

Updated Assessment of Protest-Related Deaths and Injuries in Iran: Validated Follow-Up Data and Conservative Nationwide Estimates

Observation period: 1 January 2026–23 January 2026

Updated data cut-off: 15 June 2026

Prepared by

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_ Report status

Updated human-rights documentation report and rapid-response casualty assessment

This report presents retrospectively validated clinical, emergency-care, and forensic data on deaths and injuries associated with the January 2026 demonstrations in Iran.

It is not an official national registry, a judicial determination, or a peer-reviewed epidemiological publication. Its purpose is to document the available evidence through a transparent, conservative, and reproducible methodology under conditions in which complete official and independently accessible national data remain unavailable.

_ Suggested citation

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_ Confidentiality and source protection notice

The identities of victims, family members, institutional reporters, and study coordinators are not disclosed in this report.

No victim names or other directly identifying personal information were entered into the central scientific database. Each case was assigned a unique study identification number. The corresponding link between the study identifier and the personal identity of the affected individual remained exclusively at the respective reporting site.

Source identities and institution-level identifying information are withheld where disclosure could expose participants, victims, relatives, or medical personnel to personal, professional, or legal risk.

1. Abstract

1.1 Background

Reliable casualty assessment during episodes of political violence is frequently impaired by restricted access, disrupted communications, delayed institutional reporting, fear of retaliation, and the absence of an independently accessible national registry. An earlier working paper of our Network presented validated clinical inputs and conservative nationwide estimates for deaths and injuries associated with the January 2026 demonstrations in Iran, based on information available up to 23 January 2026.

The present update incorporates retrospectively submitted and subsequently validated reports received through 15 June 2026. All included cases originated from or linked to the original observation period of 1–23 January 2026.

1.2 Methods

Data collection was coordinated by the Iran Casualty Documentation and Analysis Network (ICDAN), comprising 12 study coordinators, 86 institutional reporters, and 42 participating emergency-care and documentation sites.

A case was included only after two authorised reviewers at the same site jointly approved the record under the four-eyes principle.

No names or directly identifying victim data were transferred to the central database. Each confirmed case was assigned a unique study identification number consisting of a two-digit site code followed by an individual case number. The local link between the study identifier and the victim's identity remained at the respective site.

The update incorporates 17,567 retrospectively validated additional clinical deaths - in addition to the figures reported in our last report.

The update adds 32 execution-related deaths to the 970 cases reported previously, bringing the total to 1,002. Seventeen additional cases were reported in Tehran, 11 in Mashhad, and four in Shiraz. All included executions

were carried out during the observation period of 1–23 January 2026. Inclusion required source documentation identifying participation in those demonstrations as the stated reason for execution. Some cases became known to the network only after the initial data cut-off and were included when they were verified within the updated reporting period. All cases were locally assigned, verified, deduplicated within the separate forensic and detention-related pathway, and reconciled against locally accessible clinical records before inclusion.

The principal model applies a 10% under-ascertainment assumption only to the validated clinical deaths. The 1,002 documented execution-related deaths are then added without a separate completeness correction (2).

_ Potential underestimation

A national Iranian study using a three-source capture–recapture approach found that the Legal Medicine Organization registered approximately 86.9% of fatal injuries, implying an undercount of about 13%. The authors estimated 41,936 fatal injuries nationally compared with 36,442 officially recorded cases. Although the study addressed fatal injuries generally rather than protest-related deaths, it demonstrates that even established Iranian medico-legal registration systems may systematically miss a meaningful proportion of fatalities. Accordingly, the mortality figures presented in this report should be interpreted as minimum documented counts rather than complete estimates.

1.3 Results

The previously documented clinical total of 30,304 deaths increased by 17,567 retrospectively validated clinical cases, resulting in:

47,871

validated clinical deaths.

The model first adjusts the 47,871 validated clinical deaths for 10% under-ascertainment. It then adds the 1,002 documented execution-related deaths without extrapolation.

Combined documented basis = 47,871 clinical deaths + 1,002 execution-related deaths = 48,873 deaths.

The calculation proceeds in two steps:

Step 1 – Estimated clinical deaths: $47,871 \div 0.90 = 53,190$.

Step 2 – Combined estimate: $53,190 + 1,002 = 54,192$.

The resulting nationwide estimate is:

54,200 deaths

The calculation yields 54,192. Because the completeness assumption does not support case-level precision, the report presents the result as approximately 54,200 deaths.

1.4 Interpretation

The updated total is higher because delayed reports from peripheral and previously underrepresented institutions became available after the original data cut-off.

This is not a definitive national registry total. It is the best-supported current assessment based on internally validated reports and an explicit correction for residual under-ascertainment.

1.5 Conclusion

The updated ICDAN assessment identifies a combined documented basis of 48,873 deaths. The clinical component is adjusted using the 10% working assumption, while the 1,002 execution-related deaths are added without extrapolation. The principal narrative estimate is approximately 54,200 deaths associated with the January 2026 demonstrations.

The report separates documented clinical data, retrospective follow-up data, execution-related records, and the under-ascertainment assumption so that each step can be reviewed independently.

2. Executive Summary

2.1 Purpose of this Update

This report updates the earlier casualty assessment for the January 2026 demonstrations in Iran with information received and validated after the original data cut-off of 23 January 2026.

The report distinguishes three dates. The observation period (1–23 January 2026) defines when the qualifying event, injury, detention, or protest participation occurred. The date of death may be later when death resulted from that event. The updated data cut-off (15 June 2026) defines the final date for receiving, reviewing, and entering eligible records.

All included cases originated from the defined observation period:

1 January–23 January 2026

2.2 Nature of the Report

This is a human-rights casualty documentation report using transparent clinical and epidemiological methods.

It is not:

- an official Iranian national registry;
- a judicial finding concerning individual responsibility;
- an individual forensic certification of every victim's participation in a demonstration;
- or a peer-reviewed epidemiological publication.

Its purpose is to provide a transparent and reproducible assessment under conditions in which complete official data are unavailable and public identification of sources could expose victims, families, clinicians, and reporters to serious risk.

2.3 ICDAN Reporting Network

The update was prepared by the Iran Casualty Documentation and Analysis Network (ICDAN).

The current reporting structure comprises:

- 12 study coordinators in Iran
- 86 institutional reporters in Iran
- 42 participating emergency-care and documentation sites in Iran
- a central validation and analysis team in Munich

The participating sites include different types of institutions involved in emergency treatment, trauma care, surgery, ophthalmic referral, and forensic or detention-related documentation.

The 86 reporters do not represent 86 separate institutions. Multiple reporters may be connected to the same site.

2.4 Validation Protocol

No institutional count was accepted solely on the basis of a single reporter.

A case record was eligible for inclusion only after two authorised reviewers from the same site jointly approved it under the four-eyes principle before database entry.

Execution-related cases were processed through a separate reporting pathway.

The term validated refers to confirmation under this predefined internal protocol. It does not imply public, governmental, or independently name-based verification of every individual case.

2.5 Case Identification and Protection of Personal Data

No victim names were entered into the central study database.

Each confirmed case received a unique study identification number. The first two digits identify the reporting site, followed by the individual case number.

The connection between the study number and the victim's personal identity remained exclusively at the reporting site. It was not transferred to the coordinating team in Munich.

This structure enabled:

- local verification of individual cases;
- correction of erroneous entries;
- review of possible duplicate reports;
- clinical outcome follow-up where available;
- and protection of victims, relatives, reporters, and coordinators.

Because the local site retained the ability to reconnect the study number with the victim's identity, the data are properly described as pseudonymised, not completely anonymised.

2.6 Operational Case Definition

The dataset does not include routine hospital mortality or unrelated medical deaths.

A case was eligible when the reporting clinical, forensic, or detention-related source attributed the fatal injury or death to the use of firearms, weapons, lethal force, or another violent event causally associated with the January 2026 demonstrations.

The association with the protest context was established through the operational reporting definition. It was not dependent on proving that every deceased individual was personally participating in a demonstration at the exact time of injury.

The dataset may therefore include:

- demonstrators;
- bystanders;
- persons detained in connection with the demonstrations;
- and persons who later died from injuries sustained during the observation period.

Security and military personnel were excluded from the statistics to the extent that they could be identified as such by the hospital teams, particularly since separate figures for these groups had already been published by government authorities.

2.7 Updated Clinical Data

The earlier report documented:

30,304

clinical deaths.

The follow-up process identified:

17,567

additional retrospectively validated clinical deaths originating from the same observation period.

The updated clinical total is:

$30,304 + 17,567 = 47,871$

2.8 Execution-Related Deaths

In addition to the 970 execution-related deaths reported previously, a further:

32

Thirty-two additional execution-related deaths were identified after the initial data cut-off, producing an updated total of 1,002.

All included executions occurred during 1–23 January 2026. The reporting source had to document participation in the January 2026 demonstrations as the stated reason for execution. The 970 cases reported previously met the same inclusion criterion. The additional 32 cases were added because the network learned of and verified them only during the extended reporting period.

These cases:

- originated from a separate forensic and detention-related reporting pathway;
- were internally deduplicated;
- did not pass through the participating hospital-reporting pathway.

2.9 Principal Fatality Model

Before adjustment for clinical under-ascertainment, the combined documented basis is:

47,871 clinical deaths

plus:

1,002 execution-related deaths

giving:

48,873

fatality records.

The updated report assumes that approximately 10% of clinically documented protest-related deaths remained outside the validated clinical reporting network. No numerical completeness correction is applied to the execution-related pathway.

Accordingly:

Step 1 – Estimated clinical deaths: $47,871 \div 0.90 = 53,190$.

Step 2 – Combined estimate: $53,190 + 1,002 = 54,192$.

The principal conservative nationwide estimate is therefore:

Approximately 54,200 deaths

Under alternative clinical under-ascertainment assumptions of 5% and 15%, the combined estimates would be 51,393 and 57,321 deaths, respectively.

2.10 Rationale for Reduced Under-Ascertainment Assumption

The previous model used a 15% under-ascertainment assumption.

The current update reduces this assumption to 10% because:

- the network expanded to 12 coordinators;
- 86 institutional reporters are now involved;
- 42 emergency-care and documentation sites are covered;
- internet access was restored;
- delayed reports could be collected and reviewed;
- and previously underrepresented peripheral institutions were increasingly incorporated.

The 10% value is the principal working assumption used in the updated model. It is not an empirically measured completeness rate for the ICDAN dataset.

2.11 Interpretation of the Estimate

The estimate of approximately 54,200 deaths is not presented as an exact, final, or officially certified national total.

It is the result of four separately identifiable analytical components:

1. previously validated clinical reports;
2. retrospectively validated clinical follow-up reports;
3. separately reported execution-related deaths;
4. a 10% correction for residual under-ascertainment.

This structure allows journalists, researchers, policymakers, and human-rights investigators to examine each component separately rather than being asked to accept a single unexplained number.

2.12 Principal Limitations

The principal limitations are:

- source identities cannot be publicly disclosed;
- complete external auditing of individual records is therefore restricted;
- reporting coverage varies between regions;
- cross-site duplicate identification may be more difficult than duplicate identification within a single site;
- the 10% under-ascertainment parameter is assumed rather than directly measured;
- and the report is not an official national mortality registry.

These limitations do not invalidate the observed reports. They define the level of certainty with which the results should be interpreted.

2.13 Core Finding

As of the updated data cut-off of 15 June 2026, ICDAN had incorporated 47,871 clinical deaths validated under its internal protocol and linked to events or injuries during 1–23 January 2026. The model also includes 1,002 separately documented execution-related deaths. Together these form a combined documented basis of 48,873 deaths. After applying the 10% working assumption only to the clinical component, the principal narrative estimate is approximately 54,200 deaths.

3. Purpose and Status of the Report

This document provides an updated assessment of deaths and injuries associated with the demonstrations in Iran during the observation period from 1 January to 23 January 2026.

It incorporates reports received, reviewed, and validated through the updated data cut-off of 15 June 2026.

The report was prepared by the Iran Casualty Documentation and Analysis Network (ICDAN), comprising an Iran-based field documentation network and a central validation and analysis team in Munich, Germany.

The report has four principal purposes:

1. to document the casualty information obtained through participating clinical, emergency-care, forensic, and detention-related reporting pathways;
2. to distinguish clearly between directly reported case-level data, retrospectively validated and directly localised follow-up cases, execution-related case records, and modelled national estimates;
3. to describe the collection, validation, pseudonymisation, and analytical procedures in sufficient detail for independent methodological review;
4. to provide a current, conservative assessment where no complete and independently accessible national registry is available.

This document is best understood as a:

human-rights documentation report and rapid-response casualty assessment using transparent clinical and epidemiological methods.

It is not presented as:

- an official national mortality registry;
- a peer-reviewed epidemiological publication;
- an individual forensic opinion on every recorded death;
- a judicial determination of legal responsibility;
- or a final and immutable casualty total.

The findings remain subject to revision if additional verifiable information becomes available.

4. Observation Period, Reporting Period, and Data Cut-off

4.1 Observation Period

The defined observation period is:

1 January 2026–23 January 2026

All cases included in the updated assessment originated from events occurring within this period.

The observation period refers to the date of the qualifying protest-related event, injury, detention, execution, or participation. It does not define the period within which every record had to be reviewed, pseudonymised, or entered into the database. Retrospective review and database entry continued through the updated data cut-off of 15 June 2026. Clinical deaths following an injury could occur later when a direct causal link to the qualifying event was documented; all execution-related deaths included in this report occurred within 1–23 January 2026.

For execution-related cases, three dates must therefore be distinguished: the execution date, which had to fall within 1–23 January 2026; the date on which the network first learned of the case; and the date on which local review and database inclusion were completed. The latter two dates could fall after 23 January 2026.

4.2 Original Data Cut-off

The original working paper was closed on 23 January 2026, when the inflow of new institutional reports had slowed sufficiently to permit an initial analysis.

The original report therefore represented a time-stamped interim assessment rather than a fully reconciled final registry.

4.3 Updated Data Cut-off

The updated data cut-off is:

15 June 2026

This date indicates the point through which delayed reports were:

- received;
- cross-confirmed;
- reviewed for inclusion;
- reviewed for internal consistency and completeness;
- and incorporated into the updated dataset.

The updated cut-off does not extend the observation period.

Accordingly, the additional cases included in this version should be described as:

retrospectively validated follow-up reports concerning events originating within the original observation period.

They should not be described as deaths occurring between January and June 2026 unless the date of death itself fell later as a direct consequence of an injury sustained during the observation period.

4.4 Relevant Date Fields

Where available, ICDAN distinguished among:

- date of the protest-related event or injury;
- date of death;
- date of institutional reporting;
- date of validation;
- and date of entry into the central database.

Where precise event dates were unavailable, eligibility depended on confirmation by the reporting site that the case originated from the defined observation period.

5. Operational Case Definition

5.1 General Definition

A fatality was eligible for inclusion when the reporting clinical, forensic, or detention-related source attributed the death to:

- a firearm injury;
- another weapon-related injury;
- lethal force;
- severe physical trauma;
- or another violent event causally associated with the January 2026 demonstrations.

The causal relationship was established through the operational case definition applied by the reporting network.

It was not necessary to prove that every individual was an active demonstrator at the exact time of injury.

5.2 Potentially Included Persons

The dataset may therefore include:

- demonstrators;
- bystanders;
- persons injured during crowd-control or security operations;
- persons detained in connection with the demonstrations;
- individuals injured while assisting others;
- persons who died after transfer or delayed clinical deterioration;
- and execution-related cases in which the stated or documented reason for execution was directly attributable to participation in the January 2026 demonstrations.

5.3 Excluded Deaths

The following were not eligible:

- routine hospital mortality;
- deaths from unrelated natural disease;
- unrelated traffic accidents;
- unrelated occupational or domestic injuries;
- unrelated criminal violence;
- deaths supported only by media reports or social-media claims without site-based confirmation;
- and cases for which the temporal or causal relationship with the demonstrations could not be established under the reporting protocol;
- Security and military personnel.

5.4 Delayed Deaths

A person who survived the initial injury but later died from its direct complications remained eligible, provided that the original injury occurred within the observation period.

Such complications may include:

- hemorrhage;
- traumatic brain injury;
- sepsis;
- organ failure;
- respiratory failure;
- or postoperative complications causally linked to the original injury.

5.5 Meaning of “Protest-Related”

The term protest-related refers to the causal and operational context of the injury or death.

It does not necessarily mean:

- verified membership in a political organisation;
- confirmed attendance at a specific demonstration;
- or a completed legal determination that a state actor caused the death.

This distinction is essential to avoid conflating epidemiological inclusion with individual legal attribution.

4. ICDAN Network Structure

4.1 Network name

The updated report was prepared by:

Iran Casualty Documentation and Analysis Network

ICDAN

ICDAN is organised functionally into:

- Field Documentation Unit, Iran
- Central Validation and Analysis Unit, Munich

4.2 Current network composition

As of the updated data cut-off, the network comprised:

- 12 study coordinators
- 86 institutional reporters
- 42 participating sites

The 86 reporters are distributed across the 42 sites. Some sites have more than two reporters.

The 86 reporters do not represent 86 independent institutions. Likewise, the 42 sites are heterogeneous reporting units, not 42 equally sized hospitals with comparable case volumes.

4.3 Participating sites

The 42 sites include different types of facilities involved in emergency care or the documentation of acute injuries and deaths.

These include, depending on local structure:

- university hospitals;
- regional hospitals;
- emergency departments;
- trauma centres;
- surgical services;
- intensive-care units;
- ophthalmic referral centres;
- forensic facilities;
- detention-related medical services;
- and other institutions involved in acute care or formal documentation of deaths.

The term site refers to a defined institutional reporting unit with its own site code.

Where multiple departments belonged to the same institutional reporting structure, they were not automatically treated as separate sites.

4.4 Role of the study coordinators

The 12 study coordinators were responsible for:

- maintaining contact with assigned sites;
- supporting the local four-eyes review process;
- obtaining follow-up information;

- clarifying unresolved eligibility, classification, or coding questions before database entry;
- reviewing potential duplicate, transfer-related, and outcome-update cases before database entry;
- checking reporting periods and data completeness;
- confirming that only locally approved records entered the central dataset;
- applying the inclusion protocol;
- and transmitting validated, pseudonymised information to the central dataset.

4.5 Role of the institutional reporters

Institutional reporters were persons with direct or operational access to relevant information within their sites.

Depending on the institution, reporters included:

- physicians;
- surgeons;
- emergency physicians;
- ophthalmologists;
- nurses;
- medical-technical personnel;
- documentation personnel;
- forensic physicians;
- and other authorised institutional contacts.

Only persons with a plausible basis for access to the relevant institutional counts were used as confirming reporters.

External observers, social-media users, media organisations, and unverified third parties were not accepted as sufficient primary sources.

4.6 Central validation and analysis team

The central team in Munich was responsible for:

- database consolidation;
- review of validation status;
- numerical consistency checks;
- reconciliation of institutional totals;
- documentation of assumptions;
- calculation of modelled estimates;
- sensitivity analysis;
- and preparation of the report.

The Munich team did not receive victim names or the local re-identification keys.

5. Data Collection Process

5.1 Initial reporting

Each participating site identified relevant cases originating from the observation period.

The local reporting process drew on institutional records and available clinical or forensic documentation.

Depending on the site, these sources could include:

- emergency-department records;
- operating-room records;
- admission and discharge records;
- intensive-care records;
- mortality records;
- trauma logs;
- ophthalmic injury logs;
- forensic records;
- or detention-related documentation.

5.2 Reporter contact

At each site, two authorised reviewers examined the underlying case record before entry into the database.

The purpose of the local four-eyes review was to prevent a case from entering the database on the basis of a single unsupported assessment.

The reviewers jointly assessed identity, eligibility, classification, locality, and study coding. They were not treated as statistically independent data sources.

5.3 Institutional confirmation requirement

A case was entered only when both reviewers agreed on its inclusion and coding.

No institutional total was accepted solely on the basis of one reporter.

Cases on which agreement could not be reached were not entered. This procedure was an internal record-verification and quality-control process; it did not constitute independent external certification of the source record.

5.4 Follow-up reporting

After the original data cut-off, the expanded ICDAN network continued to obtain reports from:

- institutions that had not previously been reached;
- peripheral facilities;
- sites with delayed access to records;
- and institutions that required additional time to reconcile internal data.

The 17,567 additional clinical deaths are represented by individual case records. Each accepted record corresponds to one deceased person, is assigned to a reporting site and locality, and was validated retrospectively under the current protocol.

6. Case Identification and Pseudonymisation

6.1 No names in the central database

To protect:

- victims;
- relatives;
- institutional reporters;
- study coordinators;
- and participating sites,

no victim names were recorded in the central scientific database.

Other directly identifying personal information was likewise not transmitted to the central team.

6.2 Unique study identification number

Each case was assigned a unique study identification number.

The identifier consisted of:

- a two-digit site code;
- followed by the individual case number.

The structure can be represented schematically as:

XY–Case Number

where XY identifies the reporting site.

This system made each study identifier unique across the participating network.

6.3 Local identity linkage

The relationship between the study identifier and the victim's identity remained exclusively at the relevant site.

The central Munich team did not receive:

- names;
- addresses;
- national identification numbers;
- telephone numbers;
- or the local identity linkage file.

6.4 Correct terminology

Because the local site retained the ability to reconnect a study identifier with the person's identity, the data are described as pseudonymised and not fully anonymised.

6.5 Purpose of the local linkage

The locally retained linkage enabled:

- confirmation that a case represented a real individual;
- correction of entry errors;
- review of repeat admissions;
- local outcome follow-up;
- and investigation of possible duplicate reporting.

6.6 Source protection

The names of:

- study coordinators;
- reporters;
- victims;
- family members;
- and sensitive institutional contacts

are not published.

Institutional detail may also be withheld where disclosure could create a material risk of retaliation, professional sanction, detention, or other harm.

7. Validation Framework

7.1 Meaning of “validated”

Within this report, validated means that the information satisfied the predefined ICDAN internal reporting protocol.

It does not mean that:

- every case was publicly identified;
- every case was independently reviewed by an external institution;
- the government confirmed the case;
- or a court completed an individual forensic determination.

7.2 Levels of evidence

The report distinguishes four levels of evidence and analysis:

A. Previously validated case-level clinical data

Individual clinical case records attributed to a specific participating site, assigned a unique study identifier, and confirmed under the internal protocol.

B. Retrospectively validated case-level follow-up data

Additional individual clinical case records confirmed after the original cut-off, each assigned to a reporting site, a specific locality, and a unique study identifier.

C. Execution-related case-level data

Individual execution-related records obtained through the separate forensic and detention-related pathway, assigned and localised at case level, and internally deduplicated against that pathway.

D. Modeled nationwide estimate

The nationwide estimate derived by applying the stated residual under-ascertainment assumption to the documented clinical data.

7.3 Internal plausibility checks

The study coordinators and central team reviewed:

- consistency of the jointly reviewed case record and its study coding;
- consistency of reporting periods;
- whether the record represented a new case, a readmission, or a later outcome update;
- agreement of both reviewers on eligibility and causal classification;
- possible overlap between departments;
- possible transfers between sites;
- and whether the scale of reporting was compatible with the operational profile of the institution.

Where relevant and available, contextual indicators such as emergency throughput, surgical burden, intensive-care demand, and shortages of blood products were used only as supporting plausibility indicators.

They were not used as substitutes for case counts.

8. Inclusion and Exclusion Workflow

Under the current case-level protocol, a record was included only where the following conditions were met before database entry:

1. the case originated from the observation period;
2. the death or injury met the operational protest-related case definition;
3. the source had direct institutional access to the relevant information;
4. at least two authorised reviewers from the same site jointly verified each case record under the four-eyes principle before entry into the database;
5. agreement was reached between both reviewers on case identity, eligibility, and classification before database entry;
6. possible duplicate reporting had been reviewed;
7. the record was assigned a valid study identifier where case-level data were available;
8. directly identifying personal information was not transmitted centrally.

A case record was not entered where:

- the protest relationship could not be established;
- either of the two designated reviewers was unavailable;
- agreement between both reviewers on case identity, eligibility, or classification could not be reached;
- the reporting period was unclear;
- the number could not be distinguished from general hospital mortality;
- the information was based only on public rumours or media repetition;
- or duplication could not be adequately resolved.

9. Updated Data Categories

The updated dataset consists of three principal fatality components.

9.1 Previously validated clinical deaths

The original documented clinical total was:

30,304

These cases were reported in the previous working paper as hospital-registered or clinically documented deaths associated with the demonstrations.

9.2 Retrospectively validated clinical follow-up deaths

The follow-up process identified:

17,567

additional clinical deaths originating from the same observation period.

These cases were validated after the original data cut-off.

The updated clinical total is therefore:

$30,304 + 17,567 = 47,871$

9.3 Additional execution-related deaths

In addition to the 970 execution-related deaths reported in the earlier version, the updated reporting process identified:

32

additional execution-related deaths identified after the initial data cut-off. All included executions occurred during 1–23 January 2026, and the reporting source documented participation in the January demonstrations as the stated reason for execution.

These records arose through a separate forensic and detention-related reporting pathway.

They were internally deduplicated within that pathway and did not pass through the participating hospital-reporting structure.

9.4 Combined documented basis for the principal model

Before adjustment for clinical under-ascertainment, the combined documented basis is:

Combined documented basis = 47,871 clinical deaths + 1,002 execution-related deaths = 48,873 deaths.

This value precedes the correction for residual under-ascertainment.

10. Geographic Distribution Across Major Urban Areas

The table shows the geographic distribution of clinical deaths accepted under the current ICDAN protocol by the data cut-off of 15 June 2026. Each case record represents one deceased person. Major cities are listed separately; all other localities are grouped under “Other Cities.” This category contains 13,434 individually assigned deaths and replaces the earlier geographic estimate.

Region	Clinical deaths validated under the current protocol as of 15 June 2026
Tehran	11,306
Mashhad	3,912
Isfahan	2,601
Karaj	2,294
Shiraz	2,451
Tabriz	1,179
Qom	2,258
Ahvaz	1,422
Kermanshah	2,172
Urmia	600
Rasht	1,217
Zahedan	793
Hamadan	509
Kerman	548
Yazd	506
Ardabil	669
Other Cities	13,434
Total	47,871

11. Execution-Related Deaths

11.1 Definition

For this report, execution-related deaths are individually documented deaths reported through forensic or detention-related channels. Eligibility required evidence that the execution was carried out between 1 and 23 January 2026 and that participation in the demonstrations during that same period was the documented basis for the execution. A report could be received and validated after 23 January, but the execution date itself had to fall within the observation period. This is an operational documentation category based on the reported mode and attribution of death. It includes executions described by the reporting source as judicial, summary, or extrajudicial and does not require evidence that an ordinary judicial or appellate process was completed.

The category does not include:

- routine unrelated executions;
- deaths without a demonstrated connection to the January demonstrations;
- general prison mortality;
- or unconfirmed public allegations.

11.2 Reporting pathway

The execution-related cases were collected through a reporting pathway separate from the hospital-based clinical network.

They were not derived from emergency-department, operating-room, intensive-care, or hospital mortality records.

11.3 Previously reported execution-related deaths

The earlier report separately identified:

City	Previously reported execution-related deaths
Tehran	468
Mashhad	214
Qom	121
Shiraz	167
Total	970

These figures were previously kept separate from the national mortality estimate because potential overlap with hospital-reported deaths could not then be excluded with sufficient confidence.

11.4 Additional execution-related deaths

The updated reporting process identified a further:

32

additional execution-related deaths.

These cases:

- originated within the observation period;
- were associated with the demonstrations;
- were internally deduplicated within the separate reporting pathway;
- and did not pass through the participating hospital network.

City	Previously reported	Follow-up	Updated total
Tehran	468	17	485
Mashhad	214	11	225
Shiraz	167	4	171
Qom	121	0	121
Total	970	32	1,002

12. Duplicate Review and Reconciliation

12.1 Within-site duplicate control

Within each site, the local identity linkage allowed the reporting team to determine whether:

- the same person had been entered more than once;
- a readmission represented an existing case;
- a later outcome update belonged to a previously recorded individual;
- or a duplicate institutional record had been generated.

The unique study identifier was retained for the existing case rather than generating a new fatality record.

12.2 Execution-related records

Execution-related records were deduplicated within their separate forensic and detention-related pathway. Authorised reviewers within the protected field network reconciled these records against locally accessible clinical records using locally retained identity-linkage information. The 1,002 records cleared through this process were included as a separate, non-duplicative component of the principal model; no direct identifiers or re-identification keys were transferred to the central Munich database.

For the purposes of the principal model, only execution-related records cleared through this protected local reconciliation process were included as distinct from the clinical deaths.

12.3 Completion of protected local cross-pathway reconciliation

Only execution-related records cleared through the completed protected local reconciliation were included in the model. Records requiring unresolved clarification were not included.

No unresolved suspected duplicate was intentionally counted twice.

13. Nationwide Fatality Model

13.1 Documented clinical component

The updated validated clinical count is:

$$30,304 + 17,567 = 47,871$$

13.2 Additional non-hospital component

The updated model adds the complete execution-related total of:

1,002

execution-related deaths from the separate reporting pathway.

13.3 Combined documented basis

Combined documented basis = 47,871 clinical deaths + 1,002 execution-related deaths = 48,873 deaths.

The value 48,873 is the combined documented basis before model-based adjustment of the clinical component.

It is not yet the final nationwide estimate.

13.4 Residual under-ascertainment

The model assumes that 10% of relevant clinical deaths remained outside the validated clinical network.

The 47,871 validated clinical deaths are treated as representing 90% of the clinical total. The 1,002 documented execution-related deaths are added without extrapolation.

13.5 Calculation

Step 1 – Estimated clinical deaths: $47,871 \div 0.90 = 53,190$.

Step 2 – Combined estimate: $53,190 + 1,002 = 54,192$.

Step 2 - Principal combined estimate: $53,190 + 1,002 = 54,192$.

Principal narrative estimate:

Approximately 54,200 deaths

13.6 Interpretation of precision

The value 54,192 is retained only as the technical calculation output for transparency and reproducibility.

Because the working assumption does not support individual-case precision, it is not presented as a separate narrative result.

Throughout summaries and public communication, the report uses approximately 54,200 deaths.

14. Under-Ascertainment Assumption

14.1 Previous assumption

The earlier working paper used a 15% under-ascertainment assumption.

That assumption was intended to account for deaths:

- outside hospital pathways;
- in inaccessible regions;
- delayed in reporting;
- or otherwise absent from the validated dataset.

14.2 Updated assumption

The current report reduces the under-ascertainment assumption to:

10%

14.3 Rationale for the reduction

The lower assumption reflects the strengthened reporting structure:

- expansion from eight to 12 study coordinators;
- access to 86 reporters;
- coverage of 42 sites;
- restoration of broader internet access;
- extended retrospective follow-up through 15 June 2026;
- and improved access to peripheral and previously underrepresented institutions.

14.4 Empirical context

The assumption remains model-based rather than directly measured in the current dataset.

An Iranian three-source capture-recapture study of fatal-injury registration estimated registration completeness at 86.9%, corresponding to approximately 13.1% of fatal injuries being missed by the examined registration system. (2)

The current 10% correction is therefore more conservative than the under-registration level reported in that study.

The principal model does not apply the clinical under-ascertainment parameter to the execution-related pathway. The cited empirical evidence concerns fatal-injury registration and does not establish the completeness of execution-related reporting. The 1,002 documented execution-related deaths are therefore added as an observed component without numerical extrapolation.

14.5 Limits of the comparison

The cited study concerned formal fatal-injury registration under ordinary institutional conditions.

It did not examine protest-related deaths during a political crisis.

It therefore supports the plausibility of a non-zero correction but does not directly prove that 10% is the exact missed proportion in the ICDAN dataset.

14.6 Correct interpretation

The 10% parameter should be described as:

a conservative residual under-ascertainment assumption informed by the expanded coverage of the updated network and by published evidence that fatal-injury registration systems do not achieve complete capture.

It should not be described as a measured error rate.

15. Sensitivity Analysis

The sensitivity analysis recalculates the 47,871 validated clinical deaths under alternative completeness assumptions and then adds the fixed total of 1,002 execution-related deaths.

Assumed clinical under-ascertainment	Implied completeness	Combined estimated deaths
0%	100%	48,873
5%	95%	51,393
10%	90%	54,192
15%	85%	57,321
20%	80%	60,841

15.1 Main scenario

The principal estimate uses the 10% scenario:

54,192

15.2 Lower-bound interpretation

The uncorrected combined documented basis of:

48,873

can be read as the most conservative documented basis used in the model.

15.3 Range interpretation

The sensitivity analysis shows that the combined estimate is approximately 51,393 under a 5% clinical correction and approximately 57,321 under a 15% clinical correction. The execution-related component remains fixed at 1,002 in every scenario.

The purpose of the table is not to select the highest estimate.

It is to show openly how the result changes when the key assumption changes.

16. Scope of the Current Update

The present update is limited to the revised mortality dataset and its associated completeness model. The ocular-injury and total-injury analyses from the earlier working paper were not updated during the current follow-up cycle. They are therefore excluded from this report, including all related tables and numerical scenarios. They remain part of the historical working paper and do not contribute to the documented basis or the principal mortality estimate presented here.

17. Interpretation of the Updated Findings

17.1 Main finding

The updated ICDAN dataset substantially increases the documented fatality basis associated with the demonstrations during the observation period of 1–23 January 2026.

The clinical count increased from:

30,304

to:

47,871

through retrospectively validated follow-up reports.

After inclusion of:

32

additional execution-related deaths from the separate forensic and detention-related pathway, the combined documented basis used in the principal model is:

48,873

Applying the principal 10% residual under-ascertainment assumption to the clinical component gives the technical model result of:

54,192

The report presents this result narratively as:

approximately 54,200 deaths

17.2 Why the updated figure is higher

The increase should not be interpreted as evidence that all additional deaths occurred after publication of the earlier working paper.

Rather, it primarily reflects delayed access to cases originating within the same observation period.

The principal reasons include:

- delayed reconciliation of institutional records;
- the gradual inclusion of peripheral emergency-care facilities;
- expansion of the coordinator and reporter network;
- improved communication conditions;
- additional time for local four-eyes case review;
- and the later availability of forensic and detention-related information.

17.3 Meaning of the documented basis

The value of 48,873 represents the combined documented basis described in the report. It is not treated as a single population to which one uniform completeness factor is applied.

It consists of:

- 47,871 validated clinical deaths;
- and 1,002 execution-related deaths cleared through protected local identity-based reconciliation as distinct from the clinical reporting dataset.

It should not be described as an official or externally certified national total.

17.4 Meaning of the modelled estimate

The figure of approximately 54,200 is an estimate derived from an explicit completeness assumption.

It should be described as:

a conservative nationwide model based on a 10% residual under-ascertainment correction applied to the validated clinical count, plus 1,002 separately documented execution-related deaths without extrapolation.

It should not be described as:

- a definitive final count;
- an exact registry total;
- or a legally adjudicated number of victims.

17.5 Why the estimate remains conservative

Several features of the method were designed to avoid overstatement:

- each case record required joint approval by two authorised institutional reviewers before entry;
- possible duplicates were reviewed;
- the under-ascertainment assumption was reduced from 15% to 10%;
- and the exact model output was rounded appropriately in public communication.

17.6 Remaining uncertainty

The main uncertainty is not whether every individual case can be publicly named.

For security reasons, that is neither possible nor appropriate.

The principal remaining uncertainties concern:

- incomplete national coverage;
- imperfect access to deaths outside formal emergency-care pathways;
- the exact completeness of detention-related reporting;
- the model-based nature of the 10% clinical correction; and the unknown completeness of the execution-related pathway, for which no numerical correction was applied.

These uncertainties should be addressed through transparent sensitivity analysis rather than hidden behind a single unsupported point estimate.

18. Strengths of the Documentation Framework

18.1 Direct institutional access

The dataset was not constructed by counting repeated media reports, social-media posts, or publicly circulating name lists.

It was built through direct institutional reporting relationships involving emergency-care, trauma, surgical, ophthalmic, forensic, and detention-related sources.

18.2 Local four-eyes review

No current-version case record was entered on the basis of review by a single person.

Under the current protocol, two authorised reviewers from the same institution examined the underlying case record under the four-eyes principle and had to agree on identity, eligibility, classification, and study coding before entry. Cases on which agreement could not be reached were not entered into the central dataset.

18.3 Pre-entry consensus control

The current protocol did not compare two independently submitted cumulative totals. Both reviewers examined the same case record, and only jointly approved cases were entered.

Consequently, no post-entry discrepancy between two reporter totals arose under the current study rules. The earlier 30% discrepancy rule applied only to the initial working paper and is described solely in the version history.

18.4 Case-level pseudonymisation

The use of unique study identifiers allowed local verification without transferring names to the central database.

This created a balance between:

- source protection;
- victim protection;
- local case traceability;
- and central data minimisation.

18.5 Functional separation

The field documentation network and the central analysis team had distinct roles.

The field network collected and validated institutional information.

The Munich team consolidated, checked, modelled, and reported the data.

18.6 Separation of observations and assumptions

The report distinguishes between:

- documented clinical counts;
- retrospective follow-up reports;
- execution-related inputs;
- and national under-ascertainment correction.

This separation allows each analytical step to be examined independently.

18.7 Versioned updating

The report treats casualty assessment as a revisable process.

Earlier figures are not silently replaced.

Instead, new information is added through an updated version with a defined data cut-off and an explicit description of the changes.

19. Limitations

19.1 No official national registry access

ICDAN did not have access to a complete official national mortality registry for protest-related deaths.

The report therefore cannot claim full national ascertainment.

19.2 Restricted external auditability

The names of victims, reporters, coordinators, and sensitive institutions cannot be publicly disclosed.

This protects individuals from potential harm but limits public case-by-case replication.

19.3 Internal rather than public validation

The term validated refers to the ICDAN internal protocol.

It does not imply that every case has been independently and publicly confirmed by an external body.

19.4 Unequal regional coverage

The distribution of participating sites is not equivalent to a nationally representative probability sample.

Urban and referral institutions may be better represented than rural or isolated facilities.

19.5 Variable institutional record quality

The quality and completeness of source records may differ across sites.

Some institutions may have had:

- complete case logs;
- fragmented departmental records;
- delayed mortality reconciliation;
- or limited access to archived documentation.

19.6 Execution-related terminology

The category “execution-related deaths” reflects the description used by the relevant forensic or detention-related reporting pathway.

It does not constitute an individual legal judgment for each case.

19.7 Separation of execution-related records

The 1,002 execution-related deaths were processed through the separate forensic and detention-related pathway and cleared through protected local identity-based reconciliation as distinct from the clinical dataset. All included executions occurred during 1–23 January 2026. Eligibility required source documentation identifying participation in those demonstrations as the stated reason for execution. The 32 cases added in this update were learned of and verified only after the initial data cut-off.

The reconciliation was performed by authorised reviewers within the protected field network using locally retained identity-linkage information. The central Munich dataset received only pseudonymised records and did not receive names, national identification numbers, or local re-identification keys.

19.8 Under-ascertainment cannot be directly measured

The 10% clinical correction is an explicit model assumption.

It is supported by the expanded clinical reporting network and published evidence on incomplete fatal-injury registration, but it is not a directly observed parameter in the ICDAN dataset and is not applied to execution-related deaths.

19.9 No prospective formal ethics review

The documentation effort began under emergency human-rights conditions.

It was governed by a shared operational agreement among the study coordinators and the central Munich team rather than by a prospective formal ethics protocol.

The absence of such review should be acknowledged, but it does not alter the numerical validation rules applied to the dataset.

19.10 No claim of definitive finality

The report represents the best-supported assessment available at the updated data cut-off.

Further verifiable reports may lead to future revisions.

20. Frequently Raised Methodological Questions

FAQ 1 — Are these all hospital deaths from every medical cause?

No.

The dataset excludes routine hospital mortality and unrelated medical deaths.

It includes deaths that met the operational definition for a causal relationship with the demonstrations.

FAQ 2 — Was every deceased person individually proven to have participated in a protest?

No.

Eligibility was based on the protest-related context of the injury or death as reported by the institutional source.

The dataset may include demonstrators, bystanders, detained persons, and others affected by violence associated with the events.

FAQ 3 — What period do the figures cover?

All included cases originated from or linked to events during:

1 January–23 January 2026.

The updated data cut-off of 15 June 2026 refers to the receipt and validation of delayed reports.

FAQ 4 — Why were so many additional cases identified after January?

Many institutions required additional time to reconcile internal records.

The network also expanded to 12 coordinators, 86 reporters, and 42 sites, improving access to previously underrepresented locations.

FAQ 5 — What does “validated” mean?

It means the information met the ICDAN internal validation protocol.

Two authorised reviewers from the same site had to agree on the individual case record before entry into the database.

FAQ 6 — How did the four-eyes review work?

Two authorised reviewers from the same institution examined the underlying case record and had to agree on identity, eligibility, classification, locality, and study coding before entry. Cases on which agreement could not be reached were not entered. The procedure was an internal quality-control mechanism and did not constitute independent external certification.

FAQ 7 — What happened if the two reviewers did not agree?

The case was not entered into the central dataset unless the disagreement was resolved and both reviewers approved the final record.

FAQ 8 — Were victim names recorded?

No victim names were entered into the central database.

Each case received a unique study identifier.

FAQ 9 — Could the victims still be verified?

Yes, at the local site.

The site retained the link between the study number and the victim's identity.

This link was not transmitted to Munich.

FAQ 10 — Are the data anonymous?

They are pseudonymised, not fully anonymous.

The local reporting site retains the ability to reconnect the identifier with the person's identity.

FAQ 11 — What are the 1,002 execution-related deaths?

The total comprises 970 cases included in the earlier version and 32 additional cases that were reported and validated after the original data cut-off: 17 in Tehran, 11 in Mashhad, and 4 in Shiraz. For all 1,002 cases, eligibility required source documentation that the execution was carried out between 1 and 23 January 2026 and that participation in the demonstrations during that period was the stated basis for execution. Later reporting or validation did not extend the permitted execution-date window. All cases entered through the separate forensic and detention-related pathway.

FAQ 12 — How was the estimate of 54,192 calculated?

The combined documented basis before model-based adjustment was:

Combined documented basis = 47,871 clinical deaths + 1,002 execution-related deaths = 48,873 deaths.

The report applies the 10% correction only to the clinical count and then adds the documented execution-related deaths:

Step 1 – Estimated clinical deaths: $47,871 \div 0.90 = 53,190$.

Step 2 – Combined estimate: $53,190 + 1,002 = 54,192$.

FAQ 13 — Why use 10% under-ascertainment?

The network expanded substantially, communication improved, and delayed reports were incorporated.

The earlier 15% assumption was therefore reduced.

The 10% figure remains an explicit conservative model assumption.

FAQ 14 — Does the report assign criminal responsibility?

No. It documents reported deaths and injuries and provides casualty estimates.

It does not determine individual criminal responsibility.

FAQ 15 — Could the figures change again?

Yes. ICDAN will revise the assessment if additional verifiable evidence becomes available.

21. Correction and Version History

Version 1 – Initial working paper

Data cut-off: 23 January 2026

Principal figures included:

- 30,304 reported clinical deaths;
- 24,420 validated eye injuries;
- at least 700 enucleations;
- 970 execution-related deaths reported separately;
- and a modelled nationwide fatality estimate of 33,130 under the earlier methodology.

Last Version reported 30,304 clinical deaths: 25,654 from individually listed cities and 4,650 grouped under “Other Cities.”

For the conservative national model, the full 4,650 was replaced by the lower geographic completion value of approximately 2,506. This reduced the analytical subtotal to approximately 28,160.

Treating that subtotal as 85% complete produced the earlier national estimate of approximately 33,130 deaths. The difference between 30,304 and 28,160 therefore reflects a conservative modelling adjustment, not missing records.

In the earlier working paper, execution-related cases remained separate because cross-pathway reconciliation was incomplete. For this update, authorised local reviewers used the identity-linkage information retained within the protected field network to compare execution-related records with locally accessible clinical records.

Only records cleared as distinct were transmitted to the central dataset in pseudonymised form.

Version 2 — Current updated report

Updated data cut-off: 15 June 2026

Main changes:

- the systematic assignment of pseudonymised case records to unique study identification numbers, while all direct personal identifiers and local re-identification keys remained exclusively at the respective reporting sites;
- network expanded to 12 study coordinators;
- 86 institutional reporters;
- 42 participating sites;
- 17,567 retrospectively validated additional clinical deaths;

retrospective validation of the previously modelled “Other Cities” component and replacement of that estimate with a total of 13,434 deaths validated under the current ICDAN protocol as of the updated data cut-off;

- 32 additional execution-related deaths, increasing the execution-related total from 970 to 1,002 ($970 + 32 = 1,002$);
- residual under-ascertainment assumption reduced from 15% to 10%;
- principal estimated nationwide fatality total updated to approximately 54,200;
- case definition and validation procedures clarified;
- pseudonymisation and source-protection procedures described in greater detail;
- limitations and frequently raised methodological questions expanded.

22. Recommended Citation and Interpretation

_ Preferred formulation

ICDAN documented 47,871 clinical deaths validated under its internal protocol and 1,002 separately documented execution-related deaths linked to participation in the demonstrations of 1–23 January 2026. Applying the 10% working assumption only to the clinical count, and then adding the execution-related deaths without extrapolation, gives the principal narrative estimate of approximately 54,200 deaths.

_ Acceptable shorter formulation

ICDAN estimates approximately 54,200 protest-related deaths. This principal narrative estimate combines an adjusted clinical estimate derived from 47,871 internally validated clinical deaths with 1,002 separately documented execution-related deaths that are not extrapolated.

23. Conclusion

The updated ICDAN assessment substantially expands the documented fatality basis for the January 2026 demonstrations in Iran.

The report identifies:

47,871

validated clinical deaths and:

1,002

total execution-related deaths used in the principal model.

This produces a combined documented basis of:

48,873

fatality records.

After applying a conservative residual under-ascertainment assumption of 10% to the clinical count only and then adding the 1,002 documented execution-related deaths, the estimated nationwide death toll is:

54,192

or approximately:

54,200 deaths

The report does not claim to replace a complete national registry.

Its central contribution is the transparent separation of:

- directly reported clinical data;
- retrospectively validated follow-up reports;
- execution-related reports;
- and the national under-ascertainment assumption.

The figures should therefore be judged not by institutional authority or political alignment, but by the clarity of the underlying definitions, validation rules, calculations, and stated limitations.

24. Data Provenance Statement

The figures presented in this report originate from the ICDAN reporting network and were collected through participating emergency-care, trauma, surgical, ophthalmic, forensic, and detention-related sites.

The central dataset was not created from open-source media aggregation.

Publicly reported figures, social-media posts, and media articles could be used to identify questions requiring further inquiry, but they were not sufficient on their own for inclusion in the validated dataset.

For inclusion, information had to enter through the ICDAN reporting pathway and satisfy the applicable case-level review, coding, and duplicate-control rules.

The principal sources of information included:

- institutional emergency and mortality records;
- trauma and surgical records;
- intensive-care documentation;
- ophthalmic injury records;
- forensic records;
- detention-related documentation;
- and follow-up confirmation from authorised institutional reporters.

Because public disclosure of the names of reporters and participating institutions could expose individuals to serious risk, identifying source details are not included in the public report.

This restriction protects the reporting network but limits public source-level replication.

Accordingly, the report provides transparency through:

- a detailed description of the reporting structure;
- explicit validation criteria;
- disclosure of the number of coordinators, reporters, and sites;
- reproducible calculations;
- separation of documented case-level components from the modelled under-ascertainment correction;
- and clear discussion of limitations.

25. Data Governance and Access

25.1 Operational governance

The documentation project was initiated as an emergency human-rights and clinical documentation effort.

The operational rules were agreed among:

- the study coordinators in Iran;
- and the central validation and analysis team in Munich.

The agreed framework included:

- data minimisation;
- exclusion of names from the central database;
- use of unique study identifiers;
- restricted database access;
- source confidentiality;
- conservative validation rules;
- and controlled use of the data for documentation and analysis.

25.2 Central database access

Access to the central database was restricted to authorised members of the documentation and analysis structure.

Institutional reporters did not receive unrestricted access to the complete national dataset merely by participating in the reporting network.

The principle applied was:

access only to the extent required for the individual's assigned documentation, validation, or analytical function.

25.3 Local responsibility

Each participating site remained responsible for:

- the local identity linkage;
- local verification of the reported case;
- correction of local data;
- and secure handling of any identifying information retained at the site.

The Munich central team did not hold the local identification keys.

25.4 Use of the data

The central dataset was used only for casualty documentation, internal validation, aggregate analysis, and preparation of this report.

External communication was limited to aggregate findings, methodological descriptions, and the published report. Neither pseudonymised case records nor case-level datasets were provided to journalists, governmental bodies, human-rights organisations, medical institutions, researchers, or other external stakeholders.

The dataset was not intended for public identification of victims, disclosure of individual medical information, external case-level review, commercial use, or determination of individual criminal liability.

26. Security and Confidentiality Considerations

The confidentiality measures described in this report are not merely conventional research precautions.

They are necessary because disclosure may create risks for:

- victims who survived;
- family members of deceased persons;
- physicians and medical personnel;
- institutional reporters;
- study coordinators;
- and participating institutions.

Potential risks include:

- interrogation;
- detention;
- professional retaliation;
- dismissal;
- loss of medical licence or institutional position;
- surveillance;
- pressure on relatives;
- and destruction or manipulation of records.

For this reason:

- reporters are described by role rather than by name;
- participating sites may be described in aggregate;
- no victim names appear in the report;
- and local re-identification information remains decentralised.

Source identities cannot be published for security reasons, but supporting documentation remains within the protected reporting network. Decentralised retention of identity-linkage files reduces central exposure but leaves a residual local risk of coercive access, surveillance, device compromise, or seizure.

Each participating site was responsible for minimising locally retained identifying data, restricting access to authorised personnel, separating identity-linkage information from study records, and using storage practices appropriate to local conditions. These measures reduce exposure but cannot guarantee confidentiality in a setting involving surveillance, coercion, device compromise, or seizure. The four-eyes principle is a data-quality control and does not itself provide cybersecurity or physical protection.

27. Statistical and Analytical Principles

27.1 Conservative analytical choices

Where an analytical assumption allowed more than one defensible scenario, the report favoured the lower supported estimate. This principle was applied to modelled analyses, not to disagreement between current-protocol case reviewers.

This principle was used to reduce the risk of inflation.

27.2 No automatic extrapolation from a single high-burden site

The national estimate was not derived by multiplying the highest reported city rate across the country.

Instead, the model was based on:

- accumulated validated reports;
- separately identified non-hospital cases;
- and a defined residual under-ascertainment parameter.

27.3 Distinction between counts and estimates

The report uses the following terms consistently:

Count

A directly reported numerical value within an ICDAN reporting pathway.

Validated count

A count accepted after satisfying the applicable ICDAN internal protocol as of the stated data cut-off. Validation does not imply external certification or finality.

Estimate

A value produced by applying an explicit mathematical assumption to a documented count.

Scenario

An alternative result showing how the estimate changes when an assumption changes.

27.4 Rounding

Exact arithmetic results are shown where useful for reproducibility.

Narrative totals are rounded to avoid false precision.

The exact arithmetic output is 54,192. Because the model does not support individual-case precision, the report presents one principal narrative estimate:

approximately 54,200 deaths.

27.5 Reproducibility

The principal estimate can be reproduced from the published components:

Combined documented basis = 47,871 clinical deaths + 1,002 execution-related deaths = 48,873 deaths.

Step 1 – Estimated clinical deaths: $47,871 \div 0.90 = 53,190$.

Step 2 – Combined estimate: $53,190 + 1,002 = 54,192$.

The exact calculation is retained only for reproducibility; approximately 54,200 is the single narrative result used in summaries and public communication.

28. Alternative Analytical Presentations

28.1 Clinical-only documented total

47,871

This includes only the previously reported and retrospectively validated clinical deaths.

28.2 Combined documented basis

Combined documented basis = 47,871 clinical deaths + 1,002 execution-related deaths = 48,873 deaths.

This includes the execution-related cases cleared through protected local identity-based reconciliation as distinct from the clinical dataset.

28.3 Clinical estimate with 10% under-ascertainment

$47,871 \div 0.90 = 53,190$

This may be presented as a supplementary estimate:

approximately 53,200 deaths based on the clinical dataset alone.

28.4 Principal combined estimate

Step 1 – Estimated clinical deaths: $47,871 \div 0.90 = 53,190$.

Step 2 – Combined estimate: $53,190 + 1,002 = 54,192$.

This is the preferred principal estimate:

approximately 54,200 deaths.

28.5 Purpose of presenting both estimates

Showing both values prevents the reader from assuming that the entire national conclusion depends on the execution-related component.

The difference between the clinical-only and combined models is:

$54,192 - 53,190 = 1,002$

Thus, even without adding the complete total of 1,002 execution-related cases, the clinical-only model remains above approximately 53,000 deaths.

29. Quality-Control Questions Applied to Follow-Up Reports

For each follow-up report, the responsible coordinator was expected to consider the following questions:

1. Does the report refer to the defined observation period?
2. Is the figure cumulative or incremental?
3. Does it replace an earlier institutional figure?
4. Was the case reviewed and approved by both designated institutional reviewers before entry?
5. Do the reporters have direct institutional access to the relevant records?
6. Did both authorised institutional reviewers agree on case identity, eligibility, classification, and coding before entry into the current database?
7. Does the report concern deaths, injuries, eye injuries, or another metric?
8. Could the same cases already be included in an earlier submission?
9. Does the figure include transfers from another participating site?
10. Is the protest-related case definition met?
11. Does the report exclude routine hospital mortality?
12. Is the institutional reporting period clearly documented?
13. Is the case-level assignment, locality, and validation status known?
14. Has the report been entered with the correct site code?
15. Is any uncertainty or unresolved issue recorded?

30. Human-Rights Relevance

The purpose of casualty documentation extends beyond numerical estimation.

Reliable documentation can contribute to:

- recognition of victims;
- preservation of evidence;
- assessment of the scale and pattern of violence;
- future medical and psychosocial support;
- human-rights investigations;
- historical documentation;
- and possible future legal review.

However, the present report does not itself determine:

- whether an individual act constituted murder;
- whether a particular official ordered an act;
- whether the legal threshold for a crime against humanity was met;
- or which institution bears criminal responsibility.

Those determinations require separate legal analysis based on a broader evidentiary record.

The casualty data may inform such processes, but casualty counting and legal attribution remain distinct tasks.

31. Journalistic Use and Citation Guidance

Journalists using the report should distinguish between:

- documented clinical deaths;
- additional execution-related reports;
- and the modelled national estimate based solely on the under-ascertainment assumption.

A report should not state simply:

ICDAN reports one principal narrative estimate: approximately 54,200 deaths. This is a model-based estimate, not an exact confirmed national total.

A more accurate formulation is:

ICDAN documented 47,871 clinical deaths validated under its internal protocol and 1,002 separately documented execution-related deaths linked to participation in the demonstrations of 1–23 January 2026. Applying the 10% working assumption only to the clinical count, and then adding the execution-related deaths without extrapolation, gives the principal narrative estimate of approximately 54,200 deaths.

Where space permits, journalists should also state that:

- all cases originated from 1–23 January 2026;
- follow-up reports were validated through 15 June 2026;
- and "Other Cities" contains 13,434 individually assigned clinical deaths validated under the current protocol as of 15 June 2026; it replaces the earlier geographic estimate and is not added to it.

32. Policy Use

Governmental, parliamentary, and human-rights institutions should treat the report as:

- an evidence-informed casualty assessment;
- an indicator of the probable scale of mortality;
- and a basis for further investigation.

It should not be treated as a substitute for:

- unrestricted access to official registries;
- exhumation or forensic investigation;
- individual death certification;
- or a comprehensive national commission of inquiry.

Appropriate policy responses may include:

- demands for preservation of hospital and forensic records;
- protection of healthcare workers and witnesses;
- support for independent investigations;
- documentation of survivors and long-term disability;
- and preparation for future verification and reconciliation.

6. References

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34. Network and Author Profile

Iran Casualty Documentation and Analysis Network

The Iran Casualty Documentation and Analysis Network (ICDAN) is a human-rights-oriented clinical and forensic documentation network.

At the updated data cut-off, ICDAN comprised:

- 12 study coordinators;
- 86 institutional reporters;
- and 42 participating emergency-care and documentation sites in Iran.

Its activities include:

- collection of casualty information;
- site-level confirmation;
- source protection;
- pseudonymised documentation;
- validation of institutional reports;
- and transparent analysis of aggregate mortality and injury data.

The Field Documentation Unit operates through the participating network in Iran.

The Central Validation and Analysis Unit is based in Munich, Germany.

Author

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His clinical and humanitarian work has included the treatment and support of persons who sustained ocular and other injuries in connection with political violence in Iran.

Following the 2022 protest movement, he participated in the development of a clinical network connecting physicians and other medical professionals inside Iran and in the diaspora.

This network subsequently evolved into a more structured documentation and analysis framework and now operates under the name ICDAN.

_ Final Report Notice

This report preserves and analyses casualty information where complete official access is unavailable and disclosure could endanger sources. It is a human-rights documentation assessment, not an official national registry or judicial finding.

ICDAN distinguishes between directly documented cases, retrospectively validated reports, and nationwide estimates. Readers are encouraged to examine the definitions, numerical inputs, assumptions, and limitations separately.

__ CONTACT INFORMATION

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