Drinking Water Quality Regulator for Scotland

Incident Summary

Turret B Supply Zone Mains Repair Sampling Failure 11 February 2019

DWQR Inspector:
William Byers

Event No. 10018

Event Category: Serious

On 9th February, a burst occurred on a water main affecting the supply to consumers in the Crossgates area of Perthshire. This was repaired by early evening but on recharging the pipe with water, the main burst again. Due to the now extended timescale to restore supplies, the situation was escalated to managers and alternative tankering of water to distribution storage tanks was arranged to maintain levels in the tanks. The second burst was repaired before midnight. Due to the efforts required to resolve consequential network and consumer supply issues, the taking of a mains repair sample was deferred, only being taken at 10:45 on 11th February. This sample was reported the following day as having failed microbiological standards with 2 Clostridium perfringens and 7 Coliforms and a resample was requested to be taken. There was confusion in the arrangements for and assignment of the sampling task and this was not completed until 16 April 2019. Almost a full two months later. This sample showed the water to be compliant with microbiological standards.

This event demonstrates a laxity by Scottish Water staff in attending to the requirements for monitoring for contamination following the repair of burst water mains. I consider this to be a serious failure of operational procedures and declared this to be an incident. My investigation has identified a number of failings in the requirements of Scottish Water's procedures and application of the Hygiene Code of Practice.

Water samples should be taken immediately after the recharging of the water main following repair of a burst main, to monitor for ingress to the pipeline. In this case, deferring the sample to a time some 35 hours after normal flows were resumed negates the value and purpose of the sample. With indications that the microbiological standards had not been met, it is incumbent upon Scottish Water to quickly understand the cause and extent of failure and this clearly held no urgency or importance within the various teams involved in making the necessary arrangements. Overall ownership of obtaining a timely resample and

resolution of the failure was absent from the management of the investigation. In addition, in every sample taken on 11th February, at the burst location and within the distribution system, no chlorine residuals are recorded, which is a clear failure to adhere to requirements in procedures.

The event has been categorised as serious. Scottish Water has identified four actions which DWQR accepts are appropriate and will monitor to ensure they are completed prior to signing off the incident. DWQR made three additional recommendations.