

Neonatal Fire Safety in India: Recurring Risks, Systemic Gaps and Institutional Accountability

Briefing Note on Fire Safety in NICUs and SNCUs

1. Executive Summary

On 24 August 2026, a fire broke out in the Neonatal Intensive Care Unit (NICU) of the District Women's Hospital, Amravati, Maharashtra, killing three newborns and forcing the evacuation of 36 others. Preliminary reports indicate that a ventilator or electrical malfunction may have triggered the fire; relatives also alleged that the automated fire-suppression system did not activate. The precise cause and functioning of the safety systems remain matters for verification. Two days earlier, on 22 August 2026, a fire in the NICU of the District Hospital, Chhindwara, Madhya Pradesh, according to Civil Surgeon Dr Kanchan Dubey, was triggered by a spark in the filament of a radiant warmer. Three newborns sustained burn injuries; one infant died while being shifted to Jabalpur, and the CMHO attributed the death to a congenital heart condition. The other two were referred there for specialised treatment. Since the preparation of this briefing note, the NHRC has taken suo motu cognisance of the Amravati incident and issued notice to the Chief Secretary of Maharashtra, with a two-week response period. No corresponding NHRC, State Human Rights Commission or court proceeding concerning the Chhindwara incident was identified in the records reviewed for this briefing note; the available response comprises a district-level inquiry and compensation. This asymmetry reinforces the case for the Commission to examine the two incidents not only individually but also within the broader recurring pattern of neonatal fire-safety failures. The present representation therefore requests that the Commission, while taking account of its existing Amravati proceedings, consider widening its examination to the systemic fire-safety, audit, accountability and enforcement mechanisms governing NICUs/SNCUs in government hospitals.

Earlier incidents at Bhandara (2021, 10 newborn deaths), Bhopal (2021, 4 deaths), Delhi's Vivek Vihar (2024, 7 deaths), Jhansi (2024, 10 deaths in the fire; eight additional deaths were subsequently reported among rescued infants), and elsewhere are **not presented as separate incidents for determination by the Commission**. They are cited as evidence of a recurring pattern of fire-safety deficiencies, inadequate compliance, and weak follow-through despite previous incidents, inspections and government directions.

The central concern is therefore not merely the occurrence of individual fires, but whether public authorities have adequately **prevented, monitored, audited, verified and enforced compliance with fire, electrical and building-safety requirements in neonatal-care facilities**, and whether identified deficiencies are actually rectified before they result in further loss of life. The complaint accordingly seeks examination of the preventive and regulatory failures surrounding the two recent incidents,

including whether known or identifiable safety deficiencies were adequately addressed by the responsible authorities.

The table below situates the Amravati and Chhindwara incidents within this recurring sequence. Where post-fire inquiries or official assessments are available, they identify specific fire-safety, electrical, building-compliance or emergency-response deficiencies, providing evidence of a recurring pattern rather than isolated or unforeseeable failures.

2. Two Recent Incidents

Date / Location	Facility	Deaths	Documented Lapse
Aug22 2026, Chhindwara	NICU, District Hospital, Chhindwara	1	A fire broke out at approximately 1:50 a.m. in the SNCU after, according to Civil Surgeon Dr Kanchan Dubey, a spark occurred in the filament of a radiant warmer. Three newborns sustained burn injuries. One infant died while being shifted to Jabalpur; the CMHO attributed the death to a congenital heart condition. The other two infants were referred to Jabalpur for specialised treatment. Reports noted that Chhindwara lacked a paediatric surgeon capable of providing the required specialised intervention. Of the 33 newborns in the affected unit, 30 were safely evacuated using fire extinguishers. The hospital administration ordered an inquiry into the incident and the unit's safety arrangements.
24 Aug 2026, Amravati, Maharashtra	NICU, District Women's Hospital	3	Automated fire-suppression system non-functional, a relative alleged, District Collector Ashish Yerekar said The fire audit for last year was conducted, and they have also applied for this year's fire audit with the PWD electrical wing. I have seen the documents myself, so it is not the case that the fire audit was skipped. Civil Surgeon Dr Vinod Pawar said The fire audit was due to expire on August 21. Before that, the hospital administration had sent a letter to the Electrical Department of the Public Works Department. Discussions were underway with the concerned department, and a hospital employee was continuously following up on it.

3. Evidence of a Recurring Pattern

Earlier incidents are relevant because they demonstrate that neonatal fire risk has recurred across different states and facility types, and because several investigations identified preventable deficiencies. They should, however, be described according to what the available inquiry or official record actually establishes.

Date / Location	Facility	Deaths	Documented Lapse
Jan 2021, Bhandara, Maharashtra	SNCU, District General Hospital	10	The January 2021 fire at Bhandara District General Hospital killed 10 newborns in the SNCU. The inquiry headed by Nagpur Divisional Commissioner Sanjeev Kumar found that the fire originated from a radiant warmer/electrical wiring in the outborn section. The hospital had been functioning without a fire NOC; when the SNCU extension was constructed in 2015, no fire NOC was obtained and no fire audit was conducted. The inquiry also identified deficiencies in electrical maintenance and recommended trained engineers for government hospitals. Separately, the fact-finding process found that technicians responsible for maintaining the radiant warmer and phototherapy equipment lacked machine-specific training, that service manuals/circuit diagrams were unavailable, that CCTV was non-functional and that periodic electrical audits had not been conducted. Seven hospital staff faced disciplinary action. The Lokayukta subsequently examined the matter and pressed for fire audits and safety measures across hospitals.
Nov 2021, Bhopal, Madhya Pradesh	SNCU, Kamla Nehru Children's Hospital	4	On 8 November 2021 , a fire broke out in the neonatal/children's ward of Kamla Nehru Children's Hospital in Bhopal, killing four infants . Officials said that 40 infants were in the ward and 36 were rescued. The fire was initially attributed to a possible short circuit. Following the incident, it emerged that the hospital had neither obtained nor applied for a Fire NOC since beginning operations in 2002 , according to the Bhopal municipal commissioner and fire officer. The National Commission for Protection of Child Rights (NCPCR) took suo motu cognisance of the incident and sought an

Date / Location	Facility	Deaths	Documented Lapse
			inquiry into the circumstances surrounding the deaths. The Madhya Pradesh government also ordered a probe, and several senior hospital officials were subsequently removed from their posts,
Mar 2023, Yamunanagar, Haryana	SNCU/NICU, Mukund Lal District Civil Hospital, Yamuna Nagar	None	The Yamunanagar incident occurred on 4 March 2023 at the SNCU of Mukand Lal District Civil Hospital. Nine newborns were in the unit when a fire reportedly caused by a short circuit in an air-conditioner broke out. Staff noticed smoke at around 7:15 a.m., evacuated all nine infants and shifted them to other rooms; the fire brigade subsequently extinguished the fire. The state Director General of Health Services later visited the hospital and expressed dissatisfaction with the facilities. Because there were no reported infant deaths and the available reporting does not establish a specific regulatory violation .
May 2024, Delhi Vivek Vihar, Shahdara	Unlicensed children's hospital	7	On 25 May 2024 , a fire at the private Baby Care New Born Hospital in Vivek Vihar, Delhi, killed seven newborns and injured five others. Delhi Police found that the hospital's licence had expired on 31 March 2024 , while the licence permitted only five beds and 12 newborns were admitted when the fire occurred. Police also reported inadequate fire-safety arrangements, including the absence of fire extinguishers and an emergency exit, while the fire department indicated that the facility did not have the required fire clearance. The National Commission for Protection of Child Rights subsequently examined the case, and an NCPCR report identified the expired registration and other irregularities. The Delhi government's Anti-Corruption Branch later described the incident as potentially avoidable and found that the licence-renewal application had not been processed within the prescribed period; it also reported that the facility had more than 32 oxygen cylinders were present on the ground floor with 12 beds despite permission for five.
Nov 2024, Jhansi, Uttar Pradesh	NICU, Maharani Laxmibai	10 in fire; 8 later deaths reported	On 15 November 2024 , a fire broke out in the NICU at Maharani Laxmi Bai Medical College in Jhansi. Ten newborns died in the fire itself. The unit was severely overcrowded: reports stated that 49 infants were being

Date / Location	Facility	Deaths	Documented Lapse
	Medical College		treated in a unit designed for 18. Of the 39 infants initially rescued, eight subsequently died; the medical college administration attributed those later deaths to illness, although some parents alleged that smoke exposure worsened the children's conditions. A four-member inquiry committee headed by Director General of Medical Education Kinjal Singh investigated the incident. Following its report, the government removed Principal Dr Narendra Singh Sengar , charge-sheeted Chief Medical Superintendent Dr Sachin Mahur, and suspended Junior Engineer (Electrical) Sanjeet Kumar, NICU nursing sister-in-charge Sandhya Rai and Chief Superintendent Dr Sunita Rathore. The committee's report identified negligence and recommended measures to prevent similar incidents
May 2026, Gandhibagh, Nagpur	SNCU, Daga Memorial Govt Women's Hospital	None	The Nagpur Daga Hospital incident is similarly better classified as a near-miss. In May 2026, a fire/smoke incident occurred in the outborn section of the SNCU at Daga Memorial Government Women's Hospital. Ten babies in the affected section were safely evacuated. Hospital officials said the incident involved sparking associated with wiring/baby warmers and credited fire-safety systems and recent mock-drill training with helping avert a larger tragedy. The affected unit was subsequently shut pending a fresh fire-safety audit. Importantly, officials also said the wiring was relatively new and had undergone an electrical audit earlier in the year.

4. Why the Lapses Keep Happening

A recent commentary published in the Journal of Neonatology, 2025 identifying recurring gaps in infrastructure, fire-safety compliance, staff training, and fire-safety audits. The paper recommends a proactive, multi-layered approach like prevention, mitigation, preparedness, and recovering involving regular electrical and fire-safety audits, equipment maintenance, fire resistant design and materials, functional detection and suppression systems, clearly marked evacuation routes, regular mock drills, staff training, and NICU-specific evacuation protocols. It further proposes practical mechanisms such as role-based job cards, triage of neonates, patient-tracking forms, portable evacuation equipment, and post-

evacuation monitoring to ensure continuity of care. The authors conclude that NICUs require unit-specific fire-safety SOPs and frequent preparedness exercises to reduce risks and ensure rapid, coordinated evacuation during emergencies. However, there still remains a need for systematic empirical data on actual fire-safety compliance in Indian NICUs/SNCUs.

4.1 Compliance is treated as a one-time hurdle, not a maintained standard

Independent audits show the scale of the gap. A January 2025 Nagpur Municipal Corporation audit found 165 of 504 hospitals without Fire NOCs. A subsequent 2026 assessment found 121 of 484 hospitals without Fire NOCs and 94 operating from buildings not sanctioned for hospital use, indicating continuing gaps in facility-level fire and building compliance. In Karnataka, according to the news sources compliance at under 1% of government hospitals statewide and 5% for private hospitals. Data showed that only 14 of the 2,878 government hospitals and 315 of the 5,850 private hospitals in the state abide by fire safety norms. A 2023 study, an analysis of fire accidents occurred in Indian hospitals showed expired or inadequate fire-safety measures, weak regulatory monitoring, poor maintenance, insufficient firefighting equipment, inadequate staff training and drills, obstructed evacuation routes, and weak emergency preparedness.

4.2 Renewal is where the system fails hardest

Fire NOC validity varies across states, with no uniform national renewal period for hospitals. Delhi generally provides a three-year validity, Kerala five years, and Rajasthan annually while other states follow different or category-specific rules. More importantly, a valid NOC does not guarantee continued compliance. The 2026 national guidelines require hospitals to renew certificates before expiry and undertake periodic fire-safety audits, highlighting a critical gap between **obtaining a certificate and maintaining safety over time**. Recent hospital fires and inspections across states show that lapses in renewal, monitoring and enforcement remain a persistent weakness.

4.3 Responsibility is diffused across departments that do not answer to each other

India's hospital fire-safety system is fragmented across health, fire, electrical and public-works authorities, with weak coordination between them. Following the November 2024 Jhansi NICU fire, the Union Health Secretary directed all State and UT Chief Secretaries, by D.O. letter dated 18 November 2024, to review and strengthen fire-safety prevention and preparedness across all health facilities, building on earlier DO communications of March, May, June, and July 2024. The letter called for district-level inspection committees, a facility-level fire-safety checklist, and flagged the absence of a centralised database of health facilities as an institutional gap. This directive was separately forwarded within the ESIC hospital network for compliance action (see [ref]), illustrating the same institutional fragmentation described above: the instruction cascades through parallel administrative hierarchies without a single body verifying end-to-end compliance.

Parliamentary evidence shows the fragmented nature of hospital fire-safety oversight. In a Rajya Sabha response in March 2021, the Ministry of Health and Family Welfare stated that fire-safety audits in Central Government hospitals involved local fire authorities, internal hospital fire-safety committees and

CPWD, while overall monitoring was assigned to the Head of the Institution and implementation to the Medical Superintendent.

5. The Legal and Regulatory Framework

In May 2026, India has come up with the National Guidelines on Fire and Life safety in Health care facilities. It builds the 2020 MoHFW guidelines and aligns itself with the National Building Code and BIS standards. The 2026 document establishes that extinguishers must be appropriate, correctly placed and maintained, but **the document does not provide a single national number of extinguishers that every hospital or NICU must have**; instead, requirements are linked to the relevant standards, risk and type of facility. It also doesn't tell how many audits have identified unresolved deficiencies, or whether corrective actions have actually been completed across hospitals. Acc to the new guidelines that NICU evacuation requires specialised planning because neonates are completely dependent on staff for rescue; however, the annexure is largely a framework for preparedness and response rather than a quantified, independently enforceable NICU fire-safety standard.

The central issue is not merely that fires occurred, but whether repeated deaths of newborns in State-run healthcare facilities, despite prior knowledge of comparable risks and the existence of statutory and regulatory safety obligations, demonstrate a continuing failure of the State to discharge its constitutional duty to protect life under Article 21.

The legal and regulatory framework governing hospital fire safety in India consists of overlapping instruments rather than a single unified law. These include the National Building Code of India, applicable State fire-safety legislation, Fire NOC requirements and the Ministry of Health and Family Welfare's National Guidelines on Fire and Life Safety in Healthcare Facilities. However, as the recurring incidents demonstrate, the existence of regulatory standards has not necessarily translated into sustained compliance, enforcement or accountability.

Legal Basis for Human-Rights Accountability

The occurrence of such fires in government NICUs and SNCUs raises issues that may go beyond simple inquiries about whether the facilities complied with fire safety regulations. The repeated failure to recognise, address and monitor known or foreseeable hazards raises a serious question as to whether the State has discharged its human-rights obligations to protect life.

Article 21 of the Indian Constitution: Right to Life. Article 21's guarantee of the right to life extends not only to State actions but also requires the State to take reasonable steps to protect life when it assumes responsibility for providing care for persons. In newborn units, when the patient's only means of survival is the medical staff and its facilities, this clause becomes even more important. The Supreme Court has recognised access to timely and adequate medical care as integral to the protection of life under Article 21. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996), the Supreme Court held that failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment violates the right to life guaranteed under Article 21. In *Parmanand Katara v. Union of India* (1989), the Supreme Court affirmed the obligation to preserve human life and the need for

immediate medical assistance. These principles are relevant here because newborns receiving institutional care are wholly dependent on public health facilities and the systems maintained by the State for their survival and safety.

The duty of the State to those receiving institutional care. The state has significant influence over the atmosphere in which newborns admitted to government hospitals operate. As a result, the State has an obligation to take appropriate action to ensure that the facilities where people live adhere to the necessary safety regulations. In this regard, the NHRC's previous interventions in Bhandara and Jhansi are pertinent: action has been called for because the deaths of newborns due to fires in government hospitals are seen as human rights breaches. The Union Ministry of Health and Family Welfare also has a relevant role through the National Health Mission's Facility Based Newborn Care framework, under which Special Newborn Care Units (SNCUs) form part of the public health system. District hospitals are also expected to conform to the Indian Public Health Standards (IPHS) 2022 and are subject to quality-assurance mechanisms including the National Quality Assurance Standards (NQAS). These national financing, standards and monitoring frameworks provide a basis for examining whether fire-safety and emergency preparedness are being adequately incorporated into the functioning and monitoring of SNCUs, and explain why the Ministry of Health and Family Welfare is a relevant respondent alongside the concerned State authorities.

Regulatory obligations and failure of enforcement. The fire safety requirements for hospitals are governed by a number of laws and regulations. The National Building Code of India, fire safety legislation in the respective states, Fire NOC rules, and the Ministry of Health and Family Welfare's 2026 National Guidelines on Fire and Life Safety in Healthcare Facilities are a few examples of these laws. These rules establish specific legal requirements for fire detection, suppression, evacuation, maintenance, auditing, and readiness.

Accountability for omission. The State may still be held accountable for the supervision even though the public works, fire, health, and electrical agencies have different levels of accountability. The absence of coordination between several government agencies may constitute an institutional deficit in and of itself and has to be looked at when these agencies have distinct roles and responsibilities to avert certain foreseen dangers. The question is whether the State has a system in place for identifying deficiencies, allocating responsibility, requesting fixes, verifying compliance, and enforcing penalties for noncompliance.

Therefore, the Commission can investigate whether the recurrent newborn fatalities in neonatal wards are isolated incidents or indicators of a persistent issue with the performance of the administrative, legal, and constitutional obligations to safeguard the lives and welfare of patients in State facilities.

6. NHRC's previous take on Hospital Fires

The NHRC has previously treated deaths in hospital fires, particularly deaths of newborns in government facilities, as human rights concerns rather than purely administrative failures. In the Bhandara case, the Commission took suo motu cognisance, sought a report from Maharashtra and sought information on fire-safety audits and action against responsible officials.

After the Jhansi fire in 2024, the NHRC again took suo motu cognisance and sought information concerning the incident, responsibility, treatment, compensation and measures proposed to prevent recurrence. These precedents support framing the present representation around prevention, accountability, and recurrence rather than compensation alone.

The Commission also took suo motu cognisance of the October 2025 fire at the government-run Sawai Man Singh (SMS) Hospital in Jaipur, in which eight patients reportedly died and three were critically injured. Notices were issued to the Rajasthan Chief Secretary and Director General of Police, with a two-week period for submission of a detailed report. This is significant because it demonstrates that the Commission had already intervened in another major government-hospital fire before the Amravati incident, yet a further serious hospital fire occurred within the following year.

7. Recommended Elements for the Complaint

7.1 Widen the examination beyond Amravati to the systemic pattern

The Commission has taken suo motu cognisance of the Amravati incident. The present representation requests that the Commission consider the Chhindwara incident alongside Amravati and examine whether the recurrence of neonatal fires reflects systemic deficiencies in fire-safety maintenance, auditing, preparedness, staffing, accountability or institutional oversight. No corresponding NHRC, State Human Rights Commission or court proceeding concerning Chhindwara was identified in the records reviewed for this briefing note. The contrast between the two incidents demonstrates the limitations of case-by-case cognisance and supports a broader examination of whether previous audits, recommendations and corrective directions have translated into sustained facility-level compliance.

7.2 Seek a nationwide, time-bound audit and facility-level verification

Recommend that the Ministry of Health and Family Welfare and State/UT health authorities undertake a time-bound verification of fire-safety compliance in NICUs/SNCUs in government hospitals, with facility-wise findings submitted to the Commission. The exercise should not be limited to checking whether an NOC exists; it should verify validity, audit status, maintenance records, functionality of systems, staff training, evacuation preparedness and closure of identified deficiencies.

7.3 Establish transparent facility-level accountability

Recommend that every hospital operating a NICU/SNCU publicly identify its designated Fire Safety Officer consistent with applicable State fire-safety law and administrative requirements and disclose the date and status of its most recent fire and electrical safety audits, including whether any material deficiencies were identified and whether corrective action remains pending, subject to applicable law. This would operationalise the accountability structure recognised in the 2026 national guidelines by making responsibility and audit compliance visible at the facility level.

The Commission may further recommend that the Ministry of Health and Family Welfare incorporate the designation of a Fire Safety Officer and compliance with the prescribed fire-safety audit cycle into

relevant National Health Mission support, monitoring and review mechanisms for SNCUs, subject to the applicable legal and administrative framework.

7.4 Strengthen NICU-specific preparedness

Recommend that MoHFW and State/UT authorities ensure implementation of NICU/SNCU-specific fire preparedness measures already contemplated by the 2026 guidelines, including evacuation planning, role-based responsibilities, mock drills, portable evacuation equipment, neonate triage and post-evacuation continuity of care. The objective should be to convert preparedness from a paper exercise into a periodically demonstrated capability.

7.5 NHRC's Powers under Section 18 (a), (b), (c), (f)

Under Section 18 of the Protection of Human Rights Act, 1993, the Commission may recommend compensation, prosecution or other appropriate action under Section 18(a); approach the Supreme Court or a High Court for appropriate directions under Section 18(b); recommend interim relief under Section 18(c); and publish its findings and recommendations under Section 18(f).

In the present matter, the Commission could consider these powers in light of recurring hospital fire-safety deficiencies and the particular vulnerability of newborns in NICUs and SNCUs. The repeated identification of hospitals without valid Fire NOCs, building approvals or adequate fire-safety systems raises concerns about whether existing mechanisms are effectively preventing foreseeable risks. Proper Treatment of Covid-19 Patients and Dignified Handling of Dead Bodies in the Hospitals etc., 2020 SCC On Line SC 1036, order dated 18 December 2020 (Bhushan, Subhash Reddy and Shah JJ.), the Supreme Court addressed fire-safety and accountability in hospitals during the COVID-19 period, including the need for designated responsibility and regular verification. Although the directions arose in the context of COVID-19 hospitals, the Commission may consider whether comparable safeguards, suitably adapted to the particular risks of NICUs and SNCUs, warrant broader application.

The Commission could therefore seek the Court's consideration of whether such safeguards, suitably adapted, should extend to NICUs and SNCUs nationwide. Where individual failures are established, the Commission may also consider appropriate recommendations under Section 18(a), interim protective measures under Section 18(c), and publication of its findings under Section 18(f).

8. Core Questions for the Commission

- Was the Amravati fire-safety audit valid on the date of the fire, and what did the most recent audit certify?
- Was the required Fire NOC valid, and what were the status and reasons for any pending application or renewal?
- Did the fire-suppression, detection and alarm systems function as designed, and when were they last tested?
- Were required maintenance and compliance certificates filed for the relevant period?

- Did staff responsible for neonatal evacuation receive the required training and participate in drills?
- What corrective actions were identified in earlier fire incidents, and which of those actions were actually completed?
- Which authority was responsible for verifying completion of those corrective actions?
- What facility-level and state-level mechanism exists to ensure that a certificate continues to reflect actual safety conditions between audits?

9. Conclusion

The August 2026 incidents in Amravati and Chhindwara provide the immediate basis for examining whether existing fire-safety, audit and accountability mechanisms are functioning effectively. The Commission's suo motu cognisance of Amravati, together with the absence of comparable human-rights proceedings identified in relation to Chhindwara, also illustrates why case-by-case intervention may be insufficient. Earlier incidents show the need for a response that examines recurrence, implementation and facility-level compliance rather than another isolated post-fire inquiry.

The issue is not whether the government has ordered safety audits. It has. The issue is whether those audits resulted in actual compliance and whether authorities followed up when hospitals remained unsafe.

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