

# **Health and Safety Executive**



**Post Implementation Review of the  
Reporting of Injuries, Diseases and Dangerous  
Occurrences Regulations 2013  
(S.I. 2013/1471)**

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## Introduction

1. This report undertaken by the Health and Safety Executive (HSE) provides an overview of the Post Implementation Review of the [Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013](#) (RIDDOR 2013) which revoked and replaced the [Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995](#).
2. RIDDOR 2013 was made under the Health and Safety at Work etc. Act 1974 and these regulations require employers and other people in control of work premises, to report and keep records of:
  - work-related accidents which cause death;
  - work-related accidents which cause certain serious injuries (reportable injuries);
  - diagnosed cases of certain occupational diseases; and
  - certain 'dangerous occurrences' (incidents with the potential to cause harm).
3. These regulations implement the recommendations in Professor Löfstedt's report '[Reclaiming Health and Safety for All: An independent review of health and safety legislation](#)', published in 2011 and further simplified and clarified the requirements for informing enforcing authorities about serious work-related accidents and incidents.
4. The Löfstedt Review identified a number of issues associated with the 1995 Regulations, particularly, that the categories of incidents that were required to be reported were unnecessarily complicated. It recommended that RIDDOR and its associated guidance be amended to provide clarity for businesses on what to report and how to comply.

## European Context

5. RIDDOR implements aspects of a number of EU Directives referenced in the below, and provides the national reporting framework necessary for the effective regulation of health and safety at work.
6. Most significantly, RIDDOR implements [Article 9\(1\)\(c\) of Council Directive 89/391/EEC](#) concerning measures to encourage the improvement of the health and safety of workers. This provides that employers shall keep records of occupational accidents resulting in the incapacitation of a worker for more than three days, and report accidents to the national authority. Reports made under RIDDOR inform the provision of statistics to the EU as required by Regulation (EC) No. 1338/2088 on Community statistics on public health and safety at work.

RIDDOR 2013	EU requirement
Reg.4 Non-fatal injuries to workers	<ul style="list-style-type: none"> <li>Article 9(1) (c) and (d) of Council Directive 89/391/EEC - Requiring the recording and reporting of certain occupational accidents.</li> <li>Article 3 of Council Directive 92/91/EEC - Requiring the reporting of serious accidents and situations of serious danger at gas and oil drilling sites, including offshore.</li> <li>Article 3 of Council Directive 92/104/EEC - Requiring the reporting of serious accidents and situations of serious danger at mines and quarries.</li> <li>Article 5 of Directive 2004/49 EC - Requiring certain common reporting criteria for accidents and incidents in the rail sector.</li> <li>Regulation (EC) No 1338/2008 - Requiring the provision of statistics on workplace fatalities and accidents.</li> </ul>
Reg.6 Work-related fatalities	<ul style="list-style-type: none"> <li>Article 9(1)(c) and (d) of Council Directive 89/391/EEC - Requiring the recording and reporting of certain occupational accidents.</li> <li>Article 3 of Council Directive 92/91/EEC - Requiring the reporting of serious accidents and situations of serious danger at gas and oil drilling sites, including offshore.</li> <li>Article 3 of Council Directive 92/104/EEC - Requiring the reporting of serious accidents and situations of serious danger at mines and quarries.</li> <li>Article 5 of Directive 2004/49 EC - Requiring certain common reporting criteria for accidents and incidents in the rail sector.</li> <li>Regulation (EC) No 1338/2008 - Requiring the provision of statistics on workplace fatalities and accidents.</li> </ul>
Reg.7 Dangerous occurrences	<ul style="list-style-type: none"> <li>Article 3 of Council Directive 92/91/EEC - Requiring the reporting of serious accidents and situations of serious danger at gas and oil drilling sites, including offshore.</li> <li>Article 3 of Council Directive 92/104/EEC - Requiring the reporting of serious accidents and situations of serious danger at mines and quarries.</li> <li>Articles 7 and 14 of Directive 2000/54/EC - Requiring the reporting of potentially hazardous releases of biological agents and cases of illness attributable to occupational exposure to biological agents.</li> <li>Article 5 of Directive 2004/49 EC - Requiring certain common reporting criteria for accidents and incidents in the rail sector.</li> <li>Clauses 9 and 109 of Council Directive 2010/32/EU - Requiring the reporting of certain incidents in the healthcare sector associated with needle stick and similar injuries.</li> </ul>
Reg.8 Occupational diseases	<ul style="list-style-type: none"> <li>Regulation (EC) No 1338/2008 - Requiring the provision of statistics on workplace fatalities and accidents.</li> </ul>
Reg.9 Exposure to carcinogens, mutagens and biological agents	<ul style="list-style-type: none"> <li>Articles 7 and 14 of Directive 2000/54/EC - Requiring the reporting of potentially hazardous releases of biological agents and cases of illness attributable to occupational exposure to biological agents.</li> <li>Article 14 of Directive 2004/37/EC - Requiring the reporting of cases of cancer arising from occupational exposure to carcinogens and mutagens.</li> </ul>
Reg.12 Recording and Keeping	<ul style="list-style-type: none"> <li>Regulation (EC) No 1338/2008 - Requiring the provision of statistics on workplace fatalities and accidents.</li> </ul>

## RIDDOR 2013 - Legislative changes

7. Lord Young's report '[Common Sense, Common Safety](#)' published in 2010 recommended that HSE re-examine the operation of RIDDOR to determine whether it was the best approach to providing an accurate national picture of workplace accidents. The Löfstedt Review further recommended that incident reporting requirements should be clarified and simplified. Both recommendations were accepted by Government, who undertook to clarify, amend and implement the regulations by October 2013.

8. HSE conducted a public consultation on the proposals for substantially revised RIDDOR reporting requirements. In addition to achieving greater clarity and simplicity, the proposals sought to: focus on obtaining information required for effective regulation; cease collecting data that can otherwise be obtained or is rarely used; and to maintain compliance arising from EU commitments.

9. The consultation responses supported significant modification of the requirements governing which incidents require reporting to the enforcing authorities resulting in the following changes in RIDDOR 2013:

- Classification of 'major injuries' to workers replaced with a simplified and shortened list of 'specified injuries' to workers sustained as a result of a work-related accident;
- Clarified and shortened list of reportable dangerous occurrences (near-miss events)
- Simplified and significantly shortened list of reportable ill-health conditions in workers (replacing 47 specified ill-health conditions with 8 categories of work related diseases).
- Simplified list of dangerous occurrences within the rail-sector, and removal of the requirement to report suicides on railways.
- Specific 'stand-alone' regulation for non-fatal injuries to non-workers as a result of a work related accident.

10. Reports of accidents which incapacitate workers was changed from a three-day incapacitation period to more than seven days by the Reporting of Injuries, Diseases and Dangerous Occurrences (Amendment) Regulations 2012 ("the 2012 Regulations") as recommended by Lord Young. This change aligns with the point at which an employee who is absent from work through injury or ill-health must obtain a "fit note" from their doctor and was therefore included within the scope of this review.

## **Scope of the Post Implementation Review (PIR)**

11. RIDDOR 2013 contains a 'review clause' at Regulation 20, which require that the Secretary of State must carry out a review of the Regulations within five years of them coming into force. The review must in particular —

- set out the objectives intended to be achieved by the regulatory system established by these Regulations;
- assess the extent to which those objectives are achieved; and
- assess whether those objectives remain appropriate and, if so, the extent to which they could be achieved with a system that imposes less regulation.

12. In line with Government guidance in the 'Better Regulation Framework Manual' and 'Guide for conducting PIRs', consideration was given to the scope of the review and the level of evidence and resourcing required. It was agreed in consultation with Government economists and social scientists that this PIR required a medium level of evidence.

13. RIDDOR 2013 is applicable to all workplaces and places a duty upon the responsible person to report incidents to both workers and non-workers, should the reporting criteria be met. The review considered each regulation in turn in order to provide robust findings on the outcomes and impacts of the Regulations.

14. The evidence sought was aimed at determining whether RIDDOR 2013 had met its objectives and understanding how implementation could be improved. The research sought both qualitative and quantitative evidence from stakeholders and organisations required to comply with the legislation.

## **Research and analysis**

15. To assess whether the objectives of the regulations were achieved, if they remain appropriate, and their intended and unintended effects, the review adopted a range of evaluation approaches which took account of the level of evidence required for the scale of the regulations and their expected impact. This ensured that the review delivered a comprehensive yet proportionate consideration of the evidence and included:

- Economic evaluation – Undertaken by HSE's economists, this approach assessed the costs and benefits of the regulations and, if the benefits justify the costs.
- Theory-based impact evaluation – This evaluation was informed by HSE's statisticians and considered what outcomes, both positive and negative,

the policy had; and what impact it had relative to other factors to generate those outcomes.

- Process evaluation – This research was undertaken by HSE’s social science specialists. The approach taken comprehensively explored dutyholders’ views and experiences of how the Regulations work in practice and provided a measure of independence from the policy officials undertaking the broader evaluation and review of RIDDOR 2013.

16. A range of dutyholders from specific sectors were included in the analysis using a combination of qualitative (face-to-face meetings and focus groups) and quantitative (survey) methods. The process evaluation approach considered if the policy delivered and implemented was as intended and if there were any unintended effects; what aspects of the policy are working and if the policy is achieving its impacts and if this varies for different stakeholders or contexts.

17. The full analysis report setting out the methodology and results of the research are at Appendix 2. In summary, three overarching research questions were addressed: i) to what extent are the Regulations working; ii) is Government intervention still required and iii) are the Regulations and the way they are implemented the most appropriate approach. In addition, stakeholders were also asked more detailed research questions in relation to their respective sectors.

### **To what extent are the regulations working?**

18. The principal objectives of RIDDOR 2013 are to i) transpose the requirements of European Directives outlined in Table 1 and meet the relevant legal obligations; ii) to provide information to guide enforcing authorities’ regulatory activities; iii) to ensure duty holders are aware of health and safety failures and the need to act upon them to improve their health and safety management systems and iv) to provide data for national health and safety targets and published statistics on injuries and ill health.

19. To establish whether RIDDOR 2013 is working and remains fit for purpose, the review considered each of these over-arching objectives:

- i) To transpose the requirements of European Directives and meet the relevant legal obligations.
  - RIDDOR implements aspects of various EU Directives, most significantly [Article 9\(1\)\(c\) of Council Directive 89/391/EEC](#). This article concerns measures to encourage the improvement of the health and safety of workers. Reports made under RIDDOR inform the provision of statistics to the EU as required by [Regulation \(EC\) No. 1338/2088](#) on Community statistics on public health and safety at work.

RIDDOR also implements a number of reporting requirements deriving from various sector-specific and hazard-specific EU Directives.

ii) To provide information to guide the enforcing authorities' regulatory activities.

- The review took account of the views and experiences of health and safety regulators and how RIDDOR data is used particularly for regulatory purposes including HSE inspectors, local authority representatives, Office of Rail and Road (ORR), Office for Nuclear Regulation (ONR) and Care Quality Commission (CQC).
- The overall view is that RIDDOR is used to guide and inform regulatory activities. For HSE, RIDDOR data has specific links to its Incident Selection Criteria. RIDDOR provides timely, detailed and accurate information which allows the relevant Enforcing Authority to take appropriate action thereby discharging their statutory duty as a regulator.

iii) To ensure duty holders are aware of health and safety failures and the need to act upon them to improve their health and safety management systems.

- The review took account of the views and experiences of dutyholders using a combination of qualitative (interviews, workshops and focus groups) and quantitative (survey) methods to explore whether the need to report health and safety incidents via RIDDOR led to improved health and safety management systems (HSMS).
- Broadly, the findings were that there were a number of formal and informal reporting mechanisms operating within organisations, depending on the size and maturity of the business.
- Organisations with less-mechanised reporting structures (i.e. via a hand-written accident book) tended to have less knowledge of RIDDOR.
- Generally, dutyholders using RIDDOR found the process straightforward, with online HSE guidance useful. However, smaller businesses felt that they would benefit from more support from HSE about RIDDOR reporting requirements and criteria but were mistakenly wary of asking for advice because of fee for intervention (FFI) charges.
- RIDDOR 2013 changes were generally perceived by dutyholders as having little or no negative impact.



- The general view was that dutyholders would continue to use accident data to improve their safety systems even if the requirement to report was removed.
- iv) To provide data for national health and safety targets and published statistics on injuries and ill health.
- A significant aspect of RIDDOR is the data gathered. This data is used to inform national HSE statistics releases. For example, national annual data from RIDDOR is used for non-fatal injuries to employees reported by employers and fatal injuries to workers and is also used to support the figures taken from the Labour Force Survey (LFS).
  - RIDDOR is extensively used by others to inform their work, for example, academics will use RIDDOR data – often alongside other complimentary datasets – to explore specific aspects of the health and safety system.

20. There was a clear consensus amongst dutyholders of the importance of the specific duties in the Regulations and based on the evidence gathered and considered, concluded that RIDDOR remains fit for purpose.

### **Is Government intervention still required?**

20. RIDDOR is the only statutory reporting mechanism by which duty holders are legally compelled to report incidents which meet the reporting criteria to the relevant Enforcing Authority. Without such reports, enforcing authorities would be unable to discharge its regulatory function and as there is no suitable alternative to RIDDOR, the regulations need to remain in force.

21. As RIDDOR also transposes and implements aspects of a number of EU requirements which are compulsory for Members States (MS) to transpose into their domestic law, Government intervention in some form of regulation is required. Whilst it is still unclear exactly what the legislative landscape will look like post-BREXIT, the UK still has an obligation to transpose EU directives as long as it remains part of the EU.

### **Are the Regulations and the way they are implemented the most appropriate approach?**

22. The review considered and explored the use of alternative data collection systems with dutyholders to achieve the same objectives. Appendix 2 provides further detail but in summary, the alternatives to RIDDOR would not provide enough information to effectively enable regulators to identify where and how risks arise; any appropriate investigation action, for example for HSE, RIDDOR reports link to its inspection incident selection criteria (ISC); target regulatory work; and provide advice about how to avoid work-related deaths, injuries and ill health.

23. The evidence robustly concludes and reflects the view that RIDDOR currently meets its objectives, remains 'fit for purpose' and could not easily or desirably be replaced with another system that meets the same requirements or achieves the same objectives.

### **Summary of cost analysis**

24. The benefits of the entire RIDDOR system are considered in Part 1 of the Evidence Review (see Appendix 2) in the context of whether the system is still 'fit for purpose'. This assessment is, however, on the basis of non-monetised evidence. The evidence indicates that RIDDOR currently meets its objectives, is still 'fit for purpose' and confirms that it could not easily or desirably be replaced with another system meeting the same requirements. Part 1 of the Evidence Review provides an economic assessment of the cost of the entire RIDDOR system and indicates that the estimated total costs to society range from around £2.2 million to £3.0 million across a number of different scenarios.

25. As for the realised costs and benefits of RIDDOR 2012 and RIDDOR 2013, these are considered in Part 2 of the Evidence Review (see Appendix 2). The analysis considers the original assumptions made in the respective impact assessments and compares them on a like-for-like basis with what actually happened. The actual costs of RIDDOR 2012 were nearly identical to those predicted in the Impact Assessment (IA) and the benefits were £38k higher. As for RIDDOR 2013, higher ICT transitional costs meant the realised costs figure was about £30k higher with annual benefits being about £80k lower due to the fall in the number of RIDDOR reports being less than first anticipated.

### **Implementation in other European Member States**

26. Through the European Commission's Senior Labour Inspectors Committee - Knowledge Sharing System, HSE sent a questionnaire to member state labour inspectorates to ascertain whether or not the objectives of their regulatory regimes adopted a similar approach to that in the UK. The questionnaire considered the specific aspects of the regulatory framework that UK dutyholders were questioned on. The full questionnaire and its conclusions are at Appendix 3. Member states

were asked how they implemented the EU requirement for employers /duty holders to report:

- Non-fatal injuries to workers;
- Work-related fatalities;
- Dangerous occurrences;
- Occupational diseases; and
- Exposure to carcinogens, mutagens and biological agents; and
- How they record and keep statistics on workplace fatalities and accidents.

27. Although a limited number of responses were received, it provided a picture of a consistent approach in reporting workplace injuries, fatalities, occupational disease and exposure to carcinogens. Only two respondents continue to record absence from work following an injury (over 3 days). No respondents required the reporting of non-fatal injuries to non-workers, which is required in the UK under regulation 5, RIDDOR.

## **Conclusions and recommendations**

28. The Post Implementation Review (PIR) of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) was led by a review team consisting of HSE colleagues from RIDDOR Policy, Science Division, specialist support from Economists and Statisticians.

2.9 The review team adopted a comprehensive approach, considering each RIDDOR regulation in turn. It engaged with policy colleagues, operational inspectors and technical experts from the relevant sectors; and external stakeholders, dutyholders and interested parties and sought evidence to test the regulations against the review criteria, specifically:

- To what extent are the Regulations working?
- Is Government intervention still required?
- Are the Regulations and the way they are implemented the most appropriate approach?

30. Following the evidence gathering phase, the information was collated and analysed to inform the PIR conclusions and make the following recommendations:

### **Recommendation 1 - Regulation 5 - Non-fatal injuries to Non-workers**

31. Regulation 5 states '*Where any person not at work, as a result of a work-related accident, suffers an injury, and that person is taken from the site of the accident to a hospital for treatment in respect of that injury; or a specified injury on hospital premises, the responsible person must follow the reporting procedure*'. This

stand-alone regulation was introduced in RIDDOR 2013 and sets out a reporting requirement to report injuries to non-workers arising out of and in connection with work activities. Prior to this, RIDDOR 1995 required that reports were made in respect of persons not at work under [regulation 3](#) of those regulations.

32. Since the introduction of RIDDOR 2013, the evidence confirmed that a number of issues in respect of regulation 5 had arisen, particularly with regard to over-reporting. The evidence confirmed that there is a distinct over-reporting trend specifically in the health, education and leisure sectors which accords with the fact that the majority of their front facing business interacts predominantly with non-workers (patients, students, families etc).

33. In general the health, education and leisure sectors are well organised, resourced and compliant with their statutory health and safety duties. These sectors are also amongst the most risk averse in respect of civil claims and tend to err on the side of caution by adopting a 'report everything' culture. HSE is regularly contacted by lawyers representing claimants who have submitted claims for slips, trips and falls at such establishments, to seek confirmation if the respective dutyholder has submitted a RIDDOR report. The RIDDOR policy line is that RIDDOR is a statutory reporting requirement and is not an admission of guilt or liability.

34. Stakeholders also reported that the reporting threshold is met irrespective of the severity of the injury due to the broad scope of regulation 5 (i.e. 'that person is taken from the site of the accident to a hospital for treatment in respect of that injury'). Non-workers are often taken to hospital as a precaution with the dutyholder not having any knowledge of the outcome.

35. The vast majority of incidents reported under regulation 5 do not meet HSE's Incident Selection Criteria (ISC) and therefore no further regulatory action taken, despite the resource implications for processing such reports. In 2015, a sampling exercise was carried out by HSE colleagues in the Leisure and Entertainments Sector which found that nearly 40% of RIDDOR reports made under Regulation 5 in the leisure sector alone did not meet the eligibility criteria for reporting.

36. To address the issue of over-reporting of regulation 5, the recommendation is to narrow its scope by amending Regulation 5 to align the reporting criteria under [regulation 4\(1\)](#) of RIDDOR 2013, which applies to those at work. Regulation 4 specifies those injuries that should be reported, based on their severity.

37. The general duty under s3 HSWA for employers and self-employed persons to ensure that persons other than their employees are not exposed to risks to their health or safety as a result of the way in which their work activities are conducted also requires similar obligations to mitigate against any harm equally to employees

and those not involved in the work activity, namely non-workers (members of the public) (s2 HSWA to be read in conjunction with s3).

38. In meeting this obligation, the alignment for non-workers with the reporting requirement for workers (under regulation 4) and those in hospital (regulation 5b), where reports are required for specified injuries, would provide dutyholders with a greater degree of clarity about when the legal reporting requirements are intended to apply.

## **Recommendation 2 - Regulation 8 - Occupational Diseases**

39. The 2010 report by Lord Young, 'Common Sense, Common Safety' recommended that HSE re-examine the operation of RIDDOR to determine whether it was the best approach to providing an accurate national picture of workplace accidents. The Löfstedt Review further recommended that incident reporting requirements should be clarified and simplified. Both recommendations were accepted by Government, who undertook to implement new regulations by October 2013.

40. To implement these recommendations, HSE conducted a public consultation on proposals for substantially revised RIDDOR reporting requirements. In addition to achieving greater clarity and simplicity, the proposals sought to focus on obtaining information required for effective regulation; cease collecting data that can otherwise be obtained or is rarely used; and to maintain compliance with commitments arising from EU requirements.

41. RIDDOR 2013 subsequently introduced a number of changes to the reporting requirements:

- Simplified and shortened list of specified reportable injuries ("major injuries") to workers sustained as a result of a work-related accident;
- Clarified and shortened list of reportable dangerous occurrences (near-miss events);
- Simplified and significantly shortened list of reportable ill-health conditions in workers (replacing 47 specified ill-health conditions with 8 categories of work related diseases);
- Simplified list of dangerous occurrences within the rail-sector, and removal of the requirement to report suicides on railways.
- Stand-alone regulation for the reporting of non-fatal injuries to non-workers as a result of a work-related accident.

42. The shortened list of reportable ill-health conditions in workers (occupational diseases) introduced in RIDDOR 2013 includes: carpal tunnel syndrome, cramp of the hand or forearm, occupational dermatitis, hand arm vibration syndrome,

occupational asthma, tendonitis or tenosynovitis, occupational cancer and disease attributable to a biological agent.

43. HSE's [strategy](#) has a significant focus upon work-related ill health and this focus will continue over the coming years. There are a number of work-related diseases of specific interest to HSE from both a regulatory and scientific perspective, but with the introduction of the revised list, there is no longer a requirement for them to be reported under RIDDOR.

44. HSE's Senior Medical Advisers and Specialist Inspectors concerns are that that individuals with potentially life-threatening illness including pneumoconiosis (e.g. silicosis), extrinsic allergic alveolitis, decompression illness, pulmonary barotrauma and poisoning due to certain chemical exposures, no longer come to the attention of HSE.

45. The resulting lack of HSE investigation and enforcement where appropriate, could potentially mean that workers are left at significant risk as a result of workplace exposures. It also reduces the scope for research into these work-related diseases by HSE Science Division and therefore contributions made to the evidence base to improve worker health.

46. To address the above issues, the recommendation is to expand the list of occupational diseases required to be reported under Regulation 8, such that it appropriately reflects the breadth of occupational diseases of interest to HSE.

47. The most appropriate legislative vehicle to achieve this is to amend regulation 8 to make specific reference to a Schedule, appended to RIDDOR, which lists occupational disease that need to be reported. Schedules are desirable as they allow lists to be incorporated into the regulations without interrupting the flow of the operative requirements and can make it easier for stakeholders to understand their obligations, particularly where the lists are long, technical or subject to amendment. Any subsequent change to that list would be made by an amending regulation.

### **Recommendation 3 - RIDDOR Guidance Review**

48. The web based [RIDDOR guidance](#) was revised and updated in 2012/13 to reflect the changes in RIDDOR 2013. Stakeholder and dutyholder evidence for this PIR confirms that there is a lack of clarity regarding RIDDOR reportability and application of RIDDOR, particularly regulation 5. This could be addressed through simplifying and clarifying the existing guidance.

49. A review would provide the opportunity to consider the advice, guidance and information HSE currently provides; take account of the issues raised and lessons learned from the PIR; and revise and update RIDDOR guidance to enable

dutyholders to comply with the reporting requirements and assist them to apply RIDDOR reporting criteria to their specific sectors.

## Annex 1

<b>Title:</b> The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (SI 2013/1471) PIR <b>PIR No:</b> <a href="#">Click here to enter text.</a> <b>Original IA/RPC No:</b> HSE0072 <b>Lead department or agency:</b> Health and Safety Executive <b>Other departments or agencies:</b> <a href="#">Click here to enter text.</a>  Contact for enquiries: Miles Burger - <a href="mailto:Milesburger@hse.gov.uk">Milesburger@hse.gov.uk</a>	<b>Post Implementation Review</b>
	<b>Date:</b> <a href="#">Click here to enter a date.</a>
	<b>Type of regulation:</b> Domestic
	<b>Type of review:</b> Statutory
	<b>Date measure came into force:</b> 01/10/2013
	<b>Recommendation:</b> Keep
<b>RPC Opinion:</b> <a href="#">Choose an item.</a>	

### 1. What were the policy objectives of the measure? (Maximum 5 lines)

The overarching objectives of the RIDDOR regime are to gather data and intelligence to guide and inform regulatory activities and to provide data for the publication of annual. Specific for RIDDOR 2013, the objective was to simplify and clarify the reporting requirements for occupational accidents, dangerous occurrences and diseases, as recommended by Professor Löfstedt in his 'Reclaiming Health and Safety for All' report.

### 2. What evidence has informed the PIR? (Maximum 5 lines)

Reflecting Government guidance, a proportionate approach was agreed whereby a medium-level of evidence (in terms of scope and scale) would be collected to inform the PIR. This included: omnibus survey with over 2,000 duty-holders; pop-up survey of over 450 duty-holders; three focus groups and four one-to-one interviews with duty-holders; direct engagement with internal HSE teams (operations, statistics, policy), other regulators (LAs, CQC, ORR), relevant industry groups (gas, leisure, education) and EU states (HSA in Ireland, SLIC).

### 3. To what extent have the policy objectives been achieved? (Maximum 5 lines)

In terms of the overarching objectives of RIDDOR, the PIR found that the regime is 'fit for purpose'. As for the RIDDOR 2013 objectives, evidence indicates that it has simplified and clarified the regulations while retaining the usefulness of the RIDDOR data. Furthermore, it enacted the recommendations made in the '*Common Sense*', '*Common Safety*' and '*Reclaiming Health and Safety for All*' reviews as well as relevant EU requirements.



Sign-off for Post Implementation Review: Chief Economist/Head of Analysis and Minister

***I have read the PIR and I am satisfied that it represents a fair and proportionate assessment of the impact of the measure.***

Signed: [Click here to enter text.](#)  
enter a date.

Date: [Click here to](#)

## Further information sheet

Please provide additional evidence in subsequent sheets, as required.

### 4. What were the original assumptions?(Maximum 5 lines)

The assumptions about the costs and benefits of RIDDOR 2013 are set out in the original impact assessment (IA). It is predicted that there will be familiarisation costs as well as costs from updating and altering IT systems, HSE statistics and guidance. Other than IT costs, all the rest are based on the cost of time and are one-off transitional costs. The benefits of the regulation relate to the reduced number of RIDDOR reports being submitted, and are based on costed time saved (so 33½ minutes for duty-holders to complete a RIDDOR report and 23½ minutes for a regulator to process a report). These assumptions have been used to consider not only the impact of RIDDOR 2013, but also the potential impact of RIDDOR regime as a whole (see Cost-Benefit Analysis appendix).

### 5. Were there any unintended consequences? (Maximum 5 lines)

There were a number of anticipated, but potentially unintended, consequences due to the regulatory changes in RIDDOR 2012 and RIDDOR 2013. These included: longitudinal RIDDOR data being interrupted with the change in classifications and the move from over-3-day reporting to over-7-day; lack of clarity around non-fatal injuries to non-workers (Regulation 5); and important diseases being missed from the revised occupational disease list (Regulation 8). To this end, the PIR has a number of recommendations about reviewing Regulation 5, Regulation 8 and HSE's on-line RIDDOR reporting system.

### 6. Has the evidence identified any opportunities for reducing the burden on business? (Maximum 5 lines)

The evidence from the PIR identified that duty holders and regulators still see value in reporting non-fatal injuries for non-workers under Regulation 5, but would like a narrower definition of the circumstances in which a RIDDOR report is required. To this end, the PIR recommends that Regulation 5 is reviewed with the view to aligning its provisions more closely with that of Regulation 4's specified list of injuries. HSE believes such a change, which would narrow the scope of the regulation to the most serious injuries and make it clearer when to report, would likely lead to a reduction in the number of submitted and accepted RIDDOR reports.

### 7. For EU measures, how does the UK's implementation compare with that in other EU member states in terms of costs to business? (Maximum 5 lines)

HSE engaged with the Senior Labour Inspectors Committee (SLIC) Knowledge Sharing Site (KSS) survey about how other EU countries report workplace injuries. Based on the eight responses received, only three (including the UK) report absences from work following an injury, while no states other than the UK report non-fatal injuries to non-workers. In four states, occupational diseases are not reported by duty holders, but by doctors. These results suggest that RIDDOR asks its duty holders to report marginally more than other EU states.

# Summary of Estimated costs to Dutyholders and Government under RIDDOR

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**Economic and Social Analysis Team**  
**Health and Safety Executive**

## Summary

1. The analysis below estimates the costs of RIDDOR 2013 in its entirety. It looks 10 years into the future to consider how those costs could change based on different scenarios of changes in report numbers.
2. The purpose of this cost estimate is to inform the PIR's analysis as to whether RIDDOR remains fit for purpose, and the best way of achieving the regulations' desired outcome. A full cost analysis will provide evidence to inform the assessment as to the proportionality of the RIDDOR regulations.
3. The realised impacts estimate the costs and savings that occurred following the 2012 amendment of RIDDOR 1995 and following the implementation of the new current 2013 RIDDOR regulations, both of which were estimated at the time to deliver savings to dutyholders and regulators. These are discussed in the evidence review starting from paragraph 70, and as such will not be included in this analysis.
4. Following the observed change in report of RIDDOR numbers over the last three years, the model analysed in this paper tested the following scenarios for report numbers over the next ten years relative to 2016/17 numbers:
  - a. An increase of 2% every year
  - b. No change in the number of reports
  - c. A decrease of 2% every year
  - d. A decrease of 4% every year
5. Estimated costs to dutyholders for total reports range between around £1.1 million and £1.6 million each year across the different scenarios. For ill health reporting, the cost ranges from around £18,000 to £25,000 per year; and reports for members of public range from around £350,000 to £470,000 per year.
6. The estimated cost to Government range from around £1.1 million to £1.5 million per annum for total reports. For ill health reporting, the cost ranges

from around £17,000 to £23,000 per year and; for reports for members of public, between around £320,000 and £440,000 per year.

7. The estimated total costs to society range from around £2.2 million to £3.0 million across the scenarios. For ill health reporting the cost ranges from around £35,000 to £47,000. For reports on members of the public, the costs range between around £670,000 and £910,000.

## **Purpose of Paper**

8. This report summarises the estimated costs to duty holders and government over the next ten years of the requirements for the Reporting of Injuries, Deaths and Dangerous Occurrences Regulations 2013 (RIDDOR) for the Post Implementation Review (PIR).
9. These estimated costs to dutyholders and regulators are based upon a model developed by HSE. This cost model incorporates evidence from the 2013 RIDDOR impact assessment, which was validated by the Regulation Policy Committee; and data from HSE's Statistics Support Team.
10. These costs have been calculated over a 10-year period. They are based on scenarios of the number of RIDDOR reports to be made by dutyholders. As such, they can only provide an indicator of the possible costs. However, without any formal forecasts of RIDDOR reports, these are the best estimates available and should give a suitable estimate for the current purpose.
11. This paper also summarises evidence on the testing of estimates made in the 2013 IA on the likelihood of duty holders to familiarise with the most recent changes to the regulations.
12. Costs calculated in the paper have been rounded to two significant figures and may not appear to sum.

## **Methods and Assumptions**

### **Number of RIDDOR notifications**

13. Data provided by HSE statisticians gives a breakdown of the number of reports by injury type from 2014/15-2016/17 received, as shown in Table 1.
14. The data within this cost benefit analysis (CBA) uses the number of RIDDOR notifications *received*. This differs slightly from the Evidence Review which uses data on the number of RIDDOR notifications *accepted* (for example, in terms of estimating the realised costs and benefits). The number of RIDDOR reports *received* will tend to be higher and could be considered to be 'rawer' in data terms as they have not undergone any type of assessment

about whether they are actually reportable under RIDDOR. It was considered, however, that these numbers would be more appropriate to use in the cost section of this CBA analysis as they more accurately represent what it costs businesses to submit a report, and to government to process and decide whether to accept the submission as RIDDOR reportable or not.

**Table 1: Number of RIDDOR notifications for all injury, ill health and dangerous occurrence types (not including fatalities or automatic reports), 2014/15 to 2016/17**

<b>RIDDOR report types</b>	<b>2014/15</b>	<b>2015/16</b>	<b>2016/17</b>
Onshore injuries	76,821	73,284	73,231
Members of the public reporting of injuries	38,481	36,337	35,523
Dangerous occurrences	4,270	4,218	4,371
Gas injuries and gas dangerous occurrences	2,710	2,709	2,609
Ill health	1,615	1,974	1,846
Offshore injuries and Dangerous Occurrences	561	380	86
<b>Total</b>	<b>124,458</b>	<b>118,902</b>	<b>117,666</b>

15. The reporting requirements of RIDDOR were last changed in October 2013; therefore, the data in Table 1 shows the consistent sets of data since the change in regulation. Over that period, the number of notifications has fallen by around 6% in 3 years. These report numbers reflect the current requirements of RIDDOR that we will model over the next ten years.

16. Three years of report numbers (i.e. from 2014/15 to 2016/17) are not an ideal basis on which to make inferences about future numbers as it is only a relatively small sample and the numbers of occupational injuries and illnesses (and so RIDDOR reports) are subject to longer trends. For example, HSE has conducted research that shows that injury rates are subject to change according to the economic cycle<sup>1</sup> and the available data only captures one

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<sup>1</sup> Evidence shows that injury rates fall in recessions and rise in expansions:  
<http://www.hse.gov.uk/statistics/adhoc-analysis/economic-cycle-paper.htm>

part of the economic cycle. Therefore, in the analysis that follows we refer to the future modelling of numbers as 'scenarios' rather than as 'forecast' as they do not purport to have any predictive power.

17. It was estimated in the 2013 Impact Assessment that approximately 4% of reports were submitted via automatic systems. Evidence from the number of notifications in Table 1 suggests that around 5% of reports have been submitted via automatic systems. These systems are used by companies to record health and safety incidents for internal monitoring processes, which could be in place to support risk-management or to fulfil insurance requirements, for example. These internal processes may have a broader requirement for reporting than RIDDOR and the computer systems are able to identify whether the incident is RIDDOR reportable and submits a RIDDOR report automatically. While there is some dutyholder activity (and so cost) in preparing and submitting the report for the internal process, this cost is not driven by RIDDOR and the dutyholders that have these systems would continue to operate them even in the absence of RIDDOR. As such, there is no additional cost to the dutyholders. Therefore, they have been subtracted from the total number of notifications in Table 1 and in the associated costings that follow.<sup>2</sup>
18. In 2016/17 there were 186 published workplace deaths enforced by HSE and Local Authorities, and which fall within scope of RIDDOR. HSE also published 43 further workplace deaths on railways (enforced by the Office of Road and Rail) which fall within scope of RIDDOR. HSE is aware that there are some deaths that occur to service users (e.g. care home residents) at premises registered with the Care Quality Commission (CQC), which technically fall within scope of RIDDOR.
19. However, whilst HSE receives some of these initial reports on behalf of CQC, any further regulatory involvement or enforcement action is undertaken by them and as such, these figures are therefore excluded from HSE statistics, and this analysis.

Of the reporting types listed in the table, those of particular interest in this paper are the numbers of reporting of non-fatal injuries to non-workers (members of the public), and the number of reports of ill health. Firstly, Regulation 5 of RIDDOR 2013 introduced a specific reporting requirement for non-fatal injuries to non-workers. Since introduction, there is some evidence to suggest instances of over-reporting in certain industry sectors -

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<sup>2</sup> These reports will generate a cost to HSE or LAs to handle and process them, but for simplicity we have left them out of the analysis entirely.

predominantly those that have the most interaction with the public as part of their day-to-day business (e.g. health, education and the leisure sectors). The reasons for this are unclear, but the PIR evidence-gathering indicates that some stakeholders would find further clarity around the reporting requirements under Regulation 5 useful.

20. Secondly, the implementation of RIDDOR 2013 significantly reduced the number of occupational diseases required to be reported to HSE from 47 disease categories in RIDDOR 1995 to 8 in RIDDOR 2013. The reason for this was that *“occupational disease reporting levels are extremely low, the information being so incomplete that it is not regarded as an appropriate data set for statistical analysis”*. Yet members of HSE’s Centre for Workplace Health highlighted that the reduction in reportable occupational diseases was potentially leading to significant and life-changing ailments not coming to the attention of HSE. It was therefore considered worth investigating as part of the PIR process.

21. Of all reports made via HSE, 65% are enforced and processed by HSE and the remaining 35% are enforced and processed by LAs according to HSE data. In the costs that follow, the costs of all reports to HSE and LAs will be amalgamated to form costs to government.

#### **How the 10-year scenarios have been modelled**

22. HSE has used the percentage changes in the numbers of RIDDOR reports from 2014/15-2016/17 as a basis for modelling potential numbers of reports over the next 10 years. The observed rate of change across all reports is about a 2% fall per annum, as described in paragraph 15.

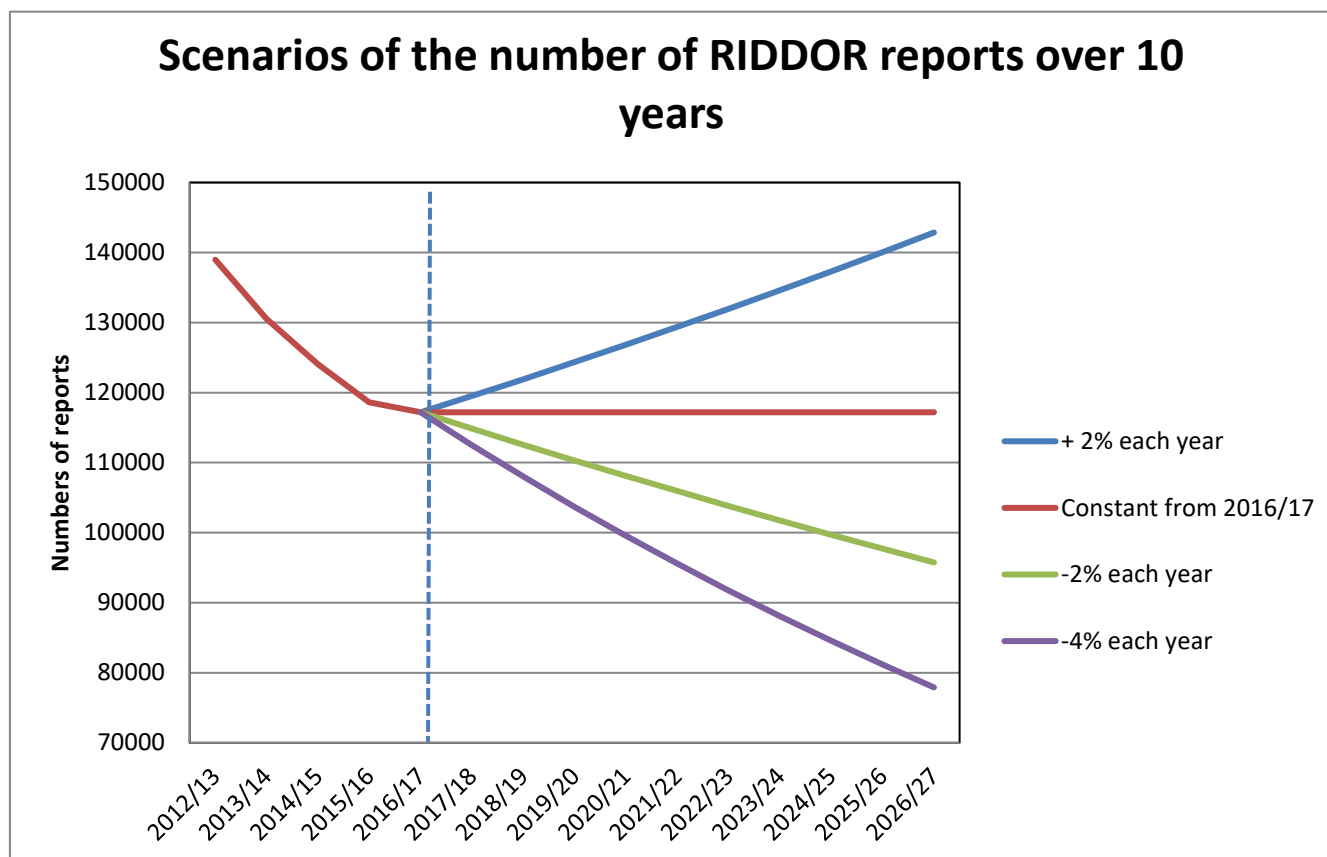
23. Following the observed change in report numbers over the last three years as described in paragraph 15, the model has tested the following scenarios:

- a. A percentage increase of 2% every year, which would be a reversal of the trend observed over the last three years
- b. No change in the number of reports since 2016/17, which is a notional ‘flatline’ scenario
- c. A percentage decrease of 2% every year, which would be a continuation of the current trend
- d. A percentage decrease of 4% every year, which would see the current trend accelerating downwards

24. Our modelling specifically looks at the number of reports for injuries to members of the public, ill health reports, and the total number of reports and

we assume that the two subgroups, as well as the total, all move by the same proportion in the scenarios. This is not supported by the observed numbers in Table 1, but we adopt it as a simplifying assumption.

**Figure 1: Scenarios of the numbers of RIDDOR reports over 10 years**



25. Figure 1 shows the different scenarios of numbers of RIDDOR reports made in the model. The increase in 2% of reports each year gives an increase of around 26,000 reports annually by the end of the 10-year period. Similarly, the decrease in 2% gives a reduction in around 22,000 reports annually by the end of the 10 years.

26. For a decrease in 4% each year, there is a reduction of around 35,000 reports by the end of the 10 years.

27. From observing the numbers as shown in Figure 1, the scenarios represent a broad range of possible outcomes – in the absence of any formal forecasting, we assess that this is a proportionate representation of reasonable RIDDOR numbers for the next ten years. As discussed in paragraph 16, the observed rate of change is based on a small sample of years. There will also be trends such as improvements in technology or changes to the economic composition of Great Britain that could change the numbers of reports that are completely



invisible in the past RIDDOR numbers and that we have not been able to model. As such, the future numbers of RIDDOR numbers should be treated only as 'what if?' scenarios. However, given that the range reflects a continuation of the trend in the last three years and its full reversal, both for a full decade, we expect that the likely path of RIDDOR numbers will be somewhere within that range.

### **Costs of a RIDDOR report**

28. The 2013 impact assessment<sup>3</sup> estimated a RIDDOR report to take 33.5 minutes of a manager's time, comprising 10 minutes to fill in the accident book, and a further 23.5 minutes to complete the RIDDOR report
29. The following analysis assumes that the value of an employee or a self-employed person's time is equal to the opportunity cost of that time to the employer or the self-employed person. This will be equal, at the margin, to the cost of labour to the dutyholder; that is the gross wage rate, plus any non-wage labour costs that the firm faces, such as National Insurance and pension contributions. The rationale for this is that the dutyholder will hire workers up until the point at which the cost of doing so (i.e. wages plus various non-wage costs paid on employed labour) is equal to the value the employer receives for the output of the additional worker. This is referred to as the full economic cost (FEC).
30. HSE estimate the FEC by uprating the wage sourced from ASHE using estimates of the proportion of non-wage costs from Eurostat. The uprating used when this PIR analysis was conducted is 19.8%, rounded to one decimal place.<sup>4</sup>
31. The most up to date hourly cost of a production manager is £25.47<sup>5</sup>; uprating this by 19.8% gives a full economic cost of time of £30.51. The time taken just to complete the report was around 23.5 minutes, giving a total cost to the dutyholder per report of around £11.95.
32. The impact assessment also estimated the time to process the report by LAs or by HSE to be 23.5 minutes. It is assumed that the report is processed in HSE by a Band 6 Administrator; and for LAs by an inspector of factories, utilities and trading standards.

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<sup>3</sup> [http://www.legislation.gov.uk/ukia/2013/33/pdfs/ukia\\_20130033\\_en.pdf](http://www.legislation.gov.uk/ukia/2013/33/pdfs/ukia_20130033_en.pdf)

<sup>4</sup> In light of more recent data from EuroStat, we have since revised this uprating to 19.9% for use in policy analysis, but we have not considered it proportionate to adjust the analysis for so small a revision.

<sup>5</sup> Source: ASHE 2016, SOC 4-digit, mean salary for a production manager (code 112)

33. The most up to date hourly cost of an HSE Band 6 Administrator is £33.24 (which is based on internal HSE financial information, rather than ASHE), giving the total cost per report of £13.02.
34. The most up to date hourly cost for LAs was found using the hourly cost of an Inspector of Standards and Regulation from 2016 ASHE data. The hourly cost is £16.28<sup>6</sup> and uprating this by 19.8% gives a full economic cost of time of £19.50 per hour. This gives a total cost per report for LAs of £7.64.
35. Using the weighted average of the reports enforced and processed by HSE at 65% and by LAs at 35% (see paragraph 21), the weighted average cost per report to government is £11.14
36. The costs per report are summarised in Table 2.<sup>7</sup>

**Table 2: Estimated costs to society per report, whether the report is submitted to HSE or to an LA**

<b>Cost to dutyholder</b>	
£11.95	
<b>Cost to HSE</b>	<b>Cost to LA</b>
£13.02	£7.64
<b>Cost to Government</b>	
£11.14	

### **Costs over ten years**

37. Table 3 shows the equivalent annual net direct cost (EANDC) for all costs based on the scenario assumptions made and explained in paragraph 23. All of the costs below are in equivalent annual terms over ten years.

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<sup>6</sup> Source: ASHE 2016, SOC 4-digit, mean salary for an Inspector of Standards and Regulation (code 3565)

<sup>7</sup> The cost to the dutyholder is very close to that estimated in the 2013 IA. This is because, although the average wage for a production manager has increased slightly since 2013, the uprating that HSE analysis uses to convert wages to full economic costs has fallen from 30% in 2013 to 19.8% today, in line with more up-to-date evidence.

The cost for HSE to process the report is estimated to be slightly higher today than in the 2013 IA reflecting changes in estimated staff costs; and the estimated cost for LA processing is estimated to be slightly lower due to the change in the method of uprating wages to full economic costs.

38. Costs to dutyholders for total reports range from around £1.1 million to £1.6 million each year across the different scenarios. For ill health reporting, the cost ranges from around £18,000 to £25,000 per year; and reports for members of public range from around £350,000 to £470,000 per year.

39. The costs to Government range from around £1.1 million to £1.5 million each year across the different scenarios. For ill health reporting, the cost ranges from around £17,000 to £23,000 per year; and reports for members of the public range from around £320,000 to £440,000 per year.

**Table 3: Estimated Equivalent Annual Net Direct Costs to dutyholders, LAs and HSE over ten years (£thousands)**

<u>(EANDCB)</u>	<i>Costs to Dutyholders</i>	<i>Costs to Government</i>	<b><i>Total</i></b>
<b>+2% every year (total)</b>	<b>£1,600</b>	<b>£1,500</b>	<b>£3,000</b>
<i>of which, Ill health</i>	£25	£23	<b>£47</b>
<i>of which, Member of Public</i>	£470	£440	<b>£910</b>
<b>Assume Constant (total)</b>	<b>£1,400</b>	<b>£1,300</b>	<b>£2,700</b>
<i>of which, Ill health</i>	£22	£21	<b>£43</b>
<i>of which, Members of Public</i>	£420	£400	<b>£820</b>
<b>-2% every year (total)</b>	<b>£1,300</b>	<b>£1,200</b>	<b>£2,500</b>
<i>of which, Ill health</i>	£20	£19	<b>£38</b>
<i>of which, Members of Public</i>	£380	£360	<b>£740</b>
<b>-4% every year (total)</b>	<b>£1,100</b>	<b>£1,100</b>	<b>£2,200</b>
<i>of which, ill health</i>	£18	£17	<b>£35</b>
<i>of which, members of public</i>	£350	£320	<b>£670</b>

\*totals have been rounded to 2 significant figures, and may not appear to sum.

40. The estimated costs of RIDDOR reporting across the different report types are proportionate to the numbers of reports of each type made. Ill health costs are smaller than the other types looked at in this analysis, in line with lower report numbers; and reports of non-fatal injuries to members of the public account for a substantial proportion of the total costs.

41. The estimated costs of RIDDOR to Government and dutyholders over the next ten years are well below the de minimis of £5m in equivalent annual net direct costs to business, which means that this PIR does not need to be submitted to the RPC.

## Familiarisation

42. Although not an ongoing cost of RIDDOR, this analysis took the opportunity to test the estimates of the costs of familiarisation on the part of dutyholders with the implementation of RIDDOR 2013. This was in part to see if the IA had been broadly correct in its assessment, but also to see if evidence could be generated to help HSE understand the practice of familiarisation with changes to its requirements and so improve similar analysis in the future.
43. The 2013 impact assessment assumed that “all business sites with more than 250 employees would spend some time familiarising themselves with the changes to the RIDDOR reporting systems and those with fewer than 100 employees would not spend any time due to the infrequency of reports they have to make. This familiarisation is assumed to take place via the reading of updated guidance. For those dutyholders sites with between 100 and 250 employees, it is assumed that those in an industry where the injury rate (according to RIDDOR data) was more than 500 per 100,000 workers would spend time familiarising and those with an injury rate of less than 500 per 100,000 workers would not”. This assumption is summarised in Figure 2.

**Figure 2:** Summary of assumption in RIDDOR 2013 regarding dutyholder familiarisation

		Number of Employees		
		Fewer than 100	100 to 249	250 or more
Injury Rate	Less than 500 per 100,000	None will familiarise	None will familiarise	All will familiarise
	More than 500 per 100,000	None will familiarise	All will familiarise	All will familiarise

44. We did not expect that all dutyholders would familiarise with the changes to RIDDOR as (a) RIDDOR is estimated to be under-reported by dutyholders when compared to large surveys of occupational illnesses and short-latency illnesses like the Labour Force Survey; and (b) most dutyholders would only need to make a RIDDOR report very seldom (if at all) and so could be expected to familiarise when needed, rather than at the point the regulations changed.
45. Familiarisation costs were estimated to be incurred where dutyholders were reading the guidance in order to understand the changes to RIDDOR. We anticipated that there would be several occasions where dutyholders would only come to read the guidance when they need to make a report, which could be seldom. In those cases, there would be no additional cost as the

dutyholder would have had to refer to the guidance even if there had been no changes to the regulations.

46. The model used in the 2013 impact assessment to estimate the number of dutyholders that would familiarise is a simple model, and it was reasonable to make the assumptions in paragraph 42 that large dutyholders would familiarise and smaller dutyholders would not. The model was created in this way as it would have been difficult to predict how many dutyholders in the UK would familiarise with the changes and which would not.
47. The IA assumed the time taken for a manager to familiarise per site was approximately one hour. We chose in this PIR to explore the IA's assumption about whether dutyholders would familiarise rather than the time it would take them as we did not expect that dutyholders would be able to recall how long they had taken to familiarise now that several years had elapsed.
48. The Omnibus Survey [See section 18 of the PIR Evidence Review] which included questions to inform this PIR asked at what point respondents familiarised with the 2013 changes to RIDDOR. It offered respondents three options:
  - a. They actively went and found out about the changes either before, during or shortly after the time they were made;
  - b. They were completely unaware of the changes; or
  - c. They who found out about the changes either before, after or during the time they were made without making a special effort to do so (such as picking it up from a training course they were attending anyway or by looking at the guidance when actually filling in a RIDDOR report).
49. Those respondents who answered that they went out and actively found out about the changes to RIDDOR (a in the above bullets) are considered to have incurred additional familiarisation costs, in line with the definition used in the IA. Those who were unaware of the changes (b) or who found through the normal course of their work (c) incurred no additional familiarisation cost dues to the changes.
50. There were 2,109 respondents to the familiarisation questions on the Omnibus Survey and we will now assess what these responses tell us about the likelihood of dutyholders to have familiarised with the changes to RIDDOR.

*"All dutyholders with more than 250 employees would spend some time familiarising"*

51. Of the 2,109 respondents, there were 637 with more than 250 employees. The IA anticipated that all of these dutyholders would have familiarised themselves with the changes when they were made. Out of these

respondents, 26% stated they actively went and found out about the changes, 37% stated they were unaware of any changes to RIDDOR, and 37% stated they found out about the changes through their normal work.

*“No dutyholders with fewer than 100 employees would spend time familiarising”*

52. There were 1,315 respondents fewer than 100 employees. The IA anticipated that none of these dutyholders would have familiarised with the changes when they were made. Out of these, 13% of the respondents stated they actively went and found out about the changes to RIDDOR, 63% stated that they were unaware of any changes, and 24% stated they found out about the changes through their normal work.

*“Dutyholders with between 100 and 249 employees would familiarise only if they were in a sector with a high injury rate”*

53. The sectors where the injury rate as measured by RIDDOR was more than 500 per 100,000 workers at the time the regulations were changed, were Transportation & Storage; Agriculture, Forestry and Fishing; Water Supply, Sewerage, Waste Management and Remediation Activities; and Manufacturing.

54. The sectors that the Omnibus Survey uses to segment its respondents do not map perfectly onto those that we used to develop the IA. Of the sectors in paragraph 53, only Manufacturing; and Transportation & Storage were explicitly discernible in the responses, while the others are included under ‘other’, along with several other sectors.

55. Of the respondents identifiable as Manufacturing; and Transport & Distribution, there were 34 from dutyholders with between 100 and 249 employees. The IA anticipated that they would all have familiarised with the changes to RIDDOR when they were made. In fact, 24% stated they actively went and found out about the changes to RIDDOR, 44% said they were unaware of any changes, and 32% stated they found out about the changes through their normal work.

*“Dutyholders with between 100 and 249 employees would not familiarise if they were in a sector with a low injury rate”*

56. In the RIDDOR data used for the IA, there were 19 sectors with injury rates less than 500 per 100,000 workers. Of these sectors, four were discernible in the Omnibus Survey sectors: Construction; Information & Communication; Financial & Insurance Activities; and Education. The others are lost in the ‘Other’ sector category, as explained in paragraph 54.

57. There were 45 respondents discernible in the Construction; Information & Communication; Financial & Insurance Activities; and Education sectors with between 100 and 249 employees. The IA anticipated that none of these

dutyholders would have familiarised with the changes when they were made. In fact, 18% stated they actively went and found out about the changes to RIDDOR, 51% said they were unaware of any changes, and 31% stated they found out about the changes through their normal work.

### Conclusion

58. The analysis above shows that the estimate described in paragraph 43 about the likelihood of dutyholders to familiarise captured the observed tendency for larger businesses to be more likely to familiarise than smaller ones, but the calculation of an all-or-none familiarisation approach by dutyholders was not observed. Figure 3 summarises the findings of the Omnibus Survey against the estimates anticipated in the IA. For the dutyholders with between 100 and 249 employees, we cannot say anything definitive about the numbers that familiarised due to (a) low sample numbers and (b) the inability to discern those sectors with an injury rate over or below 500 per 100,000 employees *except* that we can say that the rates of familiarisation were not nil nor 100%, as predicted in the IA.

**Figure 3: Summary of anticipated versus actual rates of familiarisation**

		Number of Employees		
		Fewer than 100	100 to 249	250 or more
Injury Rate	Less than 500 per 100,000	Anticipated: nil	Anticipated: nil	Anticipated: 100%
		Actual: 13%	Actual: >nil	Actual: 26%
	More than 500 per 100,000	Anticipated: nil	Anticipated: 100%	Anticipated: 100%
		Actual: 13%	Actual: <100%	Actual: 26%

59. It was anticipated in the IA that larger dutyholders i.e. those with over 250 employees, would be more likely to familiarise with the changes to RIDDOR than smaller dutyholders with fewer than 100 employees. The data generally supports this, but does not support the hard assumption that *all* large dutyholders would familiarise with the changes and that *no* small dutyholders would familiarise.

60. For the dutyholders with between 100 and 249 employees, the partial data collected appears to indicate that those in a sector with a greater injury rate would be more likely to familiarise than those with a lower rate, but the sample is extremely small and does not tell us about many or the relevant sectors.

61. This is a particularly granular analysis, and when the responses were broken down by sector and employee base simultaneously, there were very few responses. The results from this analysis illustrate a direction rather than anything conclusive, and should be treated with caution.
62. The most interesting result of the analysis is that the majority of dutyholders did not familiarise with the changes at the time they were made at all. This could be particular to RIDDOR, where a duty to report is only triggered in the event of a reportable incident and so familiarisation can reasonably be deferred until such time as action is required.



## Annex 1

**Table 4: Scenarios of the number of reports over ten years (thousands)**

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
<i>Assume +2% every year</i>	120	122	125	127	130	133	135	138	141	143
<i>Ill health</i>	1.9	1.9	2.0	2.0	2.0	2.1	2.1	2.2	2.2	2.3
<i>Members of the public</i>	36	37	38	39	39	40	41	42	43	43
<i>Assume constant from 2016/17</i>	118	118	118	118	118	118	118	118	118	118
<i>Ill health</i>	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9
<i>Members of the public</i>	36	36	36	36	36	36	36	36	36	36
<i>Assume -2% every year</i>	115	113	111	109	106	104	102	100	98	96
<i>Ill health</i>	1.8	1.8	1.7	1.7	1.7	1.6	1.6	1.6	1.5	1.5
<i>Members of the public</i>	35	34	33	33	32	32	31	30	30	29
<i>Assume -4% every year</i>	113	108	104	100	96	92	88	85	82	78
<i>Ill health</i>	1.8	1.7	1.6	1.6	1.5	1.4	1.4	1.3	1.3	1.2
<i>Members of the public</i>	34	33	31	30	29	28	27	26	25	24

**Table 4: Costs to Government over ten years of processing reports (£ thousands)**

Costs to Government	Yea r 1	Yea r 2	Yea r 3	Yea r 4	Yea r 5	Yea r 6	Yea r 7	Ye ar 8	Ye ar 9	Yea r 10	NP V	EA ND CB
Assume +2% every year Ill health	1,300 21	1,400 21	1,400 22	1,400 22	1,400 23	1,500 23	1,500 24	1,500 24	1,600 25	1,600 25	13,000 200	1,500 23
Members of the public	400	410	420	430	440	450	450	460	470	480	3,800	440
Assume constant from 2016/17 Ill health	1,300 21	1,300 21	1,300 21	1,300 21	1,300 21	1,300 21	1,300 21	1,300 21	1,300 21	1,300 21	11,000 180	1,300 21
Members of the public	400	400	400	400	400	400	400	400	400	400	3,400	400
Assume -2% every year Ill health	1,300 20	1,300 20	1,200 19	1,200 19	1,200 19	1,200 18	1,100 18	1,100 17	1,100 17	1,100 17	10,000 160	1,200 19
Members of the public	390	380	370	360	360	350	340	340	330	320	3,100	360
Assume -4% every year Ill health	1,300 20	1,200 19	1,200 18	1,100 17	1,100 17	1,000 16	980 15	950 15	910 14	870 14	9,200 140	1,100 17
Members of the public	380	360	350	340	320	310	300	290	270	260	2,800	320

**Table 6: Costs to dutyholders to complete reports over ten years (£ thousands)**

<u>Cost to Dutyholders</u>	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
<i>Assume +2% every year</i>	1,400	1,500	1,500	1,500	1,600	1,600	1,600	1,600	1,700
<i>ill health</i>	23	23	23	24	24	25	25	26	26
<i>Members of the public</i>	430	440	450	460	470	480	490	500	510
<i>Assume constant from 2016/17</i>	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400
<i>ill health</i>	22	22	22	22	22	22	22	22	22
<i>Members of the public</i>	420	420	420	420	420	420	420	420	420
<i>Assume -2% every year</i>	1,400	1,400	1,300	1,300	1,300	1,200	1,200	1,200	1,200
<i>ill health</i>	22	21	21	20	20	20	19	19	18
<i>Members of the public</i>	420	410	400	390	380	380	370	360	350
<i>Assume -4% every year</i>	1,300	1,300	1,200	1,200	1,100	1,100	1,100	1,000	970
<i>ill health</i>	21	20	20	19	18	17	17	16	15
<i>Members of the public</i>	410	390	380	360	350	330	320	310	290

# **Post Implementation Review of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (SI 2013/1471)**

## **Evidence Review**

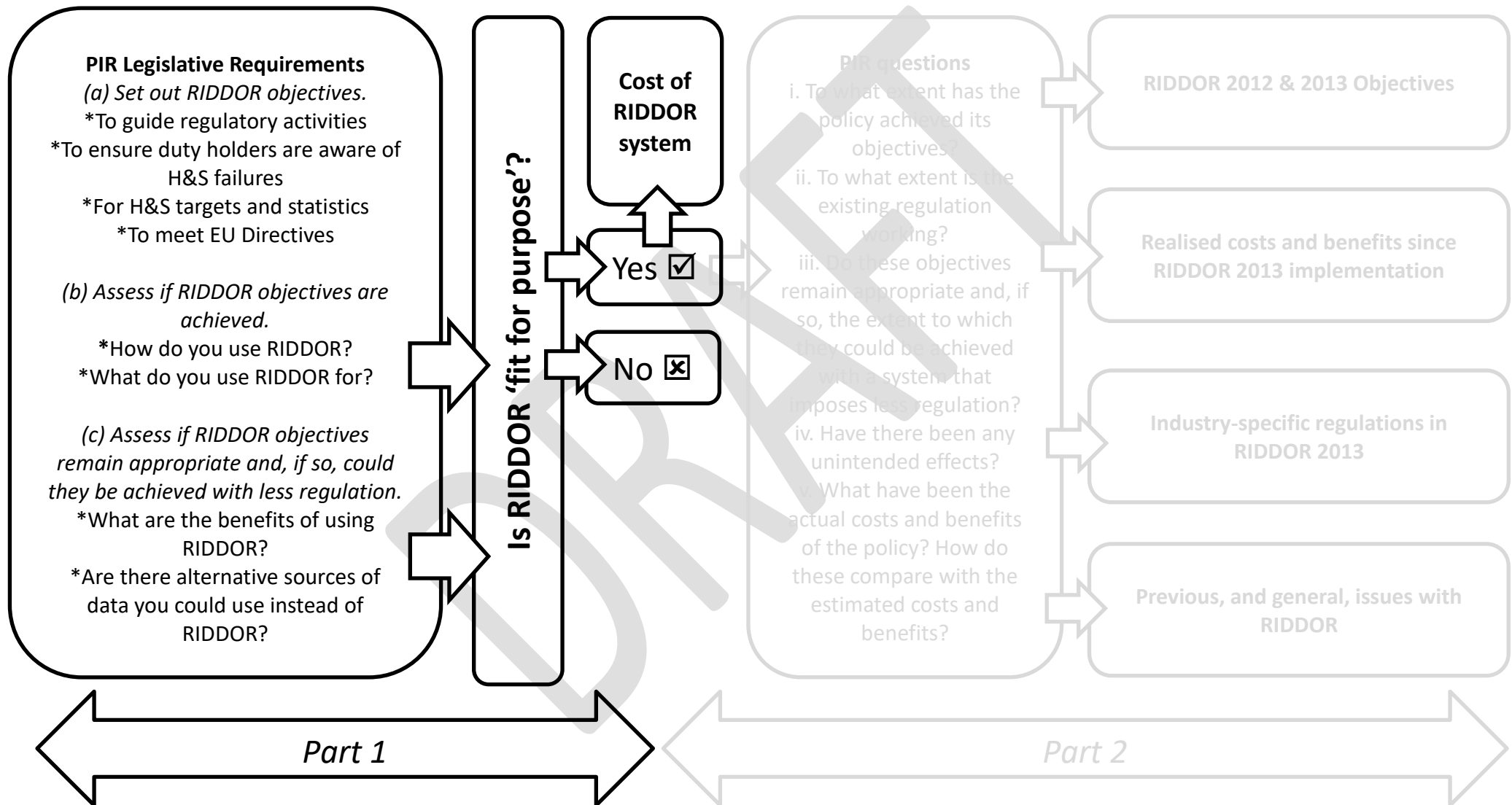
Author(s): Miles Burger

Date: 07/03/2018

## Introduction

1. This Evidence Review has been undertaken by the Health and Safety Executive (HSE) in order to accompany and support the Post Implementation Review (PIR) of the Reporting of Injuries, Diseases and Dangerous Occurrences (Amendment) Regulations 2012 (SI 2012/199) (“RIDDOR 2012”) and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (SI 2013/1471) (“RIDDOR 2013”).
2. RIDDOR puts duties on employers, the self-employed and people in control of work premises (the ‘Responsible Person’) in Great Britain (GB) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses).
3. The PIR, and the corresponding report, must meet the legislative requirement set out in regulation 20 of RIDDOR 2013 to “*carry out a review of these Regulations*”. In particular, Regulation 20 specifies that the PIR report must:
  - (a) set out the objectives intended to be achieved by the regulatory system established by these Regulations;
  - (b) assess the extent to which those objectives are achieved (e.g. to what extent is RIDDOR working?); and
  - (c) assess whether those objectives remain appropriate and, if so, the extent to which they could be achieved with a system that imposes less regulation (e.g. is government intervention still required?; and is RIDDOR still the most appropriate approach?).
4. In order to answer these questions, a mixed-method approach was used. Such an approach was felt to be both rigorous and proportionate, and included qualitative (stakeholder interviews and focus groups) and quantitative (small –scale surveys and a large Omnibus survey) approaches.
5. The initial consideration is therefore whether RIDDOR - as a suite of regulations - is still ‘fit for purpose’? Does it meet its over-arching objectives? Only once this initial ‘hurdle’ is cleared is it then appropriate to consider the more specific objectives and changes within RIDDOR 2012 and RIDDOR 2013. The Evidence Review therefore reflects this approach (see Diagram 1 – Structure of RIDDOR 2013 PIR).

**Diagram 1: Structure of RIDDOR PIR 2013 evidence review**



## **Part 1 – RIDDOR in general**

### ***Set out RIDDOR objectives***

6. In order to consider whether RIDDOR is working, and is still ‘fit for purpose’, the overarching objectives of the regulations should first be considered. A useful summary of these objectives was included within the 2005 review of RIDDOR undertaken by HSE<sup>8</sup> and could be summed up as:
  - a) to provide information to guide the enforcing authorities’ regulatory activities (*‘To guide regulatory activities’*);
  - b) to ensure duty holders are aware of health and safety failures and the need to act upon them to improve their health and safety management systems (*‘To ensure duty holders are aware of H&S failures’*);
  - c) to provide data for national health and safety targets and published statistics on injuries and ill health (*‘For H&S targets and statistics’*); and
  - d) to meet relevant legal obligations under domestic, European and, where relevant, international law (*‘To meet EU Directives’*).
7. Referencing the above objectives, please note that the term ‘duty holder’ is used by the Health and Safety Executive (HSE) to refer to any business, organisation or individual upon whom there is a statutory requirement, or *duty*, to do - or not do - something. In terms of RIDDOR, the duty is to report accidents, ill-health and dangerous occurrences under particular circumstances. Therefore anyone who has to report is a duty holder.

### ***Assess if RIDDOR objectives are achieved***

8. The evidence relating to each of these overarching objectives will be considered in turn.
  - (a) *Information to guide the enforcing authorities’ regulatory activities*
9. The consultation document for RIDDOR 2012<sup>9</sup> highlighted the various ways in which RIDDOR could be used for regulation, namely: for investigation; for intelligence; and for statistics. As such, these broad categories were used to question regulators about how they used RIDDOR data.
10. For the purposes of collecting and collating evidence for the PIR, HSE engaged with health and safety regulators including local authorities (LAs), Office of Rail and Road (ORR), Office for Nuclear Regulation (ONR) and Care Quality Commission (CQC) about how they used RIDDOR data. (It should be noted that local authorities (LAs) hold a special role in terms of RIDDOR as they are front-line regulators of health and safety (alongside HSE), yet also have sizable workforces themselves and will report via RIDDOR as an employer. In addition, the

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<sup>8</sup> <http://www.hse.gov.uk/consult/disdocs/dde22.pdf>, paragraph 12, page 7

<sup>9</sup> [http://consultations.hse.gov.uk/gf2.ti/f/16770/444133.1/PDF/-/CD243.pdf?\\_ga=2.207636689.252477413.1519644131-1242239817.1448378236](http://consultations.hse.gov.uk/gf2.ti/f/16770/444133.1/PDF/-/CD243.pdf?_ga=2.207636689.252477413.1519644131-1242239817.1448378236), paragraph 3, page 6

project team spoke to internal staff at HSE about their use of RIDDOR data for regulatory purposes. While discussions with HSE, ORR, ONR and CQC were undertaken on a one-to-one stakeholder engagement basis, information from local authorities (LAs) was gathered via an online survey (developed and managed by HSE). Members of the project team attended a meeting of the LA Health and Safety Practitioner Forum in April 2017 in order to engage with LAs and encourage them to complete the online survey which was being sent out by the Practitioner Forum's secretariat and hosted on the HElex website. In total, there were 80 responses to the survey:

How do you use RIDDOR? What do you use RIDDOR for?	Just under half of respondents use RIDDOR data for investigation, intelligence and statistics (49%), with a further one in five using it for just investigation and intelligence (21%).
	Local authorities 'always' use RIDDOR data in the following percentage of the time: work-related fatalities (individual cases) (71%); dangerous occurrences (individual cases) (49%); occupation diseases (individual cases) (38%); gas-related injuries and hazards (individual cases) (36%); and exposure to carcinogens, mutagens and biological agents (individual cases) (35%).
What are the benefits of using RIDDOR?	The primary benefits of RIDDOR data are seen to be the ability to monitor trends, to inform local intelligence and in order to direct, target and prioritise resources. In contrast, four in ten respondents (44%) provided no data in terms of RIDDOR's limitations.
Are there alternative sources of data you could use instead of RIDDOR?	Nearly half of respondents indicated that there was no source of aggregated data (45%) or individual data (44%) which could replace RIDDOR. Between a quarter (26%) and third (32%) of respondents were 'unsure' about whether there was alternative sources of data to RIDDOR. About four in ten (38% and 43%, respectively) indicated that the alternative sources of aggregated and individual case data identified would 'definitely not' replace RIDDOR.

11. In terms of HSE's view about whether RIDDOR is still 'fit for purpose' the following responses were received from staff involved in Field Operations Division (FOD); 'Going to the Right Places' project; biological agents operational work; and HSE sectors (in particular with reference to manufacturing):

How do you use RIDDOR? What do you use RIDDOR for?	RIDDOR feeds into the HSE's incidence selection criteria for H&S inspectors as well as HSE's 'Going to the Right Places' project.
	RIDDOR data is used for HSE's inspection regime in both a reactive (incidences to investigate) and proactive sense ('Find It' tool). While other data is used to target inspections, it is never to the exception of RIDDOR data.
	It has been used by the microbiology team for intelligence purposes (see ' <i>Analysis into incidents involving biological agents reported under the RIDDOR system</i> ' HEX/14/07).
	RIDDOR data is used within manufacturing sector work to identify themes, patterns and/or trends.
What are the benefits of using RIDDOR?	There is currently no other mechanism to hear about biological incidents other than via RIDDOR.
	The data can be used to discuss biological incidents with



	international regulators.
Are there alternative sources of data you could use instead of RIDDOR?	The bio-sciences sector is still relatively young and there is no overarching industry body or trade association collecting data on H&S incidents.
	While there are some trade bodies in manufacturing which collect H&S data – e.g. the Cast Metal Federation (CMF) – they tend to be the exceptions. As such there are no trade or representative bodies which collect H&S data and cover the entire manufacturing sector.

12. The views of the Care Quality Commission (CQC) were broadly the following:

How do you use RIDDOR? What do you use RIDDOR for?	RIDDOR is only relevant to the CQC in terms of adult social care (mainly 'trips and slips' within care homes).
	It is not used as the main data for CQC's regulatory work; clinical statutory notification systems are the main reporting tools.
What are the benefits of using RIDDOR?	RIDDOR can provide additional/different data compared to clinical statutory notifications.
Are there alternative sources of data you could use instead of RIDDOR?	RIDDOR reports tend to duplicate the aforementioned clinical statutory notifications. There is also an intention to harmonize clinical reporting data, which will reduce the relevance of RIDDOR further.

13. Finally, HSE engaged with the Office for Rail and Road (ORR), which receives RIDDOR reports directly from its duty holders. In comparison to the CQC – which is looking to move away from RIDDOR – ORR is currently investigating making better use of RIDDOR data in its regulatory work (i.e. similar to HSE's 'Going to the Right Places' project).

How do you use RIDDOR? What do you use RIDDOR for?	ORR relies on statutory RIDDOR data that it collects directly from rail industry stakeholders or via the Rail Safety and Standards Board (RSSB) to assist in carrying out its work as the safety regulator for Britain's railways, tramways and other guided transport systems. ORR uses RIDDOR data to inform its Board and Her Majesty's Inspectors of Railways of emerging trends in dangerous occurrences, injuries, fatalities and occupational health.
	ORR uses RIDDOR data in order to select and prioritise which incidents to investigate (similar to HSE's incident selection criteria). However, ORR would like to start using RIDDOR more proactively to target its regulatory activity (i.e. like HSE's 'Going to the Right Places' project). ORR also uses RIDDOR to publish National Statistics on rail safety.
What are the benefits of using RIDDOR?	ORR sees the benefits of RIDDOR for consistent incident reporting and data collection. Without this statutory requirement for minimum reporting standards, data collection might be less consistent and some duty holders might not provide the data at all. RIDDOR also allows ORR to compare safety performance over time although changes in reporting requirements can affect that ability. RIDDOR allows comparison of health and safety performance across all the duty holders that ORR regulates, regardless of size and activities performed. It also enables comparisons to be made across other sectors (e.g. road traffic operatives).

<p>Are there alternative sources of data you could use instead of RIDDOR?</p>	<p>RSSB collects incident data on behalf of mainline railway duty holders through its Safety Management Information System (SMIS) database. As well as collecting RIDDOR data, SMIS also collects incident data required by other legislation such as the Railways and Other Guided Transport Systems (Safety) Regulations 2006 (as amended) (ROGS) and non-legislative Railway Industry Standards (RIS). The RISs are voluntary; therefore, RSSB is under no obligation to provide data collected under these to the ORR. However, the RIS provide a consistent reporting framework. These additional sources of data supplement rather than duplicate RIDDOR data.</p> <p>The SMIS database only provides data from most mainline railway duty holders. ORR collects RIDDOR data directly from other mainline railway duty holders that do not use SMIS (such as freight operating companies) and non-mainline duty holders (tramways, heritage railways, metros and light rail operators). RSSB have also created two risk models that are derived from SMIS data records - the Safety Risk Model and Precursor Indicator Model. ORR can also use these to inform its regulatory decisions. ORR also has access to data produced by duty holders themselves. For example, an organisation's Safety, Health and Environmental report. All mainline duty holders are required to provide ORR with an annual safety report on its safety performance and experience as required by ROGS and European Regulations ("Common Safety Methods").</p>
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14. The overall view appears to be that RIDDOR is used to guide and inform regulatory activities, thereby meeting this objective and demonstrating that it is 'fit for purpose'.

*(b) To ensure duty holders are aware of health and safety failures and the need to act upon them to improve their health and safety management systems*

15. HSE engaged with duty holders via surveys, interviews and focus groups to explore whether the need to report health and safety incidents via RIDDOR led to improved health and safety management systems (HSMS).
16. A number of focus groups, and one-to-one interviews, were held with duty-holders. A full report of the research, including details of the sample, copy of the topic guides and findings of the work, can be found at Annex A. In total, there were three focus groups and four one-to-one interviews, split very roughly geographically between the North and South of the country, with a total of 19 duty-holders being involved. While there was a mix of business sizes involved in the research, the main focus was on small businesses as they were less likely to have 'routine' systems of RIDDOR reporting and would also be reporting less often. This would suggest that the need to report a RIDDOR incident could potentially have a greater impact on them, and may more readily lead them to change their health and safety systems. Broadly, the findings were:
- A number of formal and informal reporting mechanisms operate within organisations. The level of formalisation will often depend on the size and maturity of the business. Organisations with less-mechanised reporting structures (i.e. via a hand-written accident book) will tend to have less knowledge of RIDDOR. One reason for this is that they have fewer RIDDOR incidents to report. The same lack of

familiarity also means they are less comfortable dealing with health-related reporting.

- Those participants who had used RIDDOR reported that they found the process straightforward, with online HSE guidance useful. Participants from smaller organisations, however, felt that they would benefit from more support from HSE about reporting via RIDDOR, but were wary of asking due to fee for intervention (FFI) charges.
- Recent changes to RIDDOR were generally perceived by all the participants as having had little or no negative impact on duty holders. For example, the simplification of categories has made reporting RIDDORs easier.
- The requirement to report accidents to HSE helps organisations to focus and provides them with a benchmark of their safety culture. Yet the influence of RIDDOR is as part of a number of key motivators including moral, legal and financial considerations. For example, the fact that an accident had to be reported could be used as a 'stick' to encourage the workforce to behave safely and directors to take action.
- There was a general view that dutyholders would continue to use accident data to improve their safety systems even if the requirement to report was removed.

17. Alongside the qualitative research, a more quantitative approach was used to examine the effect of RIDDOR as driving improvements to duty-holders health and safety systems. This consisted of three separate, but related, survey approaches, each of which is summarised below alongside the results relating to the RIDDOR overarching objective about ensuring duty holders are aware of health and safety failures and the need to act upon them to improve their health and safety management systems .

#### *YouGov B2B Omnibus survey*

18. A number of questions about RIDDOR were added to YouGov's B2B omnibus survey, which ran between 10<sup>th</sup> and 21<sup>st</sup> July 2017. In total 2,102 responses were received (see Annex B for a copy of the questions added to the YouGov B2B Omnibus and a summary report of the results).

19. Nearly half of respondents (49%) agreed that the legal requirement to complete and send RIDDOR reports ensured that their business was aware of its health and safety failures and the need to act upon them (this increases to 78% if 'don't know' responses are removed). Similarly, 43% of people agreed with the statement 'The legal requirement to complete and send RIDDOR reports leads my business to improve our health and safety management systems' (increasing to 69% if 'don't know' responses are removed). In terms of businesses who commented on the statement "I don't think RIDDOR reports are useful to my business", responses were split broadly in thirds – agree 35%; disagree 31%; and don't know 34%.

20. When businesses were asked to imagine they were no longer legally required to report workplace injuries and diseases via RIDDOR (and provided with the reassurance that their answers would be treated anonymously) nearly two-thirds (62%) indicated that they would

still continue recording workplace injuries and diseases. If 'don't know' responses are removed, this figure increases to 80%.

*Pop-up survey at end of RIDDOR on-line reporting system*

21. A 'pop-up' survey for duty-holders completing RIDDOR reports on-line ran for a week, from Wednesday 23<sup>rd</sup> August 2017 to Wednesday 30<sup>th</sup> August 2017 and received 462 full and partial responses (see Annex C for a copy of the pop-up survey and a summary report of the results).
22. Over eight in ten respondents (86%) agreed that the legal requirement to complete and send RIDDOR reports ensured that their business was aware of its health and safety failures and the need to act upon them (this broadly similar to the YouGov omnibus figures if 'don't know' responses are removed). Similarly, 85% of people agreed with the statement 'The legal requirement to complete and send RIDDOR reports leads my business to improve our health and safety management systems' (which is a 16% difference with the YouGov omnibus figure). In contrast to the YouGov omnibus figures – which were mixed – over eight in ten (81%) respondents disagreed with the statement "I don't think RIDDOR reports are useful to my business" (with 8% answering 'don't know').
23. When businesses were asked to imagine they were no longer legally required to report workplace injuries and diseases via RIDDOR (and provided with the reassurance that their answers would be treated anonymously) nine in ten (90%) indicated that they would still continue recording workplace injuries and diseases.

*Survey of local authorities as duty-holders*

24. The survey was launched and distributed via the by Local Authority Practitioners' Forum (LAPF), and went live on Wednesday 5<sup>th</sup> April 2017 and closed on Wednesday 26<sup>th</sup> April 2017. In total, 138 full or partial responses were received (see Annex D for a copy of survey and summary report of the results).
25. Nearly three-quarters (72%) of respondents indicated that the requirement to report injuries led to improvements in their health and safety management systems.

*(c) To provide data for national health and safety targets and published statistics on injuries and ill health*

26. A significant aspect of RIDDOR is the data gathered. This data is used to inform national HSE statistics releases. For example, national annual data from RIDDOR is used for non-fatal injuries to employees reported by employers and fatal injuries to workers. It is also used to support the figures taken from the Labour Force Survey (LFS).

How do you use RIDDOR? What do you use RIDDOR for?	RIDDOR data is often provided to specialist HSE inspectors in order to support prosecutions following health and safety breaches.
What are the benefits of using RIDDOR?	For statistical purposes, HSE prefers to use the figures from the Labour Force Survey (LFS) as they are seen as being more representative and are less affected by the reporting biases which come with using RIDDOR data (e.g. companies which have good health and safety [H&S] systems tend to report via RIDDOR whereas companies with poor H&S tend not to; RIDDOR does not effectively capture ill-health data). The limitation of LFS, however, is that it does not provide the same level of detail as RIDDOR reports; it has little qualitative data and therefore less 'colour'.
Are there alternative sources of data you could use instead of RIDDOR?	<p>At the moment workers can report health and safety 'workplace concerns' directly to the HSE via a dedicated phone number or on-line form. This self-reported data could provide elements of what is currently collected via RIDDOR. While these reports will sometimes mirror a duty holder produced RIDDOR report, in many cases they do not. This means they provide data not currently captured. These reports are, however, completely voluntary so are unlikely to capture the vast majority of RIDDOR-reportable incidents. (In terms of a wider proposal '<i>getting individual workers reporting their own illnesses and injuries</i>', this is discussed in more depth when considering the pros and cons of alternate approaches to RIDDOR within Table 2).</p> <p>At the moment there are increasing moves within government to combine administrative data-sets in order to use 'big data' to generate fresh insights into policy issues. In this vein, technology could be used to collate and combine multiple sources of data to provide similar information to RIDDOR. For example, irrespective of RIDDOR, employers are obliged to record accidents in an accident book and record absences for statutory sick pay. If these datasets were combined with employers liability insurance data – which would include results of audits on employers as well as any claims made against the company – it could provide much of the information currently collected via RIDDOR. It is debateable how feasible such an approach would be, especially with the data being held in both government and commercial hands, and the data-sets themselves being used for fundamentally different purposes. (The pros and cons of using insurance company claims data is discussed in more detail within Table 2.)</p>

27. In addition to HSE making use of RIDDOR statistics in order to inform its annual health and safety releases, data from RIDDOR is used by others to inform their work. For example, academics will use RIDDOR data – often alongside other complementary datasets – to explore specific aspects of the health and safety system. To this end, three academic researchers which HSE know have previously used, or are currently using, RIDDOR data within their work were contacted. Of the two responses which were received their comments were:

How do you use RIDDOR? What do you use RIDDOR for?	Non-fatal injuries to workers was 'always' used by one respondent and 'sometimes' by the other respondent, with work-related fatalities used 'often' and 'sometimes' by the respondents. Finally, non-fatal injuries to workers was used 'rarely' by one respondent.
What are the benefits of using RIDDOR?	One respondent indicated that the benefits of RIDDOR data are: geographically referenced data; level of detail- eg. SIC, SOC groups; and availability of historic data. The other respondent highlighted that 'individual level' data was a benefit. Neither respondent identified any limitations of RIDDOR data.
Are there alternative sources of data you could use instead of RIDDOR?	Both respondents indicated that there are no alternative sources of aggregated data, or individual case data, which could be used instead of RIDDOR.

*d) Meet relevant legal obligations under domestic, European and, where relevant, international law.*

28. Great Britain has had a statutory requirement to report death and injuries in the workplace since 1980, superseding previous requirements under the Factories Act 1961. The legislative background to RIDDOR, in terms of its relationship to European Union (EU) law, is that it implements aspects of various EU Directives, most significantly Article 9(1)(c) of Council Directive 89/391/EEC; this article concerns measures to encourage the improvement of the health and safety of workers. Reports made under RIDDOR also inform the provision of statistics to the EU as required by Regulation (EC) No. 1338/2008 on Community statistics on public health and safety at work. Finally, RIDDOR implements a number of reporting requirements deriving from various sector-specific and hazard-specific EU Directives.
29. As part of the review, there is a need to consider how the rest of the EU has implemented these Directives and how they meet their legal obligations to report workplace accidents, ill-health and dangerous occurrences. To this end, HSE consulted with the Republic of Ireland's Health and Safety Authority (HAS) as well as placing a question to Senior Labour Inspectors Committee (SLIC) Knowledge Sharing Site (KSS) survey.
30. While there were a limited number of responses, there appears to be a consistent approach in reporting workplace injuries, fatalities, occupational disease and exposure to carcinogens. Only two respondent member states record absence from work following an injury (over 3 days), while no respondent member states indicate that non-fatal injuries to non-workers need to be reported (unlike RIDDOR which includes this provision at Regulation 5).
31. Ireland's health and safety legislative regime offers a good comparator to Great Britain (GB), both in locality and the necessity to meet EU obligations. Its workplace accident and dangerous occurrence reporting framework is detailed in Safety, Health and Welfare at Work (Reporting of Accidents and Dangerous Occurrences) Regulations 2016 (S.I. No. 370 of 2016) and is administered by the Health and Safety Authority (HSA). It currently covers all injuries leading to a worker being unable to carry out their normal duties for more than 3 days, which are reportable. The regulations do, however, *exclude* having to report on

occupational disease. In order to fill this gap, data from other sources (e.g. disability benefit payments) is used. Yet, overall, the HSA reports that occupational health data is poor.

32. The regulations have recently been updated so that injuries to members of the public are reported only where the injured person is taken from the location of the incident to hospital for treatment (mirroring current RIDDOR requirements).
33. As for how Ireland uses its injury and illness reported data, figures from the reporting system are compared with Ireland's labour force survey (LFS). This data is used to compensate for under-reporting when submitting its Eurostat returns. Similar to HSE in GB, reported incidents are prioritised for inspection using a risk-based algorithm developed by consultants Bomel. Ireland is currently considering moving to online-only reporting of workplace injuries.

***Assess if RIDDOR objectives remain appropriate and, if so, could they be achieved with less regulation***

34. As detailed, RIDDOR enacts a number of EU requirements which are compulsory for members states to transpose into their domestic law. While the status of RIDDOR is unclear following Brexit – as are all EU regulations – as the UK is still a members of EU it still has an obligation to transpose its EU directives. Government intervention is therefore still required and compelled.
35. In addition, in summarising responses from those stakeholders engaged with as part of the RIDDOR PIR process, the general consensus is that RIDDOR, while not perfect, is 'fit for purpose' and provides important and vital information for both regulators and duty-holders. Furthermore, there is no ready alternative to RIDDOR and any replacement would share many of the weaknesses of the current system and would lose the compulsory nature of RIDDOR (which is one of its greatest strengths). The current is therefore working well, is 'fit for purpose' and there is not a suitable or ready replacement available. To this end, government intervention is still very much required.
36. The evidence from the PIR – collected from focus groups, interviews, surveys and stakeholder engagements – indicates that both employers and regulators feel that RIDDOR is still 'fit for purpose'. To this end, in order to fully consider and assess whether RIDDOR is still the most appropriate approach to meeting the objectives details in paragraph 6, the below table details the pros and cons of the current system compared to other potential options.

**Table 2:** Pros and Cons of alternate approaches to RIDDOR

Option	Positives (+) about this approach	Negatives (-) about this approach
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<i>Collating ill-health and accident data via accident &amp; emergency (A&amp;E) departments</i>	<p>*Detailed injury data is already collected by A&amp;E departments, so it wouldn't need a new additional burdensome recording system.</p> <p>*The immediacy of injuries which result in A&amp;E treatment may mean that HSE find out about the incident more promptly than via traditional RIDDOR reporting.</p>	<p>*At the moment no occupational or work-related details are recorded alongside details of the injury (e.g. type of work; address of employer).</p> <p>*The circumstances surrounding an accident seen at A&amp;E are currently not recorded, but would be needed for HSE to determine whether to investigate or not. As such, these details would need to be collected by either the clinician or injured worker (placing an additional burden on both).</p> <p>*Workers are only likely to attend A&amp;E for the most severe and/or serious injuries – this means there will be big gaps in the data relating to less-serious injuries.</p> <p>*There may be delays in extracting the necessary information from the NHS's system and sending it to HSE – this delay may hinder investigations.</p>
<i>Getting GPs to report directly to HSE (especially for occupational diseases)</i>	<p>*Getting information at the point of diagnosis will allow occupational disease to be more readily tracked as many sufferers may have retired and their illness will not be picked up within normal workplace RIDDOR reporting.</p>	<p>*GPs do not currently record details of a person's occupation or occupational history. This would be a new requirement on them and increase the amount of information which would need to be recorded during an appointment, so adding a burden to the clinician.</p> <p>*Unlikely to be of practical value for injuries, due partly to relative ease of self-diagnosis, also more serious incidents reported via A&amp;E instead.</p>
<i>Using insurance company claims data</i>	<p>*In a number of European countries this is how injuries are reported to the regulator – i.e. via the company reporting to their insurance company, and the insurance</p>	<p>*By reports going via another party it may slow down how quickly HSE finds out about particular incidents and this may hinder its investigation work.</p>



	<p>company reporting to the regulator.</p> <p>*Could theoretically cover ill health as well as injuries.</p> <p>*Companies are incentivised to report injuries to their insurance company as non-reporting is likely to lead to invalidating their employer's liability insurance if the injured person decides to sue. That is, much of the data may already be collected, if not necessarily easy to get at.</p>	<p>*Insurance companies are not primarily concerned about health and safety – rather they are interested in reducing their exposure to losses due to litigation resulting from workplace injuries. They may, therefore, be less interested in the company improving its health and safety practices, instead simply raising the company's insurance premium.</p> <p>*Data collected via insurance may not align with the needs of the Regulator. Additionally, unlike car insurance, there does not seem to be centralised collation or standardisation by insurance companies for workplace injuries, i.e. each insurance company does their own thing, and to co-ordinate may require legislation.</p>
<p><i>Getting individual workers reporting their own illnesses and injuries</i></p>	<p>Getting workers or relative/friend to report their own injuries may increase the number of reports submitted. For example, the current Labour Force Survey (LFS) asks individuals about whether their work has caused them to be injured and it is viewed as being more robust and accurate than RIDDOR, which is seen to under-estimate injuries and ill-health.</p> <p>*This practice is already established to a smaller degree, which enables the injured person, their family/friends/co-worker (in fact anyone, or anonymously) to report an incident. The mechanism is 'reporting a workplace concern' to HSE/LA.</p>	<p>*Shifting responsibility for reporting workplace injuries and ill-health from companies to workers would be politically controversial with unions likely to strongly oppose such a move.</p> <p>*Workers would be placed in a difficult situation whereby they would have to report their employer. This may place them in direct conflict with them and cause undue workplace friction.</p> <p>*If the system was voluntary, with no legal requirement, it is unlikely to generate an accurate reflection of workplace accidents and ill-health. For instance, the current RIDDOR reporting system places a legal duty on the vast majority of GB businesses, yet it is estimated that</p>

		<p>there is still only 50 per cent compliance.</p> <p>*While responding to the LFS is voluntary, it should be noted that it is a proactive survey which directly engages workers. In contrast, if reporting was voluntary, workers would have to actively contact the HSE, making the system inevitably more reactive and less comprehensive</p>
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37. In respect of the alternatives to RIDDOR, most of them would not provide enough information to effectively enable regulators, such as HSE, to: identify where and how risks arise; whether they need to be investigated (e.g. via a link to HSE's inspection selection criteria [ISC]); target their work; and provide advice about how to avoid work-related deaths, injuries and ill health.

38. In summary, the evidence robustly reflects the view that RIDDOR is currently meeting its objectives, is still 'fit for purpose' and could not easily or desirably be replaced with another system meeting the same requirements.

#### **Cost of RIDDOR system**

39. The benefits of RIDDOR are summarised above and illustrate that the system is still 'fit for purpose'. While these benefits are not quantified (e.g. *'RIDDOR provides £x a year in benefit for businesses'*), the qualitative evidence highlights the strength and positives of the system. In order to provide context to the 'benefits' of RIDDOR, it is worth considering the costs on the other side of the equation. To this end, Appendix ?? looks at the costs to businesses and other duty holders under RIDDOR.

40. In addition, the Better Regulation Framework<sup>10</sup> indicates that all post-implementation reviews (PIRs) need to go to the Regulatory Policy Committee (RPC)<sup>11</sup> if they meet a de minimis *"threshold of +/-£5m EANDCB"* (Equivalent Annual Net Direct Cost to Business) with *"[m]easures originally estimated to have a net annual impact below this threshold need not be submitted to the RPC"*. This requirement is, however, preceded with mention of the *"objectives of the regulation"*. It is therefore unclear whether this requirement applies to

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[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/683119/better-regulation-framework-interim-guidance-2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683119/better-regulation-framework-interim-guidance-2018.pdf)

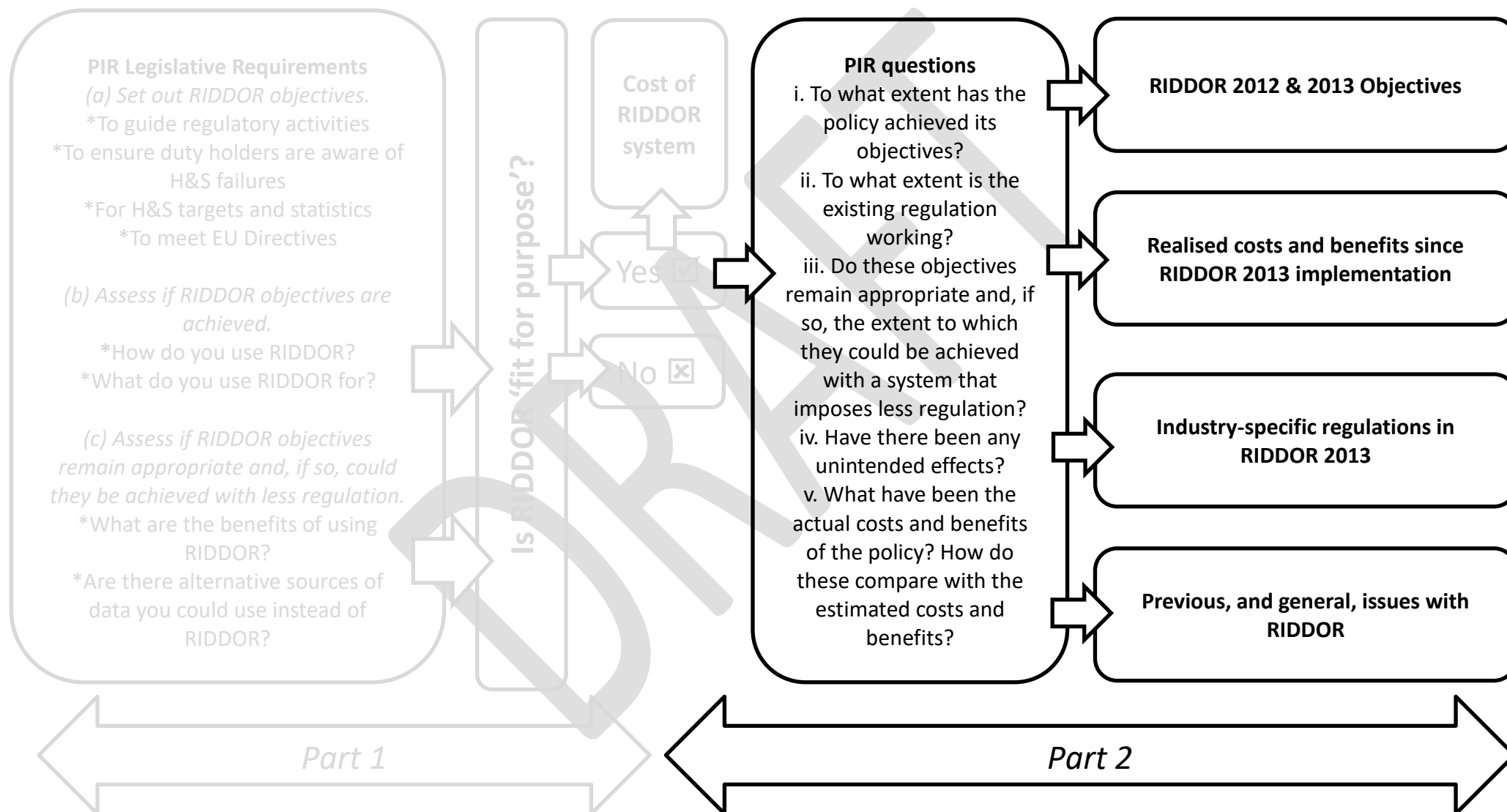
<sup>11</sup> An external and independent panel which provides government with scrutiny of new regulatory and deregulatory proposals – see <https://www.gov.uk/government/organisations/regulatory-policy-committee>

just the changes in the regulations or the regulations as a whole. If it applies to only the changes, then the RIDDOR 2012 impact assessment (IA) indicates a EANDCB of £0.24m and the RIDDOR 2013 IA indicates a EANDCB of £0.03m – so a combined figure of £0.27m - which is below the threshold. If it is referring to the regulations as a whole, then there is a need to consider the costs of RIDDOR as a whole. This is consequently covered in the analysis in Appendix??

41. Overall, considering different scenarios in terms of the number of received RIDDOR reports, the estimated total costs to society of RIDDOR range from around £2.2 million to £3.0 million. With this figure being below the de minimis threshold, the PIR does not need to go to RPC for scrutiny.

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**Diagram 2: Structure of RIDDOR PIR 2013 evidence review**



## **Part 2 – Changes due to RIDDOR 2012 and RIDDOR 2013**

42. As detailed in Diagram 2 ‘Structure of RIDDOR 2013 PIR’, the first part of the PIR considered whether the underlying aspects of RIDDOR are still working, whether Government intervention is still required and whether it is still the most appropriate approach. If there is a positive response to these aspects, only then should the PIR move onto considering the specific aspects of the changes detailed within RIDDOR 2012 and RIDDOR 2013. To this end, the above evidence clearly indicates that RIDDOR is still working, is still required and is still the most appropriate approach. Part 2 therefore considers the following questions in relation to RIDDOR 2012 and RIDDOR 2013, namely:

- To what extent has the policy achieved its objectives?
- To what extent is the existing regulation working?
- Do these objectives remain appropriate and, if so, the extent to which they could be achieved with a system that imposes less regulation?
- Have there been any unintended effects?
- What have been the actual costs and benefits of the policy? How do these compare with the estimated costs and benefits?

43. Naturally some of these questions echo those asked in relation to RIDDOR as a whole (and there is some natural ‘read-across’), but they are addressed in this part with particular reference to the regulatory changes under consideration. These changes can be broadly summarised as:

Regulation	Main changes	Objectives of regulation
RIDDOR 2012	*Needing to complete a RIDDOR report where the worker has been absent from work for more than 7 days (the previous requirement was over 3 days absence)	*To improve the workplace accident report system’s effectiveness by simplifying requirements and reducing unnecessary burdens on business. *To align the lost-time injury reporting duty with sickness absence requirements and thus injured persons who are absent from work will obtain a "fit note" from their GP and receive a professional medical assessment. *To meet the Government's commitment to implement the “ <i>Common Sense, Common Safety</i> ” recommendation to amend the lost-time injury reporting requirement under regulation 3(2) of RIDDOR.
RIDDOR 2013	*The classification of "major injuries" being replaced with a shorter list of "specified injuries" *The previous list of 47 types of industrial diseases being replaced with eight categories of reportable work-related illness *Fewer types of "dangerous occurrences" requiring reporting	*To simplify and clarify the RIDDOR reporting requirements for occupational accidents, dangerous occurrences and diseases, as recommended by Professor Löfstedt in his report, “ <i>Reclaiming Health and Safety for All.</i> ” *To ensure the continued availability of information required for effective regulation, whilst removing reporting

		requirements for data which is rarely used, or could be otherwise obtained. *To implement a number of EU Directive requirements.
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***To what extent has the policy achieved its objectives?***

44. One of the prime objectives of both RIDDOR 2012 and RIDDOR 2013 was ‘to simply and clarify’ the regulations surrounding RIDDOR. For instance, the Explanatory Memorandum for RIDDOR 2013 explicitly indicated that the changes were to “*simply and clarify the requirements for informing enforcing authorities about serious work-related accidents and incidents*”<sup>12</sup>. Furthermore, RIDDOR 2012 – and the change from over three days to over seven days reporting – harmonised the system with the requirement to obtain a ‘fit note’ from a doctor when absent from work due to ill health or injury. This change was intended to “*improve the effectiveness of the workplace accident report system by simplifying the requirements*”, making “*sickness absence easier to manage, as well as reducing the overall number of reports that must be made*”. This, in turn, would “*reduce unnecessary burdens on business and reduce the number of reports that regulators must process*”<sup>13</sup>. As to whether these objectives were subsequently achieved, research was undertaken using the following research instruments with the following results:

Research instrument	No. of respondents	Evidence
Omnibus B2B survey	<i>n</i> = 2102	Over four in ten (42%) respondents agreed that “the changes made by RIDDOR 2012 and RIDDOR 2013 have simplified and clarified RIDDOR reporting requirements”. If those respondents who indicated ‘don’t know’ are removed, this increases to over eight in ten respondents (83%) <sup>14</sup> .
On-line survey of people completing on-line RIDDOR reports	<i>n</i> = 462	Similar to the YouGov omnibus results, over eight in ten respondents (84%) agreed that “the changes made by RIDDOR 2012 and RIDDOR 2013 have simplified and clarified RIDDOR reporting requirements”, with over a quarter (28%) strongly agreeing.
On-line survey of local authorities as duty-holders (facilitated by Local Authority Practitioners’ Forum [LAPF])	<i>n</i> = 138	About seven in ten (70%) respondents agreed that the changes had “simplified and clarified RIDDOR reporting requirements”.
On-line survey of education providers	<i>n</i> = 53	Three-quarters (75%) of respondents agree with the statement about RIDDOR 2012 and RIDDOR 2013 simplifying and clarifying reporting requirements.
On-line survey	<i>n</i> = 10	While four respondents (40%) agree that the changes had

<sup>12</sup> [http://www.legislation.gov.uk/uksi/2013/1471/pdfs/uksiem\\_20131471\\_en.pdf](http://www.legislation.gov.uk/uksi/2013/1471/pdfs/uksiem_20131471_en.pdf)

<sup>13</sup> [http://www.legislation.gov.uk/uksi/2012/199/pdfs/uksiem\\_20120199\\_en.pdf](http://www.legislation.gov.uk/uksi/2012/199/pdfs/uksiem_20120199_en.pdf)

<sup>14</sup> Please note that 50% of responses to this question were ‘don’t know’. It is unclear the reason for such a high percentage of ‘don’t know’ responses, but it may be due to respondents not having reported via RIDDOR since the changes came in.

of healthcare providers		simplified and clarified RIDDOR reporting requirements, three (30%) were undecided with the three remaining respondents (30%) disagreeing with the statement (with two strongly disagreeing).
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45. The evidence from various surveys strongly indicated that duty-holders felt that the changes in RIDDOR 2012 and RIDDOR 2013 had simplified and clarified RIDDOR reporting requirements.
46. Furthermore, it should be noted that although no major changes were made to the need to report non-fatal injuries to non-workers (RIDDOR 2013 Regulation 5), there has been a reduction of around 26,000 reports annually, when comparing the 3-year average prior to 2013, and after 2013. The yearly average between 2008/09 and 2010/11 was 62,800 reports (baseline years for 2013 IA), and between 2014/15 and 2016/17 was 36,800. While RIDDOR 2013 did remove the need to report suicides on railways (which were reported to Office of Rail and Road [ORR]), it is unlikely the scale of the reduction could be solely accounted for by this minor change. As such, the reason for the reduction may be due to the 'simplified and clarified' structure of RIDDOR 2013, leading to fewer unnecessary or inappropriate RIDDOR reports being made.
47. It is hard to pin-point any systematic reason for this reduction, however a key driver for the 2013 Regulation change was to 'simplify and clarify' the Regulations, hence it is perfectly feasible to suggest this being a significant reason for this unforeseen reduction. (These figures exclude any ORR reports, as 2013 did remove).
48. While the changes to RIDDOR included a reduction in reporting for a number of categories – in order to simplify and clarify the regulations - a further objective of the changes was to ensure the continued availability of useful information. Discussion with internal HSE stakeholders indicated that RIDDOR data was still used extensively for regulation (via the inspection selection criteria and the 'Going to the Right Places' project) as well as for the production of intelligence and national statistics. Some adjustments had to be made, however, in order to preserve historical analysis. Local authority health and safety regulators were asked about this issue via the 'local authority as H&S regulators' online survey (3rd to 26th April 2017) ( $n = 80$  responses), with over half of respondents (51%) saying that the supply of useful information from RIDDOR had been retained following the changes. A further quarter (25%) was unsure, with just below a quarter (22.5%) of the remaining respondents suggesting that the useful information may not have been retained. In contrast, nearly half of people (49%) said that the 2012 and 2013 RIDDOR changes had simplified and clarified reporting requirements, with a further third (33%) unsure.
49. Reflecting on the objectives of RIDDOR 2012 and RIDDOR 2013 they all seem to have been met. For instance, the above evidence illustrates that the changes were seen by both duty-holders and regulators as 'simplifying and clarifying' RIDDOR reporting requirements and that usefulness of RIDDOR data was largely retained. As for the harmonisation of RIDDOR with 'fit note' provisions, meeting the recommendations from the *'Common Sense, Common*

*Safety*’ and *‘Reclaiming Health and Safety for All’* reports and implementing a number EU directives, all of these can be seen to have been achieved by the very production of the respective new regulations.

***To what extent is the existing regulation working?***

50. A number of changes to RIDDOR reporting were introduced via RIDDOR 2012 and RIDDOR 2013. As part of the PIR, HSE engaged with duty-holders and asked them about what they thought about the changes and whether they were supportive of them or not.

Research instrument	No. of respondents	Evidence
Omnibus B2B survey	<i>n</i> = 2102	As for the individual changes themselves (3 day reporting to 7 day reporting; major injuries to specified injuries; reduction in industrial diseases classifications from 47 to 8; and fewer dangerous occurrences which need to be reported), all of them were viewed positively achieving between 40% to 45% positive responses (again, if ‘don’t know’ responses are removed, this increases to between 81% and 91%).
On-line survey of people completing on-line RIDDOR reports	<i>n</i> = 462	The range of responses to the individual changes (3 day reporting to 7 day reporting; major injuries to specified injuries; reduction in industrial diseases classifications from 47 to 8; and fewer dangerous occurrences which need to be reported) broadly reflects YouGov omnibus results, with positive response from between 80% and 89% of respondents.
On-line survey of local authorities as duty-holders (facilitated by Local Authority Practitioners’ Forum [LAPF])	<i>n</i> = 138	In terms of the individual changes, 57% to 71% of respondents were positive about them, with the most positive change being the move from 3 day reporting to 7 day reporting; the least positive change was the need to report on fewer types of dangerous occurrence. Outside of the 3 day to 7 day reporting change, approximately a third of respondents (ranging from 31% to 33%) indicated that they were ‘neither positive or negative’ about the changes.
On-line survey of education providers	<i>n</i> = 53	Approximately eight in ten respondents indicated that they were positive about the change from 3 day reporting to 7 day reporting and the reduction in the number of disease categories (79% and 83%, respectively). As for the other changes, seven in ten (71%) respondents were positive about the new list of ‘specified injuries’ while a two-thirds (63%) were positive about the reduced list of reportable dangerous occurrences.
On-line survey of healthcare providers	<i>n</i> = 10	In terms of the various changes, between 40% and 60% of the respondents were positive about them. The change with the least number of positive respondents was the 3 day to 7 day reporting amendment. For all changes, three respondents (30%) indicated that they thought they were ‘hugely negative’.

***Do these objectives remain appropriate and, if so, the extent to which they could be achieved with a system that imposes less regulation?***

51. As with the consideration in Part 1 about whether RIDDOR represents the most appropriate approach, this question is concerned with whether there are any viable alternatives to



RIDDOR, and in the absence of a legal obligation to report would duty-holder still collect information about workplace accidents and ill-health.

Research instrument	No. of respondents	Evidence
Omnibus B2B survey	<i>n</i> = 2102	When businesses were asked to imagine they were no longer legally required to report workplace injuries and diseases via RIDDOR (and provided with the reassurance that their answers would be treated anonymously) nearly two-thirds (62%) indicated that they would still continue recording workplace injuries and diseases. If 'don't know' responses are removed, this figure increases to 80%.
On-line survey of people completing on-line RIDDOR reports	<i>n</i> = 462	When businesses were asked to imagine they were no longer legally required to report workplace injuries and diseases via RIDDOR (and provided with the reassurance that their answers would be treated anonymously) nine in ten (90%) indicated that they would still continue recording workplace injuries and diseases.
On-line survey of local authorities as duty-holders (facilitated by Local Authority Practitioners' Forum [LAPF])	<i>n</i> = 138	Respondents were asked if they were not required to report workplace injuries and diseases to HSE via RIDDOR, whether they would still record them. Over four-fifths (83%) of respondents indicated that they would 'definitely' continue recording them.
On-line survey of education providers	<i>n</i> = 53	Virtually all respondents (98%) indicated that they would 'definitely' still record workplace injuries and diseases even if they were not required to report them to HSE via RIDDOR.
On-line survey of healthcare providers	<i>n</i> = 10	Nearly nine in ten (88%) respondents indicated that they would 'definitely' still record workplace injuries and diseases even if they didn't have to report them to HSE via RIDDOR.

52. Of those duty-holders who responded, a large percentage indicated that they would still record details of accidents and ill-health even if the requirement to report this information was no longer legally required. While such a result is difficult to interpret due to its hypothetical nature, it is hoped that it reflects duty-holders appreciation of the benefits of recording such details in terms of improving their health and safety management systems.

#### ***Have there been any unintended effects?***

53. The focus of PIRs is on examining and evaluating the effects of legislative change. An essential aspect of any such consideration is whether there have been any unintended effects caused by the legislative change, either positive or negative. To this end, both duty-holders and regulators were asked about whether they thought there were any unintended effects. (Please note that data on this aspect of the PIR was provided in qualitative terms, as free-text responses within surveys. The below findings are therefore based on an analysis of these qualitative answers, grouping them into thematic strands).

Research instrument	No. of respondents	Evidence
Omnibus B2B	<i>n</i> = 2102	*Detailed comments were received from 264 respondents

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survey		<p>referring to consequences of the RIDDOR changes for them and their employers, and how they felt about them. The areas attracting the most positive comments were 'clarity' (81 respondents), reduction in 'time spent' completing RIDDOR report (40 respondents) and 23 respondents indicated that they felt that the changes to the RIDDOR regulations have helped them to improve 'health and safety' in their workplace.</p> <p>*While there were less negative comments, 38 respondents did indicate that the 'time spent' completing RIDDOR reports had been negatively affected by the changes with increased time being spent on reporting, staff training to accommodate the changes, or that the whole process had always been too time-consuming and that it had not changed sufficiently.</p> <p>*Other than 'time spent', the category which received the most negative comments was 'regulation'. While most did not comment specifically on the changes, or refer to them in the kind of detail that might indicate genuine engagement with, or knowledge of the changes, these comments were generally negative about the regulation of business. The remarks were on themes like 'increased red tape' and regulatory additions that 'benefitted no-one'.</p>
On-line survey of local authorities as duty-holders (facilitated by Local Authority Practitioners' Forum [LAPF])	<i>n = 138</i>	<p>*Respondents commented on the fact that the 2012 and 2013 changes did not provide further clarity on certain areas within RIDDOR – e.g. <i>"Schools and Community Centres find it difficult to establish how to report accidents / incidents to children and members of the public"</i>.</p> <p>*The changes make it more difficult to spot trends and identify poor performers – <i>"Fewer accidents/dangerous occurrences will be reported. It may lighten the load on business but poor performers can hide assuming that they ever reported their accidents."</i></p> <p>*There is also some lack of clarity around the 3 day to 7 day reporting change – <i>"Not sure why incidents are only reported after 7 days when we need to keep records of 3 days - why keep the records if they're not reported?"</i></p>
On-line survey of education providers	<i>n = 53</i>	<p>*A lack of clarity due to the 'slimmed down' categories, and the loss of detail, was mentioned by respondents as a consequence of the changes.</p> <p><i>"A concern that smaller employers with fewer, less experienced competent persons, or those relying on local management units to report, could struggle with the more streamlined categories and find it difficult to determine whether or not an injury or illness met the reporting criteria."</i></p> <p>*The loss of RIDDOR guidance was also mentioned.</p> <p><i>"Loss of lots of helpful guidance as guidance book not revised"</i>.</p>
On-line survey of healthcare providers	<i>n = 10</i>	<p>*Confusion and possible complacency were reported by respondents:</p> <p><i>"Details are scant and managers no longer need to report some dangerous situations in the workplace - this can lead to complacency"</i></p> <p><i>"...A much shorter list of reportables means many important issues neglected and downgraded for H&amp;S purposes by management. Fewer inspections, investigation and less learning and preventative action"</i>.</p>

Local authority as H&S regulators online survey	<i>n</i> = 80	<p>*When LAs were asked whether there were any unintended effects following the 3 day to 7 day change, they responded in their roles as H&amp;S regulators indicating that there was some confusion, under reporting and an inability to trend/compare data. This subsequently led to less investigations and less health and safety resources.</p> <p><i>“Led to less health and safety investigations being done and loss of regular experience and resources in this area of work. Management have cut resources to tackle H+S as less coming in. Some officers feel less confident.”</i></p>
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54. The comments received tended to focus on the anticipated effects of the changes – positive and negative – rather than completely new effects. It is interesting to note, however, that the main effects received both positive and negative responses. So, for example, various duty-holders mentioned that the RIDDOR changes had brought greater ‘clarity’ to reporting, yet there were others (from local authorities, education providers and healthcare providers) who said that it had made it less clear and more confused. The same also seemed to be true about whether the changes had decreased or increased time when reporting. Furthermore, a number of respondents indicated that the changes had made it difficult to compare new data with historical data, and the loss of intelligence this resulted in.

***What have been the actual costs and benefits of the policy? How do these compare with the estimated costs and benefits?***

55. In order to ascertain what the actual costs and benefits of the RIDDOR changes have been, it is first necessary to consider what was predicted within the original 2012 and RIDDOR 2013 impact assessments (IA).
56. Building on the assumptions within the RIDDOR 2012, one of the primary drivers for on-going benefits of the changes is the reduction in the amount of reports businesses need to complete and how much time this will save them. In the RIDDOR 2012 IA, it was estimated that for a business to submit a lost time RIDDOR report, it would *“take 32 and a half minutes of a manager’s time”*. This was based on evidence from HSE experts, and included:
- 10 minutes to fill in the accident book following the accident;
  - 10 minutes to gather the additional required information and prepare to submit the report;
  - 10 minutes to fill the e-form in; and
  - 2 and a half minutes to print the completed form off and file it.
57. Both RIDDOR 2012 IA and RIDDOR 2013 IA estimated that the report would be completed by a production manager<sup>15</sup>. However, were an accident to occur that did not require reporting, the employer would still have a duty to record it. It was assumed that this would take 10

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<sup>1515</sup> RIDDOR 2012 source: ASHE 2010, SOC 4 digit, average salary for a production manager (code 112) uprated by 30% to reflect non-wage costs; RIDDOR 2013 source: ASHE 2011, SOC 4 digit, mean salary for a production manager (code 112) uprated by 30% to reflect non-wage costs

minutes to do. So each report not submitted would save 22-and-a-half minutes of a manager's time.

58. The RIDDOR 2012 IA time figure were subsequently revised upwards in the RIDDOR 2013 IA to 33-and-a-half minutes of a managers time based on evidence from HSE experts and *"quantitative data supplied by individuals submitting RIDDOR reports"*. As part of the PIR, this 33-and-a-half minute was verified via the various surveys used to collect evidence.

Research instrument	No. of respondents	Evidence
Omnibus B2B survey	<i>n</i> = 2102	About one in five (19%) respondents indicated that 33½ minutes of a managers time was 'an accurate estimation' of how long it took to complete a RIDDOR report; this compares with 15% who thought 33½ minutes was too high and 11% who thought it was too low. If the 'don't know' and 'Not applicable - I have never submitted a RIDDOR report' responses are stripped out of the figures, over four in ten (42%) respondents thought it was an accurate estimation, with 38% thinking it was too high and 24% thinking it was too low.
On-line survey of people completing on-line RIDDOR reports	<i>n</i> = 462	Nearly half of respondents (47%) indicated that the 33 ½ minutes of a managers time was an accurate estimation of how long it took to complete a RIDDOR report, with a further quarter indicating that it was too high (24%) or too low (27%).
On-line survey of local authorities as duty-holders (facilitated by Local Authority Practitioners' Forum [LAPF])	<i>n</i> = 138	Over half of respondents (55%) said the RIDDOR 2013 impact assessment assumption that it takes 33.5 minutes for a manager to complete a RIDDOR report was 'about right'. A further 17% indicated that this figure was too high, while over a quarter (27%) thought the figure was too low.
On-line survey of education providers	<i>n</i> = 53	Again over half of respondents (55%) indicated that the 33.5 minute figure was 'about right' for the time taken to complete a RIDDOR report. A further 16% indicated that the figure was too high, while 29% indicated that the figure was too low.
On-line survey of healthcare providers	<i>n</i> = 10	Four in ten (44%) respondents indicated that the proposed 33.5 minute figure for completing a RIDDOR report was 'about right', with a further third (33%) thinking it was too high and a fifth (22%) thinking it was too low.

59. The findings from the surveys were mixed, with approximately half of respondents agreeing that the 33-and-a-half minutes of a manager's time was an accurate reflection of how long it takes to complete a RIDDOR report. The remaining respondents roughly fell either side of the estimate. Overall the findings were split, very approximately, into 25% indicating the estimate was too high, 50% indicating that it was about right and a final 25% indicating that it was too low. There is no overwhelming evidence of the estimate being either too high or too low, and this spread of results would place the 33-and-a-half minute figure in the middle of a normal distribution curve.

60. As well as the time employers take to complete RIDDOR reports, both the RIDDOR 2012 and RIDDOR 2013 considered the time to process reports by HSE and local authorities (LAs). The RIDDOR 2013 IA assumed the time taken to process a report for both HSE and LAs was “23-and-a-half minutes per report”, with the only difference being “the wage rate of those involved with processing these reports”<sup>16</sup>. This assumption was verified via the ‘local authority as H&S regulators’ online survey ( $n = 80$ ) with over half of LAs (56%) indicated that the assumption that processing a RIDDOR report took about 23.5 minutes was ‘about right’, with a further third (36%) indicating that this figure was too high and 6% indicating that it was too low.

61. In terms of the other assumptions detailed in the RIDDOR 2012 and RIDDOR 2013 impact assessments (IA), figures provided by HSE’s statistical team indicate what the actual numbers were following the implementation of the regulations. Please note that the data within this Evidence Review uses the number of RIDDOR notifications *accepted*. This differs slightly from the Cost Benefit Analysis (CBA) at Appendix B which uses raw data on the number of RIDDOR notifications *received*. The number of RIDDOR reports accepted will tend to be lower as they will *only* include those reports which are found to fall under RIDDOR, whereas received reports will also include those which are eventually rejected. Published RIDDOR statistics use accepted reports rather than received reports.

Impact Assessment (IA)	Assumptions in IA	Actual figures
RIDDOR 2012 impact assessment <sup>17</sup>	Staff Time – Band 2 <sup>18</sup> (0.1); Band 3 (0.25); Band 4 (0.35)	Staff Time – Band 2 (0.3); Band 3 (0.25); Band 4 (0.25)
	30,000 fewer RIDDOR notifications, of which 15% submitted electronically	29,479 fewer RIDDOR notifications, of which 5% submitted electronically
	68% of RIDDOR reports dealt with by HSE; 32% by LAs	72% of RIDDOR reports dealt with by HSE; 28% by LAs
RIDDOR 2013 impact assessment <sup>19</sup>	Staff Time – Band 4 (0.92) ICT system costs - £50k	Staff Time – Band 3 (0.58); Band 4 (0.33) ICT system costs - £75k
	11,500 fewer RIDDOR notifications, of which 4% submitted electronically	Estimated 5,700 fewer RIDDOR notifications, of which 4% submitted electronically. This was subsequently revised to 7,900 fewer RIDDOR notifications (see details below)
	70% of RIDDOR reports dealt with by HSE; 30% by LAs	72% of RIDDOR reports dealt with by HSE; 28% by LAs

<sup>16</sup> For HSE processing a Band 6 administrator wages were used, while for LAs the mean salary of an inspector of factories, utilities and trading standards was used (uprated by 30% to reflect non-wage costs) (source: ASHE 2011, SOC 4 digit, code 3565).

<sup>17</sup> [http://www.legislation.gov.uk/ukia/2011/452/pdfs/ukia\\_20110452\\_en.pdf](http://www.legislation.gov.uk/ukia/2011/452/pdfs/ukia_20110452_en.pdf)

<sup>18</sup> This refers to HSE pay bands. These map onto Civil Service pay bands – Band 2 = Grade 7; Band 3 = Senior Executive Officer (SEO); Band 4 = Higher Executive Officer (HEO)

<sup>19</sup> [http://www.legislation.gov.uk/ukia/2013/33/pdfs/ukia\\_20130033\\_en.pdf](http://www.legislation.gov.uk/ukia/2013/33/pdfs/ukia_20130033_en.pdf)

62. In the RIDDOR 2012 impact assessment (IA) it was estimated that the number of reports would fall by approximately 30,000 due to the change in notification period from over 3 days to over 7 days. While it would have been ideal to consider the raw number of RIDDOR notifications received in order to calculate the fall in RIDDOR report numbers, the reporting system changed in Sept 2011 to a mainly online one (it had previously been phone-based via HSE's Incident Contact Centre [ICC]). This change could feasibly have led to differences in the numbers of notifications recorded, due to the ICC filtering out non-reportable notifications. To this end, HSE's Statistics and Epidemiology Team (SET) used the published national statistics for over 7-day injury reports for 2011/12 and 2012/13 to calculate that there had been a drop of 29,479 in the number of reports; almost exactly what was predicted in the RIDDOR 2012 IA.
63. The reduction in the number of reports due to the RIDDOR 2013 changes was predicted to be 11,500, while the initial 'actual' figure was 5,700. Due to the large degree of difference between the predicted and actual figure, further work was undertaken by HSE's SET who subsequently revised the figure upwards to around 7,900 fewer RIDDOR reports due to RIDDOR 2013 changes. The reason for the difference between 11,500 predicted figure and the subsequent 5,700 and 7,900 figures are detailed below.
64. THE RIDDOR 2013 IA included three options for changes to the reporting regulations. Under each of the 'do something' options (options 2 and 3), where there was a predicted reduction in RIDDOR reports, the baseline number of reports was first estimated. This baseline estimate used the annual number of reports received by HSE's Incident Contact Centre (ICC) and Office of Rail and Road (ORR) for the period 2008/09 to 2010/11. This gave an annual average estimate of around 177,000 reports (this is the figure used within the IA<sup>20</sup>) and comprises approximately 169,000 reports to ICC and 7,000 ORR reports.
65. This baseline was then compared to the estimated number of reports that was expected to be received under each of 'do something' options. To this end the IA detailed the various report categories and estimated the number of reports that would be expected for each category; this was based on the reports received in the three year period between 2008/09 to 2010/11. For injuries, the IA stated the estimated number of reports expected to be submitted to HSE. It is unclear whether this included injury reports submitted to ORR too. However, the IA made no allowance for Dangerous Occurrence (DO) reports submitted to ORR under part 5 of schedule 2.
66. The total number of expected reports submitted for each 'do something' option is taken as the sum of reports under each report category, and the reduction is then calculated as the difference from the baseline. The issue with this (particularly for option 3) is that the baseline *includes* ORR reports whereas the option 2 and 3 scenarios *do not* include ORR DO reports under schedule 2 part 5. Therefore, the estimated reduction is overstated as it

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<sup>20</sup> See paragraph 84, page 20.

assumes that all ORR DO reports under part 2 cease and therefore contribute to the reduction. In actual fact, the RIDDOR 2013 changes only reduce the types of railway specific dangerous occurrences from 24 to 21, thereby retaining most of the DOs which still need to be reported.

67. As such, ORR DO reports contributed around 3,600 to the baseline (with the assumption being that the majority are under part 5 of schedule 2). If this figure is then deducted from the estimated reduction under option 3 – which was 11,500 fewer RIDDOR reports – then the estimated reduction is around 7,900; this figure is consequently more reflective of the actual reduction compared to the original calculation which suggested that there had only been a reduction of 5,700 in the number of RIDDOR reports.
68. It should also be noted that the estimation process for the RIDDOR 2013 impact assessment was particularly complex because of the change between over-3-day to over-7-day reporting which had occurred only 18 months previously. This change had meant that historical data needed to be harmonised before a baseline could be developed.
69. As for the realised costs and benefits of RIDDOR 2012 and RIDDOR 2013, these have compared the actual figures (as discussed above) to those estimated within the respective impact assessments (see Tables 1 and 2 at Appendix ??). The actual figures were supplied by HSE's Statistics and Epidemiology Team (SET). Please note that unit costs (such as staff salaries and day rates, processing costs) have not been changed to reflect 2018 prices – this is to ensure that the figures are suitably transparent and comparable. Therefore any findings have used the same base as the original impact assessment figures.
70. The impact assessment for RIDDOR 2012 estimated that the cost of the changes would be £324 thousand, with the majority being one-off transitional costs associated with businesses and regulators altering their systems. The actual figures are slightly higher (at £330 thousand) principally due to higher staff costs involved in converting the new over 7-day figures into a suitable format for Eurostat. The increase in costs is, however, balanced by an increase in the annual benefits due to the changes, with nearly £38 thousand in additional savings. While the actual reduction in RIDDOR reports was virtually 'spot-on', the number of reports submitted electronically was less than anticipated. This meant that savings from not having to complete and send in RIDDOR reports was enjoyed by more businesses.
71. The actual figures for RIDDOR 2013 indicate an increase in costs and reduction in benefits compared to the estimates originally proposed in the impact assessment. The main driver for the £30 thousand cost increase was the higher than expected costs borne by HSE of altering the collection and collation of statistics, both in terms of staff time and Information and Communications Technology (ICT). Annual benefits also fell, by over £82 thousand. This fall is almost wholly a function of the lower than expected reduction in the number of RIDDOR reports (7,900 rather than 11,500), as the other estimates of the benefits were broadly correct (e.g. number of electronic notifications, percentage of reports dealt with by HSE and local authorities).

***Industry-specific regulations in RIDDOR 2013***

72. The vast majority of changes under RIDDOR 2012 and RIDDOR 2013 are applicable to all duty-holders. Yet there are a number of industry-specific regulations under RIDDOR. To this end, it is necessary to consider how these regulations have affected the industries in question (and to move away from the PIR-focused questions as detailed in Diagram 2 'Structure of RIDDOR 2013 PIR'). The industry-specific regulations included in this review are:

- Regulation 10: Disease Offshore
- Regulation 11: Gas-related injuries and hazards
- Regulation 13: Mines, quarries and offshore site disturbance

73. HSE works extremely closely with the offshore industry in terms of its health and safety practices. Following engagement with internal HSE stakeholders, who spoke to their offshore contacts, the general consensus was that there were no significant concerns about the operation of Regulation 10. A number of other RIDDOR-related issues were, however, mentioned. For example, under the Offshore Safe Case regulations 2015 (S.I. 2015/398) there is a direct reporting requirement via the EU Reporting Regulations ((EU) No. 112/2014). This reporting requirement, however, duplicates some of the information already required by RIDDOR. In order to collect the information needed for both the RIDDOR and EU Reporting requirements, HSE has worked with the industry to develop the 'Report of an Oil and Gas Incident' (ROGI) form. This work has developed to the point that the industry is already using a word version of the form and the online version is close to completion.

74. Furthermore, in 2015, RIDDOR was amended to align reporting timescales to ten working days (EU reporting regulation) for offshore dangerous occurrences. Regulation 15 was also amended so that an incident that needed to be reported under more than one requirement could be reported on the same form (the aforementioned ROGI form). In consultation with HSE, the industry reported that there were a few incidents were being missed due to the Regulation 15 change, so HSE will be further amending this regulation in the Health and Safety (Miscellaneous Amendments) Regulations 2017 to correct this oversight.

75. HSE directly engaged with the wider onshore gas industry in order to ascertain whether there were any issues or concerns with RIDDOR 2013 Regulation 11. As such, feedback was received from the Emergency Service Providers (ESP) industry group, Institution of Gas Engineers and Managers' (IGEM) Large Business Forum (LBF) and UK LPG (trade association for the Liquefied Petroleum Gas [LPG] industry in the UK). The gas industry had a number of comments about Regulation 11 and RIDDOR in general, namely:

- There are difficulties with having to report against *"an injury arising in connection with that gas"* requirement, due to issues with detecting and diagnosing carbon monoxide (CO) poisoning. CO poisoning is unlikely to be diagnosed immediately and there is no requirement for the person or hospital to report CO poisoning to the ESP.
- There is some disconnect between the terminology used by the regulations and what industry uses. For instance, the regulations use *"likely to cause injury"* whilst industry tend to use the term *"potential"* when considering the possibility of injury. In addition,



the definition of 'gas fitting' is inconsistent between RIDDOR and other gas-related regulations. For example, Reg. 11(4) of RIDDOR defines 'gas fitting' as including "*any flue or ventilation used*", whereas the definition in Reg. 2(1) of the Gas Safety (Installation and Use) (GSIUR) makes no mention of flue or ventilation. The Gas Safety Management Regulations 1996 (GSMR) - which covers gas conveyors and gas suppliers – references the GSIUR definition of gas fitting, but under Reg. 7 (14) links reports made under RIDDOR 11(1).

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- The reporting and recording procedures for dangerous occurrences place a duty on the "*responsible person*" (Schedule 1(1)), which in domestic premises is difficult to determine.

76. A number of industries are covered under Regulation 13 including mines, quarries and offshore sites. Reflecting the offshore industry's comments about Regulation 10, they also do not have any significant issues with Regulation 13. They do, however, mention that the requirement to report a dangerous occurrence "*forthwith*" is not explicit enough, with most duty-holders not realising it's there and reporting within the standard reporting framework rather than as a matter of urgency. Furthermore, failure of lifting accessories is not currently reportable even though in an offshore environment this may lead to a major accident (e.g. lifting over live plant).
77. Quarries are another industry with which HSE has strong ties. To this end, as part of the PIR, the Quarries National Joint Advisory Committee (QNJAC) was contacted for their views along with HSE quarry policy specialists. The general feeling is that Regulation 13 is widely misunderstood by duty holders in general. Quarries, however, tend to have the specialist knowledge and expertise to effectively determine when an area should, and should not, be disturbed, so HSE takes a pragmatic approach to enforcing via Regulation 13. The regulation also provides the legislative 'back-stop' for health and safety managers to ensure that the site is not disturbed. The industry does, however, miss the approved code of practice (ACOP) which accompanied RIDDOR and its pseudo-legal status. Finally, similar to the gas-industry, quarries would value a proactive response when a RIDDOR report submitted.

#### ***Previous, and general, issues with RIDDOR***

78. Outside out of the PIR questions and industry-specific regulations, a number of other RIDDOR issues were considered as part of the review. These were issues which had either previously been considered in terms of changes to RIDDOR (Regulation 5 – non-fatal injuries to non-workers) or have subsequently been highlighted as a concern following the recent RIDDOR changes (Regulation 8 – occupational diseases).

#### ***Regulation 5: Non-fatal injuries to non-workers***

79. As part of the consultation which led to RIDDOR 2013 it was proposed that non-fatal injuries to people not at work (i.e. members of the public, customers, students, school children, etc.) should be removed as a reporting requirement. This was due to issues with the

interpretation of the threshold for reporting, with anecdotal reports of both under-reporting and over-reporting in particular sectors (the consultation used phrases such as ‘uncertainty’ and ‘anomalies’). The issue of uncertainty can be seen in the comment made in relation to unintended consequences earlier in the evidence review, namely *“Schools and Community Centres find it difficult to establish how to report accidents / incidents to childcare and members of the public”*. HSE therefore engaged with a number of different stakeholders in order to gauge whether there is widespread over-reporting and/or under-reporting, and whether there was an appetite to revisit the RIDDOR 2013 consultation proposal to remove the regulation completely. As well as survey work, the review consulted with HSE specialists and stakeholders in health, education, local authorities and the leisure sector.

Research instrument	No. of respondents	Evidence
On-line survey of local authorities as duty-holders (facilitated by Local Authority Practitioners’ Forum [LAPF])	<i>n</i> = 138	*In terms of over-and under-reporting due to regulation 5 (non-fatal injuries to non-workers the response was decidedly mixed with no clear majority – ‘some over-reporting’ (35%); ‘no over-reporting or under-reporting’ (25%); and ‘some under-reporting’ (25%). *Yet two-thirds (63%) indicated that reporting injuries to members of the public should not be removed from RIDDOR.
On-line survey of education providers	<i>n</i> = 53	*About half of respondents (49%) indicated that there was ‘some over-reporting’ with Regulation 5, while a further quarter (29%) said that there was ‘no over-reporting or under-reporting’. *Nearly two-thirds (63%) of respondents said that they disagreed with the suggestion that non-fatal injuries to non-workers should no longer be reportable. This compares to a quarter (27%) who agreed with the statement about removing reporting requirements for injuries to members of the public.
On-line survey of healthcare providers	<i>n</i> = 10	*Nearly two-thirds (62.5%) of respondents indicated that there was ‘some under-reporting’ within Reg. 5 with the other three respondents choosing ‘massive over-reporting’, ‘some over-reporting’ and ‘no over-reporting or under-reporting’, respectively. *Over half (56%) of respondents indicated that they ‘strongly disagreed’ with the suggestion to stop reporting non-fatal injuries to non-workers (Reg. 5).
Local authority as H&S regulators online survey	<i>n</i> = 80	*In respect of RIDDOR 2013 regulation 5 (work injuries to members of the public), while a third of respondents indicated that there is some under-reporting (35%) and some over-reporting (34%), over half (54%) ‘strongly disagreed’ with the suggestion that regulation 5 should be removed.

80. There is a real mix of views about whether there is under- or over-reporting within specific sectors. This suggests that there may be pockets of both over-reporting and under-reporting dependent on the policies of particular workplaces. What there is very little appetite for, however, is the complete removal of reporting injuries and illnesses via Regulation 5.

81. The view from HSE’s education policy team is that queries about RIDDOR tend to focus on uncertainty around whether an injury to a visitor or pupil ‘arises out of or is in connection

with work' and therefore is reportable. Whether it is a work activity is, in turn, related to whether there was failure in the level of supervision or the condition of the premises. Furthermore, injuries to pupils and visitors are only reportable if the person is taken directly from the scene of the accident to hospital for treatment. These issues are particularly problematic in relation to violence in schools (pupils and staff), sports activities and science activities. Due to these uncertainties, a RIDDOR report will often be submitted unnecessarily.

82. These views are echoed by CLEAPSS – which provides support for practical science and technology in schools and colleges – which suggests basing the requirement on whether the casualty is 'taken from the site of the accident to a hospital for treatment in respect of that injury' means having to rely on the employer to judge whether or not treatment is likely to be needed. This lack of clarity is not helpful, because most employers are not medically qualified. One possible solution would be to re-word Regulation 5 to say *"Where any person not at work, as a result of a work-related accident, suffers— (a) an injury of a similar level of severity as those listed in Regulation 4(1), and that person requires treatment in respect of that injury at the site or on removal from the site to hospital or similar medical facility...."*
83. The issue of confusion and lack of clarity is one which also faces the leisure sector. For example, the Adventure Activities Licensing Service (AALS) asks when a child on a school visit has an accident at an adventure centre, should both the school and centre report it? In addition, the latest RIDDOR guidance has lost the guidance that diagnostic tests such as x-rays, scans, etc. do not count as treatment for the purposes of RIDDOR. Finally, sometimes the last thing an activity centre sees or hears of a particular child following an accident is when he or she is taken away by ambulance, possibly accompanied by a teacher or parent. What, if anything, should the activity centre report?
84. Staying in the leisure sector, fairgrounds have a particular issue with the current RIDDOR Regulation 5 reporting structure. Following discussions with HSE's entertainment and leisure sector team and the Amusements Devices Safety Council (ADSC) the requirement that a RIDDOR report needs to be produced when someone suffers *"an injury, and that person is taken from the site of the accident to a hospital for treatment in respect of that injury"* has proved problematic. For instance, it is difficult for the fairground to ascertain whether the person has gone to hospital and, if so, whether they received treatment. As such, the fairground tends to complete a RIDDOR report in order to be 'on the safe side'. This has led to over-reporting. HSE current guidance thereby recommends that fairgrounds wait to complete a RIDDOR report until they are certain what's happened to the injured person. Any queries about the reporting delay are explained by reference to ensuring that the production of a RIDDOR report is absolutely necessary. This message is currently being promoted via engagement with the industry and HSE inspectors.
85. In addition, those leisure operators whose business includes rides are currently struggling with a public perception issue partially caused by RIDDOR. At the moment fairground injuries are reported under SIC code 9321 ('activities of amusement parks and theme parks'), with there being about 421 such injuries reported under RIDDOR in 2015/16. In fact only about seven and a half per cent of these injuries (about 15 or 16) actually relate to amusement or theme

parks rides; the rest relate to injuries sustained at hotels, shops, eateries, bars, etc. which are located at these parks (e.g. all the non-ride offerings at Alton Towers). The main reason for such incidents being coded in this way is due to the RIDDOR reporting system being structured so as to 'lead' respondents to use the wider 9321 SIC code. Work is, however, currently on-going with HSE's Statistics and Epidemiology Unit (SEU) to provide a wider list of options for theme park respondents to use when completing a RIDDOR report; this should allow respondents to select 'hotel' or 'restaurant' instead of 'amusement park' as the location of the incident.

86. The over-riding consensus from the evidence is that Regulation 5 should be retained, but made clearer in terms of exactly what is and what isn't reportable. It can be seen that the principle function of only generating a RIDDOR report where the injured person goes to hospital for treatment is to ensure that incidents of a suitable seriousness are captured. To this end, there seems to be scope to suggest that Regulation 5 should be reviewed in terms of making it more directly reflect seriousness of injury. For example, Regulation 4 'non-fatal injuries to workers' defines seriousness by explicitly specifying what injuries are reportable.
87. If the requirement to report under Regulation 5 was simplified and the reference to ambulances and hospitals was replaced by a similar reference to Regulation 4's 'specified injuries', what potential effect could this have? Such a change would mean that the provisions for workers and non-workers would broadly reflect what they were in RIDDOR 1985, with 'major injuries' applicable to both. If figures for pre- and post-RIDDOR 1996 are considered – which is where the RIDDOR 1985 provisions for workers and non-workers diverged, with non-workers moving towards the current requirement – HSE received roughly 12,000 reports annually under RIDDOR 85, which approximately doubled to 24,000 annually under RIDDOR 95. The bulk of the increase was as expected in terms of industries, like education, accommodation and leisure (i.e. sectors with significant contact with high levels of non-workers).
88. At the moment HSE currently receives around 34,000 reports under Regulation 5 of RIDDOR 2013. A large percentage of these are, however, technically non-reportable. That aside, roughly half of those use the definition of 'specified injury', i.e. fractures, followed by the likes of amputations, head injuries, burns, multiple injuries. It would therefore be reasonable to estimate that the number of reports would 'halve' (to 17,000) by restricting Regulation 5 reporting to the Regulation 4 definition of 'specified injuries'.

#### *Regulation 8: Occupational diseases*

89. As part of the RIDDOR 2013 regulatory changes the number of occupational diseases which are reported under RIDDOR was reduced from 47 to eight. The reason for this was that *"occupational disease reporting levels are extremely low, the information being so incomplete that it is not regarded as an appropriate data set for statistical analysis"*. Yet members of HSE's Centre for Workplace Health highlighted that the reduction in reportable occupational diseases was potentially leading to significant and life-changing ailments not

coming to the attention of HSE. It was therefore considered worth investigating as part of the PIR process.

90. To provide context to why the number of reportable occupational diseases was reduced, the RIDDOR 2013 consultation detailed the following figures:

- HSE receives around 1,600 reports of occupational diseases every year and local authorities (LAs) about 200 nationally (i.e. less than one report for every authority). Of the 1,600, around 850 were cases of hand arm vibration syndrome (HAVS), 240 were occupational dermatitis and 60 cases of occupational asthma. Figures are not available for LAs' work, but HSE investigates around 450 of these (29%). Of those investigated by HSE, just over 200 (45%) were HAVS cases, around 70 (15%) were cases of occupational dermatitis and 27 (6%) were occupational asthma.
- In addition, occupational disease reporting levels are so low, with the information being so incomplete, that it is not used for statistical purposes, with data from the labour force survey (LFS), The Health and Occupation Research Network (THOR)<sup>21</sup> and Industrial Injuries Disablement Benefit (IIDB)<sup>22</sup> used instead.

91. As to how duty-holders view the change in reportable occupational diseases, the following surveys found:

Research instrument	No. of respondents	Evidence
Omnibus B2B survey	<i>n</i> = 2102	If 'don't know' responses are removed, 68% of duty holders viewed the reduction in industrial diseases classifications from 47 to eight positively.
On-line survey of people completing on-line RIDDOR reports	<i>n</i> = 462	In commenting on the RIDDOR 2013 changes, 85% of respondents were positive about the reduction in industrial diseases classifications from 47 to eight.
Local authority as H&S regulators online survey (undertaken via HELEX)	<i>n</i> = 80	Local authorities seem to use occupational disease data, with 38% of local authority respondents indicating that they 'always' use occupation diseases data (individual cases) .

92. In addition, a number of stakeholders indicated that rather than collecting occupational disease data (which may be many years after the initial exposure) RIDDOR could/should be used to capture ill-health precursor information (e.g. exposure data, health surveillance data). This would allow for early intervention and be more preventative action.

93. The conditions which are now not-reportable following RIDDOR 2013 include ionising radiation-related and EM radiation-related illnesses, hyperbaric exposure, poisoning, certain

<sup>21</sup> <http://research.bmh.manchester.ac.uk/epidemiology/COEH/research/thor/>

<sup>22</sup> <https://www.gov.uk/industrial-injuries-disablement-benefit>

skin conditions and certain respiratory conditions. More specifically, data on the following diseases are now not collected – occupational extrinsic allergic alveolitis, pulmonary barotrauma, silicosis, lead overexposure and decompression illness.

94. Looking at the pre-2013 RIDDOR three-year average occupational disease figures to 2012, it appears that the occupational diseases which have been retained via RIDDOR 2013 reflect those which are most prevalent. In contrast, the serious ailments detailed above have very low numbers. It could therefore be argued that there is a need for reportable occupational diseases to be based more on the severity of harm rather than purely on the prevalence of disease. This is particularly true of those ailments which are currently the focus of the lung disease strand of HSE's new Health & Work programme (e.g. silicosis).

<b>Count of Disease Desc (three-year total until 2012)</b>			
<b>Disease Desc (several DO types excluded if no reports made in the time period)</b>	<b>Total</b>	<b>Actual%</b>	<b>Average per year</b>
HAVS	2585	46.5%	862
Dermatitis	717	12.9%	239
Carpel Tunnel	645	11.6%	215
Cramp hand/forearm	579	10.4%	193
Tendonitis	267	4.8%	89
Asthma	167	3.0%	56
Any infection due to micro-organisms	133	2.4%	44
Bursitis/Elbow	96	1.7%	32
Tuberculosis	59	1.1%	20
Lyme disease	41	0.7%	14
Leptospirosis	31	0.6%	10
Poisonings - specific	27	0.5%	9
Legionellosis	25	0.5%	8
Bursitis/Knee	23	0.4%	8
Hepatitis	20	0.4%	7
Chickenpox (offshore)	18	0.3%	6
Decompression	14	0.3%	5
Ionising radiation - skin	14	0.3%	5
NK	14	0.3%	5
Mesothelioma	11	0.2%	4
Pneumoconiosis	11	0.2%	4
Beat hand	8	0.1%	3
Extrinsic alveolitis	8	0.1%	3
Lung cancer (silica)	7	0.1%	2
Misc.	34	0.6%	8
<b>Grand Total</b>	<b>5554</b>	<b>100.0%</b>	<b>1851</b>

95. Furthermore, any review of which occupational diseases should be reportable under RIDDOR could consider how the most prevalent of diseases (those currently in Regulation 8) would fit if the criteria was based on 'severity of harm'. For instance, would the current list of reportable disease simply be supplemented by an additional list of more serious ailments?

Or would some of the current reportable diseases be considered outside of the ‘severity of harm’ focus?

96. Any increase to the list of reportable diseases in Regulation 8 would, however, increase the number of RIDDOR reports received. In order to provide a rough estimate of the additional number of reports which would be generated with such a change, HSE’s Statistical and Epidemiological Team (SET) analysed figures for 2012/13 – prior to the RIDDOR 2013 reduction in reportable categories – to consider the prevalence of the proposed additional disease categories. Based on this rough analysis, there may be another 25 RIDDOR reports a year. These reports would, however, be for diseases which are more serious in terms of harm and which HSE, as the regulator, should be aware of.

Disease name	RIDDOR ‘Type’ (95 Regs)	Latest full-year count 12-13	Comments on actual data retrieved
pneumoconiosis (e.g. silicosis)	Type 39 – pneumoconiosis (excluding asbestosis)  [subject to a detailed list or associated work activities eg ‘mining/working/quarrying of silica rock’]	5	
extrinsic allergic alveolitis	Type 46 - Extrinsic alveolitis (including farmer’s lung)	3	
decompression illness	Type 5 – Decompression Illness	10	Mainly diving-related; onshore (eg training) as well as offshore
pulmonary barotrauma	Type 6 – Barotrauma resulting in lung or other organ damage	2	Not necessarily ‘pulmonary’
poisoning due to certain chemical exposures	Type 28 – Poisonings by any of the following [list of 15 substances, including lead]	3	All are lead poisoning (only). Additionally, a small handful of ‘poisonings’ were reported as ‘workplace injuries’, eg carbon monoxide; also various lacerations resulting in ‘blood poisoning’.

97. The review of Regulation 8 should focus on risk-based, as opposed to prevalence-based, considerations in terms of what occupational diseases should be RIDDOR reportable. The system should also be flexible enough to react to new and emerging diseases. This sort of flexibility could be achieved by moving the list of reportable occupational diseases out of the main body of regulation to a reviewable Schedule (similar to the 'Approved List' of biological agents under COSHH 2002).

*Other issues*

98. A number of stakeholders identified changes to the online RIDDOR form which would provide additional granularity. For example:
- HSE's education team find it difficult to extract useful information from RIDDOR due to the fact that the SIC codes used do not allow for the recording of the governance structure of the school in question – e.g. part of a multi-academy trust (MAT); free school; etc.
  - On reviewing a RIDDOR report, it is not straight forward for duty-holders or regulators to subsequently change its status on the system to non-reportable.
  - Once a RIDDOR report is submitted, it is not possible to go back, make revisions and update the details. For example, if a serious injury is reported but the person dies at a later date, this will result in two RIDDOR reports.
  - The HSE Education team receive a number of requests for information about asbestos in schools. Yet the current system does not include the ability to record asbestos when making a RIDDOR report under regulation 7 'dangerous occurrences'; it simply comes under the Schedule 2, clause 10 requirement to report "[a]ny accident or incident which results or could have resulted in the release or escape of a biological agent likely to cause severe human infection or illness".
  - The gas industry report that the RIDDOR web-page for reporting a gas-related issue could be improved by: allowing photos to be attached to the RIDDOR report or include a tick box which indicates that photos are available; and including more aspects of gas work (at the moment it only stipulates 'service' or 'installation', and doesn't include 'repair').
  - In addition, the gas industry has mentioned that the guidance about how gas engineers should complete RIDDOR reports could be revised in order to make it clearer and simpler.
99. As detailed previously, a number of other regulators currently use RIDDOR data, specifically Office of Rail and Road (ORR), Office for Nuclear Regulation (ONR) and the Care Quality Commission (CQC). While ORR receives RIDDOR reports directly, both ONR and CQC are sent relevant RIDDOR reports which are received and processed by HSE and local authorities (LAs). The processing costs of doing this are currently borne by HSE, even though the other enforcing authorities (EA) receive the benefits. The majority of the costs involved are HSE and LA staff handling time, in manually identifying CQC-relevant reports, and manually forwarding the relevant reports to CQC via secure email. This is done report-by-report, as all 'CQC/ONR' reports initially default to HSE or LA, and manually forwarded to CQC/ONR. This



process cannot easily be automated. At the moment, ONR receive 0.08% of all reports made directly to HSE, and CQC just over 2%. It is questionable whether HSE should bear the costs, direct and indirect, for processing RIDDORs where HSE is not the EA, especially in relation to the CQC given the volume of reports they receive. While the volumes are not huge in absolute terms, in a time of constrained resources it is difficult to argue for the retention of this historical agreement. A possible solution would be to move CQC-related incidents out of scope of reporting via RIDDOR.

<b>All reports made to HSE system per year (2016/17)</b>	<b>123800</b>	
Of which, enforced by:		
ONR	100	0.08%
HSE (FOD and HID)	80600	65.1%
LA	43100	34.8%
<i>(Of which, CQC-related reports are roughly 2500)</i>		<i>2.02%</i>

## SUMMARY

100. Based on the evidence which has been collected, collated and analysed for the RIDDOR PIR, the following broad conclusions are supported:
- RIDDOR has largely met its overriding objectives, with duty holders, stakeholders and regulators believing that RIDDOR is ‘fit for purpose’.
  - While there are alternative data sources providing aspects of what RIDDOR collects, none of them offer the breadth and scope of coverage of RIDDOR and none have the same legislative weight as RIDDOR.
  - As for potential alternatives to RIDDOR, none are suitably feasible (in practical or financial terms) to justify replacing RIDDOR.
  - The RIDDOR 2012 and RIDDOR 2013 changes have, again, largely met their objectives.
  - Duty holders, stakeholders and regulators are broadly positive about the changes in RIDDOR 2012 and RIDDOR 2013.
    - While a number of issues have been raised in terms of RIDDOR in general, and the changes within RIDDOR 2012 and RIDDOR 2013, none are so fundamental as to undermine the positives associated with the regulations.

## Implementation in other European Member States

### Senior Labour Inspectorate Committee (SLIC)

1. The UK asked member states how they implemented into their own domestic legislation the requirement for employers /duty holders to report:

- Non-fatal injuries to workers;
- Work-related fatalities;
- Dangerous occurrences;
- Occupational diseases; and
- Exposure to carcinogens, mutagens and biological agents.
- In addition, as an EU Member State, how do they record and keep statistics on workplace fatalities and accidents.

2. Of the 28 member states in the EU we got 8 responses from Netherlands, Estonia, Finland, Bulgaria, Sweden, Romania, Latvia and Slovakia. The table below details what each respondent state records under their respective reporting regime.

	Non-fatal injuries to workers	Work-related fatalities	Dangerous occurrences	Occupational diseases	Exposure to carcinogens, mutagens and biological agents	Absence from work following accident	Record and report statistics
Netherlands	✓	✓		✓	✓	Over 3 days	
Estonia	✓	✓	✓	Only a Doctor can report occupational disease	✓		✓
Finland	✓	✓	Only where it involves a 'biological agent'	Only a Doctor can report occupational disease	✓		✓
Bulgaria	✓	✓		Only a Doctor can report occupational disease	✓		✓
Sweden	✓	✓	✓	✓			✓
Romania	✓	✓	Only where it results in material damage	✓	✓		✓
Latvia	✓	Report to Police &	Only where it involves a	Only a Doctor can report occupational	✓		✓

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		Labour Inspectorate	'biological agent'	disease		Over 3 days	
Slovakia	✓	✓	✓	✓	✓		✓

3. Although a limited number of responses were received, a picture emerges of a consistent approach in reporting workplace injuries, fatalities, occupational disease and exposure to carcinogens. Only two respondent member states record absence from work following an injury (over 3 days). No respondent member states report non-fatal injuries to non-workers (Regulation 5 of RIDDOR in the UK)

4. Great Britain has had a statutory requirement to report death and injuries in the workplace since 1980, superseding previous requirements under the Factories Act 1961. RIDDOR remains a robust and reliable reporting system which when weighed against other comparable reporting regimes suggests that the regulations remain fit for purpose.