

INQUIRY

REPORT OF THE INQUIRY COMMITTEE

Volume I

ISLAMABAD
7 SEPTEMBER 2026

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I. Executive Summary

The fire in the MCH Nursery, Pakistan Institute of Medical Sciences (PIMS), Islamabad, on 26 August 2026 claimed the lives of 14 of the 15 neonates under treatment; one survived. The Inquiry Committee examined not only how the fire began, but why it became catastrophic, whether emergency response and neonatal evacuation arrangements were adequate, where institutional and individual responsibility lay, and what reforms were necessary. Its conclusions are based on a structured 52 task investigation drawing upon forensic evidence, CCTV, call records, engineering and maintenance documents, clinical and casualty records, duty and attendance material, witness statements, contracts, regulatory records and earlier inquiries.

CCTV establishes an exceptionally rapid emergency. The fire was visibly underway by about 06:38:15; Charge Nurse Nasreen Akhtar, Security Guard Maria Saleem and Staff Nurse Razia Noreen responded within moments, with Razia rescuing a neonate and attempting to re enter. Dr. Muhammad Abdul Rehman was also present during the critical opening minute. By about 06:39:15, dense smoke had substantially obscured the camera. The evidence therefore rejects any generalized allegation that frontline personnel abandoned the newborns; several acted promptly and courageously in circumstances that became untenable within minutes.

The strongest technical evidence, from the National Forensics Agency, identifies the AC Unit No. 2 electrical supply cable near/over AC Unit No. 1 as the most probable point of ignition. Abnormal localized electrical heating, possibly from excessive current, a high resistance connection or another localized defect, most probably caused insulation failure and ignition of nearby combustible material. The evidence does not establish arson, multiple ignition points, an external IESCO fault, a pre-fire oxygen leak, or an incubator or warmer as the source. The fire was therefore most probably electrical in origin, although the precise defect and the person or entity responsible for preventing it require separate determination.

The maintenance record shows that the Nursery ACs had been serviced, but it does not demonstrate a sufficiently systematic and traceable electrical safety regime covering cables, terminations, insulation, earthing, breaker protection and thermal hotspots. The critical distinction is that equipment being operational is not the same as its electrical installation being demonstrably fire safe. The evidence reveals a wider institutional gap between keeping equipment running and ensuring that it was safe.

The consequences were magnified by the Nursery's vulnerability. Fifteen medically fragile, non-self-evacuating neonates were housed in a ten-bed unit, several dependent on oxygen or respiratory support, while only two doctors and two nurses were immediately available and protected evacuation resources were limited. No adequately documented, approved, trained and rehearsed Nursery specific fire and neonatal evacuation SOP was demonstrated, nor was a functional automatic smoke detection, alarm or sprinkler system shown to be serving the affected area. Combustible materials and the oxygen supported environment further intensified fire and smoke after ignition.

The response must be distinguished between individual reaction and institutional activation. Frontline staff acted within seconds, whereas CES records confirmed external notification at about 06:54, dispatch at 06:55 and operational arrival around 07:01. The principal concern is therefore the interval between visible fire at about 06:38 and confirmed external activation, not a long delay by CES after notification. PIMS had not demonstrated a tested incident



command system capable of immediately converting detection into alarm, external notification, evacuation, hazard isolation, access management and coordinated rescue.

The tragedy also occurred against a history of known but incompletely closed risks. Earlier CDA correspondence, the Federal Ombudsman's 2015 findings, PIMS's own 2025 acknowledgement of ageing fire safety infrastructure, and especially the 6 July 2026 Nursing Hostel fire had already highlighted deficiencies in detection, alarms, electrical inspection, evacuation, firefighting equipment, drills and emergency planning. Yet those warnings had not been converted into a comprehensive, time-bound and independently verified corrective programme before the Nursery fire. The specific AC 2 defect may not have been foreseeable; the need for stronger fire preparedness plainly was.

The Committee therefore concludes that systemic and institutional failure is established, while individual responsibility varies with the strength of the evidence. PIMS and its senior management bear the principal institutional responsibility for failing to convert known risks, prior warnings and assigned duties into an effective safety system. The Security chain carries particularly clear but insufficient documented duties; senior management responsibility requires precise business allocation and knowledge; clinical responsibility requires proof of mandatory physical or supervisory duty; and the Engineering/electrical/HVAC chain remains the most significant unresolved technical accountability line because the probable ignition source lies in the AC 2 electrical arrangement. Contractors must be examined only against the duties actually assigned to them.

The record does not presently establish criminal guilt against any named person. It supports focused investigation into four possible lines: culpable electrical installation or maintenance failure relating to AC 2; culpable obstruction of a mandatory emergency route; culpable failure to act despite specific prior warning; and any proved culpable delay in summoning external assistance. Criminal responsibility must rest on the duty owed, knowledge or foreseeability of risk, authority to act, the act or omission, degree of negligence, failed safeguard, causal contribution and applicable offence. Frontline responders whose rescue conduct is objectively established should not be blamed merely because the outcome was catastrophic.

The Committee recommends immediate fire, life safety and electrical audits; functioning detection, alarm, suppression and egress systems; a dedicated neonatal evacuation SOP with realistic drills; direct emergency notification and incident command; preventive electrical safety and asset management systems; professional and merit based hospital governance; stronger regulatory oversight; and a closed loop compliance system in which every deficiency has a responsible owner, deadline, resources, interim safeguard, independent verification and formal closure. A measure is not implemented because it is approved or under process; it is implemented only when the risk has been physically removed and independently verified.

The causal chain is coherent. A localized electrical failure most probably started the fire; combustible and oxygen supported conditions accelerated it; inadequate detection and protection failed to contain it; overcrowding, limited evacuation capacity and the absence of a rehearsed neonatal emergency system constrained rescue; delayed institutional activation weakened response; and longstanding governance, maintenance and regulatory failures allowed these vulnerabilities to coexist. The electrical spark explains how the fire began; the institutional system explains why it became a catastrophe. Fourteen newborns were lost not because one safeguard



failed, but because too many safeguards were absent, weak, delayed or never verified to be working.

2. Constitution, Mandate and Terms of Reference

Following the MCH Nursery fire at PIMS, Islamabad, on 26 August 2026, the Prime Minister constituted an Inquiry Committee¹ comprising Mr. Shahid Khan, Former Federal Secretary, as Chairman; Maj. Gen. (Retd.) Dr. Khurshid Uttra; Barrister Nabeel Ahmed Awan, Establishment Secretary; and the Deputy Commissioner, ICT, with authority to co opt additional expertise. Dr. Rashid A. Chotani was subsequently co opted as an expert member. His independent technical submissions of 31st August 2026 were also examined². The Committee was directed to submit an Interim Report³ within 48 hours, which was submitted on 28th August 2026, to be followed by a comprehensive report. The zero draft of this report was circulated on 03.09.2026 followed by the first draft on 04.09.2026 and the final draft on 6.9.2026, for review and comments of all the members which have been incorporated in this final report.

The Committee's mandate was deliberately broad. It was required to establish the cause and chronology of the fire; assess the adequacy and timeliness of PIMS and external emergency response and rescue operations; examine neonatal evacuation arrangements and compliance with fire and life safety requirements; evaluate infrastructure, equipment and regulatory oversight; determine negligence and fix individual or institutional responsibility; and recommend administrative, disciplinary, criminal and systemic measures to prevent recurrence. The Inquiry was not confined to identifying the point of ignition. It was required to examine the complete chain of prevention, preparedness, detection, notification, evacuation, rescue, oversight and accountability. The central question was therefore not simply how the fire started, but why the existing insitutional safeguards failed to prevent a technical incident from becoming a catastrophe.

3. Methodology and Evidence

To operationalize the six Terms of Reference within the limited timeframe, the Committee developed a structured 52 task investigative framework⁴ covering the full chain of causation and accountability: forensic origin and fire propagation; incident chronology; electrical, HVAC, oxygen and biomedical systems; patient census and outcomes; staff deployment and presence; CCTV and CDR analysis; emergency notification and response; exits, access and firefighting arrangements; evacuation capacity and SOPs; maintenance and preventive inspection; staffing, budgets and infrastructure; security and contractual obligations; prior incidents and corrective action; regulatory oversight; governance; person-wise responsibility; and systemic reform.

The Committee applied a clear evidentiary hierarchy, giving greater weight to forensic and physical evidence, contemporaneous CCTV and electronic records, and authenticated official documents than to later recollection, unverified allegations or media reports. It consistently distinguished between established fact, probable technical conclusion, prima facie responsibility and unresolved matter. Accordingly, preliminary witness accounts were not treated as technical proof where specialist forensic evidence existed; duty rosters were not treated as proof of actual

¹ Exhibit 101 — Notification of the Inquiry Committee dated 26 August 2026

² Exhibit 105 — Independent technical report of Dr. Chotani dated 31.08.2026

³ Exhibit 102 — Interim Report of the Inquiry Committee dated 28 August 2026.

⁴ Exhibits 49–100 — Task Nos. 1–52 constituting the Committee's structured investigative framework.

presence; and general staffing or financial deficiencies were not treated as causative without a demonstrated nexus. The guiding principle was simple: the Inquiry was required to reach the strongest conclusion the evidence could sustain, not the strongest allegation that could be made.

The evidentiary record included forensic findings, CCTV and electronic data, clinical, administrative, security and maintenance records, duty and biometric information, CDRs, witness and officer statements, and relevant regulatory and prior inquiry material, including correspondence and inspection records from IESCO and the CDA Electrical & Mechanical Wing⁵. Each record was assessed for what it actually proved, rather than what might merely be inferred from its existence.

The 52 task framework has been substantially completed and provides a sufficient evidentiary basis for determination of the substantive Terms of Reference. Task No. 52 has been absorbed into the reconciliation of witness, CCTV and CDR evidence⁶, while Task No. 51, relating to formal chain of custody documentation, remains supplementary⁷ and may be annexed without affecting the substantive findings. The Inquiry's conclusions rest on a structured, evidence weighted and causally disciplined process. The accountability has been based on proof, nexus and assigned responsibility, not assumption, hindsight or accusation.

4. Limitations and Evidentiary Reservations

The Committee conducted the Inquiry within an exceptionally compressed timeframe while examining a technically complex fire, multiple institutional actors, extensive records and potentially conflicting witness accounts. The Inquiry could therefore not replicate the depth of a full departmental, forensic or criminal proceeding. Its conclusions have accordingly been confined to what the available evidence reasonably establishes, while matters requiring further verification have been expressly identified rather than converted into definitive findings.

The evidentiary record was also incomplete in important respects. Much of the Nursery's clinical documentation was destroyed in the fire, requiring the patient census and casualty position to be reconstructed from admission and delivery registers, mortuary certificates, body handover documents and other institutional records⁸. Likewise, equipment histories, electrical testing records, preventive maintenance documentation and device specific safety certifications were incomplete⁹ for some ACs, incubators, warmers, sockets, cables and circuits. Such gaps have been treated as limitations of proof unless the record independently establishes that the relevant documentation was required to exist but was not maintained or produced.

Similar caution applies to the external notification chronology. CCTV shows the emergency visibly underway at approximately 06:38, whereas CES records the confirmed

⁵ Exhibit 3 — Inquiry Report of DG E&M, CDA; Exhibit 4 — Inventory/Inspection Report of DG E&M, CDA; Exhibit 6 — Report of IESCO.

⁶ Exhibit 100 — Task No. 52: Evidence Corroboration Report, SP.

⁷ Exhibit 99 — Task No. 51: Evidentiary Chain of Custody.

⁸ Exhibit 10 — Record of 15 Babies; Exhibit 11 — Register Entries of Child Admission in Nursery; Exhibit 13 — Death Certificates; Exhibit 14 — Mothers' Records of Delivery; Exhibit 16 — Certificates issued by Mortuary, PIMS.

⁹ Exhibit 37 — List of Equipment and Maintenance Logs of Incubators by PIMS; Exhibit 38 — Maintenance Records of Equipment by Hammad Manzoor; Exhibit 39 — Maintenance Records of Air Conditioners; Exhibit 62 — Task No. 14: Electrical Safety; Exhibit 91 — Task No. 43: Equipment.



emergency call at approximately 06:54¹⁰. Witnesses refer to earlier internal communications and possible earlier attempts to contact emergency services, but person specific responsibility for delay cannot be fixed without establishing who had the duty to notify CES, when that person became aware of the fire, whether an earlier call was actually made, and whether any attributable delay materially affected rescue or firefighting. The evidence therefore supports a stronger finding of an apparent institutional notification gap than of responsibility for the entire interval resting with any one individual.

The Inquiry distinguishes carefully between evidentiary gaps and proven failures. Incomplete records may limit attribution, but they do not justify speculation; accountability must rest on verified duty, knowledge, omission and consequence.

5. Reconciliation with the Interim Report dated 28 August 2026

The Interim Report recorded only those facts and prima facie findings supported by the evidence then available, while expressly reserving the precise ignition source, the causal effect of identified deficiencies and final fixation of individual responsibility for the comprehensive inquiry. The present Report therefore treats the Interim Report as a provisional evidentiary baseline¹¹: findings supported by subsequent evidence are confirmed, those narrowed by later material are refined, and any interim formulation no longer sustainable on the completed record is expressly superseded.

Subsequent forensic, CCTV, CDR, duty, maintenance, contractual and regulatory evidence materially strengthened the record and resolved several matters earlier left open. The principal technical refinement is that the fire is now most probably traced to abnormal localized electrical heating in the AC 2 supply cable near or over AC 1, rather than to an unresolved range of possible electrical or biomedical sources¹². The completed evidence also corrects the broader interim formulation that administrative or operational failures triggered the incident: the electrical event most probably caused ignition, while institutional deficiencies affected prevention, fire propagation, evacuation, notification and survivability. The distinction between cause of ignition and causes of catastrophe is therefore fundamental.

Other interim findings have either been strengthened or qualified. Further CCTV and witness reconciliation confirms that frontline personnel did not generally abandon the neonates and documents specific rescue activity¹³. The apparent gap between visible fire at approximately 06:38 and confirmed CES notification at 06:54 remains¹⁴, although the claimed earlier call is unverified and person specific blame requires proof of assigned duty and actual call history. Similarly, the CCTV visible adjoining Nursery door was opened at approximately 06:39:45¹⁵ and is not established as causative, while CES concerns regarding other locked or obstructed mandatory exits remain subject to door specific accountability.

¹⁰ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 5 — Report of 1122/CES, CDA; Exhibit 8 — Report of Safe City; Exhibit 52 — Task No. 4: Emergency-Call Delay.

¹¹ Exhibit 102 — Interim Report of the Inquiry Committee dated 28 August 2026.

¹² Exhibit 9 — Report of National Forensics Agency (NFA); Exhibit 49 — Task No. 1: Exact Cause of Fire.

¹³ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibits 19, 21, 22 and 23 — Statements of Dr. Abdul Rehman, Razia Noreen, Nasreen Akhtar and Maria Saleem; Exhibit 55 — Task No. 7: Individual Emergency Response.

¹⁴ Exhibit 5 — Report of 1122/CES, CDA; Exhibit 8 — Report of Safe City; Exhibit 52 — Task No. 4: Emergency-Call Delay.

¹⁵ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 57 — Task No. 9: Locked-Door Allegation; Exhibit 58 — Task No. 10: Causal Impact of Locked Door.



The completed record also requires greater precision in fixing individual and institutional responsibility. Adverse findings against clinical officers must distinguish physical ward duty from on call responsibility and establish the precise supervisory duty allegedly breached. Senior PIMS management remains subject to prima facie administrative scrutiny, but responsibility must be mapped officer by officer through business allocation, prior knowledge, authority, omission and consequence. CES is not shown to have delayed operational response after confirmed notification; any antecedent responsibility depends on proof of a statutory or administrative inspection or enforcement duty and failure to exercise it. The Security staff remains linked to a strong documentary duty under the Security SOP, although any allegation of unauthorized absence requires authenticated attendance and leave records. Likewise, the evidence does not support a blanket finding of default against Belfort Security Services¹⁶, as some of its personnel actively responded; any contractual liability must instead be tied to specific obligations concerning deployment, supervision, access, key control and emergency performance.

Potential criminal investigation lines concerning obstructed mandatory exits, failure to act upon prior warnings and possible notification delay remain open. The NFA findings add a further technical line concerning possible culpable installation, inspection or maintenance failure in the AC 2 electrical circuit, but any criminal attribution must still rest on a person specific duty and a legally sustainable causal nexus.

The Interim Report dated 28 August 2026 formed the Committee's first formal assessment on the evidence then available and remains an integral part of the present Inquiry. This investigation subsequently obtained additional forensic, CCTV, CDR, maintenance, contractual and regulatory material, enabling the Committee to confirm, elaborate and, where necessary, more precisely qualify its earlier observations. The Final Report therefore does not disown or depart from the Interim Report; rather, it builds upon and completes it, resolving matters that were expressly left open for further examination and presenting the final conclusions on the fuller evidentiary record.

6. Incident and Patient Casualty Position

On the morning of 26 August 2026, a fire broke out in the MCH Nursery at PIMS, Islamabad, where 15 medically dependent neonates were under treatment¹⁷. CCTV provides the clearest contemporaneous chronology: at approximately 06:38:15, Charge Nurse Nasreen Akhtar was seen leaving the Nursery to seek assistance from Security Guard Maria Saleem; both re entered at about 06:38:35, with flames visible in reflection. Staff Nurse Razia Noreen entered at approximately 06:38:56, emerged seconds later carrying a neonate¹⁸, and attempted to re enter, while Dr. Muhammad Abdul Rehman was seen emerging from the affected area at about 06:39:12. By approximately 06:39:15, dense smoke had obscured the camera. The sequence establishes that the fire escalated extremely rapidly and that rescue efforts commenced almost immediately.

Fire and smoke were also reported to have affected the adjoining Labour Room by approximately 06:55, where women were present and a security guard was posted. However, the

¹⁶ Exhibit 35 — Statement/Report of Belfort Security Services; Exhibit 68 — Task No. 20: Belfort Security Performance.

¹⁷ Exhibit 10 — Record of 15 Babies; Exhibit 11 — Register Entries of Child Admission in Nursery; Exhibit 92 — Task No. 44: List of Mothers/Children in Nursery.

¹⁸ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 21 — Statement of Razia Noreen; Exhibit 55 — Task No. 7: Individual Emergency Response.



Committee found no evidence of any Labour Room fatality or casualty arising from the incident. The findings and casualty assessment of this Report therefore remain confined to the MCH Nursery.

The casualty position has been conclusively reconciled from hospital and mortuary records: 15 neonates were present, 14 died and one survived¹⁹. Fourteen mortuary certificates confirm the fatalities; thirteen bodies were handed over to their families and one unclaimed deceased neonate to the Edhi Foundation. Most victims were premature or medically fragile²⁰ and dependent on oxygen, respiratory, thermal or other clinical support, making independent evacuation impossible.

The CES/Rescue 1122 incident report recorded an interim scene tally of seven alive and seven deceased during active rescue operations. This was an operational snapshot and does not contradict the final casualty count, which is based on the complete post incident admission and mortuary record²¹.

The casualty position is firmly established as 15 neonates present, 14 fatalities and one survivor, while the CCTV chronology shows an exceptionally fast developing fire and immediate frontline response. The precise medical mechanism of death for each infant, however, cannot be determined in the absence of corresponding medico legal findings. The scale of loss is established beyond doubt, but individual causes of death must not be inferred beyond the evidence.

7. Definitive Minute by Minute Chronology

The Committee reconstructed the incident chronology principally from synchronized CCTV, supported by witness statements, security communications and CES records. CCTV provides the most reliable timing for the critical opening minutes, while minor differences in later institutional timings have been identified rather than artificially reconciled.

At approximately 06:38:15, Camera No. 16 records the first objective indication of the emergency, when Charge Nurse Nasreen Akhtar hurriedly exits the Nursery and seeks assistance from Security Guard Maria Saleem. By 06:38:35, both had re entered the Nursery, with flames already visible in reflection. Staff Nurse Razia Noreen entered at about 06:38:56, emerged at 06:39:04 carrying a neonate, and re entered seconds later in a further rescue attempt. Dr. Muhammad Abdul Rehman was seen emerging at approximately 06:39:12, and by 06:39:15 dense smoke had substantially obscured the camera. The footage therefore establishes immediate frontline response and extraordinarily rapid fire development: within about one minute of the first visible warning, conditions had deteriorated into a heavily smoke affected environment²².

CES records receipt of the confirmed emergency call at approximately 06:54, dispatch at 06:55 and operational arrival at about 07:01, with a second fire vehicle following shortly thereafter²³. CCTV at the main gate independently shows guards reacting to the approaching Fire

¹⁹ Exhibit 10 — Record of 15 Babies; Exhibit 13 — Death Certificates; Exhibit 16 — Certificates issued by Mortuary, PIMS.

²⁰ Exhibit 15 — Clinical Summaries for Neonatal Admissions, including APGAR Scores.

²¹ Exhibit 5 — Report of 1122/CES, CDA.

²² Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 51 — Task No. 3: Master Incident Timeline; Exhibits 19, 21, 22 and 23 — Statements of Dr. Abdul Rehman, Razia Noreen, Nasreen Akhtar and Maria Saleem.

²³ Exhibit 5 — Report of 1122/CES, CDA; Exhibit 8 — Report of Safe City; Exhibit 52 — Task No. 4: Emergency-Call Delay.

Brigade at about 06:59:00, opening the gate at 06:59:08 and the first fire vehicle entering PIMS at approximately 06:59:15²⁴. At about 07:01:42, security personnel are seen guiding firefighters towards the incident location. The difference between the CCTV gate entry time and CES's recorded arrival is not materially inconsistent, as one reflects entry into the hospital premises while the other likely records operational arrival at or near the fire scene.

The objective chronology shows immediate frontline reaction, catastrophic smoke development within minutes, confirmed CES notification at about 06:54, dispatch at 06:55, hospital entry at about 06:59 and operational arrival around 07:01. The central chronological concern is therefore the interval between detection of the fire and effective external notification, not any prolonged delay by CES after receiving the call. The principal unexplained time interval lies between detection and confirmed external activation.

8. Probable Origin and Immediate Cause

The strongest technical evidence is the National Forensics Agency (NFA) Crime Scene Investigation Report, which identifies Zone A, particularly Wall No. 1 near the western corner of the Nursery, as the probable area of origin²⁵. The pattern of burning, melting and charring was most intense in this area and diminished outward, indicating that the fire most likely began there. Within Zone A, the NFA identified the electrical supply cable of AC Unit No. 2, where it passed over or near AC Unit No. 1, as the most probable point of initiation²⁶. The likely mechanism was abnormal localized electrical heating, potentially caused by excessive current, a high resistance connection or another localized defect, resulting in insulation failure and ignition of adjacent combustible plastic material.

The most defensible technical conclusion is therefore that the fire most probably originated from abnormal localized heating of the AC 2 supply cable near or over AC 1, while combustible materials and the oxygen supported clinical environment intensified its subsequent spread and severity. The precise electrical defect, however, has not been conclusively individualized. The technical causation and accountability must remain distinct: the NFA evidence explains where and how the fire most probably started, but responsibility depends on whether the hazardous condition should reasonably have been detected or prevented and who held the duty to inspect, maintain and ensure the safety of the relevant electrical installation. The probable ignition point is identified; the remaining question is who was responsible for preventing it from becoming a lethal failure.

9. Electrical System and Preventive Maintenance

The electrical evidence shows that the MCH Nursery was supplied through a dedicated Distribution Board with separate circuits and protective breakers for air conditioners and other loads. After the fire, three breakers were found tripped, while PIMS Engineering reported no system wide overload and IESCO recorded no contemporaneous fault²⁷ or tripping on the external 11 kV feeders. The evidence therefore points away from an external supply failure or generalized overload and towards a localized defect within the Nursery's internal electrical installation or

²⁴ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 51 — Task No. 3: Master Incident Timeline.

²⁵ Exhibit 9 — Report of National Forensics Agency (NFA).

²⁶ Exhibit 9 — Report of National Forensics Agency (NFA); Exhibit 49 — Task No. 1: Exact Cause of Fire.

²⁷ Exhibit 6 — Report of IESCO; Exhibit 34 — Statement of Hassan Nawaz, DD Engineering, PIMS; Exhibit 62 — Task No. 14: Electrical Safety.



connected equipment. This is consistent with the NFA finding of abnormal localized heating in the AC 2 supply cable, since localized overheating, arcing, insulation failure or a loose/high resistance connection can occur without overloading the wider electrical system.

The more significant weakness lies in the nature of the maintenance regime. Available records largely document complaint response, cooling deficiencies, gas charging, servicing, component replacement and restoration of AC units to working condition²⁸. They do not establish a systematic, periodic and traceable electrical safety programme covering supply cables, terminations, breakers, insulation resistance, earthing, conductor loading, isolators, connections or thermal hotspots²⁹. Thus, while maintenance activity is demonstrated, electrical fire safety assurance is not. An AC recorded as serviced and working proves operational functionality; it does not prove that its electrical supply circuit was safe.

Post incident findings reinforce this concern. The NFA recorded that three 32 amp breakers and the main breaker at the relevant Distribution Board were tripped and considered the pattern potentially consistent with previous electrical arcing, raising the possibility of a recurring rather than wholly isolated condition³⁰. Separately, the CDA Electrical & Mechanical Wing reported that contemporaneous maintenance records for the relevant circuits were not available at the site during its inspection. These findings independently support the conclusion that the preventive electrical safety regime was neither sufficiently robust nor adequately traceable.

The Nursery's dependence on individual split AC units also reflects a wider infrastructure failure. A government funded project to replace and upgrade PIMS HVAC systems, initially approved in 2018 and revised in 2021 and 2024 to a sanctioned cost of Rs. 1,654.100 million, remained incomplete when the fire occurred³¹. Responsibility for execution had shifted from Pak PWD to CDA in February 2025, while the affected areas of the old MCH Building were handed over for HVAC works only on 28 July 2026, with completion of the required Air Handling Units not expected until 30 October 2026. The continued exposure of a critical neonatal facility to individual AC unit failure was therefore not merely a local maintenance issue, but also the consequence of a prolonged, multi agency infrastructure transition involving the Ministry, Pak PWD, CDA and PMIC.

The evidence establishes maintenance, but not electrical safety assurance. The immediate technical vulnerability lay in a localized circuit that was kept operational without demonstrated periodic certification of its electrical safety, while the broader institutional vulnerability lay in an eight year infrastructure upgrade that had still not reached the Nursery. The equipment was being kept running, but the system was not demonstrably being kept safe, and fragmented ownership allowed that distinction to persist.

10. Fire Propagation and Why the Fire Became Catastrophic

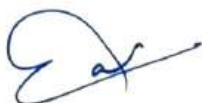
The evidence indicates that the catastrophe arose not from electrical ignition alone, but from the interaction of rapid fire propagation with inadequate protective and evacuation capacity.

²⁸ Exhibit 39 — Maintenance Records of Air Conditioners; Exhibit 40 — HVAC Record for the Year 2025 of MCH, PIMS; Exhibit 63 — Task No. 15: AC/HVAC Condition.

²⁹ Exhibit 3 — Inquiry Report of DG E&M, CDA; Exhibit 4 — Inventory/Inspection Report of DG E&M, CDA; Exhibit 62 — Task No. 14: Electrical Safety; Exhibit 90 — Task No. 42: Electrical.

³⁰ Exhibit 9 — Report of NFA; Exhibit 62 — Task No. 14: Electrical Safety.

³¹ Exhibit 44 — Brief of HVAC; Exhibit 47 — Civil Record for 2024–25–26 of MCH, PIMS; Exhibit 76 — Task No. 28: HVAC/Development Funds.



The NFA identifies abnormal localized heating in the AC 2 supply arrangement as the most probable initiating event. Once nearby combustible plastics ignited, the fire was intensified by the combustible load in Zone A, including plastic equipment, waste bin contents and potentially the vinyl/PVC laminated false ceiling³². CCTV confirms the speed of escalation: from the first visible emergency at approximately 06:38:15, the Nursery became heavily obscured by smoke within roughly one to two minutes³³.

The oxygen supported neonatal environment likely further accelerated combustion after ignition, but the evidence does not establish oxygen as the cause of the fire or the medical gas system as a pathway for its spread. The more defensible conclusion is that oxygen acted as an intensifying factor in an already developing fire, alongside combustible materials and rapid smoke production³⁴.

The electrical fault explains how the fire most probably started, while combustible materials, oxygen-supported clinical environment, inadequate early warning and limited evacuation capacity explain why it became so destructive. These factors should not be treated as co equal causes of ignition. The most probable initiating event was localized electrical heating leading to an electrical ignition, but the catastrophe was produced by the environment and systems that allowed a localized fault to escalate beyond control within minutes.

11. Oxygen and Biomedical Systems

A. Medical Oxygen and Gas Systems

A more serious weakness concerns system documentation and emergency isolation. The Nursery was reportedly created in 2011 by converting former washroom space through donor funded renovation outside the normal PIMS engineering process, and no as built medical gas layout is available in the present record³⁵. The evidence also does not clearly establish the location and accessibility of zone isolation valves, who was authorized to operate them during a fire, or whether clinical, security and engineering staff had been trained and drilled in emergency oxygen isolation³⁶. The risk arose not merely from the presence of medical oxygen, but from the absence of a clearly documented and rehearsed system for controlling it during an emergency. In a neonatal unit, where oxygen may be essential to patient survival yet capable of intensifying combustion, uncertainty over layout, isolation authority and emergency procedure represents a material preparedness and governance failure. A life support system cannot be safely managed in a fire if its configuration, isolation points and operating responsibility are not known in advance.

B. Biomedical Equipment

The available records materially weaken the earlier hypothesis that the fire originated from a known, persistently defective or neglected incubator or warmer. They do not, however, establish complete electrical safety. The PPM certificates largely confirm that biomedical equipment was

³² Exhibit 9 — Report of National Forensics Agency (NFA); Exhibit 50 — Task No. 2: Cause of Rapid Propagation.

³³ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 50 — Task No. 2: Cause of Rapid Propagation; Exhibit 51 — Task No. 3: Master Incident Timeline.

³⁴ Exhibit 9 — Report of NFA; Exhibit 64 — Task No. 16: Oxygen System.

³⁵ Exhibit 64 — Task No. 16: Oxygen System.

³⁶ Exhibit 64 — Task No. 16: Oxygen System; Exhibit 2 — Floor Plan, to the extent relevant to the medical-gas layout.



serviced and operational³⁷, but do not consistently document quantitative electrical safety testing, such as insulation resistance, earth leakage/current testing, load testing, or examination of associated plugs, sockets and external supply circuits. Operational functionality therefore cannot be equated with comprehensive electrical certification, particularly where part of the electrical supply installation falls outside the biomedical device itself.

No pre-fire oxygen leak, incubator fault or warmer fault is established as the initiating cause³⁸. Oxygen remains relevant only as a potential combustion intensification factor, while biomedical records show maintenance activity but incomplete device specific electrical safety and asset traceability assurance. The evidence does not support blaming biomedical equipment for ignition, but neither does a serviced and working record prove that every associated electrical risk had been tested and cleared.

12. Immediate Frontline and External Emergency Response

A. Frontline Response

Staff Nurse Razia Noreen's response is the most clearly corroborated individual rescue action. CCTV shows her entering the burning Nursery at approximately 06:38:56, emerging about eight seconds later carrying a neonate³⁹, and attempting to re enter moments afterward. Her inability to continue is consistent with the extremely rapid smoke development that obscured Camera No. 16 by approximately 06:39:15. The evidence therefore establishes both an actual rescue and an attempted second rescue during the most hazardous phase of the incident. The separate claim that she attempted to operate an electrical breaker is not sufficiently corroborated and should not be treated as established fact.

Security Guard Maria Saleem also responded immediately⁴⁰ after being alerted by Charge Nurse Nasreen Akhtar and entered the Nursery with her. Her account is materially consistent with the CCTV chronology, and the present record does not establish any individual dereliction in her immediate response. Broader deficiencies relating to security command, access control, key custody, emergency notification and exit management properly fall within the supervisory and institutional security chain unless a specific duty and omission are proved against her. The available evidence supports prompt and active frontline intervention by both Razia Noreen and Maria Saleem, rather than abandonment or inaction. The frontline conduct should be judged on what the evidence shows they actually did, while systemic security failures must be attributed through the proper supervisory chain rather than transferred to individuals without proof.

B. CES / Rescue / CDA Operational Response

The record shows that PIMS's main gate was closed because of ongoing construction, requiring the Fire Brigade to use an alternate entrance⁴¹. This is corroborated by CES and other

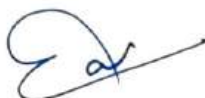
³⁷ Exhibit 37 — List of Equipment and Maintenance Logs of Incubators by PIMS; Exhibit 38 — Maintenance Records of Equipment by Hammad Manzoor; Exhibit 93 — Task No. 45: Neonatal Biomedical Equipment Integrity.

³⁸ Exhibit 9 — Report of NFA; Exhibit 37 — Equipment/Maintenance Logs of Incubators; Exhibit 49 — Task No. 1: Exact Cause of Fire; Exhibit 93 — Task No. 45: Neonatal Biomedical Equipment Integrity.

³⁹ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 21 — Statement of Razia Noreen; Exhibit 55 — Task No. 7: Individual Emergency Response.

⁴⁰ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 23 — Statement of Maria Saleem; Exhibit 55 — Task No. 7: Individual Emergency Response.

⁴¹ Exhibit 5 — Report of 1122/CES, CDA; Exhibit 17 — Statements of Rescue Workers, 1122.



material on record. CCTV nevertheless shows a gate being opened at approximately 06:59:08 and the first Fire Brigade vehicle entering PIMS at about 06:59:15⁴². The construction related closure therefore remains relevant to emergency access and on site coordination, but it is distinct from the earlier issue of delayed external notification.

PIMS had formally acknowledged the need for comprehensive fire safety modernization and sought CDA/CES assistance. This communication actually reached CES. The accountability question is therefore no longer whether PIMS replied, but what PIMS did internally after identifying the risk and what CES did after receiving the reply.

The frontline staff responded actively and CES appears to have reached PIMS within minutes once effectively notified. The principal weaknesses lie in preparedness, notification, emergency access and on site coordination, not in generalized frontline abandonment or a long post notification delay by CES. The response problem was systemic and procedural before and during activation, rather than a failure of rescuers to act once the emergency was recognized.

13. Emergency Notification and Incident Command

The evidence draws a clear distinction between immediate frontline response and effective institutional emergency activation. CCTV shows the fire visibly underway at approximately 06:38, with rescue attempts beginning within seconds, while subsequent security records indicate internal escalation through the supervisory and wireless communication chain. What is not demonstrated, however, is a single, predetermined protocol under which fire detection automatically triggered simultaneous alarm, incident command, external notification, emergency access, electrical/oxygen isolation and coordinated neonatal evacuation. The response instead appears to have evolved through successive individual communications⁴³ rather than a rehearsed institutional command system.

The principal chronological concern is the interval between detection and confirmed external notification. Muhammad Khaqan⁴⁴ reportedly stated that he attempted to contact the Fire Brigade at about 06:42, while the account of Haseeb Akram⁴⁵ places notification around 06:53, which is independently supported by the Safe City log recording a call from Haseeb, Security In charge at 06:53:00. CES records its first confirmed call at approximately 06:54, dispatch at 06:55 and arrival around 07:01⁴⁶. These records should not be conflated. The strongest established fact is that a fire visibly underway by about 06:38 resulted in confirmed CES activation only around 06:54; whether an earlier attempt was made but failed to reach CES remains relevant to individual accountability.

Once CES was effectively notified, its six to seven minute response does not appear to be the principal delay. The more significant institutional issue lies before notification: who was responsible for recognizing the need for external assistance, who had authority to make or ensure the call, and why the process was not demonstrably immediate. The available SOP framework

⁴² Exhibit 1 — Report of CCTV Analysis, SP City; Exhibit 51 — Task No. 3: Master Incident Timeline.

⁴³ Exhibit 52 — Task No. 4: Emergency-Call Delay; Exhibit 65 — Task No. 17: Nursery Evacuation SOP; Exhibit 67 — Task No. 19: Security Department Compliance.

⁴⁴ Exhibit 30 — Statement of Muhammad Khaqan, Security In-charge, MCH.

⁴⁵ Exhibit 8 — Report of Safe City; Exhibit 24 — Statement of Haseeb Akram.

⁴⁶ Exhibit 5 — Report of 1122/CES, CDA; Exhibit 52 — Task No. 4: Emergency-Call Delay.



does not clearly identify a single functionary responsible for external activation, incident command and coordinated rescue.

The evidence likewise does not establish a functioning Incident Command System during the critical first minutes⁴⁷. No record demonstrates a pre designated incident commander, clearly allocated fire and security roles, a neonatal rescue team, a designated receiving area, a single communication channel with CES, or predetermined authority for emergency isolation and evacuation. Individual staff acted courageously, security personnel escalated through their own chain and responders mobilized progressively, but these actions were not shown to have been integrated through a unified command structure.

The problem was not an absence of human response, but the absence of a tested mechanism capable of converting individual response into immediate, coordinated institutional action. PIMS therefore bears a substantive institutional responsibility for not demonstrating a clear and rehearsed system linking fire detection directly to alarm, command, evacuation, hazard isolation, access control and external notification. Person specific blame for the notification interval, however, must still depend on proof of assigned duty, time of knowledge, authority, actual action or omission, and causal consequence. In a neonatal fire that became smoke engulfed within minutes, a system dependent on sequential calls and informal escalation was inherently too slow.

14. Neonatal Evacuation, Staffing, SOPs and Drills

The adequacy of evacuation capacity must be judged against the actual patient load and level of dependency. At the time of the fire, 15 neonates were housed in a Nursery stated to have capacity for 10 beds⁴⁸. Many were premature, low birth weight or otherwise clinically vulnerable, with several dependent on oxygen, CPAP or other support, and none capable of self evacuation. Safe removal therefore required staff not only to carry each infant from danger, but also to preserve or restore essential thermal and respiratory support during and after evacuation.

Against this burden, only two doctors and two nurses were immediately available in the relevant area. Although the record contains proposed or recommended staffing ratios indicating that greater manpower may have been appropriate, their precise statutory or regulatory status has not been independently established. The Committee should therefore avoid declaring a formal staffing rule violation on that basis alone. What is clearly established, however, is the operational mismatch: four clinical staff were immediately available⁴⁹ to evacuate 15 fully dependent neonates from a Nursery that became heavily smoke affected within approximately two minutes.

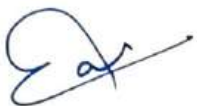
The record also does not demonstrate that PIMS had an approved, communicated, trained and rehearsed Nursery specific fire and neonatal evacuation SOP⁵⁰. No sufficiently detailed procedure has been produced covering detection and alarm, immediate external notification, incident command, allocation of rescue roles, evacuation priorities, movement of oxygen dependent infants, receiving areas, patient accountability, electrical and medical gas isolation, emergency exits and coordination with firefighters. The deficiency was therefore more

⁴⁷ Exhibit 65 — Task No. 17: Nursery Evacuation SOP; Exhibit 67 — Task No. 19: Security Department Compliance.

⁴⁸ Exhibit 10 — Record of 15 Babies; Exhibit 56 — Task No. 8: Nursery Staffing Adequacy; Exhibit 94 — Task No. 46: Neonatal Evacuation Capacity.

⁴⁹ Exhibit 18 — Duty Roster of Doctors, MOs, Nurses and Security Staff; Exhibit 53 — Task No. 5: Clinical Duty Roster; Exhibit 56 — Task No. 8: Nursery Staffing Adequacy.

⁵⁰ Exhibit 65 — Task No. 17: Nursery Evacuation SOP.



fundamental than non compliance with a procedure: the evidence does not establish that an adequate operational procedure existed in the first place.

This gap is particularly significant because the Female Nursing Hostel fire of 6 July 2026 had already identified deficiencies in smoke detection, alarms, emergency warning, drills and wider fire preparedness, yet corrective action remained incomplete immediately before the Nursery tragedy⁵¹. The August incident therefore occurred against a background of known and formally documented fire safety concerns.

The sustainable finding is one of operational inadequacy, not an unverified statutory staffing breach. Fifteen non-self-evacuating neonates, four immediately available clinical staff, limited protected transport capacity and no demonstrated full census evacuation regime created an inherently fragile emergency response. The evacuation system was not designed, staffed or rehearsed for the actual number and dependency of the babies it was required to save.

15. Fire Detection, Suppression, Access and Emergency Exits

A. Doors, Access and Egress

CES evidence identifies a broader emergency access failure. Firefighters reported locked or obstructed escape routes and, on arrival in dense smoke and severely restricted visibility, had to force open fire exit doors and an exterior glass door and create alternative access for search, ventilation and evacuation⁵². These findings independently establish deficiencies in emergency access, but they should not automatically be conflated with the separate corridor door visible on CCTV. The specific exits identified by CES should therefore be correlated with approved plans, photographs and site inspection before their legal status, designated function and responsible custody are finally fixed.

PIMS's own Security Department SOP of 27 May 2023 is directly relevant⁵³. It assigns responsibility for fire safety to the security function and requires the Assistant Director Security to ensure the availability of fire safety exits in accordance with municipal by laws, while also placing entry/exit control and spare key custody within the security chain. Ordinary access restrictions may be legitimate for security purposes, but they cannot render designated emergency routes inaccessible when needed.

The evidence supports an institutional emergency access deficiency, with a documented security duty to keep escape routes available. The security controls may regulate access, but they must never defeat emergency egress.

B. Detection, Alarm, Suppression and Firefighting

The incident specific record establishes a major deficiency in automatic fire detection and alarm protection in the MCH Nursery. Evidence examined under Tasks 11 and 12 does not demonstrate a functional automatic smoke detection or fire alarm system, nor sprinkler protection,

⁵¹ Exhibit 48 — Inquiry Report regarding Fire in Nursing College dated 6 July 2026; Exhibit 69 — Task No. 21: 6 July Nursing Hostel Fire;

⁵² Exhibit 5 — Report of 1122/CES, CDA; Exhibit 17 — Statements of Rescue Workers, 1122; Exhibit 59 — Task No. 11: Fire Exits/Escape Routes.

⁵³ Exhibit 67 — Task No. 19: Security Department Compliance; Exhibit 32 — Statement of Muhammad Usman, AD Security, PIMS.



serving the affected area⁵⁴. As a result, the fire was not automatically detected and no building wide alarm was triggered; recognition depended on someone physically observing the fire and manually communicating the emergency⁵⁵. In a neonatal unit occupied by patients incapable of self evacuation, this represented a critical failure of the first layer of life safety protection.

The evidence also supports wider deficiencies in emergency egress and layered fire protection. However, the particular adjoining door visible on CCTV is not established as causative of the fatalities. The exits identified by CES must be separately mapped, legally classified and linked to their responsible custodians before person specific accountability is fixed.

PIMS lacked an effective, integrated system of early detection, alarm, suppression and assured emergency egress in a highly vulnerable clinical area. When patients cannot save themselves, the building must detect, warn and protect before human rescue becomes the only line of defence.

16. Applicable Standards and Regulatory Requirements

The applicable fire and life safety framework at PIMS was not confined to a single code. As a major healthcare institution in Islamabad, PIMS was subject to overlapping healthcare regulation, CDA fire and building safety requirements⁵⁶, engineering controls and its own institutional SOPs. The Inquiry must therefore distinguish between legally binding statutory or regulatory requirements, internal administrative duties and international standards used only as comparative benchmarks. A deficiency should be treated as a regulatory violation only where the applicable requirement in force on 26 August 2026 is identified and proved; international good practice cannot retrospectively be treated as Pakistani law.

Against this framework, the evidence raises substantial compliance concerns relating to automatic smoke detection and alarms, sprinkler or fixed suppression systems, emergency exits and access, lighting and signage, fire drills, neonatal evacuation preparedness, incident command, electrical safety assurance and verification of corrective action. These areas broadly correspond with IHRA standards and CDA fire and life safety requirements⁵⁷. However, the Inquiry should not assume that every deficiency identified in an earlier audit necessarily remained unchanged on the date of the fire. The proper evidentiary chain is: applicable requirement, inspection or notice, identified deficiency, responsible authority, corrective action, verification and confirmed status on 26 August 2026.

The compliance must be assessed against the legal and regulatory framework actually applicable to PIMS, supported by evidence of the deficiency as it existed on the incident date. NFPA, JCI and similar international standards may inform good practice, but only become binding where incorporated into local law, approval conditions or contract. Accountability must rest on proven breach of an applicable duty, not on retrospective comparison with standards that were never legally binding.

⁵⁴ Exhibit 60 — Task No. 12: Fire Detection System.

⁵⁵ Exhibit 60 — Task No. 12: Fire Detection System; Exhibit 61 — Task No. 13: Firefighting Equipment.

⁵⁶ Exhibit 96 — Task No. 48: Applicable Technical Benchmark Standard.

⁵⁷ Exhibit 3 — Inquiry Report of DG E&M, CDA; Exhibit 4 — Inventory/Inspection Report of DG E&M, CDA; Exhibit 71 — Task No. 23: Earlier CDA/CES Notices.



17. Security and Contractual Arrangements

A. PIMS Security Department

The clearest documentary allocation of fire safety responsibility appears at Sr. No. 18 of the PIMS Security SOP⁵⁸, which assigns the Assistant Director Security responsibility for ensuring accessible fire exits in accordance with municipal requirements, functional firefighting equipment and training of relevant personnel. Security in charges and shift supervisors were further responsible for deployment, ensuring guards remained at assigned posts, controlling entry and exit points, safeguarding spare keys and reporting emergencies through the administrative and wireless chain. The amended SOP/order dated 15 April 2025 reinforces this responsibility by specifically assigning fire safety arrangements to the security supervisor. These documents therefore provide a direct basis for assessing accountability against defined duties, rather than designation alone.

The evidence also raises a separate concern regarding Security's conduct during the emergency response itself. The CES incident report and a subsequent Joint Official Statement signed by six CES officers, including the Director General, both state that hospital security personnel hindered the initial response of the fire crew⁵⁹. This allegation is distinct from, though related to, the separately identified problems of locked or obstructed exits and emergency access, and should be considered as an additional element in assessing the overall performance of PIMS Security.

The Security chain had clearly documented preventive and operational fire safety duties, and the record also raises concerns about its performance during the response. Where responsibility was expressly assigned before the fire, accountability must focus on whether those duties were actually implemented when prevention and emergency access mattered most.

B. Belfort Security Services

Clause E(xviii) placed deployed Belfort guards within the operational fire response chain by requiring them to assist in firefighting, including use of PIMS fire extinguishers during emergencies⁶⁰. The contract, however, separately required PIMS to arrange firefighting training for those guards and retained with PIMS responsibility for the hospital's broader fire safety systems and infrastructure. The contractual allocation was therefore shared but distinct: Belfort was responsible for providing and deploying guards capable of performing the stipulated emergency role, while PIMS remained responsible for training, supervision and institutional fire safety arrangements.

Accordingly, Belfort cannot be treated as having no fire response responsibility, but neither can failures relating to electrical installations, HVAC systems, alarms or fixed fire protection infrastructure be attributed to the contractor without a specific contractual and evidentiary basis. The liability must be assessed clause by clause against the duty actually assigned to each party. Belfort formed part of the response system, but PIMS retained the core institutional

⁵⁸ Exhibit 67 — Task No. 19: Security Department Compliance; Exhibit 32 — Statement of Muhammad Usman, AD Security, PIMS.

⁵⁹ Exhibit 5 — Report of 1122/CES, CDA; Exhibit 17 — Statements of Rescue Workers, 1122.

⁶⁰ Exhibit 35 — Statement/Report of Belfort Security Services; Exhibit 68 — Task No. 20: Belfort Security Performance.



responsibility for training, supervision and life safety infrastructure and cannot contract those obligations away by implication.

18. JICA Facility and Retention of the Nursery in the Old MCH

The record establishes that PIMS had a new JICA funded MCH and Children's Hospital, approved at approximately Rs. 4.27 billion, with 156 beds and specialized facilities including NICU, PICU, Maternal ICU, HDUs, emergency and operating theatres. Civil works and equipment installation were completed and the facility was formally handed over on 30 June 2024⁶¹. By 25 July 2026, PIMS itself described the new facility as fully functional, with some departments already shifted from the old MCH building. Thus, by the date of the fire on 26 August 2026, purpose built replacement infrastructure had been physically available for more than two years and was being progressively operationalized.

The record, however, does not adequately explain why the Nursery remained in the old MCH building. No contemporaneous decision note has been produced identifying who decided against relocation, what clinical, technical, staffing, equipment, medical gas or commissioning constraints prevented transfer, what risk assessment was undertaken, or what target date had been fixed. Although recruitment against 235 newly sanctioned posts remained incomplete⁶², this does not fully explain continued retention because other departments had already been shifted through redistribution of existing staff⁶³. The available project status record therefore sharpens the issue: a dedicated neonatal facility existed and was progressively coming into use, yet the Nursery remained in the old building without a sufficiently documented justification.

The continued operation of the Nursery in the old MCH constitutes a prima facie transition planning and management issue. The finding is not that relocation would necessarily have prevented every possible fire, but that neonates transferred to the new facility would not have remained exposed to the specific old Nursery electrical installation later implicated by the NFA. When safer, purpose built infrastructure is available, continued use of a higher risk legacy facility requires a documented, technically justified and time-bound decision; the present record does not demonstrate one.

19. Longstanding Institutional Fore-Warnings and Corrective Closure

The Nursery fire did not occur in an institution unaware of fire and life safety risk. As early as 2010, CDA had required PIMS⁶⁴ to undertake hospital risk assessment, emergency and evacuation planning, fire prevention measures and periodic drills, with follow up reminders when the required response was not received. These earlier communications do not prove that the same deficiencies persisted unchanged until 2026, but they establish that systematic fire preparedness had long been within the knowledge and responsibility of PIMS management.

The Federal Ombudsman's 2015 review⁶⁵ provided a broader institutional warning by identifying weaknesses in governance, accountability, infrastructure, preventive maintenance, staffing, engineering capacity, quality assurance and security services. Its relevance is not as

⁶¹ Exhibit 43 — Brief of JICA.

⁶² Exhibit 45 — Record of Ministry of National Health Services: Recruitment; Exhibit 74 — Task No. 26: Recruitment/Outsourcing Delay.

⁶³ Exhibit 43 — Brief of JICA; Exhibit 45 — Ministry Recruitment Record.

⁶⁴ Exhibit 71 — Task No. 23: Earlier CDA/CES Notices.

⁶⁵ Exhibit 103 — Wafaqi Mohtasib Report on PIMS.



evidence of the technical cause of the 2026 fire, but as proof that structural governance and maintenance weaknesses had already been formally recognized and that professional management, clearer responsibility, stronger maintenance systems, regular audits and better engineering capability had been recommended years earlier.

More recent warnings were even more direct. CDA Electrical & Mechanical Wing issued a Building Fire Safety Fitness and Hazard Alert in 2025⁶⁶, following earlier correspondence on the same subject. PIMS itself acknowledged the problem on 24 December 2025, informing CDA that the hospital's ageing and continuously operated infrastructure required comprehensive fire protection modernization and seeking technical assistance⁶⁷. By then, therefore, the need for major system level intervention was acknowledged not only externally but by PIMS itself.

The most immediate warning was the Female Nursing Hostel fire of 6 July 2026⁶⁸, only seven weeks before the Nursery tragedy. That inquiry identified deficiencies in smoke detection, alarms, evacuation preparedness, drills, electrical inspection, security response, record keeping and emergency arrangements, and recommended engineering audits, detectors and alarms, suitable extinguishers, emergency lighting, marked escape routes, regular drills and a written emergency response plan. These recommendations substantially mirrored the deficiencies later exposed in the MCH Nursery.

The handling of that warning is particularly significant. As late as 25 August 2026, one day before the Nursery fire, the July inquiry report was still being returned for revision⁶⁹, and the record does not demonstrate that its key recommendations had been converted into a comprehensive, time-bound and independently verified corrective programme. While permanent infrastructure upgrades could not necessarily have been completed within seven weeks, urgent interim safeguards, such as enhanced fire watch, targeted electrical inspection, detector/alarm measures, exit verification, drills and emergency protocols, could reasonably have been considered and documented pending permanent rectification.

The tragedy occurred against a documented history of institutional warning, acknowledgement and incomplete corrective closure. This history establishes knowledge and foreseeability, not that the same technical defect had existed for years. Accountability must therefore turn on who received the warning, what action was required, what authority and resources were available, what was actually done, and whether closure was verified before 26 August 2026. The fire may have been sudden, but the need for stronger fire preparedness was not.

20. Ministry, IHRA and External Oversight

A. Ministry of National Health Services, Regulations and Coordination

The evidence supports a Ministry level systemic oversight concern, but not designation based personal culpability. Ministry responsibility should be assessed through a clear evidentiary chain: whether the relevant risk or requirement was known to the Ministry, what authority and responsibility it possessed, what action was required, what action was initiated, whether

⁶⁶ Exhibit 71 — Task No. 23: Earlier CDA/CES Notices.

⁶⁷ Exhibit 104 — PIMS Response dated 24 December 2025 to CES Notice dated 10 December 2025.

⁶⁸ Exhibit 48 — Inquiry Report regarding Fire in Nursing College dated 6 July 2026; Exhibit 69 — Task No. 21: 6 July Nursing Hostel Fire.

⁶⁹ Exhibit 48 — Inquiry Report regarding Fire in Nursing College.



implementation was completed or delayed, and whether compliance was ultimately verified. Any disciplinary finding against an individual Ministry officer must separately establish that officer's specific duty, knowledge, tenure, authority and omission.

The stronger present finding is institutional. Staffing, infrastructure, regulatory and fire safety vulnerabilities at PIMS were being addressed through multiple parallel processes⁷⁰, but the overall system did not demonstrate an integrated mechanism for ensuring that critical operational risks were either resolved or adequately mitigated while permanent solutions remained pending. The fragmented action is not the same as effective oversight. The Ministry's failure, if established, lies not merely in whether processes existed, but in whether those processes actually delivered verified risk closure at PIMS.

B. Islamabad Healthcare Regulatory Authority

The available IHRA record shows some regulatory engagement with PIMS, but not comprehensive hospital-wide oversight in the period immediately preceding the fire. In November 2023, IHRA inspected the PIMS Blood Bank and reportedly issued directions on identified deficiencies. That inspection, however, cannot reasonably be treated as an assessment of the entire hospital, including the MCH/Nursery, fire and life safety systems, electrical installations, emergency exits or overall compliance with Hospital MSDS.

The defensible finding is therefore not that IHRA never inspected PIMS, but that the Committee has found no evidence of a comprehensive IHRA inspection of PIMS against hospital-wide MSDS, particularly fire and life safety requirements, during approximately the two years preceding the Nursery fire. The regulatory contact existed, but its scope appears limited. The partial inspection of one service cannot substitute for verified hospital-wide regulatory oversight of critical life safety risks.

C. Structural Appointment Practices

A further governance concern was raised by JED Dr. M. Iqbal Khan Durrani⁷¹, who stated that PIMS has, over time, appointed clinically trained personnel to administrative and managerial posts, including senior director level positions, without equivalent administrative qualifications or experience. He referred to a 2016 Supreme Court judgment emphasizing the distinction between clinical expertise and professional hospital administration. The Committee has not independently verified the individual cases cited and therefore does not attribute fault to any named officer on that basis. The submission is relevant, however, because it raises a broader structural question already identified in this Report: whether clinical seniority has, in some instances, been treated as a substitute for administrative, operational and safety management competence⁷².

The present record does not establish that this appointment pattern directly caused the specific failures surrounding the Nursery fire. It does, however, reinforce the broader governance finding that clinical excellence does not automatically confer competence in hospital administration, engineering oversight, emergency preparedness or life safety management. The

⁷⁰ Exhibit 45 — Ministry Record: Recruitment; Exhibit 46 — Ministry Record: Financial; Exhibit 74 — Task No. 26: Recruitment/Outsourcing Delay; Exhibit 76 — Task No. 28: HVAC/Development Funds.

⁷¹ Exhibit 27 — Statement of M. Iqbal Khan Durrani, JED.

⁷² Exhibit 27 — Statement of M. Iqbal Khan Durrani, JED; Exhibit 89 — Task No. 41: Organogram with Name, Tenure and Job Description.



competent authority should therefore review qualification and experience requirements for administrative and safety critical posts at PIMS on a professional, merit based basis.

The strongest findings against the Ministry and IHRA remain institutional, supervisory and regulatory rather than technical causes of ignition. Any person specific administrative, disciplinary or criminal liability must still be established through a defined duty, prior knowledge or notice, authority to act, actual omission and causal relevance. Institutional weaknesses may explain why risks persisted, but individual culpability must be proved, not presumed from designation.

21. Funding, Recruitment and Institutional Capacity

A. Funding, Maintenance Expenditure and Audit

A notable financial issue concerns the budget head Lines and Wires, Repair, under which the record shows only Rs.100,000 budgeted and Rs.4,900 spent in an earlier period, followed by no allocation or expenditure in FY 2023–24 and FY 2024–25⁷³. This does not establish that electrical maintenance ceased, since wiring, breakers and related works may have been charged to other maintenance heads. However, given the NFA finding that an AC supply cable was the most probable ignition point, the financial record should be reconciled with actual work orders, inspection reports and payments for wiring, Distribution Boards, breakers, sockets, earthing, cable replacement, load assessment and electrical safety testing.

The Committee should therefore avoid treating financial constraint either as irrelevant or as a blanket explanation for life safety deficiencies. The proper evidentiary chain is: identified need, formal demand, approval, release, allocation, expenditure, implementation and verification. Where a required safety measure was formally sought but funding denied, responsibility may extend beyond PIMS management; where funds existed but the risk was not identified, prioritized, properly executed or verified, the issue becomes one of institutional management and technical governance.

The present record does not identify any specific Nursery fire safety or AC 2 electrical safety proposal that was rejected for lack of funds. The issue is not simply how much money was available, but whether known safety needs were identified, funded, implemented and verified.

B. Staffing, Recruitment and Institutional Capacity

PIMS faced genuine financial and human resource constraints⁷⁴, but the record does not establish systemic financial starvation or show that any specific Nursery fire safety measure was rejected for want of funds. The more sustainable finding is whether available resources, recruitment processes and interim arrangements were effectively converted into adequate staffing, maintenance, preparedness and life safety protection at the point of care. The constraint alone does not excuse inadequate safety capacity. The issue is not merely what resources PIMS lacked, but whether the resources it had were translated into effective protection for patients.

⁷³ Exhibit 41 — Five Years' Budget and Audit Paras.

⁷⁴ Exhibit 45 — Ministry Record: Recruitment; Exhibit 73 — Task No. 25: Known HR Shortages; Exhibit 74 — Task No. 26: Recruitment/Outsourcing Delay.



22. Professional Hospital Governance and Merit Based Appointments

The evidence indicates that the failures exposed by the Nursery fire extend beyond individual operational lapses to the governance structure of PIMS itself. As early as 2015, the Federal Ombudsman⁷⁵ identified weak governance, unclear authority, diffuse accountability and inadequate professional hospital management capacity, and recommended clearer delegation, approved rules, professional administration, quality assurance and regular audit. Those earlier findings do not establish responsibility for the 2026 fire, but the persistence of similar concerns gives them direct institutional relevance.

A central governance issue is the distinction between clinical leadership and hospital administration. Senior clinicians may appropriately lead clinical departments, but management of a major tertiary hospital also requires specialist competence in administration, HR, finance, engineering, procurement, safety, emergency management, regulatory compliance and institutional risk. Clinical seniority alone should therefore not automatically qualify an individual for complex administrative or safety critical posts.

The proper test is documentary and role specific. For each senior appointment or additional charge⁷⁶, the competent authority should be able to demonstrate the sanctioned post, prescribed qualifications, recruitment or service rules, appointment process, tenure, business allocation, delegated powers and accountability arrangements. Additional charge, where unavoidable, should remain exceptional and time-bound rather than substitute indefinitely for substantive professional appointments. Concentrating unrelated functions in one officer can weaken specialization, checks and accountability, particularly where clinical, engineering, administrative and safety responsibilities intersect.

PIMS requires a professional governance model in which clinical leadership, hospital administration, engineering/facilities, biomedical services, finance, HR, quality and safety, and security/emergency management are clearly assigned to appropriately qualified professionals. The record does not prove political patronage in any specific appointment. Merit based professional management is a systemic necessity, not a retrospective allegation against individuals.

23. Disposition of Public Concerns and Objections

The Committee considered concerns raised by affected families, the media, the Senate Standing Committee, professional associations including YDA, social media and other public commentators, but treated these as lines of inquiry rather than evidence in themselves. Public scrutiny correctly highlighted important issues, including the cause of fire, alarms, exits, staffing, emergency response, prior warnings, Nursery relocation, regulatory oversight and senior management accountability. Each allegation was therefore tested against primary evidence, including CCTV, forensic findings, casualty and duty records, CES logs, SOPs and maintenance documents, and classified as established, partly established, contradicted or not established.

The generalized allegation that doctors, nurses and security personnel fled and abandoned the newborns is contradicted by the objective record⁷⁷. CCTV shows Charge Nurse Nasreen

⁷⁵ Exhibit 103 — Wafaqi Mohtasib Report on PIMS.

⁷⁶ Exhibit 89 — Task No. 41: Organogram with Name, Tenure and Job Description.

⁷⁷ Exhibit 1 — Report of CCTV Analysis, SP City; Exhibits 19–23 — Relevant Frontline Statements; Exhibit 55 — Task No. 7: Individual Emergency Response; Exhibit 78 — Task No. 30: Contradictory Evidence.



seeking assistance and re entering the Nursery, Security Guard Maria entering with her, Staff Nurse Razia rescuing a neonate and attempting to re enter, and Dr. Muhammad Abdul Rehman present in the affected area during the critical first minute. The evidence therefore establishes immediate frontline rescue activity. This does not diminish broader institutional deficiencies in staffing, evacuation planning or command, but those systemic failures cannot fairly be converted into an allegation of wholesale frontline abandonment.

The Committee has likewise found no evidentiary basis for broader claims of conspiracy, political protection, manipulation of the incident, corruption, nepotism or improper intelligence service involvement⁷⁸. Questions concerning qualifications, additional charges and appointment practices may justify governance reform and document based scrutiny, but they do not establish political patronage or misconduct without independent proof. The same principle applies to demands that any particular official be blamed or cleared: responsibility must follow assigned duty, knowledge, authority, omission and consequence, not public pressure, office held or prominence.

The public scrutiny helped identify legitimate questions, but only evidence can convert an allegation into a finding. Established failures should be stated firmly, but speculation must not be allowed to substitute for proof.

24. ToR Wise Final Findings

A. ToR 1, Determine the immediate cause and timeline of the incident

This is substantially established on the basis of the most probable forensic cause identified by the NFA. The technical origin is sufficiently established for inquiry purposes, though not to the standard of absolute mechanical certainty.⁷⁹

B. ToR 2, Assess emergency response and rescue operations both by the hospital staff and external agencies e.g. fire brigade, rescue 1122, etc.

This is established in the report. Frontline personnel responded promptly, but institutional emergency activation, notification, command and coordination were materially deficient. Individuals acted quickly, but the system did not⁸⁰.

C. ToR 3, Assess whether SOPs for emergency evacuations were followed, specifically regarding the high-risk relocation of newborns;

The foregoing is substantially established as a material deficiency in preparedness and evacuation capacity. The Nursery lacked the staffing, equipment and rehearsed systems needed to evacuate its actual high dependency patient load safely and rapidly⁸¹.

⁷⁸ Exhibit 78 — Task No. 30: Contradictory Evidence, to the extent those allegations are specifically addressed therein.

⁷⁹ Exhibit 49 — Task No. 1: Exact Cause of Fire; Exhibit 51 — Task No. 3: Master Incident Timeline.

⁸⁰ Exhibit 51 — Task No. 3: Master Incident Timeline; Exhibit 52 — Task No. 4: Emergency-Call Delay; Exhibit 55 — Task No. 7: Individual Emergency Response.

⁸¹ Exhibit 56 — Task No. 8: Nursery Staffing Adequacy; Exhibit 65 — Task No. 17: Nursery Evacuation SOP; Exhibit 94 — Task No. 46: Neonatal Evacuation Capacity.



D. ToR 4, Evaluation of Fire Safety Infrastructure and compliance of PIMS

This is substantially established at the institutional level, with significant deficiencies in fire and life safety systems, emergency egress, electrical safety assurance and regulatory compliance. Final characterization of any specific breach must, however, be tied to the precise legal or regulatory requirement applicable on 26 August 2026. The institutional deficiencies are evident, but legal liability must be requirement specific⁸².

E. ToR 5, Fix responsibility and negligence of any persons involved which resulted in the incident

This is established as numerated later at the systemic level, while prima facie individual responsibility arises only where a specific duty, prior knowledge, authority to act and corresponding omission are proved. The institutional accountability is established, but individual culpability must follow evidence, not designation⁸³.

F. ToR 6, Recommend systemic reforms for management of PIMS to avoid any such incident in future

This is fully established and requires immediate institutional, operational and regulatory reform to address the systemic deficiencies identified by the Inquiry earlier. To prevent recurrence requires not isolated corrective measures, but verified, system wide reform.

25. Causation

The evidence supports a hierarchy of causation rather than a single undifferentiated cause. At the immediate technical level, abnormal localized heating in the AC 2 supply cable most probably initiated the fire⁸⁴. Combustible plastics, other fire load materials and the oxygen supported clinical environment then accelerated flame, heat and smoke development. The consequences were aggravated by the presence of 15 neonates, none capable of self evacuation, several requiring respiratory or other support in a Nursery designed for 10 beds, limited immediately available clinical manpower and protected evacuation capacity, inadequate early warning and fixed fire protection, absence of a demonstrated rehearsed evacuation and incident command system, and weaknesses in external notification, access and integration with professional responders.

Behind these immediate factors lay a broader institutional layer: routine servicing without demonstrated preventive electrical safety assurance, longstanding fire safety warnings, incomplete corrective closure, fragmented responsibilities, delayed infrastructure and staffing transition, and weak independent regulatory verification. These factors did not physically ignite the AC 2 cable, but they materially shaped foreseeability, preventability and the failure of protective barriers⁸⁵.

⁸² Exhibits 59–64 — Fire Exits/Escape Routes, Fire Detection, Firefighting Equipment, Electrical Safety, AC/HVAC Condition and Oxygen System.

⁸³ Exhibit 80 — Task No. 32: Individual Responsibility; Exhibit 81 — Task No. 33: Administrative/Disciplinary Action.

⁸⁴ Exhibit 9 — Report of NFA; Exhibit 49 — Task No. 1: Exact Cause of Fire.

⁸⁵ Exhibits 49, 50, 52, 56, 59–65, 79 and 84 — Task papers addressing ignition, propagation, notification, staffing, exits, detection, firefighting, electrical/HVAC/oxygen systems, casualty causation and systemic versus individual failure.



The record does not establish arson, multiple ignition points, an external IESCO feeder fault, a pre-existing oxygen leak, an incubator or warmer as the proved origin, complete absence of extinguishers, wholesale frontline abandonment, a long CES delay after notification, or that the CCTV visible adjoining door itself caused the fatalities. Likewise, a secondary Intelligence Bureau attribution that Staff Nurse Razia Noreen observed a spark from an incubator/warmer is not supported by her own primary statement and conflicts with the NFA forensic finding identifying the AC 2 supply cable as the probable origin⁸⁶. It therefore does not alter the causal conclusion.

The catastrophe resulted from a cascading failure of technical, protective, evacuation, command and institutional safeguards. The consolidated causal chain is: probable AC 2 electrical heating to ignition of combustible material to exceptionally rapid fire and smoke propagation to inadequate detection and protection to limited neonatal evacuation capacity to improvised rather than rehearsed response to delayed or uncertain external activation and access constraints to catastrophic loss, against a background of known but incompletely closed institutional risks. The electrical fault started the fire, but the failure of successive safety barriers allowed it to become a catastrophe.

26. Systemic and Institutional Failures

The central institutional weakness was not the absence of departments or assigned responsibilities, but the failure to integrate clinical, engineering, security, administrative, contractor and regulatory functions into a dependable patient safety system. The record shows recurring weaknesses in preventive electrical assurance, layered fire and life safety protection, emergency planning and command, neonatal evacuation capacity, infrastructure transition, closure of prior warnings, regulatory verification and documentation.

Maintenance existed, but not a sufficiently robust preventive electrical safety regime for high risk circuits. Portable firefighting equipment was available, but the Nursery lacked a demonstrated integrated system of detection, alarm, fixed protection and assured egress. Staff responded, but no rehearsed neonatal evacuation or incident command structure was established. High dependency services continued during staffing and infrastructure transition without a clearly documented mechanism for identifying, mitigating and verifying operational risk.

The July 2026 fire and earlier CDA and Ombudsman warnings⁸⁷ show that the principal institutional risks were not wholly unforeseeable. The recurring weakness was the absence of a closed loop system converting each identified risk into a named action, responsible owner, deadline, interim safeguard, verified implementation and formal closure. Fragmented responsibility across PIMS, the Ministry, CDA/CES, IHRA, contractors and other agencies compounded this failure.

Systemic failure, however, does not imply universal individual guilt. Corrective, maintenance and recruitment processes were underway, and several frontline personnel acted

⁸⁶ Exhibit 7 — Source Report, only if independently confirmed as the document containing the attributed incubator/warmer observation.

⁸⁷ Exhibit 48 — July 2026 Inquiry Report; Exhibit 69 — Task No. 21; Exhibit 71 — Earlier CDA/CES Notices; Exhibit 103 — Wafaqi Mohtasib Report on PIMS.



courageously. Individual responsibility must therefore be established separately through proof of assigned duty, knowledge, authority, omission and material consequence.

The tragedy reflects a failure of integration and risk closure rather than a single departmental lapse. The institutional chain is clear: Known Risk to Fragmented Ownership to Incomplete Correction to Weak Preparedness to Improvised Response to Catastrophic Consequence. The responsibilities existed on paper, but they did not operate together as a functioning safety system.

27. Person-Wise Administrative and Disciplinary Responsibility

The Committee has approached individual responsibility on the principle that systemic failure does not automatically establish personal misconduct. For disciplinary purposes, responsibility must follow a defined chain: assigned duty, source of duty, prior knowledge or foreseeability, authority and opportunity to act, required action, and proved act or omission. The Committee therefore identifies prima facie grounds for proceedings, not final guilt. Each officer should face a separate, evidence based charge under the applicable E&D framework, and no person should be accused merely by virtue of designation or of causing the fire or causing fourteen deaths unless a distinct causal foundation is established.

Professor Dr. Rana Imran Sikandar, Executive Director, PIMS, bears prima facie scrutiny as institutional head for overall administrative supervision and for ensuring effective follow through on known fire and life safety risks, particularly after the Female Nursing Hostel fire of 6 July 2026. Apparently, he did not effectively ensure a time-bound corrective programme, assign responsibility, order interim safeguards, require necessary drills and emergency SOPs, and verify implementation of these in the aftermath of July fire incident. This liability, as and when established, shall be based on his lack of diligence and knowledge, failure to issue directions & optimally using the available resources and other mis-coordinated matters dependent upon external agencies⁸⁸.

Dr. Mutahir Shah, Joint Executive Director, MCH, is prima facie accountable for MCH level administrative and emergency preparedness. The affected Nursery fell within the MCH domain, yet the record does not demonstrate an approved and rehearsed neonatal evacuation system, coordinated incident command arrangements or adequate follow through on known fire safety concerns⁸⁹. Proceedings may therefore examine whether he ensured MCH specific preparedness, staff familiarization and coordination among clinical, nursing, security and technical functions, subject to confirmation of his formal business allocation and authority.

Dr. Aneza Jalil, Deputy Executive Director, is prima facie answerable for whether she exercised adequate administrative diligence after being placed on notice of the July fire and unresolved deficiencies concerning fire causation, evacuation and emergency response. She may be charged as to her failure to attend to her assigned responsibilities, inasmuch as she failed to

⁸⁸ Exhibit 25 — Statement/Report of Executive Director, PIMS; Exhibit 48 — Inquiry Report regarding 6 July 2026 Fire; Exhibits 69–72 — Prior Fire, Implementation, Earlier Notices and Interim Safeguards; Exhibit 89 — Organogram/Job Description.

⁸⁹ Exhibit 29 — Statement of Dr. Mutahir Shah, JED; Exhibit 65 — Nursery Evacuation SOP; Exhibit 89 — Organogram/Job Description.



initiate, recommend or ensure reasonable interim safeguards while the earlier inquiry and permanent corrective measures remained pending⁹⁰.

Ch. Waris Ali Raza, Joint Executive Director (Non Medical), requires scrutiny in relation to non clinical safety and administrative functions, including Security, engineering and maintenance coordination, fire safety arrangements, access and egress, and emergency preparedness to the extent these were formally assigned to him⁹¹. He may be charged with his omissions in respect of specific functions, duties and responsibilities, which lay fairly within the breadth of his designation and official role.

Prof. Dr. Nosheela Javed, Director MCH, is similarly subject to prima facie examination regarding operational preparedness within MCH and the Nursery, including neonatal evacuation arrangements, staff awareness of emergency roles, coordination among clinical, nursing, engineering and security functions, and escalation or correction of known deficiencies⁹². Her liability and culpability in departmental proceedings is based on her role and responsibilities which are a subset of his superior's overall administrative responsibility.

The strongest direct documentary basis for disciplinary scrutiny presently lies against Muhammad Usman, Assistant Director Security. The Security SOP of 27 May 2023 expressly assigned his office responsibility for fire safety arrangements, emergency exits, firefighting equipment readiness and training. His own statement further confirms that he was at his home village on 26 August without sanctioned station leave, learned of the fire at about 9:00 a.m. and reached PIMS only between 12:30 and 1:00 p.m. Separate disciplinary issues may therefore arise concerning unauthorized absence, failure to ensure emergency exits and access, firefighting readiness, training, key custody and supervisory preparedness. These allegations must remain distinct from any claim that he caused the ignition or fatalities. His role as a member⁹³ and signatory of the July 2026 Hostel Fire Inquiry is additionally significant because it demonstrates direct prior knowledge of deficiencies in security response, overnight deployment, patrol documentation and electrical safety certification⁹⁴.

Professor Dr. Sadia Riaz, HOD Neonatology, requires a more qualified assessment. She being the head of the unit was squarely and solely responsible for clinical governance and administration of human resource in that unit. Her failure to ensure presence of clinicians and required staff in the unit makes her liable for departmental proceedings on grounds of inefficiency, administrative negligence and ineffectiveness⁹⁵.

Dr. Nagham Nawaz, Senior Registrar, requires similar individualized scrutiny. Though her presence or absence in the neonatology unit at the material time would not have had any bearing on the incident or its outcomes; however, she was supposed to be the senior most clinician present

⁹⁰ Exhibit 26 — Statement of Dr. Aneza Jalil, DED; Exhibit 48 — July Fire Inquiry Report; Exhibits 69, 70 and 72 — Prior Fire, Implementation and Interim Safeguards.

⁹¹ Exhibit 28 — Statement of Ch. Waris Ali Raza, JED; Exhibit 67 — Security Department Compliance; Exhibit 89 — Organogram/Job Description.

⁹² Exhibit 89 — Task No. 41: Organogram with Name, Tenure and Job Description; Exhibit 80 — Individual Responsibility; Exhibit 81 — Administrative/Disciplinary Action.

⁹³ Exhibit 48 — Inquiry Report regarding Fire in Nursing College dated 6 July 2026; Exhibit 69 — Task No. 21: 6 July Nursing Hostel Fire.

⁹⁴ Exhibit 32 — Statement of Muhammad Usman, AD Security, PIMS; Exhibit 67 — Security Department Compliance; Exhibit 80 — Individual Responsibility; Exhibit 81 — Administrative/Disciplinary Action.

⁹⁵ Exhibit 18 — Duty Roster; Exhibit 36 — Attendance Records; Exhibit 53 — Clinical Duty Roster; Exhibit 54 — Actual Presence/Absence.



on the occasion. She did not claim, rather admitted, that she had been away to her residence during the whole night. This amounts to a reasonable and sufficient ground for disciplinary proceedings against her for inefficiency and administrative negligence⁹⁶.

The case against Dr. Abdul Rehman, Director General, Capital Emergency Service, CDA, should be based on the responsibilities assigned to his office as well to the organization that he heads, in the wider municipal ecosystem of Islamabad. As such, no disciplinary allegation of delayed operational response on 26 August is presently supported, as CES records dispatch at 06:55 following notification at 06:54 and arrival within minutes. However, his liability for departmental proceedings shall be based on his and his organization's failure to ensure mandated inspections, enforcement of relevant regulations, undertaking drills and follow ups regarding PIMS fire preparedness⁹⁷.

Shahid Mehmood, Muhammad Khaqan and Haseeb Akram, as part of the relevant security supervisory chain, require separate scrutiny regarding emergency escalation and external notification. The record indicates wireless transmission by Shahid around 06:40, a claimed attempt by Khaqan to contact the Fire Brigade around 06:42, and a later call by Haseeb around 06:53. The apparent gap before confirmed CES notification raises a serious institutional issue, but disciplinary responsibility should be fixed only after establishing who had the formal duty to call, when each individual acquired knowledge and whether any earlier call was actually made or received⁹⁸.

Engineering, electrical and HVAC personnel, together with the relevant maintenance contractor, remain a significant but incompletely individualized accountability line. The NFA identifies the AC 2 supply cable arrangement as the most probable ignition point, while the maintenance record does not demonstrate prior preventive testing of the cable, terminations, insulation, protection or associated circuit. This justifies identifying the officers, technicians, contractors and supervisory authorities responsible for installation, inspection, servicing and certification. Liability should arise only where a person specific duty was breached, a reasonably discoverable defect was overlooked, required testing was omitted or safety was falsely certified⁹⁹.

Conversely, the present record does not establish a sustainable disciplinary case concerning immediate response against Charge Nurse Nasreen Akhtar, Staff Nurse Razia Noreen, Security Guard Maria Saleem, Dr. Muhammad Abdul Rehman or Dr. Rimsha Ahmed¹⁰⁰. CCTV and corroborating evidence establish active frontline response, including raising the alarm, entering the affected area, rescuing a neonate, attempting further rescue and receiving or treating evacuated babies. Their conduct should therefore be distinguished from wider institutional failures and recorded fairly.

⁹⁶ Exhibit 18 — Duty Roster; Exhibit 36 — Attendance Records; Exhibits 53 and 54 — Clinical Duty Roster and Actual Presence/Absence.

⁹⁷ Exhibit 5 — Report of 1122/CES, CDA; Exhibit 17 — Statements of Rescue Workers; Exhibit 71 — Earlier CDA/CES Notices; Exhibit 80 — Individual Responsibility.

⁹⁸ Exhibit 8 — Report of Safe City; Exhibit 24 — Statement of Haseeb Akram; Exhibit 30 — Statement of Muhammad Khaqan; Exhibit 52 — Emergency-Call Delay; Exhibit 67 — Security Department Compliance.

⁹⁹ Exhibit 9 — Report of NFA; Exhibit 34 — Statement of Hassan Nawaz, DD Engineering; Exhibit 39 — AC Maintenance Record; Exhibit 62 — Electrical Safety; Exhibit 63 — AC/HVAC Condition; Exhibit 90 — Electrical.

¹⁰⁰ Exhibit 1 — CCTV Analysis; Exhibits 19-23 — Relevant Statements; Exhibit 55 — Individual Emergency Response.



Belfort Security Services should remain outside the civil servant E&D framework. Any default concerning deployment, supervision, access, firefighting or other contractual obligations should be addressed through a separate clause-specific contractual show cause process. Likewise, institutional shortcomings of the Ministry or IHRA should not be converted into charges against unnamed officers unless a defined statutory or administrative duty, notice, authority and omission are established.

The strongest direct documentary duty case presently lies in the Security chain; senior management accountability depends upon precise business allocation and prior knowledge; clinical cases require proof of mandatory physical or supervisory duty; CES accountability depends upon proof of antecedent legal mandate; and engineering responsibility must be individualized to the AC 2 circuit and its maintenance history. The systemic failure is established, but personal culpability must be proved officer by officer through duty, knowledge, authority, omission and consequence, not inferred from title, seniority or public pressure.

In the course of departmental proceedings, should the examination of job descriptions of any other official, officer or person indicate failure, negligence or inefficiency, such officers or officials may also be included in the proceedings.

28. Contractual Responsibility

Contractual responsibility must remain distinct from departmental discipline and criminal liability. A contractor is answerable only where a specific contractual duty, required performance, proved breach and corresponding contractual consequence are established. Mere presence at PIMS is insufficient to create liability, while outsourcing does not relieve PIMS of any retained duty to supervise, verify, train, certify or enforce performance.

The clearest contractual issue concerns M/s Belfort Security Services (Pvt.) Ltd., which provided round the clock security at PIMS, including MCH. Its obligations extended beyond routine watch and ward to deployment, access and exit control, supervision and emergency response, including participation in firefighting using PIMS equipment. Several Belfort personnel did in fact assist in rescue, firefighting, access management and responder support; a blanket finding of abandonment or wholesale contractual failure is therefore not sustainable¹⁰¹. The appropriate inquiry is narrower: whether required personnel were deployed and present, supervisory arrangements functioned, emergency routes and keys were immediately accessible, and contractual firefighting, communication and evacuation duties were properly performed. CES findings on locked or obstructed routes make this scrutiny important, but responsibility must be fixed route by route, post by post and custodian by custodian.

A separate contractual line concerns M/s BE Engineers, responsible for repair, maintenance and operation of HVAC equipment along with contractors responsible for oxygen and medical equipment repair and maintenance. Its contract required qualified manpower, servicing, inspection and preventive maintenance, while PIMS Engineering retained responsibility for supervision, verification and certification of the contractor's work. The responsibilities were

¹⁰¹ Exhibit 35 — Statement/Report of Belfort Security Services; Exhibit 68 — Belfort Security Performance; Exhibit 82 — Task No. 34: Contractual Action.



therefore shared but distinct: BE Engineers was responsible for competent execution within its contractual scope, while PIMS remained responsible for oversight and acceptance¹⁰².

The contractual liability must be clause-specific and evidence based. The outsourcing may transfer performance obligations, but it does not transfer PIMS's retained duty to supervise, verify and enforce them.

29. Prima Facie Criminally Culpable Acts / Omissions

The Committee has maintained a clear distinction between administrative negligence, contractual default and criminal culpability. A breach of official duty may justify disciplinary action without amounting to a criminal offence. Criminal liability requires a higher threshold: a legally recognized duty, knowledge or reasonable foreseeability of danger, authority and capacity to act, a sufficiently culpable act or omission, and, where death is attributed to negligence, a legally sustainable causal nexus between that conduct and the fatalities. The Committee may therefore identify matters warranting criminal investigation, but final criminal guilt must remain for the competent investigating, prosecuting and judicial authorities.

The first and technically strongest potential criminal line concerns the AC 2 electrical supply circuit. The NFA identifies abnormal localized heating in the AC 2 supply cable near or over AC 1 as the most probable point and mechanism of ignition. Although maintenance records show servicing of the Nursery ACs, they do not establish systematic pre-fire testing of the implicated cable, terminations, insulation, breaker protection, earthing or thermal condition. This does not itself prove criminal negligence, but it warrants investigation into who designed, installed, altered, inspected, maintained or certified the circuit and whether a reasonably discoverable dangerous condition was culpably left uncorrected or equipment returned to service without required safety verification¹⁰³.

The second line concerns mandatory emergency exits or escape routes reported by CES as locked or obstructed during rescue operations. Criminal investigation may be warranted if a particular route is confirmed as a mandatory emergency exit, a specific officer or contractor employee was responsible for keeping it immediately accessible, that duty was knowingly or negligently breached, and the obstruction materially delayed rescue or evacuation. The particular corridor door visible on CCTV should not itself be treated as causative unless that separate causal chain is proved¹⁰⁴.

The third line concerns culpable non action despite prior warning. The 6 July 2026 Nursing Hostel fire had already generated specific recommendations on alarms, smoke detection, electrical inspection, evacuation, firefighting equipment, training and emergency preparedness. If a particular officer is shown to have received a material warning, possessed a clear duty and authority to act, had a reasonable opportunity to implement permanent or interim safeguards, and nevertheless failed without justification, the combination of notice, foreseeability, omission and

¹⁰² Exhibit 34 — Statement of DD Engineering; Exhibit 39 — AC Maintenance Records; Exhibit 40 — HVAC Record; Exhibit 63 — AC/HVAC Condition; Exhibit 82 — Contractual Action.

¹⁰³ Exhibit 9 — Report of NFA; Exhibit 62 — Electrical Safety; Exhibit 90 — Electrical.

¹⁰⁴ Exhibit 5 — CES Report; Exhibit 17 — Rescue Workers' Statements; Exhibit 58 — Causal Impact of Locked Door; Exhibit 59 — Fire Exits/Escape Routes.



resulting harm may warrant criminal investigation. Prior warning alone, however, is insufficient; individual responsibility and causal consequence must be proved¹⁰⁵.

The fourth line concerns the apparent delay in effective external emergency notification. CCTV shows the fire visibly underway at approximately 06:38, while CES records its confirmed call at about 06:54, notwithstanding evidence of an internal wireless warning around 06:40 and an alleged earlier attempt to contact the Fire Brigade. In an incident that became heavily smoke engulfed within minutes, a culpable failure by the person specifically responsible for summoning external assistance could be significant. Criminal attribution would nevertheless require proof of who had the duty to call, when that person acquired knowledge, whether an earlier effective call was made, why any delay occurred, and whether earlier notification would probably have created a meaningful rescue opportunity¹⁰⁶.

Conversely, the present record does not disclose a sufficient basis for criminal attribution against frontline responders whose immediate rescue conduct is objectively documented, including Nasreen Akhtar, Razia Noreen, Maria Saleem, Dr. Muhammad Abdul Rehman and Dr. Rimsha Ahmed. Nor would the mere absence of an on call consultant or other officer, even if administratively irregular, amount to criminal causation without proof that physical presence was legally required and that the absence materially contributed to the deaths.

The Committee therefore considers that the relevant forensic, CCTV, CES, security, maintenance and prior warning material should be referred to the competent law enforcement agency for focused investigation of four potential criminal lines: culpable electrical installation or maintenance failure relating to the AC 2 circuit; culpable locking or obstruction of a mandatory emergency route; knowing or grossly negligent non action after specific prior warning; and any proved culpable delay in summoning external emergency assistance. Each line should be tested through the sequence: duty, knowledge or foreseeability, authority, act or omission, degree of negligence, failed safeguard, causal contribution and applicable offence. The precise penal provision should be determined only after the facts are fully established.

The record supports focused criminal investigation, but not a finding of criminal guilt against any named individual at this stage. The criminal liability must rest on a proved person specific chain of duty, culpable omission and causation, not on institutional failure alone.

30. Matters Not Established / Persons Not Adversely Implicated

The Committee considers it equally important to record what the evidence does not establish. Accountability requires both adverse and exculpatory findings, and no allegation has been treated as proved merely because of public suspicion, official designation or the gravity of the outcome. Findings have been confined to matters supported by objective, documentary or technically competent evidence.

The allegation that the newborns were deliberately locked inside the Nursery is not established. CCTV shows that one adjoining door was initially unavailable but was opened at approximately 06:39:45 while rescue activity was already underway through another access.

¹⁰⁵ Exhibit 48 — July Fire Inquiry Report; Exhibits 69–72 — Prior Fire, Implementation, Earlier Notices and Interim Safeguards; Exhibit 83 — Criminal Dimension.

¹⁰⁶ Exhibit 5 — CES Report; Exhibit 8 — Safe City Report; Exhibit 24 — Statement of Haseeb Akram; Exhibit 30 — Statement of Muhammad Khaqan; Exhibit 52 — Emergency-Call Delay; Exhibit 83 — Criminal Dimension.



Camera No. 12 further records Ghulam Murtaza attempting to gain access at about 06:39:13 and seeking assistance before the door was opened, which is inconsistent with deliberate abandonment or intentional obstruction¹⁰⁷. CES did encounter other locked or obstructed routes, establishing a serious institutional egress concern, but this does not prove that the CCTV visible door caused the fatalities. Any adverse finding must therefore identify the specific exit, its required emergency function, responsible custodian and actual consequence of its unavailability.

The generalized allegation that doctors, nurses and security personnel abandoned the neonates is likewise contradicted by the objective record. CCTV and corroborating evidence show immediate alarm, entry and re entry, rescue attempts and subsequent clinical support. Nasreen Akhtar raised the alarm and returned to the Nursery; Razia Noreen rescued a neonate and attempted re entry; Maria Saleem entered the affected area when summoned; Dr. Muhammad Abdul Rehman was present during the critical first minute; and Dr. Rimsha Ahmed assisted in receiving and treating evacuated babies. Minor discrepancies in recollection do not convert these documented actions into dereliction¹⁰⁸.

Accordingly, the present record does not support disciplinary or criminal action against these frontline responders for their immediate conduct merely because most of the neonates could not be saved. This conclusion is confined to their emergency response and does not preclude examination of any separate duty later established through an authenticated roster or specific written assignment. On the evidence presently available, however, their immediate conduct is substantially exculpatory.

The record also does not establish deliberate concealment of casualties, falsification or destruction of evidence, conspiracy, political protection, sabotage, corruption or political manipulation. Nor does it prove that retaining the Nursery in the old MCH was deliberately unsafe or that relocation to the JICA facility would certainly have prevented every possible fire. The retention decision remains a legitimate management and transition planning issue, but motive and causation cannot be inferred from inadequate documentation alone¹⁰⁹.

The Inquiry must correct unsupported allegations with the same care that it identifies proven failures. The responsibility cannot arise from designation, association, public pressure or an unsuccessful outcome; it must rest on proved duty, conduct and consequence.

31. Immediate Corrective Measures

The Committee considers that life safety action cannot await completion of disciplinary, contractual or criminal proceedings. The immediate priority is to remove continuing risks to patients and staff, particularly in Nursery/NICU, PICU, ICU, HDU, operating theatres, Emergency and other high dependency areas. PIMS should therefore undergo an independent hospital-wide fire, life safety and electrical audit based on physical testing, not paper compliance alone, covering detection and alarms, extinguishers, hydrants and hose systems, emergency lighting, exits, compartmentation, electrical installations and medical gas systems. Every

¹⁰⁷ Exhibit 1 — CCTV Analysis; Exhibit 57 — Locked-Door Allegation; Exhibit 58 — Causal Impact of Locked Door; Exhibit 78 — Contradictory Evidence.

¹⁰⁸ Exhibit 1 — CCTV Analysis; Exhibits 19–23 — Relevant Frontline Statements; Exhibit 55 — Individual Emergency Response.

¹⁰⁹ Exhibit 78 — Task No. 30: Contradictory Evidence, only to the extent the task paper specifically examines those allegations.



deficiency should be risk ranked and either rectified immediately or covered by a documented interim safeguard.

PIMS should also establish a single, tested emergency notification and incident command protocol. Detection of a serious fire should simultaneously trigger the internal alarm, direct notification of CES/Rescue/Fire Brigade, activation of a designated Incident Commander, patient evacuation, security and access measures, and engineering support without sequential administrative approval. Every shift should identify primary and alternate officers responsible for making and confirming the external emergency call, while communication links among wards, Control Room, Security, Engineering and external responders should be periodically tested and logged.

A dedicated Nursery/NICU fire and neonatal evacuation SOP should be approved and operationalized immediately. It should define alarm responsibilities, evacuation priorities, movement of oxygen and respiratory support dependent infants, electrical and medical gas isolation, receiving areas, patient identification and accountability, and mobilization of additional manpower and transport equipment. Evacuation cots, bassinets, transport incubators and portable respiratory support equipment should be provided according to actual patient census and dependency. Regular multidisciplinary drills involving clinical staff, Security, Engineering and CES should test the system under realistic conditions rather than remain limited to classroom instruction¹¹⁰.

High risk clinical services should continue only where minimum life safety safeguards are physically tested, functional and independently verified. Where permanent rectification requires time, documented interim protection must remain in place. A measure being under process is not a safety standard, continued patient care must depend on verified protection, not pending paperwork.

32. Medium and Long Term PIMS Reforms

The Committee considers that immediate corrective measures should be followed by a medium term reform programme, extending roughly from three months to two years, to replace reactive correction with a permanent safety management system. PIMS should adopt a comprehensive Hospital Fire and Life Safety Plan integrating detection and suppression, compartmentation, electrical safety, medical gases, emergency power, evacuation, security, responder access and continuity of critical care. High dependency areas such as NICU, Nursery, PICU, ICU, HDU and operating theatres should be specifically risk classified, with safeguards proportionate to the fact that many patients cannot self evacuate.

A permanent Hospital Safety and Vigilance Committee should operate under PIMS/Ministry oversight with representation from hospital management, clinicians, Engineering, Biomedical Services, Security, CES/fire services, disaster management and relevant regulators. Its role should be to conduct multidisciplinary inspections of critical systems, track high risk deficiencies and escalate unresolved matters directly to senior management and the Ministry. The essential reform is not the creation of another reporting body, but a mechanism that assigns responsibility, deadlines and verification until each safety deficiency is physically closed.

¹¹⁰ Exhibit 97 -- Task No. 49: Cross-Facility Risk Exposure.



In the short term, PIMS should also implement an integrated Hospital Management Information System and digital safety/security platform covering biometric attendance and duty rosters, patient and ward management, equipment inventory and preventive maintenance, fire safety inspections and drills, incident and work order tracking, CCTV retention, access control and centralized emergency communication. Time stamped audit trails, automatic escalation of overdue safety actions and management dashboards should provide clear accountability and real time oversight. PIMS should also progressively professionalize its administrative structure by assigning hospital management, engineering, safety, finance, HR, procurement and other non-clinical functions to suitably qualified and experienced professionals. Clinical expertise should remain central to clinical governance, but should not by itself be treated as sufficient qualification for complex administrative or safety critical appointments. Medical professionals may hold such posts where they additionally possess relevant hospital management qualifications and demonstrated administrative competence.

Pending wider governance reform, an Independent Safety and Governance Oversight Board may be constituted for a defined transitional period to supervise implementation of fire safety, engineering, staffing, emergency preparedness, regulatory and digital governance reforms. Comprising independent technical and healthcare management experts, it should receive direct compliance reports, conduct or commission unannounced audits and report periodically to the competent federal authority until sustained compliance is demonstrated.

Over the longer term, PIMS should be restructured around professional hospital governance in which patient safety carries authority equal to clinical and financial management. A senior Fire/Life Safety and Facilities function should have clearly delegated powers, direct access to the Executive Director or governing authority, a protected life safety budget and authority to restrict or close unsafe areas until minimum safeguards are restored. Administrative, engineering, biomedical, security and other safety critical appointments should be based on relevant qualifications, experience and competence, while additional charges should remain exceptional and time-bound¹¹¹.

PIMS must move from reactive maintenance and improvised response to an integrated, digitally monitored and independently verified safety management system. The medium term reform should make safety systematic; long term reform should make it professionally governed, independently assured and institutionally durable.

33. Federal Healthcare Regulatory Reforms

The Committee considers that the PIMS tragedy exposes a regulatory weakness extending beyond a single hospital. Responsibility for healthcare safety is presently dispersed among hospital management, healthcare regulators, CDA/fire authorities, engineering agencies and the Federal Government, without a sufficiently integrated mechanism to ensure that a serious deficiency identified by one authority is assigned to a responsible owner, corrected within a defined timeframe, independently re inspected and formally closed. The federal objective should therefore be a coherent healthcare safety assurance framework, particularly for tertiary hospitals and units caring for non-self-evacuating patients.

¹¹¹ Exhibit 89 — Organogram with Name, Tenure and Job Description; Exhibit 103 — Wafaqi Mohtasib Report on PIMS.



Regulation should move towards risk based, multidisciplinary inspection rather than generic compliance visits. Major hospitals should be assessed by teams with healthcare, fire/life safety, electrical, biomedical, engineering and emergency management expertise. Critical systems, including alarms, detectors, exits, emergency lighting, hydrants, medical gas isolation and electrical protection, should be physically tested rather than accepted solely on the basis of certificates, inventories or institutional representations. This requires adequate regulatory staffing, specialist qualifications, continuous training and sufficient independence from the institutions being inspected.

The Committee further recommends development of a specific federal standard for critical care fire safety, recognizing that NICUs and comparable units cannot be regulated as ordinary wards. Such standards should address patient dependency risk, safe occupancy, evacuation staffing, appropriate transport devices, compartmentation and horizontal evacuation where practicable, continuity of oxygen and respiratory support, designated receiving areas and regular multidisciplinary drills. No new or substantially renovated critical care facility should become operational until these life safety arrangements have been independently tested and certified.

The healthcare regulation must evolve from periodic registration and inspection into continuous, risk based safety assurance. A serious safety deficiency should never disappear into correspondence, it must have an owner, a deadline, verified correction and formal closure¹¹².

34. Implementation and Compliance Framework

The Committee considers that the value of its recommendations will depend not on formal acceptance, but on whether each is converted into an assigned, time-bound and independently verified action. A recurring weakness identified by the Inquiry was that deficiencies could be recorded through audits, inspections, correspondence or earlier inquiries without any dependable mechanism ensuring final correction. Accordingly, no life safety recommendation should be treated as complete until the required measure has been physically implemented, tested and verified.

Immediately upon acceptance of the Report, the Ministry of National Health Services should prepare a Consolidated Corrective Action Plan covering every recommendation. Each item should identify the deficiency, corrective measure, responsible institution and designated officer, implementation deadline, financial requirement and funding source, interim safeguard where permanent rectification requires time, verification authority and final closure status. Responsibility should be assigned by both institution and designation so that implementation does not become diffused among PIMS, the Ministry, CDA/CES, IHRA, engineering branches or contractors.

The framework should also provide consequences for unjustified non compliance. Failure by an officer to implement an assigned corrective action may warrant administrative or disciplinary proceedings; contractor default should be addressed under the relevant contract; and regulatory breaches should attract action under applicable law. Where implementation is delayed by funding, procurement or another agency, the precise stage and responsible authority should be recorded so that accountability follows the actual point of failure.

¹¹² Exhibit 96 -- Applicable Technical Benchmark Standard; Exhibit 97 -- Cross-Facility Risk Exposure.



The recommendations must operate as enforceable actions rather than advisory observations. The implementation chain should be: Finding to Corrective Action to Responsible Owner to Deadline to Resources to Interim Safeguard to Implementation to Independent Verification to Closure to Periodic Revalidation. A safety recommendation is not implemented when it is approved, it is implemented only when the risk is physically removed, independently verified and formally closed.

35. Support to Families, Survivor and Staff

The Committee considers that the consequences of the Nursery fire extend beyond the immediate loss of life and require continuing support for the bereaved families, the surviving neonate and staff directly exposed to the incident. Thirteen families lost newborn children, while one infant survived after further neonatal treatment. Institutional responsibility therefore should not end with completion of the Inquiry; PIMS and the Ministry should provide coordinated, respectful and continuing assistance rather than requiring affected families to navigate multiple offices independently.

A single Family Support and Liaison Cell should be established at PIMS under a senior officer not directly involved in any disputed aspect of the incident. It should serve as the focal point for communication, facilitate lawful access to relevant medical and administrative records, provide updates on disciplinary, criminal and corrective proceedings, coordinate admissible financial or welfare assistance, and keep families informed of material institutional actions arising from the Inquiry. Communication should remain factual, compassionate, periodic and respectful of privacy and pending proceedings.

Bereaved families should also be offered voluntary professional psychological and bereavement support, including remote counselling or referral where families reside outside Islamabad. The surviving neonate should receive clinically appropriate long term follow up, while staff directly exposed to the incident should have access to psychological support¹¹³. Any compensation, ex gratia payment or other financial relief should be processed transparently and expeditiously under applicable law and Government policy, without prejudice to independent legal rights or claims¹¹⁴.

The institutional accountability includes sustained care for those affected, not merely investigation of those responsible. This inquiry may conclude with a report, but PIMS's duty to the families, the survivor and affected staff should continue through coordinated support, transparent communication and verifiable follow up.

36. Transparency, Publication and Institutional Learning

In the interest of transparency, public confidence and institutional learning, the Committee recommends that the Final Inquiry Report, or an appropriately redacted version, be placed in the public domain by the competent authority. Publication would enable informed scrutiny by professionals, technical experts, civil society and other stakeholders, and support broader learning on hospital fire safety, emergency preparedness, healthcare regulation and institutional governance. Disclosure should, however, remain subject to due process, privacy and legal restrictions. Material should be withheld or redacted where publication could prejudice pending

¹¹³ Exhibit 95 -- Task No. 47: Clinical Outcome Tracking of Survivors.

¹¹⁴ Exhibit 98 -- Task No. 50: Family and Staff Psychological Support.



disciplinary or criminal proceedings, compromise forensic or investigative material, disclose protected medical or personal information, reveal sensitive CDR or security data, or otherwise violate applicable law. The competent authority may also establish a time-bound mechanism for receiving technically or administratively useful comments and incorporating appropriate recommendations into the corrective programme. The institutional learning from a mass fatality hospital incident should not remain confined to the inquiry file. Transparency should be the default, with only those limitations necessary to protect due process, privacy and lawful investigations.

37. Conclusion

The Committee is satisfied that the evidence gathered through its structured 52 task investigation is sufficient to determine the substantive Terms of Reference. Although certain supplementary matters, including formal chain of custody documentation and finer person specific duty reconciliation, may require further completion, no material finding rests merely on an evidentiary gap. Issues requiring disciplinary adjudication, contractual determination or criminal investigation have been identified for consideration by the competent authorities through due process.

The record also establishes that several frontline personnel responded immediately and courageously. Their actions do not negate the institutional failures identified by the Inquiry, but neither should those failures be converted into retrospective blame against those who attempted rescue. Responsibility must attach to the duty holder who had the knowledge, authority and opportunity to prevent or mitigate a proved failure, not simply to the individual most visible after the disaster.

The enduring lesson is that patient safety cannot depend on individual courage once a fire has started. It must be secured beforehand through preventive engineering, effective fire and life safety systems, adequate staffing and evacuation capacity, professional hospital governance, prompt incident command, independent regulation and a compliance regime in which risks remain open until corrective measures are physically implemented and verified. The fact finding stage is substantially complete and the evidentiary record is sufficient for final findings, accountability proceedings and implementation of reforms. The electrical failure most probably explains how the fire began; the institutional system explains why it became a catastrophe.

The Committee concludes that systemic and institutional failure is established, but individual responsibility varies according to the strength of the evidence. PIMS and its senior management bear the principal institutional responsibility for failing to convert known fire safety risks, prior warnings and assigned duties into an effective and verified safety system, subject to due process and verification of attendance and conduct. Clinical responsibility should arise only where mandatory physical or supervisory duty is proved, while frontline responders whose rescue efforts are objectively established should not be adversely implicated. The Engineering/electrical/HVAC chain remains the most important unresolved technical accountability line because the AC 2 supply arrangement is the most probable ignition source, but liability must first be individualized. Belfort and BE Engineers should be examined contractually, while Ministry, IHRA and CDA/CES responsibility is presently mainly institutional or regulatory. Criminal proceedings should remain confined to focused investigation of the AC 2 maintenance chain, mandatory exit obstruction, failure to act despite prior warning and any culpable delay in external notification. Accountability must ultimately attach to the duty actually held, the omission



actually proved and the consequence fairly attributable to it, not merely to designation, public pressure or the gravity of the tragedy.

38. Consolidated Findings

For ease of reference and implementation, the Committee consolidates below the principal findings reached on the basis of the complete evidentiary record. These findings are to be read with the detailed reasoning, qualifications and evidentiary reservations contained in the relevant sections of the Report.

- i. Incident and casualties. The fire occurred in the MCH Nursery, PIMS, on 26 August 2026, where 15 medically dependent neonates were under treatment; 14 died and one survived.
- ii. Rapid development. CCTV establishes that the emergency was visible by approximately 06:38:15 and that dense smoke substantially engulfed the Nursery within about one to two minutes, leaving an exceptionally narrow rescue window.
- iii. Frontline response. The objective record establishes prompt alarm raising, entry, rescue and treatment efforts by frontline personnel and does not support the generalized allegation that doctors, nurses or security staff abandoned the neonates.
- iv. Probable cause. The NFA identifies abnormal localized electrical heating in the AC Unit No. 2 supply cable near/over AC Unit No. 1 as the most probable point and mechanism of ignition. The precise electrical defect and responsible duty holder remain to be individualized.
- v. Alternative causes not established. The evidence does not establish arson, multiple ignition points, an external IESCO fault, a pre-fire oxygen leak, or an incubator or warmer as the source of ignition.
- vi. Electrical safety deficiency. Although AC maintenance and servicing were undertaken, the record does not demonstrate a systematic, periodic and traceable preventive electrical safety regime covering cables, terminations, insulation, earthing, breakers and thermal hotspots. Operational equipment was therefore not necessarily electrically fire safe.
- vii. Fire propagation. Combustible materials and the oxygen supported clinical environment most probably intensified flame, heat and smoke after ignition, but were not the initiating cause.
- viii. Oxygen and biomedical systems. No pre-fire oxygen leak or biomedical equipment fault is established as the cause of ignition; however, deficiencies existed in medical gas documentation, emergency isolation arrangements and comprehensive electrical safety assurance.
- ix. Evacuation capacity. Fifteen non-self-evacuating neonates were housed in a stated ten bed Nursery, while only two doctors and two nurses were immediately available and protected transport resources were limited. This constituted a serious operational mismatch.
- x. SOPs and drills. The record does not demonstrate an adequately documented, approved, communicated, trained and rehearsed Nursery specific fire and neonatal evacuation system capable of safely evacuating the actual patient load.
- xi. Fire protection. The affected Nursery was not demonstrated to have a functional automatic smoke detection and fire alarm system or sprinkler protection, leaving human observation and manual communication as the primary means of detection and activation.
- xii. Incident command and notification. PIMS did not demonstrate a tested incident command system linking fire detection directly to alarm, evacuation, external notification, hazard isolation and responder access. The principal chronological concern is the interval between visible fire at about 06:38 and confirmed CES notification at about 06:54; CES itself responded within minutes after confirmed activation.



- xiii. Doors and exits. The particular CCTV visible adjoining door is not established as causative of the fatalities. CES separately reported locked or obstructed routes, establishing a serious institutional egress concern requiring route specific identification, classification, custody and causal assessment.
- xiv. Security duties. PIMS Security SOPs expressly assigned responsibilities concerning fire safety, exits, firefighting equipment, training, access control, keys and emergency reporting, providing one of the clearest documentary duty chains in the Inquiry.
- xv. Prior warnings. CDA correspondence, the Federal Ombudsman 2015 observations, PIMS's own 2025 acknowledgement of ageing fire safety infrastructure and, most significantly, the Nursing Hostel fire of 6 July 2026 demonstrate that broader fire and life safety risks were known before the Nursery tragedy.
- xvi. Corrective closure. The record does not demonstrate that prior warnings and the July 2026 fire recommendations were converted into a comprehensive, time bound and independently verified corrective programme before 26 August 2026. The specific AC 2 defect may not have been foreseeable, but the need for stronger fire preparedness was.
- xvii. JICA transition. The continued retention of the Nursery in the old MCH, despite availability and progressive operationalization of the new JICA funded facility, was not supported by a sufficiently documented risk assessment, justification or time bound transition plan and constitutes a prima facie management issue.
- xviii. External oversight. Ministry, IHRA and CDA/CES responsibility is presently stronger at the institutional, supervisory and regulatory level than as person specific culpability. The record shows fragmented oversight and insufficient verified closure of critical risks.
- xix. Funding and capacity. PIMS faced genuine staffing and resource constraints, but the record does not establish that any specific Nursery fire safety or AC 2 electrical safety proposal was rejected solely for lack of funds. Resource constraint therefore does not by itself excuse the identified deficiencies.
- xx. Governance. PIMS requires clearer business allocation and professionally qualified management of administrative, engineering, safety and emergency functions. Clinical seniority alone is not a substitute for specialized hospital management competence.
- xxi. Systemic failure. The principal institutional failure was the absence of an integrated patient safety system, leaving known risks fragmented across clinical, engineering, security, administrative, contractor and regulatory functions and resulting in incomplete correction, weak preparedness, improvised response and catastrophic consequences.
- xxii. Institutional responsibility. PIMS and its senior management bear the principal institutional responsibility for failing to convert known risks, prior warnings and assigned duties into an effective and verified fire and life safety system.
- xxiii. Administrative and disciplinary responsibility. The record discloses prima facie grounds for administrative and E&D proceedings against officers where a defined duty, prior knowledge or foreseeability, authority and corresponding act or omission indicate negligence, inefficiency, misconduct, unauthorized absence, failure of supervision or non performance of assigned safety responsibilities. Final guilt must be determined through due process.
- xxiv. Person specific evidentiary maturity. The evidence is not equally mature against all officers. The Security chain has the clearest documented duty basis; senior management responsibility requires confirmation of business allocation, knowledge and authority; clinical responsibility depends upon proof of mandatory physical or supervisory duty; and Engineering/electrical/HVAC responsibility remains technically central but requires individualization.
- xxv. Engineering/electrical accountability. The AC 2 installation and maintenance chain remains the most important unresolved technical accountability line. Responsibility must



be traced to the persons who designed, installed, altered, inspected, maintained, supervised or certified the implicated circuit.

- xxvi. Contractual responsibility. The record warrants clause specific contractual scrutiny of Belfort Security Services, M/s BE Engineers and any other relevant contractor where a defined contractual obligation and corresponding breach are established. PIMS's retained duties of supervision, verification and enforcement remain separate.
- xxvii. Criminal dimension. The Inquiry does not presently find any named individual criminally guilty; however, the evidence warrants focused criminal investigation into possible culpable electrical installation or maintenance failure relating to AC 2, obstruction of a mandatory emergency route, culpable non action despite specific prior warning, and any proved culpable delay in external emergency notification.
- xxviii. Criminal threshold. Criminal responsibility can arise only where the investigation establishes a clear duty, knowledge or foreseeability of danger, authority to act, a sufficiently culpable act or omission, failure of a relevant safeguard and a legally sustainable causal contribution to death or injury.
- xxix. Matters not established. The record does not establish deliberate locking in of the neonates, conspiracy, sabotage, political protection, manipulation or concealment of casualties, wholesale frontline abandonment, or a prolonged CES delay after confirmed notification.
- xxx. Consolidated causation. The catastrophe resulted from a cascading failure: probable AC 2 electrical ignition rapidly escalated through inadequate detection and fire protection, limited neonatal evacuation capacity, improvised institutional response, delayed external activation and access constraints, against a background of known but incompletely closed institutional risks.

The electrical failure most probably explains how the fire began; the failure of successive institutional safeguards explains why it became a catastrophe. Systemic failure is established, while administrative, disciplinary, contractual and criminal responsibility must attach only where the relevant duty, omission and causal consequence are proved.

39. Consolidated Recommendations

The Committee recommends that the following measures be treated as an integrated corrective and accountability programme. Implementation should proceed simultaneously where practicable and should not await completion of disciplinary, contractual or criminal proceedings where immediate patient safety is involved.

- i. Independent safety audit. Conduct an immediate hospital wide fire, life safety and electrical audit based on physical testing, covering detection, alarms, firefighting systems, emergency exits, electrical installations, medical gases and other critical infrastructure.
- ii. Immediate risk rectification. Risk-rank every deficiency and either correct it immediately or institute documented interim safeguards until permanent rectification is completed.
- iii. Critical care safety. Continue high risk services such as Nursery/NICU, PICU, ICU, HDU and operating theatres only where minimum life safety safeguards are physically functional and independently verified.
- iv. Detection, alarm and suppression. Install and maintain effective automatic smoke detection, alarms, firefighting and fixed protection systems appropriate to high dependency clinical areas.



- v. Emergency exits. Map and verify all emergency exits and responder access routes, identify their legal status and custodians, and ensure that security arrangements never impede immediate emergency egress.
- vi. Preventive electrical safety. Establish a systematic and traceable preventive electrical safety programme covering cables, terminations, insulation, earthing, breakers, loading and thermal inspection, particularly in critical clinical areas.
- vii. AC 2 responsibility. Identify the officers, technicians, contractors and supervisory authorities responsible for the design, installation, inspection, maintenance and certification of the implicated AC 2 electrical circuit and determine whether any required safety measure was omitted.
- viii. HVAC and infrastructure. Expedite outstanding HVAC and infrastructure modernization, with defined ownership, timelines and independent technical certification.
- ix. Medical gas safety. Maintain verified as built medical gas drawings, clearly identified isolation valves, assigned emergency authority and trained personnel.
- x. Neonatal evacuation. Approve and operationalize a dedicated Nursery/NICU fire and neonatal evacuation SOP supported by adequate evacuation equipment, manpower mobilization and realistic multidisciplinary drills.
- xi. Incident command. Establish a tested Incident Command System providing immediate and simultaneous alarm, external notification, evacuation, hazard isolation, security/access response and responder coordination.
- xii. External notification. Designate primary and alternate officers on every shift to immediately call and confirm CES/Rescue/Fire Brigade activation without sequential administrative approval.
- xiii. Security reform. Enforce existing Security SOPs relating to exits, firefighting equipment, training, deployment, access control, key custody and emergency reporting, with clearly assigned supervisory responsibility.
- xiv. JICA transition. Review all critical services remaining in legacy buildings and transfer them to appropriate purpose-built facilities where feasible; continued use of old infrastructure should require documented risk assessment, interim safeguards and a fixed transition plan.
- xv. Professional governance. Restructure PIMS around professional hospital administration, with administrative, engineering, biomedical, safety, finance, HR, procurement and emergency management functions assigned to suitably qualified and experienced professionals.
- xvi. Merit based appointments. Appointments to administrative and safety critical posts should be merit based and qualification specific, while additional charges should remain exceptional and time bound.
- xvii. Hospital safety structure. Establish a senior Fire/Life Safety and Facilities function and a permanent multidisciplinary Hospital Safety and Vigilance Committee with authority to track deficiencies to verified closure.
- xviii. Independent oversight. Consider a time bound Independent Safety and Governance Oversight Board to monitor implementation, conduct independent or unannounced audits and report to the competent federal authority.

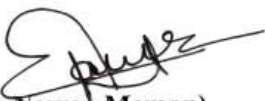


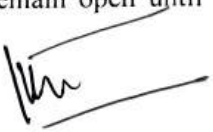
- xix. Digital safety management. Implement an integrated HMIS and safety management platform covering attendance, duty rosters, equipment inventories, preventive maintenance, inspections, drills, work orders, CCTV, access control and emergency communications.
- xx. Regulatory reform. Establish a coherent federal healthcare safety assurance framework with risk based multidisciplinary inspections and physical testing of critical systems.
- xxi. Critical care fire standard. Develop specific federal fire and life safety standards for NICUs and other high dependency units, including safe occupancy, evacuation staffing, transport equipment, compartmentation and continuity of critical support.
- xxii. Pre commissioning certification. Require independent fire and life safety certification before any new or substantially renovated critical care facility becomes operational.
- xxiii. Closed loop implementation. Every finding should be converted into a specific corrective action, assigned to a responsible officer or institution with a deadline, resources and interim safeguards where necessary; completion should occur only after physical implementation, independent verification and formal closure, followed by periodic revalidation.
- xxiv. Administrative and E&D proceedings. Appropriate administrative and disciplinary proceedings should be initiated against officers against whom the Inquiry has identified prima facie negligence, misconduct, inefficiency, unauthorized absence, failure of supervision or non performance of assigned safety duties. Each charge should identify the precise duty, knowledge, authority and alleged omission, with final liability determined through due process. In addition, wherever the job description and evidence establish the dereliction of duty, needs to be proceeded against.
- xxv. Engineering proceedings. Before disciplinary action against Engineering/electrical/HVAC personnel, identify the precise person responsible for the implicated AC 2 installation or circuit and establish the relevant duty, period of responsibility and alleged technical omission.
- xxvi. Contractual action. Initiate clause specific show cause and consequential contractual proceedings against Belfort Security Services, M/s BE Engineers or other contractors where a defined contractual obligation and prima facie breach are established, while separately examining PIMS's retained supervisory duties.
- xxvii. Focused criminal investigation. Refer the relevant forensic, CCTV, CES, Security, maintenance and prior warning material to the competent law enforcement agency for focused investigation of the AC 2 electrical chain, obstruction of mandatory emergency exits, culpable non action despite prior warning and any culpable delay in external notification.
- xxviii. Criminal evidentiary standard. Criminal liability should be determined only after establishing the duty owed, knowledge or foreseeability of the danger, authority to act, the relevant act or omission, degree of negligence, failed safeguard, causal contribution and applicable offence.
- xxix. Corrective Action Plan. Upon acceptance of the Report, the Ministry should prepare a Consolidated Corrective Action Plan assigning every recommendation to a responsible institution and designated officer, with deadlines, resources, interim safeguards, verification authority and closure status.

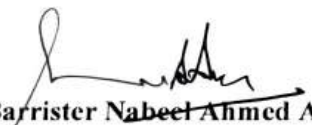


- xxx. Consequences for non compliance. Unjustified failure to implement an assigned corrective action should attract administrative or disciplinary consequences; contractual defaults should be enforced under the relevant contract; and regulatory breaches should be dealt with under applicable law.
- xxxi. Families, survivor and staff. Establish a Family Support and Liaison Cell, provide psychological and bereavement support, ensure long term clinical follow up of the surviving neonate and process any lawful compensation or relief transparently and expeditiously.
- xxxii. Transparency. Publish the Final Inquiry Report, or an appropriately redacted version, subject to privacy, due process and investigative safeguards, so that the incident contributes to institutional learning and public confidence.
- xxxiii. Capacity and Professional Hospital Management. Islamabad requires additional public hospitals, expanded healthcare capacity and professionally qualified hospital management and staffing. Consultants private practice may be conducted within designated public hospital premises only under a transparent institutional arrangement, similar to the CMH model, where patient fees are collected centrally, hospital charges are deducted and the balance is paid to the concerned specialist. The hospital retained share should be transparently utilized for staff incentives, patient services, maintenance, management improvement and institutional development.

Systemic reform must be accompanied by accountability. Officers against whom prima facie negligence or misconduct is established should face appropriate administrative or E&D proceedings; contractual breaches should be enforced against the responsible contractor; and conduct potentially crossing the criminal threshold should be independently investigated under law. At the same time, every safety deficiency must remain open until physically corrected, independently verified and formally closed.


(Irfan Nawaz Memon)
Dy. Commissioner, ICT
(Member)


(Maj. Gen (Retd) Dr. Khurshid Uttra)
(Member)


(Barrister Nabeel Ahmed Awan)
Establishment Secretary
(Member)


(Dr. Rashid A. Chotani)
(Co-opted Member)


(Shahid Khan)
Former Federal Secretary
(Chairman)
7.9.26

Dr. Syed Tauqir Shah, Adviser to Prime Minister, P.M. Office, Islamabad.

with reference to his U.O. No. 3130/APM/2026 dated 26th August 2026

LIST OF ABBREVIATIONS

Abbreviation	Full Form
AC	Air Conditioner / Air Conditioning
AD	Assistant Director
CDA	Capital Development Authority
CDR	Call Detail Record
CES	Capital Emergency Service
CCTV	Closed Circuit Television
CPAP	Continuous Positive Airway Pressure
DC	Deputy Commissioner
DD	Deputy Director
DED	Deputy Executive Director
DG	Director General
E&D	Efficiency and Discipline
ECNEC	Executive Committee of the National Economic Council
E&M	Electrical and Mechanical
HDU	High Dependency Unit
HMIS	Hospital Management Information System
HOD	Head of Department
HR	Human Resources
HVAC	Heating, Ventilation and Air Conditioning
IB	Intelligence Bureau
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
IHRA	Islamabad Healthcare Regulatory Authority
IESCO	Islamabad Electric Supply Company
JCI	Joint Commission International
JED	Joint Executive Director
JICA	Japan International Cooperation Agency
MCH	Maternal and Child Health / Mother and Child Health
MSDS	Minimum Service Delivery Standards
NFA	National Forensics Agency
NFPA	National Fire Protection Association
NICU	Neonatal Intensive Care Unit
PIMS	Pakistan Institute of Medical Sciences
PICU	Paediatric Intensive Care Unit
PMIC	Prime Minister's Inspection Commission
PPM	Planned Preventive Maintenance
PWD / Pak PWD	Pakistan Public Works Department
SOP	Standard Operating Procedure
ToR / TOR	Term(s) of Reference

List of Footnotes, Annexures and Exhibits

Exhibit No.	Document
1.	Report of CCTV Analysis – SP City
2.	Floor Plan
3.	Inquiry Report of DG E&M, CDA
4.	Inventory / Inspection report of DG E&M, CDA
5.	Report of 1122 / CES, CDA
6.	Report of IESCO
7.	Source Report
8.	Report of Safe City
9.	Report of National Forensics Agency (NFA)
10.	Record of 15 Babies
11.	Register entries of child admission in Nursery
12.	Statements of Parents
13.	Death Certificates
14.	Mother's Records of Delivery
15.	Clinical Summaries for Neonatal Admissions (with APGAR Scores)
16.	Certificates issued by Mortuary of PIMS
17.	Statements of Rescue Workers – 1122
18.	Duty Roster of Doctors, MOs, Nurses and Security Staff
19.	Statement of Dr Abdul Rehman, Duty Officer
20.	Statement of Dr Rimsha Ahmed, Duty Officer
21.	Statement of Razia Noreen, Nurse
22.	Statement of Nasreen Akhtar, Nurse
23.	Statement of Maria Saleem, Security Guard
24.	Statement of Haseeb Akram, Security Guard
25.	Statement / Report of Executive Director, PIMS
26.	Statement of Dr Aneza Jalil, DED
27.	Statement of M. Iqbal Khan Durrani, JED
28.	Statement of Ch Waris Ali Raza, JED
29.	Statement of Dr Mutahir Shah, JED
30.	Statement of Muhammad Khaqan, Security Incharge, MCH
31.	Statement of Muhammad Asif, Security Guard
32.	Statement of Muhammad Usman, AD (Security), PIMS
33.	Shamsher Ali, Security Supervisor (PIMS)
34.	Statement of Hassan Nawaz, DD Engineering, PIMS
35.	Statement / Report of Belfort Security Services
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37.	List of Equipment and Maintenance Logs of Incubators by PIMS
38.	Maintenance Records of equipment by Hammad Manzoor
39.	Maintenance of Records of Air Conditioner
40.	HVAC Record for the year 2025 of MCH, PIMS
41.	05 years Budget and Audit Paras

42.	Requests for Additional Funds by PIMS
43.	Brief of JICA
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45.	Record of M/o National Health Services Recruitment
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47.	Civil Record for the year 2024 25 26 of MCH, PIMS
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56.	Task No. 8 - Nursery staffing adequacy
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69.	Task No. 21 - 6 July Nursing Hostel fire
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75.	Task No. 27 - Funding defence
76.	Task No. 28 - HIVAC/development funds
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90.	Task No. 42 -	Electrical
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92.	Task No. 44 -	List of mothers whose children were in the nursery with date of birth and sex and date of admission to the nursery
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94.	Task No. 46 -	Neonatal evacuation capacity
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96.	Task No. 48 -	Applicable technical benchmark standard
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105.	Independent technical report of Dr. Chotani	

Link to Exhibits, Annexures and Footnotes:

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