BOARD OF CORRECTION
CITY OF NEW YORK

Special Investigation Report: New York City Department of Correction's North Infirmary Command April 6, 2023 Fire[1]

December 22, 2023

[1] Report co-authored by Director of Special Investigation Rahzeem Gray, Special Investigations Coordinator Imahnni Jeffries and Deputy General Counsel Melissa Cintrón Hernández. Assistant Executive Director of Monitoring and Research Katrina Blackman and Director of Violence Prevention Bart Baily assisted with the investigation. Many thanks to Executive Director Jasmine Georges-Yilla and Board Members for their feedback.

I. Introduction

The New York City Board of Correction ("Board" or "BOC") is an independent oversight agency charged with monitoring conditions of confinement in New York City Department of Correction ("Department" or "DOC") jail facilities. Among the five Board functions mandated by New York City Charter Section 626,[2] the Board is tasked with investigating any matter within the jurisdiction of the Department.[3]

Pursuant to that authority, the Board's Special Investigation Unit investigated a fire that occurred on April 6, 2023 at the North Infirmary Command ("NIC"),[4] on Rikers Island. This report presents a summary of the events, the Board's findings, and recommendations to DOC to avoid similar incidents in the future. Board investigators interviewed DOC staff and people in custody, reviewed surveillance video footage (also known as Genetec), DOC records, including logbooks, and New York City Fire Department ("FDNY") reports.

Major concerns identified by the Board are:

- NIC staff shut off the sprinkler system water supply to NIC housing area 2A sometime between April 1, 2022 and April 6, 2023. DOC was unable to locate weekly and monthly fire safety reports for that period, therefore DOC records do not reflect when DOC shut off the sprinkler system water supply to this particular area or how long the water had been shut off prior to April 6, 2023.
- NIC staff failed to conduct weekly and monthly fire safety audits between April 1, 2022 and April 6, 2023, as required by DOC Directive #1248 and State Commission of Correction ("SCOC") minimum standards.
- The NIC housing area "B" post officer stopped touring at the direction of a captain two hours before the fire was ignited.
- Individuals were not allowed out of their locked cells for over 25 minutes while fire and smoke conditions spread across the unit.

The Board provided DOC with an advance copy of this report and an opportunity to comment.

[2] The remaining functions are to establish and ensure compliance with minimum standards "for the care, custody, correction, treatment, supervision, and discipline of all persons held or confined under the jurisdiction of the Department of Correction," review grievances from people in custody and staff, evaluate DOC performance, and make recommendations on areas of key correctional planning.

[3] City Charter Section 626(h) sets forth that "the board, or by written designation, a member of the board or the executive director, may conduct hearings, or study or investigate any matter within the jurisdiction of the department, and the board may make recommendations and submit reports of its findings to the appropriate authorities."

[4] NIC houses people in custody with acute medical conditions requiring infirmary care or with a disability that requires Americans with Disabilities Act-compliant housing. NIC also houses some general population detainees.

II. Summary of Events

The second and third floors of the NIC "Main" building are restrictive housing units with total capacity for 84 occupants. DOC policy sets forth that people in these units receive the same amount of time outside of their cells than those in general population (14 hours per day). However, instead of congregating in a dayroom with others in custody, people housed in these units lock out into individual dayrooms directly attached to their cells. Pursuant to the Board's minimum standards on restrictive housing (effective July 9, 2021), DOC operates the structurally restrictive units at NIC as a form of restrictive housing.[5] Former DOC Commissioner Louis Molina has described NIC as "involuntary protective custody."[6] People in custody are assigned to NIC second and third floors without disciplinary hearings for as long as DOC chooses to keep them there.

On April 6, 2023, the "B" post[7] housing area logbook entry shows that, at 12:50 pm, a captain and an assistant deputy warden instructed correction officers to not tour the housing area until another officer assumed the "B" post because slots were unsecured and people in custody were flooding and "trashing" the area. Based on logbook entries, the last tour of the area took place at 10:30 am. The next change of shift for the "B" post officer would occur at 2:00 pm. DOC Directive #4517R, Inmate Count Procedures, requires "B" post officers to tour every 30 minutes in general population housing.

At approximately 1:15 pm on April 6, 2023, a 30-year-old person in custody named Marvens Thomas allegedly ignited a fire inside his cell in a structurally restrictive unit in NIC.[8] DOC records show that Mr. Thomas resided in various structurally restrictive units at NIC for a total of 584 consecutive days, from August 30, 2021 until April 6, 2023. During Mr. Thomas' placement in structurally restrictive units at NIC, he was involved in four fire-related incidents from November 12, 2021 through January 25, 2023.

DOC staff and individuals in the unit who were interviewed by BOC staff believe that Mr. Thomas started a fire on April 6, 2023 – his fifth such incident – because he was frustrated that DOC's Emergency Services Unit ("ESU")[9] confiscated his non-institutional footwear during a search the morning of April 6, 2023.

---

[5]Definitions of restrictive housing established by the Board's rules include: "The physical design of the unit cannot accommodate more than four (4) people in custody congregating in a dayroom." (Title 40 of the Rules of the City of New York § 6-03 (a) (2) (iii))

[6] New York City Council. (2022, September 28). *Committee on Criminal Justice hearing* [Video timestamp 1:09:09]. New York City Council website. https://legistar.council.nyc.gov/MeetingDetail.aspx?ID=999448&GUID=3E18E1D1-0670-4650-A65D-A19CCF521DC3&Options=info|&Search=

[7] "B" post officers or floor officers interact directly with people in custody and are posted inside the living area. The "B" post desk is usually placed near the "A" station, by the housing unit entry.

[8] Restrictive housing is a classification within the Department for the purpose of keeping a person in custody separated from, and under closer observation than, people in custody in general population (DOC Directive #6005 on Restrictive Housing Due Process, effective December 17, 1996). The directive defines involuntary assignment as one made against the person in custody's will.

[9] The Emergency Services Unit is charged with responding to emergency calls.

According to DOC's Interior Operations Report, Mr. Thomas used batteries, headphone wires, and a remote control to start the fire. Once the fire ignited, Mr. Thomas added tissues and clothing, which caused the fire to swell.

FDNY's incident report similarly notes that there were two separate and distinct fires. The first fire originated inside cell #9 – Mr. Thomas' cell – approximately six feet from its south wall and along its east wall, "in combustible material (tissues), from the heat of an improvised incendiary device." That first fire extended to the east wall and ceiling. The second fire also originated in the same cell, approximately three feet from its south wall and along its west wall, "in combustible material (blanket and clothing) from the heat of an open flame via human transport. The second fire extended to surrounding combustibles (clothing and papers). The second fire further extended and conjoined with [the first fire]." The conjoined fires extended to all four walls, the floor, the ceiling and to the cell's contents, as well as the west wall/cell #8 ceiling and the east wall/cell #10 ceiling. FDNY officials interviewed Mr. Thomas on April 7, 2023. Mr. Thomas stated that he started the fire with an incendiary device on the tabletop and then transferred the fire with toilet paper to bedsheets and clothing.

DOC staff intradepartmental memorandums and timeline of the events reflects that, at approximately 1:15 pm, the smoke from the fire activated the smoke detector situated in the unit common area, sending a notification to DOC's Fire Safety Unit ("FSU") Command. From 1:16 pm through 1:40 pm, duct detectors detected smoke conditions in cells #1 through #10.

NIC Main is supposed to be a "fireproof" structure. FSU's 2023 mission statement describes its mission as ensuring optimum fire safety at DOC facilities and assuming the full responsibility of maintaining DOC's $100 million investment in newly installed fire alarm systems in eight Rikers jails. FSU staff must monitor and respond to every fire alarm activation at all hours and oversee a $4 million annual service contract to test, inspect and maintain the fire alarm system in accordance with FDNY rules and codes. FSU consists of correction officers and civilians who work during all shifts, 24/7. FSU has been notably understaffed for over a year. DOC's organizational chart under the Deputy Commissioner of Security Operations shows that, on the date of the fire, the position of Fire Safety Manager was vacant, as well as four out of 15 FSU uniformed officers and three out of seven fire safety specialists. According to FSU staff, the position of Fire Safety Manager had been vacant since the person who previously held the role retired in late 2020 or early 2021. This position has still not been filled. As of December 2023, the unit is staffed with 10 correction officers and one captain.

Based on a report submitted by FSU staff, NIC control room staff called at 1:15 pm, reporting a fire on NIC's second floor. FSU Command staff attempted to relay the emergency to the two on-duty FSU officers through a DOC radio communication, but they were unable to make contact. At 1:20 pm, NIC control room staff called FSU Command again to request assistance and to notify FSU that FDNY had been contacted. FSU

Command informed NIC control room staff that the two on-duty FSU officers were not available because they responded to a fire alarm activation at the Robert N. Davoren Center ("RNDC") at 1:05 pm.

According to NIC's Interior Operation timeline, the "B" post officer assigned to the housing area attempted to extinguish the fire at 1:28 pm by utilizing a Class A fire extinguisher[10] but their efforts were not successful. A person in custody told Board investigators that the fire extinguisher the "B" post officer attempted to use did not work. DOC staff informed the Board that the fire extinguisher performed as designed, however, it was not sufficient to extinguish the fire. Body-worn camera footage viewed by Board investigators shows a correction officer attempting to put out the fire using a fire extinguisher at 1:28 pm, while a supervisor, off-camera, gave correction officers a direct order to not open the cells. Additionally, it showed a correction officer struggling to locate the key to access the fire hose on the second floor. After roughly one minute of searching for the key, a supervisor assisted the correction officer and found the key. Lastly, the video captures correction officers leaving the unit to retrieve fire extinguishers from nearby housing areas. The video ends at just before 1:30 pm.

Based on DOC staff reports, at approximately 1:30 pm, FSU Command staff informed the Fire Safety Director[11] that they were unable to contact the on-duty FSU officers and that FDNY were in route to NIC. A report submitted by FSU staff points out that there was minimal staffing at the time. The Fire Safety Director proceeded to NIC, accompanied by an FSU officer who had been about to go off-duty.

NIC's Interior Operations timeline reflects that at 1:30 pm, the NIC fire safety officer removed and unraveled the fire hose from the firebox, but it does not mention that they used it. The same timeline notes that DOC's probe team arrived at the scene at 1:31 pm, but given that smoke conditions increased significantly, they were unable to enter the area. At 1:34 pm, NIC staff opened the rear door for ventilation. FSU staff reporting shows that, once the FSU officer and Fire Safety Director arrived at the affected area at approximately 1:38 pm, they encountered heavy smoke and fire conditions. Probe teams and fire safety teams "were suiting up." Eight individuals still occupied their cells at the time and evacuations "needed to be conducted." The Fire Safety Director and FSU officer stretched the facility firehouse to begin fire suppression.

An intradepartmental memorandum completed by one of the two on-duty FSU officers who had been responding to a fire alarm in RNDC shows that the FSU officers received notification of the NIC fire at 1:40 pm, when they exited RNDC. They proceeded to NIC

[10] Class A fire extinguishers are meant for ordinary solid combustibles such as paper, wood, cloth, and some plastics.

[11] The Fire Safety Director is responsible for developing, implementing, and maintaining comprehensive fire safety programs and protocols to ensure the safety and wellbeing of personnel, people in custody, and facilities by minimizing fire risks, promoting fire prevention, and effectively responding to emergencies in accordance with established codes, regulations, and best practices.

immediately. FDNY's incident report and DOC's timeline of events show that FDNY Battalion 49, Engine 263, and Ladder 117 arrived outside of NIC at 1:40 pm. Once the on-duty FSU officers arrived at NIC, they escorted FDNY personnel to the site of the fire.

NIC's Fire Evacuation Plan Command Level Order 22/19, effective July 12, 2019 (in effect at the time of the fire but revised on September 13, 2023 through Command Level Order 25/23) establishes "the procedure for effecting the safe and orderly evacuation of staff, visitors, and [people in custody] in the event of a fire and/or smoke condition dictate that an evacuation is necessary." The Command Level Order sets forth the tour commander's obligation to assemble an emergency response team on standby during all evacuations. Among these duties, the tour commander must "[i]mmediately order all housing floor officers to direct [people in custody] to line-up in columns of two's (sic) facing the exit door… until such time as an order is given by a Supervisory officer to evacuate the areas." All people in custody are to be counted out and escorted under proper security via the fire stairwell. The Command Level Order further establishes that "[t]he Fire Response Team, upon evacuation, shall be directed to check all beds, showers, and dayrooms in their areas to ensure that the areas are unoccupied." Lastly, the tour commander shall use the main intake, unoccupied housing areas not affected (if practical), or the corridor leading to the visit vestibule as assembly areas for evacuation.

According to DOC's Interior Operation timeline, by 1:41 pm, correction officers began to evacuate the eight people in custody from their cells. Correction officers manually unlocked the cell doors, allowing people out of their cells and the housing area. Board staff's review of surveillance video footage shows correction officers removed the first individual from the area at 1:42 pm, 27 minutes after the fire alarm activated. Body-worn camera footage shows correction officers escorted people in custody out of the area one at a time between 1:42 pm and 1:43 pm. DOC's probe team[12] and FSU staff escorted the last person in custody out of the area at 1:46 pm. According to FSU staff reports, they conducted primary and secondary searches of all cell areas at 1:46 pm to ensure all occupants were out of the affected area once evacuations were completed.

By 1:47 pm, fire suppression attempts by FSU and NIC staff continued, and additional FSU and FDNY staff arrived on the scene.

At 1:48 pm, body-worn camera footage captured a person in custody struggling to breathe in a mini clinic area. Correction officers opened a window to allow air to flow in and poured water on the person's face before escorting him to the main clinic.

At 1:58 pm, FDNY stretched a hose line from their firefighting operations vehicle and took over fire suppression efforts. FSU and ESU staff conducted additional housing area

[12] Operations Order #01/15, Facility Probe Teams, effective March 11, 2015, states that the probe team is solely responsible for the immediate and coordinated response to all emergency alarms sounded within a facility.

searches at 1:59 pm and 2:08 pm. ESU staff also conducted searches and assessments of two upper NIC levels. FDNY completed overhaul and suppression operations at 2:12 pm. ESU and DOC's Security Operations Division established an incident command outside NIC and FSU completed its operations.

Correction officers secured four people in custody in a neighboring housing unit for at least 48 hours following the fire. However, this secondary unit is outfitted for separation status.[13] DOC's directive on separation status housing states that "[u]nder no circumstances shall the designated Separation Status housing area be opened or utilized for any purpose other than to house an individual who has failed to clear, or refused to clear, a body scan." The unit's toilets have mesh installed and are not functional. Additionally, the unit has no television and phone access is limited. CHS notes reflect that medical staff evaluated individuals in custody affected by the fire on April 6 and April 7.

FNDY's incident report states that "the byproducts of incomplete combustion" (soot or carbon monoxide) extended to 15 correctional staff and four people in custody. FSU staff reported that triage was held in the intake and visits areas, where all affected individuals in custody received medical attention, as well as correctional staff.[14] Correctional Health Services' ("CHS") medical staff received several complaints during triage, including difficulty breathing, chest pains and coughing of black material as a result of smoke exposure. Emergency Medical Services ("EMS") transported four people in custody to hospitals following triage, as well as nine correctional staff. Upon their return to Rikers Island shortly after the fire, CHS again evaluated the three individuals in custody who were sent to the hospital.

According to DOC's injury report, medical staff observed burns to Mr. Thomas' left hand, left leg, and left upper back. Once transported to Harlem Hospital, Mr. Thomas was admitted to the Intensive Care Unit due to severe burns. After multiple skin graph surgeries, Harlem Hospital discharged Mr. Thomas to Rikers Island on May 2, 2023.

Most of the damage from the fire was contained to cells #8, #9, and #10, although black soot covered surfaces throughout the unit. Logbook entries show four individuals were sent back to the fire-damaged unit on April 8, 2023 – two days after the fire. People in custody complained to Board investigators that the area was not ready to reopen in that there was black soot covering the walls and strong remnants of smoke throughout the unit. After Board investigators shared their observations and concerns with NIC

[13] Placement of an individual into a non-punitive pod who, based on security screening data and verifiable information, poses a credible threat to the safety, security and good working order of the facility. This status, and the designated housing area, applies exclusively to individuals who have failed to clear or refuse to clear a body scan. (DOC Directive #4597R-C on the Use of Body Scanners and Separation Status Housing, effective May 27, 2022).

[14] Triage is CHS staff's preliminary assessment of a patient to determine the urgency of their need for treatment and the nature of treatment required.

leadership, DOC transferred people out of the unit on April 17, 2023 and dispatched DOC maintenance staff to the unit to clean it and paint.

III. Policy Adherence Concerns

A Memorandum of Understanding between FDNY and DOC, first entered on April 18, 2011 and most recently renewed on October 1, 2023, sets forth the fire safety coordination agreement at DOC correctional facilities, as required by SCOC minimum standards.[15] On the topic of inspections, the Memorandum places the responsibility for coordinating FDNY inspections on DOC's FSU. FDNY will then notify DOC of any deficiencies encountered by FDNY personnel conducting inspections of DOC facilities by issuing violations in accordance with regular enforcement procedures or by issuing a Letter of Deficiency on FDNY letterhead. The Memorandum also requires FSU to conduct Annual Fire and Safety Inspections of DOC facilities, encompassing the DOC fire protection systems and equipment and other DOC operations in their facilities. Following the inspection, DOC has 30 days to correct all noted deficiencies or submit a corrective action plan.

DOC Directive #1248 on Facility Fire Safety Inspections and Reports, effective June 8, 1999, echoes SCOC minimum standard Section 7039.5[16] and establishes that "[t]he Commanding Officer of each facility shall appoint one or more staff members, including the dedicated fire safety officer, to conduct the weekly or monthly fire safety inspections of all areas in an effort to determine whether any fire hazards exist." The weekly and monthly inspections are to be reviewed and endorsed by the commanding officer. The directive sets forth that, "[w]hen it has been determined that a fire hazard and/or deficiency exists, the Commanding Officer shall promptly initiate the necessary actions to eliminate the noted fire hazard and/or deficiency." Lastly, the directive charges the Inspectional Services and Compliance Division with conducting unannounced audits at a minimum of one facility a week, with each facility being audited at least once a year to identify and correct safety deficiencies.

Communication from NIC's Acting Warden dated July 27, 2023 notes that the Deputy Warden of Security and assigned fire safety officer audited NIC's fire safety officer post and were unable to locate the weekly fire safety reports from April 1, 2022 through April

[15] SCOC minimum standard, 9 CRR-NY 7039.4: "The chief administrative officer of each facility shall request the appropriate authority having code enforcement jurisdiction to conduct an annual fire and safety inspection. A copy of the report based on such inspection together with a detailed statement of steps taken or to be taken to correct any deficiencies set forth in such report shall be maintained on file."

[16] 9 CRR-NY 7039.5: "(a) The chief administrative officer of each local correctional facility shall appoint one or more staff members to conduct regular inspections of all areas of the facility to determine whether a fire hazard exists and shall take the necessary action to remove such hazard.
(b) Such inspections shall be conducted at weekly intervals or more frequently in the discretion of the chief administrative officer, and the results of such inspections shall be entered in a facility log maintained for this purpose.
(c) Prior to assuming such duties, such appointed staff members(s) shall have successfully completed a fire protection seminar approved by the Office of Fire Prevention and Control."

30, 2023. Additionally, the senior stationary engineer was unable to produce the requested monthly fire safety reports from April 1, 2022 through April 30, 2023. The same communication states that DOC staff have implemented a plan of action to ensure that the facility remains in compliance with fire safety operations regulations and guidelines.

DOC staff informed Board investigators that fire extinguisher inspections happen each day when the assigned "B" post officer checks it and notes the result of the inspection in a logbook. Policy dictates that FSU officers must check it once a month, and an outside contractor must check it once a year. This precautionary measure is not in place for the sprinkler system. Further, unlike the fire alarm system, the sprinkler system did not automatically activate during the fire.

A letter from Hughes Associates, Inc. (fire protection engineers and code consultants) dated August 3, 2023 states that the photos of the fire indicate very heavy damage for a building protected by a complete sprinkler system within the cells and the areas immediately outside the cells. DOC staff informed the consultants that "the sprinklers protection for this area had been shut down due to a sprinkler being damaged by a [person in custody]. The length of time of the sprinkler impairment was not known." This letter also notes that DOC staff was unable to locate weekly and monthly fire safety reports from April 1, 2022 through April 30, 2023. According to the consultants, "[w]ithout these [reports], there is no way to track how long and when the sprinkler control valve for this area in NIC was closed."

NIC's Acting Warden informed Board investigators that, since the April 6th fire, DOC maintenance staff painted the unit, and wiped down cell doors, walls, windows, and bars, while DOC's Facility and Maintenance Repair Division ("FMRD") steamfitters replaced missing sprinkler heads and repaired broken sprinkler heads. Board investigators visited the affected area and confirmed the unit was thoroughly cleaned and painted. Board investigators also witnessed FMRD staff replacing the old, inoperable sprinkler heads in the affected unit. NIC's Acting Warden further reported that the sprinkler system at NIC is operable and prepared to discharge in the event a similar situation occurs. Board staff observed the water supply valve that sends water to NIC's sprinkler system and the pressure gauge, confirming its operability.

NIC's Acting Warden affirmed that correction officers no longer leave people in custody in cells that do not have a functional sprinkler system and that, if a sprinkler system is inoperable in an occupied cell, the person in custody is temporarily moved to a fully operable unoccupied cell until FMRD staff complete repairs. DOC asserts that this practice is done out of an abundance of caution, since there are sprinklers on the tier. DOC further informed Board staff that the Department may continue housing a person in a cell with a temporarily broken sprinkler while repairs are pending, so long as fire watch is conducted.

IV. Recommendations

1. Minimum standard Section 6-03(a)(2)(iii) defines "restrictive housing" as a location where DOC houses people in custody separately from those in general population and the "physical design of the unit cannot accommodate more than four (4) people in custody congregating in a dayroom." NIC's restrictive areas meet these criteria, therefore these units should be subject to minimum standards relating to the operation of restrictive housing including medical and mental health exclusions, strict limits on the length of placement (30 days maximum with certain exceptions), the assignment of case managers, the development of individualized behavior support plans, progression reviews and five hours of daily programming.
2. DOC must not house individuals in custody in cells with broken or missing sprinkler heads.
3. DOC must establish a sprinkler system auditing measure requiring the periodic inspection of the system—similar to the existing fire extinguisher inspection policy—and ensure the sprinklers are always functional in all areas of all facilities. [17]
4. DOC must discontinue the practice of shutting off an individual's water supply feeding the sprinkler system because they have flooded their cell and tier, and instead move the individual to a different operable cell. This practice must discontinue in all DOC facilities, not just NIC.
5. DOC must require staff to submit maintenance requests for inoperable sprinkler heads as soon as staff notes the sprinkler head is defective. Staff must accurately record those requests in the area logbooks. Housing unit staff must continuously follow up with the DOC maintenance unit until the defective sprinkler head is repaired.
6. DOC must ensure that areas affected by fires are thoroughly cleaned and do not pose a health risk to individuals in custody and staff before transferring people back into the unit.
7. When an individual is locked in a cell where a fire has begun, DOC staff must immediately open the cell door and escort the person out of the cell.
8. Housing area correction officers must prioritize the removal of all individuals held in cells during a fire emergency and evacuate them from the area as soon as the fire alarm is activated.
9. Ensure the Fire Safety Officer assigned to the jail conduct weekly fire safety audits. Additionally, ensure assigned engineer conduct monthly audits, per Directive #1258, DOC's Memorandum of Understanding with the FDNY, and SCOC Standards.
10. Pursuant to DOC's Separation Status directive, staff must not place individuals in separation status housing unless they have failed to clear, or refused to clear, a body scan.

[17] DOC informed Board staff that the agency is piloting a mobile-based application that electronically captures required weekly fire safety inspections. According to DOC, the system is currently being piloted in the George R. Vierno Center and West Facility.

11. DOC must effectively deploy and expand its Fire Safety Unit, including assigning more than two on-duty FSU officers on each shift so that they may respond to multiple emergencies simultaneously.[18]
12. DOC staff only turned on their body-worn camera on five occasions for a few minutes during the emergency response. DOC Operations Order #15/20 on the use of body-worn cameras (effective November 2, 2020) must be modified to specify that staff are obligated to activate their cameras to record emergency situations, such as fire alarms and responses.[19]

[18] DOC informed Board staff that the agency has expanded the FSU staff cohort to ensure FSU officers can respond to multiple emergencies simultaneously. Board investigators will continue monitoring staffing in FSU to assess this assertion.

[19] DOC has stated that fire safety is a departmental priority. DOC informed Board staff that timely repairs are being conducted, immediate tickets are being issued to people in custody who tamper with sprinklers, and that the new inspection system allows DOC to conduct quicker inspections. DOC additionally stated that the agency has qualified individuals in the FSU, made up of certified engineers with Certificates of Fitness, as well as steamfitters.