Neutral Citation Number: [2024] EWHC 2977 (KB)

Case No: QB-2019-001608

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/11/2024

Before :

MRS JUSTICE YIP

- -

Between :

Christopher Stephen Fraser	**Claimant**
- and -	
Ministry of Defence	**Defendant**

- -
- -

Aliyah Akram (instructed by **Hugh James**) for the **Claimant**
Andrew Ward (instructed by **Clyde & Co.**) for the **Defendant**

Hearing dates: 6th, 7th, 8th November 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 21 November 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE YIP

Mrs Justice Yip :

Introduction

1. The claimant, an Army chef, seeks damages for personal injury sustained during a cold weather survival course in January 2018.

2. The claim was brought as part of multi-claimant litigation concerning cold injuries alleged to have been caused in the course of military service. Pursuant to an agreement reached in relation to the generic issues (which agreement remains confidential between those party to it), a formulation was arrived at for resolving issues of liability and (if applicable) limitation, with causation and quantum to be determined in individual cases. It is agreed that the claimant should recover 90% of the damages assessed to be appropriate for the injuries which I find were sustained as a result of his exposure to the cold on that course.

3. It is admitted that the claimant sustained a small area of frostbite to his left ear. The primary question for my determination is whether he also sustained non-freezing cold injury (NFCI) affecting his hands. The defendant denies this and contends that any symptoms in his hands are constitutional and were not caused by the cold exposure.

Background facts

4. The claimant is now aged 39. He enlisted in the Army at the age of 16 and served between 2001 and 2013. After a period out of service, he re-enlisted in 2017. He has been engaged in catering throughout his service. Having trained as a chef, he has been promoted to the rank of sergeant and is currently a catering manager. He intends to remain in the Army until January 2029, when he will have completed his full service.

5. The claimant was born and brought up in Scotland, where winters were cold. He enjoyed outdoor activities and did not complain of the cold. During his Army service, he had been deployed overseas. He made no prior complaints about problems with his hands or cold sensitivity. He had not undertaken any cold weather training before the trip to Norway in January 2018.

The relevant cold exposure

6. While issues arose as to the claimant's reliability as a historian, there is no reason to doubt that his account at trial of the cold weather course is at least broadly accurate. (I note discrepancies about days of the weeks when cross-referenced with dates in records, but such were not material.)

7. The course lasted a week. The first three days were spent in a classroom. The group deployed into the field on the third night. They spent two nights sleeping in tents. On the final night in the field, the claimant slept in a shelter, constructed as part of the exercise. Conditions were extremely cold. I note that contemporaneous medical records describe temperatures in the minus 20s (presumably degrees Celsius). Having completed the field exercise, the claimant returned to the barracks, with his group. He had a hot breakfast and a drink of tea. He estimated that he was indoors for 30 to 40 minutes before his group was taken to complete another exercise, "the icebreaker

challenge". They travelled to the scene in a heated vehicle, a journey lasting about 5 minutes.

8. The icebreaker challenge involved skiing into water through a hole in the ice. The participant then had to remove the skis and his Bergen, pull himself onto the ice surface, state his name rank and number and ask for permission to exit. Once out, the task was completed by rolling in snow, receiving a shot of rum, then running to a heated tent to change into dry clothing.

9. I was provided with a video of the claimant completing the challenge. Once his turn came, he completed it in a couple of minutes. He was in the water for less than a minute. Before that, he had been required to wait on the ice. The ambient conditions were colder than the water. The claimant was wearing light clothing, undergarments and a thin white suit. He was eleventh in the queue of participants. Having seen the video and heard the claimant's evidence, I accept his estimate that he was out in the cold for 40 – 50 minutes before he entered the water. While waiting for his turn, the claimant intermittently did star jumps and 'finger flicks' in an effort to keep warm.

10. Having completed the challenge, the claimant returned to the barracks where he had a shower before resuming his normal duties in the kitchen. A blanket order was then issued for the chefs who had taken part to attend the medical centre. The claimant's medical notes show that he was seen that morning.

The claim

11. By his Particulars of Claim and Schedule of Loss and Damage, the claimant claimed to have suffered non-freezing cold injury to his hands and feet and frostbite injury to his left ear. He claimed that the symptoms in his feet resolved after about a year and that he continued to suffer symptoms of tingling, numbness and pain in his hands in temperatures below 10° Celsius. He contended he would remain sensitised to cold for life.

12. He sought damages for pain, suffering and loss of amenity; past and future loss of earnings (limited to loss of longer separation allowance on the basis he was restricted in deploying overseas in cold climates); future loss of earning capacity and the future cost of additional heating and warm clothing.

13. At trial, the claimant withdrew his claim that he had suffered injury to his feet. He also withdrew his claims for future loss of earning capacity and future heating costs. I note that the defendant does not assert that the claimant has been dishonest or that he has wilfully exaggerated his claim.

The evidence

14. I heard evidence from the claimant and his parents. That from the parents was limited. They confirmed that the claimant had not suffered problems with the cold in the past and that there was no relevant family history. Both parents recalled that the claimant told them he had sustained injury due to the cold in Norway and that after the exposure his hands would turn blue. His father said in his witness statement that the claimant still complains of his hands and feet becoming sore in the cold although in cross-examination, he said they did not really speak about such things during family visits.

The parents' evidence was lacking in detail and vague on dates. With respect to them, I do not think that Mr and Mrs Fraser's evidence added anything of significance to the evidential picture.

15. The claimant gave his evidence in a straightforward manner. In her closing submissions, Ms Akram highlighted entries in the claimant's personnel records which show that he is held in high regard by his superiors. It was not suggested by the defendant that he was an untruthful witness and I did not have that impression. However, there were inconsistencies in the various histories he gave to different people and at different times. The claimant's explanation for this was that the answers he gave depended on the questions asked of him. I did have the impression that the claimant was somewhat literal in answering questions and the manner in which questions were asked might account for some variation in how he responded. However, that cannot explain all the inconsistencies that were identified during the trial. Ms Akram conceded that the claimant would be regarded as a poor historian.

16. In those circumstances, I have had to look carefully not only at the claimant's evidence but also at the histories underpinning the expert opinions, particularly where they depend upon what the claimant has told the expert. Cross-referencing contemporaneous records is of particular importance in this case.

Documentary evidence

17. I had a substantial volume of written material, including generic reports prepared for the wider NFCI litigation, medical and scientific literature and the claimant's medical notes. I explained to the parties at the outset that I would only consider the material to which I was referred in the course of the trial. I have not read beyond that, and was not invited to.

The expert evidence

18. The following experts gave evidence:

    i) Mr Frank Cross, consultant vascular surgeon, called by the claimant;

    ii) Dr Colin Mumford, consultant neurologist, called by the defendant;

    iii) Professor Richard A. Watts, consultant rheumatologist, called by the claimant;

    iv) Dr Robert Bernstein, consultant rheumatologist, called by the defendant.

19. NFCI is a clinical diagnosis. It most commonly arises in military personnel and is rarely encountered (or at least rarely recognised) in normal NHS clinical practice. There has been limited high quality, peer-reviewed research in the area. Understanding of the condition continues to evolve. The pool of those with expertise in the condition is relatively small. The precise mechanism of injury is not currently known to medical science. However, it is generally understood to involve a combination of damage to small blood vessels and peripheral nerve injury. As such, there is a role for both vascular surgeons and neurologists in reporting on the condition.

20. Within the wider NFCI litigation, each side obtained generic reports in each discipline. Mr Cross was the vascular surgeon instructed on behalf of the claimants. His

counterpart was Professor Christopher Imray. Dr Mumford was the neurologist instructed by the defendants, with Dr Oliver Charles Cockerell reporting for the claimants. I have read the reports of Professor Imray and Dr Cockerell. Save for passages upon which the experts called at trial were cross-examined, I have not studied them in detail.

21. Each side elected to rely on one lead expert, the claimant selecting the vascular surgeon, Mr Cross and the defendant the neurologist, Dr Mumford. Although from different disciplines, Mr Cross and Dr Mumford considered and commented on each other's evidence and prepared a joint statement.

22. Mr Cross is no longer in clinical practice and has not undertaken clinical work since 2018. He now solely acts as a medicolegal expert. The majority of his work relates to NFCI and nearly all his reports are for claimants. Dr Mumford retired from NHS practice two years ago. He continues to do some private clinical work but mostly carries out medicolegal reporting. In the field of NFCI, his reports are for the defendant. Dr Mumford was challenged about his lack of clinical experience of NFCI. I considered his response fair and appropriate. Seeing patients with peripheral neuropathy was part of the "bread and butter" of his work as a general neurologist. Much of his work involved assessing a patient's history and identifying clinical features to make a diagnosis. Although Mr Cross had seen a few patients with NFCI outside medicolegal reporting, the point could be made that he is now somewhat removed from clinical practice. It was apparent that Mr Cross and Dr Mumford had both kept themselves informed about developments in the field of NFCI. Their professional backgrounds gave them relevant expertise. I was satisfied that each was suitably qualified to give an opinion in this case.

23. Mr Cross and Dr Mumford were each cross-examined on the basis that they displayed a lack of impartiality. I am satisfied that each of them understood their duty under Part 35 of the Civil Procedure Rules and sought to comply with it. Given that each had provided generic evidence for one side or the other, I did not find it surprising that they had continued to be instructed for claimants in the case of Mr Cross and for the defendant in the case of Dr Mumford. In itself, that did not prevent them giving objective evidence.

24. It is notable that the history obtained by Mr Cross differed from that obtained by the other experts in some material ways. It was also not consistent with the evidence given by the claimant at trial. In particular, Mr Cross described injury to the feet as well as the hands. He told me he obtained that history by asking at the start of his medical examination "Is it the hands and feet, or the hands or the feet?" He said that he always asked that question first by way of clarification. None of the other experts obtained a history involving symptoms in the feet, the medical records did not support such a history and the claimant did not maintain at trial that his feet had been involved.

25. Mr Cross described throbbing pain with tingling and numbness in the hands and feet during rewarming. Again, this was inconsistent with the history recorded by the other experts. In his witness statement, the claimant described loss of sensation and dexterity in his hands when changing in the heated tent. He expressly stated that he did not notice any symptoms to his hands, face or feet while in the shower afterwards, although he did say he had pain, tingling and throbbing in his hands by the time he went to the medical

centre. The contemporaneous records contain no reference to throbbing pain, tingling or numbness on rewarming.

26. In describing the history, Mr Cross made no mention of the claimant going inside and having a hot breakfast in between the field exercise and the icebreaker challenge. He accepted in cross-examination that he was probably unaware of that part of the history when he wrote his report.

27. All these factors, that is whether the feet were affected, the symptoms on rewarming and whether there had been a period of rewarming before the icebreaker challenge, have significance when considering the diagnosis. In my judgment, Mr Cross did not reflect sufficiently on the inconsistencies between the history he obtained and other sources of evidence. He also did not appear to reflect on the evidence he heard at trial. The main point of an expert medical witness being present while a claimant gives evidence is so that they have heard that evidence first hand and can weigh it in giving their opinion evidence. Mr Cross simply did not do that. He was asked about evidence the claimant had given about doing star jumps and about the length of time he was on the ice. Mr Cross replied with comments such as "I have no idea, you would have to ask him". The fact is the claimant had been asked in court in the presence of Mr Cross. Of course, any findings of fact remained for me not for the experts, but I would have expected Mr Cross to take on board what he had heard and to think about whether that altered his opinion in any material way. He did not give the impression of doing that. Rather, he appeared to be keen to uphold his history and to dismiss features that might in any way undermine what he has said in his report.

28. I do not mean to be unduly critical of Mr Cross. I recognise that even expert witnesses may find the experience of being cross-examined challenging and different people react in different ways to that. I have said that I was satisfied he sought to comply with his duty as an expert. However, I was left with some concern that he appeared very quick to discount factors that did not support the claimant's case and to stand by the history he had obtained even in the face of obvious contradiction.

29. Dr Mumford was more prepared to make sensible concessions in cross-examination. However, there were some respects in which his views on NFCI appeared to differ from the consensus of expert opinion. In January 2013, the Non-Freezing Cold Injury Review Group reported on the pathogenesis, diagnosis, management and impacts of NFCI ("the Montgomery report"). The report was commissioned by the military and its findings were incorporated in a Joint Service Publication (JSP539). Although not a peer-reviewed medical publication, it is apparent that the report's contributors had significant experience. It is reasonable to afford it some weight, recognising that the authors acknowledged that the pathogenesis of the condition remained uncertain and advocated further research. Dr Mumford dismissed some of the findings of the report such as the impact of sleep deprivation and nutrition and the effect of oscillating temperatures and repeated cold exposure.

30. It is fair to say that Dr Mumford was not at all dogmatic. He was willing to acknowledge the views of other experts. He was thoughtful in giving his evidence. Although it was his view that the climatic conditions to which the claimant was exposed did not support a diagnosis, he was prepared to say that he could put those concerns aside if there was a good clinical history to support NFCI. That was a significant, and in my view appropriate, concession. In short, my view of Dr Mumford's evidence was

that he was willing to accept that there was a range of opinion but that he adopted a narrower view of the criteria for diagnosis than many experts in the field.

31. I have kept these reservations in mind. I have also recognised the different perspectives brought by the experts' different professional disciplines. However, my decision is not based on an impressionistic view that one expert is generally to be preferred to the other. Rather, I have carefully analysed how the expert opinions fit with the other evidence in the case.

Summary of experts' positions

32. The following common ground can be found in the evidence given by Mr Cross and Dr Mumford at trial:

 i) The fact that the claimant suffered frostbite to his ear does not make it any more or less likely that he sustained a NFCI to his hands.

 ii) NFCI is a clinical diagnosis which depends on a reported history of exposure to cold, subsequent symptoms and signs compatible with NFCI and the exclusion of other underlying causative conditions.

 iii) The cold exposure during the icebreaker challenge alone would probably not have caused NFCI, although it is not impossible.

 iv) A good clinical history compatible with NFCI might allow any concerns that the cold exposure was insufficient to be put aside and permit a diagnosis.

 v) If the signs and symptoms of NFCI were not there, the diagnosis falls away.

 vi) The claimant now experiences colour changes in his hands and pain in his knuckles when exposed to the cold. He has experienced a worsening of symptoms in recent years. The colour changes and knuckle pain cannot be attributed to NFCI and the deterioration in symptoms is not consistent with the pattern of NFCI.

33. Mr Cross and Dr Mumford remain in fundamental disagreement as to whether the claimant suffered a NFCI to his hands. Mr Cross's opinion is that the combination of the field exercise and the icebreaker challenge amounted to sufficient cold exposure to potentially cause NFCI and that the condition can be diagnosed from the clinical history. He accepts that the condition was mild and has now largely resolved, leaving only a degree of cold sensitivity. The colour change, knuckle pain and deterioration in symptoms is due to something else.

34. Dr Mumford maintains that the claimant did not suffer NFCI. He relies on the absence of reported symptoms on rewarming. He believes it is significant that the claimant has never claimed to have had symptoms when rewarming with his hot breakfast after the field exercise. Dr Mumford takes the view that this demonstrates the claimant was uninjured at that stage and says that the exposure during the icebreaker challenge was "vanishingly unlikely" to cause a NFCI. He does not accept that the clinical history is consistent with NFCI and considers it more likely that the claimant has some other condition in his hands which accounts for the symptoms he now describes.

The rheumatology evidence

35. The parties' expert rheumatologists, Professor Watts and Dr Bernstein, were largely in agreement. They agreed that the recorded history and the history given to each of them was not consistent with a diagnosis of Raynaud's phenomenon, a constitutional condition diagnosed in the claimant by a military physician in 2019. They agreed though that the claimant did have constitutional acrocyanosis (blueness in the skin) for which there was no causal link to cold exposure. They could offer no rheumatological explanation for the knuckle pain. The claimant's medical history suggested he may be at risk for inflammatory arthritis but neither found evidence of arthritis on video examination.

The clinical history

36. I have carefully considered all the evidence and the submissions made on both sides. Having done so, what follows reflects my findings on the balance of probabilities.

37. The claimant had no history of problems with his hands and/or cold sensitivity prior to January 2018. He was a robust Scot who had experienced cold conditions before, albeit nothing as cold as the conditions in Norway.

38. The claimant became very cold during the field exercise but he did not have any symptoms in his hands before the icebreaker challenge. Whether or not he had time to fully get over the nighttime exposure, he did warm up while in the barracks. He had his breakfast, experiencing no symptoms on rewarming.

39. After standing on the ice in light clothing for around 40 minutes or more, the claimant became freezing cold. After the icebreaker challenge, his hands were so cold that he struggled to remove his wet clothing. He was shivering.

40. The claimant did not experience pain or throbbing or other symptoms on rewarming in the shower. He experienced relief on being in from the cold. He then resumed his duties in the kitchen before he was ordered to go to the medical centre as part of a blanket instruction. I accept that another chef had noticed that the tip of the claimant's ear had gone white. However, having considered the claimant's evidence and the contents of the contemporaneous records, I am unable to accept that he noticed colour change or other symptoms in his hands at that stage.

41. The note of the claimant's attendance at the medical centre at 9.27 that morning is significant. It records that the claimant complained of ear pain and of pain to his left index finger. It was thought that the finger pain was related to a jarring injury sustained while packing his Bergen with cold hands. The claimant's case is that by the time he was at the medical centre, he had also noticed colour changes in his hands and was suffering throbbing pain, tingling and numbness in his hands. I am unable to accept that. I readily acknowledge that medical records often omit details that might be thought material when analysed later. I accept that the literature shows that symptoms related to NFCI are not always properly recorded. Here though the claimant had been sent to the medical centre specifically due to concerns about possible cold injury. The recorded history is inconsistent with the claimant's case. Pain in one finger only was noted. The doctor clearly examined at least the left hand. He noted no other joint issues. He noted the claimant had been managing in the galley. He noted past medical

history that might have been relevant to joint pain. This was a thorough note and it is highly unlikely that other symptoms in the hands were reported but ignored.

42. Set against the medical record is the claimant's account at trial nearly 7 years later. Ms Akram realistically acknowledged in her closing submissions that the claimant was a poor historian. In his statement, the claimant described throbbing, tingling and numbness in his hands and feet but now accepts his feet were not injured.

43. I conclude that the claimant's evidence does not displace the clear inference from the medical records that he did not have symptoms in his hands (other than those relating to the injury to the left index finger) when he attended the medical centre. The only sign of cold injury at the time was the freezing injury to the ear.

44. On 19 March 2018, the claimant presented again with ear pain. He had experienced a recurrence while outdoors at a barbecue. He complained of sensitivity to the cold since returning from Norway. He said then that he had noticed his hands going purple in Norway. In May 2018, while being reviewed for the ear injury (which was by then much improved), he said he was getting purple discolouration in his knuckles. He had been put on light duties. In November 2018, he was medically downgraded on the basis of cold injury. It was noted he was awaiting an appointment at the cold injury clinic and that he had cold hands whilst doing PT.

45. On 22 January 2019, the claimant attended the cold injury clinic where he was diagnosed as having Raynaud's phenomenon in his hands, which was thought to be possibly age related, in which case it might get worse over the next few years. It was recorded that his sensation of hot and cold was normal, save that he reported that he could hold a hot pan for longer than he used to. The diagnosis of Raynaud's phenomenon was affirmed by the Medical Board on 24 January 2019 when making the claimant's medical downgrading permanent. Although the form recording the Medical Board's decision refers to the date of origin as January 2018 and the place of origin as Norway, it essentially repeats the history from the records and the information given to the board. It does not amount to any evaluation that the condition from which the claimant was then suffering had in fact come on in Norway in 2018.

46. On 12 June 2019, the claimant reported that he went for a run and his hands got cold. They were still numb and painful. On examination, the hands were cool and blue. He was reviewed in July 2019, when he said he still had some symptoms when preparing cold food.

47. Proceedings were issued in November 2020. Thereafter, the claimant had a telephone consultation with Dr Sarah Hollis (NFCI clinic) on 12 May 2022. Dr Hollis noted he had previously been diagnosed with Raynaud's phenomenon. His principal symptoms were purplish discolouration of the back of his hands with stabbing or throbbing pain in the knuckles which resolved on rewarming. Photographs showed sluggish circulation with discolouration. Dr Hollis concluded this was acrocyanosis and that the claimant had not sustained NFCI. However, as the advice for managing his symptoms was the same, she sent him information leaflets relating to NFCI. She explained there may be slow progression of symptoms over the years.

48. In giving evidence, the claimant said that his symptoms had deteriorated since 2019. He had begun to experience a tingly sensation in the backs of his hands in the period

2019 to 2023. He began to feel pain in his knuckles from 2021 or 2022. That pain seemed to be getting worse and overall his symptoms were a little worse than when he saw Dr Bernstein in July 2023 both in frequency and severity. The colour change was now more pronounced and spread further. He accepted he had told Dr Mumford in January 2023 that sometimes his fingers would go white. He also accepted that he may have said different things about his symptoms to different experts and at different times.

Conclusions on causation

49. In the course of her impressive closing submissions, Ms Akram conceded that the evidence did not support typical NFCI. She also acknowledged that the claimant's description of his symptoms had been variable but argued that it is recognised that there can be substantial variation in patterns of symptoms and signs within NFCI syndrome.

50. The strongest point made on behalf of the claimant was that prior to the Norway expedition in January 2018, he had never complained of any symptoms in his hands. From March 2018, he had begun to complain of problems affecting his hands and to report that they started in Norway. Although various alternative explanations have been suggested namely Raynaud's phenomenon and acrocyanosis (by treating clinicians) and a normal physiological response (Dr Mumford), none provide a full answer. Raynaud's phenomenon has now been discounted by the rheumatology experts and Dr Mumford withdrew the suggestion that there was nothing more than a normal physiological response, acknowledging "something was going on". Acrocyanosis is generally painless.

51. I recognise the findings of the Montgomery report that:

    i) NFCI is a clinical syndrome with a varying pattern of severity and time course.

    ii) It affects the lower limbs more frequently than the upper limbs and affects the digits more than the proximal limb.

    iii) Pain is present in the early stages in the vast majority of cases (but not all), and may persist.

    iv) Chronic sequelae are variable in occurrence, severity and duration.

    v) In less severe cases, increase in cold sensitivity may constitute the most troublesome residual complication.

52. There are a number of features that make it less likely that the claimant suffered NFCI, albeit none exclude the diagnosis:

    i) I have found that he did not have symptoms or signs typical of NFCI prior to going out for the icebreaker challenge and that he had rewarmed over breakfast before then.

    ii) The duration of exposure after rewarming was relatively short (albeit this does not exclude a NFCI particularly when considered in the context of the earlier cold exposure).

iii) No symptoms were noted on rewarming in the shower or when the claimant went to the medical centre.

iv) Only the hands were affected, not the feet. Statistically, NFCI is more usually seen in the feet.

v) The claimant's complaints relate to his 'hands' more than his 'fingers'. The digits are generally more affected in NFCI.

vi) There was no complaint about colour change in the initial entry in the medical records. Thereafter, he began complaining of colour changes from March 2018 and later still (from June 2019) he complained of pain.

vii) The colour change and the knuckle pain which the claimant now has cannot be attributed to NFCI.

viii) There has been a deterioration in the claimant's symptoms of discolouration and pain, which does not fit with the pattern of NFCI.

53. A finding that the claimant suffered NFCI to his hands depends on Mr Cross's expert opinion being accepted. It is agreed that a diagnosis of NFCI is heavily dependent on the clinical history. The history which underpinned Mr Cross's diagnosis was inconsistent with the history obtained by other experts, the medical records and my findings of fact.

54. Mr Cross was inclined to rely on his own "observations" in the course of medico-legal reporting as a basis for supporting his opinions. This appeared circular. For example, he relied upon having previously diagnosed NFCI in those with a history of relatively short cold exposure to support his opinion in this case. Mr Cross himself said about that "It's not very scientific, is it?" I agree with that. It is fair to note that the Montgomery report concluded that NFCI could possibly be caused by cold exposure of as little as one hour. However, Mr Cross's response suggested a degree of backward reasoning to support a diagnosis, rather than a proper weighing of all the evidence to consider what was likely.

55. That was also evident in his evidence that it was "almost certain" that the claimant had sustained damage prior to the icebreaker challenge. Pressed as to how he could say the claimant must have sustained some injury in the days before (during the field exercise), Mr Cross replied "Because he has got a NFCI". He acknowledged that duration of exposure was a relevant feature to consider. However, he effectively discounted its relevance by again working backwards. He first made the diagnosis of NFCI and then relied on that diagnosis to find an explanation that fitted. Dr Mumford was prepared to accept that a good, consistent clinical history of NFCI might allow for concerns about the duration of exposure to be overcome. However, I find that Mr Cross went beyond that. He took the diagnosis as a starting point and then stood by it, seeking explanations to overcome points that might counter a diagnosis of NFCI.

56. A similar stance was seen when it became apparent that Mr Cross had been wrong in describing injury to the feet. He ought at that stage at least to have considered how that impacted on his assessment. The way in which NFCI is properly diagnosed involved a weighing of factors for and against.

57. In the end, Mr Cross accepted that he had made the diagnosis of NFCI on the basis of the symptoms reported to him. The history he obtained does not properly reflect my findings on the evidence.

58. The claimant now has symptoms of colour changes and pain in his hands which have not been caused by NFCI. Those symptoms have deteriorated in recent years. They are not fully explained but appear to be due to one or more constitutional conditions. It may be coincidence that the claimant began to experience symptoms of the unrelated condition(s) around March 2018. It may be that having being exposed to the cold in Norway and having sustained a cold injury to his ear, the claimant became aware of things he had not previously noticed. It is not necessary to determine either way. The fact is that the clinical history, as I have found it to be, does not establish a pattern consistent with NFCI (even allowing for substantial variation as noted in the literature). In those circumstances, Mr Cross's diagnosis falls.

59. Having carefully considered how the expert evidence fits with all the other evidence and with the findings I have made, I prefer the conclusions of Dr Mumford that the clinical history and symptoms are not consistent with NFCI.

60. In those circumstances, I am not satisfied that the claimant has proved on a balance of probabilities that he suffered a NFCI affecting his hands.

Quantum

61. It follows from my finding on causation that the claimant is to be compensated for the freezing injury to his ear only. The parties agreed that, if that was my finding, he should recover only for pain, suffering and loss of amenity and that an appropriate award would be £5,000.

62. I consider that to be a generous sum given the evidence at trial about the minor nature of the ear injury. However, I readily accept that my recent experience of assessing awards for minor injuries is limited. Mr Ward fairly indicated that he did not think it appropriate to revisit the agreed sum. In the circumstances, I am content to adopt the agreed valuation, albeit without intending any judicial endorsement of that sum.

Conclusion

63. I have found that the claimant has not established on a balance of probabilities that he sustained NFCI affecting his hands. He is accordingly to be compensated only for the minor injury to his ear, in relation to which the parties have agreed quantum. I leave the parties to calculate the final sum after allowing for interest and the agreement on liability and invite them to attempt to agree an appropriate order dealing with any consequential matters. If anything remains in dispute, I will receive written submissions in the first instance.