IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004536

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Ian James Bryant
Date of birth:	10 December 1960
Date of death:	6 August 2024
Cause of death:	Injuries sustained in motor vehicle collision (driver)
Place of death:	Murray Valley Highway Barnawartha North, Victoria 3691 between Mildrens Road and Coyles Road
Keywords:	Motor vehicle collision; poor visibility; heavy fog; attempted overtaking; absence of warning signs

1. I, Coroner Catherine Fitzgerald, having investigated the death of Ian James Bryant and without holding an inquest, make the following findings pursuant to section 67(1) of the *Coroners Act 2008* (**the Act**):

    a) the identity of the deceased was Ian James Bryant, born 10 December 1960;

    b) the death occurred on 6 August 2024 at Murray Valley Highway, Barnawartha North Victoria 3691;

    c) the cause of death was from 1(a) injuries sustained in motor vehicle collision (driver); and

    d) the death occurred in the circumstances described below.

Circumstances in which the death occurred

1. At about 6.15am on 6 August 2024, Mr Bryant left his home in Tangambalanga, Victoria, to drive to his workplace. He was driving his Mitsubishi Triton dual cab utility (**Mitsubishi Triton**). Mr Bryant worked as a site manager for Zauner for about 17 years and was managing an aged care facility in Rutherglen at the time of his death.

2. At about 6.40am, motorist David Mawson was driving west on the Murray Valley Highway in Barnawartha North. Mr Mawson was driving a Kenworth prime mover truck, towing a single trailer. Mr Bryant was driving his Mitsubishi Triton behind Mr Mawson.

3. Meanwhile, motorist Timothy Gallacher was driving his Toyota Hilux utility, east on the Murray Valley Highway in Barnawartha North. Mr Gallacher recalled that his drive was uneventful, until he reached the intersection of Murray Valley Highway and Barnawartha-Howlong Road, when the conditions deteriorated. Mr Gallacher stated "*[i]t went from clear to foggy. It was enough for me to slow to about 80 kilometres per hour…I could only see about 100 metres in front*".

4. Mr Mawson similarly noted the visibility was very poor due to heavy fog. As he drove into a slight lefthand bend in the road, Mr Bryant pulled out behind him in an attempt to overtake him. When Mr Bryant's Mitsubishi Triton was about "*halfway along [his] vehicle*", Mr Mawson observed a set of headlights appeared out of the fog, travelling towards him.

5. Mr Gallacher observed Mr Mawson's headlights as well as Mr Bryant's headlights, the latter of which appeared to be coming towards him in his lane. Mr Gallacher moved to the left in an

attempt to avoid a collision whilst Mr Bryant attempted to move to the right, but the vehicles collided. The impact of the collision caused the tray and canopy of Mr Gallacher's utility to detach from the chassis and his utility came to a stop about 30 metres east past the point of impact. Mr Bryant's Mitsubishi Triton came to a stop in a paddock about 200 metres west of the point of impact. There was substantial damage to the structure of the driver's side of the Mitsubishi Triton, causing Mr Bryant severe injuries despite him wearing a seat belt and the airbags deploying.

6. Following the collision, other motorists stopped to assist and called Triple Zero. Mr Gallacher was able to extricate himself from his utility however Mr Bryant was trapped inside his Mitsubishi Triton. Paramedics attended the scene however Mr Bryant succumbed to his injuries and was declared deceased.

Investigation and coronial brief

7. The coronial investigation included a comprehensive coronial brief of evidence prepared by the nominated Coronial Investigator, Leading Senior Constable Russell Iliff (**LSC Iliff**).

8. LSC Iliff attended the scene of the collision and investigated the incident. He obtained statements from the motorists involved and inspected the two damaged vehicles. Mr Gallacher participated in drug and alcohol testing and was negative for both.

9. LSC Iliff noted that when he first arrived at the scene, at about 7.00am, the "*fog was very thick, with between 50 to 100 metres visibility depending on location*". The road surface was damp in patches, likely due to the weather conditions and the heavy fog. However, he assessed that the water on the roadway was not sufficient to have caused aquaplaning and LSC Iliff did not observe any tyre marks on the road to indicate braking, skidding or yawing. There was no damage to the road surface that could have caused or contributed to the condition.

10. At the location of the collision, LSC Iliff noted that the Murray Valley Highway is a sealed dual carriageway with various speed limits. It is a major thoroughfare used by private and commercial vehicles including heavy trucks and B-doubles. The road is divided by broken white lines and there are no warning signs to alert drivers to the upcoming bend and visibility is hampered by high grass and sporadic large trees.

11. LSC Iliff noted that shortly before the location of the collision, the speed limit on Murray Valley Highway increases from 80km/h to 100km/h. He opined that shortly before the collision, Mr Bryant exited the 80km/h section and was accelerating up to 100km/h, likely at

a faster rate than Mr Mawson was accelerating. Mr Bryant attempted to overtake Mr Mawson, however due to the heavy fog and the left-hand bend, he did not see Mr Gallacher in the oncoming lane until it was too late to avoid a collision.

12. LSC Iliff made three suggestions to prevent a similar incident occurring in the future:

    a) Change the broken dividing line to double continuous lines to prevent motorists overtaking in either direction.

    b) Install warning signs in both directions to inform drivers of the upcoming corner during periods of poor visibility.

    c) Perform regular maintenance of the vegetation to the southern side of the road to increase visibility for motorists.

Medical cause of death

13. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 7 August 2024 and provided a written report of his findings dated 8 August 2024.

14. The post-mortem examination revealed findings consistent with the reported circumstances.

15. Examination of the post-mortem CT scan showed cranial vault fractures with pneumocranium, subarachnoid and interventricular haemorrhage and fractures of maxilla, mandible, bilateral ribs, both femurs, and right ulna. There was a right tension hemopneumothorax.

16. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

17. Dr Lynch provided an opinion that the medical cause of death was *1(a) injuries sustained in motor vehicle collision (driver).*

18. I accept Dr Lynch's opinion.

Conclusion

19. Having considered all the circumstances, I am satisfied that Mr Bryant's death was accidental and it was caused by Mr Bryant attempting to overtake a truck in challenging driving

conditions. The collision occurred when Mr Bryant was on the wrong side of the road and due to poor visibility from fog and a bend in the road, he did not see the oncoming vehicle.

20. It may be that similar collisions could be prevented from occurring in the future with measures to assist safe driver behaviour, such as those suggested by LSC Iliff. It would be prudent for Wodonga Council to consider implementing these.

Recommendations

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That the Wodonga Council consider implementing the following safety measures prior to/at the location of the collision on Murray Valley Highway in Barnawartha North between Mildrens Road and Coyles Road:

a. Change the broken dividing line to double continuous lines to indicate no overtaking in either direction.

b. Install warning signs in both directions to inform drivers of the upcoming corner during periods of poor visibility.

c. Perform regular maintenance of the vegetation to the southern side of the road to increase visibility for motorists.

I convey my sincere condolences to Mr Bryant's family and friends 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:

Janice Bryant, Senior Next of Kin

Kathryn Bryant

Wodonga Council

Leading Senior Constable Russell Iliff, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 23 February 2026

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.