IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002819
COR 2023 002820
COR 2023 002821
COR 2023 002822

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Alicia Montebello born 2 September 1991 Joshua Elmes born 3 December 2007 Megan Fox born 6 February 2009 Lucus Garzoli born 3 September 2008
Date of death:	27 May 2023
Cause of death:	Injuries sustained in a motor vehicle incident
Place of death:	Wannon-Nigretta Falls Road, Bochara, Victoria
Keywords:	Motor vehicle incident – single vehicle- multiple occupants

INTRODUCTION

1. On 27 May 2023, four people died in a motor vehicle incident at Bochara in Victoria. The deceased were Alicia Montebello (31yo), Joshua Elmes (15yo), Megan Fox (14yo) and Lucus Garzoli (14yo). They were all loved and are deeply mourned by their families and friends. Jorja Fox (16yo) was also an occupant in the vehicle and survived the incident.

BACKGROUND

2. Jorja and the deceased were all friends. Alicia was friends with a number of young people in the area and would sometimes drive them around in her vehicle, a red 2001 Toyota Corolla hatchback (**the vehicle**).

3. Megan's boyfriend stated to police that he had been in Alicia's vehicle on many occasions with Alicia, Jorja, Megan and others. He stated that *"Almost every time, Alicia would be the driver when I got picked up or we started in Hamilton, and as soon as we got out of town, Alicia would swap with Jorja. They wouldn't even stop to swap drivers. They would keep rolling and switch positions whilst one of them would keep the car steady"*. Further, he recalled that Jorja would regularly drive above the speed limit.

4. Alicia lived in Hamilton and was employed at Coles. She held a valid Probationary Victorian Driver Licence and was the registered owner of her vehicle.

5. Jorja and Megan lived with their family in Hamilton and they both attended Bainbridge College. Jorja worked at Coles and held a valid Victorian Learner Permit.

6. Joshua lived in Hamilton with his family and attended Monivae College. He also worked at Coles. He had previously been in a relationship with Jorja.

7. Lucus lived in Hamilton with his family and attended Bainbridge College. He had dated Megan in the past.

THE CORONIAL INVESTIGATION

8. These deaths were reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of the deaths. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. The Court also sought a statement from Jorja but was advised by her legal representatives that she has no memory of the incident or of her movements earlier that day. They have also provided medical evidence which noted that Jorja sustained a serious head injury in the incident resulting in post-traumatic amnesia and which also provides an opinion that she does not have capacity to make financial, personal or legal decisions.

13. This finding draws on the totality of the coronial investigation including evidence contained in the coronial brief and submissions received from the families of the deceased and Jorja's legal representatives. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (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 as to those matters taking into account the consequences of such findings or comments.

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

Circumstances in which the death occurred

14. On 26 May 2023, Jorja finished a shift at Coles at around 7.00pm and Alicia finished her shift at around 11.00pm. It appears from an analysis of Alicia's mobile phone that Jorja had borrowed her vehicle after she finished work and spent some time driving it that evening before Alica finished work.

15. At around 11.00pm, Jorja sent a photograph on Snapchat to her boyfriend. He stated to police that he believed from a review of the photograph that Jorja had been sitting in the front passenger seat of Alicia's vehicle.

16. Joshua left his house at around 11:55pm and told his mother that he was going for a walk and would be back soon.

17. At some stage after Joshua left his house, he found himself in Alicia's vehicle with Alicia, Jorja, Megan and Lucus.

18. At around 12.00am on 27 May 2023, Joshua posted a video on Snapchat. The video appeared to have been taken from the rear passenger seat of a vehicle, behind the driver. It appears from the video that the vehicle was travelling at around 130 kilometres per hour along a narrow and straight stretch of road in a rural area lined with trees. Megan's boyfriend received the video and he believed that it was taken from inside Alicia's vehicle. Further, he stated that *"I could see from the video that Jorja was driving. I know that because Josh asked 'what speed are going at' and I heard Jorja say '130'. Jorja is also a lot smaller than Alicia and I could tell by where her head and body were. I heard Megan and Alicia's voice in the video too".*

19. At around 12.16am on 27 May 2023, Lucus sent a text message to his mother advising that he was at his friend Bailey's house. She subsequently contacted Bailey who told her that Lucus was not with him. She also tried to call him directly but he did not answer.

20. At around 12.18am, a closed-circuit television (**CCTV**) camera recorded a vehicle arriving at Nigretta Falls and driving around the carpark before departing. It is not possible to positively identify the vehicle from the footage but it does appear to be consistent with the make and model of Alicia's vehicle. Nigretta Falls is about 3 kilometres from the site of the collision.

21. At around 1.00am on 27 May 2023, Megan sent a photo of herself on Snapchat to her boyfriend. He stated that it appeared from the photo that she had been sitting in the backseat of a vehicle.

22. Shortly after 1.00am, Alicia's vehicle was being driven west along Wannon-Nigretta Road in Bochara when it veered off the road to the left and collided with a number of trees.

23. The collision occurred in a long and straight section of the road which consisted of bitumen. It was a narrow two-way road with gravel shoulders and there were no lane markings or fog lines. The speed limit along the relevant section of road was 100 kilometres per hour. Conditions were dry.

24. At around 9.49am on 27 May 2023, Rowan Moyle was driving west along Wannon-Nigretta Road when he came across Alicia's vehicle in bushland on the left side of the road. He stopped at the scene and contacted emergency services. When he approached the vehicle he observed that Jorja was standing nearby in bare feet and that she had an injury to right her cheek. He also observed that there were occupants in the vehicle who appeared to be deceased. Further, he noted that the vehicle's engine appeared to be cold and the blood from Jorja's injury was drying.

25. Ambulance Victoria and Victoria Police attended the scene and paramedics declared the occupants of the vehicle to be deceased. Jorja appeared to be disorientated and incoherent and had difficulty in communicating with paramedics. She was transported to the Alfred Hospital for treatment. Blood samples were not taken for testing under the *Road Safety Act 1986*.

26. At the scene, Victoria Police observed that Alicia was slumped across the driver's seat of the vehicle with her feet on the centre console, and her upper body lying on the ground outside the open door on the driver's side. The airbag on the driver's side had been deployed. There was severe damage to the driver's side of the vehicle. Joshua was seated in the rear passenger compartment behind the driver's seat. Lucus was seated in the rear passenger compartment behind the passenger seat. Megan was seated between Joshua and Lucus. There is no evidence that any of the occupants (including Jorja) were wearing seatbelts at the time of the collision.

27. Mobile phones belonging to all of the occupants were located at the scene and provided to Victoria Police. Only Alicia and Lucus's phones were capable of being analysed.

Criminal investigation

28. A thorough and comprehensive criminal investigation was carried out by the Major Collision Investigation Unit (**MCIU**) and they prepared a brief of evidence in relation to charges against Jorja including dangerous driving causing death.

29. On 28 November 2024, the Office of Public Prosecutions advised Victoria Police after reviewing the brief that it was their view that the prosecution would be unable to prove beyond reasonable doubt the identity of the driver of the vehicle and that the driving was relevantly dangerous. Ultimately, no criminal proceedings were commenced.

Identity of the deceased

30. The deceased were identified by various means including fingerprint identification, DNA comparison and visual identification.

31. Identity is not in dispute and requires no further investigation.

Medical cause of death

32. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted external examinations of the deceased and reviewed the results of computed tomography (**CT**) scans.

33. Toxicological analysis of post-mortem samples taken from Joshua Elmes identified the presence of alcohol (0.01g/100mL), cannabis, citalopram and methylphenidate. The analysis of samples from the other deceased did not identify the presence of any alcohol or other common drugs or poisons.

34. Dr Baber provided an opinion that the medical cause of death in each case was as follows:

    a) Alicia Montebello: 1(a) Upper cervical spine and skull fracture sustained in a motor vehicle incident;

    b) Joshua Elmes: 1(a) Multiple injuries sustained in a motor vehicle incident;

    c) Megan Fox: 1(a) Multiple injuries sustained in a motor vehicle incident; and

    d) Lucus Garzoli: 1(a) Head injury sustained in a motor vehicle incident.

35. I accept Dr Baber's opinion.

FURTHER INVESTIGATIONS

36. The vehicle was mechanically inspected by the Victoria Police Collision Reconstruction and Mechanical Investigation Unit. The inspection did not reveal any faults, failures or conditions which would have caused or contributed to the collision. There were no signs of tyre failure prior to the collision. Further, the examiner stated that there was no evidence to suggest that any seatbelts had been worn at the time of the collision.

37. Collision reconstruction expert Detective Senior Constable Michael Hardiman attended and examined the scene. He observed tyre marks on the road leading up to the collision site and considered that it was likely that the vehicle had been driving on the right side of the road when the driver lost control and the vehicle yawed to the left. He concluded that:

"Based on all the available evidence, it is my opinion that the Toyota Corolla was travelling in a westerly direction on Wannon-Nigretta Falls Road, Bochara. The loss of control was likely caused by a left steering input by the driver, causing the vehicle to leave the road to the left (southern side) whilst rotating in an anti-clockwise direction. The rear driver's door has impacted a large tree on the southern grass reserve area. At impact, the Corolla was likely travelling at ~57km/h and at the commencement of the tyre marks on the road surface, the vehicle was likely travelling between 85 and 100 km/h".

38. A hair sample was retrieved from between the driver's airbag and the steering wheel. Two DNA samples were also extracted from the airbag. Subsequent testing revealed that one of the DNA samples belonged to Alicia and the other belonged to an unknown female. The hair sample belonged to the same unknown female.

39. The MCIU sought an expert opinion from Thomas Gibson, a biomechanical engineer from Human Impact Engineering, in relation to determining the occupants' seating positions in the vehicle, in particular, who was driving. After assessing the evidence, including the patterns of injuries sustained by Jorja and Alicia, the damage to the vehicle and the position in which Alicia was found, he concluded as follows:

"In my opinion, the evidence indicated that Jorja Fox was the unrestrained occupant of the driver seat at the time of the crash and that Alicia Montebello was the unrestrained occupant of the front passenger seat".

40. Further, Mr Gibson considered that Jorja was ejected from the vehicle by the impact of the collision. I accept the evidence of Mr Gibson.

41. Victoria Police sought to interview Jorja in relation to the collision but she declined. She reportedly has no memory of the events leading up to and including the collision.

42. In the 10 years prior to the collision, three other accidents had been recorded on the relevant stretch of Wannon-Nigretta Falls Road, two of which involved drivers swerving to avoid an animal on the road.

43. Police investigators were unable to establish what caused the vehicle to veer off the road, with the driver swerving to avoid an animal, being distracted by a mobile phone or the steering wheel being interfered with by another person being identified as possibilities.

FINDINGS AND CONCLUSION

44. I am satisfied that Jorja was driving the vehicle at the time of the collision. The evidence does not enable me to determine what caused Jorja to lose control of the vehicle. Possibilities which cannot be excluded include her swerving to avoid wildlife, being affected by alcohol or other drugs, driving in a reckless manner, being distracted by a phone or other occupants or another occupant moving the steering wheel. The risk to the occupants was increased by their failure to wear seatbelts. I am also satisfied that the vehicle was being driven at an excessive speed at some stage in the hour before the collision.

45. Jorja, Megan, Joshua and Lucus were provided access by Alicia to her vehicle and she failed to act responsibly and protectively in a way that would ensure their safety. Further, there was no evidence the vehicle was displaying L plates at the time of the collision and Alicia's probationary licence did not authorise her to supervise a learner driver.[2]

46. Jorja also had a responsibility as a learner driver to ensure that she was properly supervised while driving, that she displayed L plates, and that the occupants wore seatbelts.

47. I am satisfied that the deceased would have died instantly or within moments of impact.

48. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identities of the deceased were:

        i. Alicia Jade Montebello, born on 2 September 1991;

[2] See *Road Safety (Drivers) Regulations 2019*, rr5 & 48.

ii. Joshua Matthew Elmes, born on 3 December 2007;

iii. Megan Ella Fox, born on 6 February 2009; and

iv. Lucus David John Garzoli, born on 3 September 2008;

b) the deaths occurred on 27 May 2023 at Wannon-Nigretta Falls Road, Bochara, Victoria, from injuries sustained in a motor vehicle incident; and

c) the deaths occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

49. The tragic circumstances of this case highlight the risks of children acting recklessly in relation to their safety and the safety of others. It reinforces the responsibility of adults to act responsibly and protectively in relation to children when they are involved with them in the operation of a motor vehicle.

50. Teenagers are capable of making many decisions for themselves which should be encouraged as they develop the skills and judgment required to live independent lives. However, risk taking behaviour by children cannot be eliminated and they will sometimes exercise poor judgment, making decisions which are not in their best interests and which may also compromise the safety of others. That is why the community relies on adults who come into contact with children to act responsibly and protectively.

I convey my sincere sympathy to the families of the deceased for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Senior Next of Kin

Jorja Fox, c/o Doogue + George Defence Lawyers

Transport Accident Commission

Commission for Children and Young People

Detective Senior Constable Melanie MacFarlane, Coronial Investigator

Signature:

Coroner David Ryan

Date: 01 October 2025

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 investigation. 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.