House of Commons

Environment, Food and Rural Affairs Committee

Failures at South East Water

Eighth Report of Session 2024–26

HC 1861

Environment, Food and Rural Affairs Committee

The Environment, Food and Rural Affairs Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department for Environment, Food and Rural Affairs and its associated public bodies.

Current membership

Mr Alistair Carmichael (Liberal Democrat; Orkney and Shetland) (Chair)

Sarah Bool (Conservative; South Northamptonshire)

Juliet Campbell (Labour; Broxtowe)

Charlie Dewhirst (Conservative; Bridlington and The Wolds)

Sarah Dyke (Liberal Democrat; Glastonbury and Somerton)

Terry Jermy (Labour; South West Norfolk)

Jayne Kirkham (Labour; Truro and Falmouth)

Josh Newbury (Labour; Cannock Chase)

Jenny Riddell-Carpenter (Labour; Suffolk Coastal)

Tim Roca (Labour; Macclesfield)

Henry Tufnell (Labour; Mid and South Pembrokeshire)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No. 152. These are available on the internet via www.parliament.uk.

Publication

This Report, together with formal minutes relating to the Report, was Ordered by the House of Commons, on 28 April 2026, to be printed.
It was published on 1 May 2026 by authority of the House of Commons.

Committee Reports are published on the Committee's website at www.parliament.uk/efracom and in print by Order of the House.

Contacts

All correspondence should be addressed to the Clerk of the Environment, Food and Rural Affairs Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 0207 219 1119; the Committee's email address is efracom@parliament.uk. You can follow the Committee on X (formerly Twitter) using @CommonsEFRA.

Contents

Summary

Select committees do not often focus directly on the leadership, behaviour and performance of individual private companies, but in the case of the highly regulated water sector, responsible for a critical resource, accountability to Parliament is justifiable. We have already scrutinised the most significant water companies in England and Wales but this is our first report on a single water company, indicating the gravity of the situation facing the residents and businesses in the communities it serves. Given the extremely negative and dangerous impact that South East Water (SEW) has had on over 300,000 people since 2020, we feel compelled to report on its leadership that otherwise appears shielded from the consequences of its incompetence.

SEW is one of England's worst-performing companies for water supply interruptions, with its eastern region facing numerous, and in many respects, similar incidents since 2018. Between November and December 2025, SEW experienced yet another major outage in the Tunbridge Wells area, caused by the shutdown of the Pembury Water Treatment Works, prompting an investigation by the EFRA Committee as well as the Drinking Water Inspectorate (DWI). The company's account of the incident, including its causes and the quality of the incident response, has been contested by not only local residents, businesses and representatives but also the DWI.

Using evidence gathered by this committee and recent reports from the DWI and Ofwat about the Tunbridge Wells incident and other incidents going back to 2020, this report finds that SEW has comprehensively failed to deliver for the consumers it serves. As set out in Chapter 2, this includes failures to identify and monitor risks—one of the core problems that led to the Tunbridge Wells incident—and a failure to maintain assets, which impacted the efficacy of assets at the Pembury Works. The company has also not invested in its wider infrastructure to remove single points of failure, improve interconnectivity, and prepare for climate change, despite these being long-term issues that the company's leadership should have factored into their long-term plans. The company has also failed to sufficiently plan for critical periods and outages, leading to poor escalation processes, insufficient alternative water supplies, inconsistent communications and a failure to support all vulnerable customers. Given the company's propensity for outages, it is incomprehensible that SEW still lacks a crisis communications strategy and still seems caught completely by surprise when vulnerable customers and important sites flag problems

with the support they have received. In real-life terms, this has seen medical and care settings going without water, schools closing—in some cases unnecessarily due to poor crisis planning by SEW—and local businesses losing millions of pounds of revenue. These issues also mean that the company has breached several licence conditions and is currently non-compliant with its legal duties.

Some of these issues, particularly long-term infrastructure concerns, predate the appointment of the current executive team. This means that shareholders should bear some responsibility for this failure to invest, as the long-term stewards of the company. However, in Chapter 3, we consider the deeper issues with the current culture at South East Water that account for why the company has failed repeatedly in recent years. This includes a failure to learn from mistakes, likely driven by an inability to identify root causes, problem-solve and or understand facts on the ground, as well as a tendency within its leadership to avoid taking responsibility or engaging properly with customers, regulators and other third parties. These behaviours led to inaccurate comments being made to this Committee in January 2026—something we will deliberate on further—but most importantly to numerous dangerous and disruptive supply interruptions for the company's customers.

South East Water presents as a company devoid of proper leadership, riddled with cultural problems that raise serious concerns about the ability of the executive team, led by the CEO David Hinton, to bring the company back into compliance and deliver the services their customers deserve. Leadership teams play a major role in how company culture develops; culture change at this scale requires South East Water's leadership to change.

We are also concerned by the behaviour and decisions of South East Water's Board. Not only by its continued backing of Mr Hinton, given the repeated failures since 2020, but also its decision to file an injunction against the publication of Ofwat's report into long-term failings at SEW, demonstrating at best a lack of transparency, and at worst an attempt to actively deceive external stakeholders.

A company described by its leadership as having a 'family feel' is perhaps better described as an unaccountable clique. As a result, we conclude that we have no confidence in either the executive or non-executive teams at South East Water. Shareholders should intervene to address the systematic, ongoing issues at the company, which are bringing misery to the consumers it serves.

1 Background and timelines

Incidents and performance since 2018

1. Since the February to March "Beast from the East" incident in 2018, when several companies suffered major water supply interruptions, South East Water (SEW) has suffered a disproportionately high number of similar events, almost exclusively in the eastern region of the company. Tens of thousands of SEW customers in Kent and Sussex experienced low or no water pressure in August 2020, February, July and December 2022, June and December 2023 and January, March, and July 2025. Since 2015–16, SEW has had one of the worst water supply interruptions performances in the industry,[1] leading to the launch of an Ofwat investigation in 2023.[2]

2. Between 29 November and 12 December 2025, a further major supply incident occurred in Tunbridge Wells following the failure of the Pembury Water Treatment Works ("Pembury Works"). It is estimated that around 24,000 properties in the Tunbridge Wells area[3]—affecting over 60,000 customers—experienced little or no access to drinking water for four to five days between 29 November and 2 December. On 3 December, SEW restarted the Pembury Works to restore essential services such as flushing toilets, despite not yet having a full solution to the underlying problem. Customers were still required to boil this water, although the water was "chemically safe". Although Pembury Works became functional on 4 December, this boil notice lasted until 12 December, around 10 days, to ensure that water produced earlier had been flushed through the network.[4]

3. Schools, care settings, GPs and local businesses were significantly impacted. Many had to close or alter operations due to the lack of water, creating disruption to education, health services and around 1500 businesses, leading to millions of pounds worth of losses to the local economy.[5] Customers, the local council and local MPs reported poorly

1 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026

2 Ofwat, Enforcement case into South East Water's supply resilience, November 2023. This has focussed on the Eastern region of the company.

3 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026

4 South East Water website, Boil water notice lifted, accessed 28 April 2026

5 Mr Mike Martin MP, Correspondence sent 23 March 2026; Tunbridge Wells Borough Council (RWS0038)

handled communications, inadequate bottled water station provision and insufficient support for vulnerable customers. The Drinking Water Inspectorate (DWI) subsequently launched an investigation into the incident.[6]

4. The Committee called in David Hinton, the CEO of SEW, and Tanya Sephton, its Customer Services Director, to give evidence on 6 January 2026. They explained that the failure of a 'coagulant'[7] due to changes in raw water quality led to water that was too cloudy to pass regulatory standards for consumption, triggering an automatic shutdown to prevent non-compliant water entering public supply.[8] Mr Hinton emphasised that the assets at Pembury Works did not fail and "did what they were supposed to do." He stated that this raw water quality change was unforeseeable but SEW would carry out its own 'independent' investigation into the incident.[9]

5. In a subsequent panel, Dr Marcus Rink, Chief Inspector of Drinking Water, presented an alternative version of events, indicating that the incident at Pembury Works was foreseeable, preventable and the responsibility of the company. As a result of this contradictory testimony, we determined that the witnesses would return to give evidence once their respective investigations had concluded. This hearing took place on 14 April 2026. The DWI shared its findings with the Committee in advance of the hearing and published them later that day: overall it concluded that the Pembury incident arose due to "long-standing weaknesses and failures in process control, monitoring, maintenance and operational management," not raw water quality.[10]

More recent incidents

6. Following our first hearing, further outages occurred in Kent and Sussex in the aftermath of Storm Goretti and a freeze-thaw event, affecting up to 30,000 SEW customers.[11] Katie Lam MP, who represents Weald of Kent, told the Committee that during the outages, SEW was "unable to answer even the most basic factual questions" about issues such as bottled water availability, and that its customers were experiencing very familiar problems with poor support, particularly for vulnerable families. Echoing

6 DWI, Drinking Water Inspectorate investigating South East Water loss of supply incident, 4 December 2025

7 In water treatment works, coagulants are used in the treatment of raw water as a means of making small particles clump together in a "floc" so they can be removed.

8 South East Water website, Boil water notice lifted, accessed 28 April 2026

9 Qq1215–1218

10 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 2.6.1

11 The Times, "South East Water criticised after town loses supply again" 10 January 2026; BBC News, "Water restored for most in Kent and Sussex after week of disruption", 16 January 2026

earlier correspondence from Mike Martin MP who was deeply involved in the 2025 Tunbridge Wells incident,[12] Ms Lam reported that her office and third-party organisations including charities were forced to step in to fill the gaps in service from SEW. The DWI announced that it was also investigating these outages; at the time of writing, the results of this investigation are not available.[13] In the days before the April hearing, a further outage took place in Kent affecting nearly 6,000 properties supplied by the Bewl Water Treatment Works.[14]

The results of Ofwat's investigations into South East Water

7. On 5 March 2026, despite attempts by SEW to get an interim injunction against it, Ofwat published the findings from its investigations into SEW's supply resilience. It concluded that throughout 2020–23, SEW had repeatedly failed to implement the changes needed to improve resilience and its incident response, which negatively affected around 286,000 consumers. It found that SEW, through a range of failures, had breached several licence conditions and contravened section 37 of the Water Industry Act 1991, meaning that it had not maintained an efficient and economical system of water supply within its area and had not made enough arrangements to provide water, or maintain, improve or extend water mains and other pipes. Ofwat considered this contravention "ongoing". Ofwat proposed a £22.46 million fine, a fine equal to 8% of turnover, out of a maximum of 10%, as well as an enforcement order requiring various steps to bring the company back into compliance. At the time of writing, Ofwat is consulting on its proposed fine and findings.[15]

8. In January, Ofwat announced that it had launched a separate investigation into whether SEW had complied with its "customer-focused licence condition" (licence condition G), which was introduced to all water company licences in February 2024. This investigation is still ongoing at the time of writing and will consider whether the company has provided adequate customer support during major incidents.[16]

12 Mike Martin MP (RWS0030)
13 Katie Lam MP (RWS0050)
14 BBC News, "Almost 6,000 homes in Kent affected as South East Water main bursts", 2 April 2026
15 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026
16 Ofwat, Ofwat opens investigation into South East Water following repeated outages, 15 January 2026

The role of the EFRA Committee and the purpose of this report

9. **CONCLUSION**
Select committees do not often focus directly on the leadership, behaviour and performance of individual private companies. The water sector, however, is a highly regulated monopoly provider of services essential to public health. Residents have no choice over their water provider yet rely on them entirely for their lives and livelihoods and have little power to hold their leaders to account in cases of failure. Throughout the course of our inquiry into 'Reforming the water sector', we have already deemed it necessary to scrutinise the most significant water companies in England and Wales to hold them to account. To report specifically on South East Water, however, indicates the gravity of the situation facing the residents and businesses in the communities it serves. Given the extremely negative and dangerous impact that SEW has had on over 300,000 people since 2020, we feel compelled to apply public accountability to the leadership of a company that otherwise appears shielded from the consequences of its incompetence.

2 Failures at South East Water

10. In this chapter, we explore the many ways that SEW has failed its customers, using the case study of the Tunbridge Wells / Pembury incident, and the published findings from DWI and Ofwat investigations.[17] SEW has supplied the Committee with a copy of its preliminary findings from its investigation into the Tunbridge Wells incident: its findings are not yet published but we do reference some of its findings in this report.

A failure to monitor threats

11. The incident at Pembury Works is an example of a core failing by SEW: a failure to monitor and mitigate key risks.

Monitoring indicators of emerging problems

12. In January, SEW told the Committee that raw water quality was the core reason why the Pembury Works failed (see Chapter 1). However, the DWI said that the crisis had been foreseeable and criticised the company for failing to monitor "critical treatment parameters" at Pembury including raw water conductivity, coagulant flow and aluminium concentrations,[18] with Dr Rink telling the Committee in January that the company was "flying blind" in the run-up to the event.[19] SEW has since admitted that "crucial parameters are not monitored" for the raw water, that there were gaps in their recording of tasks and observations[20] and that the company should have had more robust controls to manage risks at Pembury.[21] All sides now agree that a

17 DWI, South East Water, Tunbridge Wells investigation conclusion, November 2025 ; Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026

18 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 2.4.1

19 Q1381

20 Taken from SEW's preliminary report, provided privately to the Committee

21 Q1471

lack of robust monitoring and control systems inhibited the ability of the company to act early on emerging problems and made recovery more challenging.[22]

13. In particular, the DWI expressed serious concerns about missed "jar tests"[23] in October 2025, which SEW was obliged to complete as part of a recent regulatory notice.[24] The company instead relied on monitoring other, less effective indicators.[25] The DWI states that jar tests would have allowed the company to optimise coagulant dosages, prevented issues with the original coagulant and avoided the cascade of issues that ended with a shutdown of the works and ensuing supply crisis. The DWI adds that jar tests are essential at Pembury to compensate for unfit coagulant monitoring and dosing assets that could have been replaced by an automated coagulant dosing system years earlier, but had never been, for reasons unknown to the DWI.[26] In April, the CEO of SEW, Mr Hinton, Mr Hinton said that a new dosing system was due to be installed after 2028, but accepted, in accordance with the SEW investigation's findings, that this missed jar test was "unacceptable"[27] and better monitoring should have been in place to compensate for a manual system.[28]

Identifying risks

14. The DWI investigation of the Tunbridge Wells incident found that SEW had "normalised risk and therefore could not visualise when it was going wrong for a prolonged period of time."[29] This is despite the fact that after an audit of the Pembury Works in March 2024, the DWI served an improvement notice on SEW to take actions to tackle risks such as site capacity, lack of resilience, and poor maintenance, some which is still yet to be completed.[30] In recent years, SEW has also been warned by the Chartered Institute of Internal Auditors that the lack of an internal audit function[31] was likely

22 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026; Qq1456–1458

23 A process of testing raw water at a site to optimise coagulant treatment processes.

24 DWI, Notice under regulation 28(4) of the Water Supply (Water Quality) Regulations 2016 (as amended) SEW-2024–00006, 6 October 2025

25 Such as pH and alkalinity sampling

26 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 2.4.2

27 Q1473

28 Q1456

29 Q1608

30 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 4.2.5–6. Mr Hinton told the Committee that the timelines of delivery, including those elements that have not been completed, were agreed by the regulator (Q1234)

31 Internal auditors provide company boards and management assurance over financial and non-financial controls. This can include whether monitoring arrangements and risk management controls are effective.

limiting the oversight that the company had over key risks.[32] Ofwat has also found that over 2020 to 2023, the SEW Executive Team and Board have failed to monitor and challenge risks, or have adequate metrics in place, to ensure compliance with the company's legal requirements.[33]

15. SEW's investigation into the Pembury incident similarly found evidence of inconsistent operational processes and procedures within the company. It noted an unusually small number of risks logged specifically for the Pembury Works and few substantive actions, processes or frameworks to mitigate risks that had been identified. This helped to weaken several "lines of defence" and resilience at Pembury.[34] In April, Mr Hinton and Caroline Sheridan, the non-executive director that led the SEW investigation, acknowledged that the company needed better risk visibility:[35] as a case in point, the risks at Pembury were not on the Board's "risk radar"[36] before the problems emerged in late November. The company is in the process of developing a structured framework for the "management of risk from the frontline to the Board."[37]

16. **CONCLUSION**

South East Water did not have the right processes in place to identify and mitigate risks at Pembury Works, despite previous warnings from the DWI. That the company had "normalised" critical risks and was "flying blind" in the lead up to the crisis is a fundamental failure for a water company responsible for a critical natural resource. In a perverse sense, Mr Hinton was right in saying that the events were "unforeseeable"; but only because the company had actively chosen to not put in the essential monitoring processes that would have enabled action before the outages began. As a result, the company failed to properly monitor threats such as ineffective coagulant dosing systems. A failure to have the right jar test processes meant that manageable problems escalated unnecessarily, undermining routine coagulant treatments, eventually and unnecessarily turning off the taps for businesses, essential services and tens of thousands of customers.

---

32 Letters from the Chartered Institute of Internal Auditors have been shared with the Committee but the letters have also been reported in the media: for example, Financial Times, "South East Water still has 'troubling' governance gap, warn auditors", 8 February 2026

33 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.205

34 Q1496; SEW's preliminary report, provided privately to the Committee

35 Q1472

36 Q1484

37 SEW's preliminary report, provided privately to the Committee

A failure to maintain assets

17. Mr Hinton told the Committee in January that Pembury Works was refurbished in 2005 and 2010 and there are plans to implement a further £10 million refurbishment in 2028. Mr Hinton was adamant that the issue at Pembury Works was not an example of an asset failure.[38] However the DWI highlighted that routine maintenance and cleaning was not being undertaken at Pembury in the run-up to the Tunbridge Wells incident: for instance, seven of 13 scheduled site duties relating to the DAFF[39] stage were not started or completed from the 9 to 25 November. As a result, the Pembury works had been operating "sub-optimally" for the weeks and months before the incident, increasing the need to optimise coagulant doses.[40] While the incident at Pembury was triggered by poorly monitored and controlled threats, in the background, poor maintenance practices undermined the performance of the site.

18. SEW's investigation revealed that staff at Pembury Works had reduced capacity to reflect on issues and implement improvements, leading to out-of-service equipment. It also remarked that the organisation had a "reactive" rather than "instinctive" approach to safety and low completion rates for general site duties, calling for an increase in levels of planned maintenance. This aligns with the DWI's view that there had been "insufficient adherence to required procedures and site tasks" to manage risks at Pembury,[41] which SEW acknowledged to be an "aging" asset and an "asset condition risk".[42] In a change of emphasis from January, Mr Hinton admitted that the company's approach to maintenance was not proactive enough and maintenance in the run-up to the Pembury incident was "not good enough".[43] Since the Pembury incident, the company has installed filters requested by the DWI and told us it was "accelerating" the delivery of some improvements asked for by regulators.[44] Mr Hinton also told us that staff are under pressure to keep systems running across its eastern regions—the areas primarily affected by the supply interruptions—to maintain a very tight supply-demand balance. This has put pressure on operating teams, making it difficult to keep up with routine tasks.[45] This is a function of a failure to invest in long-term infrastructure resilience, which we explore further below.

38 Q1247
39 Dissolved air flotation and filtration
40 Q1381; Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, section 2.3, para 6.8.1
41 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 2.6.3
42 Taken from SEW's preliminary report, provided privately to the Committee
43 Q1470
44 Q1463
45 Q1470

19. Pembury is an example of a wider trend. Ofwat's investigations into SEW's performance between 2020 and 2023 found that the company had failed to maintain "key assets", including service reservoirs, bore holes, and trunk mains, and had low rates of mains replacements, much of which was known to be a risk; yet not enough resourcing and planning to tackle this problem had been put in place since the 2019 Price Review.[46] Known performance issues with assets were not dealt with promptly by SEW. According to its own planning documents, the company was aware there was "very little day to day proactive monitoring" of asset and network performance but had not set out how it would improve performance in this respect. Ofwat concluded that SEW had not updated its management approach to tackle the "known vulnerabilities" amongst assets in its eastern region, leading to assets falling out of service or performing less efficiently during extreme weather events, and contributing to interruptions in SEW's most vulnerable areas. Ofwat added that SEW also tended to schedule maintenance during times of critical or high demand, contrary to industry standards.[47]

20. **CONCLUSION**
Maintenance issues at Pembury contributed to the Tunbridge Wells incident in 2025, but it is South East Water's self-identified lack of proactive and "instinctive" maintenance across its network that is most concerning. One of the most fundamental and basic responsibilities of a water company is to plan for and have the staff and resources available to maintain assets. Yet SEW did not see this a priority, even in some of its most vulnerable areas, contributing to a series of major water outages between 2020 and 2023.

A failure to invest

21. Mr Hinton told the Committee in both January and April that SEW's poor record on interruptions across its eastern region is "an infrastructure issue", with large areas like Tunbridge Wells (c. 22,000 customers) too reliant on one asset for its water supply. More broadly, Mr Hinton emphasises that the region's resilience is impacted by its many small, badly connected treatment works and insufficient "headroom" (the gap between supply and demand). He argued that greater "interconnectivity" would support areas struggling to meet demand or suffering outages. Mr Hinton acknowledged that he is responsible for getting such infrastructure "in the ground" but

46 The price review is the five yearly process through which the economic regulator, Ofwat, agrees spending allowances and revenues through bills for water companies. The 2024 Price Review was completed at the end of 2024. Companies can contest Ofwat's determinations to the Competition and Markets Authority.

47 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.160

suggested that a lack of resilience standards has meant that companies have been unable to "convince the regulator" of the needed investment through the price review process. Mr Hinton told us SEW had "overspent" by over £100 million in AMP7[48] to start putting necessary infrastructure in place to protect Tunbridge Wells. For the 2024 Price Review, SEW put together a £300 million proposed investment to deliver better resilience.[49]

22. This is not the first time we have heard such arguments. In our report on 'Priorities for water sector reform' (June 2025), we acknowledged that bills have been kept too low since 2010, potentially impacting asset health, and we called for resilience standards.[50] Funding issues from the regulatory system may have intensified trade-offs between maintenance and investment, as argued by Mr Hinton, even if they are ultimately decided by the company.[51] The redeterminations from the Competition and Markets Authority, published in March 2026, have partially vindicated parts of SEW's argument by giving the company greater allowances for resilience spending in a number of areas.[52]

23. Nonetheless, it is ultimately the company's responsibility to make the case for investment, as we concluded in our report last year, although other regulatory planning processes play an important role.[53] Where SEW has protested that it has not been given funding for resilience projects, Ofwat states that SEW was often referring to works for which funding had in fact been previously agreed, poorly articulated business cases, or disagreements over whether they should be funded by enhancement or base expenditure:[54] not all of these reasons are to do with a lack of resilience standards. Ofwat notes that SEW had not contested 2014 or 2019 price review determinations, indicating satisfaction with its levels of funding, a point we have also made in our last report.[55]

---

48 The last asset management period, 2020–25. Ofwat price reviews are structured around five-yearly AMPs.

49 Q1204; Q1207; Qq1220–1222; Q1415

50 Environment, Food and Rural Affairs Committee, Priorities for water sector reform (PDF), HC 1001, 2024–25, chapter 3

51 Qq1536–1540

52 Competition and Markets Authority website, Water PR24 price redeterminations, accessed 28 April 2026. Several companies sought a redetermination of the 2024 Price Review, including South East Water.

53 Environment, Food and Rural Affairs Committee, Priorities for water sector reform (PDF), HC 1001, 2024–25, chapter 4

54 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, paras 3.141 - 3.309

55 Environment, Food and Rural Affairs Committee, Priorities for water sector reform (PDF), HC 1001, 2024–25, para 39; Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.301

24. More fundamentally, Ofwat also criticises SEW's repeated argument that it needs greater headroom and interconnectivity: they argue that this is contextual information that should inform planning processes and is no longer an acceptable reason for supply interruptions. For four years in a row, the two main water regulators have sent joint letters to SEW warning that its Water Resources Management Plan[56] does not do enough to tackle issues with the balance of supply and demand. This is vital for preparing for climate change. Ofwat has concluded that SEW "failed to maintain sufficient headroom in its eastern region" since 2018.[57]

25.

CONCLUSION

As regulators told South East Water repeatedly and jointly for over four years, the company needed to invest in new infrastructure to be properly resilient to potential shocks. In particular, single points of failure, supply shortfalls and regional connectivity should have been improved, but the company failed to take action on these well-known long-standing issues for many years. Spending allowances in previous price reviews may have made trade-off decisions more challenging, but ultimately, these decisions are primarily the responsibility of the company, which should have seen the role that poor infrastructure played in events since at least 2018. Worse still, through successive price reviews, SEW has either not attempted or did not succeed in making the necessary investment case. This also suggests that, as the long-term stewards of the business, shareholders also must share a portion of the responsibility for these failures.

A failure to prepare for and respond to incidents

26. On top of the multiple failures that caused and worsened the impact of the Tunbridge Wells incident in 2025, SEW's incident response made the situation for customers considerably more painful.[58] Incident response plans are vital for water companies, helping staff to know how to interact with customers, deliver alternative water supplies, and engage with other critical stakeholders. As will be set out further below, there are many indications that these plans were either non-existent or ineffective. The DWI, as part of its investigations into the Tunbridge Wells incident, was "unable to

56 Companies must produce Water Resources Management Plans every five years and review it annually.

57 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.308 - 3.311; Environment Agency, Ofwat, Defra, Correspondence to South East Water, 17 November 2025

58 This was discussed in detail during our January evidence session: see Oral evidence: Reforming the water sector, HC 588, 6 January 2026

conclude" that the company had "made, reviewed or revised" any outage plans specifically for the Pembury Works that would have allowed continued supply to customers and concluded that "contingency or outage planning for the area was inadequate". It noted that that the company "avoids difficult scenarios" when testing the other plans that it does have, and does not embed the learning from the tests that take place.[59] This is despite the fact that SEW has found its own "Emergency Procedures and Incident Response Plan" to be comprehensive but difficult to follow, inconsistent, dated, and often used as "guidance". This led to failings on incident logs and not appointing necessary roles to respond to emergencies.[60]

27. This is part of a broader pattern over 2020–23, during which time Ofwat concludes that SEW "failed" to have a "sufficient operational response to supply interruption incidents to ensure its customers were not unduly without water during peak periods." This included their ability to provide alternative supplies and support vulnerable persons.[61] More details are set out below.

Preparing for shocks to the system

28. The DWI's investigation into the Tunbridge Wells incident found that the company failed to take any "heightened preparedness measures" before taps started to run dry, such as securing additional supplies from other treatment works, which were also out of service. It concludes 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." It added that the company relied on mutual aid from other water companies (such as replacement filters) indicating that it lacked "strategically stored reserves" of necessary equipment and materials to maintain water supply.[62]

29. Similar concerns have been identified for earlier incidents. Ofwat's investigations found that over 2020–23, SEW demonstrated an "overreliance on mutual aid from other water companies and suppliers" and had failed to use a variety of planning tools that could have helped it manage peak demands and prepare for potential triggering events. This included having inaccurate or out-of-date calculations and modelling to anticipate critical periods and understand changing water demands. Ofwat concluded that SEW had failed to plan for its water resources at a sub-zonal level, resulting in less headroom than a reasonable company should have had leading up to critical events. Like at Pembury, SEW also had a tendency not to increase storage

59 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, para 4.177
60 Taken from SEW's preliminary report, provided privately to the Committee
61 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.365
62 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, paras 4.196, 4.29

levels in service reservoirs in anticipation of peak periods and extreme weather, despite previous warnings from the DWI that this was a nationwide standard and SEW's own awareness of its water-stressed geography.[63]

30. **CONCLUSION**
Despite South East Water's assertions to the contrary, periods of peak demand and extreme weather can and should be broadly predicted and prepared for. Ofwat and the Drinking Water Inspectorate have shown that the company failed to model upcoming peaks and troughs and take the necessary steps in preceding weeks and months to boost resilience and to reduce the risk of a crisis. Its leadership's approach to incident response planning is pitiful; there are signs that incident response plans either do not exist or are of poor quality, receiving little or no stress-testing to improve them. The recent experience of its customers, as well as an overreliance on external support, are testament to this lack of planning. This has had real-world consequences for tens of thousands of customers, many of them vulnerable.

Escalation

31. The 2025 Tunbridge Wells incident highlighted several issues with how problems are escalated at SEW. Customers and the local council were first informed of a potential supply interruption on 29 November, the day when customers first experienced outages. Tunbridge Wells Borough Council were told only a few hours before the taps ran dry, despite the service reservoir being known to have capacity for 40 hours' worth of drinking water.[64] SEW told the Committee that customers were informed when the company knew they were going to be affected; they had not wanted to escalate matters sooner in case customers were unnecessarily alarmed.[65]

32. This, however, gave stakeholders little to no time to prepare and put pressure on SEW to set up bottled water stations quickly: the short timeframe meant that the key bottled water stations were not ready until a day later, and the company had to initially rely on an inappropriately distant site at Tonbridge.[66] The DWI explained that signs of problems were clearly emerging from 9 November onwards, and it concluded that an incident was declared too slowly within the company, on the 28 November, when Pembury had shutdown multiple times in previous days, depleting levels in the service

63 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.354
64 Tunbridge Wells Borough Council (RWS0038)
65 Q1235, Q1238
66 Q1276

reservoir.[67] The SEW investigation and Mr Hinton conceded earlier signals should have been reacted to more quickly.[68] The DWI was informed of the incident at 09:49 on 30 November 2025, after the date that the incident had been internally escalated (28 November) and customers were first notified (29 November) and well after the first clear signs of a potential emergency: the DWI saw this as a breach of the company's obligations to regulators under the Security and Emergency Measures Direction (SEMD) 2022.[69]

33. Both SEW and the DWI concluded that escalation procedures were not clear enough.[70] SEW has Bronze, Silver and Gold teams which are stood up depending on "operational, tactical, and strategic management of events". As problems were developing at Pembury, the problem was first escalated to a Bronze level event on 26 November and a Silver on 29 November, around the same time that the Local Resilience Forum was contacted.[71] According to the DWI, it is unclear when the Gold Team took over, the point at which senior leaders are involved to provide overall direction and ensure that their respective teams are coordinated and resourced. The earliest potential time was 1 December, but it may have been as late as 3 December. Regardless, the DWI concluded that the Gold Team should have been stood up "much earlier".

34. In January, and again in April, we also asked how Mr Hinton operated during the incident, following criticism about his lack of visibility during the event.[72] Although he said he had sufficient operational and scientific teams onsite, he said he had "spent a lot of time at Pembury" as he felt that his background in biotechnology could assist a team that was "under stress".[73] He stood by this decision in April, although he acknowledged that he would normally, in other incidents, be "very much running the gold command, as you would expect from a CEO". However he did accept that he did not communicate to customers early enough during the incident.[74] Although Mr Hinton's decision was not specifically identified by SEW's own investigation, SEW did conclude that its escalation processes lacked "clear separation between strategic and tactical management" which led to prolonged calls and a lack of clarity in decision-making.[75] Some stakeholders that were

67 Taken from SEW's preliminary report, provided privately to the Committee; Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 2.1.2

68 Taken from SEW's preliminary report, provided privately to the Committee; Q1409; Q1455; Q1473

69 A regulation made under the Water Industry Act 1991

70 Qq1295–1299; Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026

71 Taken from SEW's preliminary report, provided privately to the Committee

72 Mike Martin MP (RWS0030); The Times, "South East Water boss 'missing in action' amid Tunbridge Wells crisis", 4 December 2026

73 Qq1288–1297; Q1515

74 Qq1516–1517

75 Taken from SEW's preliminary report, provided privately to the Committee

deeply involved during the incident, such as Mike Martin MP, felt that the CEO spent too much time at Pembury. Mr Martin said the CEO saw the crisis as "one of water chemistry", meaning that he "failed to lead the crisis management" and often "didn't have all the facts to hand."[76]

35. **CONCLUSION**
Both the Drinking Water Inspectorate and South East Water acknowledge the weaknesses of the escalation processes around the Pembury incident. This meant that operational staff were not given sufficient support to diagnose problems early and that key stakeholders were informed too late, inhibiting preparations and in breach of regulations. We are concerned that the CEO was too involved at the Pembury Works, a potential distraction from his overall crisis command. Either this is a further problem with escalation processes, or a choice by Mr Hinton to go against his company's own procedures. In either scenario, SEW appears unable to determine when and where its leadership team can provide maximum value. In the case of Tunbridge Wells, this ultimately impaired the CEO's ability to communicate to customers and may have played a role in the poor crisis response.

Bottled water stations

36. One of the most critical functions of a water company during a significant supply interruption is to provide alternative water supplies. SEW told us that its processes complied with the Security and Emergency Measures Direction (SEMD), overseen by the DWI, during the Tunbridge Wells incident. It explained that it had provided alternative water supplies through a mixture of bottled water and the mobilisation of 26 tankers to fill networks and supply hospitals. It provided over 800,000 bottles of water via three main bottled water stations, and over 1.6 million litres of water to customers.[77]

37. The DWI investigation, however, calculated that SEW had likely failed to provide the minimum amount of alternative water to meet expected standards,[78] with at best three bottled water stations serving 60,000 customers, a ratio that was not supported by any modelling, and likely to be unacceptable. The DWI was therefore "unable to conclude" that the

76 Mike Martin MP (RWS0030)
77 Correspondence from David Hinton, Chief Executive Officer, South East Water regarding the hearing on the Tunbridge Wells water outages on 6 January, dated 19 December 2025
78 Companies are expected to provide 10 litres per person per day during an emergency. The DWI calculated that the capacity of bottled water stations was likely insufficient to meet that target and was sceptical about the data supplied by the company, given the numbers of pallets used at the stations, some of the alternative supplies were non potable and some tankering was only for vulnerable sites and was of limited availability to wider customers.

company had met its alternative supply obligations under SEMD.[79] According to a recent survey, 43% of respondents who visited a bottled water station during the Tunbridge Wells incident felt that they had not received enough water.[80] This is despite similar shortages of bottled water occurring during previous SEW incidents.[81]

38. During the incident, logistical problems with bottled water stations were widely reported, including the first bottled water station located in Tonbridge, a considerable distance from the area affected.[82] Even though more appropriate stations were established later, Tunbridge Wells Borough Council flagged that there was a lack of walk-up bottled water stations, vital for those who did not have a car.[83] In the January session, it was revealed that although the company had preselected 17 scenario-based sites for bottled water stations, many were unusable, in some cases because "It was a Saturday before Christmas and all the carparks had cars in."[84] Mr Hinton accepted that the first site at Tonbridge was not ideal but necessary as other sites would not be ready until the next day.[85]

39. The DWI's investigation found similar concerns, adding that:

- Site risk assessments were carried out during, rather than before, the incident and many of these assessments discounted preselected sites for reasons that suggest that those sites were never appropriate, such as narrow entrances and limited space to operate.
- Company documents suggest that access was prioritised for customers with cars.
- The need for council-led water stations showed that the company did not have "sufficient capability, capacity and facilities" to deliver alternative supplies. We have similarly heard that the local council was not expecting to have to deliver functions such as water stations and mobile toilets.[86]

79 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, paras 4.45–448; 4.70–4.76
80 Q1618
81 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.365
82 BBC News, "South East Water faces pressure over Tunbridge Wells supply chaos", 13 December 2025; The Times, "How did South East Water become such a disaster?" 13 January 2026
83 Tunbridge Wells Borough Council (RWS0038)
84 Q1250
85 Q1276
86 Tunbridge Wells Borough Council (RWS0038); Mike Martin MP (RWS0030)

- Bottled water stations were publicised as closed overnight which "failed to provide an inclusive service", such as for those working challenging shifts.[87]

40. Mr Hinton told us in April that the company is now working on much more local ways of delivering bottled water which could avoid long distances to bottled water stations.[88]

41. **CONCLUSION**
Given the huge number of supply interruptions that South East Water has failed to manage over the years, it is remarkable that the company still struggles with the supply of bottled water during outages, has failed to learn and apply lessons and relies on the goodwill of communities. Problems discussed elsewhere in this report could arguably take significant time and resources to resolve, but knowing where to set up bottled water stations and having enough bottles to go around is a fundamental and basic responsibility. That the company is only now considering more local ways of delivering water bottles speaks to its disregard for the consumers relying on it for a life-sustaining provision.

Communication

42. Inconsistent communication was a clear issue during the Tunbridge Wells incident, particularly when estimating timescales for the restoration of water supplies to customers. This was driven by the company's optimism bias, as acknowledged by Mr Hinton,[89] an erroneous belief that a "bad batch" of coagulant was to blame and the need to backtrack when theories were proved wrong. On top of this inconsistency, the use of language such as a "bad batch of chemicals" and "contaminated water" meant that "speculation ran wild" and encouraged the spread of disinformation on social media, as the local MP told us.[90]

43. Inadequate bottled water station communications was also widely reported, and confirmed by SEW communications logs, which revealed delays and contradictions between the company website and messaging alert system.[91] Evidence seen by the DWI's investigation suggests that SEW did not meet its targets for call waiting times, which peaked on 30 November at 18 minutes.[92] Tunbridge Wells Borough Council highlighted that boil water notices were mis-targeted due to the use of "short postcodes", which made

87 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, para 4.194
88 Q1503
89 Qq1547–1551
90 Mike Martin MP (RWS0030)
91 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, paras 4.53 -4.59
92 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, para 4.137

organisations, including six schools, close unnecessarily as their areas were erroneously marked as impacted by the outages.[93] Even more concerningly, SEW was unable to provide the DWI investigation with a formalised documented communications strategy for emergencies; it only had a playbook that consisted of "a series of templates." The DWI found that there were few procedures to adapt communications in response to feedback or evolving local situations and concluded that communications decisions were ad hoc (when necessary), unrecorded, and clearly insufficiently planned for to support customers.[94] Mr Hinton acknowledged in April that crisis communication processes were not formalised but stated that emergency planning and escalation procedures did mean that communications teams were involved at a high level once an incident was declared.[95]

44. Despite this, SEW's investigation concluded that the Communications Team should have been activated earlier to anticipate information needs and shape a more coherent narrative. It recommended a number of changes to better integrate communications into incident planning, a more disciplined message-development process, and a spokesperson escalation matrix to ensure that the "right voice is deployed at the right time" alongside refreshed media training;[96] many stakeholders felt that not enough suitably senior leaders were visible during the crisis, most notably the CEO.[97] It added that the company's communications during the Pembury incident lacked empathy for the disruption caused and "emotional engagement" with customers. In this incident and those since, local MPs have found themselves acting as "clearing houses" for concerned consumers and businesses and even attracting the ire of the CEO when raising legitimate concerns.[98]

45. In April, Mr Hinton told us that the company had evolved its skill set, in recent years, for crisis communications. However, he then recognised the need to increase the size of the communications team, suggesting that this is still not a well-developed function at SEW.[99] He added that there are plans to bring in consultants to help with the development of a "crisis comms playbook" but did not supply more information regarding wider communication reforms, an answer that this Committee finds unsatisfactorily vague.[100]

---

93 Tunbridge Wells Borough Council (RWS0038)
94 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, paras 4.145–4.151
95 Q1546
96 Taken from SEW's preliminary report, provided privately to the Committee
97 The Times, "South East Water boss 'missing in action' amid Tunbridge Wells crisis", 4 December 2026
98 Mike Martin MP (RWS0030); Qq1225–1228
99 Q1543
100 Q1518; Q1543

46. **CONCLUSION**
Similarly to the provision of alternative water supplies, South East Water now has years of experience in communicating during supply interruptions. It is incomprehensible that SEW still lacks a crisis communications strategy or a well-developed communications team given the company's propensity for water outages. This put communication teams in a difficult position. Basic communications errors, like giving incorrect and inconsistent information about bottled water stations, using the wrong postcodes, poorly chosen language and a lack of empathy with customers, should not need external consultants to resolve. Vague answers to our questions to the company have not outlined what will happen to embed lessons, prevent future disconnections with operations, and ensure that a new communications "playbook" will be kept up to date and stress-tested. This does not give us confidence in the leadership's ability to learn from its previous mistakes and address the problems we have identified.

Vulnerable customers

47. During the Tunbridge Wells incident, SEW said that it provided over 38,000 deliveries to customers on the Priority Services Register (PSR). Although at first bottles were often left outside properties, the company would turn to hand-delivering bottles and take the opportunity to inform customers about the boil water notice. The company also added 644 customers to the PSR and proactively called 147 "high-need" customers to confirm their welfare. Over 84,000 bottles were delivered to 15 schools and over 35,000 bottles to both care homes and nurseries. Hospitals received over 51,000 litres of water and GPs, dental surgeries and pharmacies received over 34,000. SEW also established a "ring-fenced team" to improve the coordination of water deliveries for vulnerable non-household sites.[101] SEW told us in January that there were "isolated" issues with vulnerable customers not being able to pick up deliveries, and around 100 customers on the PSR that did not receive a delivery within 24 hours.[102] Overall, however, Mr Hinton said that the 5,000 PSR deliveries represented a "pretty substantial resource effort" and that despite a few "unfortunate case studies", the incident response to Tunbridge Wells "functioned much better" than for previous outages.[103]

101 Correspondence from David Hinton, Chief Executive Officer, South East Water regarding the hearing on the Tunbridge Wells water outages on 6 January, dated 19 December 2025
102 Qq1255–1256
103 Q1255

48. During the incident, local media reported issues with water deliveries for vulnerable customers, with some uncommunicated deliveries left outside homes overnight and some stolen.[104] Tunbridge Wells Borough Council and Mike Martin MP told us that there were "repeated reports" of care homes not receiving any or enough water and 12kg water deliveries that many vulnerable customers struggled to unwrap, lift or use.[105] Mr Martin told us that the company clearly "didn't have lists of GPs, schools nor care homes."[106] Mr Martin added that many customers with health issues suffered physically and psychologically from the incident, thanks to poorly located water stations, missed deliveries and confusing communication, preventing people from seeking help or planning effectively.[107]

49. SEW provided little evidence to the DWI that it had prioritised all its vulnerable customers at Tunbridge Wells. The DWI investigation concluded that some water deliveries were not tailored to the needs of vulnerable customers partly due to limited proactive work to identify vulnerable customers and record their needs. In addition, it added that the company had broken regulations by failing to provide 106 properties on the PSR list water deliveries within 24 hours. It agreed with contemporary reports that vital organisations, such as GP surgeries, schools, nurseries and the Tunbridge Wells Kidney Treatment Centre, which had been "overlooked as a hospital" also had gaps in support.[108] The DWI welcomed the creation of a "ring-fenced" team to tackle some of these problems, but noted it was not fully functional until several days into the incident. Regulations make it clear that companies should engage with vulnerable sites to establish the support they need during a water emergency. The DWI ultimately concluded that the company had failed to provide such support for many such sites and was "unable to conclude" that the company had due regard for other vulnerable sites such as schools, some of which had received, as noted above, inaccurate information about the need to close.[109]

50. Although this was not a main focus of Ofwat's investigation into SEW incidents between 2020–23, there are signs that this is a long-term trend. Ofwat noted that for vulnerable sites, SEW has been slow to develop business continuity plans, particularly for schools with vulnerable pupils, still implementing them four years after the 2018 freeze-thaw event and leading to the continued closure of schools during outages as late as 2023. During our April evidence session, we put concerns about vulnerable customers to the

104 Q1270
105 For instance ITV News, "'Scared' and £6,000 out of pocket: the impact of Tunbridge Wells' water outage", 1 December 2025; ITV News, 14,000 homes in Tunbridge Wells still without water after five days. 3 December 2025
106 Mike Martin MP (RWS0030); Tunbridge Wells Borough Council (RWS0038)
107 Mike Martin MP (RWS0030)
108 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, para 4.102–4.129
109 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, para 4.129, 4.88

SEW leadership team. Mr Hinton said that they would visit critical vulnerable sites to understand their needs but otherwise his answers mainly focussed on the challenges of updating the Priority Services Register.[110]

51. **CONCLUSION**

For a company with such regular issues with outages, South East Water's approach to supporting vulnerable customers gives the impression of a business caught completely by surprise. We accept that it is challenging to continuously update the Priority Services Register: people will not always inform you of vulnerabilities, transient or permanent. However, the fact that there were fundamental problems with deliveries for those that were on the PSR is indicative of a problematic approach, one that fails to record and consider the needs of customers. Moreover, vulnerable sites such as care homes were also let down, which should have been easily identifiable, had proper business continuity plans been in place. Again, the specific needs of these sites should not have been a surprise: the company's history of outages should have given it a wealth of experience in where needs are greatest.

110 Qq1555–1558

3 A culture of failure

52. In this chapter, we consider the broader cultural problems that help us better understand why the company has failed so badly during the Tunbridge Wells incident as well as the many supply interruptions in the years that preceded it.

A failure to learn from mistakes

53. As noted above, the Tunbridge Wells incident featured many problems that have emerged during previous incidents, particularly in its support for customers. This failure is highly surprising, given that the company has a wealth of experience handling supply interruptions. Communication is a striking example. After problems emerged at Pembury Works in November, the company's estimations for when supplies would be restored kept changing, causing significant customer frustrations and confusion. This was because, as Mr Hinton and Ms Sephton told us, the company was lurching from one theory to another as to why the Pembury Works had collapsed. The company was keen to communicate more with customers about the incident, in response to feedback from previous events. However, the company was not transparent enough about the assumptions underpinning these estimations and how they might change.[111] Tunbridge Wells Borough Council told this Committee that SEW's "optimism bias" regarding the restoration of supplies is "identical to what occurred during the 2022 outage, a failure SEW itself previously acknowledged."[112] SEW has since told us that to avoid customer frustrations, it is now trying to develop a strategy for informing customers about supply interruptions with an unknown resolution time.[113]

54. The DWI's investigation at Pembury found that there were lessons from previous supply interruptions that could have improved SEW's contingency planning. However it found that despite the company's awareness of issues, "these known risks do not appear to have been adequately addressed" and this constituted a breach of regulatory requirements to "review and revise" emergency plans.[114] As Ofwat concludes from its investigations, SEW has a history of failing "to effectively implement the lessons from previous events".

111 Qq1308–1316
112 Tunbridge Wells Borough Council (RWS0038)
113 Q1547; Q1552
114 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, paras 4.191–4.29

Ofwat highlights that throughout the period 2018 to 2023, SEW has created action plans with limited evidence behind them and been slow to review their progress to ensure implementation, sometimes failing to check until prompted by regulators. For instance, many actions from the 2018 freeze-thaw event had not been implemented by later that year; and some were still ongoing in 2022, when another similar event occurred.[115] SEW's own investigations into the Pembury incident called on the organisation to review its "learning effectiveness".[116]

55. A failure to learn lessons will affect performance, particularly in a sector where performance targets are constantly increased to drive improvements. Ofwat states that "since 2015–16, South East Water has been ranked below the lowest quartile for its water supply interruptions performance for seven of the years and has never been ranked median or better." In contrast, Affinity Water, a nearby water-only company, has delivered "upper quartile performance,"[117] despite previous issues. Ofwat states that companies like Affinity Water have turned things around through working "constructively" with the regulator.[118] The DWI has moved SEW into a transformation programme, due to its poor performance.[119] Although the management of SEW states that SEW is "a good company with a really big interruptions problem,"[120] both Ofwat and the DWI have concluded that this means the company is non-complaint against various legislative requirements.[121]

115 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.345

116 Taken from SEW's preliminary report, provided privately to the Committee

117 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.42 - 3.45

118 Q1610

119 Q1392

120 Q1584

121 DWI, South East Water, Tunbridge Wells investigation conclusion, November 2025 ; Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026

56. **CONCLUSION**
The Tunbridge Wells incident and Ofwat investigations reveal that South East Water's leadership has repeatedly proved itself incapable of implementing the lessons learnt from previous incidents, even simple ones such as having a communication strategy for when resolution timeframes are unclear. While the company was clearly trying to learn from its previous mistakes, it caused more problems in doing so, indicative of an inability to understand and resolve core problems. This is not through a lack of warnings or proposed solutions, but an inability to adapt swiftly to mitigate future risks. Despite claims that they are otherwise a "good company", this has manifested in a shocking performance, failing to deliver the basic function of a water company: delivering water. No other metrics of success can offset this fundamental shortcoming.

A failure to identify root causes

57. Ofwat's investigations into historic supply interruptions at SEW have revealed one of the key reasons why lessons are not being learned. It states that, contrary to company claims, SEW has persistently "failed to undertake adequate root cause analysis" of problems. Ofwat concluded that throughout incidents during 2020–23, SEW blamed "macro or external resilience challenges" without considering whether "matters within SEW's control may have contributed to the extent of the outcomes experienced". As will be discussed below, one clear example of this is the company's propensity to point to "extreme weather", "high demand" or "leakage" as leading causes of events, when these should be better seen as "triggers" and risks to mitigate. Ofwat concludes that SEW "fundamentally misunderstands" root cause analysis, a point underlined by the fact that SEW "sought clarification" on the definition of root cause analysis during Ofwat's investigation.[122] Mr Hinton told this Committee that this was simply to establish a "mutual understanding"[123] but other examples concur with the regulator's findings; after a 2022 freeze-thaw event Ofwat found SEW failed to identify or show consideration for "underlying causes" such as network maintenance, pressure management or age or condition of pipes.[124]

122 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.287 - 3.289

123 Q1417

124 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026

58. The Pembury Works incident in 2025 clearly demonstrates deficiencies in the company's root cause analysis. For example, during the event and despite SEW's "multi-stage process" to diagnose the issue at Pembury Works,[125] the DWI's report found that the company failed to undertake thorough and swift reactive jar testing which could have helped the company understand why the coagulant process was not working. Instead, as will be explored elsewhere in this report, the company over-focussed on one prevailing, and inaccurate, theory that a "bad batch" of coagulant had caused the problem. During the April evidence session, David Hinton acknowledged that its "problem-solving" was one of the core problems behind the Pembury Works incident.[126]

59. We also found evidence that the company lacked or ignored intelligence on real-world outcomes during the Tunbridge Wells incident, which is likely to impact its ability to problem-solve. For example, in January, David Hinton and Tanya Sephton both suggested that SEW's bottled water stations were broadly successful, closed for only a couple of hours, and operating well despite a few initial delivery issues.[127] Ms Sephton claimed that the company was receiving good information about bottled water deliveries from staff on the ground.[128] When asked, Mr Hinton gave the company a rating of "eight out of 10" for its incident response.[129] Much of this analysis is at odds with media reporting, commentary from Tunbridge Wells Borough Council, subsequent DWI analysis and the local MP Mike Martin, who experienced several occasions where SEW teams had inaccurate information about deliveries.[130] Although we raised these concerns with the company in January, Mr Hinton responded that they were able to be a lot more optimistic about its performance because these stories did not reflect the full picture.[131] As identified by Ofwat, this appears to be a long term trend of SEW not having the right amount of staff, processes and culture to identify issues and remediate them during various crises between 2020 and 2023.[132]

60. Where the company does have data, it also struggles to properly analyse it. In January Mr Hinton, who told the Committee that he used his biotechnology expertise to help diagnose the issues at Pembury Works,[133] told us that the coagulant "started to misbehave" on Wednesday 26

125 Correspondence from David Hinton, Chief Executive Officer, South East Water regarding the hearing on the Tunbridge Wells water outages on 6 January, dated 19 December 2025
126 Q1409; Q1455
127 Q1257; Q1270
128 Qq1311–1313
129 Q1213
130 Mike Martin MP (RWS0030)
131 Q1270
132 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.367
133 Q1288

November due to an unforeseeable change in raw water quality that could only be resolved with a new coagulant.[134] At that time, Mr Hinton was still arguing that the key lesson from the Pembury incident was that they should have a second type of coagulant on site in the future to tackle different quality raw water.[135] Using data from SEW, the Chief Inspector for Drinking Water drew entirely different conclusions, stating that there was "nothing unusual" about the raw water and signs of trouble at Pembury Works were evident from 9 November, the point at which the DWI considers the incident to have started.[136] A subsequent DWI report confirmed these assertions, and added that signs of more consequential asset failures—such as failed washes and higher concentrations of aluminium—were detected on 21 and 23 November, and should have prompted investigations well before the incident was declared.[137] Despite Mr Hinton's high involvement at Pembury Works, the DWI ultimately found that Mr Hinton's conclusions were wrong: poor monitoring was the problem and a second coagulant was not needed at all. Mr Hinton states, despite his scientific background, that this misleading account was due to the evidence he "had at the time".[138] As noted above, this is not true: DWI's analysis was based on data from the company and should have been available to senior management in January.[139]

61. SEW now accepts that a lack of proper monitoring and visibility over the issues at the Pembury Works led to the issues at the site.[140] However, the preliminary findings from SEW still contain seemingly contradictory claims that the Pembury Works was "operating normally" between 1 and 15 November, despite all sides acknowledging that the works were operating sub-optimally during that time.[141] Mr Hinton was still arguing in April that the Pembury incident was a "water quality driven event", in contrast to the findings of the DWI.[142] Yet as Dr Rink and Caroline Sheridan told the Committee, SEW's findings do not contradict the findings from the DWI, which makes the company's less clear conclusions incomprehensible to this Committee.

62. Caroline Sheridan, the non-executive that led SEW's own investigation, told us that this analysis had provided a helpful "different perspective".[143] However, the SEW report relies on vague assertions that "material

134 Q1237
135 Q1241
136 Q1381; Q1459
137 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, 2.3.4
138 Q1459
139 Q1387
140 Qq1595–1596
141 Taken from SEW's preliminary report, provided privately to the Committee; Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 6.71
142 Q1515
143 Qq1488–1491

weaknesses" across several "lines of defence" meant that small "environmental and operational challenges"—including a change in raw water quality and blockage of a chemical dosing line—led to an "escalating situation."[144] Many of the recommendations in its report are "strategic" and it is unclear how some of these will specifically address the weaknesses identified at Pembury. We therefore agree with Dr Rink that SEW's findings lack sufficient clarity, detail and evidence.[145] Although we recognise these are preliminary findings, SEW, a much larger organisation, has failed to provide as detailed an analysis as the DWI, a considerably smaller organisation.

63. **CONCLUSION**
Since at least 2020, South East Water clearly has had, and continues to demonstrate, an inability to establish the root causes of its supply resilience problems. There are likely many facets to this, including a failure to monitor the key asset indicators, and a tendency to blame external factors, as highlighted elsewhere in this report. The company leadership seems to be divorced from real-world situations, either due to a lack of feedback data and processes, or a willingness to ignore problems. There also appears to be a fundamental inability to properly analyse the data it does have, most recently demonstrated by its first misleading analysis of the Tunbridge Wells outages in November-December 2025. This misunderstanding appears to have happened throughout the organisation, including at the very top. While the company now does accept it has a problem with its problem-solving processes, vague conclusions after the event also suggest that the current leadership have still failed to conduct and accept a proper analysis.

A failure to take responsibility

64. A failure to learn from mistakes could also be indicative of a much wider cultural problem at the top of South East Water, one unwilling or unable to take ownership and responsibility for its issues.

Groupthink and a tendency to blame external factors

65. When we talked to SEW in April, the company stated that the "family feel" of the company has benefits but also "red flags."[146] SEW's own investigation into the Tunbridge Wells incident states that "a close-knit culture potentially drifting into an echo chamber, could lead to a focus on operational priorities at the expense of customer expectations." The report called on the

144 Taken from SEW's preliminary report, provided privately to the Committee
145 Q1594
146 Q1506

company to assess its "organisational culture" which included assessing indicators for "groupthink, openness and constructive challenge."[147] This conclusion tallies with the findings of the DWI investigation, which found that SEW's efforts to restart Pembury Works had become too focussed on an erroneous theory that a "bad batch" of coagulant was to blame. This lasted until 1 December, and when that was disproven, the company shifted to blaming raw water quality. Both of these theories were false, and the DWI concluded that the company's "apparent willingness" to "blame factors beyond their control" (such as faulty chemicals) inhibited its ability to assess the incident.[148] The DWI recommended that the company review its incident response processes. When we put these allegations to the senior leadership, the SEW Chair told us that the coagulation batch had changed, so it made sense to explore whether that was an issue. However, the company has acknowledged that it has an issue with problem-solving and told the Committee that it is adding more members to the executive team, to provide more robust challenge.[149]

66. Ofwat's investigations into SEW's historic outages also identified a tendency by the company to blame external factors, such as a lack of rainfall, population growth, a large number of small, unlinked water sources, and a complex topography that relies on re-pumping stages and single points of failure. We heard a number of these arguments ourselves.[150] However, as Ofwat argues, these are well-known, longstanding issues: it is the company's role "to mitigate against the effect of these factors."[151] Despite these criticisms from the regulator, in April, Chris Train continued to make the case that interconnectivity was an issue, and did not substantively answer our questions regarding efforts in earlier price reviews to boost resilience spending that could have tackled these problems.[152] We also pressed the SEW leadership on whether they still see climate change as an excuse, despite Ofwat warning the industry to prepare infrastructure for its impact as early as 2008. While they acknowledged that it was not an excuse, both the CEO and Chair continued to state that climate change has "outstripped reasonable expectations" and that it came as a surprise when their systems started to be more severely impacted by climate pressures since 2018.[153] During the evidence session, Dr Keil, CEO of the Consumer Council for Water said that "It is dangerous and misleading to suggest

147 Taken from SEW's preliminary report, provided privately to the Committee
148 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 6.6.1
149 Q1481; Q1409; Q1480
150 For example, Q1206
151 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, para 3.29
152 Q1533
153 Qq1410–1414; Q1419; Q1500

that there are some [climate change] predictions that are wrong. It is a misrepresentation. […] Companies need to prepare for climate change and not be prepared to reel that out as an excuse."[154]

67. SEW has also relied on the argument, when engaging with both Ofwat and this Committee,[155] that it has faced challenging new water use patterns since COVID due to lifestyle changes and increased working from home. However according to an Ofwat data analysis, depending on the areas, this was either never or no longer the case.[156] This has striking parallels to how SEW and the DWI arrived at very different conclusions about the causes of the Pembury Works incident while using the same datasets.

68. **CONCLUSION**
South East Water's leadership team has demonstrated a clear preference for blaming factors outside of their control for performance issues, and in some cases, they continue to do so, despite clear evidence to the contrary. A lack of data-analysis skills might be partially to blame, but it is also clear that a culture of obfuscating responsibility has also taken hold, seriously inhibiting their ability to analyse problems and learn lessons. The company's investigations, as well as that of the Drinking Water Inspectorate, have identified potential issues with a lack of challenge or groupthink within the company: that "family feel" may be closer to a "clique" than a benefit. We have serious doubts that the addition of two more executives will tackle this pervasive problem.

Engagement with regulators, customers and other third parties

69. Groupthink can be challenged through meaningful engagement with third parties. The most obvious candidates are SEW customers, who are well versed in the company's problems, and the water regulators, who have been investigating the company for some time. However, as Dr Keil highlighted to us in April, the constantly poor customer experience at SEW, much of which is about processes and culture, rather than infrastructure, is indicative that the customer may not be "top of mind with the company".[157] Statements made by the leadership at SEW suggest that the company is out of touch with its customers, despite numerous apologies. For instance, the SEW investigation report, shared with the Committee, said that "public health

154 Q1606
155 Q1204
156 Ofwat, Notice of Ofwat's proposal to issue an enforcement order and impose a penalty on South East Water Limited, March 2026, paras 3.297–3.299
157 Q1618

was protected" during the Tunbridge Wells incident, which is correct when considering that no water supplied was "unwholesome."[158] However, poorly supported vulnerable customers may disagree with that statement.

70. The fact that Mr Hinton reportedly rebuked the local MP, Mike Martin, suggests that the leadership is not open to external criticism which it regards as "politicisation" of an issue.[159] Similarly, the company's interactions with regulators suggest a defensive relationship, with SEW failing to inform the DWI of the Pembury Works incident within a reasonable timeframe,[160] and on one occasion being reluctant to share water sufficiency plans with inspectors.[161] The DWI also reported that the company had been slow to implement improvement notices made by the regulator.[162] Ofwat's testimony in April also suggested that SEW's previous engagement had not been sufficiently forthcoming or recognisant of Ofwat's role.[163]

71. The attempt by SEW to gain an interim injunction of Ofwat's report into SEW's historic outages is particularly emblematic of this problem. According to summaries of the case, SEW attempted to block publication until a judicial review was complete to ensure the company could continue to attract investors. The judge presiding over the case found that SEW had failed to make the compelling case to take this extraordinary step, adding that it would have been "objectionable in principle" to mislead credit rating agencies in this way.[164] SEW disagreed that this was an attempt to mislead and told us that the injunction's purpose was simply to allow time for more "dialogue" with Ofwat.[165] This is not credible, given there had already been over two years of interactions during the investigation, and this is a very different tone to that taken in court, during which SEW representatives called Ofwat's report "legally flawed" and largely predetermined.[166] This does not seem like open and constructive engagement.

158 Taken from SEW's preliminary report, provided privately to the Committee and Q1553. This is a term from legislative requirements.
159 Mike Martin MP (RWS0030)
160 Correspondence from DWI, Event Assessment Letter – SEMD, 14 April 2026, para 2.4
161 Q1381
162 Correspondence from DWI, Event Assessment Letter - Water Quality, 14 April 2026, para 4.2.7
163 Q1598
164 South East Water Limited vs Water Services Regulation Authority [2026] EWHC 479
165 Q1569; Qq1589–1592
166 South East Water Limited vs Water Services Regulation Authority [2026] EWHC 479

72. **CONCLUSION**

South East Water has failed to engage with key stakeholders outside the company to help it learn from its mistakes. It is unwilling to properly listen to its customers, who have repeatedly complained of addressable failures and yet continue to suffer them. The company's leadership has taken a defensive approach with regulators to the point of trying to obstruct their reports and in so doing mislead credit agencies, demonstrating at best a lack of transparency, and at worst an attempt to actively deceive external stakeholders. This is yet another cultural problem that must be addressed to allow South East Water to account for its own actions.

4 Conclusions and next steps

73. Some of South East Water's problems are a function of wider regulatory issues. For instance, we have concerns about the limited compensation due to businesses which lost millions in revenue during supply interruptions:[167] neither the Guaranteed Standards Scheme nor insurance policies seem to cover these losses.[168] We will address these wider points as part of our scrutiny of future water reform. The purpose of this report is, however, to address the multiple failures by the leadership at SEW, detailed above, which are real and numerous. This is having a serious impact on customers, not just in terms of supply interruptions, the poor provision of alternative supplies, the potential health impacts on the vulnerable and the millions of pounds worth of losses to the local economy; but also in the long-term effect on attitudes towards drinking water. Recent survey results from the area tell us that 54% of those surveyed now store bottled water at home to prepare for future incidents; 25% feel less comfortable using tap water for washing and brushing teeth; and 19% drink only bottled water.[169] This is despite the UK having world-class drinking water. Not only is this costing customers in the area more money, but it is also indicative of eroded trust in the water system as a whole.

Implications for the leadership at South East Water

74. The occasional mistake can be forgivable, particularly if lessons are learnt from and acted upon. Years of consistent failure, repeating the same mistakes, are not excusable and are a clear sign that leadership is ill-equipped to take control of the multitude of problems they have and, in many cases, they have caused or perpetuated. SEW has committed to a variety of measures to tackle its supply resilience and incident response, but given our concerns about the current leadership of the company, we are sceptical that these are enough, or if the company can deliver them. As Dr Rink told us, "the gap between cause, effect, recognition and delivery seems to be quite wide" at SEW.[170]

167 Mr Mike Martin MP, Correspondence sent 23 March 2026; Tunbridge Wells Borough Council (RWS0038)
168 Qq1330–1342
169 Qq1604–1605
170 Q1618

75. A wide array of key stakeholders have lost patience and faith in the company: concerns and criticism have come from the Secretary of State for Defra[171] and the Prime Minister,[172] and several MPs, including Mike Martin MP, have already called on the Chief Executive to resign.[173] A survey conducted by Katie Lam MP's office following the January 2026 outage, which followed our initial hearing, found that out of the approximately 2,500 responses, 85% said that SEW was "poor" or "appalling" and 90% felt that the CEO should lose their job.[174] Despite Ofwat seeing a more "conciliatory and more constructive" attitude from SEW,[175] such a loss of confidence from key stakeholders calls the ability of the executive team to continue into question. We agree with Dr Rink and Dr Keil, the respective heads of the DWI and CCW, that regaining trust is exceptionally hard once it is lost, and that SEW will have to work extremely hard to do so.[176]

76. **CONCLUSION**

Continued leadership failure is grounds for leadership change. Time and again, since 2020, South East Water's leadership has failed in its fundamental task of supplying water to its customers. That is around six years of poor performance, sometimes with multiple incidents within the same year. Most problematic from a leadership perspective are the failures identified in the company's monitoring and managing of risks and the incident response. These are largely procedural matters, entirely within the company's control and have hardly improved from incident to incident. There are some signals that action is now being taken, but it is too little, too late. Even as of April 2026, that same leadership continues to cite mitigating factors that should have been known and properly prepared for. This is the same leadership that failed to give an accurate account of the Pembury incident to our Committee in January, an issue that we will continue to deliberate on.

171 Defra press release, Emma Reynolds raises South East Water concerns with Ofwat, 14 January 2026; The Times, "South East Water chairman told 'get a grip' as it risks £28m fine",15 January 2026

172 BBC News, Water restored for most after week of disruption, 16 January 2026

173 BBC News, Under-fire water boss vows to improve services, 27 January 2026

174 Katie Lam MP (RWS0050)

175 Q1600

176 Qq1604–1605; Q1609

77. **CONCLUSION**
These failures are symptomatic of significant cultural problems that cannot be readily explained by issues with the wider regulatory framework: this includes South East Water's failure to engage with external stakeholders, inclination for groupthink, inability to analyse problems, incapability to implement basic changes and a propensity to shirk responsibility. This culture, which permeates through all the company's key decision-making processes, needs to change, and culture starts from the top. As such, we have no confidence that the executive team at South East Water is capable of this challenge, nor any confidence in the team itself.

Non-executive directors

78. The Chair of SEW, Chris Train, is clearly aware that the role of a company board is to challenge and hold to account the senior executive leadership of South East Water.[177] Major shareholders of the company, including NatWest Group's pension fund, have expressed concerns and directed SEW's Board to take steps to resolve the issues at the company.[178]

79. The company's non-executives told us that they have considered the position of the CEO, David Hinton.[179] However, despite a catalogue of failures, the non-executive team has repeatedly and unanimously continued to back David Hinton's position as CEO, as well as the rest of the executive team, seeing them as the "right solution for delivering what is best for South East Water customers."[180] They refused to indicate a clear metric or state of affairs that would cause them to change the leadership.[181] They argued that Mr Hinton had already started making the necessary changes identified by both the DWI and their internal investigation: the only problem was that they are "just not going fast enough."[182] Mr Train and Caroline Sheridan, a non-executive director and author of SEW's internal review into the Pembury incident, pointed out that the executive team was to be bolstered through some external hires. They are responsible for important areas of

177 Qq1397–1398
178 The Telegraph, South East Water investors refuse to publicly back under-fire boss, 19 January 2026; The Guardian, South East Water boss lasting weeks in post would be a surprise, 15 January 2026
179 Q1454 ; Q1504
180 Q1450; Q1452
181 Q1452
182 Q1504

delivery,[183] and are expected to help "challenge" the "decisions, actions and the directions" taken by the executive, as well as the "family-feel" of the company that can raise "red flags".[184]

80. It is not clear to us how two additional members of the executive team will truly tackle the severe cultural issues identified in this report. This is a worryingly small measure taken by the Board, given the scale of the problems. The Board have also made other worrying decisions and comments, such as:

- seeking an injunction against Ofwat, ostensibly to reduce the visibility of investors to the true scale of the problems at SEW.[185]
- commissioning a separate investigation,[186] whose findings are not as robust as they need to be, nor adding much value beyond the work of the DWI.[187]
- failing to set out the metrics by which it will judge future transformation, despite it being perfectly possible to establish customer surveys and other targets to track progress in rebuilding trust with customers.[188] The best the Chair could tell us was that "Failure is failure and we have failed."[189]

183 Qq1575–1577
184 Q1450; Q1480; Q1506
185 Q1569
186 Q1472
187 Q1597
188 Qq1606–1607
189 Q1436; Qq1508–1514

81. **CONCLUSION**

Repeating the same actions and expecting different results is not a well-regarded tactic for resolving problems. Yet the non-executives of South East Water have time and time again chosen to back a leadership that is clearly not capable of improving outcomes for customers. Their only response to the Tunbridge Wells incident is to author an unhelpful report and appoint more people to the SEW Executive to provide the constructive challenge that they themselves should be providing. On top of this, they were also the decision-maker behind an attempted and unjustifiable injunction which, we believe, is the worst example of the company's defensive, antagonistic and deceptive attitude towards external stakeholders. The only possible conclusion to draw from this evidence is that the SEW Board, potentially influenced by the "family feel" that they identify alongside the executive, is incapable of holding the executive team to account. As those ultimately represented by the Board, shareholders also must demonstrate a willingness to restore resilience and trust. A new leadership team, more investment and special measures will be necessary to affect meaningful change.

Conclusions and recommendations

Background and timelines

1. Select committees do not often focus directly on the leadership, behaviour and performance of individual private companies. The water sector, however, is a highly regulated monopoly provider of services essential to public health. Residents have no choice over their water provider yet rely on them entirely for their lives and livelihoods and have little power to hold their leaders to account in cases of failure. Throughout the course of our inquiry into 'Reforming the water sector', we have already deemed it necessary to scrutinise the most significant water companies in England and Wales to hold them to account. To report specifically on South East Water, however, indicates the gravity of the situation facing the residents and businesses in the communities it serves. Given the extremely negative and dangerous impact that SEW has had on over 300,000 people since 2020, we feel compelled to apply public accountability to the leadership of a company that otherwise appears shielded from the consequences of its incompetence. (Conclusion, Paragraph 9)

Failures at South East Water

2. South East Water did not have the right processes in place to identify and mitigate risks at Pembury Works, despite previous warnings from the DWI. That the company had "normalised" critical risks and was "flying blind" in the lead up to the crisis is a fundamental failure for a water company responsible for a critical natural resource. In a perverse sense, Mr Hinton was right in saying that the events were "unforeseeable"; but only because the company had actively chosen to not put in the essential monitoring processes that would have enabled action before the outages began. As a result, the company failed to properly monitor threats such as ineffective coagulant dosing systems. A failure to have the right jar test processes meant that manageable problems escalated unnecessarily, undermining routine coagulant treatments, eventually and unnecessarily turning off the taps for businesses, essential services and tens of thousands of customers. (Conclusion, Paragraph 16)

3. Maintenance issues at Pembury contributed to the Tunbridge Wells incident in 2025, but it is South East Water's self-identified lack of proactive and "instinctive" maintenance across its network that is most concerning. One of the most fundamental and basic responsibilities of a water company is to plan for and have the staff and resources available to maintain assets. Yet SEW did not see this a priority, even in some of its most vulnerable areas, contributing to a series of major water outages between 2020 and 2023. (Conclusion, Paragraph 20)

4. As regulators told South East Water repeatedly and jointly for over four years, the company needed to invest in new infrastructure to be properly resilient to potential shocks. In particular, single points of failure, supply shortfalls and regional connectivity should have been improved, but the company failed to take action on these well-known long-standing issues for many years. Spending allowances in previous price reviews may have made trade-off decisions more challenging, but ultimately, these decisions are primarily the responsibility of the company, which should have seen the role that poor infrastructure played in events since at least 2018. Worse still, through successive price reviews, SEW has either not attempted or did not succeed in making the necessary investment case. This also suggests that, as the long-term stewards of the business, shareholders also must share a portion of the responsibility for these failures. (Conclusion, Paragraph 25)

5. Despite South East Water's assertions to the contrary, periods of peak demand and extreme weather can and should be broadly predicted and prepared for. Ofwat and the Drinking Water Inspectorate have shown that the company failed to model upcoming peaks and troughs and take the necessary steps in preceding weeks and months to boost resilience and reduce the risk of a crisis. Its leadership's approach to incident response planning is pitiful; there are signs that incident response plans either do not exist or are of poor quality, receiving little or no stress-testing to improve them. The recent experience of its customers, as well as an overreliance on external support, are testament to this lack of planning. This has had real-world consequences for tens of thousands of customers, many of them vulnerable. (Conclusion, Paragraph 30)

6. Both the Drinking Water Inspectorate and South East Water acknowledge the weaknesses of the escalation processes around the Pembury incident. This meant that operational staff were not given sufficient support to diagnose problems early and that key stakeholders were informed too late, inhibiting preparations and in breach of regulations. We are concerned that the CEO was too involved at the Pembury Works, a potential distraction from his overall crisis command. Either this is a further problem with escalation processes, or a choice by Mr Hinton to go against his company's own procedures. In either scenario, SEW appears unable to determine when and where its leadership team can provide maximum value. In the case of

Tunbridge Wells, this ultimately impaired the CEO's ability to communicate to customers and may have played a role in the poor crisis response. (Conclusion, Paragraph 35)

7. Given the huge number of supply interruptions that South East Water has failed to manage over the years, it is remarkable that the company still struggles with the supply of bottled water during outages, has failed to learn and apply lessons and relies on the goodwill of communities. Problems discussed elsewhere in this report could arguably take significant time and resources to resolve, but knowing where to set up bottled water stations and having enough bottles to go around is a fundamental and basic responsibility. That the company is only now considering more local ways of delivering water bottles speaks to its disregard for the consumers relying on it for a life-sustaining provision. (Conclusion, Paragraph 41)

8. Similarly to the provision of alternative water supplies, South East Water now has years of experience in communicating during supply interruptions. It is incomprehensible that SEW still lacks a crisis communications strategy or a well-developed communications team given the company's propensity for water outages. This put communication teams in a difficult position. Basic communications errors, like giving incorrect and inconsistent information about bottled water stations, using the wrong postcodes, poorly chosen language and a lack of empathy with customers, should not need external consultants to resolve. Vague answers to our questions to the company have not outlined what will happen to embed lessons, prevent future disconnections with operations, and ensure that a new communications "playbook" will be kept up to date and stress-tested. This does not give us confidence in the leadership's ability to learn from its previous mistakes and address the problems we have identified. (Conclusion, Paragraph 46)

9. For a company with such regular issues with outages, South East Water's approach to supporting vulnerable customers gives the impression of a business caught completely by surprise. We accept that it is challenging to continuously update the Priority Services Register: people will not always inform you of vulnerabilities, transient or permanent. However, the fact that there were fundamental problems with deliveries for those that were on the PSR is indicative of a problematic approach, one that fails to record and consider the needs of customers. Moreover, vulnerable sites such as care homes were also let down, which should have been easily identifiable, had proper business continuity plans been in place. Again, the specific needs of these sites should not have been a surprise: the company's history of outages should have given it a wealth of experience in where needs are greatest. (Conclusion, Paragraph 51)

A culture of failure

10. The Tunbridge Wells incident and Ofwat investigations reveal that South East Water's leadership has repeatedly proved itself incapable of implementing the lessons learnt from previous incidents, even simple ones such as having a communication strategy for when resolution timeframes are unclear. While the company was clearly trying to learn from its previous mistakes, it caused more problems in doing so, indicative of an inability to understand and resolve core problems. This is not through lack of warnings or proposed solutions, but an inability to adapt swiftly to mitigate future risks. Despite claims that they are otherwise a "good company", this has manifested in a shocking performance, failing to deliver the basic function of a water company: delivering water. No other metrics of success can offset this fundamental shortcoming. (Conclusion, Paragraph 56)

11. Since at least 2020, South East Water clearly has had, and continues to demonstrate, an inability to establish the root causes of its supply resilience problems. There are likely many facets to this, including a failure to monitor the key asset indicators, and a tendency to blame external factors, as highlighted elsewhere in this report. The company leadership seems to be divorced from the real-world situations, either due to a lack of feedback data and processes, or a willingness to ignore problems. There also appears to be a fundamental inability to properly analyse the data it does have, most recently demonstrated by its first misleading analysis of the Tunbridge Wells outages in November-December 2025. This misunderstanding appears to have happened throughout the organisation, including at the very top. While the company now does accept it has a problem with its problem-solving processes, vague conclusions after the event also suggest that the current leadership have still failed to conduct and accept a proper analysis. (Conclusion, Paragraph 63)

12. South East Water's leadership team has demonstrated a clear preference for blaming factors outside of their control for performance issues, and in some cases, they continue to do so, despite clear evidence to the contrary. A lack of data-analysis skills might be partially to blame, but it is also clear that a culture of obfuscating responsibility has also taken hold, seriously inhibiting their ability to analyse problems and learn lessons. The company's investigations, as well as that of the Drinking Water Inspectorate, have identified potential issues with a lack of challenge or groupthink within the company: that "family feel" may be closer to a "clique" than a benefit. We have serious doubts that the addition of two more executives will tackle this pervasive problem. (Conclusion, Paragraph 68)

13. South East Water has failed to engage with key stakeholders outside the company to help it learn from its mistakes. It is unwilling to properly listen to its customers, who have repeatedly complained of addressable failures

and yet continue to suffer them. The company's leadership has taken a defensive approach with regulators to the point of trying to obstruct their reports and in so doing mislead credit agencies, demonstrating at best a lack of transparency, and at worst an attempt to actively deceive external stakeholders. This is yet another cultural problem that must be addressed to allow South East Water to account for its own actions. (Conclusion, Paragraph 72)

Conclusions and next steps

14. Continued leadership failure is grounds for leadership change. Time and again, since 2020, South East Water's leadership has failed in its fundamental task of supplying water to its customers. That is around six years of poor performance, sometimes with multiple incidents within the same year. Most problematic from a leadership perspective are the failures identified in the company's monitoring and managing of risks and the incident response. These are largely procedural matters, entirely within the company's control and have hardly improved from incident to incident. There are some signals that action is now being taken, but it is too little, too late. Even as of April 2026, that same leadership continues to cite mitigating factors that should have been known and properly prepared for. This is the same leadership that failed to give an accurate account of the Pembury incident to our Committee in January, an issue that we will continue to deliberate on. (Conclusion, Paragraph 76)

15. These failures are symptomatic of significant cultural problems that cannot be readily explained by issues with the wider regulatory framework: this includes South East Water's failure to engage with external stakeholders, inclination for groupthink, inability to analyse problems, incapability to implement basic changes and a propensity to shirk responsibility. This culture, which permeates through all the company's key decision-making processes, needs to change, and culture starts from the top. As such, we have no confidence that the executive team at South East Water is capable of this challenge, nor any confidence in the team itself. (Conclusion, Paragraph 77)

16. Repeating the same actions and expecting different results is not a well-regarded tactic for resolving problems. Yet the non-executives of South East Water have time and time again chosen to back a leadership that is clearly not capable of improving outcomes for customers. Their only response to the Tunbridge Wells incident is to author an unhelpful report and appoint more people to the SEW Executive to provide the constructive challenge that they themselves should be providing. On top of this, they were also the decision-maker behind an attempted and unjustifiable injunction which, we believe, is the worst example of the company's defensive,

antagonistic and deceptive attitude towards external stakeholders. The only possible conclusion to draw from this evidence is that the SEW Board, potentially influenced by the “family feel” that they identify alongside the executive, is incapable of holding the executive team to account. As those ultimately represented by the Board, shareholders also must demonstrate a willingness to restore resilience and trust. A new leadership team, more investment and special measures will be necessary to affect meaningful change. (Conclusion, Paragraph 81)

Formal Minutes

Tuesday 28 April 2026

Members present

Mr Alistair Carmichael, in the Chair

Sarah Bool

Juliet Campbell

Charlie Dewhirst

Terry Jermy

Jayne Kirkham

Josh Newbury

Jenny Riddell-Carpenter

Tim Roca

Henry Tufnell

Failures at South East Water

Draft Report (*Failures at South East Water*), proposed by the Chair, brought up and read.

Ordered, That the Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 81 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eighth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Tuesday 28 April at 11.45am.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 6 January 2026

David Hinton, Chief Executive Officer, South East Water; **Tanya Sephton**, Customer Services Director, South East Water — Q1202–1363

Marcus Rink, Chief Inspector, Drinking Water Inspectorate — Q1364–1396

Tuesday 14 April 2026

David Hinton, Chief Executive, South East Water; **Chris Train OBE**, Chair, South East Water; **Caroline Sheridan**, Non-Executive Director, South East Water — Q1397–1593

Chris Walters, CEO, Ofwat; **Dr Mike Keil**, CEO, Consumer Council for Water; **Dr Marcus Rink**, Chief Inspector, Drinking Water Inspectorate — Q1594–1619

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

RWS numbers are generated by the evidence processing system and so may not be complete.

1	AJG Hospitality Ltd	RWS0025
2	Bailey, Alison	RWS0020
3	British Water	RWS0002
4	Burrowes, Nathaniel	RWS0048
5	Chatfield, Sophie	RWS0017
6	Clay-Chapman, Helen	RWS0046
7	Clear, Caroline	RWS0016
8	Consumer Council for Water	RWS0001
9	Crackett, Tommaso	RWS0031
10	Eccles, Susan	RWS0019
11	Environment, Food and Rural Affairs Select Committee	RWS0049
12	Fenwick	RWS0035
13	Foxglove	RWS0010
14	Fullalove-Jones, Janet	RWS0040
15	Gardner, Paul	RWS0013
16	Harley, John	RWS0023
17	Hopkins, Keith	RWS0043
18	Independent Age	RWS0047
19	J.D.	RWS0045
20	Jones, Alan	RWS0028
21	KentRelief	RWS0039
22	Kouropatov, Sofia	RWS0044
23	Katie Lam MP	RWS0050
24	Lee, Alan	RWS0021

25	Lewis, Max	RWS0015
26	Marquiss, Richard	RWS0033
27	Martin, Mike	RWS0030
28	Mellor, Steve	RWS0041
29	Mills, Oliver	RWS0042
30	Neely, Danny	RWS0034
31	Oliver, Sean	RWS0024
32	Parker, Nick	RWS0037
33	Reid, Steph	RWS0029
34	Royal Tunbridge Wells Together, Business Improvement District	RWS0032
35	Sankey, Matthew	RWS0026
36	Sarah	RWS0022
37	Save Our Land And Rivers (SOLAR)	RWS0011
38	Severn Trent Water	RWS0003
39	Southern Water	RWS0004
40	Stevens, Jonna	RWS0036
41	Stevens, Michael	RWS0018
42	Strauss, Vanessa	RWS0027
43	Styles, Mr Peter	RWS0007
44	Tunbridge Wells Borough Council	RWS0038
45	Unite the Union	RWS0012
46	Waugh, Mat	RWS0014

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2024–26

Number	Title	Reference
7th	Resetting the relationship with fishing communities	HC 680
6th	Erosion of trust: the impact of coastal erosion on communities	HC 1317
5th	UK-EU agritrade: making an SPS agreement work	HC 1661
4th	UK-EU trade: towards a resilient border strategy	HC 1279
3rd	Biosecurity at the border: Britain's illegal meat crisis	HC 1296
2nd	Priorities for water sector reform	HC 1001
1st	The Government's vision for farming	HC 906
5th Special	UK-EU agritrade: making an SPS agreement work - Government Response	HC 1833
4th Special	UK-EU trade: towards a resilient border strategy (Government Response)	HC 1496
3rd Special	Biosecurity at the border: Britain's illegal meat crisis: Government Response	HC 1490
2nd Special	The Government's vision for farming: Government Response	HC 1255
1st Special	Pet welfare and abuse: Government response	HC 581