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

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

Later that night, after a short disruption to electrical systems on the ward, the ventilator stopped operating without sounding an alarm, and the room remained otherwise undisturbed.

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 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.

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.

Earlier that same 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.