IN THE MATTER OF THE MISCONDUCT PROCEEDINGS UNDER THE POLICE (CONDUCT) REGULATIONS 2020 (AS AMENDED BY THE POLICE (CONDUCT) (AMENDMENT) REGULATIONS 2024)

BETWEEN

THE COMMISSIONER OF POLICE OF THE METROPOLIS

(THE APPROPRIATE AUTHORTY)

and

DC NUNNERY (OFFICER CONCERNED)

DI COLE (OFFICER CONCERNED)

PANEL FINAL DECISION

Introduction

1. This is the written final decision in respect of the misconduct hearing for DC Nunnery and DI Cole (the Officers). The outline of the Panel's decision was provided to the Officers during the hearing.

2. The misconduct hearing was held in public from 6 to 10 July 2026 at Palestra House, 197 Blackfriars Road, SE1 8NJ.

3. A notice of hearing was published in accordance with the Police (Conduct) Regulations 2020 ('the 2020 Regulations').

4. The Panel was chaired by Commander Colin Wingrove (Chair), with independent members Ms Rachel O'Connell and Ms Lindsay Johnston. The Legally Qualified Adviser (LQA) to the Panel was Ms Salma Yousef.

5. The Appropriate Authority (AA) was represented by Mr Kevin Saunders (AA's representative) and the Officers were represented by Mr Thomas Daniels (Nunnery) and Mr Kevin Baumber (Cole). The Officers were both also supported by a Federation Representative.

6. At the outset of its determinations, and throughout the hearing, the Panel has remained mindful of the overarching purpose of police misconduct proceedings, namely:

   i. To maintain public confidence in, and the reputation of, the police service;
   ii. To uphold high standards of professional conduct and deter misconduct;

iii. To protect the public.

7. The Panel remained acutely aware of the seriousness and impact of the underlying allegations and the duration of the criminal investigation concerned in this matter.

Allegations

DC Nunnery

8. The allegation against DC Nunnery is set out below.

i. On 14 July 2022, the Metropolitan Police Service (MPS) appointed DC [REDACTED] as the investigating officer in an investigation concerning a complaint about a suspect linked to an address within the Metropolitan Police Service area. The suspect was alleged to have incited a child to engage in sexual activity through social media.

ii. At the material times, DC Nunnery (then ADS Nunnery) was DC [REDACTED] supervisor in the investigation of the complaint, and DC Nunnery:

a. Failed to diligently identify the level of supervision of the investigation that was necessary having regard to the nature of the incident that was presented to him.

b. Failed to diligently respond to CRIS reports from DC [REDACTED], which by their very nature in terms of harm, threat and risk should have been subject to supervision and oversight.

c. Failed to identify the extant risk to children posed by the suspect, diligently or at all.

d. Failed to assess the extant risk to children posed by the suspect, diligently or at all.

e. Failed to manage the extant risk posed by the suspect, diligently or at all.

f. Failed to ensure that the investigation was progressed by way of an application for a search warrant pursuant to s.8 of PACE 1984, diligently or at all.

iii. DC Nunnery failed to diligently supervise the investigation conducted by DC [REDACTED], and thereby:

a. Caused unnecessary delay in the identification and apprehension of the suspect

b. Failed to reduce the risk posed by the suspect to children during the extant investigation.

By reason of the matters set out above, either individually or collectively, the behaviour of DC Nunnery did not meet the standards required by the Standards of Professional Behaviour set out in Schedule 2 to the Police (Conduct) Regulations

2020 as to Duties and Responsibilities in that DC Nunnery was not diligent in the exercise of his duties and responsibilities.

DI Cole

9. The allegation against DI Cole is set out below.

i. On 14 July 2022, the Metropolitan Police Service (MPS) appointed DC [REDACTED] as the investigating officer in an investigation concerning a complaint about a suspect linked to an address within the Metropolitan Police Service area. The suspect was alleged to have incited a child to engage in sexual activity through social media.

ii. At the material times, DC Nunnery (then ADS Nunnery) was DC [REDACTED] supervisor in the investigation of the complaint.

iii. At the material times DI Gemma Cole was the line manager of DC Nunnery.

iv. DI Cole was under a duty to supervise the investigation of the complaint, and DI Cole:

a. Failed to diligently identify the level of supervision of the investigation that was necessary having regard to the nature of the incident that was presented to her.

b. Failed to diligently respond to requests for guidance from [REDACTED], which by their very nature in terms of harm, threat and risk should have been subject to supervision and oversight.

c. Failed to identify the extant risk to children posed by the suspect, diligently or at all.

d. Failed to assess the extant risk to children posed by the suspect, diligently or at all.

e. Failed to manage the extant risk posed by the suspect, diligently or at all.

f. Failed to ensure that the investigation was progressed by way of an application for a search warrant pursuant to s.8 PACE of 1984, diligently or at all.

v. DI Cole failed to diligently supervise the investigation, and thereby:

a. Caused unnecessary delay in the identification and apprehension of the suspect.

b. Failed to reduce the risk posed by the suspect to children during the extant investigation.

By reason of the matters set out above, either individually or collectively, the behaviour of DI Cole did not meet the standards required by the Standards of

Professional Behaviour set out in Schedule 2 to the Police (Conduct) Regulations 2020 as to Duties and Responsibilities in that DI Cole was not diligent in the exercise of her duties and responsibilities.

Regulation 30 Notice

10. On the morning of the first day of the hearing the Regulation 30 Notices, as set out above, were read out. The Panel took note that the Officers denied the allegations, and their responses are set out in the Regulation 31 responses.

Facts

11. This case concerns the investigation of an online child sexual abuse allegation. This allegation was first reported to Greater Manchester Police (GMP) in April 2022.

12. The complainant was the mother of a [REDACTED] year-old child who had been contacted through Instagram by an individual using the profile name "ellie_hope12", purporting to be a female child. During the course of those communications, the suspect was alleged to have encouraged the child to engage in indecent acts and subsequently made threats amounting to blackmail.

13. Early investigative enquiries by GMP established an IP address associated with the Instagram account. Further intelligence enquiries, including subscriber and background checks, linked the IP address to a residential address in London within the Metropolitan Police Service (MPS) area.

14. The investigation was transferred from GMP to the MPS to continue from July 2022 onwards. DC [REDACTED] from GMP recommended officers attend the address identified as soon as possible to seize devices, arrest suspects, and reduce the risk of harm.

15. Investigative actions are recorded on the MPS Crime Reporting Information System (CRIS) The Officer in the Case (OIC) from 14 July 2022 was DC [REDACTED] from East Area BCU. At this stage, however, no individual suspect had been identified, and the address was believed to be occupied by a number of potential users of the internet connection.

16. The central issue presented by the AA for the Panel to consider concerned the timing of an application of a Section 8 PACE (Police and Criminal Evidence Act) search warrant for evidence and a suspect(s) at the address. At the time of transfer in July a supervisory review was undertaken by ADS [REDACTED] which set investigative actions for DC [REDACTED] that preceded an application for a warrant.

17. Shortly after becoming OIC, DC [REDACTED] sought advice from the East Area Online Child Sexual Abuse and Exploitation (OCSAE) team whose role was to support investigations and provide specialist advice to investigators. This initial advice included obtaining further evidence prior to obtaining a warrant.

18. It is the AA's case that opportunities existed to apply for a search warrant significantly earlier than was ultimately done so, and that delays in progressing the investigation failed adequately to address the safeguarding risks identified from the outset.

19. Detective Constable Nunnery was selected to be an Acting Detective Sergeant (ADS) within East Area Basic Command Unit (BCU) Local Investigations on 22 August 2022 and conducted his first supervisory review of the investigation on 10 September 2022.

20. Between 10 September and 18 September DC Nunnery asked Detective Inspector Cole for advice regarding the investigation. DI Cole referred him to Detective Sergeant [REDACTED] who led the local OCSAE team at the time. DC Nunnery sought DS [REDACTED] advice. This advice included steps to be taken prior to seeking a search warrant.

21. A public complaint was made by the parent of Child A on 11 August 2022 concerning the progress of the investigation. This was dealt with at the time by the MPS Directorate of Professional Standards Complaint Resolution Unit and concluded on 21 September 2022 concluding that the investigation and strategy were acceptable.

22. The investigation remained ongoing and under review during the latter part of 2022. Supervisory discussions took place regarding the appropriate investigative strategy, including consideration of specialist advice from officers within the OCSAE team.

23. By late November 2022, supervisory records identified obtaining a search warrant as the next investigative step, although an application was not made until the investigation was subsequently reallocated.

24. On 5 December 2022 DCI [REDACTED], of the Central OCSAE Team, decided that the investigation should be reallocated to that unit. In an email she stated that it would be prudent for the matter to be owned by Central OCSAE because that team had the resources to obtain and execute the required warrant, undertake the necessary forensic processing and provide victim identification capability.

25. Following reallocation of the investigation to Central OSCAE, DC [REDACTED] was appointed as the new OIC on 7 December 2022. An application for a Section 8 warrant was made and granted on 9 December 2022.

26. Officers from the central OCSAE team executed the search warrant at the identified address on 14 December 2022 and arrested a male and seized electronic devices, including an iPhone. Examination of those devices identified substantial further offending involving numerous child victims, resulting in multiple additional offences being uncovered.

27. The parent of child A had exercised their right to review the outcome of the public complaint made. This was upheld by MOPAC on 6 January 2023. The IOPC subsequently directed the MPS DPS to conduct a local investigation into the conduct of DC Nunnery and DI Cole.

28. The suspect arrested later pleaded guilty to multiple counts of online grooming and sexual exploitation of young girls between March 2022 and December 2022 at Snaresbrook Crown Court on 10 June 2024.

Officers' Responses

29. In his Regulation 31 Response, DC Nunnery contended that:

    i. he inherited a partially progressed investigation in his first supervisory posting, within a chronically under-resourced team;

    ii. his decision not to apply for a warrant in September 2022 was a reasoned, professional judgment, supported at the time by the views of others including a specialist OCSAE officer;

    iii. the evidence said to justify an earlier application, principally reliance on an IP address, was legally and operationally inadequate.

    iv. he did not cause the delay complained of, since the steps he directed were necessary and logical; and

    v. DC [REDACTED] own execution of the warrant in December 2022 demonstrates the legal and child-safeguarding risks inherent in the "alternative" course the Appropriate Authority says should have been taken earlier.

30. In her Regulation 31 Response and Addendum Response, DI Cole contended that:

    i. she had no specific policy obligation to review CRIS reports of this crime type, which fell to the Detective Sergeant;

    ii. on each occasion the matter was brought to her attention she gave appropriate operational direction, including directing that risk be assessed and that specialist advice be sought;

    iii. her insistence on the chain of command when approached directly by DC [REDACTED] was a legitimate and necessary management response, not a failure of substance; and

    iv. systemic workload and resourcing pressures within Borough CID meant that the level of individual review advanced as requisite by the Appropriate Authority was not realistically achievable.

Panel's Approach

31. The Panel reminded itself of its core responsibilities:

    a. To assess the facts of the case and make findings in relation to each allegation;

    b. To determine whether those findings amount to a breach of the relevant Standards of Professional Behaviour;

c. To decide whether the conduct found proven constitutes misconduct or gross misconduct.

32. In considering the facts, the Panel remained mindful that the burden of proof is on the AA and the standard of proof is the balance of probabilities.

33. In line with the principle derived from Byrne v General Medical Council [2021] EWHC 2237 (Admin), the Panel recognised that there is only one standard of proof in civil and regulatory cases, namely whether the facts in issue more probably occurred than not.

34. The seriousness of an allegation does not of itself require more cogent evidence. The inherent probability of the relevant conduct is a matter which can be taken into account when weighing the probabilities and in deciding whether the event/conduct occurred; this goes to the quality of evidence.

35. The Panel was also mindful not to assess a witness's credibility exclusively on their demeanour when giving evidence and that their veracity should be tested by reference to objective facts proved independently in their evidence, in particular by reference to the documents in the case.

36. The Panel has also reminded itself that it should make a rounded assessment of a witness's reliability, rather than approaching their reliability in respect of each charge in isolation from the others: R (on the application of Dutta) v GMC [2020] EWHC 1974 (Admin).

37. As to individual pieces of evidence, the Panel was mindful that it is entitled to draw proper inferences, that is to come to common sense conclusions based upon the evidence which it accepts as reliable; but it must not speculate. Similarly, the Panel must not speculate about what other evidence there might have been.

38. In reaching its decisions, the Panel considered the purpose and nature of police misconduct proceedings. The primary aim is not to punish the Officer, but to uphold public confidence in the police service and protect its reputation by ensuring accountability and making clear that improper conduct will not be tolerated.

39. A secondary aim is to affirm and promote high professional standards. A further purpose is to protect the public, the Complainant, and police staff by preventing recurrence of similar misconduct. In doing so, the Panel had regard to the principles established in Bolton v Law Society [1994] 1 WLR 512; Chief Constable of Dorset v PAT, Salter (Interested Party) [2011] EWHC 3366 (Admin); and R (Williams) v PAT [2016] EWHC 2708 (Admin).

40. The Panel also considered the relevant regulatory framework and guidance, including:

a. The Police (Conduct) (Amendment) Regulations 2024 ("the Regulations"), particularly the Standards of Professional Behaviour set out in Schedule 2;

b. The 2018 Home Office Guidance ("HOG"), with specific reference to Chapter 1, which summarises the Standards;

c. The definition of misconduct under Regulation 3(1): "a breach of the Standards of Professional Behaviour";

d. The definition of gross misconduct under Regulation 3(1): "a breach of the Standards of Professional Behaviour so serious that dismissal would be justified".

41. The Panel listened carefully to all oral evidence and thoroughly reviewed the documentary evidence. It considered the totality of the evidence and submissions. While it does not propose to address every individual point raised, the Panel sets out its principal findings and conclusions.

42. The Panel also recognised the impact of the overall investigative timeline. However, the issue before the Panel was not whether the investigation could, with the benefit of hindsight, have progressed more quickly, but whether the Appropriate Authority had proved that DC Nunnery and DI Cole failed to exercise the requisite level of duties and responsibilities in supervising the investigation.

Evidence

43. The Panel had been provided with the following documents
    i. the Hearing Bundles for DI Cole and DC Nunnery,
    ii. the Regulation 31 Bundle,
    iii. the arrest statement of DC [REDACTED] dated 18.09.23; and
    iv. the bundle of character references.

Evidence of DC [REDACTED]

44. The Panel heard evidence from DC [REDACTED] who in 2022 was a member of the Central OCSAE team. In evidence she explained that she was highly experienced in the investigation of these offences and gave evidence of the approach and resources available to her as a specialist investigator in this field. She confirmed however that she was not an expert witness. DC [REDACTED also confirmed that she was providing evidence in her role as a DC rather than someone in a supervisory capacity.

45. DC [REDACTED] explained in 2022 OCSAE investigations were undertaken by the central OCSAE team, dealing with those that were more complex in nature. She was aware that BCUs had local OCSAE teams but not aware of the level of training they, or local investigators, may receive to deal with this type of offending. However, in her experience the local OCSAE team could contact the central team for advice and support. DC [REDACTED] also gave evidence that since 2022 the MPS has now moved to a centralised OCSAE approach with the resources and investigations in local hubs under the control of the central OCSAE command.

46. DC [REDACTED] gave evidence primarily in relation to the timing of the application for a search warrant pursuant to section 8 of PACE. She stated she had reviewed the chronology of the investigation and in her view, she would have obtained a search warrant at an earlier stage to minimise the risk of further harm. DC

[REDACTED] identified points at which the investigation might reasonably have progressed more quickly: in particular, the initial recommendation by DC [REDACTED] in GMP to attend the address in July and his subsequent follow up and offer to support the MPS in this action could have prompted curiosity as to an earlier application for a search warrant.

47. DC [REDACTED] also considered that the earlier supervisory reviews and advice from the local OCSAE team should also have directed officers towards obtaining a warrant sooner and that, by late November, obtaining a warrant had clearly become the next investigative step. She accepted, however, that the investigation initially had only an IP address linked to an address and no identified device or suspect.

48. The Panel accepted DC [REDACTED] evidence that she could understand why the officers took the approach they did, given the advice and guidance from the local OCSAE team, and that local CID officers would not deal with this crime type every day. Whilst it remained in her view in seeking a warrant earlier, she accepted that the investigative approach the officers took was legitimate in the circumstances. One approach was to apply for a search warrant at an early stage based upon the available information; the other was to continue investigative enquiries before seeking judicial authority, recognising that an IP address identifies a location rather than an individual or device, and that several people may have access to the internet connection.

49. DC [REDACTED] stated that investigations are dynamic and that officers may reasonably move between investigative strategies as further evidence emerges. Whilst she considered that her best practice may have been to seek a warrant as early as July, she accepted that there was no force policy requiring officers to do so, that there was no single "right" approach, and this was a matter of investigative judgment rather than any lack of integrity or diligence on the part of the officers involved.

50. The Panel heard evidence and submissions concerning the practical consequences of the warrant strategy ultimately adopted in December 2022, including criticism of certain actions taken at the scene as well as DC [REDACTED] explanation of actions taken. Those matters formed part of the broader debate about competing investigative approaches. However, the Panel's task was not to determine whether DC [REDACTED] approach was correct or incorrect, but whether the Appropriate Authority had proved that the actions of DC Nunnery and DI Cole fell below the Standards of Professional Behaviour in the strategy they adopted.

51. The Panel respected the evidence of DC [REDACTED] which represented a legitimate professional view based on her specialist role. It placed considerable weight on her acknowledgement that she could understand why the officers had chosen an alternative strategy to hers. Therefore, her disagreement with the officers' approach did not represent evidence of their misconduct.

Submission of no case

52. At the conclusion of the AA's case, Counsel for both Officers made an application that there was no case to answer in respect of the allegations.

53. The Panel carefully considered the written and oral submissions made and accepted the advice of the LQA.

54. In line with that advice and the case of *R v Galbraith* the Panel asked itself whether the evidence, taken at its highest, was such that no reasonable Panel, properly directed, could find the allegations proved on the balance of probabilities. The Panel had close regard to the requirement not to make evaluative judgments and that at this stage the issue was whether the Panel could find the allegations proved, not whether they would ultimately do so.

55. Ultimately the Panel concluded that there was a case to answer and moved to the Defence case.

Evidence of DC Nunnery

56. DC Nunnery described his policing background, starting as a uniformed officer in Response and Neighbourhood policing roles prior to taking the steps necessary to become a detective. During 2020 he undertook the National Investigators Examination alongside the separate National OPSRE Part 1 promotion examination. He was successful in both and became a Trainee Detective Constable (TDC) within the Community Safety Unit in East Area BCU in June 2020. Following his substantive appointment as a Detective Constable in May 2022 he applied to become an Acting Detective Sergeant (ADS) and in August 2022 was appointed as an ADS within Local Investigations (CID).

57. DC Nunnery explained in evidence that whilst he had considerable experience as a PC and TDC in applying for search warrants, he had no specialist experience or training in online child abuse investigations. He confirmed he had not seen a OCSAE Toolkit in 2022 (Toolkit dated in May 2023 in the evidential bundle) or received any OCSAE related training.

58. He had only recently assumed supervisory responsibilities within CID when he inherited supervision of the investigation by DC [REDACTED], for whom he became line manager. On taking over, he reviewed the existing supervisory entries, understood that specialist advice was being provided by the OCSAE team, and believed that the investigation was progressing appropriately. He confirmed he had read and reviewed the previous CRIS entries by other officers and supervisors and did not consider that the investigation had been allowed to drift.

59. The principal issue in his evidence concerned the timing of the application for a section 8 PACE warrant. DC Nunnery maintained that he did not believe the evidential threshold for a warrant had been reached until later in the investigation and that further investigative enquiries were justified before seeking judicial authority.

60. The Panel accepted DC Nunnery's evidence that he acknowledged the earlier advice sought by DC [REDACTED] from the OCSAE team, which he agreed with, and he additionally sought advice from DI Cole, and then DS [REDACTED] whose advice, on 22 September 2022, *" If you can get the victim's phone then we can of course triage. This will be your first RLE. Once reviewed we can discuss the warrant."* added weight to the advice and direction from others that provided the basis of the investigative strategy adopted by DC [REDACTED] and supervised by himself.

61. In weighing up the respective risks in relation to the timing of a warrant DC Nunnery explained he balanced the safeguarding concerns and the risk of further offending against the need to present a sufficiently robust application to the court and conduct an operation to seize devices and arrest an offender, with the risks of going too early and losing evidence or suspect or arresting innocent parties. The Panel accepted he had formed a considered view, having consulted others, in assessing the most effective way at the time to prevent further offences and manage risk, particularly at that time where the investigation had identified only an IP address and not any individual suspect or device.

62. DC Nunnery accepted that obtaining a warrant ultimately became the next investigative step by late November but maintained that, at the relevant times, he believed further investigative enquiries remained the most appropriate steps to take, supported by OCSAE advice, and did not consider that his decision-making had been wrong.

63. In cross-examination, counsel challenged his management of the investigation, focusing upon the safeguarding risks posed by delay. It was put that the known victim was [REDACTED] years old, that risk assessments identified a high likelihood of further offending, and that the investigative strategy failed adequately to address the risk of additional victims whilst enquiries continued. Counsel also highlighted the absence of regular detailed supervisory entries, the delay between identifying a warrant as the next investigative step and applying for one, and the fact that, once the investigation was reallocated, a warrant was obtained quickly and led to the identification of numerous further victims. DC Nunnery maintained that his decisions reflected an exercise of professional judgment based upon the specialist OCSAE advice he and DC [REDACTED] received, and the information available at the time.

Evidence of DI Cole

64. DI Cole outlined her experience within child abuse investigations having served in specialist Child Abuse Investigation Teams prior to their transfer into BCU Commands. DI Cole described the operational pressures facing her department, which was significantly understaffed and managing numerous serious investigations simultaneously.

65. DI Cole explained that there was no force policy prescribing precisely when a Section 8 warrant should be sought and that decisions to do so required officers to balance evidential sufficiency, safeguarding considerations, and competing

operational priorities. She expressed confidence in the investigating officers and considered them capable of exercising appropriate professional judgment.

66. During cross-examination, counsel suggested that insufficient weight had been given to the ongoing safeguarding risk and that the investigation had prioritised evidential considerations over the protection of potential child victims. It was put that the evidence required to obtain a warrant had existed significantly earlier and that, once another officer assumed responsibility, a warrant was secured within days, leading to the discovery of numerous additional victims. DI Cole in evidence maintained her assessment that on the information she had been given there was insufficient information to obtain a warrant earlier.

67. The Panel accepted DI Cole's assessment made in evidence that she recognised there was disagreement in how to progress the investigation and ultimately prevent offending, risk, and arrest the suspect. It also accepted that she had formed the view, supported by advice from OCSAE officers, they "didn't have enough" for a warrant, and on the approach advocated by DC [REDACTED] in GMP at the time, "didn't think sounded proportionate" outlining some associated risks of losing evidence, suspects and potentially arresting innocent parties. DI Cole maintained that the decisions taken reflected professional judgment rather than misconduct, emphasising the difficulties of managing risk where the identity of the offender remained unknown, and the operating context of risk, priorities and demands upon the department's resources.

68. In response to questions from the Panel, DI Cole explained her approach to supervision, the role of specialist advice from the OCSAE team, and the challenges of assessing risk where neither the suspect nor the full extent of offending had yet been identified. She maintained that the investigation had been managed by capable officers who were making reasonable professional judgments in a complex and resource-constrained environment.

Findings of Fact

69. The Panel remained mindful throughout of the gravity of the underlying offending, namely allegations that a suspect had incited a child to engage in sexual activity through social media.

70. The Panel determined that the material period under review for the purposes of assessing the actions of DC Nunnery and DI Cole was from 22 August 2022 (when DC Nunnery was appointed ADS) until 5 December 2022 (when the investigation was reallocated to Central OCSAE). In assessing the decision-making of the officers involved, the Panel also considered the chronology from the initial reporting of the allegation to GMP in April 2022.

71. The Panel also recognised the impact of the overall investigative timeline. However, the issue before the Panel was not whether the investigation could, with the benefit of hindsight, have progressed more quickly, but whether the Appropriate Authority had proved that DC Nunnery and DI Cole failed to exercise the requisite level of diligence in supervising the investigation.

72. The Panel reminded itself that the burden of proof rested upon the Appropriate Authority and that the standard of proof was the balance of probabilities.

The Panel made the following findings.

DC Nunnery

General Supervision

73. The Panel gave considerable weight to the Metropolitan Police Service General Investigation Policy, which provides that supervisors should determine the level of supervision appropriate to the circumstances of each investigation.

74. The Panel accepted the evidence of both DC Nunnery and DI Cole that DC [REDACTED] was a highly capable detective. She was a Direct Entry Detective Constable who had been a detective longer than DC Nunnery and enjoyed a reputation for being thorough and competent. That assessment was supported by the evidence before the Panel in reading the numerous CRIS entries and emails by DC [REDACTED].

75. Although DC Nunnery's first formal supervisory review did not occur until 10 September 2022, the Panel accepted the explanation that this reflected DC Nunnery's recent appointment, operational commitments and periods of leave detailed on the MPS CARM system (duties recording system). Once the investigation appeared within his workload, he conducted this first comprehensive supervisory review late at night whilst on a rest day. The Panel regarded this as evidence of his conscientiousness and diligence rather than neglect.

76. The Panel also heard from DC Nunnery that he had received no formal supervision training. However he had undertaken shadowing with colleagues, and asked for advice and support where required, as evidenced in his approach to DI Cole and subsequent email to DS [REDACTED] on 18 September to seek specialist OCSAE advice from a peer.

77. Thereafter, whilst the formal CRIS supervisory endorsements were limited, the Panel accepted DC Nunnery's evidence that he remained in regular contact with DC [REDACTED] through one-to-one discussions and informal supervision within an open-plan office environment. This evidence was not challenged by the Appropriate Authority and was supported by references within the CRIS indicating ongoing discussions between officers.

78. Whilst not determinative the Panel also recognised that DC Nunnery supervised approximately ninety live investigations across his team, many involving serious and complex matters. DC Nunnery also provided some additional insight into his supervisory duties in October 2022 where he dealt with a number of other active investigations or worked additional hours to cover supervision shortages.

79. The Panel was satisfied from the contemporaneous CRIS records that DC [REDACTED] made numerous investigative updates between September and November 2022. These updates demonstrated that the investigation continued to progress throughout this period and therefore the Panel found there was an

appropriate level of supervision during the material times.

Specialist Advice

80. The Panel noted that eight days after his initial supervisory review, DC Nunnery, having consulted DI Cole, emailed DS [REDACTED] of the Online Child Sexual Abuse and Exploitation (OCSAE) Team for specialist advice on 18 September 2022. DC Nunnery updated the CRIS on 19 September, prior to taking annual leave, asking DC [REDACTED] to action any response from DS [REDACTED] whilst he was away.

81. The email correspondence dated 22 September 2022 evidenced that in response to DC Nunnery's email, DS [REDACTED] recommended obtaining and reviewing the victim's phone before discussing a search warrant. DC [REDACTED] responded promptly, outlining the investigative work already underway with DS [REDACTED] and the Local Intelligence Team. The Panel found that this reflected an active attempt by DC Nunnery to ensure the investigation progressed efficiently and seek appropriate specialist support.

82. When DC Nunnery returned from leave on 6 October 2022, the investigative actions undertaken were consistent with the specialist advice received. The Panel attached significant weight to the fact that specialist OCSAE advice had been sought and followed throughout.

83. The Panel also noted that earlier specialist advice had been obtained from PC [REDACTED] within OCSAE and that multiple OCSAE and other specialists remained engaged with the investigation.

84. The Panel accepted DC Nunnery's evidence that he drew reassurance that he believed the correct investigation strategy had been adopted because of the advice provided by the OCSAE team, and that none of those officers, or his own DI, had suggested otherwise.

Risk Assessment and Management

85. The Appropriate Authority alleged that DC Nunnery failed to identify, assess and manage the ongoing risk posed by the suspect.

86. The Panel found that the Threat Harm Risk Investigation Vulnerability Engagement (THRIVE) assessment completed by DC [REDACTED] was reviewed and adopted by DC Nunnery. He revisited the assessment during his supervisory review on 10 September and subsequent updates maintained that the assessed level of risk remained unchanged.

87. The Panel accepted DC Nunnery's evidence that the investigative strategy for managing risk that he advocated and supervised was to gather further evidence, identify the suspect and device(s) before obtaining a search warrant in order to reduce the risk of alerting the suspect prematurely, losing evidence, or causing the suspect to abscond and be able to continue offending.

88. Whilst that strategy was not always fully documented within the CRIS, the Panel was satisfied from evidence DC Nunnery gave, and documentary evidence in email and CRIS that it was discussed during supervisory meetings and reflected in the investigative actions undertaken.

89. Notably the Panel heard in evidence, supported by email and CRIS entries, that several supervisors and specialist officers, including ADS [REDACTED], PC [REDACTED], ADS [REDACTED], DS [REDACTED] and DS [REDACTED], identified further investigative enquiries to be undertaken before progressing to consideration of a search warrant. The Panel attached weight to the consistency of that contemporaneous advice when assessing the reasonableness of the Officers' decision-making. The Panel accepted that this investigative strategy was reasonably open to officers exercising professional judgment. DC [REDACTED], called by the Appropriate Authority, accepted during evidence that there was more than one investigative approach available to the officers and that she understood why DC Nunnery and DI Cole adopted the approach that they did.

90. The Panel noted the emergence of a second potential victim during the investigation. Whilst not a separately particularised element of the AA's case, this reinforced the risk of ongoing offending. The Panel accepted that DC Nunnery nevertheless continued to follow the investigative approach advised by OCSAE and it was not satisfied that this rendered his decision-making unreasonable.

91. The Panel therefore concluded that the Appropriate Authority had failed to prove that DC Nunnery was not diligent in identifying, assessing or managing risk.

Search Warrant

92. The Appropriate Authority further alleged that DC Nunnery failed to ensure that the investigation progressed by way of an application for a search warrant pursuant to section 8 of the Police and Criminal Evidence Act 1984.

93. The evidence demonstrated that consideration had been given to a search warrant from an early stage. This included DC Nunnery's email to DS [REDACTED] on the 18 September, as well as references by other officers. However, consistent advice from specialist officers was that further digital evidence should first be obtained to identify the individual responsible and strengthen any subsequent application. The Panel was not satisfied that the evidence established there was only one reasonable investigative course available.

94. DC Nunnery recorded within his supervisory review on 10 September why a search warrant was not considered appropriate at that stage and why further digital enquiries remained necessary following the advice from OCSAE on19 September.

95. The Panel noted that obtaining digital evidence proved time-consuming because of factors outside the Officer's control, including delays in forensic examination and resource limitations affecting the Greater Manchester Police investigation and the Level 2 download undertaken by the Local Digital Forensic Investigation Team (LDFIT).

96. The Panel was satisfied that these delays were not attributable to inadequate supervision by DC Nunnery. The Panel also noted that his final supervisory entry on the CRIS in November 2022 was to seek a warrant. The Panel therefore rejected that allegation.

Delay

97. The Panel remained cognisant of the length of time the investigation had taken from the moment initially reported until the suspect was arrested. Throughout this relevant period the investigation continued to progress through phone downloads, background enquiries, digital forensic examinations, liaison with external agencies and specialist safeguarding advice.

98. The Panel also considered and accepted that DC [REDACTED] (GMP) advocated earlier intervention. However, the existence of a different investigative preference by DC [REDACTED], supported in her evidence by DC [REDACTED], did not establish on the balance of probabilities that the alternative approach taken, and supported by local OCSAE specialists in the MPS was unreasonable.

99. Having considered the evidence as a whole, the Panel was not satisfied that any delay resulted from a lack of diligence on the part of DC Nunnery. Rather, the delay principally arose from the complexity of the investigation, the time required to obtain digital evidence, and lines of enquiry being developed prior to obtaining a search warrant to minimise the risk associated with going too early.

100. The Panel therefore found that the Appropriate Authority had not proved that DC Nunnery failed to supervise the investigation diligently, caused unnecessary delay or failed to reduce the risk posed by the suspect. Whilst the investigation undoubtedly took longer than was desirable, the Panel was not satisfied that the delay was attributable to any lack of diligence on the part of either Officer.

101. Accordingly, none of the particulars alleged against DC Nunnery are proved.

DI Cole

102. The Panel also considered the allegations against DI Cole.

General Supervision

103. The evidence established that DI Cole maintained an accessible supervisory approach and expected matters to be managed through the appropriate chain of command, with DC Nunnery exercising day-to-day supervision of DC [REDACTED].

104. The Panel accepted that DI Cole regarded both officers as capable investigators and remained available to provide guidance whenever required.

105. The Panel heard evidence of DC [REDACTED] and DC Nunnery's capabilities from DI Cole. She gave an example of DC [REDACTED] approach during a serious assault investigation scene they attended, describing her as highly regarded, hardworking and meticulous. In relation to DC Nunnery, she knew he had previously

performed acting DS duties, was highly regarded, and stated she was ‘excited’ that he was coming back to the main office.

106. Whilst not determinative, the Panel noted DI Cole's evidence regarding the breadth of her supervisory responsibilities within Local Investigations. She explained that the teams for which she was responsible collectively managed up to 600 live investigations covering a range of risks, priorities and complexities. DI Cole also retained responsibility for responding to spontaneous major crime incidents and immediate threat-to-life matters.

107. DI Cole described that for certain crime types an Action, Decision, Review (ADR) screen was added to the CRIS in order to track and record supervisory actions. This particular crime type did not require an ADR screen.

108. The Panel heard evidence from DI Cole that she relied on her team to highlight cases to her for consideration where appropriate. She stated she maintained an open and visible approach, working in an open plan environment.

109. In this regard the Panel accepted DI Cole’s evidence in relation to her guidance to DC Nunnery in September to approach DS [REDACTED] in OCSAE, the advice she gave DC [REDACTED] when approached in the office in October, and her response to DC Nunnery setting out options and risk consideration in an email 13 November 2022.

110. The Panel heard DI Cole respond to Counsel questions concerning this email response to DC [REDACTED] in November and her decision to respond to DC Nunnery directly with her emphasis to ensuring DC [REDACTED] went to DC Nunnery as her supervisor in the first instance. DI Cole stated that her reply was sent late at night on a rest day and that she followed up promptly with DC Nunnery when back in the office on the Monday. She further stated that due to the range of her own responsibilities she had to ensure that the supervisors managed their officers and investigations, whilst being able to flag cases for her attention as required. The Panel accepted this was an indication of DI Cole’s diligence and a reasonable supervisory approach.

Specialist Advice

111. The evidence demonstrated that when approached in September 2022, DI Cole directed DC Nunnery to obtain specialist safeguarding advice from DS [REDACTED], recognising the need for expertise within OCSAE.

112. The Panel further heard evidence from DI Cole that she directed DC Nunnery to DS [REDACTED] because he led the OCSAE team and she also knew he had considerable experience in safeguarding investigations. She therefore concluded he would provide appropriate advice on the investigative steps to take, including whether there was sufficient information to obtain a search warrant. The Panel regarded the direction to seek DS [REDACTED] advice therefore as an appropriate supervisory direction.

113. The Panel also noted the consistent reference to the specialist advice from the local OCSAE in DI Cole’s evidence in her approach. DC [REDACTED] had stated that

she understood why the officers took the approach they did as a result of this advice, and there was no evidence presented to suggest approaching the local OCSAE was incorrect.

114. Although not every supervisory discussion was recorded formally, the Panel accepted that DI Cole remained engaged in the investigation and provided appropriate supervisory oversight through DC Nunnery.

Risk Assessment and Management

115. The Panel accepted DI Cole's evidence that she was aware of the potential risks of further offending, and she was supporting the approach to managing the risk posed by gathering further evidence before obtaining a search warrant. This would involve evidence to identify a suspect and to find them. Without this she stated that there was a risk a suspect could destroy or lose evidence and continue offending. She also stated there was no lack of effort in this regard and no conflicting advice from the OCSAE team who were providing advice.

116. In relation to risk management, the Panel accepted that directing the investigation towards specialist safeguarding advice constituted an appropriate direction by DI Cole to DC Nunnery of identifying, assessing and managing the risks presented.

117. The AA and DC [REDACTED] referred to the complaint by the parent of child A as a factor to be considered in assessing risk. The Panel accepted DI Cole's view given in oral evidence that she was aware of the public complaint made by the parent of child A in relation to the investigation, and that she believed by October that the DPS had dealt with the matter and there was no case to answer.

118. The Panel heard evidence regarding the interaction between DI Cole and DC [REDACTED] on the 3 October (while DC Nunnery was on leave) in the office where DC [REDACTED] approached DI Cole. The Panel accepted this was not a formal briefing, but the interaction was sufficient for DC [REDACTED] to record further actions as a result of the discussion they had had.

119. In relation to the email sent by DC [REDACTED] to DI Cole on 13 November and DI Cole's response to DC Nunnery, the Panel considered this to be evidence of DI Cole setting out the three options for consideration, which included obtaining a search warrant, and that risk and harm should inform the decision-making.

120. The Panel noted the emergence of a second potential victim during the investigation. Whilst not a separately particularised element of the AA's case, the Panel accepted DI Cole's evidence that she was not aware of this development until the investigation was transferred to Central OCSAE by DCI [REDACTED]. Whilst the development underlined the risk of further offending the Panel attached limited weight to it when assessing her supervisory conduct.

121. The Panel accepted DI Cole's evidence that she had concluded that the most appropriate investigative strategy intended to mitigate risk was by identifying a suspect, preserving opportunities to secure evidence and avoiding action that might

prematurely alert an unknown offender, or potentially arrest or seize devices from innocent individuals.

Search Warrant and Delay

122. The Panel also accepted DI Cole's evidence that the decision making in relation to the timing of an application for a search warrant, included the steps taken to obtain and assess further digital evidence once available, engaging OCSAE officers with specialist knowledge for advice and support, represented a legitimate investigative strategy to adopt.

123. The Panel was presented with no evidence that any applicable policy or guidance for officers was in force during 2022, that advised or required an earlier search warrant or mandated a different investigative approach.

124. Accordingly, the Panel was not satisfied that the Appropriate Authority had proved any of the particulars alleged against DI Cole.

Conclusion

125. The Panel recognises that, with the benefit of hindsight and given the seriousness of the offending, the recording of supervisory activity could have been more comprehensive. Both officers acknowledged that more detailed CRIS endorsements would have been preferable and identified this as a point of learning.

126. However, the Panel is satisfied that both Officers remained appropriately engaged with the investigation, sought and followed specialist investigative advice, maintained regular communication with the Officer in the Case, and pursued a rational investigative strategy supported by a number of experienced practitioners.

127. The Panel accepted that an earlier application for a search warrant was a legitimate investigative option and that this was the view advanced by DC [REDACTED] in GMP and subsequently by DC [REDACTED] in the MPS Central OCSAE team. However, having considered the totality of the evidence, the Panel was not satisfied that it was the only reasonable option available.

128. The contemporaneous evidence demonstrated that specialist OCSAE officers advised further investigative work before seeking a warrant and the Officers concerned were entitled to place weight on that advice. On the basis of the evidence presented to the Panel, the existence of professional disagreement as to the preferable investigative course did not, without more, establish a lack of diligence or misconduct.

129. For all of the above reasons, the Panel finds that the Appropriate Authority has failed to prove, on the balance of probabilities, any of the allegations against either DC Nunnery or DI Cole. Accordingly, the allegations are not proved.

Commander Colin Wingrove (Chair)

29 July 2026