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Forensic Analysis of Suicidal Hanging Incidents: A study in a Tertiary Care Hospital in Bangladesh

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Abstract

Suicidal hanging constitutes a significant proportion of medicolegal autopsies in Bangladesh, yet region-specific epidemiological data from tertiary care hospitals remain limited. Understanding the demographic and circumstantial patterns of these fatalities is crucial for developing targeted prevention strategies. The objective of this study was to analyze the forensic and epidemiological characteristics of suicidal hanging cases autopsied at a tertiary care hospital in Bangladesh. This prospective cohort study was conducted in the Department of Forensic Medicine at Sir Salimullah Medical College, Mitford Hospital, Dhaka, Bangladesh, from January 2025 to December 2025. A total of 61 cases of suicidal hanging were selected using a purposive sampling technique. Data were collected from post-mortem examination reports, inquest reports, and interviews with family members and were analyzed using SPSS version 23.0. The study found that suicidal hanging was most prevalent among young adults aged 21-30 years, with a male predominance (male-to-female ratio of 1.8:1). The majority of victims were married (62.3%) and from lower socioeconomic backgrounds (59.0%). Hanging was most commonly performed using a soft ligature (75.4%), with a fixed point of suspension (91.8%), and a complete suspension type (73.8%). Financial problems (29.5%) and family disputes (26.2%) emerged as the leading predisposing circumstances. In most cases (85.2%), suicide notes were not left by the deceased. Suicidal hanging in this Bangladeshi cohort primarily affects younger, married males facing socioeconomic stressors. The findings underscore the need for targeted mental health support, crisis intervention, and financial counseling to mitigate suicide risk.

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Introduction

Suicide represents a critical global public health challenge, accounting for over 700,000 annual deaths worldwide according to the World Health Organization.[1] As a preventable cause of mortality, suicide has garnered increasing attention from researchers, policymakers, and healthcare providers seeking to understand its epidemiology and develop effective intervention strategies.[2] The global burden of suicide disproportionately affects low- and middle-income countries, where approximately 77% of all suicides occur, yet research output from these regions remains comparatively limited.[3] Within the South Asian context, the situation is particularly concerning, as this region contributes nearly a quarter of the world's suicides despite comprising a smaller proportion of the global population.[4] A comprehensive review of suicide methods in South Asia over two decades (2001-2020) revealed that hanging and poisoning are the two most prevalent methods employed across the region, with hanging being the predominant method in Bangladesh, India, and Pakistan.[5] Importantly, this review identified a declining trend in suicide by poisoning, attributed to pesticide regulations, alongside a concurrent increase

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in hanging as a method of choice in several South Asian countries, including Bangladesh.[5] Bangladesh, a densely populated nation in South Asia, faces significant challenges in suicide surveillance and prevention. The country's suicide data quality has been identified as problematic, with probable under-reporting and limitations in official statistics.[6] Despite these data limitations, available evidence indicates that suicide constitutes a major public health problem in Bangladesh. A study examining asphyxial deaths at Dhaka Medical College from 2018 to 2019 found that among 224 asphyxial deaths, hanging accounted for 54.01% of cases, with the majority being suicidal in nature.[7] The same study identified unemployment (22.13%), examination failure (20.61%), and domestic violence (12.97%) as the principal provoking factors.[7] Recent research has further elucidated the epidemiological patterns of suicidal behavior in Bangladesh. A cross-sectional study conducted among patients presenting with self-harm at tertiary care hospitals in Dhaka revealed that hanging was the commonest method employed, accounting for 31% of cases, followed by cutting and piercing instruments (22%).[8] This study also highlighted the significant role of psychiatric morbidity, with 71% of self-harm patients having at least one psychiatric disorder, and family conflict emerging as the commonest risk factor (30%).[8] The immediate nature of precipitating life events was notable, with 52% of patients experiencing life events within the 48 hours preceding the self-harm act.[8] Gender-specific patterns in Bangladeshi suicide have also been documented. A newspaper-based analysis investigating gender disparities found that certain methods, including hanging, demonstrated elevated odds among women compared to self-harm methods, while factors such as family issues and blackmail showed significantly higher odds as precipitating factors in female suicides.[9] The study also identified higher suicide odds among individuals under 30 years of age and those who were employed.[9] Student suicide has emerged as a particularly concerning trend in the post-pandemic period. A retrospective analysis of online news portals examining student suicides in Bangladesh during 2022-2023 identified 984 cases, with females accounting for 61% of victims and the majority (72.5%) aged 13-19 years[10] Hanging was again the predominant method (79.7%), with emotional distress (28%), romantic relationship issues (19.5%), and academic pressure (8.4%) identified as major causes.[10] The Dhaka division reported the highest rate of student suicides, underscoring the relevance of studying suicidal hanging in tertiary care hospitals in the capital city.[10] Research has also explored suicide in specific vulnerable populations. A content analysis of prison and custodial suicide in Bangladesh from 2014-2024 identified 20 cases, with hanging accounting for 90% of all suicide deaths in custody, and victims predominantly aged between 20 and 35 years.[11] This study highlighted fears of punishment, frustration, and mental health problems as potential contributory factors.[11] The epidemiological transition in suicide methods observed across South Asia has important implications for prevention.[5] While pesticide regulation has contributed to declining poisoning suicides, hanging remains difficult to restrict through legislative means, necessitating a focus on identifying at-risk populations and addressing underlying risk factors.[5] Psychological autopsy studies from Bangladesh have identified multiple risk factors for suicide, including psychiatric disorders, adverse life events, and socioeconomic stressors.[12] The role of family dynamics in suicide prevention has also been emphasized, with family conflict identified as both a risk factor and a potential locus for intervention.[13]

Despite growing research interest in Bangladeshi suicide, there remains a paucity of prospective forensic studies examining suicidal hanging specifically in tertiary care hospital settings. Such studies are essential for generating reliable epidemiological data that can inform evidence-based prevention strategies. The present study was therefore undertaken to analyze the forensic and epidemiological characteristics of suicidal hanging cases autopsied at Sir Salimullah Medical College, Mitford Hospital, Dhaka, a major tertiary care facility serving a diverse population in the Bangladeshi capital.

Methodology

This prospective cohort study was conducted at the Department of Forensic Medicine, Sir Salimullah Medical College and Mitford Hospital, Dhaka, Bangladesh, from January 2025 to December 2025. The study population comprised all cases of hanging brought to the Mitford Hospital Morgue for medicolegal autopsy during the study period.

Inclusion criteria: All cases of hanging that were confirmed as suicidal in nature through police inquest reports, autopsy findings, and medico-legal investigation were included in the study. Cases where the manner of death was unequivocally determined to be suicidal based on a comprehensive forensic evaluation were eligible for inclusion.

Exclusion criteria: Cases of hanging where the manner of death was determined to be accidental or homicidal were excluded from the study. Additionally, cases with incomplete or missing data regarding demographic variables or circumstances of death were excluded to ensure data integrity.

Study procedure: Data were collected using a pre-designed, semi-structured data collection form developed specifically for this study. Information was extracted from multiple sources, including post-mortem examination reports, police inquest reports, and structured interviews with family members of the deceased conducted during the autopsy process. Collected data encompassed demographic characteristics (age, sex, marital status, occupation, socioeconomic status), hanging-related parameters (type of ligature, point of suspension, suspension type), and predisposing circumstances.

Data analysis: All collected data were coded, entered, and analyzed using SPSS version 23.0 (IBM Corporation, Armonk, NY, USA). Descriptive statistics, including frequencies, percentages, means, and standard deviations, were calculated for all variables. Results were presented in tabular format to illustrate the distribution of various parameters among suicidal hanging cases.

Results

A total of 61 suicidal hanging cases were autopsied at the Mitford Hospital Morgue during the one-year study period. The majority of victims were aged between 21 and 30 years (41.0%), followed by the 31-40 years age group (26.2%). Males predominated (64.0%) compared to females (36.0%), yielding a male-to-female ratio of 1.8:1. The mean age of victims was 32.4 ± 11.7 years, with male victims (34.1 ± 12.4 years) being slightly older than female victims (29.3 ± 9.8 years), though this difference was not statistically significant ($p = 0.124$) (Table-I). Married individuals constituted the largest proportion (62.3%) of victims, followed by unmarried (31.1%) and divorced/widowed (6.6%) (Fig. I). Socioeconomic analysis revealed that most victims belonged to lower (59.0%) and middle (32.8%) socioeconomic classes, with only 8.2% from upper socioeconomic backgrounds (Fig. II). Occupational distribution showed that day laborers (23.0%), housewives

(21.3%), and unemployed individuals (18.0%) were most commonly affected, while service holders (13.1%), students (11.5%), and businessmen (9.8%) constituted smaller proportions (Fig. III). Regarding hanging characteristics, soft ligatures such as cloth, rope, or saree were used in 75.4% of cases, while hard ligatures, including wire and plastic ropes, were employed in 24.6% of cases. The point of suspension was predominantly high and fixed (91.8%), with only 8.2% of cases involving low or non-fixed suspension points. Complete suspension (victim's body completely off the ground) was observed in 73.8% of cases, while incomplete suspension accounted for 26.2%. Ligature marks were typically situated above the thyroid cartilage (86.9%) and were oblique in direction (91.8%), consistent with typical hanging (Table II). Analysis of predisposing circumstances revealed financial problems (29.5%) as the most common triggering factor, followed by family disputes (26.2%), chronic illness (16.4%), and mental illness (13.1%). Romantic relationship issues accounted for 8.2% of cases, while examination failure (4.9%) and other causes (1.6%) constituted smaller proportions. Suicide notes were left in only 14.8% of cases, with the vast majority (85.2%) not leaving any written communication (Table III. Seasonal variation in suicidal hanging was observed, with the highest frequency during summer (March-June: 37.7%), followed by winter (November-February: 32.8%) and monsoon (July-October: 29.5%). The difference in seasonal distribution was not statistically significant ($p = 0.643$). Temporal analysis indicated that most hanging incidents occurred during evening hours (6 PM-12 AM: 41.0%) and afternoon (12 PM-6 PM: 31.1%), with fewer cases during morning (6 AM-12 PM: 18.0%) and night (12 AM-6 AM: 9.8%). This temporal distribution approached statistical significance ($p = 0.052$) (Table IV).

Table I: Age and sex distribution of suicidal hanging cases (N=61)

Age Group (Years)	Male (n, %)	Female (n, %)	Total (n, %)
≤20	2 (3.3)	3 (4.9)	5 (8.2)
21-30	14 (23.0)	11 (18.0)	25 (41.0)
31-40	10 (16.4)	6 (9.8)	16 (26.2)
41-50	8 (13.1)	2 (3.3)	10 (16.4)
>50	5 (8.2)	0 (0.0)	5 (8.2)
Total	39 (64.0)	22 (36.0)	61 (100)

Mean age: Male 34.1 ± 12.4 years, Female 29.3 ± 9.8 years, Total 32.4 ± 11.7 years, independent t-test: $t = 1.558$, $p = 0.124$

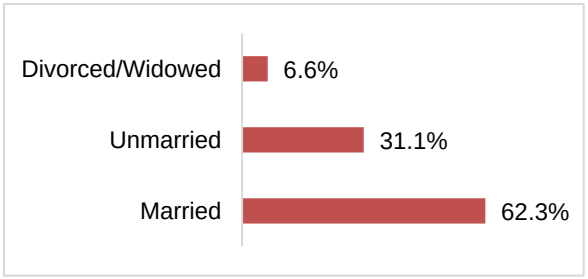

Figure I: Marital status and socioeconomic distribution (N=61)

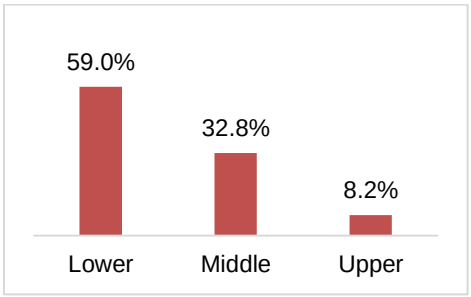

Figure II: Socioeconomic distribution (N=61)

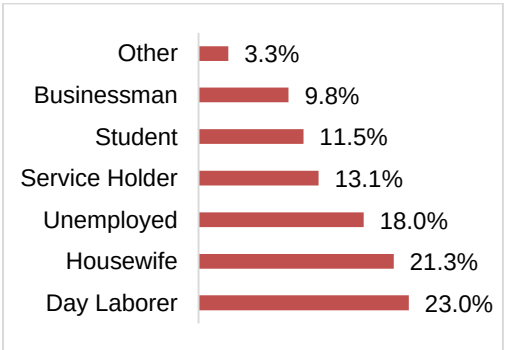

Figure III: Occupational distribution of victims (N=61)

Table II: Characteristics of hanging (N=61)

Parameter	Category	n	%
Type of Ligature	Soft (cloth, rope, saree)	46	75.4
	Hard (wire, plastic rope)	15	24.6
Point of Suspension	High/Fixed	56	91.8
	Low/Non-fixed	5	8.2
Type of Suspension	Complete	45	73.8
	Incomplete	16	26.2
Position of Ligature Mark	Above thyroid	53	86.9
	At/Below thyroid	8	13.1
Direction of Ligature Mark	Oblique	56	91.8
	Transverse	5	8.2

Table III: Predisposing circumstances and suicide note (N=61)

Parameter	Category	n	%
Predisposing Circumstances	Financial problems	18	29.5
	Family disputes	16	26.2
	Chronic illness	10	16.4
	Mental illness	8	13.1
	Romantic relationship issues	5	8.2
	Examination failure	3	4.9
	Other	1	1.6
Suicide Note	Present	9	14.8
	Absent	52	85.2

Table IV: Seasonal and temporal distribution of hanging incidents (N=61)

Parameter	Category	n	%
Season	Summer (March-June)	23	37.7
	Monsoon (July-October)	18	29.5
	Winter (November-February)	20	32.8
Time of Day	Morning (6 AM-12 PM)	11	18
	Afternoon (12 PM-6 PM)	19	31.1
	Evening (6 PM-12 AM)	25	41
	Night (12 AM-6 AM)	6	9.8

Seasonal distribution: Chi-square test, $\chi^2 = 0.884$, $p = 0.643$, Temporal distribution: Chi-square test, $\chi^2 = 7.721$, $p = 0.052$

Discussion

The present study provides a comprehensive forensic analysis of suicidal hanging cases autopsied at a tertiary care hospital in Dhaka, Bangladesh, revealing important epidemiological patterns that have significant implications for suicide prevention strategies in the country. The predominance of young adults aged 21-30 years (41.0%) in our study aligns with global and regional literature, indicating that suicide disproportionately affects younger populations. This finding is consistent with previous Bangladeshi studies reporting peak suicide incidence among individuals under 30 years of age.[9,10] The mean age of victims (32.4 years) observed in our study is comparable to findings from a recent study at Dhaka Medical College, where asphyxial deaths predominantly occurred in the 21–30-year age group.[7] The vulnerability of young adults may be attributed to the unique stressors faced during this developmental period, including financial establishment, marital adjustment, and career pressures.[14] The male predominance (64.0%) observed in our study, with a male-to-female ratio of 1.8:1, is consistent with the global pattern of higher suicide rates among males.[1] However, this finding contrasts with some South Asian studies reporting higher female suicide rates, highlighting the complex gender dynamics in regional suicide epidemiology.[5] The absence of a statistically significant age difference between male and female victims ($p = 0.124$) suggests that both genders face suicide risk during similar developmental periods, though the underlying risk factors may differ. Studies have documented elevated odds of hanging among Bangladeshi women compared to other methods, with family issues serving as prominent precipitating factors.[9] Married individuals constituted the majority (62.3%) of victims in our study, a finding that warrants

careful interpretation. While marriage is generally considered protective against suicide, the high proportion of married victims may reflect the demographic structure of the Bangladeshi population, where marriage occurs early and is nearly universal.[12] Alternatively, marital conflict may serve as a significant stressor, consistent with research identifying family disputes as a major precipitating factor for suicide in Bangladesh.[8,13] A psychological autopsy study from Bangladesh identified marital and family problems as significant risk factors, emphasizing the complex interplay between family dynamics and suicide risk.[12] The overrepresentation of individuals from lower socioeconomic backgrounds (59.0%) and the predominance of day laborers (23.0%), housewives (21.3%), and unemployed individuals (18.0%) among victims highlight the strong association between socioeconomic disadvantage and suicide risk. Financial problems emerged as the leading predisposing circumstance (29.5%) in our study, consistent with previous Bangladeshi research identifying unemployment and economic hardship as major provoking factors.[7] The relationship between poverty and suicide is complex, involving multiple mechanisms including chronic stress, limited access to mental healthcare, and reduced social support.[15] These findings underscore the need for economic interventions as components of comprehensive suicide prevention strategies. The predominance of soft ligatures (75.4%), high fixed points of suspension (91.8%), and complete suspension (73.8%) in our study reflects the typical forensic characteristics of suicidal hanging. The majority of ligature marks were situated above the thyroid cartilage (86.9%) and were oblique in direction (91.8%), consistent with classical descriptions of hanging in forensic medicine literature.[16] These findings align with previous Bangladeshi studies documenting similar hanging characteristics.[7] The absence of suicide notes in 85.2% of cases is consistent with international literature suggesting that only a minority of suicide victims leave notes, and highlights the importance of psychological autopsy methods for understanding precipitating factors.[17] Family disputes emerged as the second most common predisposing circumstance (26.2%) in our study, reinforcing the critical role of family dynamics in Bangladeshi suicide. Research has demonstrated that family conflict serves as both a risk factor and a potential locus for intervention, with studies emphasizing the family's role in suicide prevention in the Bangladeshi cultural context.[13] The collectivistic nature of Bangladeshi society means that family stressors may have particularly profound psychological impacts, necessitating family-based intervention approaches.[18] Chronic illness (16.4%) and mental illness (13.1%) were identified as significant predisposing factors in our study, consistent with global literature documenting the strong association between physical and mental health conditions and suicide risk.[2] A cross-sectional study among self-harm patients in Dhaka found that 71% had at least one psychiatric disorder, highlighting the substantial burden of untreated mental illness in this population.[8] The under-recognition and under-treatment of mental health conditions in Bangladesh, coupled with limited psychiatric services and pervasive stigma, likely contribute to the progression from mental illness to suicidal behavior.[19] Romantic relationship issues (8.2%) and examination failure (4.9%) constituted smaller but noteworthy proportions of predisposing circumstances, particularly relevant to the younger victims in our study. Recent research on student suicide in Bangladesh identified emotional distress (28%), romantic relationship issues (19.5%), and academic pressure (8.4%) as major causes, with

hanging being the predominant method (79.7%).[10] The post-pandemic period has witnessed particular concern regarding student mental health and suicide, with studies documenting increased vulnerability among adolescents and young adults.[10,20] The observed seasonal variation, with the highest frequency during summer (37.7%), though not statistically significant (p = 0.643), is consistent with some international studies reporting seasonal patterns in suicide.[21] The temporal distribution, with most incidents occurring during evening hours (41.0%) and approaching statistical significance (p = 0.052), may reflect the availability of privacy during these hours or the cumulative effect of daily stressors. Similar temporal patterns have been documented in previous research from the region.[22] Comparing our findings with the broader South Asian context reveals both similarities and differences. A comprehensive review of suicide methods in South Asia (2001-2020) identified hanging as the predominant method in Bangladesh, India, and Pakistan, with a declining trend in poisoning attributed to pesticide regulations.[5] This epidemiological transition has important implications, as hanging is methodologically difficult to restrict through legislative means, necessitating a focus on identifying at-risk populations and addressing underlying risk factors.[5] The concentration of hanging as the method of choice in the region underscores the importance of understanding method-specific risk factors and developing targeted interventions.[23] The findings of our study have several important implications for suicide prevention in Bangladesh. First, the identification of young adults, particularly those facing financial difficulties and family conflicts, as high-risk groups suggests the need for targeted mental health and social support services. Second, the predominance of hanging as a method highlights the importance of means restriction through environmental modifications, such as reducing access to suspension points in high-risk settings, including prisons and psychiatric facilities.[11,24] Third, the association with socioeconomic factors emphasizes the need for multi-sectoral approaches addressing poverty, unemployment, and economic stress as components of comprehensive suicide prevention strategies.[15,25] Several limitations of this study should be acknowledged. The single-center design and relatively modest sample size limit the generalizability of findings to the broader Bangladeshi population. The purposive sampling technique may introduce selection bias, and reliance on family reports for predisposing circumstances may be subject to recall bias and social desirability bias. Additionally, the absence of a control group precludes the calculation of odds ratios for identified risk factors. Despite these limitations, the prospective design and comprehensive forensic data collection represent strengths of this study.

Limitations

This single-center study with a modest sample size limits generalizability. Purposive sampling may introduce selection bias, and reliance on family reports for predisposing circumstances is subject to recall bias. The absence of a control group precludes calculation of odds ratios for identified risk factors.

Conclusion

This study demonstrates that suicidal hanging in Bangladesh predominantly affects young adult males from lower socioeconomic backgrounds, with financial problems and family disputes serving as major precipitating factors. The characteristic forensic findings align with classical hanging patterns. These findings underscore the urgent need for targeted

mental health services, economic support, and family-based interventions. Multi-sectoral prevention strategies addressing socioeconomic stressors are essential to reduce suicide mortality in this vulnerable population.

Recommendation

Establish community-based mental health services targeting young adults facing financial hardship and family conflict. Implement suicide surveillance systems, restrict access to suspension points in high-risk settings, and integrate socioeconomic support programs with mental health interventions for comprehensive suicide prevention.

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