

Voting Accessibility Audit 2024

Findings report on the experience of Clinically Vulnerable voters at the July 2024 General Election

July 2024

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Executive Summary

1. This report sets out the findings of Clinically Vulnerable Families' (CVF) Voting Accessibility Audit, gathering evidence from Clinically Vulnerable voters across all four UK nations during the July 2024 General Election. It builds on advocacy work earlier in the year, including a trial by Eastleigh Borough Council at the May 2024 local elections, and sets out the evidence base for the reasonable adjustments we believe are needed to make voting safe for Clinically Vulnerable people.
2. The introduction of voter ID requirements created a new barrier for Clinically Vulnerable voters who wear a mask or respirator for health reasons: being asked to remove it, even briefly, to be identified indoors. For many, this is not a minor inconvenience but a direct exposure to a health risk they have otherwise carefully managed.
3. 80 Clinically Vulnerable people responded to our audit. The findings show that where simple adjustments, such as an outdoor identity check, are offered and properly implemented, they work well and are valued by voters and, in several cases, by polling staff themselves. But implementation was inconsistent, even within areas that had already agreed to trial these adjustments, and a significant minority of respondents were pressured, refused, or made to feel unwelcome for asking.
4. CVF does not consider these adjustments to be exceptional. They are analogous to provisions already made for other voters: ramps, privacy screens for veil removal, sign language interpreters, and extended voting hours. We believe they are required under the Equality Act 2010 and the Public Sector Equality Duty, and are both feasible and, in several cases in this audit, already working well where adopted properly.

Background

5. Clinically Vulnerable people are those whose health conditions place them at significantly elevated risk of serious illness from infection. Many continue to wear a well-fitting mask or respirator (commonly FFP2 or FFP3) in indoor public spaces, in line with ongoing clinical advice, even as this practice has become less common in wider society.

6. The introduction of photographic voter ID at UK Parliamentary elections meant that, for the first time, Clinically Vulnerable voters could be asked to remove a mask indoors, in a crowded polling station, in order to exercise their right to vote. Some members of our community, unable or unwilling to accept that risk, moved to postal voting; others were turned away or chose not to vote at all.

7. Ahead of the May 2024 local elections, CVF began engaging directly with local authorities and the Electoral Commission on this issue. Eastleigh Borough Council trialled a set of adjustments for Clinically Vulnerable voters, including outdoor identity checks. We consider this trial a significant and positive first step, and it is discussed further below, but it also illustrated that adjustments agreed in principle are not always delivered consistently in practice.

8. Following that trial, and ahead of the July 2024 General Election, CVF ran a national survey inviting Clinically Vulnerable voters and their household members across all four UK nations to record their experience of voting: whether adjustments were offered, how staff responded, and what the indoor air quality was actually like. This report sets out what they told us.

The Eastleigh trial: a case study in inconsistent delivery

9. Ms Andrea Barrett, a CVF member, was unable to vote at the May 2023 local elections because she was not able to demask indoors. At the May 2024 elections, Eastleigh Borough Council had introduced staff training, outdoor identity checks, and CO2 monitors, and Ms Barrett was able to vote using the outdoor check. However, staff did not wear the mask that had been provided for them, and ventilation had not been addressed as she had requested: doors and windows had not been opened, and the CO2 monitor, though photographed outside the front door, still read 1,113ppm, indicating poor ventilation inside.

10. A second CVF member voting in the same trial area reported a different experience. A polling official initially asked her to lower her mask rather than proactively offering the agreed adjustment; she had to request it herself. Once she did, the official smiled, put on a mask, and carried out the check outdoors. Ventilation at this polling station was markedly better: 516ppm, close to the 421ppm measured outdoors at the same time.

11. Taken together, these two accounts, from the same trial, in the same council area, show both that these adjustments are genuinely workable and that their delivery depends heavily on how well individual staff have understood and adopted them. This inconsistency, even where a council has actively agreed to trial reasonable adjustments, is a theme that recurred throughout our wider audit.

The July Audit: What We Found

12. 80 Clinically Vulnerable people responded to our audit at the July 2024 General Election: 68.8% voted in England, 20.0% in Scotland, 6.2% in Northern Ireland, and 5.0% in Wales.

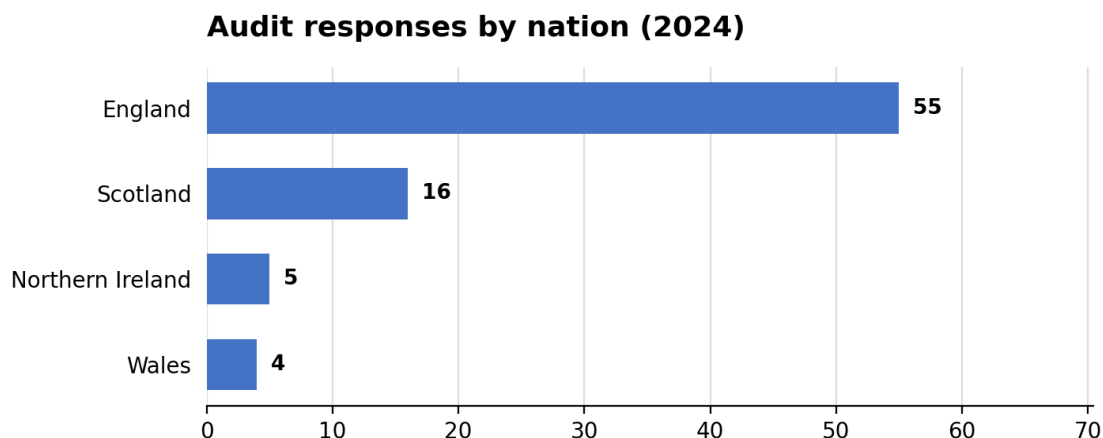


Figure 1. Geographic coverage of the audit by nation (2024 General Election, n=80).

Ventilation and air quality

13. Ventilation was inconsistent. Among 77 respondents, a front door was propped open at 79.2% of polling stations, but windows were reported closed at 35.1%, and only 10.4% reported two or more windows open. Mechanical ventilation was reported present and in use at only one polling station (1.3%). No respondent reported seeing an air filter in use.

14. Of the 14 respondents who measured CO₂ levels themselves, half (50.0%) recorded under 600ppm, indicating good ventilation. But over a third recorded levels of 800ppm or above, and one respondent recorded a reading between 1,000 and 1,500ppm.

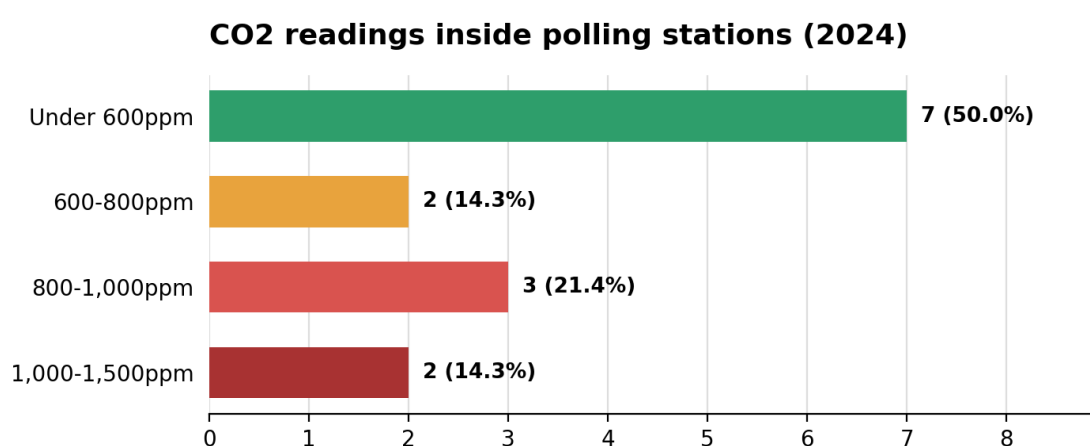


Figure 2. Indoor CO₂ readings recorded by respondents (2024, n=14). Bands reflect those used in the original survey.

15. Several respondents who did not bring a monitor described stuffy, poorly ventilated spaces regardless.

"It was warm and stuffy, no ventilation at all, no masks worn by anyone other than our family (we're vulnerable)." — Clinically Vulnerable respondent

"Windows all shut and the heater was on!!!!???" — Clinically Vulnerable respondent

Being asked to remove a mask indoors

16. Of 73 respondents who answered this question, 42.5% were asked to remove their mask indoors for identification. A further 34.2% were able to have their mask checked indoors without being asked to remove it.

17. Where a respondent was asked to demask, 58.1% asked for, and received, an outdoor check instead. 35.5% had their identity checked indoors after removing their mask. One respondent asked for an outdoor check, was refused, and removed their mask; one respondent refused to remove their mask and, as a result, did not vote.

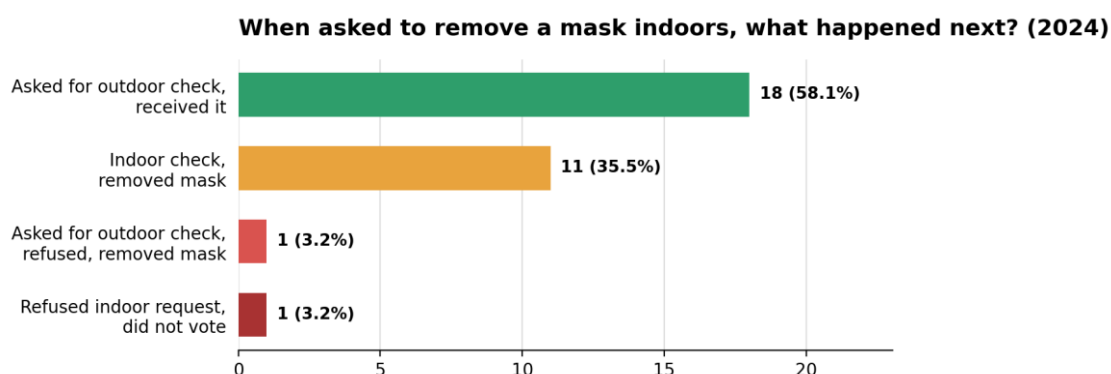


Figure 3. Outcomes for Clinically Vulnerable voters asked to demask indoors for ID checks (2024, n=31). Only the outdoor-check outcome avoids indoor mask removal.

18. For most respondents whose identity was checked indoors, the mask came off only briefly. Of 47 respondents, 70.2% were identified with their mask still on; a further 25.5% removed it briefly at the point of the check. This suggests that, in the great majority of cases, staff were able to confirm identity without requiring a lengthy or complete unmasking, when they were willing to try.

Outdoor checks: what worked, and what didn't

19. Where an outdoor check took place, staff did not wear a mask themselves in 79.2% of cases, even though several respondents described this being offered or provided. In 29.2% of cases, staff maintained a distance from the voter, and in a further 29.2% the check took place away from other people, both adjustments that respondents generally welcomed.

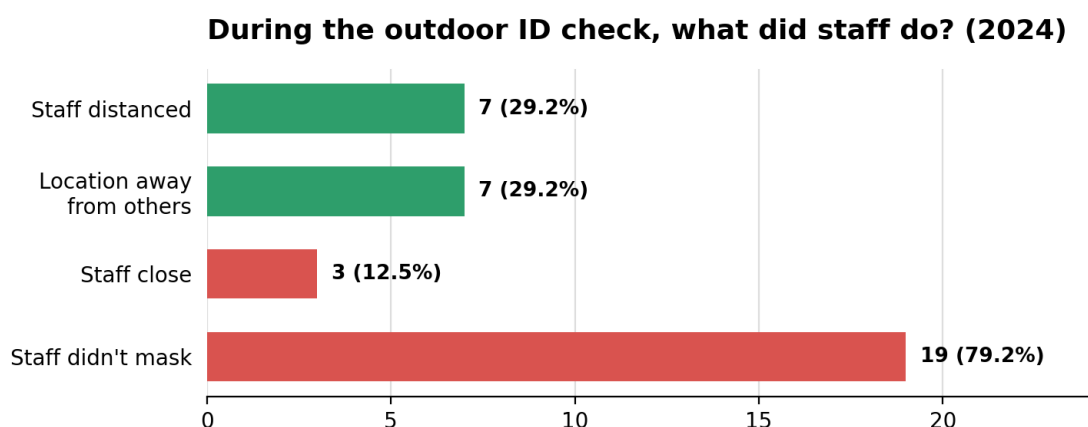


Figure 4. Reported staff behaviour during outdoor ID checks (2024, n=24). Categories are not mutually exclusive.

20. Several respondents described genuinely positive experiences once an outdoor check was agreed, including cases where staff accommodated the whole household after the reason was explained, and one respondent checked just outside the door on a windy day who was simply "OK with that."

"Staff were very understanding and nice about me showing ID outside. I masked inside."
— Clinically Vulnerable respondent

21. Others faced real resistance. One respondent was offered a "private room" instead of an outdoor check, and had to explain why this was unsafe and insist. Another described staff who initially refused, saying they were not allowed to leave the building, before eventually relenting.

"I had to refuse three times and ask to go outside... He remained unmasked. No ventilation."
— Clinically Vulnerable respondent

22. One respondents' account illustrates the cumulative toll of this resistance on health and wellbeing, not just inconvenience. One respondent described being left with post-exertional malaise (PEM) after the experience.

"Staff made me feel like an enormous inconvenience and feelings I don't have words for: I burst into tears as I voted. It was a horrific experience, and I am a woman who loves to vote."
— Clinically Vulnerable respondent

"I found the experience of trying to vote safely and protect my disabled and clinically vulnerable self-traumatising, because of the way staff treated me. I cried whilst voting and for hours afterwards. I have PEM today because of the negative experience."
— Clinically Vulnerable respondent

23. At least one respondent was told they could not vote unless they removed their mask, with no accommodation offered.

"They told me I couldn't vote unless I removed my mask and I had no choice... They were so rude it was so anxiety provoking."

— Clinically Vulnerable respondent

24. One account raises a wider concern about how consistently staff apply their own safety judgement. A respondent whose outdoor check was initially refused found staff suddenly willing to accommodate her once she mentioned she currently had Covid.

"The irony that they weren't bothered about protecting me but then when they thought they had to protect themselves they did."

— Clinically Vulnerable respondent

Contact with Returning Officers in advance

25. A number of respondents contacted their Returning Officer ahead of voting, with mixed results. Several received clear, practical assurances; one Returning Officer's response, shared in full by the respondent, set out exactly what could and could not be accommodated, including an outdoor identity check and staff distancing, while being honest that staff masking and testing could not be required. The respondent who received this reply described it as reassuring and specific, and it appears to have directly shaped a positive experience on the day.

26. Others received only an automated response, or no acknowledgement of the specific adjustments requested. One respondent's advance request was met, by their own account, with a phone call in which they were "abused." Several respondents did not contact their Returning Officer in advance at all, either because they did not know they could, or because they simply planned to mask as they would for any indoor public appointment. Where staff simply lacked awareness of these issues, goodwill alone could still produce a reasonable outcome, as one respondent found, but voters should not need to educate staff on the day in order to be accommodated.

"I asked if they were aware of the discussion around clean air and masking and they said no, they hadn't heard anything, but were very positive and said they would now open a window."

— Clinically Vulnerable respondent

Wider accessibility issues

27. Although outside the primary focus of this audit, several respondents raised broader accessibility barriers that intersect with the concerns of Clinically Vulnerable voters, including unstable ramps, heavy doors requiring two people to open, polling stations inaccessible to wheelchair users, and unclear guidance on eligibility for a signature waiver. CVF supports the principle that polling stations should be accessible to all disabled voters, and raises these findings for completeness alongside our primary recommendations.

Reasonable Adjustments Framework

28. Drawing on this evidence, and on clinical and ventilation guidance, CVF has set out the following adjustments, in three phases, which we believe are both necessary and achievable for polling stations to keep Clinically Vulnerable voters safe.

Timeframe	Key measures
Short term	• Staff sensitivity training on masked voters - Outdoor ID checks offered as standard for mask wearers • ID-checking staff to test negative and wear an FFP2-minimum mask and maintain distance • Improve natural ventilation by opening doors and windows • Monitor CO2 as a proxy for rebreathed air (below 700ppm suitable, above 800ppm a limit)
Medium term	All short-term measures, plus: • Air filtration to ensure a minimum of 6 air changes per hour • Revised CO2 thresholds where HEPA filtration is operating (below 800ppm suitable, above 1,000ppm a limit)
Long term	All short- and medium-term measures, plus: • Permanent ventilation systems providing a minimum of 13.5 litres/second/person of clean air • Annual maintenance of air filtration

29. We recognise that not every measure is achievable at every polling station immediately. The short-term measures above require no capital investment and are, as this audit shows, already achievable: several respondents in this audit experienced exactly this combination of an outdoor check, a distanced and masked member of staff, and open doors, delivered well.

Recommendations

30. Make outdoor identity checks standard practice, not a special request.

Several respondents in this audit only received an outdoor check after specifically asking, and in some cases insisting. This should be offered proactively to any masked voter, not left for the voter to request and justify.

31. Ensure Returning Officer guidance reaches polling station staff.

Eastleigh's trial showed that agreeing to adjustments centrally does not guarantee consistent delivery on the day. Advance assurances given to individual voters, such as the example in paragraph 25, should be matched by generic guidance and training given to all polling station staff, so that no voter needs to explain their situation from first principles at the point of voting.

32. Provide masks to staff conducting identity checks, and support their use.

Masks were reported provided but not worn at more than one polling station in this audit. Provision alone is not sufficient without staff being supported and expected to use them for this specific interaction.

33. Staff masking should be a Public Sector Equality Duty matter, not a courtesy.

Guidance should recommend that staff reciprocate masking on a "see a mask, wear a mask" reflecting the Public Sector Equality Duty under the Equality Act 2010, not simply as good practice. It signals to Returning Officers and polling staff that reciprocal masking is part of meeting an existing legal duty toward Clinically Vulnerable voters, not a discretionary courtesy that can reasonably be set aside on the day.

34. Address ventilation as a matter of course, not voter request.

Doors and windows should be opened as standard practice at polling stations, rather than only in response to a specific request, with CO2 monitoring used to check this is effective.

35. Recognise this as a safety issue, not a privacy one.

As one respondent's polling station staff themselves noted, an outdoor identity check accommodates infection risk in a way that a private indoor room, still relying on the same shared air, does not. Guidance should reflect this distinction clearly.

36. Give voters clarity in advance.

Where a Returning Officer can confirm exactly what will and will not be accommodated, as in the example set out in paragraph 25, this measurably improves the voter's experience and confidence. This should be standard practice, not something dependent on which Returning Officer happens to reply.

Conclusion

37. This audit shows that safe, accessible voting for Clinically Vulnerable people is achievable. Where the adjustments set out in this report were properly delivered, voters described positive, even reassuring, experiences. But delivery was inconsistent, and for a significant minority of respondents, voting in person meant navigating resistance, confusion, or outright refusal, at real cost to their health and, in some cases, their sense of safety in a process every citizen is entitled to trust.

38. Clinically Vulnerable Families looks forward to working with the Electoral Commission, Returning Officers, and local authorities to ensure these adjustments become standard practice at every polling station, so that no Clinically Vulnerable voter is forced to choose between their health and their vote.

Methodology Note

39. This audit was conducted via an anonymous online survey, open to Clinically Vulnerable voters and members of their households, and promoted through CVP's community channels. 80 respondents completed the survey following the July 2024 General Election. Not all respondents answered every question; sample sizes are stated for each finding. Responses were self-selected rather than randomly sampled, and findings should be read as illustrative of real experiences reported to us, rather than as a statistically representative survey of the whole Clinically Vulnerable population.