To whom it may concern,

I am writing to you to raise concerns regarding St John Ambulance (SJA), its procedures and the conduct of those working on its behalf, particularly between Mar–May 2020. It is my belief that these variously pose a danger to the charity's staff and volunteers, patients, assets and members of the public. It is also my belief that nothing has been learned and no responsibility has been taken, so that, without me taking this action, in the event of a 'second wave' of coronavirus cases the same thing will happen again.

I am submitting this to both the Charity Commission and the CQC. It is formatted in line with the reporting guidance for the Charity Commission; I could not find a similar document for the CQC, so I hope the information provided will suffice. Please do not hesitate to contact me if you require anything further. I have also copied in the NCVO; whilst they do not have an investigative function, my concerns relate partly to volunteer rights, and SJA are currently listed on the NCVO Web site as as signatory to the '3R Promise'.

Alongside this letter I have also attached a report I produced detailing my experiences. This was not originally produced for this purpose and so some sections are not particularly relevant, but I will supplement this letter with references to that document when appropriate.[1] Appendix B of the report, whilst lengthy, contains a complete timeline of events from Mar 5–Aug 25 and may be useful to read through if you have the time, although this should not be necessary.[2]

1. What is the name of the charity? Include its registration number if it's registered.

St John Ambulance. Registered charity no. 1077265/1. A company registered in England no. 3866129

2. What is your name?

Ben Goldsworthy

3. What is your telephone number?

+44 7914 071864

My preferred means of contact is via email (me+sja@bengoldsworthy.net).

4. What is your role at the charity? If you no longer work for the charity, please tell us when you left.

I was formerly an Emergency Ambulance Crew (EAC); I was dismissed from the organisation on Jul 23 2020.

5. Are you a charity employee or a volunteer?

I was formerly a volunteer.

1 Where the pilcrow symbol (¶) is used in a reference, this refers to the individually-numbered entries into the timeline featured in Appendix B of the report. These can be found easily within the document by searching for the number in brackets.

2 There is also a list of acronyms on pp 220–224 of the report to assist with some of the jargon.

6. What is your concern?

I have two concerns. The first is relevant to both the Charity Commission and the CQC; the second is relevant only to the Charity Commission. I'll briefly sum up both, and then go into each in more detail:

- Concern 1: During the period Mar–May 2020 (and likely beyond this), SJA ignored their own safeguards and cut corners in order to fulfil their target of having '100 ambulances on the road per day'. This resulted in the provision of inexperienced and unsupported ambulance crews, which put those crews, their vehicles, their patients and members of the public at risk.
- Concern 2: SJA's investigatory processes (as written) are unfit for purpose, counterproductive and dangerous. They are neglectful of the basic rights and well-being of those under investigation and of due process. In addition, senior role holders are either unaware of these procedures, or willingly disregard them.

<u>Concern 1</u>

On Mar 24, SJA published their plans to support the NHS during the COVID-19 pandemic. The target was set at '200 ambulance crew to provide 100 ambulance a day'.[3]

In order to fulfil this, SJA ignored its own safeguards and cut corners, resulting in underprepared and unsupported crews being sent out.

From my own experience:

- **Waived Supernumerary Shifts -** I had only completed my EMT course (comprising three weekends of training and one of assessment) on Mar 8, and normal policy required me to undertake a minimum of three supernumerary shifts (involving the conveyance of a patient to hospital) before I could crew normally. When volunteering for block deployments I repeatedly pointed this out,[4] but SJA waived this requirement at the start of April. Ultimately I had only one supernumerary shift on Apr 1, during which we took no patients to hospital.[5] On Apr 19 (after completing my tenth shift) I was told that I would have a supernumerary shift with another EAC and a paramedic on Apr 25.[6] After travelling to Newcastle (from my home in Lancaster) for this, I was instead crewed with a single EAC.[7]
- **Waived Driver Training** – I undertook an operational check drive on Mar 29, which consisted of a 45-min drive with an assessor. I was frank about my lack of driving experience, but was nonetheless approved as an operational driver[8] without having to complete any training.[9] This derogation was originally slated to last a few months, but was later extended to the end of the year.[10]
- **Hepatitis B Immunisation** – I was sent out despite not having received a Hepatitis B immunisation. This was clearly visible on my personnel record, but nobody raised this with me. When I tried to get this sorted, I was ignored.[11]

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3 See attached report, Appendix B, ¶ 21
4 Ibid., Appendix B, ¶¶ 13–14, 17–18, 27–29, 35 & 39
5 Ibid., Appendix B, ¶¶ 40–42
6 Ibid., Appendix B, ¶ 72
7 Ibid., Appendix B, ¶ 77
8 'Operational Driver' means that I was allowed to drive ambulances with patients in the back, but not under response conditions.
9 Ibid., Appendix B, ¶¶ 33–34 & 41.
10 Ibid., Appendix B, ¶ 63.
11 Ibid., Part 3, Section 3.5 (p 26) and Appendix B, ¶¶ 71, 80, 87, 100 & 117.

- **Information Not Shared with Crews** – Whilst working for NHS ambulance services, SJA crews were denied access to trust Standard Operating Procedures (SOPs) and other such documents.[12] Action was then taken against me for alleged failure to follow such protocols, which I had no way of accessing.[13]
- **Pairing of Inexperienced Crews** – On my third shift (Apr 3) I was paired with an equally-inexperienced crewmate; we commented that it was strange that they had put such a 'virgin crew' together.[14] Later (Apr 16), I was informed by an Ambulance Unit Manager that I would only be paired with experienced crewmates from then on.[15] It became clear that this was not the case on Apr 29 when, after I had to intervene to stop my crewmate from harming a patient during a routine patient transfer, I learnt that they had only been crewing for a week.[16]
- **Failure to Support –** During my fourth shift (Apr 4) I struck a traffic calming measure with an ambulance, sustaining some cosmetic damage; I reported this to the best of my ability.[17] Unbeknownst to me, my crewmate brought this to the attention of their Ambulance Unit Manager the next day, who secretly investigated me for an undisclosed length of time.[18] In his investigation report he concluded that 'BG has demonstrated a lack of ability to drive, mostly based down to confidence and exposure – however as patients and crew-mates have picked up on this, BG needs ongoing support...It is unclear if all of the COVID-19 Driver Training competencies have been met for the category of 'new driver', however having informally spoken to [the Regional Driver Training Lead (I assume)] – I understand there are pressures on the organisation and that at present it is impossible for BG to undertake an operational driving course, which he needs. But BG would benefit from some 1-to-1 tuition from a driver trainer or a more experienced colleague.'[19] This assessment was echoed by at least one former crewmate who provided a witness statement for the investigation.[20] No action was taken and no support was provided. I did not find out about the concerns raised or that the investigation had even happened until Jun 30,[21] and I did not receive a copy of the investigation report until Jul 14.[22]

At the time, I believed that these decisions were being made by people senior to me who knew better, and who would have thoroughly assessed the risks presented by them. I believed that, in light of the pandemic, imperfect solutions would have to be tolerated, but that as long as I was consistently open about my skills and shortcomings the powers-that-be would be able to make informed decisions about how best to safely utilise me, and that when inevitable issues arose and errors occurred they would be dealt with fairly.

I know now that this was entirely wrong. There was no joined-up thinking, no risk assessment, no informed decision-making. SJA was interested only in fulfilling its ambulance requirement, staff and volunteers be damned. I did what I felt was my duty, and was later punished for this.

12 Ibid., Appendix B, ¶ 97; see also minutes of appeal hearing, in which my accompanying colleague brought up the fact that he had also tried to access these documents and had been denied.
13 Ibid., Appendix B, ¶¶ 215–216 & 356
14 Ibid., Appendix B, ¶ 46
15 Ibid., Appendix B, ¶ 64
16 Ibid., Appendix B, ¶¶ 83–86
17 Ibid., Appendix B, ¶ 49
18 Ibid., Appendix B, ¶¶ 54–56
19 See MSY Investigation Report
20 See attached report, Appendix B, ¶¶ 304–307 & 318
21 Ibid., Appendix B, ¶¶ 275 & 277
22 Ibid., Appendix B, ¶¶ 352–355

Concern 2 [FAO Charity Commission only]

On May 23 I was informed that I was suspended from clinical activity pending an investigation into clinical concerns that had been raised.[23] This concluded with my dismissal on Jul 23, just under nine weeks later.[24] I appealed the decision, and my appeal was rejected on Aug 25 (i.e., just over thirteen weeks on from the initial suspension).[25]

Specifically, during my investigation I:

- was not told the initial allegations against me in a timely manner;[26]
- was not provided with any form of support during the full 13 weeks;[27]
- was denied permission to record my hearings, despite showing that the written minutes of previous hearings were inaccurate;[28]
- did not receive minutes of my Jul 16 disciplinary hearing until the rejection of my appeal (on Aug 25, i.e. almost six weeks later),[29] at which point they were unsurprisingly revealed to be inaccurate;[30]
- had evidence routinely withheld from me, and had to get the then-Freedom to Speak Up Guardian and the Director of Governance involved in order to get (some of) it shared;[31]
- had new allegations pile up without being informed (to a grand total of 13, including one of document falsification—a criminal offence),[32] only for them to be almost all abandoned (again without me being informed);
- had a crewmate told that they were not allowed to provide a positive reference for me;[33] and
- was punished for refusing to delete evidence of this misconduct.[34]

During this period it became clear that:

- the SJA investigatory process, as written, is fundamentally unsound and harmful;[35] and
- in my particular case (and probably others), that process was not being correctly followed anyway.

The first point threatens the welfare of all SJA staff and volunteers. I am not sure, however, if the second point is a similarly widespread problem, or if it was limited to my own experience and therefore outside the scope of your remit.

I can think of three possible explanations for what I experienced. Either:

- those entrusted with the handling of investigations are incompetent and do not know their own procedures (i.e., this is an organisation-wide issue that demands your attention);

23 Ibid., Appendix B, ¶ 137
24 Ibid., Appendix B, ¶¶ 393–394
25 Ibid., Appendix B, ¶¶ 443–444
26 Ibid., Appendix B, ¶¶ 141, 143, 145–148, 157, 159–161 & 163–169
27 Ibid., Appendices I & K
28 Ibid., Appendices J & B, ¶¶ 177–178, 184–185, 291, 308–310, 321 & 414–415
29 Ibid., Appendix B, ¶¶ 438 & 443
30 Ibid., Appendix J
31 Ibid., Appendix B, ¶¶ 206, 244–246, 263, 268–276, 302, 324, 340, 345–347, 351, 360–362, 374–379, 384–386, 388 & 427
32 Ibid., Appendices I, K and B, ¶¶ 275–280
33 Ibid., Appendix B, ¶¶ 282–283
34 Ibid., Appendix B, ¶¶ 368–369, 374–379 & 394
35 Ibid., Parts 1–4 and Appendices F–G

- those entrusted with the handling of investigations have access to a separate set of procedures that are different to those accessible by other staff and volunteers (i.e., this is an organisation-wide issue that demands your attention); or
- those handling my investigation had an ulterior motive and ignored their own procedures in order to achieve it (i.e., this is unique to my experience only, but nonetheless demands your attention).

Personally, I lean towards the third explanation. I simply cannot fathom that mere incompetence could be so pernicious and widespread, and so I believe it is more likely that I was unfairly dismissed in order to absolve SJA of responsibility for their errors. This feeling was reinforced by the Head of Volunteering's appeal outcome letter, which explicitly attempted to blame me for SJA's irresponsibility (in direct contravention of SJA's *Volunteer Charter*, amongst other things).[36] As a volunteer, I have no recourse to anything like an employment tribunal, so this makes a certain sense.

7. What impact does it have on the people the charity helps, its assets, services, staff or reputation?

As a result of concern #1:

- SJA volunteers were placed in an unsafe position by those who had a responsibility to safeguard them;
- SJA assets (e.g., ambulances) were put at risk;
- patients were put at risk of further harm from inexperienced crews; and
- members of the public were put at risk of harm from inexperienced crews.

As a result of concern #2:

- SJA volunteers are placed at risk of significant harm during investigations; and
- SJA volunteers are placed at an unfair disadvantage in the event of allegations being made against them (especially vexatiously, as I believe was the case for me);
- I believe that SJA have demonstrated a refusal to accept responsibility for their actions and have attempted to pass this on to the same volunteers that they had put at risk; therefore
- in the event of a 'second wave' of coronavirus (or other, similar event) placing a significant demand on the charity, I believe they will do the same thing again unless they are held to account now.

8. Have you followed your charity's complaints procedure or raised it with the charity's trustees? What was the response? If you have not raised it with your charity, please explain why not.

On Jun 10 I first contacted the then-Freedom to Speak Up Guardian, who I remained in contact with until he left the organisation on Jul 10.[37] From then I was in contact with the Director of Governance, who took over the Guardian role.[38] Both assisted me in getting evidence that was being withheld shared, and the Director of Governance accompanied me to my disciplinary hearing on Jul 16[39] and provided a witness statement during my appeal.[40]

On Jul 7, I raised my concerns to the CEO and the Director of People & Organisation and asked to have the allegations against me assessed by another Region, as I did not feel I could trust the North

36 Ibid., Appendix K
37 Ibid., Appendix B, ¶¶ 199, 203, 258, 261, 273–275, 289, 309 & 322–323
38 Ibid., Appendix B, ¶¶ 338–341 & 345
39 Ibid., Appendix B, ¶¶ 367, 371, 375, 378 & 383
40 Ibid., Appendix B, ¶¶ 413, 419, 424 & 427

Region.[41] The Director (on behalf of the CEO) did not talk to me, instead talking only to the then-Freedom to Speak Up Guardian and the Regional HR Manager (who was one of the people I had concerns about).[42] The Director concluded that I had been 'fast-tracked through...training' and that 'the organisation has [not] handled this particularly well', but otherwise dismissed my concerns and told me to continue with the process.[43]

During the investigation, at the urging of a colleague, I raised my concerns to the Head of Volunteering, who told me to continue with the process.[44] After my dismissal I appealed, on all four grounds that were available to me, to that same Head.[45] She dismissed my appeal on all four grounds.[46]

After my appeal was rejected I informed the Director of Governance and submitted the attached report to him. He told me that my case had given him 'a number of points to raise about the process, not least encouraging the use of recording of formal meetings' and apologised for 'what [I] have had go through'.

I believe that the Director of Governance will genuinely attempt to do his best (at least in terms of Concern #2), but having previously had my concerns dismissed by his fellow-Director I do not much fancy his chances. In terms of Concern #1, though, nobody has been held accountable except for me. I do not know if I am alone in this or if other volunteers have been similarly exploited and thrown under the bus, but it is clear to me that the only thing that will cause SJA to accept responsibility and make real change is external scrutiny from yourselves, and the possibility of consequences.

9. Have you contacted other organisations, like the police or HMRC? Include reference numbers, the name of who dealt with it, and their response if you have.

I discussed my concerns with Protect on Sep 21. They agreed that the Charity Commission and CQC were the appropriate bodies to raise them to, and clarified that I still had the right to raise concerns as a volunteer. They also clarified what evidence I could share.

10. Do you give permission to us to reveal your identity to the charity's trustees?

Yes. The CEO already knows my identity as I raised my concerns to him on Jul 7. Also, if you decide that my concerns have merit and action should be taken, I have one personal point to add: I would like to submit a request for a formal, written apology from the organisation.

11. If you attach evidence to your email, how is it relevant to your concern?

As mentioned above, I have attached a report I produced about my experiences and have referenced it repeatedly in this letter. In addition, I have copies of all correspondence with SJA personnel, evidence, investigation reports, etc. referenced in the report. Please see attached report, Appendix L for more information; I will be happy to provide any further evidence you require.

Yours faithfully,
Ben Goldsworthy
2020-09-23

41 Ibid., Appendix B, ¶ 311
42 Ibid., Appendix B, ¶ 314
43 Ibid., Appendix B, ¶¶ 325–327
44 Ibid., Appendix B, ¶¶ 288 & 294
45 Ibid., Appendix B, ¶¶ 398–444
46 Ibid., Appendix K