GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

[redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013** Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).
1	**CORONER** I am **Rachel Knight H M Coroner**, for the coroner area of South Wales Central.
2	**DATE OF REPORT** 28th July 2026
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

4	**THIS REPORT IS BEING SENT TO** 1. [redacted], Minister for the Department of Culture, Media & Sport 2. [redacted] Minister for Education 3. [redacted], Minister for Culture & Sport (Wales) 4. [redacted] Minister for Education (Wales) You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd September 2026. I, the coroner, may extend the period if an appropriate application is made.
5	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6	**SUMMARY OF CORONER'S CONCERN** A lack of awareness and education amongst the general public, both young and old around unsolicited social media approaches, and the danger of sextortion scamming, which may lead to further deaths.
7	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8	**INVESTIGATION AND INQUEST** **On 11/06/2025 I commenced an investigation into the death of Cai Rhys Davies. The investigation concluded at the end of the inquest on .** **The medical cause of death was:** **1a Hypoxic brain injury** **1b Asphyxiation** **1c** **1d** **II** **The circumstances were :-** Cai Rhys Davies was aged 18 when on 30th May 2025 he constructed a ligature [redacted] and was found hanging. He was resuscitated and taken to hospital, but sadly he went on to die on 3rd June 2025. Cai had a traumatic childhood and suffered with poor mental health and ADHD, and was known to engage in substance misuse. It is more likely than not that personal stress in his life together with his becoming the victim of a sextortion scam in the days before his death, more than minimally contributed to his decision to take his own life. **Conclusion:** Suicide

9	**CIRCUMSTANCES OF DEATH** In this case, Cai, a vulnerable young man, was approached via a message request directly from a stranger (scammer) posing to be a young lady of around his age. Conversation quickly turned sexual and she asked him for intimate images which were then used to blackmail him for money, by threatening to send the images to his family and friends and to upload them to a YouTube channel. The images were indeed sent to at least 1 of Cai's Facebook friends by the scammer. Cai was bombarded with video calls and messages via Facebook messenger and Whatsapp over a very short period of time making demands for money.
10	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: See above

11	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* 1. Minister for the Department for Education (Westminster) 2. Minister for the Department for Culture, Media & Sport (Westminster) 3. Minister for the Department for Education (Wales) 4. Minister for Culture & Sport (Wales) 5. Family members I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

28th July 2026

SIGNED: [redacted]

Rachel Knight H M Coroner for South Wales Central Coroner Area

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