Chapter 11 again refers to the permit to work system and shift takeovers. On pages 194 and 195, Lord Cullen concludes that there was no adequate training procedure for the permit to work system, that much reliance was placed on ad hoc methods and/or "on the job" training and that the permit to work system was not adequately monitored by the rig's safety department. The deficiencies in the permit to work system are constantly mentioned.

Page 196 of the report states that the system of shift handovers was a major factor in the disaster, and mentions critical comments by a Mr. Clark, who was a survivor of the disaster, and criticised the operation of the permit to work system in a meeting with senior Occidental management in early 1988. No action was taken.

Page 197 of the report mentions the death of Mr. Sutherland, in 1987. He was a rigger who died after falling from a canopy above a pump while carrying out maintenance. Occidental was prosecuted under the Health and Safety at Work, etc. Act 1974 for failing to ensure that persons in its employ were not exposed to unnecessary risks. Occidental pleaded guilty and was fined £400. The crucial factors in that incident were shortcomings in the permit to work system. The report states:

> “"The complaint to which Occidental pleaded guilty also specified 'inadequate communication of information from the ... day-shift to the night-shift'."”

So, once again, the permit to work system is mentioned.