Newcastle and North Tyneside
Miss Georgina Nolan
HM SENIOR CORONER
Civic Centre , Barras Bridge , Newcastle Upon Tyne , NE1 8QH
[redacted]

Date: 4 September 2025 [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Newcastle upon Tyne Hospitals NHS Foundation Trust

CORONER

1 I am Thomas Crookes Assistant Coroner for the Coroner area of Newcastle and North Tyneside.

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.

2 http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 20 February 2025 I commenced an investigation into the death of Nicola MULLISS. The investigation concluded at the end of the inquest. The conclusion of the inquest was that Nicola Mulliss died from natural causes and recognised complications of a necessary surgical procedure.

The medical cause of death was;

3 1a Infarction of Brainstem and Cerebellum

1b Staphylococcal meningitis

1c Wound infection with Staphylococcus Aureus following surgical Re-Excision of Meningioma of Sphenoid Wing

II

CIRCUMSTANCES OF DEATH

Nicola Mulliss had a history of recurring meningioma for which she underwent excision surgery in 2009 and 2011. On 29 January 2025 she had a further such procedure and initially made a good recovery. She experienced some leaking from the wound on 2 February 2025
4 and it was re-sutured.

Nicola Mulliss was re-admitted to hospital on 13 February 2025 and was found to have an infection to the operation site with staphylococcus aureus bacteria. This infection spread, resulting in staphylococcal meningitis which caused inflammation and swelling that disrupted the blood supply to her brain, leading to death on 18 February 2025.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows –

5 In evidence I was told that had a swab been taken for microbiological analysis when the wound was re-sutured, it was possible that the Staphylococcus Aureus infection could have been detected at this earlier juncture and treatment instigated before the infection spread and resulted in the fatal staphylococcal meningitis. However, I was told that it is not policy / guidance for such testing to be undertaken so this did not occur.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you / your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 31 October 2025. I, the coroner, may extend the period.

7 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; [redacted] (Mrs Mulliss' husband).

I am also under a duty to send the Chief Coroner a copy of your response.

8 The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

4 September 2025

9 Signature [redacted]

Tom Crookes Assistant Coroner for Newcastle and North Tyneside