# Method

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Our investigation is based on information collected from interviews, records, police investigations, public documents, statistics, academic literature and dialogue with several professional and expert communities, as well as special interest organisations. The information has been sorted and analysed to identify any findings that may shed light on causes and risks. During the discussion, we have elevated our findings to a thematic level.

The investigation has been conducted according to the NHIB method for investigative processes. We are also inspired by and have, in consultation with the Norwegian Safety Investigation Authority, used some of the tools from their safety framework and their analysis process for systematic investigations (80).

## Interviews

We initiated the investigation by contacting the spouse of the deceased and the municipal management of the Municipality of Tromsø. Between two visits to the municipality, we conducted interviews with a total of 28 people who were involved in the specific incident or were familiar with the work with refugees in Tromsø. The interviews included the spouse, refugees/students at the adult learning centre, the GP, the refugee doctor, the local authority's chief medical officer, the refugee health nurse, health visitor, midwife, refugee service employees, the adult learning service, the Norwegian Labour and Welfare Administration and the daycare facility, managers at

different levels in the local authority, the regional resource centre on violence, traumatic stress and suicide prevention (RVTS Nord) and the mosque.

Audio recordings were taken at all interviews and were subsequently transcribed. In some cases, supplementary information was collected before the report was finalised. The purpose of this was to clarify any ambiguities and to quality-assure the information that was used. The interviews were semi-structured, with an emphasis on open, exploratory questions.

# Written documentation and other sources

We have had access to the medical records, some of the police documentation and we have familiarised ourselves with public documents on the subject of integration. We have also followed the media coverage of the incident.

Throughout the investigation, we have been in contact with specialists at the Norwegian Institute of Public Health, the Norwegian Directorate of Integration and Diversity, the Norwegian Directorate of Immigration, the Norwegian Association of Local and Regional Authorities, the Norwegian Safety Investigation Authority, the Regional Resource Centre on Violence, Traumatic Stress and Suicide Prevention (RVTS Midt), the Norwegian Centre for Violence and Traumatic Stress Studies, the Norwegian Directorate of Health, the Transcultural Centre, the police and the following special interest organisations for refugees: INLO, NOAS, SEIF and MiRA.

We would like to thank Vibeke Ottesen and Hilde Frafjord Johnson for their input.

# Analysis and causalities

Based on interviews and the documents obtained, we examined the material to identify factors that contribute to women who settle through family reunification experiencing particular difficulties. Factors that stood out were sorted into different risk areas and analysed with regard to whether they were relevant to the investigation and whether they could provide possible explanations.

Our understanding and use of the term risk in this report is based on Aven's (81) definition of risk: "Risk: the incidence of an event and subsequent consequences, as well as associated uncertainty (it is uncertain which events will occur and what the consequences will be)."

Furthermore, we also conducted a causal analysis of the risk areas. In this, we looked at the underlying causes at various levels (MTS (man, technology, surroundings), organisation and management factors as well as framework factors).

During this phase, we used "Why-because analysis (WBA)", which moves from the operational and technical levels to the more underlying level. The idea is to repeatedly ask the question "why" to search for explanations "because" (82).

This can also be viewed as a variant of AcciMap. The method is based on asking why the incident happened in order to identify all factors that caused the incident to occur or failed to prevent it from occurring. AcciMap analyses the surrounding factors to identify failures at system level. By asking why for each causal factor, it will be possible to identify failures. This may provide a representative, general overview of the system. In this way, we can become better at preventing events (83, 84).

# Validity requirements

In questions about the reasons why an event occurred, hindsight is often a source of error that it is important to be aware of. It is not possible to test the causal explanations. In order to support

our understanding of the causalities and the necessity of the recommendations, we have assured ourselves of the following:

- Descriptions, findings and recommendations have been presented to the investigated local authority and informants.
- The explanations can be linked to documentable events or phenomena as they appear in written reports, specialist literature and/or statements in interviews.
- Findings and recommendations have been discussed with several professional and expert communities, professional organisations, special interest organisations for refugees and other authorities. Overall, we have been in contact with a total of 27 different service providers throughout the investigation and the final round of input. Each service provider has been represented by one to six people during meetings with us. Several of the comments they have provided as input have been included in the report. Throughout the investigation, we have engaged in dialogue with and received useful input from NHIB's reflection panel (85).

**Statens undersøkelseskommisjon**
**for helse-og omsorgstjenesten**

Postboks 225 Skøyen
0213 Oslo
E-post: post@ukom.no
Org nr: 921018924