attentive, but they were missing critical information.

They should have been told that there was a severe gas flow potential. They should have been told that

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there was a grave risk that the cement may not have hardened by They should have been told that the cement might not be They should have been told about the conversation between Mr. Vidrine and Mr. Hafle at 8:52 p.m.

BP has tried to shift the blame by focusing now on the BOP and claiming that -- by distorting facts about the BOP and by distorting what happened on the rig that night. PSC has sort of jumped on that bandwagon. So let me talk for the few minutes I have left about the BOP and what happened on the bridge crew.

The Court is going to hear a lot of technical details about the BOP. I am not going to go through those They are going to be presented by the technical details now. experts. Most of them are, we think, undisputed and based on the forensic evidence found by DNV.

Your Honor, that's the graphic of the blowout preventer. The reason I prepared the board over here, which is just simply a copy of that, was because I'm going to show you that the things function, and I realize that it's helpful to have that up and in place.

The evidence shows that annular functioned when it was closed by the crew that evening. This is the upper annular that you see on the chart over there that, in fact, did close.

The variable bore rams also functioned.

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But two minutes later, at about 9:47, there was the powerful explosion, and that caused the rig to lose power and to drift off station with pulled pipe.

After the explosion, it was determined that the blind shear rams had functioned. There is some dispute, and we'll talk about it at the trial, as to when. We believe they functioned as they should have functioned; but, unfortunately, the extreme flow up the well had moved the pipe off center. As DNV found, because it moved off center, when it cut it was not able to actually stop the flow of the well.

You see where the pipe is off center. That's what caused it not to stop the blowout, Your Honor.

The fact is that the men operated the BOP and that it, in fact, functioned. The piping off the side had nothing to do with maintenance. The evidence you're going to hear about batteries, it's all a red herring. The fact is the BOP functioned.

Mr. Roy had mentioned the condition based maintenance system the company used. Well, condition based maintenance is used by the United States Department of Defense, the Coast Guard, and the aircraft industry. It doesn't mean running your tires on your car until the treads are bare and your tire blows out. It means keeping track of things and fixing them before they fix [verbatim].

The Court will hear evidence that the BOP

received extensive and regular maintenance, including hundreds 11:57AM 1 of hours in January and February of 2010, before it was put 2 11:57AM

back in operation on the Macondo.

All of the major components had been inspected and maintained. The BOP was tested constantly. The blind shear rams were tested on the morning of April 20, 2010, the very day of the incident. They functioned then during the test, and they functioned during the incident.

So let me talk for the last few minutes on what happened on the bridge crew because there has been an argument raised that somehow the crew and the captain panicked and that they failed to disconnect immediately from the well.

Your Honor, that argument disrespects the memory of the men and the heroic actions of the men and women on the crew that night.

Some people seem to think that the EDS button is some sort of ejector button like you see on an Air Force F-16. It's not. It's a piece of equipment that's only designed to be used after you communicate with the drill crew.

Why? Because the drill crew is trying to control the well, and they have to take actions. If you just EDS before you're supposed to or without checking with them, or when it cuts the joints and it can't cut through the joints, you may have a rig drifting out in the Gulf of Mexico with a wide open wellbore.

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Panicking and pushing the EDS button is not what is recommended. It's almost like if you hit the ejector seat button on an F-16 before you realize that you're upside down a hundred feet above ground. You have to think before you do it.

The next claim that Mr. Roy made, that somehow there was confusion because of the dual command, is not accurate. Everybody knew that in case of an emergency, Captain Kuchta was in charge. He knew it, and the other crew members knew it.

It was totally proper for Captain Kuchta to ask questions of some people before deciding to EDS. That was entirely appropriate in an emergency. There was no panic in Captain Kuchta, and he adhered to the right procedures on the bridge crew -- on the bridge that night, Your Honor.

Perhaps the clearest indication that the crew was well trained and that they acted properly in response to this disaster is that every single man and woman who could have survived did. In the midst of a literal apocalypse of fire, explosion, burning oil, the men and women on that rig sprung into action.

You will hear testimony at this trial about literally death-defying acts of heroism. Men and women walking, climbing, crawling on the rig to save their shipmates. In the end, every single crew member who was not killed in the initial explosion survived.

I think Professor Bea may have put it best at his 12:00PM 1 deposition, Your Honor, when he was asked, "What is your 2 12:01PM opinion on the performance of the Transocean crew on April 20?" 3 12:01PM 4 Answer, "I think they were heroic." 12:01PM I think so too, Your Honor. Thank you. 12:01PM 5 THE COURT: Okay. Thank you. 12:01PM 6 7 All right. It's noontime. We're going to now 12:01PM take a lunch recess before we continue with the remainder of 8 12:01PM 9 the statements. I think we have about three hours left of 12:01PM opening statements, I calculate. So let's come back at 1:30. 12:01PM 10 12:01PM 11 Recess until then. THE DEPUTY CLERK: All rise. 12:01PM 12 12:01PM 13 (WHEREUPON, at 12:01 p.m. the Court was in luncheon 14 recess.) 15 16 17 18 19 20 21 22 2.3 24 25

REPORTER'S CERTIFICATE

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District Court, Eastern District of Louisiana, do hereby

certify that the foregoing is a true and correct transcript to

the best of my ability and understanding from the record of the

proceedings in the above-entitled and numbered matter.

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s/Cathy Pepper

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