Hackney

London Borough of Hackney
Living in Hackney Scrutiny Commission
Municipal Year 2019/20
Tuesday, 14th January, 2020

Minutes of the proceedings of the Living in Hackney Scrutiny Commission held at Hackney Town Hall, Mare Street, London E8 1EA

Chair:	**Councillor Sharon Patrick**
Councillors in Attendance:	**Cllr Sade Etti (Vice-Chair), Cllr Anthony McMahon, Cllr Ian Rathbone and Cllr Penny Wrout**
Apologies:	**Cllr M Can Ozsen**
Officers In Attendance:	**Aled Richards (Director of Public Realm) and Andy Wells (Civil Protection Service Manager)**
Other People in Attendance:	**Councillor Clare Potter, Councillor Caroline Selman (Cabinet Member for Community Safety, Policy and the Voluntary Sector), Kelly McFarlane (Director, Customer Experience), Steve Spencer (Chief Operating Officer), Carl Pheasey (Director Strategy and Policy) and John Russell (Senior Director Strategy and Planning)**
Members of the Public:	**54**
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Councillor Sharon Patrick in the Chair

1 Apologies for Absence

1.1 Apologies had been received from Cllr Ozsen, who was at Licensing Committee.

1.2 Cllr Lynch was absent.

2 Urgent Items / Order of Business

2.1 The Chair welcomed members of the public and guests, and thanked them for attending.

2.2 The meeting had been called following the latest flood in Hackney caused by a mains burst on Thames Water's network; this time in the N4 area. The school in which the meeting was being held had itself been effected.

2.3 Local Ward Councillors were present, who she knew had played active roles following the flood. In addition, Commission Members themselves had visited the affected area at the weekend prior to this meeting, and had reviewed video footage of the immediate aftermath. This had helped to ensure that Members were aware of the scale of this incident, and had at least some appreciation of the hugely detrimental impact which it had had on the lives of those residents affected.

2.4 In terms of the structure of the meeting, the first substantive item would see Council Officers present on the Council's response to the incident initial, and the latest developments around its work to both assist affected residents directly and to ensure that Thames Water were providing the required support.

2.5 The next would hear from Thames Water on this specific flood. This would seek to explore its causes, Thames' immediate response, and its ongoing management of the aftermath. In regards to this item, she thanked residents for having added suggested questions for Thames Water to a number of display boards when they had entered the school hall.

2.6 These boards were each titled with different themes / topic areas, based on the broad concerns raised by residents in local meetings following the event which one the Ward Councillors - Clare Potter - had led on. To help best ensure that as many residents as possible could have their questions answered in this meeting, the Commission would give consideration to those added to the Board when questioning Thames Water.

2.7 The third substantive item would look at Thames' performance on a broader level. This was given that this was the third time the Commission had heard from Thames in recent years, following previous main bursts and major flooding in Stoke Newington in 2017 and Lea Bridge in 2018. She hoped the Commission could explore why these incidents were being repeated, and what was being done to address this. Ofwat were in attendance for this item along with Thames Water.

2.8 The Chair wished to give particular thanks at this point to Cllr Clare Potter for her leadership following this latest incident. Cllr Potter had been particularly active in working to ensure that residents in her ward had had their concerns listened to and addressed. She invited Cllr Potter to make any opening comments.

2.9 Cllr Potter thanked the Chair. She thanked the Living in Hackney Commission for having organised this meeting. She welcomed formal scrutiny being applied to Thames Water. This would complement the local meetings held in the Ward following the incident which had focused – as had been needed - on ensuring that individual cases were being dealt with effectively. She welcomed that the regulator was in attendance for this meeting which would be more focused on the overall effectiveness of Thames Water.

2.10 The impact of the recent major mains burst could not be overestimated. 177 households had been most directly and significantly affected, with their homes severely damaged. The majority of these households had needed to leave their homes, with many not yet able to return more than three months later.

2.11 As a Councillor representing the Hackney residents most affected by the incident, she was committed to doing all she could to ensure that Thames Water provided full support until all residents were able to return to their homes, those impacted had their circumstances returned as best they could practically be to those they were before the incident, and fair and full compensation had been provided.

2.12 The Chair thanked Cllr Potter. Moving onto the agenda, there were no urgent items and the order of business was as laid out. This was with the exception of the Any Other Business item which had incorrectly been numbered as item number 4, and not as the final item in the agenda. This item would be held at the end of the meeting.

3 Declarations of Interest

3.1 There were no declarations of interest.

4 Any Other Business

4.1 There was no other business.

5 Thames Water Main Burst in the N4 area - summary of response by the Council and its partners

5.1 The Chair welcomed the following guests for this item:

- Aled Richards, Director Public Realm
- Andy Wells, Manager, Civil Protection Service

5.2 The item started with the Manager, Civil Protection Services giving an introduction to his service area before summarising the key events regarding the incident as identified by the Council, and the Council's response. Fuller information was available in the paper provided within the agenda packs.

5.3 His service was responsible for a number of Council functions, including the arrangement and co-ordination of responses to emergency incidents. The paper made a number of referrals to 'Silver'; this was an emergency services term used to identify the Officer who would hold the duty of Tactical Commander in the case of an emergency incident occurring. A rota arrangement meant that there was a designated on duty Silver Officer at all times. Command and control of these arrangements were managed through a dedicated Borough Emergency Control Centre, which would be opened following an incident.

5.4 The timeline detailed in the paper spanned from the point of the Council becoming aware of the incident at 08:04 on the 8th October through a radio message being received by Police Officers located in the Civil Protection Service's Control Centre, through to 01:00 on the 9th October when the Silver Duty was handed over from the Original Silver to incoming Silver. This said, it was important to note that – given the severity of the incident - the initial response structures remained in place until 5pm on the 11th October.

5.5 Alongside this and within procedure, a Recovery Group was set up and put into operation, with a focus on longer term issues. This took over from the Borough Emergency Control Centre on the 11th October. The Recovery Group formed in response to this incident was chaired by the Council's Director of Public Realm. This was in reflection of many of the services with roles to play in the recovery, falling within his remit.

5.6 Feeding in at this point, the Director of Public Realm made the following key points:

- As with those set up following previous floods, the Recovery Group was focused on both coordinating the Council's assistance to affected residents, and also ensuring that Thames Water were affective in dealing with issues and concerns

- This had been a very serious and event and significantly traumatic for those involved. The impact had been even greater than those seen in previous floods.

- As per points made by Cllr Potter, many displaced residents were yet to be able to return to their homes over three months after the incident. This was the case for 72 households.

- 34 of the 72 currently uninhabitable properties, were Council properties. Council Officers were regularly meeting Thames Water regarding these units, in order to ensure that repairs work started immediately following the drying out process being complete. Currently, 3 of the 34 units had dried out sufficiently to allow repairs and redecoration works to begin.

- The Council units which had been flooded were based in older buildings, and it was suspected that in some cases floor tiles present contained asbestos residue. Therefore, the Council was using a licensed specialist asbestos removal contractor for the removal of these tiles. The action taken was in full adherence to Health and Safety Executive guidance. Air quality monitoring would be carried out following the removal in order to provide further assurance around safety to tenants and leaseholders prior to them returning to their homes.

- The Council's waste and street cleansing services had been active in cleaning the area in the immediate aftermath of the flood, and in ensuring that waste collection services had been maintained. They had also liaised with Thames Water to ensure the removal of flood damaged possessions placed on the street for collection. Council Community Enforcement Officers were also in attendance to provide reassurance to the community

- Parking enforcement had been suspended following the flooding event. It had resumed from the 7th of January. This decision was made in response to evidence of drivers from elsewhere treating the area as an uncontrolled area parking area, which in turn was impacting on parking amenability for permit holders.

- In the immediate aftermath of the flood there were reports of an increase in rats in the area, most likely emerging from the mains sewer. An extensive programme of baiting was undertaken by the Council in response to this, and

monitoring pointed to the issue having been rectified. If any residents encountered any further issues he asked that they got in contact with the Council.

- Repairs to roads and pavements damaged by the flood had now been completed by Thames Water contractors, and signed off by the Council.

- On Council Tax relief, the Council had determined 79 forms with sufficient information to make a determination. This had resulted in 51 accounts being subject to discretionary council tax write offs (due to properties being uninhabitable), with a total of £33,817 written off to date. There were a further 80 cases for which forms had been sent out via email to residents understood to be affected. These were yet to have been returned. He asked for any residents who had not received their forms to contact the Council Tax service or to speak to him at the end of the meeting.

- Moving onto lessons learnt, there had been some operational aspects which the Council would reflect upon. However, more fundamentally he felt there was learning for the Council and Thames Water around how they should liaise with one another in the event – which he of course hoped would not happen – of another flood of this scale occurring in Hackney.

- He felt the Council's response to have been strong and extensive. However, he also said that it could have been delivered more seamlessly if Thames Water had shared information with the Council around the property addresses and residents which had been affected. These had been accepted as lessons learnt by the Council and – as he understood - Thames Water.

- In addition, arrangements had been made for the Council to provide training around emergency planning aspects which the Council would expect Thames Water to put in place for events such as this. There was also a future desktop exercise planned for Thames Water to learn the lessons from the management of this particular incident.

5.7 The Chair thanked the Director Public Realm and the Manager, Civil Protection Service. She wished to place on record her thanks to all Officers who had enabled the Council to respond so quickly and effectively. She was particularly grateful for the prompt set up of the rest centre which had provided a warm space for residents to go to, and to Officers who had gone out to be on the ground with residents.

5.8 This said, she recalled that at a similar meeting to this one following the previous flood in Leabridge, the suggestion had been made that Thames Water sought learning from the Council around how its response to incidents could be made more affective. This followed Thames Water acknowledging significant shortcomings in its response to that mains burst and flood. Thames Water at the meeting had been positive around this possibility, and the Council had appeared open to providing the training. It was a shame that it appeared that this had not been enacted, and that it seemed to have taken a further flood for it to be put in place.

5.9 From the video footage and her visit to the area she had grasped just how severe this flood was. It was so vital that Thames Water did all it could to

prevent further incidents like this and to respond more adequately than it had sometimes appeared to. She did worry that – had the incident occurred at a different time – there could have been grave risk of people losing their lives.

5.10 Asked to respond to the point around a training offer to Thames Water, the Manager, Civil Protection Service confirmed that following the meeting mentioned in Lea Bridge, his service had contacted Thames Water around getting this in place. However, Thames Water had not chosen to take the Council up on its offer, until after this most recent event. He was pleased that training had now been scheduled for a date in late January.

5.11 A Member was pleased that the training event for Thames Water and the desktop exercise to draw on learning from the latest flood, had now been put in place. However, given that this opportunity was not taken up by Thames Water in the past, she asked if confirmation could be provided as and when these were completed.

ACTION 1 (Manager, Civil Protection Service):
To confirm completion of training of Thames Water by the Council around emergency planning processes, and desktop exercise of learning from response to N4 mains flood.

5.12 The Chair noted the points around suspected asbestos in some of Council homes affected, and this being removed within remedial works. She welcomed the full and cautious approach the Council was taking in these cases, in terms of removal and follow up with air testing. She asked how affected residents were being assured around the robust approach in place.

5.13 The Director of Public Realm confirmed that a letter was due to be sent to residents very shortly. This contained detail around the measures being taken regarding the removal of tiles, the reasons for this, timescales, and contact details in case they had further queries.

5.14 Drawing on the questions posted on the noticeboards by residents at the start of the meeting, a Member noted that a number had commented on asbestos being covered by Council contractors in some cases, rather than being removed. She asked if confirmation could be given that materials were being removed.

5.15 The Director of Public Realm said it was important to note that Housing Services were using specialist contractors for the removal and management of materials suspected of containing asbestos in homes affected. As specialists, the contractors would have expertise in determining which materials contained or were likely to contain asbestos, and which elements should be removed rather than being left in situ. This said, air testing following works and investigations would provide assurance around safety.

5.16 The Chair welcomed that a letter was about to be sent to residents whose flood damaged Council homes were suspected of containing asbestos, on the steps being taken. However - given the concerns raised in this meeting - she hoped the letter gave full context around the approaches which specialists could take to asbestos. She appreciated that in some cases the approach could be to leave undisturbed asbestos in place where this was deemed to more

appropriate than removal. She asked if the letter contained this information, as she felt that it could provide some assurance and clarity in some cases.

5.17 The Director of Public Realm said that he understood the letter – which was being sent by Housing Services – did not contain this level of information. However, he would take up the Chair's suggestion with Housing, on her behalf.

5.18 A Member wished to raise a case where a Council leaseholder had been advised by Thames Water that asbestos works was not needed in her unit prior to Thames Water later confirming that asbestos was present. The Member strongly felt - for all Council homes affected by the flood – that the Council should be fully involved in the dialogue around any suspected presence of asbestos and the management of this.

5.19 Kelly Macfarlane, Director of Customer Experience, Thames Water came in at this point. She confirmed that arrangements were now in place to ensure full Council involvement in these cases.

6 Thames Water Main Burst in the N4 area - cause of burst and response by Thames Water

6.1 The following guests were in attendance for this item:

- Steve Spencer – Chief Operating Officer, Thames Water
- Kelly McFarlane – Director, Customer Experience, Thames Water

6.2 Invited to make any opening comments, the Chief Operating Officer, Thames made the following key points:

- He was responsible for the operation at Thames Water. This included the operation and maintenance of all treatment plants and networks in the Thames Water region.

- As a first point, he wished to give his and Thames Water's sincerest apologies for what had happened. It had been one of the most significant incidents to have happened on the network, and had turned residents' lives upside down. There were obviously long term legacy issues to work through. Thames would not walk away until all affected residents were back in their homes and had had their issues resolved.

- He gave a summary of the incident, the cause of it, and the operational response, as available in a paper in the agenda packs.

- The pipe which had failed was a section of one of Thames Water's trunk mains. These carried large volumes of water around London; in this case from a pumping station through to a reservoir. It crossed Queens Drive at a point close to where this meeting was being held.

- It was one of the larger trunk mains (36 inch). It supplied the reservoir which in turn served around 237,000 homes and important infrastructure sites including hospitals and prisons. On a normal day the pipe would carry 50 to 60 million litres of water between the ring main (going around London) and the reservoir. The volume of water which escaped was made worse by the pipe failure also causing a flow of water back from the reservoir.

- A number of connections ran from the trunk main into other mains. Investigations had shown that a pipe section of the main which crossed Queens Drive had split in two across the length. This was opposed to a hole or a particular leak causing the flood, which had typically been the case with other pipe failures. The failure occurred at 07:55 on the 8th October.

- Investigations had not been able to identify the exact reason for the failure of the pipe. There were joints between sections of pipe. Through the methodology used, it had been identified that between 25 to 50 years ago a repair had been carried out to one of the joints. There was a possibility that this repair had resulted in a weak point on the main which had then gone on to cause the failure. However, this was not certain.

- The year of manufacture of the section of pipe which split was around 1892. It was conceivable that there was a manufacturing fault, and that this combined with the impact of the joint repair and the weight of traffic at a junction at street level above, had led to the failure. However, it was not possible to reach a precise diagnosis.

- Following the failure, the full length of the piping section crossing Queens Drive had been replaced. All mains from the reservoir to Holloway Prison had been surveyed. Some points had been identified for replacement, which would be completed before it was brought back into service.

- Thames Water heard about the event at 07.55. They immediately mobilised teams, with staff arriving on site between 35 and 40- minutes later. By this time and given the scale of the devastation caused, the site was in the control of London Fire Brigade. Thames Water worked with them and for its part were focused on stemming the water still emitting from the pipe.

- The network in the area was complex in terms of cross connections and the wide range of areas which the pipe served. A plan was needed to isolate the pipe and to operate the valves needed to close off the water. The plan developed identified five valves to be closed off. Enactment of this started at between 10am and 11am. However, it was then found that the valves did not isolate the main in the way expected. Whilst the operation did lead to some drop in flow, water was still emitting.

- This led to a further work at the central office to identify the other valves which needed to be operated, before instruction was given to staff on site. Upon these being enacted flood water did start to be stemmed, in the afternoon.

- It needed to be noted that operating these valves had affected water supplies to homes in a wider area. The impact of this on those affected was compounded by Thames Water not providing adequate amounts of alternative bottled water to this area. Thames Water acknowledged their failure on this element. By the evening, the supply of alternative water issue had been largely rectified. This said, some of the wider area were still without running water the following day.

6.3 In response to a question around valves and whether these were faulty, the Chief Operating Officer, Thames Water confirmed that of the five valves identified as needing to close to stem the water, four worked as expected and

one did not. This meant that a further plan needed to be devised around other valves.

6.4 In response to the Member asking how old the faulty valve was, the Chief Operating Officer, Thames Water advised that it was likely to have been the original valve used when the main was installed.

6.5 All valves were on trunk mains. All were given a risk rating. Valves were then checked on a programmed basis according to this and other elements. One of the challenges around checks if these were done by fully closing valves, this would cause bursts. Therefore, testing was focused on them being free to move and operational. This means they would be closable if they needed to be. Typically, in one year the checking process found several hundred valves to be in need of replacement. It was the case that if the fifth valve had not been faulty, the flood would not have been so severe.

6.6 There was a balance to achieve. The main supplied water to a wide area. There needed to be a balance between stemming flooding whilst also restricting loss of water for other households and vital services including hospitals.

6.7 In terms of the response, Thames had been prompt in getting repairs and operational teams on site, and a site command established. The process followed had been similar to the Council in terms of getting a Silver command in place. As the scale of the event became more clear, he himself had taken over direct control as Gold command. This said, Thames Water held their hands up in terms of the speed in which the mains were isolated. This could have been a lot better.

6.8 Following the incident, Thames Water had made sure that all mains and valves in the area had been surveyed and checked. The section of failed pipe would be replaced. He appreciated that this was coming after the event. However, the incident had led to a reassessment of the current approach to the trunk and valves programme within an aim of best ensuring no repeat.

6.9 Given the limited time available the Chair at this point asked the Director, Customer Experience, Thames Water to make any initial comments before Members asked further questions.

6.10 The Director, Customer Experience, Thames Water made the following key points:

- She was responsible for Thames Water's customer service and the support provided to customers.

- In terms of the response to the incident, customer representatives were immediately deployed on the day to support Thames Water's appointed loss adjusters, Sedgwick. Sedgwick staff were also on site quickly.

- There had needed to be a focus on securing alternative accommodation. The level of this task had been unprecedented compared to any previous events Thames had needed to respond to. At any one time around 90 families had been rehomed, either on a short term basis whilst limited repairs were carried out, or for a longer term due to the scale of damage.

- She was aware of feedback from residents that the response on the day had been chaotic – not only due to the scale of the event. There was learning from this. However, it was also the case loss adjusters had been onsite until late at night to ensure that all households in need were provided with alternative accommodation from the first night onwards.

- There was a focus on securing accommodation for residents which was close to their homes. They used more than one property agency and looked at all options available. Cost was not an issue in this.

- After the securing of the necessary alternative accommodation, focus moved towards pumping water out of properties and assessing damage. Feedback on this would help shape improvement. Pumping water out of homes required powerful pumps which in some cases had sucked up residents' belongings. Thames Water had now invested in some smaller pumps to better avoid this happening in future.

- Thames Water were working with a number of partners. This was due to these parties' expertise and not any intention of Thames not taking full ownership of the issues.

- Sedgwick were employed as their loss adjusters, and had complete control of the site in the emergency phase. This was important as it allowed them to independently and fully assess damages.

- Willis Towers Watson were Thames' claims handlers. They made all payments and managed temporary accommodation factors. Disaster Care managed the pumping out of properties and the creation of inventories.

- Additional loss adjuster support had been put in place following feedback. Support was available in the nearby Azalea Community Centre until the 17th January. This was in reflection of Thames Water wanting to ensure customers were able to access face to face contact for a significant amount of time following the incident. Support would still be available after this point, and all customers should have had contact details for this.

- Security patrols put in place following the incident were still present, and would continue for some time to provide reassurance.

- Given the scale of the incident and the impact, Thames Water had revised its policies to significantly increase levels of discretionary payments. An approach had been reached of making a £300 payment per property for homes which had experienced moderate damage but where residents had been able to stay in their homes, and £5,000 per property where more major damage had occurred and residents had needed to be housed in temporary accommodation. These payments were discretionary, and fully separate of costs for repairs and alternative accommodation.

6.11 The Chair thanked the Customer Experience Director. However she noted that residents affected by the Lea Bridge flood in 2018 had raised similar concerns about the Thames Water response being chaotic. At that time, the Commission

had been advised that there would be learning from this. From feedback on the response to this flood, it appeared this not to have been the case.

6.12 The Customer Experience Director agreed with the Chair. The response had not been good enough, and had been chaotic. There was a commitment to improvement. Options being considered included quite simple measures such as all staff wearing high visibility clothing to better achieve a clear presence, and other elements also. She looked forward to Thames Water gaining training from the Council around response procedures. She was committed to improving these.

6.13 The Chair noted the difference in discretionary payments for those who had remained in their homes (£300) and those who had needed to move into alternative housing (£5,000). She appreciated the rationale for those having to relocate receiving higher amounts than those who were able to remain. However, she felt the £300 payment to be low, considering the distress caused and the scale of the incident. She asked if any consideration had been given to increasing this payment.

6.14 The Customer Experience Director said that as with other aspects of the response, there was learning around how Thames Water had managed the discretionary payments process. Given the scale of the incident, Thames had been very keen to get payments out quickly. They were aware that some affected residents had no access to any other funds. However, in the haste to make these payments, a number of issues had not been envisaged. This included issues around multiple tenants living in one property, relationships between tenants and landlords, and the method of payment used (Thames Water made payments by cheque as they did not have bank account details of all customers to enable direct payments into accounts).

6.15 In some cases these issues had caused frustration among a number of residents. Moving forward, learning would be that in the unfortunate event of another incident, there should be meetings with community leaders to identify the most appropriate way forward in terms of making payments.

6.16 Also, cases needed to be taken very much individually, and treated on a case by case basis within an appreciation that different people had different circumstances.

6.17 Reflecting this – and in terms of any possibility of increasing the minimum of £300 per flood damaged property - she was committed to taking each case on its merits. There had been cases where payments had been higher than £300 for flood damaged homes where residents had not been displaced.

6.18 A Member noted that her impression from previous meetings following separate floods had been that Thames Water was a business focused more on profit than on the needs of residents.

6.19 She knew a resident whose mental health had deteriorated following the flood in Lea Bridge. She asked what Thames Water were doing to quantify appropriate levels of compensation for residents who had suffered like this. She felt that the £300 minimum payment was far too low. Given the strain on health

services, she asked if Thames Water would fund people seeking counselling and or other psychological support following this flood and previous ones.

6.20 The Customer Experience Director said she fully appreciated the Member's points, and understood her views around this. This said, she and colleagues she knew were more fully committed to providing good services to customers rather than to aiding profit making. She acknowledged that Thames Water did not always get things right. In cases like the one mentioned by the Member there was a need to ensure that customers did not fall through the net. She implored anyone needing counselling or any other support as a result of this incident to raise this with the loss adjuster. Full consideration would be given to these cases.

6.21 There was a commitment to seeking to support the community. Donations to the Council and this school had been made following the recent flood, and separately following the flood in Lea Bridge. Thames Water took its corporate social responsibility seriously and was one of the largest providers of debt advice counselling in the region.

6.22 The Chair thanked the Customer Experience Director. However, she said that it was her perception and that of others she knew, that Thames Water were not taking effective action to improve its management so that these incidents did not happen. Whilst being clear that the discretionary payments (in her view) were too low, there appeared to be a culture of Thames Water responding to these incidents by repairing homes and paying people money, but not doing what was needed to prevent them happening in the first place. If the Council caused this level of damage and distress she felt sure there would be a genuine commitment to ensuring that it did not happen again. It was not clear to her or others that this was the case with Thames Water, given that some of the lines around learning and reassessing approaches were similar to ones which had been given following previous floods.

6.23 The Cabinet Member for Community Safety, Policy and the Voluntary Sector agreed with the Chair on this. She worried that it appeared that improvements previously agreed were then not enacted upon. One example was the non-take up of the Council's offer of training following the incident in Lea Bridge previous event despite having given the impression that it would. Another was the apparent non implementation of a recommendation from an Islington Scrutiny Committee following a flood in that borough around a review of a discretionary payment policy. She was concerned around how the Commission could be assured that improvements mooted in meetings like this were followed up and enacted by Thames Water.

6.24 The Customer Experience Director thanked the Members. Incidents like this hurt the company, both reputationally and financially. On the latter point, the cost of this latest incident to Thames Water was likely to total approximately £18 million. This was alongside genuine regret of the distress caused.

6.25 In terms of the discretionary payment policy, a new policy was enacted following the incident in Upper Street. However, following the recent flood Thames Water had gone past the remit of this policy in order to increase payments for displaced households from £1,500 to £5,000.

6.26 A Member noted that payments were being generally made on a per household basis. However, she asked whether the case by case was translating into an upwards revision of payments to better recognise when there were multiple people in a household.

6.27 The Customer Experience Director said that she was not committing to this. However, she again reiterated that cases would be taken individually. In some cases where residents had not moved out of their home despite it suffering significant damage, higher amounts had been paid than £300. She appreciated that the size of households varied widely. However, the approach taken would continue on a case by case basis.

6.28 Another Member noted the references to a case by case approach to discretionary payments. She asked if this was also the approach towards daily subsistence payments, as she felt it should. She noted a question from a resident around any recognition by Thames Water that some of those forced to live in temporary accommodation did not have access to the same levels of cooking facilities that they had in their homes, and or had to spend a lot more time travelling, which had meant less time to cook and a greater reliance on take away food or eating out more. She felt that a case by case approach to subsistence payments should be taken.

6.29 The Customer Experience Director said that she was not an expert around subsistence payments and could not herself to commit specifically to a case by case approach on this aspect. She asked Mark French from Sedgwick who was in the audience if he had any comments on this.

6.30 Mark French said that subsistence payments related to a monetary sum typically paid during the emergency stage following a flood, which was intended to cover food costs for those displaced from their homes. There was a defined daily amount for these payments of £25. This amount had been determined within a view that hotels generally provided breakfasts to guests within the room rate which Thames Water would cover separately, and that £25 would generally cover the costs of further daily meals required. Sedgwick had received queries around whether this defined amount was reasonable. In these cases Sedgwick had looked at the individual circumstances and in some cases had adjusted payments to go above this level.

6.31 The Member also noted comments around the payment process being slow, and wrong amounts being paid in some cases. She respectfully suggested that Thames Water might review the performance and actions taken by their staff to ensure that jobs were being done properly.

6.32 The Customer Experience Director said that following the incident, Thames Water had worked to make initial payments very quickly – within 48 hours. The timescale for more significant payments were around 10 days.

6.33 A Member noted earlier references to the distress and trauma caused by the incident. She asked whether people would be able to make claims reflecting this, including in future as any longer term impacts became clearer. She asked if people would be able to claim for the disruption caused to their Christmases by the event. She asked if all of these issues were taken into account.

6.34 Mark French confirmed that they were. Distress and inconvenience claims in law were measured by a number of factors, including the duration of the distress. Previous legal cases were used to help provide general benchmarks for levels of payment, but they would always depend on individual circumstances. For example, if a household was not able to return to live in their home for one year as a result of an incident the level of compensation would be higher – all else being equal – than for someone who had been able to return after 6 months. Another example was that greater monetary value to stress would be generally applied to households with young children.

6.35 Moving back to operational aspects relating to cause of the incident and Thames Water's management of its network, a Member noted that a conclusion was that material fatigue from an aging cast iron pipe could not be ruled out as the reason for its failure. He asked whether – if laying the pipe today – the same cast iron material would be used.

6.36 The Chief Operating Officer, Thames Water confirmed that newly installed pipes were made of materials other than cast iron.

6.37 The Member asked whether this incident and previous ones led to a conclusion that the profile of risk and planned risk mitigation ascribed to situations where trunk mains carrying very large volumes of water were made of cast iron, needed significant review. In turn he asked the extent to which any review of risk would translate into a faster and more effective replacement of cast iron trunk mains.

6.38 The Chief Operating Officer, Thames Water thanked the Member for these strong points. Following a number of bursts in recent years, Thames Water had revisited its approaches to its management of trunk mains. This had included a re-categorisation of risk profiles, with each length of main ascribed a risk level. A number of factors were used in this assessment including the age of the pipe, its condition, the nature of usage of the surface above, and also – very importantly – the impact which failure of the pipe would have. Impact scores would depend on the characteristics of the area the pipe was situated within; they would be higher where there was a prevalence of basement properties in the area, and or where there were underground stations, for example.

6.39 These assessments were used to model a trunk replacement programme which was prioritised according to risk. A significant increase – £150 million - in investment in replacing large trunk mains had been made following numerous bursts in 2016.

6.40 This said, a big challenge with trunk mains compared to a traditional mains programme was their size and where they tended to run – along major roads. For example, the trunk main which had burst in Queens Drive included a 2km section going along a stretch of Seven Sisters Road. Replacing this would be likely to require the closure of this major road for 1 year which would obviously bring very significant disruption.

6.41 This kind of scenario was played out across London; a very extensive replacement programme would not be possible without very large disruption across London. There were around 2,100km of trunk main in London alone. A blanket replacement of this network in a short time was not feasible.

6.42 These challenges were leading to a consideration of new approaches, within a programme Thames Water were calling Re-Plumb London. They were in initial discussions with the regulator around a potential new engineering solution.

6.43 In the meantime, replacement programmes would continue focused on the highest risk mains. Within this approach, Thames Water were working with industry to develop technology to better enable weaknesses in pipes to be identified prior to any failure.

6.44 Cllr Potter said that as a Ward Councillor she was aware that a number of residents living at the bottom of Queensbridge Drive and on the Kings Crescent Estate felt ignored immediately following the incident. There had not been enough Thames Water staff onsite making contact with all affected residents by knocking on doors. In the unfortunate event of an incident occurring in the future she hoped that this would be a lesson learnt and that Thames would be more effective at identifying and then contacting all those affected, on the day itself.

6.45 The Customer Experience Director agreed with Cllr Potter on this point. Thames Water had not been as proactive on the day as they should have been, with too much of a reliance on affected residents making themselves known rather than Thames Water actively identifying and making contact with all those affected. This was a point of learning for Thames Water.

7 Thames Water's performance and management of the network in Hackney

7.1 The following guests were in attendance for this item:

- John Russell, Senior Director Strategy & Planning, Ofwat
- Carl Pheasey, Director Strategy & Policy, Ofwat
- Steve Spencer – Chief Operating Officer, Thames Water
- Kelly McFarlane – Director, Customer Experience, Thames Water

7.2 Invited to make any opening comments, the Senior Director Strategy & Planning, Ofwat made the following substantive points:

- Ofwat was the national regulator for the water sector. This meant that it regulated all public water companies in England and Wales, including Thames Water.

- Its main role was to set service standards and investment packages for these companies, and to hold their performance to account.

- Ofwat did not have a role regarding specific incidents. This said, they recognised the enormous detrimental impact of the event in N4 and - given the scale of the incident - they had visited the area and been in regular dialogue with Thames Water on its response.

- In regards to Thames Water, Ofwat had had significant concerns with Thames Water's performance for a number of years. Thames Water was an outlier of poor water network performance, and Ofwat were requiring considerable improvements to operational performance and the effectiveness of its communications. It was engaging with Thames Water intensively; more so than

was the case for most other companies. They had publically challenged Thames Water since 2017 to improve its performance.

- In 2018, an Ofwat investigation found Thames Water to have breached two of its legal obligations through poor leakage management. This resulted in a record £120 million package of penalties being applied, and the gaining of commitments from Thames to improve leakage performance. Ofwat were continuing to monitor progress closely and would take action where needed.

- Ofwat had now set the investment and service incentive packages for water companies for the next five years (the Price Review (PR) 19). This was setting strong improvement requirements for Thames Water including reducing supply interruptions by 53% and leakage by 20%. These were underpinned by large financial penalties which would be applied if targets were missed. Alongside this, Ofwat were allowing significant investment by Thames Water to improve the resilience of the London network. Ofwat saw the package as delivering a clear expectation for improvement and the investment capacity required.

7.3 The Chair asked if the financial penalties already applied and those Ofwat had reserved the right to apply in future, could be recovered by Thames Water through customer bills.

7.4 The Senior Director Strategy & Planning, Ofwat confirmed that any penalties incurred by Thames Water were required to be paid by shareholders rather than customers. For the last two years Thames Water had not paid dividends to shareholders, largely due to the penalties applied.

7.5 A Member noted the point around any financial penalties applied being expected to be funded through lower profits. However, it appeared from the paper that Ofwat were to conditionally allow up to £300 million investment by Thames Water to improve London water network performance and a further £180 million to investigate and mitigate risks to water supplies, both sourced from customer bills. She asked for confirmation that this was correct. She also noted from the paper that Thames Water's shareholders were expected to make a 'substantial contribution' to improvement works. She asked what this 'substantial contribution' would equate to.

7.6 The Senior Director Strategy & Planning, Ofwat advised that the overall level of investment Ofwat were conditionally allowing Thames Water, equated to around £9 billion over a five year period. Ofwat recognised a lack of resilience within the Thames Water network, particularly in specific parts of London. Therefore, within the total approximate £9 billion, they were allowing £300 million investment to address the resilience issues. Ultimately, this investment would be funded through customer bills. However, penalties applied for any failure to deliver the improvements expected from this investment and better practice generally, would be paid for by shareholders and not customers.

7.7 The Member thanked the Senior Director Strategy & Planning, Ofwat. However, she noted the reference to a substantial contribution by shareholders, and asked what this looked like.

7.8 The Senior Director Strategy & Planning, Ofwat advised that the final PR 19 package had been published in December. Ofwat were now in dialogue with

Thames Water on detail, with the expectation set for a clear plan for the allowed investment which would include defined and measurable improvements expected throughout the five year period. Investment would be allowed through a phased, gated funding process which would allow spend to be halted if it was found not to be effective.

7.9 A Member noted the reference in Ofwat's paper to Thames Water being an outlier of poor water network performance in 2014-19, and that it was one of only four of the seventeen largest water companies to be assessed as requiring 'significant scrutiny'. She therefore understood that Thames Water could have been categorised as being in 'special measures,' prior to the most recent burst. She felt the response to this burst could be seen to be extremely poor, given the time taken to turn off the water, and the failure to get adequate bottled water to residents who had lost their supply. She asked if this should push Thames Water into more extreme special measures. She asked what Ofwat were doing to pressure Thames Water to have stronger emergency response functions, and what the lessons were for Ofwat themselves from the incident.

7.10 The Senior Director Strategy & Planning, Ofwat said that since the incident Ofwat had spent significant time with Thames, including attendance and participation in a lessons learnt exercise. They had spoken directly to affected residents. In terms of the emergency response, measures had been put in place during the PR 19 process aimed at improving Thames Water's capacity to respond effectively. For example, it set an expectation that the numbers of people listed on the Priority Services Register would be increased, would better enable companies to target support more affectively. Ofwat were working more closely with Thames Water than they ever had done before, in order to apply pressure to Thames' to deliver the improvements expected.

7.11 A Member thanked the Senior Director Strategy & Planning, Ofwat. She asked if this closer work with Thames Water might include Ofwat's involvement with the desktop exercise planned between the Council and Thames Water mentioned earlier.

7.12 Responding to this point, the Director Strategy & Policy, Ofwat, said that he would be generally very positive about Ofwat being involved in this exercise.

7.13 This said, Ofwat did try to ensure that water companies effectively owned the relationship with their customers. One of the key reasons for there being a regulator for the industry was that water companies were one of the few businesses which customers could not leave in the event of poor practice. Ofwat was working to encourage water companies to get to positions where their levels of customer service and care could compare with the best companies, including those who were competing for custom. Ofwat could better help enable this culture not by sitting too much in the middle between water provider and customer, but by actively holding providers to account against high sets of standards.

7.14 This included being clear with providers that Ofwat would closely monitor the extent to which they were engaging with their customers and all stakeholders across their patches. On this point, Ofwat were working to better enable local accountability. Currently, the ability to monitor performance at a local level as opposed to that across the full region a company covered, was limited. The

latest price review was seeking to address this, with water companies having agreed to provide more granular performance information. Moving forward, Ofwat would work with providers and stakeholders to ensure this information was reported in accessible ways, to enable customers and other stakeholders such as this Scrutiny Commission to gauge performance locally and to hold providers to account against this.

7.15 The Chair thanked the guests from Ofwat, and invited Thames Water staff to make any initial comments in response.

7.16 The Chief Operating Officer, said that Thames Water fully acknowledged the need for improvement. He would talk on measures to achieve this. However, before he did this he wanted to be clear that on a wide range of aspects, Thames Water performed very well relative to the rest of the industry.

7.17 This said, performance on one crucial area - the water network element - had been poor for some time, and amongst the poorest in the industry. This incorporated levels of interruptions to supply, numbers of bursts, and the volumes of water lost to leakages. Thames Water fully acknowledged that these were areas for improvement. This was particularly the case with leakages. These had been significantly higher than where they needed to be, with Thames Water not having met its commitments for a number of years.

7.18 They were striving to return leakage levels back down to a target which was set some years ago. They were in touching distance of achieving this for the current financial year, but it would not be clear until year end whether this was the case. This said, he could say with some confidence that 2019/20 would see Thames Water achieve its best leakage reduction in 30 years. There was much more to do but work was having an impact; Thames was spending over £1 million a day to get leakage down, and it was falling considerably. This was within an aim of getting back on track by the end of year before moving further forward – Thames Water were clear that the water network needed be an ongoing area of focus.

7.19 A resident asked what the reasonable life span of a cast iron pipe was.

7.20 The Chief Operating Officer, Thames Water said this question did not have a straight answer. There would be a natural age limit to a pipe. However, it was not the case that age was the main indictor of whether a replacement was needed. Sometimes it was found that pipes installed in the 1950s or 60s needed replacing, whereas older ones when tested were found to be sound. The oldest pipe identified on the Thames Water network was from 1802.

8 Follow up on aspects relating to 2018 flooding in Lea Bridge

8.1 The Chair advised this item related to issues apparently outstanding from the previous major flood in Hackney caused by a burst water main; in the Lea Bridge Ward in 2018.

8.2 The Commission had heard from Thames Water and affected residents and businesses following that flood. The outstanding issues had been raised by Cllr Rathbone in the Commission’s meeting in September 2019. Following this, she

had written to Thames Water. Both the Commission's letter and Thames Water's response were available in the agenda packs.

8.3 Asked to make any opening comments, Cllr Rathbone wanted to flag the human impact that these incidents could have. He on a personal level had seen the suffering caused in Lea Bridge. One vulnerable resident he supported had had a breakdown following the flood. They had lost their possessions, and there had been a lack of taking ownership by both Thames Water and the resident's landlord.

8.4 A separate issue was a new charity owner of a listed building in the ward not having been able to carry out the activities it had planned to raise funds for the building's refurbishment, due to the flood. They had been unable to secure compensation from Thames Water in recognition of this, and had since walked away from the process and been left distrusting of Thames Water.

8.5 There was sometimes too much a focus on monetary value of items lost, and less on the human impact. He welcomed the Thames Water offer of £10,000 for the community affected by the Leabridge flood, but there needed to be fuller appreciation by Thames Water of the impact of its poor management. He challenged Thames to revisit its customer care and support offer following incidents such as this. Staff needed to be available to those affected, both immediately after the incident but also for the longer term.

8.6 Asked to come in at this point, the Director, Customer Experience, Thames Water wished to thank the Member. She did not disagree with the points he had made.

Duration of the meeting: 7.00 - 9.30 pm