PRIME MINISTER'S OFFICE
ISLAMABAD

Subject: **INQUIRY INTO THE FIRE INCIDENT IN PIMS ON 26TH AUGUST, 2026 – INTERIM REPORT OF THE COMMITTEE**

The Inquiry Committee, constituted vide this Office's orders of even number dated 26.08.2026 to enquire into the subject incident, presented its interim report to the Prime Minister today on 29th August, 2026. The Committee presented the facts gathered so far, available video of the incident and its interim recommendations to the Prime Minister.

2. After perusal of the above, the Prime Minister has directed as under:

1) As recommended by the Inquiry Committee, the following officers of the PIMS and external agencies shall be placed under suspension and disciplinary proceedings shall immediately be initiated against them:

   a) Prof. Dr. Imran Sikandar, Executive Director, PIMS
   b) Prof. Dr. Sadia Riaz, HoD Neonatology, Children Hospital, PIMS
   c) Dr. Nagham, Sr. Registrar, Neonatology Department, PIMS
   d) Dr. Mutahir Shah, Joint Executive Director, MCH
   e) Ch. Waris Ali Raza, Joint Executive Director, Non-Medical, PIMS
   f) Dr. Nosheela Amjad, Director MCH
   g) Dr. Abdul Rehman, Director General, CES, CDA
   h) Mr. Muhammad Usman, Assistant Director (Security)

2) The criminal proceedings shall also be initiated against the responsible persons.

3) Ms. Nasreen, Charge Nurse and Ms. Maria, Security Guard shall be placed off-duty and not perform any duties till further orders. The decision with reference to proceeding against them or otherwise shall be taken once the final report is submitted by the Committee;

4) Ms. Razia, Staff Nurse, who evacuated the only surviving baby risking her own life shall be given a financial reward of Rs. 10,000,000/- (Rupees Ten Million only) and shall be recommended for suitable civil award;

5) The National Health Services Regulations & Coordination Division and PIMS administration shall review the contract with M/s Belfort Security, which *prima facie*, failed to fulfil its contractual obligations. In case, the alleged failure is ascertained, the company shall be proceeded against under the terms of the contract and a reference shall also be made Interior

and Narcotics Division to review the license of the firm under the relevant law/rules;

6) Dr. Muhammad Salman, CEO NIH shall immediately be transferred and posted as Executive Director, PIMS on deputation basis till further orders. He shall also hold the additional charge of the post of CEO, NIH till suitable arrangements are made; and,

7) The interim report of the Committee shall be made public by placing the same on website of National Health Services, Regulations and Coordination Division.

3. The National Health Services Regulations & Coordination, Interior & Narcotics Control and Establishment Divisions shall proceed further accordingly.

(Dr. Syed Tauqir Shah)
Advier to Prime Minister
29th-Aug-2026

Secretary, National Health Services, Regulations and Coordination Division
PM Office u.o. No.3130/APM/2026

Cc: Establishment Secretary
Secretary, Interior and Narcotics Control
AS-I, PM's Office

INTERIM REPORT: 28TH AUGUST 2026

Inquiry into the Fire Incident at MCH/Nursery, Pakistan Institute of Medical Sciences (PIMS), Islamabad, on 26 August 2026

1. Background and Mandate

The Prime Minister, taking serious notice of the tragic fire incident in the MCH/Nursery of Pakistan Institute of Medical Sciences (PIMS), Islamabad, on 26 August 2026, constituted an Inquiry Committee to determine the immediate cause and timeline of the incident; assess the emergency response of hospital staff and external agencies; determine whether emergency-evacuation SOPs were followed, particularly for newborns; evaluate the fire-safety infrastructure and compliance of PIMS; fix responsibility and negligence, if any; and recommend systemic reforms to prevent recurrence. The Committee was further required to submit an interim report containing immediate findings within 48 hours and a comprehensive report thereafter.

The Committee immediately commenced proceedings, inspected the site, examined the Nursery and adjoining areas, analysed CCTV footage, obtained relevant architectural, electrical, biomedical, maintenance, security and fire safety records, examined reports of PIMS, CDA/CES, CDA Engineering & Maintenance and IESCO, and recorded statements of relevant medical, nursing, engineering, security and emergency response personnel. The Committee also examined the inquiry into the earlier fire at the Female Nursing Hostel on 6 July 2026, which assumes particular relevance to institutional knowledge, preparedness and follow-up. The available record shows that the earlier inquiry had already identified deficiencies in fire detection, alarm, evacuation preparedness, electrical inspection, security response and record keeping.

This Interim Report records only those facts and prima facie findings presently supported by the available evidence. Matters requiring forensic, technical or documentary reconciliation, including the precise ignition source, the causal contribution of particular deficiencies and final fixation of individual responsibility, are expressly reserved for the comprehensive report. The Committee has throughout distinguished between what ignited the fire, what enabled it to become catastrophic, and who was responsible for preventable failures.

2. Immediate Cause and Timeline: ToR 1

CCTV footage presently provides the most objective reconstruction of the incident. The first visible emergency appears at approximately 06:38:15, when Charge Nurse Nasreen hurriedly emerges from the Nursery and seeks assistance. At approximately 06:38:35, she and Security Guard Maria enter the Nursery, with reflections of flames visible. Staff Nurse Razia enters at approximately 06:38:56 and emerges at about 06:39:04 carrying a baby, thereby effecting a rescue. She attempts to re-enter shortly thereafter. Dr. Abdul Rehman emerges at approximately 06:39:12, while by about 06:39:15 Camera 16 is substantially obscured by smoke. The adjoining corridor door visible on Camera 12 is opened at approximately 06:39:45, and by about 06:40:08 Camera 12 is also obscured by smoke. This evidence therefore establishes that the Nursery environment deteriorated catastrophically within approximately two minutes.

The precise technical source of ignition is not yet conclusively established. Various accounts attribute the fire to an AC, incubator/warmer or electrical short circuit/plug overloading. IESCO records do not indicate a contemporaneous external feeder fault or tripping, thereby shifting any electrical causation inquiry downstream to PIMS's internal electrical distribution, sockets, plugs, wiring and connected equipment. Preventive maintenance records also indicate that several incubators had recently been serviced and returned in working condition, although those records do not conclusively establish electrical safety of the equipment, plug, socket or associated circuit. Accordingly, an internal electrical/equipment related origin remains plausible, but it would be premature to identify any particular appliance or component as the established cause.

The Committee considers it important that uncertainty regarding the first spark should not prevent examination of the protective systems that should have prevented an initial fire from becoming a mass fatality event. The cause of ignition and the causes of the consequences are related but analytically distinct.

3. Emergency Response and Rescue Operations: ToR 2

The available CCTV evidence establishes that personnel immediately present responded and attempted rescue. Charge Nurse Nasreen sought assistance; Security Guard Maria entered the affected area. Staff Nurse Razia entered the burning Nursery, rescued one neonate and attempted to re-enter; and Dr Abdul Rehman was present within the affected area. The objective evidence therefore does not support generalized allegations that frontline medical and nursing staff simply abandoned the newborns. The record itself appropriately distinguishes individual rescue performance from antecedent institutional responsibility for preparedness.

A potentially serious issue nevertheless arises concerning external emergency notification. CCTV establishes the emergency at approximately 06:38, whereas CES records receipt of the first emergency call at approximately 06:54, dispatch at 06:55 and arrival at approximately 07:01. Other evidence reportedly refers to an earlier call. The Committee therefore does not presently attribute a concluded sixteen minute delay to any particular person or agency. Telephone records, PIMS control room records, CES call recordings/logs and synchronization of CCTV timing are to be examined to establish who first called, when an effective call reached CES, and whether any avoidable delay occurred.

Once CES records receiving the emergency call, its recorded arrival was approximately six to seven minutes later. The presently more material issue is therefore not an alleged prolonged response by CES after notification, but the internal detection, escalation and notification chain preceding that call. The supplied SOP framework of PIMS does not clearly demonstrate who was required to activate an alarm, summon CES/Rescue 1122, assume incident command, unlock emergency exits or coordinate neonatal evacuation.

4. Evacuation, Fire-Safety Infrastructure and SOPs: ToRs 3 and 4

The record establishes that rescue and evacuation were attempted, but it does not presently demonstrate an approved, communicated, trained and rehearsed MCH/Nursery-specific fire and neonatal evacuation SOP. The available PIMS SOPs regulate numerous clinical and administrative

functions, yet no comparably detailed procedure has been produced governing fire detection, alarm activation, external notification, incident command, extinguisher use, oxygen/electrical isolation, unlocking of emergency exits, evacuation priorities and safe relocation of non-ambulatory neonates.

The PIMS Security Department SOP dated 27 May 2023, however, expressly recognizes fire safety as an institutional responsibility. It requires Security to ensure fire safety for the protection of infrastructure, equipment, patients, visitors and staff and specifically places responsibility upon the Assistant Director Security for availability of fire safety exits, functionality of firefighting equipment and training of relevant personnel. PIMS had also nominated personnel for specialized fire safety training before the tragedy. The emerging question is therefore less whether fire risk was recognized administratively than whether the assigned duties and available training were translated into actual preparedness at the MCH/Nursery.

CES independently reported that fire and life-safety arrangements were inadequate and compromised, that emergency exits/escape routes were locked or obstructed, that security hindered aspects of the initial response and that crowd management was inadequate; its account records firefighters having to forcibly open locked fire exit doors and other access points. These are serious prima facie deficiencies, although the Committee is verifying the status and location of each relevant door before attributing responsibility.

The CCTV visible corridor door adjoining the Nursery requires separate treatment. It was initially closed but was opened at approximately 06:39:45, while rescue activity had already begun taking place through another access. Controlled access to a neonatal unit has a legitimate security purpose and therefore a locked or controlled door is not by itself proof of negligence. The decisive question is whether any door was a designated or required emergency exit, whether it was capable of immediate emergency release and whether its condition materially delayed evacuation or rescue.

5. Prior Warning and Institutional Foreseeability: ToRs 4 and 5

The fire at the PIMS Female Nursing Hostel on 6 July 2026, only about seven weeks earlier, is highly relevant. The earlier inquiry identified absence or inadequacy of smoke detection, automatic alarms, emergency warning mechanisms, documented drills, fire-safety inspection records and aspects of security response. It recommended a comprehensive fire-safety audit, smoke detectors, alarm and warning systems, emergency lighting, marked escape routes, functional extinguishers, periodic testing, annual electrical inspections and written emergencyresponse arrangements.

The significance of the July incident is not that it establishes the cause of the August fire. It establishes that fire risk within PIMS was no longer hypothetical and that institutional deficiencies had already been formally identified. The earlier inquiry also recorded serious deficiencies in record keeping and supervisory oversight and recommended disciplinary proceedings against the Hostel Warden and two security guards while calling for examination of supervisory responsibility within the Security Department.

The timing is particularly significant. On 25 August 2026, one day before the fatal Nursery fire, the earlier inquiry report was still being returned for revision because it had not adequately addressed its ToRs. This does not establish that completion of that inquiry would have prevented the Nursery tragedy, but it demonstrates that the institutional process for identifying root causes and translating the July fire into corrective action had apparently not reached satisfactory closure before the second fire.

The Committee is therefore examining the earlier recommendations individually to determine who received each recommendation, which officer or agency was responsible for implementation, what action was ordered, what had actually been implemented by 26 August and what remained outstanding. If material life safety deficiencies had been formally communicated to responsible officers and reasonable interim corrective measures remained unimplemented without justification, this would materially affect the assessment of foreseeability and responsibility.

6. Prima Facie Administrative and Disciplinary Responsibility: ToR 5

On the existing record, the clearest prima facie administrative issue arises within the PIMS Security/fire safety chain. The Security SOP expressly assigned responsibility for ensuring availability of fire safety exits, functionality of firefighting equipment and training of relevant staff. Those duties must now be reconciled with the independent CES findings concerning locked or obstructed emergency exits, inadequate fire and life safety arrangements and difficulties involving security during the response. The Committee therefore considers that the competent authority may initiate show-cause and disciplinary proceedings against the officer or officers actually holding these assigned responsibilities on 26 August, subject to verification of incumbency, precise allocation of duties, opportunity of hearing and applicable service rules.

The operational responsibility of the MCH Security supervisory chain also requires immediate examination. Duty posters, deployment records, key custody, gate/exit responsibility, CCTV and telephone records should establish who controlled the relevant exits, whether emergency access arrangements were known and functional, and whether the security response complied with existing SOPs. Where a specific officer's assigned duty and corresponding omission are objectively established, administrative proceedings need not await determination of the precise ignition source.

The position of M/s. Belfort Security Services (Pvt.) Ltd. requires a parallel but legally distinct contractual examination. The record shows that Belfort had security personnel deployed at MCH and that some participated in rescue, firefighting and crowd/access management. The Committee does not presently find that Belfort caused the fire or that its personnel generally abandoned their duties. However, PIMS should verify whether the contracted deployment was actually maintained, whether personnel posted at MCH had received the prescribed firefighting training, whether appropriate firefighting equipment was available to them and whether their response complied with contractual obligations. Any established default should attract contractual show-cause proceedings, applicable penalties/deductions and such further action as permissible under the contract and law, while PIMS's corresponding responsibility for arranging required training must be examined separately.

The record also raises prima facie questions at senior management and institutional levels, particularly concerning absence or ineffective implementation of a hospital/Nursery fire-emergency regime and follow-up of previously identified deficiencies. However, disciplinary responsibility should not be attributed merely by virtue of designation. Before naming individual senior officers, the Committee is establishing the chain of assigned duty; receipt/knowledge of deficiency; authority and opportunity to act; omission and resulting safety deficiency. The pre-incident knowledge of fire-safety shortcomings is important but does not, without this allocation exercise, establish negligence by a particular officer.

Similarly, Engineering, Electrical and Biomedical personnel require further technical scrutiny, but the existing evidence does not presently justify attributing the ignition or fatalities to them merely because the fire may have been electrical. Recent PPM records make a simple theory of a long-neglected visibly defective incubator less persuasive, while leaving unresolved whether the failure, if electrical, arose inside equipment or from its plug, socket, wiring or circuit.

Conversely, the available record presently provides no prima facie basis for disciplinary action against the Nursery doctors and nurses merely because the fatalities occurred. CCTV establishes active rescue attempts, while the record does not demonstrate that frontline staff had been provided with and trained in a dedicated neonatal fire evacuation SOP. Individual emergency conduct must therefore remain distinct from institutional responsibility for preparedness.

7. Prima Facie Circumstances Requiring Criminal Investigation: ToR 5

The Committee further observes that the available record discloses prima facie circumstances which may warrant investigation by the competent law-enforcement agency into possible criminally negligent acts or omissions affecting life safety. The strongest presently identifiable area concerns CES's independent findings that emergency exits/escape routes were locked or obstructed and that firefighters were compelled to breach locked fire-exit doors. If the relevant doors are confirmed as mandatory emergency exits, and it is established that persons responsible for them knowingly or negligently permitted them to remain unavailable for immediate emergency use, the matter would go beyond an ordinary administrative lapse and warrant investigation into whether the omission contributed materially to loss of life. Potentially concerned persons would be those PIMS/security officers, contractor personnel or management officers actually responsible for the relevant exits and their emergency availability, rather than persons named merely by institutional hierarchy.

A second potentially serious area concerns prior knowledge followed by failure to take corrective action. The July fire had already generated explicit recommendations concerning detection, alarms, evacuation, fire extinguishers, electrical inspection, training and emergency preparedness. If further evidence establishes that particular officers received these warnings, had a clear duty and authority to implement urgent measures, had reasonable opportunity to do so, yet without justification failed to rectify a known life safety hazard which subsequently contributed materially to the Nursery fatalities, the combination of prior notice, assigned duty, culpable omission and resulting harm may disclose ingredients requiring criminal investigation. It is therefore necessary to identify the officers responsible before making any personal attribution.

A third area is the apparent emergency notification gap. CCTV establishes the emergency at approximately 06:38 whereas CES records receiving its first call at approximately 06:54, although witness evidence reportedly claims an earlier call. In an incident that became catastrophic within minutes, any unjustified failure by a person specifically charged with raising the external alarm to promptly summon professional emergency services could be materially relevant. However, the present contradiction prevents attribution. Telephone records, control-room logs, CES call records and CCTV synchronization must first determine whether an effective call was made earlier, by whom and where it was received. Only if a culpable omission and causal nexus are established should criminal responsibility be pursued.

Accordingly, the Committee considers that administrative, disciplinary and criminal processes must remain distinct. Administrative proceedings may follow proof of failure to perform an assigned official duty. Contractual proceedings may follow breach by the security contractor. Criminal investigation requires the additional elements of an act or omission capable of constituting an offence and, where death is alleged to have resulted from negligence, a legally sustainable causal connection. The Committee may identify and refer such circumstances but should not itself pronounce criminal guilt, which falls to the competent investigative and judicial authorities.

8. Immediate Corrective Measures: ToR 6

The Committee considers that certain protective measures cannot await the comprehensive report. PIMS should immediately undertake, through competent and preferably independent technical expertise, a hospital-wide fire and life safety and electrical audit, beginning with NICU/Nursery, ICUs, operating theatres and other highrisk areas. Smoke/heat detection, alarm systems, extinguishers, hydrants, emergency lighting, electrical protection and all designated fire exits should be physically inspected, function tested and documented. Any mandatory emergency exit found locked, obstructed or incapable of immediate emergency release should be rectified forthwith, while legitimate controlled access to sensitive neonatal areas should be preserved through fire safe arrangements.

All incubators, warmers, AC/HVAC installations, sockets, plugs, distribution boards, breakers, earthing and other safety-critical electrical systems in high-risk clinical areas should undergo urgent technical inspection. PIMS should institute temporary fire watch arrangements wherever automatic detection or protection is deficient and conduct practical fire and neonatal-evacuation drills involving doctors, nurses, security and engineering personnel.

A clear and tested emergency notification and incident command protocol should be instituted immediately so that detection of fire triggers simultaneous internal alarm, mobilization of designated responders and direct notification of CES/Rescue 1122 without dependence upon informal communication through multiple administrative layers. The responsible officer for each step should be identified by designation and the process periodically tested.

Every deficiency identified by the July inquiry, CDA/CES inspections, the present Inquiry or the immediate safety audit should be entered into a time-bound compliance mechanism identifying the deficiency, responsible officer/agency, action required, deadline and independent

verification of closure. The July record demonstrates that identifying deficiencies without ensuring implementation does not provide effective institutional protection.

9. Interim Conclusion

The Committee finds at this interim stage that the fire became visibly apparent at approximately 06:38 hours and developed with extraordinary rapidity, rendering the Nursery environment substantially smoke engulfed within approximately two minutes. Medical, nursing and security personnel made immediate rescue attempts, and the objective CCTV evidence does not support a generalized finding that frontline clinical staff abandoned the newborns.

The precise ignition source remains technically unresolved. An internal electrical/equipment-related origin remains plausible, but the available evidence does not conclusively establish whether an incubator, warmer, AC, plug, socket, wiring or another component initiated the fire. Final technical causation must therefore await completion of forensic and equipment specific examination.

At the institutional level, however, the evidence already discloses prima facie serious deficiencies requiring accountability and immediate correction, particularly concerning fire/life-safety preparedness, emergency exits and access, emergency notification, evacuation planning, firefighting arrangements, security coordination and the translation of existing responsibilities into operational readiness. These concerns acquire greater significance because PIMS had experienced another fire only seven weeks earlier and deficiencies involving substantially similar institutional safeguards had already been formally identified.

The Committee therefore considers that administrative/disciplinary proceedings may be initiated where the record already establishes a specific assigned duty and prima facie non-performance, particularly within the fire-safety/security chain, subject to due process. Contractual proceedings should similarly be initiated where verification establishes default by the outsourced security contractor. Separately, circumstances involving mandatory fire exits allegedly being locked or obstructed, possible culpable failure to act upon previously identified life-safety deficiencies, and any established culpable delay in summoning external emergency services should be referred for criminal investigation where verification discloses the ingredients of a cognizable offence. Final criminal culpability should remain for the competent investigating and judicial authorities.

The emerging institutional lesson is therefore more consequential than identifying a single defective appliance or individual responder. The Committee must ultimately establish what ignited the fire; what allowed it to become catastrophic; which safeguards were absent, ineffective or not implemented; who had prior knowledge and responsibility for those safeguards; and whether identifiable omissions materially contributed to the fatalities. Final fixation of individual responsibility is reserved for the comprehensive report, but immediate patient safety measures and proceedings on already demonstrable administrative or contractual defaults need not await that determination.

Having submitted the above, the committee, at the moment of submitting this interim report, likes to state that primary facts around the tragic incident stand established; while there are others that requires further investigation and evidence to ascertain responsibility beyond doubt. Nonetheless, given what is established and evident on record, the committee finds that serious administrative and operational failures occurred at least at three levels, which triggered the incident, and damage and loss that took place. These are as hereunder:

a. Clinical: All the newborn babies were under the charge of Neonatal Intensive Care Unit, operated by Neonatology Unit of the MCH, PIMS. As the inquiry determined the presence on duty of officials less than the duty roster at the time. Ensuring presence of all doctors and allied staff at their place of duty remains a fair and square responsibility of the head of the unit, which in this case was Professor Dr. Sadia Riaz. Therefore, the committee recommends that:

    i. The following officers / officials responsible for a unsupervised NICU, in terms of qualified clinical oversight and management, failed to ensure presence of qualified healthcare professionals and by absenting from duty on the material night and time. It is recommended that they be placed under suspension immediately and proceeded against under E&D Rules 2020.

        a. Professor Dr. Sadia Riaz, HOD Neonatology, Children Hospital, PIMS.

        b. Dr. Nagham, Senior Registrar, Neonatology Department, PIMS.

    ii. Further facts are to be established regarding the actual physical presence of the other staff deputed in the MCH and nursery at the material time. Findings and recommendations in this regard will be furnished in the final report.

b. Operational & Administrative: Given the facts that in the aftermath of the fire incident that took place in Nursing Hostel in PIMS in July 2026, and the general standard of diligence and duty of care that the administration was supposed to extend to the patients visiting PIMS for treatment, the administration of the hospital failed to perform its duty and responsibility. It did not take necessary and essential steps with due diligence, which were necessary after the Nursing Hostel's incident, if not earlier; which would have included fire safety drills, ensuring integrity of fire-fighting equipment, detailed SOPs and incident handling regimes. Therefore, the committee recommends that the following officers of PIMS administration be suspended immediately and proceeded against E&D Rules 2020.

    i. Professor Dr. Imran Sikandar, Executive Director, PIMS;

    ii. Dr. Mutahir Shah, Joint Executive Director, MCH;

    iii. Ch. Waris Ali Raza, Joint Executive Director, Non-medical, PIMS;

    iv. Dr. Nosheela Amjad, Director MCH.

c. External agencies: The foremost organization responsible for maintenance and implementation of fire-safety measures and protocols in public as well as private buildings

in Islamabad, including PIMS, which attracts perhaps the largest number of public on daily and 24/7 basis is Capital Emergency Service (CES). Even after the July 2026 fire incident, the CES failed to take cognizance of systemic failure in PIMS to deal with fire incidents and did not press for any drills, issuance of protocols and SOPs etc. The committee therefore recommends that owing to this failure, the following may be placed under suspension and proceeded against E&D Rules 2020.

i. Dr. Abdul Rehman, Director General, CES, CDA, Islamabad.

ii. Muhammad Usman, Assistant Director Security for absence from duty without leave and for dereliction of duty.

d. Belfort Security failed to fulfil its contractual obligations and be proceeded under the relevant laws, by the employer PIMS.

The evidence thus for gathered by the Committee is available for the Establishment Division to prepare the statement of allegations and charge sheets as and when required including the aforementioned and others that may be found guilty of dereliction of duty as the inquiry proceeds with its final report. The precise first spark remains unresolved, but accountability does not begin and end with the spark. The emerging record requires three separate responses: discipline where an assigned public duty was prima facie neglected; contractual action where outsourced obligations were breached; and criminal investigation where a culpable omission affecting life safety may have materially contributed to the deaths. The final report should name responsibility only where the evidence completes the chain of duty, knowledge, omission and consequence.

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

(Barrister Nabeel Ahmed Awan)
Establishment Secretary
(Member)

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

(Shahid Khan)
Former Federal Secretary
(Chairman)
28.8.26.

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