extremely obese should enquire about mental health, parenting, development and psychosocial factors, and make appropriate referrals. Childhood obesity often indicates family distress and unmet need including important child mental health difficulties.

G495 INNOVATIVE TREATMENTS FOR CHILDREN: A SINGLE CENTRE REVIEW OF CLINICAL ETHICS COMMITTEE DISCUSSIONS

HL Turnham, T Radcliffe, J Brierley. *Paediatric Intensive Care, Great Ormond Street Hospital, London, UK*

10.1136/archdischild-2015-308599.448

Aims Lord Saatchi's proposed Medical Innovation Bill (MIB) has received widespread media and public interest. The Bill aims to encourage doctors to try novel treatments for those reaching the limit of standard therapy, promising protection from sanctions e.g. prosecution.

Innovative therapies (IT) are a relatively common undertaking in the rare and occasionally unique diseases encountered in children's hospitals, children are not discussed in the proposed Bill.

Brierley and Larcher proposed an ethical framework to review IT in children and we describe cases reviewed by our Clinical Ethics Committee (CEC) since introducing this approach.

Methods Tertiary paediatric hospital CEC transcripts regarding IT proposals 2011–14 reviewed.

Discussion In four years the CEC reviewed 13 IT cases, 6 were urgent and reviewed by rapid response committee. Proposals were presented by 11 different paediatric specialities - 9 single patient specific, 4 relevant to multiple patients.

The CEC consisted of at least one medical, one lay member and a member with a higher degree in medical ethics. A legal adviser attended 7 meetings and a member of the hospital spiritual team 8. Minimum of 5 CEC members at review (range 5–13). Families attended all single patient reviews.

In all cases in line with the framework medical teams justified the scientific basis for treatment (1) and provided second opinions of external specialists in the field (2). The clear informed consent to the specific proposal by the child and/or those with parental responsibility (3) were obtained, including full knowledge of alternative possibilities e.g. palliative care.(4) The entire local, and where relevant external referring, teams agreed this treatment was an appropriate course.(5) Wider issues such as burdens of treatment for the child and family as a whole (6) together with funding implications for treatment (7) and other resources e.g. PICU were also discussed. An explicit guarantee to disseminate the result of IT whatever the outcome from the team was made.

Conclusion Our CEC offers medical teams the opportunity to have innovative therapies reviewed by a multidisciplinary group using a published framework. Innovation is already happening and we are not persuaded the MIB is necessary, or protection from prosecution sensible.

G496 CARING FOR BODY AND SOUL – NAVIGATING RELIGIOUS OBJECTIONS BY MUSLIM PARENTS

[1]A Sabir, [2]A Yusuf, [1]BJ Muhammed. *[1]Paediatric and Neonatal Unit, Walsall Manor Hospital, Walsall, UK; [2]Psychiatry, Penn Hospital, Wolverhampton, UK*

10.1136/archdischild-2015-308599.449

Aim We present a 6 day old boy who suffered femoral arterial thrombosis. Parents are Muslim and disagree with the use of Heparin, as it contains pork-derived gelatine. We explore medico-religious conflict between Muslim parents and health-care professionals and how to navigate them.

Methods Male, born 38+2 weeks, NVD, 4.63 kg. Antenatal scans and serology were normal, despite maternal gestational DM (Insulin controlled). He was diagnosed with pulmonary hypertension and HOCM requiring mechanical ventilation for 5 days. Umbillical artery catheterisation inserted on D1, removed on D6 leading to femoral artery thrombosis.

Whilst awaiting emergency transfer to a surgical centre, Heparin was required but parents objected on religious grounds.

Results In the absence of suitable alternatives, we explored parent's ideas, concerns and expectations. Explaining the gravity of the situation, they still objected. Measures such as contralateral limb warming, volume expansion and GTN patches were insufficient. Seeking court approval to override the objection was under exploration and if the condition deteriorated Heparin was to be used without parental consent based on 'best interest'. Parents agreed to Heparin before this occurred. Surgery was averted and the clot resolved with Heparin infusion alone.

Conclusion Muslims come from many theological and legal backgrounds. Some view that unlawful material for consumption is unlawful for use in medicine, such as pork-derived gelatine. Many medicines contain such gelatine, e.g. Heparin, HepSaline flushes and Duoderm. When conflicts arise, the following can help as per the Hanafi legal school;

- Explore parents concerns, explain the situation sensitively. Involve chaplains and Muslim scholars.
- Consider an alternative if available, e.g. Mepitel for Duoderm.
- If no alternative is available or sufficiently effective then one can **use the product, as long as it is needed**, known to be effective (based on atleast high likelihood) and that this has been established by a qualified doctor who appreciates the ethical framework of Islamic law.
- Provide information as many Muslims lack knowledge of the facility present in Islamic law, e.g. a religious edict (fatwa) such as that written by Al-Azhar University for use of Duoderm or articles from reliable Islamic authorities; seekersguidance.org.

It is important for clergy and professionals to learn about Islamic medico-legal ethics.

G497(P) HUMAN PAPILLOMA VIRUS VACCINATION COVERAGE RATES IN 'LOOKED AFTER' YOUNG WOMEN – ANOTHER MARKER OF HEALTH DISADVANTAGE?

[1]D Beasley, [1]JA Harris, [2]H Hutchings, [1]PM Barnes. *[1]Department of Community Child Health, ABM University Health Board, Swansea, UK; [2]Centre for Health Information Research and Evaluation (CHIRAL), College of Medicine, Swansea University, Swansea, UK*

10.1136/archdischild-2015-308599.450

Aims Vaccination of young women against human papilloma virus (HPV) has important health benefits, not least in reducing lifetime cervical cancer risk. Young women who are 'looked after' are a vulnerable group, known to face disadvantage in several areas, including in relation to their health. Are we able to achieve HPV coverage rates in this group comparable to the general population in order to safeguard their future health? We set out to study this in our own Health Board area.

Methods We studied young women aged 12–18 years, 'looked after' by three Local Authorities co-terminus with our Health Board's geographical area, who by virtue of their age should have received a 3 dose HPV vaccination course. We compared vaccination coverage in this group, using their recorded vaccination status on the All Wales Child Health Database, with a cohort of young women who were not 'looked after', and who had completed academic year 9 and were resident in the same Health Board area, using NPHS Wales 'COVER' data. We statistically analysed differences observed. We established that ethical approval was not required to undertake this study.

Results Of 2555 young women who had completed year 9 and who were not 'looked after', 2308 had completed a 3 dose HPV vaccination course (90.3%). Of the 157 eligible young women 'looked after', 131 had received a comparable 3 dose vaccination course (83.4%). The difference was statistically significant (X^2 7.763, p 0.005).

Conclusion Our study of young women who should have completed a 3 dose HPV vaccination course highlights that those 'looked after' were significantly less likely to be vaccinated. We have identified yet another area of health disadvantage for this group which could have important consequences for their future health. Action is required to address this and our own recommendations will be discussed, in addition to what we see as the possible reasons for this difference. We suggest that HPV vaccination coverage rates in young women 'looked after' should be reviewed across the United Kingdom by those health professionals who work with this vulnerable group.

G498(P) ARE WE FAILING OUR CHILDREN AND OUR FUTURE? INTRODUCING MEDICAL STUDENTS TO CHILD HEALTH INEQUALITIES

B Morrissey, P Powell, J Moreiras. *Paediatrics, Whittington Hospital NHS Trust, London, UK*

10.1136/archdischild-2015-308599.451

Background and aims Huge inequalities exist in child health globally. Current under five mortality rates vary significantly between countries from 2.3 per 1000 live births in Singapore to 152.5 per 1000 live births in Guinea-Bissau. In the UK, children from poorer socio-economic backgrounds are more likely to be born small, die during their first year of life and die from an accident in childhood. We aimed to develop and evaluate a student-selected component (SSC) introducing medical students to inequalities in child health.

Methods The student-selected component (SSC) ran one afternoon a week for eight weeks. Students participated in four interactive workshops on topics around child inequality and attended a relevant paediatric clinic or service. Students completed a self-directed project exploring an area of possible inequality for children, produced a poster and gave a short presentation at the end of the SSC, which was assessed. We evaluated the SSC by e-mailing a structured questionnaire to all participants and analysed responses thematically.

Results Twelve second year students undertook the SSC. All 12 completed the post-programme questionnaire. Medical students gained the following from participating in the SSC:

1. An increased understanding of the inequalities that exist in child health. *"I was quite shocked at how large the differences were especially within the UK.*
2. Research and presentation skills.
3. An awareness of the need for effective interventions to reduce inequality and improve children's health. *"It's not just a matter of throwing money towards services for children but preventing the inequalities from happening in the first place."*
4. An increased motivation to see the situation improve. *"This has fired me up to want to do something about this in the future."*

Seven out of 12 students (58%) reported that doing the SSC had either confirmed or increased their desire to pursue paediatrics as a career. Three further students reported they had wanted to do paediatrics before doing the SSC.

Conclusions Introducing medical students to child health inequalities early on in their undergraduate training can have significant benefits, particularly in helping students to understand the broader social determinants of health, and encouraging more medical students to take up careers in child health.

G499(P) CHILD SAFETY AWARENESS IN MEDICAL STUDENTS: A NEED FOR THE LOLLIPOP LADY

[1]S Bali, [2]H Jacob, [2]C Fertleman. *[1]Paediatric Accident and Emergency Department, Chelsea and Westminster Hospital, London, UK; [2]Department of Paediatrics, The Whittington Hospital, London, UK*

10.1136/archdischild-2015-308599.452

Aims Advocating to improve child safety, as part of child health promotion, is integral to the role of all doctors working with children. Many general practitioners and doctors in training shy away from providing such advice to families because they lack the knowledge, missing important opportunities to prevent accidents in children. Variation in postgraduate rotations make medical school an ideal time to learn about child safety, a practice followed in the United States of America.

Our study explored medical students knowledge, skills and attitudes towards providing guidance about child safety.

Methods We sent a survey to all medical students undertaking their paediatric placement at one teaching hospital between 2012–13. We asked them if they felt comfortable giving advice about preventing sudden unexpected infant death, drowning and choking as well as cardiopulmonary resuscitation (CPR) and first aid. We also enquired from them about the commonest causes of death in children under five and the risk factors for accidental deaths in children.

We collected the data using SurveyMonkey™ software and analysed it using Microsoft Excel™.

Results 82 students were approached, 49(60%) responded. Most [32(65%)] felt uncomfortable giving parents advice about preventing sudden unexpected death in an infant, many [22 (47%)] about drowning advice and some [19(39%)] about preventing choking. 15(30%) felt uncomfortable giving parents advice about CPR and first aid. 27(55%) thought that accidents were a leading cause of death in children under five. 49(100%) learnt about child safety from personal experience while 26 (53%) learn about it from general practice or child health placements.