



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 4092

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the death of Travis Cashmore

Delivered On:	9 October 2023
Delivered At:	Coroners Court of Victoria
Inquest Date:	9 October 2023
Findings of:	Coroner Katherine Lorenz
Representation:	Mr Benjamin Archbold, Archbold Gittani Lawyers, appeared on behalf of Dorothy and Ronald Cashmore
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, at 45 years of age, Mr Travis Cashmore was found deceased at his home in Kirkstall, Victoria, having shot himself with a 12-gauge shotgun.
2. Mr Cashmore had lived in Kirkstall since about 2003¹. In the months leading up to his death there had been a growing animosity between himself and another Kirkstall resident, Mr Kevin Doherty, also commonly known as Kevin Knowles.
3. This appeared to have escalated 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. Mr Cashmore's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death 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. This matter was subject to a Directions Hearing held on 29 August 2022 before Deputy State Coroner Hawkins. I assumed carriage of this matter from Deputy State Coroner Hawkins in August 2023.
7. The jurisdiction of the Coroners Court of Victoria is inquisitorial⁵. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if

¹ Coronial Brief, p.92

² Coronial Brief, p.86.

³ Coronial Brief, p.93-94.

⁴ *Coroners Act 2008* (Vic) s 4.

⁵ *Ibid* s 89(4).

possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred⁶.

8. 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 are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.⁷
9. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
10. 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.
11. 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 recommendations⁸.
12. This finding is drawn from the totality of the available evidence which is the product of the investigation into the death of Mr Cashmore. 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.
13. 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.

⁶ Ibid s 67(1).

⁷ Ibid s 69(1)

⁸ The Court's prevention role is explicitly articulated in the Preamble and Purposes of the Act.

14. 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*⁹. 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

15. Two days prior to his death, 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.¹⁰ This conversation was recorded on body worn camera footage.¹¹
16. 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.¹²
17. 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.¹³

⁹ (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.

¹⁰ Coronial Brief, pp. 107-108; 112-114.

¹¹ Coronial Brief, exhibit 11.

¹² Ibid.

¹³ Coronial Brief, pp. 107;113.

18. On Friday, 22 July 2022, at approximately 9:42am, Mr Cashmore left home driving a white Ford van.¹⁴ 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*”.¹⁵
19. 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*”.¹⁶
20. 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 Doherty, accompanied by a friend of his, Benjamin Ray, was seen in the same footage heading south down Aire Street towards Kirkstall-Koroit Road.¹⁷
21. 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.¹⁸
22. At approximately 10:17am, Mr Cashmore left home again in the same white Ford van¹⁹ and travelled to Kirkstall-Koroit Road where he headed east and caught up with Mr Doherty and Mr Ray a few minutes later at the intersection of Kirkstall-Koroit Road and Scotts N Road.
23. 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

¹⁴ Coronial Brief, exhibit 6.

¹⁵ Coronial Brief, pp. 78-80; exhibit 9.

¹⁶ Coronial Brief, pp. 81-82.

¹⁷ Coronial Brief, exhibit 7.

¹⁸ Coronial Brief, exhibit 6.

¹⁹ 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.²⁰

24. 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.²¹ Mr Cashmore headed back home, returning at about 10:23am.²²

25. 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. Mr Ray and Mr Doherty were examined by paramedics on arrival and were declared deceased.²³

26. At approximately 10:38am, residential CCTV proximate to Mr Cashmore's home recorded what sounded to be an audible gunshot.²⁴

27. At approximately 1:30pm, Mr Cashmore's parents attended his home. They had spoken via text message earlier that day and had arranged to visit. They found Mr Cashmore deceased in front of a shed in the rear yard. A shotgun was observed proximate to his body.²⁵

28. They contacted emergency services who arrived a short time later and declared Mr Cashmore deceased.

Medical Cause of Death

29. On 25 July 2022, forensic pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of Mr Cashmore's body and prepared a report dated 20 October 2022.²⁶

²⁰ Coronial Brief, pp.33-42; exhibit 3.

²¹ Ibid.

²² Coronial Brief, exhibit 6.

²³ Coronial Brief, pp. 105-106.

²⁴ Coronial Brief, exhibit 6.

²⁵ Coronial Brief, pp. 96-97.

²⁶ Coronial Brief, pp. 500-506.

30. 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.
31. The findings of the CT scan and external examination showed severe injury to the head, consistent with a gunshot wound. Dr Fronczek reported that there were features in keeping with a contact shotgun wound centrally above the nose and between the eyes. Dr Fronczek noted that the direction was from the front to the back of the body.²⁷
32. Toxicological analysis of post-mortem samples identified the presence of delta-9-tetrahydrocannabinol²⁸.
33. Dr Fronczek formulated the cause of Mr Cashmore's death as: *I(a) Gunshot wound to the head.*
34. I accept Dr Fronczek's opinion.

Identity of the deceased

35. On 28 July 2022, Travis John Cashmore, born 17 March 1977, was identified through fingerprint identification.²⁹
36. Identity was not in dispute in this case and not further investigation was required.

POLICE INVESTIGATION

37. 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.
38. 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.³⁰

²⁷ Coronial Brief, p.502.

²⁸ Active form of cannabis.

²⁹ Coronial Brief, p. 515.

³⁰ Coronial Brief, pp. 130-131

- 39.** 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.³¹
- 40.** 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.³²
- 41.** The shotgun found next to Mr Cashmore's body was a 12-gauge J.V Needham manufactured, Field Hammer 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 propellant within the bore and blood-staining near the muzzle.³³
- 42.** 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.³⁴
- 43.** 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.
- 44.** 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.³⁵

³¹ Coronial Brief, pp. 132-133.

³² Ibid.

³³ Coronial Brief, p.135.

³⁴ Coronial Brief, p 156.

³⁵ Coronial Brief, pp.610-611.

FINDINGS AND CONCLUSION

45. Having investigated the death of Travis Cashmore and having held an inquest on 9 October 2023, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

- a.** that the identity of the deceased was Travis John Cashmore, born 17 March 1977;
- b.** that Mr Cashmore died on 22 July 2022, at 55 Chamberlain Street, Kirkstall, Victoria, 3283.
- c.** that the death occurred in the circumstances set out above.

46. Having considered all of the available evidence, on the balance of probabilities, I find that Mr Cashmore intentionally ended his own life.

47. 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*.

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

- a.** Dorothy and Ronald Cashmore, Senior Next of Kin
- b.** 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.
