

Electrical Hazards in Indian Hospitals: A State-wise Analysis of Reported Incidents and a Safety Improvement Framework, January–August 2026

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Research manuscript prepared from the supplied consolidated public-domain incident database

Abstract

Electrical systems in hospitals are safety-critical because interruption, malfunction or fire can affect life-support equipment, operating theatres, intensive-care units, neonatal care, diagnostics, medicines and evacuation routes simultaneously. This paper analyses a consolidated dataset of 46 unique hospital electrical-hazard incidents reported in India between 7 January and 30 August 2026. The analysis identifies the geographic distribution, temporal pattern, broad hazard class, electrical assets involved, ownership profile and reported consequences. Fire-related events account for 33 incidents (71.7%), while power-related incidents account for 13 (28.3%). Uttar Pradesh, Haryana and Kerala recorded the largest numbers in the supplied dataset, with six, five and five incidents respectively. Six incidents explicitly reported fatalities, amounting to at least 23 reported deaths in the source descriptions; this is not a population-level mortality estimate. The paper proposes a hospital electrical-safety framework centred on an annual electrical safety audit, competency-based training for operations and maintenance teams in maintenance management and emergency preparedness, rigorous project commissioning tests, documented preventive maintenance, backup-power assurance, incident investigation and management review. The findings are intended as a structured safety-learning resource rather than a claim of complete national incidence.

Keywords—*hospital electrical safety, electrical fire, power failure, healthcare engineering, preventive maintenance, emergency preparedness, commissioning tests, electrical safety audit.*

About Sustenergy Foundation

Sustenergy Foundation is a premier research house and service provider with over 18 years of expertise in **electrical safety** and **energy conservation**. With more than 15 years of professional service experience across India and abroad, the Foundation has established itself as a trusted partner in advancing sustainable energy practices. We are proud recipients of the **Kerala State Energy Conservation Award** from the Government of Kerala's Energy Management Centre, recognizing the development of the **Sustenergy Pyramid®**, a strategic decarbonisation tool for organizations. Our expertise extends to supporting hundreds of hospitals across India through comprehensive **electrical safety audits** and **energy audits**. In addition, we have developed specialized electrical safety audit protocols for diverse sectors including **cement, steel, petrochemicals, chlor-alkali, textiles, hospitals, hotels, IT/ITES, and commercial malls**. Operating across **India, Maldives, Sri Lanka, and Nepal**, Sustenergy Foundation continues to drive innovation and excellence in electrical safety and energy performance management.

I. Introduction

Hospitals depend on electrical infrastructure not only for lighting and comfort systems but also for critical clinical functions. Operating theatres, ICUs, NICUs, diagnostic services, medical gases, communications, lifts, fire and life-safety systems and information systems may all be affected by electrical failure. A localized electrical fault can therefore escalate into a clinical emergency when power continuity, protection, segregation, maintenance or emergency response is inadequate.

The present study was initiated by the Research Cell of Sustenergy Foundation to organize publicly reported hospital electrical-hazard events into a single, traceable dataset and identify recurring engineering and management themes. The incident workbook explicitly cautions that the records are compiled from media reports and other public-domain material, that no single authentic compiled source exists, and that incidents not reported publicly may be absent. Accordingly, this paper treats the dataset as an incident-learning sample and not as a statistically complete national registry.

The objectives are to: (1) characterize reported electrical hazards across Indian States/UTs; (2) examine the temporal and hazard patterns; (3) describe reported impacts on patients, staff, services and assets; and (4) translate the observations into practical engineering, maintenance, commissioning and emergency-preparedness recommendations.

II. Data Source and Methodology

The analysis uses the information collected from public domain during Jan -Aug 2026 to prepare an Incident Register, Source Verification, State & UT Analysis, Monthly Analysis, Ownership Analysis, a 243-day daily review, methodology notes and URL verification summary.

Each incident was retained as a separate record with its date, facility, State/UT, ownership where available, incident type, affected electrical asset/system, reported mechanism or circumstances, impact/consequences, hazard category and source URL. Cause descriptions were not upgraded from reported or preliminary wording to confirmed engineering causes. This is important because media reporting can describe an apparent cause before forensic investigation is completed.

For this paper, incidents were broadly classified into fire-related and power-related groups using the Incident Type field. Fire-related includes hospital, ICU, NICU, generator, panel, HVAC and equipment-associated fires. Power-related includes power failures/outages and backup-supply failures. Impact indicators were identified from the incident descriptions and are descriptive counts of records mentioning evacuation/relocation, service disruption, asset/infrastructure damage, injury/smoke exposure and explicitly reported fatality. Because one incident can contain multiple impacts, impact categories are not mutually exclusive.

III. Results

A. Overall Incident Profile

Metric	Result
Unique master incidents	46
Period covered	7 Jan–30 Aug 2026
Fire-related incidents	33 (71.7%)
Power-related incidents	13 (28.3%)
Incidents explicitly reporting fatalities	6
Reported deaths in those descriptions	≥23
States/UTs with ≥1 incident	19

Table I. Summary of the incident dataset.

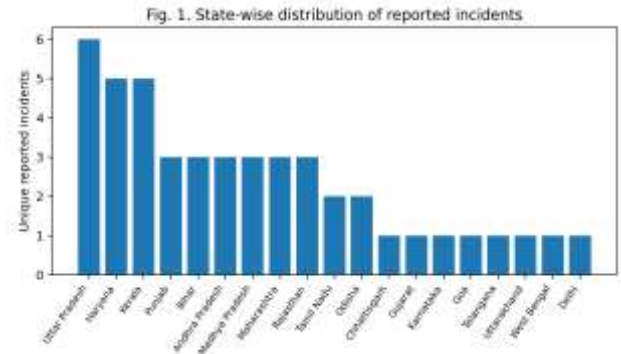


Fig. 1. State-wise distribution of reported incidents in the supplied dataset.

B. State-wise Distribution

State/UT	Incidents	Share
Uttar Pradesh	6	13.0%
Haryana	5	10.9%
Kerala	5	10.9%
Punjab	3	6.5%
Bihar	3	6.5%
Andhra Pradesh	3	6.5%
Madhya Pradesh	3	6.5%
Maharashtra	3	6.5%
Rajasthan	3	6.5%
Tamil Nadu	2	4.3%

Table II. Ten highest State/UT counts; the complete State/UT analysis in the source workbook includes zero-incident entries as well.

Uttar Pradesh has the highest count at six incidents, followed by Haryana and Kerala at five each. Andhra Pradesh, Bihar, Madhya Pradesh, Maharashtra, Punjab and Rajasthan each contribute three incidents. The distribution should not be interpreted as comparative State risk because reporting intensity, population, hospital density, media coverage and incident discoverability are not normalized.

C. Temporal Pattern

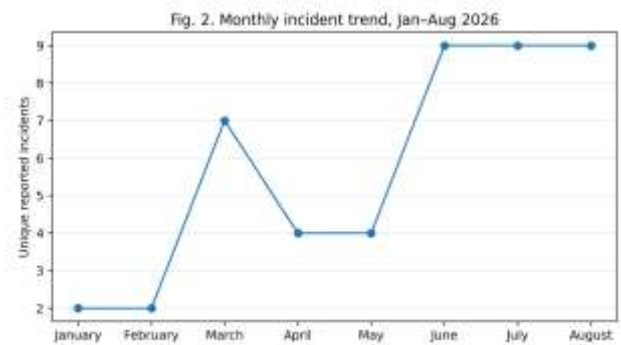


Fig. 2. Monthly trend of unique reported incidents, January–August 2026.

The monthly count increases from two incidents in January and February to seven in March, four in April, four in May, nine in June, nine in July and nine in August. The apparent increase later in the period may reflect both actual events and reporting/collection effects. It is therefore safer to use the trend for surveillance and learning rather than forecasting national incidence.

D. Broad Hazard Classification

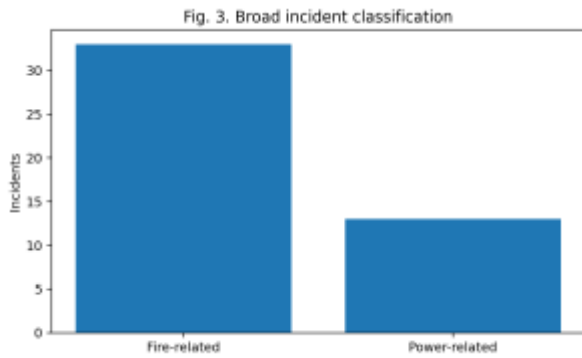


Fig. 3. Broad classification of incidents by Incident Type.

Fire-related events dominate the supplied dataset. The predominance of fire is particularly important in critical-care areas, where smoke, loss of ventilation, evacuation constraints and interruption of electrically powered clinical equipment can create simultaneous hazards.

E. Electrical Assets and Systems

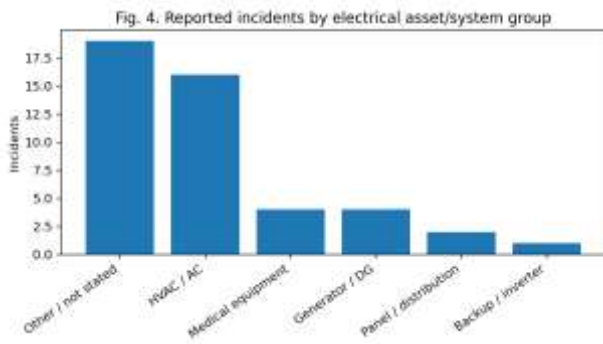


Fig. 4. Incidents grouped by the electrical asset/system described in the source register.

Asset/system group	Incidents	Engineering learning
Other / not stated	19	Cause/asset not sufficiently specified
HVAC / AC	16	Inspect, test and maintain an effective Air conditioning system
Medical equipment	4	Periodically test and maintain medical equipment
Generator / DG	4	Install, test and maintain DG sets
Panel / distribution	2	Periodically inspect and maintain electrical distribution network.
Backup / inverter	1	Inspect and maintain an effective backup power arrangement.

Table III. Consolidated electrical asset/system groups derived from the incident register.

HVAC/AC equipment, panels/distribution equipment, generators/DG systems, medical equipment and backup systems recur across the records. Several incidents are described only at a high level; consequently, the absence of a named component should not be interpreted as evidence that the component was not involved.

F. Reported Impact

Impact indicator	Records mentioning indicator	Interpretation
Evacuation / patient relocation	24	Operational and life-safety burden
Care/service disruption	12	Clinical continuity affected
Equipment / infrastructure damage	12	Asset and financial impact

Injury / smoke exposure	17	Patient/staff/public harm
Explicitly reported fatalities	6	At least 23 deaths across six descriptions

Table IV. Impact indicators identified from incident descriptions. Categories overlap; counts are record-level indicators, not totals of people affected.

The most severe records involve ICU/NICU and other patient-care environments. Examples in the supplied register include a neonatal warmer fire with a reported newborn death, ICU fires involving deaths and injuries, and a district women's hospital NICU fire with reported newborn deaths and serious injuries. Several power failures occurred during surgery or affected maternity, NICU, ICU, diagnostics or other critical services. These cases illustrate that electrical reliability is directly linked to clinical risk.

G. Ownership Profile

Ownership category	Incidents	Share
Government	18	39.1%
Not stated	17	37.0%
Private	7	15.2%
Private / Trust (non-government)	1	2.2%
Private / Non-government	2	4.3%
Government campus / public facility	1	2.2%

Table V. Ownership categories as recorded in the incident register.

Government facilities account for 18 incidents (39.1%) in the recorded ownership field, while ownership was not stated for 17 incidents (37.0%). The substantial 'not stated' share limits ownership comparisons.

IV. Discussion

The dataset indicates three interacting layers of hospital electrical risk. First is the physical infrastructure layer: panels, switchboards, cables, generators, backup supplies, HVAC systems and other electrical equipment. Second is the maintenance and management layer: inspection, preventive maintenance, testing, documentation, competency and escalation. Third is the clinical-response layer: the ability to maintain safe patient care, evacuate patients and restore essential services when an electrical event occurs.

Fire-related events are the dominant recorded hazard. In hospitals, electrical fire risk is amplified by combustible construction or stored materials, congested service spaces, continuous equipment loading, temporary installations, HVAC systems, aging distribution equipment and limited access to energized equipment for maintenance. A fire in a clinical area is also a power-quality and continuity event because isolation of a circuit or distribution board may remove essential loads.

Power failures represent a different but equally important risk pathway. The register contains events where generator/backup failure or inadequate response led to treatment under phone torchlight, interruption during surgery, prolonged outages, lift failures, or disruption to diagnostics and blood-bank operations. These observations support a system-level approach in which backup power is treated as a tested clinical safety function, not merely an installed generator.

The presence of repeated events involving panels, HVAC/AC equipment, generators and medical equipment also points to the importance of condition-based inspection and documented maintenance. Visual inspection alone is insufficient. Electrical safety programs should combine thermographic inspection where appropriate, torque verification, protective-device testing, insulation and earth continuity checks, RCD/RCBO/ELCB testing where applicable, battery and generator performance tests, transfer-switch functional tests, load-bank testing, alarm verification and review of single-line diagrams and protection coordination.

Commissioning is another critical control. New hospitals, extensions, renovated departments, replacement switchboards,

generators, UPS systems, medical electrical installations and temporary/modified systems should not be accepted solely on the basis of installation completion. A structured commissioning dossier should demonstrate testing, protection settings, interlocks, changeover operation, earthing/bonding, insulation, polarity, phase sequence, short-circuit/protection coordination assumptions, emergency power performance, functional tests and witnessed results before handover.

V. Recommended Hospital Electrical Safety Framework

A. Annual Electrical Safety Audit

Every hospital should undergo a documented electrical safety audit at least once every year, with additional audits after major modifications, serious incidents, repeated failures or changes in critical clinical services. The audit should cover HT/LT distribution, transformers, generators/DG, ATS/AMF panels, UPS and batteries, earthing and bonding, RCD/RCBO protection where required, medical locations, emergency lighting, fire alarm and suppression interfaces, cable routes, panels, temporary installations, HVAC electrical supplies, critical-load segregation, electrical rooms and maintenance records.

B. Competency-based Operations and Maintenance Training

Operations and maintenance personnel should receive periodic practical training in effective maintenance management and emergency preparedness. Training should include preventive and predictive maintenance planning, safe isolation and permit-to-work, lockout/tagout principles where applicable, emergency switching, generator/ATS operation, electrical fire response, patient-safety priorities, communication and escalation, incident reporting, root-cause analysis and post-event restoration. Competency should be assessed rather than relying only on attendance.

C. Mandatory Commissioning and Testing for Every Project

Every electrical project, expansion, replacement or major modification should include a detailed testing and commissioning plan. The plan should define test methods, acceptance criteria, responsible persons, calibrated instruments, witness points, records and sign-off. Functional testing should include normal and emergency power changeover under realistic load conditions. Critical circuits should be identified and demonstrated to perform as designed before clinical occupancy.

D. Preventive and Predictive Maintenance Management

Hospitals should maintain a critical-asset register with unique asset identification, risk classification, maintenance frequency, test history, defects, corrective actions and next-due date. High-risk assets should have condition-monitoring strategies proportionate to their criticality. Deferred maintenance should be visible to management, risk-assessed and time-bound.

E. Emergency Preparedness and Drills

Electrical emergency procedures should be integrated with hospital disaster and fire plans. Drills should test realistic scenarios such as total utility failure, generator failure, ATS failure, electrical fire in an ICU/NICU, loss of a distribution board and failure of a critical UPS. Drills should measure time to detect, isolate, communicate, restore essential services and safely relocate patients where necessary.

F. Governance and Learning

Each significant electrical incident should undergo documented investigation. The investigation should distinguish immediate cause, contributing factors, latent management conditions and system weaknesses. Corrective actions should be assigned owners and deadlines and reviewed by hospital leadership. Near-miss events should be captured so that organizations can learn before injury or loss occurs.

VI. Recommended Control Matrix

Control area	Minimum recommended action	Evidence of implementation
Electrical safety audit	At least once every year; additionally after major change/serious incident	Signed audit report + risk register + closure tracker
O&M competency	Periodic practical training on maintenance management and emergency preparedness	Training records + competency assessment + drill results
Project commissioning	Detailed testing of all electrical and critical systems before handover/occupancy	Commissioning dossier + test sheets + witness/sign-off
Backup power	Routine generator, ATS/AMF, UPS, battery and critical-load functional testing	Test logs + alarms/fault records + corrective actions
Earthing/protection	Periodic testing of earth continuity/resistance and protective devices as applicable	Instrumented test records + defect closure
Thermal/condition checks	Risk-based thermography and condition monitoring of distribution equipment	Trend reports + identified hotspot actions
Incident management	Root-cause analysis and management review of significant incidents	RCA + CAPA + effectiveness verification
Emergency drills	Scenario-based electrical failure/fire drills involving clinical teams	Drill report + response-time metrics
Documentation	Current SLDs, load schedules, protection settings and emergency switching procedures	Controlled drawings and revision records

Table VI. Proposed minimum control framework for hospital electrical safety.

VII. Limitations

This study has important limitations. The dataset is compiled from public-domain reports and media sources rather than a mandatory national incident-reporting system. Under-reporting is expected. The number of incidents cannot be used as a State risk rate without denominators such as number of hospitals, beds, electrical installations, occupancy or exposure hours. Media reports may contain evolving casualty figures and preliminary cause descriptions. Some records lack ownership, exact electrical asset or engineering cause. Duplicate reconciliation improves consistency but cannot eliminate all possible duplicate or related-event uncertainty. Accordingly, the findings are intended for safety learning, benchmarking of controls and research hypothesis generation.

The reported ≥ 23 deaths are a record-description total for six incidents explicitly containing fatality information in the supplied workbook. They should not be interpreted as an official national count, nor should the absence of a reported death be interpreted as proof that no harm occurred.

VIII. Conclusion

The 46-incident dataset demonstrates that electrical hazards in hospitals can manifest as fire, loss of essential power, failure of backup systems, disruption of critical clinical services, equipment damage, evacuation, injury and death. The concentration of reported events around fire, power continuity, panels/distribution, HVAC/AC systems, generators and medical equipment supports a lifecycle safety model rather than an equipment-only approach.

Three actions should be treated as foundational controls: (1) conduct an electrical safety audit at least once every year; (2) train operations and maintenance teams in effective maintenance management and emergency preparedness, with competency verification and realistic drills; and (3) require detailed electrical testing and commissioning for every project before handover and clinical use. These measures should be supported by risk-based preventive maintenance, backup-power testing, accurate documentation, incident investigation and management accountability. Sustenergy Foundation's compiled dataset can

serve as a starting point for a more comprehensive national hospital electrical incident registry and standardized reporting framework.

IX. Acknowledgment

The authors acknowledge the Sustenergy Foundation Research Cell and the contributors who compiled and verified the supplied public-domain incident records. The authors also acknowledge that the incident database is a compilation for safety-learning purposes and does not represent an official government or regulatory registry.

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Appendix A. State/UT Incident Counts

State/UT	Unique incidents
Andhra Pradesh	3
Arunachal Pradesh	0
Assam	0
Bihar	3
Chhattisgarh	1
Goa	1
Gujarat	1
Haryana	5
Himachal Pradesh	0
Jharkhand	0
Karnataka	1
Kerala	5
Madhya Pradesh	3
Maharashtra	3
Manipur	0
Meghalaya	0
Mizoram	0
Nagaland	0
Odisha	2
Punjab	3
Rajasthan	3
Sikkim	0
Tamil Nadu	2
Telangana	1
Tripura	0
Uttar Pradesh	6
Uttarakhand	1
West Bengal	1
Andaman and Nicobar Islands	0
Chandigarh	0
Dadra and Nagar Haveli and Daman and Diu	0
Delhi	1
Jammu and Kashmir	0

Ladakh	0
Lakshadweep	0
Puducherry	0

Table VII. Full State/UT count table from the supplied workbook. Zero values indicate no incident in the supplied merged dataset, not proof of no incident occurrence.

Appendix B. Incident Master Register (Condensed)

Incident ID	Date	Hospital / Facility	State / UT	Incident Type	Hazard Category
HZ2026-001	07-Jan-2026	MKCG Medical College & Hospital, Berhampur	Odisha	Major power failure during surgery	Power failure / backup
HZ2026-002	20-Jan-2026	Government Bharatiya Hospital	Rajasthan	Fire	Fire
HZ2026-003	04-Feb-2026	Government Medical College Hospital, Komi	Kerala	Generator-room fire	Fire / DG
HZ2026-004	09-Feb-2026	Raja Hospital, Kanpur	Uttar Pradesh	NICU warmer fire	Medical equipment / fire
HZ2026-005	01-Mar-2026	Government General Hospital, Nellore	Andhra Pradesh	Maternity/ch ildren ward fire	Fire / HVAC electrical
HZ2026-006	14-Mar-2026	NIMHANS	Karnataka	Fire	Fire
HZ2026-007	16-Mar-2026	SCB Medical College & Hospital, Cuttack	Odisha	Trauma-care ICU fire	Fire / ICU / electrical
HZ2026-008	17-Mar-2026	Government Medical College Hospital	Kerala	Fire	Fire
HZ2026-009	21-Mar-2026	SRN Hospital, Prayagraj	Uttar Pradesh	ICU fire	Medical equipment / fire
HZ2026-010	27-Mar-2026	NSCB Medical College Hospital	Madhya Pradesh	Fire	Fire
HZ2026-011	29-Mar-2026	Gajanan Hospital and Critical Care Centre	Maharashtra	Fire	Fire
HZ2026-012	12-Apr-2026	Government District Hospital	Madhya Pradesh	Power failure	Power failure
HZ2026-013	14-Apr-2026	Taluk Hospital, Thuravoor, Alappuzha	Kerala	Medicine-store fire	Fire / HVAC / property damage
HZ2026-014	19-Apr-2026	Anand Hospital	Gujarat	Fire	Fire
HZ2026-015	21-Apr-2026	Anandalok Hospital, Salt Lake, Kolkata	West Bengal	Hospital fire	Fire / HVAC / operations
HZ2026-016	12-May-2026	Government General Hospital	Andhra Pradesh	Fire	Fire
HZ2026-017	12-May-2026	Civil Hospital, Sirsa	Haryana	Main electrical-panel fire	Electrical panel / fire
HZ2026-018	20-May-2026	Panacea Hospital, Dehradun	Uttarakhand	ICU fire	Fire / ICU / HVAC
HZ2026-019	23-May-2026	Apollo Speciality Hospitals, OMR, Chennai	Tamil Nadu	Power failure	Power failure / backup
HZ2026-020	01-Jun-2026	Taluk Hospital, Kunnankulam, Thrissur	Kerala	Emergency-department switchboard fire	Electrical panel / fire
HZ2026-021	02-Jun-2026	North Goa District Hospital, Mapusa	Goa	4-hour power outage	Power failure / DG
HZ2026-022	02-Jun-2026	LIMS Hospital, Shamshabad	Telangana	Electrical smoke/fire scare	Electrical fault / HVAC
HZ2026-023	04-Jun-2026	Prasad Hospital, Muzaffarpur	Bihar	ICU fire	Fire / ICU / electrical
HZ2026-024	10-Jun-2026	Private hospital, Paota B Road, Jodhpur	Rajasthan	Hospital fire	Fire / HVAC / electrical maintenance
HZ2026-025	11-Jun-2026	Empathy Hospital, Bhiwandi	Maharashtra	Generator-unit fire	DG / fire
HZ2026-026	15-Jun-2026	AS Multi Kidney Hospital, Dabri, New Delhi	Delhi	Meter/panel fire	Meter room / electrical fire
HZ2026-027	17-Jun-2026	Rainbow Children's Hospital	Andhra Pradesh	Fire	Fire
HZ2026-028	26-Jun-2026	One Stop Centre, Lok Bandhu Hospital campus, Lucknow	Uttar Pradesh	Electrical-panel fire	Electrical panel / fire
HZ2026-029	04-Jul-2026	Civil Hospital, Narnaul/Mahendragarh	Haryana	Power outage + generator failure	Power backup

HZ2026-030	09-Jul-2026	District Civil Hospital	Haryana	Power failure	Power failure
HZ2026-031	12-Jul-2026	Civil Hospital, Gidderbaha, Muktsar	Punjab	Power failure during surgery	Power backup / surgery
HZ2026-032	13-Jul-2026	District Civil Hospital, Karnal	Haryana	5.5-hour power failure + backup failure	Power failure / backup
HZ2026-033	16-Jul-2026	Janana Hospital	Rajasthan	Power failure	Power failure
HZ2026-034	16-Jul-2026	Lala Lajpat Rai Hospital, Kanpur	Uttar Pradesh	Electrical-panel fire	Electrical panel / diagnostics
HZ2026-035	17-Jul-2026	District Hospital, Ambedkar Nagar	Uttar Pradesh	X-ray-area MCB panel fire	Electrical panel / diagnostics
HZ2026-036	19-Jul-2026	Model Sadar Hospital	Bihar	Power failure	Power failure
HZ2026-037	28-Jul-2026	Mekahara Government Hospital	Chhattisgarh	Fire	Fire
HZ2026-038	04-Aug-2026	Government Medical College Hospital, Maternal and Child Block	Kerala	Fire	Fire
HZ2026-039	04-Aug-2026	Civil Hospital, Jalandhar	Punjab	NICU fire	Fire / NICU / HVAC
HZ2026-040	08-Aug-2026	Sadar Hospital	Bihar	Power failure	Power failure
HZ2026-041	11-Aug-2026	BK Civil Hospital	Haryana	Power failure	Power failure
HZ2026-042	18-Aug-2026	Satluj Hospital, Phagwara	Punjab	Generator fire	DG / fire
HZ2026-043	22-Aug-2026	Chhindwara District Hospital SNCU	Madhya Pradesh	NICU radiant-warmer fire	Medical equipment / NICU / fire
HZ2026-044	24-Aug-2026	District Women's Hospital, Amravati	Maharashtra	NICU fire	Medical equipment / NICU / fire
HZ2026-045	29-Aug-2026	Navodaya Hospital	Uttar Pradesh	Fire	Fire
HZ2026-046	30-Aug-2026	Thiruparankundram Government Hospital, Madurai	Tamil Nadu	Repeated power outages affecting care	Power reliability

Table VIII. Condensed master register..