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7 April 2026

Mr [redacted]
Chief Executive Officer
South East Water Plc
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Dear [redacted]

SECURITY AND EMERGENCY MEASURES EVENT

Location: **Tunbridge Wells, Kent**
Nature: **Loss of Supplies and Media Interest – (Pembury works)**
Date of event: **29 November 2025**

1. Introduction

1.1 The purpose of this letter is to inform you of the conclusions and recommendations arising from the Drinking Water Inspectorate's (the Inspectorate) assessment of the event involving loss of supplies and issuing a boil water notice in the Tunbridge Wells, Kent area.

1.2 When notified of an event, the Inspectorate gathers information considered to be relevant and assesses this in conjunction with information provided by South East Water (the company) about the circumstances of the event and any actions taken. The Inspectorate then considers the way in which the event was handled, whether any breaches of the Security and Emergency Measures Direction (SEMD) 2022 (as amended) (the Direction) occurred, and whether potential offences under the Water Industry Act 1991 (the Act), may have been committed. This event assessment letter should be read in conjunction with the Inspectorate's water quality event assessment letter.

1.3 The company notified the Inspectorate of this event on 30 November 2025. The Inspectorate's SEMD conclusions and recommendations are set out below.

Contents

2. Executive summary

2.1 This document sets out the Inspectorate's assessment of the major loss of supply and associated boil water notice (BWN) that affected up to 60,170 consumers supplied by Pembury water treatment works in the Tunbridge Wells area from 29 November 2025. The assessment **concludes** that the event was foreseeable, preventable, and the result of long-standing weaknesses in South East Water's (the company) emergency preparedness, operational resilience, data quality, and incident management.

2.2 There was a water quality incident at Pembury works which shut down the works and drained the supplying service reservoirs. This led to a loss of supply event and later a BWN when water was supplied which was not fully meeting the requirement of regulation 26(1). Further details on the cause and remediation of this event can be found in the water quality letter for this event.

2.3 The following highlights the critical failures made by the company with relation to the Security and Emergency Measures Direction.

2.4 **Failure to notify and report:** The company failed to notify the Inspectorate in a timely manner upon becoming aware of an actual or likely emergency. SEMD triggers such as tankering, internal escalation, and mutual aid requests occurred before the formal notification on 30 November 2025. Statutory 3-day and 20-day reports were incomplete and missing critical information and required further questioning to determine critical facts and timelines.

2.5 **Inadequate planning and preparedness:** The company lacked sufficient outage, contingency and alternative supply plans. Lessons from the 2018 Freeze-thaw event and multiple 2022–2023 Tunbridge Wells events were not embedded within the company, and the same issues arose for the same customers. Blackhurst service reservoir (SR) experienced low levels from August 2025, yet no heightened preparedness measures were initiated.

2.6 **Insufficient alternative water provision:** Based on the data provided by the company, bottled water provision appears to fall short of the statutory 10 litres per person per day requirement across the first five days. Non-potable water sources were incorrectly counted toward drinking water totals. Tanker data was inconsistent and unverifiable, preventing assurance that each customer received minimum supply.

2.7 **Poor Accessibility of bottled water stations:** The bottled water stations which were opened were not centrally located, disadvantaging non-drivers, and communications about openings were often contradictory or delayed. At peak, three stations served over 60,000 customers, a ratio of customers per station failed to meet the company's own standards.

2.8 **Vulnerable customers, vulnerable sites and other important sites:** Deliveries to many vulnerable customers, care homes, GP surgeries, and schools were delayed and inconsistent. The Priority Services Register (PSR) was incomplete

and updated reactively. Critical sites such as the Kidney Treatment Centre experienced closures due to lack of support.

2.9 **Inadequate communications:** The company lacked a documented communications strategy. Messaging through website, AquaAlerter and press statements were delayed, contradictory, unclear or a combination of all of these. No learning from previous events where once again optimism bias eroded trust and impacted decision-making for those affected by the outage.

2.10 **Deficient command and control:** Despite meeting criteria for the most senior level incident team the company operated at a lower level beyond its stated triggers when it should have been escalated, impacting its response and control of the event.

2.11 **Lack of testing and learning:** Lessons from previous incidents and exercises were not fully embedded. Alternative water deployment and reasonable worst-case planning remained inadequate despite repeated recommendations.

2.12 The Inspectorate identified multiple breaches across all areas of emergency planning within the Direction. Failures were repeated, systemic, and are likely to recur without enforcement. Enforcement action under section 18 of the Act will be initiated.

3. Overall Water Quality conclusions

3.1 The Inspectorate's assessment **concludes** that this incident was both foreseeable and avoidable, arising not from raw water deterioration but from long-standing weaknesses in process control, monitoring, maintenance, and operational management.

3.2 Raw water quality during the period remained within historical norms, and there was no evidence of a sudden or exceptional raw water event that could explain the treatment breakdown. Instead, a series of preventable failures including unstable coagulation, a lack of proactive jar-testing for coagulation optimisation, ineffective backwashing, increasing granular activated carbon (GAC) head loss, poor visibility of critical treatment parameters, and the absence of reliable real-time monitoring, progressively reduced the site's capacity and ultimately led to works failure.

3.3 The assessment highlighted systemic organisational issues, including insufficient adherence to required procedures and site tasks, missed opportunities for early intervention, inadequate investment in automation and monitoring systems, and an over-reliance on unsubstantiated external explanations during incident response. These factors collectively impaired the company's ability to diagnose and resolve the underlying process issues quickly enough to prevent loss of supply and consumer impact.

3.4 Overall, the incident reflects a multi-factor breakdown within the company's operational, procedural, and management controls, rather than circumstances outside its control. As a result, consumers experienced prolonged disruption to essential drinking water supplies.

4. Security and Emergency Measures Direction (SEMD)

4.1 The Security and Emergency Measures Direction is made by the Secretary of State under section 208 of the Act and allows the Secretary of State to make directions in the interests of national security and for the purpose of mitigating the effects of any civil emergency which may occur.

4.2 In the context of the Direction and from section 208 of the Act, a civil emergency is "*a reference to any natural disaster or other emergency which, in the opinion of the Secretary of State, is or may be likely, in relation to any area – (a) so to disrupt water supplies or sewerage services; or (b) to involve such destruction of or damage to life or property in that area, as seriously and adversely to affect all the inhabitants of that area, or a substantial number of them, whether by depriving them of any of the essentials of life or otherwise*."

Overview of Event

4.3 On 29 November 2025, a significant loss of supply event occurred affecting up to 60,170 consumers in the Tunbridge Wells area supplied by Pembury works.

4.4 Pembury works relies on treatment of gravel-spring and greensand groundwater by coagulation, dissolved air flotation and filtration (DAFF), GAC filtration and disinfection. From the 26 November 2025, the site experienced repeated shutdowns linked to unstable coagulation, elevated post-DAFF turbidity, incomplete backwashes, and increasing GAC head loss. These failures progressively reduced output to levels insufficient to maintain treated water storage at Blackhurst SR, resulting in a loss of supply event and subsequent issuing of a BWN so that the site could be operated outside of the normal turbidity disinfection requirement.

4.5 The Inspectorate's assessment, based on site visits, a review of site logs, SCADA trends, sampling data and information provided by the company, has **concluded** that the event was foreseeable and preventable. The site had experienced earlier signs of instability that, if appropriately investigated and acted upon, would have prevented the works failure and subsequent loss of supply and the impact on consumers.

Reporting

4.6 Paragraph 16(1)(a) of the Direction states that "the company must, as soon as it becomes aware of any actual or likely emergency or security event affecting its water supply or sewerage functions, notify— (a) the appropriate authority." In this instance the Inspectorate is the appropriate authority.

4.7 The specific requirements for a company to notify Emergency Planning (EP) related SEMD events to the Inspectorate are set out within the Emergency Planning Guidance for the Water Industry (2025) (EPG). "The company must notify [Department for Environment, Food and Rural Affairs] Defra and DWI

[the Inspectorate] as soon as they become aware of any actual or likely event that meets the criteria within the EPG."

4.8 SEMD is the principal general direction issued under section 208 of the Act. Under paragraph 3 of the Direction, when preparing and revising their emergency plans, companies are required to, "*have regard to any relevant guidance, procedures, requirements, best practice and any risks, including long term risks, relating to civil emergencies and national security*". The EPG constitutes relevant guidance in this context.

4.9 South East Water first notified the Inspectorate at 09:49 on 30 November 2025. The company had internally escalated the incident on the evening of the 27 November after they had started utilising tankers to try and stabilise reservoir water levels. The company started running a silver incident team on 29 November 2025 in the morning as well as requesting mutual aid from other water companies. I **conclude** that the use of tankers in this instance represented a potential emergency affecting the company's water supply function and therefore should have been notified as an event as soon as it became aware of an actual or likely event. The forming of a silver incident team, and separately the request for mutual aid also constituted reportable triggers. I therefore **conclude** that this is a breach of the company's duty to notify as required in paragraph 16 of the Direction which is enforceable under section 18 of the Act.

4.10 Following an initial notification, water companies are required to provide a report setting out their response after three working days and, if requested due to the nature of the event, a follow-up report after 20 working days to the Inspectorate. This timeframe and the contents required to be provided within these reports are set out within EPG. I **note** that the event was ongoing and the company was, at the time of the 3-day report, unsure of the cause of the event; several items of critical information required for assessment by the Inspectorate, were not forthcoming. The 3-day report did not include:

- A likely resolution or timeframe.
- Information on mutual aid or the multiagency response.
- Legal instruments in place covering the event.
- Details of media interest.
- Communications issued to customers and or the media/press.
- Strategic decisions and command and control arrangements.
- Time/date of contact with relevant stakeholders (such as government departments, the Inspectorate and MPs).

4.11 The 3-day report was submitted on 4 December 2025 at 08:54. Whilst the company was in the midst of the event, the timeliness and accuracy of information provided via reports to regulators were critical to understand the situation as it progressed. It is **noted** the 2022 freeze-thaw event did not

proceed to the serving of a legal instrument after the company provided additional evidence after the assessment was completed.

4.12 On 9 December 2025, the Inspectorate's SEMD team sent 66 specific queries to the company following a review of the 3-day report and a request for a 20-day report.

4.13 The 20-day report was submitted on time on 30 December 2025 at 20:53. The report was missing detail set out within the EPG for information typically required in a 20-day report. In addition, the company failed to provide responses to a number of the 66 additional information requests made by the Inspectorate's SEMD team. Several of the responses that were received were lacking in sufficient detail. Those queries that were missing a response, or sufficient detail were subsequently requested on 9 January 2026 to be responded to along with responses to further queries.

4.14 The company did not provide the following information, or an explanation for its absence to the Inspectorate with the 20-day report, as requested.

- Outage plans for Pembury or Tonbridge works.
- A copy of the multi-agency de-brief.
- Copies of relevant and pertinent emails related to the events at Pembury works.
- Specific details on what Mutual Aid was requested and used.
- Details of how the population affected compared to the minimum plans the company are required to have provision for.
- Provisions for increasing resourcing at the call centre following the outage.
- Details on how vulnerable customers were proactively contacted to understand their requirements.

4.15 The majority of the above documents were subsequently provided on 23 January 2026. It was at this point the company met the Inspectorate's request for "all relevant emails and email chains prior to, related to or pertinent to the two events at Pembury and Tonbridge works. Or containing discussion for the potential of an event at Pembury and Tonbridge works between 1 December 2024 and 31 December 2025". However, the company was unable to provide this data set to the Inspectorate and did not meet the deadline in response to the request.

4.16 The company indicated that there may be up to three million emails pertinent to the request. The Inspectorate has therefore not required the company, at this time, to satisfy the request, acknowledging the company has suggested this would result in a significant draw on resource. The company has indicated it would be "*likely to need to engage external support to assist with this given the potential volume of documents*".

4.17 Paragraph 16(2) of the Direction states that the "*company must provide a report to the appropriate authority setting out its response to an emergency or security event within 20 days of being requested to do so by the appropriate authority and the report must be in such form as the appropriate authority may prescribe".* I **conclude** that the company should review its reporting processes to ensure that 3-day and 20-day reports are submitted on time and also meet, as a minimum, the requirements set out within EPG. The company should provide sufficient information in the 20-day report to allow the Inspectorate to accurately assess an event.

Plans

4.18 Paragraph 4(1) of the Direction requires the company to "make, keep under review and revise such plans as it considers necessary to ensure, during any civil emergency or event threatening national security – (a) the continued exercise of all of its water supply or sewerage functions; and (b) the continued exercise of such of those functions as it can continue to exercise if the nature of the civil emergency or security event is such that not all functions can be exercised."

4.19 The company recognised a number of challenges to supply within its **CMA statement of case** where it acknowledged the pressure on water resources which are located in the "most exposed region to supply-demand imbalances in England". A key issue that is acknowledged is the "[lack of] *network interconnectivity and water supply system headroom in the Kent and Sussex regions leading to greater exposure to supply interruptions*…."

4.20 The company previously recognised supply challenges in 2018, on its website[1] following the 'Beast from the East' freeze-thaw event. The company acknowledged it received complaints about bottled water stations, and poor communication and that businesses were less satisfied than household customers. The lessons learnt included improving resilience at strategic infrastructure sites, improving the resilience of bottled water stations and developing a geographically based communications crisis plan that captures local challenges and approaches.

4.21 Whilst the event in this report did not share the same root cause as the 2018 event, many of the lessons taken from that event, if fully implemented, could have helped mitigate the issues seen during the 2025 Pembury event. For example, Action 10 from the company's own report on the 2018 event provides an action to carry out, "*Reviews with businesses to generate business continuity plans i.e. for large schools*".

4.22 Following the 2022 freeze-thaw event and the subsequent loss of supply event in 2023, which both impacted Tunbridge Wells, Ofwat commissioned research[2] where it noted issues with PSR and consumer communications along with a

[1] Learning lessons from the 'Beast from the East' | South East Water
[2] Ofwat and CCW research into South East Water incident response - Ofwat

series of lessons to be learnt by the company. Set out below are where these issues appear to have reoccurred two years later.

4.23 I **note** that the company did not request any support through the business planning process from the Inspectorate, for any items that would avoid the failure of piped supply in the price review 2024 (PR24) process.

4.24 When asked for the company's treatment works outage plan for the site, the company's response was "*There are no outage plans in the system for either Tonbridge WTW or Pembury WTW*". When asked to provide its plan to provide piped supply to consumers within Tunbridge Wells, the company provided a series of paragraphs summarising the current network system and how it maintains supplies; how it looked to a) maximise the number of customers on supply during the incident; b) deploy sufficient alternative water above minimum supply requirements during the incident; c) re-establish supplies and resolve the incident; and a long-term investment plan to increase resilience and remove the single source of supply risk for Tunbridge Wells.

4.25 Therefore, based on the information provided, I am **unable to conclude** that the company made, reviewed or revised such plans that it considered necessary to ensure the continued exercise of its water supply function. I am therefore **minded to enforce** to ensure there are sufficient plans to exercise its water supply function.

4.26 Analysis of service reservoir storage levels suggest the company was having issues with Blackhurst SR with three incidents since August 2025 when levels within the reservoir cells dropped below 40%. Figure 1 indicates an overall downward trend in reservoir levels from the initial decrease at the start of October 2025. It is unclear what actions the company took in response to these levels dropping. The company provided no evidence that it initiated heightened preparedness measures in response to this period of compromised performance. The requirements of heightened preparedness are set out within section 4.7 of the EPG.

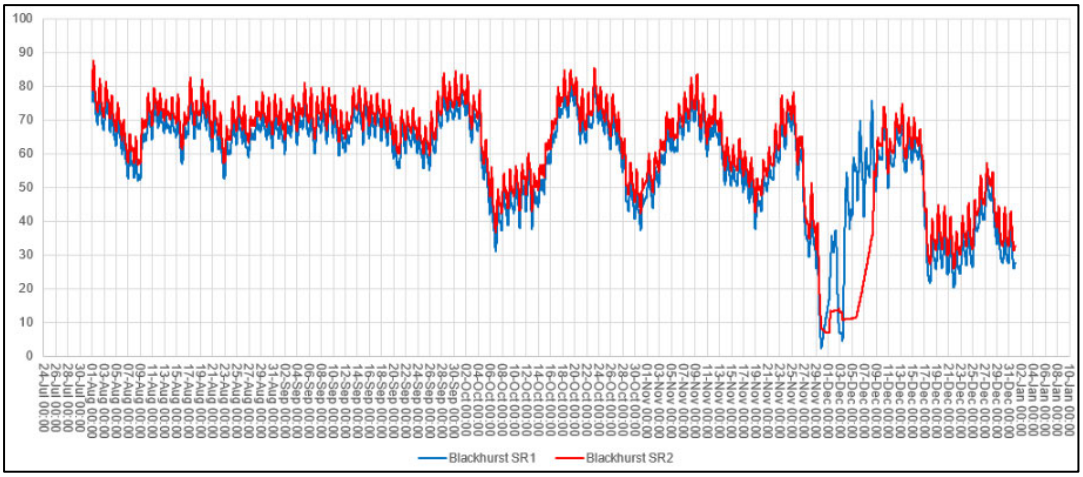

Figure 1: Blackhurst SR Levels from 1 August 2025 to 31 December 2025

4.27 The Direction requires in paragraph 4(4) that "plans for water supply must be prepared on the basis that the company must – (a) continue to carry out – (i) all of its water supply functions; or (ii) where the nature of the civil emergency or security event is such that this is not possible, those functions which it can continue to exercise; (b) in the event of an unavoidable failure of piped water supply, ensure that such minimum supply is provided by alternative means."

4.28 Additional mitigation which was enacted by the company included an additional supply of water from Bewl works and Yew Tree Road. However, this was constrained due to the loss of Tonbridge works due to elevated solvent concentrations in the raw water exceeding treatment capacity, and turbidity from the Bewl to Kippings Cross water transfer. As these measures were constrained, the company was unable to avoid the emptying of Blackhurst SR.

4.29 I **conclude** the above demonstrates that the contingency or outage planning for the area was inadequate and insufficient for the company to continue to carry out its water supply functions. Given the previous loss of supply instances in the area, and the company's awareness of these issues, these known risks do not appear to have been adequately addressed. Based on the assessment of the root causes detailed above in section 3 (Overall Water Quality conclusions) I **conclude** the event was avoidable and therefore a breach of the Direction.

Alternative Water

4.30 Paragraph 4(4)(d) of the Direction states that "plans for water supply must be prepared on the basis that the company must identify and prioritise— (i) its vulnerable customers; and (ii) in the case of a water undertaker, its vulnerable sites within its area."

4.31 The EPG states that companies must make a minimum supply available to consumers during a loss of supply event. This is set out as 10 litres of drinking water per person per day for the first 120-hours (five days). This timeframe is measured from the start of the event, or practically the first loss of supply, and not when bottled water was first made available. Should the outage be prolonged beyond this time, an increase to 20 litres of drinking water per person per day thereafter must be offered to all those affected. After the 120-hour timeframe has passed companies must communicate the increased offering and be able to evidence that it has done so. Emergency plans should also consider the higher-than-average quantities of water needed by some vulnerable customers, particularly those with specific medical needs.

Bottled Water

4.32 In the 20-day report, the company provided the Inspectorate with a dataset of bottled water available. The data provided used interchanging quantities of 'pallets', 'batches', 'deliveries', 'litres' and 'bottles'. As a result, some assumptions have had to have been made in the interpretation of the data. I

note that within the 20-day report the company uses customers and properties interchangeably, properties require a multiplication factor of 2.4 to convert this figure to consumers.

4.33 The company stated the maximum population affected by loss of supply was 60,170 people, however not all of these people would have been without a piped water supply for the whole duration of the event due to the nature of the interruptions experienced. Some consumers may have experienced intermittent supplies with some water available for periods on some days, which makes assessing the amount of water made available to consumers difficult to evidence. The company did not provide a clear breakdown of which customers and areas lost supply and the respective durations.

4.34 Within the 20-day report, the company stated it distributed 1,600,968 litres from bottled water stations. The maximum daily volume of bottled water provided was 258,792 litres on day 4 (2 December 2025) (see Table 1). Based on the maximum impacted population this volume is lower than the minimum volume of water in the EPG requirements (10 litre per person per day) for all days of the outage. Each of the first five days of the outage the EPG requirements were not satisfied through bottled water provision alone. Some alternative water would have been provided to PSR customers, however the difference between alternative water supplied and customers being off would not have been met though PSR deliveries alone.

Date	**SEW 20-Day Customers off supply (Table 7 of 20 Day)**	**SEW 20-Day Customers off supply (Table 17 of 20 Day)**	**EPG Requirements in litres (10** l/person) **Based on max population** of data	**Bottled water station litres provided** and calculated customers
29/11/25	"First customers experiencing no water or low pressure. Calls received in the downstream network from 12:00. Boosted areas impacted early evening 7:00 pm and reservoir isolated later in the evening impacting the whole area."	7,500 properties up to 23,500 properties Standard calculation for Properties -> Population is 2.4 customers per property = 18,000 **to 56,400 individuals**	564,000 litres	14,760 litres Company state 24 litres per customer collected = 615 customers
30/11/25	6,000 **to 24,000 "customers"**	24,000 properties = 57,600 **individuals**	576,000 litres	226,320 litres = 9,430 customers
1/12/25	18,000 **to 22,500 "customers"**	24,000 properties = 57,600 **individuals**	576,000 litres	163,344 litres = 6,806 customers
2/12/25	0 **to 14,000 "customers"**	14,000 properties = 33,600 **individuals**	336,000 litres	258,792 litres = 10,783 customers
3/12/25	24,000 "customers"	24,000 properties	576,000 litres	183,024 litres = 7,626 customers

BWN applied 12:00		= 57,600 **individuals**		
4/12/25		8,000 properties remain off = 19,200 customers	192,000 litres	140,712 litres = 5,863 customers
5/12/25		24,000 properties back in supply = 0 customers	0	98,400 litres = 4,100 customers

Table 1: Comparison of customers out of supply, bottled water provision and EPG requirements

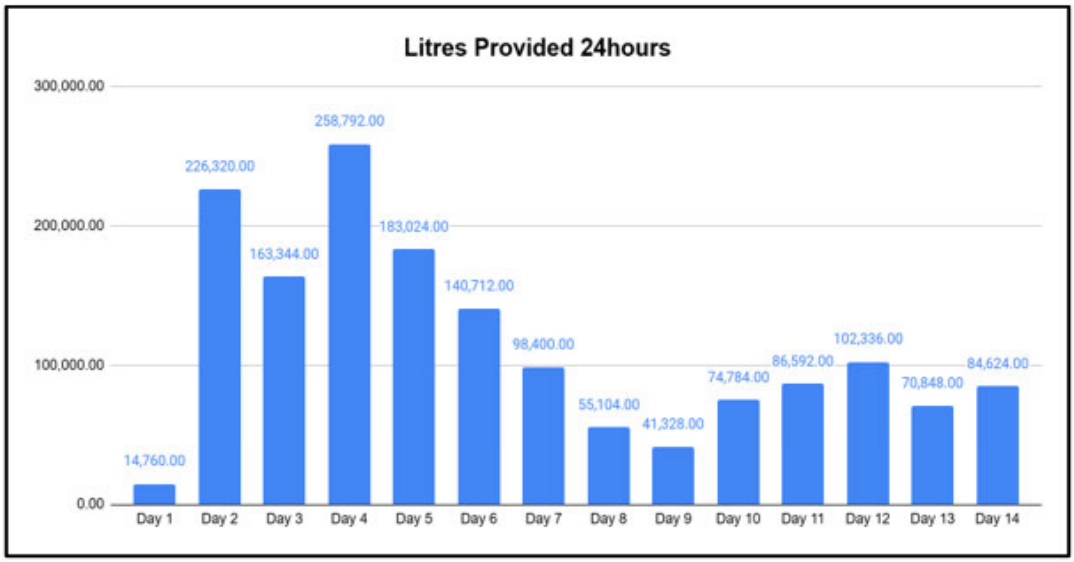

Figure 2: Graph from 20 Day Report litres provided from bottled water stations.

4.35 I **note** that from day 9 to day 12 the number of litres provided from bottled water stations increased despite the company confirming all customers were back in supply.

4.36 The company stated they "EXCEEDED" compliance with the total volume of alternative water across the event. Their submission states they made "available" 2,294,880 litres of water daily. However, this figure cannot be accepted at face value due to a number of caveats outlined below.

4.37 The figure appears to rely on three bottled water stations having their full 200 pallet store available at each station each day. This number of pallets was only used on 30 November 2025, when all three of the stations used more than 200 pallets of water. I **note** that two of the bottled water stations did not open until after 18:00 on this day and closed by 22:30, therefore it is unclear how this number of pallets were used in this time period across these stations. No further evidence was provided on pallet deliveries made to bottled water stations to corroborate the tables provided in the 20-day report. After this date

there was only one site (Sports Centre) on one day (1 December 2025) which used more than 200 pallets in a single day.

4.38 The initial figures provided also included 500,000 litres available daily via grab bags and bowsers, intended for sanitation purposes only, and is not suitable for consumption. In follow up data provided on 2 February 2026 the company could only demonstrate that 144,000 litres were available via this method on a single day and not throughout the loss of supply. The company provided no other evidence related to Arlington tanks, bowsers or unwholesome water distribution. I **note** the figure has reduced by 356,000 litres in follow-up submissions. I further **note** that the company had stated that the 500,000 litres was part of the "total daily water available" however this would only have been available on one day, 3 December 2025.

4.39 Furthermore, and critically, the 'grab bag' distribution method does not provide drinking water to consumers. The company has stated in the 20-day report that this was for sanitation only. The Arlington tanks liners are currently restricted and cannot be used for drinking purposes. The company has not provided evidence that this distribution method had an associated instruction for consumers not to drink the water. This contribution of either 500,000 litres, or 144,000 litres, cannot be counted towards the EPG requirements of drinking water made available to consumers. I **remind** the company that it has the responsibility for making consumers aware that water from grab bags and from bowsers must not be used for drinking purposes, unless the bowsers are regulation 31 compliant and the instructions for use are followed. The company did not provide any evidence of regulation 31 compliance for the bowsers or evidence of how customers were notified of the allowed use purposes of the water from these sources.

4.40 Whilst the requirements of sanitation were critical to the public health of the population, this is not specifically covered by the Direction and the appropriateness or adequacy of the amount of water provided for sanitation will not be commented on.

4.41 The inclusion of tanker support also cannot be included in calculations for "total daily water available" for this event. Whilst tankering is allowable within the EPG as an alternative water method, there were specific tankers assigned to the hospitals to meet the need of these specific vulnerable sites. It is inaccurate to use this volume in the total amount available to all other customers. Equally, hospital populations would not be included in the domestic population figures, and therefore the volume supplied to a hospital should be treated in addition to the domestic population. Furthermore, a member of the public would not be able to access the supplies at the hospital and avail themselves of 10 litres of water. It is further **noted** that some of the tanker volumes moved into service reservoirs might have been into cells that were not supplying water to the distribution network and thus was also not available.

4.42 Similarly, when injecting directly into the network from a tanker, either at a reservoir or at an injection point such as a hydrant, the volume within the tanker cannot be equally attributed out to all consumers affected by the loss of supply. Therefore the "1,000,000 litres of tanker support" the company indicated in their 20-day report cannot be included in the calculations demonstrating the company made 10 litres of water available to each the affected population.

4.43 Tanker supplies are sometimes described as "unconstrained" supplies as the distribution can vary. This means that depending on the network configuration tanker support might provide a single customer with 150 litres and another customer nothing. Injecting 150 litres into the network would not be the same as suggesting 15 people were supplied with the minimum supply. The EPG notes "*If a company decides to include methods such as direct injection or re-zoning it is the responsibility of the company to ensure everyone can receive the minimum amount of alternative water, and that customers are aware of what restrictions (if applicable) may apply to the amount of water they can use*". The company has not provided evidence that it ensured everyone could receive the water.

4.44 Following further queries sent to the company after the 20-day report, the company provided additional data on 2 February 2026 for its tanker movements from 27 November 2025 to 30 December 2025. This data was not detailed enough to show exact tanker trips, it instead provided combined daily totals of trips and volumes transported. As this was not provided as individual lines of data, it is not possible to determine how much water was injected into the network, compared to into service reservoirs or directly into vulnerable sites.

4.45 Some of the information provided from the 2 February 2026 data set includes:

- The first tanker began on 27 November 2025 with three tankers making 18 trips to add water to Blackhurst Reservoir.
- The most tankers used in a single day was 33 tankers on 7, 8 and 9 of December.
- The highest volume transferred was 5,940,000 litres. This occurred every day from 7 to 13 December.
- A total of 5,004 trips were made moving a total volume of 150,120,000 litres of water.
- Up until the 13 December 2025 when the BWN was lifted 2,232 trips were made moving 66,960,000 litres.

4.46 However, once again these figures must be caveated with assumptions made by the company. The total volume has been calculated assuming that each and every tanker trip transferred exactly 30,000 litres of water. I **note** that the

company's action plan for purchasing new tankers included four 30,000 litre tankers, four 19,000 litre tankers and two 8,000 litre tankers. This action was due to be reported on 30 April 2026, however the company completed the purchase of tankers earlier than the reporting date. These smaller tankers do not appear to be reflected in the numbers provided.

4.47 Within the 20-day report, the company stated that they mobilised a total of 26 tankers, made a total of 1,430 trips and delivered a total of 37,103,000 litres of water during the incident. These figures do not match against the subsequent data provided on 2 February 2026 and outlined above. This discrepancy between the data sets undermines the accuracy of the data provided by the company.

4.48 Therefore, I am **unable to conclude** that the company ensured that such minimum supply was provided by alternative means as required under paragraph 4(4)(b) of the Direction.

4.49 The EPG states that "*The plans should aim at commencing the distribution of water by alternative means as soon as possible after the failure has occurred*". Additionally, "*If a company decides to deploy alternative water stations, they should take all reasonable measures to ensure those are accessible (both in terms of proximity to affected populations, and access if located in areas prone to traffic congestion) to ensure all customers receive an inclusive service. In addition, the locations should be reviewed and revised proactively through the duration of the event, for example moving an existing station or opening additional stations*."

4.50 The company set up its first bottled water station at 19:30 on Saturday 29 November at Sovereign Way East Car Park, TN9 1QH. This location is within the town of Tonbridge, not Tunbridge Wells. The company states in the 20-day report that this location was "*not central to the impacted area but was available to quickly be mobilised while other more suitable locations were being secured and set up."* This site was open for two and a half hours until it was closed again at 22:00.

4.51 This site was attempted to be opened the following day but was shut due to large crowds. The company has not provided specifics on timings of this site opening and closing on 30 November 2025.

4.52 Based on Google Maps, the site was a minimum five miles from the affected area with the furthest extent of the affected supply zone over 10 miles away. A journey of at least 20-minutes round trip for the nearest affected consumers. This further assumes there was no traffic or waiting required for collection of water. Mike Martin, Member of Parliament for Tunbridge Wells, described traffic in the town as being "*gridlocked with 90-minute queues to get to bottle stations.*" The company was unable to confirm wait times for vehicles but

suggested local roadworks and peak time congestion could have been to blame on the Sunday afternoon and evening.

4.53 The company notified consumers through their website that the first bottled water station was open at 19:52 on 29 November 2025. The first AquaAlerter text message was sent at 06:23 on 30 November, 11 hours and 29 minutes after the website had updated. This update indicated that the bottled water station at Sovereign Way would be open until 22:00 on the evening of 30 November.

4.54 The next communication to instruct customers about bottled water came at 11:53 on 30 November, via the company website. It informed customers of a new station that was to be opened at Tunbridge Wells Sports Centre. This information was then sent via AquaAlerter at 12:24, 29 minutes later.

4.55 On Sunday 30 November, three bottled water stations were established. Firstly, at Tunbridge Wells Sports Centre, St John's Road (TN4 9TX) which opened at 11:30. Later that same day, RCP Parking (TN2 5TP) and Odeon Cinema Car Park, Knights Way (TN2 3UW) were opened at 18:00 and 18:30 respectively. There were seven hours with only a single bottled water station being open to accommodate the approximately 55,000 people who would have been without water by this time.

4.56 There were contradictory messages being sent out on the company's website and to those customers who had signed up to AquaAlerter messaging system. Both updates were time stamped as 14:40.

> The company's Website: *… Bottled water stations are now open until 10:00 pm this evening, located at: Tunbridge Wells Sports Centre - St John's Rd, Royal TN4 9TX Sovereign Way East Car Park Tonbridge TN9 1QH …*
>
> AquaAlerter: *… Our bottled water station at Tunbridge Wells Sports Centre, St John's Rd, Royal Tunbridge Wells, TN4 9TX is currently closed while we replenish stock. We hope to have this opened again shortly…*

4.57 The 20-day report stated that the station at the Sports Centre was closed from 14:00 to 15:00 for "restocking". However, the company's own website was at this time instructing people to visit that site should they require bottled water. This closure came three hours after the station was initially opened. During the restocking period there would have been no other bottled water stations open at this time providing alternative water.

4.58 Further updates on the website were given throughout the 30 November 2025 informing customers of two extra sites opening. There was no update provided on which sites would be open on 1 December 2025 and from what time. Despite bottled water stations being open from 08:30 on 1 December 2025 the website was only updated at 09:15. This update was sent via AquaAlerter at 13:29.

4.59 The messaging provided to customers around bottled water station locations and opening times was delayed, contradictory and confusing. For those consumers who had signed up to receive SMS updates (AquaAlerter) these often were delivered many hours after the website was updated. I **conclude** that the company did not follow section 4.4 of the EPG which states it should consider how consistent communications methods and messages are maintained throughout an incident.

4.60 In the EFRA committee statement on 6 January the company states "*in the Tunbridge Wells area we have 17 sites pre-selected, and we will choose between those depending on the size of the event*". Within the 20-day report the company states "*16 sites for the Tunbridge Wells area that were scoped and site use agreed in principle with their owners*." Within the submission provided by the company on 2 February was a list of 18 sites considered during this event. Within this list were the five sites which were eventually used, including the site in Tonbridge.

4.61 The company stated that "*these [risk] assessments were carried out during the incident, to ensure that sites were suitable for use at the time*". Some of the reasons given for a site not being suitable included "*Narrow entrance unable to fit HGV into site.*", "*One entrance in and out, too small to operate*", "*There is not enough room to fully mobilise or setup*", "*No area for us to set up a station nor manage the traffic management within the area*". These reasons for suitability indicate that they would not only be unsuitable for an incident of this scale, but for any incident requiring a bottled water station to be set up.

4.62 The list goes on to suggest that of the 13 sites that were on the list, and not used, only two would possibly be able to be used in the future following further discussions or restrictions on cars using a car park. I **note** the company carried out these assessments during the incident and not prior to the event occurring. The company did not provide any evidence of any activity to determine site suitability or risk assess sites prior to the event occurring, despite having experienced multiple previous loss of supply events in the region in the recent past.

4.63 The company stated their chosen locations for bottled water stations were *"carefully chosen to try and ensure all customers were within a short drive of a station.*" This demonstrates priority was given for those customers with access to a car over those without.

4.64 With the majority of predetermined stations unavailable it would indicate that the location choices were not suitable for large scale outages and may only have been suitable for smaller impacted populations and at certain times of the year.

4.65 Section 3.2 of the EPG states that it is the company's responsibility to ensure all impacted consumers are able to obtain the minimum amount of water during

an incident and that all companies should consider their plans for alternative water with the local context, ensuring there is sufficient flexibility in planning considerations. Therefore, I **conclude** that the company did not consider its plans on the local context ensuring there was sufficient flexibility in planning considerations.

4.66 By opening the site on Sovereign Way on the evening of 29 November, it allowed some people to collect water. Each car which passed though the station was provided with two packets of six two litre bottles of water (24 litres). During the two and half hours the site was open on this day, 14,760 litres of water were distributed from this site. Assuming each customer/car took 24 litres of water this indicates 615 consumers/cars received bottled water from this site during this period. This is insufficient based on the population who were without water by this time, which was estimated by the company as approximately 56,400 (23,500 properties) which would require 564,000 litres of alternative water.

4.67 The EPG states that companies "*Should take all reasonable measures to ensure those are accessible (both in terms of proximity to affected populations, and access if located in areas prone to traffic congestion) to ensure all customers receive an inclusive service*". The company opened a bottled water station at Sovereign Way, Tonbridge. This was at a location away from the affected population and only accessible to those able to travel in a vehicle. EPG further suggests that companies should use the Ofwat definition for vulnerable persons which includes "*economic factors*". Therefore, there is the risk that locating bottled water stations away from consumers without access to private transport, that all consumers may not have a reasonable opportunity to access an inclusive service.

4.68 Three stations remained open throughout the period the BWN was in place. During this time, footfall was described as "minimal". Figures provided by the company indicate 614,016 litres of water were collected during the period the BWN was in place. This equates to 25,584 people across the three sites and eight days of the BWN. All bottled water stations were eventually closed once the BWN was lifted at 15:00 on 12 December.

4.69 The company provided their Alternative Water Supply (AWS) Procedure for Water Supply Disruptions. This report was dated January 2025. It did not include any version control or history of amendments from reviews following previous events or incidents. The company's standards for bottled water locations indicate that each station should be able to cope with 5,000 customers, with larger sites able to cope with 10,000 customers.

4.70 With 60,170 people affected and, at most, three bottled water stations open at any one time these stations had to deal with over 20,000 customers, double the company's own standards. I **note** that Inspectors, in their assessment of similar loss of supply events from around the industry, report companies typically

establish bottled stations at a ratio of one station for every 5,000 population and as low as one station for every 2,500 people as traffic is often cited as a concern for stations being larger.

4.71 The company stated that they "*calculated that three water stations would be sufficient to manage the expected attendance for this incident*". When asked, the company subsequently provided four risk assessments for the sites that were used within Tunbridge Wells. Within the documents there were tick box lists of particulars that must be met, for a site to qualify as a potential location for a bottled water station. However, the risk assessments provided, show no calculations or modelling of any kind to support its assertion that three water stations would be sufficient.

4.72 By setting up three bottled water stations for a maximum population affected of 60,170 this would mean that each station was required to accommodate 20,057 people each day. With the three main stations open daily from 09:00 to 22:00 (13 hours) this would result in 1,543 people being supplied each hour at each site, or 26 people every minute, or one every 2.3 seconds. Based on these figures it is unlikely that the company would be able to achieve these logistics, even if it had sufficient amounts of bottled water.

4.73 The company closed all of its bottled water stations at 22:00 each night due to "*safety reasons*". Security guards were present on site and the company states that these personnel were able to provide water to customers who requested it. However, this information was not made available to customers, who would have assumed bottled water was not available overnight. **I remind** the company that the EPG states that "*within 24 hours, and up to 120 hours, of the company becoming aware of an incident the company must make available a minimum of 10 litres per person per day to **all** customers off supply*". This includes customers such as those working shifts, those without transportation, with childcare requirements or any other reason which may make attending the sites within the opening hours difficult, inconvenient or in some cases impossible. It is reasonable for a customer to assume a station is closed if this is what the messaging states, and they would not reasonably turn up to a 'closed' station with the expectation of being able to obtain water, therefore the Inspectorate considers for the durations that the station was advertised as being closed that water was unavailable.

4.74 Paragraph 4(6)(a) of the Direction states that "*plans must make provision for—(a) the carrying out of functions by a sufficient number of appropriately trained personnel and the training of relevant members of staff*." The company provided the water to three additional bottled water walk-in stations which were resourced by local authority staff. The EPG states that companies must have the capability, capacity and facilities that are required to implement their plans, and should use a People, Processes, Information, Technology and Facilities (PPITF) approach, using a range of scenarios. Should the company

"choose to include volunteer resource within their plans, they should be able to demonstrate a level of confidence in volunteer availability and have alternative arrangements should this resource not be available".

4.75 Whilst I welcome the contribution made by local authority staff in opening additional bottled water stations in the centre of the town to allow for pedestrian access to collect bottled water, this suggests that the company did not have sufficient capability, capacity and facilities to implement its plans.

4.76 It is acknowledged that the company is only required to plan for [redacted] of its total population losing supply. It is **noted** in the EPG that companies are encouraged to exceed this minimum planning requirement if their reasonable worst-case scenario is larger. The company stated that [redacted] is its current capability in their latest RAG submission to the Inspectorate, however in the business planning period it also acknowledged that a reasonable worst-case scenario (RWCS) could be much larger. It would be reasonable to expect the company to have plans to cope with their RWCS, funded through the business planning process. EPG also notes that the company is responsible for "**all** customers off-supply", and the planning requirements are representative of a balance between the companies own assets and mutual aid they are confident that they can receive.

Mutual Aid

4.77 Following the submission of the 3-day report, the company was asked if any mutual aid was used and if so, to provide evidence of all requests made, responses received and actual mutual aid received. This information was not provided to the Inspectorate in adequate detail in the 20-day report and was therefore requested again in the follow-up questions.

4.78 The company made requests for three distinct areas of mutual aid. Firstly, for tankers and drivers on 2 December which resulted in a greater amount of resource offered than could be accepted due to constraints around driver duties. In the previously mentioned loss of supply events the company had two tankers available. During this event there were 12 tankers in the South East Water fleet, with additional tankers mobilised utilising mutual aid and contracted organisations. Mutual aid was received from Southern Water, Severn Trent Water and Dŵr Cymru Welsh Water.

4.79 Secondly, on 5 December a request for filtration and a pumping system was made, which was supplied by Severn Trent Water.

4.80 Finally, on 8 December a request for additional sampling resource was made with a sampler made available from Southern Water on 9 December to assist with the sampling necessary to facilitate lifting the BWN.

4.81 Within section 4.5 of the EPG the requirements for analytical services state that *"emergency plans should include…. This includes but is not limited to sampling,*

laboratory analysis, data analysis and impact analysis" and further states "*Where relevant, companies should have formal contingency arrangements with other laboratories and formalised mutual support agreements. Water companies need to ensure their plans include meeting all relevant water quality regulations and guidance*" I am therefore **unable to conclude** that a mutual aid request for additional samplers four days into a BWN would constitute a formalised mutual support agreement and was, based on the email provided by the company, an ad hoc request made during the planning stages of lifting a BWN. I therefore **conclude** that the company did not have formal contingency arrangements in place.

Vulnerable Customers and Priority Service Register (PSR)

4.82 The Direction 4(4)(d) states that the company must "identify and prioritise (i) its vulnerable customers; and (ii) in the case of a water undertaker, its vulnerable sites within its area."

4.83 Section 3.3 of the EPG uses the Ofwat definition[3] of a vulnerable customer as "A customer who due to personal characteristics, their overall life situation or due to broader market and economic factors, is not having reasonable opportunity to access and receive an inclusive service which may have a detrimental impact *on their health, wellbeing or finances*".

4.84 The company states it prioritised customers who had notified it they were unable to collect bottled water, and those who identified during the incident as vulnerable. The company prioritised "tier 1" non-household sites such as A&E hospitals, followed by "tier 2" such as non-A&E hospitals. The company set up a ring-fenced team to improve the coordination of water deliveries for vulnerable non-household sites, however this was not from the start of the incident but instead started on 4 December 2025.

4.85 The Inspectorate has requested feedback from other stakeholders (including Members of Parliament, Kent County Council, Tunbridge Wells Business Improvement District (BID) and Tunbridge Wells Borough Council) to verify the statements made by the company within its 20-day report around vulnerable customer as the information provided by the company lacked timescales for when arrangements were in place.

4.86 Mike Martin Member of Parliament for Tunbridge Wells states that "*GP surgeries were completely missed from the water deliveries and had to source their own water.*" "*Some care homes received no deliveries at all, with one example of the care home requesting water on the Sunday and still picking it up themselves on the Tuesday afternoon*." "*The towns kidney dialysis unit had to shut down for several days leaving the patients to travel elsewhere*".

[3] Ofwat Vulnerability focus Report

4.87 The Borough Council states "*On Monday 1 December there were reports of four care homes not receiving any water and one not enough. Issues continued until Thursday 4 December when they put in place a dedicated team for care homes and for schools*."

4.88 I **note** that whilst the company did put in place a ring-fenced team to improve coordination, this was in response to repeated calls for improvements to be made and was not stood up until 4 December, six days into the loss of supply and a day after the BWN had been put in place.

4.89 At the start of the event the company was aware of 4,399 customers who were on the PSR. Of these, 1,736 had a flag that they would be "unable to collect". Deliveries were initiated on 29 November however this was only for those customers with the unable to collect flag attached to their records. This was not all customers on the PSR or all vulnerable customers.

4.90 By the end of the event the company had increased their PSR list by 645 to 5,044, a 15% increase. These individuals came from requesting to be added to the list through contact with the company, the MP office or the Local Resilience Forum (LRF).

4.91 The company has subsequently informed the Inspectorate that over December 2025 there were 2,813 customers added to their PSR, however it is not clear if this figure is for the area affected by this outage, or the whole company.

4.92 Mike Martin MP confirmed that over 160 vulnerable person requests were received by his office as they were unable to get through to the company, and further notes that in some cases vulnerable people went without water deliveries for several days before seeking the help of neighbours.

4.93 The company provided the first deliveries to a list of consumers (254 deliveries) supplied by the LRF on 3 December. This was the fifth day that deliveries were being made to vulnerable customers, but the first delivery for these specific customers. Given the delay to receiving this list from the LRF and deliver to these consumers, it is evident that not all vulnerable customers received deliveries of the adequate amount of alternative water within the first 24 hours.

4.94 The LRF provided list of customers, were called by the company. These calls were made on 5 December to find out if any additional help was required and if more water needed to be delivered. No further calls were made to these customers.

4.95 The EPG further states that companies should follow Ofwat's guidance for maintaining an up-to-date PSR and CCWater's research into support for vulnerable customers. Companies should proactively liaise with other bodies, such as local authorities and health authorities to establish how and when they can share, as far as possible, information available about vulnerable customers.

4.96 Despite going through a two-yearly revalidation exercise in 2025, the company failed to ensure all those who should be on the list were. Revalidating an existing list will only confirm or remove those already on the list. Instead, proactive engagement to look externally and to ensure any individuals who should be on the PSR and were missing, were added. I **conclude** that from the information provided the company was not proactive in its liaison with other bodies to share information and relied on the event occurring to update their records.

4.97 During the period of the BWN (3 December to 12 December) deliveries were made to those vulnerable customers who were unable to collect, on alternative days with double the volume of water left with the customer. The company has not provided evidence to show that all customers were made aware that the deliveries would not occur every day during this period and this extra water was meant to last twice as long as the earlier daily deliveries. I **require** that where 'double deliveries' are made the customer should be clearly made aware of the duration it is expected to last.

4.98 Out bound calls (OBC) were made to all PSR customers who had flagged as "*Blind, Partially Sighted, Developmental Conditions and Dementia*" or "*those with physical impairment, recovering from hospital, restricted hand movement, dementia, or mental health*". It is not clear if all of these flags were included as the company has provided different criteria for the call list in different submissions to the Inspectorate. These calls were made on 3, 5, 8, 10 and 12 December 2025. The calls were to offer assistance with carrying in, or opening the bottled water, and to check the customers understood the boil water notice. I **note** it took until the fifth day of deliveries before these calls were made. There was no other group of vulnerable customers who received such calls.

4.99 The Direction states the company must prioritise vulnerable customers. Guidance then further requires "*Emergency plans should take into account the higher-than-average quantities of water needed by some vulnerable customers, in particular those with specific medical needs.*" Deliveries to PSR customers consisted of two packs containing six times two litre bottles, 24 litres in total each delivery. These packets are plastic wrapped and would weigh over 12 kg for each packet. Most deliveries were dropped at the front door of customers' properties and left. There was anecdotal evidence of deliveries being stolen or removed from the front door not by the intended recipients. Further accounts that some vulnerable consumers would be unable to bring in the bottles or use the water directly from the bottle. Whilst the company eventually made some outbound calls to check for assistance this was not extended to all vulnerable customers who may have difficulties associated with their specific vulnerabilities without a flag in place. I therefore **conclude** that the company

did not take into account the specific needs of all vulnerable customers throughout this event.

4.100 EPG guidance includes the requirement that "*plans should also consider vulnerable customers who may not have facilities or capability to boil water where boil notices are issued and arrange appropriate alternative water provisions."* Whilst PSR deliveries did continue through the BWN, they were only to those flagged as "unable to collect". There is no evidence provided from the company that those unable to collect are the same group of people would be unable to boil water. I **note** that the company kept bottled water stations open, thus allowing those unable to boil water to collect alternative water without the need for boiling.

4.101 The company was asked directly to evidence "*that all affected consumers on the PSR had access to the required amount of water, including additional requirements they might have had, for the duration of the outage".* The company provided a statement with no further evidence. The statement related to daily data reports from the third party provider which included photos of every delivery drop (these reports were not included in the submission). There was no actual evidence provided by the company beyond the statement, and the statement did not mention any additional requirements. Therefore, **I am unable to conclude** that the company adequately prioritised its vulnerable consumers.

4.102 Following the event and during the company's reconciliation period it was highlighted that 106 properties (254 consumers) that should have received a delivery within the first 24 hours as they were on the PSR list, did not, and only did so within the first 48 hours. Therefore, I **conclude** that the company did not prioritise **all** vulnerable customers and provide them with the minimum alternative drinking water in accordance with paragraph 4 of the Direction.

4.103 The company stated that "*We rang daily just to check-in with all customers.".* This statement was not evidenced with records of calls made to any customers. Further information provided by the company suggests outbound calls to a selection of PSR customers were made every other day. Therefore, the Inspectorate cannot verify these claims and the statement made might not be an accurate account of what happened. **I remind** the company of section 207 of the Act and that care should be taken with details and statements included in reports submitted for assessment.

Vulnerable Sites

4.104 A 'vulnerable site' is a non-household property that is normally occupied by vulnerable customers, such as, but not limited to, a hospital, correctional facility or a care home. The Direction 4 4(d)ii) requires that "plans for water supply must be prepared on the basis that the company must—identify and

prioritise—(ii) in the case of a water undertaker, its vulnerable sites within its area."

4.105 The company provided the following table as part of its 20-day report.

	20-Day Report		02/02/2026 Data submission	
Customer Type	**Nos**	**Litres**	**Nos**	**Litres**
Priority Services Register deliveries	38,706*	864,936	38,706*	864,936
Schools	15	168,264	18	257,316
Care homes	19	76,752	20	182,040
Nurseries	29	70,848	29	70,848
GP, dental surgeries and pharmacies	29	34,440	33	98,400
GP			9	47,232
Dental			13	19,680
Pharamcy			11	31,488
Hospitals	3	51,168	4	57,072
Community Hub/ Age Concern UK/ Salvation Army	3	86,592		
Local Authorities			27	170,232
Total		**1,353,000**		**1,799,244**

Table 2 Comparison of vulnerable and important site deliveries from 20-Day and 2 February submission *PSR no. quoted is for total deliveries, whereas for the other Customer Type categories is the number of individual properties delivered to.

Hospitals

4.106 Within the 20-Day report the company state "The area contains two hospitals, Tunbridge Wells Hospital and Nuffield Hospital, and The Tunbridge Wells Kidney Treatment Centre, as well as eight GP surgeries and 11 dental surgeries." I **note** that the company in Table 2 list three hospitals.

4.107 The company further state "*We immediately mobilised the emergency plans for two hospitals, ensuring continuous supply throughout*." The Inspectorate **welcomes** that these two hospitals were supported with tankers for the duration of the event.

4.108 The Tunbridge Wells Kidney Treatment Centre however appears to have been overlooked as a hospital setting despite being included in some of the company's own figures as a hospital. The Inspectorate considers that as this is part of outpatients for Guys and St Thomas' Hospital that it should be included under the definition of hospital for SEMD. The company state that support was provided to the Kidney Treatment Centre on the 30 November 2025, and then daily from the 2 December 2025. In the EFRA Committee hearing, the company stated that tanker support was not possible due to the site not having the correct injection point.

4.109 In section 3.4 of the EPG, it states the company is required to refer to good practice guides developed by MOSL for emergencies for non-household customers[4]. The company state the tier 1 sites include A&E hospitals whilst tier 2 sites are Hospitals without A&E. This does not follow MOSL's good practice guide which splits incident size by tiers, and sites by categories. MOSL categorises sites such as hospitals as category 1, as they are sites that cannot close.

4.110 Paragraph 3 of the Direction states "*The company must, in complying with this Direction, have regard to any relevant guidance, procedures, requirements, best practice and any risks, including long term risks, relating to civil emergencies and national security"*. The EPG notes that it is not expected for companies to have bespoke plans for all vulnerable sites, it is expected that companies proactively engage with sites that have a greater need during an emergency. I consider the Kidney Treatment Centre as having a greater need in an emergency. The company therefore should have considered this in its plans and should have made arrangements to implement these plans during this event. The company should have identified the need for tanker injection in both of the 2022 or 2023 post incident reviews, requests from a previous MP Greg Clarke, or in proactive engagements and made arrangements to be able to implement those plans. The Kidney Treatment Centre had to close, causing patients, some of whom were in critical condition, to travel to London for treatment.

4.111 I therefore **conclude** that the company breached paragraph 3 the Direction, and additionally breached paragraph 4(4)(d)(ii) of the Direction "*Plans for water supply must be prepared on the basis that the company must —(d) identify and prioritise—(ii) in the case of a water undertaker, its vulnerable sites within its area*."

Care Homes

4.112 The company states within the 20-day report that 19 care homes were supplied with 76,752 litres of water. The submission received on 2 February 2026 stated that 20 care homes received deliveries totalling 182,040 litres. This is another example of data being provided in response to further questions which contradicts the information provided within the 20-day report.

4.113 The table of data provided on 2 February 2026 also states that all of the care homes received their first delivery on 3 December 2025. This is over 3 days from the event starting.

4.114 As noted above, in the hospitals section, the EPG states that "*a 'vulnerable site' is a non-household property that is normally occupied by vulnerable customers, such as (but not limited to) a hospital, correctional facility or a care*

[4] RWG Unplanned Events and Incidents Good Practice Guide

home". The Inspectorate does not expect companies to have bespoke plans for all vulnerable sites but does expect companies to proactively engage with sites identified as having a greater need during an emergency, to establish what support is required and reflect these within its plans.

4.115 The Inspectorate received a statement from Kent County Council (KCC) which stated that South East Water had made prior contact with one of the care homes prior to the outage and undertook a site visit to understand the requirements of the site. However, despite this prior visit, which indicated some form of proactive engagement, the resulting response from South East Water was lacking to such an extent that the Kent Fire and Rescue service were required to make an urgent delivery of water to the home, as the expected delivery to this site was delayed. This was one of six care homes to receive fire service delivery to mitigate the threat to life/welfare. These six sites had already received previous deliveries and were therefore known to SEW, however the frequency or number of deliveries made, was insufficient.

4.116 The company stated within its 20-day report that all care homes were contacted daily to confirm they had enough water, but the company also received reactive requests escalated through local MP's office or the Tactical Coordination Group. These reactive requests were prioritised over the planned drops which the company state "*did cause some delays to the planned distribution, causing some deliveries to occur at unsociable hours*".

4.117 Early on in the event, it was reported by KCC that domiciliary care agencies who attended bottled water stations to pick up water on behalf of the vulnerable people they support, were advised by staff at the bottled water stations that they could only pick up water for one household per visit. Despite assurances from South East Water at subsequent meetings that there should have been no such rationing in place, this had not been fed back to all the bottled water stations, and the issue was faced on "multiple occasions".

4.118 I therefore **conclude** that the company was in breach of paragraph 3 the Direction. In addition, it breached of paragraph 4(4) of the Direction "*Plans for water supply must be prepared on the basis that the company must —(d) identify and prioritise—(ii) in the case of a water undertaker, its vulnerable sites within its area*."

Schools and Nurseries

4.119 Within the 20-day report, the company did not provide specific details on deliveries to schools, with the first mention of a specific help to this group of important sites after the setting up of a "ring-fenced team". This happened on Thursday 4 December 2025. The aim of this team was to "improve the coordination of water deliveries with non-household vulnerable sites including care homes, providing daily contact and management of deliveries."

4.120 On 5 December 2025 this team also targeted engagement with local schools, GP surgeries and dental practices, and nurseries to support them operating and included bottled water deliveries for handwashing, cooking and drinking. I **welcome** the setting up of such a team to carry out these activities however it is **noted** that these activities should have been carried out from the first day of the outage and not the fourth day of customers being without water.

4.121 The company further states the team enabled a "*proactive approach to contacting vulnerable sites each day to confirm their specific needs and ensure all deliveries were made during business hours.*" This would indicate that prior to the team being set up the specific needs were not being met and deliveries were being made outside of business hours.

4.122 The company states in the 20-day that "*six schools initially closed*" and were only offered bottled water deliveries when the BWN was implemented. This then allowed the schools to reopen. Schools were then provided water "*when requested*". These statements indicate that schools were closed during the period of loss of supply. In the information provided on 2 February 2026 the company has included a list of 18 schools, however a breakfast club is included twice and is also included as a main school, therefore leaving a list of 16 schools which had closed, and not the six schools as initially stated. This is another example of data being provided after being questioned, which contradicts the information provided within the 20-day report.

4.123 The local MP has indicated that 22 schools in the area were in fact closed as a result of the loss of supply event. There were six further schools that were closed as a result of the company only providing short postcodes for the BWN. Initially, as part of the BWN, South East Water released a list of postcodes affected. This list used only the first three digits (for example TN1, TN2). This was then expanded to four digits (for example TN1 1, TN2 1) which narrowed down the affected area slightly. However, as a result of this, a number of areas were incorrectly labelled as required to follow the BWN advice, such as Hadlow (postcode began TN11). This was despite these customers having not lost water previously and not usually being supplied by Pembury works or Blackhurst service reservoir.

4.124 The six schools in these affected postcodes were confused as to whether they needed to follow the BWN. Out of caution and to follow the advice that was in the public domain they chose to shut. This was despite having no issues with their water supply. The general concern also led to students being taken out of some schools which had remained open due to the uncertainty around the water supply.

4.125 This confusion and partial information impacted the confidence for these schools, parents and the general public around the information provided by the company. Further comment will be made in the communications section of this letter around the communications provided from the company.

4.126 The company states "*Our GIS system includes the locations of all GPs Schools, Nurseries, Care Homes and Dentists in the area.".* Conversely the MP stated that "*SEW didn't have a list of schools in the area – KCC had to provide the list of state schools, and we added on several independent schools that they were not aware of.*"

4.127 All schools, state or independent, are considered as important sites within 3.3 of the EPG and companies are expected to engage with such sites to understand and have regard to their needs during an emergency. I **am unable to conclude** that the company had due regard for all important sites within the affected area, as required within the EPG. I further **note** that nurseries were similarly affected.

Other Medical Facilities

4.128 There are a number of other medical sites which closed or did not exercise their full function during the loss of supply event, including GP surgeries, dentists and pharmacies. The sites under the definition of 'Important sites' are sites essential to the welfare of the community during an incident response, and their closure will have a material impact on that local community. Section 3.3 of EPG states that companies are "expected to proactively engage with these sites to understand their needs during an emergency". The company has classified GP surgeries as vulnerable non-household sites.

4.129 The company states "*Our GIS system includes the locations of all GP's Schools, Nurseries, Care Homes and Dentists in the area."* However, Mike Martin MP has subsequently stated "*GPs were completely missed from SEW water deliveries, and they had to source their own water. It became clear that SEW didn't have a list of the GPs until my Office sent them one*". Data provided on 2 February 2026 indicates that nine GP surgeries received bottled water deliveries from 2 December 2025. Mike Martin MP's office sent a list over to the company, and this would only have been done if they felt there was a need in this case, alongside the fact that other care settings had not received water I am **unable to conclude** that the company was working to a full list of these sites and engaged with them to understand their needs during an emergency.

Non-Domestic Customers

4.130 Paragraph 4(4)(e) of the Direction states that "the company must have regard to (i) the needs of non-domestic users as well as domestic users." The company have not specifically commented on the regard it had to the needs of non-domestic customers within its 20-day report. The Inspectorate has reached out to the Tunbridge Wells Business Improvement District (BID) for feedback. Their statement to the EFRA committee talks of the uncertainty around timescales originally being stated as to when the incident would be resolved. It is highlighted that legislation (such as for example Food Hygiene

regulations[5] and the Health and Safety at Work Act[6]) typically requires that hospitality businesses are not allowed to operate in the absence of running water. No alternative water was specifically provided to affected businesses.

4.131 Feedback received from local businesses include statements that they could not plan as South East Water did not provide guidance of information to businesses. They were treated the same as all other customers, with updates coming from the website, which has already been noted to have been late, poor quality and sometimes contradictory.

4.132 BID state "*The outage has had a significant impact on businesses at a critical time of year directly (e.g. by being forced to close or being unable to operate because of the lack of toilet facilities for staff or because bookings were cancelled) and indirectly (e.g. because of a lack of footfall and car parks being use for bottled water stations). A further issue was the lack of confidence amongst the public in the quality of water – even after the Boil Water Notice was lifted.*"

4.133 BID also highlight that businesses could not plan effectively as they had little idea what was happening. The limited information provided on specific issues was also highlighted for example cafés are unsure if a coffee machine can operate under a boil water notice. The changing nature of information also added to a lack of clarity for business.

4.134 There were increased burdens for businesses that were able to operate. For example, one business had to purchase 28,000 litres of water to enable a pre-booked event to take place.

4.135 I therefore **conclude** that the amount of regard given to non-household users was not sufficient to meet 4(4)(e) of the Direction.

Resources

4.136 The Direction states that 4(6) "plans must make provision for – (a) the carrying out of functions by a sufficient number of appropriately trained personnel." As noted in the bottled water section the council were staffing some bottled water stations. Additionally, the Fire Service and volunteer groups were part of a number of groups backfilling staffing needs for the company. Whilst these organisations should be recognised and thanked for assisting, it is likely that the scale of the assistance given was due to a lack of a sufficient bottled water stations being set up and an insufficient number of trained people from the company, and therefore I **conclude** that this is a breach of the Direction.

4.137 The company stated within its 20-day report that the company has an "aim" that all calls to the call centre are answered within 5 minutes. They did not meet this target time for five days from 29 November 2025 (seven minutes) to

[5] Setting up your food business premises | Food Standards Agency
[6] Welfare at work - Guidance for employers on welfare provisions

3 December 2025 (six minutes) with a peak average response time of 18 minutes on 30 November 2025. Not only was the 30 November 2025 the longest response time, but also 50% of calls on this day were hung up and abandoned.

4.138 Section 4.4 of the EPG states "c*ompanies must be contactable 24 hours a day for emergencies, and able to rapidly respond through a range of communication methods (including, but not limited to, telephone, email, and social media).*"

4.139 I **conclude** that given the large number of abandoned calls and extended wait time well beyond the companies own stated aim time, the company was unable to rapidly respond to the emergency. In addition, the number of reactive calls that had to be fielded by the office of Mike Martin MP indicates the extent to which customers were unable to get through to their water company in an emergency and had to resort to another channel to receive assistance and help.

Reserves

4.140 Paragraph 4(6)(b) of the Direction states that "plans must make provision for (b) strategically stored reserves of sufficient types and quantities of equipment and materials necessary to enable the company to continue to carry out its water supply or sewerage functions." The company initially requested turbidity filters via mutual aid and then later procured these themselves. The company is required to take a People, Processes, Information, Technology and Facilities (PPITF) approach considering a range of scenarios.

4.141 Whilst it might be considered unreasonable to have new treatment processes within its strategically stored reserves, the mutual aid request has demonstrated that other companies do hold these items. It is foreseeable that a turbidity issue might arise at a treatment works, and the company did not appear to have any strategically stored reserves to deal with the issue.

4.142 I therefore **conclude** that the company did not have strategically stored reserves of sufficient types and quantities of equipment and materials necessary to enable the company to continue to carry out its water supply or sewerage functions.

Communications

4.143 Paragraph 4(6)(c) of the Direction states that "plans must make provision for (c) appropriate emergency communications facilities and procedures for managing and maintaining communications and support to customers throughout an emergency or security event."

4.144 The company states within the 20-day report "*as would be expected with an event of this magnitude a significant amount of information and updates were*

disseminated by the South East Water communications team". They go on to state that "*this included providing regular updates to the local MP, and the Water Minister, other stakeholders, media statements and interviews. In addition, the social media updates, website FAQ's, customer emails, business stakeholder updates, myth busting incorrect information*."

4.145 The Inspectorate requested from the company its communications strategy for the event. The company stated "*The strategy followed our well-established approach for widespread incidents. We utilise multiple communication channels and ensure maximum reach in terms of sharing the public service messages. In terms of customer notifications, our key tool is AquaAlerter SMS messaging service. Throughout the incident the Company communicated with local councillors, MPs, Kent Resilience Forum, local business groups, NHH retailers, PSR customers, PSR stakeholders, media, Defra press office, DWI and other regulators. We also had teams liaising directly with schools, nurseries, care homes, dentists and hospitals*." No formalised documented strategy was provided beyond this response.

4.146 The company then referred to two "playbooks" which were used during the incident. One was around the water treatment works outage whilst the other was for the boil water notice. The company informed the Inspectorate that the playbooks "*have media engagement, stakeholder engagement, social media engagement and regulatory general engagement at their cores*". These playbooks were not initially provided along with the 20-day report to evidence the statements it had made. The Inspectorate requested these playbooks be submitted.

4.147 Upon inspection, the playbooks are no more than a series of templates allowing a user to amend particular sections and details to then be distributed as stakeholder emails, customer emails, reactive press statement, Facebook, banner copy and FAQ.

4.148 It is expected that a typical communication playbook should describe a company's policies, workflows and procedures. It should be an actionable guide documenting business strategies and processes to ensure team alignment, consistency and efficient execution.

4.149 The documents provided and described above cannot be reasonably described as playbooks as understood by a commonly accepted definition and would have provided no strategy to the company in dealing with an event. An example of playbook planning can be found Incident response processes - NCSC.GOV.UK**.** Although this is a cyber example the principles are what the Inspectorate would expect to see in a typical playbook.

4.150 The company has not provided plans for how, when and why it communicates with stakeholders. The evidence does not indicate there was any procedure to adapt responses to customer feedback or local priorities as incidents evolved.

It appears that ad hoc decisions were made which were not recorded, making it impossible for a post event 'lessons learnt' exercise to be completed, with improvements made and embedded in readiness for future events. As there was a lack of plans, areas such as consistent communication methods and messages were not maintained.

4.151 I therefore **conclude** the company's communications strategy was inadequate and the company lacked documented plans, appropriate emergency communications facilities, or procedures for managing and maintaining communications and support to customers throughout an emergency or security event.

4.152 The Inspectorate has reached out to affected Members of Parliament (MPs) to understand their experience with the communications from South East Water to themselves and their constituents during this event. The public communications were described by Mike Martin MP as "*either overoptimistic, absent and changed repeatedly at short notice; incorrect and contradictory; unclear and poorly worded; or in at least one case, dangerous to infant human health*". In addition, an inter-agency communications group had been set up to try and improve the communications coming from the company. However, the company sent a junior employee who was not empowered to make decisions during the meeting and needing them to be "*taken away*" to the company to be discussed and decided, thus delaying key decisions and messages being published. It was noted that the head of communications did not attend the LRF communications cell until 9 December 2025.

4.153 It appears through the 3-day, 20-day reports and stakeholder statements that communications emanating from the company was insufficient. The information being sent out from various company sources was often delayed and inconsistent. This meant when the company communicated there was a lack of trust of the messages being delivered to affected customers. Examples of these communication issues have been mentioned throughout this letter. Including, but not limited to, the bottled water stations, school closures, cause of event and likely return to supply for customers.

4.154 An accusation levelled at the company from Tunbridge Wells Borough Council following the previous loss of supply events was that the company communicated with an optimism bias that did not allow affected customers to plan appropriately as they were led to believe that issues would be short lived and resolved before they would need to act to mitigate the impacts. This optimism bias then affected decisions made in tactical and strategic coordinating groups. It is **noted** that the same bias was present during this event. There appears to have been no lessons learnt from previous events.

Command and Control

4.155 Paragraph 4(6) of The Direction states "Plans must make provision (e) for the establishment of appropriate command and control arrangements to manage an emergency or security event."

4.156 The company's incident structure involves Bronze, Silver and Gold teams which are stood up dependent on operational, tactical, and strategic management of events. The different colours refer to the increasing seniority of staff involved. Events can range from Level 0 (routine event no escalation required) to Level 4 (Severe incident) to escalate to external agencies, regulators and other stakeholders.

4.157 The company's procedures as submitted with the 20-day report indicate that a Level 4 event is triggered when greater than 5,000 customers are impacted by an event or when over 100 people are affected for over 12 hours with multi-agency arrangements invoked. This event should have been classified and run as a Level 4 event, according to the company's procedures, from at least the afternoon of 29 November 2025.

4.158 The company began running a Bronze level 2 event on 28 November 2025, following low levels in Blackhurst Reservoir and tankering being stood up.

4.159 The event was then escalated to a Silver Level 3 event on 29 November 2025 following further shutdowns at Pembury works on Friday 28 November 2025. Section 4.6 of the EPG states "*companies should be able to quickly establish a clear decision-making structure, with the ability to rapidly cascade decisions*." I **remind** the company that escalation of events should be timely.

4.160 The LRF was first contacted on 29 November 2025 regarding support for resourcing bottled water stations and to provide a list of the affected postcodes. As a multi-agency response was requested, and the population affected at this time exceeded 5,000 customers the company's own procedures suggest that a Gold level 4 Event should have been stood up. The event remained at Silver level 3.

4.161 The company has provided contradictory statements for when Gold Command took over the running of the event and when the Level was escalated to Level 4. The first time Gold Command may have met was Monday 1 December 2025. Alternatively, the escalation may have occurred on 2 December 2025 when "*On the 2nd December with the potential for a Boil Water Notice to be issued to all customers in the affected area, Gold level meetings were implemented, and the event was formally escalated to level 4."* Or another statement later states "E*scalated to a L4 incident on Wednesday 3 December*."

4.162 The Gold level meetings were not always specifically held as a specific Gold level incident call, instead they may have been included as agenda items on existing executive meetings. I **note** that there were frequent board level notifications beginning on 1 December 2025 until 17 December 2025.

4.163 The company identified some deficiencies in the command-and-control arrangements in facilitating shared situational awareness, decision making and risk assessments. The most notable was when sharing information with external suppliers and stakeholders was made more complex due to the difference in core systems for example Google Sheets versus Microsoft Excel. It is recommended within EPG Annex C to have a consistent approach for the sharing of data about vulnerable customers.

4.164 The company also provided an additional procedure following further queries after the 20-day report. The text within this procedure indicated that "*A Major incident response is required for incidents affecting more than 35,000 people in an urban location and more than 20,000 people in a rural location*". These numbers appear to have come from historical guidance that has been revoked. I **note** that the company uses the term "major incident" for various situations where each cannot occur concurrently.

4.165 From the statements and evidence provided to the Inspectorate it is difficult to determine when and why the event was escalated from level 2 through to level 4. It would appear that the company also struggled to appropriately classify this event and should have been running it as a Gold level 4 much earlier. This does not constitute an appropriate command and control arrangements to manage an emergency event, and I therefore **conclude** this is a breach of the Direction.

Testing and Exercising

4.166 Paragraph 8(a) of the Direction requires companies to "regularly test the effectiveness of its plans to ensure they remain appropriate; and (b) take steps to address any vulnerabilities identified." Furthermore, the EPG states "Companies are expected to test their alternative water plans regularly, including (but not limited to) deployment of resources, working with relevant third parties, and command structures. This should include a mix of desktop exercises and physical testing."

4.167 In 2024 the Inspectorate carried out a desktop audit of the company, as part of the annual reporting process. The company were asked to provide evidence of testing and exercising carried out.

4.168 In June 2023 the company ran an exercise around alternative water supply for a hospital. In September 2023 and October 2023, the company ran a desktop event for Bronze and Silver Management training. In November 2023 a "Boil notice scenario" was exercised.

4.169 In March 2024 the company ran an exercise around low reservoir levels and supply issues to customers. The learning from this event was documented by the company to include a "*timelier approach in setting up the incident team and the required actions could be achieved to afford a better and quicker response".* The exercise also "*quickly established the timely engagement of the*

comms team did not take place and an effective spokesperson for press liaison was never established."

4.170 At the time of the audit the Inspectorate **noted** the company did not appear to regularly test alternative water deployment, nor did it submit any learning from live incidents. This was followed up with a recommendation that the company regularly tests its alternative water deployment covering all methods that it might use.

4.171 It was also **noted** that the company has undertaken a test for a Hospital in Maidstone, Kent. No objectives or learning were submitted as part of the audit, and therefore the Inspectorate recommended that the company documents objectives it wants to achieve from an exercise, alongside learning. The last pertinent recommendation made within the audit was that the company tests its RWCS.

4.172 As part of the audit the company indicated a future plan of exercising for 2024/25 to include a plan to test boil water notices, a power outage, a shared exercise with another water company testing security, and live deployment of alternative water and response to test SOPs (standard operating procedures) for both the 'field' and 'control room'.

4.173 The company has confirmed that it has completed the SOP test, the power outage and the boil water notice tests.

4.174 In relation to this event, subsequent questions to the company, confirmed that they would not choose Tunbridge Wells for a live incident test due to the following reasons:

- *"We had actual incidents at Tunbridge Wells in 2022 (summer demand and a Freeze/Thaw) so have already identified and tested alternative water locations."*
- *"To undertake live alternative water in Tunbridge Wells as part of an unplanned event is complicated as the area is already very congested so any AW deployment creates traffic congestion."*

4.175 I **remind** the company that if it is taking real events as part of its testing and exercising regime, these should be documented against objectives that are required to be met and learning outcomes. The objectives should be established as part of the yearly planning for testing and exercising to identify if a live incident has fully met the learning outcomes. The learning outcomes should be embedded within plans for future events.

4.176 I further **remind** the company that testing and exercising does not need to be "live" and can be desktop or workshop based, however items such as traffic congestion should be reasons to carry out a desktop exercise/modelling and not avoid it.

4.177 I **conclude** that the company does not appear to embed learning from testing or exercising in future plans. It also does not appear to learn from past events with the experiences embedded to ensure that improvements take place outside of live events. The company further suggests that it avoids difficult scenarios in its testing and have not taken on board previous recommendations to test reasonable worst-case scenarios to date.

Previous Loss of Supply Events

4.178 The Inspectorate **notes** that four previous events affected the Tunbridge Wells area. DWI Ref:2022/8835 (Blackhurst Loss of Supply) occurred in November 2022 whilst DWI Ref:2022/8868 (Tunbridge Wells Freeze-thaw) and DWI Ref: 2022/8873 (Freeze-thaw Event Winter 2022) both occurred in December 2022. DWI Ref:2023/9081 (Tunbridge Wells High Demand) occurred in June 2023. These four events affected large swathes of the same supply area as this event. Of the 24 District Meter Areas (DMA) which were impacted in the November 2025/December 2025 event:

- Two DMAs were affected in all four of the previous events. Tunbridge Wells Forest Road and Tunbridge Wells High Level B experienced their fifth loss of supply event within three years.
- Seven DMAs were affected in three of the four events, two DMAs were affected in two of the four events, and five DMA were affected in a single previous event.
- Eight DMAs experienced their first loss of supply event.

4.179 The Inspectorate previously **noted** in DWI Ref:2022/8868 that lessons appear to have been overlooked from another previous event in 2018 (DWI Ref:2018/6504) and a suggestion was made by the Inspectorate in its assessment that lessons learnt should be embedded into the policies and procedures.

4.180 As part of the 20-day report for this event the company were asked to outline what lessons had been learnt from previous events. The company stated "*the size and scale of alternate water provision was significantly larger than previously deployed*", **"***the Company increased tanker provision from two to 26 tankers (12 internal and 14 via mutual aid), provided more than four times the number of PSR deliveries; supplied more than four times the number of water via bottled water stations; sent almost one million messages through AquaAlerter (a system implemented in response to the 2022 event)...and provided over 37 million litres of water via tankers*." The company also stated, "*We took on board learnings from other company incidents and the insight shared by Ofwat/CCW on issuing of BWN."*

4.181 The information supplied by the company acts as a comparison to a single previous event in 2022. It does not outline why or how these actions were

carried out, it also does not indicate whether the numbers provided were sufficient in this particular event. No specifics were given on what actual learnings were instigated and what insights had been shared regarding the issuing of the BWN.

4.182 Following the event DWI Ref:2022/8868 the Inspectorate **concluded** that the company did not supply the correct amount of bottled water to vulnerable customers within the correct time frames. The Inspectorate initiated enforcement covering the event DWI Ref:2022/8868 related to the PSR, however the company was able to provide additional data showing that deliveries had been made reducing the shortfall significantly. The enforcement was not taken further, in line with the Inspectorate's enforcement policy. This information was not made available during the Inspectorate's assessment and only came to light once enforcement proceedings had been initiated.

4.183 In the event DWI Ref:2023/9081 the Inspectorate **concluded** that the company did not act proactively to minimise the event impact. It was **noted** that activity to mitigate the impacts of the event only started after the impact was realised, despite an opportunity to act prior to the event. The Inspectorate, again, was **unable to conclude** that the correct amount of alternative water had been made available to vulnerable customers during the event. It was further **noted** that the company had multiple incidents in the recent past, that resulted in loss of supply to its consumers due to weather conditions. The Inspectorate **recommended** that the company establish a process to forecast and risk assess extreme weather conditions and put in place proactive control measures. The Inspectorate was **unable to conclude** the event DWI Ref:2023/9081 was unavoidable and initiated the action.

4.184 The Inspectorate accepted an undertaking under section 19 of the Act from the company, for these, and other site-specific actions. This undertaking was accepted on 25 March 2024 and given the reference SEW-2023-00009. The undertaking requires the company to improve resilience and customer protection by strengthening demand management, incident response and communications, improving tanker capability and support for vulnerable customers, and enhancing system reliability through longer-term improvements at Tonbridge works and increase abstraction at Pembury works. This undertaking is ongoing and has a completion date of 30 April 2031.

4.185 Prior to this event, and since 2020, the company has reported 20 events across its supply area to the Inspectorate where a loss of supply event occurred. The total combined population affected by these events was 1,057,306, some customers were impacted on more than one occasion.

4.186 In 2025 alone there were six loss of supply events. Details of these events can be found in Annex A. Prior to November 2025 customers within the Tunbridge Wells area had faced four separate loss of supply events in a little over three years since November 2022. Since this event was notified, and during the

period of assessment, two further loss of supply events occurred, with many of the same customers within Tunbridge Wells facing loss of supplies for a second and third time within a month and seventh time within three years. These more recent events will be the subject of their own event assessment.

4.187 When a company has been found to be in breach the Direction the Inspectorate must carry out its response based on the graduated enforcement policy. As a result of the events mentioned above and also further audits and assessments, the Inspectorate has previously made 15 recommendations for emergency planning. All but one of these recommendations were applicable to lessons that should have been prevented during this event, with the single remaining recommendation relating to Freeze-thaw, which will be reviewed against the 2026 events. The 14 pertinent recommendations include areas such as reasonable worst-case scenarios, bottled water stations, contingency plans, provision of information, vulnerable customers, exercising, demand side strategies, resilience and alternative water supplies. Further details of these recommendations can be found in Annex B.

Conclusion

4.188 In conclusion the company did not have plans to continue the exercise of its water supply function or robust plans to deal with an emergency. The company did not follow its own policies when escalating events which resulted in delayed decision-making impacting customers. Based on the breaches outlined in this report, previous events and failure to meet dates within the existing undertaking, the Inspectorate must therefore **conclude** that further enforcement is necessary.

4.189 The company provided conflicting data and statements of what occurred during the event, further doubt was introduced with statements from third parties. I once again **remind** the company of section 207 of the Water Industry Act 1991 and that care should be taken when providing details, data and statements that are included in reports submitted for assessment. I further **remind** the company of the previous recommendation SEMD 15/2023 "I recommend that *the company ensures that there is adequate information provided in reports sent to the Inspectorate, for water quality, SEMD and NIS. This is not only a requirement of the Water Industry Act but will help the Inspectorate make a fair and accurate assessment in a timely manner.*

4.190 This letter demonstrates several instances of noncompliance with both the Direction and EPG across multiple areas: affecting alternative water supply, vulnerable customer support, communications, preparedness, mutual aid and command structures. Failures were persistent and repeated from previous events, reflecting insufficient planning, weak operational resilience, delayed escalation, and inadequate learning from past events. The Inspectorate

concludes that at least eleven paragraphs of the Direction saw at least one breach. In summary, the company were deficient in the following areas:

4.191 **Preparedness and plans**: The Inspectorate **concluded** that the company failed to make, review, or maintain adequate plans to ensure continuity of water supply as required under the Direction. There was an ongoing awareness of supply-demand vulnerabilities within the Kent and Sussex supply area and network interconnectivity issues. The company had experienced repeated previous operational failures following which they failed to review and revise its plans. The company does not appear to have either developed or submitted evidence of effective outage or contingency plans for the Tunbridge Wells supply system. In addition, the company was having issues with Blackhurst service reservoir (SR) since August 2025 when levels within the reservoir cells dropped below 40% on multiple occasions. The Inspectorate **concludes** that the event was not 'unavoidable' contrary to paragraph 4 of the Direction.

4.192 **Alternative Water:** The information provided throughout the company's multiple submissions was inconsistent which undermined assurances of the figures presented for the company's alternative water provision. Non-potable sources such as bowsers and grab bags were incorrectly counted toward alternative drinking water provision. Tanker injections could not be equitably allocated to prove each affected customer received the minimum volume of water despite being attributed as "available water".

4.193 **Vulnerable customers and sites:** The Priority Services Register (PSR) was not adequately proactively maintained to seek out new customers. Deliveries to some vulnerable customers were delayed beyond 24 hours breaching the Direction for prioritising vulnerable customers, ensuring water is available and ensuring they have equal opportunity to access to services. Some high-risk sites such as the Kidney Treatment Centre, GP surgeries, care homes and schools experienced missed deliveries or gained belated support after multiple days without any water supply. A ring-fenced coordination team was stood up on 4 December 2025, five days into the loss of supply.

4.194 **Accessibility of bottled-water stations:** The first station at Tonbridge was not centrally located for the affected Tunbridge Wells population. Customers faced long travel journeys as well as further queuing whilst awaiting to access the stations. The opening times and chosen locations disadvantaged non-drivers. For much of 30 November 2025 only one station served over 50,000 customers. At maximum station availability, only three stations served up to approximately 60,000 customers, well below the company's own ratio of 5,000 to 10,000 customers per station. All stations were publicised as being closed overnight therefore removing 24/7 access and failing to provide an inclusive service.

4.195 **Notification and reporting**: Despite clear SEMD triggers a few days prior to the event including tankering; formation of Silver team; mutual aid requests being made, the company did not notify the Inspectorate until the 30 November 2025, after customers experienced loss of supply. The 3-day report was submitted late and lacked required content. The 20-day report omitted required material and left several specifically raised questions unanswered. Follow up reports and responses caused further confusion and did not provide the assurances required that the previously reported information was accurate.

4.196 **Operational capability and mutual aid:** The resources and reserves of the company was insufficient, leading to reliance on external parties such as local councils, Fire Service and volunteer organisation. Call-centre performance was inadequate with long waits and abandonment of customers calls especially on Sunday 30 December 2025 indicating a lack of sufficient resource. Analytical sampling mutual aid was arranged ad hoc and not pre-planned as required within EPG.

4.197 **Command and Control:** The event should have internally been escalated to Gold level 4 earlier but was incorrectly maintained at Silver level 3, delaying strategic coordination and response.

4.198 **Mutual aid and communications**: Communications lacked a documented, tested strategy. The company put a lot of emphasis on playbooks which were no more than templates rather than operational guides. Messaging to customers was delayed and when it was broadcast often contradictory with existing messages from other sources. The company displayed an optimism bias undermining public trust, situational awareness and prevented customers and businesses making informed decisions.

4.199 **Testing, learning and post-incident review**. The company has not embedded lessons from exercises or other prior loss of supply events. Alternative water deployment and reasonable worst-case scenarios were not robustly tested. Statements made by the company admitted that the company avoided testing challenging scenarios, preventing meaningful organisational learning.

4.200 Given the repeated instances of loss of supply and failure to make plans to exercise all of its water functions, together with the associated water quality impacts described in this letter, I **conclude** that a similar event is likely to occur again unless the company undertakes improvements to its supply system. The Inspectorate therefore considers that enforcement action is now required to ensure measures are taken to prevent a recurrence.

4.201 I am now initiating enforcement action under section 18 of the Water Industry Act 1991. This will be sent under separate cover.

5. **Other relevant matters**

5.1 I am copying this letter to the EFRA Parliamentary select committee, UKHSA Kent Health Protection Team (South East), and Tunbridge Wells Borough Council.

Please respond to my recommendations and suggestions within 20 working days of the date of this letter.

Please contact me if you have any queries regarding this letter.

[redacted]

Annex A:

South East Water loss of supply events reported to the DWI since 1/1/2020. Those affecting Tunbridge Wells have been **highlighted in bold.**

Event Ref and Name	**Date**	**Location impacted**	**Population affected/ Duration**	**DWI Action**
2020/7732 High Demand - Media Interest	9/8/20	Areas of Kent and Sussex	[redacted]/ 96 hours	1 Recommendation made
2020/7808 St Francis loss of Supply Media Interest	22/9/20	Balcombe, Cuckfield, Barcombe, Butlers Green, Underhills	[redacted]/ 30 hours	No recommendations or suggestions made
2022/8449 Storm Eunice	**18/2/22**	**Whole Company**	[redacted]/ **126 hours**	**No recommendations or suggestions made**
2022/8605 Summer Demand Media Interest and LOS	18/7/22	Kent (Challock and Molash)	[redacted]/ 120 hours	1 Recommendation made
2022/8625 Maidstone Loss of Supply Media Interest	24/7/22	Maidstone	[redacted]/ 30 hours	1 Recommendation made
2022/8813 Hawkhurst Loss of Supply	7/11/22	Hawkhurst	[redacted]/ 120 hours	5 Recommendations made
2022/8835 Blackhurst Loss of Supply	**24/11/22**	**Tunbridge Wells**	[redacted]/ **99 hours**	**1 Recommendation made**
2022/8860 Powdermill LOS	13/12/22	Battle	[redacted]/ 72 hours	2 Recommendations made
2022/8868 Tunbridge Wells LOS - Media	**16/12/22**	**Tunbridge Wells**	[redacted]/ **120 hours**	**5 Recommendations made**
2022/8873	**18/12/22**	**Kent and Sussex**	[redacted]/ **144 hours**	**1 Recommendation made**

Freeze-thaw Event Winter 2022				
2023/8945 Hollingbourne Loss of Supplies	11/2/23	Maidstone	[redacted]/ 70 hours	1 Recommendation made
2023/9049 Maidenbower Loss of Supply	15/5/23	Maidenbower	[redacted]/ 24 hours	2 Recommendations made
2023/9081 High Demand Media Interest	**13/6/23**	**Kent and Sussex**	[redacted]/ **168 hours**	**6 Recommendations made S19 Undertaking SEW-2023-00009 Loss of Supply**
2024/9541 Windover Loss of Supply-Media Interest	28/2/24	Alfriston/ Wilmington, East Sussex	[redacted]/ 63 hours	7 Recommendations made
2025/10147 Sevenoaks Loss of Supplies Media Interest	27/1/25	Sevenoaks, Tonbridge	[redacted]/ 5 hours	2 Recommendations made
2025/10215 Polegate and Eastbourne Loss of Supply	5/3/25	Polegate and Eastbourne	[redacted]/ 124 hours	1 Recommendation made
2025/10241 Trosley LOS	22/3/25	Maidstone	[redacted]/ 134 hours	Suggestions made
2025/10338 Bolney Loss of Supply and Media Interest	8/6/25	Bolney and Cuckfield, West Sussex	[redacted]/ 58 hours	2 Recommendations
2025/10377 Herne Bay Loss of Supply	1/7/25	Herne Bay	[redacted]/ 55 hours	4 Recommendations made
2025/10384 Whitstable Loss of Supply and Media Interest	3/7/25	Whitstable	[redacted]/ 156 hours	4 Recommendations made

Annex B:

SEMD Emergency Planning Recommendations.

Date	Reference	Recommendation	Pertinent to this event
6/4/23	SEMD 09/2023	I recommend that the company reviews their winter freeze-thaw preparation plans to assist in the planning for the availability of operational assets and to introduce enhanced operating regimes for assets for suspected freeze-thaw incidents.	No
6/4/23	SEMD 10/2023	I recommend that the company undertake a critical review of its reasonable worst-case scenario, this should be shared with the Inspectorate in response to this letter, along with the methodology used and an action plan to achieve the new requirements.	Yes
6/4/23	SEMD 11/2023	I recommend that the company mitigates any identified risks when assessing setting up bottled water stations, to provide a service to the inhabitants of the area. I also require the company to build health and safety into the alternative supply plans. If a risk cannot be mitigated for the consumer the company should treat these consumers as vulnerable.	Yes
6/4/23	SEMD 08/2023	I recommend that the company review the requirement to create specific contingency plans for all treatment works and zones, with a particular focus on power interruptions and losses of supply.	Yes
12/6/23	SEMD 15/2023	I recommend that the company ensures that there is adequate information provided in reports sent to the Inspectorate, for water quality, SEMD and NIS. This is not only a requirement of the Water Industry Act but will help the inspectorate make a fair and accurate assessment in a timely manner.	Yes
12/6/23	SEMD 14/2023	I recommend that the company reviews its procedures to ensure it considers the full definition of a vulnerable customer detailed in the EPG.	Yes

30/8/24	SEMD 30/2024	I recommend that the company regularly tests its alternative water deployment covering all methods that it might use. For example, Tankering, bottled water and Arlington tanks.	Yes
30/8/24	SEMD 31/2024	I recommend that the company documents objectives it wants to achieve from an exercise, alongside learning. These objectives might well be achieved through live incidents, over any given year and therefore it should just leave objectives outstanding to achieve. By setting objectives the company should be able to identify all learning areas are covered.	Yes
30/8/24	SEMD 32/2024	I recommend that the company exercises personnel on a regular basis.	Yes
30/8/24	SEMD 33/2024	I recommend that the company organise as well as take part in multi-agency exercising.	Yes
30/8/24	SEMD 34/2024	I recommend that the company tests its RWCS.	Yes
28/11/25	SEMD 73/2025	I recommend that the company review its demand side strategies for the areas affected by these events.	Yes
28/11/25	SEMD 74/2025	I recommend that the company reviews it contingency plans for the affected areas in light of the event, and how such plans are updated when issues arise at assets included in the original contingency plans.	Yes
28/11/25	SEMD 75/2025	I recommend that the company should review its resilience of the affected area to ensure that it can continue to carry out all of its water supply functions.	Yes
28/11/25	SEMD 76/2025	I recommend that the company reviews its methodology for the provision of sufficient alternative water supplies to ensure alternative water is accessible and inclusive for all customers in line with the requirements of EPG as soon as it becomes aware of an incident	Yes