REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

Roland Jean MICHAUD (Deceased)

1.	CORONER I am Alan Wilson, Senior Coroner for the coroner area of Blackpool & Fylde.
2.	DATE OF REPORT 23rd July 2026
3.	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.
3.	THIS REPORT IS BEING SENT TO **1. [redacted] Chief Medical Officer, Blackpool Teaching Hospital NHS Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th September 2026. 1, the coroner, may extend the period if an appropriate application is made.
4.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	SUMMARY OF CORONER'S CONCERN Blackpool Victoria Hospital is the location of a regional cardiac centre. The team there receive patients from a range of District hospitals including Lancaster, Preston, Chorley, Furness, Blackburn. I have a concern that some patients are not being transferred to the regional cardiac centre in a timely manner, thereby placing patients at risk. The concern is in relation to patients whose symptoms / presentation requires application of the Acute Coronary Syndrome [ACS] pathway.

6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and 1 believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On 2nd January 2026 1 commenced an investigation into the death of Roland Jean Michaud, aged 67 years. The medical cause of death was: 1a Ischaemic heart disease How, when and where: Roland Michaud died in Blackpool Victoria Hospital on 30lh December 2025 from the effects of ischaemic heart disease. Conclusion: NATURAL CAUSES
8.	CIRCUMSTANCES OF DEATH [Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words] Roland Michaud was aged 67 years. In 2008, he underwent coronary artery bypass graft surgery including stent insertion, since when he has experienced no significant heart - related issues over subsequent years. On 10th December 2025, he attended his local Emergency Department at Furness General Hospital reporting some chest pain on exertion over a period of approximately two weeks. On assessment, he was appropriately discharged home with a view to attending a cardiology appointment as an outpatient. By the morning of 26th December 2025, he had returned to hospital reporting more episodes of chest pain. At that time, his presentation was not indicative of a STEMI [ST Elevation Myocardial Infarction] and following discussions with the Lancashire Cardiac Centre based at Blackpool Victoria Hospital, it was decided he should continue to be managed locally at Furness General Hospital. Over subsequent days, Roland experienced further episodes of chest pain. By early afternoon on Saturday, 27th December 2025, a doctor felt it necessary to make a referral which was sent electronically from Furness to Blackpool. By 30th December 2025, after discussions between two Consultant Cardiologists, he was transferred to Blackpool for diagnostic coronary angiography, and a procedure was performed that afternoon. Whilst Roland had remained in Furness General Hospital, the need for him to be transferred to Blackpool earlier went under- appreciated, in part due to sub-optimal communication between the two hospitals. However, there is no evidence to suggest that earlier transfer would have made a difference to when Roland died. During the procedure on 30th December 2025 which concluded at 16.54 hours, no significant concerns arose, but post- operatively, and after he had been moved to the Cardiac Care Unit, at around 1800 hours his condition became concerning when he was noticeably short of breath, with reduced blood pressure. He appeared unwell but reported no chest pain. At a time when Clinicians were considering how to address this, he went into cardiac arrest. Despite life-saving efforts he could not be revived, and Roland's death was confirmed at 19.44 hours that evening. A postmortem examination revealed severe coronary artery atheroma, but no iatrogenic injury had occurred during the procedure. The degree of heart disease was sufficient to have caused Roland's death, although it could not be ascertained more precisely why he deteriorated when he did after the procedure. Patients attending one of those hospitals with a more concerning presentation than Roland Michaud may find themselves on the Primary Coronary Intervention [PCI] pathway and transferred to Blackpool relatively quickly - from information provided at the inquest, this process appears to be working satisfactorily and no concerns arise.

	A concern does arise in relation to patients whose symptoms / presentation may be less concerning initially, meaning the Acute Coronary Syndrome pathway applies.
9.	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: [250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This statement must not propose what action should be taken, as coroners cannot make recommendations]. During the inquest I received evidence from a helpful witness who works at Blackpool Victoria Hospital as a cardiac coordinator who told the court that: • She reviews referrals from local district hospital and facilitates the transfer of patients for coronary angiogram and other cardiac interventions that may be required. • In her role, she finds herself dealing with transfers to Blackpool which ought to have happened earlier. I formed the view this could be for a range of reasons including - • Limited personnel performing the cardiac coordinator role. • No cardiac care-coordinator working over weekends and Bank Holidays. • Poor record keeping. • The number of cardiac patients the team in Blackpool deal with. • A lack of understanding about the Acute Coronary Syndrome pathway and what is expected. My concern is the approach to some of the less obviously concerning cases - ACS pathway cases rather than PCI pathway cases - means patients who may need transfer to the regional cardiac centre are not being transferred in a timely manner therefore putting patients at risk. I forward this letter to you as the Chief Medical Officer so you can consider this concern with your senior colleagues in the cardiac centre.
10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* 1. Furness General Hospitals Trust 2. The Chief Medical Officer at other district hospitals who may transfer patients to the regional cardiac centre, namely: • Royal Preston Hospital • Royal Lancaster Infirmary • Chorley & South Ribble Hospital • Royal Blackburn Teaching Hospital

	I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026;. Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE [redacted]