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Hospital Fires Keep Killing — India's Fire Safety Failure Is Systemic, Not Accidental

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Hospital Fires Keep Killing — India's Fire Safety Failure Is Systemic, Not Accidental

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INTERVIEW ANGLE

"Why do hospital fire tragedies keep repeating in India despite judicial interventions and what systemic reforms are needed?"

WHY IN NEWS

A fire in a hospital ICU in March 2026 has once again reignited public outrage over the recurring failure of fire safety standards in Indian healthcare facilities, exposing a pattern of institutional neglect that has persisted across decades, states, and government regimes.

A PATTERN, NOT AN EXCEPTION

When a hospital ICU catches fire and patients die, the political response follows a predictable script: shock, condolence, suspension of a junior official, promise of inquiry. Within weeks, attention fades. Months later, another hospital burns.

This is not a story about one rogue institution. It is a story about a regulatory ecosystem that has been designed — whether by neglect or intent — to look the other way. The fires are not accidental in the meaningful sense. They are the predictable outcome of structural failures: buildings that have never been retrofitted, fire exits that are routinely locked, oxygen cylinders stored near ignition sources, electrical wiring that predates independence-era regulations, and staff who have never participated in a fire drill.

The tragedy at AMRI Hospital in Kolkata on December 9, 2011 — which killed 94 people, making it one of independent India's deadliest healthcare fires — should have been the inflection point. The Supreme Court of India took suo motu cognisance of the disaster and directed all state governments to audit fire safety compliance in hospitals. Fourteen years later, the audits remain largely perfunctory and compliance remains cosmetic.

HOW THE REGULATORY FRAMEWORK FAILS

The fire safety architecture for hospitals in India is a study in dispersed responsibility and zero accountability. At the state level, Fire No Objection Certificates (NOCs) are issued under individual state fire services acts — there is no central statute. A hospital must obtain a fire NOC before construction and, in theory, periodically renew it. In practice, the NOC has become a one-time formality: once obtained, it is rarely revoked regardless of subsequent violations.

The National Building Code 2016, issued by the Bureau of Indian Standards (BIS), sets technical standards for fire safety — sprinkler systems, fire compartmentalisation, emergency lighting, fire exit widths. However, compliance with NBC 2016 is not retrospectively enforceable on older buildings. A hospital built in 1985 is under no legal obligation to install sprinklers unless it seeks a fresh building permit or undergoes major renovation.

The Clinical Establishments (Registration and Regulation) Act, 2010 — which governs the registration of clinical establishments across India — does not mandate fire drills, fire risk assessments, or staff fire training as conditions for registration or renewal. This is a glaring omission. A hospital can be licensed to treat hundreds of critically ill patients without demonstrating any capacity to evacuate them safely.

Voluntary accreditation through the National Accreditation Board for Hospitals (NABH), which does include fire safety as a criterion, covers approximately 700 hospitals out of more than 70,000 registered clinical establishments in India. That is a coverage rate of roughly 1 per cent. For the 99 per cent, there is no independent fire safety audit built into the operating licence.

THE SPECIFIC HAZARDS OF ICUS

Intensive Care Units present a uniquely dangerous fire environment that demands specific regulatory attention. ICU patients are immobile — they cannot self-evacuate. They are attached to multiple electrical devices drawing continuous power. Oxygen-enriched environments dramatically lower the ignition threshold of materials. Yet Indian regulation does not differentiate between ICU fire safety requirements and those for an administrative corridor.

The Bhandara district hospital fire in Maharashtra on January 9, 2021 — in which ten newborns perished in a Special Newborn Care Unit — illustrated exactly this hazard. A short circuit in an overloaded electrical panel ignited in a room filled with medical-grade oxygen. There were no sprinklers. There was no fire suppression system. The staff on duty had received no fire emergency training. The infants, entirely dependent on caregivers, had no chance.

Across these tragedies — AMRI 2011, Delhi AIIMS Trauma Centre 2016, Bhandara 2021, and now 2026 — the physical causes are almost identical: faulty electrical systems, proximity of oxygen to ignition risk, absence of automatic suppression, and locked or blocked fire exits. That these same conditions persist across a decade of post-tragedy promises reflects a regulatory failure of the highest order.

WHAT ACCOUNTABILITY LOOKS LIKE ELSEWHERE

In the United Kingdom, every National Health Service (NHS) facility is subject to a mandatory annual fire risk assessment conducted by a competent person, with findings documented and acted upon as a condition of continued operation. The Regulatory Reform (Fire Safety) Order 2005 places personal criminal liability on the "responsible person" — typically the hospital chief executive — not merely on facility managers or maintenance staff. Failure to comply is not a civil infraction; it is a criminal offence.

In the United States, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) conducts unannounced inspections and can revoke accreditation — with immediate implications for insurance reimbursement — if fire safety standards are not met. The fire code compliance is embedded in the financial architecture of healthcare delivery.

India has neither of these levers: no mandatory annual inspection tied to licence renewal, and no personal criminal liability for institutional leadership.

THE REFORM AGENDA

Three systemic changes are essential and achievable without constitutional amendments.

First, fire safety inspection must become a mandatory precondition for hospital licence renewal under the Clinical Establishments Act. Annual fire risk assessments — conducted by state fire services or empanelled third-party auditors — must be filed with the registering authority. Failure to file or to remediate identified hazards must result in automatic suspension of operating licence.

Second, criminal liability for fire safety failure must extend to hospital trustees and board members, not just facility managers. When patients die in a preventable fire, the persons who controlled capital allocation decisions — and chose not to invest in sprinklers or electrical upgrades — must face consequences commensurate with the harm caused.

Third, India needs a Central Clinical Establishment Authority with cross-state enforcement powers, or at minimum a National Fire Safety Protocol for Healthcare Facilities that is binding on all states under concurrent list powers. The current state-by-state patchwork creates regulatory arbitrage: hospitals choose jurisdictions with weaker enforcement.

The fires will keep happening until accountability is no longer optional.

UPSC RELEVANCE

NABH, Clinical Establishments Act 2010, National Building Code 2016 (BIS), Fire NOC, AMRI fire 2011.

MAINS GS-2:

Regulatory gaps in healthcare governance; role of central versus state authority in clinical establishment oversight; accountability mechanisms in public administration; comparative health system governance.

📌 FACTS CORNER — KNOWLEDGEPEDIA

MAJOR HOSPITAL FIRE INCIDENTS — INDIA:

AMRI Hospital, Kolkata — December 9, 2011; 94 killed; largest hospital fire in independent India

Delhi AIIMS Trauma Centre — 2016; fire contained but highlighted ICU electrical hazard

Bhandara District Hospital, Maharashtra — January 9, 2021; 10 newborns killed in SNCU fire (short circuit in electrical panel)

March 2026 ICU fire — latest in recurring pattern; triggered renewed policy debate

REGULATORY FRAMEWORK — KEY INSTRUMENTS:

Fire NOC: Issued under respective State Fire Services Acts; no central statute; largely treated as one-time formality

National Building Code (NBC) 2016: Published by Bureau of Indian Standards (BIS); sets technical fire safety standards; not retrospectively enforceable on pre-existing buildings

Clinical Establishments (Registration and Regulation) Act, 2010: Governs registration of clinical establishments; does NOT mandate fire drills or fire risk assessments for licence renewal

Supreme Court Suo Motu Order — 2011: Directed all states to audit hospital fire safety after AMRI; compliance has been minimal and unverified

NABH (NATIONAL ACCREDITATION BOARD FOR HOSPITALS):

Established under Quality Council of India (QCI)

Accreditation is voluntary, not mandatory

Approximately 700 hospitals accredited

Total registered clinical establishments in India: 70,000+

NABH coverage: ~1% of all hospitals

ICU FIRE HAZARDS — SPECIFIC RISKS:

Oxygen-enriched environments lower ignition threshold of materials

Patients are immobile — cannot self-evacuate

High electrical load density from life-support equipment

No separate ICU-specific fire suppression mandate in Indian regulations

GLOBAL COMPARISON:

UK NHS: Mandatory annual fire risk assessment; Regulatory Reform (Fire Safety) Order 2005; personal criminal liability on “responsible person” (hospital CEO)

USA: Joint Commission on Accreditation of Healthcare Organizations (JCAHO); unannounced inspections; non-compliance can revoke accreditation and cut insurance reimbursement

OTHER RELEVANT FACTS:

Bureau of Indian Standards (BIS) is the national standards body under the BIS Act 2016 (Ministry of Consumer Affairs)

Clinical Establishments Act 2010 is a concurrent list subject; not all states have adopted it (Tamil Nadu, Delhi have their own Acts)

Fire is classified as a State subject under the Seventh Schedule; Centre cannot directly enforce fire NOC compliance

The National Disaster Management Authority (NDMA) has issued guidelines on hospital fire safety (non-binding)

> Retrofitting older hospitals with sprinkler systems is estimated to cost ₹15–25 lakh per floor depending on building area

Sources: The Hindu, PIB

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