IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 4085

COR 2022 4086

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the deaths of Benjamin Paul Ray and Kevin Timothy Patrick Doherty

Delivered On:	9 October 2023
Delivered At:	Coroners Court of Victoria
Inquest Date:	9 October 2023
Findings of:	Coroner Katherine Lorenz
Counsel Assisting the Coroner:	Dylan Rae-White, Principal Solicitor, instructed by Declan McGavin, Coroner's Solicitor, Coroners Court of Victoria
Keywords	Homicide; Suicide; Fatal shooting

INTRODUCTION

1. On Friday, 22 July 2022, as they walked along Kirkstall-Koroit Road in Kirkstall, rural Victoria, Benjamin Ray (aged 49) and Kevin Doherty (aged 50) were fatally shot by Travis Cashmore (aged 45) who later ended his own life with the same firearm.

2. Mr Doherty had lived in Koroit since about 2017. Mr Ray lived in Koroit between about 2015 and 2020 and it was during this period that the two became friends. Mr Doherty was commonly also known as Kevin Knowles.

3. Mr Cashmore had resided in Kirkstall since about 2003.[1] The evidence shows there was growing animosity between Mr Doherty and Mr Cashmore, particularly following an incident in December 2021 where Mr Doherty reportedly threatened to kill one of Mr Cashmore's friends, Vincent Jackson. Mr Doherty was subsequently criminally charged following this incident and became subject to a Personal Safety Intervention Order preventing him from being within five metres of Mr Jackson or within 100 metres of his residence.[2]

4. Mr Cashmore's father reported that Mr Cashmore spoke about Mr Doherty "*nearly every day in the last six months*". He reported that Mr Cashmore would often talk about "*the relentless harassment and intimidation*" and how he "*couldn't understand how a person with so many convictions could remain in society to harass and torment so many people*".[3]

THE CORONIAL INVESTIGATION

5. The deaths of Mr Ray and Mr Doherty each constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as their deaths occurred in Victoria and appeared to have been "*unexpected, unnatural or violent or to have resulted directly or indirectly, from an accident or injury*".[4]

6. An inquest was mandatory in each of these cases. It is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of

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[1] Coronial Brief, pg. 92.
[2] Coronial Brief, pg. 86.
[3] Coronial Brief, pg. 93-94.
[4] *Coroners Act 2008* (Vic) s 4.

homicide and no person or persons have been charged with an indictable offence in respect of the death.[5]

7. I note the observations of the Victorian Court of Appeal in *Priest v West*, where it was stated:

> *If, in the course of the investigation of a death it appears that a person may have caused the death, then the Coroner must undertake such investigations as may lead to the identification of that person. Otherwise, the required investigation into the cause of the death and the circumstances in which it occurred will be incomplete; and the obligation to find, if possible, that cause, and those circumstances will not have been discharged.*[6]

8. Consistent with this judgment, and mindful that the Act mandates that I must conduct an inquest, one of the purposes of the inquest is to investigate any evidence that may lead to the identification of the person (or persons) who may have caused the death, bearing in mind that I am required to make findings of fact and not express any judgment or evaluation of the legal effect of those findings.[7]

9. This matter was subject to a Directions Hearing held on 29 August 2022 before Deputy State Coroner Hawkins in accordance with Practice Direction 5 of 2020 which requires that a Directions Hearing be held in all cases that require a mandatory inquest within 28 days of the death being reported to the Court. I assumed carriage of this matter from Deputy State Coroner Hawkins in August 2023.

10. The jurisdiction of the Coroners Court is inquisitorial.[8] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[9]

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[5] *Coroners Act 2008* (Vic) s 52(5).
[6] Priest v West and Percy (2012) VSCA 327.
[7] Perre v Chivell (2000) 77SASR 282
[8] Ibid s 89(4).
[9] Ibid s 67(1).

11. It is the role of the coroner to establish facts, not to lay or apportion blame. It is not the coroner's role to determine criminal guilt or civil liability arising from the investigation of a reportable death and it is specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[10]

12. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

13. For coronial purposes, the circumstances in which death occurred refers to the context, background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

14. The broader purpose, or prevention role, of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the coronial findings and by the making of recommendations.[11]

15. While I have investigated the deaths of Mr Ray and Mr Doherty independently, given their deaths arise from closely related and intertwined circumstances, I decided to hold one inquest and deliver one joint finding.

16. This finding is drawn from the totality of the available evidence which is the product of the investigation into the deaths of Mr Ray and Mr Doherty. This evidence is included in the Coronial Brief tendered at inquest. The Coronial Brief was compiled by Detective Senior Constable Craig Wastell who was assigned to be the Coroner's Investigator in this case and conducted enquiries on my behalf.

17. While I have thoroughly and carefully considered all of the available evidence in preparing this finding, I do not purport to summarise all of the evidence but rather only refer to that which is directly relevant to my findings or necessary for narrative clarity.

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[10] Ibid s 69(1)
[11] The Court's prevention role is explicitly articulated in the Preamble and Purposes of the Act.

18. All coronial findings must be made based on relevant facts established on the balance of probabilities. I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[12] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

19. On Wednesday, 20 July 2022, at about 12:30pm, Mr Cashmore attended Koroit Police Station. He spoke with Leading Senior Constable Christopher Kelly and Senior Constable Brett Thornton out the front of the station.[13] This conversation was recorded on body worn camera footage.[14]

20. During this interaction, Mr Cashmore alleged that Mr Doherty had been breaching the Personal Safety Intervention Order made in protection of Mr Jackson. Mr Cashmore enquired as to what and how much evidence police would need to charge Mr Doherty and claimed to have video footage of Mr Doherty breaching the order by walking past Mr Jackson's property. The officers advised that they would need a copy of the footage and an accompanying statement, or they would need to directly observe Mr Doherty in breach of the order. Mr Cashmore said he would provide Mr Jackson with the footage who could then provide it to police should he decide to make a complaint.[15]

21. Mr Cashmore appeared calm and articulate during this conversation. Following this exchange, as LSC Kelly and SC Thornton walked back towards the station, both reported hearing Mr Cashmore say words to the effect of: "*leave your gun on the counter, so I can take care of him*". LSC Kelly and SC Thornton did not acknowledge this comment and it was not captured on the body worn camera footage which had now been turned off.[16]

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[12] (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.
[13] Coronial Brief, pp. 107 – 108; 112-114
[14] Coronial Brief, exhibit 11.
[15] Ibid
[16] Coronial Brief, pp. 107;113

22. On Friday, 22 July 2022, at approximately 9:42am, Mr Cashmore left home driving his white Ford van.[17] He travelled to Koroit township, attending the *Koroit Newsagency and Lotto* where he purchased *Oz Lotto* tickets. He was known to attend here at least weekly. The staff member that served him reported that there was nothing unusual about his demeanour on this occasion and described him as his "*usual smiling self*".[18]

23. Another staff member reported an interaction that they recalled having with Mr Cashmore when he attended the newsagency some months earlier. It was reported that while Mr Cashmore was looking at the front page of the Warrnambool Standard Newspaper, he asked "*do you know if Kevin Knowles is out of jail?*". Mr Cashmore then reportedly said words to the effect: "*he has threatened to kill me several times*".[19]

24. Following his purchase on 22 July, Mr Cashmore headed back to Kirkstall. Residential CCTV footage showed Mr Cashmore's van travelling north along Aire Street at about 10:03am. Seconds later, Mr Ray and Mr Doherty were seen in the same footage heading south down Aire Street towards Kirkstall-Koroit Road.[20]

25. At about 10:07am, Mr Cashmore arrived home. A few minutes later at about 10:15am, residential CCTV proximate to Mr Cashmore's home, recorded what sounded to be an audible gunshot.[21]

26. At approximately 10:17am, Mr Cashmore left home again in the same white Ford van[22] and travelled to Kirkstall-Koroit Road where he headed east and caught up with Mr Ray and Mr Doherty a few minutes later at the intersection of Kirkstall-Koroit Road and Scotts N Road.

27. During this interaction, Mr Cashmore produced a shotgun which he discharged at Mr Doherty who was struck in the head and upper body and fell to the ground. Mr Ray began

[17] Coronial Brief, exhibit 6.
[18] Coronial Brief, pp. 78-80; exhibit 9.
[19] Coronial Brief, pp. 81-82.
[20] Coronial Brief, exhibit 7.
[21] Coronial Brief, exhibit 6.
[22] Ibid

to run east along Kirkstall-Koroit Road. Mr Cashmore followed him in the van a short distance and discharged another shot, striking Mr Ray who fell onto the grass verge.[23]

28. Mr Cashmore continued driving east along Kirkstall-Koroit Road a short distance before turning around and heading back west. On the return, as he approached Mr Ray, Mr Cashmore's van mounted the grass verge and drove over Mr Ray's body. He then returned the van to the sealed road before driving over Mr Doherty.[24] Mr Cashmore headed back home, returning at about 10:23am.[25]

29. At approximately 10:22am, another road user who had observed the incident unfold, contacted emergency services. Victoria Police and Ambulance Victoria paramedics arrived on scene a short time later.[26]

30. Mr Ray and Mr Doherty were examined by paramedics on arrival. They were both observed to have suffered significant injuries. Mr Doherty was declared deceased on arrival. Mr Ray was initially treated but declared deceased a short time later.[27]

31. Mr Cashmore was also found deceased a few hours later at his home in Kirkstall in circumstances suggestive of suicide and a 12-gauge shotgun located proximate to his body.[28]

Medical Cause of Death

32. On 25 July 2022, forensic pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) externally examined the bodies of Mr Ray and Mr Doherty and prepared a report in each case dated 20 October 2022.[29]

33. In preparing her report, Dr Fronczek considered the Victoria Police Report of Death (Form 83), Victoria Police's Section 27 Request for Autopsy, the VIFM contact log and routine post-mortem Computed Tomography (CT) scans.

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[23] Coronial Brief, pp. 33-42; exhibit 3.
[24] Ibid.
[25] Coronial Brief, exhibit 6.
[26] Coronial Brief, appendix 2.
[27] Coronial Brief, pp. 105-106.
[28] Coronial Brief, pp. 96-97.
[29] Coronial Brief, pp. 467-474; 484-491.

34. The external examinations and forensic imaging revealed severe injuries to the head and the upper body of Mr Ray and Mr Doherty.

35. Of both, Dr Fronczek reported that the injuries of the head were *"ballistic in nature, with a possible contribution of blunt force injury".* This ballistic trauma was in keeping with a distant range shotgun wound. The injuries to the chest were described as *"blunt force in nature"*.[30]

36. Dr Fronczek opined that the injuries were of a nature that would have caused rapid unconsciousness and death and were not survivable.

37. Toxicological analysis of post-mortem samples collected from Mr Doherty identified the presence of paroxetine[31], delta-9-tetrahydrocannabinol[32], 11-nor-delta09-carboxy-tetrahydrocannabinol and methylamphetamine.[33]

38. Mr Ray's toxicological analysis showed the presence of citalopram.[34]

39. Dr Fronczek formulated the cause of Mr Ray's and Mr Doherty's deaths as: *1(a)* Head and chest injuries.

40. I accept Dr Fronczek's opinion.

Identity of the deceased

41. On 27 July 2022, Benjamin Paul Ray, born 18 June 1973, was identified through fingerprint identification.[35]

42. On 28 July 2022, Kevin Timothy Patrick Doherty, born 27 December 1971, was identified through fingerprint identification.[36] It is noted that Mr Doherty was also known as Kevin Knowles though it is understood his legal name, as confirmed on his birth certificate, remained Doherty at the time of his death.

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[30] Coronial Brief, pp. 469; 487.
[31] Selective serotonin reuptake inhibitor (antidepressant).
[32] Active form of cannabis.
[33] N-methyl derivative of amphetamine.
[34] Selective serotonin reuptake inhibitor (antidepressant).
[35] Coronial Brief, p. 516.
[36] Coronial Brief, p. 514.

43. Identity was not in dispute in this case and no further investigation was required.

POLICE INVESTIGATION

44. Following the deaths of Mr Ray and Mr Doherty, Victoria Police established a crime scene at the intersection of Kirkstall-Koroit Road and Scotts N Road and commenced an investigation.

45. As part of the investigation, the scene was forensically examined by members of Victoria Police's Major Crime Scene Unit and Ballistic Unit. Several photographs were taken and multiple items were seized. Amongst the items found at the scene, police seized a fired cartridge case and 2 fired shotgun cartridge wads.[37]

46. Police also executed a search warrant of Mr Cashmore's residence and his white Ford van located on the property. In addition to the shotgun located next to Mr Cashmore's body, police also found a fired cartridge case chambered in the left barrel of the shotgun and a cartridge case lying between Mr Cashmore's legs.[38]

47. On inspecting the van, police found and seized three fired cartridge cases, a box of .22 cartridges located in the van's cargo area and took swabs of gunshot residue. Biological tissue was also discovered on the underside of the van and four samples were taken for testing.[39]

48. The shotgun found next to Mr Cashmore's body was a 12-gauge J.V Needham manufactured, Field Hammer Gun model, double-barrel break-open shotgun with exposed hammers and dual triggers. It had black adhesive tape wrapped around the barrels and forend. The barrels had been shortened and the right firing pin was faulty which meant the right barrel was incapable of being discharged. This fault did not impact the ability of the left barrel to be loaded, unloaded or discharged provided the right barrel was not loaded. The left barrel had partially burned grains of propellent within the bore and blood-staining near the muzzle.[40]

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[37] Coronial Brief, pp. 130-131.
[38] Coronial Brief, pp. 132-133.
[39] Ibid.
[40] Coronial Brief, p. 135.

49. The shotgun was not registered and Mr Cashmore did not hold a firearm licence to possess it. It is not known how Mr Cashmore acquired the shotgun.

50. Victoria Police's Ballistics unit performed a series of comparisons between the seized fired cartridge cases and test fired cartridge cases from the shotgun. It was concluded that the fired cartridge cases had been discharged from the 12-gauge shotgun located next to Mr Cashmore's body.[41]

51. The biological tissue samples taken from the underside of the van were compared with DNA reference samples from Mr Ray and Mr Doherty. The results indicated the tissue was likely that of Mr Ray and Mr Doherty.[42]

FINDINGS AND CONCLUSION

52. Having investigated the deaths of Benjamin Ray and Kevin Doherty and having held a joint inquest on 9 October 2023, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act.

53. In relation to the death of Benjamin Ray, I find:

a. that the identity of the deceased was Benjamin Paul Ray, born 18 June 1973;

b. that Mr Ray died on 22 July 2022, near the intersection of Scotts N Road & Kirkstall-Koroit Road, Kirkstall, Victoria, from head and chest injuries; and

c. that the death occurred in the circumstances set out above.

54. In relation to the death of Kevin Doherty, I find:

d. that the identity of the deceased was Kevin Timothy Patrick Doherty, born 27 December 1971;

[41] Coronial Brief, p. 156.
[42] Coronial Brief, pp. 610-611.

e. that Mr Doherty died on 22 July 2022, near the intersection of Scotts N Road & Kirkstall-Koroit Road, Kirkstall, Victoria, from head and chest injuries; and

f. that the death occurred in the circumstances set out above.

55. Having considered all of the available evidence, on the balance of probabilities, I am satisfied that Travis Cashmore intentionally caused the deaths of Benjamin Ray and Kevin Doherty by discharging a 12-gauge shotgun at them which inflicted unsurvivable injuries.

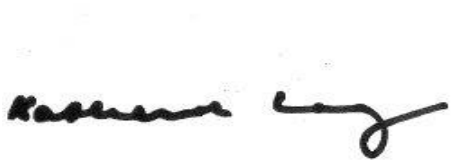
56. I note that section 49(1) of the Act requires the Principal Registrar to notify the Director of Public Prosecutions if the coroner investigating the death believes an indictable offence may have been committed in connection with the death. While I am of the belief that an indictable offence may have been committed in this case, in light of the police investigation and death of Mr Cashmore, a referral to the Director of Public Prosecutions would appear otiose and there is no evidence to suggest the involvement of any other party.

57. I order that this finding be published on the Coroners Court of Victoria website in accordance with Rule 68 of the *Coroners Court Rules 2019*.

58. I direct that a copy of this finding be provided to the following:

a. Brodie Knowles, Senior Next of Kin for Kevin Doherty
b. Paul and Cheryl Ray, Senior Next of Kin for Benjamin Ray
c. Leading Senior Constable Craig Wastell, Coroner's Investigator

Signature:



Date: 9 October 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.