Health and Safety Executive's consultation: proposed amendments to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

Response from the Society of Occupational Medicine (SOM)

Last updated: 24 June 2026

Introduction to the Society of Occupational Medicine
The Society of Occupational Medicine (SOM) is the leading UK organisation for healthcare professionals with an interest in health and work. Our members typically work in the field of occupational health (OH). SOM and its members work across the UK to improve participation in the workplace by disabled people. SOM is committed to working with employers and employees to promote a healthier workforce. Greater workforce participation and improved productivity are also aligned with the Government's focus on increasing growth. High-quality health and work expertise is a vital ingredient to support HSE's strategy on prevention, ensuring safe workplaces and improving wellbeing at work, and therefore promote economic growth by increasing workforce participation.

RIDDOR is the primary statutory mechanism through which regulators receive individual-level data on work-related ill health, it underpins both occupational health practice and regulatory enforcement. SOM has drawn on the expertise of its members in preparing this response, who include occupational physicians, OH nurses, and specialists in specific diseases and occupational health policy.

We have focused our response on the areas where our members' expertise is most directly relevant:

- the expansion of the occupational disease list (Proposal 2),
- the broadening of the accepted diagnosis definition (Proposal 3),
- improvements to the reporting process (Proposal 5), and
- a number of concerns that fall outside the individual proposals but which we consider material to the integrity of the RIDDOR framework.

Executive summary
SOM supports the direction of the proposed amendments and recognises the importance of bringing RIDDOR up to date. However, we have concerns in the following areas:

- The consultation underestimates the additional workload that the proposed changes would generate for OH practitioners, employers, and HSE itself. HSE's own published incidence data for the relevant conditions is an order of magnitude higher than the figures used in the cost-benefit analysis, and this discrepancy demands explanation before final decisions are made.
- The proposal to broaden who can issue a valid diagnosis for RIDDOR purposes directly contradicts existing HSE guidance in several key areas, most clearly in relation to vibration-related disease (L140). SOM supports recognising a wider range of practitioners, but only where they hold appropriate occupational health competence.
- We consider that work-related suicide warrants further and more substantive consideration for inclusion within RIDDOR.
- The consultation does not address sexual assault and rape in the workplace within the RIDDOR framework. SOM considers this a significant omission and recommends that Regulation 4 be amended to capture these incidents explicitly.
- The confidentiality and consent implications of broader practitioner reporting require careful consideration and explicit guidance before any legislative change is implemented.

Proposal 2: Revised list of reportable occupational diseases

Responds to: Q17 – Agree/disagree with proposed occupational disease list | Q19 – Opportunities to use additional data to reduce risks (I will tick 'strongly agree' for all for consistency)

We support the principle of expanding the list of reportable occupational diseases. We agree the current six-condition list is inadequate. The case study around accelerated silicosis, where HSE cannot identify affected workplaces because silicosis is not currently reportable, illustrates precisely the regulatory blind spots that a broader list should address.

We support the reintroduction of conditions previously removed following the Löfstedt review, including asbestosis, pneumoconiosis, and hand-arm vibration syndrome (HAVS). We also support the addition of conditions reflecting modern hazards such as bronchiolitis obliterans.

Responds to: Q20 – Unintended consequences of revising the disease list | Q43 – Comments on the cost-benefit analysis

The workload estimates are not credible

We have significant concerns about the cost-benefit analysis underpinning Proposal 2. The estimated additional reports of around 797 per annum (p.40 of the consultation document) appear substantially inconsistent with HSE's own published incidence data.

For example, the consultation estimates approximately 100 additional reports per annum (p.40 of the consultation document) for noise-induced hearing loss (NIHL). However, HSE's own published statistics record around 15,000 cases of hearing problems caused or made worse by work each year.[1] HSE also records approximately 22,000 new cases annually of self-reported breathing or lung problems caused or made worse by work.[2] Even allowing that not all such cases would meet the RIDDOR reporting threshold, the gap between these figures and the consultation's modelled estimates is striking. This requires explanation and revision.

Our concerns are not just analytical. If the actual volume of new reports is substantially higher than the 797 mid-point estimate, then the administrative burden on employers, OH services, and HSE's processing capacity would be significantly greater than the consultation assumes.

We urge HSE to provide a clear reconciliation of these figures before the policy is finalised, and to model a realistic range of scenarios informed by published incidence data.

Responds to: Q20 – Unintended consequences of revising the disease list

Standardised diagnostic criteria are essential

We strongly support the application of standardised diagnostic criteria for each condition on the expanded list. Without consistent criteria, the same clinical presentation could be reported by one employer and not another, undermining the data quality that RIDDOR is designed to deliver. Inconsistent diagnoses would also create disproportionate compliance costs: an incorrect diagnosis triggering a RIDDOR report can generate enforcement action and personal injury litigation, with significant consequences for employers, particularly SMEs.

[1] https://www.hse.gov.uk/statistics/causdis/deafness/index.htm
[2] https://www.hse.gov.uk/statistics/assets/docs/respiratory-diseases.pdf, p.12

Responds to: Q18 – Other occupational diseases which should be included

Work-related stress and suicide

We accept that work-related stress (WRS) presents genuine definitional and attribution challenges, so we do not oppose its exclusion from the list. However, we would want suicide to be RIDDOR-reportable, and do not think HSE's case for excluding work-related suicide is sufficient.

We understand HSE's rationale is that determinations of causation rest with Coroners and Procurators Fiscal, and that requiring employers to attribute a death to work-related factors would pre-empt these processes. But this does not fully engage with the question. RIDDOR does not require employers to make definitive causal findings; it requires them to report incidents where work may be a relevant factor. A threshold analogous to that used for dangerous occurrences (reasonable grounds to believe work was a contributory factor) could be designed without requiring employers to make determinations that are properly within judicial competence.

We recommend that HSE commission a dedicated review of whether, and how, work-related suicide could be incorporated into RIDDOR or a parallel reporting mechanism.

Proposal 3: Broadening the scope of accepted diagnosis

Responds to: Q21 – Agree/disagree with broadening the definition of 'diagnosis' | Q21a – Explanation

We support the principle of broadening the range of practitioners whose diagnosis can trigger a RIDDOR report. Many workers with occupational diseases are first assessed by practitioners other than GPs. Requiring a further GP appointment solely for RIDDOR purposes can create unnecessary delays and burdens on primary care. As such, the direction of this proposal is sensible.

However, we have concerns about the failure to distinguish between general professional registration and occupational health competence in this proposal. There is a lack of clarity in the document around the definition or application of a 'competent person'.

Responds to: Q21a – Explanation for response | Q27 – Unintended consequences of broadening diagnosis scope

The proposal risks confusion and contradicting existing HSE guidance

For several of the conditions proposed for inclusion in the revised disease list, HSE's own guidance already specifies who is competent to make a diagnosis for regulatory purposes. Indeed we wish to preserve clarity that practitioners without OH competence may collect data but are not allowed to interpret results. The consultation document is unclear on this point, stating both that registered nurses or physiotherapists may 'reasonably by able to diagnose some of the occupational diseases listed" (consultation document, p.42), but then state that "a diagnosis is only valid and accepted under RIDDOR if it is…given by a GMC registered and licensed doctor" (ibid,.p.43).

This inconsistency is not resolved in the consultation document. It likely would, if implemented as drafted, create significant confusion for practitioners and employers, for example in relation to HAVS where Guidance L140 applies. We understand that HSE has previously resisted suggestions that practitioners without OH qualifications and disease-specific training should be able to diagnose vibration-related disease for surveillance purposes. This proposal appears to confuse that position.

Responds to: Q21a – Explanation for response | Q27 – Unintended consequences

Pre-existing anomaly in current rules

We note also that there is a pre-existing anomaly in the current rules: any GMC-registered doctor without an OH qualification or specialist HAVS training is technically able to issue a

diagnosis for RIDDOR purposes. This applies even where L140 Guidance to the Control of Vibration at Work regulations 2005)[3] would require specialist competence for the equivalent health surveillance function. The proposed changes would extend and entrench this existing inconsistency rather than resolve it. **We would urge HSE to use this opportunity to address both the pre-existing anomaly and the new one created by the proposals, by adopting a competence-based approach across the board.**

The fit note analogy is limited

The consultation draws an analogy with the 2022 extension of fit note certification rights to registered nurses, physiotherapists, pharmacists, and occupational therapists as part of cost benefit analysis. We think this is a limited comparator to be treated with some caution as to what these changes would do to reporting numbers. Fit notes do not always reliably reflect true pathology or work-relatedness. We feel that work relatedness in the areas of mental health and musculosketetal conditions often falls better into a 'work attributed' category rather than truly 'work related.'

Responds to: Q21a – Explanation | Q25a – Impact on healthcare practitioner practice | Q26a – Additional guidance/support needed

SOM's recommended approach

We recommend that the proposals be amended so that the range of practitioners authorised to make a RIDDOR diagnosis is linked to demonstrated occupational health competence, not merely registration with a professional body. Specifically:

- For conditions where HSE guidance already specifies competency requirements, only practitioners meeting those requirements should be authorised to issue a diagnosis sufficient to trigger a RIDDOR report. These conditions would include HAVS, asbestosis, decompression illness, and other conditions requiring specialist OH assessment
- For other conditions, broadening to include OH-qualified nurses, OH physiotherapists, and occupational physicians would be appropriate and proportionate.
- The term 'registered nurse' as used in the proposal should be explicitly distinguished from 'OH-qualified nurse' in the legislation and associated guidance.
- HSE should consider whether occupational therapists (OTs) should also be recognised. OTs are included in the fit note framework and frequently work with workers experiencing functional limitations.

Any legislative change should be accompanied by detailed guidance setting out the competency requirements for each disease category on the revised list.

Responds to: Q27 – Unintended consequences of broadening diagnosis scope

Confidentiality and consent

Broadening the scope of diagnosis will increase the volume of personal and medical information flowing from practitioners to employers and then to HSE. Under current arrangements, this flow is mediated by the confidentiality obligations of the medical profession. Where individuals without formal medical confidentiality training handle sensitive diagnostic information (for example, some employer representatives and administrators involved in the reporting chain), there is a genuine risk of inappropriate disclosure.

We recommend that HSE develop explicit guidance on patient consent for RIDDOR reporting and on the confidentiality obligations of all parties in the reporting chain. This should be published and in place before any legislative change comes into force.

Proposal 4: Revised list of dangerous occurrences — sexual assault and rape in the workplace

[3] https://www.hse.gov.uk/pubns/priced/l140.pdf

Responds to: Q29 – Other dangerous occurrences which should be included | Q47 – Further comments on RIDDOR regulation

We support the principle of updating Schedule 2 to capture risks from emerging sectors, including geothermal energy, offshore wind, and new chemicals and explosives. However, the consultation misses an important opportunity by failing to address sexual assault and rape in the workplace within the RIDDOR framework.

Physical violence resulting in injury may be reportable under existing provisions, but sexual assault including rape is not specifically recognised in RIDDOR or its associated guidance. This is a significant gap. Work-related sexual violence causes serious and lasting harm to victims. It is also an indicator of serious failures in workplace management and culture that the regulator has a legitimate interest in understanding and responding to.

Alternative data sources, such as criminal convictions, court proceedings, and employment tribunal cases, are partial. They are also heavily constrained by the use of non-disclosure agreements, which limits their utility for regulatory intelligence purposes.

We recommend that Regulation 4 be amended to include rape and serious sexual assault within the list of reportable workplace incidents, and that HSE develop associated guidance to support consistent reporting. This should not require the incident to have resulted in seven or more days' incapacitation.

We acknowledge that 'rape' is a criminal law finding rather than a clinical determination. Associated guidance should make clear that the reporting obligation arises where the responsible person has reasonable grounds to believe that a serious sexual assault has occurred in connection with work, not that they are required to make a legal determination of the offence committed. This approach is consistent with how other categories of dangerous occurrence are framed, where the test is reasonable belief rather than certainty.

Proposal 5: Improving the reporting process

Responds to: Q34 – Agree/disagree with proposed amendments to the reporting form (I'll put 'agree' on the multiple choice answers for consistency)

We support HSE's efforts to improve the usability of the RIDDOR reporting form and to reduce both under-reporting and over-reporting. The practical improvements identified in the consultation are sensible and should be implemented, including clearer routing questions, improved embedded guidance, and exploration of automated reporting.

However, we are cautious about reforms that treat simplification as an end in itself. Accurate RIDDOR reporting depends on the person completing the form understanding whether an incident meets the reporting criteria - not simply on the form being easy to fill in. Where an employer lacks access to qualified OH advice, a simpler form may make it easier to submit a report without making it more accurate.

In some of our members' experience, employers who have access to qualified OH advice do not generally find it difficult to make RIDDOR reports when the criteria are clearly met. This suggests that the primary barrier to accurate and timely reporting is not the complexity of the reporting form, but the availability of competent OH advice at the point of decision. Simplification of the form is of course welcome, but it is not a substitute for ensuring that employers can access qualified OH support.

Responds to: Q35 – Future digital reporting features | Q37/38 – Automated reporting systems (I'll add the automated reported as 1, and the others as 2 unless you would like me to do otherwise)

Automated reporting

We support HSE's proposal to explore re-enabling automated reporting from employers' own health and safety management systems. This has real potential to reduce administrative burden for larger employers and to improve data timeliness. That said, we note that automated systems must be configured to apply current RIDDOR criteria, and that these systems will require updating when the criteria change following this consultation. HSE should engage with employers and software providers early to ensure a smooth transition.

Responds to: Q34a – If disagree, explain | Q44 – Unintended consequences not covered elsewhere

Risk of simplified diagnostic language generating inaccurate reports

SOM members have raised a specific concern about the proposed simplified description of noise-induced hearing loss as 'hearing loss caused by loud sounds'. This represents a simplification of the clinical and legal test for occupational NIHL. A simplified threshold, combined with easier reporting, risks triggering reports that do not meet the clinical standard. This could in turn lead to unwarranted enforcement action and greatly increase litigation costs for employers who have in fact managed noise risks appropriately.

Responds to: Q42 – Familiarisation time per person | Q43 – Comments on the cost-benefit analysis

Cost-benefit analysis and familiarisation

Our primary concern with the cost-benefit analysis has been set out above in relation to Proposal 2: the estimated number of additional reports appears to be substantially inconsistent with HSE's own published incidence data. This likely underestimates the knock-on implications for the estimated costs to businesses set out in the consultation document, all of which assume a modest increase in reporting volume.

Contact details

For more information, or to discuss any of the points raised above, please contact Nick Pahl, CEO, Society of Occupational Medicine: nick.pahl@som.org.uk