MODULE 16 | EMERGENCIES, DISASTERS, SECURITY AND SERVICE CONTINUITY

Hospital Security, Violence Prevention and Safe Evacuation

63

LECTURE

Practical hospital governance in Punjab, Pakistan

Protect people, preserve access to care and control danger.
Make each shift ready to act and account for patients.

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SELF-STUDY PDF

Protect people while keeping care accessible

The Medical Superintendent needs an organised response to violence, intrusion, fire and unsafe patient movement.

- Assign duties for every shift.
- Check law and safety arrangements.
- Prevent escalation and preserve evidence.
- Test evacuation and safe patient handover.

OFFICIAL SOURCE

A principle tied to a named law, standard or official guidance.

WORKING METHOD

A practical control or teaching format to adapt to the authorised system.

TEACHING CASE

An invented hospital example, used to practise applying the correct process.

Study output

A security risk review, a checked evacuation plan and a recorded exercise with corrective actions.

Module 16 | Presentation 2 of 3. Allow 45-60 minutes with exercises. All explanations are on the pages; check the cited sources before live use.

Three connected parts of emergency leadership

Use this lecture with the hospital response and service-continuity lectures.

Lecture	Main question	Practical output
62 | Emergency response	How will we organise a major incident and a sudden rise in demand?	Incident arrangements and a tested response plan.
63 | Security and evacuation	How will we protect people and move patients safely if needed?	Security review and evacuation exercise.
64 | Continuity and recovery	How will essential care continue and services safely recover?	Continuity plan and recovery checks.

Module 12 covers routine facilities and workplace safety. This lecture focuses on leadership during a security or evacuation event.

WORKING METHOD | Illustrative material is identified in the text.

Start with the correct source and scope

An internal security procedure must fit the law, the building and the clinical service.

Source	What the hospital should establish
PHC hospital standards	Applicable category, emergency plans, equipment fitness, evacuation evidence and staff readiness.
Security legislation	Whether the establishment has been notified, and which competent directions apply.
Building and fire requirements	Applicable certificate, current regulations, local approvals and competent technical assessment.
Technical guidance	Use it to improve planning; do not describe foreign guidance as a Punjab statutory duty.

Record the current instrument, its scope, the responsible officer and the evidence of compliance.

Sources: **V1**: FMS standard 23 | **V2**: sections 2-7 | **V4**: scope | **V9**: application

Check notification under the security law

The Punjab Security of Vulnerable Establishments Act 2015 includes hospitals in its definition, together with the notification requirement.

Check the official position

- Obtain the establishment notification and current security advice. Identify the competent Security Advisory Committee and the officer receiving correspondence.
- Confirm who is the manager for the Act and how that role relates to the Executive Director, MS and security lead.

Keep a compliance record

- File inspection findings, written advice, the hospital response and evidence that required arrangements work.
- Escalate an unmet requirement with the risk, temporary protection, resources needed and responsible authority.

Do not treat the word hospital alone as proof of notification, or an unresolved scope question as a reason to leave people unprotected.

Sources: **V2**: sections 2-7

Check the building-specific safety route

The Punjab Community Safety Act 2021 has its own definition of a covered building.

Identify applicability

- Section 2(a) uses an occupied floor more than 50 feet above the lowest level. Do not substitute total roof height for this test.
- For a covered building, establish the section 3 Safety Measure certificate and section 4 safety-manager arrangements.

Use the current requirements

- Keep the actual certificate, conditions, expiry and competent inspection record. Obtain current Gazette amendments to the building regulations.
- Ask competent fire and building professionals to confirm the strategy, escape arrangements and unresolved defects.

Other PHC, fire and building requirements remain relevant even if this particular statutory height definition is not met.

Sources: **V4**: sections 2-4 | **V9**: competent authority

Assign the response for every shift

Suggested responsibility map. Confirm the hospital appointments and powers.

Role	Responsibility during the event
Incident lead / duty administrator	Coordinate decisions, call support, protect services and record escalation.
Clinical and nursing leads	Assess patients, maintain care, set clinical movement needs and confirm handover.
Security supervisor	Control unsafe access, summon help, guide responders and preserve relevant evidence.
Fire, estates and technical leads	Advise on hazards, safe routes, systems and authorised isolation or restoration.
Liaison and information officers	Coordinate with responders and families; issue authorised, verified updates.

Name a deputy and a working contact for each role. An office-hours roster cannot support a 24-hour hospital.

WORKING METHOD | Illustrative material is identified in the text.

Review security through the patient journey

Suggested joint round with security, nursing, clinical staff, estates and patient relations.

01 Arrival

Can ambulances and urgent patients reach assessment safely?

02 Waiting

Are delays explained and help requests answered?

03 Clinical areas

Is entry matched to the person’s role and patient need?

04 Sensitive areas

Are medicines, records, plant rooms and stores protected?

05 Night work

Can staff summon help and move safely between areas?

06 Exit

Do security controls still allow safe emergency escape?

Record the hazard, who may be harmed, the temporary control, owner and review date. Assess behaviour and circumstances fairly.

WORKING METHOD | Illustrative material is identified in the text.

Use access control without obstructing care

Suggested arrangements must fit the hospital layout, local risk and patient needs.

Control	Practical check
Staff and contractors	Identify the person, purpose, permitted area and supervisor; recover unneeded access.
Visitors and attendants	State visiting arrangements clearly; allow clinically justified assistance through an authorised exception.
Vehicles and deliveries	Keep ambulance routes, fire access and unloading areas usable.
Restricted spaces	Control keys and entry to critical plant, medicines, records and other sensitive areas.

Do not make a missing visitor pass an obstacle to immediate emergency assessment. Clinical need should reach a clinical decision-maker.

WORKING METHOD | Illustrative material is identified in the text.

Reduce the conditions that allow conflict to grow

WHO guidance supports better work organisation, timely information, early security help and staff preparation.

Before a confrontation

- Explain triage, delays and the next update through a responsible staff member. Provide a visible route for questions and complaints.
- Use the local risk review to improve lighting, staffing, alarms and access. Give lone workers a reliable way to request assistance.

Prepare the workforce

- Train staff to recognise threats, communicate calmly and call trained support. Practise the local response in the actual work area.
- Make reporting straightforward. Review threats and near misses as well as injuries, and support affected staff.

A complaint may be valid even when a person’s conduct is unacceptable. Address the safety risk and investigate the complaint through their proper routes.

Sources: **V5**: prevention and response

Use a clear first response to threatening behaviour

Suggested principles for trained staff; follow the approved local procedure and call help early.

1	**Recognise danger**	Assess immediate risk to people. Do not remain in an unsafe confrontation to finish an argument.
2	**Communicate calmly**	Use a clear, respectful explanation and a practical next step. Avoid public humiliation or promises you cannot keep.
3	**Get support**	Alert the clinical lead and security. Request police or emergency assistance when the threat requires it.
4	**Protect and record**	Move others to safety where feasible, continue necessary care and record the facts after immediate danger is controlled.

Security staff need defined lawful limits. Restraint or sedation is not a routine response to a complaint and requires appropriate clinical and legal authority.

WORKING METHOD | Illustrative material is identified in the text.

Keep clinical assessment separate from punishment

Distress or altered behaviour may accompany illness. A security response must allow a suitable clinical assessment.

Clinical responsibility

- Ask the responsible clinician to assess possible medical causes, capacity and immediate treatment needs when safe to do so.
- If restrictive measures are clinically necessary, use the applicable law and approved protocol, trained staff, monitoring and a documented review.

Administrative responsibility

- Protect patients and staff, provide a safe assessment setting and obtain trained help. Do not order medication as a disciplinary measure.
- Use the correct complaints, safeguarding, employment or police route for the actual concern. Avoid labels that assume guilt or diagnosis.

The MS coordinates safety and accountability; qualified clinicians remain responsible for clinical decisions.

WORKING METHOD | Illustrative material is identified in the text.

Make alerts understandable on every shift

A local code is useful only when people know what it means and what to do.

Part of the alert	What to define and practise
Meaning	Exact event covered. Code White, if used, is a local convention, not a universal statutory standard.
Activation	Who can raise the alert, the working contact and the backup if the telephone fails.
Message	Location, nature of danger, people affected and help required, without unnecessary patient details.
Response and stand-down	Who attends, who leads, how clinical care continues and who confirms the alert has ended.

Teach temporary, outsourced and newly rotated staff. Test a missed call or failed alarm as well as the normal route.

WORKING METHOD | Illustrative material is identified in the text.

Manage the security contract as a clinical support service

Suggested checks for procurement, legal review and day-to-day supervision.

01 Eligibility

Check applicable company licensing and personnel requirements.

02 Coverage

Define posts, shifts, relief arrangements and escalation.

03 Competence

Verify induction, communication and emergency training.

04 Conduct

Set lawful limits, respectful behaviour and confidentiality.

05 Equipment

Confirm permitted equipment, working communications and checks.

06 Evidence

Match attendance, incident records and supervision to contract obligations.

The contractor’s uniform or invoice does not prove adequate cover. Identify the hospital officer who verifies delivery.

WORKING METHOD | Illustrative material is identified in the text.

Use cameras with purpose and control

Closed-circuit television (CCTV) may support safety and investigation. It is not a substitute for a response team.

Before installation

- Approve the purpose, coverage and access. Assess privacy, especially in consultation, examination and other sensitive areas.
- Check image quality, time accuracy, recording, secure storage and the response to a failed camera.

During use

- Limit viewing and export to authorised people. Maintain the approved retention schedule and a record of disclosure.
- Preserve relevant footage promptly after an incident or lawful request; prevent automatic deletion while a preservation hold applies.

Do not circulate patient images or incident clips through personal groups. Verify the lawful disclosure route and keep an export record.

Sources: **V1**: IMS confidentiality

Act promptly when a vulnerable person is missing

Suggested hospital procedure for an infant, child or at-risk adult; agree details with clinical, safeguarding and police partners.

1	**Raise the alert**	Confirm the report, identity and last known location without delaying urgent escalation.
2	**Coordinate the response**	Activate the approved missing-person plan, assign a lead and involve security, the clinical team and police as indicated.
3	**Protect and trace**	Check authorised information, movements and footage. Control relevant access without trapping others or blocking emergency care.
4	**Record and reconcile**	Document actions and contacts. Confirm identity and a safe handover if the person is found, then review the incident.

Do not publish identifying details, accuse an individual or impose an improvised campus lockdown without the appropriate authority and risk assessment.

WORKING METHOD | Illustrative material is identified in the text.

Manage a serious threat through trained responders

For a suspicious object, credible threat or armed violence, the hospital plan must connect immediately with police and emergency services.

Protect people

- Keep people away from the danger and follow the approved shelter or movement instructions. Do not ask untrained staff to inspect or handle a suspicious object.
- Give responders an accurate location and known facts. Avoid unnecessary movement into the affected area.

Protect essential care

- The incident lead coordinates clinical alternatives, access for responders and verified staff messages. Keep a safe route for necessary care where possible.
- Restrict sensitive information to those who need it. Preserve the threat message and relevant records through the authorised evidence process.

The response depends on the actual threat. A generic instruction to evacuate the entire hospital can move people into greater danger.

Sources: **V7**: safety, security and communication

Keep an incident record that can be checked

Suggested factual record. Separate what was seen from what was reported or inferred.

Record	Include
Event	Date, time, place, immediate risk, affected people and source of information.
Actions	Alerts, care provided, protective actions, decisions and the officer making each decision.
Evidence	Witness details, relevant records and footage; who secured and accessed each item.
Follow-up	Police or other report reference, support offered, outstanding risks and assigned corrective actions.

Preserve originals. For a transfer of evidence, record the item, purpose, sender, recipient, time and acknowledgement.

WORKING METHOD | Illustrative material is identified in the text.

Support people and examine what failed

The response continues after the immediate threat ends.

For affected people

- Arrange appropriate medical assessment, emotional support and occupational-health follow-up. Explain available reporting and complaint routes.
- Protect confidentiality and consider safe duties or work arrangements through the authorised process.

For the institution

- Review the event with relevant staff. Identify failures in access, communication, staffing, equipment or escalation without assuming a single cause.
- Assign actions and verify completion. Keep disciplinary, clinical, criminal and system-learning processes distinct but properly coordinated.

A fall in reported incidents can mean under-reporting. Review staff confidence and reporting quality before claiming an improvement.

Sources: **V5**: reporting, support and monitoring

Know the PHC emergency-planning indicators

Category I hospital MSDS, standard 23, links a written plan to equipment, practice and staff capability.

Indicator	Requirement in plain language
126	Plan for early detection, containment and abatement; provide required equipment and relevant-authority fitness evidence.
127	Keep and display a safe-exit plan with roles, routes, assembly areas and places for evacuated patients.
128	Hold mock drills at least annually, covering different areas and shifts; keep findings and changes.
129	Keep training evidence and confirm staff understand their own role and other roles in the response.

An annual PHC minimum does not cancel a stricter requirement in another applicable instrument or a need for more frequent practice.

Sources: **V1**: standard 23, indicators 126-129

Inspect the route, not only the wall plan

Suggested joint checks before relying on an evacuation route.

01 Escape

The actual route is clear, recognisable and usable.

02 Doors

Exit controls permit escape; fire doors perform their intended function.

03 Warning

Alarms are detected, communicated and acted upon in all relevant areas.

04 Protection

Required equipment and systems have valid checks and recorded defects.

05 Responders

Fire and ambulance access remains available.

06 Destination

The receiving area can safely support the planned patients.

Resolve the conflict if a security lock, parked vehicle, stored bed or renovation barrier prevents safe escape.

WORKING METHOD | Illustrative material is identified in the text.

Set a safe immediate response to smoke or fire

The approved site plan must define the actions staff can take within their training and without entering danger.

1	**Raise the alarm**	Activate the local fire response and contact Rescue 1122 through the approved route. State the location and known danger.
2	**Protect people**	Move people in immediate danger if it can be done safely; obtain trained help and preserve a safe escape route.
3	**Limit spread safely**	Follow the plan for doors and access. Only trained staff should use suitable firefighting equipment when safe.
4	**Coordinate care**	The clinical and incident leads organise patient support, movement and technical actions with the responders.

Do not delay the alarm to investigate alone, enter smoke, or disconnect essential equipment without assessing the patient consequences.

Sources: **V1**: indicators 126-129 | **V3**: emergency coordination

Choose movement according to danger and design

Technical concepts to discuss with competent fire professionals. They are not interchangeable instructions.

Option	Meaning and condition
Shelter in a safe area	Remain in an assessed safe place when movement would increase risk; maintain care and reassess.
Horizontal evacuation	Move on the same level into a suitably protected adjoining area. A normal corridor is not automatically a refuge.
Vertical evacuation	Move between floors by the approved safe route using trained support and suitable equipment.
Off-site evacuation	Transfer to a safe external destination with patient tracking, transport and an agreed clinical handover.

Progressive horizontal evacuation depends on suitable protected compartments, enough capacity and trained staff. Confirm these conditions locally.

Sources: **V6**: chapters 2-3

Decide the extent of evacuation with clinical input

Immediate protective action and a coordinated larger evacuation are related but different decisions.

Immediate danger

- The site procedure should empower trained staff to raise the alarm and protect people immediately, without waiting for a committee meeting.
- Staff must avoid putting themselves or others into an unsafe route. Keep the incident lead informed as soon as practicable.

Wider movement

- The incident lead, clinical leads and competent responders assess the hazard, building protection, time available and receiving capacity.
- Record the decision, affected areas, routes, patient needs and review trigger. Reassess if smoke, structural danger or service failure changes.

The safest destination is determined by conditions and care needs, not merely by the nearest open space.

Sources: **V3**: coordinated response | **V6**: patient dependency

Plan support for dependent patients

Suggested patient-movement checks for the clinical lead and receiving team.

01 Identity

A reliable identifier travels with the patient.

02 Clinical need

Record current condition, urgent treatment and infection precautions.

03 People

Assign the right escort and enough trained movement support.

04 Equipment

Arrange suitable transport equipment and essential monitoring.

05 Supplies

Confirm medicines, oxygen and power needed for the journey and delay.

06 Destination

Agree a receiving place, responsible clinician and handover.

Plan for critical care, theatres, maternity, children and people with mobility, sensory or communication needs. Do not assume visitors can safely carry patients.

WORKING METHOD | Illustrative material is identified in the text.

Coordinate oxygen, power and lift decisions

These technical decisions can immediately affect several patients or areas.

Oxygen and electricity

- Oxygen supports combustion. Identify the affected supply and the patients who depend on it; arrange an appropriate alternative.
- Only authorised competent staff should isolate or restore systems under the emergency plan, in coordination with clinical teams and responders.

Movement systems

- Do not use ordinary passenger lifts during a fire. Any designated evacuation-lift use needs the approved design, procedure and competent control.
- Practise equipment-assisted movement safely. Routes, staffing, devices and patient dependency must be considered together.

A blanket order to turn off all oxygen or power can create a second emergency. The action must fit the specific hazard and patient needs.

Sources: **V8**: oxygen fire risk | **V6**: assisted evacuation and lifts

Track every movement to a receiving person

Suggested movement log; prepare a paper version in case systems fail.

Field	Record at departure and arrival
Patient	Unique identifier and suitable identifying details, checked at handover.
Move	Starting area, destination, departure time and actual arrival time.
Support	Clinical needs, escort, transport method, essential equipment and information.
Handover	Sender and receiving staff member; care concerns and confirmation of receipt.

A vehicle leaving the gate is not a completed transfer. Reconcile the receiving acknowledgement and unresolved patient locations.

WORKING METHOD | Illustrative material is identified in the text.

Worked example: account for all patients

At an invented exercise, 24 patients were present in Ward A when the movement plan began.

Internal movement	16 patients have confirmed arrival and handover in Ward B.
External transfers	6 patients have confirmed arrival and handover at the receiving hospital.
Care in place	2 patients remain with a named clinical team in the assessed safe area.
Reconciliation	16 + 6 + 2 = 24. Every original patient has a documented current location.

This checks the count. Also verify individual identities: matching totals alone can hide a duplicate entry and a missing person.

TEACHING CASE | Illustrative material is identified in the text.

Prepare a receiving area for care

Suggested readiness questions before sending patients to an assembly or holding area.

01 Safety

Is it clear of the hazard and safe from traffic and weather?

02 Space

Can the actual patients, beds and equipment fit safely?

03 Care

Are responsible clinical and nursing teams present?

04 Services

Are necessary power, oxygen, water and communications available?

05 Separation

Can infection precautions, privacy and safeguarding be maintained?

06 Next move

Who coordinates onward transfer and updates the movement log?

An outdoor assembly point for mobile staff may be unsuitable for ventilated or otherwise dependent patients.

WORKING METHOD | Illustrative material is identified in the text.

Keep families, staff and responders informed

Suggested information arrangements that protect both safety and confidentiality.

For families and the public

- Use a named information point away from response routes. Give verified service updates and explain how relatives can obtain authorised information.
- Confirm patient identity and the recipient’s entitlement before sharing individual location or health details. Record sensitive disclosure decisions.

For response teams

- Give concise location, hazard, access and patient-support information through the agreed liaison officer.
- Record requests, accepted tasks and the next update. Make clear when a figure is provisional or an event is unconfirmed.

Avoid public patient lists, identifiable photographs and conflicting messages from multiple staff members.

Sources: **V1**: confidentiality | **V7**: communication

Test the response without exposing patients to harm

Suggested exercise design. PHC allows a mock evacuation of an area to help test the plan; a whole-hospital plan is still required.

1	**Set the objective**	Choose one risk and define what successful action would look like, such as alerting the night response team.
2	**Prepare safely**	Approve the scope, observers, simulation arrangements and stop rule. Protect real clinical services.
3	**Observe the work**	Record what staff actually do: contacts, route choice, support, patient tracking and handover.
4	**Correct and retest**	Agree owners and dates for failures. Test important corrections and retain evidence of the result.

Use table-top discussion and suitable simulations before complex movement drills. Training attendance alone does not demonstrate practical readiness.

Sources: **V1**: indicators 127-129

Report readiness with evidence and open risks

Suggested dashboard for the MS and institutional leadership; set local targets through the proper process.

Measure	Question behind the number
Shift coverage	Are the required roles staffed, with deputies and working contacts?
Equipment and routes	What critical defects are open, and what temporary protection is in place?
Exercise performance	Which actions failed or were delayed, and have corrections been demonstrated?
Incidents and learning	What harm, threats and repeated causes are recorded; are staff willing to report?

Report overdue high-risk actions separately. A high overall percentage can hide one serious unsafe condition.

WORKING METHOD | Illustrative material is identified in the text.

Apply the lesson to three decisions

Write your answer and the reason before turning to the next page.

1 | The locked exit

A new security door reduces unauthorised entry but staff cannot open it promptly from inside.

What should the MS require before accepting this arrangement?

2 | The interrupted transfer

Twenty patients were due to move. Twelve arrivals are confirmed, six remain with the ward team and two have left without an arrival acknowledgement.

Can the incident lead report that all patients are accounted for at a safe destination?

3 | The threatening relative

A relative makes a credible threat after a long unexplained wait. Staff want to remove the patient’s record and publish the CCTV clip.

What are the immediate safety and information-control priorities?

Write the action, responsible role, evidence needed and reason. All scenarios are invented.

TEACHING CASE | Illustrative material is identified in the text.

Answers and reasons

Use the evidence, the calculation and the cited source.

1 | Correct the unsafe exit

Arrange immediate safe access and competent review of the locking arrangement. Security must preserve the approved escape function. Test the actual door and record the correction before acceptance.

2 | Close the tracking gap

No. Twelve + six = eighteen confirmed locations; two patients are in transit with receipt unconfirmed. Trace each transfer promptly, support continuing care and obtain named arrival acknowledgements.

3 | Protect and preserve

Call trained security and clinical support; involve police when indicated. Maintain needed care and address the complaint. Preserve records and footage securely; use only authorised disclosure, not public circulation.

Patient safety, factual records and competent decisions must remain connected throughout the response.

Prepare a security and evacuation readiness brief

Use a non-confidential real case or the invented examples in this lecture.

1 | One risk and its controls

Choose one area. State the risk, controls, evidence, gaps and the owner of each action.

2 | One checked movement plan

Show the activation route, responsible staff, safe destination, patient-support needs and tracking method.

3 | One exercise and follow-up

Record what was tested, what failed, who will correct it and how the important corrections will be verified.

Ask a clinical lead, security lead and competent fire or estates officer to review the brief. Confirm current applicable directions and approval before implementation.

Use anonymised information for teaching. Keep sensitive layouts, vulnerabilities and contact lists within authorised hospital records.

WORKING METHOD | Illustrative material is identified in the text.

Sources and continued use | 1

Select a source title or its official-source link to open the document.

V1

Minimum Service Delivery Standards for Hospitals 2024

PHC Category I hospital manual. FMS standard 23, indicators 126-129: emergency plans, equipment, evacuation, drills and staff training. IMS standards support confidentiality and record control.

Punjab Healthcare Commission | **Official source**

V2

Punjab Security of Vulnerable Establishments Act 2015

Act XIV of 2015. Sections 2-7 address scope, notification, Security Advisory Committee and security arrangements. Check the notification and written advice applying to the actual establishment.

Law and Parliamentary Affairs Department, Punjab | **Official source** | **Official Punjab Laws copy**

V3

Punjab Emergency Service Act 2006

Official Rescue text. Sections 3 and 5 address continuing responsibilities and Rescue functions; sections 16-17 concern assistance and emergency powers. Liaise with the competent responders.

Punjab Emergency Services Department | **Official source**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 2

Select a source title or its official-source link to open the document.

V4

Punjab Community Safety Act 2021 and building regulations

Sections 2-4 of the Act identify scope, certificate and safety-manager arrangements. The official building-safety page provides the base 2022 regulations. Obtain applicable later Gazette amendments before live use.

Punjab Emergency Services Department | **Official source** | **Building safety and regulations**

V5

Violence and harassment: occupational hazards in health care

WHO prevention resource. Work organisation, early help, staff preparation, reporting and follow-up. International guidance; suggested hospital formats in this lecture are original working methods.

World Health Organization | **Official source**

V6

HTM 05-02: Firecode, 2015 edition

Chapters 2-3 explain healthcare fire strategy, patient dependency and progressive horizontal evacuation. NHS technical guidance is not Punjab law; a competent local assessment must establish the safe strategy.

Department of Health / NHS England | **Official source**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 3

Select a source title or its official-source link to open the document.

V7

Hospital emergency response checklist, 2011

WHO all-hazards guidance for hospital administrators. Security, communication, continuity and recovery principles. Used as technical guidance, not as a mandatory Punjab incident-command model.

World Health Organization | **Official source**

V8

Medical Oxygen Fire Risk: Mitigation Measures

WHO technical resource, 29 April 2021. Oxygen increases fire risk. Isolation and alternative supplies need trained clinical and technical coordination, with continued patient support.

World Health Organization | **Official source**

V9

Building Code of Pakistan: Fire Safety Provisions 2016

Official PEC publication. Means of escape, protection systems and the authority having jurisdiction. Use competent professionals and the current applicable approvals; this lecture does not prescribe design dimensions.

Pakistan Engineering Council | **Official source**

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.