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EDITORIAL ANALYSIS

New-Age Fires: Why ICU Blazes Need a Category of Their Own

THE HINDU

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New-Age Fires: Why ICU Blazes Need a Category of Their Own

The Hindu 28 August 2026 GS2

INTERVIEW ANGLE

"After the Jhansi NICU fire killed 18 newborns in 2024, inquiries were held and rules restated. Two more NICU fires followed this month. What does that tell you about the difference between issuing a rule and changing a system?"

Source: Original editorial ↗ The Hindu

Every fact web-verified against primary sources

THE LIFT LINE

The Amravati fire was put out in thirty minutes. Three babies still died, because in a sealed intensive care unit the smoke does not wait for the fire.

WHY THIS EDITORIAL MATTERS FOR YOUR EXAM

Health infrastructure quality, regulatory enforcement and accountability for recurring public-safety failures sit squarely in GS2, and this is a case where the failure repeats across states with the same signature. It is also usable in an ethics answer on **negligence versus system design**.

GS Paper 2: Issues relating to development and management of social sector services relating to health; government policies and interventions and issues arising from their implementation.

BACKGROUND AND CONTEXT

India's fire-accident profile has changed. Historically the losses were in **industrial facilities, large offices, mass gatherings, firecracker units and railway compartments**, caused by faulty machinery, weak safety procedures and careless handling of flammable material.

Those risks persist. What has been added over roughly the last fifteen years is **residential buildings, hotels and hospitals**, especially **Intensive Care Units**. The dominant cause has shifted to **electrical fires**, driven by heavier appliance loads, overloaded circuits and poor maintenance.

Two incidents this month:

INCIDENT	WHAT HAPPENED	OUTCOME
Amravati, Maharashtra (NICU)	Fire suspected to have started in a **faulty ventilator**; extinguished in **30 minutes**	**Three babies died**, of smoke, not burns
Chhindwara, Madhya Pradesh (District Hospital NICU)	**Short circuit in a warmer**	**Three newborns, days old, suffered burns**

The reference point is **Jhansi, 2024**, where a NICU fire killed **18 newborns**.

THE ANALYSIS

Why an ICU is not just another room with a fire risk

Three features combine, and no general fire code addresses their combination.

Oxygen enrichment. Medical oxygen raises the flammability of everything in the room. Materials that smoulder in ordinary air burn readily in an oxygen-rich environment, and the ignition energy required drops sharply. A short circuit that would scorch a wall elsewhere starts a fire here.

Sealed compartments. ICUs are climate-controlled and closed to maintain asepsis. That is a clinical requirement and a fire-safety liability: **smoke accumulates rather than dissipating**, and the compartment fills long before the fire itself becomes large.

Patients who cannot self-evacuate. This is the decisive one. Ordinary fire-safety design assumes occupants who can walk to an exit when an alarm sounds. In a neonatal ICU **every occupant must be physically carried**, most are attached to ventilators or warmers, and the staff-to-patient ratio determines how many can be moved per minute.

Why “extinguished in 30 minutes” is the wrong metric

The Amravati fire was controlled quickly by any conventional standard. Three babies died anyway. That single fact dismantles the metric the system currently uses.

Fire services are measured on response and suppression time. ICU deaths are determined by smoke ingress time and evacuation capacity, both of which are settled long before the first engine arrives, by decisions about compartmentation, smoke extraction, materials and staffing.

Measuring the wrong thing is how a system can be seen to perform well while producing the same outcome repeatedly.

The repetition is the finding

The editorial notes that the Amravati fire **shared many features with previous incidents**. Over fifteen years, ICU fires including Jhansi in 2024 have not served as a wake-up call.

When the same failure mode recurs across Maharashtra, Madhya Pradesh and Uttar Pradesh, the explanation cannot be local negligence in each place. It is that **no institutional mechanism converts the finding of one inquiry into a binding requirement everywhere else**. Inquiry reports are written and filed. Nothing carries the lesson across state lines.

What treating it as a distinct category would mean

Not more general fire rules, but **category-specific requirements**: evacuation drills designed for non-ambulatory patients, restrictions on flammable materials in oxygen-enriched zones, dedicated smoke extraction for the compartment, electrical load audits for equipment-dense rooms, and design norms that assume a carried evacuation rather than a walked one.

DATA AND INSTITUTIONS VAULT

PRELIMS-GRADE FACTS:

August 2026: NICU fires at Amravati (Maharashtra) and Chhindwara District Hospital (Madhya Pradesh); three deaths at Amravati, three infants burned at Chhindwara.

Jhansi NICU fire, 2024: 18 newborns died.

The Amravati fire was extinguished in 30 minutes; the deaths were caused by smoke.

Suspected causes: a faulty ventilator at Amravati, a short circuit in a warmer at Chhindwara.

Fire services are a State subject, listed in the State List of the Seventh Schedule under public order and local government; there is no central fire service law binding on states.

The National Building Code of India, 2016, published by the Bureau of Indian Standards, contains fire and life-safety provisions in Part 4. It is a recommendatory document that acquires force only when a state or local body adopts it into its building bye-laws.

Health is also a State subject (Entry 6, State List); public health and hospitals are administered by states.

The National Disaster Management Authority has issued guidance on hospital safety, and the Supreme Court has issued directions on hospital fire audits after earlier incidents.

Hospital accreditation in India is through NABH, under the Quality Council of India. It is voluntary for most facilities.

> *the* **National Building Code is not law by itself.** *It is a BIS standard, and it binds only where a state or municipal body has adopted it into its own building bye-laws. This is why fire-safety compliance varies so widely between states, and it is a favourite distinction in questions about why national standards fail to produce national outcomes.*

> *deaths in enclosed-space fires are usually caused by* **smoke inhalation and toxic combustion products***, not by burns. Fire-safety design accordingly prioritises* **compartmentation and smoke management** *over suppression speed.*

THE DEBATE

For a distinct ICU category: the hazard profile is genuinely different, general codes assume ambulatory occupants, and the repetition of the same failure across states shows the general approach is not working.

Against, or at least a caution: India's problem is rarely the absence of a rule and usually the absence of enforcement. Adding a new specialised code to an unenforced general code may produce another unenforced code. The binding constraint may be **inspection capacity and the incentive to comply**, not standard-setting.

The reconciliation: the distinct category is worth creating precisely because it is **small and auditable**. There are a finite number of ICUs, they are already licensed and inspected for clinical purposes, and a targeted requirement attached to an existing licence is far more enforceable than a building code applied to every structure in a city.

HOW TO THINK ABOUT THIS

The transferable frame: **when the same failure recurs across jurisdictions, stop looking for the local cause.** Individual negligence explains one incident. It cannot explain the same incident in three states over two years. Recurrence with an identical signature is evidence of a **structural gap**, usually a missing mechanism for turning an inquiry finding into a binding requirement elsewhere.

The diagnostic question to carry: **after the last inquiry, what changed that would have prevented this one?** If the answer is "a report was submitted", the system has no learning mechanism, only a documentation one.

WAY FORWARD

1. **Create a distinct regulatory category for critical-care fire safety**, with norms written for non-ambulatory patients in oxygen-enriched sealed compartments.

2. **Attach fire compliance to the hospital licence**, so that the existing renewal cycle carries the requirement instead of relying on a separate inspection regime.
3. **Mandate evacuation drills specific to carried evacuation**, timed and recorded, with a defined staff-to-patient ratio for the exercise.
4. **Require electrical load audits for equipment-dense clinical areas**, since ventilators, warmers and monitors have multiplied on circuits designed for far less.
5. **Establish a national incident registry with binding follow-up**, so that a finding at Jhansi becomes a compliance requirement at Amravati rather than a filed report.

PYQ LINKAGE AND PRACTICE

Connects to standing themes on **health infrastructure**, **regulatory enforcement capacity**, and **accountability in public services**. Practice question: *"Recurring accidents with an identical failure signature indicate an institutional gap rather than individual negligence. Examine with reference to fire safety in Indian hospitals."*

Source: New-Age Fires: Why ICU Blazes Need a Category of Their Own — Ujiyari.com | Free UPSC & State PCS Editorial Analysis

KEY ARGUMENTS AT A GLANCE

The Hindu argues that the profile of India's fire accidents has shifted over the last fifteen years from industrial facilities and mass gatherings to residential buildings, hotels and hospitals, that electrical faults driven by heavier appliance loads and poor maintenance now predominate, and that intensive care units are a special case because they combine oxygen-rich air with sealed compartments and patients who cannot evacuate themselves, so ICU fires should be treated as a distinct regulatory category with their own drills, materials standards and design norms rather than folded into general fire-safety rules.

✓ SUPPORTING

- The back-to-back neonatal ICU fires this month in Amravati in Maharashtra and Chhindwara in Madhya Pradesh killed and injured newborns, and the Amravati fire shared many features with previous incidents, which is evidence that the lessons of earlier disasters have not been institutionalised.
- The Amravati fire was extinguished in 30 minutes, yet three babies died because smoke fills a sealed ICU compartment far faster than a fire spreads, which shows that response time is the wrong metric for this category of accident.
- The Jhansi NICU fire of 2024, in which 18 newborns died, did not function as a wake-up call, and repetition of the same failure mode across states points to a systemic gap rather than to local negligence.

✍ MAINS ANSWER FRAMEWORK

QUESTION

Fire safety failures in Indian hospitals recur despite repeated inquiries. Examine the regulatory and institutional reasons, and suggest what a category-specific approach to intensive care unit fire safety would involve. (250 words)

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