Nicole C. Pearson [SBN 265350]
Jessica R. Barsotti [SBN 209557]
Rita Barnett-Rose [SBN 195801]
LAW OFFICES OF NICOLE C. PEARSON
3421 Via Oporto, Ste. 201
Newport Beach, CA 92663
Telephone: (424) 272-5526
Nicole@FLTJllp.com; Jessica@FLTJllp.com;
Rita@FLTJllp.com

Attorneys for Plaintiffs

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SANTA CLARA

CHILDREN'S HEALTH DEFENSE-CALIFORNIA CHAPTER, a California 501(c)(3) non-profit corporation, on its own and on behalf of its members; **HARLOW GLENN**, an individual and **JACKSON DRUKER**, an individual,

Plaintiffs,

vs.

THE PRESIDENT AND TRUSTEES OF SANTA CLARA COLLEGE, a California Corporation, **DR. LEWIS OSOFSKY,** an individual, **DEEPA ARORA,** an individual, **AND DOES 1-10, inclusive,**

Defendants.

Case No.: 22 CV 395570

DECLARATION OF PETER MCCULLOUGH, MD IN SUPPORT OF PLAINTIFFS' EX PARTE MOTION FOR A TEMPORARY RESTRAINING ORDER AND ORDER TO SHOW CAUSE

Date: March 21, 2022
Time: 8:30 a.m.
Dept.: 20

First Amended Complaint Filed: March 14, 2022
Trial Date: Not yet set.

ORAL ARGUMENT REQUESTED

DECLARATION OF PETER MCCULLOUGH

I, Peter McCullough, declare:

1. I am over the age of 18, and not a party to this action. Except as set forth herein, I have personal knowledge of the facts set forth in this statement and declaration, and if called upon to do so, I could and would testify competently to them.

2. The statements herein in the referenced filing I declare under penalty of perjury under the laws of the State of California, are true and correct, except those based on information and belief, and those I believe to be true.

3. 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.

4. 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.

5. 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.

6. 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*.

7. I have testified before the U.S. Senate Committee on Homeland Security and Governmental Affairs, U.S. Senate Special Panel "COVID-19: A Second Opinion," 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.

8. 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 54 peer-reviewed publications on the COVID-19 infection cited in the National Library of Medicine.

9. 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. I co-moderated and testified at the U.S. Senate Special Panel "COVID-19: A Second Opinion" led by Senator Ron Johnson, on January 24, 2022.

10. My expertise on the SARS-CoV-2 infection and COVID-19 syndrome, like that of infectious disease specialists, is in concert with the running duration of the crisis 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.

11. 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.

12. The spike protein produced in the human body after COVID-19 vaccination 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.

13. 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 such as the unprecedented number of adverse event reports resulting in disability and death after COVID-19 vaccination.

14. COVID-19 vaccine adverse events account for 98% of all vaccine-related adverse events from December 2020 through the present in VAERS meaning the COVID-19 vaccines are the most unsafe vaccine products of all time in VAERS.

15. There are emerging trends showing that the vaccines are especially risky for those ages 12- 29 in my expert medical opinion, with complications in the cardiovascular, neurological, hematologic, and immune systems, which is the age range of most college students. Increasingly the medical community is acknowledging the possible risks and side effects including myocarditis, Bell's Palsy, Guillain-Barre Syndrome, intracranial thrombosis, pulmonary embolus, vaccine-induced thrombocytopenia, and severe allergic reaction causing anaphylactic shock.

16. 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.

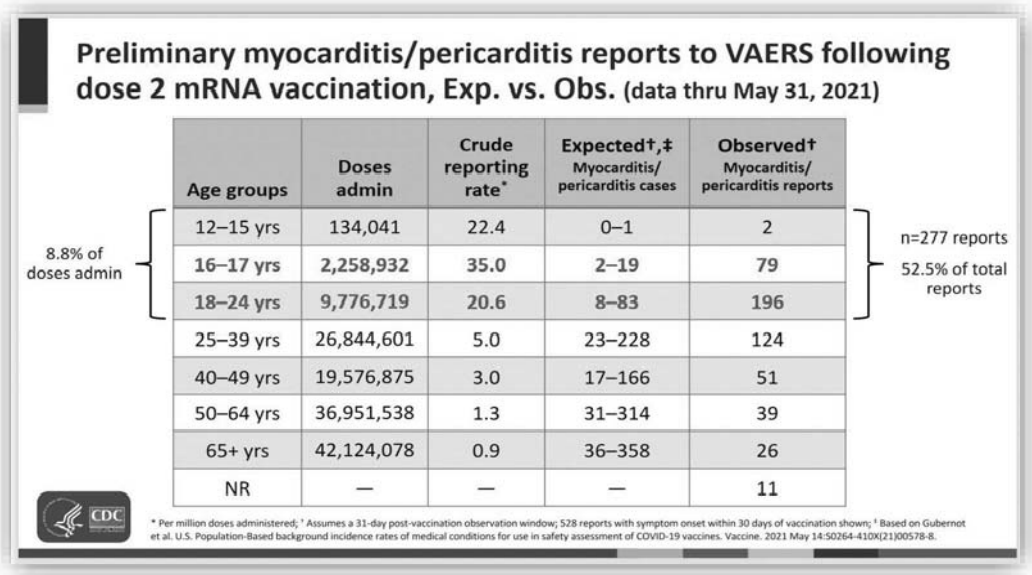
17. COVID-19 vaccine-induced myocarditis has a predilection for males below age 30 years also myocarditis has resulted from COVID-19 vaccination up to age 70 years. The Centers for Disease Control has held emergency meetings on this issue and the medical community is responding to the crisis and the 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.

18. Multiple recent studies and news reports detail people 18-50 dying from myocarditis after receiving the COVID-19 vaccine (Choi, Verma, Gill). According to the CDC, 475 initial cases of pericarditis and myocarditis have been identified by June 2021 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). From that time to the present, there has been an explosion of myocarditis/pericarditis cases, with 33,590 found in the VAERS system by the OpenVaers query methods as of February 11, 2022. (https://openvaers.com/covid-data). Some of these cases includes those who have received booster injections.

19. In the original cases, the FDA found that people ages 12-24 account for 8.8% of the vaccines administrated, but 52% of the cases of myocarditis and pericarditis reported.

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.

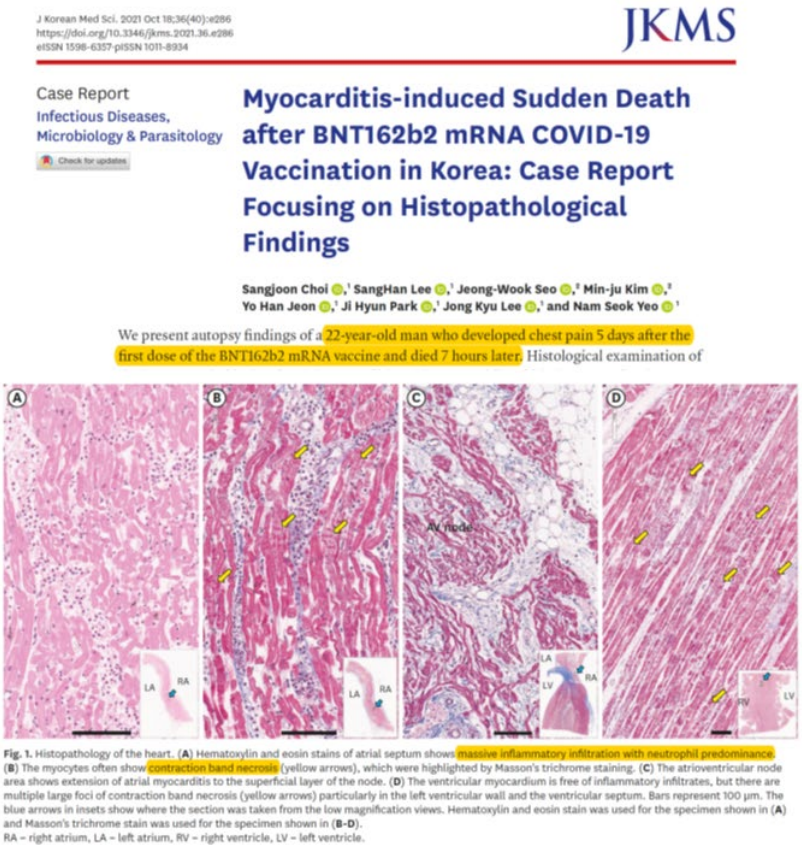
20. Further, the CDC announced in June 2021 that the vaccine is "likely linked" to myocarditis. The CDC Advisory Board panel reports 'likely association' of heart inflammation andmRNA COVID-19 vaccines in young people, (June 24, 2021) https://www.advisory.com/daily-briefing/2021/06/24/heart-inflammation.

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

22. I have seen and examined adolescent and young adult patients with post-COVID-19 injection 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 injection 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 arereassessed. 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. 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.

23. Myocarditis has now been reported after Pfizer, Moderna, JNJ, and AstraZeneca vaccines (Ali Ali et al).

24. 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 148 young individuals aged 18-29 (VAERS).

25. 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. 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.

26. In my expert medical opinion, which is within a reasonable degree of medical certainty, the health risks of taking a COVID-19 vaccine, including a "booster" injection, are significantly greater than consequences from contracting COVID-19, especially for young, college-aged adults.

27. It is my expert medical opinion that it is not good clinical practice to encourage subsequent "booster" vaccine injections where the risks of the original vaccines have shown to be high.

28. In my expert medical opinion, the risks associated with the investigational COVID-19 vaccines, including "booster" injections, 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. Adverse events in large numbers have occurred after COVID-19 vaccination including disability and death. 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 college students.

Dated: March 19, 2022

19-MAR-2022

Dr. Peter A. McCullough, MD