JUDICIARY OF
ENGLAND AND WALES

STUART SMITH
DISTRICT JUDGE (MAGISTRATES' COURT)

IN THE EXETER MAGISTRATES' COURT

DRINKING WATER INSPECTORATE

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SOUTH WEST WATER LIMITED

SENTENCING REMARKS

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1. This case concerns a serious failure by South West Water Limited, the statutory water undertaker for this region, which resulted in the supply of water unfit for human consumption to thousands of people within the Littlehempston Water Supply Zone during the spring of 2024.

2. South West Water Limited, appears before this court for sentence upon its guilty plea to a single count under section 70 of the Water Industry Act 1991. The offence concerns the supply of water unfit for human consumption to households and businesses across the Littlehempston Water Supply Zone, and in particular the communities of Brixham, Hillhead and Kingswear, during the period from March to June 2024. The company accepts that during that period, treated water supplied to the public became contaminated with Cryptosporidium, a pathogen capable of causing significant gastrointestinal illness.

The Emergence of the Outbreak

3. In late April and early May 2024, an increasing number of residents in Brixham and surrounding areas began to present with symptoms consistent with cryptosporidiosis. By 10

May, the UK Health Security Agency had identified an unusual cluster of confirmed cases. On 13th May, UKHSA notified South West Water directly, reporting that at least eight individuals had tested positive, with the number rising rapidly. That same day the company reviewed its recent sampling data. All routine treated-water samples from Littlehempston Water Treatment Works were clear, and there had been no reports of bursts or loss of pressure in the distribution system.

4. By 14th May, an Incident Management Team, effectively an outbreak control team, was convened under UKHSA leadership. Although epidemiological information was still limited, a cluster of cases was increasingly apparent in areas supplied by the Hillhead Service Reservoir. Several patients had reported abnormal water taste or odour. One questionnaire recorded two individuals from the same household, one drinking only bottled water and remaining well, the other drinking mains water and becoming unwell. The IMT considered that although no water sampling results yet indicated a problem, the water supply "seemed the most logical explanation" for the clustering of illness.

5. At this point the company gave public reassurances that water remained safe to drink, relying on the absence of any indicator organisms and on historic sampling data. That picture changed decisively in the early hours of 15th May.

6. Between 04:00 and 05:30 on 15th May, two separate high-volume samples, one from Hillhead Reservoir, the other from a customer tap in the Hillhead area, returned positive detections for Cryptosporidium oocysts, confirming contamination of the treated water network. These were the first positive findings after days of heightened surveillance. South West Water promptly advised UKHSA of its intention to issue a Boil Water Notice. That notice was implemented at around 9am, ultimately covering approximately 16,000 properties and roughly 39,000 people.

7. The public health implications were immediate and profound. Many residents had already been ill for days or weeks before the BWN was issued. Schools, nurseries, care homes and businesses faced major disruption. Some households, particularly those with vulnerable children, described severe anxiety and distress, and numerous individuals required medical treatment.

Investigation into the Cause

8. A major multi-agency investigation began at pace. Attention quickly focused on the section of trunk main running from Alston Service Reservoir to Hillhead Service Reservoir. This main passed through agricultural land at Hillhead Farm, including a field known as Kennelsfield. On the morning of 15th May, South West Water technicians attempted to walk the line of the main, but access to the land was refused by the farmer. Formal notice was required before entry was eventually granted later that afternoon.

9. At 3:20pm on 15 May, technicians located an air valve that formed part of the pumped main serving Hillhead. They found that the concrete chamber surrounding the valve had been

entirely removed, the metal lid was missing, and the chamber had been deliberately filled with soil, silt and water. The valve itself was submerged and when excavated was found to be leaking and making a suction sound. Photographs show a visibly flooded and disturbed excavation site.

10. Air Valves (AV) are important safeguards against contamination on water mains because they regulate the controlled entry and release of air, helping to maintain stable pressure within the system. When operating correctly they prevent pressure drops that could otherwise draw in external water and allow air to escape while the pipeline is under pressure. If an air valve or its chamber becomes damaged or is flooded it can provide a direct route for contaminants to enter the main especially when negative pressure creates a vacuum and can draw in water.

11. The AV in Kennelsfield was found to have a broken seal, likely caused by it being buried in silt. However, it is the fact the AV was submerged in soil, silt and water which would have been the causative factor in Cryptosporidium being drawn into the water supply regardless the state of the seal. The technicians isolated the valve immediately and reinstated the chamber and lid by early evening.

12. Subsequent DNA profiling by the Cryptosporidium Reference Unit found Cryptosporidium parvum in a soil sample taken 1–2 metres from this chamber, matching six out of seven loci of the unique "Brixham profile" associated with human cases. Water samples taken from Hillhead Reservoir after the valve's isolation showed a marked reduction in oocyst levels with no positive detections after the 29th May.

13. The investigation did not end there. Between 29th May and 3rd June, South West Water's Water Regulations inspectors identified unlawful cross-connections between the farm's private borehole system and the public mains supply. These connections lacked any Category 5 backflow protection, meaning faecally contaminated water from troughs, hosepipes and farmyard surfaces could be drawn into the public network during pressure fluctuations. Several of these connections were initially denied, later revealed only after repeated visits. Photographs taken on site show cow excrement around standpipes and chambers. These conditions presented a serious contamination hazard. The first of these cross connections was isolated on 30th May, the second connection isolated on 2nd June.

14. Although the borehole water itself later tested negative for Cryptosporidium, the hydraulic connection between the farm's internal system and the public network created a persistent risk of contaminated backflow, especially where animal faeces could enter troughs or fittings.

15. The company's initial response to the Cryptosporidium outbreak was predicated on it having entered the drinking water supply through the damaged air valve. In its 3-day report it identified the air valve as the likely cause of the event, which was repeated in the 20-day report.

16. South West Water's plea however, is entered on the basis that the cause of the outbreak was ingress of Cryptosporidium into the mains water system probably via two points at Hillhead Farm; the damaged AV chamber, and the illegal cross-connections. They postulate that ingress began via the illegal cross-connections as early as March and continued via the damaged AV chamber once cattle were moved into Kennelsfield on the 19th April. South West Water Limited do not, in their plea, suggest that the illegal cross-connections were the predominant or primary cause of the outbreak, simply that there is a realistic possibility, which they say cannot be excluded, that both the illegal cross-connections and the damaged AV chamber were each sources of the ingress of Cryptosporidium into the water supply.

17. The Drinking Water Inspectorate accept whilst there is a possibility that Cryptosporidium could have entered the drinking water supply via the cross-connections, they say all the evidence is consistent with the damaged AV chamber being the main point of ingress of Cryptosporidium into the drinking water supply and therefore the predominant cause of the outbreak. However, the prosecution do not ask me to make findings on the precise contributions of both potential causes of Cryptosporidium ingress, given that the Defendant company has accepted that Cryptosporidium did indeed enter via the AV chamber, that it accepts it did not inspect that AV, that it failed to implement an AV inspection regime and that they do not suggest in their basis of plea that any ingress via the illegal cross-connections was the predominant or primary cause of the outbreak.

18. I make it clear therefore that I am sentencing South West Water Limited on the basis of their written plea, namely that the cause of the outbreak was ingress of Cryptosporidium into the mains water system via two probably points at Hillhead Farm; both the damaged AV chamber, and the illegal cross-connections.

Regulatory Concerns

19. The risk of contamination through AVs was known since as early as 2013 following a report prepared by UK Water Industry Research, which South West Water Limited participated in. The water regulator had also been publishing reports and notifying water companies repeatedly from 2016 as to the risks posed by AVs and reminding water companies to adopt risk-based inspection policies.

20. The Drinking Water Inspectorate had, in 2020, issued a clear recommendation to South West Water: that the company adopt a risk-based programme for the regular inspection and maintenance of air valves, which are known to present a potential ingress risk when damaged or submerged. The company drafted such a policy, but it was not implemented for a period of 4 years. Indeed, many operational staff later confirmed they had never been instructed in it, and no evidence exists that it was operationalised. It is not disputed that the air-valve at Kennelsfield had not been visually inspected since at least 2011 and that after the incident further water valves were found to be buried or flooded.

21. This failure to implement a known and recommended risk-control measure forms a significant part of the factual matrix before the court.

Scale of the Harm

22. The epidemiological study undertaken by UKHSA analysed 769 responses, identifying at least 537 probable or confirmed cases, with symptoms including diarrhoea, abdominal pain, nausea, dizziness, fatigue and fever. At least 10 individuals were admitted to hospital. Vulnerable people were heavily affected. Schools experienced drops in attendance - Year 11 pupils at Brixham College saw a 9% decline, affecting exam performance. Care homes, nurseries, and businesses also reported severe disruption.

23. The disruption to daily life was extensive. Households were required to boil water for drinking, cooking, brushing teeth, and for infant feeding for periods of up to eight weeks. Many residents spoke of confusion, conflicting messages, and persistent anxiety. The cumulative impact on public confidence in the safety of drinking water was substantial.

The Company's Response

24. Once contamination was confirmed, South West Water mobilised a large-scale incident response. It issued the Boil Water Notice, established bottled-water stations, made extensive doorstep deliveries to vulnerable customers, and deployed hundreds of employees and contractors. It also engaged in significant engineering interventions, including high-velocity flushing, swabbing, the installation of UV and microfiltration units, and 17 phases of ice pigging, which would normally require months of planning. Approximately £38 million was spent on operational response, engineering works, compensation and community measures.

25. The company has since apologised, accepted responsibility, and taken steps to improve its inspection and risk-management systems.

26. In summary, this was a major public health incident. Contaminated water was supplied to a large community; hundreds became ill; essential public services were disrupted; and confidence in the region's drinking water was seriously undermined. The company accepts that it did not take all reasonable steps or exercise all due diligence to prevent the supply of unfit water, as required by law. It now falls to the court to assess the seriousness of the offence, including culpability and harm, and to impose a sentence that is fair, proportionate, and appropriate for a very large organisation of this scale.

27. I recognise that this case has affected a significant number of people and businesses in the Brixham community, a number of whom have written personal impact statements detailing the disruption, harm and distress they and their families have had to endure. Some have felt compelled to attend court on this or on earlier occasions to witness first-hand the defendant company being held to account through the judicial process. Understandably the case has also attracted widespread media coverage, commentary and reporting. I make clear to all that the decision I make today in terms of sentence will be based upon the evidence and facts presented in court, the submissions of the parties and the relevant legal framework. My

task is not to impose a sentence that satisfies public opinion but to impose one that is lawful, proportionate and consistent with the guidelines established for that category of offence.

Approach to Sentencing

28. There is no directly applicable sentencing guideline for an offence contrary to section 70 of the Water Industry Act 1991. Where there is no definitive sentencing guideline for the offence, to arrive at a provisional sentence I must instead take account of all of the following:

    a) the statutory maximum sentence for the offence, which for this offence is an unlimited fine,

    b) sentencing judgments of the Court of Appeal (Criminal Division) for the offence; and

    c) definitive sentencing guidelines for analogous offences.

29. When considering definitive guidelines for analogous offences I must apply these carefully, making adjustments for any differences in the elements of the offence. I have been referred to two potentially analogous guidelines that may assist:
    a. The Unauthorised or harmful deposit, treatment or disposal etc of waste and illegal discharges to air, land and water (organisations) guideline, "*The environmental guideline*"; and
    b. The Breach of food safety and food hygiene regulations (organisations) guideline, "*the food safety guideline"*.

30. This is not a case that involves ecological or environmental damage, nor the illegal discharge of pollutants to a watercourse which may ordinarily engage the environmental guideline. The offending behaviour relates to the fitness of and risks related to the supply of drinking water. In that regard South West Water Limited act akin to a food producer or manufacturer, applying a treatment process to purify and supply potable water direct to the homes of its 1.7million customers across Devon, Cornwall and the Isles of Scilly. I consider that potable water should properly be considered food for these purposes, requiring a high standard of safety and hygiene in its treatment and filtration. I determine that the most appropriate analogous guideline to refer to therefore is the food safety guideline.

31. I note an important distinction between South West Water Limited and typical food producers and manufacturers. The latter operate in a competitive marketplace and are consequently exposed to significant reputational and commercial harm arising from any breach of food safety or hygiene regulations. A loss of consumer confidence can directly affect demand and profitability, and thus acts as a natural deterrent, with an additional punitive effect where breaches occur.

32. By contrast, water companies operate, in effect, as regional monopolies. Consumers have no meaningful ability to switch supplier or seek alternative provision without relocating outside

the relevant area. They are therefore entirely dependent upon the services provided and are, in practical terms, captive customers. Given the essential nature of water and the absence of market discipline, there exists a clear imbalance of power and a corresponding vulnerability on the part of consumers. In my judgment, that collective vulnerability and disparity in bargaining power will justify an upward adjustment when applying the relevant sentencing guidelines.

33. The general principles I must apply to determine the appropriate level of fine are set out in section 125 of the Sentencing Code; these include imposing a fine that reflects the seriousness of the offence and requires me to take into account the financial circumstances of the company. The level of fine should reflect the extent to which the offender fell below the required standard and should meet in a fair and proportionate way the objectives of punishment, deterrence and removal of any gain derived through the commission of the offence. The level of the fine should be sufficient to bring home to the management and shareholders the need for regulatory compliance.

Step 1 – Part 1 Assessment of Culpability

34. In assessing culpability I apply the Food Safety and Hygiene Guideline, which requires me to determine whether the offender's conduct falls within the descriptions of "high", "medium" or "low" culpability by reference to the identified factual features.

35. High culpability is characterised by offending which "fell far short of the appropriate standard", including by failing to put in place recognised industry measures, ignoring concerns raised by regulators, allowing breaches to subsist over a long period of time or where there has been a serious or systemic failure to address risks to health and safety.

36. Medium culpability, by contrast, captures cases where systems were in place but were not sufficiently adhered to or implemented, and where the offending falls between the descriptors in the high and low culpability categories.

37. On behalf of the prosecution, it is submitted that the offending falls properly within high culpability. The prosecution contend that the defendant's failings were not isolated or technical but reflect a serious and sustained departure from the standards required of a major public utility responsible for the safety of drinking water.

38. In that regard, the prosecution places particular reliance on the fact, that firstly, the defendant was on clear notice of the risk posed by air valves within its network and the need for inspection and management of that risk and secondly, the Drinking Water Inspectorate had made specific recommendations some 4 years earlier that a risk-based inspection regime be introduced.

39. The prosecution submits that, when viewed through the lens of the guideline, this brings the case squarely within the examples of “ignoring concerns raised by regulators”, and “allowing breaches to subsist over a long period of time”

40. The prosecution also highlights that although a policy was eventually drafted, it was not implemented, and critically, within the organisation no effective system existed to ensure that the policy was operationalised or monitored thereafter. This failure to implement a system of inspection of infrastructure assets, they state, created a risk of contamination entering the water supply whether because of poorly maintained components, accidental or deliberate damage. The prosecution detail this not simply as a failure of execution, but an example of an organisational failure at a systemic level, revealing inadequacies in governance, oversight and internal assurance mechanisms.

41. The prosecution characterises the offending as one where the defendant fell far short of the appropriate standard, its failures were serious and organisational in nature, and they relate directly to the management of risks to human health. On that basis, they contend that the case is a paradigm example of high culpability.

42. On behalf of the defendant, it is submitted that such a characterisation is not justified, and that the proper categorisation is medium culpability.

43. The defence emphasises that, when the guideline is applied correctly, this case does not exhibit the hallmarks of high culpability such as a flagrant disregard for the law, a deliberate ignoring of regulatory concerns, or a systemic failure across the organisation to address risk.

44. Instead, the defence submits that the true position is that the defendant did not ignore the regulator’s recommendation, it responded promptly, and it took steps to develop a risk-based AV inspection policy. The failure identified is not one of omission altogether, but one of implementation error due to an innocent mistake.

45. The defence places significant weight on the wider operational context, that at the material time there was no established or universally recognised industry standard requiring such a regime, that the defendant’s approach to AVs mirrored that of the wider industry, and that the organisation had in place extensive systems, controls and monitoring arrangements in relation to water safety more generally.

46. The defence assert that it is not correct that there was no monitoring of AV’s in place. They report that the water main was continuously monitored as part of their wider leakage control activities and would be immediately inspected if any pressure issues were identified, that inspection would include any AVs within that section of main, and that in addition, it was periodically proactively monitored by engineers by them walking the trunk line. I consider that this system of monitoring was self-evidently inadequate, it was clearly reactionary rather than a proactive risk based approach and I find there was no meaningful or effective programme of routine visual inspections of AV’s in place prior to the incident.

47. The Defendant contends that there is no evidential basis for concluding that the failure was systemic in the sense intended by the guideline, nor that there is evidence that the defendant was turning a blind eye to risk or consciously accepting it. Rather, the defence characterises the case as falling squarely within the definition of medium culpability: a case in which systems were in place but were not sufficiently adhered to or implemented.

48. Having considered the parties' submissions, I am satisfied that this case crosses the threshold into high culpability but properly falls towards the lower end of that category.

49. I reach that conclusion for the following reasons. Firstly, I find they did ignore the repeated concerns raised by the regulator. South West Water Ltd had been on notice that air valves within its network posed a potential risk for ingress of contaminates into the water supply as had been repeatedly alerted to them initially in the UK Water Inspectorates Report (UKWIR) of 2012 and then the published Chief Water Inspector's reports. These later reports referenced water quality risks associated with damaged or faulty air valves since as early as 2016 and had recommended the need for inspection and management of that risk.

50. The report in Quarter 2 in 2018 noted, following an E.Coli detection at a reservoir managed by Thames Water, that "*appropriate maintenance of air valves was an ongoing problem across the industry*" and that the Thames Water failure "*should serve as an appropriate reminder for companies to ensure that the air valves are visited on a risk-based programme to ensure that they are operational and remain free from the risk of contamination*"

51. The 2018 inspector's summary further advised all water companies to "*ensure that had appropriate risk-based methodologies in place to ensure risks related to ingress via air valves are appropriately addressed*"

52. In 2019 air valve maintenance deficiencies were identified at Wessex Water and at Anglican Water. The summary report concluded that "*Air valves are often essential in network operations, yet potentially present a significant contamination risk. Locations that may become flooded should be avoided where possible and all companies should have risk based inspection programmes in place for air valves.*"

53. More critically, the Drinking Water Inspectorate had made a specific and direct recommendation to South West Water in 2020 following an inspection at their Widworthy reservoir which had found evidence of recent excavation of sediments from around the air valve structure. They recommended that the company implement a regular programme of air valve inspection using a risk-based approach.

54. Whilst I find South West Water did not wilfully ignore the recommendations for an inspection regime as steps were initiated to develop a policy, I do consider that in all practical sense they did ignore those recommendations as they categorically failed to actually enact any programme or regime of inspection of their AV assets.

55. Secondly, I find there was a significant failure to ensure that a control measure addressing those identified risks to public health was in place and crucially operational. The defendant had acknowledged, and indeed formally recorded, the need for a risk-based inspection regime in respect of air valves and had developed a policy to address that risk. However, that policy was neither in place nor implemented. There was no meaningful inspection system in place, any monitoring as part of the wider leakage control activities was in my view inadequate, and I do not consider that the descriptor within the guideline for medium culpability of having "*systems in place which were not sufficiently adhered to or implemented*" can reasonably apply in this case.

56. In circumstances where the consequence of such failure was the risk (and ultimate reality) of contaminated water being supplied to the public, I find that represents a serious departure from the standard properly expected of an organisation in the defendant's position.

57. Thirdly, the failure was not momentary or isolated, it persisted over a significant period of time and arose from a deficiency in organisational oversight and assurance, in that the business incorrectly believed the system to be in place when it was not. That amounts in my view to a systemic failure of governance within the organisation.

58. Those features are sufficient to bring the offending within the description of an organisation that fell far short of the appropriate standard, such that a finding of high culpability is justified.

59. However, there are a number of important factors which in my view place this case at the lower end of that category, and which prevent it from approaching the more serious examples of high culpability identified in the guideline.

60. Firstly, this is not a case of deliberate breach or conscious disregard of risk. The evidence establishes that the defendant did respond to regulatory engagement, it did not ignore the recommendation for an inspection regime but instead took steps to develop such a system. The failure, therefore, lies not in inaction but in execution, arising from error rather than from indifference or defiance. This is an important distinction when considering whether the case falls within the paradigm example of "ignoring concerns raised by regulators".

61. Secondly, I accept that at the material time there was no clearly established or universally applied industry standard requiring such a regime. Whilst the recommendation was plainly one which ought to have been properly implemented, the absence of a settled industry benchmark tempers the extent to which the defendant can be said to have fallen far below an established norm.

62. Thirdly, the defendant had in place extensive and otherwise sophisticated systems for the management of water safety, including monitoring, sampling and risk management processes. These included a Drinking Water Safety Plan, a compliant cryptosporidium sampling and testing regime and a Quality Management System which had been independently certified. There were also 107 individual control measures intended

specifically to reduce the risks associated with Cryptosporidium. This is not a case in which there was a wholesale absence of systems, nor one in which safety was systematically disregarded. Rather, it is a case in which a specific and important element within a wider framework was absent.

63. Fourthly, there is no proper basis for concluding that the failure to enact or implement the policy reflected a wider systemic culture of non-compliance. The evidence indicates that this was an isolated organisational failure, albeit a very serious one, rather than a broader failure across the business to engage with or respond to risk.

64. South West Water in their written basis of plea contend that it is not possible to say when the AV chamber was damaged nor whether an inspection regime would have identified this damage before the contamination occurred. Whilst these two observations are accurate, I do not consider them relevant when assessing the company's culpability. It is that absence of any effective AV inspection regime which causes the defendant's conduct to fall far short of the appropriate standard and which in this instance unfortunately resulted in the supply of water unfit for human consumption which is my focus. I do not consider that I need to precisely attribute the cause of the Cryptosporidium ingression into the water supply in order to make a reasoned assessment of culpability.

65. I note that even under South West Waters drafted air valve inspection policy, the air valve in Kennelsfield had been misclassified requiring inspection at a frequency of every 48 months as opposed to every 24 months as would have been necessary due to its known high-risk location.

66. The unvarnished reality is that there was no visual inspection scheme in place, the last documented visual inspection of the air valve in Kennelsfield was in June 2011 and moreover the company had little idea the state of any of its 10,000+ AV assets as was clearly evident when further submerged AV's were identified by the DWI during their investigation.

67. As regards the potential ingression of Cryptosporidium due to the illegal cross connections at Hillhead farm. I accept the submissions made on behalf of South West Water that such cross connections are incredibly rare, often hidden and almost impossible to identify on any routine inspection. Identification of such connections relies on candid and transparent disclosures from farmers and landowners, which was not forthcoming from the farmer in this case. I accept it took a number of visits to Hillhead farm to finally identify all the non-compliant connections, and I do not consider there to be any culpability arising in the company's conduct in respect of those connections nor in the absence of any inspections to the farm concerned.

68. Drawing these matters together, I am satisfied that the defendant's conduct involved a serious failure in relation to a risk to public health, sufficient to meet the definition of high culpability but that the absence of indifference or defiance of the concerns of the regulator, the steps taken in response to regulatory advice, the presence of broader safety systems, and the absence of a clear industry standard mean the case does not approach the more

serious examples within that category. Accordingly, I find that culpability is properly assessed as high, but at the lower end of that category.

Step 1 – Part 2 Assessment of Harm

69. The harm caused by this incident was wide-ranging, multi-layered and profound, affecting individual health, vulnerable groups, educational settings, businesses, and the wider community's trust in the public water supply. This was not a short-lived inconvenience; it was an event that undermined daily life across an entire region for weeks and, in some cases, months. The boil water notice, which at its height impacted 16,000 properties, was in place for a total period of 54 days from between the 15th May to the 8th July 2024, with the first cluster of cryptosporidiosis cases being notified to the UK Heath Security Agency by Torbay Hospital as early as the 10th May.

70. A considerable number of victim personal statements have been submitted to the court by the prosecution. Whilst it has not been possible to refer to each of them in open court, they have all been read and considered.

Illness and Physical Suffering

71. The epidemiological analysis conducted by the UK Health Security Agency identified 537 cases of cryptosporidiosis within the affected population, comprising 28 laboratory-confirmed cases (25 of which matched the Brixham genotype) and 509 probable cases based on clinical symptoms.

72. All of these individuals suffered the characteristic symptoms of cryptosporidiosis: prolonged diarrhoea, abdominal pain, nausea, and in a substantial number of cases fatigue, headaches and fever.

73. For many residents, the illness was not brief. The statements record individuals sufficiently unwell that day-to-day functioning was impaired, with repeated bouts of diarrhoea, dehydration, dizziness, and episodes of collapse. More than 150 individuals sought medical help, and at least 10 required hospital admission.

74. Several accounts describe severe and distressing gastrointestinal episodes, including urgent bowel movements, incontinence, and repeated vomiting. One individual who was admitted to hospital describes the illness as among "*the worst weeks of my life*". Another describes feeling "*absolutely exhausted*" These effects were experienced not just by adults but also by children, infants, and people with underlying vulnerabilities, for whom the disease can be particularly dangerous.

Impact on Vulnerable and High-Needs Individuals

75. The evidence contains deeply troubling accounts from families with neurodiverse children and those with complex health needs who experienced severe deterioration. One mother described her autistic son, who uses water play to regulate sensory stress, becoming terrified of water after being told it was contaminated, leading to night terrors and emotional regression.

76. Another parent reported that her child with severe anxiety and pathological demand avoidance suffered panic attacks, loss of routine, and profound emotional distress. She described her 8-year-old autistic son as "*extremely scared and distressed*" becoming "*dysregulated and violent*" due to the invasive hospital treatment he required. These experiences were not isolated; several statements from parents of neurodivergent children describe a sharp and lasting deterioration in wellbeing.

Impact on Education

77. The impact on local schools was substantial. Brixham College, serving the largest cohort in the region, reported that attendance fell sharply across all year groups, with Year 11 attendance dropping by 9.27% in the weeks leading up to GCSE examinations. Forty-three "special consideration" applications were required, 11 for confirmed cryptosporidiosis, and others for serious illness consistent with infection. Examination performance was measurably affected: the school's GCSE results for 2024 were its worst on record, a matter the Principal explicitly attributed to this incident.

78. Pupils missed lessons, arrived late, endured painful symptoms during school hours, or were repeatedly sent home. One 14-year-old described the humiliation of leaving school each time diarrhoea became uncontrollable. Several children, particularly those with pre-existing health conditions, were unable to attend school at all for extended periods.

79. At Mayfield Chestnut School, serving children with social, emotional and mental-health needs, six pupils and five staff fell ill. Staff absence caused considerable disruption for a population uniquely sensitive to changes in routine, with associated operational and financial consequences.

Impact on Businesses

80. Businesses across Brixham, Paignton and Kingswear were heavily impacted. Hospitality venues, shops, and tourism-dependent businesses reported cancellations, lost revenue, and curtailed services during what should have been a high-season period.

81. Families unable to work due to illness or caring responsibilities lost income.
UKHSA's survey recorded 233 people taking time off work, either due to their own illness or to care for others.

82. Some businesses faced costs associated with sourcing safe water, increased cleaning, and loss of custom due to public concern. The wider economic harm was serious enough that a dedicated recovery package was later established with the English Riviera BID, illustrating the broader consequences for the regional economy.

Disruption to Daily Life

83. For many households, basic activities, drinking, cooking, brushing teeth, preparing infant formula, washing salads, bathing children, became sources of anxiety. The Boil Water Notice remained in place for up to eight weeks for some households. Some families spent weeks boiling water late into the night to meet their needs; others reported skin irritation from bathing.

84. The situation was made more difficult by confusion and conflicting communications, including an instance where 28 properties were incorrectly told their Boil Water Notice had been lifted, only to be told later the opposite. This created uncertainty and undermined public confidence in the management of the incident.

85. One individual reported having a trip abroad impacted and having to cancel a long haul holiday as a consequence of the effects of cryptosporidiosis.

Psychological Harm and Community Anxiety

86. A striking feature of the evidence is the degree of psychological and emotional harm. Residents describe fear, anger, loss of trust and a sense of vulnerability in their own homes. Some speak of being afraid to drink water even after the BWN was lifted. Many report weeks of worry over the potential long-term health effects for young children who ingested contaminated water.

87. Parents described the distress of watching their children suffer, or of fearing that vulnerable relatives would become seriously ill. For some, the incident triggered anxiety attacks, avoidance behaviours, and; in households with children with additional needs, behavioural regression and episodes of acute distress.

Impact on Public Services

88. The incident placed considerable burden on public infrastructure:

    i. GP surgeries were inundated with symptomatic patients.

    ii. Hospitals managed admissions and clinical investigations related to the outbreak.

    iii. Schools had to close water fountains, restrict activities, purchase bottled water, and adapt curricula, including cancelling science and catering activities.

iv. Council services coordinated with SWW on bottled-water provision and public safety communications.

v. Care homes and nurseries faced acute challenges in maintaining hygiene and safe hydration.

These burdens were substantial, stretching public services not designed to handle a mass waterborne outbreak.

Loss of Confidence in the Water Supply

89. Finally, the harm extends beyond physical illness. Perhaps the most enduring effect is the loss of public trust in the region's drinking water. Residents repeatedly describe feeling unsafe, anxious, and fearful when using tap water, long after the contamination was removed. Several state explicitly that the experience has permanently altered their behaviour, with many continuing to avoid drinking tap water altogether. One resident put it starkly: "*In this country, we are lucky to have good drinking water—but we have lost trust in our water supply*." That sentiment reflects a deep and lasting harm: a community whose confidence in a fundamental public utility has been profoundly shaken.

90. It is conceded by South West Water Ltd that this is a harm category 1 case. Whilst the adverse physical effects experienced by individuals would more appropriately fall into category 2, it is the very large number of people and businesses that are impacted which amount to a widespread impact, which means this case falls into category 1.

91. However, there are a number of factors which in my view place this case towards the higher end of that category, namely; the disproportionate severe effects on vulnerable individuals, the significant disruption to education, employment and other community services, the lasting loss of public confidence in the safety of the water supply and the protracted duration of the incident which significantly effecting the community of Brixham and Hillhead for a period of over 8 weeks. Accordingly, I find that harm is properly assessed as category 1, but at the higher end of that category.

92. By reference to the table for large organisations the starting point for High Culpability, Category 1 harm would be £500,000 with a range of £200,000 to £1,400,000.

93. In assessing the appropriate starting point, I have regard to my finding that culpability falls towards the lower end of the relevant category, which would ordinarily indicate a provisional figure below the identified starting point. However, I have also found that harm falls towards the higher end of the category, which would justify a figure above that starting point.

94. In my judgment, the elevated harm factors outweigh the reduced culpability although the two considerations broadly balance one another. Standing back, I determine that the appropriate provisional starting point, by reference to the table for large organisations, is £700,000.

Step 2 - Organisation Size and Starting point

95. It is conceded that South West Water Limited's annual turnover for the year ending 2025 of £739 million would greatly exceed the £50 million turnover for 'large organisations' and would mean they would properly be categorised as a 'very large organisation' for the purpose of the Guideline.

96. Where sentencing a very large organisation, the guidelines provide that I should consider fines outside the range for large companies, and that it may be necessary to move outside the suggested range to achieve a proportionate sentence. I must not, however, simply apply a mathematical formula to the starting points and ranges for large organisations.

97. The Court of Appeal have in series of cases reiterated the correct approach to sentencing very large organisations. I concisely list those cases I have had regard to and their applicable principles below:

    a. *R v Sellafield [2014] Env. L.R 521* – The correct approach is to first consider the seriousness of the offence and then the financial circumstances of the offender. The fact that the defendant is a VLO makes no difference to that basic approach.
    b. *R v Tata Steel UK Limited [2017] EWCA Crim 704* – The CoA endorsed the approach of moving up a harm category on the guidelines to reflect the VLO status of the company.
    c. *R v Whirlpool UK Appliances Limited [2017] EWCA Crim 2186* – The CoA following the 'step change' approach from Tata Steel and commented that the calculation of a fine through the structure of the Guideline does not dictate an arithmetic or linear approach to turnover.
    d. *R v Thames Water Utilities Ltd [2019] EWCA Crim 1344* – The CoA ruling that the court is not bound by, or even bound to start with, the ranges of fines suggested by the Sentencing Council in the case of organisations which are merely 'large'. In an appropriate case a court may well consider, having regard to the financial circumstances of the organisation, that to achieve the objectives in section 143 of the Criminal Justice Act, the fine must be measured in millions of pounds.
    e. *R v Places for People Homes [2021] EWCA Crim 410* – In the case of VLO's the starting points and ranges for large organisations do not apply. The guiding principles are those set out in section 142, 143 and 164 of the Criminal Justice Act 2003, with particular emphasis on the imperative that the penalty is proportionate to the means of the offender and should bring home to management and shareholders the need for regulatory compliance.

98. Applying those principles, and adopting the "step change" approach identified in *Tata Steel*, I consider the adjusted appropriate provisional starting point for South West Water Ltd—an organisation with a very large annual turnover—to be £1,700,000. This reflects an increase

multiplier of approximately 2.5, which is consistent with the uplifts for very large organisations approved by the Court of Appeal.

Aggravating Factors

99. In determining the appropriate sentence, I have considered the aggravating and mitigating features of the case. Firstly, the defendant has a lengthy record of 137 previous convictions, principally for environmental offences involving unlawful discharges and breaches of permit conditions, many of which have been characterised as negligent with occasional findings at higher culpability levels in more serious cases. Financial penalties have ranged from modest fines to multi-million-pound penalties reflecting the increasing seriousness. Of particular relevance is a recent conviction in 2022 for the supply of water unfit for human consumption in the Barnstaple and Ilfracombe area, for which a substantial financial penalty of £233,000 was imposed.

100. Taken together, the record demonstrates a consistent and repeated pattern of regulatory non-compliance over a prolonged period, albeit largely in a different area of environmental regulation. This record of previous convictions justifies a modest upward adjustment of £225,000.

101. Secondly, the wider community impact of the offending and the protracted duration of the incident. This was an incident affecting a substantial population across a defined geographical area over many months. Hundreds of individuals became ill, many suffering prolonged and distressing symptoms, and essential services, including schools, businesses and healthcare, were all disrupted. I have already reflected the scale of this impact in my elevated assessment of harm, and I take care therefore not to double count it.

102. Finally, the offence involved the supply of contaminated drinking water, which is a matter of particular gravity. The provision of safe drinking water is a fundamental public service, and those entrusted with that responsibility are subject to a high duty of care. As I have already observed, water companies are properly to be distinguished from typical food producers and manufacturers. In circumstances where consumers are wholly dependent upon a sole provider and lack any realistic ability to seek alternative supply, there exists a clear collective vulnerability and imbalance of power. That feature, in my judgment, reinforces the need for an upward adjustment when applying the food safety sentencing guidelines, I make a further upward adjustment of £300,000 to reflect this.

Mitigating Factors

103. There is, however, substantial mitigation in this case. Firstly, there has been a clear acceptance of responsibility and genuine remorse. The company has acknowledged its failings and has apologised publicly and directly for the consequences of the incident. David Harris, Managing Director of Water Services also expresses the company's sincere and

unreserved apology to its affected customers in a letter to the court dated 22nd May 2026. He reiterates South West Water Ltd's profound regret at the significant disruption, distress and inconvenience experienced and conveys the company's deep remorse for what happened.

104. Secondly, the defendant has cooperated fully with UKHSA, the DWI and investigators. There has been no need for a Newton hearing, and the matter proceeds on an agreed factual basis.

105. Thirdly, once contamination was confirmed, there was an extensive and rapid operational response. The company implemented a Boil Water Notice, mobilised large-scale bottled water distribution totalling 1.58 million bottles, undertook significant engineering interventions including 27 full flushes and 17 phases of ice pigging as well as installing 1.2km of new pipework, and they worked closely with public authorities to manage the incident. Some of which would have been no more than was expected by the company to remedy the issue and fulfil its obligation to supply drinking water fit for human consumption.

106. The company mobilised and redeployed substantial personnel and resources to ensure adequate support and high visibility presence for the incident. It held 15 drop-in sessions, held a public meeting and issued weekly newsletters. It is reported that as a result of its proactive approach to customer welfare calls this led to the identification of hundreds of additional Priority Service Register customers not previously known.

107. Fourthly, there has been very substantial financial remediation, with approximately £38 million expended on response measures, infrastructure works, customer support and compensation. The company reports spending £2.4million on enhanced customer promise payments and a further £11.3 million on customer compensation payments.

108. Fifthly, this is not a case in which there were no systems or safeguards in place. On the contrary, the company operated water safety plans, monitoring systems and compliance structures. The failure was that a particular system, namely the air valve inspection regime, had been developed but not implemented, rather than a complete absence of any risk management.

109. Finally, there were external contributing factors of real significance. The evidence establishes deliberate or unlawful third-party actions, including the dismantling of the air valve chamber and the presence of illegal cross-connections. Those matters materially contributed to the ingress of contamination and reduce the extent to which the incident can be attributed solely to the defendant's failings.

110. Taken together, all these mitigating factors justify a modest downward adjustment of £225,000.

111. The provisional sentence at the end of step 2 is therefore £2,000,000.

Step 3 – Proportionality assessment

112. Step 3 of the guidelines require me to 'step back' and review the initial fine based on turnover and to make any necessary upward or downward adjustments to it to ensure that it fulfils the objectives of sentencing and is sufficiently substantial to have a real economic impact which will being home to both management and shareholders the need to operate within the law and is one which properly reflects the current financial circumstances of the company.

113. At the plea hearing, I observed that the Food Safety Sentencing Guideline came into effect in February 2014 and, unlike the majority of sentencing guidelines, which are dynamic and determine fines by reference to a percentage of an offender's turnover or income, this guideline is effectively static. The starting points and ranges are expressed as fixed monetary sums which were considered sufficiently proportionate and punitive at the time of their introduction.

114. I invited the parties to make submissions on my provisional view that it might be appropriate to adjust those 2014 figures to reflect the economic realities of inflation, in order to ensure that any fine imposed continues to meet the objectives of sentencing and has a real economic impact on the offender. Submissions were duly made on that issue.

115. It is, in my judgment, self-evident that figures which were proportionate and punitive in 2014 will not have the same effect in 2026. By reference to the Bank of England Consumer Price Index calculator, there has been an average annual inflation rate of approximately 3.32%, with a cumulative increase in value of just over 39%. On that basis, a fine of £500,000 in 2014 would equate to approximately £695,000 today in order to achieve a comparable punitive effect.

116. On behalf of South West Water Ltd, it is submitted that, as sentencing guidelines are subject to periodic review and scrutiny by the Court of Appeal, it would be inappropriate and inconsistent for this court to apply any form of inflationary adjustment.

117. I do not accept that submission. Whilst the guideline contains no express provision for adjusting figures to reflect inflation, it remains incumbent upon the court, at Step 3, to ensure that any fine is proportionate and sufficiently substantial to have a real economic impact. In undertaking that assessment, I consider it entirely proper to have regard to changes in the value of money over time.

118. In those circumstances, I am satisfied that, in order to ensure that the applicable starting point and range continue to achieve the intended punitive effect, an upward adjustment of £780,000 to reflect inflation is both appropriate and proportionate. This increases that provisional sentence to one of £2,780,000.

119. Turning then to consider the financial circumstances of the company. The financial material placed before the court includes a summary of the company's position over the last three financial years, supported by links to its full accounts. While the detailed figures for each year are not set out in full within the bundle, the overall picture is clear. The company operates at significant scale, with consistently high turnover, £731 million in 2024 and £739 million in 2025. This is reflective of its position as a regional water undertaker serving a substantial customer base.

120. However, the most recent financial year, ending 2025, discloses that the company recorded a pre-tax loss of approximately £48.6 million. The year previous a small profit of just £2.5 million was recorded. This indicates that, notwithstanding its substantial turnover, the company is presently loss-making and operating on a negative profit margin.

121. The financial information demonstrates that, whilst the defendant has very substantial revenues, its profitability is limited and, in the most recent year, negative. This is a relevant consideration under Step 3 of the guideline, which requires me to examine the financial circumstances of the offender in the round and to take into account not only turnover but also profitability. A company with a small profit margin, or one operating at a loss, may justify some downward adjustment in order to ensure that the fine imposed is proportionate and reflects the economic realities of the organisation.

122. Having reviewed the financial summaries and underlying material, I do not consider it necessary to make any adjustment to the fine. I note that a substantial proportion of the company's revenues is absorbed by financial costs and reflected in the accounts through asset depreciation, rather than generating distributable profit. In particular, a significant proportion of the losses reported in 2025 is attributable to the £38 million incurred by South West Water Ltd in its response to this Cryptosporidium outbreak. I also observe that as-yet-unpaid shareholder dividends for 2025 were declared as £125 million.

123. Notwithstanding the recorded loss in the most recent financial year, that loss must be viewed in the context of the company's very substantial turnover. In all the circumstances and having regard to the level of fine I propose to impose; I am satisfied that no further adjustment is required to ensure proportionality or to achieve a real economic impact.

Step 4 – Adjustment for other factors

124. Step 4 of the guidelines require me to consider any wider impacts of the fine within the organisation or on innocent third parties such as the impact of the fine on the company's ability to improve conditions or its impact on its customers and staff. I note the public statements which have been made by South West Water Ltd that any fine imposed today will not be added onto customer bills but will instead be paid out of profits and dividends to shareholders. As such I do not consider any further adjustment at step 4 is required.

125. Step 5 is not applicable.

Step 6 – Reduction for guilty plea

126. The Defendant has entered a guilty plea at the first reasonable opportunity. I reduce the sentence by a third to reflect that early admission and to give full credit for that guilty plea.

127. Step 7 requires me to consider compensation and any relevant ancillary orders. I take into account the voluntary compensation and "customer promise" payments that have already been made. However, given the very large number of those affected, together with the wide variation in their individual circumstances, it would neither be appropriate nor practicable for the court to undertake any meaningful or properly informed assessment of compensation in this sentencing exercise.

128. Step 8 -totality - is not applicable as I am dealing with a single offence.

129. The final fine I impose therefore is one of £1,853,000

130. I impose the mandatory government surcharge of £2000

131. I impose costs agreed in the sum of £75,000

132. THAT IS A TOTAL OF £1,930,000

133. Payment to be made within 28 days of today, and subject to a collection order.