

Boeing 737 MAX: The Cost of Organisational Silence

Boeing 737 MAX: Örgütsel Sessizlik in 346 Hayata Maliyeti

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Company	Boeing
Sector	Aviation & Manufacturing
Period	2016–2019
Breaking Point	Organisational Silence
Outcome	346 lives lost · \$20 billion in losses

Boeing engineers knew about the dangers of the MCAS software. Internal communications documented this. But that knowledge never reached the decision table. Two crashes in 2018 and 2019 cost 346 people their lives. This is not the story of a software failure. It is the story of organisational silence — and the leadership failures that enabled it.

1. Background: Competitive Pressure and the Decision to Accelerate

In 2011, Airbus announced the new-engined A320neo. Boeing's response was not to design a new aircraft but to update the existing 737 airframe: the 737 MAX. But when the new, larger engines were repositioned further forward, the aircraft's aerodynamics changed — it developed an increased tendency to pitch up under certain conditions.

To correct this, MCAS (Maneuvering Characteristics Augmentation System) software was developed. MCAS would automatically push the nose down under certain conditions. But with a single sensor failure, it could activate repeatedly and uncontrollably. Boeing did not fully disclose this risk to the FAA; pilots were not even informed of MCAS's existence.

2. Leadership Fracture: Known but Unsayable

Internal communications revealed in the 2020 U.S. House of Representatives investigation showed that Boeing engineers had been raising concerns for years. In 2016, one engineer wrote: "I would not let my family fly on this aircraft." But these warnings were not escalated. The pressure to compete with Airbus had created an environment where dissent was unwelcome.

This is the essence of organisational silence: individuals within an organisation know something is wrong, but choose — or feel compelled — not to speak. The reasons are

well-documented in organisational psychology: fear of isolation, the illusion of group cohesion, authority bias, and the belief that speaking up will change nothing.

3. The Crashes

On 29 October 2018, Lion Air Flight 610 crashed 13 minutes after takeoff, killing all 189 people on board. MCAS had activated repeatedly due to a faulty angle-of-attack sensor. On 10 March 2019, Ethiopian Airlines Flight 302 crashed under near-identical circumstances, killing all 157 people on board.

In the five months between the two crashes, Boeing and the FAA were aware of the MCAS risk but did not ground the aircraft. Both crashes were preventable. The Boeing 737 MAX was grounded worldwide on 13 March 2019.

4. Organisational Psychology: Why Silence Prevails

Research by Morrison and Milliken (2000) identifies two primary drivers of organisational silence: implicit management beliefs that dissent is dangerous, and fear of negative consequences for speaking up. Both were present at Boeing.

Key mechanisms that enabled the silence:

Authority Bias: Engineers deferred to management decisions even when they disagreed. The assumption that leadership "must know better" suppressed critical feedback from reaching decision-makers.

Competitive Framing: The urgency to compete with Airbus created a culture where slowing down — even to address safety — was framed as failure. Speed became the dominant value.

Diffusion of Responsibility: In large organisations, individuals often assume someone else has already escalated a concern. No one person feels fully responsible for the outcome.

System Trust: Engineers trusted that the certification process would catch serious errors. The FAA's oversight failures compounded this misplaced confidence.

5. Leadership Lessons

The Boeing 737 MAX crisis is not primarily a story about technology. It is a story about what happens when an organisation's leadership structures make it impossible for critical information to flow upward.

Three imperatives emerge for leaders in high-stakes environments:

Create psychological safety as a structural condition, not a cultural aspiration. Engineers must know that raising concerns will not damage their careers. This requires explicit leadership commitment, not slogans.

Separate commercial urgency from safety decisions. When competitive pressure shapes safety assessments, the organisation has already failed. Leaders must actively protect the independence of safety-critical judgments.

Design escalation paths that bypass hierarchy. If critical information can only travel upward through normal reporting lines, it will be filtered, delayed, or suppressed. Anonymous reporting channels and independent review mechanisms are not bureaucratic luxuries — they are structural safeguards.

Conclusion

"Organisational silence kills" is not a metaphor at Boeing. It is the finding of the official investigation. The 346 people who died did not die because a sensor failed. They died because the people who knew the sensor could cause a catastrophic failure did not — or could not — say so loudly enough for it to matter.

For leaders across industries, the question is not whether this could happen in your organisation. The question is: what structures do you have in place to ensure it does not?