***Project Business Management* [1,2]**

Decision Inertia

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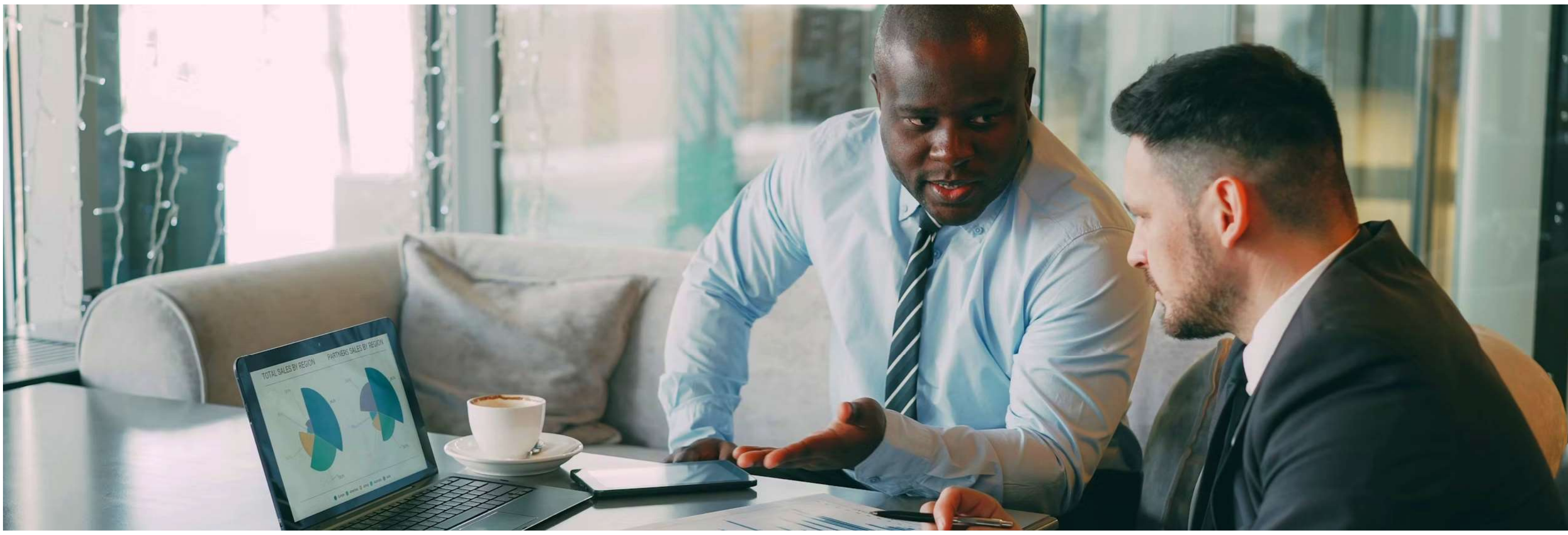
"Rule #82: Wrong decisions made early can be recovered from. Right decisions made late cannot correct them."
– From: 100 Rules for NASA Project Managers[3]



Summary

Projects rarely die from one bad call. They die because people cling to yesterday's decisions long after reality has moved on. In cross-corporate Project Business — where customers, contractors, and partners juggle risks and incentives — early choices harden fast and become untouchable. This article exposes that silent killer: decision inertia. Three case stories — Titanic, Fukushima, and a modern logistics software fiasco — reveal the same pattern: assumptions turned into dogma, warnings brushed aside, and pride defending decisions long after their justification evaporated. The message is blunt: update your decisions, or they will update you. The article ends with concrete steps leaders can use to break decision inertia before it breaks their project.

[1] This is an article in a series by Oliver Lehmann, author of the book "Project Business Management" (ISBN 9781138197503), published by Auerbach / Taylor & Francis. See full author profile at the end of this article. A list of the other articles in PM World Journal can be found at https://pmworldlibrary.net/authors/oliver-f-lehmann.

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[3] (Madden & Stewart, n.a.)

Introduction

Projects sometimes fail because people make bad decisions. They may also fail because people make good or necessary decisions and then refuse to revisit them when circumstances change. In cross-corporate Project Business – where customers, contractors, regulators, and suppliers interact under commercial pressure – early choices tend to harden quickly. Once locked in, they outlive their logic.[4]

This mechanism has a name: **decision inertia**.[5]

Decision inertia is not indecision. It is the opposite. It is the stubborn continuation of a once-reasonable path long after the underlying assumptions have collapsed. It shows up in maritime disasters, industrial failures, and modern customer projects just as reliably as in history's most tragic engineering stories. And it thrives particularly well in project networks, where responsibilities are distributed, information is uneven, and everyone quietly hopes that someone else will raise the alarm – and absorb the costs of doing so.

The following three case stories – Titanic, Fukushima, and a modern software project – demonstrate how decision inertia forms, why it persists, and what it costs. Each example shows different industries, technologies, and eras. Yet the pattern is always the same:

- early assumptions treated as permanent truth,
- warning signs discounted or ignored,
- decisions defended long after their justification has evaporated,
- and a cross-corporate environment that makes adaptation harder than sticking to the plan.

Projects succeed when decisions remain alive, revisited, questioned, and adjusted. They fail when decisions become fossils.

These stories show why vigilance, humility, and structured re-evaluation are not optional – they are essential countermeasures against the most dangerous force in Project Business: a decision that should have been updated but wasn't.

[4] (Hammond, Keeney & Raiffa, 1998)
[5] (Kahneman, 2013)

Three Case Stories

Case Story 1: Titanic – A Decision That Outlived Its Logic

A Project, Not an Operation

RMS Titanic sailed on her maiden voyage on 10 April 1912. A maiden voyage is not routine operation – it is a project. New machinery, a freshly assembled crew, untested processes, and heightened public attention create a volatile environment where assumptions must be challenged proactively. That did not happen.

On the night of 14 April, the ship entered a large field of icebergs. Despite multiple warning messages, she continued at roughly 22 knots (≈ 41 km/h; ≈ 25 mph).[6] On a moonless night, in a field of icebergs, without binoculars and of course without radar, this appeared reckless. Hours later, the ship struck an iceberg and sank, with more than 1,500 lives lost.

These are the basic facts. The deeper issue lies in why the ship was travelling at such speed.

Why Cheap Coal Leads to Bunker Fires – A Straightforward Chain

For readers without maritime-engineering experience, the connection between coal quality and bunker fires is not intuitive. The causal chain is simple:

1. Lower-grade coal contains more volatile elements → heats up easily.
2. It also contains more moisture and dust ("fines") → pockets of heat become trapped.
3. As coal slowly oxidizes, it generates internal heat → like compost warming from inside.
4. A hidden hotspot emerges → smoldering before any flame is visible.
5. The only safe mitigation is to burn the affected coal → nothing else works reliably.
6. Burning more coal increases steam pressure → which increases ship speed.

In early 1912, Britain had just emerged from a nationwide miners' strike. High-grade steam coal was rarely available. Ships routinely loaded mixed or low-grade coal containing the dust, moisture, and volatile components known to self-ignite in storage. Under these circumstances, the risk of a bunker fire on Titanic was not remote; it was embedded in the fuel itself.

[6] (Lord Mersey, 1912)

The bunker fire was not bad luck. It was a procurement-driven hazard, created upstream and delivered into the ship's deep vaults.[7]

Navigating Between Two Monsters – Straight from Homer's Odyssey

The captain's situation becomes clearer when framed through Homer's Odyssey, where Odysseus must steer his ship between two monsters, Scylla and Charybdis. Avoiding one means drifting dangerously close to the other. It is the oldest literary depiction we have of conflicting hazards and impossible choices.

Titanic faced a similar structural dilemma. Only one monster was natural; the other was human-made:

Monster 1 – The Ice

A natural hazard: A vast ice field lay ahead, confirmed by multiple radio warnings.

Monster 2 – The Bunker Fire

A procurement hazard, men-made: A smoldering coal fire at a critical bulkhead.

- Fed by low-grade coal.
- Invisible until well advanced.
- Managed only by burning the coal aggressively.

Each monster demanded the opposite response:

- To handle the ice, the captain needed to slow down.
- To handle the fire, he needed to burn coal faster — forcing the ship to speed up.
- For a period, high speed was a rational compromise between two incompatible risks.

Taking a more Southern route, circumventing the ice field, seemed equally impossible. It would have included:

- adding distance,
- adding time,
- consuming more coal (which they were already burning at an accelerated rate due to the bunker fire),

[7] (Wormstedt, Layton & Fitch, 2013)

- and missing schedule expectations on the most publicized maiden voyage in maritime history.

Nationalistic Culture in 1912 – A Pressure Nobody Names Today

1912 sat in a period of intense national competition, only two years before WW1. But nationalism did not mean "patriotism on deck." It meant something more operational and more insidious:

1. The Atlantic crossing was a prestige battlefield

Britain and Germany were locked in a commercial and political rivalry.

- Cunard (British) had the Lusitania and Mauretania, the speed champions.
- The Germans had Kaiser Wilhelm der Grosse, Deutschland, Kronprinz Wilhelm, and Kaiserin Auguste Victoria.
- White Star Line — also British — built Titanic not for speed, but for size, comfort, and dominance of the "luxury segment."

Still, there was immense national pressure to perform. Stopping, diverting south, slowing down: these were culturally coded as weakness, "un-British hesitation," or "yielding to nature."

2. Edwardian Britain valued steadiness and confidence

The officer class was trained in:

- composure,
- adherence to plan,
- and a stoic, masculine ideal of "pressing on".
- Slowing down because of unseen hazards?
- That ran against the ethos.

Rerouting far south? That looked like retreat.

This cultural backdrop doesn't "explain" the disaster — but it amplified the reluctance to change course or speed.

Decision Inertia – The Fatal Mechanism

The fatal failure did not lie in the initial compromise. It lay in failing to revise the decision when the situation changed. By the afternoon of 14 April, the bunker fire had been brought under control. The unstable coal had been burned away.

The bulkhead's immediate thermal threat had passed. The operational constraint that had forced higher speed no longer existed.

Yet the ship continued at roughly the same pace. Why? Because several reinforcing factors kept the original decision standing:

1. Operational momentum

A ship the size of Titanic does not change speed casually. Slowing down requires coordination, a clear trigger, and explicit intent. "Maintain speed" remained the default.

2. Bridge culture of the era

Edwardian seamanship prized steady speed. Changing speed without an obvious emergency was discouraged. "Slow for ice" was considered prudent — but not mandatory, and not uniformly practiced.

3. Absence of a structured risk review

There was no formal process on board requiring the Bridge to reassess risk when conditions changed. Once a decision was made, it persisted by default.

4. Information silos

Engineering and the Bridge worked in parallel domains. The fire crew's assessment that the hazard was contained did not automatically trigger strategic reconsideration at the command level.

5. Misjudgment of the ice distribution

Some officers believed the densest part of the ice had been passed. This false sense of clearance reduced perceived need to adjust speed.

6. Cognitive bias: commitment to the existing plan

Humans resist revisiting decisions made under pressure.

Changing the plan would implicitly acknowledge the earlier risk — difficult on a maiden voyage under scrutiny.

7. The project setting amplified risk blindness

This was not a stable operation. This was a first-run, high-expectation project. Projects tend to normalize temporary decisions until they quietly become "the plan."

The consequence**:** The ship held its course and speed — not because the logic still held, but because nobody revalidated the decision after the fire was contained.

This is decision inertia in its most dangerous form: a decision stays alive after the **grounds** that justified it have died. Titanic's fate was sealed not by the decision itself, but by the failure to update it.

Case Story 2: Fukushima – Decision Inertia in Slow Motion

On 11 March 2011, a magnitude 9.0 undersea earthquake struck off the northeastern coast of Japan. It generated one of the strongest tsunamis ever measured. The initial seaquake shook the Fukushima Daiichi Nuclear Power Plant violently and caused substantial structural and equipment damage. But the plant's design anticipated severe earthquakes, and its systems — though battered — were still functioning.[8]

What turned a damaged power plant into a disaster was the second blow: the tsunami, arriving roughly 40 minutes later. The wave overtopped the coastal defences, flooded low-lying areas of the site, and disabled the plant's control and emergency systems, including the diesel generators and electrical switchgear needed for cooling. Without cooling, three reactor cores overheated and melted down.

It is tempting to view this cascade as an unavoidable natural catastrophe: an extreme quake, an extreme wave, and a nuclear plant unfortunate enough to be in their path. But the documented history tells a different story — one rooted not in engineering complexity but in organizational decision-making, assumptions that hardened into "facts," and a long-standing pattern of decision inertia.

The Original Decisions

Construction of Fukushima Daiichi began in the late 1960s. The plant was built on a coastal terrace roughly 10 meters above sea level. In front of it stood a modest seawall around five to six meters high. Both choices were based on what oceanographers and seismologists of the time believed were the maximum credible tsunami heights for the region. These early estimates were derived from incomplete records and limited modelling methods. They were assumptions, not validated upper limits.

Over time, those assumptions solidified into factoids — widely accepted "truths" that no one questioned anymore. The height of the seawall, the elevation of the site, and the placement of critical equipment were treated as unquestionably sufficient.[9]

[8] (Kurokawa, K. et al., 2012)
[9] (IAEA, 2015)

The Growth of Contradictory Evidence

In the following decades, three independent streams of evidence challenged the original design assumptions:

- Geological research uncovered ancient tsunami deposits showing run-ups well beyond the plant's design basis.
- Historical analyses documented earlier events in the region exceeding 10 meters and sometimes far more.
- Modern modelling projected scenarios that dwarfed the 1960s estimates.

The operating company, TEPCO's internal studies raised warnings, too.[10] Vulnerabilities in seawater ingress, basement installations, and the collapse of cooling capability under flood conditions were repeatedly identified. These were not abstract concerns — they were concrete engineering risks.

Still, nothing changed.

Where Decision Inertia Sets In

Here the pattern becomes familiar to anyone working in Project Business.

Once major design choices are made — elevation, flood protection, equipment placement — organizations tend to lock in. They anchor themselves to early decisions and resist revisiting them. Correcting the flawed assumptions at Fukushima would have required:

- raising the seawall,
- relocating emergency systems from basement levels,
- redesigning flood protection,
- confronting regulators,
- and acknowledging that earlier decisions were wrong.

The cost, disruption, and political discomfort were simply too great. So the original assumptions stayed in place.

This is decision inertia: the organizational habit of defending historical decisions rather than updating them when new evidence emerges.

[10] (Tepco, 2012)

The Listening Problem

Warnings existed. Specialists voiced concerns. Data accumulated. Yet none of it penetrated the decision-making structure.

Why?

Because listening forces action. And action forces admission that previous assurances were misplaced.

Challenging the factoid would have required decision makers to become listeners — to engage with inconvenient information, reopen decisions they considered closed, and confront the implications.

They did not.

Overconfidence in a Single Barrier

The seawall and the site elevation became symbolic proof that the plant was safe. A single protective measure replaced a proper, layered defence strategy. From that point, decisions cascaded:

- Flood-proof doors were deemed unnecessary.
- Basement-level placement of emergency diesel generators seemed acceptable.
- Strengthening defences was considered excessive.
- Updating tsunami assumptions felt like academic overkill.
- Confidence replaced caution.
- Myth replaced analysis.
- Assumption replaced evidence.

The Event

It was in 2011 that a tsunami reached around 15 meters. It overran the seawall instantly. Water poured into basement levels, drowning the power systems that the plant desperately needed to survive the aftermath of the earthquake. Cooling capability was lost and three reactors entered meltdown.

The wave exceeded not the limits of nature but the limits of the organization’s willingness to revise outdated assumptions.

Lessons for Project Business

Fukushima is ultimately not a nuclear engineering story. It is a Project Business story — a demonstration of how cross-corporate projects fail when:

- early assumptions become sacred,
- contradictory evidence accumulates without effect,
- listening demands too much courage,
- and decisions become fossilized instead of being revisited.
- Most large project failures are not sudden surprises.

They are predictable consequences of decisions that were never re-examined.

In cross-corporate environments — where customers, contractors, regulators, and suppliers share accountability — decision inertia becomes even more dangerous. Once one party freezes, the entire ecosystem freezes with it.

Fukushima's Universal Lesson

The risks that destroy projects are rarely the unknowns. They are the unknown-to-you-because-you-stopped-listening.

Case Story 3: When "All Agile" Collided With Cross-Corporate Reality

A midsize software contractor, Silkworm, Inc., won a customer project for a logistics company, Maybeetle Ltd.[11] The task appeared straightforward: replace an aging dispatching system that Maybeetle's operations staff had been keeping alive through daily improvisation. Silkworm's delivery lead announced with missionary confidence: "We'll do it all agile. Full Scrum. No exceptions."

It sounded modern. It sounded efficient. And, frankly, it sounded cheap.

Maybeetle's management nodded politely. Their operations team did not. Their world ran 24/7, under pressure, under scrutiny, and in constant competition for scarce resources. They needed predictability and order, not – as they called it – sprint-driven patchwork.

[1111] Company names changed

The Big-Bang Mistake

Both companies' management teams agreed early on that the go-live would be executed as a big bang: the old system switched off and the new one activated in one dramatic step.

There was no technical necessity for this. A staged, low-risk ramp-up would have been entirely feasible: careful steps, controlled transitions, minimal operational disturbance.

But management wanted its "push-the-button" moment.

Even when it became obvious that the complexity of the interconnected systems made a big bang dangerously risky, the decision was not revisited. The prestige of the moment outweighed the need for a safer approach.

A Fragile Web of Cross-Corporate Systems

In logistics, the software solutions of many companies are tied together. They talk with each other, exchange data, trigger processes, and keep the complex cross-corporate machine running effectively and efficiently. When one system changes something, the others feel it instantly. Even a tiny modification – a field name, a timing rule, a number format – can break the flow.

In this project, a seemingly harmless sprint change by Silkworm to the delivery-timestamp format caused one partner company's system to stop reading incoming orders. Their trucks stood idle for hours because no new routes came through.

One small tweak on the Silkworm side triggered real operational trouble in several other companies at once. And similar problems occurred repeatedly.

The Agile Bubble Meets Operational Reality

Two months into development, the cracks were no longer theoretical.

- Sprint outputs could not be tested by Maybeetle's operations: they needed interface freezes weeks in advance to prepare staff and warn partners.
- Backlog grooming became trench warfare: operations demanded commitments; Silkworm insisted that fixed commitments contradicted agile principles.
- Daily standups turned into theatre: the real dependencies sat in operations and partner companies – none willing or able to play along with Scrum rituals.

Then came the silent killer: training.

The new system required significant preparation for dispatchers and supervisors. But Silkworm's short-term sprint planning never produced a reliable training schedule – and the content kept changing. Maybeetle couldn't free staff for last-minute training, especially not for material that might be obsolete by the next review.

The outcome was predictable: features went live with untrained users, and the night shift paid the price.

Decision Inertia Takes Over

The breaking point came when a workflow update passed the sprint demo but caused chaos in real operations. Warehouses reverted to manual dispatching. Emergency processes kicked in. Partners complained.

Maybeetle escalated – formally, loudly, and repeatedly. Silkworm's project manager finally faced the uncomfortable truth:

Agile works beautifully when the team owns the playground and the project is on a discovery tour, where no one knows where it will finally lead.

This team didn't own the playground. Operations, partners, and their systems did – and they required long-term predictability and order.

But by then, it was too late.

Collapse

The big-bang go-live, combined with unstable sprint output, triggered a lengthy operational blackout at Maybeetle. Dispatchers returned to whiteboards and phones. Warehouses worked in emergency mode. Several logistics partners declared "critical incident" status because their own systems were starved of data.

Trust did not return – it disintegrated.

Executives questioned the entire philosophy behind the project. The reputation of the initiative collapsed internally on both sides. Employees began referring to the project as a warning, not a success story.

And then came the final blow:

Maybeetle filed litigation against Silkworm for the operational and financial damages – idle trucks, missed delivery windows, emergency labour, reputational harm, and penalties from downstream partners.

- Relationships built over years were destroyed within weeks.
- The new system was remembered not for what it promised, but for the chaos it unleashed.

Decision Inertia at Work

Two key decisions shaped the project's fate – and both became textbook cases of decision inertia: decisions taken early, held tightly, and defended long after the evidence showed they were wrong.

1. The "Do it all agile" decision

> Silkworm committed to a full-agile delivery model without any situational analysis. No one asked:
>
> Where is agile suitable – and where does it collide with operational reality?
>
> Agile methods – especially Scrum – require constant access to target stakeholders for information, clarification, and rapid feedback.[12] In this project, those stakeholders were Maybeetle's operational staff. But these people had no time to talk to developers: they were busy keeping warehouses organized and trucks, trains, and ships running. Their world does not allow for on-demand availability, daily check-ins, or fast-turnaround clarifications.
>
> To make matters worse, the developers and their target stakeholders worked in different organizations. Access was limited, formal, and episodic – the opposite of what Scrum requires to function.
>
> Despite the mounting evidence, Silkworm stuck to the methodology. The early commitment hardened into decision inertia.

2. The big-bang go-live decision

> The decision to switch systems in one dramatic step was taken early – not out of necessity, but out of preference. It promised a neat transition and a symbolic moment.
>
> A staged, controlled, low-risk introduction would have been feasible. And when the true scale of the cross-corporate system complexity became clear, the big-bang plan should have been abandoned.
>
> But it wasn't.
>
> Prestige outweighed prudence.

This decision also solidified into decision inertia, with predictable and severe consequences.

These two decisions – methodological overreach and a reckless go-live strategy – show how early choices can calcify into rigid commitments. Once locked in, they become harder to challenge than to justify, even when the evidence turns damning.

[12] (Boehm & Turner, 2004)

In the next section, we examine why decision inertia emerges so often in project business – and how organizations can detect and counteract it before the consequences become irreversible.

A Call to Action

Decision inertia is not exotic. It is not rare. It is the everyday enemy of cross-corporate Project Business. Senior leaders, project managers, contracting officers, and engineers all face the same challenge: early decisions harden quickly, and once hardened, they resist inspection.

To counter this, organizations need to do three things consistently:

Revalidate old decisions

> Put critical decisions on a timer. If circumstances change or new information surfaces, force a review rather than waiting for a crisis to make the decision for you.

Institutionalise listening

> In cross-corporate projects, warning signals rarely originate inside your own organization. They come from contractors, subcontractors, regulators, or the customer's operations. Build mechanisms that pick up these signals early – and treat silence as a red flag, not reassurance.

Create multi-layered protection

> Avoid single points of "guaranteed safety." Whether it is a seawall, a methodology, or a go-live concept, one layer alone invites overconfidence. Project Business requires defence-in-depth: technical, organizational, commercial, and relational layers working together.

Challenge prestige decisions

> The most dangerous decisions are often the ones no one wants to reopen because they carry symbolic weight — a maiden voyage, a flagship methodology, a politically convenient factoid. These are exactly the decisions that require scrutiny.

Strengthen commercial and contractual awareness

> In Project Business, inertia spreads across organizational boundaries. Customers, contractors, and partners all have different incentives. Misaligned interests accelerate risk unless the project leadership actively exposes and aligns them.

Close the action gap

> Most organizations do not fail because they lack knowledge. They fail because they lack structured routines that turn knowledge into repeated action. Make "decision review" a habit, not an exception.

If readers want to go a step further and build deeper professional capability in cross-corporate Project Business, the Project Business Professional (PBP) qualification offers a structured path to do so – but that is the last step, not the first.

Conclusion

Decision inertia is not a mysterious force – it is the predictable outcome of organizations clinging to early choices long after reality has moved on.

The three case stories show the same pattern: assumptions harden, warnings go unheard, and commercially entangled project networks amplify every hesitation. Whether the stage is an ocean liner, a nuclear plant, or a cross-corporate software rollout, the lesson is identical: decisions must stay alive. Leaders who build routines to question, verify, and adjust their decisions protect not only their projects, but their customers, partners, and reputations.

In Project Business, vigilance is not optional – it is the only defense against watching yesterday's assumptions become tomorrow's failures.

Appendix: What is Project Business?

Many of today's projects are no longer internal endeavors. In a world shaped by global supply chains, outsourcing, and cross-border collaboration, projects are increasingly delivered by networks of companies. These projects are not just technical undertakings – they are commercial ventures.[13]

Project Business arises when two or more companies team up to perform a project under contract. It operates at the boundaries between organizations and often involves diverse legal systems, cultures, and moral compasses. Some project networks are simple; others are complex and fragile ecosystems with dozens, sometimes hundreds of organizations involved.

Though long overlooked, Project Business contributes an estimated 20% to 30% of global GDP and employs more project managers than internal projects. It deserves far more attention – not only for its scale but for the unique challenges it poses.

[13] (Lehmann, 2018)

Traditional project management handbooks (for example, Turner[14]) typically address internal projects within organizations. By contrast, project business takes place across corporate boundaries, introducing commercial, legal, and relational complexities that such works only partly cover. Project business (cross-corporate, customer-contractor) has different challenges and rules – success depends here not only on planning and execution, but on commercial acumen, legal awareness, and a deeply cooperative mindset. Trust must be built among parties with differing interests and asymmetric power to enable collaboration toward shared success.

The risks in Project Business go beyond deadlines and deliverables – they include cash flow instability, legal exposure, reputational damage, and contractual disputes. Where information is asymmetrical and objectives diverge, the project manager must act as negotiator, strategist, and builder of partnerships.

[14] (Turner, 2009)

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- https://pmworldlibrary.net/authors/oliver-f-lehmann