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Communities and authorities need to be well prepared for communication and media management in the presence of current, emerging or evolving risks. The conception of risk usually overlaps with definitions on crises and disasters. Risk communication is often used broadly to capture both risk and crisis communication. Crisis communication, often conflated with risk communication, is a separate field, but can include aspects of risk communication (Sheppard et al, 2012).

Historically, risk communication research tends to most frequently involve case studies and lists of best practices. Among earlier case studies are the September 11th terrorist attacks (Carey, 2003, in Noll) and Hurricane Katrina (Sheppard et al, 2012). Risk communication studies have a tradition of focusing on information presentation, persuasion, and strategic messaging. Additionally, failures at controlling or managing risk effectively can lead to a crisis, or a crisis may lead to the necessity for risk communication (Coombs, 2010).

Critical event phases - at disasters, terror attacks or major accidents - are often defined by the following distinctions:

- **Preparedness**: pre-event risk communication outlining practical preparedness measures, including education on likely risk characteristics of various threats
- **Response (Imminent Warnings)**: crisis communication and guidance regarding protective actions to take immediately prior to, in the midst of, or during the hours immediately following an event;
- **Recovery**: messages communicating needs and guidance in the weeks, months, and years following an event.

(Sheppard et al, 2012).
Acts of terror often entail major challenges for healthcare services. Not just the medical support, but also the authorities’ crisis communication and media management is under pressure. The following text will summarize experiences by the results of an observatory study on the bomb attack in Oslo and the shootings at Utøya, Norway, 2011. The report focuses on the communication and media management during the response phase of the bombings and shootings. The main focus is on how the medical and health care services managed during the first hours and the followings days after the events.

The preconditions for the work presented (Englund et al, 2012, KAMEDO 97) are that the Swedish National Board of Health and Welfare was requested to provide support to the commission that was established in Norway to evaluate the Norwegian society’s handling of the incidents of the 22 July, the “22 July Commission” (NOU 2012:14). The KAMEDO observer reports study the medical, psychological, organizational and social aspects of disasters. In the report from the 22 July Commission, crisis communication and media management got a more prominent position than in previous KAMEDO reports. One reason is that the Norway attacks seemed to generate more extensive media coverage – and not least social media activities – than what has been the case at earlier observed events.

The following text is part of the previous published report:
http://www.socialstyrelsen.se/publikationer2012/2012-12-23

The KAMEDO report in turn was part of the Norwegian Government report, as the National Board of Health and Welfare was requested to provide support to the commission that was established in Norway to evaluate the Norwegian society’s handling of the incidents of 22 July, the “22 July Commission”:

The text, which is based on parts (authored by Liselotte Englund) from the KAMEDO report, is published with permission from The National Board of Health and Welfare.
THE 22 JULY EVENTS
On a Friday afternoon, July 22, 2011, a homemade bomb planted in a car exploded and ripped through the central area of Norway’s capital, Oslo. Windows were blown out in the government district, killing 8 people, and wounding dozens more.

In total, 77 people were killed on the 22 July 2011, eight as a result of the bomb explosion in the government district and the rest in the shootings at the island Utøya, where the Norwegian Labour Party’s youth organisation was holding its summer camp. At least 90 people are estimated to have been injured in the bomb attack. Those injured were evacuated from the island, either by land ambulance to the local hospitals – for example Ringerike in the municipality Hønefoss - or by helicopter to the University Hospital at Ullevål, Oslo.

The events of the 22 July involved major parts of Norwegian society. It required great efforts from the medical services and there was a major demand for psychosocial support. Furthermore, the events triggered enormous interest in the media to which the parties involved were forced to respond. Risk and crisis communication was important parts of the crisis management.

COMMUNICATING RISK AND TRAUMA
Information, communication and media relations are central activities during crisis situations. Evaluations after serious incidents often indicate certain deficiencies within these areas, at the same time as they emphasize the importance of both good communication and media relations. The readiness to meet the needs of the media for information is part of this communications preparedness, including providing journalists, photographers and others suitable working conditions. A WHO report concerning the tsunami disaster (2005) asserts that the media’s speed is often unrivalled, and that the journalists play an important role in the provision of information during both the acute phase and recovery phase. According to the authors, professional actors in the media and communications area play a crucial role. Particularly emphasized is the local media’s – especially the radio – importance for mediating information to those directly and indirectly affected. The WHO authors also consider that the media’s critical reporting often contributes to shedding light on weaknesses relating to organization and preparedness, and speed up the improvement work.

Previous KAMEDO reports (http://www.socialstyrelsen.se/kamedo ) have highlighted these areas to varying degrees – a few of them describe experiences of the media at the scene and other contain summaries of media reporting after a certain incident. The purpose of the section of the KAMEDO report about the 22 July events in Norway 2011 (Englund et al, 2012) - relating to communi-
cation and media relations - was to reproduce experiences and lessons from the medical care perspective. The evaluation besides studying the health care services also partly describes the police authority (in the capacity of being responsible for communication and media relations at the incident scene) and the municipalities involved (as municipal leaders for the municipal emergency services).

MATERIAL AND METHOD
The terror attacks that Norway suffered on the 22 July 2011 have been described as the worst atrocities the nation has experienced since the Second World War. Many of the experiences can be related to Swedish emergency preparedness, and lessons can be learnt from the Norwegian handling of the incidents (Eklund in Englund et al, 2012).

Work on the report started in October 2011 and the completed report was delivered to the 22 July Commission in mid April 2012.

The data was primarily gathered through qualitative interviews, during fall 2011. The interviews were stenographed during conversations, due to the limited amount of time making recording and transcribing the interviews difficult. Respondents were stationed within the healthcare, medical services, police, municipalities and the media. Main informants were communication officers, but also medical doctors and staff with other relevant functions in leading positions.

Various types of written material have been obtained. For example strategic communication plans and crisis communication plans. Some interview questions were based on the different parts/themes of the communication plans. The aim was to check how the staff followed the plans and how they evaluated their own achievements in terms of following the plan and/or improvising in the moment.

POTENTIAL RISKS
The Norwegian Directorate for Civil Protection and Emergency Planning (DSB) stated in a national vulnerability and emergency preparedness report for 2011, that there has never been any serious terror threat levelled at Norway. The report assesses the terror threat towards Norway as being low. (DSB, 2011). A risk analysis of a major terror attack in Oslo is presented in mentioned report. A fictive case where groups of terrorists carry out parallel attacks against several targets with both explosives and firearms, is mentioned as something that is considered to be a realistic “worst-case scenario”. According to DSB, a relatively unlikely scenario. (DSB 2010 & 2011) In conclusion, DSB points out that the risk analysis is highly uncertain with respect to both the probability and consequences of such an incident (DSB, 2011). Still, it happened (Eklund, in KAMEDO 97, p.26).
Like the Swedish crisis management system, the Norwegian one is ruled by three main principles:

1. responsibility - the normally responsible party is also responsible for it in the event of a crisis
2. proximity - crises shall be handled at the lowest possible geographic level
3. similarity - the crisis organisation shall be as similar as possible to the normal organization. (Ivarsson et al, 2011).

COMMUNICATION PLANS AND MEDIA PREPAREDNESS
Norwegian crisis communication is complex, due to the fact that there are many different parties and responsible authorities that work at different levels and which overlap with each other both geographically and operationally. In some cases there are comprehensive crisis communication plans and, in other cases, communication and media relations warrant just a couple of lines in the emergency preparedness plan. The work with communication and media relations is also characterised by whether an entire communications unit is available (as is the case at Ullevål Hospital – the University hospital of Oslo), whether it is a public relations officer in another town who is responsible (as is the case at Ringerike Hospital – a minor regional hospital closer to Utøya) or whether the municipality’s information unit is operationally responsible (which is the case in the City of Oslo for Oslo’s general emergency ward and in Hole Municipality for Ringerike’s general emergency ward). Sometimes the organisation is less clear where several parties cooperate within the same temporary constellations.

COMMUNICATIONS RESPONSIBILITIES AT HOSPITALS (ULLEVÅL AND RINGERIKE)
Oslo University Hospital Trust, which incorporates Ullevål Hospital, has an emergency communications plan of more than 60 pages that is continually updated. It is stored digitally and is printed out for all staff when required. The plan was revised three days before the attacks of the 22 July 2011 and includes organisational descriptions, check-lists, a description of the communication staff’s emergency room and much more. The plan contains a list of “standard statements that provide breathing-space” as well as a wealth of advice concerning contact with the media. The check lists concern various different aspects of communication, the characteristics of the crisis and communications advice for use before, during and after a crisis. There are also check-lists for other types of crisis incidents. Furthermore, there is internal and external contact information, including an overview of the various parties that foreseeably could be affected by the crisis incidents. The plan also contains a matrix that assigns tasks. This
describes 20 different functions over a wide spectrum of responsibility areas, everything from activation of the press centre, to supplying the staff with food and drink. One of the functions has the task of following media reporting, while another logs all of the information. Two people devote themselves entirely to the production and publication of news, both internally and externally.

In the event of major disasters, Oslo University Hospital and Ullevål Hospital have responsibility for the communications of the regional health trust’s eleven hospitals. This means that all other hospitals involved are to report their status to the University Hospital, which coordinates the communications work.

COMMUNICATIONS RESPONSIBILITIES AT THE INCIDENT SCENE
In the event of extraordinary incidents, the Oslo police (of interest here due to its role as incident scene manager) organises itself in accordance with a specific emergency preparedness model. Within the Police Commissioner’s unit, a number of “P functions” are created, where P5 is the information function that looks after both internal and external communication, as well as press information and media relations. The communication procedures mean that no one may make a statement to the media (either to an individual reporter or via a public press statement) without it first having been discussed by the P5 and the response leader. All P-unit functions are physically located at the Oslo police station and are superior to the entire regular police organisation. The police have a dedicated web platform containing all communication plans and function descriptions. There are also templates for press statements to be used in various types of situations and incidents, in both Norwegian and English.

COMMUNICATION MANAGEMENT AND ORGANISATION
The majority of those who awaited in communication and crisis preparedness in Oslo on the 22 July 2011 were first alerted via media and then later through the authority’s regular alarm system. A text message from a relative or a subscribed newsflash on the mobile phone was for many the first signal that they should ready themselves. This clearly demonstrates that the role of media cannot be underestimated in the alarm phase. There are always differing opinions regarding the form and content of the reports, but the speed from incident to alarm is often unsurpassed. A small number of people heard a bang or ambulance sirens and went to work out of pure instinct, or might have already been working when the emergency alarm arrived.

Oslo Municipality learned a number of lessons from the incident, among them that a special telephone emergency number should be established for media so that they do not block emergency lines that are intended for the citizens.
Personnel at Oslo University Hospital emphasise the conflict between the strict confidentiality of the medical profession and the police’s more open stance. There were moments when the medical carers considered that the police supplied little too much information about the victims.

MEDIA PREPAREDNESS AT INCIDENT SCENES AND HOSPITALS

When disasters occur during “inconvenient working hours”, which they often tend to do, all of the actors involved are put to an even harder test. The regular working day may be over, key persons are on holiday, substitutes are not familiar with procedures and the initial period from alarm to work effort is longer than usual. This was also the case on the 22 July. In Oslo Municipality, two hours passed before the communications staff had been gathered, and Oslo Police had gathered only four people after the first hour. Ullevål Hospital was the quickest to respond. After half an hour, an emergency communications staff of four members had been formed, with more being added later.

One of the challenges with communication faced by many authority actors – especially when the victims are children and youths – relates to the information flow via social media and mobile communication. This must be considered in parallel with the work of disseminating correct and factual information, both directly to citizens (for example, via websites) and through the media. Great source criticism and ethical problems emerged here, as well as a communication problem.

When a local incident quickly becomes a national emergency, it might also be suitable that a national communication organisation comes into effect. One viewpoint that became evident regarding the communications work at Sundvolden Hotel (the assembling place for survivors and relatives, near Utøya) is that on such occasions the Directorate of Health should send someone responsible for communications and media to the scene. Sundvolden Hotel was requisitioned as a support centre at an early stage, and Hole Municipality’s crisis team assembled there in order to receive the arriving teenagers. The medical care staff at Sundvolden were uncertain about who was responsible for communications and what should be explained, and by whom. A function that can address these issues quickly and strategically would have been valuable.

Representatives of Ringerike Hospital stated after the event that it is extremely important to have specially appointed personnel who manage communications and media matters, even at smaller hospitals. In addition, the police could not be contacted in this case, and the hospitals were kept altogether too poorly updated about the course of events. Hospital staff kept themselves informed primarily via the internet, radio and TV, which once again emphasises the need of a media centre to satisfy the internal need for communication. According to a central
source at the hospital, a contingency preparedness can be useful because “the press is only interested in scandals and royalty”. The fact that a small provincial hospital treated 35 seriously injured people did not, however, receive a great deal of attention by the media.

MANAGEMENT DURING CRISIS
Those in charge at Ringerike expressed that the disaster strengthened team spirit, despite the tragic circumstances. For the personnel, the situation proved that a hospital needs a manager at the scene. This is also very important for the communications situation, or as one source said: “A doctor cannot be remotely controlled – you have to live with those that you shall control”.

Allegedly, the communications work was characterised by the expression, “Nobody assumes leadership if the senior doctors do not”. This means that the workers with extensive experience often become natural leaders in difficult situations when the regular work managers are not present. A previous Senior Consultant was called in and given the task of managing the press. The disaster plan functioned without problem with the specific exception of contact with the press, where preparedness was worse. The hospital considered that the situation was managed well regardless, and with great flexibility, especially considering that a hundred or more journalists – reporters and photographers – from different countries were gathered at the scene.

BOTH ACCORDING TO THE PLAN AND FLEXIBLE
An organisational and strategic communications problem that became evident is the somewhat complex Norwegian medical care organisation. At a large hospital such as Ullevål, the majority of things could be performed in accordance with the crisis communications plan. At Ringerike, the emergency plan was followed in detail, but communications and media management seems to have been somewhat more improvised, even though the results were good.

The municipal emergency services and centre at Sundvolden Hotel complied formally with the respective municipalities’ crisis communications plans. This was generally applied in Oslo, but the work at Sundvolden was organised essentially without any communications support and neither the police nor municipality contributed any communications resources. Despite this, and the fact that there was no written guidance regarding the communications work, everything functioned very well. Sometimes common sense, attentiveness, flexibility and some imagination go a long way.
MEDIA EXPOSURE OF SURVIVORS AND PATIENTS

Good media preparedness entails not simply “managing” the media, but also giving their representatives suitable working conditions in the form of premises to work in as well as access to electricity and the flow of information. However, this type of press centre must be chosen carefully. At Ullevål Hospital, a premises located in a building that is separate from the Emergency Department and the care wards, which protected the patients from media exposure. At Ringerike Hospital, the journalists were given a room connected to the care wards, which might have placed them too close to the patients. Several patients at Ringerike were also given exposure through early interviews and images, and the question may be asked whether the care personnel protected their patients to a sufficient extent. When a doctor states that “the youth use media to debrief themselves”, the protection must probably be considered to have been poor.

The personnel at both Ullevål and Ringerike claimed that they attempted to dissuade young patients from speaking to the media on several occasions during the first twenty-four hours, but that many young people took the initiative themselves. Patients of legal age were allowed to decide for themselves, but sometimes the parents also instigated the media contact. The medical carers cannot be accused of insufficient protection or ethics in such a situation. Personnel at Ullevål implemented two interesting and creative measures that were not mentioned in any crisis plans: Red tape on the hospital floor marked a boundary for journalists, and white sheets were hung in windows to provide protection of privacy.

The circumstances were different at the Sundvolden Hotel, and no press centre was established despite the enormous media gathering. The information from crisis management to the media, however, was systematic and functioned well with the municipality director as spokesperson. In contrast, the small number of young people who came out from the hotel and met the media became ‘fair game’ at an altogether too early stage. They were still extremely vulnerable so close to the incident, which the media may have been perceived to exploit in an unethical manner. At the same time, the world seemed to hold its breath in wait for the first eyewitness accounts, and the pressure on the media was intense.

The media reporting was also quickly characterised by the ability of some of the young people to meet evil with love, for example, the young woman who said that “if one man can show so much hate, think about how much love we can show together”. The statement was inscribed on a monument nearby the bridge Utvika (arrival site for the evacuees, approximately 600 meters from the Utøya jetty). The media contributed to spreading this and similar positive, self-reinforc-
ing images, and many volunteers think that this facilitated both the individual and collective crisis management after the incident.

SOCIAL MEDIA
The majority of those interviewed think that their respective organisations must become better at using social media quickly and systematically when crisis incidents occur. Experiences from the 22 July demonstrate both the public’s wide usage of social media in crisis situations and also the speed and impact that they have when an authority is the sender. The media use social media as sources to a large extent, but authorities do this to a lesser degree. Ullevål Hospital has come furthest in this regard, through having used Twitter and to some extent Facebook, to search for blood donors, among other things. After the 22 July incidents, the Oslo Police has established a Twitter account in order to provide continual information about incidents and accidents.

INTERNAL COMMUNICATION
Internal and external communication shall be managed in parallel and synchronisation, which can probably be considered as common sense in the majority of communications operations. Within communications theory it goes without saying, and the same applies to the current use of modern digital channels (Coombs, 2012). Personnel should not need to rely on media in order to obtain information about incidents that concern their work efforts or workplace. This information should come from within the organisation. But, it is often not the case in reality, for several reasons. In a crisis situation it is necessary to prioritise and the external is always discarded first on these occasions. Internal communication is primarily verbal, through quick progress meetings, for example. There are, in addition, many working at hospitals that do not have access to computer-assisted communication. Text messages may work, or internal TV screens, but these methods are seldom particularly developed. If incidents occur outside of regular working hours and with low staff levels at the workplace, internal communication is perhaps even more lowly prioritised. On the 22 July, many of those who worked with rescue efforts, care and communications received their first hand information from the media.

AREAS FOR IMPROVEMENT
From a communications perspective, it is likely that both the Norwegian and Swedish medical care profession can become better at utilising the speed of the media in the crisis management work. The care profession shall not simply “manage the media” in the sense of satisfying their requirements, providing them
with information or keeping them away from incident scenes, but shall include an active utilisation of and interplay with the media in a good emergency preparedness plan. This may relate to “accepting” the media’s speed and utilising their alarm function, actively using both traditional and social media as information channels and, not least, crisis staff following the media reporting themselves in order to stay updated. It should be taken for granted that a media room is incorporated into every crisis communications staff. As at Oslo University Hospital, a function in the crisis communications staff should be assigned to follow the media reporting intensively and report internally on the important parts within the organisation. This also relates to how the medical care profession is portrayed in the media. Furthermore, the health and medical care profession may notice any incorrect facts and act quickly to have them corrected in the relevant media. In Norway, Oslo University Hospital used Twitter as a channel for both the press and the citizens. It is likely that in many cases the Swedish medical care profession’s communications plans need to be updated in order to meet the needs of a more modern media situation. One issue to be examined is the potential need to include procedures for Twitter, Facebook and text messaging in the emergency preparedness plans. In addition, it is of great value to produce rules for how to relate to patient interviews on the hospital’s premises (care rooms), as well as for situations when patients take the initiative themselves to make contact with the media. It is also worth examining whether the hospital has a realistic emergency preparedness for an international media presence, and whether procedures exist for the establishment of a press centre that is located some distance away from urban areas.

CONCLUSIONS

Based on the information which has emerged regarding communication and media management linked to healthcare and medical operations, the following conclusions could be drawn: Communications preparedness is an extremely important part of general emergency preparedness. An emergency plan should include descriptions of functions, routines for internal and external communication, media relations at the incident scene and hospitals, as well as preparations for the handling of international media attention. The media’s function as a form of alarm and as a source of information is significant in the event of serious incidents. The citizens themselves also have an important alarm function as text, Twitter and Facebook messages sent via mobile phones are often a fast and effective way of reaching many different kinds of recipients: affected, relatives, friends, the media and even staff at hospitals, the police and other authorities. Media attention should be monitored internally during the acute phase and the period immediately after. Monitoring the media coverage could reduce risks of
myths and disinformation. The emergency plan of every hospital should include a stance with regard to patient interviews. This makes it easier for staff to refer to rules, which can provide both them and patients with a certain respite from the media.

Communicating risk can both be help and harm to the crisis management. Learning from earlier events will be embedding for a better crisis management as well as a better risk perception and management among the citizens.

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The bomb attack in Oslo and the shootings at Utøya, Norway, 2011

Memory stone at Utvika, opposite Utøya at Tyrifjorden, Norway. The inscription: “If one man can show so much hate, think about how much love we can show together”.  
*Photo: Liselotte Englund*