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An Investigation of the Therac-25 Accidents

Nancy G. Leveson, University of Washington
Clark S. Turner, University of California, Irvine

A thorough account of the Therac-25 medical

Computers are increasingly being introduced into safety-critical systems and, as a consequence, have been involved in accidents. Some of the most widely cited software-related accidents in safety-critical systems involved a computerized radiation therapy machine called the Therac-25. Between June 1985 and January 1987, six known accidents involved massive overdoses by the Therac-25 — with resultant deaths and serious injuries. They have been described as the worst series of radiation accidents in the 35-year history of medical accelerators.[1]

With information for this article taken from publicly available documents, we present a detailed accident investigation of the factors involved in the overdoses and the attempts by the users, manufacturers, and the US and Canadian governments to deal with them. Our goal is to help others learn from this experience, not to criticize the equipment's manufacturer or anyone else. The mistakes that were made are not unique to this manufacturer but are, unfortunately, fairly common in other safety-critical systems. As Frank Houston of the US Food and Drug Administration (FDA) said, "A significant amount of software for life-critical systems comes from small firms, especially in the medical device industry; firms that fit the profile of those resistant to or uninformed of the principles of either system safety or software engineering."[2]

Furthermore, these problems are not limited to the medical industry. It is still a common belief that any good engineer can build software, regardless of whether