
TKIL AAROHAN • LEADERSHIP DEVELOPMENT PROGRAMME

MODULE 4 • PRE-READ 2

Case Study Exercise

Prakash Incorporation — A Metropolitan Power Distributor

A crisis-response scenario for examining ownership, accountability, and coordination under pressure — to be read, internalised, and answered before the workshop.

CONFIDENTIAL — MANDATORY PRE-WORK

Do not discuss or verify your answers with anyone before the workshop.

PREPARED BY**Skalent® INDIA***Road Maps of Success***PREPARED FOR****TKIL Industries***Formerly thyssenkrupp Industries India***REFERENCE DATE****1st June 2026***Complete before the workshop*

MODULE 4 • PRE-READ 2

Case Study Exercise

Title: Scenario of a Major Metropolitan Power Distributor, Prakash Incorporation.

Instructions

1. This is a mandatory pre-work for Module4.
2. This is not to be discussed or verified with anyone before our workshop.
3. You have to read, internalise the case and complete the answers to the questions in the response-sheet provided to you.
4. Kindly maintain confidentiality after completing this exercise.

Your task

1. Thoroughly read and understand the case, then identify the core problem and key issues.
2. Clearly communicate your thought process, use data from the case to support your answers, and present a concise recommendation.
3. Use a pen and paper to jot down key information and your analysis as you go.
4. Answer all the questions after reading the case.
5. Consider Today's date as 1st June 2026 for reference.

**DO NOT DISCUSS YOUR ANSWERS WITH ANYONE IN THE OFFICE.
WE WILL DO IT IN AN INTERESTING WAY DURING THE WORKSHOP.**



Background

In a bustling metropolitan region known for its dense population and rapidly growing energy demands, a large electricity distribution utility company, Prakash Incorporation, is responsible for maintaining uninterrupted power supply across both residential neighbourhoods and critical infrastructure zones. The company, which caters to millions of consumers across residential, commercial, and institutional segments, had undertaken a major digital modernization program one year back. These advancements were designed to enhance grid visibility, support predictive maintenance, and improve the speed and accuracy of field responses.

Beyond the technology upgrade, the leadership team had emphasized on a strategic foresight—ensuring that operational excellence, business continuity, and customer trust were at the centre of every modernization initiative. The digital transformation was therefore not only about automation but also about building decision intelligence, where data from the field could guide future infrastructure investments and enable proactive crisis management. But there was always an unsaid resistance to change in the system. On the other hand the customer feedback was somewhat discouraging last year.

Among the departments leading the change in this transformation were Network Operations & Reliability (NOR) and Strategic Sourcing & Asset Management (SSAM). While NOR is responsible for the health and continuity of the electrical network, SSAM ensures the timely procurement, availability, and deployment of all materials—from cables and insulators to high-value equipment like power transformers. The interdependence between these two departments is always a conflict, especially during peak load conditions when operational and logistical complexities converged.

With summer peaking and temperatures soaring, the city's power load was running high. The infrastructure, although upgraded, was operating at near-full capacity, particularly in high-density areas. Last two years, the crisis management teams have barely managed emergencies. We are not sure if the teams were saw upcoming seasonal demands and the monsoon forecast.

The Incident

On a late summer afternoon this May, heavy thunderstorms rolled into the western corridor of the city, bringing with them strong winds, lightning strikes, and intense rainfall. Within a span of 20 minutes, multiple high-voltage feeders tripped, and field sensors began transmitting alerts of transformer overheating and shutdowns across the West Zone.

One particular alert stood out: a transformer feeding electricity to a stretch of residential areas and a hospital had failed. The hospital had a limited-duration backup supply, sufficient only to support life-critical functions. A prolonged outage could directly impact surgical operations and intensive care units.

The centralized Outage Management System (OMS) flagged this situation as a Level-1 priority. Simultaneously, NOR's dashboard showed multiple concurrent alerts across other substations.

While the field crews were mobilized, they realised that critical spare transformers were unavailable locally due to a recent warehouse reshuffle. No one knew who had planned this shuffle. Worse still, a pending inbound shipment of new transformers had been delayed by a logistics vendor due to rerouted cargo during the storm. The team was struggling to find records/documents regarding this shipment and was unsuccessful.

This was not merely an operational challenge—it was a complete team failure. The situation had now escalated into a full-blown crisis: NOR had to execute urgent replacements with limited field resources, while SSAM had to secure backup equipment faster than the traditional procurement timeline allowed. Time was running out.

The Response

In this challenge, both departments faced trouble.

The NOR team was spending too much time on how to dispatch ground engineers and fault detection teams to physically verify damage. Leveraging the newly deployed field app, the team leader was able to track crew location, but forgot to assign job tickets in real time, and view restoration status updates. The smart sensors embedded in transformers helped pinpoint the exact fault location, but the untrained engineers struggled to re-route power to unaffected feeders & minimize the area of outage. The team kept waiting for clear instructions and clarity.

The crisis demanded a completely different approach. The NOR leadership struggled to understand the predictive data from the OMS. This was a critical decision that balanced safety, speed, and social impact.

Meanwhile, the field supervisor reached out to the hospital's dean, explaining the cause and giving a preliminary restoration estimate. It was clear that he did not have all the facts of the situation when he apologised to the hospital dean. He was never in favour of any digitization. If he had the old hand-challan tracking, he would have resolved things better. He also blamed the other functions for this mess.

On the materials front, a senior procurement officer from the SSAM team jumped into action. A compatible transformer was located 90 km away in a satellite storage unit. Recognizing the urgency, she directly contacted the regional store-in-charge, got an expedited release approved, and arranged for a dedicated flatbed carrier to transport it through the night.

To make up for lost time, she also personally coordinated with the local transport authority for movement clearance through storm-affected routes. Back at headquarters, she kept updating the warehouse and field teams, ensuring they had updated information, complete communication & total visibility on estimated delivery timelines.

As the transformer arrived on-site close to midnight, field technicians were already prepping the base. A senior maintenance engineer – an expert in this installation was instructed to stay from the site and not get involved. The field team somehow managed to work with limited resources and almost no guidance.

With some coordination, the replacement was completed in the next few hours. However, Quality checks were still pending. The line was ready but waiting for supervision. The field supervisor was nowhere to be seen. One of the NOR leaders bypassed the protocols and gave a 'go-ahead' that night.

The hospital resumed full supply by the next day, and residential zones were restored gradually over the next 3 days due to delays, lack of co-ordination and proactive staff. The complaints of the end-users (residents in the affected areas) mounted to a massive number that week – however none of the departments took notice.

Post-Restoration Actions

The following day, a review meeting was held by both NOR and SSAM leadership. The team reviewed not just the events of the 3 days but also the systemic learnings: the importance of accurate inventory visibility, the advantage of digital crew tracking, and the value of pre-authorized emergency dispatch procedures. The busy operational team, however, could not see the big picture.

The field engineer who went missing did not seem to have an explanation. He claims he had sent emails and escalated... but had no justification.

Feedback from the hospital administration – was mostly positive; but it highlighted the work behaviour of the field staff and their confused team. The many-thousand online complains from the residents are still not acknowledged or closed.

Surprisingly, no one in the leadership team escalated the matter.

MODULE 4 • RESPONSE SHEET

Case Study Response Sheet

PRINT THESE ANSWERS AND GET IT TO THE WORKSHOP (page 5 onwards)

DO NOT DISCUSS YOUR APPROACH / ANSWERS WITH ANYONE

Your Name:

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Q1 What are the top 5 challenges you see in the case here. Please suggest some solutions for each of these.*(Kindly rank the issues in order of priority. Most important issue – 1st)*

1.

2.

3.

4.

5.

Q2 If you were the field supervisor, what steps would you take to analyse the crisis & ensure both speed and quality in delivery? *(Please give clear solutions, using bullet points)*

Q3 W.r.t ownership and accountability – Where do you see gaps? Who all defaulted? Why do you think so?
(Please identify the characters & give reasoning, using bullet points)

Who went wrong?	Where was the mistake?

Who went wrong?	Where was the mistake?

Please complete these 3 questions and get a print to the workshop.

DO NOT COME UNPREPARED.

The rest of the questions will be during the workshop.