

**IN THE HIGH COURT OF SOUTH AFRICA  
(GAUTENG DIVISION, PRETORIA)**

**KMI**

Case number:

In the matter between:

**THE AFRICAN CHRISTIAN DEMOCRATIC  
PARTY (THE ACDP)**

First applicant

**FREE THE CHILDREN - SAVE THE NATION  
NPC**

Second applicant

**CARING HEALTHCARE WORKERS  
COALITION NPC**

Third applicant

**COVID CARE ALLIANCE NPC**

Fourth applicant

and

**THE MINISTER OF THE NATIONAL  
DEPARTMENT OF HEALTH (DoH) DR M  
PHAALA**

First respondent

**THE ACTING DIRECTOR OF THE NATIONAL  
DEPARTMENT OF HEALTH DR N CRISP**

Second respondent

**THE SOUTH AFRICAN HEALTH PRODUCTS  
REGULATORY AUTHORITY (SAHPRA)**

Third respondent

---

**SUPPORTING AFFIDAVIT**

---

*D P Mc*

*D KM*

I, the undersigned,

**DR PETER MCCULLOUGH**

do hereby declare as follows: -

1. I am an adult medical practitioner and specialist residing in the United States of America.
2. I depose to this affidavit on behalf of the applicants. I have not been paid by anyone to provide this opinion. I am providing this declaration as I have serious, grave concerns for children and the public-at-large.
3. The facts herein contained are, save where otherwise stated or appears to the contrary, within my personal knowledge and both true and correct.
4. I make this affidavit in support of the truth of the contents contained herein. In short: I believe within a reasonable degree of medical certainty that the COVID-19 vaccine(s) are not safe generally. It is my belief based on a reasonable degree of medical certainty that the vaccine could cause the death of children. I believe within a reasonable degree of medical certainty that the data upon which the respondents have based their authorization and children's vaccine roll out programmer upon, is flawed and/or inaccurate; and imposing this vaccine is not only dangerous and could cause harm to children but is also entirely unnecessary. In support, I submit the following for the court's consideration: -

O P Mc  
KM D

**EXPERTISE**

5. Attached to this Declaration as **EXHIBIT 1** is my *Curriculum Vitae*. 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 went on to complete 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. I participate in the maintenance of certification programs by the American Board of Internal Medicine for both Internal Medicine and Cardiovascular Diseases. I am an active scholar in medicine with roles as an author, editor-in-chief of a peer-reviewed journals, editorialist, and reviewer at dozens of major medical journals and textbooks.
  
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

◊ PMc  
◊ km

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.

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 Cardiocascular 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*. 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

D P Mc

DKM

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. 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. 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 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.

8. Since the outset of the 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 47 peer-reviewed publications on the COVID-19 infection cited in the National Library of Medicine. Through a window to public

P Mc  
D  
D KM

policymakers, I have contributed extensively on issues surrounding the COVID-19 crisis in a series of OPED's for *The Hill* in 2020. Starting in 2021, I publish a weekly contribution on *America Out Loud, The McCullough Report*. 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 investigation of a COVID-19 vaccine on April 14, 2020. 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 my 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. 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. See attached *Curriculum Vitae*.

#### **AS TO MY EXPERT OPINION**

9. The CDC recently reported the lowest number of cases since March of 2020 (the

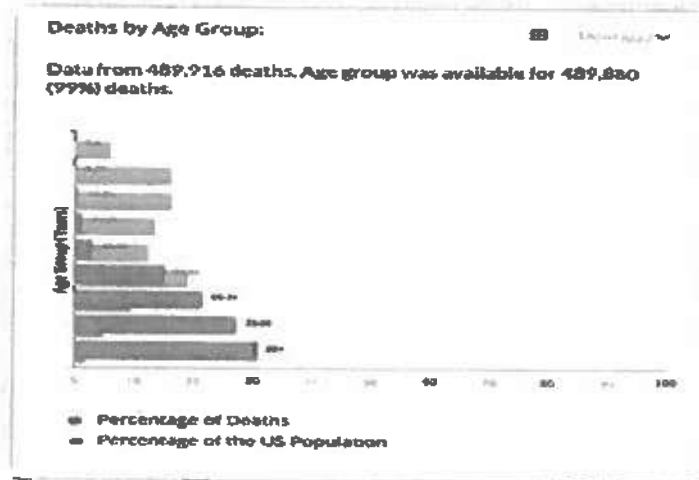
P7Mc

D

KMD

beginning of the COVID-19 pandemic). Sam Baker & Andre Witherspoon, COVID-19 cases hit lowest point in U.S. since pandemic began, AXIOS (June 3, 2021).<sup>1</sup>

10. As is evident from the graph below, there is little risk of death for those who are 17 years of age or younger of death from COVID-19.



<sup>1</sup> <https://www.axios.com/coronavirus-cases-infections-vaccines-success-fa7673a1-0582-aefb-3b5170268048.html>. 4e69-

0 PMc  
KMO

Table 2: COVID-19 Rate Ratios by Age.<sup>2</sup>

11. There is also negligible risk for adults younger than the age of 60. For example, for each

**Risk for COVID-19 Infection, Hospitalization, and Death By Age Group**

— Source: CDC, 2021 —

**Rate ratios compared to 18- to 29-year-olds<sup>1</sup>**

	0-4 years old	5-17 years old	18-29 years old	30-39 years old	40-49 years old	50-64 years old	65-74 years old	75-84 years old	85+ years old
<b>Cases<sup>2</sup></b>	<1x	1x	Reference group	1x	1x	1x	1x	1x	1x
<b>Hospitalization<sup>2</sup></b>	<1x	<1x	Reference group	2x	2x	4x	6x	9x	15x
<b>Death<sup>2</sup></b>	<1x	<1x	Reference group	4x	10x	35x	95x	230x	610x

All rates are relative to the 18- to 29-year-old age category. This group was selected as the reference group because it has accounted for the largest cumulative number of COVID-19 cases compared to other age groups. Sample interpretation: Compared with 18- to 29-year-olds, the rate of death is four times higher in 30- to 39-year-olds, and 610 times higher in those who are 85 years and older. (In the table, a rate of 1x indicates no difference compared to the 18- to 29-year-old age category.)

18-29-year-old that dies from COVID-19, four 30-39-year-old individuals die, ten 40-49-year-olds, thirty-five 50-64-year-olds die, ninety-five 65-74-year-olds die, 230 75-84-year-olds die, and 610 over 85 years of age die. See Table 2.

12. 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.

13. A meta-analysis of contact tracing studies published in The Journal of the American Medical Association showed asymptomatic COVID-19 spread was negligible at 0.7%. Zachary J. Madewell, Ph.D.; Yang Yang, Ph.D.; Ira M. Longini Jr, Ph.D.; M. Elizabeth Halloran, MD, DSc; Natalie E. Dean, Ph.D., Household Transmission of SARS-CoV-2: A Systematic Review and Meta-analysis, JAMA Network Open.<sup>3</sup> Accordingly, a rational and ethical prevention measure to reduce the spread of

<sup>2</sup> <https://www.cdc.gov/coronavirus/2019-ncov/COVID-19-data/investigations-discovery/hospitalizationdeath-by-age.html>

<sup>3</sup> <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774102> (last visited June 20, 2021).

O P Mc  
DKM

COVID-19 is a simple requirement, as part of formal policies, that persons with active symptomatic, febrile (feverish) respiratory illnesses, like COVID-19, should isolate themselves. Indeed, during the H1N1 influenza A pandemic, fully open, unmasked college campuses were advised by federal health officials, "*Flu-stricken college students should stay out of circulation*" and "*if they can't avoid contact they need to wear surgical masks*".<sup>4</sup>

#### COVID-19 VACCINE RESEARCH AND DEVELOPMENT

14. 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.
15. The Pfizer, Moderna and JNJ 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).<sup>5</sup>
16. 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*

---

<sup>4</sup> Great Falls Tribune, Advice: Flu-stricken college students should stay out of circulation, August 21, 2009, page 5, section A, available at <https://www.newspapers.com/image/243611045>

<sup>5</sup> 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>

PMC  
D  
KM<sup>D</sup>

*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 JNJ vaccines should not be undertaken without the proper consent and arrangements for long-term follow-up. 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 JNJ vaccines because they are different, are expected to produce different libraries of limited antibodies to the now extinct wild-type spike protein. 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 Reports both indicate the SARS-CoV-2 wild type virus to which all the vaccines were developed is now extinct.<sup>6</sup> 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

---

<sup>6</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1001354/Variants\\_of\\_Concern\\_VOC\\_Technical\\_Briefing\\_17.pdf](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/datracker/?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fvariant-proportions.html#variant-proportions](https://COVID-19.cdc.gov/datracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fvariant-proportions.html#variant-proportions)

P Mc

D

P Km

apparent with the burgeoning number of cases of myocarditis or heart inflammation among individuals below age 30 years.

### COVID-19 VACCINE RISKS

17. The current COVID-19 vaccines are not sufficiently protective against contracting COVID-19. A total of 10,262 SARS-CoV-2 vaccine breakthrough infections had been reported from 46 U.S. states and territories as of April 30, 2021. Among these cases, 6,446 (63%) occurred in females, and the median patient age was 58 years (interquartile range = 40 74 years). Based on preliminary data, 2,725 (27%) vaccine breakthrough infections were asymptomatic, 995 (10%) patients were known to be hospitalized, and 160 (2%) patients died. Among the 995 hospitalized patients, 289 (29%) were asymptomatic or hospitalized for a reason unrelated to COVID-19. The median age of patients who died was 82 years (interquartile range = 71 89 years); 28 (18%) decedents were asymptomatic or died from a cause unrelated to COVID-19. Sequence data were available from 555 (5%) reported cases, 356 (64%) of which were identified as SARS-CoV-2 variants of concern, including B.1.1.7 (199; 56%), B.1.429 (88; 25%), B.1.427 (28; 8%), P.1 (28; 8%), and B.1.351 (13; 4%). None of these variants are encoded in the RNA or DNA of the current COVID-19 vaccines. In response to these numerous reports, the CDC announced on May 1, 2021, that community breakthrough cases would no longer be reported to the public and only those vaccine failure cases requiring hospitalization will be reported, presumably on the CDC website.<sup>7</sup> This overt asymmetric reporting will create the false picture of only unvaccinated individuals

<sup>7</sup> (<https://www.cdc.gov/mmwr/volumes/70/wr/mm7021e3.htm>).

P7Mc

O

D  
KM

developing COVID-19 when in reality patients who are fully vaccinated will be contracting breakthrough infections except for those vaccinated individuals who were previously immune from prior COVID-19 infection.

18. The Delta variant of SARS-CoV-2 accounts for the 98.9% of present cases in the United Kingdom, Israel, the United States and South Africa.<sup>8</sup> (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. See Table 4.



Table 4: Israel Confirmed Cases, Vaccinated vs. Unvaccinated Source:

<sup>8</sup> (<https://covid.cdc.gov/covid-data-tracker/#variant-proportions>).

P7Mc  
 O  
 KMP

<https://datadashboard.health.gov.il/COVID-19019/general>

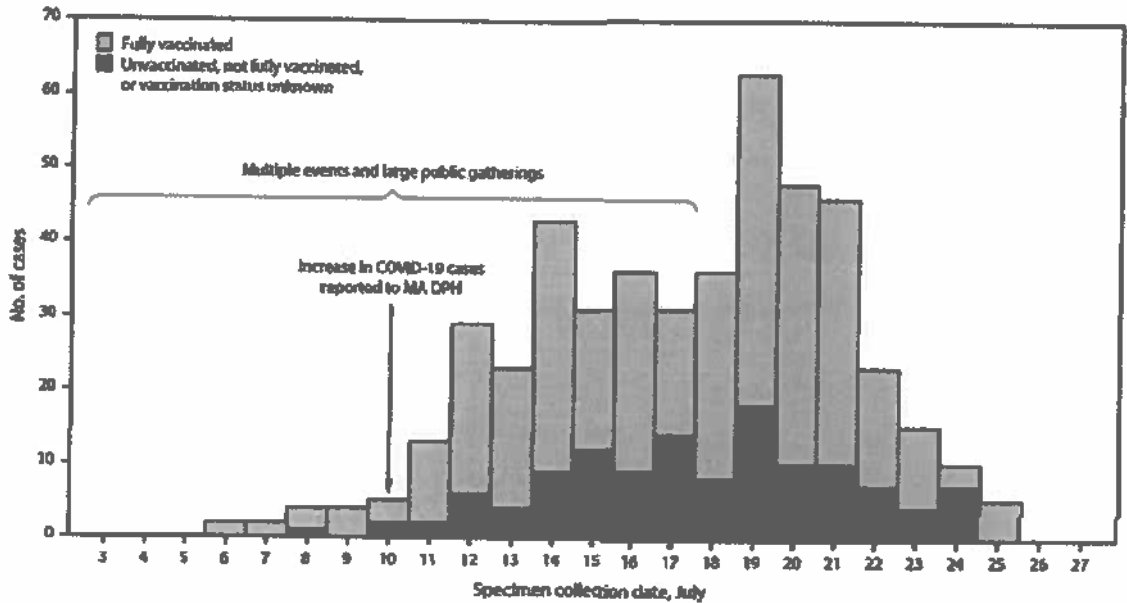
19. This has promoted the emergence of the Delta variant as the dominant strain and because it is not adequately covered by the Pfizer COVID-19 vaccine, >80% of Israeli COVID-19 cases have occurred in persons fully vaccinated. This confirms the failure of the vaccines against COVID-19.
  
20. In the 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.<sup>9</sup>
  
21. The CDC 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.<sup>10</sup>

<sup>9</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1001354/Variants\\_of\\_Concern\\_VOC\\_Technical\\_Briefing\\_17.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001354/Variants_of_Concern_VOC_Technical_Briefing_17.pdf)

<sup>10</sup> <https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7031e2-H.pdf>.

PMc  
O  
OKM

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



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

22. 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.
23. The total safety reports in VAERS for all vaccines per year up to 2019 was 16,320. The total safety reports in VAERS for COVID-19 Vaccines alone through October 1, 2021, is 778,683. Based on VAERS as of October 1, 2021, there were 16,310 COVID-19 vaccine deaths reported and 75,605 hospitalizations reported for the COVID-19 vaccines (Pfizer, Moderna, JNJ). By comparison, from 1999, until

P Mc  
O

O

December 31, 2019, VAERS received 3167 death reports (158 per year) adult death reports for all vaccines combined. Thus, the COVID-19 mass vaccination is associated with at least a 39-fold increase in annualized vaccine deaths reported to VAERS.

24. COVID-19 vaccine adverse events account for 98% of all vaccine-related AEs from December 2020 through the present in VAERS.
25. The COVID-19 vaccines are not safe for general use and cannot be deployed indiscriminately or supported, recommended, or mandated among any group.
26. 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, 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).<sup>11</sup>

---

<sup>11</sup> <https://www.cdc.gov/mmwr/volumes/70/wr/mm7002e1.htm> (last visited June 26, 2021).

P7Mc  
D  
KM  
D

27. The Center 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).
  
28. 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 should 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>.
  
29. 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

0 PMc  
KM  
DM

Advisory Committee June 10, 2021, Meeting Presentation.<sup>12</sup>

30. 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.

Table 5: VAERS Report

**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	35-358	26
NR	--	--	--	11

8.8% of doses admin (for 12-24 age group)

n=277 reports  
52.9% of total reports (for 12-24 age group)

\* Per million doses administered. † Reported to VAERS by May 31, 2021. ‡ Expected number of myocarditis/pericarditis cases based on expected number of myocarditis/pericarditis cases per million doses administered. †† Based on expected number of myocarditis/pericarditis cases per million doses administered. ††† Based on expected number of myocarditis/pericarditis cases per million doses administered.

31. Further, the CDC just announced 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).<sup>13</sup>

32. The CDC recently released data stating that there have been 267 cases of myocarditis or pericarditis reported after receiving one dose of the COVID-19 vaccines and 827 reported cases after two doses through June 11. There are 132

<sup>12</sup> <https://www.fda.gov/media/150054/download#page=17> (last visited June 21, 2021).  
<sup>13</sup> <https://www.advisory.com/daily-briefing/2021/06/24/heart-inflammation>.

D P Mc  
OKM

additional cases where the number of doses received is unknown. Id. There have been 2466 reported cases of myocarditis that have occurred, and the median age is thirty.<sup>14</sup>

33. On June 23, 2021, Dr. Matthew Oster, who serves on President Joe Biden's CDC COVID-19 Task Force, stated in a Power Point presentation that the mRNA vaccines are causing myocarditis in "young men aged 16 - 30", adding "It does appear that mRNA vaccines may be a new trigger for Myocarditis". See Matthew Oster, Overview of Myocarditis and Pericarditis: ACP COVID-19 Vaccines Work Group June 23, 2021.<sup>15</sup>
34. On June 29, 2021, the Defense Health Agency (DHA) published a report in the *Journal of the American Medical Association Cardiology* (JAMA) entitled, "Myocarditis Following Immunization with mRNA COVID-19 Vaccines in Members of the U.S. Military".<sup>16</sup> The study reports that previously healthy service members have developed myocarditis, a severe and life-threatening inflammation of the heart, within an average of just four days of receiving their first shot of either the Pfizer-BioNTech or the Moderna vaccine.
35. 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

---

<sup>14</sup> Id. <https://www.openvaers.com/COVID-19-data> (accessed July 17, 2021)

<sup>15</sup> <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-06/02-COVID-Oster-508.pdf> (last visited October 12, 2021); see also <https://nypost.com/2021/06/23/covid-19-vaccines-from-pfizer-moderna-likely-linked-to-rare-heart-condition-cdc-panel/>

<sup>16</sup> <https://jamanetwork.com/journals/jamacardiology/fullarticle/2781601> (last visited October 12, 2021).

P P Mc  
DKM

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.<sup>17</sup> Acute myocarditis can lead to sudden death.

36. The vaccine is also far less safe than previous vaccines like the meningococcal

---

<sup>17</sup> 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](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-myocarditis-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, Heffö T, Heymans S, Jahns R, Klingel K, Linhart A, Maisch B, McKenna W, Mogensen J, Pinto YM, Ristic A, Schultheiss HP, Seegewiss 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/ehz210. Epub 2013 Jul 3. PMID: 23824828

O P Mc  
O KM

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).

37. 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.<sup>18</sup>
38. 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.
39. 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 2). Further, milder side effects from the vaccine include changes in hormone and menstrual cycles in women, fever, swelling at the injection site, etc.<sup>19</sup>

---

<sup>18</sup> 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.

<sup>19</sup> 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,

P Mc  
D  
D KM

40. At the time of this report, the CDC/FDA as the US public vaccine sponsors have yet to present to America a comprehensive COVID-19 vaccine safety report according to manufacturer, region, and patient categories who have volunteered for vaccination. Likewise, there has been no comprehensive report on vaccine efficacy particularly in the present era of the Delta variant.
41. 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**

42. 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 were 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.

---

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)

O PMc  
OKM

43. 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.<sup>20</sup>
44. 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.
45. 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.
46. 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."*<sup>21</sup>

---

<sup>20</sup> 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)

<sup>21</sup> (<https://www.medrxiv.org/content/10.1101/2021.01.29.21250653v1>).

PMc

0

OKM

## Natural Immunity to COVID-19

47. 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.
  
48. It is my opinion that SARS-CoV-2 causes an infection in humans that results in robust, complete, and durable immunity, 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 12- to 17-year-old age bracket.
  
49. 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.<sup>22</sup>

---

<sup>22</sup> 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);

D P Mc  
D PKM

50. Cleveland Clinic studied their employees for the effects of natural immunity in unvaccinated people.<sup>23</sup> 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.
51. 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>.
52. 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

---

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/10.1101/2021.05.11.21256578v1> (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 naive and COVID-19 recovered individuals, bioRxiv (pre-print), <https://www.biorxiv.org/content/10.1101/2021.03.22.436441v1> (last visited June 26, 2021); Eilia 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 28, 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/10.1101/2021.04.20.21255670v1> (last visited 06/26/21).

<sup>23</sup> 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).

P Mc  
O KM  
D

COVID-19 are long-lasting.<sup>24</sup>

## CONCLUSION

53. In my expert medical opinion which is and is within a reasonable degree of medical certainty, despite the current Delta variant outbreak, the increasing likelihood of herd immunity to COVID-19, the low risk to children and adolescents of serious complications or death due to COVID-19, the negligible risk of asymptomatic spread of COVID-19, the vastly improved COVID-19 treatments currently available all make the risks inherent in COVID-19 significantly lower than they were in 2020.
54. 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 implying the vaccines have become obsolete with antigenic escape or resistance to variants (e.g. Delta) that have evolved to infect persons who were vaccinated against the now extinct wild-type SARS-CoV-2 strain.
55. 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. In my expert medical opinion, the risks associated with the investigational

---

<sup>24</sup> 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>

PMc  
D Km  
D

COVID-19 vaccines far 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 those who have the vaccine, especially those between the ages of 12 and 17 years of age, most of whom do not have the wherewithal to understand the risks they are taking on by taking the vaccine. Unfortunately, the risks of the vaccine, especially the risk of myocarditis are not widely known. It is important that these children be protected from the vaccines.

  
**DEPONENT**

THIS SIGNED AND SWORN TO AT Dallas TX USA ON THIS 28th DAY OF October 2021, THE DEPONENT HAVING ACKNOWLEDGED THAT HE KNOWS AND UNDERSTANDS THE CONTENTS OF THIS AFFIDAVIT, THAT IT IS BOTH TRUE AND CORRECT TO THE BEST OF HIS KNOWLEDGE AND BELIEF, THAT HE HAS NO OBJECTION TO TAKING THE PRESCRIBED OATH AND THAT THE PRESCRIBED OATH WILL BE BINDING ON HIS CONSCIENCE.

  
**COMMISSIONER OF OATHS**

**FULL NAMES:** Margaretha Wilhelmina van Dyk  
**DESIGNATION:** Practicing Attorney, VDMS Inc  
15 Orchard Road, Bordeaux,  
Randburg, South Africa  
**ADDRESS:** Commissioner of Oaths ex officio

KM  
D