Several weeks before the incident, during a routine administrative review of hospital operations, a hospital administrator approved a policy to reduce overnight staffing levels on the ward as part of a broader efficiency plan.

On a later day, during scheduled equipment maintenance in one of the patient rooms, a maintenance contractor disabled a ventilator alarm while performing a standard test of the machine’s functions.

After completing the test and documenting the procedure, the contractor left the room without re-enabling the alarm before moving on to another task elsewhere in the building.

On the night of the incident, as staff assignments were being finalized at the start of the shift, a nurse was assigned more patients than usual across several rooms on the ward.

Later that night, while activity on the ward remained relatively quiet, a brief interruption in power occurred, affecting several pieces of equipment for a short period of time.

Following the power interruption, the ventilator stopped operating without sounding an alarm, and the room remained otherwise undisturbed for some time.

Some time later, during a scheduled round, the nurse entered the room and found a patient experiencing respiratory distress.

In the months that followed, after records and logs had been collected, an inquest reviewed the sequence of events surrounding the incident.