



Radioactive Vulnerabilities

Radiation Fears to Digital Nightmares



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- Senior Security Consultant at Secure Ideas
 - Jacksonville HQ office
- Industry Experience
 - Started as SOC Analyst
 - Reverse engineering malware & threat intelligence
 - Pentesting, Security Consulting, & Training
- Other Interesting Facts
 - All around geek
 - Collector of things
 - Lockpick enthusiast
 - My favorite game genre is Survival-Horror

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- Been with Secure Ideas since 2021
- Based in Jacksonville, Florida
- Sec+, CISSP



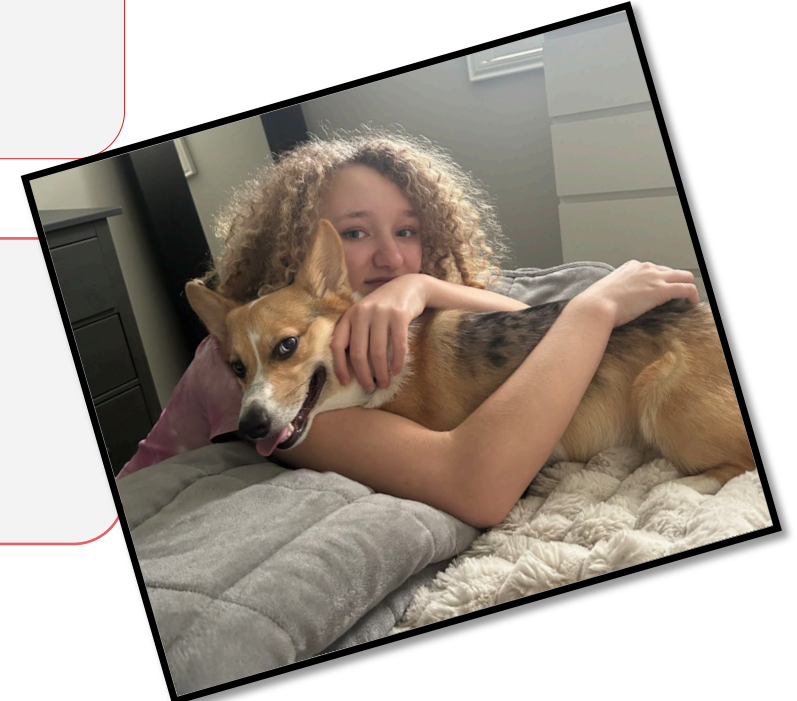
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Focus Areas

- Networking
- Web Applications
- Physical Pentesting

Other Fun Facts

- Former Chef
- Corgi/Teen Mom
- Horror Fan
- BSides Jacksonville Coordinator
- Costco Member





Waterfall

Called waterfall because
it arranges phases
sequentially

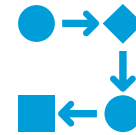
Each phase depends on
outcome from previous
phase



Iterative

Breaks the software
development process
down into smaller
segments

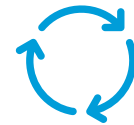
Intends to improve and
build from the small
segments



Spiral

Combination of Waterfall
and Iterative

Emphasis on risk
assessment

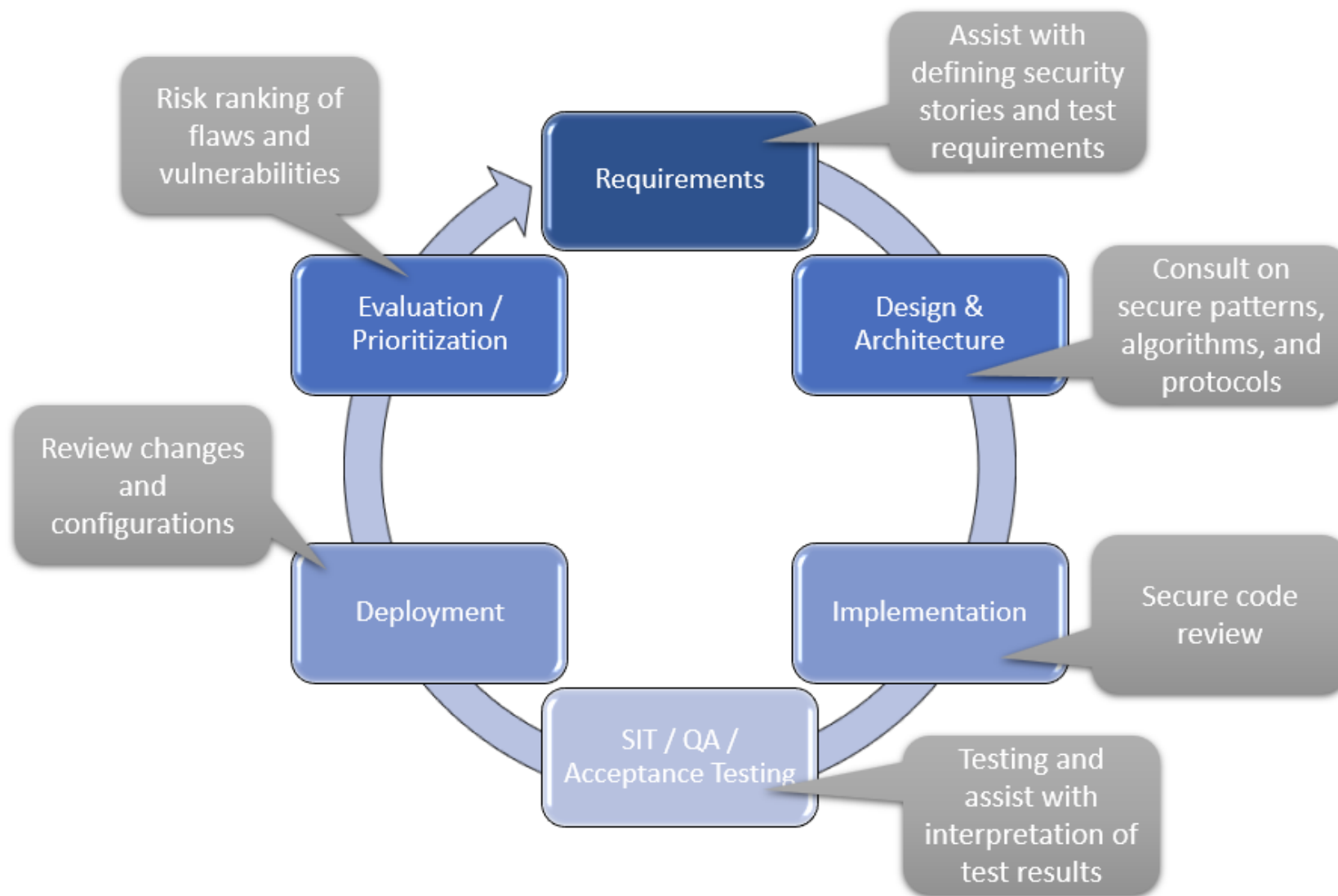


Agile

Adopts incremental and
iterative principles

Has a manifesto....

Built with security in mind





Requirements



- The application security team should be heavily involved in the requirements phase of the SDLC for several reasons:
 - The requirements phase is usually the best opportunity for the security team to gain visibility into upcoming features that may have security implications.
 - By participating in sprint planning, the security team can argue for the priority of security features.
 - The security team can immediately begin planning test scenarios to improve the efficiency of testing activities later in the SDLC.



Design and Architecture



- Ideally, development teams should utilize and trust the security team as advisors during this phase
 - Security teams should:
 - Advocate for secure coding practices
 - Know what algorithms, protocols, and platforms are approved by the organization

SIT, QA, and Acceptance



- The security team has a few tasks during the various testing activities of the SDLC, as follows:
 - In the time leading up to testing, the security team will assist with defining security test cases.
 - The security team may be responsible for some testing, such as running DAST tools or conducting penetration testing.
 - After testing, the security team will help interpret and filter the results from tooling to ensure issues delivered to the development team are relevant.

SAST VS DAST



- Static Application Security Testing



- Dynamic Application Security Testing



Security is a Full-Stack Responsibility



Database	App Server	Client-side Application
<ul style="list-style-type: none">- Use minimal privileges on Application accounts- Disable direct login for these accounts- When possible, disable features that weaken security e.g. xp_cmdshell- Log key events- Maintain backups- Test the backups	<ul style="list-style-type: none">- Auth check every request- Filter and validate input- Use parameterized queries to protect the DB- Use TLS Encryption- Encode user-supplied output- Protect against CSRF in concert with the client- Supply correct security headers on responses e.g. CORS policy, flags on cookies- Avoid incorporating user input into system commands- Log key events (after stripping sensitive data)	<ul style="list-style-type: none">- Coordinate with the App Server against common client-side attacks such as CSRF- Avoid DOM manipulation that unsafely incorporates user input- Implement a content-security-policy when possible. Keep it as restrictive as possible.

Case Study: Therac-25

- The Therac-25 was produced by Atomic Energy of Canada Limited (AECL) in 1982 as a computer-controlled radiation therapy machine, following the Therac-6 and Therac-20 models





Malfunctions & Accidents

- Between 1985 and 1987, at least six accidents occurred with the Therac-25, resulting in patients receiving massive overdoses of radiation due to software errors.
- Patients experienced radiation doses hundreds of times greater than intended, leading to fatalities and serious injuries.
- The accidents were attributed to concurrent programming errors (race conditions) that caused the machine to administer lethal doses of radiation.

PATIENT NAME: John			
TREATMENT MODE: FIX			
		BEAM TYPE: E	ENERGY (KeV): 10
		ACTUAL	PRESCRIBED
UNIT RATE/MINUTE	0.000000	0.000000	
MONITOR UNITS	200.000000	200.000000	
TIME (MIN)	0.270000	0.270000	
GANTRY ROTATION (DEG)	0.000000	0.000000	VERIFIED
COLLIMATOR ROTATION (DEG)	359.200000	359.200000	VERIFIED
COLLIMATOR X (CM)	14.200000	14.200000	VERIFIED
COLLIMATOR Y (CM)	27.200000	27.200000	VERIFIED
WEDGE NUMBER	1.000000	1.000000	VERIFIED
ACCESSORY NUMBER	0.000000	0.000000	VERIFIED
DATE: 2012-04-16	SYSTEM: BEAM READY	OP.MODE: TREAT	AUTO
TIME: 11:48:58	TREAT: TREAT PAUSE	X-RAY	173777
OPR ID: 033-tfs3p	REASON: OPERATOR	COMMAND: █	



Incidents

July 25th, 1985

Patient received a massive overdose due to an error message
"H-tilt" displayed by the machine

Deadly Code



- The source code has never been publicly released
- The code snippet represents a simplified version of the logic in the Therac-25 machine that may have contributed to the fatal radiation overdoses.
- The presence of a race condition in the software allowed the machine to fire a concentrated X-Ray beam when it should have continued normal operation. This flaw, combined with other issues in the software, led to the horrific catastrophe

```
GNU nano 6.2                                therac_Sample *
// Code snippet from the Therac-25 machine that led to fatal radiation overdoses
if (Class3 == 1) {
    // Concentrated X-Ray beam firing codepath
    FireXRayBeam();
} else {
    // Normal operation codepath
    ContinueNormalOperation();
}
```



Manufacturer Responses

- They denied that the machine could have caused the radiation burns and overdoses experienced by patients.
- They refused to believe that the incidents were linked to the Therac-25 machine.
- At the time of the accidents, the treatment prescription printout feature was disabled, leading to a lack of hard copy treatment data.
- The manufacturer and operators did not acknowledge the machine's role in causing the severe radiation burns until later investigations revealed software errors and issues with the machine's safety mechanisms
- The manufacturer's response included making extensive design changes to the Therac-25 machine, including implementing hardware safeguards against software errors. These changes were made after the machine was recalled in 1987 following the series of accidents

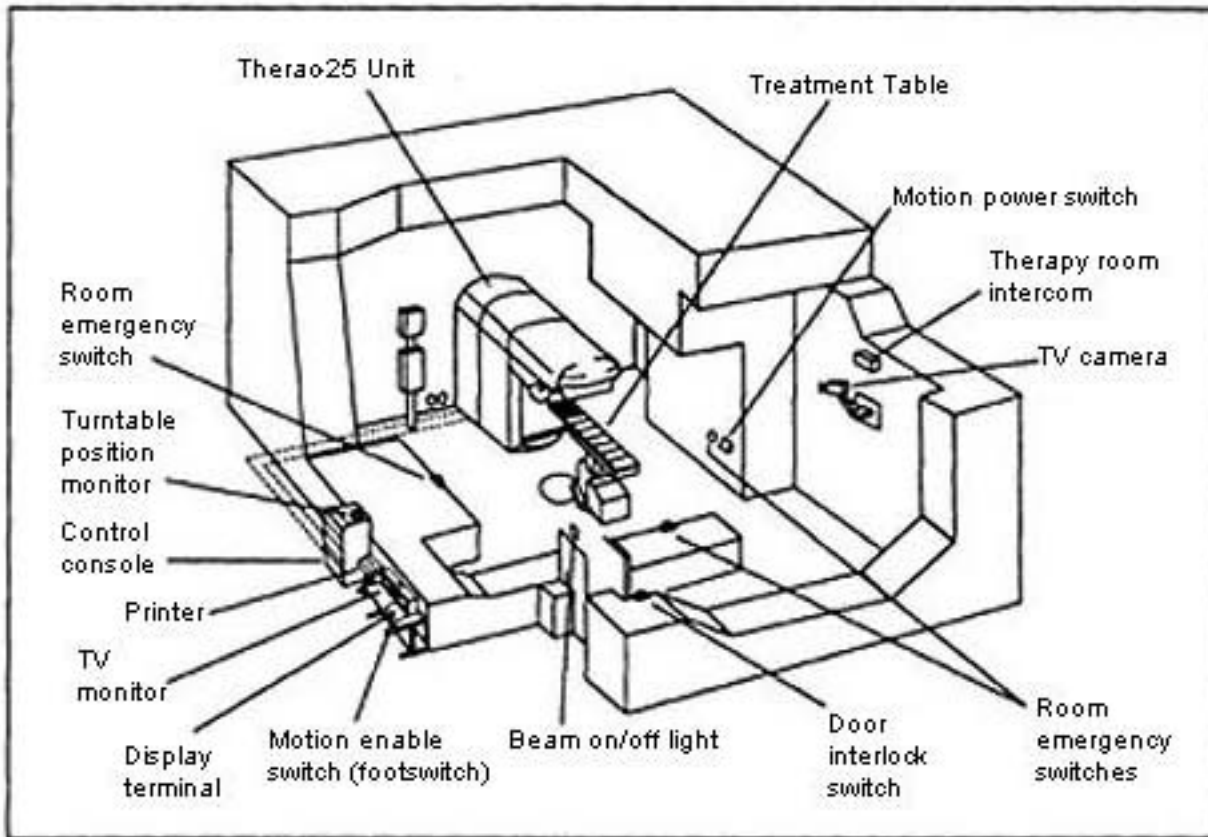


Figure 1. Typical Therac-25 facility



Investigations

The FDA (Food and Drug Administration) declared the Therac-25 defective under the Radiation Control for Health and Safety Act.

The FDA mandated that the manufacturer submit a corrective action plan (CAP) for approval, which included over 20 changes to the system hardware and software to enhance safety measures



Legal Actions

Several victims or families of deceased patients filed lawsuits against the manufacturer, AECL (Atomic Energy of Canada Limited).

These lawsuits were settled out of court.

Questions

