In the months that followed, an inquest reviewed the sequence of events.

Some time earlier, the nurse entered the room and found a patient experiencing respiratory distress.

Later that night, the ventilator stopped operating without sounding an alarm.

Several weeks before the incident, a hospital administrator approved a policy to reduce overnight staffing levels on the ward.

On the night of the incident, a nurse was assigned more patients than usual.

On a later day, a maintenance contractor disabled a ventilator alarm while performing a routine test.

After completing the test, the contractor left the room without re-enabling the alarm.

Earlier that same night, a brief interruption in power occurred on the ward.