

Exhibit 2

**IN THE UNITED STATES DISTRICT COURT FOR THE
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION**

Keira M., minor, by next friend STACIE ODENEAL; Darnell H., minor, by next friend SHERRY TAYLOR; Jasmine G., minor, by next friend STACIE ODENEAL; Amara G. and Zane G., minors, by next friend DARLENE VASTANO; Aaron C., Arielle H., Ava C., Andrew C., and Adrian H., minors, by next friend TRINA ROGERS; Zander M., minor, by next friend MARJORIE BRISTOL; Dewayne W., minor, by next friend EMILY JENKINS; Max W., minor, by next friend, SHERRY TAYLOR; Thomas H., minor, by next friend TIA BAILIFF; Jonah W., Sarah W., Adam D., Alice W., and Gavin W., minors, by next friend TIA BAILIFF; and on behalf of all others similarly situated,
Plaintiffs,

v.

MARGIE QUIN,
Commissioner, Tennessee Department of Children's Services; CARLA AARON, Deputy Commissioner, Child Safety, Tennessee Department of Children's Services; and KAREN JOINTER BRYANT, Deputy Commissioner, Child Programs, Tennessee Department of Children's Services,

Defendants.

Case No. 3:25-cv-00566

District Judge Aleta A. Trauger

AFFIDAVIT OF JENNIFER CAROTHERS

I, Jennifer Carothers, declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the following is true and correct:

1. I am over the age of eighteen and competent to testify.
2. I have personal knowledge of the matters set forth herein.
3. I left my job at the Tennessee Department of Children's Services ("DCS") in February 2026., because I can no longer agree with or be complicit in what is occurring within the department. I would have left sooner but needed to secure other employment before I could leave.
4. I have worked in human services since graduating from West Virginia Wesleyan College in 2009. My professional experience includes work in Pennsylvania child protective services, housing services, and since 2019, with Tennessee DCS.
5. I was employed with Tennessee DCS from 2019 to 2020. I left for approximately one and a half years and returned in April 2022. I have been employed continuously since that time until submitting my resignation.
6. I served as a Case Manager III out of the Bradley County office, covering nine counties, including Bradley County and McMinn County.
7. Throughout my time as a Case Manager III, I personally stayed in the DCS office more than 50 times overnight in Bradley and McMinn County offices with children who had nowhere else to go. These were children who were not permitted to remain at Isaiah House placements because of behavioral needs or because they had already stayed too long there. The offices became de facto living spaces.

8. In the Bradley County DCS offices, children did not have access to bathing facilities. This meant that children, some of whom were already traumatized, medically fragile, or struggling with behavioral health conditions, were unable to maintain basic hygiene.
9. Beginning in the winter of 2024/2025, I personally reached out to a contact at a local church to arrange for the children in the Bradley office to be able to come shower at their facility. Prior to this there were periods where the local Isaiah home would let children from the Bradley office shower there, but they would often and without warning discontinue that access, so there was no set place for children to shower. I reported the lack of consistent access to showers to the foster care supervisor for the region and was advised that the best course of action was to go ahead and reach out to the local church.
10. Throughout 2023-2025 I saw children in the Bradley and McMinn offices who were without basic hygiene necessities and toiletries. When they entered care, they were given a small bag of toiletries but by the time they were staying in an office they often no longer had toothbrushes, deodorant or soap.
11. Throughout 2023-2025 in the Bradley and McMinn offices food options were limited and often consisted of microwaveable items such as ramen or snacks.
12. Throughout 2023-2025, children in the Bradley office were sleeping in the visitation room which did not have any windows to the outside.
13. For the first few years of my employment children in both the Bradley and McMinn offices were sleeping on 4-inch-thick camping mattresses. In 2024, the offices got queen-sized air mattresses.
14. Throughout 2023-2025 the room where children slept in the Bradley office often had mice and office in general had cockroaches.

15. There was no laundry in the building. One worker took it upon herself to take the sheets and towels to the laundromat when there was turnover of children in the office. In Bradley children's clothes were only washed infrequently when the Isaiah homes allowed them to come over for dinner, then the workers were permitted to do laundry there.
16. There was nowhere for children to play. In the Bradley office there was one tv with a binder of DVDs that a worker brought from home and a few books and board games. In the McMinn office there was a tv with a PlayStation. But there was nowhere for the children to play outside. I personally arranged for transport of the children to a local church to use their rec center on occasion. But this was against the rules as we are not supposed to solicit donations, and many of the workers did not know this was an option so this was an inconsistent practice.
17. I personally observed a child as young as eight sleeping on an air-mattress in the Bradley office during the winter of 2024–2025.
18. Children with medical needs staying in offices, transitional homes and Isaiah homes were not properly supported. In 2024, I arrived for a sitting shift at the McMinn Isiah home where the caseworkers on the previous sitting shift had given a pre-diabetic child inappropriate food for his medical needs. Staff were not trained to monitor diabetes..
19. There is no training on caring for children with disabilities, including autism, resulting in workers staying in offices, transitional homes and Isaiah homes possessing vastly different levels of knowledge and competency. When workers are inexperienced or lack disability-informed training, children face heightened risks of misunderstanding, neglect, and harm.
20. Throughout my time there, children were inconsistently given their medications and medications were not consistently logged as required. Children sometimes kept medications in their bedrooms and dispensed them themselves.

21. Until recently, children were not consistently receiving mental health services. As of Fall 2025, a mental health assessor has been assigned to each region to conduct assessments at transitional homes.

22. I personally observed a ten-year-old girl with learning disabilities who was moved between the Bradley and McMinn offices for approximately two to three months in Winter 2024/ Spring 2025. She struggled with self-regulation, frequently lost belongings, and wet the bed. Staff were often unkind to her. One day she wet herself and because there was no shower, she was cleaned with baby wipes and sent to school in boys' clothing available at the office as she had no more clean clothes of her own. There were multiple instances where she had no clean clothes and staff had no access to laundry to wash her soiled clothes. On another occasion this little girl told me during my afternoon sitting shift that she had "swallowed money" that morning. A caseworker had not done anything about this all day and so I directed a foster care worker to take her to urgent care. I sent an email to the supervisor of foster care and her Guardian ad Litem about this child's situation. I was encouraged to submit a safety report to the state; to my knowledge nothing came of this action. I was instructed by the supervisor of foster care to make it *look* like we were taking better care of this child, and to wake her up every other hour to use the bathroom in order to prevent bed wetting.

23. On another occasion during the winter, on a day when school had been cancelled due to extreme cold weather, she did not have a winter coat because it had been left behind at a prior placement, staff did not go retrieve it, or get her a new one, but instead let her outside without a coat on.

24. I sat with a ten-year-old child in November 2024 who had remained in the office environment for over four months. It was reported to staff that he repeatedly expressed suicidal

ideation and wrote on the windows that he wanted to die. He directly asked me, “Why do I have to stay here? I want windows. Even prisoners have windows.” There was no outdoor time, no consistent recreation, and no shower on site .When I reported this to supervisors, I was told to file a safety report with the state. I would get a call saying they received the report but then no actions were taken.

25. In March 2025, DCS policy changed, requiring staff to complete six-hour “sitting” shifts instead of the previously mandated four-hour shifts, on top of their full-time casework duties. The number of sitting shifts required per month varied. As of February 2026, staff in Bradley and McMinn are required to complete five sitting shifts a month. However, there were times during my employment, specifically winter of 2024, where staff were required to do two to three shifts a week. Staff are expected to complete these shifts and their full-time casework duties without resorting to overtime, as overtime is discouraged or outright prohibited. During a sitting shift staff is in charge of all of the care needs for the children, this includes preparing food (most often in microwaves), getting children prepared for school, sometimes transporting them to school, managing interpersonal dynamics between kids, and overall supervision. . We often receive emails from management stating there is no more overtime, and that staff must fit their sitting shifts into their allotted 37.5 workweek. This is an impossible task. To add an additional 30 to 72 hours of work to our already full plates of managing our individual cases, often between 30 and 50 families, traveling between each of these visits, attending meetings with families, and staying on top of paperwork and case plans, felt impossible. Additionally travel time—sometimes up to 1.5 hours to Lenore City for a sitting shift—is not counted toward sitting time. Workers are expected to absorb these additional hours without exceeding approved work time.

26. In October 2025, Commissioner Quinn sent an email that said that in order to reduce caseworker sitting shifts, only one DCS worker was required to sit at a time. Sometimes there would also be a security guard or an Isaiah house volunteer. Specifically, I remember one time in 2024, where I was alone for an entire sitting shift at the Bradley Isiah House. Additionally, the caseworker sitting could be any gender regardless of the gender of the children's gender. However, in my experience this did not reduce my number of shifts as so many caseworkers were quitting that we still had to pick up their shifts.
27. In Summer 2025, I sat at Emanuel House, a facility run by a private church. It has no oven, only microwaves. The environment is chaotic, with numerous teenagers and minimal supervision. Staff often sat passively while children struggled with interpersonal issues or challenges regulating their emotions.
28. At some point in late Summer 2025, children were no longer permitted to remain overnight in the Bradley office because the Fire Marshal had warned the Commissioner, he would press charges if children were again housed in offices. I was not formally informed of this policy change but was instead informed by a CASA worker.
29. The Hamilton office also received a report from the Fire Marshal that children were not permitted to sleep in the offices, but it has not been enforced.
30. As such, children are now housed in the Lenore City office instead and DCS started placing more children at facilities like, St. Nicks, a facility with gates and locks.
31. I receive nearly daily emails reporting staff resignations.
32. From the fall of 2024 through March of 2025, when it was becoming apparent that leadership was firing people who spoke up, I repeatedly communicated these concerns to

leadership. I was directed by Jaime Greene-Lamb to file safety reports detailing unsafe conditions. I filed multiple reports. Investigators from Nashville would call, but little changed.

33. The stress on workers is extreme. One colleague has expressed suicidal ideation. Staff frequently appear physically exhausted, with bloodshot eyes and visible signs of burnout. This is not routine crisis work. It is sustained trauma exposure without systemic correction.

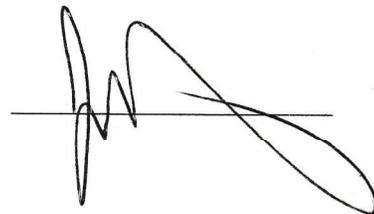
34. I have worked in crisis settings for my entire career. This situation exceeds crisis. Children are warehoused in offices or unstable facilities without adequate hygiene, medical oversight, mental health services, education stability, or recreation.

35. I am resigning because I cannot continue to participate in a system where the harm occurring in my presence outweighs the good, I am attempting to do. I do not want to look back decades from now and see this period described as a time when we knowingly allowed children to suffer.

36. It is not acceptable to walk past children or colleagues expressing suicidal ideation and treat it as an ordinary workday.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 1st day of March, in 2026.

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke at the end, positioned to the right of the date.