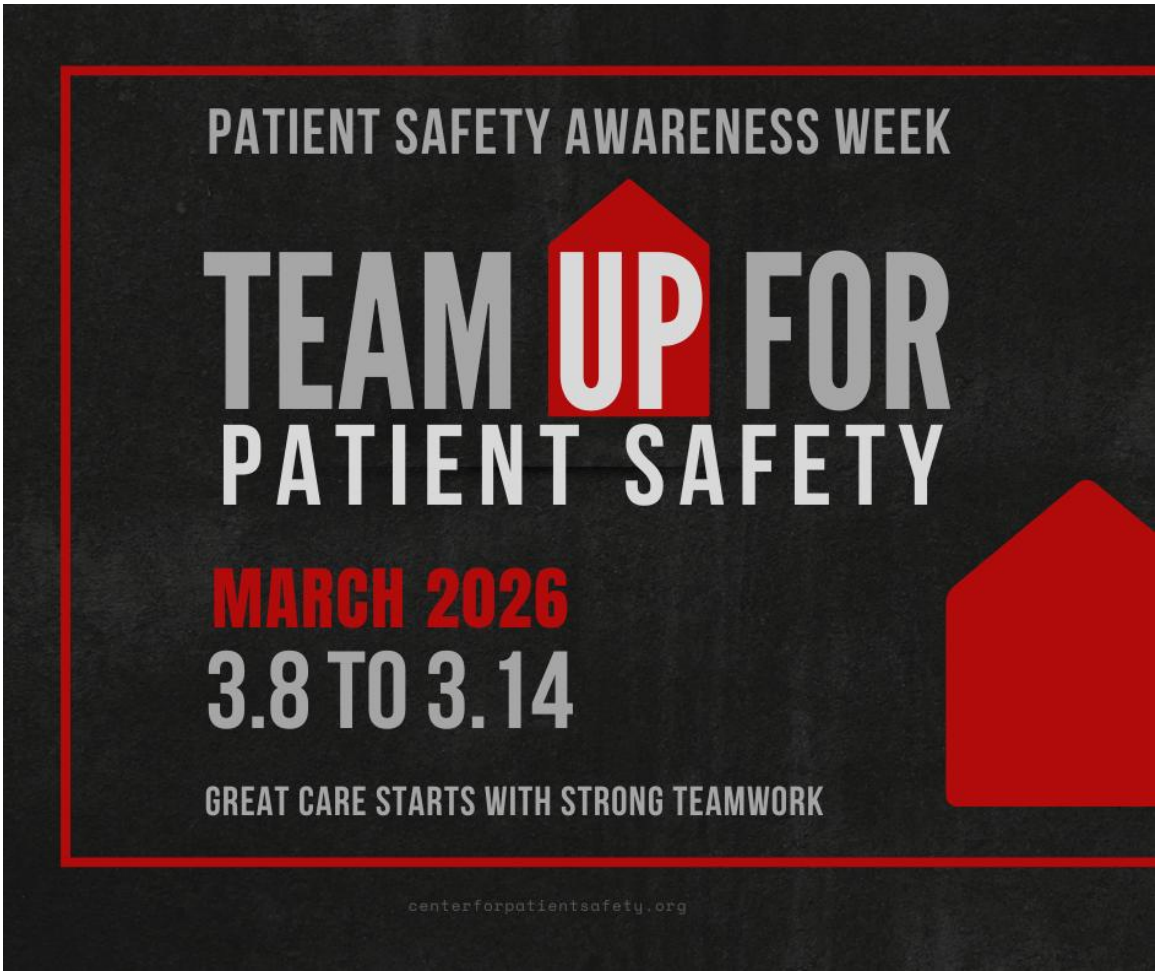


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## Patient Safety Tip of the Week

## March 10, 2026

## The Invisible Force Podcast

In our November 2025 What's New in the Patient Safety World column "MRI Hazards - Big and Small" we noted a fatal MRI incident that occurred in July 2025. A 61-year old man was pulled into an MRI machine after he walked into the room wearing a large weight-training chain around his neck (AP News 2025). Though published details were scant at the time, there is actually a video of the incident on Instagram. It shows the man entering the MRI room (Zone IV), approaching the machine, turning to move around his wife's walker, reaching for his wife's hands and pulling her to a sitting position, and then being sucked to the MRI machine where it looks like he is being choked by the metal chain around his neck. His body went limp, and it is not clear how long he was trapped (some reports said he remained attached to the machine "for almost an hour before they could release the chain from the machine") and when or if the magnet was turned off. He was eventually taken to a hospital and died the following day.

John Posh and Toby Gilk discuss the incident on The Invisible Force Podcast with updated information from multiple sources.

Perhaps the first revelation was related to the setting. While the imaging site was labelled as having "open MRI", this particular MRI was not an open unit. Rather it was a conventional MRI that was housed in a semi-like trailer that was permanently attached to the building with other MRI's via a covered walkway. Mr. McAllister was sitting in the room adjacent to the MRI, next to the MRI technician. His wife was having an MRI of her knee, so she was slid feet first into the MRI bore. It was not clear whether the scan had been completed or she had some problem with it, but she called out for her husband to help her. The MRI tech came into the room and slid the table out of the bore. Mr. McAllister walked in, tucked his cellphone into his back pocket, and reached for his wife's hands and pulled her up to a sitting position. His back was to the MRI bore. When he took a half step backward, he was sucked into the MRI bore by the chain around his neck.

Mr. McAllister was wearing around his neck a 20-lb. steel chain with a padlock-like portion, which he used for weight training, and it apparently was hidden in a fabric sleeve. Posh and Gilk estimate that the steel chain may have been exerting about a 1000 lb. force. The video shows his limbs flailing as the MRI technician attempts to pull him out of the bore and his wife is tugging on his belt. Apparently shortly thereafter he "went limp" according to his wife.

Posh and Gilk discuss how the chain, under that great pressure, likely compressed vascular supply to the brain, and may have compressed his airway and even potentially damaged his cervical spine.

Posh and Gilk have a great discussion about the magnetic field in the MRI room. The field is not uniform. "Active shielding" narrows the magnetic field to an area closer to the bore, almost like a "girdle" or "spanx". But once you reach a "launch point", the strength of the field increases dramatically. They use the analogy of the refrigerator magnet. If you are moving the refrigerator magnet near the refrigerator you may not feel much pull until you reach a point where it suddenly is sucked to the refrigerator. That is what

happened with Mr. McAllister. When he pulled his wife to a sitting position, his back was to the MRI bore. He appeared to take a half step backward and then was powerfully sucked into the bore. The video of the incident on Instagram shows him seemingly standing safely as he pulls his wife to a sitting position, then suddenly being sucked into the MRI bore when he took a half step backward.

Posh and Gilk also have a great discussion about quenching the magnet. They nicely explain how the internal coil is electrified and then cooled. They explain why turning the external electrical power does not turn off the magnet and that the only way to turn off the magnet is by pressing the quench button. They note that there is an E-Stop button which stops the scan and unlocks the slide table and an EPO (emergency power off) button but neither of these stops the magnet. Staff in this incident apparently pressed the quench button but thought that had not actually quenched the magnet. Posh and Gilk note there have been at least 2 precedents in which pressing the quench button has failed. But it is not clear that it failed in this case. A witness across the street said he saw smoke rising from the back of the building, suggesting that a quench had actually taken place.

This particular MRI had been purchased as a used unit, and the service contract was with a third party. Staff ultimately contacted that third party in hopes they could get the magnet turned off. A serviceman from that third party did arrive on the scene and had to access the MRI through the rear freight door that was only accessible from the outside. It is not clear how the magnet was eventually turned off. But eventually Mr. McAllister was able to be removed from the bore of the MRI and EMT responders were able to attend to him. According to his wife, it was about an hour before he was freed from the MRI. He was transported to a hospital and died the following day.

Though this was a fixed trailer housing the MRI, some important issues would apply to any of the mobile MRI's that are housed in semi-style trailers. The MRI unit took up almost the entire width of the trailer. There was no room for someone to walk around the side of the MRI to get to the rear. The only access to the rear was via the rear door of the trailer. That obviously creates difficulties for anyone responding to a medical or other emergency within the unit.

In Episode 4, Posh and Gilk note that initial reports of the accident said Mr. McAllister's entry into the MRI room was "unauthorized". They speculate as to the source of that particular wording. But they have a good discussion of the "4 Zone Model" for MRI sites. In that model, there are 2 types of screening:

- Clinical
- Physical

The clinical screening is the questioning about items that might be contraindicated during an MRI scan or items that might be interfered with by the magnetic field. The physical screening takes place in Zone II and looks for ferromagnetic materials on the person. There should then be a locked door between Zone II and Zone III. Mr. McAllister is seen on the video moving from Zone III (the control room) to Zone IV. Therefore, he should have gone through both the clinical and physical screenings and passed through a locked door to be in that control room. We are left to speculate whether the screenings were not

done or whether Mr. McAllister had "barged through" a locked door. We suspect we'll hear a lot more about this in future episodes.

Episode 4 also discusses some of the confusion raised by the announcement the following day that Mr. McAllister had died "due to multiple heart attacks".

Episode 4 then begins the discussion on oversight or regulation of MRI units (or maybe lack thereof!). Because MRI is a federally regulated medical device, users are required to report to the FDA any cases where death occurs. The podcasters checked the FDA's MAUDE database and found that Siemens (the manufacturer) did report this, but the operator (Nassau Open MRI) did not. They leave us in suspense regarding what any regulatory bodies, like the New York State Department of Health, may have done.

There have been 4 episodes to date on this incident on The Invisible Force Podcast. They label these as "Act 1" or what happened on the day of the accident. We are promised that "Act 2" will be on everything that happened after that and how it may impact future MRI safety.

The Invisible Force Podcast intends to report on various incidents related to MRI and encourages listeners to report tips to them about MRI-related patient safety events they have seen or experienced. This should be a very valuable resource.

**Some of our prior columns on patient safety issues related to MRI**:

- February 19, 2008 "MRI Safety"
- March 17, 2009 "More on MRI Safety"
- October 2008 "Preventing Infection in MRI"
- March 2009 "Risk of Burns during MRI Scans from Transdermal Drug Patches"
- January 25, 2011 "Procedural Sedation in Children"
- February 1, 2011 "MRI Safety Audit"
- October 25, 2011 "Renewed Focus on MRI Safety"
- August 2012 "Newest MRI Hazard: Ingested Magnets"
- October 22, 2013 "How Safe Is Your Radiology Suite?"
- October 21, 2014 "The Fire Department and Your Hospital"
- August 25, 2015 "Checklist for Intrahospital Transport"
- August 2016 "Guideline Update for Pediatric Sedation"
- October 2016 "MRI Safety: There's an App for That!"
- January 17, 2017 "Pediatric MRI Safety"
- August 8, 2017 "Sedation for Pediatric MRI Rising"
- March 2018 "MRI Death a Reminder of Dangers"
- March 2018 "Cardiac Devices Safe During MRI But Spinners!?"
- November 2018 "OMG! Not My iPhone!"
- April 2, 2019 "Unexpected Events During MRI"
- September 2019 "New MRI Hazard: Magnetic Eyelashes"
- October 15, 2019 "Lots More on MRI Safety"

- November 5, 2019 "A Near-Fatal MRI Incident"
- November 2019 "ECRI Institute's Top 10 Health Technology Hazards for 2020"
- January 7, 2020 "Even More Concerns About MRI Safety"
- March 2020 "Airway Emergencies in the MRI Suite"
- October 2020 "New Warnings on Implants and MRI"
- January 2021 "New MRI Risk: Face Masks"
- June 1, 2021 "Stronger Magnets, More MRI Safety Concerns"
- November 2021 "Yet Another Risk During MRI"
- January 2022 "MRI Safety Issues"
- July 26, 2022 "More Risks in the Radiology Suite"
- October 24, 2012 "Serious MRI Accident at Unregulated MRI Center"
- November 21, 2023 "Another Terrifying MRI Accident"
- January 2024 "Guns and MRI Don't Mix"
- February 20, 2024 "What is a "Safety Case"?"
- June 11, 2024 "Nursing in the MRI Suite"
- August 13, 2024 "Preventing Thermal Injury During MRI"
- October 2024 "Another MRI Accident Reveals Gap in Oversight
- October 2024 "MRI Special Patient Considerations"
- October 8, 2024 "First Responders and MRI"
- April 22, 2025 "Updated ACR Manual on MRI Safety"
- May 2025 "Add Another Item to Your MRI Screening Protocols"
- November 2025 "MRI Hazards - Big and Small"
- January 6, 2026 "Here's Why Firefighters Need MRI Training"

**References**:


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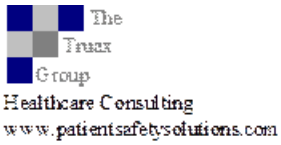


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