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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

(Central Division)

LA COUNTY FREE FOUNDATION, A CALIFORNIA NON-PROFIT CORPORATION, AS AUTHORIZED AGENT FOR 683 FIREFIGHERS AND OTHER EMPLOYEES OF THE LOS ANGELES COUNTY FIRE DEPARTMENT, Plaintiff, vs. COUNTY OF LOS ANGELES, Defendant.	Case No.: 21STCV40499 Assigned to Hon. Lawrence Riff| Dept 51 **DECLARATION OF DR. PETER MCCULLOUGH, MD, MPH IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION** Date: May 4, 2022 Time: 9:00 am Dept: 51 Complaint Filed: Nov. 3, 2021

I, Dr. Peter McCullough, do hereby declare as follows:

1. I am over eighteen years of age. I am competent to give this sworn declaration. I understand that I am swearing or affirming under oath to the truthfulness of the claims made in this affidavit under penalties of perjury; that I have read these statements in this declaration.
2. These statements are my understanding of the facts underlying the opinions I render herein. My opinions provided are based on a reasonable degree of medical certainty.
3. I have been engaged by McBride Law PC to render testimony on behalf of plaintiff and its 683 members, including firefighters and other LA County Fire Department employees.

EDUCATION AND BACKGROUND

4. After receiving a bachelor's degree from Baylor University, I completed my medical degree as an Alpha Omega Alpha graduate from the University of Texas Southwestern Medical School in Dallas. I completed my internal medicine residency at the University of Washington in Seattle, a cardiology fellowship including service as Chief Fellow at William Beaumont Hospital, and a master's degree in public health in the field of epidemiology at The University of Michigan. I am board certified in internal medicine and cardiovascular disease and hold an additional certification in clinical lipidology, and previously echocardiography.
5. I participate in the maintenance of certification programs by the American Board of Internal Medicine for both Internal Medicine and Cardiovascular Diseases. I practice internal medicine and clinical cardiology as well as teach, conduct research, and I am an active scholar in medicine with roles as an author, editor-in-chief of a peer-reviewed journal, editorialist, and reviewer at dozens of major medical journals and textbooks.

CLINICAL TRIALS EXPERIENCE

6. I have led clinical, education, research, and program operations at major academic centers (Henry Ford Hospital, Oakland University William Beaumont School of Medicine) as well as academically oriented community health systems. I spearheaded the clinical development of in vitro natriuretic peptide and neutrophil gelatinase associated lipocalin assays in diagnosis, prognosis, and management of heart and kidney disease now used worldwide. I also led the first clinical study demonstrating the relationship between severity of acute kidney injury and mortality after myocardial infarction. I have contributed to the understanding of the epidemiology of chronic heart and kidney disease through many manuscripts from the Kidney Early Evaluation Program Annual Data Report published in the American Journal of Kidney Disease and participated in clinical trial design and execution in cardiorenal applications of acute kidney injury, hypertension, acute coronary syndromes, heart failure, and chronic cardiorenal syndromes. I participated in event adjudication (involved attribution of cause of death) in trials of acute coronary syndromes, chronic kidney disease, heart failure, and data safety and monitoring of antidiabetic agents, renal therapeutics, hematology products, and gastrointestinal treatments. I have served as the chairman or as a member of over 20 randomized trials of drugs, devices, and clinical strategies. Sponsors have included pharmaceutical manufacturers, biotechnology companies, and the National Institutes of Health.

LECTURES AND RELATED

7. I frequently lecture and advise on internal medicine, nephrology, and cardiology to leading institutions worldwide. I am recognized by my peers for my work on the role of chronic kidney disease as a cardiovascular risk state. I have over 1,000 related scientific publications, including the "Interface between Renal Disease and Cardiovascular Illness" in *Braunwald's Heart Disease Textbook*. My works have appeared in the *New England Journal of Medicine*, *Journal of the American Medical Association*, and other top-tier journals worldwide. I am a senior associate editor of the *American Journal of Cardiology*.
8. I have testified before the U.S. Senate Committee on Homeland Security and Governmental Affairs, the U.S. Food and Drug Administration Cardiorenal Advisory Panel and its U.S. Congressional Oversight Committee, The New Hampshire Senate, the Colorado House of Commons, and the Texas Senate Committee on Health and Human Services. I am a Fellow of the American College of Cardiology, the American Heart Association, the American College of Physicians, the American College of Chest Physicians, the National Lipid Association, the Cardiorenal Society of America, and the National Kidney Foundation; and I am also a Diplomate of the American Board of Clinical Lipidology.

AWARDS

9. In 2013, I was honored with the International Vicenza Award for Critical Care Nephrology for my contribution and dedication to the emerging problem of cardiorenal syndromes. I am a founding member of Cardiorenal Society of America, an organization dedicated to bringing together cardiologists and nephrologists and engage in research, improved quality of care, and community outreach to patients with both heart and kidney disease. I am the current President of the Cardiorenal Society of America,

an expert organization dedicated to advancing research and clinical care for patients who have combined heart and kidney disease.

EDITORIAL POSITIONS

10. I am the former Editor-in-Chief of *Cardiorenal Medicine*, a primary research journal listed by the National Library of Medicine which is the only publication with a primary focus on research concerning patients with combined heart and kidney disease. Finally, I am the current Editor-in-Chief of Reviews in Cardiovascular Medicine, a widely read journal that publishes reviews on contemporary topics in cardiology and is also listed by the National Library of Medicine.

COVID-19 CONTRIBUTIONS

11. Since the outset of the COVID-19 pandemic, I have been a leader in the medical response to the COVID-19 disaster and have published "Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection," the first synthesis of sequenced multidrug treatment of ambulatory patients infected with SARS-CoV-2 in the American Journal of Medicine and updated in *Reviews in Cardiovascular Medicine*. I have 52 peer-reviewed publications on the COVID-19 infection cited in the National Library of Medicine.
12. Through a window to public policymakers, I have contributed extensively on issues surrounding the COVID-19 crisis in a series of OPED's for *The Hill* in 2020. I testified on the SARS-CoV-2 outbreak in the U.S. Senate Committee on Homeland Security and Governmental Affairs on November 19, 2020. I testified on lessons learned from the pandemic response in the Texas Senate Committee on Health and Human Services on March 10, 2021, and on early treatment of COVID-19 at the Colorado General Assembly on March 31,

2021. Additionally, I testified in the New Hampshire Senate on legislation concerning the investigational COVID-19 vaccine on April 14, 2020.

13. My expertise on the SARS-CoV-2 infection and COVID-19 syndrome, like that of infectious disease specialists, is approximately 18 months old with the review of hundreds of manuscripts and with the care of many patients with acute COVID-19, post-COVID-19 long-hauler syndromes, and COVID-19 vaccine injury syndromes including neurologic damage, myocarditis, and a variety of other internal medicine problems that have occurred after the mRNA and adenoviral DNA COVID-19 vaccines.

14. I have formed my opinions in close communications with many clinicians around the world based on in part our collective clinical experience with acute and convalescent COVID-19 cases as well as closely following the preprint and published literature on the outbreak. I have specifically reviewed key published rare cases and reports concerning the possible recurrence of SARS- CoV-2 in patients who have survived an initial episode of COVID-19 illness.

COVID-19 VACCINE RESEARCH AND DEVELOPMENT

15. The COVID-19 genetic vaccines (Pfizer, Moderna, J&J) skipped testing for genotoxicity, mutagenicity, teratogenicity, and oncogenicity. In other words, it is unknown whether or not these products will change human genetic material, cause birth defects, reduce fertility, or cause cancer.

16. The Pfizer, Moderna, and J&J vaccines are considered "genetic vaccines", or vaccines produced from gene therapy molecular platforms which according to US FDA regulatory guidance are classified as gene delivery therapies and should be under a 15-year regulatory cycle with annual visits for safety evaluation by the research sponsors. FDA. Food and Drug Administration. (Long Term Follow-up After Administration of Human Gene Therapy Products. Guidance for Industry. FDA-2018-D-2173. 2020. Accessed July 13,

2021, at https://www.fda.gov/regulatory-information/search-fda-guidance-documents/long-term-follow-after-administration-human-gene-therapy-products.

17. The FDA has "advised sponsors to observe subjects for delayed adverse events for as long as 15 years following exposure to the investigational gene therapy product, specifying that the long-term follow-up observation should include a minimum of five years of annual examinations, followed by ten years of annual queries of study subjects, either in person or by questionnaire." (emphasis added) Thus, the administration of the Moderna, Pfizer, and J&J vaccines should not be undertaken without the proper consent and arrangements for long-term follow-up which are currently not offered in the US. (See, EUA briefing documents for commitments as to follow up: Moderna, Pfizer, J&J). They have a dangerous mechanism of action in that they all cause the body to make an uncontrolled quantity of the pathogenic wild-type spike protein from the SARS-CoV-2 virus for at least two weeks probably a longer period based on the late emergence of vaccine injury reports. This is unlike all other vaccines where there is a set amount of antigen or live-attenuated virus. This means for Pfizer, Moderna, and J&J vaccines it is not predictable among patients who will produce more or less of the spike protein. The Pfizer, Moderna, and J&J vaccines because they are different, are expected to produce different libraries of limited antibodies to the now extinct wild-type spike protein.

18. We know the spike protein produced by the vaccines is obsolete because the 17th UK Technical Report on SARS-CoV-2 Variants issued June 25, 2021, and the CDC June 19, 2021, Variant Report both indicate the SARS-CoV-2 wild type virus to which all the vaccines were developed is now extinct. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001354/Variants_of_Concern_VOC_Technical_Briefing_17.pdf; https://COVID-19.cdc.gov/COVID-19-

datatracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019 ncov%2Fcases-updates%2Fvariant-proportions.html#variant-proportions.

19. The spike protein itself has been demonstrated to injure vital organs such as the brain, heart, lungs, as well as damage blood vessels and directly cause blood clots. Additionally, because these vaccines infect cells within these organs, the generation of spike protein within heart and brain cells, in particular, causes the body's own immune system to attach to these organs. This is abundantly apparent with the burgeoning number of cases of myocarditis or heart inflammation among individuals below age 30 years.

20. Because the US FDA and CDC have offered no interpretation of overall safety of the COVID-19 vaccines according to the manufacturer or as a group, nor have they offered methods of risk mitigation for these serious adverse effects which can lead to permanent disability or death, no one should be pressured, coerced, receive the threat or reprisal, or be mandated to receive one of these investigational products against their will. Because the vaccine centers, CDC, FDA, and the vaccine manufacturers ask for the vaccine recipient to grant indemnification on the consent form before injection, all injuries incurred by the person are at their own cost which can be prohibitive depending on the needed procedures, hospitalizations, rehabilitation, and medications.

21. In general, it is never good clinical practice to widely utilize novel biological products in populations that have not been tested in registrational trials. For COVID-19 vaccines, this includes COVID-19 survivors, those with prior suspected COVID-19 infection, those with positive SARS-CoV-2 serologies, pregnant women, and women of childbearing potential who cannot assure contraception.

22. It is never good research practice to perform a large-scale clinical investigation without the necessary structure to ensure the safety and

protection of human subjects. These structures include a critical event committee, data safety monitoring board, and human ethics committee. These groups in large studies work to objectively assess the safety of the investigational product and research integrity. The goal is mitigating risk and protecting human subjects. It is my understanding that the COVID-19 vaccine program is sponsored by the CDC and FDA and has none of these safety structures in place. It is my assessment, that the COVID-19 clinical investigation has provided no meaningful risk mitigation for subjects (restricting groups, a special assessment of side effects, follow-up visits, or changes in the protocol to ensure or improve the safety of the program).

THE DELTA VARIANT

23. As of September 2021, the Delta variant of SARS-CoV-2 accounted for the 98.9% of present (https://covid.cdc.gov/covid-data-tracker/#variant-proportions) cases in the United Kingdom, Israel, and the United States.(Because of progressive mutation of the spike protein, the virus has achieved an immune escape from the COVID-19 vaccines with the most obvious example being Israel where indiscriminate vaccination achieved 80% immunization rates. This promoted the emergence of the Delta variant as the dominant strain by September, 2021. Because the Delta variant is not adequately covered by the Pfizer COVID-19 vaccine, >80% of Israeli COVID- 19 cases occurred in persons fully vaccinated. This confirms the failure of the vaccines against the Delta variant of COVID-19. Source: https://datadashboard.health.gov.il/COVID-19019/general

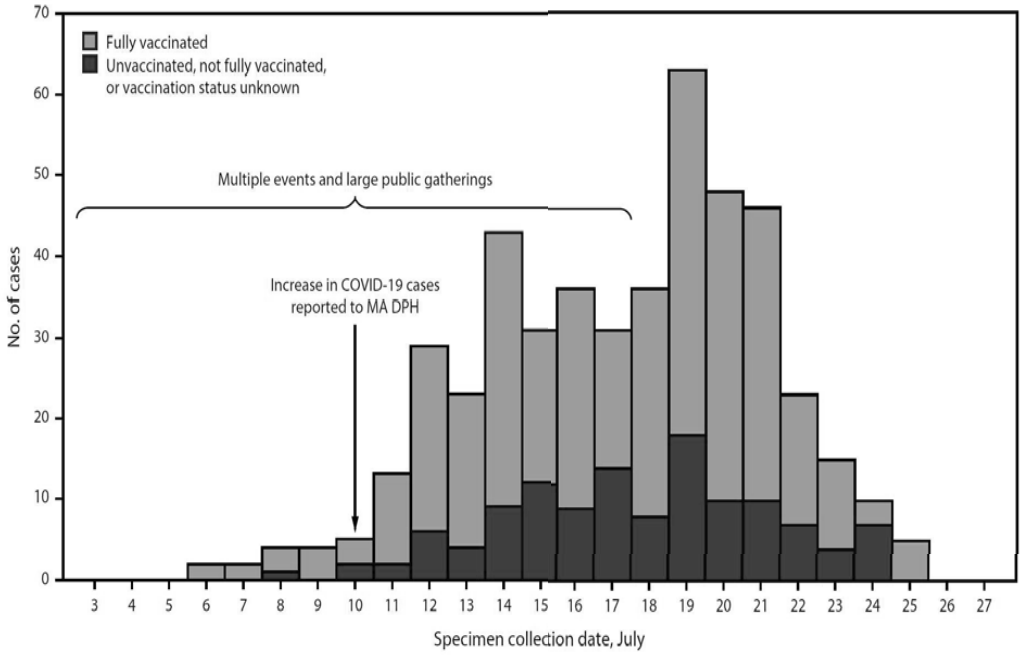
24. In the SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 17 25 June 2021, 92,056 cases had the Delta variant and 50/7235 fully vaccinated and 44/53,822 of the unvaccinated

died. This indicates that the fully vaccinated who contract the Delta variant have an 8.6-fold increased risk for death, (95% CI 5.73-12.91), $p < 0.0001$, as compared to those who chose to remain unvaccinated, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001354/Variants_of_Concern_VOC_Technical_Briefing_17.pdf

25. The CDC has published a report titled: "Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021" demonstrating complete failure of the COVID-19 in controlled spread of SARS-CoV-2 in congregate settings. My interpretation of this report is that the vaccines are not sufficiently effective to make the elective, investigation vaccine recommended for use beyond individual preference.
https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7031e2-H.pdf

See table immediately below.

FIGURE 1. SARS-CoV-2 infections (N = 469) associated with large public gatherings, by date of specimen collection and vaccination status* — Barnstable County, Massachusetts, July 2021



Abbreviation: MA DPH = Massachusetts Department of Public Health.
* Fully vaccinated was defined as ≥14 days after completion of state immunization registry–documented COVID-19 vaccination as recommended by the Advisory Committee on Immunization Practices.

26. Young Xi and colleagues have demonstrated that in the high Delta populations that the present vaccines only had ~20% vaccine efficacy which is inadequate to support use of the vaccines.

See table immediately below.

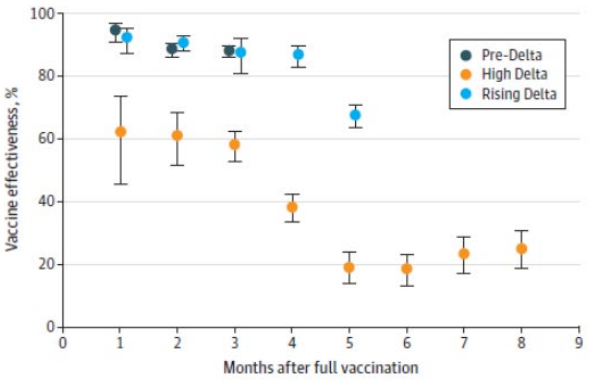
JAMA Network Open

Research Letter | Infectious Diseases

Estimated Effectiveness of COVID-19 Messenger RNA Vaccination Against SARS-CoV-2 Infection Among Older Male Veterans Health Administration Enrollees, January to September 2021

Yinong Young-Xu, ScD; Gabrielle M. Zwain, BA; Ethan I. Powell, BA; Jeremy Smith, MPH

Figure. Estimated Messenger RNA Vaccine Effectiveness Against SARS-CoV-2 Infection by Delta Variant Period, January to September 2021



JAMA Network Open. 2021;4(12):e2138975. doi:10.1001/jamanetworkopen.2021.38975

THE OMICRON VARIANT

27. The Omicron variant is presently (as of January 14, 2022) the dominant strain, representing 95% of all newly-diagnosed cases of Covid-19. In my research and review, Omicron presents the following general characteristics:

a. Omicron has broken through all forms of immunity both natural immunity from the prior variants as well as through the vaccines.

b. A natural infection of Omicron develops immunity against future Omicron infections on the scale of a 14-fold boost in antibody related immunity.

c. A natural infection of Omicron develops only a 4-fold boost against the Delta variant.

d. Omicron is the most heavily mutated form of the virus. It multiplies in the nose 70 times faster than Delta.

e. Symptoms of the Delta variant were more severe including attacking pulmonary systems in younger people.

f. Symptoms of the Omicron variant are mild, typically including a day or two of fever or warmth.

28. Hansen and colleagues have shown that the present vaccines have effectively no efficacy against Omicron.

Title: Vaccine effectiveness against SARS-CoV-2 infection with the Omicron or Delta variants following a two-dose or booster BNT162b2 or mRNA-1273 vaccination series: A Danish cohort study

Authors:

Christian Holm Hansen PhD*[1], Astrid Blicher Schelde PhD*[1], Ida Rask Moustsen-Helm PhD[1], Hanne-Dorthe Emborg PhD[1], Tyra Grove Krause PhD[2], Kåre Mølbak DMSc[2], Palle Valentiner-Branth PhD[1] on behalf of the Infectious Disease Preparedness Group at Statens Serum Institut

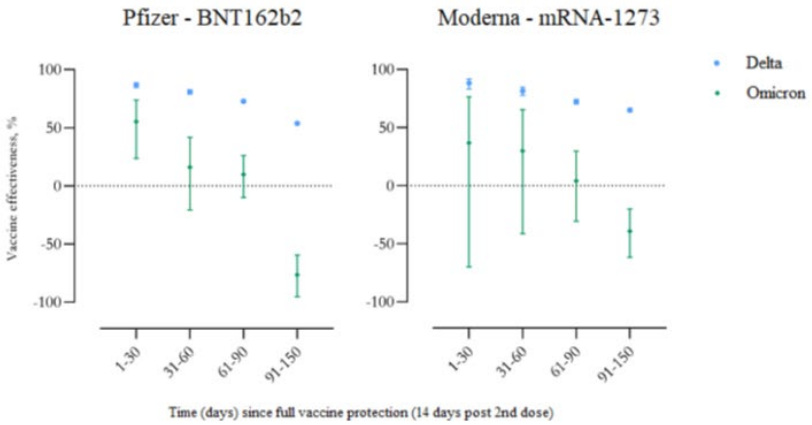


Figure Vaccine effectiveness against SARS-CoV-2 infection with the Delta and Omicron variants, shown separately for the BNT162b2 and mRNA-1273 vaccines. Vertical bars indicate 95% confidence intervals.

medRxiv preprint doi: https://doi.org/10.1101/2021.12.20.21267966; this version posted December 22, 2021.

ADVERSE EFFECTS OF THE COVID-19 VACCINES

29. In 1990, the Vaccine Adverse Event Reporting System ("VAERS") was established as a national early warning system to detect possible safety problems in U.S. licensed vaccines. VAERS is a passive reporting system, meaning it relies on individuals to voluntarily send in reports of their experiences to the CDC and FDA. VAERS is useful in detecting unusual or unexpected patterns of adverse event reporting that might indicate a

possible safety problem with a vaccine.

30. COVID-19 vaccine adverse events account for 98% of all vaccine-related AEs from December 2020 through the present in VAERS.

31. There are emerging trends showing that the vaccine is especially risky for those 12- 29 in my expert medical opinion with complications in the cardiovascular, neurological, hematologic, and immune systems. (See, Rose J, et al). Increasingly the medical community is acknowledging the possible risks and side effects including myocarditis, Bell's Palsy, Pulmonary Embolus, Pulmonary Immunopathology, and severe allergic reaction causing anaphylactic shock. See Chien-Te Tseng, Elena Sbrana, Naoko Iwata- Yoshikawa, Patrick C Newman, Tania Garron, Robert L Atmar, Clarence J Peters, Robert B Couch, Immunization with SARS coronavirus vaccines leads to pulmonary immunopathology on challenge with the SARS virus, https://pubmed.ncbi.nlm.nih.gov/22536382/ (last visited June 21, 2021); Centers for Disease Control and Prevention, Allergic Reactions Including Anaphylaxis After Receipt of the First Dose of Pfizer-BioNTech COVID-19 Vaccine—United States, December 14– 23, 2020 (Jan 15, 2021), https://www.cdc.gov/mmwr/volumes/70/wr/mm7002e1.htm (last visited June 26, 2021).

32. The Centers for Disease Control has held emergency meetings on this issue and the medical community is responding to the crisis. It is known that myocarditis causes injury to heart muscle cells and may result in permanent heart damage resulting in heart failure, arrhythmias, and cardiac death. These conditions could call for a lifetime need for multiple medications, implantable cardio defibrillators, and heart transplantation. Heart failure has a five-year 50% survival and would markedly reduce the lifespan of a child or young adult who develops this complication after vaccine-induced myocarditis (ref McCullough PA Reach Study).

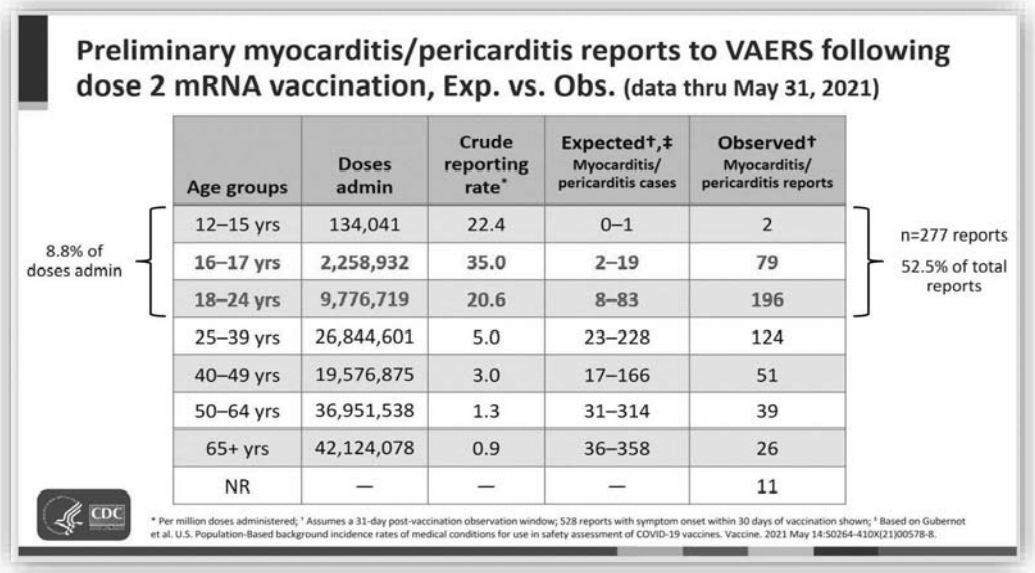
33. COVID-19 vaccine-induced myocarditis has a predilection for young males

below age 30 years. The Centers for Disease Control has held emergency meetings on this issue and the medical community is responding to the crisis and the US FDA has issued a warning on the Pfizer and Moderna vaccines for myocarditis. In the cases reviewed by the CDC and FDA, 90% of children with COVID-19 induced myocarditis developed symptoms and clinical findings sufficiently severe to warrant hospitalization. Because this risk is not predictable and the early reports may represent just the tip of the iceberg, no individual under age 30 under any set of circumstances should feel obliged to take this risk with the current genetic vaccines particularly the Pfizer and Moderna products. https://www.fda.gov/news-events/press-announcements/coronavirus-COVID-19-update- june-25-2021.

34. Multiple recent studies and news reports detail people 18-29 dying from myocarditis after receiving the COVID-19 vaccine. According to the CDC, 475 cases of pericarditis and myocarditis have been identified in vaccinated citizens aged 30 and younger. See FDA, Vaccines and Related Biological Products Advisory Committee June 10, 2021, Meeting Presentation, https://www.fda.gov/media/150054/download#page=17 (last visited June 21, 2021).

35. The FDA found that people 12-24 account for 8.8% of the vaccines administrated, but 52% of the cases of myocarditis and pericarditis were reported. Id.

See table immediately below.



Preliminary myocarditis/pericarditis reports to VAERS following dose 2 mRNA vaccination, Exp. vs. Obs. (data thru May 31, 2021)

Age groups	Doses admin	Crude reporting rate*	Expected†,‡ Myocarditis/ pericarditis cases	Observed† Myocarditis/ pericarditis reports
12–15 yrs	134,041	22.4	0–1	2
16–17 yrs	2,258,932	35.0	2–19	79
18–24 yrs	9,776,719	20.6	8–83	196
25–39 yrs	26,844,601	5.0	23–228	124
40–49 yrs	19,576,875	3.0	17–166	51
50–64 yrs	36,951,538	1.3	31–314	39
65+ yrs	42,124,078	0.9	36–358	26
NR	—	—	—	11

8.8% of doses admin

n=277 reports
52.5% of total reports

CDC

* Per million doses administered; † Assumes a 31-day post-vaccination observation window; 528 reports with symptom onset within 30 days of vaccination shown; ‡ Based on Gubernot et al. U.S. Population-Based background incidence rates of medical conditions for use in safety assessment of COVID-19 vaccines. Vaccine. 2021 May 14:S0264-410X(21)00578-8.

36. Further, the CDC announced in June 2021 that the vaccine is "likely linked" to myocarditis. Advisory Board, CDC panel reports 'likely association' of heart inflammation and mRNA COVID-19 vaccines in young people, (June 24, 2021) https://www.advisory.com/daily- briefing/2021/06/24/heart-inflammation.

37. The present cumulative numbers of deaths, emergency visits, cases of myocarditis/pericarditis, and permanent disability are shown below. Id. https://www.openvaers.com/COVID-19-data (accessed January 14, 2022)

VAERS COVID Vaccine Adverse Event Reports

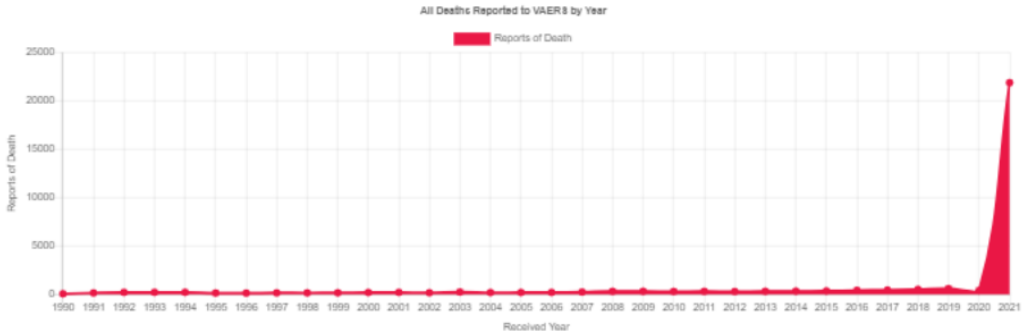
Reports from the Vaccine Adverse Events Reporting System. Our default data reflects all VAERS data including the "nondomestic" reports.

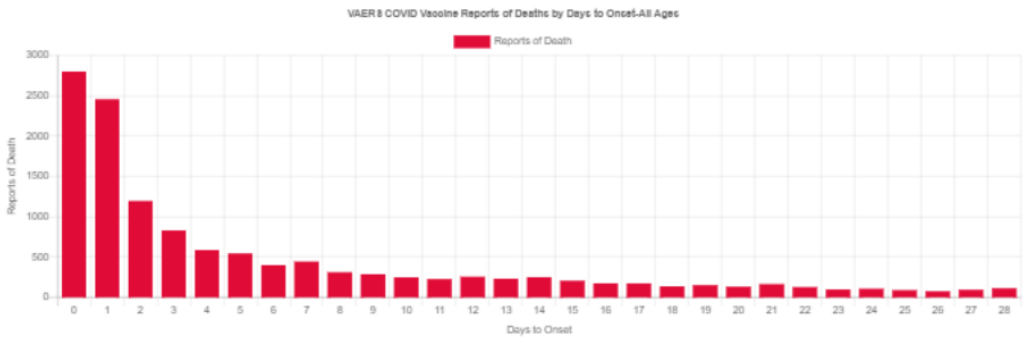
All VAERS COVID Reports | US/Territories/Unknown

1,016,999 Reports
Through December 31, 2021

21,382 DEATHS	**113,303** HOSPITALIZATIONS	**110,785** URGENT CARE
158,762 DOCTOR OFFICE VISITS	**8,765** ANAPHYLAXIS	**12,765** BELL'S PALSY

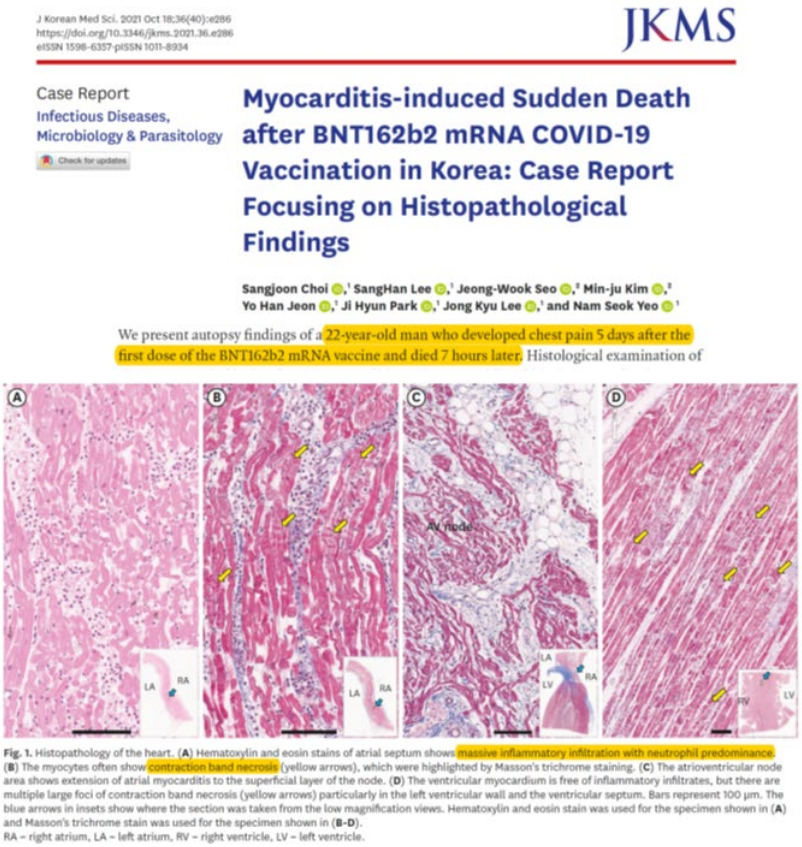
3,511 Miscarriages	10,863 Heart Attacks	23,713 Myocarditis/Pericarditis	36,758 Permanently Disabled
5,102 Thrombocytopenia/ Low Platelet	24,344 Life Threatening	36,955 Severe Allergic Reaction	11,628 Shingles





38. I have seen and examined adolescent patients with post-COVID-19 myocarditis which typically occurs two days after the injection, most frequently after the second injection of mRNA products (Pfizer, Moderna). The clinical manifestations can be chest pain, signs and symptoms of heart failure, and arrhythmias. The diagnosis usually requires a clinical or hospital encounter, 12- lead electrocardiogram, blood tests including cardiac troponin (test for heart muscle damage), ECG monitoring, and cardiac imaging with echocardiography or cardiac magnetic resonance imaging. Given the risks for either manifest or future left ventricular dysfunction, patients are commonly prescribed heart failure medications (beta-blockers, renin-angiotensin system, inhibitors), and aspirin. More complicated patients require diuretics and anticoagulants. For post- COVID-19 vaccine myocarditis, I follow current position papers on the topic and restrict physical activity and continue medications for approximately three months before blood biomarkers and cardiac imaging are reassessed. If there is concurrent pericarditis, non-steroidal anti-inflammatory agents and colchicine may additionally be prescribed. Multiple medical studies are starting to come out detailing this problem.[i] Acute myocarditis can lead to sudden death as shown by the case reported by Choi and colleagues.

See table immediately below.



J Korean Med Sci. 2021 Oct 18;36(40):e286
https://doi.org/10.3346/jkms.2021.36.e286
eISSN 1598-6357·pISSN 1011-8934

JKMS

Case Report
Infectious Diseases, Microbiology & Parasitology

Check for updates

Myocarditis-induced Sudden Death after BNT162b2 mRNA COVID-19 Vaccination in Korea: Case Report Focusing on Histopathological Findings

Sangjoon Choi ,[1] SangHan Lee ,[1] Jeong-Wook Seo ,[2] Min-ju Kim ,[2] Yo Han Jeon ,[1] Ji Hyun Park ,[1] Jong Kyu Lee ,[1] and Nam Seok Yeo [1]

We present autopsy findings of a 22-year-old man who developed chest pain 5 days after the first dose of the BNT162b2 mRNA vaccine and died 7 hours later. Histological examination of

Fig. 1. Histopathology of the heart. (**A**) Hematoxylin and eosin stains of atrial septum shows massive inflammatory infiltration with neutrophil predominance. (**B**) The myocytes often show contraction band necrosis (yellow arrows), which were highlighted by Masson's trichrome staining. (**C**) The atrioventricular node area shows extension of atrial myocarditis to the superficial layer of the node. (**D**) The ventricular myocardium is free of inflammatory infiltrates, but there are multiple large foci of contraction band necrosis (yellow arrows) particularly in the left ventricular wall and the ventricular septum. Bars represent 100 μm. The blue arrows in insets show where the section was taken from the low magnification views. Hematoxylin and eosin stain was used for the specimen shown in (**A**) and Masson's trichrome stain was used for the specimen shown in (**B–D**).
RA = right atrium, LA = left atrium, RV = right ventricle, LV = left ventricle.

39. The US FDA has given an update on the J&J vaccine concerning the risk of cerebral venous sinus thrombosis and thrombosis with thrombocytopenia in women ages 18-48 associated with low platelet counts. This complication causes a variety of stroke-like syndromes that can involve the cranial nerves, vision, and coordination. Blood clots in the venous sinuses of the brain are difficult to remove surgically and require blood thinners sometimes with only partial recovery. In some cases, special glasses are required to correct vision and these young adults can be expected to miss considerable time away from school undergoing neurological rehabilitation. Because this risk is not predictable no woman under age 48 under any set of circumstances should feel obliged to take this risk with the J&J vaccine. Such catastrophic neurologic thrombotic events could occur in first responders or critical infrastructure employees while on duty.

https://www.fda.gov/news-events/press-announcements/joint-cdc-and-fda- statement-johnson-johnson-COVID-19-vaccine.

40. Additionally, the US FDA has an additional warning for Guillen-Barre Syndrome or ascending paralysis for the J&J vaccine which is not predictable and when it occurs can result in ascending paralysis, respiratory failure, the need for critical care, and death. Not all cases completely resolve, and some vaccine victims may require long term mechanical ventilation, or become quadra- or paraplegics. Prolonged neurological rehabilitation is commonly required, and this will call for time away from school and studies for those children injured from the J&J vaccine with Guillen-Barre Syndrome. This syndrome is unpredictable and could occur in a critical worker while on duty and thus potentially harming others (passengers, coworkers, etc). https://www.fda.gov/media/150723/download.

41. The vaccine is also far less safe than previous vaccines like the meningococcal meningitis vaccine that is typically required on college campuses which in 2019 recorded zero deaths. The COVID-19 vaccines since their EUA approval on May 10, 2021, have already claimed the lives of 15 children and 79 young individuals under age 30 (VAERS).

42. For example, the VAERS (Vaccine Adverse Event Reporting System) data from the CDC shows, for 18-29-year-olds, there have been no deaths from the meningococcal vaccine from 1999 - 2019. See, United States Department of Health and Human Services (DHHS), Public Health Service (PHS), Centers for Disease Control (CDC)/Food and Drug Administration (FDA), Vaccine Adverse Reporting System (VAERS) 1990 - 06/11/2021, CDC WONDER On-line Database. Accessed at https://wonder.cdc.gov/vaers.html on June 23, 2021, 1:43:33 PM, ("Query Criteria"), Attached as Exhibit C.

43. The main side effects people reported from the meningitis vaccine are headache, injection site pain, nausea, chills, and a fever, and even these were limited as no more than fifteen of each were reported. Id. The student

population and their parents, in general, accept the requirements for meningococcal vaccination because the vaccines are safe, effective, and do not pose a risk of death, unlike the COVID-19 vaccines.

44. In the brief time the COVID-19 vaccines have been available, there have been many more serious symptoms and even a death of a healthy 13-year-old boy . (See Nationwide VAERS COVID-19 Vaccine Data through June 18, 2021, attached as Exhibit B). Further, milder side effects from the vaccine include changes in hormone and menstrual cycles in women, fever, swelling at the injection site, etc. Jill Seladi-Schulman, Ph.D., Can COVID-19 or the COVID-19 Vaccine Affect Your Period? (May 25, 2021), https://www.healthline.com/health/menstruation/can-COVID-19-affect-your-period#COVID-19-and-men%20strual-cycles (last visited June 26, 2021); Rachael K. Raw, Clive Kelly, Jon Rees, Caroline Wroe, David R. Chadwick, Previous COVID-19 infection but not Long-COVID-19 is associated with increased adverse events following BNT162b2/Pfizer vaccination, (pre-print) https://www.medrxiv.org/content/10.1101/2021.04.15.21252192v1 (last visited June 26, 2021).

45. Recent studies from Tess Lawrie, MBBS, PhD, a highly respected evidence-based professional, on the UK's equivalent of the VAERS systems concluded that the vaccines were unsafe for use in humans due to the extensive side effects they are causing. Tess Lawrie, Re. Urgent preliminary report of Yellow Card data up to 26th May 2021, (June 9, 2021), http://www.skirsch.com/COVID-19/TessLawrieYellowCardAnalysis.pdf

RISKS OF COVID-19 VACCINES FOR THOSE RECOVERED FROM COVID-19

46. There is recent research on the fact that the COVID-19 vaccine is dangerous for those who have already had COVID-19 and have recovered with inferred robust, complete, and durable immunity. These patients were excluded from

the FDA-approved clinical trials performed by Pfizer, Moderna, and J&J. From these trials the safety profile was unknown when the products for approved for Emergency Use Authorization in 2020. There has been no study demonstrating clinical benefit with COVID-19 vaccination in those who have well documented or even suspected prior COVID-19 illness.

47. A medical study of United Kingdom healthcare workers who had already had COVID-19 and then received the vaccine found that they suffered higher rates of side effects than the average population. Rachel K. Raw, et al., Previous COVID-19 infection but not Long-COVID-19 is associated with increased adverse events following BNT162b2/Pfizer vaccination, medRxiv (preprint), https://www.medrxiv.org/content/10.1101/2021.04.15.21252192v1 (last visited June 21, 2021).

48. The test group experienced more moderate to severe symptoms than the study group that did not previously have COVID-19. Id. The symptoms included fever, fatigue, myalgia-arthralgia, and lymphadenopathy. Id. Raw found that in 974 individuals who received the BNT162b2/Pfizer vaccine, those with a prior history of SARS-CoV-2 or those who had positive antibodies at baseline had a higher rate of vaccine reactions than those who were COVID-19 naive. Id.

49. Mathioudakis et al. reported that in 2020 patients who underwent vaccination with either mRNA-based or vector-based COVID-19 vaccines, COVID-19-recovered patients who were needlessly vaccinated had higher rates of vaccine reactions.

50. Krammer et al. reported on 231 volunteers for COVID-19 vaccination, 83 of whom had positive SARS-CoV-2 antibodies at the time of immunization. The authors found: "Vaccine recipients with preexisting immunity experience systemic side effects with a significantly higher frequency than antibody naïve vaccines (e.g., fatigue, headache, chills, fever, muscle or joint pains, in order of decreasing frequency, $P < 0.001$ for all listed symptoms,

Fisher's exact test, two-sided)."
(https://www.medrxiv.org/content/10.1101/2021.01.29.21250653v1).

NATURAL IMMUNITY TO COVID-19

51. To my knowledge, there are no trustworthy studies that demonstrate the clinical benefit of COVID-19 vaccination in COVID-19 survivors or those with suspected COVID-19 illness or subclinical disease who have laboratory evidence of prior infection.

52. It is my opinion that SARS-CoV-2 causes an infection in humans that results in robust, complete, and durable immunity for the wild type through Delta strains, and is superior to vaccine immunity which by comparison has demonstrated massive failure including over 10,000 well-documented vaccine failure cases as reported by the CDC before tracking was stopped on May 31, 2021. There are no studies demonstrating the clinical benefit of COVID-19 vaccination in COVID-19 survivors and there are three studies demonstrating harm in such individuals. Thus, it is my opinion that the COVID-19 vaccination is contraindicated in COVID-19 survivors many of whom may be in the student population.

53. Multiple laboratory studies conducted by highly respected U.S. and European academic research groups have reported that convalescent mildly or severely infected COVID-19 patients who are unvaccinated can have greater virus-neutralizing immunity— especially more versatile, long-enduring T- cell immunity—relative to vaccinated individuals who were never infected. See Athina Kilpeläinen, et al., Highly functional Cellular Immunity in SARS-CoV-2 Non-Seroconvertors is associated with immune protection, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.05.04.438781v1 (last visited June 26, 2021); Tongcui Ma, et al., Protracted yet coordinated differentiation of long-lived SARS- CoV-2-specific CD8+ T cells during

COVID-19 convalescence, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.04.28.441880v1 (last visited June 26, 2021); Claudia Gonzalez, et al., Live virus neutralisation testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 isolates of SARS-CoV-2, medRxiv (pre-print), https://www.medrxiv.org/ content/10.1101/2021.05.11.21256578vl (last visited June 21, 2021); Carmen Camara, et al. Differential effects of the second SARS-CoV-2 mRNA vaccine dose on T cell immunity in naïve and COVID-19 recovered individuals, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.03.22.436441v1 (last visited June 26, 2021); Ellie N. Ivanova, et al., Discrete immune response signature to SARS-CoV-2 mRNA vaccination versus infection, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.04.20.21255677v1 (last visited June 26, 2021); Catherine J. Reynolds, et al, Prior SARS-CoV-2 infection rescues B and T cell responses to variants after first vaccine dose, (pre-print), https://pubmed.ncbi.nlm.nih.gov/33931567/ (last visited June 21, 2021); Yair Goldberg, et al., Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2 vaccine protection: A three-month nationwide experience from Israel, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.04.20.21255670vl (last visited 06/26 21).

54. Cleveland Clinic studied their employees for the effects of natural immunity in unvaccinated people. Nabin K. Shrestha, Patrick C. Burke, Amy S. Nowacki, Paul Terpeluk, Steven M. Gordon, Necessity of COVID-19 vaccination in previously infected individuals, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.06.01.21258176v2 (last visited June 21, 2021). They found zero SARS-CoV-2 reinfections during a 5-month follow-up among n=1359 infected employees who were naturally immune remained unvaccinated and concluded such persons are "unlikely

to benefit from COVID-19 vaccination." Among those who were vaccinated, unlike the naturally immune, there were vaccine failure or breakthrough cases of COVID-19. Id.

55. An analysis by Murchu et al demonstrated in 615,777 individuals which included well-documented COVID-19 as well as subclinical infections with positive serologies, there was a negligible incidence (<1%) of COVID-19 over the long term. Murchu found no evidence of waning immunity over time suggesting no possibility that future vaccination would be indicated for any reason. https://onlinelibrary.wiley.com/doi/10.1002/rmv.2260.

56. A recently published article in Nature reported that prior infection induces long- lived bone marrow plasma cells which means the antibodies to prevent reinfection of COVID-19 are long-lasting. Jackson S. Turner et. al. SARS-CoV-2 infection induces long- lived bone marrow plasma cells in humans, (May 24, 2021) https://www.nature.com/articles/s41586-021-03647-4

OPINIONS

1. In my expert medical opinion which is and is within a reasonable degree of medical certainty, the health risks of taking a COVID-19 vaccine are significantly greater than contracting the Omicron variant of COVID-19.
2. In my expert medical opinion, the epidemic spread of COVID-19, like all other respiratory viruses, notably influenza, is driven by symptomatic persons; asymptomatic spread is trivial and inconsequential.
3. It is my expert medical opinion that the COVID-19 vaccines are progressively losing efficacy over the prevention of COVID-19 and in widely vaccinated countries (Israel, Iceland, Singapore) up to 80% of COVID-19 cases have been previously vaccinated—especially with respect to the Omicron variant. This implies that vaccines have become obsolete with antigenic escape or resistance to variants (e.g. Delta or Omicron) that have

evolved to infect persons who were vaccinated against the now extinct wild-type SARS-CoV-2 strain.

4. It is my expert medical opinion that it is not good research or clinical practice to widely utilize novel biologic therapy (mRNA, adenoviral DNA COVID-19 vaccines) in populations where there is no information generated from the registrational trials with the FDA, specifically COVID-19 survivors, suspected COVID-19-recovered, pregnant or women who could become pregnant at any time after investigational vaccines.
5. In my expert medical opinion, the risks associated with the investigational COVID-19 vaccines outweigh any theoretical benefits, are not minor or unserious, and many of those risks are unknown or have not been adequately quantified nor has the duration of their consequences been evaluated or is calculable. Therefore, in my expert medical opinion, the Emergency Use Authorization and mandatory administration of COVID-19 vaccines creates an unethical, unreasonable, clinically unjustified, unsafe, and unnecessary risk to Firefighters. Likewise, in my medical expert opinion, the mandatory administration of COVID-19 vaccines in county employees creates unnecessary risk to the employees and other citizens who rely on first responders and other critical infrastructure workers.

Sworn and subscribed to this 14th day of January, 2022:

Dr. Peter A. McCullough, M.D., M.P.H.

Endnote below:

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[i] See, e.g., Tommaso D'Angelo MD, Antonino Cattafi MD, Maria Ludovica Carerj MD, Christian Booz MD, Giorgio Ascenti MD, Giuseppe Cicero MD, Alfredo Blandino MD. Silvio Mazziotti MD, Myocarditis after SARS-CoV-2 Vaccination: A Vaccine-induced Reaction?, Pre-proof, Canadian Journal of Cardiology, https://www.onlinecjc.ca/article/S0828-282X(21)00286-5/fulltext (last visited June 26, 2021); Jeffrey Heller, Israel sees probable link between Pfizer vaccine and myocarditis cases(June 2, 2021), https://www.reuters.com/world/middle-east/israel-sees-probable-link-between-pfizer-vaccine-small-number-myoca rditis-cases-2021-06-01/(last visited June 26, 2021); Tschöpe C, Cooper LT, Torre-Amione G, Van Linthout S. Management of Myocarditis-Related Cardiomyopathy in Adults. Circ Res. 2019 May 24;124(11):1568-1583. doi: 10.1161/CIRCRESAHA.118.313578. PMID: 31120823. Caforio AL, Pankuweit S, Arbustini E, Basso C, Gimeno- Blanes J, Felix SB, Fu M, Heliö T, Heymans S, Jahns R, Klingel K, Linhart A, Maisch B, McKenna W, Mogensen J, Pinto YM, Ristic A, Schultheiss HP, Seggewiss H, Tavazzi L, Thiene G, Yilmaz A, Charron P, Elliott PM; European Society of Cardiology Working Group on Myocardial and Pericardial Diseases. Current state of knowledge on aetiology, diagnosis, management, and therapy of myocarditis: a position statement of the European Society of Cardiology Working Group on Myocardial and Pericardial Diseases. Eur Heart J. 2013 Sep;34(33):2636-48, 2648a- 2648d. doi: 10.1093/eurheartj/eht210. Epub 2013 Jul 3. PMID: 23824828.