Candid Cycle

SAMPLE REPORT · FICTIONAL ORGANISATION AND DATA

Cold-Storage Power Failure: Team Report

Post-incident review · Lantern Bay Logistics Pty Ltd

Cycle	Cycle 1. Post-incident review
Scope	Response to the loss of mains power at the cold-storage depot on 12–13 May 2026, and the arrangements that sat behind it.
Input window	18–29 May 2026
Contributors	8 of 9 invited contributors submitted a reflection. A report needs at least three.
Plan	Starter plan (up to 9 contributors)
Issued	5 June 2026. Released after account holder review.

8 of 9
Contributors submitted

6
Improvement themes

6
Prioritised recommendations

7 of 8
Most widely shared theme

Confidentiality statement. This report was produced from anonymous contributor submissions. The facilitator and account holder did not see any individual response, only the themes below. No names or identifying roles appear anywhere in this report, evidence is grouped by theme and never by person, and every quotation is labelled “Anonymised submission excerpt” and edited where needed to protect identity while preserving meaning. The report was drafted with AI assistance and released after review by the account holder.

Executive Summary

Contributors are proud of how people responded on the night, and equally clear that the response was held together by individual effort rather than by plans or systems. Seven of eight describe the continuity plan as out of date, hard to find or never exercised. Six of eight say the backup power weakness was already known and rated High, but the upgrade had no budget. Five say experienced people carried the response for about 30 hours with no ready deputies, and five say a similar short outage at another depot in 2025 was never reviewed.

Context

Scope. Response to the loss of mains power at the cold-storage depot on 12–13 May 2026, and the arrangements that sat behind it.

Mains power to the cold-storage depot failed on 12 May and was out for about 19 hours. The on-site backup generator did not start. A hired generator was connected after roughly six hours. Contributors estimate that temperature-controlled stock worth about AUD 410,000 was at risk and about AUD 85,000 was written off. These figures are contributors' estimates and have not been verified against finance records.

Recurring strengths

Strength	Raised by	What contributors said
Fast, practical response by the cold-chain team	7 of 8	Manual temperature checks and stock moves began within the hour and kept most stock within tolerance.
Customers were told early	5 of 8	Account managers contacted affected customers within about two hours, before most customers asked.
Neighbouring depots offered help without being asked	4 of 8	Pallet space, staff and a forklift were offered by the other two depots on the first night.

Improvement Themes

Themes are grouped by topic, never by person. Counts show how many of the 8 contributors raised each theme, and a contributor can raise more than one.

1. A known risk had no funded treatment Raised by 6 of 8

Backup power was listed as a High risk on the register in the previous year and an upgrade had been proposed. Contributors say it was discussed but never given a budget line or a date.

> *"We all knew the generator was the weak point. It was on the list. Nobody had the money to fix it, so it stayed on the list."*
>
> Anonymised submission excerpt

2. The continuity plan was not known, current or exercised Raised by 7 of 8

Most contributors did not know where the plan was or what part they were meant to play. The plan has never been exercised, and the cold-storage depot follows a different version from the main depot.

> *"I had never seen the plan. I found out which version we were using about three hours in."*
>
> Anonymised submission excerpt

3. The response depended on a few experienced people Raised by 5 of 8

Two or three people covered most of the first 30 hours. There was no agreed deputy for key response roles and no handover arrangement.

> *"The same people were on site from the first call to the following evening. Nobody else knew enough to take over."*
>
> Anonymised submission excerpt

4. Emergency decisions were made outside agreed limits Raised by 4 of 8

Hiring the generator and disposing of stock were approved by phone. Some contributors were later unsure whether the approvals were valid and no record of them was kept.

> *"We did the right thing, but I could not tell you who actually signed it off, and there is nothing written down."*
>
> Anonymised submission excerpt

5. Earlier lessons were not carried forward Raised by 5 of 8

A shorter outage at another depot in 2025 was never formally reviewed. Contributors say corrective actions are kept in different places and there is no common method for post-incident review.

> *"We had a power dip at another depot last year. I do not remember anyone writing up what we learned."*
>
> Anonymised submission excerpt

6. An earlier warning had no owner Raised by 4 of 8

The generator concern was raised at an executive meeting in March. It was noted but no owner or due date was set, so it was not followed up.

> *"It was raised, everybody nodded, and then it was just not anyone's job."*
>
> Anonymised submission excerpt

Snapshot: yes, partially, no

Closed questions are reported as a breakdown rather than a single percentage, because a single figure would overstate what seven or eight people can show.

Question	Yes / Partially / No (n = 8)
Before the failure, did you know where the continuity plan was and what your part in it was?	
Was the first response fast enough to protect most stock?	
Were emergency decisions made within agreed authority and recorded?	
Was the backup power weakness already known before 12 May?	

Key Learnings and Plus/Delta

- The organisation identifies its weaknesses before they cause harm, but has no routine step that makes someone fund, schedule or own the fix.
- Individual commitment is covering for gaps in planning, deputies and recorded decisions. That works until the same few people are unavailable.
- Lessons from smaller events are not captured, so the same type of event is met as if it were new.

Plus: keep doing	Delta: change
• Quick manual response by the cold-chain team • Early, direct contact with customers • Cross-depot goodwill and offers of help • Honest contributions to this review	• Fund and date the treatment for known High risks • Find, update and exercise the continuity plan • Name deputies for key response roles • Record who authorised emergency spend • Review every incident the same way and share the result • Give every escalated issue an owner and due date

Prioritised Recommendations

Owners and timing are suggestions for the account holder and team to confirm or change. Ordering reflects how widely each theme was shared and how much it exposes people or customers to harm, and is not a validated risk ranking.

#	Recommendation	Suggested owner	Suggested timing
1	Decide on funding for the backup power upgrade at the cold-storage depot and set a delivery date	Operations executive, with finance	By 30 June 2026
2	Merge the continuity plans into one current version and run a documented exercise at the main depot	Risk and compliance lead	Exercise by 30 September 2026
3	Name a deputy for each key response role and agree a shift handover for long events	People and culture lead	By 31 July 2026
4	Record emergency approvals and clarify who may authorise urgent spend out of hours	Finance executive	By 31 July 2026
5	Introduce one post-incident review template and one shared corrective-action register	Operations executive	By 31 August 2026
6	Give every issue raised at executive meetings an owner and a due date	Chief executive	From the next meeting

Next cycle. Carry these six priorities into the next cycle so contributors can say what has and has not changed.

Appendix: Anonymised Evidence

Excerpts are grouped by theme, never by person. Each is labelled “Anonymised submission excerpt”.

A known risk had no funded treatment

> *“Backup power has been on the High list since last year. The upgrade was proposed twice and not funded.”*
>
> Anonymised submission excerpt

> *“Everyone in the depot knew the generator had not been tested under load.”*
>
> Anonymised submission excerpt

The continuity plan was not known, current or exercised

> *“We have a plan on paper. I could not tell you the last time anyone read it.”*
>
> Anonymised submission excerpt

> *“The two depots use different versions, and neither version mentioned a generator failure.”*
>
> Anonymised submission excerpt

The response depended on a few experienced people

> *“I did two days with about five hours’ sleep. There was nobody to hand over to.”*
>
> Anonymised submission excerpt

> *“If those two had been away that week, I do not know what we would have done.”*
>
> Anonymised submission excerpt

Emergency decisions were made outside agreed limits

> *“The generator hire went well over what I would normally be allowed to sign. It was approved on the phone and not written up.”*
>
> Anonymised submission excerpt

Earlier lessons were not carried forward

> *“Our actions after an incident live in my own spreadsheet. Other depots have their own.”*
>
> Anonymised submission excerpt

An earlier warning had no owner

> *“It was raised in March. There was no action next to it in the minutes.”*
>
> Anonymised submission excerpt